

**SOCIAL STUDIES STUDENTS' PERCEPTION ON LEARNING SEX
EDUCATION IN SECONDARY SCHOOLS IN EGOR LOCAL
GOVERNMENT AREA OF EDO STATE**

BY

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UNIVERSITY OF BENIN

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**A PROJECT SUBMITTED TO THE DEPARTMENT OF
CURRICULUM AND INSTRUCTIONAL TECHNOLOGY,
FACULTY OF EDUCATION, UNIVERSITY OF BENIN, BENIN
CITY. IN THE PARTIAL FUFILMENT OF THE REQUIREMENT
FOR THE AWARD OF BACHELOR OF SCIENCE EDUCATION
(B.SC (ED)) DEGREE IN SOCIAL STUDIES EDUCATION**

JUNE, 2019.

CERTIFICATION

This is to certify that this project work was carried out by **Faith AHUNWAN** with matriculation number **EDU1311101** in the Department of Curriculum and Instructional technology, Faculty of Education, University of Benin, Benin City, Nigeria, in partial fulfilment for the requirement for the award of B.Sc. (Ed) Degree in Social Studies.

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DEDICATION

This project work is dedicated to God Almighty for His grace, protection, mercy, knowledge and guidance towards my life and throughout my study in the University.

ACKNOWLEDGMENT

I will not cease, but to keep thanking the Almighty God who through human instruments, brought this work to fruition. I give glory and honour to Him, particularly for His sufficient grace that carried me throughout my study in University of Benin.

All thanks to my project supervisor, Dr. O.S. Olanrewaju who gave good guidance in the writing of this project, the support and patience he showed every time he made corrections is appreciated.

To all the lecturers of Curriculum and Instructional Technology, especially the Acting Head of Department; Dr. John Egharevba, Prof. (Mrs.) L. Eraikhuemen, Prof. Anthony Imiavan, Dr. (Mrs.) F.N. Ofuani and Dr. (Mrs.) I.K. Oteze and many others. I say thank you.

Special thanks to my lovely family, my husband Mr. Kingsley Igbineweka and my lovely daughter, Perculiar for their love and support towards my success.

Profound thanks to my parents, Mr. and Mrs. Festus Ahunwan and my siblings, Peace, Joy, Happiness and Samuel for their care and love. God bless you all abundantly.

Special thanks to my wonderful and cute friends, Stella, Precious, Glory, Bright and Mrs. Celina for their support and encouragement. To all other persons who have contributed immensely, but because of space, could not be mentioned, I express my unreserved gratitude. May God reward you all for your kind efforts, Amen.

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ABSTRACT

This study assessed students of social studies perception on the learning of sex education in secondary schools in Egor Local Government Area of Edo State. The descriptive survey method was adopted for the study. A sample size of 250 respondents was used. A structured questionnaire was used for data collection of the study. The statistical tools used to analyzed the research questions were the frequency count, simple percentage and mean score. The findings revealed that social studies students had knowledge of sex education, that religion belief affected the learning of sex education in secondary schools. That cultural belief affected the learning of sex education in secondary schools and that perception of sex education by students affected the learning of sex education positively in secondary schools.

Based on the findings, it was recommended that both parents and teachers should teach of more comprehensive sex education without any element of prejudice to any aspect of the content. Since the students were of the opinion that the teachers were the best person to discuss sex related issues with, teachers should strive to create a friendly atmosphere with the students so that they can be properly guided on sex related issues. Contraception should be taught in sex education in line with the culture of the society, religious leaders should make it a sole responsibility by organizing seminars, moral lessons basically on sex education to educate young people on how to tackle sexual harassment.

CHAPTER ONE

INTRODUCTION

Background of the Study

Many young people do not get adequate training regarding their sexual lives. This leaves them potentially vulnerable to coercion, abuse and exploitation, unintended pregnancy and Sexually Transmitted Diseases (STDS), including HIV. Many young people approach adulthood faced with conflicting and confusing messages about sex and gender. This is often made worse by embarrassment, silence and disapproval of open discussion of sexual matters by adults, including parents and teachers, at the very time when it is most needed.

The sex education and its introduction in secondary schools have witnessed much controversies and misconception by many teachers, parents, the society and students. The concept of sex education which is sometimes called sexuality education or sex and relationship education attracts a plethora of definitions from different people. According to Frimpong (2010), sex education is "the systematic attempt to promote the healthy awareness in the individual on matters of his/her sexual development, functioning, behavior and attitudes through direct teaching".

Similarly, the Sexuality Information and Education Council of the United States (SIECUS) in Njoku (2008), sees sex education as "a planned process of education that

fosters the acquisition of factual information, the formation of positive attitudes, beliefs and values as well as the development of skills to cope with the biological, psychological, socio-cultural, and spiritual aspects of human sexuality' From these definitions, it can be deduced that sex education is a deliberate, planned and organized learning experience in the aspect of human sexuality which is intended to equip young people with the requisite skills and adequate knowledge which will enable them to develop positive attitude on sex related issues as well as to take rational decisions in line with societal expectations. It is important to note that sex education was not just incorporated into social studies for knowledge acquisition but to help young people develop attitudes, values, goals and practices that are based on sound knowledge which will enable them to express their

Sexual and mating impulses in a manner that is socially and ethically acceptable as well as personally satisfying (Abdu, 2006; Okafor in Bozimo & Ikwumelu, 1999). The concept of sex education in Nigerian schools is not a new concept in Nigeria. epoju (2005) and Abdu (2006) postulated that traditional form of sex education and family life education has been in existence where kinship systems, age grade and coming of age ceremonies or initiation ceremonies where the youths were tutored about manhood and womanhood. It was purely biological and cultural, while various methods of contraceptives were just kept at the domain of married people and kept secret. Many young people were kept in the dark as they were not opportuned to be properly educated on family life and sex education because their training was on "dos and don'ts".

Traditionally, sex education was to be given to every child and adolescents by his/her immediate family but these practice has been eroded by the influence of modernization, western civilization, and collapsing family life; thereby leaving the young ones at the mercy of the wider society and other socializing agents who may not give accurate information that can assist the young ones in their transition to adulthood. This vacuum in the life of adolescents is what the school needed to fill through the teaching of sex education in social studies.

The recognition of the above gap as well as the risk in adolescents reproductive health who are prone to unplanned sex, unwanted pregnancy, unsafe abortion, sexual Acoercion, sexual violence, sexually transmitted infections (STIs) and even Human Immune Deficiency Virus (HIV) owing to lack of information or misinformation about the implications of their reproductive behavior and health risks especially from under-age sexual practices and other anti-social practices prompted the Federal government of Nigeria through the National Council on Education (NCE) to incorporate sexuality education into the national school curriculum in 1999 (Onwuzobe & Ekanem, 2009). This became necessary in order to prepare adolescents for their adult roles in line with acceptable societal standard, and to also empower young people to have greater control over their sexuality and reproductive life to their own benefit both socially and economically. It is also a means of safeguarding or protecting the youths against the

consequences of sexual ignorance as well as preparing them for responsible life (Njoku, 2008).

Since the family which is the primary agent of socialization where sex education ought to be taught seems not to help the adolescents in this regard, as issues that have to do with sexuality is oftentimes not discussed with them, owing to the belief that keeping them in perpetual ignorance about their sexuality will prevent them from immoral behavior (Abdu, 2006), many adolescents have resorted to confiding in their friends and school mates who often mislead them knowingly or unknowingly (Udemezue, 2011).

