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ANALYSIS OF FAMILY ROLE IN HIV/AIDS PREVENTION AMONG THE ILAJES' OF SOUTH WESTERN NIGERIA

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Abstract

The global statistics on HIV/AIDS still show that over 40 million persons are infected. The sub-Saharan African countries contain above 60 percent of the Global burden and Nigeria, carries about 8 percent of the Global burden (Ifeanyi, 2004). There has been a steady increase in the HIV/AIDS prevalence in Nigeria is since the 1980s. While worldwide spending on AIDS treatment totalled between $3.3million and 4.5 million in 1990, only two percent of the money was spent in Africa where 50 percent of the world's AIDS cases are found. Expectedly, the developed countries provided over 84 percent of the amount. However the world health organization stressed that in order to have any real hope of slowing the spread of the epidemic, the world needs to spend at least 20 times more in developing countries in the global fight against AIDS. The organization also pointed out that what the world community commits to preventing AIDS in the4 next couple of years will directly affect the course of the epidemic over the next two or three decades. In response to the epidemic, various measures have been taken at the local, national and international levels to prevent the transmission. Despite such programmes for prevention, efforts to date have not been sufficiently impactful to adequately control HIV/AIDS. Various drugs have been invented, new once are being discovered and administered, yet people are still being infected and are still subjected to various excruciating experiences. Prevention remains the best way of capturing the epidemic. Therefore in recognition of existing lacunae in previous programmes and attempts made to prevent the epidemic, the study examines roles of the family in HIV/AIDS prevention.

Keywords: HIV/AIDS, Epidemic, Infection, Drugs, the Family, PLWHA.

INTRODUCTION

The global statistics on HIV/AIDS still show that over 40 million persons are infected. The sub-Saharan African countries retain above 60 percent of the global burden and Nigeria, even with a reduced prevalence from 5.8 percent in 2001 to 5 percent in 2003, shares about 8 percent of the global burden (Ifeanyi, 2004). However, there has been a steady increase in the HIV/AIDS in Nigeria since the 1980s.

In fact, the sub-Saharan Africa is the hardest hit region in the world (Lamptey, 2002; Ahamefule, 2004). In Nigeria, like other countries in the sub-Saharan Africa, HIV/AIDS continues to ravage families and communities. On a global level, 14,000 people become infected with HIV each day (Lamptey, 2002:3). At least 95 percent of these new infections occur in less developed countries and unless the international community launches a

coordinated and massive response to the epidemic there will be 45 million new infections by 2010 (Lamptey, 2002; Federal Ministry of Health, 2001).

In recent times, more people died of AIDS related illness than any other causes. As at 2000, the cumulative HIV/AIDS associated deaths worldwide was 21.8 million and 3.2 million of these deaths were children. Most of these deaths were in the sub-Sahara African countries, including Nigeria (the most populous country in Africa with an estimated population of approximately 126 million (Population Reference Bureau, 2003). South Africa has the highest number (5 million) of HIV infections across the globe. This is followed by Botswana with 39 percent adult HIV prevalence rate (Population Reference Bureau, 2003; Nwafor and Madu, 2002; Lamptey, 2002).

While worldwide spending on AIDS treatment totalled between $3.3 million and N4.5 million in 1990 only two percent of the money was spent in Africa where 50 percent of the world's AIDS cases are found. Expectedly, the developed countries provided over 84 percent of the amount. But the World Health Organisation stressed that in order to have any real hope of slowing the spread of the epidemic, the world needs to spend at least 20 times more in developing countries in the global fight against AIDS. The organization also pointed out that what the world community commits to preventing AIDS in the next couple of years will directly affect the course of the epidemic over the next two or three decades. Has the family been considered as a veritable tool in the prevention of the epidemic?

In response to the epidemic, various measures have been taken at the local, national and international levels to prevent the transmission. Despite such programmes for prevention, efforts to date are not sufficiently impactful to adequately control HIV/AIDS. Various drugs have been invented, new ones are being discovered and administered, yet people are still being infected and are still subjected to various excruciating experiences. Prevention remains the best way of capturing the epidemic. Therefore in recognition of existing lacunae in previous programmes and attempts made to prevent the epidemic, the study examines family role in HIV/AIDS prevention.

The paper intends to analyse the family role in HIV/AIDS prevention.

