HIV/AIDS EDUCATIONAL NEEDS OF CHURCHES AND MOSQUES IN OYO STATE, NIGERIA

BY

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DEDICATION

To the many,

who believes in skirmishing HIV/AIDS in this generation and

all those interested in fashioning a nation free of HIV/AIDS epidemic.

ABSTRACT

The five percent HIV prevalence rate of year 2004 in Nigeria has clearly shown that the country is at a critical stage in the HIV/AIDS epidemic. A recent survey indicated that religion plays an important role in decision making in the lives of Nigerians and that members of faith-based organisations usually look up to their leaders as legitimate sources of ideas and opinions. Given the pivotal role that faith-based organisations could play in HIV/AIDS prevention and control programs, this study was undertaken to assess the HIV/AIDS educational needs of church and mosque congregation in Oyo State, Nigeria.

A cross-sectional survey was conducted using a multi-stage sampling technique to stratify churches and mosques into different denominational affiliations in Oyo State. Respondents were proportionately selected after worship activities in churches and mosques. A pre-tested semi-structured questionnaire focussing on HIV/AIDS awareness, perceived seriousness and knowledge, sexual practices and preferred HIV/AIDS educators was used to interview 1000 faith-based organisation members (500 church and 500 mosque members). Respondents were purposively equally distributed (500 males and 500 females). Data collected was analysed using Epi-Info v.6 and SPSS v.11.

Results showed that five hundred and thirty-seven (53.7%) respondents were married, 38.7% had secondary/modern school certificate and mean age was 33.3 ± 13.4. Majority of the respondents (99.9% Christians and 99.0% Muslims) were aware of HIV/AIDS. Overall, 84.2% respondents believed AIDS is serious. [50.9% Christians and 49.1% Muslims]. Although, the knowledge of HIV/AIDS transmission was high in respect to sexual intercourse [Christian, 99%; Muslim, 98.8%] and blood transfusion [Christian, 98.2% ; Muslim, 96.6%], Muslims were significantly more knowledgeable than Christians on mother to child transmission of HIV during breastfeeding (p=0.00). Contrarily, misconceptions were significantly higher among Muslims in respect to food sharing (p=0.00), kissing (p= 0.00) and mosquito bites (p=0.00). Similar findings were reflected in

Knowledge of HIV/AIDS prevention. However, about one-fifth of the respondents in each faith-based organisation have misconceptions that HIV/AIDS could be caused by mosquito bites, coughing, sneezing and kissing. Slightly higher proportion of Christians, 99 of 246 (40.2%) compared to Muslims, 81 of 180 (45%) ever had pre-marital sex (p=0.00). Conversely, 46 of 325 (14.2%) Christians and 46 of 364 (12.6%) Muslims had extra-marital sex (p=0.00). Three hundred and eighty-nine (77.8%) Muslims and 53.4% Christians reported that their faith-based organisations have never organised HIV/AIDS education programmes apart from ad-hoc references during sermons. Nevertheless, 94% Christians and 94.6% Muslims favoured the inclusion of formal HIV/AIDS education programmes in their faith-based organisations including condom use [46.8%Christians and 51.6% Muslims]. Most Muslims 84% and Christians 75.4% prefer their religious leaders as HIV/AIDS educators. Further training of religious leaders was suggested for improving the effectiveness of HIV/AIDS educational programmes in faith-based organisations.

These findings suggest that Churches and Mosques congregation are knowledgeable about HIV/AIDS transmission and prevention and are positively disposed to HIV/AIDS education in their organisations. However, religious leaders need to be formally trained for effective and sustained delivery of HIV/AIDS education in faith-based institutions and also encourage them to organise HIV/AIDS programmes for their faith-based organisations.

Keywords: HIV/AIDS, Educational needs, Churches, Mosques, Faith-based organisations

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CERTIFICATION

I certify that the work was carried out by Mrs Adebusola Oluwatosin Oyeyemi of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria.

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Congregation - people attending or worshipping in Church and Mosque, also known as members

Pentecostal churches - Other churches (such as Redeemed Christian Church of God, Assemblies of God Church), apart from orthodox (catholic, Methodist, Anglican and Baptist) and the white garment churches.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

HIV/AIDS has reached epidemic proportions in many communities around the world and continues to increase at an alarming rate. It is a global health crisis and has been described as the greatest threat to human well-being and public health in modern times (United Nations (UN) Assembly, 2001). According to U.N. figures, nearly 5 million people were infected by HIV globally in 2005 and some 40.3 million people are living with the virus (New York Times, 2005). Africa, with only 10 percent of the world's population, suffers over half of its HIV infections. Millions of people have already died from this disease and millions more are directly or indirectly affected, thus, the ravages of AIDS have thus negated several years of efforts by African countries aimed at real socio-economic development (UN Assembly, 2001).

In Nigeria, HIV/AIDS affects people of different religious denomination including Christians and Muslims. In 2003 a congress of Religious Leaders and faith based organisations declared a joint war against HIV/AIDS as a common enemy attacking and killing human beings (World Council of Churches (WCC), 2001). It was further reported that the Leaders expressed their willingness not only to work for the spiritual well being of their communities but also for the eradication of HIV/AIDS through human rights and cultural approaches. This suggests that Faith-based organisations are working to create moral and social networks based on their belief in the sacred worth of every human being and the recognition of the HIV/AIDS pandemic. (International HIV/AIDS Advisory Board (IHAB), 2003).

Since people living with HIV/AIDS in Nigeria today are mostly Christians and Muslims and given the large number of Christians and Muslims in Nigeria, faith-based organizations have a crucial role to play in promoting HIV/AIDS preventing behaviour and providing care and support activities to mitigate the epidemic impact. This is

important because the epidemic is far from being purely medical or clinical but relates to cultural ethical practices, socio- economic conditions of life, social roles of men and women, sexuality, taboos, forbidden practices and other social justice factors. This implies that the AIDS problem must be tackled from different angles: namely, those of science, economics, demographics, ethics and religion.

It has been recognized that the sexual nature of HIV transmission has been troublesome for the faith based organisations. Its attribution to sex, sin, shame, and stigma has caused many faith based organisations to remain publicly silent about HIV/AIDS (WCC, 2001). This stance, combined with the cultural taboos against open dialogue about sexual matters that exist in many cultures, has been an obstacle to the dissemination of preventive and protective messages about HIV/AIDS. In light of these combined factors, there is an unprecedented urgency for faith-based organisations to respond positively and compassionately to the current crisis.

In making HIV/AIDS eradication a top priority in highly religious communities as in Nigeria, these faith-based organisations [illegible] need to help overcome the stigma of HIV/AIDS through education and training and by promoting attitudes of forgiveness and reconciliation. Also Churches are realizing that the basic "abstain and be faithful" directives are not working and there is disagreement among Christians on the promotion of condom use as an HIV prevention measure. Christian Connection for International Health (CCIH) in 2007 reported that condom use cannot be dictated or decided for individual Christians because Christians are fallible human beings with free will. The argument which [illegible] suggests that Christians do not like to promote condom use [illegible] for a need to actively engage them in other prevention and caring measures for those already infected and affected by HIV/AIDS as well as [illegible] on open dialogue on condom usage (CCIH, 2007).

1.2 Statement of the problem

The epidemic is still far from coming to a halt, although there was a drop in prevalence rate from 5% in 2004 to 4.4% in 2005. Projections show that [illegible]

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1.2 Statement of the problem

The epidemic is still far from coming to a halt, although there was a drop in prevalence rate from 5% in 2004 to 4.4% in 2005, Projections show that by 2010, Nigeria is likely to

have 500,000 new cases annually assuming nothing is done about it. Faced with this situation, mobilization is increasing world-wide in order to halt its spread and reduce its impact on socio-economic life and, in the long term eradicate it entirely. Presently, Faith-Based Organisations (FBOs) are not doing enough to deal with HIV/AIDS.

Furthermore, HIV/AIDS and unprotected sex have been reported among Muslims and Christian congregations. According to UNAIDS (2003), HIV infections have been reported in every single Muslim country and an estimated 300,000 people are living with HIV in North Africa and Middle East. This has shown that anyone can be infected by HIV, including Muslims. In a participatory study conducted on Adolescent Sexual and Reproductive Health (ASRH) by Young Men Christian Association (YMCA) in Nigeria, in 1999, among 1254 adolescents (10 to 26 years) over seventy-five percent (943) had had premarital sex. Of this number, one third received payment for the sex while only one third reportedly used condom. Although, most of the respondents cited lack of sexuality information as a major problem, none mentioned their Churches/Mosques as sources of AIDS information and only 8.6% said they were at risk of getting HIV/AIDS. These findings suggest that Christian/\Muslim youth are at risk of HIV infection contrary to their low risk self perception.

1.3 Justification

It has been reported that each day, the death rate from AIDS is on the increase, life expectancy is declining, livelihoods are being destroyed and for many, hope is in short supply (IHAB, 2003). The lives of Christian and Muslims women and the young people are especially endangered. The faith community has always been the resource that Nigerians turn to in the time of crisis. Therefore, there is a strong need to exploit these institutions to play more active role in HIV/AIDS education.

In Nigeria, Christian and Muslim faith-based organizations are strategically positioned to play a major role in the fight against HIV/AIDS. However in order to do this effectively, it is important to assess the congregation knowledge, the risk behaviour that expose them to getting infected and affected by HIV/AIDS and their HIV/AIDS educational needs.

The information obtained could be used to equip the Christian and Muslim leaders to deliver HIV/AIDS messages effectively in their various faith-based organizations.

Despite efforts aimed at controlling HIV/AIDS, churches and mosques are not being fully involved in the control efforts in Nigeria because of negative reactions of faith-based organisations to HIV/AIDS. An attempt by YMCA (Nigeria) in 1999 to inculcate HIV/AIDS issues into its program six years ago, first met with resistance from the elders and officials of YMCA at the national level. It took evidence-based data from a survey of sexual risk practices of Christian youth in YMCA to convince these elders and officials to have a Reproductive Health-HIV/AIDS policy (Oladepo, 2006). This study will identify from the congregation members their HIV/AIDS knowledge and attitudes to the inclusion of HIV/AIDS into Church and Mosque programmes.

Given the pivotal role that faith-based organisations could play in HIV/AIDS prevention and control programs, this study was undertaken to assess the HIV/AIDS educational needs of church and mosque congregation in Oyo State, Nigeria.

1.4 Research Questions

1. What is the level of knowledge of HIV/AIDS transmission and prevention amongst Christians and Muslims?
2. Do Christians and Muslims perceive HIV/AIDS to be a serious problem?
3. What are the misconceptions towards HIV/AIDS?
4. What do the members of faith-based organisations feel about discussing HIV/AIDS in their institutions?
5. Do Christians and Muslims have access to HIV/AIDS education in their churches and mosques respectively?
6. Whom would Christians and Muslims prefer as their HIV/AIDS educator?

The answers to these questions will provide baseline information for which appropriate intervention can be designed and tested in the future.

1.5 Objectives of the study

General objective: The main objective of this study is to determine the HIV/AIDS Educational needs of churches and mosques in Oyo State.

Specific Objectives:

The specific objectives of the study are to:

1. Assess the HIV/AIDS knowledge of Christians and Muslims
2. Assess the attitudes of Christians and Muslims towards HIV/IADS and HIV/AIDS related practices.
3. Identify sexual risk taking practices of the respondents.
4. Use the information derived to suggest strategies for improving HIV/AIDS education in churches and mosques.

1.6 Hypothesis

The following research hypotheses were formulated for the study.

1. There is no significant relationship between educational status and respondents' knowledge of HIV/AIDS.
2. There is no significant difference in level of knowledge of HIV/AIDS between Christians and Muslims.
3. It states that there is no significant difference in respondents' attitudes towards HIV/AIDS messages between Church and Mosque congregations.

1.7 Limitations of the Study

The findings of this study relied solely on the respondents' reports with an assumption that responses were given with uttermost sincerity. In overcoming this, completion/filling of questionnaire forms were done anonymously and absolute confidentiality was given during data gathering.

CHAPTER TWO

LITERATURE REVIEW

This chapter presents a review of literature in the following areas:

1. HIV/AIDS situation in Nigeria
2. HIV/AIDS policy in Nigeria
3. HIV/AIDS and religion
4. Faith-based Organisations involvement in HIV/AIDS
5. Sexual behaviour and practices of Christians and Muslims
6. Belief and opinions of Christians and Muslims on HIV/AIDS
7. Conceptual Framework – PRECEDE Model

2.1 HIV/AIDS situation in Nigeria

Nigeria's first case of AIDS was diagnosed in a 13-year-old girl in 1986 (Federal Ministry of Health (FMOH), 2001). Serial sentinel surveys were carried out thereafter in 1993, 1996, 1999, 2001, 2003, 2004 with the latest for 2005 being 4.4%. Results showed increasing prevalence from 3.8% in 1993, to 4.5% in 1996 to 5.4% in 1999 and steadily rose to 5.8% in 2001 though, a slight decline in prevalence rate of 5.4% was recorded in 2003 and a critical rate of 5.0% in 2004 and 4.5% in 2005 (Skogseth, 2006).

These data show that from 2001, there is a decline in HIV infection rate, nonetheless the high rates of infections is still of concern. Given the large population; the country, Nigeria, has the highest number of HIV/AIDS -infected adults in West Africa (UN, 2004). Poverty, lack of knowledge on prevention, lack of empowerment of women and girls, the vulnerability of youth with 60% of the population under 24, and strong stigma and discrimination against people living with and affected by HIV and AIDS constitute the difficulties in tackling HIV/AIDS, (UN, 2004).

Projections of the HIV/AIDS epidemic in Nigeria vary widely. It has been projected that by 2010, Nigeria's HIV prevalence rate may reach 9.24% (high scenario) or 6.73% (low

scenario), see table 1. The FMOH (2002) developed a high scenario and a low scenario of HIV projections in Nigeria. Using these projections, the cumulative number of deaths as a result of AIDS by 2015 will reach 9.4 million using the high prevalence scenario and 8.1 million under the low prevalence scenario.

The US National Intelligence Council (2002) projects a gloomier situation. By 2010 they estimated that there will be 10-15 million HIV cases in Nigeria. This number would constitute roughly 18 to 26 percent of adults; close to the current rates in some of the hardest hit countries in southern Africa. It was also estimated that by 2005, 50% of mortality in the 15-49 age group would be AIDS-related (UNICEF, 2001).

Table 1a: HIV Projection in Nigeria by FMOH (2002)

	2005	**2010**
	HIV prevalence for 15-49 year olds	
High Scenario	7.75%	9.24%
	6.8%	6.73%
Low Scenario	4.9 million infected	5.5 million infected

UNAIDS Epidemic Projection Package, 2003.

2.1.1 HIV/AIDS policy in Nigeria

A review of the 1997 HIV/AIDS policy originally put together under the auspices of the Federal Ministry of Health began in 2001. The review was undertaken with technical assistance from the POLICY Project funded by USAID and involved a wide range of stakeholders. This policy entrenched the multisectoral approach and called for the establishment of a statutory body to coordinate and facilitate the national HIV/AIDS response. The policy's main objectives were to:

- Promote a national multi-sectoral and multidisciplinary response to the epidemic in addition to the establishment of an appropriate legal and institutional framework for its coordination;
- Identify sectoral roles and assign responsibilities for the implementation of programmes based on sectors' comparative advantages and core competencies;
- Increase awareness and sensitisation among the general population about HIV/AIDS;
- Foster behaviour change as the main means of controlling the epidemic;
- Improve national understanding and acceptance of the principle that all persons must accept responsibility for prevention of HIV transmission and the provision of care and support for those infected and affected;
- Provide access to cost-effective care and support for those infected, including anti-retroviral drugs;
- Protect the rights of those infected and affected by HIV/AIDS as guaranteed under the constitution and laws of the Republic;
- Remove all possible barriers to HIV/AIDS prevention and control.
- Empower people infected and affected by HIV/AIDS through training, counselling, and education to cope with their circumstances.
- Develop standards and guidelines that lead to the institutionalisation of best practices to mitigate the impact of AIDS.
- Stimulate research, monitoring and evaluation of programs, relevant documentation of activities related to the epidemic and the dissemination of information generated to stakeholders and the general population.
- Ensure that prevention programmes are developed and targeted at vulnerable groups such as women and children, adolescents and young adults, sex workers, long distance commercial vehicle drivers, prison inmates, migrant labour etc (Federal Government of Nigeria (FGON), 2003).

This policy was formally launched by the President of Nigeria on the 4th of August 2003. Active dissemination of this policy is now underway and will serve as the framework for developing specific sectoral policies.

One noticeable input of the policy formulation process was the wide stakeholder participation and the wide level of consultation. In spite of this many persons consider themselves distant from the policy making process. Many NGOs claim not to have been consulted during the process although they were represented through their umbrella group. The same has been stated by some religious organisations that were equally invited. This could mean that they do not consider their umbrella organisations as speaking for them or their umbrella organisations not giving enough feedback after returning from their assignments. This is of critical importance as the process was designed to ensure ownership by all (Mafeni and Oluwole, 2003).

The policy tried to fill in gaps that had been identified in the 1997 'health sector' HIV/AIDS policy. The previous policy had made very little mention of care and support for persons living with HIV/AIDS, and even less on HIV/AIDS impact mitigation.

While the revised policy articulates better the country's intention to provided care for PLWHA, it does not state any preferential treatment. The country commits itself to make all forms of treatment available but does not commit itself to subsidising the cost of care (Mafeni and Oluwole, 2003).

2.2 Factors affecting HIV/AIDS

Nigeria is a huge and complex country, with diverse ethnic groups, languages, cultures, religious and regional political groups. HIV/AIDS interventions must recognize this diversity, which however add to the complexity of a national HIV/AIDS response.

Factors which may drive the epidemic include:

High and growing rates of untreated Sexually Transmitted Infections (STIs) with inadequate health care provision - For both young men and young women, STIs greatly increase the risk of HIV infection. People who have other STIs are two to eight times more likely to contract HIV/AIDS during sex with an infected person (World Youth Report, 2003). The presence of another STI makes an HIV-positive person more infectious and also makes an HIV-negative person more susceptible to infection. Some

STIs increase the replication of HIV. Those that cause lesions and ulcers provide openings through which HIV can pass from person to person. The presence of STIs also increases the presence of CD4 lymphocyte cells in the genital tract. These lymphocytes carry HIV in sero-positive persons. STIs can increase the amount of HIV shed into genital secretions by more than 100 times, raising the probability that the secretions will contain enough HIV to cause infection. Thus, while there is normally a greater risk of HIV transmission from men to women, in the presence of an STI in either partner HIV transmission is equally likely in both directions (World Youth Report, 2003)

High mobility and migrant worker populations – The culture of mobility is basic to human existence and development. Voluntary and involuntary migration connected with local and international travel, refugee movements, and army movements have emerged as major factors in the spread of the virus across countries, borders, and regions (Adeyi, Kanki, Odutolu & Idoko, 2005). Little exists in the literature that substantiates hypotheses about a strong association between migration and HIV-positive status. Parts of Nigeria, especially the southwest who had more than half a century of migrant labour, trading and commercial sex contacts with Ghana and Cote d'Ivoire turned out to be the country's earliest hot spots for HIV (Adeyi, Kanki, Odutolu & Idoko, 2005).

Low acceptance, utilization and access to condoms - A survey conducted in 1999 indicated that a significant proportion, 93% of sexually active young men aged 15 – 24 years in Nigeria did not use a condom at last sexual intercourse, because they felt there was no or small risk of getting HIV (United Nations Children Fund (UNICEF, 1999). Data form the National HIV/AIDS and reproductive health survey of 2003 showed that only 54% have heard of condoms in rural areas compared to 86% in urban areas. Though majority of the respondents surveyed felt that condoms were accessible and affordable, only a small fraction 22% of all the sexually active respondents were using condom at the time of the survey (National HIV/AIDS & reproductive health survey (NHRHS, 2003). Adolescents who deny their personal risk of contracting HIV/AIDS often ignore AIDS prevention messages, dismissing their relevance, and their failure to take precautions places them at a higher risk of infection (Gardner, Blackburn and Upadhyay, 1999). Even when the risk of infection is understood, some young people ignore it. Young

women may intentionally engage in risky sexual behaviour, especially in cultures where marriage is highly valued and a woman's status is linked to finding a husband and having children. Many young people purposely downplay or overlook the risks because they are afraid to ask about a partner's sexual history or that a condom be used, for fear it might endanger the relationship. Others engage in risky sex for money, which may seem, or indeed be, a more urgent priority (Gardner, Blackburn and Upadhyay, 1999).

Active Commercial Sex Workers industry (with 34% HIV positive in 1996 and likely to be significantly higher now) - According to Babatunde Osotimehin, Chairman of Nigeria's National Action Committee on AIDS (NACA), sex workers in Nigeria (as elsewhere) are particularly at risk of HIV (Skogseth, 2006). Also, Amina Titi Atiku Abubakar, founder of Women Trafficking and Child Labour Eradication Foundation (WOTCLEF) and wife of the Vice President of Nigeria, stated that a majority of returned trafficking victims are HIV positive. It was also conceded, however, that the economic returns to young women form commercial sex were so high and the social sanctions so weak it was unlikely that the tide of inflow into commercial sex work could be stemmed, AIDS or no AIDS (Adeyi, Kanki, Odutolu & Idoko, 2005).

Urbanization distorts and eroded traditional societal norms, which protect and value faithfulness. – Residence in urban or rural areas helps determine people's economic and social options, opportunities, and limitations and creates the context for developing the coping mechanisms for sexual needs, satisfaction, and consequences. Urban areas and the network of roads that link them throughout Nigeria have produced arteries of infection that stand out from the more remote rural areas of the country (Caldwell, Caldwell and Orubuloye, 1990). Expansion in the entertainment industry resulted in the creation of 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 (Adeyi, Kanki, Odutolu & Idoko, 2005). In the p. ast,the universality of marriage and early timing of marriage served as safety nets reducing the incidence of premarital sex promiscuity (Farooq and Adedokun, 1976).Traditional sexual

codes are suppose to be strong and strict for the young female, but the lucrative nature of commercial sex work broke down some gender codes of sexual behaviour by granting, young women the option of exploiting their bodies to greater economic effect and survival (Adeyi, Kanki, Odutolu & Idoko, 2005).