Apart from their friends, they also source for information from the internet, television, pornographic films and materials which often mislead them and cause more havoc and confusion.

1.1 STATEMENT OF THE PROBLEM

The research work aims at examining the various levels of awareness of the HIV/AIDS scourge among youths in secondary schools especially in Ikpoba Okha Local Government Area of Edo State.

It is set:

- (i) To determine their level of awareness as regards the HIV/AIDS as a killer disease.
- (ii) To determine their level of promiscuity along the line of their level of awareness.
- (iii) To know their level of awareness as regards the transmission of HIV/AIDS.
- (iv) To determine to what extent, how this awareness, if any, has affected their sexual behavior.
- (v) To know their level of awareness as regards the control/prevention of HIV/AIDS.

1.2 OBJECTIVE OF THE STUDY

This study seeks to examine the level of awareness of HIV/AIDS and the sexual behavior of students in Ikpoba Okha Local Government Area of Edo State with the hope of achieving the following:

- (i) To attempt an assessment of AIDS awareness among students in the Senior Secondary Schools in Ikpoba Okha Local Government Area of Edo State.
- (ii) To examine the attitude of these students towards the spread and consequences of the disease.
- (iii) To help them to understand their sexuality and educate them on their roles in the society.

- (iv) To maintain and adopt effective productive control of HIV/AIDS and other sexually transmitted diseases.

1.3 SCOPE OF THE STUDY

This study will be conducted among students in secondary schools in Ikpoba Okha Local Government Area of Edo State. The study will seek to examine their knowledge of AIDS and how it affects their sexual behavior. The adolescents to be selected for the study are currently in their SSS classes and the schools for the survey are:

- (i) Henson Demonstration Secondary School, Benin City;
- (ii) Niger College, Benin City; and
- (iii) Immaculate Conception College (ICC), Benin City.

The above schools are all predominately mixed and female schools in Ikpoba Okha Local Government Area of Edo State.

1.4 SIGNIFICANCE OF THE STUDY

The importance of this research will be justified on the ground that the relationship between AIDS and sexual activity amongst youths cannot be overemphasized. Sex is a predominantly mode of AIDS transmission and the presence of sexually transmitted disease such as syphilis and gonorrhoea increase the odds of transmitting and contracting AIDS. The disease AIDS has not only been referred to as

medical issues but also as a social issue. One major sensitive group that has not been reached collectively are young women who are “the mothers of tomorrow”.

The report of the Nigerian demographic and Health survey suggests that by age 20, approximately 80 percent of Nigerian girls have experienced sexual intercourse. In addition, a sizeable proportion of Nigerian teenagers have multiple sex partners. It is worthy of note that 7,000 young people, aged 10-24 are infected everyday with HIV with a staggering 1.7 million youth infected yearly in African countries.

This study therefore is an attempt to suggest ways of increasing the awareness level of AIDS and its relationship to sexual behavior among youths in secondary schools with a view that the information provided would educate them on the seriousness of AIDS to human race. The study will also inform young people of the causes, mode of contact, position and consequences of AIDS. Lastly, the study seeks to suggest ways of positively changing negative sexual behaviours. This will be in turn contributes to reduce the spread of HIV/AIDS in Nigeria.

1.5 RESEARCH HYPOTHESES

- (i) There is a direct relationship between the level of education and awareness/perception of AIDS among secondary school students.
- (ii) There is significant difference between AIDS and knowledge of its consequences.

- (iii) Youths with one sex partner are less likely to be infected with AIDS than those with multiple sex partners.
- (iv) Peers influence increased sexual behaviour/activity.

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CHAPTER TWO

LITERATURE REVIEW

2.1 ADOLESCENTS

Adolescents form an important component of the Nigerian population. In 1970, male and female adolescents aged 15-24 constituted 18% of the total population, which translated into a figure of 11 million. Of this number, 50.4% were females. One feature which the adolescent population shares with the total population is its rate of incidence since the early 1960s. According to the medium variant UN projection, the adolescent projection rose to 15 million by mid-1980. These projections also indicate that the adolescent population will increase to 22 million 1990 and by the year 2000, the total adolescent population is expected to increase faster than the total Nigeria population.

AIDS stand for four words-Acquired Immune Deficiency Syndrome. The word “immune:” refers to the defence system of the body which helps to fight all kinds of diseases. However, this system does work in a body that is infected with AIDS. AIDS was first reported in 1981 and is caused by a virus-a tiny germ invisible to the naked eye called Human Immune Deficiency Virus (HIV). This attack selected cells in the human system and produces defeats in function which may not be apparent for some yeas (Leonie Mcsweeny: 1999, p. 12).

Consequently, these defeats lead to a severe suppression of the immune system's inability to resist harmful organizations. This leaves the body open to invasion by various infections, which are called "opportunistic diseases", and to the development of unusual cancers.

It is therefore no longer news that HIV is now well established in Nigeria. Although the virus was first identified in Nigeria in 1986, over 4 million Nigerians were estimated to have contracted it by the end of 1998. This puts Nigeria among the first four countries in Africa with the highest burden of the disease which has now permeated the entire Nigerian social fabric affecting men and women in urban and rural areas as well as adolescent, commercial sex workers, traders, servicemen and women, high profile politicians and students. It is now tagged with which names as "the silent killer", "king of STDs", "the plague from God", "end of the road" and a lot more. In addition, this epidemic has assumed major proportions and projections indicate that if progress is not made against it, it will rank as history's greatest killer (Madhok, R. et al., 1987) and Jacquelyn, H.F. 1989).

Indeed everyone must feel vulnerable to the disease which is fast rampaging the most productive age groups in the Nigeria population. Millions have died of the disease and this has brought untold hardship and disorganization to many Nigerian families.

The origin of AIDS is controversial due to the fact that Western scientists have claimed that it occurred in infected animals and later transmitted to man, probably from monkeys (Joubemsa: 1987, Vol. 6 and Leslle, P., 1990). On the other hand, African scientists maintain that it originated to Africa by tourist of America and was introduced to Africa by tourists from there.

Edwards et al. (1995), and Leonie Mscweeny (1991) identified two strains of HIV: HIV -1 and HIV – 2. HIV – 1 is the major causative agent of AIDS in North America, Europe and Central Africa while HIF – 2 is an additional cause in West Africa Countries such as Senegal, Cote d’ Voire and Guinea Bissau (Roderick, N.M.M. et al., 1992).

AIDS – the punishment of our generation and time globally has killed about 16 million people since its outbreak. The annual report by United States Population Reference Bureau states that 2.6 million deaths in 1999 claimed that 95% of people with HIV/AIDS are in developing countries with population. In addition, over 4 million Nigerians are infected. Worldwide, 7.4 million people were newly infected last year with the human immune deficiency virus which causes AIDS. A total of 15.2 million children have been orphaned since the diseases first spread (The Daily Times: August 9, 2006, p. 6).

There are now 16 countries where more than one-tenth of the population aged 15-49 carried the AIDS virus, all in sub-Saharan Africa. In seven of these, at least adult in

five is infected. Women are harder hit than men (This will be explained later). The Southern African national of Botswana has the highest rate with 36 percent of adults infected. In South Africa, which has a 20 percent infection rate, there are 4.2 million people living with the virus- the highest single national total in the world.

