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The Beagle is a peer-reviewed international research journal addressing issues in the broad field of education. The Beagle is published twice a year (in June and November) with two issues constituting a volume. Five editions of the journal have previously been published. The journal accepts manuscripts on a continuous basis for possible inclusion in its upcoming issues. Articles are typically expected to be published 2 - 3 months after they are first submitted or 2 - 4 weeks after acceptance and submission of corrected copies.

Call for Papers

The Beagle welcomes papers from academics, researchers and practitioners on all aspects of education especially primary education and early childcare education. The journal focuses on major shifts in educational policy and governance, curriculum and pedagogy, and in the everyday lives and practices of students and teachers. Topics may include, but are not limited to learning theory and application, instructional design theory and application; online learning and teaching initiatives; use of technology in education; innovative learning and teaching practices, experiences in adult and out-of-school educational programmes, vocational & entrepreneurship education and training programmes, educational administration and policy, and so on.

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There is no submission fee. Publication fee for each accepted article is Fifteen Thousand Naira (N15,000) (Nigerian currency) for authors based in Nigeria. Articles from outside Nigeria attract One Hundred US Dollar ($100) publication fee.

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- Manuscripts must be submitted using Microsoft Word and should not exceed 6,000 words, excluding abstract and references.
- Manuscripts must be written in English, double-spaced, including quotations and references, and employ a 12-point Times New Roman font.
- Headers, footers, footnotes and end-notes must NOT be employed.
- Use of personal pronouns ("I", "we", "our", etc.) should be avoided in all but Position Papers and Instructional Design Notes. Use third-person (e.g., "the author" instead of "I") or passive voice (e.g., "data were collected" instead of "we collected data") whenever and wherever possible.
- All manuscripts must include a brief but informative abstract. It should not exceed 200 words and should describe the scope of the work and the main findings. References to the literature should not be included in the abstract.
- A set of 5 - 6 keywords should follow the abstract to assist in indexing the article. These should not duplicate words appearing in the title.
- A separate cover page must be included with all submissions. This should show:
  a) the full name, affiliation, and e-mail address of each author, and
  b) the author designated as the contact person/lead author.
- Authors' names or other identifying information should not appear on any of the manuscript
  pages but only on the cover page.

Where appropriate, the following suggested format is recommended:
- Title
- Abstract followed by 5-6 keywords
- Main text (Introduction, Literature Review, Methods, Results, Discussion, Conclusion
  and Recommendations)
- Acknowledgments
- References
- Appendices (where necessary)
- All tables must be generated using the Table function in MS Word. All tables and
  graphic figures must be placed at the appropriate locations in the paper.
- Citations and references should be prepared according to the latest edition of the
  style elements can be found at: [www.apastyle.org/learn/tutorials/basics-tutorial.aspx](http://www.apastyle.org/learn/tutorials/basics-tutorial.aspx)
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Once the Editors determine that the manuscript is appropriate for the journal, the manuscript is sent through a double-blind peer review. Final publication decisions will be made by the Editors, taking into account the recommendations of the reviewers. Authors will be notified of the Editors' publication decisions and will be provided copies of the reviewers' comments.

Once an article has been accepted for publication, authors will be expected to submit a revised version of the article, including any recommended changes, in a timely manner. Accepted manuscripts are expected to come out of prints within 2-3 months after they are first submitted or 2-4 weeks after acceptance and submission of corrected copies.

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EDITORIAL NOTE

The Beagle, an International Journal of Educational Practice, is published twice a year (June and November) with two issues constituting a volume. This edition (Volume 6 No 1) is special for two reasons. The first is that unlike the previous five (5) editions, the journal has gone international in collaboration with the University of Abomey, Calavi, Republic of Benin reflecting the Publishers desire to expand the scope of courage and readership of the Journal. Secondly, the edition is also supported by the Tertiary Education Trust Fund (TETFUND). This edition covers a wide range of issues in the areas of Pre-primary, Primary, Secondary and Tertiary Education as well as general discourse in educational theory and practice.

Olu AKEUSOLA
Associate Professor of Comparative Grammar.
Editor in Chief.
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SOCIETAL ATTITUDE TOWARDS PEOPLE LIVING WITH HIV/AIDS IN EPE-LAGOS, NIGERIA.

