

# An Assessment of the Role of School Counsellors in Preventing HIV/AIDS among Secondary School Students in Osun State, Nigeria

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## Abstract

*The study investigated the level of awareness of HIV/AIDS among secondary school students in Osun State, It assessed the precautionary measures taken by secondary school students against the transmission of HIV/AIDS and appraised the activities of school counsellors in the prevention of HIV/AIDS. The study was an ex-post facto. Data were collected through a survey that was conducted among secondary school students in ten Local Government Areas (LGA) of Osun State.*

*The results showed that level of awareness of HIV/AIDS among the students was high. Majority of the respondents (99.0%) indicated that they had heard about AIDS. Also, 98.0% believed that there is AIDS. However, 67.9% indicated that they have never seen an AIDS patient. With regard to how AIDS can be contacted, majority of the respondents (85.7%) indicated through sharing of syringes, blade and shaving kits, sexual intercourse with an infected person (82.0%), transfusion of infected blood (81.3%) and homosexuality (63.8%). Awareness of HIV/AIDS had a positive relationship with the practice of precautionary measures against the transmission of the disease ( $r= 0.20, p<0.05$ ). There was also a significant relationship between activities of school counselors and the practice of precautionary measures ( $r= 0.32, p<0.05$ ). The results however showed no significant difference between male and female secondary school students in their practice of precautionary measures against the transmission of HIV/AIDS ( $t = 0.89, p> 0.05$ ). The study concluded that school counsellors are indispensable in the prevention of HIV/AIDS among secondary school students and that effective health education is the antidote for the prevention and spread of the pandemic.*

## Introduction

One of the leading causes of premature death in the last twenty years has been the scourge of Acquired Immune Deficiency Syndrome (AIDS). The disease, AIDS, was first heard of in 1981. Within twenty years, it spread to all continents of the world and remains a great killer to which no man has found a solution. In 1988 alone, about 5.8 million new cases occurred, bringing the total number of people living with Human Immuno-deficiency Virus/AIDS by December, 1998 to approximately 33.4 million. The Joint United Nations Programme on HIV/AIDS (UNAIDS, 2007) estimates that there are now 40 million people living with HIV or AIDS worldwide. Since the beginning of the epidemic, AIDS has killed more than 25 million people worldwide. It has replaced malaria and tuberculosis as the world's deadliest infectious disease among adults and is the fourth leading cause of death worldwide. Fifteen million children have been orphaned by the epidemic. Young people worldwide are the sub-group most affected while about

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half of new HIV cases are occurring in people aged 15-24. According to Okonofua (1999) it is no longer news that the Human Immuno- deficiency Virus is now well established in Nigeria. Although the virus was first identified in Nigeria in 1988, over 4 million Nigerians were estimated to have contacted the virus by the end of 1998. This makes Nigeria the second country in Africa with the heaviest burden of the disease, in terms of absolute number of those afflicted, second only to South Africa.

The disease has now permeated the entire Nigeria society. It affected men and women in urban and rural areas, as well as adolescents, commercial sex workers, traders, high profile politicians and socialites, servicemen and women, truck drivers and students. Indeed, everyone must feel vulnerable to the disease, which is fast rampaging the most productive age groups in the Nigerian population. Several thousands have died from the disease, and this has brought untold hardship and disorganization to many Nigeria families.

In Nigeria, the burden of HIV/AIDS on the citizenry is alarming. Statistics on the spread of the disease show that Nigeria records about 1,400 new infections every day. This figure represents one new infection per minute. By October 1998, it is believed that Nigeria records about 571,036 cases of HIV infection. In the hierarchy of the world's most infected AIDS nations, Nigeria is said to occupy the 27<sup>th</sup> position, constituting 8.9 percent of global infection and 12.5 percent of the African HIV/AIDS burden.

Professor Debo Adeyemi, one time health minister in Nigeria, describes the spread of HIV/AIDS as alarming. According to him, about 25 million adults in Nigeria are already infected with the disease. He reasons that with his figure, assuming that there are no new cases of infection, fatality from the disease will surpass the totality of deaths recorded from the Nigeria civil war by the year 2010.

The disease up till now has got no cure despite many years of drug and vaccine research activities. Although few drugs are now available that could prolong the lives of infected persons through reduction of the load of the virus and improvement in the number of white blood cells. Such drugs are, however, very expensive, globally, and quite scarce in Nigeria. Good nutrition and prompt treatment of presenting diseases can also prolong the life of an infected person. Thus, the only effective way of controlling HIV/AIDS, presently, is by prevention, with education as the main thrust of this approach.

How counsellors react to a counsellee and how they communicate these feelings are of critical importance in counselling. Adolescents come to the counsellor for help and understanding. They bring to the counsellor confused feeling, ideas, fears and hopes with which they are struggling. The counsellors attitudes toward them determine in large measure the extent to which they will attempt to cope constructively with their problems and undertake positive actions. If the counsellor demonstrates a genuine acceptance of these adolescents, they will feel that they are received.

Inadequate knowledge of HIV/AIDS among adolescents, particularly secondary school students calls for a study that will assess the role of school counselors in the prevention of the disease. This study specifically investigated the level of awareness of HIV/AIDS among secondary school students in Osun State and assessed the precautionary measures taken by secondary school students against the transmission of HIV/AIDS. This was with a view to assessing the role of school counselors in the prevention of the pandemic among secondary school students in Osun State.

### **Objectives of the Study**

The specific objectives of the study are to

- (a) investigate the level of awareness of HIV/AIDS among secondary school students in Osun State;
- (b). assess the precautionary measures taken by secondary school students against the transmission of HIV/AIDS;
- (c). appraise the activities of school counsellors in the prevention of HIV/AIDS.