In other countries, life expectancy rates are being slashed. In Zimbabwe, a male who was 15 in 1983 had a 15 percent chance of dying before reaching his 50th birthday. This likelihood rose to 50 percent for those turning 15 in 1997.

According to UNAIDS' report, the infection rates in teenagers and young women in some African countries is "frighteningly high". Nearly six out of 10 women under 24 in the South Africa town of Durban tested positive in a study (Sunday Punch: July 2, 2000, p. 16).

It has been proved that, Africa is the most affected by HIV infection and AIDS. The African continent probably has the highest proportion of HIV infection in the healthy population and the highest incidence of AIDS. To support the above statement with statistically data, the Nigerian Tribune (December 9, 1998, p. 12) reports that out of the 33.4 million persons infected with HIV worldwide, over 22 million live in Africa.

AIDS in Africa is a heterosexually transmitted disease, a situation that is the opposite of that which exist in Western nations where it is widely known that the homosexual is the principal victim (Leslie, P., 1990).

2.2 TRANSMISSION OF HIV/AIDS

Being infected with HIV has been isolated from a number of body fluid including saliva, tears and urine. However, many researchers agree on the following modes of contracting HIV.

- 1. Sexual Contact with an infected Person:** This can be through heterosexual and homosexual relationships. In addition, having more than one sexual partner also carries an especially high risk the more sexual partners a person has, the more likely the person will come in contact with someone infected. People such as sexually active young teenagers, prostitutes and their clients are therefore particularly at risk.
- 2. Through blood transfusion or contact with infected blood:** Through the use of skin-piercing instruments as in the case of administration of injections (in medical setting and among drug users), scarification, ear-piercing, circumcision, manicure and pedicure, shaving and cutting of umbilical cord.
- 3. Through mother to child:** Which can occur while the baby is in the womb (circulation to the foetus via the umbilical cord), during the process of delivery (when the baby comes in contact with cervical/vaginal secretions and mother's blood) and through breast-feeding.

By far, the sexual route is the commonest for HIV infections in our environment, and the presence of other sexually transmitted diseases such as syphilis and genital sores enhances the possibility of HIV infection during sexual contacts. Every sexual contact with a person of unknown HIV status put one at risk of HIV infection.

Though the disease HIV/AIDS is endemic, the organism is not everywhere. Indeed it cannot exist in more than a few places. In other words, it cannot survive outside the human body. Even when there is a close contact with a person severely affected, the virus can invade the body only through sexual activity or being introduced into the blood stream (Leslie Paine, 1990).

Based on the above therefore, several reports have stated that HIV/AIDS cannot be contracted through the following means:

- (i) Casual contacts with infected persons such as shaking of hands, sharing some toilets, eating together, and even hugging;
- (ii) Insect bites of mosquitoes, bedbug e.t.c;
- (iii) Donating blood-provided the equipment used are sterilized. A blood donor is not at risk, the greater risk lies with the recipient of the blood.

2.3 SYMPTOMS OF HIV/AIDS

It is very important to know that there is a distinction between being infected with HIV and having AIDS. It is not everyone who is infected with HIV that develop AIDS. The symptoms associated with the disease is essentially the product of the weakened immune system of the patient and its consequent inability of fight off diseases, even most of the minor ones.

The World Health Organization (WHO: 1992) gives a list of symptoms of HIV/AIDS infection in an individual. These are:

1. Extreme weight loss;
2. Severe diarrhea longer than one month;
3. Fever of long time duration;
4. Oral thrush (numerous white spots in the mouth and on the tongue);
5. Chest infections and continuous cough that do not respond to treatment.
6. Swelling in the neck and armpits;
7. Night sweats;
8. Skin rashes;
9. Loss of memories;

10. General tiredness.

About all of the above mentioned are termed “opportunistic infections”. When it becomes apparent that someone is suffering from at least one opportunistic infection, this indicates the onset of full blown AIDS (Women’s Health Forum, Vol. 4, No. 2, 1999, p. 5).

2.4 CONTROL/PREVENTION OF HIV/AIDS

Till date, HIV/AIDS has no cure, despite many years of drug and vaccine research activities. However, a few drugs are now available that could prolong the lives of infected persons through reduction of the load of the virus and improvement in the number of white blood cells (Tell Magazines: November 19, 1998, p. 24). Such drugs are however, very expensive, globally and quite scarce in Nigeria, good nutrition and prompt treatment of presenting diseases can also prolong the life of an infected person. Thus, the only effective way of controlling HIV/AIDS presently, is prevention, with education as the main thrust of this approach.

Prevention of infection through the practice of safer sex refers to any sexual practices that reduces the risk of passing HIV from one person to another reducing the number of sexual partners, avoiding sex with partners who have open or STDs, limiting the number of sexual partners and use of condoms are all part of safer sexual practices.

In general, the best protection is to choose ‘sexually related activities’ that do not allow semen, vaginal fluid (including menstrual blood) to enter the mouth, anus or vaginal or to touch the skin where there is an open cut or sore (as body fluid can carry HIV). Thus the most effective way to protect sexual transmission of HIV is to abstain from sex or for two people who are infected to be completely faithfully to each other. Alternatively, the correct use of condom (male or/female types) during every sexual encounter from beginning to the end, will reduce the risk significantly.

Other steps to be taken to avoid the spread of disease include effective screening of every blood donor and donated blood before transfusion, sterilization of medical and skin-piercing instruments, counseling of infected women to possibly avoid pregnancies. Furthermore, the use of leak proof coffin to bury all cases of AIDS or those suspected of dying of AIDS. Also performance of traditional rituals on such bodies should be discouraged.

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In addition to the above, a strong and effective information, education and communication (IEC) campaign is needed in this direction to adequate, information all and sundry about the disease. Experience from countries like Uganda, where the epidemic is on the decline shows that in addition to effective public campaign, the support of the political leadership for HIV/AIDS control programmes is also very important (Women's Health Forum: 1999, p. 5).

Hence Jacquelyn H.F. (1989), declares that knowledge and attitudes are interrelated. Anxiety, fear, discomfort and negative social attitudes usually decrease with increase knowledge of the disease and its transmission.

2.5 WOMEN AT RISK: THE SEPARATE EXPERIENCE

Though Edward C.R.W. et al. (1950) and Awake (November 8, 1998, p. 15) agree that the people at risk of contracting AIDS are homosexuals, bisexual, prostitutes, recipients of blood, children affected mothers and rug users, Mat. Essex et al. distinguished four groups of African women at risk of contracting AIDS. These are as follows:

- 1. Young Women:** The predicament of African women is explained by two sets of factors. The first set of factors is the socio-cultural factors that are beyond their control and these create high-risk situations. The second set of factors is the circumstances that result from the social context, which may be amend to

personal choice and decision-making. Among the first set of factors are African tradition that permits sexually experienced men to seek much younger sexual partners and wives. Many of these young women cannot refuse the sexual advances of older men, nor can they bear the social stigma of being without a husband or without children. With increasing socio-economic disruptions in Africa, premarital and extramarital sexual engagement with men could become more common as an economic survival strategy for young women. Young women, adolescents and girls are also put at risk through aggressive seduction or rape by men who assume that they are free of HIV.