Sexual networking practices such as polygamy - 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 at marriage between monogamous and polygamous women, the length of postpartum sexual abstinence and lactational amenorrhea (Adeyi, Kanki, Odutolu & Idoko, 2005). Those males in this situation sexual needs are met by sex workers in urban areas and by a significant member of divorced, separated, or widowed women (Caldwell, Oruloye and Caldwell, 1991). In addition, certain living and cultural arrangements facilitate the sexual access of young family members to the wives of older relatives or the access of visitors to wives, (Adeyi, Kanki, Odutolu & Idoko, 2005). All these devices are likely predictors of exposure to sexual networks and to HIV infection.

Gender and Cultural Issues - Discrimination, inequalities, lower educational status, economic dependence on men and the formidably defended cultural and social norms make it difficult for disempowered women to refuse sex or negotiate for safer sex. Marital rape and domestic violence in these situations is high. A culture of silence hides the numerous episodes of sexual abuse and violence against women. This lack of response extends from community level through to law enforcement agents and the courts. The unwillingness of community leaders, which includes the church and mosque whose hierarchies are mostly men, to speak out against these injustices enables the perpetuation of the situation and the 'protection' of those responsible (Parry, 2003). Society implicitly (and sometimes explicitly) condones the subordination of women, thus limiting their options to desperation measures such as prostitution and begging as economic survival strategies, particularly for single women with children to feed. In many African countries there is belief that sex with a virgin (girl child) will cleanse an infected man of HIV/AIDS. This may have led to a great increase in the incidence of rape amongst young children. Many African Independent Churches, Syncretic and traditional

religions, which command large adherence,. do not have a clear stand on cultural practices, still widely practiced, that expose people to infection such as widow inheritance, sexual cleansing, female genital mutilation and polygamy. Many of these groups lack formal structures and thus are difficult to involve in sharing of HIV/AIDS information. Within churches themselves, there are glaring examples of gender discrimination where women are frequently excluded from decision-making (Parry, 2004).

Low status of women - The gender inequality is not something unique to Nigeria or even Africa, but Nigeria sees the problem in a greater than average degree as evidenced by the figures of women's literacy, mother and infant mortality, and poverty figures (Quast, 2005). The sexual domain is marked by some of the most adverse inequities between the sexes, including unequal sexual negotiating power. So total is the dominance of men that women may be considered to have only duties and responsibilities and no rights (Adeyi, Kanki, Odutolu & Idoko, 2005). Women in Nigeria are considered to be the poorest of the poor. "Compared to their male counterparts, Nigerian women are disadvantaged in access to justice and political participation, their economic roles and control over resources, education and access to health care, and ability to protect themselves against HIV/AIDS". The higher economic status, self-reliance and self-esteem, imbues them with power to make changes and choices about their lives. The choices extend to education, housing health-care, and political participation (Quast, 2005). Although women's status would undoubtedly rise, for the foreseeable future Nigerian women lacked the opportunities of men (Nigeria Society, 2003)

Poverty and poor access to education and health care - Nigeria's poor health care system and poverty is likely to speed up progression from HIV to full-blown AIDS (UNAIDS, 2002), poverty destroys aspiration. Despite repeated promises of poverty alleviation over the years; the actual number of people living in poverty in the society seems to be increasing (Dike, 2003). Certainly, correlation and estimates do not prove

causation, but the synergistic relationship between AIDS and poverty is undeniable, especially with regards to malnutrition – a key feature of poverty. Biomedical evidence shows that malnutrition weakens the immune system, which increases the risk of contracting HIV with each contact, regardless of the number of sexual encounters, and hastens the progression from HIV to AIDS (Stillwaggon, 2002). Where poverty and accessibility to food is lowest, HIV prevalence is greatest. Thus, it is no coincidence that AIDS has spread [illegible] Saharan Africa, where 34% of total population was malnourished between 1997 and 199[illegible]

Amidst the extreme poverty that accompanies HIV-intense regions, a "sugar daddy" phenomenon, whereby young girls exchange sexual favors for food, shelter, employment and school fees, has instead proven itself as a strategy for premature death rather than survival (UNICEF, 2003)

2.3 Response to HIV/AIDS in Nigeria

Response to HIV/AIDS in Nigeria has taken an unsteady form. In 1986, the response was to deny the fact that this was a significant problem, though, a National Expert Advisory Committee on AIDS (NEACA) was established in the same year, little else was done. No concerted attempts were [illegible]itiated to prevent the spread of the epidemic. Later in 1988, the advisory board was replaced with the National AIDS and STD Control programme under the Federal Ministry of Health. Unfortunately this was not well funded. Consequently the epidemic smoldered largely unnoticed until it reached significant levels.

The main perception was that this was a disease of the western world associated with men who had sex with men. The first sentinel survey conducted in 1991 showed the HIV prevalence to be 1.8%. Even then because there was very little visible evidence of AIDS, the country took only a few essentially cosmetic actions. Public enlightenment campaigns attempted to scare people into adopting safer sexual practices but these were limited and fell on the deaf ears of a largely disbelieving public. Unfortunately, with benefit of hindsight, it is now realized that this scare mongering led to the high levels of stigma and discrimination towards those living with HIV/AIDS that became so rife.

By 1996 when the prevalence was 4.5%, the health authorities took note of this fact and catalyzed the creation of states AIDS control programs all health sector driven, but with very limited public awareness and mobilization campaigns. Funds allocated for HIV interventions were largely insignificant and what little that took place was funded essentially through donor assistance. The death of the popular musician, Fela Anikulapo Kuti and the public declaration by his family (headed by his elder brother, a former Minister of Health) that he died of complications of AIDS helped shock Nigerians into accepting that the epidemic was real and very much with us.

Thus, in 1997 the first HIV/AIDS policy was written and adopted under the Federal Ministry of Health. Various programmes were set up to control the epidemic, which largely focused on prevention activities. These included strategies to increase the awareness and knowledge of citizens on HIV/AIDS; increasing knowledge of protective measures to take including the use of condoms; and the control of sexually transmitted infections (STI) through various means including the early detection and correct management of STI utilizing the syndromic management approach.

With further rise in the HIV prevalence in subsequent surveys, it became obvious that further drastic steps needed to be taken. When compared to many other Sub-Saharan African countries, 'Nigeria's epidemic was comparatively young but due to her large population, the burden was already telling. In line with global thinking, it became apparent that the health sector could not fully tackle the many challenges thrown up by this epidemic that was threatening to reverse many of the developmental gains in the developing nations. A multi-sectoral, multi-tier, and multi-disciplinary approach was needed to maximize resources available for effectively combating this threat (Mafeni and Fajemisin, 2003).

Dramatically, the country stepped up the response to HIV/AIDS in the year 2002 with the national response been characterized by a multi-sectoral approach within an enabling framework and this is reflected in its membership. Currently the membership comprises of high-level representatives from Ministries, the private sector, faith based community,

nongovernmental organisations and networks of people living with HIV/AIDS (FMOH 2003).

Conclusively, Nigeria is moving towards 'one' national response with the full and committed participation of civil society, the public sector, the UN system and the donors all collaborating and coordinating to harmonize (Ohiri-Aniche and Odukoya, 2004). Furthermore, the veil of silence and stigma that has crippled efforts to respond to AIDS is finally lifting in many countries, including Nigeria leaders of governments, businesses and religious and cultural institutions are increasingly coming forward to take action against AIDS (UN, 2004).

However, the main problem is the lack of infrastructure and coordination to organize a prevention program in such a big country. As opposed to Senegal, talking about sex is still a taboo in Nigeria. Sex education is not taught in schools and there are no campaigns for the use of condoms. Although the availability of information on the AIDS and its dangers is adequate, Nigeria has a long way to go before eradicating the HIV presence in the country (Sala@m, 2006).

2.4 HIV/AIDS and Islam

According to Mohammed (2005), many Muslims belief that AIDS epidemic is the consequence of sinful behaviour such as drug use or promiscuity. Though Muslims appear to believe that "HIV/AIDS is the result of disobedience to the laws of God which provokes his wrath" (Mohamed, 2005), paradoxically, other ways of contamination are being recognized timidly, such as blood transfusion, mother to child transmission or other factors of propagation such as early sexual relationships, polygamy and some Muslim practices. However, people who are HIV positive or who have AIDS are not abandoned for the Qu'ran recommends that help be given to all who are in need, whatever the faults (WCC, 2001).

Muslim countries, previously considered protected from HIV/AIDS due to religious and cultural norms, are facing a rapidly rising threat (Hasnain, 2005). Nigeria where 60% of the population is Muslim is one of the five most seriously affected countries in West

Africa. The Nigerian AIDS situation is very worrying. In Nigeria, where 6 to 10 percent of adults are infected, half of the people practice some form of Islam (Sala@m, 2006). Although the HIV epidemic in Muslim Africa should have sounded a wake-up call to other Islamic communities, few Islamic authorities north of the Sahara seem to have heard the alarm (Sala@m, 2006). It has been reported that Islam appreciates the powerful sexual desires that humans have and encourages that these desires be fulfilled in marriage. Islam is reported to have always encouraged discussions in matters that will help protect people's health and life and provide people with a moral code for sexual enjoyment (World Faiths Development Dialogue (WFDD), 2003).

Although the religion recognizes that people engage in sexual activities before marriage and that people are having extra-marital sex, however since Islam means the submissions or surrender of one's will to Allah. It follows that a Muslim should not be involved in any act that is prohibited by Islam (Mohamed, 2005). Nevertheless, Muslims need to face the reality that not all its followers can fully abide with the Islamic teachings. According to an internationally renowned Muslim scholar Dr Abdullah Hakim Quick, Muslims need to realize that HIV/AIDS is not a non-Muslim disease as it is increasingly impacting on the Muslim Community, (Quick, 2005).

Many Muslims view the AIDS epidemic through the 'prison of sin' and as the consequence of sinful behaviour, such as drug use or promiscuity (Health and Science, 2005). Accordingly to Quick (2005), processes of counseling must be tawbah-based (Seeking forgiveness). In this way, a person who sinned is assisted to recognize the sin abstain from it, seek forgiveness, and protect himself or herself from ever returning to it. The door of forgiveness and mercy is open to anyone and no one has the right to close it. Islam is reported to be a religion that is full of compassion, love and mercy (Health and Science, 2005). According to the Quran, it was reported that Prophet Mohammed reminded Muslims that "*You will not enter into paradise until you believe, and you will not believe until you love one another*" thus, within the sphere of caring for AIDS patients, Muslims must deal with those who are ill. While there are physical parameters that need to be observed when dealing with those affected by the disease, such as putting one's hand on their foreheads, asking them how they are" (Tirmidhi) and ablutions

thereafter, HIV positive people should not be treated as lepers but should be shown compassion, love and affection (Positive Muslims, 2003).

Awareness of the HIV/AIDS epidemic is growing among the Muslim community and efforts are being initiated to prevent its spread. According to Eberstadt and Kelly (1995), Muslim societies need to respond to the still-gathering HIV/AIDS epidemic and harness their religious piety to deal with this epidemic. It has also been reported that Muslims have assumed, for a long time, that HIV/AIDS is an issue that would not affect them. The vice chairman of the Supreme council of Kenyan Muslims, said Imams now talk in the mosque about AIDS, something they would not have done in the past. "The change is about 100 percent," he says. This is in recognition of the profound toll that the epidemic is taking on the continent. Some 15 million Africans have already died of AIDS, another 30 million are estimated to be carrying HIV, and 13 million children have lost at least one parent, according to statistics released in Nairobi by the United Nations Joint Program on AIDS and HIV (Crawley, 2003).

The reality of HIV infection is beginning to surface in the Muslim world. Although the prevalence rates of Muslim infections may seem small when compared with the tragedy that is unfolding in southern Africa, they stand in sharp contrast to official estimates that suggest no disease at all (Eberstadt and Kelley, 2005). Records, according to the UNAIDS (2005) report places the total HIV population of North Africa, the Middle East and Middle Asia at nearly 1 million people. At the end of 2003, UNAIDS estimated that up to 420,000 people in Mali, 180,000 in Indonesia, 150,000 in Pakistan, and 61.000 in Iran had HIV/AIDS . Those numbers, however, are severely understated. UNAIDS figures depend upon surveillance data: thus a lack of information can be taken as a lack of infection. The Muslim communities in these countries are carrying out programmes basically on imparting messages, practices and morals which advocate justice, empowerment and affirmation of life in respect to HIV/AIDS transmission, treatment and prevention. In South Africa, the Muslim Awareness Programme (MAP), a faith-based organisation promotes HIV/AIDS prevention strategies based on the moral teachings of Islam. The activities carried out in this faith-based organisation include the promotion of abstinence from all sexual activity outside marriage, refraining from drug use and

instilling faithfulness within marriage. In stark contrast to the prevention strategies of the South African government, primarily centered on the distribution of condoms and the promotion of "Safe Sex", this faith-based organisation (MAP) has adopted the motto, "Save Sex" (Health and Science, 2005).

Taking their message to people of all faiths, the organisation has adopted several strategies to combat HIV/AIDS that includes education, training and counseling for those affected by and infected with HIV/AIDS. Meanwhile, the NGO positive Muslims respond to stigma and discrimination within the larger South Africa community (UNAIDS/WHO, 2005). In Mali, backed by population Service International and USAID, the Malian League of Imams and Islamic Scholars created four lessons for the Imams' Friday prayers, including prevention guidance and messages of compassion for people living with HIV (UNAIDS/WHO, 2005). From studies conducted on HIV/AIDS in Islamic countries, it has been shown that awareness programs must be located within the social and religious centre of each Islamic community, which is the mosque. A women's group in Toronto during provisional of counseling services noted the increase in HIV infection among married Muslim women who were in long term relationships (Health and Science, 2005).

2.5 HIV/AIDS and Christianity

From the christians' point of view, the real cause of the rampart spread of the illness is the non-respect of God's law, which is expressed by fornication, infidelity, loose living and the sex trade (Health and Science, 2005). Contrary to the Muslim opinion, the Churches do not consider AIDS as a punishment of God, though, the primarily sexually acquired immunodeficiency AIDS has been used by Christian churches that those suffering from AIDS are penalized for their immoral behavior. However, it is also believed that the God of Bible is a merciful God who does not seek the death of the sinner but rather that he should repent. Nevertheless, that does not exclude the fact that God gave free choice to men and women who thus alone remain responsible for their acts and their consequences (WCC, 2001).

Up till now, Churches in Nigeria have not developed any theological and ethical approach as basis for their actions. Most of them react to the emergency situation by using any kind of the available methods and resource (WCC, 2001). An example of this is that of a YMCA (Nigeria) elder, who initially did not see reason for any policy on HIV/AIDS until data on adolescent sexual behaviour reproductive health practices were shown and given to them. According to the results of a YMCA Nigeria participatory census conducted in 2003, of the 1254 adolescents that participated (age distribution of 10 to 26 years) in Nigeria, about seventy-five percent (943) had had sex before. One third of them received payment for the sex they had while only one-third reportedly used condom.

Among the most common problems of youth reported are lack of health information, prostitution and infection. When asked about the source of information about AIDS, none mentioned their Church/Mosque but mainly from media, health workers and peers and only 8.6% said they were at risk of getting HIV/AIDS! (YMCA, 2003).

The challenge of the HIV and AIDS pandemic touches the church given the heart of its faith and in the body of the community. It is also a challenge to the churches beliefs and what the congregation understand themselves to be. The churches are in a powerful position because of their extensive networks and influence at all levels of society (Machel, 2001). The churches are responding quickly to the HIV crisis, using extensive and well-established networks, providing care to the sick on a vast scale, although, they have become less involved in prevention work (Machel, 2001).

Although talking about sex is regarded in many church settings as a sin, yet it is critical that the churches engage young people on issues of sex and HIV, and support others in their efforts to do so. It has been reported that the churches have been concerned that sexual health and HIV education may lead to promiscuity amongst young people (UNAIDS, 1997). However, according to evidence-based data available "Examining the evidence of links between sexual health and HIV education and promiscuity in the majority of countries" it has been reported that, the majority of young people are sexually

active from a very young age and therefore risk of being infected with HIV and that good quality sexual health and HIV education will not increase promiscuity. On the contrary, it will promote safer behaviour, and reduce HIV, other STIs and teenage pregnancy. (Grunseit, Kippax, Aggleton, Naldo and Slutkin, 2003 & UNAIDS/97).

A study conducted by UNAIDS (1997), concluded that good quality sexual health and HIV education reduces levels of pregnancy and STIs, including HIV and reduces stigma and discrimination against people living with HIV and AIDS. In addition, condoms, used correctly and consistently, are effective in preventing HIV infection among young people who are sexually active and that there is, as yet, insufficient evidence to conclude that abstinence-only programmes are beneficial in delaying sexual debut at this critical time when the HIV epidemic is affecting young people so severely (Garvey, 2003).

In all countries affected by HIV/AIDS, the community is key in providing care and support. In Africa in particular, the church is central to the community and the voices of church leaders are greatly respected. This suggests that churches are of major importance in a number of ways: they provide health care, care for orphans, and offer spiritual support; and they are well placed to encourage changes in people's behaviour, which can prevent the virus from spreading. In this regards, Christians, who are part of the worldwide body of Christ, are being requested to support those communities that are infected and affected by HIV/AIDS both at home and overseas by:

- raising awareness of HIV/AIDS among all the people it works with, whether supporters or partner organisations, and equipping them to address the problem openly and sensitively
- strengthening – through its partners–community-based prevention, care and support
- taking HIV/AIDS seriously in every aspect of its work
- lobbying and campaigning for national and international responses that complement community-based efforts
- supporting churches and church-based organisations in what they do with respect to HIV/AIDS (Machel, 2001).

The World Council of Churches, a Protestant umbrella group, launched what it calls the Ecumenical HIV/AIDS Initiative in Africa in 2002, a program to help churches implement an action plan for responding to the disease. "There has been a significant move in the past year or two among religious leaders to take on their responsibility to break the stigma," (Crawley, 2003).

Many African churches are also beginning to intensify their battle against AIDS. In year 2003, the All African Council of Churches (AACC) called on all of its church-related partners to actively participate in building aw eness about HIV/AIDS and helping those who are HIV-positive. The AACC called member churches to create networks, develop behavior-change (prevention) groups, and especially care for women and young people. The AACC is promoting a holistic approach as the most effective one, involving both prevention and care (Family Health International (FHI), 2005).

It is in the prevention of AIDS that almost all Churches are involved. Many men and women run the risk of being infected due to a lack of information on the mode of HIV transmission. Thus, lectures and discussions have been organised by Churches in most parishes. Moreover, in most churches chastity, abstinence and mutual fidelity for couples are the unquestionable route to prevention. This prevention consists therefore of each church or ecumenical institution carrying out according to its means and in its own context, the following activities: information and awareness-building sessions; training of trainers, support for those requesting meetings, photo exhibitions, design and distribution of educational posters and encouragement of serological testing before marriage (FHI, 2005).

Different denominations of churches have different views to prevention and management of HIV/AIDS. The Methodists, Baptists, Lutherans, Anglicans and Presbyterians accept the condom because they claim to be realistic and in favour of any means which will protect the faithful from HIV. In Senegal, for example, the Protestant Aid Association, a structure created by the Protestant Church, is the regular supplier of birth control devices

to various health centres and posts. On the other hand, the Catholics, Evangelicals and Adventists are against this move in the name of religious morality. For them, promotion of the condom is an anti-religious act and an invitation to pre-marital sex among young people and to infidelity in the case of married couples (Green, 2003).

In Luzira, Uganda, a project was organized through churches to educate the community and offer counseling at the grass roots level. The project workers were two Reverends, four lay health advisors (LHAs), two community workers, and two visiting counselors. These workers provided counseling, sex education, moral rehabilitation, and condom distribution to the community. This was a huge feat because the idea of condom distribution in churches as discussed earlier is an extremely controversial issue. There are also many myths that condoms are evil, do not work properly, or is a part of conspiracy from the West to kill Africans (McGeary, 2000).

Rather, many churches, believe that the prevention messages should give abstinence and marital fidelity all their intrinsic value. However, the use of the condom is tolerated within a couple where there is an acknowledged risk of contamination of one spouse (WCC, 2001). It should be pointed out that if all Churches acknowledge the sexual mode as the principal mode of transmission, sexuality must be at the centre of prevention measures. However, Church leaders are not prepared to tackle the problem as neither catechism nor training programmes for pastors have taken into account the sexuality dimension. (WCC, 1997).

Until recently, most churches have been in denial about the AIDS problem in Africa. Discussion of sexuality in Africa carries a heavy taboo, and because the most common mode of HIV transmission is through sexual intercourse, many faith-based institutions remain stuck on issues of stigma and judging others. Many churches are further constrained by a lack of programmatic experience, administrative capacity, and accountability. However, many are starting to realize the necessity of approaching the subject.

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The Young Men's Christian Associations (YMCAs) are in the forefront of actions to reduce the spread of AIDS. With the exception of Benin Republic, where the movement is just starting, they are well mobilized in Ghana, Liberia, Nigeria, Senegal and Togo, being particularly involved especially in the promotion of the reproductive health of adolescents with special emphasis on AIDS.

2.6 Faith-based Organisations (FBOs) involvement in HIV/AIDS

In the era of HIV/AIDS, FBOs have been the recipients of many accusations: of being a 'sleeping giant'; of promoting stigmatizing and discriminating attitudes based on fear and prejudice; of pronouncing harsh moral judgements on those infected; of obstructing the efforts of the secular world in the area of prevention; and of reducing the issues of AIDS to simplistic moral pronouncements, that have not made Churches or Mosques places of refuge and solace, but places of exclusion to all those "out there" who are but 'suffering the consequences of their own moral debauchery and sin." While we do not deny that, in too many instances, these accusations have tragically and regrettably been justified, it has not been always and everywhere (Parry, 2004). Whilst the moral debate – particularly around the condom issue – has raged in many circles, stalemating action and in many eyes discrediting the FBOs' commitment to tackling AIDS and saving lives, congregations and parishes have themselves been in the forefront of care and support right across Africa. A great number of these initiatives did not wait for funding in order to begin, they just responded. Their courage and determination in the face of so many obstacles is a humbling challenge and is a reflection of deep compassion in a real world of suffering (USAID, 2000).

