

**KNOWLEDGE AND ATTITUDE OF STUDENTS TOWARDS HIV/AIDS  
VOLUNTARY COUNSELING TEST (VCT); A CASE STUDY OF  
FEDERAL UNIVERSITY OYE EKITI, UNDERGRADUATE STUDENTS.**

**BY**

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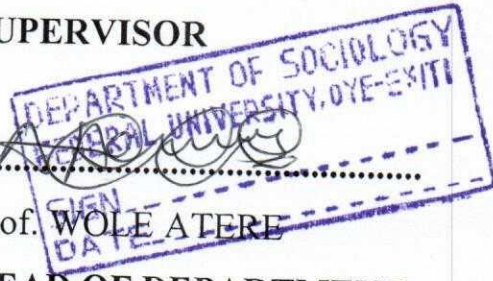
## CERTIFICATION

This is to certify that OSALONI OLUWASEGUN FUNMILAYO of the department of sociology, Faculty of Humanities and Social Sciences, Federal University Oye-Ekiti, Ekiti State, carried out this research project under my supervision.



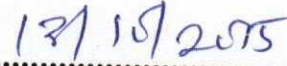
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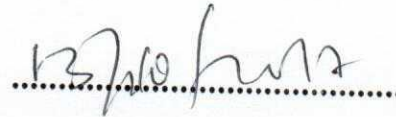


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# DEDICATION

This project is dedicated to God Almighty for His mercies, kindness and faithfulness in seeing me through this programme.

I also dedicate this work to my parents who struggled tirelessly to fund my education with the grace of God upon their lives.

To those who struggle to educate themselves in spite of the socio-economic upheaval in Nigeria and to the wretched on earth, psalm 126:5-6 is your portion

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## ABSTRACT

This study assessed the knowledge and attitude of students at Federal University of Oye Ekiti towards HIV/AIDS Voluntary Counselling and Test (VCT) in the campus: determine the knowledge of voluntary pre – test counselling for HIV among undergraduates students at FUOYE, examine respondents status of HIV/AIDS, determine their level of participation in pre – test counselling, and ascertain their attitude towards VCT. A presented questionnaire was administered on a cross-section of 200 students in the various departments in the faculties in Federal University of Oye Ekiti. Information about knowledge of HIV/AIDS and attitudes towards VCT was drawn out among the respondents. Findings reveal that 28.0% of the respondents got to know about HIV/AIDS through friends, most of the respondents 95.0% said yes, they know ways through which people can contact HIV/AIDS while only 21.0% said it is mainly through mother to child transmission, 53.0% of the respondents said yes, they have ever gone for HIV/AIDS test, 45.0% of the respondents said no, 64.0% said no, they have never gone for voluntary and counselling test (VCT), The study concluded that that the students of Federal University Oye-Ekiti demonstrated a positive attitude towards HIV/AIDS voluntary counselling and test (VCT) because it enables them to know their HIV/AIDS status, it also curtail to the barest minimum the spread of venereal diseases which is rampant among students in tertiary institutions but the major challenge is that they did not know places where the test can be conducted.

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## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background to the Study.

Human immune virus/acquire immune deficiency syndrome [HIV/AIDS] is a worldwide problem and despite all effort been made to control its spread, it is becoming the main cause of death among the highly productive and reproductive members of the society. Globally, there were 36.1 million HIV infected adult alive as at December 2000, and by the end of 2005, worldwide HIV/AIDS infection were estimated to be about 40.3 million of which the highest rate of infection [25.8million] were found in sub-Saharan Africa. At the end of 2010, an estimated 34 million people were living with HIV worldwide. In sub-Saharan Africa, an estimated 1.9 million became infected in 2010. This was 16% fewer than the estimated 2.2 million people newly infected with HIV in 2001 [UNAIDS technical update, 2002; Lamptey, Johnson and Mayra, 2006; UNAIDS global HIV/AIDS response, 2011]

HIV/AIDS was first identified in Ghana in March, 1986 with a national rate of infection of 1.5%. in 2004, the infection rate has risen to 2.7%. Even though the infection rate reduced to 2.1% in 2011, it is estimated that over 225,000 people are living with HIV in Ghana [AIDS Commission, 2012]. These figures however may not reflect the actual situation in the country but account only for cases reported at health facilities. It has also been realise so far that large number of people [especially in Africa] are losing their lives to this virus yet we have only seen a small fraction of the illness and death, this pandemic can cause [AIDS in Ethiopia, 2000].

HIV/AIDS is not just a health issue but it is having social developmental and economic impact on countries monetary cost of caring for HIV/AIDS patients for instance is considerably high. These patients are estimated to draw the scarce resources allocated for the health sector thus money budgeted for purchase of medical stock, equipment and facilities are

channelled into caring for the health needs of these AIDS patients [I.e. to such side the cost of anti-retroviral drugs]. Socially, the pandemic is disrupting family ties, increasing the number of every orphan and resulting in an increase in the number of street children [AIDS in Ethiopia 2000; UNAIDS Technical update, 2000]. Poverty is also expected to increase and development reduces because of the disease effect on households, government businesses and national economics [MITCHEL, 2002]. The impact therefore having huge effect on development in Ghana and Africa as a whole [Stover, 1994]. If this impact continues unchecked, HIV/AIDS would affect development in many countries, retard growth weaken human capital, increase poverty and inequality and leave the next generation at risk of the impact of the pandemic [National AIDS/STD control programme 2004]

HIV testing and screening is one of the strategies to control HIV/AIDS and it emphasized that testing shall be encouraged along with counselling services (FMOH, 2006), thus the concepts" voluntary counselling and testing (VCT) for HIV / AIDS. Voluntary HIV counselling and testing (VCT) is the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV (UNAIDS, 2002).At this junction, the imperative need for VCT can't be over emphasised. VCT provides people with an opportunity to learn and accept their HIV status in a confidential environment with counselling and referral for on-going emotional support and medical care. The manner, in which news of HIV zero status is given, is very important in facilitating adjustment to news of HIV infection. Counselling and testing makes the individual confident in his /her relationship. He /she do not need to worry about HIV. It helps the individual to link with support networks around for example AIDS alliance of Nigeria (AAN). It also helps the individual to take steps to protect his or her health and that of his or her family. It promotes and sustains behavioural changes needed for the control and prevention of HIV transmission. HIV counselling and testing (HCT) is strong weapon against stigma and discrimination, provides accurate

information on HIV /AIDS prevention. Counselling as part of VCT ideally involves at least two sessions (pre-test counselling and post-test counselling). More sessions can be offered before or after the test or during the time the client is waiting for test results. The main goal of this counselling session is to help clients understand their test results and initiate adaptation to their zero positive or negative status. VCT has become increasingly important in national and international prevention and care efforts. Knowledge of zero status through VCT can be a motivating force for HIV positive and negative people alike to adopt safer sexual behaviour, which enables zero positive people to prevent their sexual partners from getting infected and those who test negative to remain negative. Eytayo Lambo (2006) in his forward address to the federal ministry of health on national Guidelines for HIV/AIDS counselling and testing, HIV counselling and testing (HCT) is an entry point to both HIV prevention, treatment and care services and a vital component for the expansion of access to comprehensive care for people living with HIV and AIDS (PLWHAS). HIV counselling and testing is offered routinely as part of basis care for Ante natal care (ANC)

However, testing is still voluntary and a pregnant woman has a right to consent or refuse HIV testing should she choose to do so. Studies in both USA and developing world have demonstrated that voluntary counselling and testing can lead to self-reported changes in high risk sexual behaviour between both HIV positive and negative people. These findings have boosted interest and support for VCT as a valuable component of a comprehensive HIV / AIDS prevention programme among international organizations. VCT offers a holistic approach that can address HIV in the broader context of poverty and relationship to risk practice. VCT requires time, acceptance accessibility, consistency, accuracy and confidentiality. Study has shown that it helps to reduce stigma and secrecy surrounding HIV / AIDS. WHO (2003) opined that VCT services that are linked to youth friendly service are crucial to slow the spread of HIV infection as well as cost effective strategy for facilitating

behavioural change. Despite the fact that this helps in reduction in HIV transmission, many young people do not avail themselves of this services. It is against the above argument that this study is therefore geared towards investigating the Attitude of students of Federal University of Oye Ekiti towards HIV/AIDS VCT.

### 1.2 **Statement of the Problem**

An average Nigerian likes free thing because it does not attract money no matter what it takes. But if an organization comes up with a bonanza or subsidy of their product or services, people's turn out will be very poor simply because it attracts money despite the subsidy by the management of the organization.

It been observed that HIV/AIDS test declared free of charge nationwide in all health facilities be it public or private receive a very poor low turnout and a lot of people live without knowing their status despite the fact that they engage in unprotected reckless sexual activities with different partners. It means the knowledge and attitude towards HIV/AIDS Voluntary Counselling and Testing (VCT) is very poor and negative. It is noteworthy that most youths will not want to submit themselves for this test because of fear of the unknown and also some have the fear of Stigmatization attached to HIV/AIDS victims. It is based on this that this study seeks to investigate the knowledge and attitude of students at Federal University of Oye-Ekiti towards HIV/AIDS Voluntary Counselling and Testing.

### 1.3 **Research Questions**

This study will help to survey the knowledge and attitude towards Voluntary Counselling and Testing of HIV/AIDS among Federal University Oye Ekiti students by addressing the following questions,

- (1) Do FUOYE students have a good knowledge of voluntary counseling?
- (2) What is their level of participation in counseling?
- (3) What is their attitude towards voluntary counseling and testing (VCT)?