- 2. Women who are wives and mothers:** Rwabukwali et al. (1993), have shown that women in traditional marriages and regular partnerships rarely exhibit risky sexual behaviours. Most of the women in their study who were HIV positive had no sexual partners outside marriage. “The women who indicated that they did not intend to change”. They believe it was the husband’s behaviour that put them at risk and that needed to change. also where polygamy is still culturally valued, the virus may be spread from an infected husband to all his wives.

Thus, among all African women affected by AIDS, the women who are wives and mothers are uniquely vulnerable because they stand at personal risk when being directly infected by HIV, her health is impaired and her capacity to fulfill the earlier delineated socio-cultural producer roles

within the kinship network is limited. With AIDS, her future reproductive role is also jeopardized. The consequent failure in these roles could be abandonment or divorce by her husband, blame from relatives for husband's illness if he falls sick, and a deep sense of shame, anxiety, guilt and depression if she produces a child who fails to thrive or who dies. Because many African wives and mothers lack formal education and independent means to free themselves from the quagmire of problems that AIDS create, they are often trapped in a hopeless situation.

- 3. Women with Multiple Partners:** Before AIDS, few male-dominated African governments or women's advocacy groups bothered to investigate the underlying problems leading African women to enter into prostitution. Because of AID, much more sympathetic scholarly treatment has been given to exploring the root causes of prostitution. Mholoyi et. al are among the many that have identified economic need as the force driving many women to prostitution. The selling of sex, they argue may be the only choice many have 'between starvation and survival'.

A 1989 report by SWAA observes that, despite the fear of HIV infection, the threat of poverty compels many women to continue in prostitution. It recommends that the socio-economic determinants of such multiple partner risk-taking be fully examined and the related problems are remedied.

4. Women as Survivors: A final group who must struggle against AIDS is the survivors. Among these are the widows of men who have died of AIDS, who must live with bereavement and an often-unplanned future, and also must often become heads of households. This usually means providing clothing, shelter and education for their children. Widows who were infected by their husbands face these tasks with falling health and while coping with the trauma of their own impending death. Still other widows find that the death of their husbands strip them of all property; some lose their surviving children, are cast out of the marital home without the support of their immediate family or that of their husband's kin.

Lastly, elderly women may also become HIV infected through husbands who continue to have sexual relationships with younger women. Others who have lost their adult children to AIDS are left alone to rear their grandchildren.

2.6 SEXUAL BEHAVIOUR AMONG YOUTH

Of the major causes of moral degeneration in our society today is the almost breakdown of the traditional moral standards due to the infusion of foreign ideas, population explosion, economic plus watered down religion. Psychologists and Sociologists know that between the breakdown of an established traditional way of life and the development and establishment of new ones, there is a cultural lag, which usually takes many years of building up. It is during this period of anomie the period of no moral

guidance that the people experiencing the lag, the unprotectedness behave out of pattern in a degenerating way.

The Nigerian Demographic and Health Survey reports that by age 20, close to 80 percent of Nigerian girls have experienced sexual intercourse. Close to 82 percent of females and 72 percent of males in a research had intercourse by the age of 19 in Ibadan. Research findings indicate that in urban areas. Also teenagers especially boys hardly ever keep one sexual partner (National Concord: May 28, 1996, p. 14).

It was revealed that teenagers who mostly engaged in sexual activities do not make use of contraceptives and even when they do, they made use of ineffective methods. This often leads to infection of STDs/AIDS and unwanted pregnancies (Uche C. 1999).

Obviously, friendly amongst youths sometimes does more harm than good. In this present generation, teenagers involve themselves in games of friendship, which may not favour some of them. Girls, being the weaker sex are easily deceived by boys with their sweet-coated tongues and unfulfilled promises.

Teenagers disrespect their parents since their counterparts are able to provide them with their necessary needs, which the parents cannot provide for them. Some unlucky girls whose friendship of his kind becomes unfortunately pregnant may lead to abortions by quack doctors that might render them infertile after settling down for marriage (Mrs. Ngozi Ogbonna).

The situation has become so ugly that Aparo L.S. (1988), asserts “the Nigerian woman’s pride has been nailed to the coffin by the act of immorality just because of acquiring wealth. Motherhood would be in shambles when young girls and women alike engaged in immoral acts like prostitution stocking private parts with harmful drugs like cocaine, heroin, opium hard currency etc. What sort of training is these young mothers of tomorrow giving to their offspring and what type of Nigerians are they producing for the future?

In conclusion therefore, parents and school authorities owe it as a duty to impact the awareness of sex education on the young ones in order to avert the unpleasant outcome of STDs/AIDS that normally results from lack of knowledge.

2.7 ADOLESCENTS’ PERCEPTION OF AIDS

To date, information on perception of HIV/AIDS among young people in sub-Saharan Africa is generally lacking and it is not clear what AIDS education campaign has specifically achieved between 1987 and 1999. In countries for which data are available—including Congo, Zimbabwe, Uganda, Tanzania and South Africa, relatively high levels of AIDS awareness were reported among secondary school students and the knowledge that HIV can be sexually transmitted appeared common. As with adults however, AIDS awareness does not necessarily indicate as accurate understanding and misconception about how AIDS is transmitted are common among adolescents.

Glew Williams et al. (1989) in their survey discovered that more than half of the students studied for example, expressed varying degrees of confusion about the precise mode of transmission. Whereas many mentioned heterosexual intercourses as a vehicle of spread and believed that HIV can be prevented, knowledge about preventive techniques and behaviours remained superficial and the belief that AIDS is curable spread widespread.

Simultaneously held beliefs that there is or will soon be a cure for AIDS may impede individual's risk reduction as has been observed among other age groups in different parts of the world. Moreover, African students often refer to AIDS as a disease of prostitutes and tend to believe that their own risk of HIV infection is low.

As in the case of women, particularly poor levels of knowledge about AIDS were reported among girls in rural areas, against indicating that female sexuality and problems encountered by women may not be receiving the emphasis they deserve in traditional societies.

In Africa where the proportion of school age youths actually enrolled in school is about one-half of the total eligible population. Out of school adolescents deserve more attention. To date little is known about how HIV affects this group and to what extent they have other access to AIDS prevention information. Given that condom use has been reported to be on the rise among people with multiple sexual partners and who are

engaged in other risky lifestyles, it may be assumed that this, to some extent include out of school adolescents as well as those enrolled in formal educative systems. However, few if any data substantiate this.

2.8 AIDS IN NIGERIA

The first case of AIDS in Nigeria was discovered in 1984 involving a sexually active girl of 13 years (Federal Ministry of Health: 1992). Even since, reported cases have been on the increase each year. For example, in 1990, 90 AIDS cases were reported throughout the country, in 1991, it increased to 218, 367 in 1992 in the first nine months of 1993 (WHO: 1993). By the close of 1993, close to 1000 had been identified with about 6000 HIV positive cases.

The National AIDS/STDs Control Programme (NASCP) of the Federal Ministry of Health in the post Express of January 7, 1999, estimated that close to 3 million Nigerians were living with HIV as at December 1998. The demography of reported AIDS cases in Nigeria indicates that about two-third of those cases are males and the disease is more rampant between the age of 20-39 in both sexes with more than 66% of patients concentrated within this age brackets. HIV infection and even full-blow AIDS have been reported in almost all states of the country. The WHO/AIDs surveillance reports that Lagos, Kaduna, Enugu, Plateau, Bornu, Edo and Benue States have the highest reported case of AIDS.