FBOs are an integral part of life and society in most parts of Africa because of their involvement with the people at every aspect of their lives and for the many services they offer. They have the widest network coverage in the continent, the largest constituency of people, and an enviable infrastructure, extending from the international community, to the most marginalized (Parry, 2004). FBOs shape values and attitudes about family life and sexual self-understanding, both intentionally and unintentionally (FHI, 2003).

The churches and mosques have strengths, credibility, and are grounded in communities. This offers them the opportunity to make a real difference in combating HIV/AIDS. At the same time, increasing resources are being devoted to supporting Faith-Based Organisations in global campaigns like the Global Fund for AIDS, Tuberculosis and Malaria, and the U.S. Presidential Initiative on HIV/AIDS. Yet, remarkably little guidance is available for policy makers on exactly what the strengths of Faith-Based Organisations are. FBOs are involved in significant and positive activities in AIDS prevention, care and support at the community, state and national levels. The most common include: 1) awareness/education; 2) Home care; 3) Counseling and supporting testing; 4) Food and material support and 5) support for orphans however, awarcness on prevention often did not translate into behavior change (Liebowitz, 2004).

Although many Muslim leaders have done little to control HIV/AIDS other than deport the foreigners that they blame for the disease, a handful of leaders have acknowledged the epidemic and are working diligently to find ways to control infections (Eberstadt and Kelly, 2005). In Tanzania, where HIV/AIDS is the number one killer disease between ages 15 and 49, the religious leaders said they could not campaign for the use of condoms as a means of curbing HIV/AIDS as this runs counter to their doctrines, but agreed that it is the responsibility of the government to do so. They also agreed to collaborate with the government in educating their followers about avoiding extra-marital sexual relations. The leaders also emphasized the importance of HIV/AIDS education for children through Sunday schools, and quranic schools, as well regular religious classes given to primary school children. They called on the governme to give more support for promoting ways to prevent the disease -- including abstinence aithfulness between partners and condoms -- and to commit more resources for HIV/AIL prevention and care and for mitigating its impact (United Nations Development Prograr me, 2002).

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and were aware that AIDS is transmitted by a virus called HIV (WCC, 2001). Moreover, the viral etiology of HIV infection is the only one accepted and recognized by the Churches. In addition, they recognized particularly poverty, which generally leads to rural exodus, migration and prostitution, to which are added ignorance, denial of the illness, the harmful effects of the media, beliefs and certain cultural practices. Although, Nigeria seems to be better off than that of other neighbouring countries, the country is a victim of unequal distribution of the country's resources, which is a distinctive characteristic, contributing to the spread of HIV/AIDS (WCC, 2001).

On 16 April, 2002, leaders of the Christian Association of Nigeria, The Supreme Council for Islamic Affairs of Nigeria and the Christian Health Association of Nigeria were convened by The Balm In Gilead and began a discussion on how the faith community could begin to respond to the challenges of the HIV/AIDS pandemic in the country. The meeting was held at the Shehu Musa Yara'Adua Centre in Abuja. At this historic gathering of Muslim and Christian leaders to address HIV/AIDS issues, Dr. Lateef Adegbite, Secretary General of the Supreme Council for Islamic Affairs, and Archbishop John Onaiyekan, President of the Catholic Bishops Conference of Nigeria, endorsed a partnership with The Balm in Gilead to fight HIV/AIDS in Nigeria. A unanimous decision was reached by the leadership to establish a joint council of Christians and Muslims to be the leading partner with The Balm in Gilead to address HIV/AIDS issues in the country. The Inter-faith HIV/AIDS Council of Nigeria was conceived and endorsed by the highest levels of both the Christian and Muslim political structures to address the challenges of HIV/AIDS throughout the Christian and Muslim communities across the country with a Declaration of Unity from the Christian and Muslim communities to address the problems associated with HIV/AIDS, (Nwashili, 2004).

The Interfaith HIV/AIDS Council of Nigeria is committed to building the capacity of the faith community in Nigeria and to facilitating the establishment of a systematic HIV/AIDS service delivery mechanism throughout the country, which will operate via local churches and mosques. The Council is also providing training and coordination advocacy and technical assistance to churches and mosques to provide HIV/AIDS

education intervention that prevent mother-to-child-transmission, voluntary counselling and testing programmes, care and support for people living with HIV/AIDS and their family members, including orphans affected by HIV/AIDS in both urban and rural communities.

The Organisational objectives of the Council are to

- bring the two major religious groups (Christians and Muslims) together to present a common front in the fight against HIV/AIDS.
- establish and maintain the pre-eminence of quality capacity building among the faith groups in addressing the problem of HIV/AIDS.
- advocate for the rights of people living with and those affected by HIV/AIDS in Nigeria and
- collaborate with governments and NGOs in the prevention and control of HIV/AIDS and in giving care and support to people living with HIV/AIDS. (Nwashili, 2004).

In summation, Faith-Based Organisations' activities in home-based care, education and awareness raising, and nutritional support were particularly valued in the communities where they worked. In addition, some FBOs encouraged faithfulness, abstinence and condom use as strategies for HIV prevention. Although there was substantial disagreement about the effectiveness of abstinence and condom use as prevention strategies, all were seen as useful prevention strategies by particular FBOs or groups within FBOs. Where FBOs were able to generate a feeling of community ownership, as in home care, or target their programming to relevant groups, their programs proved particularly successful.

However, Faith-Based Organisations have limitations of capacity, resources, and skills. These limitations make them ill suited for certain kinds of HIV/AIDS programming. In some cases, Faith-Based Organisations were able to overcome these limitations by building collaborative relationships with NGOs, government and other FBOs. Those that did so were often able to carry out more creative and broader programs. At the same time,

FBOs also have constraints based on their belief system, leadership, and exclusiveness. Realizing these constraints can provide those involved in FBOs activities in HIV/AIDS work a more useful framework for building effective intervention.

2.7 Sexual behaviour and practices of Muslims and Christians

Though Islam only approves sex between married couple, it is acknowledged that this view is not held by everyone. Muslims living in the western countries and elsewhere find that society around them accepts short-term sexual relationships and sex between people of the same sex. This may put them at risk of acquiring sexually transmitted infections, and HIV (World Faiths Development Dialogue (WFDD), 2003). It is assumed that HIV is mainly transmitted through unprotected sex with an infected person and Islam preaches the most important means of protection: abstinence from sex and to remain faithful to one's partner in marriage, and not to have any sex before or outside such a relationship. Besides, staying away from sex altogether or faithfulness in a relationship, using condoms is regarded as one of the ways to reduce the risk of HIV and other sexually transmitted infections.

However, one does not always know the full history of sexual activity of one's partner in marriage, "all of us know that alcohol and sex outside marriage are prohibited in Islam and all of us know of some Muslims who engage in these things, and all of us know our own lives and history better than outsiders". This is why it is important for all individuals to also go for HIV tests before engaging in marital sex (WFDD, 2003).

It is estimated that one third of the world's population is Christian. In sub-Saharan Africa, over half the population belongs to the Christian community. All available data shows that young people have sex and that many have sex from a very early age. Yet, as the HIV pandemic spreads, a further 6,000 young people are infected each day (WCC, 2001). The reality is that large numbers of young people, sexually active from a very young age, are not receiving adequate sexual health and HIV education, do not have knowledge or skills to protect themselves from HIV, and are therefore becoming infected and dying. The churches now recognize that the difficulties they have experienced in dealing with

issues of sex and sexuality have weakened the response in relation to prevention of HIV (WCC, 2001). It is reported that silence, contradictory and punitive messages, or messages that undermine those of HIV professionals contribute to confusion, stigma and discrimination. A WCC report summarizes it thus: 'We confess our silence'. We confess that sometimes our words and deeds have been harmful and have denied the dignity of each person' (World Council of Churches, 2001). Since it is easier to influence young people's behaviour before behaviour patterns are established. Sexual health and HIV education need to be taught before young people become sexually active that is, before their early teens.

Churches are rooted in communities, and are well placed to work with and support and lobby traditional, local and national leadership in preventing HIV among young people. This is because churches have well-established networks through which people can be reached and these networks become even more important in countries where high proportions of young people do not go to school.

2.8 Conceptual Framework

The Precede Model

PRECEDE (Predisposing, Reinforcing and Enabling Causes in Educational Diagnosis and Evaluation) model is a standard scientific approach to planning programmes in health education. This planning and diagnostic framework was presented by Green, Kreuter, Deads, Patridge in 1980. It is made up of a series of sequential steps for diagnosing the causes of a problem and consequently selecting the most appropriate health intervention for solving the identified problem. It involves identifying behavioural and non-behavioural causes of a problem, with much emphasis laid on the behavioural aspect in the model. With these diagnoses, appropriate intervention(s) can be planned for any recognized crisis.

The PRECEDE model is presented in a framework encompassing six phases:

Phases One - Two	-	Epidemiological and Social diagnosis
Phase Three	-	Behavioural diagnosis.
Phases Four - Five	-	Educational diagnosis
Phase Six	-	Administrative diagnosis

The epidemiological and social diagnosis (Phases I and 2), present the effect of both health and non-health problems on the quality of life; but emphasis is on health problems which are identified through various sources such as review of literature or documents, surveys and interviews. The epidemiological diagnosis deals with the incidence, prevalence and distribution of the health or social problems while the social diagnosis aspect focuses on social problems that have negative impacts on health. In this study these epidemiological diagnosis include incidence of HIV/AIDS including other sexually transmitted infections (STIs). Sexual risk behaviour like unprotected sex, sharing of sharp instruments, multiple sexual partners. While the social diagnosis includes inadequate awareness and educative programmes on HIV/AIDS, levels of education and religious affiliation.

The third phase (Phase 3) - the behavioural diagnosis, recognizes that the identified health problems are influenced by both behavioural and non-behavioural causes. The model focuses more on health related behaviour. In this study, health behaviour on which a health education intervention is necessary in order to bring out a positive effect on the quality of life include sharing of sharp objects, having multiple sexual partners, pre and extra marital sex, and non use of condom.

Phases 4-5 present the educational diagnosis, which includes the behavioural antecedents of the PRECEDE model. It recognizes three components of antecedent factors that have an influence on health related behaviour. These include the predisposing, enabling and reinforcing factors.

The administrative diagnosis phase (phase 6) is a stage during which the health education intervention or strategy that would influence behaviour is identified. The intervention is directed at the most important factor identified in the educational diagnosis (predisposing, enabling, reinforcing factors) that can bring out a positive change in behaviour giving the attention to detail available resources. An example of such strategy is training. The antecedents are described as follows:

Predisposing factors

These include issues with which individuals come into a situation such as health knowledge, attitudes and values, health beliefs, norms and perceptions. In this study, these are the awareness of faith based organization members on HIV/AIDS. value they place on health, the knowledge they have on various ways of transmission and prevention of HIV/AIDS and attitudes towards people living with HIV/AIDS.

Enabling Factors

Enabling factors are modifiable through educational processes and these include skills and other resources required by Faith-based organisations to act, perform or function in the situation (availability of health education programmes, time, information, education and communication (IEC) materials and support from the government and).

Reinforcing Factors

Reinforcing factors determine whether a behaviour that is motivated and enabled will persist once it has been tried. In this study the reinforcing factors include willingness and disposition of the religious leaders to carry out HIV/AIDS educational programmes and knowledge of religious leaders and key members within the faith based organizations on HIV/AIDS. Other reinforcing factors include confidential and non-judgmental educational programmes by religious leaders and health care providers.

2.8.1

FIGURE: 1 PRECEDE FRAMEWORK: Application to HIV/AIDS Educational Needs of Churches and Mosques congregation.

Phase 6
Administrative diagnosis

Health Education
* Continuing education for religious congregations, awareness campaign, sex education and counseling.
* Provision of IEC materials
* Encourage educative programmes on HIV/AIDS

Policy
* Should address the HIV/AIDS epidemic
* Promote use of condoms in prevention of HIV/AIDS
*Doctrine of FBOs to encourage condom use
*Government to provide support HIV/AIDS programs

Phase 4 –5 Educational diagnosis

Predisposing Factors
* Awareness of religious leaders on HIV/AIDS
* Value religious leaders place on health
Awareness and interest shown by congregation on HIV/AIDS
* Religious leaders' belief that there is benefit in awareness campaign on HIV/AIDS
* Knowledge religious leaders have about the various ways HIV/AIDS can be transmitted

Enabling Factors
* Doctrines of religious groups
* Availability of HIV/AIDS educational programmes
* Time
* Support from the government
* Availability of IEC materials
* Skill or ability of religious leaders and key members in the congregation in giving awareness/education on

Reinforcing Factors
* Level of education of religious leader
* Age of religious leader
* Confidential and non judgmental educational programmes by religious leaders and health care providers.

Phase 3 - Behavioural diagnosis

* Behaviour and Lifestyle
* churches and mosques congregation denial of HIV/AIDS

Environment
* Conducive environment
* Attitude of faith based organization members in involvement in positive activities in HIV/AIDS prevention, care and support. services

Phase 1-2 Epidemiological and Social diagnosis

Health Status
* STIs, HIV/AIDS prevalence.
* Unprotected Sex

Quality of life
Low morbidity and mortality rate

CHAPTER THREE

METHODOLOGY

3.1 Research Design

This study is a cross-sectional survey of Muslims and Christian's congregation in Oyo State, Nigeria in relation to their awareness, knowledge and perceived seriousness of HIV/AIDS, sexual practices and preferred HIV/AIDS educators.

3.2 Description of the Study Area

Oyo State is an inland state in south-western Nigeria, with its capital at Ibadan. It is bounded in the south by Ogun State and in the north by Kwara State, in the west is bounded partly by Ogun State and partly by the Republic of Benin while in the east it is bounded by Osun State. Ibadan has been functioning as one of the major administrative, commercial and educational centres in Nigeria for decades. It is also reputed for being the largest indigenous city in sub-Sahara Africa. The state occupies a total of 28,454 km² (Oyo state ministry of information, youth sports and culture (OSMOIYSC, 2002) with a projected population of 6,617.720 for 2004 based on 1991 census of 3,488.789 (National Population Commission, 2004). The State is made up of Thirty-three (33) Local Government Areas. Politically the State is also divided into three senatorial districts namely, Oyo North, Oyo Central and Oyo South.

The topography of the State ranges between 125m above sea level in the Southern part and 375m in the North. The State has the tropical deciduous rain forest in the South and the savannah vegetation in the northern part (OSMOIYSC, 1999). Two seasons are experienced in the State and these are the Raining season, which starts in April and ends in October and the Dry season, which covers the remaining months of the year. The mean annual rainfall is between 1,250mm in the northern area and 1,750mm in the southern part.

History

It was formed in 1976 from the former Western State, and originally included Ọsun State, which was split off in 1991. Ọyọ State is homogenous, mainly inhabited by the Yoruba ethnic group who are primarily agrarian but have a predilection for living in high density urban centers. The indigenes mainly comprises the Oyos, the Ibadans and the Ibarapas, all belonging to the Yoruba family and speaking the same Yoruba language. Other people from within and outside the country trade and settle in the state mostly in the urban areas. The capital, Ibadan is reputed to be the largest indigenous city in Africa, south of the Sahara. Ibadan had been the centre of administration of the old Western Region, Nigeria since the days of the British colonial rule. Other notable cities and towns in Oyo State include Oyo, Ogbomoso, Iseyin, Okeho, Saki, Eruwa, Lanlate, and Igbo Ora. The climate in the state favours the cultivation of crops like maize, yam, cassava, millet, rice, plantain, cacao tree, palm tree and cashew. There are a number of government farm settlements in Ipapo, Ilora, Eruwa, Ogbomosho, Iresaadu, Ijaiye, Akufo and Lalupon. There is abundance of clay, kaolin and aquamarine. There are also vast cattle ranches at Saki, Fasola, Moniya and Ibadan (Wikipedia, 2016).

Landmarks

The first university to be set up in Nigeria was the University of Ibadan (established as a college of the University of London when it was founded in 1948, and later converted into an autonomous university in 1962). It has the distinction of being one of the premier educational institutions in West Africa. The other Universities in the state are; Lead City University, Ibadan, Ajayi Crowther University, Oyo and the Ladoke Akintola University of Technology, Ogbomoso. The Polytechnic, Ibadan is one of the best polytechnics in Nigeria, and there are also 324 secondary schools as well as 1,576 public primary schools in the state. Other noteworthy institutions in the city include the University College Hospital; the first teaching hospital in Nigeria and the internationally acclaimed International Institute of Tropical Agriculture (IITA). Another prominent landmark in Oyo State is Cocoa House, the first skyscraper built in Africa. The state is also home to NTA Ibadan, the first television station in Africa and Liberty Stadium, Ibadan the first stadium built in Africa. Other major tourist attractions located in the state include: Agodi Botanical Garden, Ado-Awaye Suspended lake, Mapo Hall, University of Ibadan

Ethnic Composition, Language, Culture, Arts, Occupation and Religion

Oyo State is broadly occupied by Yoruba speaking people. Within this broad grouping are four roughly defined subgroups with distinct Yoruba dialects, namely, the pure Oyo, Ibadan, Ibarapa and Okeogun. The main ethnic minorities in the State include the nomadic Fulanis, Ibos, Hausa and migrants farm labourers from other States

Out of the four dialect defined subgroups, it is the Ibarapa and OkeOgun areas that have retained stronger cultural homogencity followed by the purc Oyo (areas of Oyo and Ogbomoso). Ibadan is a product of a cultural mix of the Oyo, Ife and Ijebu dialectal developments through its historic antecedents.

Apart from its administrative functions, Oyo also served as a centre of trade in agriculture and crafts manufacturing. Other factors of traditional urbanization in Yoruba land generally and in Oyo State in particular, include the farming practices along with the trading and craft specializations, which formed the basis for the establishment of monetary transactions long before contact with the outside world.

Three main features of development programmes have aided rural development in the state since its creation in 1976. These include the rural electrification, water projects and construction of rural roads. These three elements not only opened up the rural areas to further development investments, particularly of cottage industries, they have helped in reducing the tempo of rural-urban drift within the state and aided the uniform distribution and stabilization of population density in the state.

The major source of income for a great number of people living in the state is Agriculture with few small and medium scale entrepreneurs.. About 65% of the people live in the rural areas while 35% reside in urban settlements (OSMOYSC. 1999). There are about 20 and 10 types of churches and Mosques respectively in Oyo State. Out of which 11 Church (Christian Association of Nigeria, 2004) and 7 Mosque denominations/sects are registered or structured The common day of worship among the Churches is Sunday while that of the Muslims is Friday.

Most of the faith-based organisations (Christianity and Islam) have their headquarters in the capital of the state, Ibadan, with the target population scattered throughout the state. Individuals who attend religious services frequently and who value religion in their lives are believed to receive more frequent religious messages against immoralities and probably more likely than others to develop sexual attitudes and behaviour that are consistent with their religious doctrines. Premarital and extramarital sexual activities are strongly preached against in Christianity and Islam that is, abstinence and faithfulness to the unmarried and the married respectively. But when unmarried and the married do otherwise, they are referred to as fornicators and adulterers respectively. The punishment for these offenders also known, as "sinners" is to confess their sins and ask for forgiveness from the almighty God according to what is written in the holy books, Bible (Christians) and Quran (Muslims). In reality, for one to commit fornication or adultery, sex must have taken place between opposite sex, but 'Sex' is seen as a foul word to be used in "holy places" like church or mosque. Therefore, preaching or teaching on HIV/AIDS faces an obstacle in these organisations since sex is seen as a major channel through which the AIDS virus is spread.

3.3 Description of Target Population

The targeted populations are the congregation of registered and structured Churches and Mosques in Oyo State, Nigeria. The congregations, otherwise known as members are the individuals that attend worships in their various Churches and Mosques and are also affiliated to these faith-based organisations (Churches and Mosques) in Oyo State, Nigeria.

3.4 Inclusion Criteria

Eligible respondents were those who were active members in the church/mosque and have been worshipping in the church/mosque for at least six months prior to the period of the survey. Their ages ranged from 15 to 70 years.

3.5 Sampling Procedure

A multi-stage sampling technique (four-level) was used to select the study population. In the first stage, the names of structured and registered Churches and Mosques in Oyo State (appendix 1) obtained from the Christian Association of Nigeria (CAN), the

Ja'amat Nasirul Islamiyat (JNI) and the Muslim Association of Nigeria (MAN) respectively were grouped within the major three (3) zones in Oyo State. These zones are

1. Ibadan/Ibarapa
2. Oyo/Oke-Ogun
3. Ogbomoso

Second, the churches and mosques were stratified into different denominational groups (thirteen (13) denominations of churches and seven (7) sects of Muslims (mosques)). Third, 50% of each denomination/sect of churches and mosques in these three zones were randomly selected based on weighted ratio of 5:2:1 (Ibadan/Ibarapa (5), Oyo/Oke-Ogun (2) and Ogbomoso (1)). Finally, five hundred members from each religion were purposively selected from Churches and Mosques giving a total of 1000. See table 1a below for details.

Table 1b: Number of selected Christians and Muslims according to zones

Number of Respondents	Zones			
	Ibadan/Ibarapa	Oyo/Oke-ogun	Ogbomoso	Total
Christians	378	78	44	500
Muslims	406	78	16	500
Total	784	156	60	1000

Respondents (members) were randomly administered questionnaire to. This is to give equal chance of selected people in each reporting domain (Churches and Mosques). Members who volunteered and made themselves available were interviewed after worship/services in Churches and Mosques. The various denominations selected and the number of respondents interviewed in each denomination is shown in Appendix I.

3.6 Sample Size

Data on the exact population of Christians and Muslim is dearth, and this is evident in the exclusion of religious data from the 2006 census conducted. However, a total of 1000 respondents were interviewed from Churches and Mosques in Oyo State to make a well represented sample. This comprised of 500 Christians and 500 Muslims.