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Abstract
The study investigated the attitude of people of different sex, age, profession, education and religion towards people living with HIV/AIDS. A total of one thousand, two hundred and forty participants were selected, using random sampling technique. Research instrument was a self-developed (20 items) validated questionnaire (r = 0.61). Data generated were analysed using descriptive statistics of frequency count and percentages for the research questions and inferential statistics of t-test and ANOVA for the five hypotheses at 0.05 alpha level. Findings revealed that, generally, the society have positive attitude towards people with HIV/AIDS. It further revealed significant difference in mean attitude scores among people of different age groups (F(2,1297)=4.693 p<0.05); profession (F(4,429)=12.252 p<0.05) educational background (F(4,429)=5.408 p<0.05) and religion (F(3,1297)=13.00 p<0.05). However, there was no significant difference in attitude scores between male and female (t-value =1.089 p>0.05). Based on the findings of this study, it was recommended that sex and AIDS education should be made available in religious institutions, homes, through the media and other public places.

Keywords: HIV/AIDS, Education, Attitude, Religion, Profession, Sex education

Resume
L'étude a examiné l'attitude des gens de différentes catégories, voire sexe, âge, profession, éducation et religion envers les personnes avec VIH/SIDA. Les sondés étaient au nombre de mille deux cent quarante. L'instrument de la recherche utilisée était sélection au hasard, (r=0.61). Les données étaient analysées en utilisant la fréquence descriptive statistique pour les cinq hypothèses à 0,05 niveau alpha. Les résultats ont révélé que la plupart des gens ont une attitude positive envers les sidéens. La moyenne de différents groupes : âge (F(2,1237)=4,693 P<0,05); profession (F(4,1235)=12,252 P<0,05) éducation (F(4,1235)=5,408 P<0,05) et religion (F(3,1236)=13,00 P<0,05). Néanmoins, il n’y avait pas de différence entre hommes et femmes sondés (t-value=1,089 P>0,05). Nous recommandons que l'éducation de VIH/SIDA soient encouragés dans des églises, maisons à travers le media et les places publiques.

Introduction
Disease is a part of human race and it is a condition that impairs normal tissue function (Davis and Lederberg, 2000). The world has from time to time experienced disease outbreak. Davis and Lederberg (2000) reported that for the past two decades, a dozen of new diseases have emerged while the traditional diseases that appeared to be on their way out (such as malaria and tuberculosis) are re-emerging or resurfacing. One of such new infectious disease is Acquired Immune-deficiency Syndrome (AIDS) caused by Human Immunodeficiency Virus (HIV) (Awake, 2004).
The presence of disease in the life of individual and the community at large is associated with reduction in productivity and economy due to body weakness and medical bills. Sometimes disease is associated with denial discrimination and stigma. In collaboration with this, Brown, Trujillo and Macinlyne (2001) stated that stigma is a common human reaction to disease. Throughout history many diseases have carried considerable stigma, including leprosy, tuberculosis, cancer, mental illness, and many Sexually Transmitted Diseases (STDs). HIV/AIDS is only the latest disease to be stigmatized. Stigma can result from a particular characteristic, such as a physical deformity, or it can stem from negative attitudes toward the behavior of a group, such as homosexuals or prostitutes. Stigmatization is a dynamic process that arises from the perception that there has been a violation of a set of shared attitudes, beliefs, and values. These can lead to prejudicial thoughts, behaviors and/or actions on the part of governments, communities, employers, health care providers, co-workers, friends, and families (Cameron 1993; Jayaraman 1998; Zierler et al. 2000).

HIV infection is one of the major causes of disease and death among persons aged 25-44 years. It has already taken millions of lives and caused enormous personal, social and economic losses throughout the world (World Health Organisation, 1999). Monaco, Tanga, Nuwaya, Aggleton and Tyre (2001) equally stated that AIDS have negative impact on the social and economic life of the people. It has equally brought about reduction in the size of labour force and this in turn has reduced cultivation of land for food and cash-crops. The consequences of these are threat to food security for the population and decline in income.