(4) Do they have knowledge of their HIV status?

#### **1.4 Objective of the Study**

Every rational research has its aims and objectives. Therefore, the main objectives of this research is to examine the Attitude of students at Federal University of Oye Ekiti towards HIV/AIDS Voluntary Counselling and Testing. The specific objectives are to

1. determine the knowledge of voluntary pre – test counselling for HIV among undergraduates students at FUOYE,
2. examine respondents' status of HIV/AIDS
3. determine their level of participation in pre – test counselling, and,
4. ascertain their attitude towards VCT.

#### **1.5 Significance of the Study.**

The result of the study will add to the present body of knowledge in the area of HIV/AIDS. This will also add to the existing body of knowledge of future students as they can use it as a reference material Research Questions. The study will help to survey the knowledge and attitude towards voluntary counseling and testing of HIV/AIDS among Federal University of Oye Ekiti students and help in formulating policy makers regarding HIV/AIDS VCT.

#### **1.6 Scope and Limitation of the Study**

This research is centred on the knowledge and attitudes of FUOYE students towards HIV/AIDS. It is delimited to the knowledge and Attitude of the students towards HIV/AIDS voluntary counselling and testing. It is confined to undergraduates of Federal University of Oye Ekiti.

#### **1.7 Definition of terms**

The use of some terms in this research may often create problems because it may lead to misconception of postulation as well as the ideas that i tried or intend to put across. In order to avoid these problems, the terms used are classified below;

- A. HIV: HIV stands for Human Immune Deficiency, the virus that causes AIDS.
- B. AIDS: Acquire Immune Deficiency Syndrome.
- C. VCT: Voluntary Counseling and Testing (VCT) allow individuals to learn their HIV status through pre- and post-test counseling and an HIV test.
- D. PITC: Provider-Initiated Testing and Counseling.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 HIV/AIDS In Nigeria

The first two cases of HIV and AIDS in Nigeria were identified in 1985 and were reported at an international AIDS conference in 1986. In 1987 the Nigerian health sector established the National AIDS Advisory Committee, which was shortly followed by the establishment of the National Expert Advisory Committee on AIDS (NEACA). At first the Nigerian government was slow to respond to the increasing rates of HIV transmission and it was only in 1991 that the Federal Ministry of Health made their first attempt to assess the situation with HIV and AIDS in Nigeria. The results showed that around 1.8 percent of the populations of Nigeria were infected with HIV.

Subsequent surveillance reports revealed that during the 1990s HIV prevalence rose from 3.8 percent in 1993 to 5.4 percent in 1999. Following a peak of 5.8 percent in 2001, HIV prevalence then declined steadily throughout the decade. When antiretroviral drugs (ARVs) were introduced in Nigeria in the early 1990s, they were only available to those who paid for them. As the cost of the drugs was very high at this time and the overwhelming majority of Nigerians were living on less than \$2 a day, only the wealthy minority were able to afford the treatment. When Olusegun Obasanjo became the president of Nigeria in 1999, HIV prevention, treatment and care became one of the government's primary concerns.

The President's Committee on AIDS and the National Action Committee on AIDS (NACA) were created, and in 2001, the government set up a three-year HIV/AIDS Emergency Action Plan (HEAP). In the same year, Obasanjo hosted the Organization of African Unity's first African Summit on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases. In 2002 the Nigerian government started an ambitious antiretroviral treatment programme, which aimed to supply 10,000 adults and 5,000 children with antiretroviral drugs within one year. An



initial \$3.5 million worth of ARVs were to be imported from India and delivered at a subsidized monthly cost of \$7 per person. The programme was announced as 'Africa's largest antiretroviral treatment programme'.

By 2004 the programme had suffered a major setback as too many patients were being recruited without a big enough supply of drugs to hand out. This resulted in an expanding waiting list and not enough drugs to supply the high demand. The patients who had already started the treatment then had to wait for up to three months for more drugs, which can not only reverse the progress the drugs have already made, but can also increase HIV drug resistance. Eventually, another \$3.8 million worth of drugs were ordered and the programme resumed. ARVs were being administered in only 25 treatment centers across the country which was a far from adequate attempt at helping the estimated 550,000 people requiring antiretroviral therapy.

Despite increased efforts to control the epidemic, by 2006 it was estimated that just 10 percent of HIV-infected women and men were receiving antiretroviral therapy and only 7 percent of pregnant women were receiving treatment to reduce the risk of mother-to-child transmission of HIV. As a result, in 2006 Nigeria opened up 41 new AIDS treatment centers and started handing out free ARVs to those who needed them. Treatment scale-up between 2006-7 was impressive, rising from 81,000 people (15 percent of those in need) to 198,000 (26 percent) by the end of 2007. Nigeria's programme to prevent the transmission of HIV from mother to child ( PMTCT ) started in July 2002. Despite efforts to strengthen PMTCT interventions, by 2007 only 5.3 percent of HIV positive women were receiving antiretroviral drugs to reduce the risk of mother-to-child transmission. This figure had risen to almost 22 percent by 2009, but still remained far short of universal access targets which aim for 80 percent coverage. In 2010 NACA launched its comprehensive National Strategic Framework to cover 2010 to 2015, which required an estimated N756 billion (around US\$ 5 billion) to

implement. Some of the main aims included in the framework are to reach 80 percent of sexually active adults and 80 percent of most at-risk populations with HIV counseling and testing by 2015, ensure 80 percent of eligible adults and 100 percent of eligible children are receiving ART by 2015; and to improve access to quality care and support services to at least 50 percent of people living with HIV by 2015. Despite being the largest oil producer in Africa and the 12th largest in the world, Nigeria is ranked 156 out of 187 on the United Nations Development Programme (UNDP) Human Poverty Index. This poor development position has meant that Nigeria is faced with huge challenges in fighting its HIV and AIDS epidemic.

## **2.2 Concept of HIV/AIDS and VTC**

Relevant literature was reviewed using the following sub headings student's sex on attitude towards HIV/AIDS campaign student's religious beliefs and attitude towards HIV/AIDS campaign. HIV stands for Human Immune Deficiency, the virus that causes AIDS. When a person is infected with this virus, his or her body fluids such as blood, semen and vaginal secretions will contain HIV and antibodies against the virus. The virus stays in the body and slowly destroys the body's defense mechanisms. The duration of time it takes for a person infected to fall ill varies and takes between several months to seven years. Therefore an infected person can spread the virus unknowingly (Akisolu, 2004). When the virus has destroyed the body immune system, the symptom of AIDS begins to manifest. At this stage of full-blown AIDS, the body's natural defense system is weakened and the infected person becomes vulnerable and is at the mercy of all kind of infection such as prolonged the neck, groin or armpit, persistent cough, skin infections and unexplained weight loss (Shaffer, 1994).

Voluntary Counselling and Testing (VCT) allows individuals to learn their HIV status through pre- and post-test counselling and an HIV test (WHO, UNICEF AND UNIADS 2009). VCT is client-initiated, as opposed to provider-initiated testing and counselling (PITC) when health care providers initiate discussion of HIV testing with clients who are seeking

health care for other reasons. VCT can be provided through stand-alone clinics or offered through community-based approaches, such as mobile or home-based HIV testing. In addition, counselling for VCT may take place at the individual, couple, or group level. VCT was originally implemented as an individual-level, clinic-based procedure. Different modalities evolved, including community-based and couple-based approaches, to increase access and uptake. Across all of these different strategies, by combining personalized counselling with knowledge of one's HIV status, VCT is designed to motivate people to change their behaviours to prevent the acquisition and transmission of HIV, reduce anxiety over possible infection, facilitate safe disclosure of infection status and future planning, and improve access to HIV prevention and treatment services. From 2007-2008, the number of facilities offering VCT increased 35% globally; however, the majority of people globally remain unaware of their HIV status.<sup>1</sup> Despite decades of VCT implementation, additional research is needed to understand the best approaches for increasing uptake of VCT and reduction of HIV-related risks in the context of VCT.

### **2.3 Sources of HIV/AIDS**

HIV is found in blood and other body fluids of an infected person such as semen and vaginal fluids. HIV can only be transmitted between two people if one of them is already infected.

1. **Virginal Sex:** HIV is found in the sexual fluids of an infected person. For a man, this means the pre-come and semen fluids that comes out from the penis before and during sex. For a woman it means HIV is in the vaginal fluids that are produced by the vaginal to keep it clean and to help make intercourse easier. If a man with HIV has vaginal intercourse without a condom, then HIV can pass into the woman's body through the lining of the vaginal, cervix and womb. The risk of HIV transmitted is increased if the woman has a cut or sore inside or around her vaginal this will make it easier for the virus to enter her blood stream. A cut or

sore might not always be visible, and could be so small that the woman would not know about it. If a woman with HIV has a sexual intercourse without a condom HIV could get into a man's body through a sore patch on his penis or by getting into his urethra (the tube that runs down the penis), or the inside of his foreskin (unless this has been removed by circumcision). Any contact with blood during sex increases the chance of infection for example, there may be blood in the vagina if intercourse occurs during a woman's period, some sexually transmitted diseases – such as; gonorrhoea – can also raise the risk of HIV transmission.

2. **Anal Sex:** Receptive Anal intercourse (i.e. sex where a man's penis is inserted into a person's anus), carries a higher risk of HIV transmission than Receptive vaginal intercourse. The lining of the Anus is more delicate than the lining of the vagina, so is more likely to be damaged during sex. Any contact during sex increases the risk of infection. If a man takes the insertive position in anal sex with a man or woman who has HIV, then he too risks becoming infected.

