KNOWLEDGE, PERCEPTION AND INVOLVEMENT OF ISLAMIC RELIGIOUS LEADERS IN HIV/AIDS PREVENTION IN IBADAN NORTH LOCAL GOVERNMENT AREA, NIGERIA

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DEDICATION

This study is dedicated to the glory of Almighty Allah, The Lord of the worlds; Who

"Teaches by pen….Teaches man what he knew not".

And to every life in distress due to AIDS; as well as all souls fighting in the battle against the scourge.

CERTIFICATION

I certify that this study had been carried out by **IKUDAISI, Sefiu Olatunde** in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Nigeria.

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ABSTRACT

Religious leaders are potential change agents for HIV/AIDS prevention activities in their communities. Previous studies on the role of religious leaders in HIV Prevention in Nigeria have focused more on Christian religious leaders. Not enough is known about the HIV Prevention efforts of Islamic religious leaders. This study was therefore designed to assess Islamic religious leaders' (IRLs) knowledge, perception and involvement in HIV/AIDS prevention education in Ibadan North Local Government Area (LGA), Nigeria.

The cross-sectional study involved 427 IRLs selected from Mosques and Faith-Based Organizations (FBOs) in the LGA through a 3-stage random sampling technique. A validated semi-structured questionnaire which included questions on perception, level of involvement and a 15-point knowledge scale was used. Data were analyzed using descriptive statistics, t- test, Chi-square and logistic regression. Knowledge scores of 2-7, 8-10 and 11-15 were rated as poor, fair and good respectively. Level of significance was set at 0.05.

Respondents' mean age was 49.6 ± 16.0 years and 96% were males. All had heard about AIDS and their main source of information was the mass media (98.4%). Respondents' mean knowledge score was 9.1 ± 2.3. Respondents with poor, fair and good knowledge were 26.7%, 51.3% and 22.0% respectively. Many respondents (56.2%) could not correctly identify HIV as the causative agent of AIDS. Knowledge about abstinence from pre- and extra- marital sex as a means of prevention was high (96.5%) and 98.1% perceived that HIV/AIDS is a threat to societal well-being. The opinion of 51.3% was that Muslims were as vulnerable to HIV infection as other religious groups. Most respondents (97.4%) were of the view that IRLs have important roles to play in prevention of HIV infection. Only 8.2% had ever attended training on HIV/AIDS and 22.2% had ever preached about HIV/AIDS-related issues to their congregations. Eighty percent of respondents who had preached on HIV had not had any training on HIV. Only 4.4% of leaders had ever organized HIV/AIDS-related educational activities such as seminars/workshops (80%) and awareness campaign (15%) in their mosques/FBOs. Religious leaders in mosques used for daily prayers only and those in mosques used for Friday prayers were six times (OR=0.182; 95%CI=0.054-0.608) and nine times

(OR=0.103; 95%CI=0.019-0.567) less likely to organize HIV/AIDS educational programme compared with their counterparts in FBOs. The major barriers against implementing such programmes were lack of knowledge (25.1%) and lack of access to educational material (12.6%). Most respondents (94.1%) were of the view that religious leaders need basic HIV/AIDS knowledge to effectively educate their congregations and 95.6% were willing to be formally trained on HIV/AIDS. Suggestions for effective engagement of IRLs in HIV prevention included providing capacity building opportunities (30.4%) and education materials (31.9%).

Knowledge and perception of HIV/AIDS among the IRLs was fair. However, majority were not involved in HIV/AIDS prevention education programmes. Formal training by health workers, advocacy and technical supports are needed to address this challenge.

Key Words: Islamic Religious Leaders, HIV/AIDS, Perception, HIV/AIDS educational activities.

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ACRONYMS

ADID	Association for Integrated and Diversified Development (Mauritania)
AIDS	Acquired Immune Deficiency Syndrome
ARFH	Association for Reproductive and Family Health
ARHAP	African Religious Health Assets Programme
ART	Anti – Retroviral Therapy
AusAID	Australian Agency for International Development
BCC	Behavioural Change Communication
BCOS	Broadcasting Cooperation of Oyo State
BMOIW	Federation of Indonesian Muslim Women Organizations
CIPK	Council of Imams and Preachers Of Kenya
CISCGHAN	Civil Society Consultative Group on HIV/AIDS in Nigeria
COPHIA	HIV/AIDS Prevention, Care And Support Project
CRHEP	Community Reproductive Health Education and Promotion
CSOs	Civil Society Organizations
EPP	Estimation and Projection Package
FAEPTI	Family AIDS Education and Prevention Through Imams
FBOs	Faith-Based Organizations
FCT	Federal Capital Territory
FHI	Family Health International
FMOH	Federal Ministry of Health
FOMWAN	Federation Of Muslim Women Association in Nigeria
GHI	Global Health Initiative
HCT	HIV Voluntary Counseling and Testing
HERFORN	Health Reform Foundation of Nigeria
HIV	Human Immunodeficiency Virus
HPI	Health Policy Initiative
HSS	HIV Sero-Sentinel Survey
IMA	Islamic Medical Association (South Africa)
IMAU	Islamic Medical Association of Uganda

IRLs	Islamic Rligious Leaders
LGA	Local Government Area
MAEP	Madarasa AIDS Education and Prevention
MAGA-APIC	Muslim Action Guide against AIDS, Poverty, Illiteracy and Conflicts
MAIDS	Muslims against AIDS
M & E	Monitoring and Evaluation
MAP	Multi-Country AIDS Program
MAP	Muslim AIDS Program
MDGs	Millennium Development Goals
MSSN	Muslim Students Society of Nigeria
MUI	The Council of Indonesian `Ulama
MUSWEN	Muslim Ummah of South West Nigeria
NAC	National Aids Commission (Malawi)
NACA	National Agency for the Control of AIDS
NACOMYO	National Council of Muslim Youths
NARHS	National HIV/AIDS Reproductive Health Survey
NASFAT	Nasurl-Ul-Lahi- Il-Fatiu Society of Nigeria
NDHS	National Demographic Health Survey
NEPWAN	Network of People Living With AIDS
NFACA	National Faith Based Committee on AIDS
MC	Male Circumcision
NGOs	Non-Governmental Organizations
NSCIA	Nigerian Supreme Council for Islamic Affairs
NSF	National Strategic Framework
NTA	Nigerian Television Authority
NU	Nahdatul Ulama (Indonesia)
OVC	Orphan and Vulnerable Children
OYSACA	Oyo State Agency for the Control of AIDS
PBUH	Peace Be Upon Him
PEPFAR	President's Emergency Plan for AIDS Relief
PLWH	People Living With HIV

PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission
QOMFAT	Qomorudeen-Fathi-il-Society of Nigeria
RAP	Religious AIDS Programme
RE	Religious Entity
RLs	Religious Leaders
SAP	Social Advocacy Project
SEATS	Service Expansion And Technical Support
SFH	Society for Family Health
SPSS	Statistical Package for Social Science
SRH	Sexual and Reproductive Health
SSA	Sub- Sahara Africa
SSP	State Strategic Plan
STIs	Sexually Transmitted Infections
TMC	The Muslim Congress
TRA/PB	Theory of Reasoned Action/Planned Behaviour
UCH	University College Hospital
UI	University of Ibadan
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VAWs	Voluntary AIDS Workers
WHO	World Health Organization

OPERATIONAL DEFINITION OF TERMS

Knowledge: It refers to body of facts and principles in the contexts of HIV/AIDS already accumulated by the study population.

Attitude: Study population's disposition towards HIV/AIDS.

Perception: The way the study population view HIV/AIDS epidemic and give meaning to the disease.

Involvement: Study population's behaviour/practices towards the prevention of HIV/AIDS prevention.

Prevention: The act of stopping HIV from spreading.

Religion: An act of worship (or system of beliefs in) the Supreme Being that has its own ceremonies and traditions based on divine revelations.

Mosque: Place of worship, learning and other religious activities for Muslims.

Ratibi: A mosque for daily prayers only.

Jamiu: A mosque for both daily prayers and Friday prayer. Also called Central Mosque.

Faith-Based Organization: An organized Islamic society/group where Muslims engage in religious devotions and spiritual companionships

Imam: A male cleric who leads Muslim community in the five daily congregational prayers and guides other worshippers in all acts of devotion.

Chief Imam: A male (usually senior) cleric who heads central mosque in a community and leads the Friday congregational prayer and other major prayers such as for religious festivals and burial.

Amir: An appointed male spiritual leader of a male-(or mixed) Islamic society.

Amirah: An appointed female leader of a female group; or for the female members in a mixed group (and she assists the Amir).

Mufaseer: An assistant to imam in running the affairs of a mosque. He is knowledgeable enough to give scriptural explanations on issues.

Assistant Imam: An assistant to imam in running the affairs of a mosque. He can lead the congregation in daily prayers in the absence of Imam.

Congregation: People attending mosque and religious circle/group for prayers and other forms of prescribed socio-religious activities. They are also called members.

CHAPTER ONE

INTRODUCTION

Background

The Acquired Immune Deficiency Syndrome (AIDS) that was first reported in 1981 has now become a serious global public health problem. Unknown nearly three decades ago, HIV has already caused an estimated 25 million deaths worldwide and has generated profound demographic changes in the most heavily affected countries (UNAIDS, 2008). The number of people living with HIV (PLWH) at the end of 2010 was estimated at 34.0 million. Sub- Sahara Africa (SSA) continues to be the region most affected by HIV/AIDS. In 2010, the total number of PLWH reached 22.9 million in the region, 68% of the global total. One half of people living with HIV globally are women and 59% of all HIV-positive women live in SSA. In SSA, women are more likely to become infected with HIV than are men-the most recent prevalence data show that in the region 13 women become infected for every 10 men infected (UNAIDS, 2010, 2011). Of the 116.6 million children orphaned by AIDS globally, 89% live in SSA. Although other regions are less severely affected, 4.0 million people in South and South - East Asia and 1.5 million in Eastern Europe and Central Asia were living with HIV (UNAIDS, 2011).

Inherent differences in population distribution in Africa (compared to the industrialized world) contribute to the severity of HIV/AIDS on the continent. The most sexually active age groups represent a larger proportion of the population in SSA. In sub-Saharan Africa, where the majority of new HIV infections continue to occur, an estimated 1.9 million [1.7 million–2.1 million] people became infected in 2010 (UNAIDS, 2011). Overall SSA is the region hit hardest by the HIV/AIDS epidemic, differential rates of infection have been observed. Adult prevalence rates of HIV in Senegal is 0.9%; 25.9% in Swaziland; 11.5% in Mozambique; 23.6% in Lesotho; 17.8% in South Africa; 14.3% in Zimbabwe; 1.8% in Ghana; 3.2% in Togo; 3.4% in Cote d'Ivoire; 1.5% in Liberia; 5.3% in Cameroon; 6.5% in Uganda; 6.3% in Kenya; 5.6% in Tanzania and Nigeria 3.6% (UNAIDS, 2010).

HIV/AIDS has been reported in every continent and in every country. It poses a major challenge to the achievement of the Millennium Development Goals (MDGs).

According to the United Nations Development Programme (UNDP), HIV has inflicted the "single greatest reversal in human development" in modern history. In the countries most heavily affected, HIV has reduced life expectancy by more than 20 years, slowed economic growth, and deepened household poverty. The natural age distribution in many national populations in SSA has been dramatically skewed by HIV, with potentially perilous consequences for the transfer of knowledge and values from one generation to the next (UNAIDS, 2008).

Nigeria is Africa's most populous country with national population of over 140 million people. The HIV/AIDS epidemics have continued to evolve in the country since the official report of the first case in 1986. There was a progressive increase in adult HIV prevalence rate from 1.8% in 1991, 3.8% in 1993, 4.5% in 1996, and 5.4% in 1999, to a peak of 5.8% in 2001. However, repeated drops in prevalence rate were recorded in 2003, 2005 and 2007 at 5.0%, 4.4% and 3.1% respectively. The national HIV prevalence appeared to stabilize between 4.4%, 4.6% and 4.1% from 2005, 2008 to 2010 (FMoH, 2011).

There is need to be cautious about the national prevalence trend due to the changing pattern of the epidemic. While there has been wide variation across the states in the country, all the states in Nigeria have had a generalized epidemic since 2003. Featuring prominent in the general population is transactional sex. The epidemic reveals many of the fractures, stresses and strains in the society and the well-known and continuing link between poverty and disease. Despite high knowledge and awareness of HIV/AIDS, heterosexual intercourse remains the major mode of transmission of HIV (UNFPA, 2005).

It has become evident that HIV/AIDS pandemic is a development issue rather than the original health–only paradigm. Three decades of tackling AIDS have yielded important successes and have taught crucial lessons about which approaches work best. Since both a cure and an HIV vaccine remain elusive the reconstruction of the response at both global and national levels has ensured the inclusiveness of all relevant stakeholders in the fight against the pandemic. An overall lesson is that an effective response is anchored on the following three (3) highly inter- related strategies:

- Decreasing the risk of infection to slow the epidemic

- Decreasing vulnerability to reduce both risk and impact and
- Reducing impact in order to decrease vulnerability (FMoH, 2005).

A multi-sectoral approach is now widely adopted. The Nigerian response has followed the outlined pattern. In 2003, the National HIV and AIDS Policy which provides the over-arching control for the HIV response for all sectors was launched (FMoH, 2005).

Statement of the problem

West Africa remains the most highly religious region with 99% of people belonging to a religious denomination (Beal, 2005). The entire Nigerian populace from all works of life belongs to one religious group or the other; and the faith communities are a major part of the Nigerian society. Both Christianity and Islam are popular religions in Nigeria with a major impact in the lives of their adherents. The two religions assign top priority to good health; and thus impose a duty on adherents to safeguard it and not allow any change to overcome it through ill usage. It is important to note that HIV/AIDS infection in Nigeria has made in road into all segments of the population, including groups not usually considered to be at risk – the family (NACA, 2006). In 2010, about 281,000 new infections and 56,000 HIV positive births brought the total estimated number of PLWHA in Nigeria to 3.1 million (NACA, 2010).

The AIDS epidemic is affecting the religious community in many ways. First, most of the people suffering from AIDS are religious people, members of churches and mosques. People who used to devote time to religious causes are now involved in caring for PLWHA (McCain, 2003). As AIDS progresses in adults and many more people die from the disease, the problems of orphans and vulnerable children will increase (FMoH, 2005; 2010). As the impacts of AIDS reaches far into the future, yet, it seems that most Nigerians still fail to take necessary precautions against contracting the disease which is devastating and debilitating the country.

Religious leaders are at the heart of family and community acceptance of and response to challenges of AIDS epidemic. They possess an ordained role of leadership, are well situated to address social issues and have the capacity to bring communities together. Their jurisdiction often includes a number of areas closely connected to HIV and AIDS, such as morality, beliefs about spiritual bases of disease, and rules of family

life and sexual activity (NACA, 2006); including trust, responsibility and accountability in terms of rights. As HIV infection is invariably the result of human behaviour, change in behaviour has long been understood as essential to curbing the spread of infection. Behaviour-change interventions to reduce HIV transmission must therefore be given credibility through the involvement of moral and religious authorities who have the greatest influence in a community's everyday life. Both Christianity and Islam emphasize the importance of maintaining a healthy lifestyle and the two sacred books are filled with instructions/counsels that incorporate the call to (preservation of) good health. For example, the Qur'an states that "God would not alter any grace He has bestowed on a folk unless they alter what they themselves have" (Q8:53). It is also stated: "Do not expose yourselves to ruin" (2:195); and "Do not approach any immorality, open or covert" (6:151). The Bible teaches also that sex is a good thing within the right context; not casual relationship- "It is good for a man not to touch a woman. Nevertheless, to avoid fornication, let every man have his own wife, and let every woman have her own husband" (1 Corinthians 7: 1-5).

HIV/AIDS is likely to be with us for a long time. The virus is hidden within communities, spreading invisibly – oftentimes along the line of relationships. Since both a cure and an HIV vaccine remains elusive, preventing new infections remain a primary goal. As important decision-makers, religious leaders are usually looked upon as legitimate sources of ideas and as experts who should guide the congregations in taking right decisions on various behaviours that can influence their lives individually and as a group. Drawing from their religious texts, religious leaders can promote a return to the proper moral framework among adherents which ensures risk behaviour modification, using persuasion and motivation. This would greatly assist not only to guarantee both spiritual felicity and physical well-being, but also achieve (as potential outcomes of their actions) family and society protection from the risks of HIV infection; and prevention of the spread of the epidemic. The major contribution that religious leaders and teachings (can) play in this struggle should therefore be adequately harnessed by engaging the power of religious communities at the grassroots level.

Adequate knowledge about HIV/AIDS is an essential prerequisite for people to be able to take positive steps to respond to HIV/AIDS crisis. Previous attempts to assess

the roles and capacities of religious leaders towards AIDS prevention in Nigeria include the studies by Orubuloye, Cadwell and Caldwell (1993); Oladepo, Usendia and Ajuwon (1998); and Oyeyemi (2008). According to Oyeyemi (2008), majority of Christian and Muslim congregations in Oyo State favoured inclusion of formal HIV/AIDS education programmes in their Faith Based Organizations (FBOs) and most of them preferred their religious leaders. However organization of HIV/AIDS educational programmes was quite low in both mosques and churches in the State. Oladepo et al. (1995) had earlier found that Christian church leaders' knowledge about AIDS was inadequate, and that only a few of them had ever educated their congregations. However, not enough is known about Islamic religious leaders regarding their capacity and potential for, and their level of involvement in AIDS Prevention Education in Nigeria. This study therefore assessed the knowledge of HIV/AIDS, perception and the level of involvement in HIV/AIDS Education among Islamic religious leaders.

Justification

Inclusion of faith communities and religious leaders in Nigeria HIV response was meant to ensure that a greater percentage of the population would be reached with HIV/AIDS education and messages (NACA, 2006). However, anecdotal evidence suggests that Muslim views are not adequately represented in the HIV and AIDS programmes. It is important to address this common sentiment and understand how culture-specific approaches can reach more people (FMoH, 2005). The study is therefore significant for four reasons:

1. This study is an attempt to identify the strength and gaps in Islamic leaders' HIV/AIDS-related knowledge on prevention and control. Since this study was aimed at encouraging the involvement of religious leaders in AIDS education, the information generated can provide valuable insight into the educational needs of such leaders, which can be attained through training.
2. HIV/AIDS epidemic affects all communities; and much has been written on the prevention efforts of faith communities. This study, therefore, is an attempt to contribute to (local) knowledge by focusing on the community responses among

Islamic religious leaders (especially in South West Nigeria) towards the national multi-sectoral prevention model.

3. HIV/AIDS epidemic has given a practical justification for (a better) application of community participation as a strategy for health promotion action. From available data, there has been a consistent rise (upward trend) in HIV prevalence in Oyo State since 2005; and in 2010, site prevalence of 3.7% reported in Ibadan is higher than for any other previous year. The study findings shall therefore, not only contribute towards the overall, evidence-based impact assessment of local/national HIV/AIDS initiatives; it will equally assist stakeholders to improve quality, coverage and efficiency of prevention activities at the community level.
4. Holy Scriptures discuss reproduction and sexual health. However, wrong constructions of HIV/AIDS are often found among religious communities - not the least because of religious dogma and stereotype. Hence, it is important to know and document opinions, thoughts and sentiments on HIV/AIDS prevention among Islamic religious leaders from urban settings like Ibadan. Consequently, data obtained from this study may therefore be used for reference purposes in planning, developing and implementing appropriate strategic prevention activities and, or delivery methods that will respond to local context and make programme access possible in religious communities across Oyo State and beyond.

Broad objective: To assess the Islamic religious leaders' knowledge, perception and their involvement in HIV/AIDS education programmes in Ibadan North Local Government Area.

Specific objectives

The specific objectives were to:

1. assess the level of knowledge of Islamic religious leaders on HIV/AIDS.
2. describe the attitude of Islamic leaders about HIV/AIDS.
3. highlight Islamic leaders past and current HIV/AIDS prevention activities
4. determine the willingness of the Islamic religious leaders to be involved in HIV/AIDS education training programme.

Research questions

1. What is the level of knowledge of Islamic religious leaders on HIV/AIDS?
2. What is the attitude of Islamic religious leaders towards HIV/AIDS prevention and control?
3. What is the proportion of Islamic religious leaders who are willing to be involved in HIV/AIDS education training programme?
4. What is the degree of HIV/AIDS education activities within mosques and other religious institutions/organizations?

Hypotheses

1. There is no significant relationship between the demographic characteristics of respondents and HIV/AIDS-related knowledge.
2. There is no significant relationship between the demographic characteristics of respondents and attitude towards HIV/AIDS prevention.
3. There is no significant relationship between HIV/AIDS-related knowledge and involvement in HIV/AIDS education activities by respondents.
4. There is no significant relationship between demographic characteristics of respondents and willingness to participate in HIV/AIDS education programmes.

CHAPTER TWO

LITERATURE REVIEW

2.1 Nature and extent of HIV/AIDS

The Acquired Immune Deficiency Syndrome (AIDS) that was first reported in 1981 has now become a serious global health problem. Unknown three decades ago, HIV has already caused an estimated 25 million deaths worldwide and has generated profound demographic changes in the most heavily affected countries (UNAIDS, 2008). On a global scale, the HIV epidemic has stabilized, although with unacceptably high levels of new infections and AIDS deaths. While the percentage of people living with HIV (PLWHA) has steadily increased as new infections occur each year, HIV treatments extend life, and new infections still outnumber AIDS deaths.

2.1.2 The global situation

At the end of 2010, 34.0 million people were estimated to be living with HIV globally (up from 28.6 million in 2001 and 33.3 million in 2009), 2.7 million people became newly infected and 1.8 million died of AIDS (UNAIDS, 2010; 2011). In 2007, Over 6800 people become infected everyday while around 6000 die of the disease (WHO, 2008). Still, there were more than 7,000 new infections per day in 2010, a reflection of continuing new infections, people living longer with HIV (that is, expansion of access to antiretroviral therapy, ART), and general population growth. Most new infections are transmitted heterosexually, although risk factors vary. Young people (15-24) account for 42% of new infections worldwide. In 2010, an estimated 390 000 (340 000 – 450 000) children less than 15 years become infected with HIV, with 250 000 AIDS- related deaths. Globally, the number of children younger than 15 years living with HIV increased from 1.6 million (1.4–2.1 million) in 2001 to 2.0 million (1.9–2.3 million) in 2007, 2.5 million (1.6 – 3.4 million) in 2009 and 3.4 million at the end of 2010. Most children with HIV live in Sub- Sahara Africa (SSA) (91%) (UNAIDS, 2010; 2011).

SSA, with only about 12% of the world's population, continues to be the region most affected by HIV/AIDS. Inherent differences in population distribution in Africa (compared to the industrialized world) contribute to the severity of HIV/AIDS on the

continent. The most sexually active age groups represent a larger proportion of the population in SSA. Heterosexual intercourse remains the epidemic's driving force in SSA (UNAIDS, 2008). An estimated 1.9 million people were newly infected with HIV in SSA in 2010, bringing to 22.9 million the number of people with HIV. Two-thirds (67%) of the global total of 34.0 million people with HIV live in the region; and nearly three quarters (72%; 1.3 million) of all (1.8 million) AIDS deaths occurred there. One half of people living with HIV globally are women, and 76% of all HIV-positive women live in SSA.

Although there was a notable decline in the regional rate of new infections, the majority of new HIV infections continue to occur in SSA, accounting for 70% of new infections in 2010 (UNAIDS, 2011). The vast majority of people newly infected with HIV in SSA are infected during unprotected heterosexual intercourse (including paid sex) and onward transmission of HIV to newborns and breastfed babies. UNAIDS (2010) report maintained that having unprotected sex with multiple partners remains the greatest risk factor for HIV in this region. Large proportions of people living with HIV are in long-term relationships—62% in Kenya and 78% in Malawi, for example. As mainly heterosexual epidemics evolve, the numbers of discordant couples (only one person is infected with HIV) increase and HIV transmission within long-term relationships increases. Research in 12 countries in eastern and southern Africa shows that prevalence of discordant couples is high, ranging between 36% and 85% (UNAIDS, 2010).

Despite the modest decline in HIV adult prevalence worldwide and increasing access to treatment, the total number of children aged 0–17 years who have lost their parents due to HIV has not yet declined. Indeed, it has further increased from 14.6 million [12.4 million–17.1 million] in 2005 to 16.6 million [14.4 million– 18.8 million] in 2009. Most of them live in SSA (89%). The number of orphans due to AIDS living in six countries—Kenya, Nigeria, South Africa, Uganda, United Republic of Tanzania, and Zimbabwe—is more than 9 million, with Nigeria alone counting 2.5 million orphans due to HIV (UNAIDS, 2010).

Although other regions are less severely affected, 4.0 million people in South and South–East Asia; 1.5 million in Eastern Europe and Central Asia; 1.3 million in North America; 470,000 in Middle East and North Africa; 840,000 in Western/Central Europe;

790,000 in East Asia; 200 ,000 in Caribbean and 54,000 in Oceania were living with HIV (UNAIDS, 2011).

Table2.1: Estimated People Living with HIV in 2010.

Region	Total Number (%) of People affected (million)
Global	34.0 (100)
Sub-Sahara Africa	22.9 (67)
South and South-East Asia	4.0 (12)
Eastern Europe and Central Asia	1.5 (4)
North America	1.3 (4)
Middle East and North Africa	0.47 (1)
Western and Central Europe	0.84 (2)
East Asia	0.79 (2)
Caribbean	0.20 (0.6)
Oceania	0.54 (0.2)

Source: UNAIDS (2011) World AIDS Day Report and Global Summary of the AIDS epidemic.

2.1.3 The situation in Africa

Almost all of the nations in SSA region have generalized epidemics – that is, their national HIV prevalence rate is more than 1% (UNAIDS, 2011). However, Sub- Saharan Africa's epidemics vary significantly from country to country in both scale and scope. Not only are biological factors, such as male circumcision and the presence of sexually transmitted infections, given as possible reasons for these differences, but various social and cultural factors have also been postulated. Religion may well be one of these factors (Beal, 2005). Adult national prevalence is below 2% in several countries of West and Central Africa, as well as in the horn of Africa, but in 2007 it exceeds 15% in seven southern African countries (Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe), and was above 5% in seven other countries, mostly in Central and East Africa (Cameroon, the Central African Republic, Gabon, Malawi, Mozambique, Uganda, and the United Republic of Tanzania). Southern Africa continues to bear a disproportionate share of the global burden of HIV: 35% of HIV infections and 38% of AIDS deaths in 2007 occurred in that sub region (UNAIDS, 2008). In 2010, South Africa

has the highest number of PLWH in the world (5.6 million); and Swaziland has the highest prevalence rate in the world (25.9%) (UNAIDS, 2011). As at the end of 2009, adult prevalence rates of HIV in Senegal is 0.9%; 25.9% in Swaziland;1.8 % in Ghana; 3.2% in Togo; 1.5% in Liberia; 5.3 % in Cameroon ;6.5 % in Uganda and 3.6 % in Nigeria (UNAIDS, 2010).

Most epidemics in SSA appear to have stabilized, although often at very high levels, particularly in southern Africa. Additionally, in a growing number of countries, adult HIV prevalence appears to be falling. Of the 33 countries where HIV incidence has fallen by more than 25% between 2001and 2009, 22 are in sub-Saharan Africa alone. The biggest epidemics in the region—Ethiopia, Nigeria, South Africa, Zambia, and Zimbabwe —have either stabilized or are showing signs of decline. These figures demonstrate that positive behaviour change can alter the course of the epidemic—while stigma and discrimination, lack of access to services and bad laws can make epidemics worse. In both cases, the effects are often profound.

For the region as a whole, women are disproportionately affected in comparison with men, with especially stark differences between the sexes in HIV prevalence among young people. In SSA, women are more likely to become infected with HIV than are men - as at the end of 2010, women were more than half of all PLWH in SSA (59%) (UNAIDS, 2011). SSA still bears an inordinate share of the global HIV burden. Although the rate of new HIV infections has decreased, the total number of people living with HIV continues to rise (UNAIDS, 2010).

Table 2.2: Sub-Sahara Africa HIV/AIDS at a glance in 2010

Prevalence rate (adult)	5.0% (4.7% - 5.2%)
Estimated No of PLWH	Total: 22.9 million
Annual AIDS-related death	1.2 million (1.1 million – 1.4 million)
New HIV infection	1.9 million (1.71 million - 2.1 million)
Estimated orphans due to AIDS	14.8 million

Source: UNAIDS (2011) World AIDS Day Report

2.1.4 The Nigerian situation

Nigeria has the second highest number of PLWHA in the world after South Africa. UNAIDS estimated 34.0 million PLWH in 2010 in the world. Nigeria, with about 3.1 million PLWH, makes 10% of the global HIV burden. However, there is gender inequality in the distribution with males accounting for 1.32 million and female accounting for 1.83 million in the HIV estimates and projections for 2011. Women are more affected in the defining feature of the epidemic with policy implications for prevention of mother to child transmissions. Hence, addressing gender inequality is crucial in the control of the epidemic. The ever increasing number of AIDS orphans was estimated at 2.12 million in 2008, 2.175 million in 2009 and 2.229 million in 2010 (FMoH, 2010). However, UNAIDS put the Nigerian figure at 2.5 million orphans in 2009 (UNAIDS, 2010).

Nigeria recorded the first case of acquired immunodeficiency syndrome (AIDS) in 1986. Nigeria, through the Federal Ministry of Health, instituted regular surveillance system using clinic-based and population-based surveys to monitor the epidemic. This is to obtain reliable information about HIV prevalence and behaviors associated with HIV transmission or acquisition. These surveys have shown the dynamic nature of HIV epidemic in relation to temporal changes, geographic distribution, magnitude, and modes of transmission. In each of the sentinel surveys there were significant variations in the different states of the federation. Furthermore, this surveillance system provides opportunities to monitor trend in prevalence, create awareness about early response, inform priority setting for new interventions and measure the effectiveness of public health interventions in the control of the epidemic.

Antenatal sentinel survey conducted among pregnant women age 15-49 has been used to monitor the trend of the epidemic since 1991. There was a rapid rise in HIV prevalence in the sentinel surveys carried out from 1991 to 2001 (1.8% in 1991 to 4.5% in 1996 and then to 5.8% in 2001). Subsequently, the trend reversed and took a downward turn from 5.8% in 2001 to 5% in 2003 and then to 4.4% in 2005. A slight increase was again observed in HIV prevalence from 4.4% in 2005 to 4.6% in 2008. The prevalence has stabilized between 4.4% (2005) and 4.1% (2010).

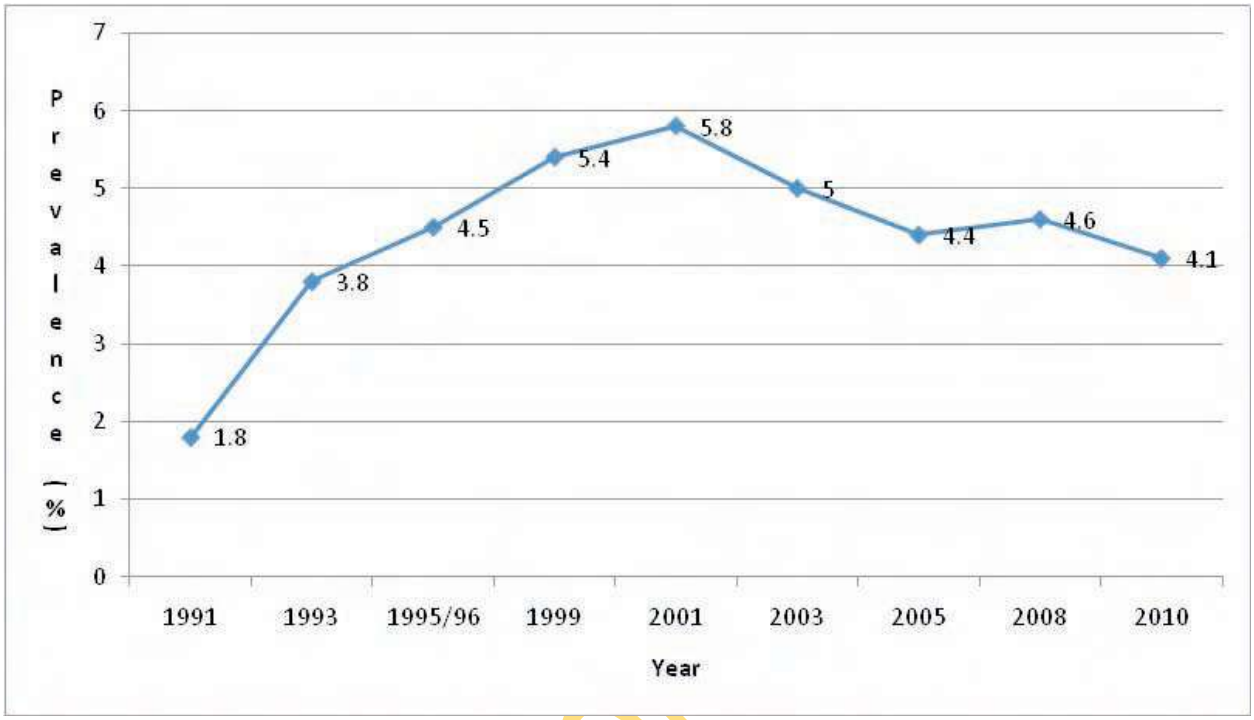

Figure 2.1: National HIV Prevalence Trend from 1991 – 2010 (HSS 2010)

Source: Federal Ministry of Health 2010 National HIV Sero-prevalence Sentinel Survey.

Nigeria HIV prevalence is estimated at 3.6% (NARHS 2007) which is a population based survey. Prevalence was slightly higher in urban areas (3.8%) compared to rural areas (3.5%). North Central Nigeria has the highest prevalence of 5.7% with South East having the least 2.6%. Youths (ages 15 – 24 years) had a prevalence of 2.4% which was about 67% of the national HIV prevalence of 3.6% in the survey; which buttresses the fact that youths are important risk group in HIV epidemic.

The NARHS report further shows that HIV prevalence in the general population was higher among those with tertiary education (4.0%) compared to those without education (2.7%). HIV prevalence among those who had sex in the last 12 months was male (3.9%) and female (4.4%). In addition, among males that ever had sex HIV prevalence was 3.8% unlike in males that never had sex 1.7%, while in female that ever had sex was 4.7% and those that never had sex 1.7%. Males that exchanged sex for gifts had prevalence of 5% and those that did not had HIV prevalence of 3.9%. Females that

exchanged sex for gifts had prevalence of 5.2% and those that did not had HIV prevalence of 3.9%. Females with two or more non-marital sexual partners had prevalence of 14.5% unlike males with two or more non-marital sexual partners with prevalence of 1.5%.