### **Research Hypotheses**

In order to empirically achieve in a non – spurious manner the objectives of the study, the following hypotheses were postulated and tested:

1. Awareness/knowledge of HIV/AIDS will not significantly influence the practice of precautionary measures against the transmission of the disease.
2. Gender will have no significant influence on secondary school students' practice of the precautionary measures against the transmission of HIV/AIDS
3. Activities of school counsellors will have no significant influence on the practice of precautionary measures against the transmission of HIV/AIDS

### **Review of Empirical Studies**

#### *(i) Beliefs and Attitudes about AIDS*

This section presents several works that have been done on AIDS. It presents the disease's aetiology and some forms of attitudinal changes, which have accompanied AIDS as a result of social norms and personal beliefs. In particular, works that pertain to beliefs about AIDS in Nigeria shall be reviewed.

There are so many norms and personal beliefs and attitudes concerning AIDS that it would be almost impossible to mention them all, but the point of this study are to investigate the most prominent ones. First is the attitude of total disbelief. This is the most drastic and it comes in several forms. In Africa,

there are large groups of people that claim that AIDS is a “White Man’s Disease”, equating it with illnesses such as anorexia or bulimia (Daily Mail & Guardian, 2002). They believe it is just as foreign, claiming that their original traditions have not changed. They feel that regarding sexual practices, their traditions have not changed – which is polygamy and having concubines. They claim that Africans are not the inventors of taking intravenous drugs for pleasure, and homosexuality is a taboo. As a result, people with this belief look upon the AIDS issue with scorn and contempt. Needless to say, such people do not tend to change their attitude towards their sexual behaviour.

Even among scientists of the Western world, there are unbelievers Eugene (2001) of the *Alive and Well* magazine claim that there are no reliable HIV/AIDS tests and that those in use now, the ELISA and the Western Blot tests can only detect the presence of antibody proteins that are assumed to belong to HIV. These tests, he argues, cannot look for, and cannot detect active HIV virus, and only active virus is capable of causing disease. According to him, in addition to testing for AIDS, there are about seventy other things apart from HIV antibodies that can elicit positive test results namely, a cold, the flu, herpes, hepatitis, vaccinations (including those for flu and hepatitis), Candida, foreign sperm, drug use, being or having ever been pregnant, normal cellular proteins, and more. Also, there is no standard for what constitutes as a positive result. Viral load tests, which many believe can detect and measure virus, are unable to perform either of those tasks. These tests can only find bits of genetic material; they cannot diagnose a viral infection, measure levels of active virus, and are not even approved by the Federal Diagnostic Agency for diagnostic use.

There are however still the statistics on AIDS that are rising everyday. Another school of thought believes that the problem in Africa is poverty and not a mysterious syndrome. Eugene claims that millions of Africans have for years suffered from weight loss and chronic diarrhoea, fever and persistent coughs, symptoms that have always been associated with rampant poverty, malnutrition, malaria, parasitic infections and tuberculosis, in 1985, these very symptoms became the official definition of AIDS in Africa. What is going on then is the reclassification of conditions common to people in the Third World as AIDS, and the result of poverty, civil war, drought and endemic disease being blamed on sex. HIV tests are not required for an AIDS diagnosis in Africa and much of the Third World. The symptoms mentioned above are the only criteria necessary for a person to have AIDS. In fact, most African AIDS patients, as many as 70% are found to be negative when tested for HIV. Most news reports on AIDS in these regions are based on estimates rather than actual cases are actual deaths. According to Simba Kamunono (2000), the world’s biggest killer and the greatest cause of ill health across the globe is listed at the end of the International Classification of Diseases, given the code Z59.5 – extreme poverty. Kamunono claims that research has shown that poverty is the main reason why babies are not vaccinated, why clean water and sanitation are not provided, why curative drugs and other treatments are unavailable, and why mothers

die at childbirth. Every year in the developing countries, 12.2 million children die from poverty-related causes.

Another attitude towards AIDS is the lack of evidence. Some people believe that since they have never seen an AIDS patient, there is the possibility that the syndrome does not exist. This is most likely a true assertion given the conservative atmosphere in Africa. People do not let their emotions show, considering it something of a stigma. Consider the AIDS patchwork quilt in the United States on which each patch represents an AIDS victim. Such blatant admissions to trauma are rare in Africa. Again, since most of the population of HIV positive patients are youth, it is necessary to consider the invincibility fable (Elkind & Bowen, 1979). This is a phenomenon whereby many adolescents and young adults believe that they are somehow immune to the laws of mortality. The other reason for lack of evidence is that AIDS is not a disease but rather a syndrome. AIDS in itself does not kill but rather its resultant diseases do as the virus will have weakened the body's immune system. According to Schoepf, most people with HIV have no symptoms and can remain healthy for years. Between a third and a quarter will develop full-blown AIDS within five to seven years. It is thus possible to know HIV positive people and not be aware of it. Most people in this category tend to readdress their attitudes towards sex and their sexual behaviour.

The most serious form of unbelief comes from the notion that AIDS as a whole is political propaganda. One school of thought refers to AIDS as "America's Idea of Discouraging Sex" (Kandel, 1994). People that share in this belief claim that it is yet another form of ethnic cleansing by the Western world, an excuse to ignore thousands of Africans dying and educating them to resign to their fates as AIDS victims. For these people, the AIDS "invention" is yet another excuse to let millions die from varying disease from common cough to diarrhea, illnesses which are often simply a result of malnutrition and absence of or inadequate basic amenities, all of which are a common scourge of Africa. There is indignation expressed by these people about the suggestion that the AIDS virus was first isolated in the body of the Green Rhesus monkey in East Africa, a suggestion that AIDS started in Africa. Responses to AIDS have political dimensions in Africa, as elsewhere. Public health action takes place in an environment in which differences in understanding and unequal power relationships prevail. For some people, not only do the campaigns on AIDS prevention not work, they also manage to increase their hostility for the Western world, claiming that AIDS is another gimmick to try and remove something precious from Africa and replace it with something horrible (Mtobeshi, 2000).

Regarding political issues of a different nature, Odebiyi & Olowu (1991) reported that the controversy of AIDS origin has been linked to the Cold War between the East and the West. Soviet scientists have said that AIDS is a biological warfare developed by the Central Intelligence Agency (C.I.A.) and the Pentagon and tested in Africa. This was reported based on findings that the disease is new to Africa.