3. **Oral Sex:** Oral sex with an infected partner carries a small risk of HIV infection. If a person gives Oral sex (licking or sucking the penis) to a man with HIV, then infected fluids will get into their mouth. If the person has bleeding gums or a sore or ulcer somewhere in the mouth, there is a small risk of HIV entering their bloodstream. The same is true if infected sexual fluid from a woman gets into the mouth of her partner. There is also a small risk if a person with HIV gives Oral sex when they have bleeding gums or a bleeding wound in their mouth. However, HIV in saliva does not pose a risk of HIV infection through Oral sex, there are preventive methods.

4. **Injection Drugs:** People who inject drugs are at a high risk for exposure to HIV. Sharing unsterilized injecting equipment is a very efficient way to transmit blood-borne

viruses such as HIV and Hepatitis sharing needles and work (syringes, spoons, filters, and contaminated water), is more likely to transmit HIV than sexual intercourse.

5. **Mother To Child Transmission:** An infected pregnant woman can pass HIV unto her unborn baby during pregnancy, labour or delivery. HIV can also be transmitted through breastfeeding. This type of HIV transmission is also known as a vertical transmission. If a woman is aware of the infection, there are drugs she can take to quickly reduce the chances of her child becoming infected.

6. **Blood Transfusion And Blood Product:** Some people have been infected through a transfusion of infected blood. These days, all the blood used for transfusion in high-income countries is tested for HIV and infection through blood transfusion is now extremely rare. Yet this is not the case in some middle and low income countries, where a lack of adequate blood safety procedures means HIV transmission through blood transfusion continues to occur. Blood can be separated into its different components, for example; Red blood cells, White blood cells, Platelets, Plasma and immunoglobulin. These are known as blood products Whilst white blood can be placed through a rigorous screening process and infected donations discarded, some blood products such as those used by people with Haemophilia, can be heat treated to make them safe.

7. **Tattoos/Piercing:** Anything that potentially allows another person's blood to get into your blood stream carries a risk. If the equipment has not been sterilized, there could be a risk of HIV from tattoos or piercing if the previous person was infected with HIV. In most developed countries there are hygiene regulations governing tattoos and piercing parlours to ensure all instruments used are sterile. If you are thinking of having a tattoo or piercing, ask staff at the shop what procedures they take to avoid HIV infection.

## 2.4 Source of Not Contacting Hiv/Aids

1. **Kissing:** To become infected with HIV you must get a sufficient quantity of the virus into your body. There is HIV in saliva, but the virus is only present in very small quantities and such has never been known to transmit HIV from kissing. Unless both partners have large open sores in their mouth or severely bleeding gums, there is no HIV transmission risk from mouth- to-mouth kissing.
2. **Sneezing And Coughing:** HIV is unable to produce outside its living host (i.e. a human) HIV does not survive long in the open air and this make the possibility of this type of environment transmission remote no environment transmission has been recorded. This means that HIV cannot be transmitted through spitting, sneezing and sharing of glasses or musical instrument. Moreover, HIV transmission cannot occur via swimming pools shower or by sharing washing facilities or toilet seats.
3. **Insect:** Studies conducted by many researchers have shown no evidence of HIV transmission through insect bites, even in areas where there are many case of HIV and AIDs and large populations of insect such as mosquitoes. The lack of such out breaks, despite considering efforts to detect them, supports the conclusion that you can't get HIV from insects. HIV only lives for a short time and can't reproduce inside an insect. So even if the virus enter a mosquitoes or another sucking or biting insect, the insect does not become infected and cannot transmit HIV to the next human it feeds on or bites.
4. **Injecting Drugs with Sterile Needles:** Injecting with a sterile (clean) needle and works will not transmit HIV, as long as clean equipment is used each time and none of it is shared. However, there are still many other risks associated with injecting drugs. If a person is on drugs (including alcohol) then there judgement maybe clouded, making them more likely to become involved in risky sexual behaviour, which increase the chance of exposure to HIV.

## **2.5 Effect of HIV/AIDS on the Economy**

HIV and AIDS affect economic growth by reducing the availability of human capital. Without proper prevention, nutrition, health care and medicine that are available in developing countries, large numbers of people are falling victim to AIDS. People living with HIV/AIDS will not only be unable to work, but will also require significant medical care. The forecast is that this will probably cause a collapse of economies and societies in countries with a significant AIDS population. In some heavily infected areas, the epidemic has left behind many orphans cared for by elderly grandparents.

The increased mortality in this region will result in a smaller skilled population and labour force. This smaller labour force will be predominantly young people, with reduced knowledge and work experience leading to reduced productivity. An increase in workers' time off to look after sick family members or for sick leave will also lower productivity. Increased mortality will also weaken the mechanisms that generate human capital and investment in people, through loss of income and the death of parents. As the epidemic progresses, the age profile of those infected will increase, though the peak is expected to stay within the working age population. HIV disproportionately infects and impacts on women, so those sectors employing large numbers of women e.g. education, may be disproportionately economically impacted by HIV.

## **2.6 Prevention of HIV/AIDS**

**Education:** Sex is traditionally a very private subject in Nigeria and the discussion of sex with teenagers is often seen as inappropriate. It is evident that some groups, particularly religious and cultural leaders, have acted as a barrier to previous attempts to provide sex education for young people in Nigeria. However, successful delivery of sex education to young people is

reliant on increasing the participation of these community leaders in the planning and implementation of such programmes.

- In 2009 only 23 percent of schools were providing life-skills based HIV education.
- Only 25 percent of men and women between the ages of 15 and 24 correctly identified ways to prevent sexual transmission of HIV, in 2010.

In some regions of Nigeria girls marry relatively young, often too much older men. Studies have found those who are married at a younger age have less knowledge about HIV and AIDS than unmarried women, and are more likely to believe they are low-risk for becoming infected with HIV. HIV and AIDS education initiatives need to ensure they focus on married girls, as they are less likely to have access to health information than unmarried girls. However, the need to improve knowledge about HIV among girls overall (both married and unmarried) remains, as HIV prevention knowledge is significantly less among girls (aged 15-19), compared to boys. Addressing the social and cultural factors that contribute to early sexual debut among girls, notably gender inequality, in Nigeria is integral to successful HIV prevention among this group.

- In North Western Nigeria around half of girls are married by age 15 and four out of five girls are married by the time they are 18.
- Twice as many girls than boys are engaging in sexual activity before the age of 15 years.

**Condoms:** Using a condom is the most effective way for a person to protect themselves from HIV, unless they practice abstinence. However, restrictions on condom promotion in Nigeria have hampered efforts to promote this form of HIV prevention. In 2001, a radio advertisement was suspended by the Advertising Practitioners Council of Nigeria (APCON) for promoting messages suggesting that it is acceptable to engage in premarital sex as long as a condom is



used. In 2006 APCON also started to enforce stricter regulations on condom advertisements that might encourage 'indecenty'.

Nevertheless, in their National Strategic Plan 2010-2012 Nigeria set the target of having 80 percent of sexually active men and women using condoms consistently and correctly with non-regular partners by 2015; indicating a positive change in attitude towards condom use. However, nearly half (42 percent) of HIV infections occur among people considered to be having low-risk sex; those in cohabiting or married partnerships. This is a result of low condom use among regular sexual partners, but when one partner is engaging in high-risk behaviours outside of the relationship.

- More than 2 billion male condoms and 886,979 female condoms were distributed, both by NGOs and the Federal Ministry of Health, in 2010.

**Media Campaigns & Public Awareness:** As Nigeria is such a large and diverse country, media campaigns to raise awareness of HIV are a practical way of reaching many people in different regions. Radio campaigns like the one created by the Society for Family Health are thought to have been successful in increasing knowledge and changing behaviour. "Future Dreams", was a radio serial broadcast in 2001 in nine languages on 42 radio channels. It focused on encouraging consistent condom use, increasing knowledge and increasing skills for condom negotiation in single men and women aged between 18 and 34.

In 2005, a campaign was launched in Nigeria in a bid to raise more public awareness of HIV/AIDS. This campaign took advantage of the recent increase in owners of mobile phones and sent text messages with information about HIV/AIDS to 9 million people. Another high profile media campaign is fronted by Femi Kuti, the son of Fela Kuti, the famous Afrobeat musician who died of AIDS in 1997. He appears on billboards alongside roads throughout Nigeria with the slogan 'AIDS: No dey show for face', which means you can't tell someone has AIDS by looking at them.

**Prevention of Mother-To-Child Transmission of HIV:** In Nigeria, a small proportion, only 18 percent, of pregnant women with HIV access antiretroviral therapy to protect their children. As a result, Nigeria has achieved a small decline in new infections among children, since 2009; an estimated 69,400 children were newly infected with HIV in 2011. This has led to a rise in the total number of children living with HIV in the country to an unprecedented 440,000. Over a quarter of pregnancies among women with HIV resulted in transmission to the child. Improvements in the uptake of HIV testing and counselling, and scaling up access to the most effective antiretroviral regimens (triple ARV regimens) among pregnant women are essential targets Nigeria must meet if they are to halt the rising numbers of children living with HIV.

- Less pregnant women are receiving single-dose nevirapine for PMTCT; 8.4 percent in 2011, compared with 24.5 percent in 2010.
- More pregnant women are receiving effective antiretroviral treatment for PMTCT; 33.2 percent received a triple ARV regimen in 2011, compared with 25.2 percent in 2010.