1. identify the attitude of the Ilaje towards HIV/AIDS.
2. examine the consequences of HIV/AIDS on the Ilaje's family
3. find out the roles that family members play in the prevention of HIV/AIDS infection in their family.
4. examine the ways by which the family can help reduce HIV/AIDS

Methodology

Methodology is the blueprint and procedure that must be followed in data collection. Methodology determines the quality and success of any research work. Thus, it serves as the philosophy of the research process. Survey design will be adopted for the study and quantitative technique particularly well structured questionnaire will be employed to elicit data. The methodology of the study will be discussed under the following sections: research design, study population, sampling procedure, research instrument and method of data analysis.

Research Design

Survey design is adopted for the study because it does not involve deliberate manipulation of the research subjects as in the Experimental Design (Asika, 2004). The variables that will be measured in the study could be captured through the application of well-structured questionnaire.

Study Area

The study area is restricted to the Ilaje community in the south-western Nigeria. The Ilaje originally settled in riverine areas of Ondo State from where some of them migrated to Lagos Island and settled.

Study Population

The study population consists of men and women aged 15 - 64 years because they are the cohorts that suffer most from HIV /AIDS. Study population cut across about 10, 000 Ilajes, who presently settle in Lagos Island.

Sampling Procedure

Multi stage sampling techniques was employed to draw a representative sample for the study. The choice of this sampling procedure is informed by the absence of reliable sampling frame and the need to generate self-sampling frame to guarantee that the study sample is representative. The sampling process will cut across different stages as follows: First, a list of all major streets among the Ilaje was prepared. There are about thirty of such streets. Second, through simple random process, fifteen of these streets were selected. Third, at this stage, a census of households in each of the selected streets was conducted and systematic random sampling was employed to select 20 households from each street. Fourth, within each of the selected households, a sample of male and female in the 15-64 years age bracket was drawn. Finally, in each of the selected households 2 persons (1 male and 1 female) were selected via simple random process. Therefore in each selected street, 20 households and 40 persons were selected. In all the fifteen streets selected, a sum of 600 respondents was randomly selected on proportional basis.

Theoretical Framework

Opinions of different scholars are summarised to find out the current state of knowledge on the family role in HIV/AIDS prevention. It is obvious that many studies established relationship between the family and HIV/AIDS prevention but specific positive cultural pattern is still elusive hence stigma and discrimination against the PLWHA remain unabated. Thus, this paper would identify the gaps in literature with respect to examining the analysis of family role in HIV/ AIDS prevention. Therefore, to find out the current state of knowledge on the study, this paper presents a review of previous attempts made by scholars concerning HIV/AIDS infection and control. This paper is hereby discussed under the following sections:

1. Prevalence of HIV/AIDS in Nigeria
2. Socio-cultural factors influencing HIV/AIDS in Nigeria
3. Consequences of HIV/AIDS on the family
4. Prevention of HIV/AIDS in Nigeria

Prevalence of HIV/AIDS in Nigeria

The first AIDS case in Nigeria was reported in 1986. Since then the numbers rose exponentially to 18, 334 as of December 1997, with more than 50 per cent of the cases reported between 1996 and 1997. In 1999, total number of AIDS cases grew. The National AIDS and Sexually Transmitted Diseases Control Program (NASCP) of the Federal Ministry of Health estimated that this figure represents less than 20 per cent of actual cases due to non-recognition of cases, non-diagnosis, under-reporting, late reporting and no reporting.