The emergence of HIV/AIDS pandemic has evoked a wide range of reactions from individuals, communities and even nations, from sympathy and caring to silence, denial, fear, anger, and even violence. Stigma is an important factor in the type and magnitude of the reactions to this epidemic (Malcolm, 1998). Stigma and discrimination relating to HIV/AIDS undermines public health efforts to combat the epidemic. HIV-related stigma and discrimination is “a process of devaluation of people either living with or associated with HIV and AIDS; discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status (UNAIDS in Lisanne Lean, Kate, 2001). AIDS stigma negatively affects preventive behaviours such as condom use, HIV test-seeking behaviour, care-seeking behaviour upon diagnosis, quality of care given to HIV-positive patients, and perception and treatment of people living with HIV/AIDS by communities, families, and partners, willingness to disclose HIV status, and social support solicited and received (Brown, Trujillo and Macintyre, 2001).

WHO (1999) stated that individuals with HIV/AIDS apart from suffering from serious illness often suffer from isolation and condemnation and are excluded from social interaction with family and friends as well as with the community. Patients and their families often lose access to education, their jobs and sometimes health care. Misconceptions resulting from ignorance about HIV and sexual orientation also lead to hostility and harassment. Family and friends of people with AIDS also endure the pain of isolation, fear and despair.

A major problem that we have to deal with in this regards is that, as a society we do not treat people living with HIV/AIDS like any other people who are faced with ill health. Since the mid 1980s, it has been evident that discrimination, stigmatization and denial are still very serious problems in our society. What is disturbing is that while the society stigmatizes people living with HIV/AIDS, and considers them as “immoral individuals”, the tendency for Faith Based Organizations to exclude such individuals on the basis of theology of sin even aggravates the situation (Mugambi, 2006). Consequences of stigma can be viewed along a continuum from mild reactions (e.g. silence and denial), to ostracism and ultimately violence. HIV stigma is often layered on top of many other stigma associated with such specific groups as homosexuals.
and prostitutes and such behaviours as injecting drug use and casual sex. These layers of stigma have unfortunately helped to extend and deepen the AIDS stigma to many who are infected with or affected by the disease (Herk 1993; Rushing 1995; Sontag 1990). For instance, one of the most publicized events occurred in a Durban township in 1998, when Gugu Dlamini, an AIDS activist, was killed by members of her community for openly disclosing her HIV status. While this is not an isolated event, it highlights the potential consequences of AIDS stigma (Malcolm et al, 1998).

Statement of Problem
Stigma is an undesirable or discrediting attribute that an individual possesses, thus reducing the individual’s status in the eyes of society. Stigmatization is the societal labeling of an individual or group as different or deviant. This study investigated attitude of residence of Epe-Lagos, Nigeria towards people living with HIV/AIDS. It also sought significance difference in mean attitude scores of various groups.

Research Questions
1. What is the profile of the respondents in the study?
2. What is the attitude of the respondents towards people living with HIV/AIDS?

Null Hypothesis
The null hypotheses were tested at 0.05 level of significance:
1. There is no significant difference in the mean attitude scores of male and female respondents.
2. There is no significant difference in mean attitude scores of teenagers, youths and adults respondents.
3. There is no significant difference in mean attitude scores of civil servants, business tycoon, artisans, apprentices and students.
4. There is no significant difference in mean attitude scores of degree holders, NCE/Diploma holders, school certificate holders and those with no formal education.
5. There is no significant difference in mean attitude scores of Christians, Muslims, traditionalists and those with no religion.

Methodology
Population and Sampling Techniques
The population for the study consisted of all residents of Epe local government area of Lagos state, Nigeria from age thirteen years and above. A sample of one thousand, two hundred and forty respondents from the population was randomly selected.

Instrument
The only instrument for the study was a self developed 20 item questionnaire in two sections. Section A sought information on demographic data of respondents, while section B contained twenty- item attitude statements that measure their attitude towards people living with HIV/AIDS. The instrument was validated and reliability coefficient was determined to be 0.61 using Cronbach alpha.
Administration of Instrument
The instrument were administered and retrieved with the assistance of colleagues and student of Michael Otedola College of Primary Education, Noforija, in Epe local government area of Lagos state, Nigeria.

Data Analysis
The data generated was analysed using descriptive statistics of mean and standard deviation for the two research questions as well as inferential statistics of t-test and one way analysis of variance (ANOVA) for the five null hypotheses generated.

Results

Research Question One: What is the profile of the respondents in the study?