Ojei (2001), a Nigerian activist who also denies the existence of AIDS claims that although it might exist, it is not caused by HIV and might not be a sexually transmitted disease. Rather, he believes that it is yet another international political ploy to thin out Africa's population. According to him, President Thabo Mbeki of South Africa sponsored experiments in 1999 to isolate HIV but even now, the experts have not been able to accomplish this. A report on the virus having been isolated was later discredited when the scientists confessed that it was actually staphylococcus that had been isolated and even now, there are quoted symptoms of staphylococcus that are identical to that of AIDS patients (Akingugbe & Falase, 1999).

Having considered so many forms of disbelief, the next group of people are those that are bound by the norms that AIDS does exist but is not as serious as the public is being led to believe. The first main reason in this attitude is the discrepancy in the statistics on HIV/AIDS patients. One census claimed that by 1998, more than 40 million people had contracted HIV/AIDS (Schoepf, 2000), while a W.H.O. census counted them to be 5.6 million people as at 1999 (Kamunono, 2000). Celia Ferber, on her journey to Uganda in 1998 admitted that figures had been grossly exaggerated saying that the medical journal, the Lancet, stated that 60% of all children in Uganda were infected with HIV while the actual figure was recognized as 5 to 7%. She believes that AIDS has turned into a scapegoat; an excuse not to treat other infections that war and poverty bring along with them (Ferber, 1998). People holding on to this belief admit the existence of the syndrome but try to repress it so they do not have to take precautionary measures which they view as unpleasant such as wearing a condom during sexual intercourse.

Taking Africa in context, the most serious obstacle facing the acceptance of AIDS are the traditional patriarchal beliefs and the psychological fear of the unexplainable. AIDS often provokes fear and hostility towards the afflicted. Husbands may abandon wives. Families unable to hide the nature of the illness may find themselves isolated. AIDS orphans may be shunned and left to roam the streets where they are particularly vulnerable to HIV infection. With many people falling sick and others overworked and demoralized by so much death around them, the impact on all economic activities in the affected area is severe. AIDS particularly disrupts seasonably labour-intensive agriculture, food processing and family life. Blaming others allows people to deny risk and to avoid taking realistic steps towards protecting themselves and others. Where people believe that women or unseen forces cause AIDS, witch-hunts and social unrest compound socioeconomic disruption. For example, in Zimbabwe, there is a general belief that only girls who engage in pre-marital sex can catch AIDS. Another belief is that having sex with a virgin can cure the symptoms of AIDS altogether. These people are reluctant to put faith in Western medicine and some even believe that using condoms can actually cause AIDS.

Effective prevention involves enabling large numbers of people to change sexual practices that are widely considered to be natural and essential to health. Children are highly valued and they may allow a woman to hold a steady partner and gain community respect. Condoms are not popular among men, many of whom employ a double standard to rationalize their relations with numerous, often younger, sex partners, while they strictly control their wives' sexuality. Condoms have been widely stigmatized by association with prostitutes and STDs. Even men who wish to use condoms may fear that their lover will berate them with accusations of mistrust, and so they may avoid the subject. Few women, married or single, can refuse a steady partner, even if they suspect that he may be infected, nor can most suggested condom protection. Penalties for doing so might include beatings or abandonment.

In many countries, powerful interest groups have treated AIDS, like other STDs, as a moral issue rather than a health issue. Many adults believe that sex education and condoms will increase sexual activity (seen as immorality) among youth, although research carried out in numerous settings shows that this is not the case. Many men believe that access to condoms will lead wives to become unfaithful. Most wives, who become infected, however, are infected by their husbands. Where national, community, and non-governmental organization leaders share a moralistic perspective, this stance inhibits effective prevention campaigns. In Uganda, Tanzania, Senegal strong resistance to effective prevention by religious leaders and community elders continued into the early 1990s. Alarmed governments nevertheless instituted safer-sex education and made STD treatment and condoms widely available and acceptable, especially among young people. The incidence of new infections apparently began to decline in these countries in 1996. Elsewhere, the virus continues to spread, not only in cities where the epidemic was well established in the 1980s, but also to rural areas and to countries that once had very low levels or were free of HIV.

Doctors and students of aetiology hold another belief that is held about the plight of AIDS victims in this age. There is a general belief claiming that is relief to be had from history, citing epidemics that once seemed incurable and are now a thing of the past (Cassell, 2000). Diseases such as the Bubonic plague that started in the 1330s claimed the lives of as many as 25 million people in the first five years, and then disappeared as mysteriously as it came (Rice, 1994). Other names that struck fear in the hearts of the most experienced physicians include tuberculosis, poliomyelitis and cancer. However, these diseases are now either mere history or are easily treated. It is a possibility that with daily advances in modern medicine AIDS can also become curable. However, as yet, AIDS remains incurable and is killing people daily. The emphasis should be removed from future hopes of cures and instead be placed on prevention which is better than any cure. Indeed, a W.H.O. official, Sera Tsholozza from South Africa quoted her native proverb, saying, "When a snake enters the house, we kill it first before we begin to look for the hole where it passed through".

For the average individual whose beliefs are based more on fear and reluctance to face the truth than on knowledge, there is yet one more one excuse not to change their attitudinal behaviours. Some claim that drugs must exist to either delay the symptoms, build the immune system back up, or to cure the illness completely. They believe that these medicines are simply expensive and pharmaceutical companies are getting rich through the new "incurable disease". There are, after all, notable personalities, namely Earvin "Magic" Johnson who have claimed to be HIV positive for years and their viral infection has not yet developed into full-blown AIDS, which means that there is a possible hidden cure. *Catie*, a scientific journal devoted to the treatments that have been procured for the AIDS illness, shows that between 1996 and 2001 alone, at least 50 different forms of medication have been procured including AZT, Invirase and Non-Nucleoside Reverse Transcriptase Inhibitors ("NNRTI"). It is important to note that these drugs cannot actually cure AIDS but merely inhibit its development.

The final group of people whose broad social norms and attitudes are recorded in research are the people who have a realistic grasp on the AIDS concept, have been affected by the disease either directly or indirectly, and have changed their sexual behaviour as a result of their beliefs and experiences.