**Preventing HIV Among Most-At-Risk Groups:** The high HIV prevalence reported among high-risk groups, as well as their link to the general population should place these individuals at the centre of HIV prevention programmes. Nevertheless, HIV prevention messages are not sufficiently reaching people that fall within these groups. One of the major barriers to accessing HIV prevention programmes for MSM and sex workers are laws that prohibit their activities. For example, same-sex relations in Nigeria are criminalised with 14 years' imprisonment, and in early 2014 a new law was passed to further criminalise the LGBT community. It states that people who participate in gay organisations or publically show same-sex affection will be imprisoned for 10 years; those that support gay organisations face the

same conviction. There is concern that this will limit access for the LGBT community to HIV services.

**Men Who Have Sex with Men (MSM):** MSM living in Nigeria are considered to have a high and increasing risk of becoming infected with HIV. Despite the need for improvements in HIV knowledge and awareness among this group, less men who have sex with men were reached with HIV prevention programmes in 2011 (24 percent), than in 2009 (58 percent). Condom use has remained generally unchanged since 2007, with only half of men reporting use of a condom. To prevent onward transmission of HIV men who have sex with men should know their HIV status. Yet, HIV testing among this group is low and declining, with only a quarter testing for HIV.

- HIV prevalence was reported as high as 17 percent in 2011, up from 14 percent in 2009.
- Only half of men used a condom, the last time they had anal sex with a male partner, in 2011.

**Sex Workers:** People who receive money for sex (male and female sex workers) are considered at risk of HIV infection. This risk can be reduced by using condoms consistently and correctly. However, many sex workers in Nigeria are not being reached by HIV prevention programmes and therefore do not have the knowledge about how to protect themselves from HIV and other STDs. Considerably less sex workers were reached with HIV prevention messages in 2011 (26 percent), than in 2009 (80 percent). Whilst consistent condom use has been found to be extremely high among sex workers with their clients, many are not using condoms consistently during sex with partners. However, expanding HIV prevention messages to male sex workers is of particular importance, as condom use with clients is extremely low among this group, particularly in comparison to female sex workers.

- A quarter of sex workers were living with HIV in 2011.

- Nearly all sex workers (89 percent) reported condom use with their most recent client, in 2011.

**People Who Inject Drugs:** Sharing injecting equipment, such as a needle or syringe, can transmit HIV. People who use drugs must take precautions such as always using clean injecting equipment to prevent HIV infection. Although most people who inject drugs in Nigeria do so safely, this number is declining. Reversing this trend should be a priority if HIV transmission through injecting drugs is to be minimised in Nigeria. Achieving this is reliant on Nigeria increasing existing harm reduction services and implementing new services, not currently available, such as needle exchanges.

- About 4 percent of people who inject drugs in Nigeria are living with HIV; a decline of about 2 percent since 2009.
- 71 percent of people who inject drugs, injected safely in 2011; less than in 2009.

**HIV Testing:** Very few Nigerians know their HIV status. This can place people at risk of becoming ill, as they do not access timely HIV treatment and care. It also increases the risk of onward transmission to sexual partners. People who want to get tested for HIV often have to travel long distances, and into rural centres, as there is a distinct lack of HIV testing and counselling facilities. In 2011 there were only 1357 HIV testing and counselling facilities nationwide and only 12 percent of women and men aged 15-49 had received an HIV test and found out the results. This shows how desperately the government needs to scale up HIV testing services. Moreover, HIV testing and counselling of pregnant women is central to the prevention of mother-to-child transmission, yet this remains extremely low with only 1 in 6 pregnant women receiving it in 2011.

The uptake of HIV testing among most-at-risk individuals, such as sex workers, injecting drug users (IDUs) and men who have sex with men (MSM), must increase if Nigeria is to see a decline in the currently high levels of HIV prevalence reported among these groups.

- HIV testing among sex workers has increased, but remains low, with only 42 percent receiving an HIV test and the results within the previous 12 months, in 2011.
- Uptake of HIV testing is poor among MSM; only a quarter had received a test in 2011, less than in previous years.
- Few IDUs know their HIV status; only one in five reported to have received a test in 2011.

Some reports have suggested that health care facilities offering HIV testing in Nigeria do not follow international standards about confidentiality and ethics. In one particular study, over half of people living with HIV reported that they did not know they were being tested for the virus and around one in seven health care professionals admitted to never receiving informed consent for HIV tests. Implementing these standards will go some way towards improving the uptake of HIV testing. However, if HIV testing is to improve among most-at-risk individuals legislation, that criminalises their activities, must be replaced by legislation that enables them to access health services free from the risk of discrimination and arrest.

### **2.7 Knowledge, Awareness and Attitude of Youths towards HIV/AIDS Voluntary Texting And Counselling.**

A study conducted among law under-graduates in Anambra state showed that over 70% of the respondents being of age range of 20 to 24 years. This age group has been found to be at the greatest risk of HIV/AIDS because of their documented risky sexual behaviour (Pettiform et al., 2005; Eaton et al., 2003) and vulnerability due to their lack of knowledge and skills required to protect themselves. The majority at risk are those who engage in unsafe sex, unsafe injection drug use, exposure to contaminated blood and blood products, skin piercing, tattooing and scarification.

In Nigeria, young people constitute about 40 million of her estimated 140 million people (National population commission, 2006) and they contribute significantly to new

infections in Nigeria and other sub Saharan African countries (Federal Ministry of health, 2007). In Africa, an estimated 1.7 million young people are infected annually (WHO/UNAIDS, 2000). Globally, over 40% of all new infections in 2007 were in young people aged 15 to 24 years old, with 65% occurring among youths living in Africa (United Nations, 2008). Preventing HIV infection among the young people is particularly urgent in sub Saharan Africa where in many of her countries, young people more than 30% of the population and general HIV prevalence comprise exceeds 10% (United Nations, 1999). It is also an important commitment each country can make to its future economic and social well-being. The utilization of intervention programs however depends on their knowledge about the program and its accept-ability by the young people.

The study demonstrates a high level of knowledge about HIV/AIDS and an average knowledge about VCT for HIV/AIDS. This correlates with some reports from Nigeria (Ikechebelu et al., 2006; Iliyasu et al., 2005), but contrasts with the findings from Danbar village in Northern Nigeria (Alemu et al., 2004) and findings among Tanzania healthcare professional students (Mgoshha et al., 2009), and Uganda (Nuwaha et al., 2002). The differences may be due to the differences in the biosocial characteristics, behavioural and environmental factors of the study group.

Like in some studies (Mgoshha et al., 2009; Ikechebelu et al., 2006), the mass media was discovered to be the major source of information about VCT of HIV. This strongly indicates that some successes are being re-corded by the massive media campaign being mounted by the Government, Non-Governmental organizations (NGOs) and international agencies against the spread of HIV/AIDS and on the positive step in preventing its spread. Media campaigns have also been documented to be a veritable tool in the campaign against the spread of HIV/AIDS. It is very disappointing however that none of the respondents had VCT centre as their primary source of information about HIV/AIDS and VCT for HIV/AIDS.

This could be as a result of wrong location site which are far from the young people or places where the young people cannot easily access or does not find comfortable to attend. It is necessary to establish VCT centres specifically targeting the young people because their reason of seeking VCT for HIV/AIDS services, outcome and needs following VCT for HIV/AIDS can be different from others. More so, they bear the highest burden of the disease (UNICEF, 2007).

Unlike the findings in other studies in Nigeria (Ikechebelu et al., 2006; Iliyasu et al., 2006), most of the students were aware of at least a centre where VCT services are rendered. This is very much expected because of the differences in the educational status of the respondents and for the fact that most of the VCT centres are located in the urban areas where most of the university undergraduates reside. In addition, some of them would have heard VCT centres mentioned in the mass media.

The misconception about VCT among this population is a source of concern considering their level of education. The understanding of the participants about VCT for HIV/AIDS include a process that enables individuals make informed decision about being tested for HIV, a form of treatment for people with HIV/AIDS, and a form of service advisable only for people with an increased risk of contracting HIV. Although similar misconceptions have also been reported elsewhere (Iliyasu et al., 2006), this calls to question the content of health information passed to our people through various sources of information. This gap of information regarding VCT for HIV/AIDS can lead to low utilization of VCT services, increased stigmatization with resultant adverse effects on the efforts to check the spread of the disease. These study group comprises of the elites, future parents and the nation's work force consequently therefore; adequate and appropriate knowledge of VCT for HIV/AIDS will be of tremendous impact on the general populace. Churches being a significant source of information to our respondents calls for the need for our health care

programmers and policy formulators, NGOs, governments at all levels to establish, foster or strengthen partnership with faith based organizations and churches to facilitate access to information about VCT for HIV/AIDS.

The uptake rate of 83.93% among the respondents who are aware of VCT for HIV/AIDS is very encouraging and similar to report from Lagos, Nigeria (Ekanem and Gbadegesin, 2004) but contrasts with the report from Kano, Nigeria (Iliyasu, 2006) and South Africa (Kalichman and Saimbayi, 2003). Nevertheless, the fact that about half of the respondents who were not aware of their HIV status still express their unwillingness to undertake VCT for HIV/AIDS should be of concern to all. The reasons adduced by the respondents for their unwillingness to undertake VCT is based on false assumptions, misconceptions and the lack of adequate, proper and appropriate knowledge about HIV/AIDS. There is need therefore to intensify reproductive health education efforts among the young people. This will impact tremendously on primary prevention of HIV/AIDS and clinical management of the cases.