Table 1: Frequency Count and Percentages of Respondents

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency Count</th>
<th>Percentage (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>586</td>
<td>47.3</td>
<td>1240</td>
</tr>
<tr>
<td>Female</td>
<td>654</td>
<td>52.7</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>1240</td>
</tr>
<tr>
<td>Teenagers</td>
<td>329</td>
<td>26.5</td>
<td></td>
</tr>
<tr>
<td>Youths</td>
<td>639</td>
<td>51.5</td>
<td></td>
</tr>
<tr>
<td>Adults</td>
<td>272</td>
<td>21.9</td>
<td></td>
</tr>
<tr>
<td>Profession</td>
<td></td>
<td></td>
<td>1240</td>
</tr>
<tr>
<td>Civil Servant</td>
<td>437</td>
<td>35.2</td>
<td></td>
</tr>
<tr>
<td>Business Tycoon</td>
<td>69</td>
<td>5.6</td>
<td></td>
</tr>
<tr>
<td>Artisans</td>
<td>50</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>Apprentices</td>
<td>44</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td>Students</td>
<td>640</td>
<td>51.6</td>
<td></td>
</tr>
<tr>
<td>Degree Holders</td>
<td>449</td>
<td>36.2</td>
<td></td>
</tr>
<tr>
<td>NCE/Diploma</td>
<td>368</td>
<td>29.7</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td>1240</td>
</tr>
<tr>
<td>School Certificate</td>
<td>323</td>
<td>29.7</td>
<td></td>
</tr>
<tr>
<td>Primary Leaving Certificate</td>
<td>73</td>
<td>5.9</td>
<td></td>
</tr>
<tr>
<td>No formal education</td>
<td>27</td>
<td>2.2</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td>1240</td>
</tr>
<tr>
<td>Christian</td>
<td>791</td>
<td>63.8</td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>409</td>
<td>33.0</td>
<td></td>
</tr>
<tr>
<td>Traditional</td>
<td>24</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>16</td>
<td>1.3</td>
<td></td>
</tr>
</tbody>
</table>
Fig. 1: Gender

Fig. 2: Age Description

Fig. 3: Respondents Profession

Fig. 4: Respondents Educational Background

Fig. 6: Respondents Religion
Table 1 showed the profile of respondents in the study. Of the one thousand two hundred and forty (1240) respondents, five hundred and eighty-six (586) were male and six hundred and fifty-four (654) were female. Also, three hundred and twenty-nine (329) of the respondents were in the age distribution 13-19 years old (which is referred to as the teenagers). Six hundred and thirty-nine (639) respondents were in the age distribution 20-39 years old (which is referred to as the youth), while two hundred and seventy-two (272) respondents were in the age distribution 40 years and above (which is referred to as adults). The table equally showed the number of respondents in different professions, educational background and religion.

Research Question Two: What is the attitude of the respondents towards people living with HIV/AIDS?

Table 2: Frequency distribution of respondents' attitude score

<table>
<thead>
<tr>
<th>Attitude Scores</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Remark</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 – 30</td>
<td>11</td>
<td>0.88</td>
<td>Fair</td>
</tr>
<tr>
<td>31 – 40</td>
<td>285</td>
<td>22.98</td>
<td>Good</td>
</tr>
<tr>
<td>41 – 50</td>
<td>937</td>
<td>75.56</td>
<td>Very good</td>
</tr>
<tr>
<td>51 – 60</td>
<td>17</td>
<td>1.37</td>
<td>Excellent</td>
</tr>
<tr>
<td>Total</td>
<td>1240</td>
<td>1.00</td>
<td></td>
</tr>
</tbody>
</table>

Table 2 revealed frequency distribution of respondents' attitude score. Seventeen (17) of the respondents fall in 51-60 score (which is remarked excellent). Nine hundred and thirty-seven respondents' score falls in between 41-50 score (which is remarked very good). This indicated that majority of the respondents possess good attitude towards people living with HIV/AIDS.