Cochran and Mays (1989), coined the term "worried well" to refer to those individuals who perceive themselves to be at risk of HIV infection but currently are not infected. This includes those who have concerns based on realistic appraisals of personal vulnerability and those who inaccurately estimate their own risks. Studies such as the ones by Masters, Johnson & Kolodny (1988), fuel the fear to low-risk heterosexual women so much that they may inadvertently contract the disease. This observation was further supported by Cassens (1985) and Cohen (1987), who discovered that anxiety, denial, fear, grief and bereavement are all psychological aspects associated with AIDS and the spectrum of HIV infection. These were findings from a research conducted on those women who are care-givers for those with AIDS, for those who have lost friends or former sexual partners to AIDS, and for mothers who must confront their sense of responsibility and fear in the case of a drug addicted child or a sexually active child, including those with gay sons.

The psychological and psychiatric conditions associated with HIV and the diagnoses of AIDS/ARC (Acquired Immune Deficiency Syndrome/Aids Related Concerns) have been well identified. Miller and Green (1985) focused on the psychological consequences of the 'worried well' individuals who are not HIV infected but concerned about their risk of being infected. The risk of HIV infection according to them depends not only on the occurrence of risky behaviour, but the performance of this behaviour in an environment where HIV is present.

Garry et al (1988), reported that for those women who were sexually active in the United States particularly during the 1970s, an era of sexual experimentation, their AIDS anxiety may have a real,



although relatively unlikely, basis. To help reduce anxiety levels Garry suggested that it is important to help people assess their own relative risk realistically, because for most people, this will very quickly allay anxiety. Unfounded perceptions of risk, based on misinformation or a personal tendency to catastrophe, creates unnecessary worry.

*(ii) Attitude towards AIDS in Nigeria*

Attitude and attitude formation in Nigeria is as diverse as the cultural fabric the nation is made of. Education on sexuality has been unsuccessful in Nigeria because the older generation is unwilling to let their children become involved in what they consider frivolous discussions about sexuality or early sexual relations. According to Esiet (2001), sexuality education is not about teaching young people the various positions of sexual intercourse. The educational and health programs have taken into consideration that young people account for more than 50% of those contracting STDs and HIV/AIDS annually in Nigeria. As a result, sexuality education seeks to address the biological, psychological and spiritual dimensions of a person's being, including the necessary skills to adopt realistic attitudes, communicate effectively, and to responsible decision making. Sexuality education involves acquiring information and forming attitudes, beliefs, and values about one's identity, relationships, and intimacy. It includes sexual development, reproductive health, interpersonal relations, affection, intimacy, body image, and gender roles (Grunseit & Kippax, 1993).

According to the Federal Ministry of Health and Human Services (1994), without sex education, 7 out of every 10 Nigerian boys and 5 out of every 10 Nigerian girls attending secondary school are sexually experienced before the age of ten. By the time they leave secondary school, 1 out of every 5 Nigerian girls has terminated an unwanted pregnancy. Even though abortion is illegal, hundreds of Nigerian girls are terminating unwanted pregnancies with the help of back street abortionists – usually with unsterilised instruments. Apart from the problems associated with limited financial resources, teenage pregnancy and abortion-related complications are the leading single factors adversely affecting female education in Nigeria.

There is widespread belief that Nigeria, the most populous nation in Africa, is yet to wake up to the reality of AIDS. Already, over 6% of the population is infected, and the government admits that in some hospitals, 60 to 70% of the cases are AIDS related (Beauchemin, 2001). Beauchemin (2001), claimed that traditions and practices still prevalent in Nigeria and sheer ignorance are responsible for the lack of acceptance of the HIV/AIDS phenomenon in Nigeria.

In some cultures in Nigeria, males are encouraged to have sex early in life in order to prove their virility. According to Obinya (2001), "A father who has a 16 or 18 year old son who is still a virgin will encourage him to go to a commercial sex worker to get experience". It is also common in Nigeria to have more than

one sexual partner. In the same part of the country, men often have three or four wives, and some can have as many as 30. "It is culturally acceptable for a man who has four wives to go out with a 13 year old and go to bed with her in the pretence that he will make her his fifth wife".

In other areas, it is customary for men to honour a visitor with a young girl or even their own wife to sleep with. In yet other regions there are festivals where indiscriminate sex is allowed and it is possible for anyone to sleep with anyone else. As in other countries in Africa, it is also common for young Nigerian girls to have sex to pay for their schooling or food. "It is a practice that is well acceptable and widespread", says Cyrilla Bwakira of UNICEF, "That probably also explains why you have such high HIV prevalence rate among young people".

Ignorance too plays a major role in the spread of HIV/AIDS. A recent survey among young people aged 18 to 19 showed that in some areas only 15% knew how to protect themselves. "We have not seen that in any other country in Africa for the last 10 years", says Bwakira. "The total comprehensive knowledge about HIV/AIDS is even worse at 4%. Still yet, more than 30% of these young people report having had sex before the age of 16".

The attitudes of core transmitters, people such as sex workers and truck drivers known to have multiple sex partners, must also be considered as they have a large influence on the spread of the disease. Researchers from the Society for Family Health (SFH) discovered that only 1 in 5 of the 2,634 women working in brothels that were interviewed were aware of transmission of HIV/AIDS. Cunliffe-Jones (2001), interviewed 2,578 sex workers and discovered that although a majority are aware of AIDS but knowledge of how it spreads is low. He estimates around 80,000 sex workers across brothels in Nigeria, serving an average of four clients per day. Also, while condom use is increasing, almost half of sex workers do not insist on protection. As a result, infection rates are high.

## **Factors Contributing to the Spread of HIV in Nigeria**

### *(i). Lack of Sexual Health Information and Education*

Sex is traditionally a very private subject in Nigeria for cultural and religious reasons. The discussion of sex with teenagers, especially girls, is seen as indecent. Until recently there was little or no sexual health education for young people and this has been a major barrier to reducing rates of HIV and other STIs. Lack of accurate information about sexual health has meant that there are many myths and misconceptions about sex and HIV, contributing to increasing transmission rates as well as stigma and discrimination towards people living with HIV/AIDS.