Nigeria has a generalized epidemic with a prevalence above 1% as defined by UNAIDS/WHO Working Group in 2000. In the most recent 2010 sentinel survey, national HIV prevalence for women attending ANC was 4.1%. This sentinel survey was carried out in the 36 states of Nigeria and the Federal Capital Territory (FCT). Despite national prevalence of 4.1%, there are several variations by state and local government area. The results of the survey indicate that Kebbi state in the North West zone of Nigeria had the lowest prevalence of 1.0%, while Benue state in North Central zone had the highest prevalence of 12.7%. A total of 16 States and FCT had prevalence above 5%. The three States with the highest rates were Benue, Akwa Ibom and Bayelsa. The prevalence was generally higher in urban than rural areas except in eight States, namely Benue, Adamawa, Kaduna, Akwa-Ibom, Yobe, Jigawa, Kebbi and Ondo where the reverse was the case. While six States showed a consistent downward trend between 2005 and 2010, eight States showed a consistent rise. Other States showed no consistency in trend.

The highest site prevalence of 21.3% in the country was reported in Wannune (Benue State) while the lowest prevalence of 0.0% was reported in four sites, namely Kwami (Gombe State), Rano (Kano State), Owhelogbo (Delta State) and Ganawuri (Plateau State). At the zonal level, prevalence is lowest in the North West (2.1%) - with rural prevalence of 1.7% and urban prevalence of 2.7%. - and highest in the North Central (7.5%) - with rural prevalence 2.7% and urban prevalence 8.2%.

The prevalence rose with increasing age-group and peaked at age 30-34 years (5.7%) after which it declined. Age group specific prevalence is highest in the age group 30-34 years (5.7%) and lowest in the 40-44 years age group (2.9%). Single women had higher HIV prevalence than married women (5.6% versus 4.9%), while women who were divorced, separated or widowed recorded the highest prevalence (6.9%) (FMOH, 2011).

With the current HIV prevalence of 4.1%, it was estimated that the number of people living with HIV at the end of 2010 is 3.14 million using Estimation and Projection Package (EPP) and Spectrum models. The number of new infections is 281,180 (adult

126,260 and childhood 154,920); total number that requires antiretroviral therapy is 1,512,720 (adults 1.3 million and children 212, 720). Estimated annual AIDS deaths in 2010 is 215,130 (males 96,740 and females 118,390). Furthermore, the number of children orphaned by HIV is 2,229,883. National response targets from the Nigerian National Response Information Management System Operation Plan 2007 – 2010 are reduction of HIV prevalence by 25%; prevention of 55% of new HIV infections and treatment of 550,000 HIV positive people by 2010 (NACA, 2010).

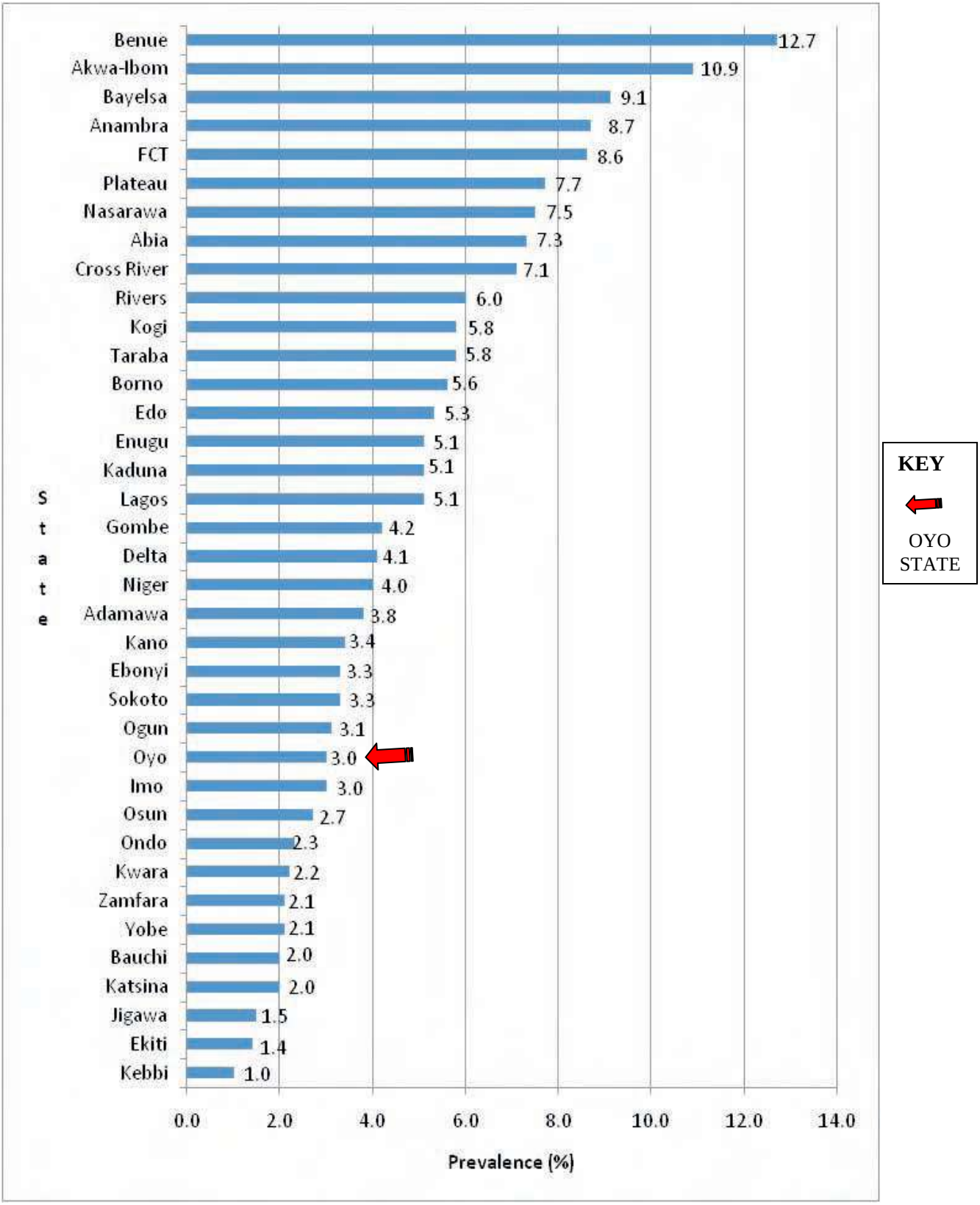

Figure 2.2: HIV Prevalence in States in Nigeria
Source: Federal Ministry of Health 2010 National HIV Sero-prevalence Sentinel Survey.

Table 2.3: HIV/AIDS status at a glance 2010

National Median HIV prevalence (ANC)	4.1%
Estimated No of people living with HIV/AIDS	Total: 3.14 million
Cumulative AIDS death	Total: 2.1 million (male 970,000; female 1.13 million)
Annual AIDS Death	Total:215,130 (male 96,740; female 118,390)
Number requiring Antiretroviral Therapy	Total 1,512,720 (adult 1.3 million; children 212,720)
New HIV infection	Total: 281,180 (adults 126,260; childhood 154,920)
Annual HIV positive births	56,681
Total AIDS orphans	2,229,883

Sources: FMOH (2010) ANC 2010 Report HIV estimates and projection
NACA (2011) Update on the HIV/AIDS Epidemic and Responses in Nigeria

2.1.5 Oyo State

The first HIV case was recorded in Oyo State in 1987. The State's HIV prevalence rate rose progressively from 0.1% in 1991/92 and peaked at 4.2% in 2001. It thereafter decreased to 3.9% in 2003 and 1.8% in 2005. However, there has been an upward trend between 2005 and 2010 in the State from 1.8% (2005) through 2.2% (2008) to 3.0% (2010) (FMoH, 2010). Also, in the city of Ibadan, HIV prevalence was 3.3%, 1.7%, 1.0% and 0.3% in 2001, 2003, 2005, and 2008 respectively. In 2010, prevalence was 3.7% (FMOH, 2010). Among the factors driving the disease in the State include ignorance, low risk perception, worsening poverty level, risky sexual behaviour and harmful cultural practices (OYSACA, 2008).

Table 2.4: HIV prevalence trends in Oyo State and its urban sites from 2001 to 2010

	2001 (%)	2003 (%)	2005 (%)	2008 (%)	2010 (%)
Oyo state	4.2	3.9	1.8	2.2	3.0
Ibadan	3.3	1.7	1.0	0.3	3.7
Saki	4.7	6.4	3.3	2.7	3.3
Ogbomosho	4.7	3.7	1.3	3.3	4.3

Source: FMOH. ANC HIV Sentinel Survey 2010.

2.2 Economic and social impact of HIV/AIDS

The cost of the epidemic to individuals, families, communities and countries is incalculable. It is a potent obstacle to the achievement of the Millennium Development Goals (MDGs). In the countries most heavily affected, it has reduced life expectancy by more than 20 years, slowed economic growth, deepened household poverty and undermined vital sectors on which economic development depends. In spite of this, the epidemic continues to expand due to failure to tackle societal factors that affect HIV risk and vulnerability in most countries (UNAIDS 2008).

HIV/AIDS is largely a problem of poverty and power imbalances. People who have limited control over their lives are particularly prone to get infected. Forced migration, seasonal labour movements, exploitation in general and positions of dependence, overcrowding, gender inequality, subordination and servitude (within marriage and elsewhere) all contribute to the spread of HIV/AIDS (Islamic Relief, 2008).

In many of Sub-Saharan African societies, AIDS emerged against a backdrop of extreme poverty, squalor, hunger, unemployment (Ajala, 2006), conflict and inadequate infrastructure. These factors combined have exacerbated the spread of the disease in this region of the world and it is the one hardest hit by the epidemic (Arrehag, de Vylder, Durevall and Sjöblom, 2005). In Nigeria, existing problems like political instability, ethnic crises, social decadence, urban migration, unemployment, poor and inadequate infrastructural facilities, widespread poverty and irregular academic sessions in all tiers of

the educational system contribute greatly to HIV/AIDS vulnerability and prevalence (Ajala, 2006). Other major factors in the transmission of HIV in Nigeria are low literacy levels, high rates of casual and transactional unprotected sex in the general population, low levels of male and female condom use, cultural and religious factors, as well as stigma and discrimination (NDHS, 2008). It has also been observed that Nigeria is a complex mixture of diverse ethnic groups, languages, cultures, religions, and regional political groupings; and all of these are major challenges for HIV prevention programs (USAID, 2002).

Describing the seriousness of HIV/AIDS, Barnett and Whiteside (2006) said that the epidemic of HIV/AIDS would affect not only the health of individuals but also the welfare and well-being of households, communities and, in the end, entire societies. While taking stock of the impact, UNICEF (2006) maintained that HIV/AIDS plunges life into a daily ordeal for (these) millions, with millions more of family members bearing the brunt of care, and the cost of care. Those affected have watched their husbands or wives, or children or relatives sicken, and die. A great unknown number have perished, including infected newborns coming into the world with the imminent prospect of death. Those infected who live on struggle silently, fighting opportunistic infections, or worsening tuberculosis, or other diseases that prey on their bodies' weakened immunity. As AIDS progresses in adults, a growing number of children are left with the inevitability of becoming orphans. Yet they are ostracized, discriminated, forced to live in shame because AIDS, unlike all other diseases, is singularly stigmatized (UNICEF, 2006).

2.2.2 Africa

Overall SSA is the region hit hardest by the HIV/AIDS pandemic. The HIV/AIDS epidemic is especially erasing decades of progress in increasing the life expectancy especially of the people of West Africa. The vast majority of people in West Africa who have HIV/AIDS are between the ages of 15 and 49, and millions of adults are dying young or in early middle age. It has been reported that many West African countries have lost close to a decade from previous life expectancy estimates as a result of HIV/AIDS. The epidemic is also reversing progress in poverty reduction. AIDS is exacerbated by poverty, therefore affecting poorer populations disproportionately to middle or higher

income groups. Nigeria alone has the second-largest number of people living with HIV after South Africa.

HIV/AIDS can have devastating effects on households. Many families lose their primary income earners, while others lose the incomes of family members forced to stay home and care for the sick. Caring for an individual with AIDS in SSA can take up as much as one-third of a family's monthly income. As more family members fall ill and die due to causes attributable to the virus, the dependency ratio increases. Grandparents can no longer rely on their children for support; instead, they become responsible for their grandchildren and the burden of support that this situation imposes. The projected increase (by 2010) in economic dependency ratios due to HIV/AIDS deaths and illness is 3.5 percent in Nigeria (USAID, 2009).

Millions of children are becoming orphans as a result of HIV/AIDS. The magnitude of the situation is particularly serious in Nigeria, where almost one million children have lost one or more parents to HIV/AIDS. Many children who lose parents also lose their childhood and are forced by circumstances to become generators of income or food or caregivers for sick family members. They suffer increased health problems related to inadequate nutrition, housing, clothing, and basic care. They are also less able than other children to attend school regularly. It has been found that rising HIV rates were correlated with lower levels of education. This in itself indicates an increased risk for HIV infection.

Stigma and discrimination have long been identified as major obstacles that keep people living with HIV from accessing prevention, treatment, and care services. Accepting attitudes toward people with HIV were low in Nigeria, with fewer than 10 percent of men and fewer than 5 percent of women expressing accepting attitudes toward people with HIV. Stigma often leads to discrimination and other violations of human rights that affect the well-being of people living with HIV (USAID, 2009).

HIV infection is widely stigmatised because of its association with behaviours that may be considered socially unacceptable by many people. People living with the virus are frequently subject to discrimination and human rights abuses: many have been thrown out of jobs and homes, rejected by family and friends, and some have even been killed. Together, stigma and discrimination constitute one of the greatest barriers to

dealing effectively with the epidemic. They discourage governments from acknowledging or taking timely action against AIDS. They deter individuals from finding out about their HIV status. And they inhibit those who know they are infected from sharing their diagnosis and taking action to protect others and from seeking treatment and care for themselves (UNAIDS, 2010). Experience teaches that a strong movement of people living with HIV that affords mutual support and a voice at local and national levels is particularly effective in tackling stigma. Moreover, the presence of treatment makes this task easier too: where there is hope, people are less afraid of AIDS; they are more willing to be tested for HIV, to disclose their status, and to seek care if necessary.

2.3 Prevention and treatment

Numerous prevention interventions exist to combat HIV, and new tools, such as vaccines, are currently being researched. Effective prevention strategies include behavior change programs, condoms, HIV testing, blood-supply safety, harm-reduction efforts for injecting drug users, and male circumcision (Kaiser Family Foundation, 2011).

Three decades of tackling AIDS have yielded important successes and have taught crucial lessons about which approaches work best. Since both a cure and an HIV vaccine remain elusive the reconstruction of the response at both global and national levels has ensured the inclusiveness of all relevant stakeholders in the fight against the pandemic (that is, a multi-sectoral approach is now widely adopted). An overall lesson is that an effective response is anchored on the following three (3) highly inter- related strategies:

- Decreasing the risk of infection to slow the epidemic
- Decreasing vulnerability to reduce both risk and impact and
- Reducing impact in order to decrease vulnerability (FMoH, 2005).

Experts recommend that prevention be based on "knowing your epidemic," that is, tailoring prevention to the local context and epidemiology, and using a combination of prevention strategies, bringing programs to scale, and sustaining efforts over time (Kaiser Family Foundation, 2011).

2.3.2 Global Response to HIV/AIDS

International efforts to combat HIV began in the first decade of the epidemic with the creation of the WHO's Global Programme on AIDS in 1987. UNAIDS was formed in 1996 to serve as the UN system's coordinating body and to help galvanize worldwide attention to AIDS. The role of affected country governments and civil society also has been critical to the response. Over time, funding by donors and others has increased and several key initiatives have been launched:

- In 2000, all nations agreed to global HIV targets to halt and begin to reverse the spread of HIV by 2015, as part of the UN Millennium Development Goals (MDGs), and the World Bank launched its Multi-Country AIDS Program (MAP).
- In 2001, a United Nations General Assembly Special Session on HIV/AIDS (UNGASS) was convened and the Global Fund was created. More recently, at the June 2011 (2010) UNGASS meeting, world leaders adopted a new Declaration that reaffirmed commitments and called for an intensification of efforts to combat the epidemic through new commitments and targets.
- Most funding has come from international donors who disbursed $6.9 billion in 2010, up from $1.2 billion in 2002; to address HIV in developing countries. Hard hit countries have also provided significant resources to address their epidemics.
- Private sector, including foundations and corporations (e. g. Bill & Mellinder Gates Foudation) also plays a major role (Kaiser Family Foundation, 2011).

2.4 HIV/AIDS knowledge and behaviour

Adequate knowledge about HIV/AIDS is an essential prerequisite for people to be able to take positive steps to respond to HIV/AIDS crisis. Comprehensive knowledge of HIV remains low in West Africa and is an obstacle to reducing new infections. For example, according to the Demographic Health Survey (DHS) conducted across West Africa from 2003 to 2008, less than 50% of the population between the ages of 15 and 49 had comprehensive correct knowledge about HIV/AIDS (USAID, 2009).

Findings from Nigerian 2008 National Demographic and Health Survey (NDHS 2008) indicated that majority of Nigerians (women 88 % and men 94 %) aged 15-49 have heard of HIV or AIDS. However, only 23 % of women and 36 % of men have what can

be considered comprehensive knowledge about the modes of HIV transmission and prevention. Comprehensive knowledge means knowing that using condoms and having just one uninfected, faithful partner can reduce the chance of getting HIV, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about HIV transmission or prevention, that HIV and AIDS can be transmitted through supernatural means or through mosquito bites.

Most HIV cases in Nigeria occur as a result of heterosexual contact. Featuring prominent in the general population is transactional and intersectional sex. The epidemic reveals many fractures, stresses and strains in our society and the well- known and continuing link between poverty and disease. Despite high knowledge and awareness of HIV/AIDS, heterosexual intercourse remains a major mode of transmission of HIV (UNFPA, 2005). The 2008 NDHS findings about the level of higher-risk sexual intercourse (i.e., sexual intercourse with a non-marital, non- cohabiting partner) indicate that 1% of women and 10 % of men had two or more sexual partners during the 12 months preceding the survey. Ten percent of women and 23% of men had higher-risk sexual intercourse in this period. Among these respondents, only 33% of women and 54 % of men reported that they used a condom the last time they had sexual intercourse with a higher-risk sexual partner.

The 2008 NDHS obtained information on common misconceptions about HIV transmission. The majority of the respondents (64% of women and 62% of men) live in rural areas. The majority of respondents have had some education; however, 36% of women and 19% of men have never attended school. About 45% of all respondents are Muslim; 54% of respondents are Christian (12% Catholic); and one percent of respondents are Traditionalist. The ethnic composition of the sample indicates that Hausa (22%), Yoruba (18%), and Igbo (16%) are the major ethnic groups in Nigeria. Other ethnic groups constitute about 44% of the total sample, (underscoring the multiplicity of ethnic groups in Nigeria).

Sixty-six percent of women and 78% of men agree that a healthy-looking person can have HIV. With respect to misconceptions about methods of HIV transmission, 56% of women and 61% of men believe HIV cannot be transmitted by mosquitoes. Fifty-three percent of women and 66% of men believe HIV cannot be transmitted by supernatural

means. Sixty four percent of women and 74 % of men believe a person cannot contract HIV by sharing food with a person who has AIDS. Only 35% of women and 45% of men know that the two most common misconceptions about HIV and AIDS (i.e., HIV can be transmitted by mosquito bites and by supernatural means) are incorrect, and they are also aware that a healthy-looking person can have HIV.

On perceptions and beliefs about abstinence and faithfulness, a lower proportion of men (89%) believe that married men should only have sex with their wives, while a higher proportion of men (94%) think that married women should only have sex with their husbands. However, only 28% of women and 36% of men think that most married men they know only have sex with their wives. Less than half of the women (44%) and men (46%) think that married women only have sex with their husbands.

Knowing one's HIV status is important for helping individuals make specific decisions about adopting safer sex practices to reduce the risk of contracting or transmitting HIV. For those who are HIV positive, knowledge of their HIV status allows them to take actions to protect their sexual partners and to access treatment services for themselves. Nigerian 2008 NDHS shows that overall, 49% of women and 65% of men know a place where they can get an HIV test. The majority of women (83%) and men (85%) have never been tested for HIV. Seventeen percent of women and 15% of men were tested for HIV at some time prior to the survey. However, among women and men who were tested for HIV in the past 12 months, only 7 percent of women and 7 percent of men received their test results.

2.5 National response to the HIV/AIDS epidemic

The first case of AIDS in Nigeria was identified in 1985 and reported at an International AIDS Conference in 1986. Nigeria had gone through various stages over the years in the control of HIV epidemic. Stages include the period of denial of the existence of HIV, followed by accepting the existence of HIV infection and employing effective measures to reduce new infections in the country. This effort has over time recorded a progressive reduction in HIV prevalence. HIV prevalence was 1.8% in 1991, 3.8% in 1993, 4.5% in 1996, 5.4% in 1999 and 5.8% in 2001. Thereafter, a decline was noticed as

the prevalence dropped through 5.0% in 2003 to 4.4% in 2005 and now stabilized between 4.6% and 4.1% (in 2008 and 2010).

The National Strategic Framework (2005–2009) was created and used by all states to develop State Strategic Plans, which address their specific needs. Nigeria developed a plan for scaling up for Universal Access to HIV prevention, treatment, care and support in February 2006 (USAID, 2009). The goal of the National Strategic Framework (NSF) is to reduce HIV incidence and prevalence by at least 25%, and provide equitable prevention, care, treatment, and support while mitigating its impact among women, children and other vulnerable groups and the general population by 2009.

The NSF objectives have served as a guide towards strategic plan and action till date. The NSF has been reviewed and a new six year National Strategic Framework for the period 2010-2015 has been developed to further strengthen the national response (NACA, 2010).

HIV/AIDS is an epidemic within epidemics, managed with varying degrees of commitment by different countries depending on other priorities and political appointments (Hasnain, 2005). The HIV epidemic in Nigeria is characterized by one of the most rapidly increasing rates of new HIV/AIDS cases in West Africa. This infection rate, although lower than that of neighboring African countries, should be considered in the context of Nigeria's relatively large population. It was estimated that 3.11 million Nigerian adults and children will be living with HIV/AIDS by the end of 2010 from the HIV estimates and projection model (NACA, 2010). NACA (2010) has therefore identified a number of challenges in Nigeria's HIV response efforts that the nation needs to work hard to overcome; and they are:

a. Inadequate funding and coordination of HIV prevention, treatment, care and support which is not commensurate with the scale and complexity of HIV epidemic in Nigeria
b. Over-dependence on donor support
c. Weak political and financial commitment at state and LGA levels
d. Lack of National HIV/AIDS Research Agenda and poor coordination of research efforts

e. Coverage and quality of PMTCT in Nigeria is poor (UNGASS indicator 25: percentage of infants born to HIV-infected mothers who are infected in 2009 was 13.1%)
f. Limited knowledge of the drivers of the epidemic.
g. Low risk perception among policymakers and general population.
h. Inadequate supportive legislation for national and state level HIV/AIDS response
i. Institutionalization of AIDS Spending Assessment for data on evidence based funding, resources, needs, gaps and sustainability.
j. Inadequate implementation of National M&E system and limited data use.
k. Focus has been mainly on intervention monitoring rather than impact evaluation.
l. Inadequate human capacity to effectively implement national response.
m. Poverty and gender inequality have continued to drive the epidemic.

Other challenges that are being tackled include:

- The Nigerian national response is still largely donor driven.
- Political commitment is not strong enough at the state and local government levels.
- There is still much stigmatization and discrimination against people living with HIV/AIDS.
- Inadequate community directed interventions (NACA, 2010).

2.5.2 Policy and programmatic response

The government of Nigeria, through the HIV/AIDS governing body, NACA, has formulated policies that affect every area of the nation's multi-sectoral response to HIV/AIDS. The first policy statement was developed in 1997 by the Federal Ministry of Health. This was at the advent of the epidemic. This policy statement was later revised in 2003 by the National Agency for the Control of AIDS in collaboration with other stakeholders with the sole aim of mitigating the impact of the HIV/AIDS. The policy focused on five thematic areas:

- Prevention of HIV/AIDS
- Law and ethics

- Care and support
- Communication
- Program management and support

In a bid to strengthen the national response and to incorporate emerging issues, a 2009 revised policy was developed. Some of the issues that the revised policy hopes to critically address are the following:

- The rising HIV prevalence among women
- The expansion in number of orphans and vulnerable children
- The stigmatization of people living with HIV/AIDS and violation of their rights as well as their roles and responsibilities.
- The differences in communication messages on abstinence, condom use etc in secondary schools and higher institutions of learning.
- The issues associated with increased access to treatment and care.

The following are some of the key considerations which inform the articulation of the policy:

- HIV/AIDS epidemic in Nigeria threatens the well-being of many Nigerians, burdens families, impoverishes communities, weakens institutions and threatens the social and economic development of the country.
- As a public health issue, HIV/AIDS directly affects the health of millions of infected persons, contributes to maternal and under-five mortality rates and places unprecedented stress on already overburdened health care system.
- Significant sections of the population are most at risk of infection due to social, cultural, and economic conditions which create and sustain vulnerability to HIV infection. The most vulnerable are women and girls, young people, the physically challenged people and migrant populations.
- HIV/AIDS-related stigma remains all pervasive and that people infected or affected by HIV/AIDS are discriminated against and denied access to compassion, care and support and social services.
- Culture, traditions and religion have strong influence on behavior, attitudes and practices of majority of Nigerians and traditional and faith based institutions as

gate keepers of attitudes and behavior are critical assets in the fight against the disease.

- Effective response to HIV/AIDS requires respect for, protection of and fulfillment of all human rights- civil, political, economic, social, and cultural - and upholding the fundamental freedoms of all people in accordance with the country's constitution and existing international human rights principles, norms and standards (National Policy on HIV/AIDS, 2009).

These issues have been incorporated into the new revised policy. The aim of the national policy is to provide a framework for advancing the multi-sectoral response to HIV/AIDS in Nigeria. The main target of the policy document is to have 'halted, by 2015 and to begin to reverse the spread of the HIV/AIDS virus among Nigerians'.

The National Strategic Framework (NSF) was developed from this policy statement. The NSF has been in operation since 2005 till the end of 2009 as a skeletal structure on which HIV plans and activities are hinged on. The 2005 – 2009 NSF has been reviewed and a new NSF II 2010 – 2015 is in place. The thematic areas in the revised policy are as follows:

- Prevention of new infections and behavior change
- Treatment of HIV/AIDS and related health problems
- Care and support for people living with and affected by AIDS
- Institutional architecture and resourcing
- Advocacy, legal issues and human rights
- Monitoring and evaluation
- Research and knowledge management

2.5.3 Policy implementation: Roles and Responsibilities

The national situation of persistent high level of HIV-risky behaviour in the face of high level of HIV awareness calls for continuous and concerted focus on effective preventive interventions that will address the specific needs of each key population segments and stimulate the adoption of appropriate behaviour that reduces the risk of HIV transmission (National HIV Policy Document, 2009).

The policy undertakes to define and streamline the roles, responsibilities of and relationships among key state and non-state actors in the national response to reduce duplication and strengthen coordination for effective service delivery, among others.
The Civil Society:

Faith-Based Organizations

Faith-Based Organizations shall:

- Integrate messages and information about abstinence, prevention, care and support into activities and promote family and moral values.
- Advocate for care and support of PLWHA, OVC and vulnerable groups including children and widows and promote stigma and discrimination reduction.
- Advocate rights of women and eliminate harmful practices against women

Traditional and Religious Leaders

As custodians of culture and gatekeepers of behavior in communities, traditions and religion shall:

- Provide leadership to eliminate negative cultural practices which increases the vulnerability of women and girls to STIs and HIV/AIDS.
- Support HIV/AIDS programmes in their community and advocate reduction of stigma and discrimination against infected and affected persons.
- Uphold, promote and mobilize communities to disseminate cherished traditional values such as fidelity, delay of sexual debut and abstinence and support families to inculcate same in children and young people (National Policy on HIV/AIDS, 2009).

The strategic plan development process in Oyo State ensured that the State plan of action was aligned with goal and objectives of the NSF. The goal of the State Strategic Plan (SSP) is the "Reduction of the prevalence and incidence of HIV and AIDS by at least 30% by providing preventive, treatment, care and support services, while mitigating the impact among vulnerable groups and the general population in Oyo State by 2012".

One of the 12 areas of priority identified for HIV and AIDS programming interventions in the State is Behavioural Change Communication (BBC) and Education.

Nine strategies are also identified with 22 focused activities to translate this plan into reality. The strategies were derived from issues relating to advocacy, mobilization, community participation, capacity building and resource mobilization. They include:

- Advocacy to strategic stakeholders and community gatekeepers.
- Promote behavioural change through special events and activities.
- Strengthen the capacity of stakeholders for prevention and stigma reduction.
- Promote access to and sustain demand for information and services through community outreaches (OYSACA, 2008).

2.6 Civil society participation in the National HIV Response

There was a growing realization, in the global struggle against AIDS, of the need for greater networking and collaboration in order to be more effective. Following the commitment by all the nations of the world at the UN General Assembly Special Session on HIV/AIDS in 2001, it was said that 'we need to mobilize an army in order to achieve these goals' (Parry, 2003). Nigeria HIV/AIDS response is multi-sectoral which involves participation of all sectors to limit the spread of HIV by bringing in their competencies and capacities in an effectively coordinated response model. Multi-sectoral response involves civil society organizations (CSOs), network of people living with AIDS (NEPWAN), faith based organizations, line ministries, non-governmental organizations, development partners and the private sector (NACA, 2010).

Civil Society Organizations, Faith Based Organizations (FBOs) and community leaders have valuable roles in preventing new infections and mitigating the impact of HIV in Nigeria. Civil society encompasses such organizations as local and international non-governmental organizations, community-based organizations, community development associations, Faith-Based Organizations, support groups for people living with HIV/AIDS (PLWHAs), professional associations, and trade unions. The emergence of the Civil Society Consultative Group on HIV/AIDS in Nigeria (CISCGHAN) in 2002 provided the first opportunity for local CSOs to provide coherent input to Nigeria's HIV/AIDS policy formulation and implementation (NACA, 2010).

2.6.2 Challenges

The multi-sectoral approach adopted by the Nigerian government in its HIV/AIDS program has provided a conducive environment for CSOs intervention in the sector. Despite the achievements of CSOs in Nigeria, there are a number of challenges militating against their successes. These challenges include:

1. **Limited Institutional Capacity:** Though the CSO capacity for implementing programs is generally good, most of those skills lie within the narrow confines of prevention efforts that focus on sensitization and information, education and communication.
2. **Poor Documentation:** The lack of documentation tends to be a weakness of CSOs in Nigeria. They need to improve in the area of documenting programming lessons, experiences and successes. Skills for documentation are weak with lack of an effective project monitoring system further, as there is limited framework to capture change.
3. **Donor Driven Agenda:** Funding for HIV/AIDS in Nigeria is mainly from international donors. CSOs have no choice but to conform to donor driven agendas which may not necessarily solve immediate community needs.

2.7 Faith-Based Organizations (FBOs)

Religion is a visible thread that runs through many traditional and contemporary societies (Yusuf, 2005). According to UNAIDS (2008) 70 percent of the world's population identify themselves as members of a faith community, putting religion and religious leaders in a privileged position to influence people's behaviour and attitudes (PlusNews/IRINS, 2010). Faith-based Organisations (FBOs) are an integral part of life and society in most parts of Africa. They are to be found within every community and hold much credibility with the people because of their presence at grassroots, 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, 2003).

It is generally accepted that religious entities (REs) have long engaged in health-related activities such as providing educational interventions and caring for individuals

affected by disease. In many locations around the world, such REs have been in the forefront or alone in the struggles to ameliorate suffering and provide support, and have often been doing so with little attention or documentation from public health authorities (Olivier, Cochrane, Schmid and Graham , 2006). A 2007 World Health Organization report found that between 30 and 70 percent of all health-care infrastructures across the African continent are operated by faith - based groups (PlusNews/IRIN, 2010).

2.7.2 The role of FBOs in HIV/AIDS prevention and control programming

The connection between religion and health is well established (Mohammed, 2010). There are several reasons why an approach to the AIDS pandemic that seriously considers the role of religion in general remains a legitimate one. First, religion continues to play a pivotal role in most societies in general and in relation to the HIV pandemic, an estimated forty percent of the care is provided by religious institutions. To engage with the religious tradition and its interlocutors, the clergy and religious institutions is worthwhile. The role of religion becomes particularly accentuated at critical moments in the lives of communities or nations when confronted with events that are, for whatever reasons, regarded as 'yet unfathomable' and people are desperate to make sense of what is happening to them. The 'newness' of AIDS, the extent of its spread and the inability to find a vaccine or a cure for it makes it one such issue. Many of those infected report that the first thought that occurred to them was to run to God and demand to know 'what sin have I committed' (Esack, 2007).

Second, mosques, imams, and other religious affiliated groups or people have been much-trusted sources of not only spiritual education but, for some, all education. The influence of religious leaders on HIV awareness and prevention is crucial as Muslim communities often look to religious seniors for assistance and advice. Their status as community leaders, opinion leaders and role models makes them ideal educators for the Muslim community.

Third, AIDS presents Islamic thought with a number of serious challenges regarding a host of issues such as disease as divine retribution or grace, taboos, silence about sin, sex and sexuality. Finally, given the centrality of faith to many of those vulnerable to HIV or those living with it - or dying because of it - it is absolutely essential

to advance conversation among Muslims about the question of Islam and AIDS (Esack 207).

The role of faith leaders and communities is critical in the overall struggle against HIV/AIDS (WHO, 2008; USAID, 2007; Marshall, 2004). Religious leaders are the natural actors to challenge the economic, business and social systems that increase the vulnerability of people. Besides their support to universal access, faith leaders/communities are also responsible for mobilizing governments to play their respective roles in terms of rights, resources, and institutions (Thoraya, 2010). On the community level, religious organizations are influential social networks that have the power to support or stigmatize people living with HIV/AIDS (PLWHA), promote or impede HIV education, and endorse or reject medical treatment of HIV (Yamanaka**,** John**,** Watt**,** Ostermann and Thielman, 2009).

As a deeply religious country, religion plays pertinent roles in the personal, family, and community lives of Nigerians. In Nigeria, there are various umbrella bodies that are able to draw different faith groups together, e.g. the Interfaith HIV/AIDS Council of Nigeria. The National Interfaith Coalition against AIDS was inaugurated in April, 2002. In Oyo State, Interfaith Coalition on HIV/AIDS was officially inaugurated in June 2008.

2.7.3 Faith–Based Organizations in Nigerian National Response.

The Faith Based Organizations are an essential part of the society, highly respected, with much credibility. The inclusion of the religious groups in the fight against HIV/AIDS is necessary to ensure that greater numbers of people are reached with HIV/AIDS information and education. It is important to note that, the infection has made in road into all segments of the population including groups not usually considered to be at risk – the family. The high mortality rate is also associated with an increasing number of orphans (NACA, 2006).