The main mode of contracting HIV/AIDS in Nigeria is through heterosexual sex, which accounts for more than 71% of AIDS cases. Another avenue for transmitting AIDS is by blood transfusion -25% and 1.4% from mother to child. 255 of the remaining mode of transmission of AIDS could not be specified (WHO, 1993).

Nigerian Tribune (Tuesday 16th March, 1990, p. 3) showed that epidemiology surveillance report by NASCP has indicated that at least 20% of Nigerians living with AIDS are civil servants. In addition, Deret Briggs of the Lagos University Teaching Hospital revealed that the sex distribution of 1996 indicated that 7.64% of HIV positive persons were males and 23.64% were females.

2.9 SOCIAL AND CULTURAL RESPONSE TO HIV/AIDS

The features of a culture derive from the components of the demographic and socio-economic composition of the population. The most important demographic and socio-economic features are age, residence, education, marital status and religion, family/social units, and ethnic identity. These features influence the spatial and sexual mobility of people, their exposure to infection, and their health care-seeking and managing responses.

Age is a changing characteristic with direct impact on sexuality through biological processes as well as co-ails devices. The onset of sexual feelings, the timing of marriage, the sexual debut, and the ability to cope with the demands of sexuality all relate

to the age of the individual. Equally powerful is the effect of the link between age and cultural patterns on the level of culture change and cultural shifts (19). The young are, in the right atmosphere, receptive to new lifestyles and ideas.

Sex forms the basis of allocating roles, privileges, and positions open to members of a community. This typecasting of individuals by gender starts from birth. Most societies share these roles and rights in such a way as to subjugate females to males. The sexual domain is marked by some of the most adverse inequities between the sexes, including unequal sexual negotiating powers. The different timing of marriage by sex, the practice of polygamy, and the age gap between spouses with polygamous union all sustain these inequalities. So total is the dominance of men that women may be considered to have only duties and responsibilities and no rights. Yet the roles of women in the domestic domain make them major assets for care giving in times of health emergencies.

In this context of both the age and sex of individuals, Carael and Makinwa have suggested that the tendency for females' first intercourse to occur at a relatively young age in part explains the spread of HIV among female youths.

Residence in urban or rural area helps determine people's economic and social options, opportunities, and limitations. It also creates the context for developing the coping mechanisms for sexual needs satisfaction, and consequences. Expansion in the

entertainment industry resulted in the creation of the drinking bars, brothels, and rooming houses in large towns where rural-urban migrants, single men, and married men all have access to sex for cash. In effect, both urban and rural areas offer challenges and opportunities for HIV prevention and management.

Education, one of the most potent acquired socio-economic characteristics, is by itself not always the predictor of risk exposure. In combination with other lifestyle issues such as opportunity for travel, type of employment, and access to cash income though, it is closely related to the dynamics of HIV infection, prevention, and management in a population. In effect, both a negative and a positive loop operate between education and the epidemic.

The type of marriage may influence the sexual practices within each type and thus affect the potential exposure to the risk of HIV infection within marriage. The link operates through differential age and marriage between monogamous and polygamous women, the length of postpartum sexual abstinence and lactational amenorrhea. Although a strong negative relationship exists between polygamy and community fertility, it has been difficult to establish any significant differences in HIV prevalence with the type of marriage. This is hardly surprising since serial monogamy is an alternative to having multiple sexual partners.

According to Caldwell, Orubuloye, and Caldwell, polygamy for the Ekiti Yoruba means a reduction of the access of some males to mates and an occasion for engaging in premarital and extramarital sexual activities. Those male sexual needs are met by workers in urban areas and by significant number of divorced, separated, or widowed women. In addition, certain living and cultural arrangement facilitate the sexual access of young family members to the wives of older relatives or the access of visitors of wives of hosts. All these devices are likely predictors of exposure to sexual networks and to HIV infection.

Within polygamy or outside of marriage young girls are often the preferred and possible the easier targets of older men. The public implication shows up in the differential levels of infection between young males and young females in some populations.

Religion plays a major role in the both social behavior and health belief systems. Religion and modernization are modifying some of the sexual excesses of males within traditional sexual codes, yet this modification may be contributing to an increase in the use of sex workers.

Other features of family formation have a potential impact on the epidemic. In the past, the universality of marriage and early timing of marriage served as safety nets for reducing the incidence of premarital sex and promiscuity. Mate selection processes are

now less autocratic and allow greater sexual experimentation between consenting adults than in the past. Even religious dogma and values have failed to reverse the trend. The ease with which children born out of wedlock can receive legal status is a major factor driving this liberal mate selection process. In effect, having multiple sexual partners may not be seen in terms of loose morals but as an integral part of mate selection. Adapting the process of HIV prevention may be more feasible than its drastic modification or condemnation.

The formation of social units-such as the family, trade groups, and ad hoc self-help groups-is based on combinations and permutations of these demographic and social parameters. Some units, such as the family, are formed after elaborate rituals and processes, while others are temporal and easy to form and dissolve as occasion demands. These social units provide the setting within which the interaction of culture, sexuality and risk of HIV infection takes place. So complex are these interactions that an assumption of a static and predictable role of social and cultural factors in the epidemic is likely to be invalid. As with other social and demographic variables, the epidemic can alter the structure and functionality of a family, yet the family is also the frontline unit for caring for people infected with or affected by HIV.

Ethnic identity is the medium through which all the social and economic variables are filtered, and individuals make decisions that they believe confirm their identity. In Nigeria, with a population of more than 130 million and 247 ethnic groups, it is unhelpful

to assume that cultural practices affecting sexual and reproductive health are monolithic and universal to all ethnic groups. Such practices as bride wealth and postpartum abstinence can vary significantly between, and in some cases, within the major Nigerian ethnic groups. What is needed therefore is a brief exploration of the ways in which cultural changes from within and without can be used to design constructive roles in HIV prevention.

2.10 REASONS FOR THE RISE OF HIV/AIDS

While it has been noted that the trend in the spread of HIV infection is being gradually curtailed in some parts of the world, including Africa countries such as Uganda, the rate in some countries is still very much on the increasingly side.

Several factors are responsible for all the increasingly prevalence of HIV/AIDS in Nigeria. These include the deteriorating national economy which makes commercial sex an attractive option for several people. In particular, since the epidemic began years ago, no single Nigerian Government has implemented substantive intervention programmes to reduce the effect of the disease. And yet, it is well known that in some African countries where the incidence of the disease is now stabilizing such as Kenya, Senegal etc., government has always taken the lead to design and implement programmes to stem the rising wave of the epidemic.

On the other hand, a lot of Nigerians still take the issue of HIV/AIDS as a huge joke. The situation is also being worsened by the unchecked activities of traditional healer, many of who are found making false claims about the diseases or the existence of a cure. Statements like “HIV/AIDS is just an advanced gonorrhoea” simply speak volume of the ignorance of many of our traditional healers, just as many of their claims about healing are nothing but fluke.

Other factors fueling the increasing occurrence of the diseases in our environment include stigma and shame. Work situation results in separation of couples, such as is the case of migrant labour, long distance during the military assignment, also indirectly encourage the spread of the disease since new sexual networks may be formed during the accompanying loneliness.