The finding that about a good number of the students who were not aware of their HIV status said they require counselling before they can visit VCT centre(s) shows that they have not fully appreciated the extent, content and the holistic nature of services rendered at these centres. It also reveals that the students are actually one of the populations in need of the VCT for HIV/AIDS. The other reasons given by the students for not approving of or utilizing VCT for HIV/AIDS correlate with the reports from other studies (Day et al., 2003; Iliyasu, 2006).

The significant relationship between the knowledge of the students HIV status and discrimination is worthy of note. The fact that the greater the number of students who knew their HIV status the lesser the rate of stigmatization shows that VCT for HIV/AIDS could be a veritable instrument in the fight against stigmatization and discrimination against people living with HI/AIDS. The knowledge of the students HIV/AIDS status also significantly increased



with their knowledge about VCT for HIV/AIDS as people can only utilize the services they are aware of. It is therefore imperative that dissemination of information about VCT for HIV/AIDS should be intensified among the young people. There are challenges faced by the patronage of the VCT centres in Nigeria by the youths which has made the patronage of Voluntary Counseling and Testing (VCT) still very low. It shows that the factors hindering the acceptance of VCT as expressed by youths in Nigeria is as a result of the following;

- I. Ignorance.
- II. Poverty.
- III. Inadequate number of VCT centers.
- IV. Stigma.
- V. Discrimination as major factors responsible for the low patronage of VCT centers.

## **2.8 Theoretical Framework**

### **2.8.1 The Health Belief Model**

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors. This is done by focusing on the attitudes and beliefs of individuals. The HBM was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services. The model was developed in response to the failure of a free tuberculosis (TB) health screening program. Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviors, including sexual risk behaviors and the transmission of HIV/AIDS.

### **2.8.2 Core Assumptions and Statements**

The HBM is based on the understanding that a person will take a health-related action (i.e., use condoms) if that person:

1. feels that a negative health condition (i.e., HIV) can be avoided,

2. has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition (i.e., using condoms will be effective at preventing HIV), and
3. believes that he/she can successfully take a recommended health action (i.e., he/she can use condoms comfortably and with confidence).

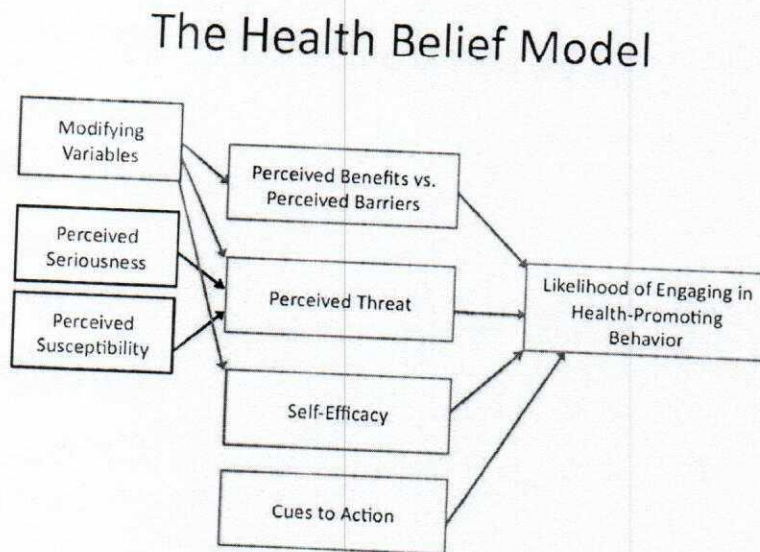
The HBM was spelled out in terms of four constructs representing the perceived threat and net benefits: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. These concepts were proposed as accounting for people's "readiness to act." An added concept, cues to action, would activate that readiness and stimulate overt behaviour. A recent addition to the HBM is the concept of self-efficacy, or one's confidence in the ability to successfully perform an action. This concept was added by Rosenstock and others in 1988 to help the HBM better fit the challenges of changing habitual unhealthy behaviours, such as being sedentary, smoking, or overeating.

Table from "Theory at a Glance: A Guide for Health Promotion Practice" (1997)

Concept	Definition	Application
<b>Perceived Susceptibility</b>	One's opinion of chances of getting a condition	Define population(s) at risk, risk levels; personalize risk based on a person's features or behavior; heighten perceived susceptibility if too low.
<b>Perceived Severity</b>	One's opinion of how serious a condition and its consequences are	Specify consequences of the risk and the condition

<b>Perceived Benefits</b>	One's belief in the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take; how, where, when; clarify the positive effects to be expected.
<b>Perceived Barriers</b>	One's opinion of the tangible and psychological costs of the advised action	Identify and reduce barriers through reassurance, incentives, assistance.
<b>Cues to Action</b>	Strategies to activate "readiness"	Provide how-to information, promote awareness, reminders.
<b>Self-Efficacy</b>	Confidence in one's ability to take action	Provide training, guidance in performing action.

## 2.9 Conceptual Model Figure1: The Health Belief Model



Source: Glanz et al, 2002, p. 52

### 2.10 Scope and Application of the theoretical framework

The Health Belief Model has been applied to a broad range of health behaviors and subject populations. Three broad areas can be identified (Conner & Norman, 1996): 1) Preventive health behaviors, which include health-promoting (e.g. diet, exercise) and health-risk (e.g. smoking) behaviors as well as vaccination and contraceptive practices. 2) Sick role behaviors, which refer to compliance with recommended medical regimens, usually following professional diagnosis of illness. 3) Clinic use, which includes physician visits for a variety of reasons.

Example

This is an example from two sexual health actions.

Concept	Condom Use Education Example	STI Screening or HIV Testing
1. Perceived Susceptibility	Youth believe they can get STIs or HIV or create a pregnancy.	Youth believe they may have been exposed to STIs or HIV.
2. Perceived Severity	Youth believe that the consequences of getting STIs or HIV or creating a pregnancy are significant enough to try to avoid.	Youth believe the consequences of having STIs or HIV without knowledge or treatment are significant enough to try to avoid.
3. Perceived Benefits	Youth believe that the recommended action of using condoms would protect them from getting STIs or HIV or creating a pregnancy.	Youth believe that the recommended action of getting tested for STIs and HIV would benefit them — possibly by allowing them to get early treatment or preventing them from infecting others.

<p><b>4. Perceived Barriers</b></p>	<p>Youth identify their personal barriers to using condoms (i.e., condoms limit the feeling or they are too embarrassed to talk to their partner about it) and explore ways to eliminate or reduce these barriers (i.e., teach them to put lubricant inside the condom to increase sensation for the male and have them practice condom communication skills to decrease their embarrassment level).</p>	<p>Youth identify their personal barriers to getting tested (i.e., getting to the clinic or being seen at the clinic by someone they know) and explore ways to eliminate or reduce these barriers (i.e., brainstorm transportation and disguise options).</p>
<p><b>5. Cues to Action</b></p>	<p>Youth receive reminder cues for action in the form of incentives (such as pencils with the printed message "no glove, no love") or reminder messages (such as messages in the school newsletter).</p>	<p>Youth receive reminder cues for action in the form of incentives (such as a key chain that says, "Got sex? Get tested!") or reminder messages (such as posters that say, "25% of sexually active teens contract an STI. Are you one of them? Find out now").</p>

Several theories and models have been developed and used to understand health seeking behaviour and health outcomes. The common general model used for analysis of

health behaviour is the health belief model, which has been used as one size fits all in health related studies. There are several other models/theories used for studying health behaviour of individuals such as the theory of reasoned action and planned behaviour; risk reduction model etc. Although these frameworks have been useful in improving our understanding of the health behaviours and outcomes, they however, have been unable to decipher the social reasoning as it relates to the spread of HIV-AIDS among young people. Hence social cognitive theory appear relevant and been used to guide research relative to HIV/AIDS knowledge, attitudes towards VCT among youth, as well as the development of AIDS prevention programmes specifically designed for youth.

Bandura social-cognitive framework, people learn from a variety of experiences, including their own, and by observing the behaviour of other people in their community. The theory predicts that adolescents will be better able to engage in positive self-directed change if they have knowledge about HIV/AIDS VCT. Therefore, individuals who are less knowledgeable about HIV/AIDS VCT and those who have adverse health beliefs are most likely to engage in risky behaviours as they do not perceive themselves to be at risk. More also, youth who have correct knowledge about both HIV prevention and transmission tend to hold a positive view about PLHWA and have increased chances of accessing HIV information and services. In line with Bandura social-cognitive framework, this study adopts to measure the knowledge, opinions and Attitudes about HIV/AIDS based on a set of variables. The knowledge, opinion and attitudes variables are posited to be influenced by the respondent's characteristics (of sex, age, education, residence, religion, sexual initiation and number of partners). It is understood that the respondent's characteristics work to affect the respondent's reception of new knowledge and will in turn act to effect behavioural change. Acquisition of knowledge together with the respondents' background has a bearing in the changing traditional and cultural opinions about HIV and therefore their attitudes towards VCT. Thus,

respondent's with increased knowledge about the prevention and transmission of HIV, and with less misconceptions about HIV tend to hold positive attitudes about HIV/AIDS and VCT

### **2.10.1 Limitations of the theory**

The health belief model attempts to predict health-related behaviors by accounting for individual differences in beliefs and attitudes. However, it does not account for other factors that influence health behaviors. For instance, habitual health-related behaviors (e.g., smoking, seatbelt buckling) may become relatively independent of conscious health-related decision making processes.

Additionally, individuals engage in some health-related behaviors for reasons unrelated to health (e.g., exercising for aesthetic reasons). Environmental factors outside an individual's control may prevent engagement in desired behaviors. For example, an individual living in a dangerous neighborhood may be unable to go for a jog outdoors due to safety concerns.