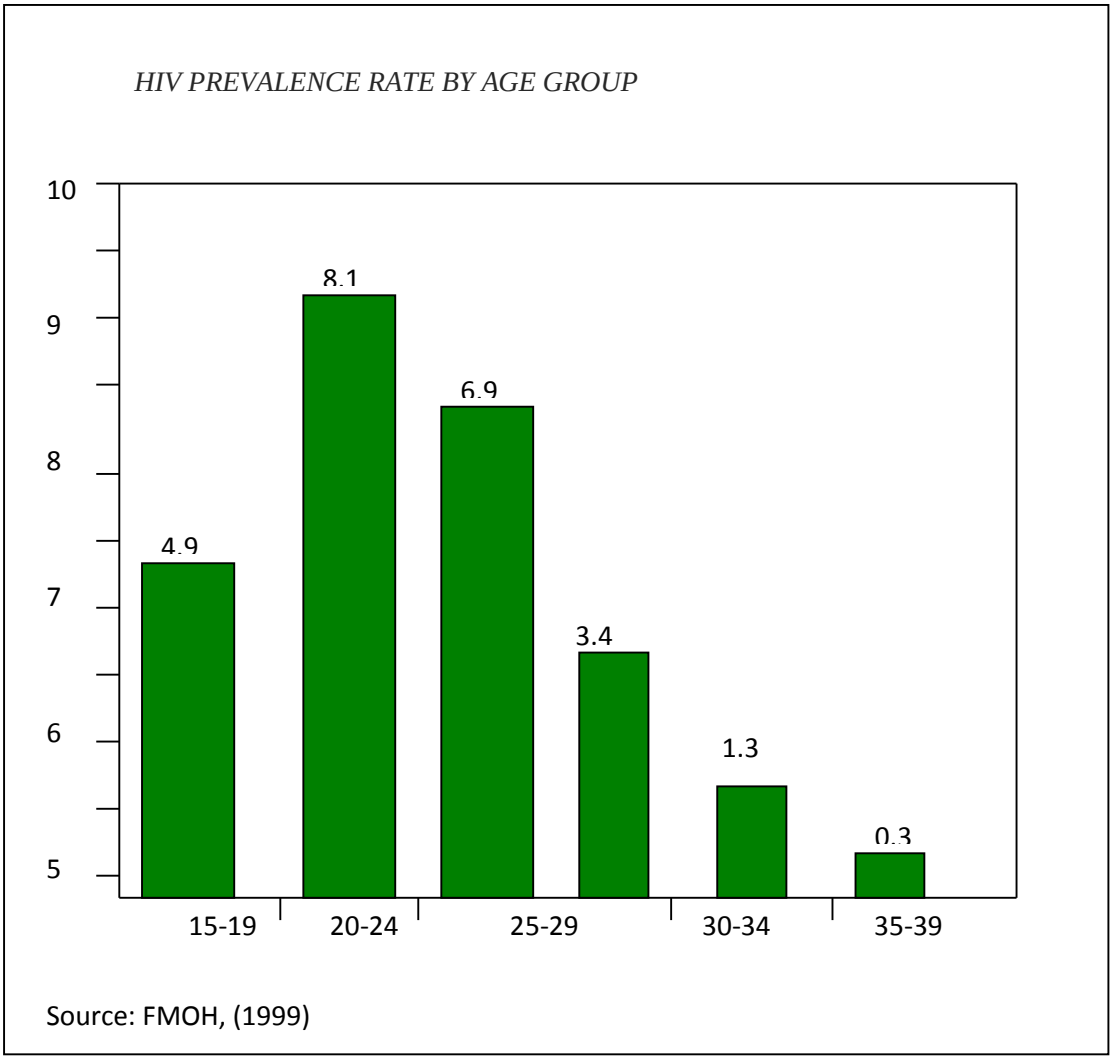
National Sentinel Surveillance data from 1990 – 1999 showed an increase in prevalence from less than 1 per cent in 1990 to 1.2 per cent (1991/1992), 3.8 per cent (1993/1994), 4.5 per cent (1995) and 5.4 percent (1999). The prevalence of 5.4 percent indicates that about 2.6 million Nigerians are currently living with AIDS. Yet, the seemingly low national prevalence seems to camouflage the explosive increase in certain areas of the country. Benue State, for example, experienced an increase of more than 700 percent in four years. The prevalence of PLWHA in the state rose from 2.3 percent in 1995 to 16.8 percent in 1999. It is important to note that out of the 73 sentinel sites surveyed in 1999, HIV prevalence was greater than 10 percent in 8 states. Also among youth aged 20-24, the prevalence was between 4.2 percent and 9.7 percent. Another significant information arising from the sentinel surveillance is the fact that 14 states had average HIV prevalence rates that were higher than the national average of 5.4 percent. Also, 19 of the 36 states reported a higher proportion of HIV/AIDS in rural areas.

Many reports confirmed that HIV rates are moderately high in most working sector in Nigeria. For instance out of 398 workers studied; only 37.9% knew about the causative agent of HIV/AIDS. A sum of 96% claimed to have heard of the disease called HIV/AIDS but only 17% knew the mode of transmission and 19% could identify the group at high risk for contracting HIV/AIDS (Odujinrin and Akinkuade, 1991; Dare and Adeniyi, 1994)

WHO (2000) estimated that 95% of Persons Living With HIV/AIDS live in Less Developed Countries and half of them are under 25 years. It was also stated that young women are particularly vulnerable to HIV/AIDS for biological and cultural reasons. For instance, adolescent women are at biological disadvantage because they have fewer protective antibodies than older women and the immaturity of the cervix increases the likelihood that exposure to the infection will result in HIV/AIDS transmission. It is evident from the above that the labour force has the highest HIV/AIDS infection rates.