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3.7 Instrument for data collection

A set of semi-structured questionnaire was designed for collection of data for this study. The questionnaire was developed to elicit information from Churches and Mosques congregation. It contains the following sections:

1. Demographic Characteristics such as gender, age, marital status, level of education, type of work, denomination, ethnic group, frequency of attending worship.
2. Knowledge of HIV/AIDS, perceive seriousness and chances of contracting HIV/AIDS. Questions asked include the causes, mode of transmission and prevention of HIV/AIDS
3. Attitude and practices towards HIV AIDS messages, frequency of HIV AIDS programmes attended in and organised by the Church or Mosque. Questions on respondents' attitude to people living with HIV AIDS were also asked here
4. Suggestions for training on HIV AIDS. Questions asked include respondents' HIV/AIDS Educational needs and Preferred HIV AIDS Educators

3.8 Validity

Validity can be defined as the degree to which the test measures what it is suppose to measure (Key, 1997). Approaches to the validity of tests and measures include content and construct validity. In ensuring these the researcher with the help of her supervisor and other senior colleagues, obtained groups of items which are representative of the content of the trait to be measured. These included knowledge, attitude, perceived seriousness, risk and demographic information. These variables were pooled together to form appropriate section headings of the questionnaire. The semi-structured questionnaire was translated to Yoruba language for ease of administration.

3.9 Reliability

The reliability of a research instrument concerns the extent to which the instrument yields the same results on repeated trials. To ensure reliability, a pretest study was carried out using the final draft of the validated questionnaire on 100 respondents (50 church and 50 Mosques members) in Osogbo, Osun State Nigeria. The pre-testing was carried out using simple random sampling technique was employed in selecting the Faith Based Organizations

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denominations and respondents. Developed semi-structured questionnaires were first tested in Osogbo, Osun State before the final administration of questionnaire was conducted. The questionnaires were interviewed guided administered for the pretest and final administration. Respondents were proportionately and randomly selected for interview after worship activities on Sundays/Fridays and other worship days in Churches and Mosques. The pre-testing enabled the researcher to discover possible errors and ambiguities, which were rectified before the final administration of the questionnaire. For instance, questions asked on mode of transmission and prevention of HIV/AIDS were changed to closed-ended types instead of open-ended types as they were during pre-testing. Also, questions on pre and extra marital sexual activities were divided into two questions to cater for the unmarried and the married separately. During the pretest, it took an average of one hour to administer a questionnaire whereas in the final administration a questionnaire took an average of 45minutes to administer, probably because some question types were changed into close-ended as oppose to how they were during the pretest. Respondents also suggested after worship interviews, especially Sundays and Fridays for Christians and Muslims respectively.

3.10 Method of data collection

Twenty Polytechnic and University graduates fluent in English and Yoruba languages were trained for this study. Letters of introduction (appendix 4) of research assistants to selected churches and Mosques Leaders were obtained from the Department of Health Promotion and Education, College of Medicine, University of Ibadan. This was necessary to serve as evidence and reminder as the researcher had already visited majority of these selected Churches and Mosques (see appendix 5) to fix possible period of the interviews. Interview of respondents were done after worship services on Sundays and Fridays for Christians and Muslims respectively. For most of the Interviews, respondents were interviewed in Yoruba for proper understanding of the content of the questions. And for the non-Yorubas, English and pigeon English were used for the Interviews. The questionnaire administrations ran over a period of six weeks.

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3.11 Ethical consideration

Advocacy trips were first made to the District Headquarters of Churches and Mosques in Oyo State (appendix 6). Thereafter, a planning meeting on HIV/AIDS prevention was organised (appendix 7) for the leaders of these Churches and Mosques in the Department of Health Promotion and Education, College of Medicine, University of Ibadan, Ibadan where 52 Christian and Muslim leaders were in attendance. This meeting, which was held two months to the final administration of the questionnaire, served as a sensitization workshop about the study as well as to get their consent and those of their congregation. During this meeting, the Muslims leaders demonstrated a more positive disposition to the study than the Christian leaders. Similar study on the Religious leaders was suggested during the meeting. Also, the leaders requested for a feedback of the interviews with their members and the researcher granted this. In addition, the Muslim leaders implored that a meeting with the leagues of Imams be held for final approval from the entire Islamic body in Oyo State. This was done two weeks after the initial planning meeting at Oja-Oba Central Mosque, Ibadan, Oyo State.

At the planning meeting they were informed that participation is voluntary and they should encourage their members to participate. During the questionnaire administration proper, respondents were first asked if they were willing to partake in the interview. After giving their consent, they were assured that information provided would be kept strictly confidential (see appendix 2 - Questionnaire)

3.12 Data Analysis

Data (Questionnaire) retrieval was done by the researcher. The research assistants collected the information from the respondents, edited the questionnaire in the field and submitted his/her quota for the day to the re: rch supervisor. Where possible, through re-visits, omissions and mistakes were traced their original source and corrected. The returned questionnaire forms were cleaned y sorting out the completed ones and assigning identification numbers to them fo: easy recall. The researcher prepared the coding guide and research assistants hand-coded the completed questionnaires with the help of the coding guide. The Epi-Info v6 was used for data entry, validation and cleaning. In order to further minimize inconsistent and illegal entries, the CHECK option

of the Epi-Info menu was used to guide the data entry exercise. The data were subsequently imported into Statistically Package for Social Scientists (SPSS) vs10 software package and this software was used to generate frequency tables, graphs and perform cross-tabulations. Chi-square and ANOVA statistics were used to test for significance and draw inferences at 0.05 level of significance.

CHAPTER FOUR

RESULTS

4.1 Demographic characteristics of the respondents

Respondents' Gender, Age and Religion Distribution

As presented in table 1, 50% (500) of the respondents were males and so do females. The respondents comprised of 500 Christians and 500 Muslims. The mean age was 33.3 years with a standard deviation of 13.4 years (Christian mean age, 33.7 and SD of 13.6; Muslims mean age 33.1 and SD of 13.1). Majority of both groups, 303 (60.6%) Muslims and 234 (46.8%) Christians were married.

Respondents' level of education, frequency of worship and occupation

Four hundred and fifty two (90.4%) of the Muslims and 487 (97.4%) of the Christians have ever attended school. A higher proportion of the Christians 443 (88.6%) had more than primary school education compared with their Muslim counterparts 324 (64.8%). Majority of the Muslim respondents 495 (99%) and 430 (86%) of the Christians were Yoruba (see Table 1). As regards the frequency of Mosques or Churches attendance. 386 (77.2%) of the Muslim respondents reportedly attended Mosques daily while 233 (46.7%) of the Christian respondents reportedly attended Churches more than once weekly. Furthermore, 179 (35.9%) of the Muslims were traders compared with 55 (11%) Christians; and 153 (30.6%) of the Christians and 93 (18.7%) Muslims were in one way or the other schooling.

Table 2: Demographic characteristics of respondents

Demographic characteristics of respondents	Christian N = 500 (%)	Muslim N = 500 (%)	Total N = 1000 (%)
SEX			
Male	253 (50.6)	247 (47.4)	500 (50)
Female	247 (49.9)	253 (50.6)	500 (50)
Total	**500**	**500**	**1000**
AGE			
15-24	166 (33.3)	131 (26.4)	297 (29.7)
25-34	124 (24.9)	181 (36.4)	305 (30.5)192
35-44	92 (18.5)	100 (20.1)	(19.2)
45-above	116(23.3)	85 (17.1)	201(20.1)
Total	**498**	**497**	**995**
MARITAL STATUS			
Currently Married	234 (46.8)	303 (60.6)	537 (53.7)
Formally Married	30 (6.0)	32 (6.4)	62 (6.2)
Never Married	236 (47.2)	165 (33.0)	401 (40.1)
Total	**500**	**500**	**1000**
EDUCATIONAL STATUS			
Never attended school	13 (2.6)	48 (9.6)	61 (6.1)
Primary	44 (8.8)	128 (25.6)	172 (17.2)
Secondary/Modern	161 (32.2)}	226 (45.2)}	387 (38.7)}
Higher/ Tertiary	282 (56.4)} 88.6%	98 (19.6)} 64.8%	380(38.0)}76.7%
Total	**500**	**500**	**1000**
ETHNIC GROUP			
Yoruba	430 (86)	495 (99)	925 (92.5)
Ibo	2 (0.4)	1 (0.2)	3 (0.3)
Hausa	41 (8.2)	3 (0.6)	42 (4.2)
Others	27 (5.4)	1 (0.2)	30 (3.0)
Total	**500**	**500**	**1000**
Frequency of Church/Mosque Attendance			
Daily	166 (33.2)	386 (77.2)	552 (55.2)
Weekly	88 (17.)	47 (9.4)	135 (13.5)
More than once a week	233 (46.)	62 (12.4)	295 (29.5)
Monthly	7 (1.4)	2 (0.4)	9 (0.9)
Others	6 (1.2)	3 (0.6)	9 (0.9)
Total	**500**	**500**	**1000**

4.2 Respondents' HIV/AIDS risk taking practices

Sexual Practices – Extra-marital and Pre-marital

On sexual risk practices, 46 of 234 (19.7%) Christians that were married had extra-marital sex compared with 46 of 303 (15.2%) Muslims (Figure 2). Twenty of 46 (43.5%) Christians that engaged in extra marital sex had more than secondary/modern school education, 16 (34.8%) had secondary education, 8 (17.4%) had primary education and 2 (4.3%) never attended school. Of the Muslims, only 7 (15.2%) had more than secondary/modern education, majority, 34 of 46 (74%) fell in the categories of those that had primary and secondary education equally. 2 (4.3%) had never attended school and 3 (6.5%) did not specify their highest level of education. Majority 82 (89.1%) of the respondents involved in extra marital sex reportedly had sex with their men/women/boy/girl friends and concubines while the rest 10 (10.8%) had forgotten whom they had extra-marital sex with and 1 respondent did not respond.

Contrarily to extra-marital sex practices, a higher proportion of Muslim, 81 of 165 (49.1%) compared to Christians 99 of 236 (42%) reported that they had pre-marital sex (Figure 3). The highest number of people that engaged in pre marital sex among the Christians were those with Tertiary education, 63 (63.6%), followed by secondary education, 27 (27.3%), then 7 (7.1%) with primary education and 2 (2%) who never attended school. For the Muslims, 39 (48.1%) had tertiary education, 29 (35.1%) had secondary, 11 (13.6%) had primary while 2 (2.5%) never attended school.

Figure 2: Percentage of respondents as regards extra-marital sex practice

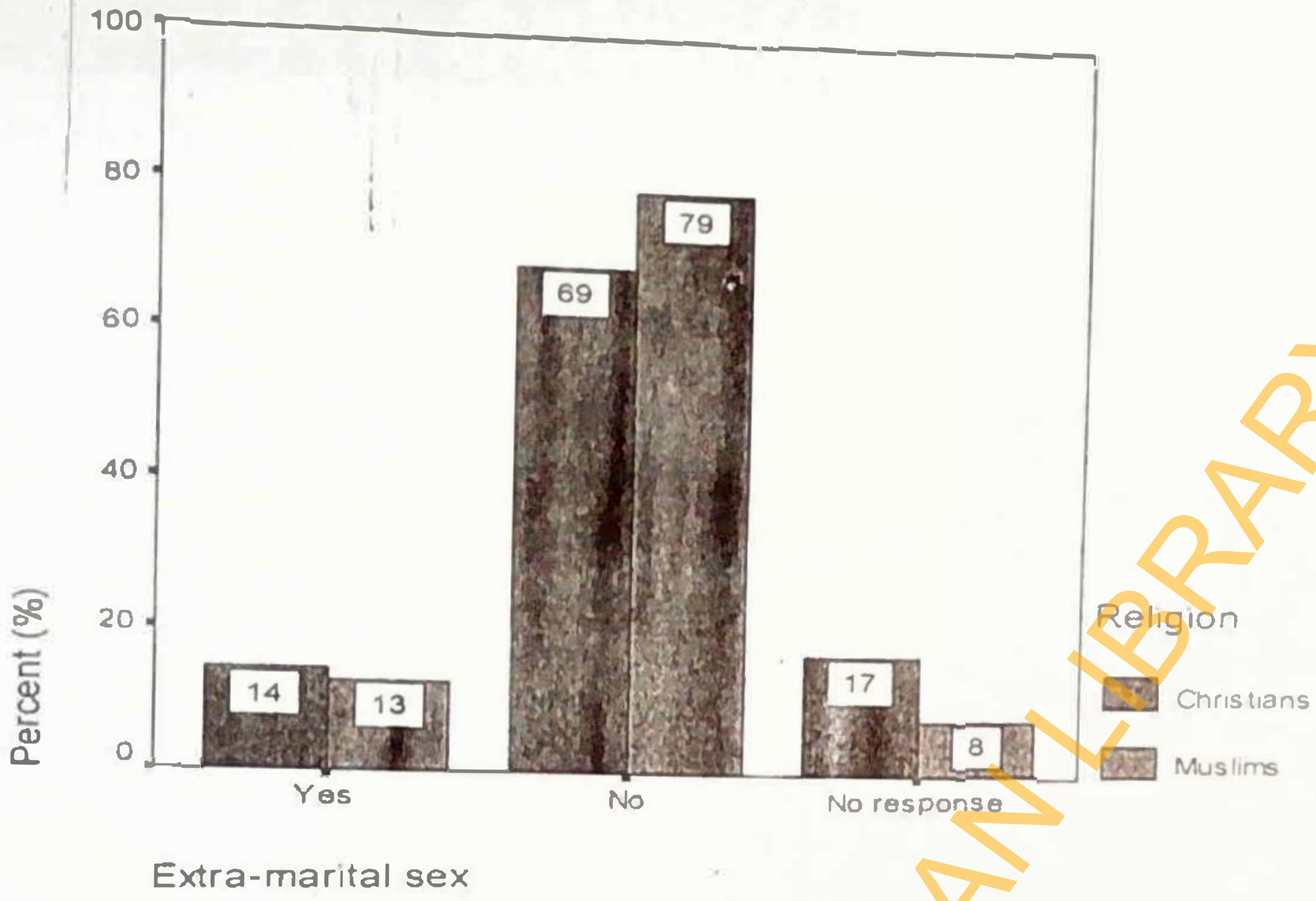
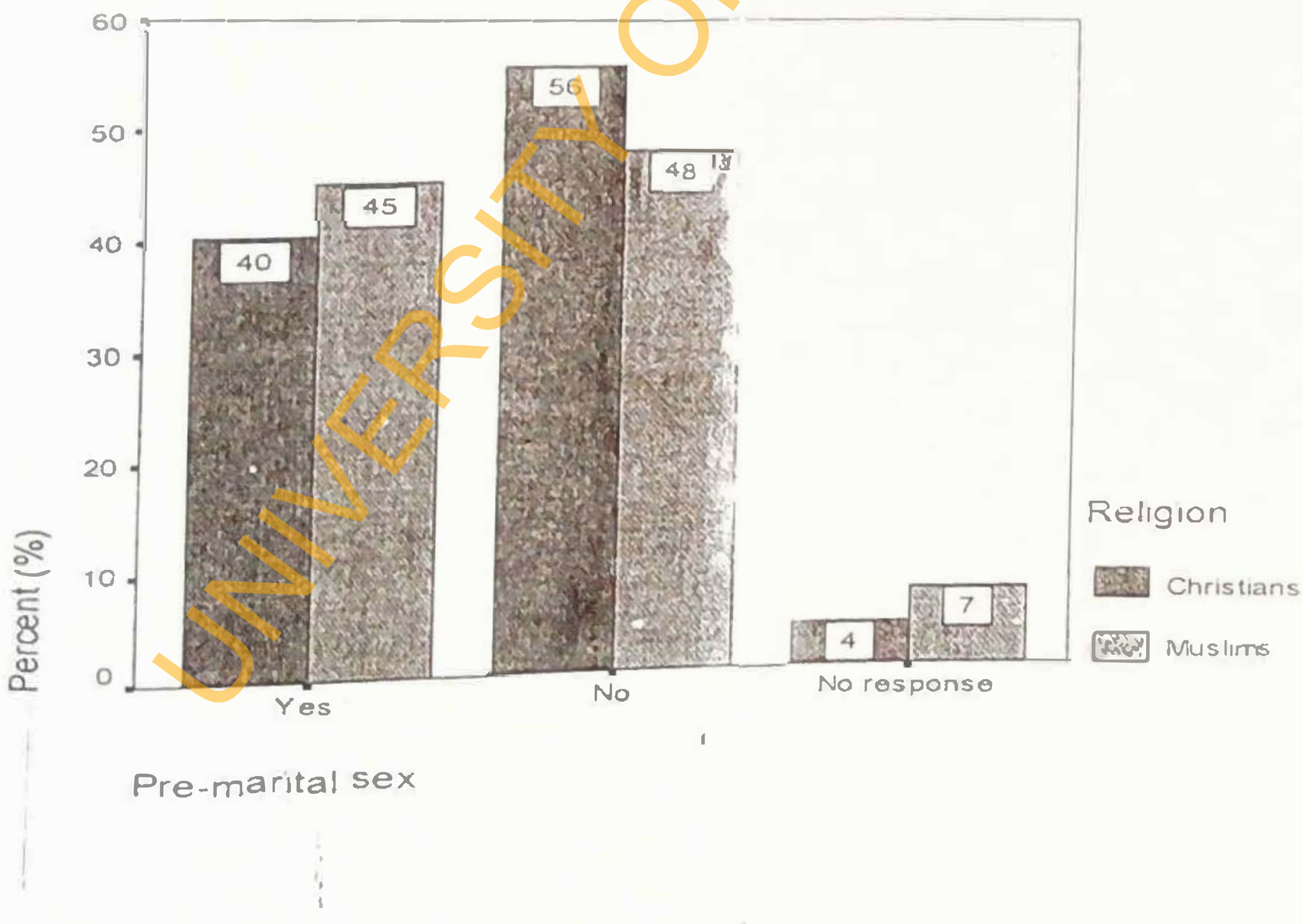


Figure 3: Percentage of respondents as regards pre-marital sex practice



Also, majority (93.9%) of those that reportedly ever had pre-marital sex had it with their fiancée/boyfriends/girlfriends while one respondent (0.6%) reported having it with a rapist, 3 respondents reported having it with several people and 8 respondents did not specify who they had sex with.

Interestingly, the ratio of male to female engaged in extra marital sex in both faith-based organizations is 4:1 [(Christians; 37males and 9females) (Muslims; 38males and 8females)]. For pre marital sex, male to female ratio among Christians is 1:1 (53:46) and 2:1 (52:29) among Muslims.

Number of non-marital sexual partners

About the number of sexual partners respondents have, fewer number of Muslim 37 of 126 (29.4) than Christians 24 of 141 (17%) had more than one sexual partner (table 7) although this is not statistically significant (p.0.333)

Table 3: Distribution of respondents' number of sexual partners

No of sexual partners	Christians (%) n=141	Muslims (%) n= 126	Total % n = 267
0	4 (2.8)	1 (0.8)	5 (1.9)
1	110 (78.0)	86 (68.3)	196 (73.4)
more 1 (range of 2 to 8)	24 (17)	37 (29.4)	61 (22.8)
No response	3 (2.1)	2 (1.6)	5 (1.9)

Other risk practices by respondents

As shown in table 4, more Muslims 183 (36.6%) compared with Christians 14 (29.2%) share sharp instruments. Similarly, fairly higher proportion of Muslims 260 (52.0%) compared with 211 (42.2%) Christians have had sex with partners who will not use condom. However, the proportion of Christians 56 (11.2%) who took alcohol was higher compared with the Muslims 27 (5.4%).

Table 4: Distribution of respondents in relation to other risk behaviour

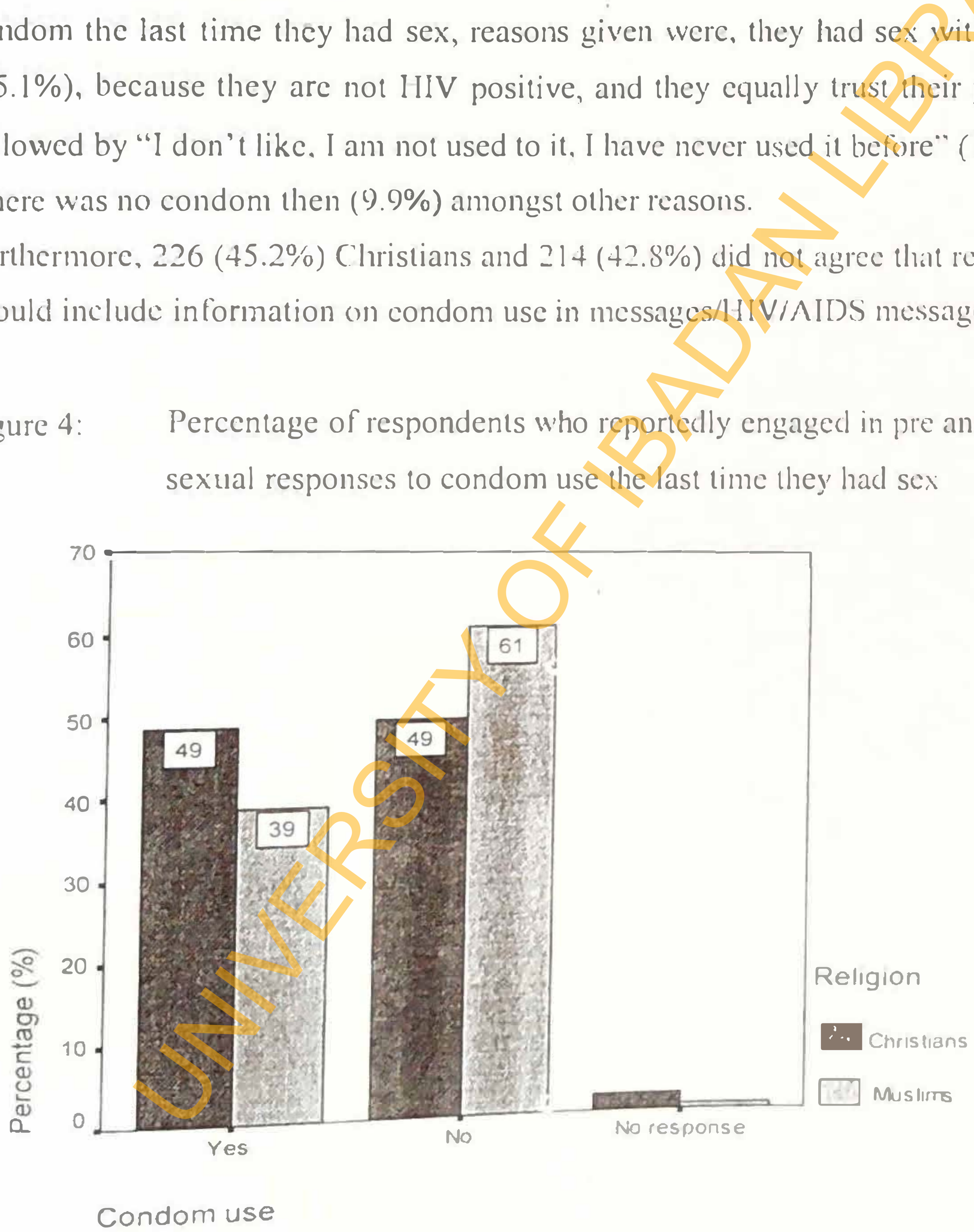
Risk practices	P value	Christians		Muslim		Total	
		Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)
Do share sharp instrument	0.029	14 (29.2)	70.6	183 (36.6)	317(63.4)	329(32.9)	670(67.0)
Do go to salon with personal kit	0.603	234(46.8)	265(53.3)	236(47.2)	264(52.8)	470(47.0)	529(52.9)
Refuse to have sex with partner who will not use condom	0.005	256 (51.2)	211(42.2)	201(40.2)	260(52.0)	457(45.7)	471 (47.1)
Ever taken unscreened blood in a health facility	0.394	10(2.0)	486(97.2)	12(2.4)	486(97.2)	22 (2.2)	972(97.2)
Smoked cigarette 3 months prior to the survey	0.255	9 (1.8)	489 (97.8)	13(2.6)	487(97.4)	22(2.2)	97(97.6)
Taken alcohol 3 months prior to the survey	0.001	56 (11.2)	441 (88.2)	27(5.4)	473(94.6)	83 (8.3)	914 (91.4)

Condom use behaviour

With regards to condom use, less than fifty percent of respondents in both faith based organization that reportedly engaged in pre and extra-marital sex used condom the last time they had sex preceding this study (Christians 72 (48.6%) and Muslims 63 (38.7%)) (See figure 4). On why they used condom, 45.5% of all respondents said to prevent pregnancy, followed by those who said to protect themselves from diseases (22.5%), and 20.6% specifically said to prevent against AIDS. Other reasons include: no trust for partner (1.9%) and to be personally comfortable (3.1%). Of those who did not use condom the last time they had sex, reasons given were, they had sex with their spouses (15.1%), because they are not HIV positive, and they equally trust their partners (14%) followed by "I don't like, I am not used to it, I have never used it before" (12.2%) then by "there was no condom then (9.9%) amongst other reasons.