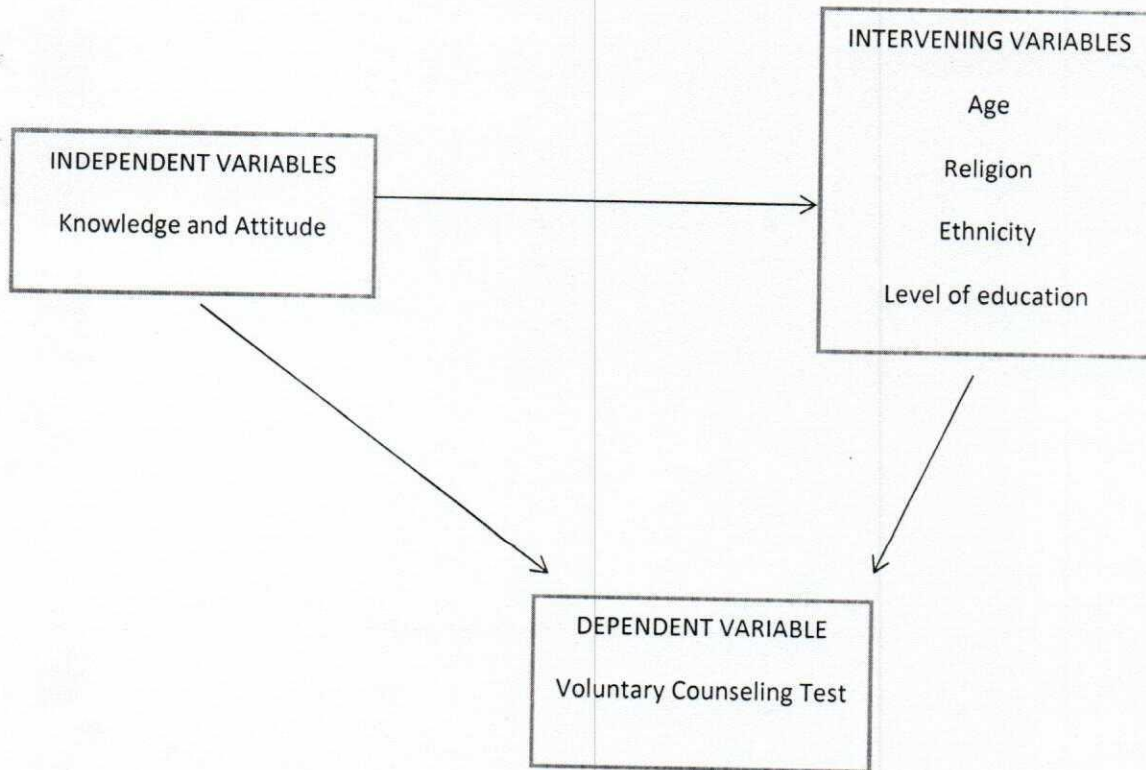
Furthermore, the health belief model does not consider the impact of emotions on health-related behavior. Evidence suggests that fear may be a key factor in predicting health-related behavior. The theoretical constructs that constitute the health belief model are broadly defined. Furthermore, the health belief model does not specify how constructs of the model interact with one another. Therefore, different operationalizations of the theoretical constructs may not be strictly comparable across studies. Research assessing the contribution of cues to action in predicting health-related behaviors is limited.

Cues to action are often difficult to assess, limiting research in this area. For instance, individuals may not accurately report cues that prompted behavior change. Cues such as a public service announcement on television or on a billboard may be fleeting and individuals may not be aware of their significance in prompting them to engage in a health-related behavior. Interpersonal influences are also particularly difficult to measure as cues.



## 2.11 Conceptual Framework

**Figure 1: conceptual framework of the study**



**Source: Author's work, 2015**

The above conceptual framework describes the interrelation among the independent variable, intervening variable and the dependent variable. The independent variable can influence the utilization of voluntary counselling test on HIV/AIDS. The Intervening variables are variables that interact with the independent variables to affect the outcome of the dependent variable and they tend to either weaken or strengthen the dependent variable. Beyond the influence of the independent variable on the dependent variables, the intervening can also indirectly influence the utilization of VCT. More so, by intervening variable, an individual who has a low level of education will indirectly have little knowledge about VCT.

## CHAPTER THREE

### METHODOLOGY

#### 3.0 Introduction

This chapter focuses generally on the methodology implored this study. It discusses issues relating to the research design for the study; the population from which the sample is taken and the procedure used in selecting the sample. It also discusses the instruments and methods implored for collecting the data as well as the weakness of methodology/techniques utilized in the processing and analysing the data collected.

#### 3.1 Research Design

The research design was a survey cross-sectional design. The researcher did not manipulate any variable rather the variables of interest were sought for in the participants using inventories. The participants in the study were two hundred (200) undergraduates in the age range 13 to 37 years old randomly selected from the various departments of the faculties in the university; Faculty of Science and Faculty of Humanities and Social Sciences of Federal University of Oye-Ekiti. Faculty of science consist of the following departments; Mathematics, Geo-physics, Geology, Physics, Computer science, Plant science, Animal science, Bio-chemistry and Micro-biology while the faculty of humanity and Social science includes; Sociology, Economics and Development studies, Demography and Social statistics, Psychology, English and literary studies and Theatre and Media art.

#### 3.2 Population of the Study

Population is the total number of elements in which the researcher interest lies. It may be considered universal aggregate or entire group whose characteristics are to be studied. The general population of Federal University of Oye Ekiti campus comprise of over two thousand two hundred and twenty one undergraduate students which cut across various

faculties in the University. The total number of Two Hundred (200) undergraduate will be selected for the research.

### **3.3 Sample Size.**

Population is sometimes referred to as the universe and it is defined as the entire group whose characteristic are to be estimated (Ndagi 1984). To this end, a sum total of two hundred students will be selected for this study. The selections will cut across all faculties and departments.

### **3.4 Sampling Techniques**

Sampling size, sample is defined as a limited number of elements from a population which represent the population (Ndagi 1984). Indeed, by sampling techniques and sample size, simply put sampling is the process of selecting a part (called a sample) from the whole (called a population) in order to make inference about the whole. Then a sample is then that small part selected from the whole or population. The main purpose of sampling is to reduce time and money that would be spent if the total population was studied. A purposive sampling technique were adopted for this study. This is because the students were not in place where they can be reach.

### **3.5 Instrument for Data Collection**

Questionnaire was employed for data collection for this research study. This method was used because it enabled the researcher to cover a wide or large number of respondents and issues. The questions were structured in such a way as to enable the researcher to obtain primary information relevant to the purpose and objectives of the study.

In administering the questionnaire, the respondents were taken confidentially and anonymity. This was necessary because most of the times, people are afraid of revealing certain information about themselves and their organization. Beside data collected from the

questionnaire as discussed above, the researcher also consulted text books, journals, magazines, newspapers and monographs.

### **3.6 Weakness and Data Methodology**

There was no method of data collection and analysis in the research process that is free from defects. They all have their inherent weakness but it was left for the researcher to minimize them. One of the pitfalls in methodology comes from the use of structured questionnaire method in collecting the data. This method provides little room for probing, more especially as it becomes difficult to tell when a respondent is sufficiently motivated. This means that certain useful information that would have been able to adequately provide answers in solving the issue at hand are lost. This has the effect of affecting the result. Again, it is money and time consuming, this might make it impossible for adequate and wide consultation to be made; furthermore, questionnaire may suffer from poor response rate, which often affect the result of the research.

### **3.7 Method of Data Analysis**

Quantitative data collected through the questionnaire were cleaned to avoid inconsistent response and analysed using the Statistical Packages for the Social Sciences (SPSS) software. Quantitative methods of data were analyzed using software called SPSS. Information was represented in tables using frequency and percentages.

## CHAPTER FOUR

### DATA ANALYSIS AND INTERPRETATION

#### 4.0 Introduction

This chapter is on the analysis of the primary data collected for this study. It is discussed in different sub-themes.

#### 4.1 Respondents Background Information

**Table 4.1: Age of the Respondents**

Age Range	Frequency	Percentage
13 -17 years	52	25.7
18 – 22 years	92	45.5
28 – 32 years	32	15.8
33 – 37 years	12	5.9
38 years above	12	5.9
<b>Total</b>	<b>200</b>	<b>100.0</b>

Source; field data, 2015

Table 4.1 shows that most of the respondents 45.5% were within the age range of 18-22 while only 5.9% were between age 33 and above years. This means there are young undergraduate students in the location of study while the institution also has students that are relatively old.

**Table 4.2: Respondents Sex**

Sex of respondents	Frequency	Percentage
Male	94	46.5
Female	106	53.5
<b>Total</b>	<b>200</b>	<b>100.0</b>

Source; field data, 2015

Table 4.2 is on the sex of the respondents. Majority of them 53.5% were female while only 46.5% were male. This simply indicate that there more female undergraduate students than their male counter parts that participated in this study.

**Table 4.3: Religion of Respondents**

Type of Religion	Frequency	Percentage
Christianity	114	56.4
Muslim	62	30.7
Traditional Religion	24	11.9
<b>Total</b>	<b>200</b>	<b>100.0</b>

Source; field data, 2015

Table 4.3 shows that 56.4% of the respondents were Christians, 30.7% of the respondents were Muslims while only 11.9% were of the Traditional religion. This means the study location is Christians dominated and also it is found among the respondents those who practice and believe in the traditional religion. This will in a way sustain our culture.