Federal Ministry of Health (2002) noted that the number of HIV/AIDS victims in Nigeria would rise steadily until 2015. Similarly, more than 700,000 persons are estimated to die of the epidemic very soon, reaching 4.9 million in 2005 and reaching a plateau of 5.5 million in 2010. It is also noted that the death rate in Nigeria is 14 per 1000, which implies that approximately 1.65 million deaths are annually recorded (Madu and Nwafor, 2002).

Fig 1 PREVALENCE OF HIV/AIDS IN NIGERIA



Socio-Cultural Factors Influencing HIV/AIDS in Nigeria

The spread of HIV has been rapid in many African Countries. The sexual route is the commonest route of transmission in all regions. Since the epidemic began, the factors responsible for its spread have been quite similar from region to region. The predominant route of transmission of HIV in Africa is heterosexual and this is facilitated by the presence of other sexually transmitted diseases (WHO, 2000; African Development Bank, 1993).

In 1998, "the combined wars in Africa killed 200,000 people. Some of the factors that are responsible for the rapid spread of HIV are as follows: Low perception of risk, especially among the active labour force; lack of an effective national blood service; cultural attitudes which make it difficult for women to take decisions about reproductive health issues; Myths and misconceptions about HIV/AIDS; distress in the national economy; low acceptability, availability and use of condoms; and lack of appropriate medical care for STIs. All these factors militate against desired behaviour changes, which could lead to decreased incidence of HIV/AIDS in Nigeria.

In realisation of the foregoing, it is generally agreed that unprotected sexual intercourse, among other factors (infected blood transfusion and mother to the child), is largely responsible for HIV/AIDS infection. In different parts of the world, it is generally believed that over 80 percent of new infections occur through sexual intercourse (Sorenson, 1973; Anderson, 1982; Ladipo, 1983; Taylor, 1985; Dare and Deland, 1994).

Religion beliefs such as Sharia as well as Stigmatization and discrimination remain the major obstacles against HIV/AIDS prevention in Nigeria. In many of the hardest hit countries, government officials and ordinary citizens-including those most affected by the epidemic– often continue to look the other way because of the rejection, discrimination and shame attached to HIV/AIDS (UNAIDS, 1998)

In recent times, some state governments in Nigeria, following the scaling up to the Sharia legal system in their states ordered PLWHA to vacate their states. Jigawa State is an example of a state that ordered PLWHA out of its territory. It is obvious that in the state with anti HIV/AIDS policy, the PLWHA would operate underground and they are not likely to have access to adequate prevention measures including information about antiretroviral drugs.

Many People Living With HIV/AIDS in Nigeria are daily subjected to stigma and discrimination, which lead to violation of their human rights. For instance, discrimination against People Living With HIV/AIDS occurs in the health sector through testing some People Living With HIV/AIDS without their consent, breach of confidentiality and denial of treatment due to HIV/AIDS status. In the workplace, People Living With HIV/AIDS are either refused employment or dismissed from work due to HIV/AIDS status. In addition, People Living With HIV/AIDS are often ejected from their accommodation and some are often ostracized by friends and family members due to HIV/AIDS status. These amount to violation of human rights of People Living With HIV/AIDS as enshrined in the international and regional human rights instruments (Durojaiye, 2004).

It is in this context that the Global Business Council on HIV/AIDS agreed that policies must be made to prevent the further spread of HIV while also protecting the human rights of those who are infected with HIV and those who are not. The Global Business Council on HIV/AIDS seriously consider the following: A review of the legality of HIV/AIDS policies; an evaluation of their public health goals; an assessment to determine whether the policies can achieve those goals; and cost – benefit analysis to determine whether the benefits outweigh the financial human rights burdens.

Consequences of HIV/AIDS on the Family

Many studies have identified various consequences of HIV/AIDS. Some of those studies focused on the workplace. For instance, A USAID funded study of Transport Company in Zimbabwe estimated that the HIV/AIDS related cost was 20 percent of the profits. Thus, there is a causal relationship between HIV/AIDS and declining profitability. The principal areas of HIV/AIDS impact on organisation are increased absenteeism and increased organisation disruption. Recent studies of East Africa business showed that absenteeism accounted for between 25-54 percent of costs thereby leading to reputation losses and reduction in customers. The observed increased in absenteeism was due to HIV induced illnesses, demand for caring for family members and the need to attend funerals (UNAIDS, 2000).