The entire Nigerian populace from all works of life belongs to one religious group or the other and this has made the inclusion of various religious groups in the fight against HIV/AIDS critical. It has been proven that Nigerians are the most religious people in the world. Faith based organizations (FBOs) are an integral part of life and

society found within every community, respected and hold much credibility. Using this platform ensures that a greater percentage of the population will be reached with HIV/AIDS education and messages. The FBOs have the necessary infrastructure with an established grass root network, which makes them a valuable resource, and conduits for providing information, creating awareness, care and support for PLWHAs. The faith community in Nigeria exists in varied groups or denominations with large membership congregating at least once a week to listen attentively to messages from the Quran or the bible, which is taken as the whole truth –

- Firstly, FBOs are rooted in local structures and are therefore in an excellent position to mobilise communities to respond to the HIV and AIDS crisis. In many cases, FBOs and people of faith have been among the first to respond to the basic needs of people affected by the disease, and indeed have pioneered much of the clinical and community-based work.
- Oftentimes, FBOs are contacted after diagnosis with HIV and also when that same person who had died of AIDS is buried. By providing direct care to the sick, by visiting them, praying with them, consoling them with the word of God, being supportive and sympathetic listeners, and understanding their many problems and frustrations, people of faith are the ones' that offer companionship and solidarity to them, and to their families and vital communities.
- The management of people with HIV/AIDS has become a reality. As the number of HIV positive people increases and people become sick with AIDS, it is imperative that FBOs at all levels are able to care and support those infected and affected with compassion and with confidence.
- As the epidemic unfolds, FBOs will be burdened, sometimes perhaps beyond their capacity, as they are required to deal with the epidemic, and in particular the people who are infected and affected by the epidemic.

- FBOs directly impact on social institutions, such as schools, which socialize people and change values over time. In addition, their jurisdiction often includes a number of areas closely connected to HIV and AIDS, such as morality, beliefs about the spiritual bases of disease, and rules of family life and sexual activity.

Due to their strong influence on their members, they are in a unique position to contribute to the campaign against the pandemic in Nigeria (NACA, 2006).

According to Osotimehin (former NACA Director-General), religion played a vital role in the well being of people living with HIV/AIDS and a positive response could be achieved through religious leaders' contributions by virtue of their status, credibility and influence; and that it is imperative for religious leaders to help integrate PLWHA into the community and provide wise counsel on the adoption of "abstinence" as the watch word (NACA, 2006).

The unique qualities of the faith based organization led to the hosting of the first interfaith (National Faith Based Organizations) forum in April 2003 with the aim of deliberating on the issues of HIV/AIDS and agreeing on the way forward. The second interfaith forum was held in June 2005, and lead the resolution to establish the National Faith Based Advisory Committee on AIDS (NFACA). NFACA was thus inaugurated in 2006. The 16-man committee was set up on recommendations from the 2nd forum on National Faith Based Organization held in 2005 to sensitize, create awareness and mobilize the faith community for action – that is, enhance behavioral change which could be achieved by continuous interactions. In addition to the change envisaged, there is need for provision of drugs, social and spiritual supports.

The committee was set up to assist NACA coordinate the faith based organizations (FBOs).

The National Faith Based Advisory Committee on HIV and AIDS (NFACA)

Purpose

The purpose of the Committee is to:

- Act as a formal advisory body bringing together the Islamic and Christian faiths
- Provide an environment that encourages partnership, mutual respect and the sharing of best practice in community engagement.
- Enhance the work of Faith Based Organizations on HIV and AIDS in the faith community at National, State and Local Government level.

Specifically, the Committee will assist the NACA to:

a). Make recommendations for appropriate interventions within the faith community

b). Advise on policy, emerging issues, programmatic issues and challenges as well as agree on priority areas for programming

c). Assist in the development of resource mobilization strategies, and confirm existing or new resources for the implementation of HIV/AIDS activities

d) Create a framework for future development and activities of the faith community.

e) Ensure equitable distribution of programmes and resources for the faith community.

f) Create a framework for monitoring the use of resources at the grass root level

g) Organize biennial Interfaith Fora (NACA, 2006).

2.7.4 Limiting factors to FBOs action

Without a doubt, FBO are in the forefront of care initiatives especially in Southern Africa. Yet, despite years of experience with HIV/AIDS, and a plethora of responses, the overall sense of urgency and level of response, quality and coverage, is in no way commensurate with the size of this growing epidemic. Numerous factors are contributory not the least being those financial constraints and lack of technical assistance. Others include lack of policy, lack of information and training, and lack of networking (Parry, 2003).

Policy

Until very recently, few denominations had actually developed a policy specifically about HIV/AIDS. An official policy denotes commitment, focuses action that is motivating and is empowering to the implementers. In Nigeria, few FBOs with HIV/AIDS policy include NASFAT as well as The Redeemed Christ Church of God (RCCG).

Information and Training

It is not reasonable to assume that religious leaders have all the information, in order to adequately and effectively communicate to their wider audience. These leaders themselves need access to accurate information and training to counteract irrational fears

and discrimination. Examples of Uganda and Senegal clearly demonstrate that even the most conservative cleric can become an agent for change when properly informed and involved. Coupled with this, is a great need for theologically based reflections on HIV/AIDS and liturgical material (Parry, 2003). Among the major challenges discussed and brought out under HIV/AIDS Prevention by Islamic scholars at the 2008 stakeholders meeting in Kaduna are inadequate capacity of the Imams, scholars and traditional rulers to preach HIV/AIDS messages; viewing of HIV/AIDS as a moral issue that should not be discussed in the mosque; and ignorance and misconceptions about the existence of HIV/AIDS.

Their recommendations include that the Development Partners should build capacity of Imams, Islamic scholars and traditional leaders on HIV/AIDS and Islam; scholars should prepare and preach sermons to the Muslim on Islamic family life as well as to increase awareness on the importance of HCT; and use of Imams to mobilize the Muslim families to access PMTCT services (Partners, 2008).

Advocacy

This is too muted given the scale of the problem and the injustices that exist. FBO have a responsibility to be the voice of the voiceless and to hold governments accountable to their constitutions and the conventions to which they are signatories. Not only should FBO join their voices with those advocating for justice and more equitable rights but also for other major issues such as debt relief released for social programming, and conflict resolution (Parry, 2003).

Networking

Of great hope is the way that people of different faiths and seemingly insuperable doctrinal differences respond together. The need for increased coordination and collaboration has never been greater. Some leaders have expressed caution about entering into networks with other agencies which advocate AIDS prevention techniques which may be contrary to the (religious) moral teaching. In primary prevention strategies, FBO should not be required to compromise their doctrines with the secular world. At the same time, the secular partners should not be required to justify their approach from the 'moral

high ground' of FBOs. It should be possible to identify different ethical approaches and explore ways of complementing rather than confronting.

2. 8 Religious communities and subtle stigmatization

HIV-related stigma may well be the greatest obstacle to action against the epidemic, for individuals and communities as well as political, business and religious leaders. An all-out effort against stigma will not only improve the quality of life of people living with HIV and those who are most vulnerable to infection but meet one of the necessary conditions of a full-scale response to the epidemic (Piot and Coll Seck, 2001) .

Fighting HIV/AIDS in religious communities often means fighting ignorance and taboos (Islamic Relief, 2008).While the role of religion is well documented in addressing many health-related issues through primary prevention and preventive health, the position of religious leaders as it relates to HIV prevention is often controversial (Mohammed, 2010). In the era of HIV/AIDS, FBOs have been the recipients of many accusations, including the promotion of stigmatizing and discriminating attitudes based on fear and prejudice; of pronouncing harsh moral judgments 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'' (Parry, 2003).

Faith leaders are often uniquely positioned to open discussion on the more sensitive dimensions of the HIV/AIDS pandemic, and mobilize the community (Marshall, 2004). However, much of the stigma currently attached to HIV is a result of commonly dispensed religious messages (FHI, 2007). In a study on FBO involvement in HIV prevention, it was reported that in all study countries, the engagement of FBOs in communications aimed to decrease risk is the most controversial element of their involvement (Global Health Council, 2005). For instance, ever since the first case was diagnosed in 1984, the disease has challenged social and religious taboos in Saudi Arabia. Imams in mosques spoke of AIDS as the “wrath of God” brought upon people who committed “sexual deviancy” (Fattah, 2006). Also, there is a tendency within churches and FBOs to view HIV/AIDS mainly in a moral context-HIV/AIDS has been used within some religions to promote moral church doctrine. Rather than accepting the

clinical realities of the disease, some churches are using it as a tool for propaganda and conversion, encouraging only personal salvation as a way to cure HIV/AIDS (Kuijper, 2006). Lagarde, Enel, Seck, Gueye-Ndiaye, Piau, Pison, Delaunay, Ndoye and Mboup (2000) had earlier observed that some religious leaders have seized upon the occurrence of AIDS epidemics to put forth their moral recommendations. In reality therefore, there is a schism between those who are promoting physical wellbeing and those advocating the spiritual wellness which is most pronounced in the absence of trust between the secular and the faith based civil society organizations (Thoraya, 2010).

Religious leaders involved in HIV prevention efforts rely on their holy texts - the Qu'ran for Muslims and the Bible for Christians - to get their message across (NewsPlus, 2010). Nevertheless, Clergy, particularly at the parish level, are perceived to lack sufficient information about HIV and vulnerability to effectively shape prevention messages (Global Health Council, 2005). As Thoraya (2010) pointed out, Religious leaders' (RLs') responsibility, which they will not abdicate, includes providing moral ideals and spiritual empowerment as basic imperatives of the faith. However, in the area of HIV, the RLs have to deal with the reality of the context of HIV as well as the economic and social conditions that fuel vulnerabilities.

RLs therefore need to understand how they can best serve with their own power (Thoraya, 2010). As Tiendrebeogo and Buykx (2004) pointed out, facilitating church leaders to look at HIV/AIDS as a spiritual, economic, cultural and gender issue had led to a better understanding of the problem, which goes beyond the moral issues that churches have focused on as the cause of the spread of HIV/AIDS (Tiendrebeogo and Buykx, 2004). By giving RLs the tools to dispense a tolerant and productive message that is, at the same time, in keeping with their religious views; a disseminating process can be started that has great potential to penetrate all layers of society (FHI, 2007). For instance, in 1996, a meeting on AIDS prevention was organized for Christian leaders with support of USAID/AIDSCAP; and every bishop in Senegal attended. A consensus was reached that AIDS prevention was an important national priority. Also in 1998, an average of 150 religious leaders (ministers, imams, deacons, elders) were being trained monthly (on AIDS education and what religious leaders could do to help prevent it) in each of

Uganda's 45 districts per year, resulting in the training of some 6750 religious leaders in HIV/AIDS (Tiendrebeogo and Buykx, 2004).

Within a new development paradigm, the spiritual and the physical aspects of human development can be united. The dialogue to build understanding and cooperation between the two types of institutions (religious and secular) is critical, and should be built on the understanding that they are equal but different, and they complement each other (Thoraya, 2010). The UNAIDS' commissioned review of FBO contribution to HIV-prevention efforts recommended that 'steps be taken to overcome any conflict or antagonism between a faith-based approach and a secular, public health approach". The report presented comparative advantages of FBOs in prevention activities with illustrations of positive examples of FBO participation in Uganda, Senegal, Jamaica and Dominican Republic (Global Health Council, 2005).

Religious Leaders and communities are relevant stake holders in the multi-sectoral HIV response model; that must transfer appropriate and accurate knowledge and messages (about all aspects of HIV infection and AIDS) especially on prevention. JAMRA is a Muslim organization in Senegal who pro-actively approached the country's national AIDS programe in 1989 to discuss prevention strategies. A survey it conducted concluded that religious leaders wanted information about HIV/AIDS. Educational materials were designed to meet their needs, and training sessions for religious leaders and decision makers were widely implemented (Tiendrebeogo & Buykx, 2004).

The tension between public health messages (that are scientifically based and which address safe practices, founded on knowledge, access to treatment, voluntary testing and counselling, and empowerment of people living with HIV) and spiritual messages (of compassion for people living with HIV) requires providing religious leaders with up to date and accurate information about HIV so they can convey the right information to their constituencies (Thoraya, 2010). For these messages to be effective, the correct information about HIV must address different contexts including indigenous churches and traditional institutions, Thoraya emphasized. According to Muturi (2007), capacity building of religious leaders as HIV/AIDS communicators and Behavioural Change facilitators; and a collaborative effort between FBOs, and health organizations would enhance their HIV/AIDS response. Contributing to the debate, Health Policy

Initiative (HPI/USAID) (2007) maintained that in the absence of mechanisms ensuring their involvement, religious leaders lacked access to sufficient or accurate information on HIV/AIDS. Understanding key issues related to the epidemic is an essential element of religious leaders' sustained support of sound HIV/AIDS control measures. This knowledge provides a foundation on which they can build communication and dialogue compatible with the interest of their congregations and their beliefs. It is only training, education and dialogue that can enable them to promote community discussion on reproductive issues like HIV/AIDS (ESD, 2008).

2.9 Faith-Based interventions and responses to HIV/AIDS

Religious institutions were among the first to become active in fighting the spread of HIV/ AIDS, and are often caregivers of the sick, the dying and the orphans. Around the world, individual places of worship within communities – including churches, mosques, synagogues, temples and hospitals with religious affiliations – have taken the initiative to address HIV/AIDS and its impact at the local level.

Workshops and seminars for and by leaders of Buddhist, Christian, Hindu, Muslim and other faith groups, have contributed directly to awareness raising and knowledge of HIV/AIDS among different target groups (UNICEF, 2006). Initiated by a lay Buddhist teacher in 1997, the Sangha Metta ('Compassionate Brethren') project in Thailand trains monks and nuns (about 3000) in AIDS-related concerns, equipping them with participatory management skills and tools to work in their communities in order to prevent HIV infection and provide support for affected families. A crucial part of the training involves promoting positive attitudes among monks and nuns through close contact with people living with HIV. Buddhist doctrine and, in particular, the teachings on suffering and compassion contained in the Four Noble Truths and the Four Sublime States, is used to emphasize the importance of compassion and awareness in responding to people living with HIV.

Project-trained monks teach villagers how to reduce high-risk behaviour, how to gain awareness of HIV, and how to prevent prejudice and discrimination. They conduct home visits and demonstrate care towards people living with HIV, providing Buddhist-based counselling and advice on home-based care. Also, Monks and nuns operate a

medicine bank and collection of alms (including basic household items such as food and toiletries) for distribution to people living with HIV. Furthermore Monks conduct awareness-raising events within their communities, advertising 'HIV-friendly temples' to promote the integration of people living with HIV into communities, and broadcasting presentations by people living with HIV and temple discussions to local communities. The respect given to monks has meant that a gesture as simple as a monk accepting and eating alms from someone with HIV has helped to reduce the fear and stigma associated with the disease. By putting compassion into practice and raising awareness, monks have helped to promote openness and acceptance towards people living with HIV and to dispel myths relating to the transmission of HIV through casual contact.

The Sangha Metta project has assisted in establishing similar programmes in six neighbouring countries: Bhutan, Burma, Cambodia, China, Laos and Viet Nam. In addition, the Sangha Metta training model has also been used successfully with Christian, Hindu and Islamic leaders from Sri Lanka, Nepal, Pakistan and Afghanistan. Similar activities are now being conducted in those countries and an inter-faith network is being established (Aggleton, Wood, Malcolm and Parker, 2005).

Catholic AIDS Action was the first national, faith-based response to the HIV epidemic in Namibia. Established in 1998 (following the granting of approval by the Namibian Catholic Bishops' Conference), Catholic AIDS Action is involved in HIV prevention activities. Workshops were conducted for church leaders-bishops, priests, religious sisters and deacons- around stigma and discrimination. Trained volunteers give talks about AIDS at church meetings, schools and community events. They use these opportunities to encourage communities to be more open about the reality of AIDS, to combat stigma and dispel misinformation about HIV transmission. Although they do not distribute condoms, volunteers provide factual information about condoms and about where they can be obtained. Catholic AIDS Action decided to adopt an approach to HIV prevention that would promote Christian values, while also emphasizing the importance of safeguarding human life through safer sexual behaviour. In an effort to break the silence surrounding AIDS, Catholic AIDS Action has undertaken a series of high-profile events, including conferences on 'Living positively with AIDS', a march and public rally,

and an official disclosure event of a group of HIV-positive people from the organization Lironga Eparu (Aggleton, Wood, Malcolm and Parker, 2005).

The major religious organizations in Uganda – Catholic, Anglican and Muslim – got involved in AIDS prevention with funding from the WHO Global Programme on AIDS channeled through the Ministry of Health (1987), and also from USAID (1992); for the promotion of fidelity and abstinence. Beginning in 1993, Uganda recorded a downward trend in HIV infection rates which continued throughout the nineties. By 2000, Ugandan Ministry of Health and Demographic Health Surveys reported abstinence in the previous year was between 25% and 30%. Most of this reflected youth delaying sexual debut.

The Anglican Church of Uganda also implemented special prevention programmes aimed at youth in Sunday schools and primary schools. Apart from the Anglican CHUSA project, there was also a Catholic-run project. SIDA Service is community-based initiative in Senegal. The Catholic outfit also became involved in prevention as well as counseling and psychosocial support.

West Africa is home to most of the continent's 150 million Muslims, but the Catholic Church and other Christian denominations also hold a great deal of influence in sub-Saharan Africa. In mainly Catholic Burundi, the Church got involved soon after the first case of AIDS in 1988. Muslim leaders followed suit a few years later. In Benin also, the Catholic Church was involved in the fight against AIDS, Goudjo said, but "through its own means and moral principles" (PlusNews, 2010). Pathfinder/Kenya's community-based HIV/AIDS Prevention, care and support Project (COPHIA) worked with a number of FBOs including the Redeemed Gospel Church, Anglican Church of Kenya's Christian community services department and the Integrated AIDS Programme- a Catholic Organization (Burket, 2006).

The 1st International Muslim Leaders Consultation on HIV/AIDS (1st – 4th November 2001) took place at the International Conference Centre – Kampala, Uganda. The theme of the conference was 'Strategies for strengthening and expanding the international Muslim Community response to AIDS'; and the overall goal of the consultation is to achieve greater involvement and better co-ordination of Muslim communities in their HIV/AIDS prevention and control efforts both nationally and

internationally'. One of the five objectives of the consultation was meant to discuss and articulate the Islamic contribution to HIV/AIDS prevention (IMAU, 2001).

Indonesia is home to the largest national population of Muslims in the world. Approximately 85 to 90% of Indonesia's 225.3 million people (210 million Indonesians who described themselves as Muslim in 2004) are Muslims. Indonesia has a concentrated HIV epidemic, primarily among its injecting drug users population. In 2007, adult HIV prevalence for Indonesia is 0.2 [0.1 – 0.3] with estimate of 270 000 [190 000 – 400 000] PLWHA (UNAIDS, 2008). MUI (The Council of Indonesian `Ulama), issued a fatwa about AIDS in November 1995 in Bandung wherein it was simply identified as sin or curse from God. Since then as an organization it has been rather quiet on the pandemic. However, with the support of AusAID, religious leaders have begun to mobilize religious networks in some provinces of Indonesia to educate the community about AIDS prevention. Islamic scholars have held workshops in which the literature of the religion is studied in order to identify principles within the text that support AIDS prevention. The primary message of Muslim clerics who preach HIV & AIDS awareness in mosques, schools, and community halls has been abstinence and fidelity, but condom use is advised in certain circumstances. The Indonesia Mosque Association, also known as the Yayasan Dana Islamic Centre, has played some role in addressing HIV & AIDS; in 1999 it purportedly trained 300 Islamic preachers in South Sulawesi in AIDS awareness.

In order to educate and to prevent the spread of HIV/AIDS and other STDs among young people, the Bangladeshis have successfully experimented with placing awareness programs in mosques—the social and religious center of each community. Since imams (religious leaders) play such an important role in shaping social and religious values, training them to educate people to the dangers of HIV/AIDS is a natural step. With assistance from the Islamic Foundation, the Islamic Medical Mission, and the United Nations Development Programme (UNDP), thousands of religious leaders—including a few female leaders—have been trained to deliver educational and prevention messages designed to combat HIV and other STDs, messages they now deliver on a regular basis. These teachings discourage prostitution and homosexual activity, but in cases of existing STD, and especially HIV, infection they also promote condom use to prevent the spread of infection to wives and even their unborn children. Recent efforts

include expanded training for female religious leaders on how to educate women as well (Kelly and Eberstadt, 2005).

Faith- based organizations (FBOs) are social and cultural entities with potential to influence knowledge, attitude and behaviour for HIV/AIDS prevention (Muturi, 2007). When religious leaders endorse new ideas or behaviour change initiatives, change is seen more quickly than when messages are spread by purely secular means (Burket, 2006). They can use their networks and influence to address the many challenges of AIDS.

The two most significant Islamic organizations in Indonesia are Muhammadiyah and the Nahdatul Ulama (NU). In 2005 Muhammadiyah promoted a 'Book of Sermons on HIV & AIDS Prevention,' which addresses lifestyle responsibilities of individuals and families, how to engage youth, the need for compassion, and reducing discrimination. Training courses are being organized to help local religious leaders use the book and incorporate the messages into sermons. Earlier in 2002 the Federation of Indonesian Muslim Women Organizations (BMOIW) organized a two day seminar to address the increasing number of HIV & AIDS cases in the country. Eighty women preachers, *muballighat*, and one male government official attended the workshop. The group is working to create a network of women and mothers throughout the country to focus on coping with unequal gender relations and the need to protect families and children from HIV & AIDS.

In Tanzania the Zanzibar Children Fund (ZCF) -an FBO- brought together a network of Madrasa teachers, Imams, and other community leaders to speak out on HIV/AIDS issues among the local population, especially the young people. According to Paydos (2006), ZCF ran a series of HIV/AIDS workshops for over four hundred (400) Imams and Madrasa teachers from districts of the Zanzibar Island in 2004. The workshops integrated Qur'an verses and Islamic traditions, including basic information, discussions on stigma reduction, and methods of communicating their messages to the community. As a result of the workshops, the leaders formed a network and established an HIV/AIDS committee in every town. According to Paydos, 'through ijmaa (consensus opinion), all the leaders agreed that facing the challenges of HIV/AIDS is both a responsibility of their faith and a duty to their community'.

The Lambeth, Southwark and Lewisham African Muslim Communities Campaign against HIV in the United Kingdom. It is a partnership between a number of African community based organisations and local mosques with African congregations who were concerned about the impact of HIV and STIs within their communities. Lambeth, Southwark and Lewisham Primary Care Trusts provide public health support and funding for the project. It aims to raise awareness of HIV/STIs and other sexual health issues, to prevent HIV/STI transmission, signpost people to appropriate services and to support members of Muslim communities living with HIV who may face stigma and discrimination. Work of the project includes outreach at mosques and cultural centres, HIV/STI information and education events, youth activities and a support group for HIV positive Muslim people (Sukainah, Yousra and Georgina, 2010).

It has been argued that majority of the Nigeria population are Muslims (Pew Forum, 2010; Esack, 2007; WWC, 2001). In spite of this, anecdotal evidence suggests that Muslim views are not adequately represented in the HIV and AIDS programmes in Nigeria (FMoH, 2005). However, there has been a growing realization for Muslim organizations to intervene in HIV/AIDS prevention, control, care and support (Partners, 2008). The decision of the Nigerian Supreme Council for Islamic Affairs (NSCIA) to develop a policy that will be used for future HIV/AIDS intervention in the Muslim community led to a stakeholders' meeting in collaboration with NACA and other international partners in April, 2008 (Partners, 2008). Participants at the Kaduna stakeholders' meeting came up with tentative vision, mission, goals and objectives of the Islamic HIV/AIDS Policy. The tentative vision was "A healthy Muslim Ummah free from HIV/AIDS". The critical parts of the policy as should be contained in the framework were outlined, with targets and strategies which will all be within the context of Islam. The policy framework was to cover the following thematic areas: Prevention; Treatment, Care and Support; Women and children; Community response; Research and Programme Management.

In Lagos Nigeria, groups of Muslim women belonging to Al' Muminat (The Believing Women) meet to tackle the very secular issue of AIDS, and along with discussing spiritual matters. The Social Advocacy Projects (SAP) arm of Al' Muminat introduced the talks a number of years ago, and now organizes anti-AIDS campaigns

targeted at the Muslim community. The Al Mu'minat women's group has been running AIDS awareness programmes in mosques and schools to combat the high levels of ignorance about the disease. The group also organizes rallies to protest against discrimination of people living with HIV (IRIN/PlusNews, 2011).

Another group Muslim Action Guide Against AIDS, Poverty, Illiteracy and Conflicts (MAGA-APIC) trains Muslim youths to become peer educators and has developed a training manual for Islamic scholars with the theme "Its great to wait" that promotes HIV prevention through abstinence. As a result of its activities and those of other faith-based groups, MAGA's national coordinator, believes that Muslims have become more receptive to HIV/AIDS campaigns. "More people have come for testing and are now living positively with lower levels of stigma and discrimination than before," he noted. However, according to the Coordinator of Muslims Against AIDS (MAIDS) religious objections to the use of condoms and a reluctance to accept anything perceived as conveying "western values" have dogged efforts to win the support of Muslim communities for anti-AIDS campaigns. But following reports that several predominantly Muslim states in the north and south of the country have HIV prevalence rates of between 5 and 6 percent, significantly higher than the national average of 4.1 percent, a growing number of Islamic faith-based organizations are reaching out to Nigeria's Muslims with education about HIV/AIDS.

MAIDS promotes what it calls "Islamic-compliant" HIV prevention methods to improve the chances of acceptance by Muslims. Rather than distributing condoms, for example, they advocate sexual faithfulness among couples and abstinence from sex for unmarried people. The group also promotes the wearing of the hijab (a long scarf covering the hair and outer garments) by Muslim women in the belief it reduces sexual promiscuity.

A Muslim AIDS activist in Nigeria (Ibrahim Umoru) conceded that the work of Islamic faith based groups had resulted in some improvements in the levels of stigma against people living with HIV and AIDS but said that much work remained to be done. He advocated a more proactive approach by Muslim leaders. "Some of the Ulamas [Islamic leaders] indulge in a 'holier than thou' attitude and still encourage the belief that

people get infected due to promiscuity, which is not the case as we all know," he said (IRIN/PlusNews, 2011).

2.9.2 Collaborative responses

Collaborative responses of religious bodies are represented in different forms throughout Africa (Parry, 2003). Some religious leaders have sought to forge links with secular players in the fight against AIDS, in order to use all available means to limit the sometimes alarming spread of the virus in the region without violating the teachings of their faith (PlusNews, 2010).

Ethiopia has formed 'The Organization for Social Service for AIDS in Ethiopia' bringing in religious organizations and HIV/AIDS focused NGOs to support the Ministry of Health. Through it, religious leaders are trained, anti-AIDS clubs are formed, and other services are rendered, all with considerable impact.

In South Africa, Muslims have networks that are replicable models for other countries and regions. In 1996, South African Department of Health invited religious groups to get together to share ideas to curb HIV/AIDS epidemic, leading to the formation and launch of Religious AIDS Programme (RAP). Consequently, three Muslim groups - IMA of South Africa - medical aspects (MAP), Jamiatul Ulema - shariah input and Islamic Careline - awareness, counselling, care –giving - launched Muslim AIDS program (MAP) in 1998.

The Islamic Medical Association (IMA) is a network which deals with HIV/AIDS health issues. There is an Islamic Leadership Association, and a network for HIV positive Muslims, with services to support community members in their hour of need (Parry, 2003). Islamic Medical Association (IMA) of South Africa's awareness campaign include pamphlets, booklets and a book containing basic information about HIV and AIDS; Jumuah talks on HIV and AIDS and guidelines for burial (ghusl).

Examples of collaboration between Muslims, State and other faiths in Senegal have become recognized as UNAIDS 'Best Practices." In Senegal, AIDS was first reported in 1986. A National AIDS Programme was established and had strong political support. Religious leaders played a crucial role in the country, where 98% of the population is Muslim. As early as 1989 the Islamic organization JAMRA began talking

about its roles in prevention activities. In 1995, a conference of senior Islamic leaders gave clear support to AIDS- Prevention activities. High- level leadership resulted in destigmatization and openness about the epidemic (Barnett and Whiteside, 2006). Furthermore, a number of Senegalese imams, after preaching fidelity and abstinence, advise their congregations to get additional information. According to Bamar Gueye, whose Muslim NGO, JAMRA, focuses on AIDS and drugs, a doctor is present during HIV/AIDS awareness sessions. "We don't promote condoms but we tell the audience, 'whether you're Christian or Muslim, you have no right to spread the disease, so ask this health specialist what you should do'," he said.

This sharing of responsibilities makes it possible to respect certain limits. "If you bring a carpenter with his hammer and nails to the hospital and tell him to operate on a patient, he won't be able to - it's the same thing with religious leaders. They stop at a certain point and a doctor takes over," Gueye pointed out. The increasing cooperation between religious and secular leaders in the fight against AIDS is widely seen as a positive development. "It's this synergy that has made our prevention campaign a success," said Jamra's Gueye, pointing to Senegal's HIV infection rate, which, at about one percent, is one of Africa's lowest (PlusNews, 2010).

Similarly recognized is the example of the Islamic Medical Association of Uganda (IMAU). Major projects conducted by IMAU in Uganda and major achievements on HIV/AIDS prevention include Family AIDS Education and Prevention through Imams (FAEPTI); Madarasa AIDS Education and Prevention (MAEP project); Sexually Transmitted Infections (STI) Project; Community Reproductive Health Education and Promotion (CRHEP); and Service Expansion and Technical Support (SEATS).

In the FAEPTI project (which started in 1992 and covered 15 districts in Uganda) IMAU works closely with Muslim communities to combat AIDS using the Islamic approach. This approach includes: 1) Education of communities on the scientific information about AIDS prevention, care and support. 2) Education on Islamic teachings that support AIDS prevention, and the care and support of those infected and affected by AIDS. 3) Use of the Islamic administrative structure from the Mufti at the top to the Imams (Mosque leaders) at the grass roots to deliver AIDS related education and services.

IMAU introduced the Family AIDS Education Through Imams (FAEPTI) project to the Rayaat community in 1995. IMAU equipped the Imams and Voluntary AIDS Workers (VAWs) with scientific knowledge on HIV/AIDS, basic counseling and communication skills.

The activities in delivering AIDS-related services, spearheaded by the Imam in Rayaat Mosque include the following:

1. The Imam spends some time during his sermons (Khutba) to educate the congregation members about HIV/AIDS prevention and care and support of those affected. He uses Islamic religious values to encourage community members to change their behaviour to that supportive of AIDS prevention and control.
2. The Imam and Voluntary AIDS Workers (VAWs) visit homes and families to educate them on HIV/AIDS prevention and control. The Imam and his team use a participatory education approach where relevant questions related to HIV/AIDS issues are asked to family members who then give their responses. In this way the Imam and the communities get a deeper understanding of the issues and how they can be addressed locally.
3. The Imam and VAWs visit sick people regularly including those suffering from AIDS. This helps to raise hope to those affected. They support the families to seek medical care whenever there are serious problems.
4. Orphan care is one of the major activities at Rayaat. Orphans are catered for in terms of education and limited financial support is given to them to cater for their needs.
5. Rayaat mosque collaborates with a nearby health centre to assist in dealing with health problems of the community including treatment of AIDS patients referred by the Imams and VAWs.
6. Rayaat mosque is involved in activities to generate income to assist in running its AIDS related activities. With the support of IMAU and ActionAid Uganda, they acquired sewing machines. These machines are used to train pupils in the school as well as other students outside the school in the techniques of tailoring.

In the MAEP project, the Imams and a selected team of youth assistants were trained to integrate AIDS education and prevention within Madarasa education.

The Muslim Leaders in Uganda code-named this struggle the **Jihad on AIDS.** The Jihad on AIDS is a continuation of the Jihad Nafs (Jihad of the soul). This involves striving to control the soul in order to avoid evil behaviour such as sexual behaviour likely to bring AIDS. The Jihad Nafs was declared by Prophet Muhammad (SAW) over 1400 years ago and now requires energizing (Sheik Mubaje, 2001).

A booklet entitled "AIDS education through Imams: A spiritually motivated community effort in Uganda" and a video entitled "The Long Jihad: A bitter battle against AIDS" were produced in 1999. The IMAU/UNAIDS Video summarizes the Experience of the Muslim community in Uganda in fighting AIDS.

The IMAU strategy was identified by the Joint United Nations Programme on HIV/AIDS (UNAIDS) as one of the examples of "Best Practice" for mobilizing Muslim communities to combat AIDS. The five components of the Best Practice Strategy for mobilizing Muslim communities to fight AIDS in Uganda are:

1. Using the Qur'an and Hadith to support AIDS prevention and control efforts.
2. Using the Imams and mosques to spearhead AIDS prevention and control efforts at the grassroots level.
3. Providing training, technical assistance and logistical support to the Imams and Voluntary AIDS Workers to assist them in their work.
4. Accountability to the communities: Gaining trust of the communities by discussing and identifying their needs, addressing the needs, being accountable to the communities and fulfilling promises i.e seriousness in conducting business.
5. Working with other partners and allies to mobilize human, financial and technical resources for AIDS prevention and control activities (IMAU, 2001).

Pathfinder/Ethiopia helped establish the Development Arm of the Ethiopian Islamic Affairs Supreme Council, encouraging the leadership to engage in the fight against HIV/AIDS. The Ethiopian Muslim Development Agency now has a National Directorate and zonal councils that carry out education and sensitization of community groups on ways to prevent HIV infection. Both organizations receive funding from the

President's Emergency Plan for AIDS Relief in Africa to continue these activities (Pathfinder International, 2006).

Malawi is one of the most severely AIDS-hit countries in the sub-Saharan Africa. It was reported that Muslim organizations in Malawi are joining hands in attending for the needs of AIDS victims in the Southern African country, especially during Ramadan, while scholars are sensitizing the public on the dangers of stigmatizing or discriminating against the infected and affected persons. Considering the grave consequences that may result due to laxity by the Muslim community in taking action against the pandemic, most organizations declared jihad against the pandemic.

A local NGO in Mauritania, the Association for Integrated and Diversified Development (ADID) attempted to get religious leaders involved in HIV prevention efforts. According to Abdulaye Ba "We started from the premise that human life is sacred, and protecting it is of fundamental importance". "The religious leaders came on board when they realized that AIDS could be contracted in hospital, and that the head of state, imams, and educated people could all catch it. Before, they had only connected it with sex." In the space of 18 months ADID trained 75 of the 115 imams in the main northeastern port city Nouadhibou (PlusNews, 2010).

Several Muslim organizations have initiated family HIV/AIDS education through local imams and Madrassah (religious schools) teachers in both the rural and urban areas. Muslim institutions such as the Bilal Trust's Madina Social Services in southern Malawi and Social Islamic Development in central and northern Malawi have established clinics and mobile clinics to help people, including the HIV-positive, access medicine free of charge. The Muslim umbrella body, Muslim Association of Malawi, has also been obtaining grants from the government through the National AIDS Commission (NAC) to facilitate outreach awareness programs among Muslims across the country. According to its Publicity Secretary, Sheikh Muhammad Uthman, they have mounted a campaign aimed at sensitizing the general public on the dangers of discriminating against the infected and affected persons and the need to feed them.