*(ii). Stigma and Discrimination*

*Stigma and Discrimination* against people living with HIV/AIDS are commonplace in Nigeria. Both Christians and Muslims see immoral behaviour as being the cause of the HIV/AIDS epidemic. This affects attitudes towards people living with HIV/AIDS services because of the ignorance and fear about HIV and AIDS. There is so much ignorance that 60% of healthcare workers think HIV positive patients should be isolated from other patients.

*(iii). Poor Health care Services*

Over the last two decades, Nigeria's healthcare care system has deteriorated because of political instability, corruption and a mismanaged economy. Large parts of the country lack even basic healthcare provision, making it difficult to establish HIV testing and prevention services as those for the prevention of mother-to-child transmission. Sexual health clinics providing contraception and testing and treatment for other STIs are also few.

*(iv). Marriage Practices*

Harmful marriage practices violate women's human rights and contribute to increasing HIV rates in women and girls. In Nigeria there is no legal minimum age for marriage and early marriage is still the norm in some areas. Parents see it as a way of protecting young girls from the outside world and maintaining their chastity.

Many girls get married between the ages of 12 and 13 and there is usually a large age gap between husband and wife. Young married girls are at risk of contracting HIV from their husbands as it is acceptable for men to have sexual partners outside marriage and some men have more than one wife (polygamy). Because of their age, lack of education and low status, young married girls are not able to negotiate condom use to protect themselves against HIV and STIs.

*(v). Female Circumcision*

Female circumcision/female genital mutilation (FGM) is a cultural practice whereby all or part of the external female genitalia is removed by cutting. Around 60% of all Nigerian women experience FGM and it is most common in the south, where up to 85% of women undergo it at some point in their lives. FGM puts women and girls at risk of contracting HIV from unsterilized instruments, such as knives and broken glass that are used during the procedure.

*(vi). Sex Workers*

Although prostitution is illegal in Nigeria there are more than a million female sex workers. HIV infection rates among sex workers have been estimated to be as high as 30% in some areas. There are low levels

of condom use among sex workers because of a lack of knowledge about HIV transmission and poor acceptance by male clients.

### **The Role and Responsibilities of the Nigerian School Counsellors**

In the increasing complexity of the industrialized evolving world like Nigeria, one finds it difficult to foresee what the future holds. The occupational activities by apprenticeship system of yester-years have given way to the more technological complex society of Nigeria today. In this respect every individual, more than ever before, feels the need of counselling. Yet, after a decade of the existence of guidance and counselling in Nigeria, the general public lacks the full understanding of what counselling profession is all about. School counsellor's role and responsibilities are grossly relegated to the concerns of the maladjusted individuals, yet others still see their responsibilities as circulating around the secondary school system only without full cognizance of the fact that counselling gravitate to all levels of educational system –preschool and the tertiary inclusive.

It is perhaps this very lack of understanding that has led the counselling professions in Nigeria to move more energetically into the public communication arena “to tell what they are about”, to upgrade their training, and to seek protection to their profession from unqualified intruders through certification and licence. Differing characteristics of various school levels settings, and clientele, by necessity, result in variations in that roles and functions. There is growing need for school counsellors, therefore to formulate the basic philosophical principles and identifiable patterns of role and responsibilities in which they must operate. An understanding of this can help to provide some insights into infrequently asked question. ‘How come school counsellors do what they do the way they do it?’

In order for the school counsellors to function effectively, they must clearly understand their role and responsibilities. In Nigeria their role which include diagnosis, assessment of individuals' potential, information, students' orientation, consultations and referral, counselling both in individual and group setting; placement and follow-up, career education remedial, in-service training, research activities and checking -in the drop outs, should be clearly stated. This includes making a clearer picture of their role in relationship with the school administrators, and other members of student service team. The general public should be educated through the Counselling Association of Nigeria, in order to establish our professional stance. This will enable counsellors to function freely without interference from assignments or activities that are inappropriate. It will also enable counsellors to become clearly accountable in the stated functions and responsibilities.

Based on the foregoing discussion, the role of the school counsellor in the prevention of the transmission of HIV/AIDS among secondary school students cannot be overemphasized.

The implication of this is that the counsellor himself must be skilful, knowledgeable, accessible, competent and aware of his own limitation before he can be of meaningful assistance to the client. The counsellor's personal effectiveness will determine the success or failure of the counselling relationship. It is he who can either facilitate or inhibit the counselee. It follows that the counsellor must be a person of stability, flexibility and understanding. He needs to be objective about his/her client's subjective feeling, but in an emphatic way. Counselling must lead to increased self – confidence on the part of the client. The wise counsellor attempts to make his own decisions, never making a decision for his client. The goal of the counsellor is to assist the counselee to develop and carry out a course of action voluntarily. This he (the school counselor) must do with all sense of purpose.

The following are possible suggestions for a counsellor in a helping relationship:

1. Recognise the sensitivity of the client;
2. Convince the client of your sincerity and confidence;
3. Maintain tactful kindness when dealing with the accumulation of strains and stresses of some lives;
4. Show empathic feelings. The atmosphere should be that of acceptance understanding and willingness to listen and help;
5. Face reality with the client, but use judgement as to when and how to bring him or her to face facts;
6. Move slowly through the ramification of conversation and help the client organise confused thinking.

## **Methodology**

### *Research Design*

With regard to the measurement and analysis of the variables under consideration and in the generation of our primary data, the study employed a descriptive type of survey research. A sample survey, according to Burton (2000), is the only practical way to get an answer whenever the investigator is interested in assessing or estimating the present state of affairs with regard to some variables that change over time for a large group of subjects.

The independent variables under investigation are awareness/knowledge about HIV/AIDS, gender and role of school counsellor, while the dependent variable is precautions against the transmission of HIV/AIDS.