Finally and as stated earlier, inadequate attention and action by the government and people of the country in response to the HIV/AIDS situation has contributed substantially to the rising trend of the disease.

2.11 CONSEQUENCES OF HIV/AIDS

It has been observed that the HIV/AIDS epidemic has brought along with it terrible consequences that are social, economic, psychological and medical in nature.

Socially, there have been reported negative attitudes shown by people towards HIV/AIDS victims. People often view the disease as a social stigma thereby the choice of

HIV/AIDS test before marriage and if positive, the relationship is history. In some places, rejection by the victim's family and the community can cause great emotional stress (Federal Ministry of Health and Services, 1992). Children born by HIV/AIDS positive women are likely to be infected which could be before, during or after delivery. In addition, it has discovered that besides people who have become ill, those who are infected with HIV and remain well have their own predicaments for which they need support. The partners of those affected families and other carriers carry heavy emotional burdens (Gordon, G., 1988).

Economically, a major area of concentration should be how it affects the working population. In particular, lack of knowledge and fear about HIV/AIDS infection means that people with the disease are discriminated against by employers and colleges. For example, some employers have introduced routine HIV testing for employees and applicants who apply for work. Those who tested positive are either dismissed or refused employment. According to Time Magazine, July 17, 2000, page 22, companies in Kenya use a variety of ways to avoid losing worker, and in so doing distort employment patterns. Further, inspite of the fact that the younger people are better educated, older men are employed because they do not "fool around much". Thus, unemployment will definitely come the way of HIV/AIDS carriers especially those that do not look psychologically agile, strong and healthy.

The psychological effort of HIV/AIDS is not different the already mentioned. Various emotional reactions go with HIV/AIDS people. Due to the devastating and destructive life of the individual, his life is painful and a pity to behold. High rate of suicide among infected persons are being recorded. Moreover, AIDS related anxiety might lead to distressing phobic and hypertensive state in otherwise healthy people (Leslie, P. 1990).

Health wise, STDs are significant causes of damage to the human reproductive systems especially the female system. Disease such as gonorrhoea, syphilis, herpes, pelvic inflammatory disease etc. infect both sexual partners and can cause scarring especially in the female's fallopian tubes and other problems such as ectopic pregnancies. However, repeated infection of PIP and other STDs can lead to infertility. Though AIDS does not directly affect fertility, it does make the HIV infected person more susceptible to infections. Lexicon Universal Encyclopedia (1994) also points out that, studies of HIV positive women have found a pattern of increased infection of reproductive organs before diagnose with AIDS.

Leslie Paine (1990) remarks that, AIDS and related conditions occur mostly in young people. Both acute and chronic brain infections may accompany HIV infection, either as a result of the organism itself invading cells in the brain or as complications of the opportunistic infections, which are the hallmark of full-blown AIDS.

In conclusion therefore, the whole effect or consequences of HIV/AIDS mentioned above are all tragedy to poor nations according to Newsweek, December 8, 1987, as UN delivers a bleak message about the world widening AIDS gap captioned “Hope in the Rich World, Despair for the Poor”.

CHAPTER THREE

METHODOLOGY

This study is designed to investigate and to know the attitude, and awareness of AIDS and sexual behavior among SSS III in Benin City of Edo State.

The description of research methodology in this chapter would include the following: Population Studied, Sample Size and Sampling Technique, Research Instrument, Method of Data Analysis and Validation and Reliability of Instrument used.

3.1 STUDY POPULATION

The research was carried out in Kpoba Okha Local Government Area of Edo State among students between the age of 15 and 23 years.

3.2 SAMPLE SIZE AND SAMPLING TECHNIQUE

Simple random sampling technique was adopted in the selection of respondents. This involves random selection of three secondary schools namely; St. Maria Gorretti Girls Grammar School, Niger College School and Immaculate Conception College (ICC), all in Benin City.

From the three secondary schools, students were also randomly selected. One hundred and fifty (150) students constituted the sample size. Fifty respondents were got from each secondary school.

3.3 RESEARCH INSTRUMENT

The instrument of the study was largely through the use of questionnaires. This instrument was selected for two reasons; first, the literacy level would pose no difficulty in answering the questions and secondly, it is my opinion that questionnaires would ensure uniformity and consistency in the questions asked. There were questions on demographic characteristics, history of sexual activities, knowledge of HIV/AIDS and its consequence and perception of HIV/AIDS and its consequence and perception of HIV/AIDS and advice for youths.

3.4 ADMINISTRATION OF THE INSTRUMENT

Though the respondents were not informed beforehand, they were implored to be as honest as possible with the assurance that the information and opinions were meant for academic research and would be treated in strict confidence.

The questionnaires were collected immediately after completion so as to guarantee a hundred percent return of the completed questionnaires and to prevent the respondents from asking questions from other students or consulting relevant books before completing the questionnaire.

3.5 METHOD OF DATA ANALYSIS

The questionnaires were collected and analyzed based on the frequencies and percentages. Also, the data were coded, tabulated and interpreted as they related to the research objectives and hypotheses.

3.6 VALIDATION AND RELIABILITY

A draft of the questionnaire was submitted to the supervisor who after reviewing the questionnaire, made corrections and approved it for use.

CHAPTER FOUR

DATA ANALYSIS

4.1 DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE POPULATION

An analysis of data collected at the end of the exercise revealed that one hundred and forty-one (41) structured questionnaires were returned while nine (9) were not returned. There were forty-nine (49) males representing 34.8% of the total respondents and ninety-two (92) females representing 65.3% of the total respondents. Among the various age groups examined, the age group 15-17 made up about 49.7% age group 18-20 continuing another 34.1% and age 21-23 made up 16.3% of the total sample population.

With regards to religious background, the data revealed one hundred (100) as Christians, a figure that represent 70.9% of the total respondents. Also, twenty-five (25) respondents as Muslims, a total that represents 17.7% and six (60 respondents as tradition, a total that represents 4.3%. Ten (10) out of the total respondents indicated other religion, a total that represents 7.1% of the total respondents.

Parents' Demographic Data

With view from parental responsibilities to the effect of AIDS on the lives of their children due to their parental care and lifestyle, the data revealed forty-five (45) singles 39.7% of the total respondents, sixty four (64), Married ones representing, 45.4%, a total of eleven (11) divorce representing 7.8%, and twenty one (21) of the parents are separated representing 14.9%. Also revealing the occupational life of the parents, the data revealed thirty seven (37) of the parents are civil servants representing 26.2% while self-employed were thirty five (35) representing 24.8%, nineteen (19) of the parents were

farmers, representing 13.5% were traders representing 25.5% and fourteen (14) of the parents were professional in their career, representing 9.9%.