It was further revealed that HIV/AIDS result into high rates of morbidity and mortality, which generate increasing disorganization within the family due to rising number of orphans, loss of breadwinners and declining social security for the children. HIV/AIDS increases cost in many ways such as insurance cover, pension, health management and funerals. A study of commercial agro-allied estate in Kenya showed that AIDS related medical expenses rose to over 400 percent above the projected expenses without AIDS. Barclays Bank in Zambia experienced 36 AIDS death out of 1600 employees (a rate ten times the death rate in most US companies) (UNAIDS, 2000, UNAIDS, 2003).

In light of the foregoing, AIDS, in the world today, is regarded as the leading cause of death. It has dire effects on the family. HIV/AIDS affects men and women very differently. It also contributes significantly to the rise of female-headed households and because AIDS claims people at the prime of their youth, most of the widows are younger and are compelled to work very hard to cater for their numerous dependents, some of whom have been left behind by their husbands (Jones and Jones, 1975).

The negative impact of AIDS is left in virtually every facet of the family. It kills adults prematurely as people in their most productive age (15 and 60) are being killed. HIV/AIDS undermines development. The impact of AIDS is often intricately linked to complex social and developmental issues that include human rights, discrimination, poverty, inadequate healthcare and the marginalization of women. In effect, with the national prevalence of 5.4 percent, the direct and indirect cost of AIDS could exact a heavy toll on the Nigerian economy.

By the year 2002, about 4.9 million youths in Nigeria are HIV-infected. Hospital records have shown in some places that children who occupy three quarters of beds on hospital paediatric were ill from HIV. Millions of adults have died leaving behind them-orphaned children and surviving partners who are infected and also in need of care. Families are struggling to find money to pay for funerals and employers of labour now train more hands to replace dead ones. There is a dismal decline in life expectancy due to AIDS death and also deteriorating child survival rates. Prospect for economic development continues to be dented as the HIV/AIDS epidemics continue to eat away at the economy. It is now clear that, even in Nigeria, business is already beginning to suffer due to the negative impact of HIV/AIDS (Nwafor and Madu, 2002).

Prevention of HIV/AIDS

According to the United Nations (1996), "several years of experience in addressing the HIV/AIDS epidemic have confirmed that the promotion and protection of human rights constitute an essential component in preventing transmission of HIV and reducing the impact of HIV/AIDS. The protection and promotion of human rights are necessary both to the protection of the inherent dignity of persons affected by HIV/AIDS and to the achievement of public health goals of reducing vulnerability to HIV infection, lessening the adverse impact of HIV/AIDS on those affected and empowering individuals and communities to respond to HIV/AIDS.

Over time, many companies have used, the employee's education approach in providing HIV/AIDS awareness to employees and the PLWHA. This is based on the belief that

employees' education programmes can effectively harness social normative influence to successfully promote HIV prevention, care and coping responses (Wilson et al., 1996).

Many organisations have formulated policies to tackle the danger of HIV/AIDS in order to be part of the solution to the disease, which threatens labour, their families, and the entire work environment. For instance, Coca-Cola, which is a multinational corporation and the largest private sector employer in Africa, has created workplace policies that focus on awareness, prevention, care and treatment for all company employees and their spouses and children. In September 2002, the company expanded the programme to include all 40 independent bottlers of Coca-Cola in Africa, resulting in a comprehensive HIV/AIDS programme for the whole Coca-Cola Africa System.

The rationale behind the formulation of HIV/AIDS programmes includes: fighting HIV/AIDS pandemic in Africa, de-stigmatising PLWHA, extending the productive lifespan of labour and their families and managing the costs of rising medical expenses. Quarterly prevention and awareness campaigns are conducted to include STD diagnosis and treatment, condom distribution, prevention/awareness information, medical coverage for labour and their families, establishment of labour assistance programmes such as free and confidential voluntary counselling and testing for labour, spouses, partners and children.