Hypothesis One: There is no significant difference in mean attitude scores of male and female respondents

Table 3: T-test analysis of mean attitude score of male and female respondents

<table>
<thead>
<tr>
<th>Gender</th>
<th>N</th>
<th>X</th>
<th>S.D.</th>
<th>Df</th>
<th>F</th>
<th>T</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>586</td>
<td>43.2184</td>
<td>3.9027</td>
<td>12.38</td>
<td>.186</td>
<td>1.089</td>
<td>.666</td>
</tr>
<tr>
<td>Female</td>
<td>654</td>
<td>42.0775</td>
<td>4.0274</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3 revealed that the difference in mean attitude score of male and female respondents is not significant (p<0.05). The mean attitude score for male respondent is 43.2184 ($X_1 = 43.2184$), while that of female respondents is 42.0775 ($X_2 = 42.9725$). The difference in the two mean attitude scores is not significant. Therefore null hypothesis one is not accepted. This indicated that male and female respondents possess similar attitude towards people living with HIV/AIDS.
Hypothesis Two: There is no significant difference in mean attitude scores of teenagers, youth and adult respondents

Table 1: One-way Analysis of Variance (ANOVA) on teenager, youth and adult respondents’ attitude towards people living with HIV/AIDS.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>146,998</td>
<td>2</td>
<td>73.499</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within groups</td>
<td>19373.244</td>
<td>1237</td>
<td>15.661</td>
<td>4.693</td>
<td>.009</td>
</tr>
<tr>
<td>Total</td>
<td>19520.242</td>
<td>1239</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1 revealed that the difference in mean attitude scores among teenagers, youths and adults is significant ($F_{(2,1239)} = 4.693; p < 0.05$). Therefore, null hypothesis two which states that there is no significant difference in mean attitude scores among teenager, youth and adult respondents is hereby rejected. The alternative hypothesis which states that there is significant difference in mean attitude scores among teenager, youth and adult respondents is hereby upheld.

Hypothesis Three: There is no significant difference in mean attitude scores of civil servants, business operatives, artisans, apprentices and students

Table 4: One-way Analysis of Variance (ANOVA) on civil servants, business operatives, artisans, apprentices and students’ attitude towards people living with HIV/AIDS.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>745,035</td>
<td>4</td>
<td>186.259</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within groups</td>
<td>18775.207</td>
<td>1235</td>
<td>15.203</td>
<td>12.252</td>
<td>.000</td>
</tr>
<tr>
<td>Total</td>
<td>19520.242</td>
<td>1239</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5 revealed that the difference in mean attitude scores among civil servants, business operatives, artisans, apprentices and students is significant ($F_{(4,1235)} = 12.252; P < 0.05$). Hence, the null hypothesis three which states that there is no significant difference in mean attitude scores among civil servants, business operatives, artisans, apprentice and students is hereby rejected. The alternative hypothesis which states that there is significant difference in mean attitude scores among civil servants, business operatives, artisans, apprentices and students is hereby upheld. This indicated that the attitude of civil servants, business operatives, artisans, apprentices and students towards people living with HIV/AIDS differ.
**Hypothesis Four:** There is no significant difference in mean attitude score of degree holders, NCE/Diploma holders, school certificate holders and those with no formal education.

*Table 4: One-way Analysis of Variance (ANOVA) on degree holders, NCE/Diploma holders, school certificate holders and those with no formal education attitude towards people living with HIV/AIDS.*

<table>
<thead>
<tr>
<th>Educational Background</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>336.021</td>
<td>4</td>
<td>84.005</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within groups</td>
<td>19184.221</td>
<td>1235</td>
<td>15.534</td>
<td>4.408</td>
<td>.000</td>
</tr>
<tr>
<td>Total</td>
<td>19520.242</td>
<td>1239</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 6 revealed that the difference in mean attitude scores among degree holders, NCE/Diploma holders, school certificate holders and those with no formal education is significant ($F_{4,1235} = 4.408; P<0.05$). Therefore null hypothesis four which states that attitude scores among degree holders, NCE/Diploma holders, certificate holders and those with no formal education is hereby rejected. The alternative hypothesis which states that there is significant difference in the mean attitude scores among degree holders, NCE/Diploma holders, school certificate holders and those with no formal education is hereby rejected. By implication, the attitude of degree holders NCE/Diploma holders, school certificate holders and those with no formal education towards people living with HIV/AIDS differ.

**Hypothesis Five:** There is no significant difference in mean attitude scores of Christians, Muslims, traditionalists and those with no religion.