Furthermore, 226 (45.2%) Christians and 214 (42.8%) did not agree that religious leaders should include information on condom use in messages/HIV/AIDS messages.

Figure 4: Percentage of respondents who reportedly engaged in pre and extra marital sexual responses to condom use the last time they had sex



Past HIV tests among respondents

When respondents were asked if they had actually taken an HIV test, from a total of 500 respondents from each religion only 11.4% (57) of Christians and 67(13.4) Muslims have ever been tested to see if they have AIDS virus. In terms of gender proportion, the highest was from Muslim males (52.8%) and the least from Christian males (38.6%). Over 50% of the test was carried out one year or more prior to when the study was conducted. When asked if respondents would want to be tested for HIV 62.4% (312) Christians and 69.2% (346) Muslims said "yes".

4.3 Respondents' awareness, perception and knowledge of HIV/AIDS

Awareness about HIV/AIDS was generally high among both Muslims (99%) an Christians (99.8%). It was highest among Christian males, 252 (50.2%) and Muslim females, 252 (50.9%) and least among Muslim males, 243 (49.1%). There was no remarkable difference in the belief level of HIV/AIDS' existence among the Christians {472 (94.4%)} and the Muslims, {484 (96.8%)}. On perceived seriousness of the disease, over 80% of both categories of religion agreed that HIV/AIDS is a serious disease because it cannot be cured (Table 5). However, more Christians 301 (60.2%) compared with Muslims 216 (43.2%) were able to correctly identify the relationship between HIV and AIDS. Information on knowledge of HIV/AIDS is slightly higher among Christians (97.2%) than the Muslims (89.7%). Overall, the mean score on a 32-point scale of knowledge on HIV/AIDS is 25.4.

Table 5: Respondents' Knowledge of HIV/AIDS

	Christian N=500	Muslim N=500	Total N=1000
Awareness	499 (99.8)	495 (99)	994 (99.4)
Beliefs that HIV/AIDS exists	492 (98.4)	484 (96.8)	976 (97.6)
Perceived that AIDS is serious	423 (84.6)	408 (81.6)	831 (83.1)
Correct relationship between HIV & AIDS	301 (60.2)	216 (43.2)	517 (51.7)

Respondents' knowledge and misconceptions of mode of transmission of HIV

Respondents were asked to indicate 'yes' or 'no' on listed items on HIV/AIDS causation. Majority of the respondents identified blood transfusion (97.4%), Sexual intercourse (98.5%), and sharing of sharp instruments (96.9%) as routes of transmission of HIV with slight differences among Christians and Muslims. Muslims were more knowledgeable in the area of transmission of HIV through mother to child (during breast feeding, 78.8% and during delivery, 81%) and tattooing/ incision (89.8%) compared with Christians (during breast feeding (68.2%), during delivery (77.4%) and tattooing/ incision (84.2%)). 80.8% Christians believed that sharing food with infected person could not transmit HIV compared with 65.2% Muslims. Also, percentage of the Muslims (30.2%) that believed that hugging or shaking of hands with infected person could transmit the AIDS virus is higher than that of the Christians (11.2%). Almost three-quarters of both faith-based organisations (73.2% Christians and 71% Muslims) believed that HIV could be transmitted through homosexual contacts. On a 17 point scale of mode of transmission of HIV/AIDS Christians were slightly more knowledgeable with a mean score of 13.91 compared with Muslims, 13.02. The finding are presented in Table 6.

However, there were misconceptions on the mode of HIV/AIDS transmission amongst respondents of both faith-based organization but with higher percentage which is statistically significant ($p < 0.05$) among the Muslims in the areas of kissing which was highest (65.2%), sharing food with infected persons, through mosquito bites, coughing and sneezing and witchcrafts (Table 7).

Table 6: Respondents' knowledge of HIV/AIDS modes of transmission

	Christians (N=500) (%)		Muslim (N=500) (%)		Total (N=1,000) (%)		p value
	Yes	No	Yes	No	Yes	No	
Sharing food with infected person	96 (19.2)	404 (80.8)	174 (34.8)	326 (65.2)	270 (27)	730 (73)	0.000
Blood transfusion	491 (98.2)	9 (1.8)	483 (96.6)	17 (3.4)	974 (97.4)	26 (26)	0.000
Sex with prostitutes	491 (98.2)	9 (1.8)	490 (98)	10 (2)	981 (98.1)	19 (19)	0.000
Sexual intercourse with multiple partners without using condom	494 (98.8)	6 (1.2)	495 (99)	5 (1)	989 (98.9)	11 (11)	0.000
Homosexual contact	366 (73.2)	134 (26.8)	355 (71)	145 (39)	721 (72.1)	279 (27.9)	0.000
Sharing of sharp instruments e.g. barber's clippers, blades	488 (97.6)	12 (2.4)	481 (96.2)	19 (3.8)	969 (96.9)	31 (31)	0.000
Injection	477 (95.4)	23 (4.6)	471 (94.2)	29 (5.6)	948 (94.8)	52 (52)	0.000
Kissing	218 (43.6)	282 (56.4)	326 (65.2)	174 (34.8)	544 (54.4)	456 (45.6)	0.000
Mosquito bites	190 (38)	310 (62)	311 (62.2)	189 (37.8)	500 (50)	500 (50)	0.000
Hugging or shaking hands with an infected person	56 (11.2)	444 (88.8)	151 (30.2)	349 (69.8)	207 (20.7)	793 (79.3)	0.000
Mother to child during pregnancy	430 (86)	70 (14)	434 (86.8)	66 (13.2)	864 (86.4)	136 (13.6)	0.000
Mother to child during delivery	387 (77.4)	113 (22.6)	405 (81)	95 (19)	792 (79.2)	208 (20.8)	0.000
Mother to child during breastfeeding	341 (68.2)	158 (31.6)	394 (78.8)	105 (21)	735 (73.5)	263 (26.3)	0.000
Coughing or sneezing on somebody	131 (26.2)	369 (73.5)	245 (49)	255 (51)	376 (37.6)	624 (62.4)	0.000
Tattooing/Incisions	421 (84.2)	79 (15.8)	449 (89.8)	51 (10.2)	870 (87)	130 (13)	0.000
Circumcision	440 (88)	60 (12)	442 (88.4)	58 (11.6)	882 (88.2)	118 (11.8)	0.000
Witchcraft	180 (36)	320 (64)	318 (63.6)	182 (36.4)	498 (49.8)	502 (50.2)	0.000

Table 7: Percent distribution of Respondents who had misconceptions about HIV/AIDS transmission according to religion and formal education

	Muslims (N= 500)			Christian (N= 500)			Total (N= 1000)
	Yes (%)	*AS	*DAS	Yes (%)	*AS	*DAS	Yes (%)
Food sharing with infected person	174 (34.8)	140 (80.5)	34 (19.5)	96 (19.2)	90 (18)	6 (1.2)	270 (27.0)
Kissing	326 (65.2)	275 (84.4)	49 (15.6)	218 (43.6)	207 (95.0)	11 (5.0)	544 (54.4)
Mosquito bites	311 (62.2)	265 (85.2)	44 (14.8)	190 (38.0)	182 (95.8)	7 (4.2)	501 (50.1)
Witchcraft	182 (36.4)	149 (81.9)	31 (18.1)	180 (36.0)	175 (97.2)	4 (2.8)	362 (36.2)

Key
*AS – Attended School
*DAS – Did not attend school

Knowledge and misconceptions of HIV/AIDS prevention

Knowledge about prevention of HIV was also high but not as high as that of knowledge on transmission. As shown in table 8, knowledge of avoiding sex with persons with many partners was the highest (96.2%), followed by avoiding sex with prostitutes (95.5%), avoiding sharing sharp instruments (94%), then avoiding blood transfusion (91.7%) and limiting sex to one partner (91.4%). Trivial differences could be noticed in the percentages of Christians and Muslims in-terms of knowledge of prevention. For example, limiting sex to one partner, Christians (91%) and Muslims (91.8%); avoiding sharp instruments (93.6% Christians and 94.4% Muslims); avoiding sex with homosexuals, Christians (83.6%) and Muslims 84% and avoiding blood transfusion (89.8% Christians and 93.6% Muslims). Significantly, more Muslims (91.6%) than Christians (83.8%) agreed that avoiding sex with persons who inject drugs intravenously can prevent HIV/AIDS , ($p=0.0001$). Overall, on a 15-point scale, the mean score on knowledge on prevention of HIV/AIDS among Muslims is 11.03 while that of Christian is 11.52.

Commonly, about 25% of both faith-based organisations members have the misconception that receiving care from religious leaders or praying regularly can prevent one from getting HIV. Also about 15% of the all the respondents believe that the use of antibiotics and protection seeking form traditional practitioners can prevent on form contracting HIV. More than half of the Muslims, (56.8%) said avoiding kissing could prevent HIV compared with 33.6% Christians.

Table 8: Respondents' knowledge of HIV prevention

	Christians (N=500)			Muslims (N=500)			Total (N=1000)		
	Yes (%)	No	Don't know	Yes (%)	No	Don't know	Yes	No	Don't know
Abstain from sex	439 (87.9)	51 (5.1)	10 (2)	432 (86.4)	55 (11.1)	13 (2.6)	871 (87.1)	106 (10.6)	23 (2.3)
Use condom	425 (85)	56 (11.2)	19 (3.8)	423 (84.6)	42 (8.4)	26 (5.2)	857 (85.7)	98 (9.8)	45 (4.5)
Avoid Mosquito bites	177 (35.4)	290 (58)	33 (6.6)	281 (56.2)	191(38.2)	28 (5.6)	458 (45.8)	481 (48.1)	61 (6.1)
Limit sex to one partner	455 (91)	39 (7.8)	6 (1.2)	459 (91.8)	36 (7.2)	5 (1)	914 (91.4)	75 (7.5)	11 (1.1)
Avoid sex with prostitutes	480 (96)	15 (3.0)	5 (1.0)	475 (95)	18 (3.6)	7 (1.4)	955 (95.5)	33 (3.3)	12 (1.2)
Avoid sex with homosexuals	418 (83.6)	34 (6.8)	48 (9.6)	420 (84)	35 (7.0)	44 (8.8)	838 (83.8)	69 (6.9)	72 (7.2)
Avoid sex with persons with many partners	480 (96)	15 (3.0)	5 (1)	482 (96.4)	12 (2.4)	5 (1)	962 (96\.2)	27 (2.7)	10 (1)
Avoid sex with persons who inject drugs intravenously	419 (83.8)	48 (9.6)	33(6.6)	458 (91.6)	15 (3.0)	26 (5.2)	877 (87.7)	63 (6.3)	59 (5.9)
Avoid blood transfusion	449 (89.8)	40 (8.0)	11 (2.2)	468 (93.6)	18 (3.6)	14 (2.8)	917 (91.7)	58 (5.8)	25 (2.5)

Table 8: Respondents' knowledge of HIV prevention (continued)

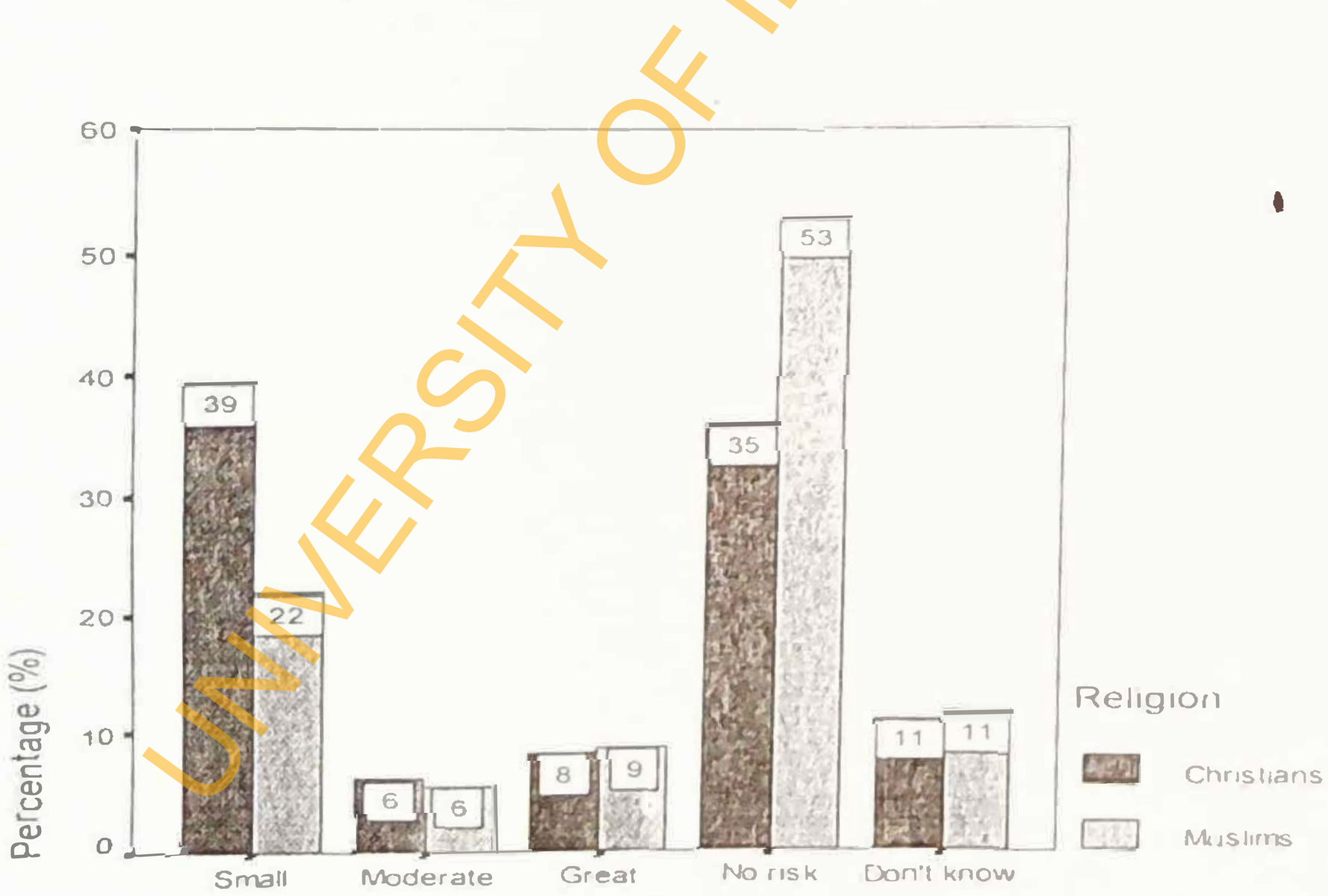
Avoid sharing sharp instruments e.g. barber's clippers, razor blades	468 (93.6)	23 (4.6)	9 (1.8)	472 (94.4)	19 (2.8)	9 (1.8)	940 (94)	42 (4.2)	18 (1.8)
Avoid kissing	168 (33.6)	299 (59.8)	33 (6.6)	284 (56.8)	177 (35.4)	39 (7.8)	452 (45.2)	476 (47.6)	72 (7.2)
Seek protection from traditional practitioner	60 (12)	393 (78.6)	47 (9.4)	92 (18.4)	360 (72)	48 (9.6)	152	753	95
Use antibiotics/drugs	66	395	39	90	355	55	156	750	94
Receive care from religious leaders/pray regularly	128	349	23	148	332	20	276	681	43
Take immunization or vaccine	117	336	47	130	308	62	247	644	109

Knowledge on identifying a healthy looking person living with HIV was also investigated. Respondents' answers to the possibility of a healthy looking person having HIV were almost the same amongst Christians and Muslim with over 85% of the respondents in each religion saying yes, that it is possible for a person to look healthy and still have HIV.

4.4 Personal Risk Perception of Contracting HIV

Respondents were asked to rate their chances of being infected with HIV and these chances were classified into small, moderate, great, no risk and don't know. Overall, only 8.4% rated their chances of being infected great, 5.9% rated their chances low, 30.5% said small and 43.8% believed that they were at no risk. Similar patterns were obtained for respondents in both faith-based organisations with 39.2% and 35.2% Christians and 21.8% and 52.4% Muslims, saying there chances were small and have no risk respectively (see figure 5 below).

Figure 5: Percentage of respondents' chances of getting HIV/AIDS by Religion



4.5 Attitudes of respondents towards HIV/AIDS messages

With regards to respondents' attitude to HIV/AIDS information, more Christians 53.4% than Muslims 34.4% disagree with the statement that HIV/AIDS is a punishment from God for our numerous sins and this is statistically significant ($p = 0.000$). Significantly, more Muslims 92.8% than Christians 85.4% agreed that religious leaders should include HIV/AIDS information in the messages/sermon regularly. Similarly more Muslims agreed that VCT should be made compulsory for church/mosque members. (Muslim 65.6% and Christians 57.0%). Detailed responses on other attitudinal statements are shown in the table 9 below.

Table 9: Distribution of respondent showing their attitudes towards HIV/AIDS messages

Statement	*p value*	Christian			Muslim			Total		
		Agree %	Disagree %	Undecided %	Agree %	Disagree %	Undecided %	Agree %	Disagree %	Undecided %
HIV/AIDS is a punishment from God for our numerous sins	0.000	194 (38.8)	267 (53.4)	39 (7.8)	283 (56.6)	172 (34.4)	45 (9.0)	477 (47.7)	439 (43.9)	84(8.4)
Any member of the church/mosque with HIV/AIDS does not deserve our care and love because they are sinners	0.000	41 (8.2)	447 (89.4)	8 (1.6)	108 (21.6)	375 (75.2)	14 (2.8)	149 (14.9)	822 (82.3)	22 (2.2)
It is acceptable for AIDS to be discussed in church/mosques	0.220	453 (90.6)	41 (8.2)	6 (1.2)	452 (90.4)	40 (8)	4 (0.8)	905 (90.5)	81 (8.1)	10 (1)
People who have the germ (HIV) that causes AIDS should not be allowed to mix with other people	0.000	86 (17.2)	396 (79.2)	18 (3.6)	170 (34)	317 (63.4)	13 (2.6)	256 (25.6)	713 (71.3)	31 (3.1)
Anyone can get HIV/AIDS	0.048	405 (81)	72 (14.4)	16 (3.2)	394 (78.8)	93 (18.6)	12 (2.4)	799 (79.9)	165 (16.5)	28 (2.8)
I would not be afraid to submit my blood for HIV/AIDS tests	0.126	414 (82.8)	68 (13.6)	17 (3.4)	417 (83.4)	76 (15.2)	6 (1.2)	831 (83.1)	144 (14.4)	23 (2.3)
Church/Mosque members should be bothered about HIV/AIDS because it is a threat to them	0.008	391 (78.2)	92 (18.4)	17 (3.4)	420 (84)	75 (15)	4 (0.8)	811 (81.1)	167 (16.7)	21 (2.1)

It is important for Christian/Islamic religious leaders to attend HIV/AIDS seminars/workshops	0.096	482 (96.4)	8 (1.6)	9 (1.8)	470 (94)	20 (4)	10 (2)	952 (95.2)	28 (2.8)	19 (1.9)
HIV/AIDS prevention education is difficult and should not be incorporated in Church/Mosque sermons because it bothers on sex	0.055	107 (21.4)	382 (76.4)	10 (2)	143 (28.6)	350 (70)	6 (1.2)	250 (25)	732 (73.2)	16 (1.6)
Religious leaders need basic and technical knowledge to be able to explain HIV/AIDS issues to their congregation	0.947	478 (95.6)	15 (3)	6 (1.2)	474 (94.8)	18 (3.6)	7 (1.4)	952 (95.2)	33 (3.3)	13 (1.3)
Religious leaders should include HIV/AIDS information in their messages/sermons regularly.	0.001	427 (85.4)	53 (10.6)	19 (3.8)	464 (92.8)	32 (6.4)	4 (0.8)	891 (89.1)	85 (8.5)	23 (2.3)
Religious leaders should organize HIV/AIDS educational programmes for Church/Mosque members frequently.	0.358	470 (94)	17 (3.4)	13 (2.6)	473 (94.6)	20 (4)	7 (1.4)	943 (94.3)	37 (3.7)	20 (2)

HIV/AIDS testing (VCT) should be made compulsory for church/mosque members.	0.001	285 (57)	158 (31.6)	53 (10.6)	328 (65.6)	147 (29.4)	24 (4.8)	613 (61.3)	305 (30.5)	77 (7.7)
Abstinence is a major virtue to be emphasized in HIV/AID information especially to the unmarried youth in churches/mosques.	0.053	477 (95.4)	18 (3.6)	3 (0.6)	461 (92.2)	33 (6.6)	6 (1.2)	938 (93.8)	51 (5.1)	9 (0.9)
Religious leaders should emphasize being faithful to ones partner for all married people.	0.268	494 (98.8)	4 (0.8)	2 (0.4)	488 (97.6)	10 (2)	1 (0.2)	982 (98.2)	14 (1.4)	3 (0.3)
Religious leaders should include information on condom use into their message/HIV/AIDS programmes	0.170	234 (46.8)	226 (45.2)	40 (8)	258 (51.6)	214 (42.8)	27 (5.4)	492 (49.2)	440 (44)	67 (6.7)

4.6 Attitudes towards people living with HIV/AIDS

Almost sixty-two percent of the Muslims and 51.6% Christians said they were not willing to eat from the same plate with their members who had HIV. However over 70% respondents from both religion said they could worship with them. Also, there appears to be little difference in the percentage of Christians (41.2%) and Muslims (41.6%) who were willing to keep secret of their members who become ill with AIDS. Table 10 shows information on respondents' response to statements relating to attitude towards PLWHA in their churches and mosques.