2.10 Conceptual framework

The PRECEDE Model as well as Theory of Reasoned Action/Planned Behaviour (TRA/PB) were used to explain the factors at play in the behaviour relating to the involvement/participation of Islamic leaders in education activities on the prevention and control of HIV/AIDS.

2.10.2 The PRECEDE Model

This model is a planning model that offers a framework for identifying (a mix of) intervention strategies to address factors (that are) linked to the desired outcomes and for achieving objectives. According to this model, health behaviour ([none] preaching about HIV/AIDS education in mosques) is influenced by both individual and environmental forces; hence it has two distinct parts: an "educational diagnosis" and "ecological diagnosis".

The diagnostic steps (Figure 2.3) of the model address both educational and environmental issues. These steps are

1. Social assessment/diagnosis
2. Epidemiological Assessment/diagnosis.
3. Behavioural and environmental assessment/diagnosis.
4. Educational and ecological assessment/diagnosis.
5. Planning or Administrative and Policy assessment/diagnosis.

Green's PRECEDE Model of behaviour change may be linked with the non-teaching about HIV/AIDS prevention and control in mosques.

From epidemiological and social assessments of HIV/AIDS pandemic, it is a global problem of staggering dimensions. Termed as the first disease of globalization, it has no national and socioeconomic boundaries. It has been reported in every continent and every country; and continues to expand due to ineffective approaches of or failure to tackle societal factors that affect HIV risk and vulnerability in most countries.

There is no effective/total cure or preventive vaccine against it to date. In terms of sexual health and well-being, everybody is at risk. Preventing transmission remains the mainstay of the AIDS response and human behaviour is critical and important .The epidemic is generalized in Nigeria. Wider delivery of effective behaviour change

strategies is central to reversing the HIV epidemic. This aspect of the model was captured by questions 15 and 21 of the instrument.

Behavioural diagnosis involves the systematic identification of health practice(s)/behavior (in this case non-teaching of AIDS Education to Muslim congregations) that appear to be causally linked to the health problem(s) (continual expansion of HIV infection/transmission especially through heterosexual and inter sectoral sex relationships) identified in the epidemiological diagnosis. Behavioural assessment helps to identify factors, both internal and external to the individuals (i.e. the religious leaders), that affect teaching about HIV/AIDS to their congregations. From reviewed literature, some of the factors include looking at HIV/AIDS as a moral issue (i.e. caused by sins related to sex); considering open discussion of sex as a taboo and ungodly/unreligious; looking at HIV/AIDS secular campaigns/programmes as undermining religion teachings and values on sexuality (i.e. promote promiscuity); over involvement in religious rituals and worships at the expense of health and HIV/AIDS education; and that Muslims are also among those that engage in sexual practices and risky behaviours prohibited by Islamic religion ,and which ironically help in promoting the transmission of the HIV/AIDS diseases. This aspect was reflected in the study instrument by questions 19, 20, 25, 26, and 52.

Educational diagnosis is the determination of the factors influencing the behaviour that have been implicated to cause the health problem (non teaching of HIV/AIDS education in the context of religion). This step identifies preceding and reinforcing factors that must be in place to initiate and sustain the desired behaviour (teaching of HIV/AIDS to the congregations). According to Green, the behaviour of an individual can be influenced by several factors which can be grouped into three; viz

1. Predisposing Factors: knowledge, attitude, belief, values and perception. These variables directly influence or motivate behaviours, and provide the motivation or rationale for action. Questions 16, 17 and18 were meant to capture this part of the model.
2. Enabling Factors: which facilitate the realization or achievement of the motivation. They are the resources and skills, as captured by questions 29 and 45.

3. Reinforcing Factors: which promote the continuity or perpetuation of the behaviour. These refer to influence of peer groups, family members and models that determine whether health actions are supported or not. Questions 14 and 37 attempted to reflect this portion of the model.

In light of the above, the Islamic religious leaders' awareness of HIV/AIDS and the importance of HIV/AIDS health education activities to their congregations (predisposing factors) are important. Skills and resources (enabling factors) such as availability of teaching aids, finance and sustenance of interest of the mosque/organization members on HIV/AIDS education may have a direct influence on the religious leaders. These enabling factors are necessary for the performance of the designed act. If the enabling factors are not available, positive change in behaviour may not occur. These factors are also modified by the leaders' educational level, and their group denominations.

The influential role of the religious leaders on each other with regards to how to defend criticisms for talking about issues like sexuality and condom use in the mosques may help to allay anxiety of some of the leaders. Also encouragement from mission boards network and league of Imams and Alfas (Ullamahs) will give/create the needed conducive environment to address HIV/AIDS and related Reproductive and sexual issues by Islamic religious leaders. In boosting this further is the engagement of (Muslim) Health professionals who are working with HIV/AIDS patients. They can provide data and share experiences as evidence about HIV/AIDS situation in the society. Provision/supply of information materials on HIV/AIDS will further enhance the commencement and, or sustenance of the campaign against the disease.

Administrative/Planning diagnosis involves the identification of policies and regulations, resources and circumstances that may help or hinder performance of behaviour (or programme implementation) - here, teaching of AIDS Education to Muslim congregations. Questions 39, 40, 41, 42, 43 and 44 reflected this portion of the instrument. An educational diagnosis is needed to design a health education/promotion intervention. Information thus gathered from the previous diagnostic steps will then determine intervention strategies for successful education intervention.

Strategies to achieve the desired health enhancing behaviour (HIV/AIDS Prevention education) will include the followings- communication and information strategies; Social support strategies and Developmental strategies.

- Communication and information strategies: These will include use of appropriate mass and interpersonal approaches such as workshops, lectures, symposia and debates; peer communication to promote awareness in meetings and fora; through socio-religious activities (e.g. wedding/nikkah and naming ceremonies) as well as sermons. The questions on the instrument related to this were questions 47 and 48.
- Social support strategies: such as training of Imams and Alfas on HIV/AIDS Prevention Education; setting up of Health and HIV/AIDS committees in mosques ; (design and conduct of) regular HIV/AIDS Programmes in mosques; resource linking; interpersonal and family counselling; use of peer educators; skills training; support groups. The question related to this was question 28.
- Developmental strategies: Institutional capacity building for health action (i.e. community organization); build alliance and collaboration with health agencies, Faith Based Organizations and religious leaders; (funding and production of) religious sensitive Behaviour and Communication Change (BCC) materials; Muslim opinion leaders support; advocacy for policy formulation/implementation (through the League of Imams and Alfas, and other Islamic umbrella bodies); use of peer educators. Related question to this was question 49.

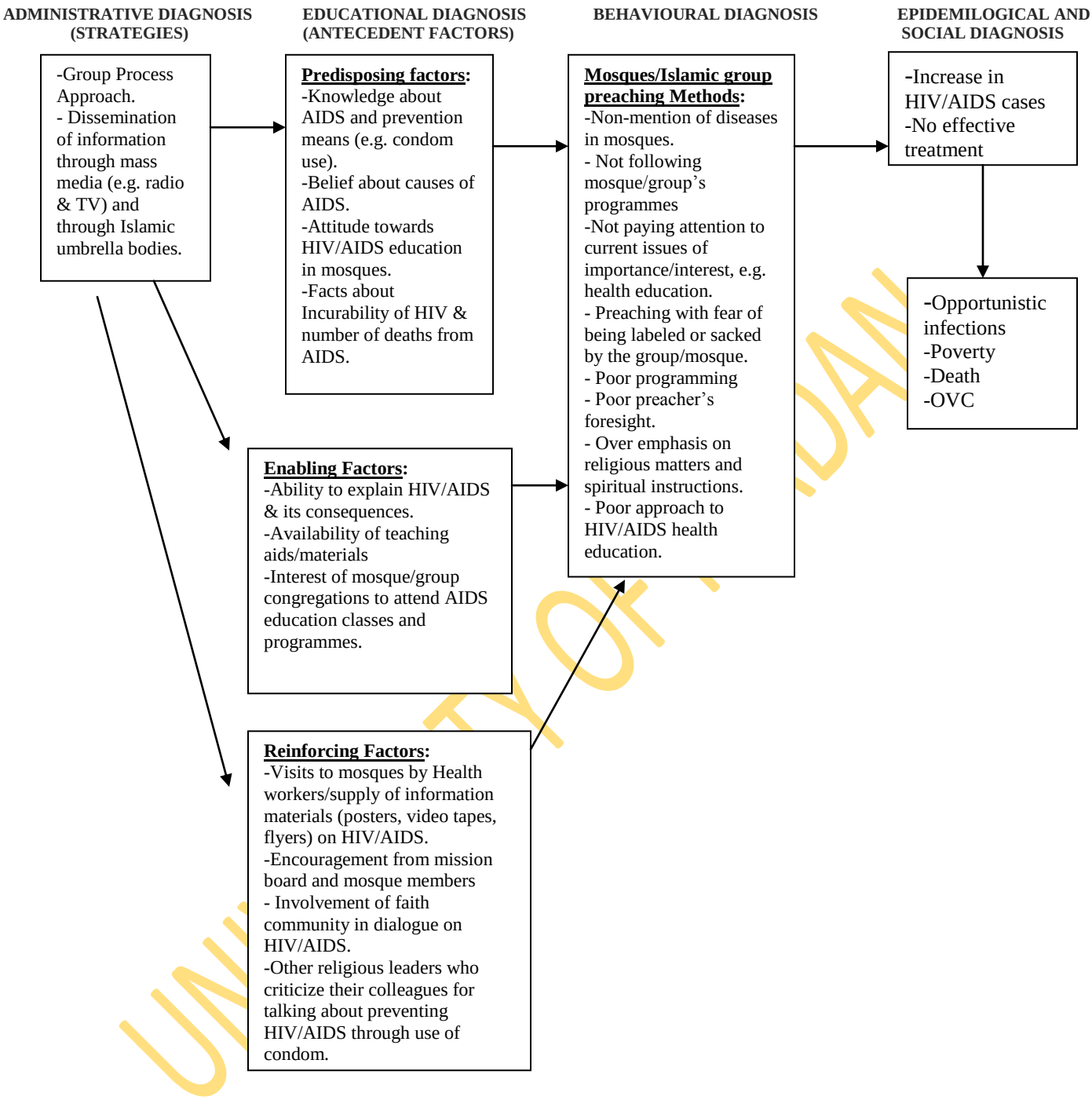

FIGURE 2. 3: APPLICATION OF PRECEDE MODEL (BEHAVIOURAL ANTECEDENT) TO HIV/AIDS PREVENTION EDUCATION

2.10.3 Theory of Reasoned Action/ Planned Behaviour (TRA/TPB)

Theory of reasoned Action/Planned Behaviour (Figure 2.4) explores the relationship between behaviour and beliefs, attitudes and intentions. According to this model, people are reasonable beings who systematically process and use all information available to them when they plan their behaviour. People in most cases, will tend to perform a behaviour when they evaluate it positively and when they believe (significantly) that others think they should perform the behaviour. To change people's behaviour, it is therefore necessary to understand and change the cognitive structures that govern specific behaviour.

(Formulating) behavioral intention is the most important determinant of behaviour and the final step in the cognitive process before actual behaviour/action takes place. Behavioural intention is influenced by attitude(s) towards (performing) a behaviour- in this case educating congregation members on HIV/AIDS -; and the perception of social norms favourable to the behaviour (subjective norm). These attitudes are in turn shaped/influenced by beliefs concerning what is entailed in performing the behaviour and the efficacy of the action in achieving expected outcomes (adherence to, and practice of religious teachings/principles about sexuality that will lead to right changes in mindsets as well as behaviour and attitude needed in preventing the spread of the HIV/AIDS epidemic) and by attitudes towards those outcomes. Perception of social norms is influenced by beliefs about the strength of others' opinions on the behaviour and by the person's own motivation to comply with the opinions of those significant others/referents.

One important additional construct is perceived behavioural control. It has to do with people's (i.e. Islamic leaders) beliefs that they are confident enough to control/take charge of performance of a particular behaviuor-HIV/AIDS education to stop the spread of the epidemic. Azjen and Driver (1991) argued that people might try harder to perform a behaviuor –educating congregations on HIV/AIDS - if they feel they have a high degree of control over it. The presence or lack of things (such as knowledge s of [causes, mode of transmission and prevention of] HIV/AIDS, the strategic training programmes, financial enpowement, access to information, etc.) that will make it easier or harder to perform the behaviour affect perceived behaviuoral control.

Attitude: (towards HIV/AIDS education) is the personal evaluation of the behaviour; i.e. educating religious adherents on Islamic teachings / model on (respect for) sexual health and rights for the prevention of HIV/AIDS spread and management.

When an Islamic leader truly believes that teaching and encouraging practice of chastity and abstinence will prevent adultery/fornication and other vices that contribute to HIV/AIDS spread and transmission, his personal evaluation of giving such education will be high. He therefore will have positive attitude (and greater probability) towards giving HIV/AIDS education. If, however, his/her belief is that his congregation members do not commit fornication/adultery; that HIV/AIDS is punishment for sexual sins, and discussing it or sexuality is wrong, sinful and ungodly, then the value of his evaluation of AIDS education will be low. Hence, he will have negative attitude (and less probability) towards giving HIV/AIDS education. Such leaders will rely on encouragement from other colleagues. This may explain why AIDS education in mosques can be low. Questions 19, 22, 27 and 32 of the instrument were meant to capture this portion of the model.

Behavioural Intention: Perceived likelihood of Islamic leaders to perform a behaviour (giving HIV/AIDS education). It is influenced by the combined effect the attitudes of these leaders, subjective norms regarding HIV/AIDS and their perceived behavioural control.

Intentions are indications of how hard people are willing to try, or how much effort they are planning to put into performing a behaviour. Generally, the stronger the intention or the commitment to do something, the greater the probability that it will be done.

When an individual (a religious leader) has a very high personal evaluation of (hence a positive attitude to) the need for a behaviour (giving AIDS education to congregations) that is stronger than the desire to please or comply with (opinions of) key referents (e.g. other religious leaders, mission board and congregation members), such a leader is better placed to perform the behaviour- giving AIDS education. Furthermore, intention to perform a behaviour also depends on subjective norms of the individual. When the perceived control over the behaviour is positive, then the leader will be sure to perform the behaviour.

When a religious leader, however, has a low personal evaluation of (hence a negative attitude to) the need for HIV/AIDS education his desire to comply with opinions of key referents will have a negative impact on his intention to teach HIV/AIDS education. He therefore is likely not to perform the behaviour.

Subjective norms: Beliefs of these Islamic leaders about the strength of others' opinions, i.e. whether key people (e.g. other religious leaders, mission boards and/congregation) will approve/ disapprove of carrying out HIV/AIDS activities within the mosque/group; and the motivation to comply with their opinions and behave to gain their approval.

If HIV/AIDS education is not acceptable to congregation members and bodies of Islamic religious leaders, and if it is important to impress/please them, it will be difficult for the religious leaders to go against their opinions and teach AIDS education. It is therefore important to establish whether this behaviour (teaching HIV/AIDS education) is under attitudinal or normative control for the religious leaders. Question 30 of the instrument reflected this part of the model.

Perceived behavioural control/ Self-efficacy: Beliefs of Islamic leaders that it is incumbent and divinely mandatory on a leader to shepherd his congregation to the right way and godly conduct (i.e. adherence to religious principles on sexuality). Teaching/preaching to and encouraging the congregation will save them from perdition and self inflicted sufferings, calamities and destruction; that will lead to social dislocations in family and communal/societal lives.

To have intention to change/engage in behaviour is not enough; people should also believe that they have the ability to perform the desired behaviour (giving AIDS education) successfully. It is the ease or difficulty of performing a specific task/behaviour. People with high self-efficacy (or a high perception) are better motivated to master new situations and behaviour, and more persistent in their attempts to reach specific goals than those with low self-efficacy.

Low self-efficacy has been identified as an obstacle to change/performance of behaviour; and has been found to correlate positively with an unwillingness to change/perform behaviour. Hence, people's self-efficacy should be increased/reinforced by making sure that they possess the required skills-communication, negotiation and

problem solving- to carry out the desired actions; and that they know exactly how to apply the newly acquired behaviour (Van Dyk, 2005). Questions that were meant to capture this aspect of the model were questions 24, 33, 35, 50 and 51.

The chances that a person will perform a or change her/his behaviour (teach HIV/AIDS education) are much better if that individual

- forms a strong intention to give AIDS education to her/his congregation members;
- demonstrates a favourable attitude, i.e. towards AIDS Education;
- has positive subjective norms; and
- also has high level of self-efficacy and a perception that she/he can control that behaviour (Van Dyk, 2005).

With this theory there will be appreciation, understanding and establishment of the Islamic religious leaders' intention, beliefs, attitudes, subjective norms and self-efficacy towards giving AIDS education. This will give the cognitive, emotional and social components that should be included in any programme design for the leaders on teaching AIDS education successfully and effectively as expected of them.

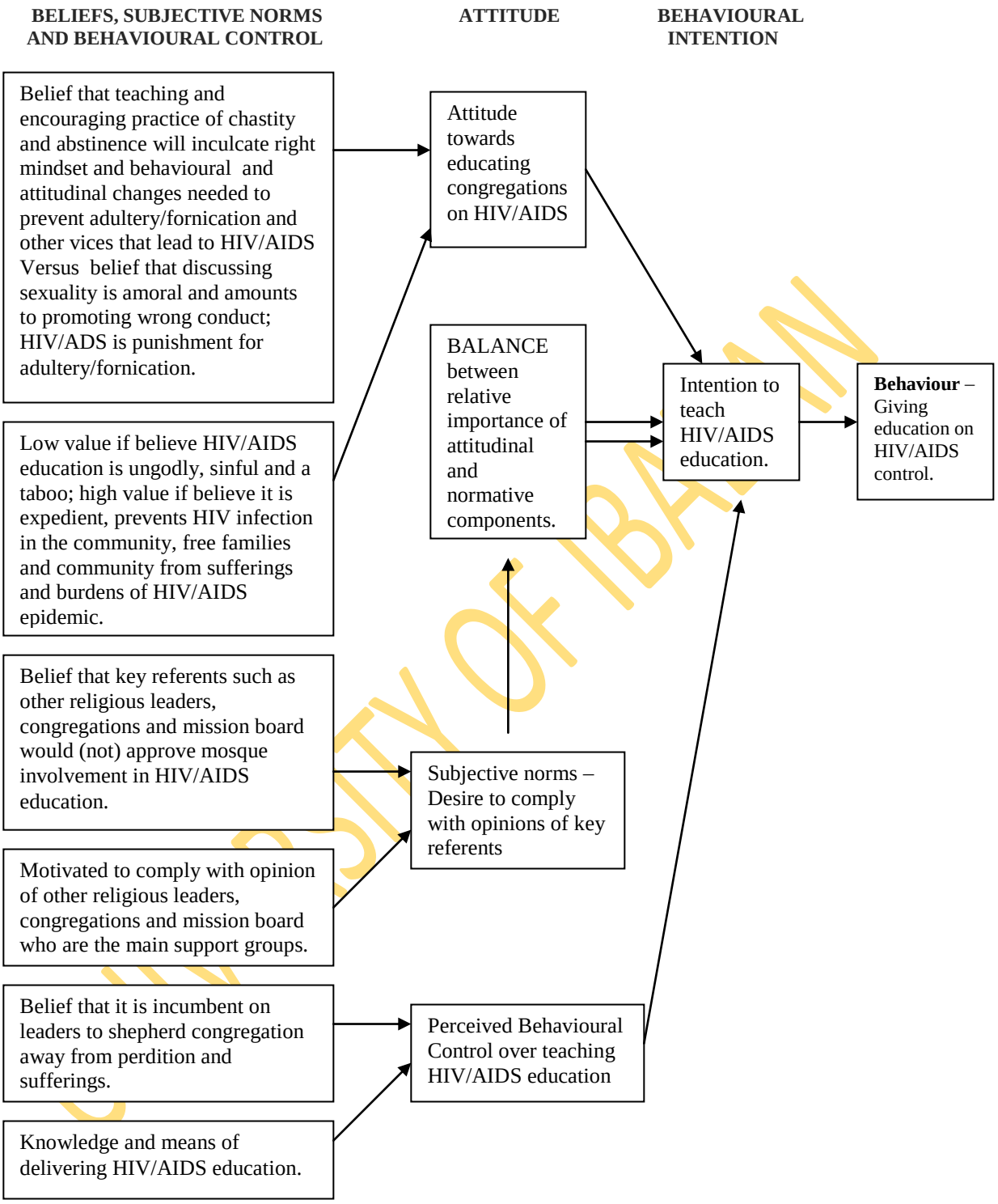

FIGURE 2.4: THEORY OF REASONED ACTION/PLANNED BEHAVIOUR AND TEACHING HIV/AIDS EDUCATION

CHAPTER THREE

METHODOLOGY

Study design

This study was a descriptive cross sectional survey meant to assess and document Islamic leaders' knowledge regarding HIV/AIDS as well as their perception on HIV/AIDS risk-vulnerability, attitude and willingness towards participation in HIV/AIDS control programmes. Also, it documented the HIV/AIDS education activities carried out in the mosques and among Islamic groups in Ibadan North LGA.

Study area

The study was carried out in Ibadan North Local Government Area (LGA). Ibadan is the capital of Oyo State, Nigeria. Ibadan is a large indigenous African city. It is in the South-Western Zone of Nigeria. It lies between latitudes 7 and 9 30' North of the equator and longitudes 2 30; of the prime meridian. The population (based on 2006 national census) was put at 2.6 million. The inhabitants are made up of people from different parts of Nigeria and other parts of the world. The city, located on a major transport route to the northern parts of Nigeria, is the largest of contemporary traditional Yoruba towns. The city carries a network of informal commerce that is translated into scores of open air markets. Presently Ibadan has 11 Local Government Areas (LGAs) namely; Ibadan South West, Ibadan South East, Ibadan North, Ibadan North East, Ibadan North West, Oluyole, Ona-Ara, Egbeda, Akinyele, Ido, and Lagelu.

With the view to make Ibadan describable, the city has been divided into three (3) zones based on historical progression of the residential structure by Bridger and Adeniyi (1978) as follows:

i) The traditional or inner core area.

ii) The transitional area.

iii) The suburban periphery.

The inner core is the oldest part of the city where the early settlers live. It is congested (i.e. slum settlements with high population density) and lacks the modern touch of physical planning and amenities and has low level of socioeconomic activities. It

spreads over places like Beere, Idi-Ose, Oopo Yeosa, Inalende, Oje, Oke Are, Oja-Oba and Orita–Aperin. The peripheral zone is the direct opposite of the inner core. The areas here were formerly farmlands owned by indigenes. The zone is inhabited mostly by the elite and is characterized by well laid out residential apartments, low population density and the availability of essential social services. The zone includes areas like Bodija Housing estates, University of Ibadan, Jericho, Agodi and Iyaganku Government Reservation Areas as well as other emerging well planned areas like Ashi and Akobo Estates. The transitional zone is the intermediate between the inner core and the periphery in the sense that it has the characteristics of both. Population density here is moderate compared to that of the traditional areas in the core zone, although areas here are not well laid out as those found in the peripheral zone. The zone is inhabited by migrants from other Yoruba towns and other Nigerian ethnic groups and those people who moved away from the congested inner core/family compound houses once favoured at the inception of the city to settle in a less congested area. The zone covers areas like Molete, Oke–Ado, Oke–Bola, Mokola, Agbowo, Eleyele, Oke Itunnun, Ijokodo, etc.

Ibadan North Local Government was created on the 27th September, 1991 from the defunct Ibadan Municipal Government (along with others). All the areas and communities that comprise this LGA are a mix of and fit into the characteristics of the three zones of the city. The temporary headquarters of the Local Government is accommodated at Quarter 87 at Government Reserved Area at Agodi where the secretariat is located. Ibadan North LGA comprises of 12 political wards.

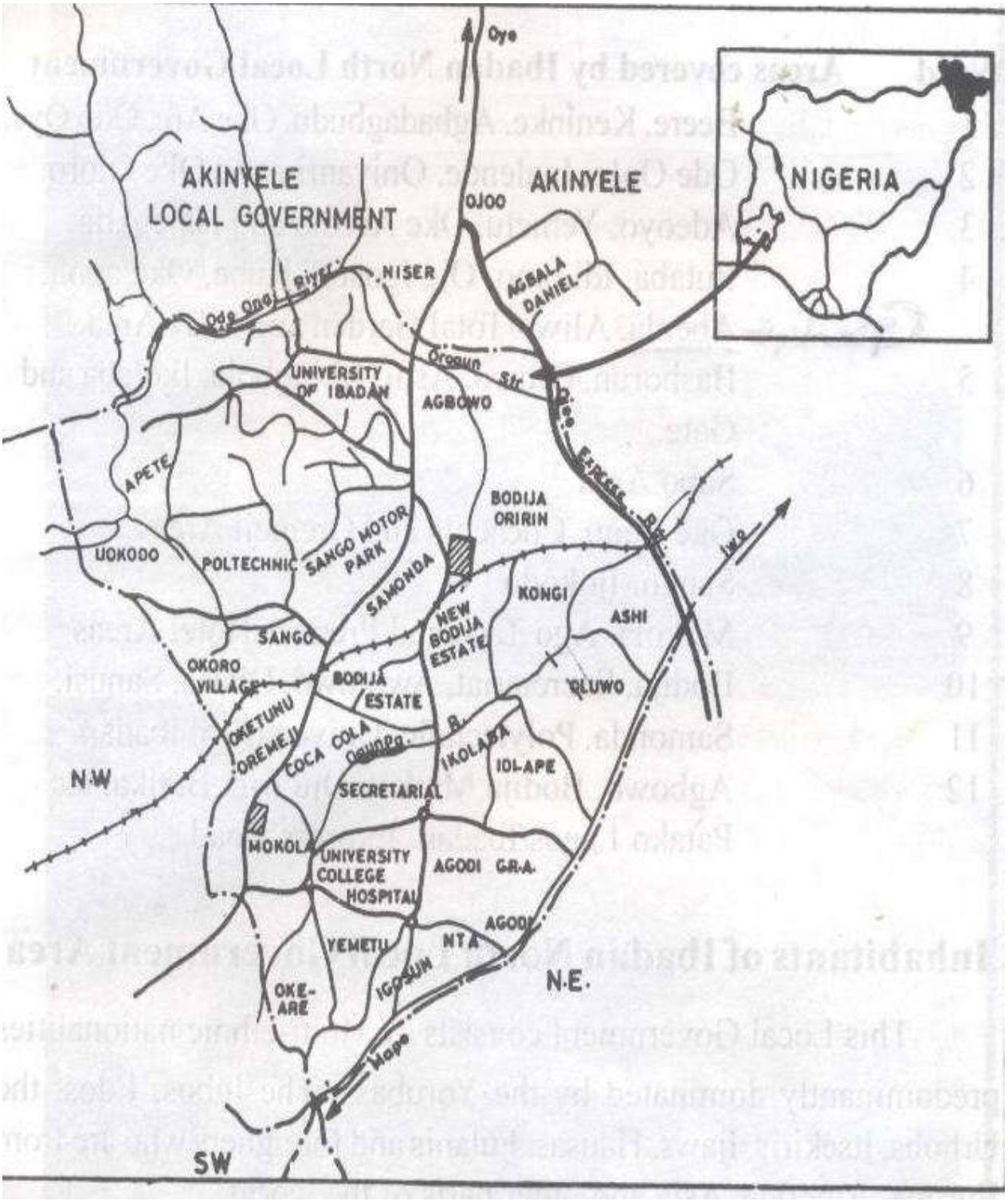

Figure 3.1: Map of Ibadan North Local Government Area

Table 3.1: Wards and areas of Ibadan North Local Government Area

WARDS	Areas/Communities
Ward One	Beere, Keninke, Agbadagbudu, Oke-Are, Odo Oye.
Ward Two	Ode Oolo, Inalende, Oniyanrin and Oke Oloro.
Ward Three	Adeoyo, Yemetu, Oke Aremo and Isale Alfa.
Ward Four	Itutaba, Idi omo, Oje Igosun, Kube, Oke apon, Gbenla, Aliwo/Total-Garden and NTA Area.
Ward Five	Bashorun, Oluwo, Ashi, Akingbola, Ikolaba and Gate.
Ward Six	Sabo area.
Ward Seven	Oke- Itunun, Coca cola and Oremeji Areas.
Ward Eight	Sango, Ijokodo.
Ward Nine	Mokola, Ago Tapa and Premier Hotel Areas.
Ward Ten	Bodija, Secretariat, Awolowo, Obasa, Sanusi.
Ward Eleven	Samonda, Polytechnic, University of Ibadan.
Ward Twelve	Agbowo, Bodija Market, Oju Irin, Barika, Iso Patako, Lagos/Ibadan Express road.

Source: Olusegun (2001): Handbook on Ibadan North Local Government

The Local Government Area has a population of 308,119 people. The Male made up of 152,608 while the Female population was 155,511 people (2006 population Census).The people are of multi- ethnic nationalities predominantly dominated by the Yorubas. The nationalities include the Igbos, Hausas, Fulanis, Edos, the Urhobos, Ijaws, Itsekiris and foreigners from other African countries as well as Europe, America and Asia. Majority are in the Private sector, mainly traders and artisans. A good number are Government workers/civil servants.

Located within the LGA are three government secretariats (namely, the Federal, the State and the Ibadan North LGA secretariats) as well as other government agencies like Immigration, Customs and the Nigerian Television Authority. There are six major markets in the local government - Bodija market; Sango, Mokola, Sabongeri Markets; Gate and Ijokodo/ Gbaremu Markets. Thousands of people patronize these markets on daily basis. People equally travel from outside the city and other states to buy and sell in these markets. Bodija market is reputedly the largest food and commodity market in the state; and attracts market men and women who bring their produce from not only the food-producing areas of the state (such as Oke-Ogun and Ibarapa), but also from the Northern part of the country. This market is also known for timber buying and selling as well as cow and cattle/goat businesses. Other small businesses include brothels, bars and beer parlours. There are motor parks in many areas of the LGA such as Sango, Beere, Oje and Mokola - including lorry/trailer motor parks particularly within the Bodija and Sango markets. A large number of hotels (including high profile ones) exist in many communities across the LGA; such as the Premier hotel, K.S. Motel and University of Ibadan Hotel.

Tertiary educational institutions comprise of the University of Ibadan, the Ibadan Polytechnic as well as University College Hospital (UCH) Schools of Nursing and Environmental Health. Though the schools are residential, accommodation pressure on the campuses had made many students to secure accommodation and live in neighbouring communities (such as Agbowo, Yemetu, Sango, Ijokodo e.t.c). Many primary and secondary schools (both public and private) are located in the LGA. Two big government Hospitals within the LGA (the University College Hospital (UCH) and State Maternity Hospital at Adeoyo) provide medical services. There are also Primary Health Care

Centres at Idi Ogungun, Oke- Are, Barika, Sango, Bodija, Ashi, and Bashorun; as well as many private clinics. They supplement the services of the big government hospitals. There are a number of NGOs as well whose activities and efforts focus on or are health-related. They include Association for Reproductive and Family Health (ARFH) and Society for Family Health (SFH). Oyo state Agency for the Control of AIDS (OYSACA) is also based in the area.

Christianity and Islam are the two predominant religions being practiced by the people in the area; however activities of traditional religionists could still be recognized.

Study population

The study population was the leaders of all the mosques and Islamic groups/FBOs located in the LGA. There are two types of mosques: 1) mosques for everyday prayers only (called Ratibi) and 2) mosques for everyday prayers and/or (Friday) weekly prayer (called Jamiu) – located either within the communities or at workplaces/religious centres. The mosques and Islamic religious groups usually have religious leadership hierarchy. The religious leadership is headed by an appointed Imam (Ratibi), Chief Imam (Jamiu) or Amir/Amirah (FBO) with assistants to help him/her. The religious leaders are in charge of the conduct of all religious activities such as leading prayers, fellowships/companionships, giving sermons and teaching religious education. Their roles extend to include other social obligations such as mobilizing people for various social, cultural, medical/health activities - naming, marriage, house-warming and burial ceremonies as well as sanitation exercise. The Islamic societies/groups that have mosques use them for these programmes and activities; while others that do not have often make use of mosques in the communities for similar purposes.

Inclusion / exclusion criteria

Eligible respondents for the study were leaders in:

(1) Regular mosques with built/physical structure (i.e. not make shifts);

(2) Mosques without accessibility restriction(s) to community members (i.e. mosques not located within the compound of a house);

(3) Mosques with substantive imams (duly appointed and recognized by the Muslim community/the Islamic society);

(4) Islamic societies/groups based and operating in the wards/communities.

Sample size determination

Official data on the exact number of Imams and Amir(ah)s of mosques and Islamic societies respectively, in Ibadan North LGA was not available as at the time of the study. Hence enumeration of the mosques was done by physical counting of the existing mosques and Islamic societies. Three hundred and fifty- five (355) mosques and 21 FBOs were identified by the researcher in communities across the LGA, totalling 376. In a study by Oyeyemi (2008), 55.6% of Muslim respondents said that they had been educated on HIV/AIDS from their mosques. Hence, 55.6% of Islamic religious leaders are expected to have educated their congregations.

The minimum sample size was calculated using the Fisher, et al. (1991) sample size determination technique; using the statistical formula

$$nf = \frac{n}{1 + \left(\frac{n}{N}\right)}$$

Where

n = the desired sample size (when population is > 10,000)

nf= the desired sample size (when population is <10,000)

N= the estimated population size

and

$$n = \frac{Z^2 pq}{d^2}$$

Where

n = The desired sample size (when population is > 10,000)

d = Degree of accuracy = 0.05

Z = The standard normal deviate usually set at 1.96 which corresponds to 95% confidence interval.

P = Proportion of Islamic Religious Leaders expected to have carried out HIV/AIDS prevention activities = 56% = 0.56.

q= 1 – P = 1 – 0.56 = 0.44

$$n = \frac{(1.96)^2 \times 0.56 \times 0.44}{(0.05)^2}$$

= 379

Since the proportion of the study population is less than 10,000, the desired sample size is calculated using the statistical formula

$$nf = \frac{n}{1 + \left(\frac{n}{N}\right)}$$

Where

N = the estimate of the population size which is 376

n = the desired sample size (when population is > 10, 000) which is 379

Hence

$$nf = \frac{379}{1 + (379/376)}$$

= 189

The sample size was then rounded up to 500 since the assistants were also interviewed; and to ensure a higher validity of the study findings. The total sample of 500 was shared proportionately among the study participants in the 12 wards; with the sample size for each ward determined using the following formula:

$$\text{Ward sample size} = \frac{\text{Number of mosques in ward}}{\text{Total number of mosques in the 12 wards}} \times \text{Estimated sample size}$$

For example,

1. Sample size for Ward 1 = $\frac{24}{376} \times 500$

= 31.9 = 32

2. Sample size for Ward 12 = $\frac{80}{376} \times 500$

=106.4 = 106

The sample sizes for other wards were similarly calculated as done in the examples above (table 3.3 below). Proportionate and representative sampling was further ensured in each ward by using the following formula:

$$\text{Sample size for mosque category} = \frac{\text{Number of mosque in the category}}{\text{Total number of mosques in the ward}} \times \text{calculated ward sample size}$$

For example in Ward 5:

$$\text{Sample size for daily-prayer-only mosque} = \frac{13}{32} \times 43$$
$$= 17.5 = \mathbf{18}$$

$$\text{Sample size for daily/Friday-prayer mosque} = \frac{15}{32} \times 43$$
$$= 20.1 = \mathbf{20}$$

$$\text{Sample size for Islamic group/FBO} = \frac{4}{32} \times 43$$
$$= 5.3 = \mathbf{5}$$

These calculations done above were again repeated for all the 11 remaining wards (table 3.3 below).