These demographic analyses of respondents are shown below:

Table 4.1.1: Sex of Respondents

Sex	Number	Percentage (%)
Male	49	34.75
Female	92	65.25
Total	141	100.00

Table 4.1.2: Area Group (in years)

Age Group	Number	Percentage (%)
15-17	70	49.65
18-20	48	34.04
21-23	23	16.31
Total	141	100.00

Table 4.1.3: Religious Background

Religion	Number	Percentage (%)
Christianity	100	70.92
Muslim	25	17.73
Tradition	6	4.26
Others	10	7.09
Total	141	100.00

Table 4.1.4: Parents' Marital Status

Status	Number	Percentage (%)
Single	45	39.71
Married	64	45.39
Divorced	11	7.80
Separated	21	14.89
Total	141	100.00

Table 4.1.5: Occupation of Parents

Occupation	Number	Percentage (%)
Civil Servant	100	70.92
Self-Employed	35	24.82
Farmer	19	13.48
Trader	36	25.53
Professional	14	9.92
Total	141	100.00

4.2 KNOWLEDGE AND CAUSES OF HIV/AIDS

On the question-what is AIDS? Only 28.4% of the respondents could define AIDS as “Acquired Immune Deficiency Syndrome”, 17.7% also described it as an incurable disease; 23.4% indicated that it is a deadly disease; 4.3% described it as a virus disease transmitted through blood; 2.8% implied it as a big disease, 3.6% said it is a killer disease, 8.5% explained it as a silent killer, another 7.1% responded that it’s an incurable disease caused by HIV and has no cure. Also 2.1% believed that AIDS is a bad disease, while 7% claimed that the disease does not exist at all, the remaining 1.4% were not indicated.

Similarly, the above shows that despite hearing about AIDS, many of the respondents did not know what it actually means.

In connection to the causes of AIDS, only a few respondents correctly stated that HIV causes AIDS. Others gave answers on how HIV could get into the body instead of identifying HIV as the cause. These include the respondents who put forward that AIDS is caused by sexual intercourse by blood transfusion, the use of unsterilized sharp body piercing instruments, prostitution and others.

Knowledge of HIV/AIDS

Table 4.2.1 Ever Heard of AIDS?

Responses	Number	Percentage (%)
Yes	134	95.04
No	7	4.96
Total	141	100.00

Table 4.2.2: What is AIDS?

Responses	Number	Percentage (%)
Acquired Immune Deficiency Syndrome	40	28.37
Incurable Disease	25	17.73
Deadly Disease	33	23.40
Silent killer	12	8.51
A virus disease transmitted through blood transfusion	6	4.26
Big disease	4	2.84
Bad disease	3	2.13
Incurable disease	10	7.09

It does not exist	1	0.71
Killer disease	5	3.55
Not indicated	2	1.42
Total	141	100.00

Table 4.2.3: The Cause of AIDS

Response	Number	Percentage (%)
Blood transfusion	30	21.28
Sexual intercourse	4	31.21
Unsterilized sharp instruments	40	28.37
Prostitution	8	5.67
Exchange of blood/cuts	5	3.55
Sharing item with effected person	10	7.09
Total	141	100.00

4.3 MODES OF CONTRACTING HIV/AIDS

The knowledge of HIV/AIDS transmission shows that many avenues are generally recognized by respondents. The various ways of contracts are shown below.

Table 4.3.1: Mode of Contracting HIV/AIDS

Responses	Number	Percentage (%)
Unprotected sexual intercourse	58	41.13
Blood transfusion	18	12.77
Mother to child	10	7.09
Unsterilized body piercing instruments	30	21.28
Anal/oral sex infection	6	4.26
Pedicure/manicure	8	5.67
Oath taking	5	3.55
Deep kissing	3	2.13
Not indicated	3	2.13
Total	141	100.00

Table 4.3.2: People Affected with HIV/AIDS

Response	Number	Percentage (%)

Seen	35	24.82
Have not	65	46.09
Not indicated	41	29.07
Total	141	29.07

Moreover, on the knowledge of persons with HIV/AIDS, 24.8% of the students claimed to have seen somebody afflicted with the disease, 46.1% had never seen real cases of AIDS while 29.1% could not say whether they had seen infected person(s) or not. This may explain why students could not fully appreciate the risk and seriousness of AIDS disease.

4.4 PAST AND PRESENT HIV/AIDS RELATED RISK BEHAVIOUR

An analysis of past HIV/AIDS related behavior using lifetime number of sexual partner indicated that 70.9% of respondents were sexually experienced. Among them, 14.2% had 1-2 lifetime sexual partners; 29.8 had 3-5 partners and 27.9% had between 5 and 9, while 22.9% had no sexual experience.

Table 4.4.1: Number of Sexual Partners

Partner	Number	Percentage (%)
1-2	20	14.18
3-5	42	29.79
5-9	38	26.95

None	31	21.99
Not indicated	10	7.09
Total	141	100.00

Table 4.4.2: Preventive Sex Measures

Responses	Number	Percentage (%)
Yes	105	74.47
No	20	14.18
Not indicated	16	11.35
Total	141	100.00

Table 4.4.3: Types of Preventive Measure Used

Measures	Number	Percentage (%)
Use of pills	25	17.73
Use of condom	78	55.32

Safe period	16	11.35
Others	6	4.26
Not indicated	16	11.35
Total	141	100.00

Table 4.4.4: If HIV Positive

What to do	Number	Percentage (%)
Distribute it	5	3.55
Pray for death	10	7.09
Pray for cure	80	56.74
Run away	5	3.55
Pretend that nothing happened	7	4.96
Other actions	15	10.64
Not indicated	19	13.48
Total	141	100.00

Further analysis of prior risky sexual behavior revealed that only 74.5% took preventive measures during sexual intercourse while 14.2% did not make use of any

preventive measure and 11.4% did not indicate. Among those who take preventive measures, there was a high level of ignorance as regards the preventive of HIV/AIDS. A total of 17.7% thought HIV/AIDS could be prevented through the use of pills, 55.3% admits that it can be prevented through the use of condoms, 11.4% agree that it is through strictly indulging in sexual intercourse during ‘safe periods’ especially in females. Also, 4.3% did not give other measures and 11.4% did not signify. This shows the low level of understanding of HIV/AIDS as regards how to take necessary steps to avert and prevent the contact of the disease. Among the respondents, only 55.3% and some proportion of other responses asserted rightly the use of condoms to control and prevent HIV/AIDS epidemic.

To the question “if you were HIV positive, what would you do? 3.5% admitted that they would distribute it to as many people as possible, 7.1% would pray for death, 56.7% prayed for and wish for cure, 3.6% said they would run away to a place where they are not known, 5.9% said they would pretend as if nothing had happened 10.6% gave other responses while those who did not give any responses were 13.5%.

HYPOTHESIS 1

There is a significant different between AIDS awareness and knowledge of its consequences among female students.

Table 4.4.5: AIDS Awareness and Knowledge of its Consequences

Responses	Number	Percentage (%)

Agree	102	72.34
Disagree	21	14.89
Can't say	18	12.77
Total	141	100.00

HYPOTHESIS 2

Table 4.4.7: Reasons Why Girls Have More Than One Sexual Partner

Responses	Number	Percentage (%)
Peer influence	40	28.37
Material benefits	80	56.74
High sexual urge	10	7.09
Others	11	7.80
Total	141	100.00

From the data above, 28.4% of respondents claimed that peer influences the sexual behavior of female students, 56.7% identified the quest for material gains as being responsible for having more than one partner, 7.1% asserted high sexual urge and lastly a percentage of 7.8% revealed other reasons.

In conclusion therefore, peers do not influence the sexual behavior of female students. Hence the hypothesis is therefore negative and rejected.

Furthermore, to investigate the level of concern about HIV/AIDS, the respondents were requested to advise fellow students especially the females on how to prevent further spread of the pandemic.