Table 10: Percent distribution of respondents attitude towards PLWHA by religion

Statement	Christians %		Muslims %		Total %		*p* value	X^2
	Yes	No	Yes	No	Yes	No		
Willingness to eat from the same plate with member with HIV/AIDS	48.4	51.6	38.4	61.6	4 34	56 6	0.007	12.17
Willingness to worship with member who is AIDS ill	90.0	10.0	74.6	25.4	82.3	17.7	0.000	54.68
HIV patient but not sick to continue attending worships	90.4	9.6	75.2	24.8	82.8	17.2	0.000	49.38
Pastor/Imam with HIV virus continue preaching	62.6	37.4	49.2	50.8	55.9	44.1	0.000	27.34
Member ill with AIDS to remain secret	41.2	58.8	41.6	58.4	41.4	58.6	0.483	2.46

Chi-square X^2 analysis significant at alpha level of 0.05 confidence level = 95%

4.7 Previous exposure to HIV/AIDS information in churches and mosques

Significantly, 64% of the Christians and 55.6% Muslims respondents said that they have been educated on HIV/AIDS from their churches and mosques respectively (p=0.019). However 92.2% (461) Christians and 93% (46.4) Muslims said they have changed their behaviour to prevent getting AIDS since they have heard about AIDS. Other forms of exposure to HIV/AIDS information are presented in Table 11 below.

Table 11: Respondents' exposure to HIV/AIDS information

Exposure to HIV/AIDS education	Christian N=500	Muslim N=500	Total N=1000
As part of sermon	345 (69%)	327 (65.5%)	672 (67.2%)
During organized educational programme (apart from sermon)	179 (35.8%)	79 (15.8%)	258 (25.8%)

Regarding HIV/AIDS programmes conducted in the churches and mosques, below is table 12 showing the specific programmes and their frequencies or number of times they have been organized prior to the period of the survey.

Table 12: Distribution of HIV/AIDS programmes in churches and mosques

	Church	Mosque	Total
HIV/AIDS programmes	**Frequency**	**Frequency**	**Frequency**
Seminal/ conferences	69	24	93
Training/ workshop	21	14	35
Health talk/ lecture	85	36	121
Youth programs	20	6	26
Counseling	21	10	31

However, only 144 (28.8%) Christians and 70 (14 %) Muslims reportedly ever attended the HIV/AIDS educational programmes listed above.

4.8 Training Needs

Respondents were asked to list what they would like to learn more about HIV/AIDS to make them more informed about the disease. Majority, 82.4% of the Christians and 86.5% of the Muslims mentioned, "Basic knowledge on HIV/AIDS , followed by Cure and Management of HIV/AIDS (29.4% of the Christians and 24.2% of the Muslims). Overall, when their responses were characterized into age groups, most of the responses fell within age groups 25 – 34 and 15 – 24. Other training needs identified by the respondents according to selected characteristics (sex, religion, age groups and

educational status) are presented in table 13. However, out of the total number (107 (11%) of respondents that said they were not ready to learn more about HIV/AIDS. 67 (62.6%) were females while the rest 40 (39.4%) were males.

4.8.1 Things respondents would like to learn about HIV/AIDS

Table 13: Percent distribution of respondents training needs according to selected characteristics

Characteristics	Training needs						
	Basic knowledge on HIV/AIDS	Relationship with and Rehabilitation of PLWHA	Nothing	Cure and Management of HIV/AIDS	Where it was discovered	Everything	VCT and identification of centre
Sex							
Male	52.3	49.6	37.4	56.2	63.5	41.7	63.6
Female	47.7	50.4	62.6	43.8	36.5	58.3	36.4
Religion							
Christian	82.4	14.9	8.1	29.4	6.6	9.1	1.0
Muslim	86.5	8.8	13.9	24.2	6.4	8.2	1.2
Age							
15 – 24	29.9	23.9	31.8	28.8	30.2	32.1	27.3
25 -- 34	32.2	28.3	23.4	30.0	27.0	33.3	54.5
35 – 44	18.2	22.1	22.4	21.2	27.0	15.5	0
45 – above	19.7	15.3	22.4	20.0	15.9	19.0	18.2
Highest Educational Status							
Never attended school	4.2	4.5	18.4	3.5	7.9	7.1	0
Primary	17.9	7.1	19.4	12.0	14.3	20.2	0
Secondary/Modern	42.1	39.3	30.1	41.1	34.9	31.0	54.5
Higher/Tertiary	35.8	49.1	32.0	43.4	42.9	41.7	45.5

4.9 Preferred HIV/AIDS Educator

Respondents' answers to whom they prefer as their HIV/AIDS educators are presented in table 14 below.

Table 14: Preferred HIV/AIDS educators in Churches and Mosques

HIV/AIDS educators	Christians (%)	Muslims (%)	Total (%)
Pastors/Imam/Sheik	377 (75.4)	420 (84)	797 (79.7)
Sunday School teachers/Arabic tutors	342 (68.4)	374 (74.8)	716 (71.6)
Health workers	488 (97.6)	477 (95.4)	965 (96.5)
Any church/mosques member	339 (67.8)	387 (77.4)	726 (72.6)
Others (Social Groups)	45 (9)	60 (12)	105(10.5)

4.10 Suggestions for Improvement in HIV/AIDS programmes

To improve effectiveness of HIV/AIDS programmes organized by both faith-based organizations, suggestions by respondents include Continuous education/consistent preaching/information on HIV/AIDS (Christian, 24.2%; Muslims, 30.8%), specially organised training for religious leaders (Christians, 14.4%; Muslims, 13.4%), Training to be conducted by health workers in churches and mosques (Christians, 11.4%, Muslims, 14%) among others listed in table 15 below.

Table 15: Respondents' suggestion for Improvement of HIV/AIDS programmes

Suggestions	Christians %	Muslim %	Total %
Organisation special training for religious leaders	14.4	13.4	13.9
Provision of incentives for participants during training for conformability	3.4	6.8	5.1
Organisation of seminar/workshop on HIV/AIDS regularly and it should be announced before hand	10.6	7.4	9
Religious leaders should mobilize members for effective participation in HIV/AIDS educational programmes	4.2	1.4	2.8
Organisation of HIV/AIDS programme for youth on	8.4	4.2	6.3
Continuous education/consistent preaching and information on HIV/AIDS	24.2	30.8	27.5
Presenting PLWHA to members to guide against stigmatization	1	0.8	0.9
Seminar after religious Service	1.4	1.8	1.6
HIV messages to be put in every prayer day /vigil	0.8	3	1.9
Organise programme during holiday for students and adult participation	0.6	0.4	0.5
Counseling of religious members	2.6	1.6	2.1
Government should provide information on HIV/AIDS	4.8	3	3.9
Training to be done by health workers to enlighten people on HIV/AIDS	2	0.6	1.3
Distribution of postals and handbi lls	11.4	14	12.7
By evaluating of HIV/AIDS programme	4	3.2	3.6
Church/Islamic authorities should be involved in planning	1	0.2	0.6
Film show/Organisation of jingle//Advertise HIV/AIDS /programme/Announcement/Drama presentation/Frequent information on radio	9.4	9	9.2
Prayer to complement the programmes	0.2	0.8	0.5
There should be co-operation between the Government and Church leaders	0.4	0.6	0.5
Logistic assistance from the government/Government should provide job	1.4	2.2	1.8
Care and love to be given to HIV/AIDS patients and continue to pray for them	0.6	-	0.3
Make provision for VCT	1.4	0.6	1
No suggestion	2	4	3

4.11 Testing of Hypothesis

Hypothesis one

It states that there is no significant relationship between educational status and respondents' knowledge of HIV/AIDS. Table 16 shows the results of the ANOVA test used for the relationship between knowledge of HIVAIDS and educational status. Nine hundred and twenty-one (mean knowledge score =25.6) of those who attended school compared to those who did not attend school, 69 (mean knowledge score = 22.7) had knowledge of HIV/AIDS. However, a significant relationship (p= 0.000) exists between respondents' educational status and knowledge of HIV/AIDS. The difference in knowledge of HIV/AIDS according to educational status of the respondents was significant (p<0.05). Therefore, the null hypothesis is rejected and the alternate hypothesis that there is significant relationship between educational status and respondents' knowledge of HIV/AIDS is accepted.

Table 16: Mean HIV/AIDS knowledge Score of Respondents by Educational status

Educational status	Total (n)	Mean	Standard Deviation (SD)
Attended school	921	25.6	3.8
Did not attend school	69	22.7	4.7
Difference		2.9	

ANOVA

Variation	Sum of Squares	df	Mean square	F statistic	p-value
Between Groups	572.185	2	286.093	18.694	0.000
Within Groups	15166.346	991	15.304		
Total	15738.531	993			

Hypothesis Two

It states that there is no significant difference in level of knowledge of HIV/AIDS between Christians and Muslims. In testing this hypothesis, respondents were categorized into religion (Christians and Muslims). One-way analysis of variance (ANOVA) statistics was used to analyse data. The mean score on knowledge of HIV/AIDS for Christians is 26.1. (SD = 3.8) compared to the Muslims, 24.7 (SD = 4.0), with statistical difference of p=0.000, See table 17 below. These differences were statistically significant $p < 0.05$ and therefore it can be concluded that there is a significant difference in the level of knowledge of HIV/AIDS of Christians and Muslims. Thereby, the null hypothesis is rejected and the alternate hypothesis is accepted that there is a significant difference in the level of knowledge of HIV/AIDS of Christians and Muslims..

Table 17: Mean score of respondents knowledge of HIV/AIDS by religion

Religion	Total (n)	Mean	Standard Deviation (SD)
Christians	499	26.1	3.8
Muslims	495	24.7	4.0
Difference		1.4	

ANOVA

Variation	Sum of Squares	df	Mean square	F statistic	p-value
Between Groups	468.431	1	468.431	30.451	0.000
Within Groups	15270.100	992	15.393		
Total	15738.531	993			

Hypothesis three

It states that there is no significant difference in respondents' attitudes towards HIV/AIDS messages between Church and Mosque congregations. Responses to the attitudinal items below were tested using chi-square ($X^{2)}$ statistic at alpha level of 0.05 and 95% confidence level. In testing this, respondents' responses to attitudinal statements were grouped into Christian and Muslim categories. Out of the seven statements testing for the attitude of respondents towards HIV/AIDS messages in church and mosque (Table 18), only four, statements 1, 3, 5 and 6 show statistical difference of $p<0.05$. Test of analysis shows statement 1 being most significant ($p=0.000$). Therefore, in respect to attitudinal statements that HIV/AIDS is a punishment from God ($p=0.000$), HIV/AIDS is not a threat ($p=0.008$), religious leaders should not include HIV/AIDS information in sermon regularly ($p=0.001$) and VCT should not be made compulsory for church and mosques members ($p=0.001$), the null hypothesis is hereby rejected and the alternate hypothesis accepted.

However, attitudinal statements 2, 4, and 7 show statistical differences of $p>0.05$, that is, attitudes of not accepting AIDS to be discussed in church/mosques ($p=0.220$), that HIV/AIDS prevention education is difficult and should not be incorporated into sermon because it bothers on sex ($p=0.055$) and that it is not important for religious leaders to attend HIV/AIDS seminars/workshops ($p=0.096$), are not statistically significant. Therefore the null hypothesis is not rejected.

Table 18: Respondents attitude towards HIV/AIDS messages by Religion

Statement	Christians % (N = 500)	Muslims % (N = 500)	df	p-value	X^2
	Yes	Yes			
(1) HIV/AIDS is a punishment from God for our numerous sins	38.8	56.6	3	0.000	37.6
(2) It is not acceptable for AIDS to be discussed in church/mosques	8.2	8.0	3	0.220	4.41
(3)Church/Mosque members should not be bothered about HIV/AIDS because it is not a threat to them	18.4	15.0	3	0.008	11.8
(4) HIV/AIDS prevention education is difficult and should not be incorporated in Church/Mosque sermons because it bothers on sex	21.4	28.6	3	0.055	7.58
(5) Religious leaders should not include HIV/AIDS information in their messages/sermons regularly.	10.6	6.4	3	0.001	17.51
(6)HIV/AIDS testing (VCT) should not be made compulsory for church/mosque members.	31.6	29.4	3	0.001	16.14
(7) It is not important for Christian/Islamic religious leaders to attend HIV/AIDS seminars/workshops	1.6	4.0	3	0.096	6.36

alpha level of 0.05 confidence interval 95%

CHAPTER FIVE
DISCUSSION OF RESULTS

5.1 Respondents' level of knowledge of HIV/AIDS

This study shows that both the churches and mosques congregation are aware and believed that HIV/AIDS exist and over 80% of both faith based organization members perceived it as a serious disease because it is not curable. This may be attributed to the efforts of interfaith HIV/AIDS Council of Nigeria Organization, which has decided to present a common front to fighting HIV/AIDS. This might also have occurred as a result of exposure of members of both FBOs to the media – television and radio. In addition, a greater percentage of the Christians 60.2% than the Muslims 43.2% could correctly define the relationship between HIV and AIDS (Table 5). This seems to confirm a statement by the Vice Chairmen of Supreme Council of Kenya Muslims that Imams were not discussing HIV/AIDS issues with their members in the past (Christian Science monitor, 2003). They are, now, just talking about HIV/AIDS in the mosques.

Knowledge about transmission and prevention is high, though misconception about transmission is still high. Christian and the Muslims still have misconceptions that sharing food with infected person, kissing and mosquito bites could transmit HIV. These misconceptions may relate to respondents' belief that since mosquitoes feed on human blood, it will actually pass the virus from an infected person to an uninfected person and that HIV is a food borne diseases since some of the food borne diseases such as gastroenteritis and cholera are associated with diarrhea, which is symptom of AIDS. This is also ascertained from a survey conducted in Nigeria in 2003 (NARHS (2003), that the high knowledge of HIV has little impact on misconceptions about HIV transmission especially in the South West (in which Oyo state is part of).

In relation to prevention, most respondents identified avoiding sex with persons with many partners (96.2%) and limiting sex to one partner (91.4%) respectively as means of HIV prevention. This corroborated with the report of Abdullah Hakim Quick (Health and Science, 2005) that many Muslims see AIDS as the consequence of sinful behaviour such as drug use and promiscuity This finding corroborated with the

behaviour such as drug use and promiscuity This finding corroborated with the findings of a survey conducted by WCC in 2001, which reported that all religious leaders interviewed, both Christians and Muslims seemed to be familiar with the means of transmission. Interestingly, there is no significant relationship between educational status of respondents and their knowledge of HIV/AIDS transmission and prevention.

As shown in this study (Figure 5), perceived risk of contracting HIV is low. Majority (74.3%) of the churches and mosques congregation perceive their chances of getting HIV/AIDS to be small or no risk at all. This is a confirmation of a previous survey conducted by NARHS in 2003, where it was also revealed that 72% of respondents who have heard about AIDS said they stood no chance of contracting HIV. More Muslims (53%) than Christians (35%) believed they were not at risk of getting HIV. This concurred with a report of Health and Science, 2005, which stated that Muslims have assumed for a long time, that HIV/AIDS is an issue that would not affect them. In addition, this may be explained by a statement made by Ebedstart and Kelly (2005) that the HIV/AIDS prevalence rates of Muslim infections may seem small when compared with the tragedy that is unfolding in southern Africa, thereby making them to feel that they are not at risk of contracting the disease.

5.2 Attitudes of respondent towards HIV/AIDS messages

This study reveals that some respondents from both Faith based organizations agreed that HIV/AIDS is a punishment from God for our numerous sins but with a greater percentage from the Muslims 56.6% compared with Christians 38.8% ($p<0.05$). This may not be far fetched from the role that religion plays in the lives of people. Sexual promiscuity, a social stigma attached to HIV/AIDS, which exists in all societies but much more pronounced in Muslim cultures is considered to be a sinful behaviour (Hasnain, 2005). This sinful behaviour is also identified as a major route of HIV transmission, therefore it not unlikely that, respondents perceive HIV/AIDS as a punishment from God. According to Ebedstart and Kelly (2005), Islamic culture and Muslim beliefs, unfortunately, are affecting the spread of HIV negatively and that is why many Muslims view the AIDS epidemic through the "prison of sin" and as the consequence of sinful behaviour. World Faith Development Dialogue, (2003) also confirmed that both Christians and Muslims see immoral behaviour as being the cause

HIV/AIDS epidemic and this affects attitudes towards people living with HIV/AIDS (PLWHA).

The study reveals that approximately about 50% of the respondents in Churches and Mosques actually agreed with the inclusion of information on condom use in the religious leaders HIV/AIDS messages. Although, over 90% respondents in each faith-based organisation still agreed that faithfulness to one partner and abstinence are still major virtues to be emphasized in HIV/AIDS information to married couples and unmarried youth respectively in the churches and mosques. However, this finding supports a report by FHI (2005) that the Methodists, Baptists and Presbyterians accept the condom because they claim to be realistic and in favour of any means which will protect the "faithful" from HIV. Contrarily, McGeary (2000) reported that some religious groups see the promotion of condom as anti-religious act and as an invitation to premarital sex among the young people and to infidelity among married couples. This is the opposite of a part of UNDP's (2002) report that the religious leaders in Tanzania (where the number one killer disease between ages 15 and 49 is HIV/AIDS) said they could not campaign for the use of condom and also the FHI (2005) report pointed out that the African Council of Churches (AACC) see the holistic approach of abstinence and mutual fidelity as the most effective of HIV/AIDS prevention.

On attitudes towards people living with HIV/AIDS , from the findings, it appears Christians have a more positive disposition towards PLWHA than the Muslims Surprisingly, over 50% of the members of churches and mosques interviewed said they were not willing to keep a secret of any member became ill of AIDS. This is opposing to a report by WCC (2001) that HIV positive or those who have AIDS are not abandoned for Quran recommends that help be given to all who are in need, whatever the faults and contrary to Mike Crawley's statement that there has been a significant move in the past year or two among religious leaders to take on their responsibility to break the stigma associated with PLWHA, (Christian Science Monitor, 2003).

5.3 Risk Practices of Respondents

Sexual intercourse with non-marital partners is often considered to be of higher risk than sex with marital partners (NARHS, 2003). Despite the fact that both Christianity

and Islamic religions frown at sex outside marriage, it is not uncommon to hear about pre and extra martial sex among the members of these religion groups. From this study, it was revealed that 14.2% Christians and 12.6% Muslims, engaged in extra marital sex. The higher percentage among the Christians may be explained through the doctrine of the Bible, which kicks against polygamy in the religion, especially for 'workers' in the churches. Some Christians hold on to this doctrine and for that reason, prefer to engage in extra marital affairs rather than going against the Bible and marry more than on partner which is, polygamy. Furthermore, the high percentage among Muslims maybe due to the Islamic doctrine/custom that allows Muslim men to marry more than one wife, which may or may not be the consequence of the extra-martial affairs. Though there was a small Christian Muslim differential, the ratio of male to female that engaged in extra-marital sex is ratio 4:1 in both religions, reinforcing findings from other studies that males engage in risk practices. It may also reflect a Yoruba cultural norm that condemns premarital and extramarital sex but not in circumstances such as during a period when the wife is pregnant, nursing children or out on a long journey.

The higher male to female ratio among Muslims (2:1) than Christians (1:1) may be explained by the fact that some Muslims youth may see themselves as potential husbands with more than one wife as the religion permits that. The study also shows that more Muslims respondents (39.4%) than Christians (17%) respondents had more than one sexual partner, These finding are supported by the report of the renowned Muslims scholar who stated that young people engage in sexual activities outside marriage (Quick, 2006) and also by UNAIDS (2003) who reported that talking about sex is hard in Christianity but it has been revealed that the majority of young people are sexually active.

Condom use

As revealed by this study, most of the respondents (85.7%) that engaged in both extra and pre marital sex believed the use of condom as a way of preventing HIV/AIDS , but less than 50% of them used condom the last time they had sex preceding study. (72(48.6%) Christians and 63(38.7%) Muslims). This is in contrast to the statement of Lawrence Adeokun (Adeyi, Kanki, Odutolu & Idoko, 2005) that people's beliefs

ultimately influence their health-care-seeking behaviour and efforts to protect themselves from infection.

5.4 HIV/AIDS Education

Many of the respondents, (average of 60% of the Churches and Mosques Congregations) reported that they have been educated on HIV/AIDS from their Churches and Mosques in form of Seminars, Lectures, Counseling, Training Workshops and Youth programmes. This suggests that HIV/AIDS messages are being disseminated in Churches and Mosques but the frequency and intensity are unknown.