Table 3.2: Mosques, Islamic groups and their ward distribution

WARD	Daily-Prayer–only Mosque	Friday-Prayer Mosque	Islamic Group	Total
1	22	2	Nil	24
2	20	3	3	26
3	42	6	2	50
4	32	4	1	37
5	13	15	4	32
6	11	1	1	13
7	9	5	Nil	14
8	39	15	2	56
9	3	4	Nil	7
10	9	4	4	17
11	10	6	4	20
12	63	17	Nil	80
Total	269	86	21	**376**

Table 3.3: Proportional distribution of the study sample size among mosques and FBOs in the LGA wards

Ward	Sample Size			
	Mosques		FBOs	Ward Total
	Daily-prayer-only	Friday-prayer		
1	29	3	-	32
2	27	4	4	35
3	55	8	3	66
4	42	5	2	49
5	18	20	5	43
6	13	2	2	17
7	12	7	-	19
8	51	20	3	74
9	4	5	-	9
10	11	6	6	23
11	8	14	5	27
12	83	23	-	106
Total	353	117	30	**500**

Sampling technique

A 3-stage stratified random sampling technique was used to select the participants from the study population. The first stage was the enumeration of the mosques in communities across the LGA. In the second stage, the 376 mosques and Islamic groups identified in Ibadan North LGA were grouped and later stratified according to their locations in the wards and type/category (Table 3.2 above). In the third stage, simple random sampling technique was used to select respondents. In selected mosques and Islamic groups/organizations, the heads (Imam/Amir/Amirah) and assistants were interviewed. Where there was no assistant at all, the available leader was interviewed. In all, 427 questionnaires were adequately completed and suitable enough for use in data analysis, out of 465 administered. The response rate was 91.8 %.

Instruments for data collection

Two instruments were used to collect the data, namely (1) a semi structured questionnaire (which was both self administered and interviewer administered) and (2) record review guide.

The developed questionnaire consists of four sections

a) Demographic characteristics such as age, sex, level of education, denomination, and leadership position in mosque/Islamic group.

b) Awareness, knowledge and opinion about HIV/AIDS.

c) State of preparedness towards participation in HIV/AIDS prevention.

d) Factors affecting the delivery of HIV/AIDS education programes.

The questionnaire items were drawn in English and translated into Yoruba language for easy administration.

Review of record

Records were requested for activities on HIV/AIDS education. The following documents in the mosques and Islamic organizations were reviewed and relevant information extracted, using a record guide (as used by Oladepo et al. (1995)) - Sermon files and notebooks, mosque/organization programme book, organization health committee files, mosque/ organization collections and general discussion files. The

review solely covered HIV/AIDS education activities carried out in the mosques/organizations (from year 2000 till date).

Validity and reliability

The research instrument was developed based on literature. It was first given an in-house pre-test for content validity in the Department of Health Promotion and Education, Faculty of Public Health, University of Ibadan; and amendments were made accordingly. As part of the validity procedure, independent persons translated the instrument to Yoruba and back to English languages. The final draft of the instrument was then pretested in a pilot study among 52 randomly selected Islamic religious leaders from 40 mosques and 4 Islamic societies in Ibadan North East Local Government. The two LGAs are similar in their characteristic and consist mainly of core, transitional and peripheral areas. This is to ensure relevance, appropriateness and adequacy of the items in the instrument. Pretest results enabled the researcher to make necessary corrections and modifications on the questionnaire, which were effected before the final administration. For instance, question 15 that read "What is AIDS?" was reframed and later read "In your own understanding, which disease is called AIDS?" ; question 16 that read " What is HIV?" was also restructured to read "What is the relationship between HIV and AIDS?" and question 52 ("Do you believe that AIDS exists?") was relocated from the second to the last section of the instrument.

The reliability of the research instrument was measured at the SPSS alpha Cronbach model; and a reliability coefficient of 0.508 was obtained.

Method of data collection

Quantitative methods (interview and review of records) were employed for data collection. Face-to-face interview was conducted as respondents preferred to be interviewed on most occasions. Interview of respondents was done mostly at early hours of the morning and in the evening period; as well as during weekly religious programmes on Fridays and Sundays. In some instances appointments and re-visits were arranged (sometimes on phone), which necessitated follow–ups.

Data management and analysis

The data generated in the study was collected, collated and cleaned by the researcher and the assistants. The researcher prepared the coding guide and hand coded the completed questionnaire using the coding guide. The statistical package for Social Science (SPSS) software was used for data entry and analysis, using descriptive statistics, t- test, Chi-square, ANOVA and logistic regression. A 15–point knowledge scale was used. The minimum score was 2 while the maximum score was 14. Respondents that scored 2-7 were categorized as having poor knowledge, those that scored 8-10 as having average knowledge and those that scored 11-14 as having good knowledge. The attitudinal score was assessed by assigning 1 point to a response that indicated positive attitude. No mark was given to any response that indicated negative as well as undecided responses. A 13-point scale was thus generated from the thirteen attitudinal questions in the instrument.

All findings were presented in frequency tables, cross tabulations and figures. Level of significance was set at 0.05.

Table 3.4: Study objectives and data analysis methods

Objectives	Data Analysis Method
Objective one	T-test and ANOVA
Objective two	Chi-square
Objective three	Chi-square
Objective four	Chi-square

Limitations of the study

The findings of this study were based largely on the responses of and claims by the respondents, as there was a generally poor documentation of activities related to HIV/AIDS. Other limitations of this study include the followings.

1. Refusal to participate in the study was experienced in ward 6. The researcher could not secure the consents of all the Islamic religious leaders but one in the Hausa community (i. e. Sabo area) of the LGA. The case was similar for the Hausa community at Bodija market in Ward 12. This situation means that the views of the Hausa ethnic group could not be adequately captured. The response from this community may have particularly contributed to the quality of the study findings.

2. Very few participants were females; and their small number affected the gender balance on data collection. This may equally have affected (probably) the quality of some of the study findings in terms of generalizability.

Ethical consideration

The Researcher could not secure Ethics Approval from U.I/U.C.H Ethics Committee for this study. Plan was to obtain the Ethics Approval but attempt made was futile due to the protracted national strike by university workers in Nigeria in year 2009. However, the study still followed the ethical principles guiding the use of human participants in research. Adequate information on the objectives of the study, associated benefits and likely inconveniences (for enrolling for the study) was given to the respondents. Participation in the study was purely voluntary following informed consent. Willing participants were given assurance of their confidentiality; and that there won't be any consequences for not taking part in the study.

CHAPTER FOUR

RESULTS

4.0 The results of this study are presented in this chapter. They are presented under 8 broad headings; namely, demographic characteristics, knowledge about HIV/AIDS, perception on relative likelihood of Muslims and others to be infected with HIV/AIDS, attitudes towards HIV/AIDS, HIV/AIDS prevention activities, HIV/AIDS training attendance, suggestions for effective HIV/AIDS Prevention education by religious leaders as well as tests of hypotheses.

4.1 Demographic characteristics of the respondents

As shown in Table 4.1, majority (96.0%) of the respondents were males while the remaining 4% were females. The mean age was 49.6 years with a standard deviation of 16.0 years. Most respondents (69.1%) are 40 or more years of age. Almost nine in 10 (89.7%) of the respondents were married; with 7% being single. Figure 4.1 shows respondents'age distribution by sex.

Three hundred and forty (79.6%) of the respondents had ever attended school. As presented in the Table, 26.7% had secondary education; while 14.5% and 14.1% had NCE/Diploma/HND and university education respectively. The distribution of respondents according to ethnicity shows that nearly all (98.1%) were Yorubas.

The position of the respondents in their various mosques and Islamic societies reveals that 29.3% were Imams, 14.1% were Chief Imams and 3.3% were Mufaseers. Both Amir(ah)s and Assistant Amir(ah)s were equally 4.7%. Figures 4.2 and 4.3 show the percentage distribution of respondents by the Islamic society to which they are affiliated; and years of experience on their current position respectively. The mean year of experience on the current position as a religious leader was 11.2 years with a standard deviation of 9.8 years.

Table 4.1: Demographic characteristics of Islamic religious leaders (N= 427)

Variable	No	Percentage (%)
Sex		
Male	410	96.0
Female	17	4.0
Age group		
20-29 years	41	9.6
30-39 years	91	21.3
40-49 years	88	20.6
50-59 years	85	19.9
60 years and above	122	28.6
Marital status		
Married	383	89.7
Single	30	7.0
Widow(er)	13	3.1
Separated	1	0.2
Educational Status (Western)		
Primary	104	24.4
Secondary/Modern	114	26.7
NCE/Diploma/ HND	62	14.5
University	60	14.1
No formal education	87	20.4
Ethnic Group		
Yoruba	419	98.1
Hausa	1	0.2
Ibo	0	0.0
Others	7	1.7
Position		
Chief Imam	60	14.1
Imam	125	29.3
Amir(ah)	20	4.7
Assistant Amir(ah)	20	4.7
Assistant Imam	188	44.0
Mufaseer	14	3.3

(N= 427)

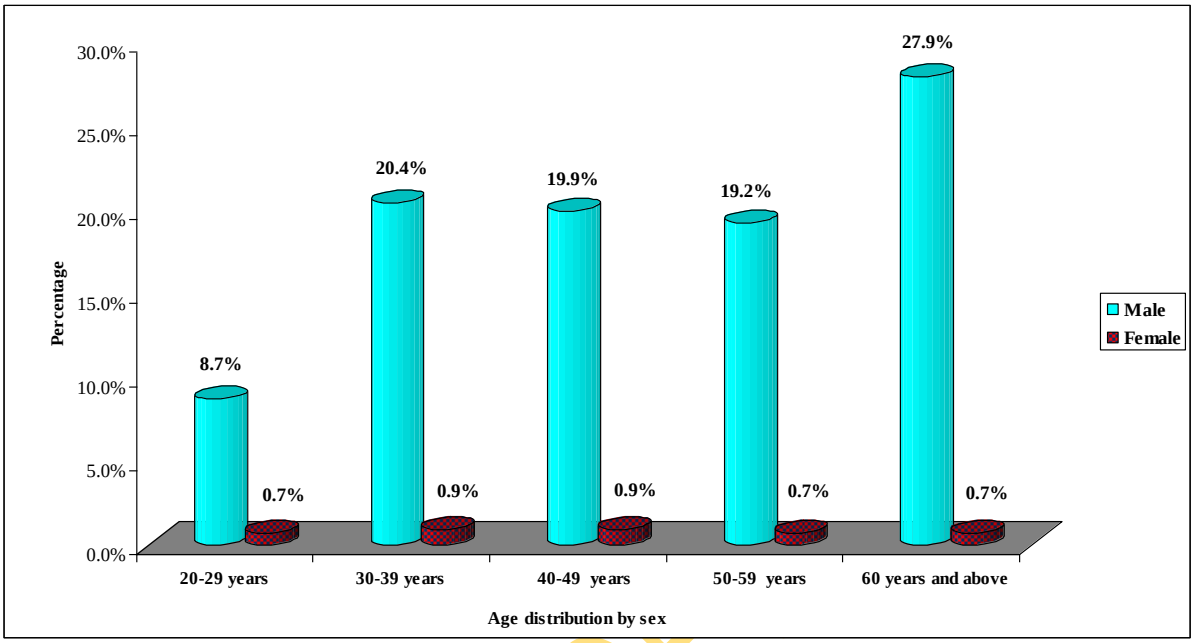

Figure 4.1: Respondents' age distribution by sex

(N= 427)

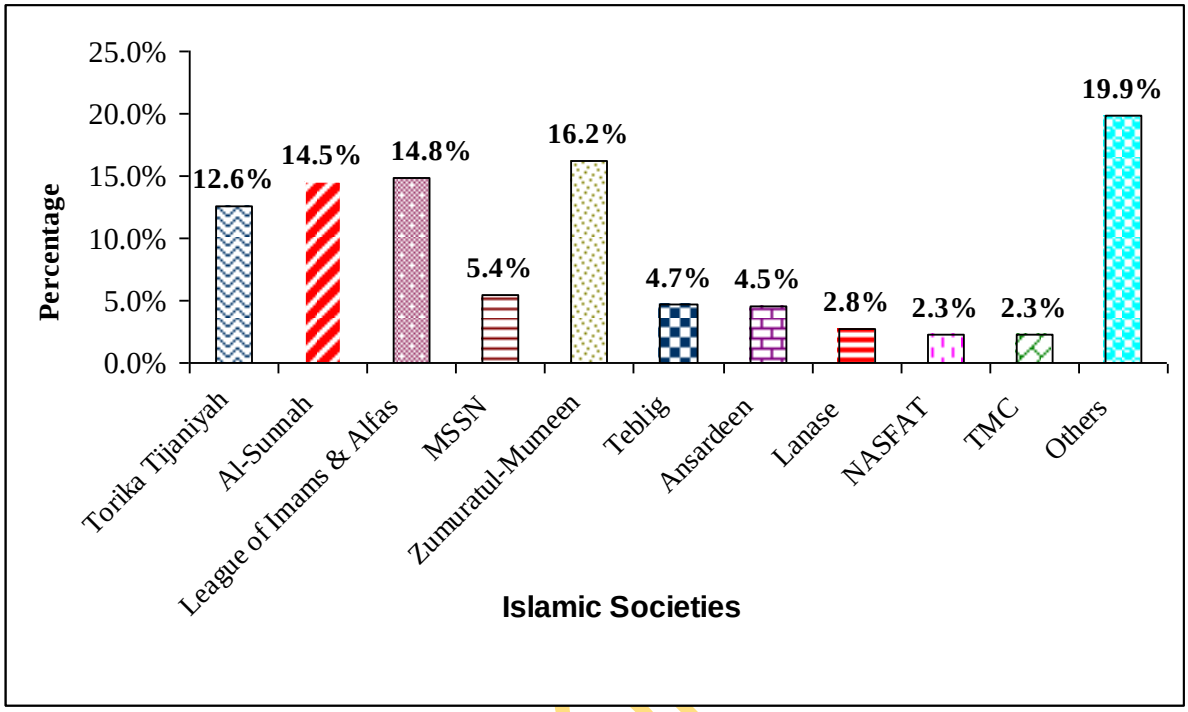

Figure 4.2: Respondents distribution by religious society of affiliation

(N= 427)

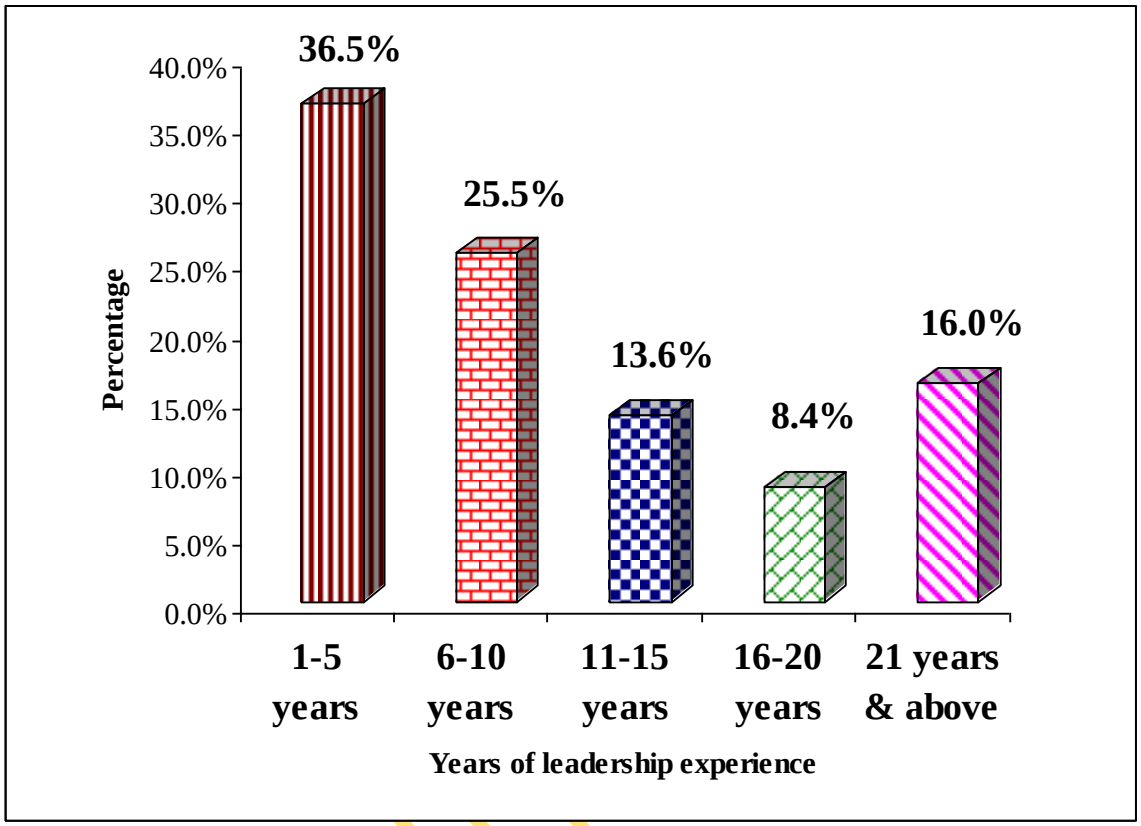

Figure 4.3: Respondents distribution by year of experience on leadership position

4.2 Knowledge about HIV/AIDS

Awareness about AIDS was generally high with all (100%) respondents having heard about the disease. The mean period of becoming aware of AIDS was 10. 8 years with standard deviation of 5.8 years. Almost all (98.6%) of the Islamic religious leaders believed that AIDS exists as a disease. The main source of HIV/AIDS information for nearly all of respondents was the Mass media (98.4%). Table 4.2 below shows other sources of respondents' HIV/AIDS information.

Table 4.2: Distribution of respondents by sources of HIV/AIDS information*

Information Source	Frequency	Percentage
Mass Media (T.V, radio and newspaper)	420	98.4
Family and Friends	336	78.7
Doctors and Health Workers	166	38.9
Religious meetings / forums	106	24.8
School	89	20.8
Workshop / Lecture	74	17.3
Others (workplace, market, books/IEC materials and NGO)	12	2.8

Note: *Multiple responses accommodated

4.2.2 Understanding/Knowledge of AIDS disease and relationship with HIV

Respondents' description of AIDS as a disease is presented in Table 4.3. Half (50%) of the respondents understood AIDS as a chronic/incurable disease; 43.1% as a sexually transmitted disease; 25.5% as cause of weight loss; and 8.7% as a disease of the blood/ body fluid. When asked on what relationship exists between HIV and AIDS, less than half (187; 43.8%) of respondents indicated that (untreated) HIV infection causes AIDS.

Table 4.3: Respondents' description of AIDS*

AIDS is:	Correct Answer by Frequency	Percentage (%)
Sexually Transmitted Infection	184	43.1
Uncurable /killer/ chronic disease	214	50.1
Disease of blood/ body fluid	37	8.7
Causes weight loss / weakness	109	25.5

***Note: Multiple responses accommodated**

4.2.3 Respondents' knowledge of mode of transmission of HIV

When asked to respond to some statements about ways by which HIV is transmitted, almost all of the respondents identified unprotected sex with infected persons (99.1%) and more than four in five (87.1%) identified sharing unsterilized sharp objects. One-third (33.5%) of the respondents correctly rejected mosquito bite as means of HIV transmission; with just over two-thirds (68.1%) and more than three in four (77.3%) also rejecting witchcraft/spiritual attack and handshake with infected persons as means by which the virus is spread respectively. The findings are presented in Table 4.4.

Respondents had misconceptions on HIV transmission through mosquito bites (51.3%), spiritual attack/witchcraft (18.5%) and handshake (11.2%) (Table 4.4).

Table 4.4: Respondents' knowledge of HIV transmission routes

	YES (%)	NO (%)	DON'T KNOW (%)
By sharing unsterilized sharp objects.	372(87.1)*	24 (5.6)	31 (7.3)
Through unprotected sex with infected persons.	423(99.1)*	1 (0.2)	3 (0.7)
Through Mosquito bites.	219(51.3)	143(33.5) *	65 (15.2)
Through witchcraft/spiritual attack.	79(18.5)	291(68.2)*	57 (13.3)
Through handshake with infected persons.	48(11.2)	330(77.3)*	49 (11.5)

Note: * indicate correct answers

4.2.4 Respondents' knowledge of ways of preventing HIV spread

In respect of HIV prevention, knowledge of abstaining from pre- and extral-marital sexual relationship was highest (96.5%), followed by avoiding re-use of injecting needles (95.8%), and blood screening for HIV before transfusion (93.9%).Two in five (40.8%) of respondents correctly rejected use of antibiotics before and after sex as preventive measure for HIV spread; while less than half (44.5%) of respondents rejected that not sharing toilet with infected persons will prevent HIV spread (Table 4.5).

On a 15-point HIV/AIDS knowledge scale the overall mean knowledge score of 9.1±2.3 was attained by the respondents. Majority (51.3%) have fair knowledge, 22.0% have good knowledge and 26.7% have poor knowledge. Female respondents however were significantly more knowledgeable with a mean score of 10.7±1.8 than their male counterparts with 9.0±2.3. Significant differences were found in HIV/AIDS knowledge of the respondents based on positions. The Assistant Amir(ah)s had the highest mean knowledge score of 10.5±1.9 while the Assistant Imams had the lowest (9.1±2.2) (Table 4.6)

Table 4.5: Respondents knowledge of ways of preventing HIV spread

	YES (%)	NO (%)	DON'T KNOW (%)
Use of drugs (antibiotics) before and after sex.	126(29.5)	174 (40.8)*	127 (29.7)
Blood screening for HIV before transfusion.	401(93.9)*	5 (1.2)	21 (4.9)
Not sharing toilet with infected persons.	202(47.3)	190 (44.5)*	35 (8.2)
Avoiding re-use of injecting needles.	409(95.8)*	4 (0.9)	14 (3.3)
Abstaining from pre- and extral- marital sex.	412(96.5)*	9 (2.1)	6 (1.4)

Note: * indicate correct answers

Table 4.6: HIV/AIDS mean knowledge scores among Islamic religious leaders

Item	No	$\bar{x}$	SD	P value
Sex				
Male	410	9.0	2.3	0.003
Female	17	10.7	1.8	
Age group				
20-29	41	9.5	2.3	
30-39	91	10.2	1.7	
40-49	88	10.0	2.0	0.000
50-59	85	8.8	2.1	
60 and above	122	7.6	2.3	
Education				
Primary school	104	8.8	1.9	
Secondary/Modern school	114	9.3	2.1	0.000
NCE/Diploma/HND	62	10.0	2.0	
University	60	10.7	2.0	
Non- formal	87	7.4	2.4	
Position				
Chief Imam	60	9.0	2.1	
Imam	125	8.7	2.5	
Amir(ah)	20	10.0	2.5	0.004
Assistant Amir(ah)	20	10.5	1.9	
Mufaseer	14	10.1	2.3	
Assistant imam	188	9.1	2.2	
Total	**427**	**9.1**	**2.3**	

Range of mean score 2-14 **Overall mean score 9.1 (SD 2.3)**

4.3 Opinions on relative likelihood of Muslims and others to be infected

When asked about their opinions on relative likelihood of Muslims (as a group) and others to be infected with HIV/AIDS, just over half (51.3%) of the respondents was of the opinion that Muslims are equally likely as others to be infected with HIV/AIDS. More than two in five (42.9%) considered Muslims as less likely than others to be infected with HIV; while 5.9% perceived Muslims as more likely than others to be infected (Table 4.7). Larger percntage (88.2%) of female compared to male (49.8%) respondents expressed the view that Muslims are equally likely as others to be infected ($p < 0.05$). Respondents in the age group 40-49 years old were less likely than respondents in any of other age groups to opine that Muslims are equally vulnerable to HIV infection. Largest prcentage of respondents with non-formal education (59.8%) and least of those with NCE/ND/Diploma education (40.3%) were likely to consider that Muslims are equally vulnerable as other groups.

Table 4.7: **Respondents opinion on likelihood of Muslims to be infected with HIV/AIDS** **(N= 427)**

Variable	Muslims more vulnerable (%)	Muslims less vulnerable (%)	Muslims equally vulnerable (%)	X^2	P - Value
Sex					
Male	25(6.1)	181(44.1)	204(49.8)		
Female	0 (0.0)	2 (11.8)	15(88.2)	9.74	0.008
Age					
20 – 29	1 (2.4)	18(43.9)	22(53.7)		
30 – 39	1(1.1)	44(48.4)	46(50.5)		
40 – 49	6(6.8)	42(47.7)	40(45.5)	13.13	0.123
50 – 59	4(4.7)	36(42.4)	45(52.9)		
60 and above	13(10.7)	43(35.2)	66(54.1)		
Educational status					
Primary education	10 (9.6)	42 (40.4)	52 (50.0)		
Secondary/Modern	1 (0.9)	53 (46.5)	60 (52.6)		
NCE/Diploma/HND	5 (8.1)	32 (51.6)	25 (40.3)	22.87	0.004
University	0 (0.0)	30 (50.0)	30 (50.0)		
Non- formal	9 (10.3)	26 (29.9)	52 (59.8)		
Position					
Chief Imam	5 (8.3)	28 (46.7)	27 (45.0)		
Imam	12 (9.6)	45 (36.0)	68 (54.4)	13.49	0.197
Amir(ah)	1 (5.0)	8 (40.0)	11 (55.0)		
Assistant Amir(ah)	0 (0.0)	9 (45.0)	11 (55.0)		
Mufaseer	1 (7.1)	3 (21.4)	10 (71.5)		
Assistant imam	6 (3.2)	90 (47.9)	92 (48.9)		
Total	**25 (5.8)**	**183 (42.9)**	**219 (51.3)**		

4.4 Respondents' attitudes towards HIV/AIDS prevention

Respondents were asked to give their views and feelings on 13 different HIV-related statements, in order to assess their disposition towards HIV/AIDS control. Their responses are presented in Table 4.8 below.

The perception of respondents about HIV/AIDS epidemic shows that almost all (98.1%) agreed to the statement 'HIV/AIDS is a danger to health and well-being of the society'. Nearly as many (95.8%) also agreed that 'Anyone can get HIV/AIDS irrespective of age, race and religion'. Almost all (97.4%) answered in the affirmative to the statement 'Islamic religious leaders have important roles to play in the efforts to prevent the spread of HIV/AIDS'.

More than two in five (44.5%) respondents disagreed with the statement 'people living with HIV/AIDS (PLWHA) are to be blamed for their condition'; but still nearly as many (40.5%) were favourably disposed to it. Also, three in five (59.5%) of the respondents agreed with the statement 'patients with HIV should be isolated and detained in hospital to prevent re-infecting others'.

When responding to the statement 'Islamic religious leaders need basic information and technical knowledge on HIV/AIDS before they can effectively/accurately explain it to their congregation members', more than nine in 10 (94.1%) respondents were favourably disposed. More than nine in 10 (96.3%) however disagreed with the statement 'Islamic leaders should not discuss HIV/AIDS because it bothers on sexual matters and promotes immorality'. In the same vein, nine in 10 (91.6%) were not favourably disposed to the statement 'HIV/AIDS Prevention education is not important in mosques because it cannot prevent Muslims from contracting the disease'. Furthermore, respondents' attitudes to the statement 'Islamic religious leaders should introduce and organize HIV/AIDS prevention programmes for mosque members regularly' revealed that more than nine in 10 (95.1%) answered in the affirmative. Lastly, two-thirds (66.7%) of respondents were not favourably disposed to the statement 'Islamic leaders must seek permission from mosque committee/members before giving sermons on HIV/AIDS'.

In response to the statement 'Islamic religious leaders should encourage congregation members to go for HIV testing to know their status', nine in 10 (91.8%)

respondents answered in the affirmative. With regards to the statement 'Prayer and worship are enough to protect the congregations from HIV/AIDS', nearly two-thirds (65.6%) disagreed; but still one in three (33.9%) answered in the affirmative. More than nine in 10 (94.6%) of the respondents agreed with the statement 'Islamic societies should provide material and spiritual supports for people living with HIV/AIDS'.

Table 4.8: Respondents'attitude towards HIV/AIDS prevention (N= 427)

Statement	Agree (%)	Disagree (%)	Undecided (%)	Total (%)
HIV/AIDS is a danger to health and well-being of the society	419 (98.1)	6 (1.4)	2 (0.5)	427 (100.0)
Anyone can get HIV/AIDS irrespective of age, race and religion	409 (95.8)	14 (3.3)	4 (0.9)	427 (100.0)
People living with HIV/AIDS are to be blamed for their condition	173 (40.5)	190 (44.5)	64 (15.0)	427 (100.0)
Patients with HIV should be isolated and detained in hospital to prevent re-infecting others	254 (59.5)	162 (37.9)	11 (2.6)	427 (100.0)
IRLs have important roles to play in the efforts to prevent the spread of HIV/AIDS	416 (97.4)	4 (0.9)	7 (1.7)	427 (100.0)
IRLs should not discuss HIV/AIDS because it bothers on sexual matters and promotes immorality	14 (3.3)	411 (96.3)	2 (0.4)	427 (100.0)
Prayers and worship are enough to protect the congregations from HIV/AIDS.	145 (33.9)	280 (65.6)	2 (0.5)	427 (100.0)
HIV/AIDS Prevention education is not important in mosques because it cannot prevent Muslims from contracting the disease	31 (7.2)	391 (91.6)	5 (1.2)	427 (100.0)
IRLs should introduce/ organize HIV/AIDS prevention education programmes for mosque members regularly	406 (95.1)	16 (3.7)	5 (1.2)	427 (100.0)
IRLs need basic information and knowledge on HIV/AIDS for effective discussion with their congregation members	402 (94.1)	19 (4.5)	6 (1.4)	427 (100.0)
IRLs must seek permission from mosque committee/members before giving sermons on HIV/AIDS	136 (31.9)	285 (66.7)	6 (1.4)	427 (100.0)
Islamic societies should provide material and spiritual support for people living with HIV	404 (94.6)	13 (3.1)	10 (2.3)	427 (100.0)
IRLs should encourage congregation members to go for HIV testing to know their status.	392 (91.8)	25 (5.9)	10 (2.3)	427 (100.0)

Overall mean attitude score of respondents was 10.7±1.6 out of 13. Two hundred and fifty nine (60.7%) had positive attitude while 168 (39.3%) had negative attitude towards HIV/AIDS prevention (Table 4.9). Table 4.9 further shows influence of respondents' characteristics (gender, age group, educational status and position) on their attitude towards HIV/AIDS prevention. Furthermore, attitude and attitudinal means of participants (by selected demographic variables) towards HIV/AIDS education are shown in Tables 4.10 and 4.11 respectively.

Table 4.9: Distribution of respondents by selected demographic variables (N= 427)

Variable	Positive (%)	Negative (%)	Total	X^2	P value
Sex					
Male	246 (60.0)	164 (40.0)	410 (100.0)		
Female	13 (76.5)	4 (23.5)	17 (100.0)	1.86	0.173
Total	**259 (60.7)**	**168 (39.3)**	**427 (100.0)**		
Age group					
20-29	25 (61.0)	16 (39.0)	41 (100.0)		
30-39	61 (67.0)	30 (33.0)	91 (100.0)		
40-49	67 (76.1)	21 (23.9)	88 (100.0)	27.31	0.000
50-59	54 (63.5)	31 (36.5)	85 (100.0)		
60 and above	52 (42.6)	70 (57.4)	122 (100.0)		
Total	**259 (60.7)**	**168 (39.3)**	**427 (100.0)**		
Education					
Primary school	55 (52.9)	49 (47.1)	104 (100.0)		
Secondary/Modern school	72 (63.2)	42 (36.8)	114 (100.0)		
NCE/Diploma/HND	47 (75.8)	15 (24.2)	62 (100.0)		
University	53 (88.3)	7 (11.7)	60 (100.0)	48.93	0.000
Non- formal	32 (36.8)	55 (63.2)	87 (100.0)		
Total	**259 (60.7)**	**168 (39.3)**	**427 (100.0)**		
Position					
Chief Imam	36 (60.0)	24 (40.0)	**60** (100.0)		
Imam	73 (58.4)	52 (41.6)	125 (100.0)		
Amir(ah)	15 (75.0)	5 (25.0)	20 (100.0)	8.46	0.132
Assistant Amir(ah)	17 (85.0)	3 (15.0)	20 (100.0)		
Mufaseer	10 (71.4)	4(28.6)	14(100.0)		
Assistant imam	108 (57.4)	80 (42.6)	18 (100.0)		
Total	**259 (60.7)**	**168 (39.3)**	**427 (100.0)**		

Table 4.10: Islamic religious leaders' attitude towards HIV/AIDS education

Statement	Agree (%)	Disagree (%)	Undecided (%)	Total (%)
IRLs should not discuss HIV/AIDS because it bothers on sexual matters and promotes immorality	14 (3.3)	411 (96.3)	2 (0.4)	427 (100.0)
HIV/AIDS Prevention education is not important in mosques because it cannot prevent Muslims from contracting the disease	31 (7.2)	391 (91.6)	5 (1.2)	427 (100.0)
IRLs should introduce/ organize HIV/AIDS prevention education programmes for mosque members regularly	406 (95.1)	16 (3.7)	5 (1.2)	427 (100.0)
IRLs need basic information and knowledge on HIV/AIDS for effective discussion with their congregation members	402 (94.1)	19 (4.5)	6 (1.4)	427 (100.0)
IRLs must seek permission from mosque committee/members before giving sermons on HIV/AIDS	136 (31.9)	285 (66.7)	6 (1.4)	427 (100.0)

Table 4.11: Means of respondents' attitudes towards HIV/AIDS education by selected demographic variables (N=427)

Variable	No	Attitudinal Mean	SD	X^2	P value
Sex					
Male	410	4.4	0.8	0.0	0.969
Female	17	4.4	0.9		
Age group					
20-29	41	4.2	0.8		
30-39	91	4.5	0.7		
40-49	88	4.7	0.5	21.4	0.000
50-59	85	4.5	0.9		
60 and above	122	4.3	0.9		
Education					
Primary school	104	4.5	0.8		
Secondary/Modern school	114	4.5	0.7	10.4	0.034
NCE/Diploma/HND	62	4.5	0.7		
University	60	4.5	0.8		
Non- formal	87	4.2	0.8		
Position					
Chief Imam	60	4.6	0.6		
Imam	125	4.4	0.8		
Amir(ah)	20	4.5	0.5	14.2	0.014
Assist. Amir(ah)	20	4.4	0.8		
Mufaseer	14	4.5	0.5		
Assistant imam	188	4.4	0.8		
Total	**427**	**4.4**	**0.8**		

4.4.2 Attitude of respondents towards the use of religious doctrine in HIV/AIDS education and messages

Nearly all (98.6%) respondents answered in the affirmative when asked whether they approve that HIV/AIDS education and messages be taught using religious values and doctrines. Their preferred forums for delivering HIV/AIDS education to the Muslim congregations are shown in Table 4.12.