Table 4.4.8: Youth Awareness Campaign

Awareness	Number	Percentage
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		(%)
Organizing orientation for the youth	39	27.66
Preaching awareness	19	13.48
Proper knowledge on AIDS	41	29.08
Total abstinence from unsterilized instruments	7	4.96
Proper education on HIV/AIDS	11	7.80
Spiritual guidance	13	9.22
Other response	11	7.80
Total	141	100.00

From the above diagram on youth awareness campaign shows that, 27.7% need serious orientation on HIV/AIDS, 13.5% want it preached form door to door steps, 29.1% said it should be given proper knowledge on HIV/AIDS, 5% said total abstinence should be given much attention, 7.9% said proper education should be given to school children, 9.2% says spiritual intervention is the best, while 7.8% gave other forms of advice.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 SUMMARY

The analysis of the results of this work reveals the following: firstly, that there is a high level of awareness of HIV/AIDS among the respondents that constituted the study population. Secondly, that the level of awareness is not demonstrated in the prevention of risky behavior, for example, the use of condoms was practiced by on 55.32% of the study population. Finally, that a majority of the students appeared to be different about HIV/AIDS severity, fatality and consequence.

It's obvious from this study that though students were generally, aware of HIV/AIDS and had fairly accurate information about it, fortunately they were not quick at taking actions that would prevent or reduce the risk of STD and HIV/AIDS transmission. In these days of the

AIDS scourge and epidemic, sexual and networking should be associated with condom use and immediate report of infection to medical personal concern to one's sexual partner so that he or she should seek medication. There is also the need to worry about a proportion of the population that is ignorant of HIV/AIDS, indifferent to it or feels that it has not spread widely. To some extent however, sexual behavior among youths has been modified since the behaviour among youths has been modified since the awareness of AIDS.

According to 1999 HIV/SYPHILIS Sentinel Zero Prevalence Survey Nigeria, released on 30th November, 1999, Nigeria ranks fifth in HIV infection in sub-Saharan Africa. The overall natural HIV prevalence rate in Nigeria is said to be 5.4 indicating that rate of infection in the worst affected state has increased by not more than 500%. Also

youths within 20 to 24 years of age represent the highest rate of infection put at 4.2% to 9.7 of the overall level of prevalence (The Post Express: December 1, 1999). This should be a cause for alarm and urgent action because even though a large number of young people are not yet infected with HIV, they run a great risk of being infected if they are not educated and enlightened about the risks and how to avoid being infected. We thus have a situation where adolescents lack adequate knowledge about their development and its implications; they lack knowledge about what proactive and promotional health measures and services exist, where these services and how to utilize the services.

Consequently, various factors contribute to this gloomy trend in adolescent and youth sexually and health issue.

There is ineffective natural planning of family life education (FLE) for adolescents; parental apathy and denial of the problems, inadequate number of adolescent sexuality education or premarital counseling programmes, growing sexual permissiveness as a result of urbanization and social changes, limited access to enough counseling and contraceptive services.

5.2 CONCLUSION

AIDS and sexual behaviour among SSS III female students has been examined. It was discovered that there is a high level of awareness of AIDS among female students, that there is high knowledge of its consequences, and that the level of awareness is not demonstrated in the prevention of risky sexual behaviour.

In conclusion therefore, the battle against HIV/AIDS concerns every individual groups, NGOs and governments. Individuals are implored to keep to methods of preventing HIV/AIDS as earlier mentioned. The first resource a nation can be proud of is its human resources. Youths today are leaders of tomorrow and on account of this, government, families, school authorities e.t.c. should put the health of the nation in mind

by actively supporting HIV/AIDS awareness campaign through the sexual behaviour of our adolescents.

5.3 RECOMMENDATIONS

It is hereby recommended that these research findings, are not final. They might not be applied to make generalization about AIDS and sexual behaviour among female students in Benin City because of time factor, financial constrain, smallness of sample size and the research being carried out only in one town.

Besides, the following are being recommended to help female students, youths in general, government and subsequent researchers into this particular topic:

1. Government should introduced and encourage sex education in school curriculum. It should be given in schools either as a subject to be studied or as orientation lecture or as symposium. Since adolescents and students get information about sex and sexuality through sources that may not be reliable (e.g. from peers, textbooks, media, films, magazine, novels, etc). It is therefore necessary to provide sex education inn schools.

Sex education is regarded as a process of making an individual develop a positive and a wholesome attitude towards sex as to avert risks associated with value knowledge about sex such as teenage pregnancy and sexuality transmitted disease. Sex education has many advantages which include the following:

- (a) It helps adolescent avert problems associated with sex because they will know through sex education perfect and informed understanding of the physiology or functioning of their own bodies and how to relate with opposite sex;
- (b) It helps to eliminate focus and entities that are related to individuals' sexual development and adjustment;

- (c) It helps to develop a society with minimum prostitution and illegitimacy, irrational fear of sex explanation;
- (d) It gives the individual insight concerning his or her relations to members of both sexes and to understand his/her responsibilities to other;
- (e) It provides enough knowledge about sexual abbreviations (sexual harassment, rape, prostitution) to enable the individual protect himself or herself against exploitation and against injury to his/her physical and mental health; and
- (f) It provides the understanding and conditioning that will enable each individual utilize his or her sexuality effectively in his/her several roles such as spouse, a parent and a citizen.

The disadvantages which sex education can created include:

- (i) Conflict between information sexual education received by individuals from churches, parents and with those taught in the schools.
 - (ii) An increase in children's interest in immoral sex and high rate of promiscuity, sex education is still viewed as imperative because of its numerous advantages. It is also meant to include family life education and HIV/AIDS awareness education with great emphasis on the dangers of HIV/AIDS.
2. Government is strongly recommended to support HIV/AIDS awareness campaign through public enlightenment to adequately inform every Nigerian about the disease. The natural effort should also make provisions for support of the already infected people including counseling, physical support and clinical care. For a free HIV people, a behaviour that has not yet been formed and for adults, it is aimed at changing a behaviour that crucially exists.

3. Commercial sex (prostitution), promiscuous life style involving multiple sexual partners and short term sexual relationship should be discouraged by individual and society as a whole. These have been largely responsible for high natural HIV prevalence rate in Nigeria. Short-term sexual relationships eventually leave one insecure alone and perhaps afflicted with STDs (Awake, December 1998).
4. Students should strictly adhere to methods of protecting to principles laid down by WHO. These are abstinence; the use of condoms, screening of blood before transfusion, the use of sterilized piercing instruments etc. because our culture encourages such practices as scarification, tribal marks, piercing of ear and nose, it is the responsibility of all healthcare workers to educate people on the dangers inherent in the use of unsterilized instruments.
5. Adults should desist from going to secondary schools and higher institutions of learning to infect students with STDs especially AIDS in the name of “girlfriend, sugar daddies and sugar mummies”.
6. Parents should stop the act of engaging their children in women and female trafficking to European countries for prostitution.
7. Groups and Non-Government Organizations connected with health-related services should height the level of awareness and severity of HIV/AIDS. NGOs are encouraged to continue with their good works in order to face the new challenge ahead.

With respect to teenagers, the advent of HIV/AIDS has called for the need to return to the norms of premarital chastity not only for girls but also for boys as enshrined in the traditional morals of most cultures in Nigeria.

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