5.5 Training needs

On the issue of educational status and training needs, respondents with secondary/modern school education topped the list of those that wanted to learn more on HIV/AIDS with 97.2%, followed by those with Higher/tertiary education (96.6%), then primary education (92.4%) and lastly, 85.1% of those that never attended school. From this, it can be deduced that educational status has no significant relationship with training needs, because if it does, it is expected that those who never attended school would want to know more. Also this may be explained by an adage which says that people who are knowledgeable on something will always seek for more knowledge on that thing.

The higher percentage (95%) of Health workers as preferred HIV/AIDS Educators in Churches and Mosques than religious leaders (Pastors and Imams/Sheik) (80%), may be due to the fact that most of the respondents believed that though the religious leaders are knowledgeable about HIV/AIDS but they are not as equipped as the professionals (Health Workers). In addition, the preference for the religious leaders may be because of the beliefs and trusts in their leaders. Therefore, the need for the training of the Religious leaders, as one of the major training needs identified by the respondents.

Lastly, the respondents suggested Provision of funds for HIV/AIDS programmes in faith-based organisations, Continuous education/consistent preaching on HIV/AIDS, Special training for religious leaders, regular organisation of Seminars and Workshops on HIV/AIDS, Use of IEC materials and organisation of HIV/AIDS

educational programmes for youth as the way forward for improving HIV/AIDS programmes in Churches and Mosques.

5.6 Conclusion

Going by the UNAIDS indicators (NARHS, 2003) for knowledge of HIV/AIDS transmission (sexual intercourse, blood transfusion, Mother to unborn child and sharing sharp objects) and prevention (using condoms and limiting sex to one faithful uninfected partner), knowledge on transmission is 93% while that of prevention is 89% among the total respondents.

This study not only addressed the educational needs of Churches and Mosques Congregation in Oyo State but also explore their exposure to HIV/AIDS information in the churches and Mosques. Though, respondents reported of information through or as part of sermon in Churches and Mosques, the study revealed that organisation of special HIV/AIDS educational programmes apart from sermon are quite low in both faith-based organisations. Of those that were aware of these programmes, only few attended the little number of specially organised HIV/AIDS educational programmes in churches and mosques. In addition, only just about one-fifth of each faith-based organisations leaders specifically preached on HIV/AIDS (Tables 11 and 12).

Conclusively and as evident from this survey, Christians are more knowledgeable or familiar with HIV/AIDS issues than their Muslim counterparts though misconceptions about HIV/AIDS exists among respondents in Churches and Mosques.

5.7 Recommendations

1. Religious leaders need to include HIV/AIDS information in their messages/sermons regularly.
2. It is necessary that educational intervention providing correct knowledge of HIV/AIDS be put in place to allay misconceptions in both faith-based organisations but more importantly in the Mosques.
3. Monthly educational programmes on HIV/AIDS need to be organised in churches and mosques by religious leaders.

4. The opinions of both churches and mosques congregations should be sought when fixing time and date for any HIV/AIDS educational programmes for full participation.
5. Condom use should be included in HIV/AIDS education given not only in some Churches and Mosques, but in all FBOs.
6. Religious leaders need to go for formal training/seminars/workshops on HIV/AIDS to make them more equipped with right information on HIV/AIDS.

5.8 Suggestions for further research

1. Evaluation of HIV/AIDS educational programmes in FBOs; Frequency, intensity and impact of HIV/AIDS educational programmes in FBOs.
2. Bridging gaps between religious teaching and practice and use of condoms as a prevention against HVI/AIDS

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APPENDICES

Appendix 1: Names of structured and registered Churches and Mosques in Oyo State used for the study.

The Christian denominations selected for this study were:

1. Catholic Church
2. Baptist Church
3. Anglican/Presbyterian/African Church
4. Methodist Church of Nigeria
5. Church of the Lord/Cherubim &Seraphim
6. Celestial Church of Christ
7. Christ Apostolic Church/ The Apostolic Church
8. Redeemed Christian Church of God
9. Assemblies of God Church
10. Pentecostal Fellowship of Nigeria (PFN)

While the Muslim sects selected were:

1. Ans-ar-udeen
2. Ahmadiya
3. Naw-ar-udeen/ Naw-ar-ul Islam
4. Quomu Nasirudeen
5. Other groups (Teblique, Islamiyat)

Number of members interviewed in Churches and Mosques

Church (Denomination)	Number interviewed	Mosque (Denomination)	Number interviewed
Catholic	53	Ansarudeen	104
Baptist	55	Ahmadiya	115
Anglican/Presbyterian/African	66	Nawarudeen/ Nawarulslam	51
Methodist	61	Quomu Nasirudeen	223
Church of the Lord/C&S	12	Others(Teblique, Islamiyat	7
Celestial Church	31		
CAC/The Apostolic	90		
Redeemed Christian	89		
Assemblies of God	31		
PFN	12		
TOTAL	**500**		**500**

Appendix 2: Questionnaire (English)

KNOWLEDGE AND ATTITUDE TOWARDS HIV/AIDS AND HIV/AIDS RELATED PRACTICES AMONG CHURCH AND MOSQUE MEMBERS

INTRODUCTION

Greetings. My name is ..... I am working with the African Regional Health Education Centre (ARHEC), College of Medicine, University of Ibadan. We are conducting a study on HIV/AIDS and would very much appreciate your participation. The information gathered will enable us plan HIV/AIDS education for church/mosque leaders. We won't take much of your time. Whatever information you provide will be kept strictly confidential and will not be shown to another person. We hope you will participate in this study since your views are important. May I begin this interview? **(If No, thank respondent and terminate the interview)**

Survey Identification Number _____

Name of location/Community where interview was conducted _____

Date of Interview _____

Name of Interviewer _____

SECTION A: DEMOGRAPHIC CHARACTERISTICS

I'm going to ask you some questions about yourself.

1. Gender: 1. Male 2. Female

2. How old were you at your last birthday? (*Age in completed years*) ___

3. What is your marital Status?

   1. Currently married 2. Formerly married 3. Never married

4. Have you ever attended school? 1. Yes 2. No

5. What is the highest level of school attended?
   1. Never attended school 2. Primary
   3. Secondary/Modern School 4. Higher/Tertiary

6. What type of work do you do currently? _____

7. What is your ethnic group? (1) Yoruba (2) Hausa
   (3) Igbo (4) Others(*specify*) .....

8. Are you a Moslem or a Christian?

1. Christian

Denomination

(i) Catholic
(ii) Anglican
(iii) Methodist
(iv) Baptist
(v) C & S
(vi) Seventh Day Adventist
(vii) Church of the Lord
(viii) Celestial Church
(ix) CAC
(x) ECWA
(xi) Others specify _____

2. Moslem

Denomination

(i) NASFAT
(ii) Islamiyat
(iii) Tebliq
(iv) Ansarudeen
(v) Ahhamadiya
(vi) Quareeb
(vii) Nawarudeen
(viii)Muslim Congress TMC)
(ixQuomu Nasirudeen
(x) Muslim Students Society (MSSN)
(xi)Others specify ____

9. How often do you attend a Church/Mosque?

1. Daily 2. Weekly
3. More than once weekly
4. Monthly 5. Others (specify)

10. When was the church/mosque established? _____ (years ago)

SECTION B: INFORMATION ON KNOWLEDGE OF HIV/AIDS

11a. Have you heard about HIV/AIDS ? 1. Yes 2. no

11b.) Do you believe that HIV/AIDS exists? 1. Yes 2. No

12. What is the relationship between HIV and AIDS?

_____
_____
_____
_____

13. How can a person get AIDS? (*Please tick (√) the appropriate*)

		Yes	No	Don't know
1.	Sharing food with infected person			
2.	Blood transfusion			
3	Sex with prostitutes			
4.	Sexual intercourse with multiple partners without using condom			
5.	Homosexual contact			
6.	Sharing of sharp instruments e.g. barber's clippers , razor blades			
7.	Injection			

8.	Kissing			
9.	Mosquito bites			
10.	Hugging or shaking hands with an infected person			
11.	Mother to child during pregnancy			
12.	Mother to child during delivery			
13.	Mother to child during breastfeeding			
14.	Coughing or sneezing on somebody			
15.	Tattooing/Incisions			
16.	Circumcision			
17.	Witchcraft			
18.	Others (please specify)			

14. How can a person prevent getting HIV/AIDS ? *(Please tick (√) the appropriate)*

		Yes	No	Don't know
1.	Abstain from sex			
2.	Use condom			
3.	Avoid Mosquito bites			
4.	Limit sex to one partner			
5.	Avoid sex with prostitutes			
6.	Avoid sex with homosexuals			
7.	Avoid sex with persons who have many partners			
8.	Avoid sex with persons who inject drugs intravenously			
9.	Avoid blood transfusion			
10.	Avoid sharing sharp instruments e.g. barber's clippers, razor blades			
11.	Avoid kissing			
12.	Seek protection from traditional practitioner			
13.	Use antibiotics/drugs			
14.	Receive care from religious leaders/pray regularly			
15.	Take immunization or vaccine			
16.	Others (specify)			

15. Is it possible for a healthy looking person to have AIDS?

1. Yes 2. No

16. Which of the following statements best reflects your opinions about HIV/AIDS ?

1. It is not a serious problem
2. It is serious because it cannot be cured
3. Its seriousness is being exaggerated
4. No cause for alarm, only those who are sexually promiscuous get HIV/AIDS
5. Undecided

17. Do you think your chances of getting AIDS are

Reason

1. Small .....
2. Moderate .....
3. Great .....
4. No Risk .....
5. Don't know .....

SECTION C:

ATTITUDE AND PRACTICES OF CHURCH/MOSQUE MEMBERS TOWARD HIV/AIDS MESSAGES/INFORMATION

Below are statements about HIV/AIDS . for each tick (√) whether you agree or disagree with it or you are undecided.

	Statements	Tick (√)		
		Agree	Disagree	Undecided
18.	HIV/AIDS is a punishment from God for our numerous sins			
19.	Any member of the church/mosque with HIV/AIDS does not deserve our care and love because they are sinners			
20.	It is acceptable for AIDS to be discussed in church/mosques			
21.	People who have the germ (HIV) that causes AIDS should not be allowed to mix with other people			
22.	Anyone can get HIV/AIDS			
23.	I would not be afraid to submit my blood for HIV/AIDS tests			
24.	Church/Mosque members should be bothered about HIV/AIDS because it is a threat to them			
25.	It is important for Christian/Islamic religious leaders to attend HIV/AIDS seminars/workshops			
26.	HIV/AIDS prevention education is difficult and should not be incorporated in Church/Mosque sermons because it bothers on sex.			
27.	Religious leaders need basic and technical knowledge to be able to explain HIV/AIDS issues to their congregation			
28.	Religious leaders should include HIV/AIDS information in their messages/sermons regularly.			
29.	Religious leaders should organize HIV/AIDS educational programmes for Church/Mosque members frequently.			
30.	HIV/AIDS testing (VCT) should be made			

	compulsory for church/mosque members.			
31.	Abstinence is a major virtue to be emphasized in HIV/AIDS information especially to the unmarried youth in churches/mosques.			
32.	Religious leaders should emphasize being faithful to ones partner for all married people.			
33.	Religious leaders should include information on condom use into their message/HIV/AIDS programmes			

For Married

34a. Have you ever had extramarital sex? 1. Yes 2. No (*If No, go to Q38*)

34b. If yes, with whom? _____ (*go to Q36*)

For Unmarried

35a Have you ever had sex? 1. Yes 2. No (If No, go to Q38)

35b. If yes, with whom? _____

36. How many partners do you have? _____ *(actual number)*

37a. Did you use condom the last time you had sex? 1. Yes 2. No

37b. If Yes, why .....

37c. If No, why .....

38. Do you share sharp/piercing instruments e.g. razor blade? 1. Yes 2. No

39. Do you go to the salon with your personal kits? 1. Yes 2. No

40. Can you refuse to have sex with a partner who will not use condom?

1. Yes 2. No

41. Have you ever taken unscreened blood in a health facility?

1. Yes 2. No

42. Have you ever been tested to see if you have the AIDS virus?

1. Yes 2. No **(If No, Go to Q44)**

43. If yes, when was the last time that you were tested? ____ (*months ago*)

44. Would you want to be tested for the AIDS virus? 1. Yes 2. No

45. Have you ever been educated on HIV/AIDS from church/mosque?

1. Yes 2. No

46. Since you have heard about AIDS, have you changed your behaviour to prevent getting AIDS? 1. Yes 2. No

47. In the last 3 months, have you smoked cigarette? 1. Yes 2. No

48. In the last 3 months, have you taken alcoholic beverage? 1. Yes 2. No

Please respond to each of these statements. (*Please tick (√) the appropriate*)

	STATEMENTS	Yes	No	Don't know
49.	Would you be willing to eat from the same plate with a member of your church/mosque you knew has HIV/AIDS ?			
50.	If a member of your church/mosque became ill with AIDS, would you be willing to worship with him/her?			
51.	If a member of your church/mosque has HIV but is not sick should he/she be allowed to continue attending your church/mosque?			
52.	If a Pastor/Imam has the AIDS virus should he/she be allowed to continue preaching in the church/mosque?			
53.	If a member of your church/mosque became ill with HIV would you want it to remain secret?			

54. Apart form sermon, has your Church/Mosque ever organized any HIV/AIDS educational programme? 1. Yes 2. No 3. Can't remember *(if 'No' or 'Can't remember', go to Question 59a below)*

55. If Yes, how many of such HIV/AIDS programmes have been organized?

_____

56. What are these HIV/AIDS programmes and how frequent were they conducted?

	Programme	No of times conducted
1.		
2.		
3.		
4.		

57. Have you ever attended any of the programmes? 1. Yes 2. No *(if No, go to 59a)*

58. Which one(s) of these HIV/AIDS programmes have you attended in the last three months and why?

	Type of programme attended	Reason for attendance
1.		
2.		
3.		
4.		

59a. Has your church/mosque leader ever included HIV/AIDS information as part of his/her sermon to the congregation? 1. Yes 2. No

59b. If "yes", how many times in the last three months? _____

60a. Has your church/mosque leader specifically preached on HIV/AIDS to the congregation? 1. Yes 2. No

60b If "yes", how many times in the last three months? _____

SECTION E: SUGGESTIONS FOR TRAINING ON HIV/AIDS

61. Please list all the things you would like to learn about HIV/AIDS to make you more informed about the disease

a.....

b.....

c.....

d.....

62. From your own view who would you prefer to teach/educate Church/Mosque members about HIV/AIDS issues in your Church/Mosque (please tick (√) all that applies to you)

	Person	Tick (√)	
		Yes	No
1.	Pastors/Imam/Sheik		
2.	Sunday School Teachers/Arabic Tutors		
3.	Health Workers		
4.	Any Church/Mosque member		
5.	Others (please specify.....		

63. In which forum do you want HIV/AIDS to be discussed in the Church/Mosque setting?

(Tick (√) all that applies to you).

	Church/Mosque Setting	Tick (√)	
		Yes	No
1.	During Sermons		
2.	During Counseling Sessions		

3.	During Sunday School/Arabic Lessons		
4.	During Retreats or Out door programmes		
5.	Special time be created for HIV/AIDS Education		
6.	Others (please specify.....		

64. Make suggestions on what can be done to improve effectiveness of HIV/AIDS programmes organised by Churches or Mosques?

_____

_____

_____

_____

Thank you for taking time to answer these questions

Appendix 3: Questionnaire (Yoruba)

KNOWLEDGE AND ATTITUDE TOWARDS HIV/AIDS AND HIV/AIDS RELATED PRACTICES AMONG CHURCH AND MOSQUE MEMBERS

INTRODUCTION

A ki yin. Oruko mi ni ..... mo si se pelu Africa Regional Health Education Centre (ARHEC), College of Medicine, University of Ibadan. A nse iwadi lori arun eedi, inu wa yoo dun ti a ba le wa pelu wa ninu iwadi yi. Awon nkan ti a ba ri yio je ki a le seto fun idanileko lori arun eedi fun awon olori ijo. A ko ni gba yin ni akoko. Gbogbo ohun ti e ba so ni yio wa ni ifi pamo laarin wa. A fero wipe e o dara po mo wa ninu iwadi yi nitori wipe iriri yin se pataki fun wa. Se ki a bere iwadi na?

Section A: Demographic Data

1. Okunrin 2. Obinrin

2. E jowo omo odun melo ni e se ni ojo ibi ti e se kehin _____ (odun)

3. Ipo wo ni e wa nipa igbeyawo?

   (1) Mo ti gbeyawo (2) Mo ti gbeyawo ri

   (3) Nko ti gbeyawo ri

4. Nje e lo si ile iwe ri? 1. Beeni 2. Beeko

5. Iwe melo ni eka ti o ga ju

   (1) Nko lo ile iwe rara (2) Ile

   (3) Ile iwe girama (4) Ile iwe giga

6. Iru ise wo ni en se lowo lowo bayi? _____

7. Omo eya wo ni yin? 1. Yoruba 2. Ibo 3. Hausa

   4. Omiran (so ni pato) _____

8. Elesin wo ni yin? (1) Kristian (2) Musulumi

9. Bawo ni e se ma nlo si ile ijosin to?

   (1) Ojojumo (2) Lose se (3) Ju ekan lo lose

   (4) Ososu (5) Omiran (so ni pato)

10. Nigba wo ni a da ile ijosin yin le? _____

SECTION B: ORO IMO NIPA ARUN EEDI ATI KOKORO TI O N FA

11a. Nje o ti gbo nipa arun eedi? 1. Beeni 2. Beeko

11b. Nje o gbagbo wipe arun eedi? 1. Beeni 2. Beeko

12. Kini ajo sepo to wa laarin arun eedi? _____

13. Bawo ni eniyan se le ko arun eedi

		Beeni	Beeko	Nko mo
1.	Pinpin onje pelu eniti o ni arun eedi			
2.	Eje gbigba			
3.	Ibalopo pelu asewo			
4.	Ibalopo pelu eniyan pupo lailo rubber idabobo			
5.	Ibalopo okunrin si okunrin/obinrin si obinrin			
6.	Nipa abefele/nkan igerun			
7.	Abeere gbigba			
8.	Ifenukonu			
9.	Ki efon je eniyan			
10.	Didimo tabi owo bibo pelu eniti o ti lugbadi eedi			
11.	Iya omo ninu oyun			
12.	Iya si omo nigba ibimo			
13.	Iya si omo nipa omu mimu			
14.	Iko wiwu tabi sinsin si eniyan lara			
15.	Finfin ara			
16.	Ila abe kiko			
17.	Lilo awon nkan ti o mu/ abe fele			
18.	Emi okukun			
19.	Omiran (so ni pa to)			

14. Kini eniyan le se lati year fun arun eedi tabi kokoro ti on fa (HIV)?

		Beeni	Beeko	Nko mo
1.	Yiyera patapata fun ibalopo			
2.	Wo roba idabobo			
3.	Ki efon ma jeniyan			
4.	Didin olubalopo ku si eniyan kan pere			
5.	Iyera fun ibalopo pelu asewo			
6.	Yiyera fun ibalopo okunrin si okunrin/obinrin si obinrin			
7.	Yiyera fun ibalopo pelu eniti o ni olubalopo pupo			
8.	Yiyera fun ibalopo pelu eniti o gun ara re ni abeere ogun oloro			
9.	Yiyera fun eje gbigba			
10.	Yiyera fun ajumolo abefele			

11.	Yiyera fun ifenukonu			
12.	Tito awon onisegun ibile lo fun abo			
13.	Lilo ogun ti anena kokoro			
14.	Gbigba itoju lodo awon olori elesin/adura orekore			
15.	Gbigba abere ajesara			
16.	Omiran (so ni pato)			

15. Nje ose se ki eniyan ti o dape ni arun eedi? 1. Beeni 2. Beeko

16. Ewo ninu awon gbolohun wonyi ni o so nipa ero re nipa arun eedi (mu okan peere) (1) Ki ise arun ti o lewu rara

(2) O je arun ti o le wu nitoripe ko se wo

(3) Afikun/Asoju wa nipa olewu arun eedi

(4) Ko si ewu, awon ti o nse ise kise ni o le ko arun eedi

(5) Nko le so

17. Nje oso wipe kiko arun eedi re?

Idi

1. Kere .....
2. O mo niwon .....
3. Otobi .....
4. Ko si ewu .....
5. Mi ko mo .....

SECTION C: IHA ATI IHUWASI AWON OMO IJO SI AWON ORO LORI HIV/AIDS

Wonyi ni awon gbolohun ti o ro mo arun eedi, so boya *o faramo*, abi o *ko faramo*, abi o *ko mo*

	Gbolohun	Faramo	Nko faramo	Nko mo
18.	Arun eedi je ijiya lati odo Olorun fun awon ese wa ti o po lapo ju			
19.	Omo ijo ti o ni arun eedi ko ye fun itoju ati ife wa nitoripe elese ni			
20.	Oje itewogba ki a so nipa arun eedi ni ile ijosin kritiani/musulumi			
21.	Omo ijo ti o ni kokoro HIV ti on fa eedi ko gbodo ba awom omo ijo to ku josin papo			
22.	Arun eedi ko yo enikeni sile			
23.	Mi o beru lati fi eje ni sile fun ayewo kokoro HIV/eedi			
24.	Omo ijo gbodo mu oro eedi ni okukundun nitoripe ohun ti olewuni			
25.	Ose Pataki fun olori esin Kristani/Musulumi lati lo fun idanileko lori HIV/AIDS			
26.	Eko nipa didena arun eedi takoko nitorina ko ya ki o wa ninu oro iwasu nitoripe on so nipa ibalopo			
27.	Awon olori esin nilo imo ati eto to o jinle ki won ki o to le se alaye nipa oro arun eedi fun omo ijo			
28.	Awon olori esin ni lati ma fi oro nipa eedi sinu iwasu won lorekore			
29.	O ye ki awon olori esin se eto eko nipa arun eedi fun awon omo ijo			
30.	Ayewo fun arun eedi ye ki oo je dandan fun awon omo ijo			
31.	Yiyera fun ibalopo patapata se gbogi ninu oro nipa eedi paapaa fun awon ti ko ti gbeyawo ninu ijo			
32.	Oye ki awon olori esin tenumo sise oloto si ara eni fun gbogbo awon ti o ti gbeyawo			
33	Oye ki awon olori esin oro nipa lilo roba idabobo si iwe iwasu ati eto eko HIV/eedi			

Fun awon ti o ti gbeyawo

34a. Nje oti ni asepo pelu enikeni yato si iyaw/oko re lehin igbeyawo? 1. Beeni 2. Beeko

34b. Ti o ba je beeni, pelu tani? _____

Fun apon/omidan

35a. Nje oti ni ibalopo? (1) Beeni (2) Beeko (Ti o ba je beeko lo si Q38)

35b. Ti o ba je beeni pelu tani _____

36. Olubalopo melo ni o ni

37a. Nje o lo roba idabobo ni ibalopo ti se o kehin? 1. Beeni 2. Beeko

37b. Ti o ba je beeni, ki ni idi _____

37c. Ti o ba je beeko, kini idi _____

38. Se o ma n pin awon nkan ti omu bi abefele lo pelu elomiran?

1. Beeni 2. Beeko

39. Se o ma nlo si bi ti oti se/ge irun pelu a won nkan iserun tire?

1. Beeni 2. Beeko

40. Nje o le koja lo lati ni ibalopo pelu enikeji re ti ko fe lo roba idabobo? 1. Beeni 2. Beeko

41. Se o ti gba eje ti a ko se ayewo re lati ile eto ilera/ ile iwosan ri?

1. Beeni 2. Beeko

42. Nje o ti lo se ayewo bo ya oni kokoro eedi ri? 1. Beeni 2. Beeko

(Bi Beeko, lo si Q46)

43. Ti o ba je beeni, igbawo ni ayewo ikehin ti o se? (Osu_____ sehin)

44. Nje o nfe lati se ayewo fun kokoro eedi? 1. Beeni 2. Beeko

45. Nje o ti ri eko ko nipa arun eedi lati ijo re? 1. Beeni 2. Beeko

46. Lati igba ti o ti gbo nipa arun eedi, nje o ti yi wa pada lati ma de na kiko arun eedi? 1. Beeni 2. Beeko

47. Ni iwon osu meta sehin, nje o mu siga? 1. Beeni 2. Beeko

48. Ni won osu meta sehin, nje o mu oti lile? 1. Beeni 2. Beeko

49.	Nje o le jeun ninu abo kanna pelu omo ijo re ti o mo pe oni arun eedi?			
50.	Nje o le ra efo lowo omo ijo re ti o ni kokoro HIV			
51.	Ti omo ijo re kan ba ni aisan nipa eedi, nje o le finu			

	findo lo sin pelu re			
52.	Ti omo ijo re kan ba ni kokoro HIV ti ko si se aisan, nje o ye ki a gbalaye lati tesiwaju lati ma josin ninu ijo?			
53.	Ti alufa/imamu ba ni kokoro HIV, se o ye ki o tesiwaju lati ma waasu ninu ijo?			
54.	Bi omo ijo ba nse aisan ti oro mo kokoro eedi, nje o fe ki a se ni bonkele abi rara?			