Table 4.12: Percentage distribution of respondents on preferred forums for delivering HIV/AIDS education*

Forum	Frequency (%)
Sermon	387 (90.6)
Counselling sessions	389 (91.1)
Religious and Arabic classes	367 (85.9)
Camps and Seminars	391 (91.6)
Open Dawah / Outreaches	381 (89.2)
Special time for HIV/AIDS Education	366 (85.7)
Socio-religious events	329 (77.0)

Note: *Multiple responses allowed

4.5 HIV/AIDS Prevention activities ever carried out

Majority (94.4%) of respondents claimed to have ever carried out HIV/AIDS-related activity. As shown in Table 4.13 below, more than half (53.9%) of respondents said that they gave ad-hoc information on HIV/AIDS to their respective congregation members in their preaching. While 22.2% delivered HIV/AIDS-specific sermons, 4.4% had ever carried out educational programmes/activities among their respective congregations. Fifty nine (13.8%) respondents said that Health workers had visited/been invited to give HIV/AIDS education/lecture in (to) their mosques/groups. Tables 4.14 and 4.15 further show the distribution of respondents that had carried out any form of HIV-related activity by some selected variables.

Table 4.13: Respondents that had ever disseminated HIV/AIDS-related information *

Mode of Dissemination	Frequency (%)
As part of sermons (Ad hoc)	230 (53.9)
Specific preaching/sermon	95 (22.2)
Health talk / lecture by invited/visiting Health worker.	59 (13.8)
Organized educational programmes (apart from sermon)	19 (4.4)
Total	**403 (94.4)**

*** Note: Multiple responses were accommodated**

Table 4.14: Distribution of respondents that had ever carried out HIV/AIDS activity

Variables	Ad-hoc HIV Information	Specific preaching on HIV/AIDS	Organized HIV/AIDS education programme
Sex			
Male	221 (96.1)	92 (96.8)	14(73.7)
Female	9 (3.9)	3 (3.2)	5 (26.3)
Education			
Primary	56 (24.3)	21 (22.1)	3 (15.8)
Secondary/Modern	58 (25.2)	24 (25.3)	4 (21.1)
NCE/OND/HND	42 (18.3)	19 (20.0)	3 (15.8)
University	38 (16.5)	21 (22.1)	8 (42.1)
None	36 (15.7)	10 (10.5)	1 (5.2)
Age group			
20-29	19 (8.3)	8 (8.4)	1 (5.2)
30-39	53 (23.0)	25 (26.3)	6 (31.6)
40-49	59 (25.7)	26 (27.4)	2 (10.5)
50-59	50 (21.7)	20 (21.1)	4 (21.1)
60 and above	49 (21.3)	16 (16.8)	6 (31.6)
Position			
Chief Imam	41 (17.8)	18 (18.9)	1 (5.2)
Imam	69 (30.1)	28 (29.5)	2 (10.5)
Amir(ah)	8 (3.5)	5 (5.3)	4 (21.1)
Asst. Amir(ah)	10 (4.3)	6 (6.3)	4 (21.1)
Mufaseer	10 (4.3)	4 (4.2)	0 (0.0)
Asst. Imam	92 (40.0)	34 (35.8)	8 (42.1)
Total	230 (100.0)	95 (100.0)	19 (100.0)

Table 4.15: Respondents' involvement in HIV/AIDS activities by knowledge

Variable	Yes (%)	No (%)	Total (%)	X^2	P-value
Ad-hoc information					
Poor knowledge	18(4.2)	96 (22.5)	114 (26.7)		
Fair knowledge	49 (11.5)	170 (39.8)	219(51.3)	5.816	0.016
Good knowledge	28 (6.5)	66(15.5)	94 (22.0)		
Total	95(22.2)	332(77.8)	427(100.0)		
HIV-specific sermon					
Poor knowledge	49(11.5)	65(15.2)	114 (26.7)		
Fair knowledge	127(29.7)	92(21.6)	219(51.3)	4.823	0.028
Good knowledge	54(12.7)	40(9.3)	94 (22.0)		
Total	230 (53.9)	197(46.1)	427(100.0)		
HIV education Programme					
Poor knowledge	4 (0.9)	110(25.8)	114 (26.7)		
Fair knowledge	8 (1.9)	211 (49.4)	219(51.3)	2.550	0.279
Good knowledge	7 (1.6)	87 (20.4)	94 (22.0)		
Total	19 (4.4)	408 (95.6)	427(100.0)		

Table 4.16 shows the bivariate analysis for organization of HIV/AIDS prevention programme with selected demographic characteristics of respondents. A higher percentage of female respondents (29.4%) had organized a HIV/AIDS prevention programme compared to male respondents (3.4%) ($p<0.05$). A higher percentage of respondents who had tertiary education had organizaed HIV/AIDS prevention programme (9.0%) compared to those that had primary/secondary education (3.2%) and those with no formal education (1.1%) ($p<0.05$). Furthermore, a higher percentage of respondents who were in FBOs (22.7%) had organized HIV/AIDS prevention programme compared to respondents who were in mosques used for daily prayer only (2.8%) and respondents who were in mosques used for Friday daily prayer (1.5%) ($p<0.05$). Logistic regression of organization of HIV/AIDS prevention programmes shows that religious leaders in mosques used for daily prayers only were six times less likely to organize HIV/AIDS educational programme compared with their counterparts in FBOs (OR=0.182; 95%CI=0.054-0.608); and those in mosques used for Friday prayers were nine times less likely to organize HIV/AIDS educational programme compared with their counterparts in FBOs (OR=0.103; 95%CI=0.019-0.567). These were statistically significant. Religious leaders with primary/secondary level of education were about two times more likely to have organized a HIV/AIDS prevention program compared to those with no formal education (OR=1.767, 95%CI=0.206-15.158). Religious leaders with tertiary level of education were about three times more likely to have organized a HIV/AIDS prevention program compared to those with no formal education (OR=2.850; 95%CI=0.311-26.129). These were however not significant. Also, chief imams/mufaseer were twice less likely to have organized a HIV/AIDS prevention program compared to amir(ah)s/assistant imams (OR=0.468; 95%CI=0.118-1.852) (Table 4.17).

Table 4.16: Organization of HIV/AIDS prevention programme by different categories of Islamic religious leaders (N=427)

VARIABLE	YES (%)	NO (%)	Total	X^2	P-Value
Sex					
Male	14 (3.4)	396 (96.6)	410 (100)	25.948	0.001
Female	5 (29.4)	12 (70.6)	17 (100)		
Age Group					
20-29	1 (2.5)	39 (97.5)	40 (100)		
30-39	6 (6.6)	85 (93.4)	91 (100)	2.433	0.657
40-49	2 (2.2)	87 (97.8)	89 (100)		
50-59	4 (4.7)	81 (95.3)	85 (100)		
60 and above	6 (4.9)	116 (95.1)	122 (100)		
Education					
Primary/Secondary	7 (3.2)	211 (96.8)	218 (100)		
Tertiary	11 (9.0)	111 (91.0)	122 (100)	9.000	0.011
None	1 (1.1)	86 (98.9)	87 (100)		
Position					
Chief imams/mufaseer	3 (1.5)	196 (98.5)	199 (100)	7.588	0.006
Amir(ah)/Assistant imam	1.6 (7.0)	212 (93.0)	228 (100)		
Mosque category					
Daily-prayer-only					
Mosque	7 (2.8)	244 (97.2)	251(100.0)		
Friday-prayer Mosque	2 (1.5)	130 (98.5)	132(100.0)	38.875	0.001
Faith-Based Organization	10 (22.7)	34 (77.3)	44 (100.0)		
Total	19 (4.4)	408(95.6)	427 (100)		

Table 4.17: Odds ratio of Independent factors affecting organization of HIV/AIDS prevention programme

Variable	Odds ratio	95% CI OR	P-Value
Marital Status			
Married	0.765	0.233-2.512	0.659
Single/others (ref)			
Education			
Primary/Secondary	1.767	0.206-15.158	0.603
Tertiary	2.850	0.311-26.129	0.354
None (ref)			
Position			
Chief imam/mufaseer	0.468	0.118-1.852	0.279
Amir(ah)s/Assistant imam (ref)			
Mosque category			
Daily-prayer-only Mosque	0.182	0.054-0.608	0.006
Friday-prayer Mosque	0.103	0.019-0.567	0.009
Faith-Based Organization (ref)			

Regarding the HIV/AIDS programmes organized and conducted in the mosques/Islamic societies, below is Table 4.18 showing the types/nature of the educational activities as well as number of times they had been organized; and mosques and groups concerned. Nearly half (42.1%) of the respondents who had ever carried out HIV/AIDS prevention activities educated the whole of their congregation. Another 21.0% targeted women; one in 10 (10.5%) educated the youths; while 5.3% each made the garage boys, and men their respective target groups (Table 4.19).

Table 4.18: Mosques / Islamic societies and organized HIV/AIDS prevention education programmes

Type of HIV/ AIDS Prevention Activities	Ahmadi-Yah Mosq	Al – Burhan+	Banatul Islam+	Dauda Mosq*	FOM-WAN+	Iya Isale Afa Msq	Kunfaya-Kun Msq	NAS - FAT+	Olohung-bebe Mosq	Yekere Mosq.*
Drama sketch on HIV/AIDS	-	-	-	-	X	-	-	-	-	-
Mass Awareness Raising campaign on HIV/AIDS	-	-	-	-	X	-	-	-	-	-
World AIDS Day rally / Programe	-	-	-	-	-	-	-	X	-	-
HIV/AIDS Awareness Programme (TOT)	-	-	-	-	X	-	-	-	-	-
Awareness education On HIV/AIDS	-	X	X	-	X	-	X	-	X	-
Peer group education (TOT) on HIV/AIDS.	-	-	-	-	X	-	-	-	-	-
HIV/AIDS and its Prevention	X	-	-	X	-	X	-	X	-	X
Distribution of IEC and related Materi-als to group members	-	-	-	-	-	-	-	X	-	-

***Mosq. = Mosque.**
+ = Islamic society.

Table 4.19: Target groups of HIV/AIDS prevention education activities (N=19)

Target Groups	Frequency (%)
Motor garage boys	1 (5.3)
Muslim women	4 (21.0)
Group / congregation members	8 (42.1)
Youths	2 (10.5)
Men	1 (5.3)
Not stated	3 (15.8)

4.5.2 Reasons for carrying out HIV/AIDS education activities and reasons for not educating congregation about HIV/AIDS

The major reason given by the respondents for carrying out HIV/AIDS education in mosques and among their groups was "To raise awareness and enlighten members on HIV/AIDS" (63.2%). Other reasons included "To caution members to be more careful because HIV/AIDS is now rampant" (15.8%); and "Need for HIV testing before marriage" (10.5%) (Table 4.20).

As shown in Table 4.21, various reasons were also given by respondents who did not educate their congregation about HIV/AIDS. Just above a quarter (26.2%) of the respondents said that it was because they don't have enough HIV/AIDS knowledge; another 13.2% mentioned lack of material assistance/support; while close to a third (30.9%) said that they have not thought of it as being important, and neither were they sensitized on its necessity/desirability. Other reasons are shown in the table.

Table 4.20: Reasons for carrying out HIV/AIDS education programme activities by respondents*

Reasons	Frequency (%)
To raise awareness and enlighten members on HIV/AIDS	12 (63.2)
To caution members (to be more careful) because HIV/AIDS is now rampant	3 (15.8)
Reduction / prevention of HIV/AIDS	3 (15.8)
Need for HIV testing before marriage	2(10.5)
Not stated	1 (5.3)

* Multiple responses allowed

Table 4.21: Reasons for not educating congregation members about HIV/AIDS by respondents (N=408)

Reasons	Frequency (%)
We have not thought of it (as being important) and have not been sensitized on its necessity	126 (30.9)
We talk about it in sermons (i.e. preach against fornication /adultery)	62 (15.2)
The need for it has not arisen; it has not affected any of us and we don't suspect any member	34 (8.3)
We don't have enough HIV/AIDS knowledge	107 (26.2)
We don't get material support/assistance	54 (13.2)
HIV/AIDS programmes are (have been) centrally organized by (for/in) the society/community for our members	14 (3.4)
It is government responsibility to educate people about the disease; we believe everybody is already aware of HIV/AIDS through media	28 (6.8)
This is a workplace mosque (i.e. government office)	4 (1.0)
It can lead to promiscuity / we don't want to compromise our position regarding loose or free sexual relationship	3 (0.7)
No time for such programme	7 (1.7)
Not stated	84 (20.6)

4.5.3 Difficulties Encountered during HIV/AIDS Education Programmes

As regards difficulties encountered during HIV/AIDS education programmes in the mosques/FBOs, only two of the 19 who had ever educated their members said they encountered some difficulties. The two difficulties mentioned were, namely, nature of the age group being taught (that is, women of reproductive age) and that men also requested for training.

4.6 Past HIV/AIDS training attendance

Less than one in 10 (8.2%) of the respondents had ever attended any form of education training on HIV/AIDS. Of this group, 54.3% of them had given HIV/AIDS sermon while 45.7% had not. More males (88.6%) than females (11.4%), and more assistant Imams (45.7%) than Imams (22.9%) and Amir(ah)s (14.3%) had ever attended a training on HIV/AIDS (Table 4.22).

Table 4.22: Percentage distribution of respondents by HIV/AIDS Training attendance (N= 427)

Variable	Yes (%)	No (%)
Sex		
Male	31 (88.6)	379 (96.7)
Female	4 (11.4)	13 (3.3)
Position		
Chief Imam	4 (11.4)	56 (14.3)
Imam	8 (22.9)	117 (29.8)
Amir(ah)	5 (14.3)	15 (3.8)
Asst. Amir(ah)	2 (5.7)	18 (4.6)
Mufaseer	0 (0.0)	14 (3.6)
Asst. Imam	16 (45.7)	172 (43.9)
Educational status	4 (11.4)	100 (25.5)
Primary school	8 (22.9)	106 (27.1)
Secondary/Modern sch.	4 (11.4)	58 (14.8)
NCE/ND/HND	16 (45.7)	44 (11.2)
University	3 (8.6)	84 (21.4)
No formal education		
Sermon on HIV/AIDS	19 (54.3)	76 (19.4)
Had delivered	16 (45.7)	316 (80.6)
Had not delivered*		
Total	35 (8.2)	392 (91.8)

***** Respondents who could not remember were included

4.6.2 Willingness to participate in HIV/AIDS training programme

About 95.6% of the respondents said that they were willing to participate in HIV/AIDS education training programme. Few (4.4%) however showed no interest. Table 4.23 below further shows the distribution of respondents' willingness by gender, age group, educational status and position.

The reason given for not willing to participate by most was "I don't think I will need such education again apart from Islam's injunctions and provisions against fornication /adultery". Other reasons include "I don't have time / I'm busy; it will disturb me on my (religious) engagements" (31.5%); and "I always believe HIV/AIDS to be a commercial disease than real" (5.3%) (Table 4.24).

Table 4.23: Respondents willingness to participate in HIV/AIDS-education training by selected demographic variables (N= 427)

Variable	Training participation			X^2	P value
	Willing (%)	Unwilling (%)	Total (%)		
Sex					
Male	393 (95.9)	17 (4.1)	410 (100.0)		
Female	15 (88.2)	2 (11.8)	17 (100.0)	2.23	0.135
Total	**408 (95.6)**	**19(4.4)**	**427 (100.0)**		
Age group					
20-29	38 (92.7)	3 (7.3)	41 (100.0)		
30-39	86 (94.5)	5 (5.5)	91 (100.0)		
40-49	87 (98.9)	1 (1.1)	88 (100.0)	3.74	0.441
50-59	80 (94.1)	5 (5.9)	85 (100.0)		
60 and above	117 (95.9)	5 (4.1)	122 (100.0)		
Total	**408 (95.6)**	**19(4.4)**	**427 (100.0)**		
Education					
Primary school	98 (94.2)	6 (5.8)	104 (100.0)		
Secondary/Modern school	110 (96.5)	4 (3.5)	114 (100.0)		
NCE/Diploma/HND	59 (95.2)	3 (4.8)	62 (100.0)		
University	56 (93.3)	4 (6.7)	60 (100.0)	2.33	0.676
Non- formal	85 (97.7)	2 (2.3)	87 (100.0)		
Total	**408 (95.6)**	**19(4.4)**	**427 (100.0)**		
Position					
Chief Imam	58 (96.7)	2 (3.3)	**60** (100.0)		
Imam	122 (97.6)	3 (2.4)	125 (100.0)		
Amir(ah)	18 (90.0)	2 (10.0)	20 (100.0)	4.39	0.494
Assistant Amir(ah)	19 (95.0)	1 (5.0)	20 (100.0)		
Mufaseer	14 (100.0)	0 (0.0)	14(100.0)		
Assistant imam	177 (94.1)	11 (5.9)	188 (100.0)		
Total	**408 (95.6)**	**19(4.4)**	**427 (100.0)**		

Table 4.24: Reasons for not willing to participate in HIV/AIDS education training by the respondents (N= 19)

Reasons	Frequency (%)
I don't think I will need such education again apart from Islam's injunctions and provisions against fornication /adultery.	10 (52.6)
I don't have time/I'm busy; it will disturb me on my (religious) engagements.	6 (31.5)
I always believe HIV/AIDS to be a commercial disease than real.	1 (5.3)
I'm into traditional practices.	1(5.3)
I am not prone to HIV/AIDS ; only young ones can go for such programmes	1(5.3)

4.7 Respondents' suggestions to be effective HIV/AIDS Prevention educators

On what religious leaders will need to effectively fulfill the task of educating their congregations on HIV/AIDS- related issues, suggestions given by respondents are shown in Table 4.25. These include training workshop and capacity building on HIV/AIDS (30.4%); material and financial supports to organize HIV/AIDS programme activities (31.9%); regular preaching/ education on HIV/AIDS to the congregations (27.2%); and collaboration between government, health workers and religious leaders and their leadership (10.3%).

Table 4.25: Respondents' suggestions to be effective HIV/AIDS prevention educators*

Suggestions	Frequency (%)
Training workshop and capacity building on HIV/AIDS.	130 (30.4)
To serve as model.	12 (2.8)
Necessary material/financial supports to organize HIV/AIDS programme activities.	136 (31.9)
Commitment, consensus and cooperation among Islamic religious leaders and scholars on the campaign against HIV/AIDS among Muslims.	34 (8.0)
Collaboration between government, health workers, and religious leaders and their leadership on designing and implementing prevention programmes.	44 (10.3)
Meeting with People Living with HIV/AIDS (for the purpose of conviction).	6 (1.4)
Incentives for religious leaders as motivation.	43 (10.1)
Regular preaching/education on HIV/AIDS to the congregations (for them to know it is real).	116 (27.2)
To eschew sentiment and timidness; and not to see (discussing) sexual and reproductive issues as a taboo.	8 (1.9)
No response	41 (9.6)

*** Multiple Responses were Included.**

4.8 Testing of Hypotheses

Hypothesis one

Ho1: There is no significant relationship between HIV/AIDS – related knowledge and the demographic characteristics (gender, age group, educational status and position) of respondents.

As shown in Table 4.6, the result of T-test and one–way analysis of variance (ANOVA) test for the relationships between HIV/AIDS knowledge and gender, age group, educational status and position of respondents is reported below.

(a) The mean HIV/AIDS knowledge score for the study respondents was 9.1±2.3. Four hundred and ten male respondents (9.0±2.3) compared to 17 female respondents (10.7±1.8) had knowledge of HIV/AIDS. However, a significant relationship exists between respondents' gender and HIV/AIDS knowledge ($p<0.05$). Alternative hypothesis, that there is significant relationship between respondents' HIV/AIDS-related knowledge and gender, is accepted.

(b) Comparing the mean HIV/AIDS knowledge score of the respondents and their age groups, a statistical difference exists between the age groupings. These differences were statistically significant ($p<0.05$); and as such the alternative hypothesis is accepted that there is a significant difference in the level of HIV/AIDS knowledge by age groups.

(c) Comparing the HIV/AIDS knowledge score of the respondents and their educational status, a statistical difference ($p = 0.000$) exists between respondents' knowledge and educational status; and the difference is statistically significant ($p<0.05$). Therefore, the alternative hypothesis that there is significant difference in the level of HIV/AIDS knowledge by educational status is accepted.

(d) Comparing the HIV/AIDS knowledge score of the respondents and their position, a statistical difference ($p = 0.004$) exists between respondents' knowledge and position; and the difference is statistically significant ($p<0.05$). Therefore, the alternative hypothesis that there is significant difference in the level of HIV/AIDS knowledge by position is accepted.

Hypothesis Two

Ho2: There is no significant relationship between attitude towards HIV/AIDS prevention and the demographic characteristics (gender, age group, educational status and position) of respondents.

Responses to attitudinal items on the study instrument were categorized on a 13-point scale as positive or negative; and were tested using Chi square. Overall mean attitude score was 10.7±1.6 out of 13. The attitudes of respondents and their gender, age group, educational status as well as position are then compared (Table 4.9).

(a) Comparing attitude towards HIV/AIDS prevention and respondents' gender, the test result shows that higher proportion of female respondents had positive attitude towards HIV/AIDS prevention; but gender has no significant relationship with attitude ($p > 0.05$).The null hypothesis that there is no significant difference in attitude of respondents towards HIV/AIDS prevention by gender is therefore not rejected.

(b) In comparing attitude towards HIV/AIDS prevention and respondents' age group; while positive attitude increases with age among respondents in reproductive age bracket, it decreases with age among older respondents. Largest proportion of respondents in the age group '40 – 49' (76.1%) has positive attitude compared to other age groups. The difference in attitude towards HIV/AIDS prevention according to age group of respondents is significant ($p<0.05$). The alternative hypothesis is therefore accepted that there is significant difference in attitude of respondents towards HIV/AIDS prvention by age group.

(c) Comparing the attitude towards HIV/AIDS prevention and respondents' educational status, test result shows that positive attitude towards HIV/AIDS prevention increases with education status; and largest proportion of respondents with university education (88.3%) had positive attitude. The difference in attitude towards HIV/AIDS prevention according to educational status of respondents is significant ($p<0.05$).The alternative hypothesis that there is significant difference in respondents' attitude towards HIV/AIDS prevention by educational status is accepted.

(d) Comparison of attitude towards HIV/AIDS prevention and respondents' position shows that the largest percentage of Assistant Amir(ah)s (85.0%) and least percentage of Assistant Imams (57.4%) had positive attitude. However, position has no significant relationship with attitude ($p>0.05$). The null hypothesis that there is no significant difference in respondents' attitude towards HIV/AIDS prevention by position is not rejected.

Hypothesis Three

Ho3: There is no significant relationship between HIV-related knowledge and involvement in HIV/AIDS activities by respondents.

Responses to three categories of items on HIV/AIDS activity - (33) Have you ever included HIV/AIDS information in your sermon to your Mosque/group members?; (35) Have you specifically preached on HIV/AIDS to the congregation?; and (39) Has your mosque/group ever organized any HIV/AIDS Preventive education Programme for congregation members? - were tested using the Chi-square. The knowledge scores of respondents and their (non-) involvement in the three categories of HIV/AIDS activity of ad-hoc information, HIV/AIDS-specific sermon and HIV/AIDS education programme are then compared (Table 4.15).

(a) Comparing the HIV-knowledge score of respondents and their (non-) involvement in discussing or giving ad-hoc information on AIDS, the test result shows that the difference in HIV-knowledge score of respondents according to their (non-) involvement is significant ($p<0.05$). The alternative hypothesis that there is significant difference in HIV/AIDS-related knowledge of respondents and their discussing or giving ad-hoc information on AIDS is accepted.

(b) Comparing the HIV-knowledge score of respondents and their (non-) involvement in giving HIV/AIDS-specific sermon, the test result shows that the difference in HIV-knowledge score of respondents according to their (non-) involvement is significant ($p<0.05$). The alternative hypothesis that there is significant difference in HIV/AIDS-related knowledge of respondents and their giving HIV/AIDS-specific sermon is accepted.

(c) Comparing the HIV-knowledge score of respondents and their (non-) involvement in organizing HIV/AIDS education programme, the test result shows that the difference in HIV-knowledge score of respondents according to their (non-) involvement is not significant ($p>0.05$). The null hypothesis that there is no significant difference in HIV/AIDS-related knowledge of respondents and their organizing HIV/AIDS education programme is therefore not rejected.

Hypothesis Four

Ho4: There is no significant relationship between demographic characteristics of respondents (gender, age, educational status and position) and the willingness to participate in HIV/AIDS education programme.

Responses to one item – (49) Will you be willing to participate in HIV/AIDS education training programme?- were tested with gender, age group, educational status as well as position of respondents and then compared using the Chi-square (Table 4.23).

(a) Comparing respondents' response on willingness to participate in HIV/AIDS training and their gender, the result shows that there was no statistical difference between respondents' response towards willingness to participate in HIV/AIDS training by gender ($p>0.05$). The null hypothesis that there is no significant difference in the willingness to participate in HIV/AIDS education programme by gender is not rejected.

(b) Comparing the willingness to participate in HIV/AIDS education programme and respondents' age group, the result shows that the difference in willingness to participate in HIV/AIDS education progamme by age group of respondents is not significant ($p>0.05$). The null hypothesis that there is no significant difference in willingness to participate in HIV/AIDS education programme by age group is therefore not rejected.

(c) Comparison of respondents' willingness to participate in HIV/AIDS education progamme and their educational status shows that the difference in willingness to participate in HIV/AIDS education programme according to educational status of respondents is not significant ($p>0.05$). The null hypothesis that there is no

significant difference in willingness to participate in HIV/AIDS education programme by educational status is therefore not rejected.

(d) Comparing respondents' willingness to participate in HIV/AIDS education progamme and respondents' position, the result shows that the difference in willingness to participate in HIV/AIDS education programme according to position of respondents is not significant ($p > 0.05$). The null hypothesis that there is no significant difference in willingness to participate in HIV/AIDS education programme by position is not rejected.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.0 The study findings and their implications for HIV/AIDS prevention education were discussed in this chapter. The chapter ended with conclusion, recommendations and suggestions for further research study.

5.1 Respondents' demographic characteristics

Majority of the respondents in this study are males; aged 40 years and above; and married. These traits are historically true of divine religion. Theology is a male-dominated institution – all the Prophets are males. According to popular Islamic tradition, the Prophet of Islam attained Prophethood/Messengership at the mature age of forty, and was already married. So, the age and marital status of the respondents indicate their maturity for the role; and their congregations are more likely to respect their views on issues subsequently. Also, majority of the IRLs had ever attended school; with more than half (55.3%) having at least secondary education. The level of education possessed by many of the respondents, especially those with post-secondary school qualification (48.6%), is an indication that IRLs are getting better equipped and empowered to face the modern-day challenges of being (more) relevant and functional in their roles as religious leaders. This quality of education also places them at an advantage to seek health information and attend HIV/AIDS training which can enhance their preaching and prepare them to serve as advocates to promote community discussion on HIV/AIDS–related issues.

Majority (46.4%) of the IRLs have affiliation to four of the old set of local Islamic groups in Ibadan; namely Zumuratul-Mumeen, League of Imams and Alfas, Torika Tijaniyah and Lanase. Others are affiliated to the modern set of Islamic groups such as Ansardeen, FOMWAN, MSSN, NASFAT, Al-Mumeenat, and NACOMYO. Islam has always been experienced in a variety of modes depending on all the usual factors that influence communities, their belief systems and the power relations therein (Esack, 2007). According to Abass (2003) Islam was introduced into Ibadan around 1829; and Islamic societies are established to inject new ideas that could match the complexity of the contemporary society. While some of these religious entities are local some have national scope and outlook (e.g. Ansardeen, FOMWAN, MSSN, NASFAT

and NACOMYO). For attempts to bring Muslims on board to be as comprehensive as possible; and to delineate areas for high publicity value interventions as well as for longer term community work, the Muslim community had been looked at in terms of divisions/categories to provide an idea of how authority is exercised in the context of a major contemporary social problem (Esack, 2007). According to Esack (2007), religious authority is exercised in multiple and overlapping forms in the Muslim world, and it is important to understand how religious leadership functions in relation to the AIDS pandemic. The local competing formations for religious authority must therefore be factored into any (public health) intervention, he further stressed.

5.2 Respondents' level of HIV-related Knowledge

In the fight against AIDS, population themselves go to search for information (Lo Kebe, 2001); and in areas overwhelmed by hunger, poverty, and disease, religious leaders need more information to help their followers make informed choices about their health (Burket, 2006).

The entire study participants are aware of HIV/AIDS and almost all (98.6%) believe the disease exists. Their major source of information on the disease is the mass media (i.e. radio, television and newspapers); as well as family members and friends. Less than half (43.8%) of the Islamic Religious Leaders (IRLs) were however aware that HIV is different from AIDS. Their level of awareness confirms NACA (2010) claim that there has been increased HIV awareness among the general population in Nigeria. It can be attributed to the presence of (and exposure to myriad of HIV/AIDS programmmes on) many media houses, particularly those based in Ibadan. They include The Nigeria Television Authority (NTA), the Broadcasting Corporation of Oyo State (BCOS), Galaxy Television, Federal Radio Corporation of Nigeria, Splash FM radio station and Nigerian Tribune newspaper, among others. Nigerian Journalists have also been actively engaged, like many other stakeholders, in the country's multisectoral HIV/AIDS response efforts through the platform named 'Journalists Against AIDS (JAAIDS) Nigeria'. Also, a number of Civil Society Organizations such as Association for Reproductive and Family Health (ARFH) and Society for Family Health (SFH) are located in Ibadan- specifically

in the study area. They are equally involved in HIV prevention programmes and activities in the communities.

The female study participants were more knowledgeable than their male counterparts on HIV/AIDS. Certain factors may be responsible for this. For instance, volunteer care-givers are a critical source of support for the majority of PLWHA worldwide; and while FBOs constitute significant proportion of care-giver organizations, volunteer care-givers are predominantly women (Akintola, 2010). According to Burkett (2006), they see their volunteerism as a part of their faith and an extension of their worship. Given the fact that HIV infection had made in road to all segments of Nigerian population, including the family (NACA, 2006), some of the female IRLs may have been personally involved in one way or the other in caring for infected/affected relatives, family members, friends or even their organizations' members. Akintola (2010) reported a female volunteer that said: "This volunteering thing has helped me a lot because of AIDS…. I didn't know anything about AIDS, but now I can help people with the knowledge I get from training and daily experience". FOMWAN is one of the Islamic societies that participated in the study and operates orphanage home where orphans and vulnerable children (including orphans due to HIV/AIDS) are being cared for. Another important fact is that all the female study participants belonged to Islamic societies/groups. Some of them have access to local, national and international opportunities available to civil society (including FBOs) on HIV/AIDS initiatives. This and other reasons – including targeting women groups for reproductive health programmmes (most into which HIV/AIDS issues have been mainstreamed) – therefore might have further significantly contributed to the higher HIV/AIDS-related knowledge of the female participants.

Contrarily, clergy, particularly at the parish/community level, had been reported to lack sufficient information about HIV (Global Health Council, 2005; HPI, 2007). Majority of the male IRLS are Imams at local mosques across the communities. They have affiliation to the old local Islamic societies in Ibadan such as Zumuratul-Mumeen, League of Imams and Alfas, and Lanase. Obviously lacking in the LGA as at the time of this study was any active engagement and direct involvement of the Islamic administrative structure (that is, using the Imams and mosques) at the grassroots for

HIV/AIDS education; as prescribed by the Joint United Nations Programme on HIV/AIDS (UNAIDS). Majority of the male IRLs therefore had not been able to have access to opportunities that would have equipped them with adequate and relevant information and knowledge on HIV/AIDS.

The study finding on the IRLs' low knowledge about the relation between HIV and AIDS is in agreement with finding by Oyeyemi (2007) that only 43.2% of Muslim respondents in Oyo State could correctly define the relationship between HIV and AIDS. This finding also reinforces the belief expressed by PLWHA in a Ugandan study that "many people are not aware of the distinction between HIV and AIDS" (Kafuko, 2009). Therefore, the claim of high HIV/AIDS awareness among the general population, as shown here, may not actually imply accurate and reliable information. The IRLs may not know that an HIV positive person may not necessarily have AIDS until some years later. They may not be conscious that in spite of AIDS being uncurable yet, with proper treatment an HIV positive person can conduct his/her daily life and activities normally. To this end therefore, the media appears inadequate in increasing the respondents' knowledge; though it has successfully raised their awareness level on HIV/AIDS.

5.2.2 Respondents' knowledge of means of HIV Transmission and Prevention

The future course of the national response to the HIV and AIDS epidemic depends on a number of factors including levels of HIV and AIDS-related knowledge among the general population; social stigmatization; and provision and uptake of HIV counselling and testing (NHDS, 2008).

The study respondents generally have good awareness knowledge of the main modes of transmission and prevention of HIV. There is a universal awareness about unprotected sex with infected persons as a means of transmission of HIV. Many reports (UNAIDS, 2008, 2010; NACA, 2010; UNFPA, 2005) have reiterated that heterosexual sex remains the primary mode of transmission for HIV in Africa; and accounts for 80-95% of HIV infections in Nigeria (NACA, 2010).

The respondents also have high awareness on abstinence and faithfulness as means of preventing HIV infection. This is consistent with scriptural instructions - in the Qur'an, though, as was the case with Jewish and Christian scriptures, abstaining from sex

outside of marriage was also regarded as the mark of a believer (Esack, 2007). Religious communities define norms; even impose them on a number of areas relevant to HIV/AIDS interventions, such as morality and reproductive rules (ARHAP, 2006). One of the three behaviour change models being sought to reduce sexual transmission of the virus in Nigeria's HIV prevention programme is sexual abstinence and mutual faithfulness between HIV-negative partners (NHDS, 2008).

There are misconceptions among the IRLs on how HIV can be transmitted and prevented. Study participants had misconceptions that Mosquito bite, witchcraft, handshake and sharing toilets with infected people can transmit HIV. Belief by majority (51.3%) that mosquito bites can transmit HIV is in contrast with scientific evidence on HIV transmission that 'HIV is not spread by mosquitoes or other biting insects' (UNAIDS, 2008). However, it may not be unconnected with the fact that both HIV/AIDS and malaria are transmittable. Mosquitoes feed on human blood by sucking, and in the process transmit malaria parasite among people. Likewise HIV can be transmitted through (but not only by) infected blood transfusion/(infected) blood contact with blood in vivo. Malaria, an endemic disease of major public health concern in Nigeria, was jointly recognized alongside HIV/AIDS as an equally anti-development disease by the world leaders in 2000. Persistent, massive media sensitization on HIV/AIDS and malaria, unlike in the past may have raised the public profile of the two diseases in the society to the extent that respondents (more especially the educated among them) rationally, albeit erroneously, construct a link between mosquito feeding habit with HIV transmission.