As a follow up on the above the company gathers both qualitative and quantitative data from all the key locations on a quarterly basis, through a formal evaluation and data collection process. These data usually cover condom distribution, education and awareness sessions, labour participation levels, health care costs, feedback on community outreach activities, number of deaths, absence tracking and so on. The information gathered is used for HIV/AIDS policy adjustment. Through HIV/AIDS programmes factors influencing HIV/AIDS and treatment care and support programmes have been reviewed.

Other companies have also formulated policies to tackle HIV/AIDS in the workplace. American International Assurance, Thailand in 1992 entered into partnership with various NGOs and public health organisations focusing on HIV/AIDS prevention. Chevron Nigeria Limited in 1997 sought to address the problem of HIV/AIDS due to increasing number of diverse motivational factors such as sexual networking at oil locations. Hence the company has engaged in a range of HIV/AIDS education. The company has also engaged with labour unions to identify and map out union leaders roles in workplace intervention and in support of management efforts (UNAIDS, 2003).

In 1998 Levis Strauss and Company developed education video as its new HIV/AIDS policy, which was established in 1982 in Sans Francisco, the USA to create awareness about HIV/AIDS. The company policy is similar to the long-standing HIV/AIDS policy adopted by the some industries in France. In the same piece, Volkswagen, Brazil provided assistance and care to PLWHA including employees by giving employees access to antiretroviral drugs, regular viral load tests and referral to specialised hospitals and home care treatment. In a different way, Anglo Coal established programme for the treatment of opportunistic infections, condom distributions and counselling for employees and partners as a mechanism of managing care and prevention of HIV/AIDS (UNAIDS, 2000).

Theory is a set of propositions or ideas that provide explanation for social phenomena. Theory provides a complementary evidence to support the justification for social research, which in turn serves as the testing ground for validity of theories. Therefore, health belief model and Symbolic Interactionism are employed and synthesised to give the study adequate methodological and theoretical grounding. The relevance of health belief mode can be understood in the light of the family awareness about HIV/AIDS. Such awareness has implications for the family role in HIV/AIDS prevention. Since awareness is likely to influence action, hence the relevance of symbolic interactionism. Interactions between family members may produce stigma and discrimination against person living with HIV/AIDS or predisposition to prevent the epidemic. It is in this light that health belief model and symbolic interactionism become inevitable in the study. Health belief model explains the people's awareness about illness and actions taken for treatment, while symbolic interactionism explains people response to symbols such as HIV/AIDS.

Health Belief Model {HBM}

This model assumes that the beliefs and attitudes of people are critical determinants of their health related behaviour {Igun 1988; Jegede 1998}. Jegede {1995} posited that due to the dynamic nature of culture, beliefs about health seeking tend to change. Health belief model {HBM} is a decision making model that outlines, explains and predicts the likelihood of initiating certain health behaviours which could be preventive or curative treatment (Graeff et al 1993; Rosenstock, 1974).

The model holds that cues to action such as the presence of symptom and the variations in utilization behaviour can account for beliefs concerning four sets of variables: The individual view of own vulnerability to illness; His beliefs about the severity of the illness, which may be defined in terms of physical harm or interference with social functioning; The person's perception of the benefits associated with actions to reduce the level of threat or vulnerability; and his evaluation of potential barriers associated with the proposed action which may be physical, psychological or financial. Perceived susceptibly and perceived seriousness create perception before action.

Jegede (1998) opined that for someone to remain healthy, he must take positive decision and act upon them and therefore, depends on human nature, culture, pattern of health related behaviours and the degree of susceptibility to that particular disease. When individuals are highly susceptible to HIV/AIDS their perception about the epidemic would depend on the public opinion and belief system of the society. For effective prevention of HIV/AIDS every member of the family must accept that HIV/AIDS can affect anybody irrespective of age, race, culture and family background. It is also imperative for every individual to appreciate the seriousness and severity of the HIV/AIDS consequences on the family. Therefore, health educations of the society is very paramount in initiating action to be taken towards seeking various preventive measures to HIV/AIDS and evaluate the potential barriers associated with proposed action by using the available preventive and other HIV/AIDS control measures. In addition, other theories like Herbert Mead's symbolic interaction theory is needed to capture the sociological implications of individual perception of HIV/AIDS with associated stigmatization.

Symbolic Interactionism

According to this perspective, people interact with their fellows on the basis of symbols and language, which are modified in the process of interaction itself. George Herbert [1863-1931] is the most important thinker in the history of symbolic interactionism. Mead's theory accorded primacy and priority to the social world. That is, it is out of the social world that consciousness, the mind and the self emerges. The most basic unit in his social theory is that any act involves two or more persons, and the basic mechanism of the social act is the gesture. Mead looked at an array of mental process as part of the larger social process, including reflective intelligence, consciousness, mental images, meaning, and most generally, the mind. All the mental processes are, in Mead's view, lodged not in the brain but rather in the social process.