*Table 7: One-way Analysis of Variance (ANOVA) on Christians, Muslims, traditionalists and those with no religion attitude towards people living with HIV/AIDS.*

<table>
<thead>
<tr>
<th>Religion</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>597.108</td>
<td>3</td>
<td>199.036</td>
<td>13.000</td>
<td>.000</td>
</tr>
<tr>
<td>Within groups</td>
<td>18923.134</td>
<td>1236</td>
<td>15.310</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>19520.242</td>
<td>1239</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7 revealed that the difference in mean attitude score of Christians, Muslims, traditionalists and those with no religion is significant ($F_{3,1236} = 13.000; P<0.05$). Hence, the null hypothesis which states that there is no significant difference in mean attitude scores among Christians, Muslims, traditionalists and those with no religion is hereby rejected. The alternative hypothesis which states that there is significant difference in mean attitude scores among Christians, Muslims, traditionalist and those with no religion is hereby upheld. This indicated that the attitude of Christians, Muslims, traditionalists and those with no religion towards people living with HIV/AIDS differ.

**Discussion of Findings**

The findings of this study generally revealed that the society has positive attitude towards people living with HIV and AIDS, this is contrary to the report of WHO (1999), Mugambi, (2006), Kayawe, Kelly and Beggaley, (1998) that people living with HIV/AIDS are stigmatized, discriminated and sometime lost
their jobs or cannot get employed. Monica, et al (2001) also reported that studies have shown that community members were sometimes unwilling to provide care and social support to people with AIDS because of fears of HIV transmission, the stigma associated with AIDS, and judgmental attitudes. Close neighbours although extended assistance, they usually did so only when asked directly. They further reported that widows and children of men who have died of AIDS-related conditions are ostracized and denied of familial care (including food) and these threatens their survival, particularly in rural communities. Finally they stated that HIV/AIDS was seen to cause insecurity in employment and discrimination in the workplace because some organizations terminated the contracts of people with AIDS when they become ill while those who were HIV-positive and unemployed found it difficult to find work; those who did find work were likely to encounter discrimination because of their HIV status.

The positive attitude of the society as shown in the result of the study corroborates Falodun (1989) and Omowa (1994) who reported that the student of University of Ibadan have adequate knowledge of the signs and symptoms of AIDS. Ajala (2000) also stated that there is an increase in the level of understanding throughout the community in general and the secondary school population in particular of the personal and social problems associated with HIV/AIDS. Furthermore, in line with the findings of the study, Ogundece (2004) stated that Castol (1998) and Ajala (2000) reported that Secondary School student are aware of the behaviour that can lead to higher risk of HIV infections and the behaviour that can eliminate the risk of spreading HIV infection. This finding is an indication that various enlightenment programmes by government, non-governmental organizations and other agencies are yielding positive results.

Furthermore the study also revealed significant difference in mean attitude scores of people of different age groups, profession, and educational background. This is in line with Malcom (1998) findings which reported that HIV/AIDS related stigmatization and denial take different forms and are manifested at different levels societal, community and individual contexts. Many people suspected of living with HIV/AIDS have refused to disclose their status or go for test for fear of lack of confidentiality, which is highly likely in many settings, prejudice, discrimination, loss of a job, strains on or the breakup of relationships, social ostracism, or violence (Brown, Trujillo and MacIntyre, 2001). This result is unexpected because understanding of causes, effect and prevention of HIV/AIDS depends on exposure of educational background and social status.

The study further revealed no significant difference in attitude scores between male and female respondents. This finding is in agreement with the work of Falodun (1989), Castol (1998) and Omowa (1994). The reason one may adduce for this findings is that HIV/AIDS being a global phenomenon is not bedeviled with gender stereotyping.

Conclusion and Recommendation

The findings generally revealed that the society have positive attitude towards people living with HIV/AIDS. Also, there were significant differences in mean attitude scores among people of different age, profession, educational background and religion towards people living with HIV/AIDS. Stigmatization and discrimination against people living with HIV/AIDS range from unemployment or termination of employment, to isolation and denial of other basic needs of education, shelter, food. These have psychological, mental and physical effects on the individual and sometimes, family members. Therefore, in order to save these people from the trauma of stigmatization, the following recommendations are proffered. More AIDS education should be given to the people. Sexuality education should be made available to religious institution, homes through the media and other public places.
References


Awake (2004). Are We Winning the Battle Against Diseases?