The misconception about (and knowledge gap on) transmission by spiritual means substantiates claim by Kuijper (2007) that in large part of the developing world, unlike the more secularized western world, religion and spirituality is very much part of daily life. A Nigerian study reported by Jimoh (2009) indicated that people who are rumored to have died from AIDS are frequently thought by their family members to be victims of witchcraft, and diagnosis and treatment sought from a range of non-biomedical practitioners. Another Ugandan study revealed that some PLWH denied that they are HIV positive and instead attributed their health to acts of witchcraft (Kakufo, 2009). The belief that HIV is an illness sent by enemies or bad spirits, rather than being an infectious disease, has major implications not only for HIV prevention efforts but also for treatment.

Patients who believed that HIV infection was caused by magic often came for help dangerously late" (PlusNews, 2008).

The misconceptions that HIV could be transmitted through handshaking and by sharing toilet support and confirm finding by Kafuko (2009) and UNAIDS (2008) that challenges against HIV response efforts include fear of acquiring HIV through everyday /casual contact with infected people, which is evidence of low knowledge about HIV transmission. Practices that tend to isolate PLWH had been reported within the church in Uganda where people who are known to have HIV are the last to be dipped at baptism ceremonies within the SDA church, (Kafuko, 2009). Since Muslims have day to day contact in worship places – such as sharing toilets for purification purposes- misconception such as this therefore is capable of generating community stigma and discrimination against PLWHAs; and according to UNAIDS (2008), this can be successfully addressed through programming (since it is due to lack of detailed knowledge and information). Many respondents' misconception (and knowledge gap) on use of antibiotics/drugs as a preventive means may not be unconnected with the fact that HIV is essentially a sexually transmitted disease (STD); and they might therefore believe that it can be handled the way certain other STDs are usually treated by use of antibiotics.

Issues of misconceptions (Kafuko, 2009) and knowledge-gaps (El-Gibaly and Hemeyda, 2010) about the HIV/AIDS by religious leaders had been earlier established. So, being important source of information and influence on people's behaviour, these findings underscore the need for adequate education of the IRLs, as PlusNews (2008) puts it, to dispel health myths and make them to identify the symptoms of HIV infection and encourage patients to go to a clinic for testing and treatment.; and know about possible negative reactions when herbal remedies and antiretroviral (ARV) drugs are taken together, including the HIV risks associated with certain rituals.

5.3 Opinions on relative likelihood of Muslims and others to be infected

Religious leaders in Nigeria are usually looked upon as legitimate sources of ideas and experts who should guide the congregation in taking right decisions on various behaviours that can influence their lives individually and as a group. It is important to

know their opinions, thoughts and sentiments for the purpose of developing strategic prevention strategies.

Majority (51.3%) of the IRLs were of the opinion that Muslims as a group are relatively equally vulnerable to HIV infection as others. A health report by Muslim Ummah of South West Nigeria (MUSWEN) maintains that, although there is no evidence that diseases like HIV/AIDS are worse in Muslims than other Nigerians, HIV/AIDS is one of the major health problems of South West (SW) Muslims (MUSWEN, 2007). However, this result contradicts the finding by Mohamed (2010) that majority (54.2%) of adult immigrant Muslims in America believed that HIV/AIDS is not a threat to the Muslim community. Other studies had given evidences of lower HIV prevalence rates among Muslim communities and groups in SSA (Gay, 2004) and Nigeria (APIN, 2005; Mack, 2006).

A likely explanation for this general view may be because of the respondents' high awareness knowledge of means of HIV transmission; namely: unprotected sex with HIV-infected persons (99.1%); receiving blood not screened for HIV (93.9%); repeated use of injecting needles (95.8%) and sharing unsterilized sharp objects like blade (87.1%). According to UNAIDS (2008), 'HIV does not discriminate: anyone who has unprotected sex, uses unsterilized injecting equipment, or has a transfusion with contaminated blood can become infected with HIV'. In addition, though respondents were not asked whether Muslims espouse Islam's instructions relating to sexuality; IRLs' view may well reflect and reinforce the general opinion on the connection between HIV/AIDS epidemic and the larger challenges of human depravation in the society. Recent discussions have identified various social determinants of health in Nigeria, including government neo-liberal economic policies, corruption, urban-rural migration, unemployment, gender inequality, poverty, physical and social environment, and social support. Intensifying poverty continues to create health risks and propensity for risky behaviours among the vulnerable segments of the population (HERFON, 2006). With about 2.98 million PLWH, the country makes about 9% of the global HIV burden (FMoH, 2010). Hence, as Esack (2004) puts it, 'simply being Muslim is not sufficient security against a disease that breeds in conditions of misery and affects people living therein irrespective of their faith'. Respondents' opinion therefore seems to indicate that

they are in tune with the reality of the long-term nature of the HIV threat and the prevailing societal sources of HIV risk and vulnerability in Nigeria and the urban character of the HIV/AIDS epidemic; coupled with the fact that the influence of religious doctrine, as well as traditional moral values continues to be eroded/degraded in the society, especially in terms of the cultural and socio-economic dynamics of contemporary urban living as evidenced in Ibadan city. That they are not ready to mark their distance, deny or state invincibility from the disease buttressed Esack (2007) claim that there is a significant increase in the willingness of Muslim organizations and religious leaderships to acknowledge the reality of HIV & AIDS in the Muslim world; and further indicates recognition (on their part) of the need to take appropriate action to control HIV spread among Muslim community. This thus serves as an impetus for their effective engagement for behavioural change activities/risky behaviours modification in their communities (i.e. for implementing a faith-based initiative targeting HIV/AIDS-related issues).

The female respondents were significantly more likely to say that Muslims have relatively equal vulnerability to HIV infection as others. This is in accord with report by Largade and colleagues (2000) that men who consider religion to be very significant were significantly less likely to feel at risk of getting HIV whereas women were much more likely to feel at risk (i.e. religion may give men a protective feeling, whereas for women it may be associated more with submission and lack of control over their personal risk of HIV infection).

It is noteworthy that 42.9% of the IRLs perceived Muslims to be comparatively less vulnerable to HIV infection. This suggests that the disease is not a threat to the Muslims. Considering HIV as a non-threat could promote an attitude of complacency about important measures that would prevent the further spread of the disease, Mohamed (2010) argued. Recent research (Hasnain, 2005) also suggested that HIV/AIDS is becoming an increasing threat in many Muslim countries in Africa and Asia; and that by the year 2010, 40% of the African population, where the disease burden is highest, will be Muslim. Barnett and Whiteside (2006) had warned that HIV infection can silently move forward in a population and does not alert communities yet to take adequate precautions to halt the spread of the infection. It is important to know however that there is universal acknowledgement among the study respondents that HIV in practical terms is

a major health problem with potential harm for Muslims; and nearly all considered health education on prevention to be necessary for Muslims. This finding demonstrates that educational prevention approaches could work well for this population, if provided in the correct settings.

5.4 Attitudes towards HIV/AIDS prevention

Containment of the HIV/AIDS epidemic depends on effecting change in behavior and lifestyle to break the chain of transmission. The commitment of religious leaders constitutes an important opportunity to control and limit the impact of the epidemic.

The assessment of the attitude of the study participants showed a positive attitude towards HIV/AIDS prevention. They generally acknowledged HIV/AIDS as a major health problem; with potential harm for the Muslim community. They also correctly ascertained that they can and should play an important role in addressing the primary socio-cultural and behavioural risks associated with the spread of the disease in the society. These findings are in line with Cairo Declaration of Religious Leaders in the Middle East and North African region, which states thus: "We, the Muslim and Christian leaders, working in the field of HIV/AIDS in the Arab world… face the imminent danger of the HIV/AIDS epidemic and have a great responsibility and duty that demands urgent action" (FHI, 2007). According to UNDP &UNAIDS (2002) "HIV/AIDS is now well accepted as a challenge for the world community in the sense that it transcends boundaries of nations, classes, ethnicity and sexual preference". Barnett and Whiteside (2006) maintained that "HIV/AIDS is changing not only individual lives but also the trajectories of whole societies." UNICEF (2006) equally pointed out that HIV/AIDS plunges life into a daily ordeal for millions, with millions more of family members bearing the brunt of care, and the cost of care. Contrarily however, one study results showed that Muslim religious leaders do not perceive AIDS as a major health problem in Jordan *(*Abu-Moghli and Nabolsi, 2010). Hasnain (2005) maintained that the current course of the epidemic is unlikely to change unless the people affected, and those at risk, make a concerted effort to adopt preventive measures. Throughout the world religious leaders are looked to for guidance and advice on all aspects of life (Burket, 2006). They are often uniquely positioned to open discussion of the more sensitive dimensions of the HIV/AIDS pandemic, and mobilize the community (Marshall, 2004). Experience from Mali, as

documented by HPI (2007), showed that involvement of religious leaders makes HIV/AIDS control more holistic and it constitutes a major opportunity for quantitative and qualitative improvements in the national response to HIV/AIDS, particularly in terms of prevention. The IRLs in the Jordan study however equally agreed that they have responsibilities towards the prevention of HIV/AIDS (Abu-Moghli & Nabolsi, 2010). As Thoraya (2010) pointed out, religious leaders are the natural actors to challenge the economic, business and social systems that increase the vulnerabilities of people. This generally positive disposition of the study respondents towards HIV/AIDS prevention therefore makes them ideologically and psychologically prepared for engagement in the fight against AIDS.

5.4.2 Attitudes about information, education, and communication related to HIV/AIDS

The study participants did not consider discussing sexual–related matters a taboo; they rather agreed that providing HIV-related information to the mosque community will increase and deepen their understanding and help them face the challenges of the epidemic. Also, they highly favoured introducing organized HIV/AIDS educational lectures for the congregations. This is consistent with assertion made by Sheik Mubbaje (2001) at the first international Muslim leaders' consultation on HIV/AIDS that regulation of sexual behaviour was not new in Islam; and IRLs had been educating people about it for many years (even before HIV came). Ragab, Mahmoud and Serour, (2005) stressed that the Holy Qur'an discusses reproduction and sexual health; and Muslim men and women never felt shy to ask the Prophet (PBUH) about intimate sexual matters. As faith leaders are often uniquely positioned to open discussion of the more sensitive dimensions of the HIV/AIDS pandemic, and mobilize the community (Marshall, 2004); McCain (2003) said the AIDS crisis is giving the faith communities the opportunity to talk about sex in a positive wholesome manner. In contrast to this finding however, is the popular notion that sex and sexuality is a controversial issue that is considered in Muslim communities as a private matter or taboo as reported by many (Amod, 2004; Hasnain, 2005; Piggot, 2009; Mohamed, 2010). A recent study also found IRLs agreed that sex education contributes to healthy behaviours, and consequently to the

prevention of HIV transmission (Abu-Moghli & Nabolsi, 2010*).* In Senegal, the religious communities mainly work in education and sensitization programmes; and the Muslim religious leaders in particular have been at the forefront of the national response to HIV/AIDS, reinforcing the traditional sexual norms that have protected the country from a widespread HIV/AIDS epidemic - through preaching in Mosques and by incorporating AIDS education into their religious teaching programmes (USAID, 2004). The National Policy on HIV/AIDS (2009) said that in Nigeria, the religious leaders are best positioned as a stakeholder to promote abstinence and mutual sexual fidelity as the best protection against HIV/AIDS among their adherents. The disposition of the study respondents therefore offers an opportunity to mobilize and harness their potential to increase awareness of and knowledge about HIV/AIDS; and to promote safe sexual behaviours via religion and education among Muslims at the community level.

The IRLs maintained that they need basic information and knowledge on HIV/AIDS before they can effectively and accurately educate their congregations. This finding confirms the personal experience of Sheik Ali Charles Banda of Zambia who said: 'I find that just reading from the scriptures--I mean, from the Koran, the Hadith, and the teachings of Islam--without understanding the scientific aspect on how the virus is transmitted to another person--makes an imam not able to make an informed Islamic point of view on HIV and AIDS' (Goldman, 2008). According to Odimegwu (2003), there is the need to provide correct information about HIV through sources that are credible to target audience. Marshal (2004) and HPI (2007) like many others had insisted that the central condition for the involvement of religious leaders as advocates for HIV prevention is having access to information. This knowledge, HPI concluded, provides a foundation on which they can build communication and dialogue compatible with the interests of their congregations and beliefs. When introducing HIV/AIDS education to the population through them, Imams in Senegal (Lo Kebe, 2001), Uganda (Kagimu, 2001) and Kenya (ESD, 2008) were trained and equipped with scientific knowledge on HIV/AIDS to promote community discussions. "The leaders of various religions in Nigeria should be targeted for peer education training. Their knowledge of HIV/AIDS, progression, transmission and prevention should be updated", Odimegwu (2003) maintained. The ultimate goal of training the study respondents therefore is to address

misconceptions, misinterpretations, cultural and traditional practices among Muslims that hinder HIV/AIDS interventions in the community. As HPI (2007) pointed out, this is important because of their strong position and ability to open and maintain channels of mutual listening and to develop close trusting relationships with congregation members, which enable them to inform, educate and encourage healthy changes on sensitive sexuality–related issues often considered taboo by other HIV prevention and education efforts.

5.4.3 Attitudes about stigma and discrimination related to HIV/AIDS

Stigma and discrimination have long been identified as major obstacles that keep people living with HIV from accessing prevention, treatment, and care services (USAID, 2009). On the community level, religious organizations are influential social networks that have the power to support or stigmatize people living with HIV/AIDS (PLWHA), promote or impede HIV education, and endorse or reject medical treatment of HIV (Yamanaka**,** John**,** Watt**,** Ostermann and Thielman, 2009).

Respondents generally showed the desire, and acknowledged the need, to give spiritual and material supports to PLWHAs. There was however a near half–split on attributing responsibility and blame to infected individuals. Majority of the respondents also showed subtle articulation of HIV/AIDS prejudice/stigma by endorsing isolation and retaining of HIV–infected patients in hospitals to prevent them from re-infecting others. A study by Ansari and Gaestel (2010) among religious leaders (Muslim, Catholic and Protestant) in Senegal showed that though most of the RLs believed that addressing the HIV/AIDS epidemic and the reduction of HIV/AIDS–related stigma and discrimination are priorities, yet some leaders still hold beliefs about HIV/AIDS that may ostracize PLWHAs. Earlier study by Odimegwu (2003) among the general population in Osun and Imo states of Nigeria had revealed that there was a mixture of stigma and empathy towards PLWHAs. Paruk, Mohamed, Patel and Ramgoon (2006) argued that HIV infection, with its connotations of promiscuous behavior, has divided religious opinion as to whether sufferers should be punished (for sinful behaviour) or embraced (based on religious tolerance). They further quoted Green (1995), that it is possible that people may hold stigmatizing and non- stigmatizing views at the same time. Value/moral judgment

may hinder the giving of needed support to seek further information, medical treatment or for emotional encouragement.

The same black and white approach can also prevent faith groups from promoting practical measures - such as the use of condoms - because they may see this as condoning "immoral" behaviour (Piggot, 2009). The endorsement of isolating and retaining HIV-infected people in hospital by the respondents may be related to underlying fears of transmission. According to Green (1995), fear of transmission is so great among the general population that they sometimes tend to exaggerate the risk of infection. Intentional infection and abuses arising from HIV/AIDS in Africa and elsewhere have been reported ((Setswe et. al., 2007; The Punch, 2010). In a quantitative survey conducted in Nigeria, majority (58.4%) agreed that infected people do not mind spreading the virus to others (Odimegwu, 2003). In Egypt, IRLs also expressed the fear that the stigma surrounding PLWHAs could force them to seek revenge on the society by spreading the disease (Ragab, Mervat and Serour, 2005). In their contribution, Genrich and Braithwaite (2005) submitted that HIV/AIDS–related stigma and discrimination will continue until RLs possess accurate information about HIV transmission, which may then be conveyed to congregations; and until RLs are sensitized to the experiences of PLWHAs. Ansari and Gaestel (2010) then suggested that training to sensitize religious leaders on HIV/AIDS therefore should focus more on the everyday experience of PLWHAs, promote the value of condom use, even if solely among married couples, and reinforce religious leaders' roles as spiritual counsellors to reduce stigma and discrimination.

5.4.4 Attitudes related to HIV Testing (HCT) and treatment

Responses to HIV/AIDS can be placed along a continuum of prevention, care and treatment. Voluntary counseling and testing (HCT) has become an important component of the global response to HIV/AIDS (USAID, 2009). It is also an important tool for preventing mother-to-child transmission of HIV and increasing access to HIV/AIDS care, including antiretroviral therapy; but remains relatively uncommon worldwide-as the proportion of people tested between the ages of 15-49 does not exceed 31% in selected PEPFAR countries in 2008 (USAID, 2009).

Majority of the study respondents endorsed the idea that IRLs should encourage their congregation members to go for HIV testing to know their status; and equally rejected the idea that prayer and worship will be enough to protect the congregation against HIV/AIDS. These findings confirm observation/report by Health Policy Initiative (2007) that religious leaders are eager and willing to advocate for improved health services. A testing drive being conducted by the Council of Imams and Preachers of Kenya (CIPK) has been reported, where hundreds of locals are getting tested in response to calls by the imams - Muslim scholars - in mosques (IRIN/NewsPlus, 2010).

Contrarily, Burket (2006) reported that some religious leaders believe that prayer is enough to protect their followers from AIDS; and in Kenya, some pastors did not advocate testing for HIV because they believed prayer to be enough protection against the disease. Study finding by Yamanaka, John, Ostermann and Thielman (2009) showed that majority (80.8%) of their respondents believed that prayer could cure HIV (although almost all said that they would begin ARV treatment if they became HIV-infected). Karama (2009) had also observed that there are many HIV/AIDS patients in Kenya who died after they had refused to take medications during the fasting period of Ramadan. Seeking appropriate treatment and care for a sick person is strongly encouraged in Islam (Ibrahim & Songwathana, 2008). Treating AIDS requires the daily delivery of medications as well as the clinical management of patients for the rest of their lives; and early diagnosis of HIV and access to basic preventive care can slow progression to AIDS (UNAIDS, 2008). To accompany people on their sero-status journey requires training on HCT counselling and interpersonal communication skills; hence the desire and willingness of the IRLs to be advocates for HCT therefore requires that they be adequately trained. Their dispositions further reflect their recognition of the seriousness of HIV/AIDS and the importance of preventing infection; as well as their readiness to support the available treatment to reduce unwanted outcomes; and it is a good example of maximizing resources and increasing coverage of service. This, according to Watt, Maman , Jacobson , Laiser and John, (2009) is another opportunity to strengthen HIV/AIDS response to prevent HIV transmission at mother-to–child, young and adult levels; share information about HIV treatment/living with HIV, and emphasize that prayers and medical care go hand–in–hand.

5.4.5 Attitude towards the use of religious doctrine in HIV/AIDS education and messages

There was a universal approval by the respondents that HIV/AIDS education and messages be taught using religious values and doctrine; with majority favouring available opportunities in the community to educate people. This finding seems to support and confirm the consistent position of Islamic religious leaders on many occasions that the way forward for AIDS prevention from the Islamic perspective includes the promotion and use of the Islamic teachings and practices to support AIDS prevention and control (WHO, 1992; IMAU, 2001; Esack, 2007). Their position is also consistent given the role religious leaders play as gate keepers for many social and religious obligations and activities, as implied in the Cairo Declaration of Religious Leaders (in the Arab States) in response to HIV/AIDS Prevention which states, among other things, that "We emphasize the need to break the silence, doing so from the pulpits of our mosques, churches, educational institutions, and all the venues in which we may be called to speak. We need to address the ways to deal with the HIV/AIDS epidemic based upon our genuine spiritual principles and our creativity, and armed with scientific knowledge, aiming at the innovation of new approaches to deal with this dangerous challenge" (Positive Muslims, 2007). According to Andreas and Jean (2010), faith informs and guides behavior on countless levels; and faith leaders have been in the business of behavior change for millennia. Couching behavior change communications messages in religious language and beliefs could make them even more effective. The value and effectiveness of faith-based BCC messages follows directly from the credibility and influence that faith leaders already enjoy.

However, the position of religious leaders in relation to HIV prevention is often controversial (Mohammed, 2010); and there usually is tension between public health messages and spiritual messages (Thoraya, 2010). Clergy, particularly at the parish level, are perceived to lack sufficient information about HIV and vulnerability to effectively shape prevention messages (Global Health Council, 2005).Some religious people are actually adding to the stigma and discrimination associated with it as a result of commonly dispensed religious messages (FHI, 2007); seizing upon the occurrence of

AIDS epidemics to put forth their moral recommendations (Lagarde et. al., 2000; Kuijper, 2006; Fattah, 2006). Sheik Ali Banda confirmed this when he said: 'I can't deny the fact, including myself - being one of those imams who stood in the mosque and talked about HIV as a curse from God, and God is punishing the disbelievers, people who don't believe in God' (Goldman, 2008).

As Lewis (2002) noted, HIV/AIDS is an issue which bristles with moral questions and moral imperatives; and the sacred texts from which all religion flows demand a higher level of morality. However, reducing the issues of AIDS to simplistic moral pronouncements have not made churches and mosques places of refuge and solace, but places of exclusion to all those 'out there' who are suffering the consequences of their own moral debauchery and sin (Parry, 2003). This means that as religious doctrine regarding (especially) illicit sex is going to be uplifted; the negative sanctions and social stigma attached to risk behaviours and HIV/AIDS – greater and much more pronounced in Muslim cultures – will prevent those at risks (especially women) from coming forward for appropriate counseling, testing and treatment (Hasnain, 2005). Thus, the purpose of engaging the pulpit to expand community discussion on sensitive aspects of HIV/AIDS and mobilize the faith community to reduce/eliminate stigma and discrimination and accelerate towards universal access would have been defeated. This issue of discrimination is a crucial one as many respondents still believed that HIV-infected people be isolated and retained in hospital as this study showed. It has also been observed that while religious leaders involved in HIV prevention efforts rely on their holy texts to get their messages across (NewsPlus, 2010); many need additional support in message development and presentation (HPI, 2007). The tension between public health messages and spiritual messages therefore requires providing religious leaders with up to date and accurate information about HIV so they can convey the right information to their constituencies (Thoraya, 2010). By giving the religious leaders the tools to dispense a tolerant and productive message that is, at the same time, in keeping with their religious views, a disseminating process can be started that has great potential to penetrate all layers of society (FHI, 2007).

5.5 HIV/AIDS educational activities

Majority of study respondents had either mentioned HIV/AIDS in their preaching/discussions (53.9%) or delivered HIV–related sermons (22.2%); while health workers had visited/been invited to give HIV/AIDS- related talk/lecture to their mosques' /groups' members. The result of a UNDFPA study by El-Gibaly and Hemeyda (2010) showed that 72 percent of the imams said that they talk with people about HIV/AIDS in their Friday sermons or other occasions. PlusNews (2010) also reported that some religious leaders have sought to forge links with secular players in the fight against AIDS, in order to use all available means to limit the sometimes alarming spread of the virus in the (West Africa) region without violating the teachings of their faith. According to the report, a number of Senegalese imams, after preaching fidelity and abstinence, advise their congregations to get additional information. In the words of Sheik Mubajje on Ugandan Muslim Supreme Council's effort on HIV/AIDS, 'the health professionals agreed to work together with us to educate communities to combat AIDS using Islamic teachings to support scientific information'(IMAU, 2001**)**. For instance, a doctor is present during HIV/AIDS awareness sessions by JAMRA, a Muslim NGO in Senegal. According to the coordinator of JAMRA, "sharing of responsibilities makes it possible to respect certain limits. Religious leaders stop at a certain point and a doctor takes over" (PlusNews, 2010).This approach indicated that the IRLs recognized the importance of educating their congregations on prevailing (health-related) issues in the society and their own limitation in doing this.

There was no proper documentation of sermons in the mosques/societies concerned. Parry (2003) had observed that information was not always easily accessible as FBOs are busy 'doing' but are notoriously bad about, or are not trained for, monitoring, evaluating and documenting their efforts.

Very few (4.4%) respondents had ever organized HIV/AIDS educational programmes/activities among their respective congregations. Methods used were drama sketch, educational training/workshop, awareness campaign/rally and distribution of IEC materials. The prevention activities were targeted at the whole of congregation; women; youths; men and garage boys. *S*imilar to these findings, Tan and Nadchatram (2010) reported the conduct of a Mosque AIDS Awareness Program for Islamic religious

community and Mosque members in Malaysia using methods like workshop, peer education, lecture, colouring contests, banners and carnivals. The AIDS Awareness Program was specifically designed to cater for parents, young people and children.

The major reasons given by the leaders who disseminated HIV/AIDS information and carried out HIV/AIDS education in mosques and Islamic religious groups included "to raise awareness and enlighten members on HIV/AIDS", "to caution members to be more careful because HIV/AIDS is now rampant" ; and "need for HIV testing before marriage". Similar to this finding, the reasons for the HIV programme conducted by the Council of Imams and Preachers of Kenya (CIPK) included to enlighten and encourage Muslim youths, couples and Kenyans in general on the importance of getting tested (IRIN/NewsPlus, 2010). In England, a project by the name African Muslim Communities against AIDS involving local mosques was aimed, among other things to raise awareness of HIV/STIs and other sexual health issues, to prevent HIV/STI transmission and signpost people to appropriate services (Jauhar, Bagadi and Caswell, 2007).

IRLs in mosques were found to be much less likely to organize a HIV/AIDS prevention programme compared to their counterparts in FBOs. This could be likely due to the fact that many of the relatively new Islamic groups, established purposely to match the complexity of the modern contemporary society (Abass, 20003), operate as FBOs; and a few of them had benefited from local, national and international opportunities available to civil society on HIV/AIDS initiatives. For instance, nearly all of the eight Nigerian participants at the First International Muslim Leaders consultation on HIV/AIDS in Uganda in 2001 were representatives of Islamic NGOs. Also, the membership of the 16-man National Faith Based Advisory Committee on AIDS in Nigeria include representatives of MSSN, FOMWAN, NASFAT, Ansardeen society of Nigeria and Islamic Medical Association of Nigeria, among others. Information from Oyo state Action committee on AIDS showed that, of the 41 NGOs funded between 2005 and 2007 by, six were FBOs; and included FOMWAN and NASFAT. Available records at the FBO-level further showed that FOMWAN obtained support on HIV/AIDS awareness programmes from Future Group International, Texas and UNICEF in 2000 and 2001. In the same vein, AIDS awareness programmes being run by the Social Advocacy

Project (SAP) arm of Al-Mumeenat (The Believing Women) in S/W Nigeria had been officially acknowledged and reported (PlusNews, 2010).

Contrarily, majority of the IRLs are imams at local mosques, and, or missioners of locally organized religious groups across the communities. They have affiliation to the old local Islamic societies in Ibadan (such as Zumuratul-Mumeen, League of Imams and Alfas, and Lanase) that were, by virtue of their inadequate exposure, much less likely to be connected to or able to access opportunities available to civil society (including religious communities) on HIV initiatives. As at the time of this study obviously lacking in the LGA was any active engagement and direct involvement of the Islamic administrative structure (that is, using the Imams and mosques) at the grassroots for HIV/AIDS education; an approach recommended by UNAIDS as one of the examples of Best Practices to strengthen the voice and action of religious leaders in the response to HIV (UNAIDS/IMAU, 1998). They therefore lacked the wherewithal to organize HIV/AIDS prevention education programme.

Majority of the IRLs in the study area were not involved in HIV/AIDS prevention education. Main reasons given as being responsible are that they don't have enough HIV/AIDS knowledge and material assistance/supoort to organize such programme. This is similar to the findings by many studies (Lagarde et. al., 2000; Parry, 2003; Chinouya & O'Keefe, 2005; HPI, 2007; USAID, 2009). According to USAID (2009) many Faith-based Organizations (FBOs) express an interest in working in the area of HIV/AIDS prevention but lack the skills and resources to approach the issue with their congregations and communities. Some of the IRLs also said "we have not taught of it as being important and nobody had sensitized us on its necessity". They said that this study had sensitized them and created in them interest in HIV/AIDS education. It had been pointed out that the religious leadership at all levels of society needs training in order to do an effective job in educating adherents (Lewis, 2002), as faith leaders are often uniquely positioned to open discussion of the more sensitive dimensions of the HIV/AIDS pandemic, and mobilize the community (Marshall, 2004).

NACA (2010) however maintained that inadequate community directed interventions is a challenge in Nigeria HIV response - the high rates of transmission of HIV result largely from failure to use the available and effective prevention strategies and

tools, and poor coverage of HIV prevention programmes. Esack (2007) had earlier posited that the local formations for religious authority must be factored into any (public health) intervention as religious authority is exercised in multiple and overlapping forms in Muslim world. Report had it that, in Mali, in the first major phase of involvement of religious leaders in the fight against HIV/AIDS, the religious leaders did not have relevant information on HIV/AIDS which would enable them to understand the key issues and to address the faithful in mosques and other places of worship; and their initial position was passive observation and ideological opposition (HPI, 2007).

5.6 Participation in HIV/AIDS Training

Only few (8.2%) respondents had attended any form of HIV/AIDS training prior to this study; and nearly all (95.6%) respondents indicated their willingness to participate in HIV/AIDS education training programme. A recent UNFPA study in Egypt showed that only 8.0% of the imams reported having received training on HIV/AIDS (El-Gibaly & Hemeyda, 2010). This study finding again confirms the persistence of the gap earlier noticed by Odimegwu (2003) that the religious leaders (of various religions) are a good resource that has not being adequately explored in Nigeria. In the same vein, a good number of Imams interviewed across South Asia, including those in Afghanistan, expressed the willingness to be trained; and said they were ready to do more to prevent HIV/AIDS from hurting their countries if the government would approach them and provide training (UNICEF, 2006). Many have recommended education and capacity building for religious leaders (Lewis, 2002; Odimegwu, 2003; Marshall, 2004; Hasnain, 2005; Genrich & Braithwaite, 2005; UNICEF, 2006; Wheeler, Khasim, Mingjian and Wei, 2007; HPI, 2007; Muturi, 2007; ESD, 2008; Thoraya, 2010).

UNICEF (2006) pointed out that training is an important intervention needed to broaden religious leaders' role in prevention, care and support. Muturi (2007) also added that capacity building of religious leaders as HIV/AIDS communicators and behaviour change facilitators; as well as a collaborative effort between FBOs and health organizations would enhance their HIV/AIDS response. As Andreas and Jean (2010) posited, giving faith leaders the knowledge and tools to use their influence to change health- and development-related behavior is not, therefore, a complete departure from

their normal activities. The high ideological, psychological and spiritual motivations and potential of the study participants therefore need to (and should actually) be adequately harnessed through training and education workshop so that HIV activities can be effectively initiated, strengthened and where applicable expanded in the Muslim community in particular and the larger society in general.

5.7 Suggestions on what Religious Leaders needed to be effective HIV/AIDS educators

On what religious leaders will need to effectively fulfill the task of educating their congregations on issues related to HIV/AIDS, suggestions given by the respondents included training workshop and capacity building on HIV/AIDS (30.4%); material and financial supports to organize HIV/AIDS programme activities (31.9%); regular preaching/education on HIV/AIDS to the congregations (27.2%); and collaboration between government, health workers and religious leaders and their leadership (10.3%); financial incentives as motivation (10.0%). Other salient suggestions are meeting with PLWHA (for the purpose of conviction) and to eschew sentiment, timidness and not to see (discussing) sexual and reproductive issues as a taboo. Hasnain (2005) had said, "For HIV Prevention programmes to be successful, collaboration with religious scholars and leaders is a key element. It is critical to win their confidence and educate them". Chinouya and O'Keefe (2005) and UNICEF (2006) also pointed out that Faith leaders themselves expressed a willingness to work in partnership with statutory providers and be recognized as equal partners in the fight against HIV stigma, and wished for their capacity to be developed to support those who were living with HIV. Training for religious leaders is an area identified by many as both needed and a positive step forward. Financial assistance is also essential to expanding the role of FBOs in HIV/AIDS prevention and care. According to HPI (2007) also, to help religious leaders further anchor and sustain their role in HIV/AIDS control technical capacity building is important.

UNAIDS (2008) insisted that to maintain a robust prevention response, countries need to nurture a "prevention movement", build the human and technical capacity needed to sustain prevention efforts, and work to stimulate greater demand for prevention

services. Workshops and seminars for and by leaders of Buddhist, Christian, Hindu, Muslim and other faith groups, have contributed directly to awareness raising and knowledge of HIV/AIDS among different target groups (UNICEF, 2006). In virtually all situations where faiths and religious communities have played a critical role; and are 'part of the solution' in fighting HIV/AIDS, there have been strategic engagement of, as well as active, supportive dialogue with religious leaders to educate them on the disease, broaden their vision and build their capacity for effective discharge of their expected roles. Case studies of Uganda (IMAU, 2001), Senegal (USAID, 2007) and Mali (USAID/HPI, 2007) highlight this functional approach; and the part played by faith leaders in their success stories had been globally acknowledged.

Conclusion

Globally, attention has turned to religion to combat HIV/AIDS scourge. Governments, agencies and NGOs have trained religious leaders to ensure that they become well–educated about the disease; and empowered with adequate information to pass on to their congregations. Nigeria's HIV prevention programme has sought to promote abstinence and mutual sexual fidelity (as the best protection against HIV/AIDS) through the religious leaders among their adherents (National HIV Policy Document, 2009). To this end, this study provides an insight into Islamic Religious Leaders' knowledge and perception; and highlights their involvement in the local HIV/AIDS initiatives.

The findings of this study indicated a fair knowledge and positive attitude towards HIV/AIDS prevention among the respondents. However, IRLs do not have adequate knowledge and accurate information about HIV transmission and prevention; indicating a need for better and more accurate information. They perceived HIV/AIDS as a major health problem with potential harm for the Muslim community in particular and larger society in general. While IRLs correctly ascertained that they have responsibility towards the prevention of HIV/AIDS and agreed that HIV/AIDS education (in religious context) can and will contribute to the prevention of transmission, they reflected varied responses to PLWHAs. Level of involvement of the IRLs in prevention programmes is however unsatisfactorily low and limited, in spite of their durable presence in the communities.

Although many (76.1%) mentioned HIV/AIDS in their discussions and sermons; just only 4.4% organized HIV/AIDS education programmes; and only 8.2% had attended a form of HIV/AIDS training.

Recommendations

With the long–term nature of vulnerability and risk of infection, HIV/AIDS is always with surprises and new demands. To stop the run of HIV/AIDS menace in Nigeria, it has been suggested that there is need to focus attention on holistic, participatory and community–driven remedial strategies. (More) effective engagement with religious communities/leaders should be explored and their potentials adequately harnessed.

Capacity building will strengthen the synergy between the various religious denominations; strengthen the leadership of religious leaders (on their roles and responsibilities) in the face of HIV/AIDS; contribute to decreasing the spread of HIV/AIDS; and empower religious associations with reference to prevention and psychosocial and spiritual care in the context of HIV/AIDS.