SECTION D: ORO LORI BI ETO HIV/AIDS SE N LO SI MOSALASI/SOOSI

55. Nje ijo re ti se eto idanileko lori HIV/eedi ri. 1. Beeni 2. Beeko
3. Nko le ranti

56. Ti o ba je beeni, bi meelo ni awon eto idanileko na? _____
_____

57. Ki ni awon eto HIV/eedi wonyi ati bawo ni wo se po to?
_____
_____
_____
_____

58. Nje o ti le lo si okan kan ninu awon eto wonyi? 1. Beeni 2. Beeko

59. Nje olori ijo re ti le ti so nipa HIV/eedi ninu iwasu re si awon omo ijo?
1. Beeni 2. Beeko

60a. Nje o bi ijo re ti momo se iwasu lori arun eedi fun awon omo ijo?
1. Beeni 2. Beeko

60b. Ti o ba je beeni, oto igba me lo ninu osu mefa se hin? _____

SECTION E: IMORAN TABI ABA FUN IDANILEKO LORI EEDI ATI KOKORO TI ON FA

61. Jo wo so gbogbo ohun ti o feran lati mo nipa arun eedi lat le so odo eniti o ni imo kikun nipa arun na?
a. _____
b. _____
c. _____
d. _____

62. Gege bi o se ro, ta ni oo faramo ki o da awon omo ijo leko lori oro HIV/eedi ni ile Ijosin.

		Beeni	Beeko
1.	Pasito/Imamu		
2.	Oluko ile eko ojo isinmi/Afa		
3.	Alejo emimo nipa eto ilera		
4.	Omo ijo		
5.	Onisegu oyinbo		
6.	Omiran (so nipato)		

63. Labe akoso wo nigba wo ni o fe ki oro nipa HIV/AIDS igba aye ninu yio re?

		Beeni	Beeko
1.	Ninu iwasu/Waasi		
2.	Akoko igbani niyanju		
3.	Ni ile eko ojo isinmi/ni ile eko kehu		
4.	Nigba itun ara enidi/ipade ita gbangba		
5.	Akoko ti a ya sile soto fun nile lo lon HIV/eedi		
6.	Omiran (so nipato)		

64. So awon nkan ti a le se fun idagbasoke lati ife se mu le eto lori HIV/eedi ni Church/Mosalasi?

_____

_____

_____

Ese pupo fun asiko ti e fi sile lati dahun awon ibere wonyi

Appendix 4
Letters of introduction

16th November, 2005

TO WHOM IT MAY CONCERN

LETTER OF INTRODUCTION

I am pleased to introduce to you _____ who is a research assistant on a project "HIV/AIDS Educational Needs of Churches and Mosques in Oyo State", being carried out by the African Regional Health Education Centre, Department of Health Promotion and Education, College of Medicine, University of Ibadan. This study will take place between 17th November and 16th December, 2005.

Your most open and sincere answers are needed to make the research successful. I assure that all the information given to us will be kept confidential. Please get in touch with Mrs Busola Oyeyemi, on the telephone numbers 08023348030 and 08052256917, should you require any additional information about this project.

Your cooperation and participation in this project is appreciated.

Thank you.

Yours sincerely,

Adebusola Oyeyemi

Appendix 5
Selected Churches and Mosques in Oyo State

CHURCHES

ANGLICAN

S/N	NAMES OF LEADERS	ADDRESS/TELEPHONE NO	TOWN
1.	Ven Q.Q. Oduntan	St Michaels Anglican Cathedral – Esiele 08043155683 08035773010 038-240225	Oyo
2.	Ven B.F. Iyiola	St. David's Anglican Church, Agboin 08033612204 08033470573	Ogbomoso
3.	Ven B.A.B. Adebola	St. Paul's Anglican Church Archdeaconry, Okuta-pemo, Iseyin 08038280198	Iseyin
4.	Ven. Emmanuel O.K Adeboye	St. Paul's Anglican Church Odo-ona	Ibadan
5.		St Peters Church, Aremo, Ibadan	Ibadan
6.	Ven. Joseph Ade Akanbi JP "Chief Baba Eto"	St. Andrew's Anglican Church, Bamigbola, Igbo-Elerin P.O. Box 6975, Agodi, Ibadan, P.O. Box 6975, Agodi, Ibadan	Ibadan
7.	Ven. D.O Jaiyeola	Anglican Church, Igbo-Elerin, Archdeaconry	Ibadan
8.		St. Anne's Anglican Church Molete	Ibadan
9.	Ven. B.A.B Adebola	Iseyin Archdeaconry	Ibadan

METHODIST

S/N	NAMES OF LEADERS	ADDRESS/TELEPHONE NO	TOWN
1.	Mr. A.O Afolabi	Methodist Church Circuit, Caretaker, 038-721065 08035846826	Ogbomoso
2.	Rev. O.T. Ogunfile	Methodist Cathedral Arowomole 08035659347	Ogbomoso
3.	Rev. E.S. Adeoye	Methodist Church Nig. Ogunte Area. Idere. P.O. Box 352, c/o Chief S.O. Olasunsi 08037192063	Igbo-Ora
4.	Rev I.A. Oluwafemi	Methodist Church Iseri, Isey in. 08046472823 038-340072	Iseyin
5.	Rev. F. Fayanj.u	Methodist Church, Igbo-Elerin Circuit	Ibadan

6.	Rev. Bamigboye	Methodist Church, Agbeni, Ibadan. 08037169521	Ibadan
7.	Very Rev. I.B. Osunjuyigbe	Caretaker Circuit	Ogbomoso
8.	Very Rev. J.A. Gbadeola	Arowomole Circuit	Ogbomoso

CATHOLIC

S/N	NAMES OF LEADERS	ADDRESS/TELEPHONE NO	TOWN
1.	Rev Fr. Peter Audu	St. Anthony Catholic Church, P.O. Box. 038-249169	Awe
2.	Fr. Fapohunda Anthony	St, Ferdinand's Catholic Church, Arowomole Area. 08035632687	Ogbomoso
3.	Rev (Fr) Michael Falade	St, John The Baptist Catholic Church, Isalu 08034266781	Isalu
4.	Rev. Father Domungo	St Ignatius of Loyola, Old Ife Road 08023456401	Ibadan
5.		St Peters Catholic Church, Apata, Ibadan	Ibadan
6.	Monsignor Felix	Seat of Wisdom U.I 08033253121	Ibadan
7.		John The Baptist, Iseyin	Iseyin

ASSEMBLIES OF CHURCH

S/N	NAMES OF LEADERS	ADDRESS/TELEPHONE NO	TOWN
1.	Rev. Oyebamiji Williams	Assemblies of God Church Mabaloye Box 648 Oyo 0803464724 08043208361 038-240350	Oyo
2.	Deacon Emmanuel Sunday	Assemblies of God Church Comprehensive Hospital Odogbo Area, Igbo-Ora, P.O. Box 334 08033683913	Igbo-ora
3.		Assemblies of God Oke-Ado, Ibadan. 08037211526	Ibadan
4.		Assemblies of God Church, NTC Road, Ibadan	Ibadan
5.	Rev. Johnson Oyebamiji	Assemblies of God Ibarapa Section	Igbo-ora
6.	Rev. David Adisa	Assemblies of God Church	Ogbomoso
7.		Assemblies of God Church, Mokola	Ibadan

REDEEMED

S/N	NAMES OF LEADERS	ADDRESS/TELEPHONE NO	TOWN
1.	Pastor Tope Adeyemo	Federal College of Education Audit Dept. P.M.B 1089 08045027171	Oyo
2.	Pastor Femi Oriowa	RCCG Oyo I Opposite State Hospital, Owode	Oyo
3.	Pastor Adewuyi G.O	The Redeemed Christian Church, Iyana Church Victory Parish 08055255943	Ibadan
4.	Pastor Sam Adebowale	Redeemed Christian Church Oluwo-Nla Bashorun, New Bodija	Ibadan
5.	Pastor S.A. Owolabi	RCCG, Old Bodija No 66. Francis Okediji, Street. 08023367862	Ibadan
6.	Pastor I.O Fasidi	RCCD U.I Zone	Ibadan
7.	Pastor G.A. Omodele	RCCG, Iwo Road Living Water Parish	Ibadan
8.	Pastor G. Fasan	RCCG, Bolumole Ring Road	
9.	Pastor Femi Lanrewaju	RCCG, Overcomers Parish Molete 08052082195	Ibadan
10.	Pastor A. Adegbola	RCCG (Oyo II)	Oyo

BAPTIST

S/N	NAMES OF LEADERS	ADDRESS/TELEPHONE NO	TOWN
1.	Rev. H.A. Adigun	Agunpopo Baptist Church	Oyo
2.	Rev. I.A.A. Olajide	Alaba Olawoyin Baptist Church P.O. Box 46, Ilora 036-241719	Ilora
3.	Rev. Gbola Aremu	Ebenezer Baptist Church P.O. Box 161, Oke-Elerin 08035793210	Ogbomoso
4.	Rev. Tayo Adeyanju	Olodanbo Baptist Church, Ayegun Street, Maternity Adeoye Area. 038-721944 08033820780	Ogbomoso
5.	Rev. J.O. Oyeleke Deacon A.M. Dahunsi	Calvary Baptist Church Idofin, Oke-Odo, P.O. Box 105	Igbo-Ora
6.	Pastor Bayo Olayode	Oluwole Baptist Church, 08034346731	Iseyin
7.		Ogbomoso N/E Baptist Assembly	Ogbomoso
8.		Eleyele Baptist Church	Ibadan
9.		Ifelodun Iseyin Baptist Church	Iseyin

CELESTIAL

S/N	NAMES OF LEADERS	ADDRESS/TELEPHONE NO	TOWN
1.	Most Snr. Evang. M.O. Ajayi	Celestial Church of Christ Akeetan Titun, P.O. Box 274 . 08033886677	Oyo
2.	Ven. Most Senior Evangelist E.O Adewale	Celestial Church, Apete, Eleycle District	Ibadan
3.	Mr. Adetule Adebare	Celestial Church, Yemetu	Ibadan
4.		Celestial Church Mapo.	Ibadan

MOSQUES

ANSAR-UD-DEEN

S/N	NAMES OF LEADERS	ADDRESS/TELEPHONE NO	TOWN
1.	Alhaji Khalid Olanrewaju Junoid	Ansar-ud-deen Society of Nigeria, Sagamu, Igbo-Ora Branch, Oyo State. 08033592163	Igbo-Ora
2.	Alhaji K. Amusa	Ansar-ud-deen Eruwa Central Mosque, Oke-Ola Aborerin, Oyo State 08038352355	Eruwa
3.	Alhaji Rufai (Chief Imam)	Ansar-ud-deen Central Mosque, Isemi-Ile, Okeho	Okeho
4.	Alhaji Isiaka Raji (Chief Imam)	Ansar-ud-deen Central Mosque, Isemi Ayetoro-Oke, Okeho	Okeho
5.	Alhaji Ismail Salam (Chief Imam)	Ansar-ud-deen Central Mosque, Isemi/Imoba	Okeho
6.	Alhaji Arimiyan Akewukowo (Chief Imam)	Ansar-ud-deen Central Mosque, Ile Imam Oke Afin, Iganna	Iganna
7.	Alhaji Imam Bayo Fasasi (Balogun II)	Ansar-ud-deen Central Mosque, Ilero	Ilero
8.	Alhaji Abdulazeez Yusuff Abina	Ansar-ud-deen Mosque Ayegun, Ogbomoso 08034248169, 038-720902	Ogbomoso
9.	Ratibi Abdul Wahab	Ansar-ud-deen Central Mosque, Araromi Agip Area 038-340202	Iseyin
10.	Imam Abdukareem Bsuari Abodunrin	Ansar-ud-deen Central Mosque, Olupe Compound Ipapo, Saki Road. 08034350228	Iseyin
11.	Imam Zakariya Balogun	Ansar-ud-deen Mosque Odo-Ona SW8/412C Araromi Street, Isale Akako, Odo-Ona P.O. Box 37749, Dugbe, Ibadan 08023400895, 08033813083	Ibadan

		Mosque Akeetan Titun Oyo	
3.	Chief Imam Alhaji Sodiq Rahim	Fiditi Central Mosque 08033107516	Oyo
4.	Alhaji Jamiu Oloriri (Imam)	Araba titun, Omi-Adio Behind Ansarudeen Mosque	Ibadan
5.	Mr. O.E. Durojaye	SW8/1347 Anfani Layout, Oke-Ado, Ibadan. 02-2314898	Ibadan
6.	Ma'ruf Bilal	Alisuna Mosque Owode Oyo 08038270827	Oyo
7.	Azeez Raji	SW9/671 Alamu Layout Apata Ibadan	Ibadan
8.	Alh. Badmus A.N	ANDS Central Mosque Oyo 080344[illegible]514	Oyo

Appendix 6
List and addresses of district HQs of churches and mosques visited and invited for the planning meeting

- **Churches**

1. Most Rev. Dr. Alaba-Job
   Catholic Archbishop of Ibadan Bishop Court Onireke Quarters

2. Most Rev.Dr.J.B.Adelakun
   President, C.A.N. Oyo State& Catholic, Bishop of Oyo Diocese

3. Most Rev.Dr.Ogunyemi
   The Methodist Archbishop of Ibadan

4. Rt. Rev.J.O. Akinfenwa ,
   The Anglican Bishop of Ibadan Bishop's court Bodija, Ibadan

5. Rt. Rev. S. Okubadejo
   The Anglican Bishop, Ibadan North Diocese, c/o St. Peters Aremo, Ibadan

6. Most Elder Apostle Gboyega Alao
   General Superintendent& Supreme Head Sacred Cherubim& Seraphim
   Basorun Ibadan.

7. Pastor Dr. N.E. Udofia
   President, C.A.C. World-wide, Oniyere, Ibadan

8. Pastor Dr.E.H.L.Olusheye
   President, C.A.C.-World- Wide Alugbua Bashorun, Ibadan

9. Rev.Dr.S.A. Ishola
   General Secretary, Nigeria Baptist, Con ntion, Oke-Bola Ibadan.

10. Rev.A.O.fatorin
    Chairman Ibadan, D.C.C. ECWA c/o C llenge, Ibadan.

11. Bishop wale Oke
    General Overseer, Christ life Church, Olaogun Ibadan

12. Pastor Elijah Abiina
    General Overseer, Gospel Faith Mission Int., Ojoo, Ibadan.

13. Superior Evang.M. A. OTAKOYA(SP)
    Celestial Church of Christ c/o STATE HQ Agbowowo U.I Ibadan

14. Rev.Dr. Prince M.O. Adebanjo
    Chairman OAIC& Ibadan south West Local Govt.C.A.N.

15. The Bishop in-charge
    Church of the Lord Aladura Oke-ado,Ibadan Oyo State

16. Pastor J.S. Afomode
    Area Superintendent, The Apostolic Church, Inalende, Ibadan
17. Rev. Sunday Popoola
    Chairman PFN Oyo State WOCOM
18. Rt. Rev. I.F. Oladosu
    African Church Bishop of Ibadan

19. Rev. Vincent Alajc
    Assemblies of God Church, Mokola, Ibadan.

20. Rev.Dr.M.O. Oladeji
    Secretary, Ogbomoso Baptist Conference, Elekara Oyo

21. Rev. Joseph Ayanlola
    Secretary, Ogomoso Baptist Conference, Ogbomoso

22. The State Officer In-Charge
    Salvation Army Church Ibadan, Oyo State

23. The president Onaolapo
    7th day Adventist Church Ibadan, Oyo State

24. Pastor in-charge
    Deeper Life Church, Ibadan Oyo State

25. Bishop Adelakun
    Victory Church, Oluyole ring Road, Ibadan

26. Rev. Dr. Obed Ogbugara
    General Overseer, Glory Tarbanacle , Bodija, Ibadan.

27. The general Overseer
    New Convenient Church, Ijokodo, Ibadan

28. The Primate
    Saviours Apostolic Church, Inalende Oke Parde, Ibadan.

29. Pastor Jimi Ajibade
    Redeemed Christ. Church of God, Anlugba Basorun, Ibadan.

30. Apostle Lanre Ibiwale
Christ Life Mission Church Aladura

Mosques

List of Islamic bodies invited for the planning meeting

1. The Imam
1, Ahmadiya Street, Oke-Ado, Ibadan

2. Youmbas Anjena International
c/0 Centrl Mosque, Oja-Oba, Ibadan

3. Nasirudeen Society of Nigeria
Araromi Mosque, ita-maya, Oke-Ado, Ibadan.

4. Islamic youth League Nigeria
Quarters 459, Agodi G.R.A., Ibadan.

5. Sheriff Guard of Nigeria
Quarters 459, Agodi G.R.A., Ibadan

6. Ansarudeen Society of Nigeria
Liberty Road, Ibadan.

7. Oja-Oba Central Mosque
Oja-Oba, Ibadan

8. Quareeb Muslim Society of Nigeria
c/o Oja-Oba Central Mosque
Oja-Oba, Ibadan.

8. Teblique Organisation
c/o MufuLanihun Comprehensive School, Ibadan.

9. Chief Imam
Olanase Muslim Organisation
c/o Alhaji Qusum Olanase, Aremo, Ibadan.

10. Adura Nigba Society
Oriyangi Oremeji/ Agugu, Ibadan.

11. NASFAT
Ibadan Branch, Ibadan.

12. UI/UCH Muslim Community
    U.I/UCH Central Mosque
    UI, Ibadan.

13. Alhaji Muri Adetunji
    Mosadoluwa Central Mosque, Agbowo
14. Shehu Tajudeen Olaide
    Kaomu Nasirudeen in Islam (ijo-Ogunse)
    Agugu, Ibadan.

15. Shehu Bankole Akeem Adewale
    Nawair – ud-deen Society of Nigeria
    Oke parde.

16. Alh. Karimu Atanda Nofiu
    Nurudee Society of Nigeria,
    Ibadan Chapter.

17. Alh. Ganiyu Lawal Oderinde
    Istijab Adura Ngba Ibadan.

Appendix 7
Letter of Invitation to the Planning meeting

Department of Health promotion & Education
College of medicine, University of Ibadan
Ibadan, Nigeria.
08023348130

September 2, 2004

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INVITATION TO PLANNING MEETING ON HIV/AIDS STUDY
Thursday September 9, 2004

I send greetings to you in the name of our God.

I am pleased to invite you to attend a planning meeting on a project titled "**HIV/AIDS EDUCATIONAL NEEDS OF CHURCHES AND MOSQUES IN OYO STATE, NIGERIA".** This project was developed in recognition of the important role that religious leaders can play in preventing further spread HIV in Nigeria.

The purpose of the meeting is to identify the nc ls of Church and Mosque congregation concerning HIV/AIDS and to discuss the moda y for data collection and implementation of effective HIV/AIDS prevention programs in lected churches and mosques in the state. Your presence and contributions to the d ussions at this meeting will play significant role in ensuring the successful impl nentation of the program.

The details about the meeting are provided below:

Date: Thursday September 9, 2004

Venue: PSM building, Department of Health promotion & Education, College of medicine, University College Hospital (UCH), Ibadan.

Time: 11am prompt.

Thank you sir.

Yours sincerely,

Busola Oyeyemi (Mrs)