### *Population and Sample*

The study population for this study consisted of all public secondary schools in Osun State. According to the Guideline for Admission into Junior Secondary School and Technical colleges 2005/2006 Session issued by the Curriculum Development and Evaluation Department of the Ministry of Education, Osogbo, there are 326 public secondary schools in 31 Local Government Areas (LGAs) including an Area Office, in Osun State. Six secondary schools were purposively selected from the ten randomly selected LGAs

(See Table 3.1 below). Two different samples were used for the study. The first sample consists of One thousand, two hundred (1200) secondary senior secondary school students made up of twenty (20) students in SSII and SSIII from each of the sixty selected secondary schools. The students were selected using stratified random sampling. The second sampling type comprised thirty (30) School Counselors drawn purposively from thirty (30) secondary schools with counselors in the State.

*Socio-Demographic Data*

The first set of information gathered on the students from the sixty secondary schools was their socio-demographic characteristics. This was to serve the purpose of fitting the students personality characteristics with their responses to issues explored in the study. Some of the socio-demographic characteristics covered in the survey included sex, age, class, religion, parents' educational status.

*Respondents by Sex*

The study was carried out in senior secondary classes two and three from sixty public secondary schools in Osun State. One thousand, two thousand students responded to the research instrument. The sample consists of five hundred and eighty six (586) male and six hundred and fourteen (614) female by the distribution of the students sample by sex is presented in the Table 1 below.

**Table 1: The Distribution of Students' Sample by Sex**

<b>Sex</b>	<b>Number</b>	<b>Percentage</b>
Male	586	48.8
Female	614	51.2
<b>Total</b>	<b>1200</b>	<b>100</b>

**N=1200**

*Respondents by Age*

Considering the total sample, the ages with the highest number of respondent were 16, 17, 18. While two hundred and thirty – four (19.5%) of the one thousand, two hundred (1200) respondents were 16 years old, two hundred and eighty (23.3%) were 17years old, three hundred and forty- eighty (29.0) were 18 years old. The least age represented was 23 years (0.2%).

The distribution of the students sample by age is presented in Table 2 below.

**Table 2: The Distribution of Students' Sample by Age**

Age	Number	Percentage
10	4	0.4
15	60	5.0
16	234	19.5
17	280	23.3
18	348	29.0
19	136	11.3
20	96	8.0
21	22	1.8
22	18	1.5
23	2	0.2
<b>TOTAL</b>	<b>1200</b>	<b>100</b>

**N=1200**

*Respondents by Class*

Respondent were selected from senior secondary classes two and three. While six hundred and twenty (620) respondents were in SSII, five hundred and eighty were in SSIII. The distribution of the students sample by class is presented in Table 3 below.

**Table 3: The Distribution of Students Sample by class**

Class	Number	Percentage
SSII	620	51.7
SSIII	580	48.3
Total	1200	100

**N= 1200**

*Respondents by Religion*

Majority of the respondents (79.0%) were Christians, while two hundred and thirty-six (19.7%) were Muslims. The distribution of the students' sample by religion is presented in table 4 below.

**Table 4: The Distribution of Student's Sample by religion**

Religion	Number	Percentage
Christian	948	79.0
Muslim	236	19.7
Traditional	16	1.3
Total	1200	100

N = 1200

*Respondents Parent's Educational Status*

The distribution of respondents by their parents' educational status shows that the parents of four hundred and forty-eight respondents (37.3) had secondary school/Teachers grade II certificate while the parents of four hundred and fifty-two respondents (37.7%) were graduates. Parents of fifty-four respondents (4.5%) were illiterates. Table 5 below shows the distribution of the students' sample by their parent's educational status.

**Table 5: The Distribution of Students' Sample by their Parent's Educational Status.**

Parent's Educational Status	Number	Percentage
No education (illiterate)	54	4.5
Primary School certificate	246	20.5
Secondary School / Teachers' Grade II Certificate	448	37.3
Graduate	452	37.7
<b>Total</b>	<b>1200</b>	<b>100</b>

**N =1200**

*Research Instruments*

Two sets of paper and pencil self-designed questionnaires were used to collect quantitative data directly from the selected students and school counselors. The questionnaires were used to measure both the dependent and independent variables for the study. The questionnaires comprised mostly structured close-ended items. The questionnaire for students contained five sections. The first section (Section A) sought information on respondents' socio-demographic background. In this section, there were items on



Name of School and class of the student, sex, age, religion, parent's educational status and whether the school has a counselor or not.

The second section (Section B) measured students' awareness/knowledge of the transmission of HIV/AIDS. The section has two parts. The first part asked whether the respondent had ever heard about AIDS, whether respondents believe that there is AIDS, whether the respondents have ever seen an AIDS patient and how did the respondent know whether the person was an AIDS patient or not. The last item in the first part of section B of the student questionnaire asked from respondents the medium through which AIDS can be contacted. The response category for this part was Yes/ No / Don't know. Each respondent was left with the option of picking one of the options.

The second part of Section B has ten (10) close-ended items which measure respondents' awareness of HIV/AIDS. The response category for the items are Strongly Agree= 5, Agree= 4, Don't know =3, Disagree = 2, and strongly Disagree = 1.

The third section (Section C) has two parts. the first part contained a number of statements on precautions against the transmission of HIV/AIDS with five possible responses ranging from strongly Agree = 5, Agree = 4, Don't know =3 ,Disagree = 2, and strongly Disagree = 1.the second part of the section contained five statements on the practice of the precautionary measures against the transmission of HIV/AIDS with five possible responses ranging from very often = 5, often = 4, not at all = 3 , Rarely = 2 ,Never = 1.

The fourth section (Section D) sought information on the role of school counselors. There were ten (10) items in the section. Each of the items was measured by a five point possible responses ranging from strongly Agree = 5, Agree = 4, Don't know =3, Disagree = 2, and strongly Disagree = 1.

The questionnaire for School Counselor contained four sections. Section A sought information on counselors' socio-demographic background. The other three sections contained close-ended items which focused on Counselling activities, Counselling facilities and counselors' training programmes. Each of the items in Sections B and D was measured by a Yes = 1 /No = 0 response while items in Section C were measured by adequate = 2, inadequate = 1, not available = 0

### **Validity of the Research Instruments**

Two methods of validation measurement that is face and content validities were used for ascertaining the validity of the research instruments. To ensure its face validity the research instruments were given to experts in the subject- matter area to judge the appropriateness of each item of the instrument by mere look. Their comments with those of the supervisors were used to obtain final items which were further

subjected to content validity by the same experts who were asked to ascertain the relevance of each item to traits measured.