**Table 4.4: Marital Status of Respondents**

Marital Status	Frequency	Percentage
Single	150	75.0
Married	46	23.0
Separated	04	2.0
<b>Total</b>	<b>200</b>	<b>100.0</b>

Source; field data, 2015

Table 4.4 discusses the marital status of the respondents. About 75.0% of the respondents which is the majority were single, 23.0% were married while only 2.0% of the respondents were separated. This indicates that there are some of the students or respondents who are already fathers or mothers despite the fact that they are students.

**Table 4.5: Respondents Level**

Respondents Level	Frequency	Percentage
100 level	32	16.0
200 level	62	31.0
300 level	70	35.0
400 level	36	18.0
<b>Total</b>	<b>198</b>	<b>100.0</b>

Source; field data, 2015

Table 4.5 shows that 35.0% of the respondents were in 300 level while only 16.0% of the respondents were in 100 level. This shows that all the existing levels in the study location participated in the study. It shows a good representation of the levels.

**Table 4.6: Faculty of the Respondents**

Faculty of Respondents	Frequency	Percentage
Humanities and Social Science	75	37.5
Sciences	58	29.0
Agriculture	35	17.5
Engineering	32	16.0
<b>Total</b>	<b>198</b>	<b>100.0</b>

Source; field data, 2015

The faculty of the respondents was discussed in the table 4.6. most of the respondents 37.5% were in Faculty of Humanities and Social Sciences while 16.0% of the respondents were in Faculty of Engineering. This means that all the faculties were represented even though Faculty of Humanities and Social sciences were more than other faculties.

#### 4.2 Respondents Knowledge of HIV/AIDS

**Table 4.7: If Respondents have heard about HIV/AIDS and Voluntary Counselling and Test**

Option	HIV/AIDS		VCT	
	Frequency	Percentage	Frequency	Percentage
Yes	198	99.0	138	69.0
No	02	1.0	50	25.0
Don't Know	-	-	12	6.0
<b>Total</b>	<b>200</b>	<b>100.0</b>	<b>200</b>	<b>100.0</b>

Source; field data, 2015

Table 4.7 is on whether respondents have ever heard about HIV/AIDS and voluntary counselling and test (VCT). About 99.0% of the respondents said yes, they have heard of HIV/AIDS and 69.0% said yes they have ever heard of VCT while only 6.0% of the respondents said they don't know. This depict that almost all the respondents have ever heard of HIV/AIDS compare to voluntary counselling and test (VCT). This is simply because HIV/AIDS has been in existence for a very long time unlike VCT.

**Table 4.8: Medium through which Respondents heard about HIV/AIDS and VCT**

Different Medium	HIV/AIDS		VCT	
	Frequency	Percentage	Frequency	Percentage
Friends	56	28.0	18	9.0
Family member	34	17.0	08	4.0
Mass Media	28	14.0	28	14.0
Social Network	30	15.0	24	11.9
Hospital	50	25.0	66	33.0
Others/Not applicable	02	1.0	-	-
Not Applicable	-	-	56	28.0
<b>Total</b>	<b>200</b>	<b>100.0</b>	<b>200</b>	<b>100.0</b>

Source; field data, 2015

Table 4.8 shows that 28.0% of the respondents got to know about HIV/AIDS through friends and 33.0% of the respondents heard about VCT in the hospital. This indicates that there are several mediums through which the respondents can hear about any of the concepts or terms.

Also, while they hear of HIV/AIDS through friends while VCT was in the hospital because HIV/AIDS has become a household name globally unlike VCT which majority run away from or are scared of.

**Table 4.9: If Respondents know how HIV/AIDS is contacted?**

Option	Frequency	Percentage
Yes	190	95.0
No	10	5.0
<b>Total</b>	<b>200</b>	<b>100.0</b>

**Source; field data, 2015**

Table 4.9 shows that most of the respondents 95.0% said yes, they know ways through which people can contact HIV/AIDS while only 5.0% of the respondents said no, they do not know ways people could contact it. This means the number of respondents who claim not to know ways AIDS can be contacted is very insignificant. It also means almost all the respondents are well informed as far as AIDS is concerned.

**Table 4.10: Different ways of Contacting HIV/AIDS**

Different ways people contact HIV/AIDS	Frequency	Percentage
Virginal Sex	28	14.0
Anal sex	04	2.0
Oral sex	14	7.0
Injection drug	38	19.0
Mother to child transmission	42	21.0
Blood transfusion and Blood product	34	17.0
Tattoos/Piercing	06	3.0
Unsterilized metal objects	24	12.0
Not Applicable	10	5.0
<b>Total</b>	<b>200</b>	<b>100.0</b>

**Source; field data, 2015**

Table 4.10 explains the main way through which people can contact AIDS. Most of the respondents 21.0% said it is mainly through mother to child transmission, 19.0% said it is through injection drug, 17.0% is through blood transfusion and blood product while only 3.0% of the respondents said it is through Tattoos/piercing. This indicates that there are various ways people could contact AIDS but it is mostly through mother to child transmission because the population of Nigerians is growing very fast even secondary school students give birth to



unwanted children. This category of young parents have little or knowledge or understanding on HIV/AIDS.

**Table 4.11: If Respondents have ever gone for HIV/AIDS Test**

Option	Frequency	Percentage
Yes	106	53.0
No	90	45.0
Don't Know	04	2.0
<b>Total</b>	<b>200</b>	<b>100.0</b>

Source; field data, 2015

Table 4.11 shows that 53.0% of the respondents said yes, they have ever gone for HIV/AIDS test, 45.0% of the respondents said no, they have not gone for HIV/AIDS test while only 2.0% of the respondents don't know. It simply means that even though most respondents know their HIV/AIDS status through test, it is sad that about 47.0% of the respondents did not subject themselves to HIV/AIDS. This is dangerous for any society or organization or institution like FUOYE.

**Table 4.12: Respondents recent HIV/AIDS Test**

Recent HIV/AIDS Test	Frequency	Percentage
< a month ago	16	8.0
2 - 4 month ago	18	9.0
5 -7 month ago	24	12.0
8 - 10 month ago	34	17.0
11 -12 month ago	18	9.0
Not Applicable	90	45.0
<b>Total</b>	<b>200</b>	<b>100.0</b>

Source; field data, 2015

Table 4.12 shows that 17.0% of the respondents did HIV/AIDS test within 8-10 months ago, 12.0% did the test 5-7 months ago, 9.0% of the respondents did their test 2-4 months and 11-12 months ago while 45.0% of the respondents did not respond to this question. It means those that subject themselves to HIV/AIDS did it in less than a year ago. This enables them to be very sure of their HIV/AIDS status anytime and anywhere.

### 4.3 Respondents Knowledge of Voluntary Counselling and Test

**Table 4.13: If Respondents have ever gone for Voluntary Counselling and Test?**

Option	Frequency	Percentage
Yes	62	31.0
No	128	64.0
Don't Know	10	5.0
<b>Total</b>	<b>200</b>	<b>100.0</b>

Source; field data, 2015

Table 4.13 most of the respondents 64.0% said no, they have never gone for voluntary and counselling test (VCT), 31.0% of the respondents said yes, they have ever gone for VCT while only 5.0% of the respondents said they don't know. This simply means almost 65% of the whole respondents have not done VCT. This is also very dangerous situation especially in a tertiary institution like FUOYE.

**Table 4.14: Where Respondents heard about Voluntary Counselling and Test**

Place Respondents did VCT	Frequency	Percentage
School health center	12	6.0
Government Hospital	32	16.0
Private Hospital	14	7.0
Mobile Clinic	04	2.0
Private organization	138	69.0
<b>Total</b>	<b>200</b>	<b>100.0</b>

Source; field data 2015

Table 4.14 shows that 69.0% of the respondents did their voluntary counselling test in private organization, 16.0% of the respondents did theirs in government hospital, 7.0% of the respondents said they did their VCT in private hospital while 2.0% of the respondents did their VCT in mobile clinic. It indicate that although there are several places where people can get to know about VCT but it is important to note that private organisations or bodies such as UNICEF, UNDP and WHO and some philanthropic bodies engage in creating an effective and wide range awareness about VCT especially during national event anywhere in the country. For instance, Obafemi Awolowo University, Ile-Ife hosted NUGA last year, at the event center, private body came with the awareness and test for HIV/AIDS voluntary and counselling test (VCT).

**Table 4.15: Respondents Experience during VCT**

<b>Respondents Experience</b>	<b>Frequency</b>	<b>Percentage</b>
Good	32	16.0
It is fun	16	8.0
Educative	12	6.0
No Response	140	70.0
<b>Total</b>	<b>200</b>	<b>100.0</b>

**Source; field data, 2015**

Table 4.15 shows that 16.0% of the respondents said their experience of VCT is good, 8.0% of the respondents said their experience is fun, 6.0% said it is educative while 70.0% of the respondents did not respond to the question. This depicts the fact that the experience of the respondents differ from one person to the other. It is noteworthy that a whole 70.0% of the respondents did not respond simply because they did not participate in the exercise from the outset.

**Table 4.16: Why some Respondents have not done VCT**

<b>Reasons why Respondents did not do VCT</b>	<b>Frequency</b>	<b>Percentage</b>
Its only meant for HIV patients	33	16.5
Am afraid	29	14.5
Discrimination	20	10.0
I do not know any center	56	28.0
Not Applicable	62	31.0
<b>Total</b>	<b>200</b>	<b>100.0</b>

**Source; field data, 2015**

Table 4.16 disclose that 28.0% of the respondents said they have not done VCT because they do not know any center, 16.5% of the respondents said the test is only meant for HIV patients, 14.5% said that they are afraid while 31.0% of the respondents not applicable. This means there are several reasons why most of the respondents did not subject themselves to VCT. It is disheartening to note that quite a number of respondents do not know where to do VCT, this show that awareness for VCT is still very poor.