1. Imams need information on topics such as Sexual and Reproductive Health (SRH) and Prevention of Mother to Child Transmission. Training will provide a forum to re-examine some traditional assumptions/practices and clarify Islam values around SRH and HIV prevention; while providing accurate technical information on these topics.
2. Prior to involvement in community–based education, care and HIV/AIDS support initiatives, religious leaders must possess compassion that is reinforced by personal experiences with PLWHAs. Other studies have found that PLWHAs are receptive to faith-based counseling and support provided by RLs and congregation members. Thus, a consultative dialogue between PLWHAs and religious leaders is pivotal to a successful faith-based HIV/AIDS initiative.
3. Strategies should be devised to broaden the volunteer base of FBOs and mosques (as assistant imams are generally well-educated to serve this purpose). They can also function effectively as advocates in the community, stimulating more dialogue on reproductive health and HIV prevention issues.

4. Development of religious-specific training materials to further empower religious leaders.
5. Incentives to motivate and sustain grass-root prevention activities.
6. A coordinating body that will supervise and monitor the mosque/ FBOs should be formed for easy coordination of activities.
7. Some FBOs currently support health and religious education, as well as welfare services without a component on HIV/AIDS. They need to be trained and involved in HIV/AIDS Prevention activities.

Recommendation for further study

(1) Effect of HIV and AIDS education training of Islamic religious leaders on community-based prevention activities.

(2) HIV/AIDS-related Knowledge and practices among students of Muslim Religious Schools in Ibadan metropolis.

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APPENDIX I

QUESTIONNAIRE

KNOWLEDGE, PERCEPTION AND INVOLVEMENT OF ISLAMIC RELIGIOUS LEADERS IN HIV/AIDS PREVENTION IN IBADAN NORTH LOCAL GOVERNMENT AREA, NIGERIA

INTRODUCTION

Greetings. My name is **Ikudaisi Sefiu Olatunde**, a student of the department of Health Promotion and Education, Faculty of Public Health, University of Ibadan.This questionnaire is aimed at collecting information on the knowledge, perception and the involvement of Islamic religious leaders in HIV/AIDS prevention. I will very much appreciate your participation in the study sir/ma. I wish to inform you that there are no rights or wrong answers to the questions I will ask you. Please be informed that participation is voluntary. Your identity, and responses and opinions you provide will be treated in strict confidence.

Please tick (**X**) the appropriate answer in the box as well as the column in front of some question items and provide answers to questions that have no suggested responses. Many thanks for your anticipated co-operation.

Can I continue with the interview sir/ma? _____

(If response is "No" thank respondent and terminate the interview)

Survey Identification #..... **Date**.....

SECTION A: DEMOGRAPHIC INFORMATION

1. Gender: 1) Male ( ) 2) Female ( )

2. Age (in completed years):_____

3. Marital Status: 1) Married ( ) 2) Single ( ) 3) Widow(er) ( )
   4) Divorced ( ) 5) Separated ( )

4. Highest education qualification attained

ARABIC		**WESTERN**	
1) Ibtidai	( )	1) Primary school	( )
2) Idadi	( )	2) Secondary school	( )
3) Thanawi	( )	3) NCE/Diploma/HND	( )
4) Diploma	( )	4) University	( )
5) University	( )	5) No formal education	( )

6) Others (Please indicate)_____

5. Ethnic Group: 1) Yoruba ( ) 2) Hausa ( ) 3) Igbo ( )

4) Others (specify) _____

6. Name of Mosque/Organization: _____

7 Position in mosque/organization: 1) Chief imam ( ) 2) Imam ( )

3) Amir(ah) ( ) 4) Assistant Amir(ah) ( )

5) Mufaseer ( ) 6) Assistant Imam ( )

8. Category of Mosque:

1) For daily Prayer only (Ratibi) ( ) 2) For daily/ Friday Prayers (Jamiu) ( )

3) Workplace Mosque ( ) 4) Community Mosque ( )

5) Others: _____

9. When was your mosque/group established?_____

10. The name of Islamic society to which you belong:

1) Teblig. ( ) 2) Ansardeen ( ) 3) Ahmadiyah ( )

4) Tadm'nu (OTM) ( ) 5) Nawaruden ( ) 6) Anwarul-Islam ( )

7) NASFAT ( ) 8) QUAREEB ( ) 9) The Muslin Congress ( )

10) Muslim Students Society (MSSN) ( ) 11) Zumuratul-Ijaj ( )

12) Others (Pleases specify)_____

11. Years of experience in your present position: _____

SECTION B: INFORMATION ON KNOWLEDGE OF HIV/AIDS

12. Have you heard about HIV/AIDS 1) Yes ( ) 2) No ( )

13. If 'Yes', when? _____

14. What are your source(s) of information on HIV/AIDS?

	SOURCES	YES	NO
1	Mass media (T.V, radio and newspaper)		
2	Family and Friends		
3	Doctors AND Health workers		
4	Workshop		
5	Religious meetings/for a		
6	School		
7	Others (specify)		

15. In your own understanding, which disease is called AIDS?

_____

_____

16. What is the relationship between HIV and AIDS?

_____

_____

_____

17. Some people have said some statements about ways by which HIV is transmitted and prevented. Please, consider and respond whether true, false or you don't know to each of the following statements.

Ways by which HIV is transmitted

	HIV can be transmitted :	True	False	Don't Know
1	by sharing infected/unsterilized sharp objects like blade, injecting needle, barber's clippers,etc			
2	through unprotected sex with infected person(s).			
3	through mosquitos/insects bites.			
4	through witchcraft/Spiritual attack.			
5	through hand shake with infected person(s).			

18. **Ways of preventing HIV Infection**

	HIV infection can be prevented through/by:	True	False	Don't Know
1	use of drugs (antibiotics) before and after sexual act.			
2	screening of blood for HIV before transfusion			
3	not sharing toilet with infected person(s)			
4	avoid re-use of injecting needles			
5	abstaining from sexual acts before and outside marriage			

SECTION C: PERCEPTION TOWARDS PARTICIPATION IN HIV/AIDS PREVENTIVE EDUCATION

19. Which of the following statements best reflect your opinion on HIV/AIDS?
As a group

(1) Muslims are more vulnerable than others to be infected with HIV/AIDS. ( )

(2) Muslims are less vulnerable than others to be infected with HIV/AIDS. ( )

(3) Muslims are equally vulnerable as others to be infected with HIV/AIDS. ( )

Attitude towards Participation in HIV/AIDS Prevention Education

S/N	Statements	Agree	Disagree	Undecided
20	HIV/AIDS is a danger to health and well-being of the society			
21	Anyone can get HIV/AIDS irrespective of age, race and religion.			
22	People living with HIV/AIDS are to be blamed for their condition.			
23	Patients with HIV should be isolated and detained in hospital to prevent re-infecting others.			
24	Islamic religious leaders have important roles to play in the efforts to prevent the spread of HIV/AIDS			
25	Islamic leaders should not discuss HIV/AIDS because it bothers on sexual matters and promotes immorality.			
26	Prayer and worship are enough to protect the congregations from HIV/AIDS.			
27	HIV/AIDS Prevention education is not important in mosques because it cannot prevent Muslims from contracting the disease			
28	Islamic religious leaders should introduce and organize HIV/AIDS prevention education programmes for mosque members regularly.			
29	Islamic religious leaders need basic information and technical knowledge before they can effectively/accurately explain HIV/AIDS issues to their congregation members.			
30	Islamic religious leaders must seek permission from mosque committee/members before giving sermon on HIV/AIDS.			
31	Islamic societies should provide material and spiritual support for people living with HIV/AIDS.			
32	Islamic religious leaders should encourage congregation members to go for HIV testing to know their status.			

SECTION D: FACTORS AFFECTING THE DELIVERY OF HIV/AIDS EDUCATION PROGRAMMES

32. Have you ever included HIV/AIDS information in your sermon to your Mosque/group members? 1. Yes ( ) 2. No ( ) 3.'Cant Remember' ( )

34. If 'Yes' how many times in the last one year? _____

35. Have you specifically preached on HIV/AIDS to the congregation?
1. Yes ( ) 2. No ( ) 3. 'Cant Remember' ( )

36. If 'Yes' how many times till date? _____

37. Has any Health worker come to deliver lecture on HIV/AIDS in your mosque/association?
1. Yes ( ) 2. No ( ) 3. 'Cant Remember' ( )

38. Has your mosque/group ever organized any HIV/AIDS preventive education programme for congregation members?
1. Yes ( ) 2. No ( ) 3. 'Can't Remember' ( )

39. If **'No' or 'Can't' Remember'** Please go to Question 44

40. If 'Yes' how many of such HIV/AIDS Programmes have been organized till date? _____-

41. Please state the following regarding these HIV/AIDS Programmes

Programme Activity	Time Conducted	No of Times Conducted	Target Group(s)	Reason(s) For The Programme

42. Do you encounter any problems/ difficulties making your mosque/group members understand what HIV/AIDS is and how it can be prevented and controlled?
1) Yes ( ) 2) No ( )

43. If 'Yes' Please state the problem(s)
_____
_____

44. If 'No' to Question 39 above, state reasons why you have never educated your congregation members about HIV/AIDS.
_____
_____

45. Have you attended any HIV/AIDS Training Programme? 1. Yes ( ) 2. No ( )

46. If 'Yes' when and where?

	TOPIC	PERIOD	PLACE

47. Do you approve that HIV/AIDS education and messages be taught in line with religious values and doctrines?

1. Yes ( ) 2. No ( )

48. In which forum do you want HIV/AIDS education to be delivered?

	Tick all that applies to you	**YES**	**NO**
1	During sermons		
2	During counseling sessions		
3	During religious and Arabic classes		
4	During camps or seminars		
5	During open dawah/outreach		
6	Special time be created for HIV/AIDS education		
7	Others (Please specify)		

49. Will you be willing to participate in HIV/AIDS Education Training Programme?

1. Yes ( ) 2. No ( )

50. If 'No' give reasons.

_____
_____
_____

51. What other things do you think Islamic religious leaders need in order to effectively fulfill this task?

_____
_____
_____
_____

52. Do you believe that AIDS exist? 1. Yes ( ) 2. No ( ) 3. Not sure ( )

APPENDIX II

AKOJOPO IBEERE

IMO, ERO ATI LILOWO AWON ASIWAJU ESIN ISLAM NINU DIDEKUN ARUN HIV ATI EEDI NI IJOBA IBILE ARIWA IBADAN, NAIJIRIA

IJUWE

Mo ki yin. Oruko mi ni **Ikudaisi Sefiu Olatunde**, akeko lati Ile-iwe giga Unifasiti Ibadan. Akojopo ibeere yi waye lati je ki a mo ero awon asiwaju esin Islam lori kokoro HIV ati arun EEDI, ati bi o se ye won si; pelu akitiyan ati igbese won lati dekun itankale arun yi. Maa dupe pupo fun kikopa yin ninu iwadi mi sa/ma. Mo fe je ki e mo pe ko si idahun ti o tumo sipe e gba tabi si awon ibeere ti ng o ma bi yin. Bakanna, kikopa ninu iwadi yi kii se dandan; ti e ba fe ni. Maa si fun awon idahun, ero ati oruko yin ni aabo ati asiri tio peye.

E jowo e fi amin (**X**) yii si inu apoti idahun ibeere eyi ti o ba ye ni iwaju ibeere wonyi, ati idahun si ibeere ti ko ni awon idahun ti a ro lokan. A dupe pupo fun ireti ifowosowopo yin.

Se mo le tesiwaju pelu ibeere yi sa/ma? (Ti idahun ba je 'rara', dupe lowo oludahun ki o si mu ibeere wa sopin).

Survey Identification #.....
Date.....

ABALA A: ITAN IGBESI AYE EEYAN

1. Se Okunrin ni o tabi obinrin? 1) Okunrin ( )
   2) Obinrin ( )
2. Omo odun mel ni o? _____
3. Kin ipo re nipa oro oko/aya nini?
   1) Mo ti gbeyawo/loko ( )
   2) Apon/Omoge ( )
   3) Opo ni mi ( )
   4) Mo ti ko iyawo/oko mi sile ( )
   5) Nko ba iyawo/oko mi gbe po ( )
4. Iwe/kewu melo lo ka to ga julo?

EKO KEWU		EKO IWE	
1) Ibtidai	( )	1) Iwe alakobere	( )
2) Idadi	( )	2) Ile iwe giga	( )
3) Thanawi	( )	3) Ile iwe olukoni/gbogbonse	( )
4) Diploma	( )	4) Ile iwe giga julo	( )
5) Ile eko giga julo	( )	5) Nko lo si ile iwe	( )
6) Kewu ile/agbele ke	( )		

5. Eya wo ni o je?
1) Yoruba ( ) 2) Hausa ( ) 3) Igbo ( )
4) Eya miran (jowo so oruko eya re)_____

6. Oruko mosalasi/Ijo:_____

7. Ipo re ni mosalasi/ijo re: 1) Imam agba ( ) 2) Imam ( )
3) Amir(ah) ( ) 4) Igbakeji Amir(ah) ( ) 5) Mufaseer ( )
6) Igbakeji Imam ( )

8. Iruwo ni mosalasi re nse? 1) Ratibi ( ) 2) Jamiu ( )
3) O wa ni ibi ise ( ) 4) O wa ni adugbo ( )
5) Se aleye iru wo ni:_____

9. Igbawo ni a da mosalasi/ijo re sile?_____

10. Oruko ijo Musulumi ti o wa:

1) Teblig. ( ) 2) Ansardeen ( ) 3) Ahmadiyah ( )

4) Tadm'nu (OTM) ( ) 5) Nawaruden ( ) 6) Anwarul-Islam ( )

7) NASFAT ( ) 8) QUAREEB ( ) 9) The Muslin Congress ( )

10) Muslim Students Society (MSSN) ( ) 11) Zumuratul-Ijaj ( )

12) Daruko ijo wo ni:_____

11. Iye odun ti o ti lo ni ipo ni mosalasi/ijo re bayi:_____

ABALA B: IROYIN LORI IMO NIPA KOKORO HIV ATI ARUN EEDI

12. Se o ti gbo nipa kokoro HIV ati arun EEDI?
1) Beeni ( ) 2)Beeko ( )

13. Ti o ba je 'Beeni', ni igba wo leyi? _____

14. Awon ona wo ni o gba mo nipa HIV/AIDS?

	AWON ONA	BEE NI	BEE KO
1	Oniroyin (bii ero amohunmaworan, asoromagbesi ati iwe iroyin)		
2	Ebi ati awon ore mi		
3	Dokita ati awon eleto ilera		
4	Idanileko		
5	Ipade esin		
6	Ile-eko		
7	Ona miran (daruko)		

15. Ni agboye tire, arun wo ni a npe ni EEDI?

_____
_____
_____

16. Kinni ajosepo to wa laarin kokoro HIV ati arun EEDI?

_____
_____
_____

17. Orisirisi ona ni awon eniyan nso pe kokoro HIV ngba lati tan; ati ona lati dekun itankale kokoro yii. Jowo, ronu ki o si dahun boya ooto ni, iro ni tabi o ko mo si okookan awon oro ti o wa ni isale yii.

Awon ona ti kokoro HIV ngba lati tan

Kokoro HIV lee tan:		Bee ni	Bee ko	Nko mo
1	Lati ibi ajolopo nkan mimun bii abefele, abere gbigba ati abe ifari ti eni ti o ni kokoro HIV ti lo			
2	Lati ibi ibalopo alaidabo bo pelu (awon) eni ti o ni kokoro HIV			
3	lati ibi ki efon tabi kokoro miran je eniyan			
4	Lati ibi afise tabi owo aye			
5	Lati ibi owo bibo pelu (awon) eni ti o ni kokoro HIV			

18. **Awon ona lati dekun itankale kokoro HIV**

Itankale Kokoro HIV see dekun pelu:		Bee ni	Bee ko	Nko mo
1	Lilo ogun apakokoro oyinbo siwaju ati lehin ibalopo			
2	Sise ayewo eje fun kokoro HIV siwaju ki a to fun alaisan			
3	lati ma jolo ile-igbose po pelu (awon) eni ti o ni kokoro HIV			
4	Yiyago fun atunlo abere gbigba ju fun eniyan kan lo			
5	Kikoraro kuro nibi ibalopo siwaju igbeyawo ati pelu eni ti kiise aya/oko eni.			

ABALA C: IWOYE SI KIKOPA NINU IDANILEKO FUN DIDEKUN ITANKALE ARUN HIV ati EEDI

19. Ewo ninu awon oro/gbolohun isale yii ni o le fi ero re han julo lori arun HIV ati EEDI?

(1) Awon Musulumi seese ki won ko arun HIVati EEDI ju awon ijo yoku lo ( )

(2) Awon Musulumi seese ki won ma ko arun HIV ati EEDI to awon ijo yoku ( )

(3) Awon Musulumi seese ki won ko arun HIV ati EEDI gege bi awon ijo yoku ( )

Iha ti O ko si kikopa ninu didekun itankale arun HIV ati EEDI

S/N	Awon gbolohun oro	Mo fara mo	Nko fara mo	Nko le so
20	Arun HIV ati EEDI je ewu fun alaafia ati irorun ni awujo			
21	Enikeni lo le ni arun HIV ati EEDI lai fi ti ojo ori, eya tabi esin se			
22	Awon ti ongbe pelu HIV ati EEDI ni a o da lebi lori ipo ti won wa			
23	Awon alaisan ti o ni kokoro HIV ye ki won wa laye oto; ki won si dawon duro si ile-iwosan lati dena ki elomiran ma baa ko kokoroyi lati ara won			
24	Awon asiwaju esin Islam ni ipa Pataki lati ko lori igbiyanju lati dena itankale arun HIV ati EEDI			
25	Ko ye ki awon asiwaju esin Islam maa soro lori arun HIV ati EEDI nitoripe o nii se pelu oro ibalopo akoati abo; ti o le ran iwa ibaje lowo			
26	Adua ati irun kiki to lati daabo bo awon olujosin kuro nibi arun HIV ati EEDI			
27	Eko nipa didena itankale arun HIV ati EEDI kose pataki ni mosalasi toripe ko le dena ki awon Musulumi ko arun yii			
28	O ye ki awon asiwaju esin Islam gbe idanileko kale lori didena arun HIV ati EEDI fun awon omo ijo won lorekoore			
29	Awon asiwaju esin Islam ni bukata si imo ati irohin tokun lori arun HIV ati EEDI siwaju ki won to le maa salaye daadaa nipa re fun awon olujosin tabi omo ijo won			
30	Awon asiwaju esin Islam gbodo gba iyonda lowo awon alakoso ati olujosin ni mosalasi siwaju ki won to se waasi lori arun HIV ati EEDI			
31	Awon legbelegbe ninu Islam gbodo se iranlowo adua ati ohun ilo fun awon ti o ngbe pelu arun HIV ati EEDI			
32	O ye ki awon asiwaju esin Islam maa gba awon omo ijo won ni iyanju lati lo se ayewo fun kokoro HIV lati mo ipo ilera won nipa re			

ABALA D: Awon ohun ti o nse idiwo fun eto idanileko lori arun HIV ati EEDI

33. Nje irohin nipa arun HIV ati EEDI ti jeyo ri ninu waasi re fun awon omo ijo/olujosin ni mosalasi re bi?
    (1) Bee ni ( ) (2) Bee ko ( ) (3) Nko le ranti ( )

34. Ti o ba je "Bee ni", o to igba emelo ti eyi ti waye laarin odun kan si asiko yi?_____

35. Nje o ti diidi se waasi ti o da lori arun HIV ati EEDI fun awon omo ijo tabi olujosin ni mosalasi re bi?

(1) Bee ni ( ) (2) Bee ko ( ) (3) Nko le ranti ( )

36. Ti o ba je "Bee ni", o to igba emelo ti eyi ti waye titi di si asiko yi? _____

37. Nje eleto ilera ti wa ri lati se idanileko lori arun HIV ati EEDI ni mosalasi/ijo yin?

(1) Bee ni ( ) (2) Bee ko ( ) (3) Nko le ranti ( )

38. Ti o ba je "Bee ni", o to igba emelo ti eyi ti waye titi di si asiko yi? _____

39. Nje mosalasi/ijo re ti gbe eto idanileko kale ri lori arun HIV ati EEDI fun awon olujosin/omo ijo bi?

(1) Bee ni ( ) (2) Bee ko ( ) (3) Nko le ranti ( )

Ti o ba je **"Bee ko", tabi "Nko le ranti"**, jowo lo si ibeere ekerinlelogoji (44)

40. Ti o ba je "Bee ni", igba emelo ni eto idanileko bayi ti waye titi di si asiko yi? _____

41. Jowo se alaye wonyi lori awon eto idanileko naa

Irufe Eto Idanileko	**Asiko ti o waye**	**Iye igba ti o waye**	**Awon ti a fi ori idanileko so**	**Awon idi ti a fi gbe idanileko kale**

42. Nje e koju isoro/ipenija eyikeyi nipa ati je ki awon olujosin gbo agboye ohun ti arun HIVati EEDI nse; ati ona latidena/dekun re?

(1) Bee ni ( ) (2) Bee ko ( )

43. Ti o ba je 'Bee ni' jowo so irufe isoro tabi ipenija wonyi

_____
_____
_____

44. Ti o ba je **"Bee ko"** si ibeere ikokandinlogoji (39), so awon idi ti e ko ti fii se igbekale irufe eto idanileko yi ri ni mosalasi/ijo yin.

_____
_____
_____

45. Nje o ti kopa ri ninu eyikeyi idanileko lori arun HIV ati EEDI?

(1) Bee ni ( ) (2) Bee ko ( )

Ti o ba je “Bee ni”, ni igba ati aaye wo ni o ti waye?

Akori idanileko	Igba	Aaye

47. Se o fi owo si wipe agbekale eko lori arun HIV ati EEDI gbodo maaje ni itele ilana ati ofin oro olohun? (1) Bee ni ( ) (2) Bee ko ( )

48. Ni awon aaye tabi igba wo ni O nfe ki idanileko lori arun HIV ati EEDI ti maa waye?

	S’ami si gbogbo eyi ti o fe	Bee ni	Bee ko
1	Ni awon asiko waasi sise		
2	Ni awon asiko idani nimoran ati igbani niyanju		
3	Ni awon akoko eko esin ati kewu		
4	Ni awon akoko ipago		
5	Ni awon akoko ipepe ati itaniji si esin		
6	Yiya asiko oto sile fun idanileko lori arun HIV ati EEDI		
7	Ni awon akoko ayeye sise		
8	Apejo miran bii (soni pato)		

49. Se o fe lati kopa ninu eto idanileko lori arun HIV ati EEDI?
(1) Bee ni ( ) (2) Bee ko ( )

50. Ti o ba je ‘Bee ko’so idi

_____

_____

51. Kinni awon nkan miran ti o ro wipe awon asiwaju esin Islam nilo ti igbiyanju won yi yoo ba lapa?

_____

_____

52. Se o gbagbo pe aarun HIV ati EEDI nbe bi?
(1) Bee ni ( ) (2) Bee ko ( ) (3) Ko da mi loju ( )

APPENDIX III

RECORD REVIEW GUIDE

NAME OF THE MOSQUES/GROUPS	DATE OF SERMON / ACTIVITIES ABOUT HIV/AIDS-RELATED ISSUES	CONTENTS	NUMBER OF PERIODS

APPENDIX IV

Names of mosques in Ibadan North Local Government Area used for the study.

WARD ONE

S/N	Names of Mosques	Community located
1	Islamic Missionary Society Central Mosque	Odo-Oye
2	Ayegbami Mosque	Odo-Oye
3	Ayope Mosque	Isale-Afa
4	Kifu Mosque	Isale-Afa
5	Sawia Mosque	Isale-Afa
6	Oluwatosin Mosque	Yemetu
7	Inaolaji Central Mosque	Agbadagbudu
8	Are Latosa Mosque	Oke-Are
9	Ogo-Oluwa Mosque	Oke-Are/Agala
10	Ajimotokan Mosque	Beere/Kannike
11	Olubodun Mosque	Beere/Kannike
12	Bello Bodija Mosque	Beere/Kannike

WARD TWO

S/N	Names of Mosques	Community located
13	Al-Barika Central Mosque	Ire Akari/Ode-Oolo
14	OlohunSogo Mosque	Ire Akari/Ode-Oolo
15	Bola Mosque	Ode-Oolo/Inalende
16	Lakanpo Mosque	Ode-Oolo/Inalende
17	Nawar-deen Society Central Mosque	Ode-Oolo/Inalende
18	Adeta Mosque	Inalende/Agala
17	Layaju Mosque	Inalende
20	Nurudeen Society (Atomoesin) Mosque	Inalende
21	Ayilara Mosque	Inalende
22	Ansarul-Islam (Ayegun) Mosque	Inalende
23	Akowo Mosque	Oniyanrin
24	Alagbeja Mosque	Oniyanrin
25	Alagogo Mosque	Oniyanrin/Agala
26	Odunade Mosque	Opo Yeosa
27	Atuka Mosque	Oke Sapati

WARD THREE

S/N	Names of Mosques	Community located
28	Omo Shehu Central Mosque	Yemetu Igosun
29	Igosun Mosque	Yemetu Igosun
30	Olohunsogo Central Mosque	Oje-Igosun
31	Igbira Mosque	Yemetu Alawada
32	Oluwakemi Mosque	Yemetu-Kanbi Alawada
33	Fiwakesin Mosque	Yemetu Alawada
34	Matanga Mosque	Yemetu Agip
35	Abijamori Mosque	Yemetu Aladorin
36	Yekere Central Mosque	Yemetu/Idi-ose
37	Akabiako Mosque	Yemetu
38	Omo Iya Mosque	Oke-Aremo/Yemetu
39	Alaadun Mosque	Oke-Aremo
40	Adeoyo Maternity Central Mosque	Adeoyo Hsopital
41	Logudu Mosque	Adeoyo-Isale Afa
42	Atere Mosque	Adeoyo
43	Dauda Mosque	Adeoyo
44	Irepodun Mosque	Kadelu compound, Adeoyo
45	Ali Balogun Mosque	Oje

WARD FOUR

S/N	Names of Mosques	Community located
46	Oje market Central Mosque	Oje market
47	Ariyibi Mosque	Oje Igosun
48	Omikunle Mosque	Yemetu Igosun
49	Onimosa Mosque	Onimsa/Yemetu Igosun
50	Omo Oba Mosque	Oke compound
51	Oke Apon Central Mosque	Oke Apon
52	Al-Qudus Mosque	Kube
53	Iya Isale Afa Mosque	Kube
54	Abidi-odan Mosque	Abidi-odan/Ajibodu
55	Orisunbare/Fojugbagi Mosque	Atenda

WARD FOUR (CONTD)

56	Gaa Mosque	Gaa Atenda
57	Asawale Mosque	Ajibodu street, Atenda
58	Oganla Mosque	Ajibodu stret, Atenda
59	Lamini Mosque	Lamini/Atenda
60	Aliwo Central Mosque	Aliwo
61	Alaro Mosque	Gbenla – Ile Alaro
62	Idi-Omo Mosque	Idi-Omo
63	Odonigi Mosque	Idi-Omo/Itutaba
64	Surajudeen Islam Society Mosque	Itutaba/Oje

WARD FIVE

S/N	**Names of Mosques**	**Community located**
65	Islamic Missionary Society Central Mosque	Bashorun
66	Opeyemi Mosque	Bashorun
67	BCOS (Cenral) Mosque	Bashorun
68	Allahu-Wahid Mosque	Ashi/Egbeleke
69	Eberu Olohun Mosque	Ashi
70	Ashi Central Mosque	Ashi
71	Rainbow Mosque	Ashi/Rainbow
72	Olona Central Mosque	Akingbola
73	Elerumoke Central Mosque	Akingbola/Bodija
74	Akingbola Central Mosque	Akingbola
75	Ikolaba Central Mosque	Ikolaba
76	Federal Secretariat Mosque	Ikolaba
77	Ibadan North secretariat Central Mosque	Gate
78	Oyo SUBEB Mosque	Agodi Gate
79	Araromi Central Mosque	Gate
80	Total Central Mosque	Gate

WARD SIX

S/N	**Names of Mosques**	**Community located**
81	Daru-Dawah Mosque	Sabo, zone 4

WARD SEVEN

S/N	Names of Mosques	Community located
82	Al-Barika Central Mosque	Oke-Itunu
83	OlohunsogoCentral Mosque	Oke-Itunu
84	Egbotoluwa Mosque	Oke-Itunu
85	Hijrah Mosque	Ajegunle/Coca Cola
86	Nurudeen oke ifelodun Mosque	Coca Cola
87	Aragba Lay-out Central Mosque	Coca Cola
88	Ahmadiyah Jamat Mosque	Coca Cola
89	Olusogo Mosque	Ore meji

WARD EIGHT

S/N	Names of Mosques	Community located
90	Sango Central Mosque	Sango ojurin
91	Shorunke Memorial Mosque	Sango
92	Olohungbebe Mosque	Sango
93	Olohunlose Mosque	Sango ojurin
94	Humu Hani Alaga Central Mosque	Sango oja
95	Onle Nla Mosque	Sango oja
96	Alapata Mosque	Sango oja
97	Olohun Ero Mosque	Surulere street, Sango
98	Bembo Olohunsogo Mosque	Bembo Sango
99	Al- Barika Mosque	Bembo Sango
100	Olohunda Central Mosque	Iso pako,Sango
101	Ajere Mosque	Iso pako, Sango
102	Akorede Central Mosque	Akorede/Sango
103	Akoronfayo Mosque	Patako
104	Pebore Mosque	Patako
105	Patako Central Mosque	Patako
106	Omo Shehu Mosque	Idi- Ito/ Patako
107	Boro Central Mosque	Boro, Alaro
108	Ayegbami Mosque	Alaro Ijokodo
109	Fijabi Mosque	Okoro/Oke Itunu
110	Fiwarerekesin Central Mosque	Okoro

WARD EIGHT (CONTD)

111	Alhaji Lawal Mosque	Okoro
112	New Adamasingba Mosque	Okoro
113	Engineer Mosque	Okoro
114	Gbaremu Central Mosque	Ijokodo
115	Ijokodo Central Mosque	Ijokodo
116	Oro-Ofe Mosque	Ijokodo
117	Awerijaye Mosque	Ijokodo
118	Ijokodo community Central Mosque	Ijokodo
119	Olohun Gbadu'a Mosque	Agbaje Ijokodo
120	Aloko Mosque	Agbaje Ijokodo
121	Fadlullahi Central Mosque	Agbaje Ijokodo
122	Ansar-deen Central Mosque	Ijokodo
123	MobOluwaduro Mosque	Agbaje Ijokodo
124	Custom Central Mosque	Ijokodo
125	OlohunLose Mosque	Ijokodo

WARD NINE

S/N	**Names of Mosques**	**Community located**
126	Nasirudeen OlohunSogo Central Mosque	Mokola/Premier Hotel
127	Premier Hotel Central Mosque	Premier Hotel
128	Ago Tapa Central Mosque	Mokola/Ago Tapa
129	Ago Ilorin Central Mosque	Mokola/Ago Ilorin
130	Ago Igbira Mosque	Mokola/Ago Igbira
131	Itesiwaju Adeen Mosque	Kabiawu street/Mokola

WARD TEN

S/N	**Names of Mosques**	**Community located**
132	AL-Barika Mosque	State secretariat
133	Masjidul-Awwal	State secretariat
134	State secretariat Central Mosque	State secretariat
135	Aninaloju Mosque	Ajibade/Coca Cola
136	Zikirat Memorial Mosque	Obasa
137	Bodija Muslim community central Mosque	Housing, old Bodija
138	UCH Central Mosque	UCH

WARD ELEVEN

S/N	Names of Mosques	Community located
139	Izudeen-Islam Mosque	Samonda
140	Samonda Central Mosque	Samonda
141	The Polythecnic Central Mosque	Polythecnic Ibadan
142	Abadina Mosque	U.I
143	U.I Central Mosque	U.I

WARD TWELVE

S/N	Names of Mosques	Community located
144	Ogo Oluwa Mosque	Agbowo zone
145	MosadOluwa Mosque	Agbowo zone
146	Ahmadiyah Central Mosque	Agbowo zone
147	L. Adisa Central Mosque	Barika
148	ImamZubair Central Mosque	Barika
149	Aranse-Oluwa Mosque	Barika
150	Ojokondo Mosque	Ojokondo
151	Temidire Central Mosque	Ojokondo
152	Ike-Oluwa Central Mosque	Ojokondo
153	MobOluwaduro Mosque	Apata zone, Agbowo
154	Ike Olohun Mosque	Apata zone, Agbowo
155	Apata kekere Mosque	Apata zone, Agbowo
156	Kunfayakun Mosque	Apata zone, Agbowo
157	Ogo Oluwa Mosque	Apata zone, Agbowo
158	Ansarudeen Central Mosque Division 6	Apata zone, Agbowo
159	Apata Central Mosque	Apata zone, Agbowo
160	Tawakakitu Mosque	Agbegba zone,Agbowo
161	Agbegba Central Mosque	Agbegba zone/Agbowo
162	OlohunGbebe Mosque	Ilupeju zone, Agbowo
163	Ilupeju Mosque	Ilupeju-OlohunGbebe zone
164	Araromi Mosque	Aponrin zone
165	AponrinCentral Mosque	Aponrin zone
166	Araromi Ilupeju Mosque	Olive Aduloju
167	Ifedapo Mosque	Olive zone

WARD TWELVE (CONTD)

168	Animashaun Mosque	Farayola zone
169	Suadai Farayola Central Mosque	Farayola/Bodija
170	Istijabah Mosque	Alamuyo
171	Alhaji Raheem 10/10 Mosque	Alamuyo, isopako
172	Iyana Bodija Central Mosque	Temidire express
173	Aduamigba Mosque	Express, Iyana Bodija
174	Bodija market Central Mosque	Bodija market
175	Surulere Central Mosque	Bodija market
176	Odunola Mosque	Bodija iso Pako
177	Irorun-Oluwa zone 6 Mosque	Bodija iso Pako
178	Alamuyo (Better Life) Mosque	Bodija iso Pako
179	Ifesowapo zone 9 Mosque	Bodija iso Pako

Names of Islamic societies/groups used for the study

S/N	Names	Community located	Ward
1	Shabab Nasruul-Islam	Inalende/Bola	2
2	Al-Mu'minat organization	Inalende	2
3	The Muslim Congress (TMC)	Oke-Aremo	3
4	Imole Adura Atude society	Odonigi/Itutaba	4
5	FOMWAN	Bashorun	5
6	Dawah Front of Nigeria	Bashorun	5
7	Qomorudeen-Fathi-il-Society of Nigeria	Bashorun	5
8	AL-BUR'AN Islamic organization (Zone II)	Sango ojurin	8
9	AL-WAJUD Prayer Group	Housing cooperation	10
10	UCH MSSN	UCH	10
11	Banatu-L –Islam Prayer Group	UCH	10
12	UI MSSN	University of Ibadan	11
13	NASFAT	Samonda	11
14	Sherifudeen Jihadist Islamic Organization	Apete	11
15	Poly MSSN	Polythecnic of Ibadan	11