Symbolic integrationists are not concerned with the social structural causes of HIV/AIDS, which Marxists might say are related to class inequality, but instead with the social process by which certain individual are perceived as HIV positive. They are concerned to show how certain individual see themselves in terms of their HIV status. Thus the positive HIV status is an important factor influencing the family role in HIV/AIDS prevention. However, many PLWHA still do not disclose their HIV identity due to their mode of interaction with the epidemic. For instance, the interaction of the PLWHA is usually based on fear of stigma arising from public awareness about their positive HIV status. The theory is an explanatory supposition that account for the concept, etiologic, nature, typology, burden and perception of a social stigma as well as strategies commonly employed by the stigmatized for managing information about their stigma status. Stigmatization is the behavioural and attitudinal response directed by people who claim to be normal against those who have been affected by HIV/AIDS. It involves the discriminatory treatment suffered by members of certain groups in the course of social interaction.

Individuals are stigmatized at one time or another, or in one setting or another. The theory reveals that the possessions of stigma always suffer from discrimination. Consequently, stigma bearers are victims of a host of physical and psychosocial burden, in order to cope; the stigmatized reportedly evolve and use effective strategies for managing information about their status and social identity.

Inherent in this theory is an idea that the prevalence of stigma cuts across sexes, various age groups and different social strata. The 'normal' as a group always perceive the stereotypes as inferior. The perception is perpetuated by the use of various labels, stereotypes or derogatory terms to describe the stigmatized. The stigmatized persons on the other hand perceive the normal as being unpredictable in terms of the way they react to stigma. Owing to the discriminatory treatments meted out by morals, stigmatized persons design and use various strategies of coping or ameliorating the burden induced by these undesirable differences. The techniques used by the stigmatized to hide their stigma include: concealment of stigma symbols through change of name, rejection of bifocal lenses as suggestive of old age, confiding of secrets in a carefully selected few, and avoidance of intimacy with others so as to avoid the consequent obligation to divulge closely guarded information.

Conclusion

The findings from the study have demonstrated that the family has a role to play in HIV/AIDS prevention in which education of family members has been recognized at average level. The family role in HIV/AIDS prevention covered mandatory home training for children, HIV/AIDS education, and campaign against HIV/AIDS infection. It has been found that there is a significant relationship between opinion about the epidemic and HIV/AIDS status of family members. This study has implications for the family in terms of its potential ability for reducing the high effects of HIV/AIDS.

In the family, HIV infection can be reduced and brought to the minimum level if all family members went for HIV test and prevented themselves from the spread of the disease. This requires proper policy through adequate awareness campaign for HIV test for everybody. Thus, it could be said that level of awareness about HIV/AIDS prevalence is positively related to individual willingness to go for HIV test due to the fact that if the individuals are free from HIV/AIDS their moral will be high and this will go a long way to increase their life expectancy.

Education of family members is much likely to reduce the HIV/AIDS infection in respect to the extent that education would give them the necessary ideas needed in fighting against HIV/AIDS infection. Also, education would go a long way in helping people know all about the killer disease and how this disease and other STD can be controlled so as for them to be free from infection of HIV/AIDS. It can be concluded that there is a significant relationship between educational qualifications and vulnerability to HIV/AIDS.

Recommendations

Consequent upon the major findings of this study the following recommendations become inevitable for future research purposes.

1. The role of the family in HIV/AIDS prevention should be made known to the general public. This will create the awareness of the killer disease.
2. Proper prevention methods should also be made available at affordable prices so as to make every individual both the rich or the poor be able to take part in the prevention of HIV/AIDS.
3. Protected sex and one partner should be encouraged among the sexually active individuals in the family.
4. The mass media should also be involved in the spread of awareness of prevention of HIV/AIDS infection to the general public. The media campaigns against HIV/AIDS should start from the family.
5. To make awareness effective, the rights of all children should be recognized and their ideas should be taken into consideration in decision-making process concerning their sexual behaviour.
6. Availability of free condom for sexually active family members should be of utmost priority to family head because a family head that ignores the sexual behaviour of its members is bound to lose many of its children to HIV related problems.

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