**Table 4.17: Number of times Respondents have gone for VCT**

Number of times of doing VCT	Frequency	Percentage
1 time only	28	14.0
2 times only	24	12.0
3 times only	10	5.0
4 times only	04	2.0
Never done	122	61.0
No Response	12	6.0
<b>Total</b>	<b>200</b>	<b>100.0</b>

Source; field data 2015

Table 4.17 shows that 14.0% of the respondents said they have done VCT only one time, 12.0% did for two times, 5.0% did it three times while 61.0% of the respondents said they never did VCT. This indicates that while some respondents have done VCT several times in order to be sure of their status at all times, majority of the respondents have not done voluntary counselling and test at all.

#### 4.4 Respondents Attitude to Voluntary Counselling and Test

**Table 4.18: Attitude of Respondents to Voluntary Counselling and Test**

INDICES	SA	A	N	D	SD
The health workers are not accommodating to HIV/AIDS patients	30(15.0%)	38(19.0%)	26(13.0%)	48(24.0%)	58(29.0%)
I am afraid of knowing my HIV/AIDS status	26(13.0%)	86(43.0%)	08(4.0%)	56(28.0%)	24(12.0%)
I can commit suicide if tested HIV/AIDS negative	08(4.0%)	44(22.0%)	40(20.0)	64(32.0%)	44(22.0%)
My attitude towards VCT is negative	04(2.0%)	60(30.0%)	60(30.0%)	68(34.0%)	08(4.0%)
I don't want to die early because of stigmatization of HIV/AIDS	70(35.0%)	104(52.0%)	06(3.0%)	20(10.0%)	-

Source; field data, 2015

Table 4.18 measure attitude of respondents to voluntary counselling and test. 29.0% of the respondents strongly disagree that health workers are not accommodating, 43.0% of the respondents agree that they are afraid of knowing their HIV/AIDS status, 32.0% of the respondents disagree that I can commit suicide if tested HIV/AIDS negative, 34.0% disagree that my attitude towards VCT is negative and 35.0% of the respondents strongly agree that I don't want to die early because of stigmatization of HIV/AIDS. This indicate that even though

it seems the respondents will maintain a positive to VCT exercise anytime and anywhere, they said they did not have a negative attitude towards VCT but at the same time they do not want to die yet.

## CHPATER FIVE

### SUMMARY, CONCLUSION AND RECOMMENDATIONS

#### 5.0 Introduction

This chapter discusses the summary of the study, the conclusion arrived at in the course of this study and the recommendations reach base on the results of the findings.

#### 5.1 Summary

This section is on the summary of the whole project starting from chapter one to chapter four. Chapter focus on issues like background to the study, significance of the study, statement of the problem, research questions and objectives of the study. Chapter two review relevant but current past empirical studies in order to fill an academic gap in these works. Chapter three is the methodology, it looks at issues like design of the research, population of the study, sample size for the study and sampling technique. The instrument used for data collection was also discussed, method of data analysis was explained. Chapter four discussed the findings of the study in different themes. Some of the findings are 45.5% were within the age range of 18-22, majority of them 53.5% were female while only 46.5% were male. 56.4% of the respondents were Christians and 75.0% of the respondents which is the majority were single.

Also, findings revealed that 99.0% of the respondents said yes, they have heard of HIV/AIDS and 69.0% said yes they have ever heard of VCT while only 6.0% of the respondents said they don't know, 28.0% of the respondents got to know about HIV/AIDS through friends and 33.0% of the respondents heard about VCT in the hospital, most of the respondents 95.0% said yes, they know ways through which people can contact HIV/AIDS while only 5.0% of the respondents said no, they do not know ways people could contact it, 21.0% said it is mainly through mother to child transmission, 19.0% said it is trough injection drug, 53.0% of the respondents said yes, they have ever gone for HIV/AIDS test, 45.0% of the

respondents said no, they have not gone for HIV/AIDS test while only 2.0% of the respondents don't know, 17.0% of the respondents did HIV/AIDS test within 8-10 months ago, 64.0% said no, they have never gone for voluntary and counselling test (VCT), 69.0% of the respondents did their voluntary counselling test in private organization, 16.0% of the respondents said their experience of VCT is good, 8.0% of the respondents said their experience is fun, 28.0% of the respondents said they have not done VCT because they do not know any center, 14.0% of the respondents said they have done VCT only one time, 29.0% of the respondents strongly disagree that health workers are not accommodating.

## **5.2 Conclusion**

This section is the concluding part of this study. The study concluded that that the students of Federal University Oye-Ekiti demonstrated a positive attitude towards HIV/AIDS voluntary counselling and test (VCT) because it enables them to know their HIV/AIDS status, it also curtail to the barest minimum the spread of venereal diseases which is rampant among students in tertiary institutions but the major challenge is that they did not know places where the test can be conducted.

## **5.3 Recommendations**

This study came up with some recommendations base on the quantitative data collected for this study. The recommendations are as follows:

- i. The study recommended that management of FUOYE should put in place an arrangement that will enable students especially the new students to undergo VCT in the course of their registration.
- ii. Management must ensure that student do VCT every semester in order to manage or control the unnecessary spread of venereal diseases among students.
- iii. The health sector should expedite action in educating the general public and even students in their respective institutions on the issue of VCT.

- iv. Health personnel should always hold talk or workshop with students regularly in order to sensitize them and even build or prepared their minds in term of voluntary counselling and test (VCT).
- v. Management should ensure that students play safe any time they feel like exercise their sexual urge to reduce SDT in the campus.



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## APPENDIX

### Questionnaire

My name is Osaloni Oluwasegun Funmilayo a final year student in the Department of Sociology at federal university of Oye Ekiti. I am conducting a research on the title, 'Knowledge and Attitude of students at Federal University Oye Ekiti (FUOYE) towards HIV/AIDS Voluntary Counselling Test (VCT).'. I plead with you to answer the following questions as your responses will aid this research. I promise that all your responses will be treated confidentially.

#### Section A: Respondent's Background Information

1. What is your age (as at your last birthday)?

- A. 13-17
- B. 17-22
- C. 22-27
- D. 28-32
- E. 32-37
- F. 38-others

2. Sex:

- A. Male
- B. Female

3. Religion:

- A. Christian
- B. Islam
- C. Traditional

4. Marital Status:

- A. Single

- B. Married
- C. Divorced
- D. Separated
5. Level;
- A. 100level
- B. 200level
- C. 300level
- D. 400level
6. Faculty;
- A. Social science and humanities
- B. Science
- C. Engineering
- D. Agriculture

**Section B: Knowledge of HIV/AIDS**

7. Have you ever heard about HIV/AIDS?
- A. Yes
- B. No
8. If yes where?
- A. Friends
- B. Family member
- C. Mass media
- D. Social network
- E. Hospital
- F. Others
9. Do you know how HIV/AIDS is being contracted?

- A. Yes ()
- B. No ()

10. Tick as many as possible way of contacting HIV/AIDs that you know

- A. Virginal Sex ()
- B. Anal Sex ()
- C. Oral Sex ()
- D. Injection Drugs ()
- E. Mother To Child Transmission ()
- F. Blood Transfusion And Blood Product ()
- G. Tattoos/Piercing ()
- H. others ()

.....

11. Have you ever gone for HIV/AIDS test?

- A. Yes ()
- B. No ()

12. If yes, how was your experience? .....

13. If no why?.....

14. How many months was your most recent HIV/AIDS test?

- A. <Months ago ()
- B. 2-4 months ago ()
- C. 5-7 months ago ()
- D. 8-10 months ago ()
- E. 11-12 months ago ()

**Section C: Knowledge of Voluntary Counselling Test**

15. Have you ever heard about Voluntary Counseling Test?

- A. Yes ()

B. No ( )

C. Don't know ( )

16. What do you understand by Voluntary Counseling

Test?.....

.....

.....

17. If yes, through which medium?

A. Friends ( )

B. Family ( )

C. Mass media ( )

D. Social network ( )

E Hospital ( )

18. Have you ever gone for VCT?

A. Yes ( )

B. No ( )

19. If yes where?

A. School health center ( )

B. Government hospital ( )

C. Private Hospital ( )

D. Mobile Clinic ( )

E. Other Public sector (specify).....

20. If yes, how was your experience like?.....

21. If no why?

A. Its only HIV patient ( )

B. Am afraid ( )

- C Discrimination ()
- D. I do not know any center ()
- E. Others (specify).....

22. How many times have you gone for VCT in the last 7 months?

- A. 1 time only ()
- B. 2 times only ()
- C. 3 times only ()
- D. 4 times only ()
- E. Never ()

23. Below are some set of questions about your perspective about Voluntary Counseling

Test. Please indicate your opinions about those questions with the following figures.

- 5. Strongly agree
- 4. Agree
- 3. No opinion
- 2 Disagree
- 1. Strongly disagree

OPTIONS	SA	A	ID	D	SD
The health workers are not accommodating to HIV/AIDS patients					
Am afraid of knowing my HIV/AIDS status					
I can commit suicide if tested HIV/AIDS positive					
My attitude towards VCT is negative					
I don't want to die early because of stigmatization of HIV/AIDS					