### **Reliability of the Research Instrument**

After validating the questionnaire, its reliability was also estimated by the test- result method. According to Ojerinde (1986), test-retest coefficient is a type of reliability co-efficient obtained by administering the same test a second time after a short interval and correlating the two sets of score.

In order to modify the structural design of the questionnaire and to test for vagueness and clarity of items, it was administered twice within one month between pre-test and the post – test on a pilot group of fifty students randomly selected from a secondary school in Osun State. The secondary school (for the pilot study) was specifically selected to be different from those used for the study but of comparable status. The responses of the first administration of the instruments were computed and correlated with values obtained in the second administration using Pearson Product Moment Correlation formula. The result of correlational analysis had a reliability coefficient of 0.78 and the value was considered reasonably high and so the instruments were taken as reliable measure of the variables of interest.

### **Administration of the Research Instrument**

Data were collected from all the selected public secondary school students in SSII and SSIII classes using the prepared paper and pencil, self –reported questionnaires. Principals and school counselor of all the selected sixty (60) secondary schools in Osun State had been contacted through personal letter from the researcher before the administration of the questionnaires for their consent and cooperation. The questionnaires were administered to all the 1200 students in SS II and SS III in all the selected secondary schools with the assistance of school counselor in schools where there are counselors and with the assistance of research assistance in schools where there are no counselor. For ease of administration, the students drawn from each class were pooled together in a classroom.

Instructions on how to complete the questionnaire were read to the students. The questionnaire for school counselors also followed the same pattern. The completed questionnaires were collected at the end of the period specified for the filling of the questionnaire.

### **Method of Data Analysis**

The responses by subjects to the items of the questionnaires were compiled into contingency tables according to the main variables being examined. The data generated were analyzed using both descriptive and inferential statistics. All the four hypotheses generated for the study were subjected to appropriate statistical analysis. While Hypothesis 1, and 3 were analyzed using Pearson Product Moment Correlation, Hypothesis 2 was analyzed using T-test statistic. All the hypotheses were tested at 0.05 level of significance.

## Results and Discussion

### Hypotheses Testing and Discussion of Findings

*Hypothesis 1. 'Awareness of HIV/AIDS will have no significant relationship with the practice of the precautionary measures against HIV.'*

This Hypothesis was tested using the Pearson correlation. See Table 6 below.

**Table 5**  
**Relationship between Awareness of HIV/AIDS and the Practice of Precautionary Measures**

Variable	N	R	df	p
Awareness of HIV/AIDS and precautionary measures against HIV	1200	0.200	1198	0.05

R-calculated ( $r=0.200$ ) is greater than the r-critical value (0.139). Since the r-calculated is greater than the r-critical value, the null hypothesis which states that there is no significant relationship between awareness of HIV/AIDS and the practice of precautionary measures is rejected. There is therefore a significant positive relationship between awareness of HIV/AIDS and the practice of precautionary measures against the transmission of HIV.

### Discussion

The findings of the first hypothesis point out that there is a positive significant relationship between awareness of HIV/AIDS and the practice of precautionary measures against the transmission of the disease ( $r = 0.200$ ). This finding is supported by the findings of Odebiyi and Olowu (1991) in their survey study of attitudinal and behavioural factors in the transmission of the HIV virus. They asserted that the major roles that psychologist/counselors could play in addressing the AIDS epidemic is maintaining vigorous research programme that could construe the cognitive, affective and behavioural aspects of the individual on the HIV/AIDS problems. The result showed that secondary school students being aware of the deadly disease (AIDS), take necessary precautionary measures against its transmission.

*Hypothesis 2, 'Gender will have a significant influence on students' practice of the precautionary measures against the transmission of HIV/AIDS'.*

In testing this hypothesis, male and female subjects' scores on the practice of precautionary of HIV/AIDS were subjected to independent t-test analysis. See Table 7 below.

**Table 7**  
**T-test Analysis of Male and female student's practices of the precautionary measures against the transmission of HIV/AIDS.**

Variables	N	$\bar{X}$	SD	df	t-cal	p
Male	586	14.98	3.44	1198	0.89	0.05
Female	614	15.02	3.11			

The t-calculated (0.89) is less than the t-critical value of 1.96. Since the t-calculated is less than t-value, the null hypothesis which states no significant influence between male and female students' practice of the precautionary measures against the transmission of HIV/AIDS is accepted. There is therefore no significant difference between male and female secondary school students in their practice of precautionary measures against the transmission of HIV/AIDS. This shows that both male and female students have the same attitude/ behavior towards the practice of precautionary of measures against the transmission of HIV/AIDS.

#### Discussion

The findings of the second hypothesis point out that there is no significant difference between male and female secondary school students' practice of precautionary measures against the transmission of HIV/AIDS ( $t = 0.89$ ). This finding agrees with that of Reich and Painter (1994) who revealed that some minority gay men believe that oral intercourse is safe. This perception may be significant determinants of their involvement in the practice of unsafe sex that pose either high risks for HIV infection. The results show that both male and female secondary school students have the same attitude/behaviour towards the practice of precautionary measures against the transmission of HIV/AIDS.

*Hypothesis 3: Activities of School Counselors will have no significant relationship with the practice of precautionary measures against the transmission of HIV/AIDS.*

Scores on activities of school counsellors and the practice of precautionary measures against the transmission of HIV/AIDS were subjected to Pearson Product Movement Correlation. See Table 8 below.

**Table 8**  
**Relationship between Activities of School Counselors and the Practice of Precautionary Measures**

<b>Variable</b>	<b>N</b>	<b>R</b>	<b>Df</b>	<b>P</b>
Activities of School Counselors and The Practice of Precautionary Measures against HIV	1200	0.324	1198	0.05

The r-calculated (0.32) is less than the r-critical values of 0.139. Since the t-calculated is less than t-value, the null hypothesis which states no significant relationship between activities/role of school counselors and the practice of precautionary measures against the transmission of HIV/AIDS is rejected. There is therefore a significant relationship between the activities of school counselors and the practice of precautionary measures against the transmission of HIV/AIDS.

#### Discussion

The third hypothesis which stated that School Counselor's role will have no significant relationship with the practice of precautionary measures against the transmission of HIV/AIDS was rejected. This shows that school Counsellor's activities have relationship with secondary school students' practice of precautionary measures against the transmission of HIV/AIDS. The result obtained indicates a significantly low, positive relationship between school counselor's activities and students' practice of precautionary measures against the transmission of HIV/AIDS ( $r = 0.324$ ). The reason for this might be due to the fact that school counselor's effectiveness in the performance of their duties as it relates to the provision of information on sex education and health related issues have assisted students in the various steps that they took against the transmission of AIDS.

#### Implications of the Study for Counselling

The counselor plays an important role in contributing to the students own self-understanding and growth (Wrenn, 1962). The counsellor's task is not to attempt to change the student directly, but to facilitate the student's own efforts toward more productive behaviour. It is generally better to prevent a problem than allow the problem to occur before searching for a solution. This is more so in the management of adolescent and youth problems than any other issues. Many of the adjustment behaviour problems of secondary school students are highly refractory in the sense that once they are learned, they are difficult to change. For example, once a youngster starts engaging in socially undesirable sexual behavior, it may be very difficult to change such habit.

It might be a better counseling strategy therefore, if helpers (counselors) will find ways of preventing those socially undesirable behaviours pattern wherever they are likely to occur. One other technique for preventing the socially undesirable sexual behavior is to counsel the youth in creativity strategies. School counseling and psychological services must be made in such a way that the repercussion of unsafe sexual intercourse might be used as aspect of group counseling, health talk, school social care service and so on. Physicians and other health workers may be brought into schools at regular intervals to increase students' awareness about HIV/AIDS and the possible consequence of unprotected sexual intercourse.

A group counselling sessions might also be arranged so that an inventory of physical ailments associated with unprotected sexual intercourse could be used to increase the awareness of students regarding dangers of HIV/AIDS. The counsellor is expected to apply informational service designed to help students adjust to their environment. In view of the fact that the counsellor cannot handle all the problems of adolescents, there are certain situations which confront the adolescent which the counselor on his own cannot handle; therefore he (the counsellor) needs to refer the counsellee to sources or other centers where his or her (counsellee's) problems could be adequately handled. This means that the counsellor should be knowledgeable about other services close to the locality that could be of use to the client. In referring the client, he should be able to give adequate information about the source to which the client is being referred.

The counselor must possess certain personal qualities and characteristics which will make students gravitate to him. He must have empathic understanding. That is, the ability to transpose oneself imaginatively into the feeling of another. Counsellors should offer rapport in order to establish an open line of communication between them and their clients.. This implies building and maintaining a counsellor – counsellee working relationship. This allows the two of them to function in an association of mutual respect and trust.

Counselling programmes should be intensified in schools and students should be counselled on how to build up a well adjusted personality as this will go a long way to reducing the incidence of behavioural maladjustment. In the area of HIV/AIDS prevention, the counselor is expected to incorporate informational service about what HIV/AIDS is, how HIV/AIDS can be contacted, risk behavior of HIV/AIDS, prevention of HIV/AIDS and the consequences of unprotected sexual intercourse. He (the counselor) has to get himself involved in health education and community mobilization through workshops and seminars. Teachers and parents should be involved. They will be able to teach the students through their own examples.

Students have to be taught the techniques of being able to be aware of and manage effectively their own cooperative interactions with other people. The prevention of HIV/AIDS can only be achieved through

effective health education and HIV/AIDS awareness campaign. The main focus should be on refraining from pre-marital sexual activities. Secondary school students should be counselled on the consequences of unprotected sexual intercourse and to abstain from “engaging in unsafe sexual practices” since he may enjoy the effect of the experiment and try again.

Guidance counselors must be thoroughly aware of and sensitive to the facts of the specific population and the setting they serve. Without detailed knowledge gained through personal concern and constant examination of the best factual data available, counselors have no sure foundation upon which to base their actions. It is within a helping relationship that inappropriate, self destructive attitudes are changed into self-enhancing ones. The counsellor should help in keeping students cumulative records and anecdotal records of significant behaviour for the purpose of counselling. Everything possible should be done by the counsellor to prevent students from contracting HIV/AIDS. Students can only be helped to build on their strengths when the counsellor shows his or her genuine concern and trust for them.

The practical implications of the findings of the present study as it relates to secondary school students, is that they should learn how to reduce the risk of becoming infected with HIV/AIDS.

## **Conclusion**

From the analysis of the data and the interpretation of results, it can be concluded from this study that level of awareness of HIV/AIDS among the students was high. Majority of the respondents (99.0%) indicated that they had heard about AIDS. Also, 98.0% believed that there is AIDS. However, 67.9% indicated that they have never seen an AIDS patient. With regard to how AIDS can be contacted, majority of the respondents (85.7%) indicated through sharing of syringes, blade and shaving kits, sexual intercourse with an infected person (82.0%), transfusion of infected blood (81.3%) and homosexuality (63.8%). Awareness of HIV/AIDS had a positive relationship with the practice of precautionary measures against the transmission of the disease ( $r= 0.20$ ,  $p<0.05$ ). There was also a significant relationship between activities of school counselors and the practice of precautionary measures ( $r= 0.32$ ,  $p<0.05$ ). The results however showed no significant difference between male and female secondary school students in their practice of precautionary measures against the transmission of HIV/AIDS ( $t = 0.89$ ,  $p> 0.05$ ).

The role of the school counsellor in preventing HIV/AIDS cannot be underestimated. They play important role in contributing to the students' own self understanding and growth. Pending the discovery of an effective vaccine or therapy, effective health education is the only antidote for the prevention and spread of the pandemic among secondary school students.

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