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# *Education: An Antidote for the Spread of HIV/AIDS*

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*There are growing fears about the rate at which AIDS is spreading across the globe today, particularly in Africa. In 20 years, AIDS has become the greatest pandemic ever, and indications are that it will continue to increase. Because there is no universally accepted curative drug for the treatment of the epidemic, this report describes an attempt at providing education as a preventive method for the spread of the deadly disease. It is also an attempt to rise to this challenge by a systematic analysis of appropriate theories that can lead to insight into the epidemic. An empirical approach will further add to scholarly understanding and much-desired solutions. Suggestions are offered on how to achieve these goals through integration of HIV/AIDS education into school curricula, and how nursing practice can help in the education about and treatment of the disease. This report is the first part of a two-phased study from a sociologic point of view of an emergent universal health problem.*

**Key words:** *education, antidote, spread of HIV/AIDS*

As deadly AIDS remains incurable, and HIV, which causes the disease, is becoming more elusive and thwarting every effort to render it impotent, health authorities, government, nongovernmental organizations, sociologists, health educators, and various health-related researchers are reappraising the existing methods of curtailing the infection. The need to re-evaluate control strategies is predicated on the growing incidence of the disease despite various programs put in place to check the menace. In the first ever country-to-country analyses of AIDS

spread jointly put together by the United Nations and World Health Organization, it was obvious that the rate at which the deadly infection is spreading is quite embarrassing (“Spread of HIV/AIDS,” 1998).

As the number of individuals and households affected by HIV multiplies, so the social impact of the epidemic both widens and deepens, health facilities are stretched to supply services, and social support systems and traditional coping mechanisms face unprecedented challenges. There is a profound social impact of AIDS in developing countries to which attention must be drawn (Holland et al., 1990).

According to Adegbenjo (2001), HIV/AIDS can be seen as a social issue, and thus the public has taken it up. Existing knowledge of sexuality, drug subcultures, lifestyles, health and illness, the mass media, racism, gender, and power are all being drawn upon to provide these explanations. The urgency of the perceived need to change people’s behaviors rapidly in the face of a global threat to human health has called attention to the value of social sciences and medicine.

There are growing fears about the rate at which AIDS is spreading across the globe today. In 20 years, it has become the greatest pandemic ever, and indications are that it will continue to increase. For example, in Zimbabwe, it is estimated that 25% of people aged between 15 and 49 years are infected with HIV (Chireshe & Chireshe, 2003). It is also estimated that over 36 million are infected with HIV

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and another 1 million died of AIDS worldwide in 2000, the highest annual total since the epidemic started. This is despite the use of antiretroviral drug therapy, particularly in wealthier nations (“[Will the Deadly March of AIDS Be Halted?](#)”, 2002). To show the seriousness and effects of the epidemic in Africa, a Joint United Nations Programme on AIDS fact sheet confirmed that some 2.2 million people in sub-Saharan Africa died of AIDS in 2001 alone, and approximately 3.5 million Africans became infected with HIV, bringing the total number of adults and children living with HIV/AIDS in the region to 28.5 million. The estimated number of children orphaned by AIDS in the region is 11 million.

It is projected that, between 2010 and 2020, 55 million Africans will die earlier than they would have because of AIDS. According to this report, the epidemic’s toll continues to mount, even in countries already experiencing very high HIV prevalence rates. The number of AIDS-related deaths among young adults in South Africa, for example, is expected to peak between 2010 and 2015, when it is estimated that there will be more than 17 times as many deaths among persons aged 15 to 34 as there would have been without AIDS. In a country-to-country analyses of the heavy toll of this epidemic, seven countries, all in southern Africa, now have prevalence rates higher than 20%: Botswana (38.8%), Lesotho (31%), Namibia (22.5%), South Africa (20.1%), Swaziland (33.4%), Zambia (21.5%), and Zimbabwe (33.7%).

In Nigeria, the current conservative figure puts the number of people with HIV/AIDS at 2.5 million, with 1,435 new cases of the disease being reported every day. Going by the projection, no fewer than 184,000 children will be orphaned in the country during the same period by AIDS, bringing the total figure to 611,000 ([Adegbenjo, 2001](#)). In Nigeria’s state of Oyo, a newspaper reported that the spread of HIV/AIDS has reached an alarming rate: the number of victims reported in hospitals had increased to 66,000 ([Guardian, 2001](#)). The danger is that adolescents lack knowledge about high-risk behaviors associated with HIV/AIDS that could help prevent the spread of the disease ([O’Neil, 2000](#)).

With the foregoing, we see that the AIDS epidemic is having a devastating impact on productivity and that most of the victims are students or people in the prime of their lives in terms of productive capac-

ity. The African continent is particularly at a disadvantage in combating the disease because of the high cost of medical care. For instance, developed nations are relatively successful in managing the infection through newly developed, although still very expensive, drugs. However, the remedy is prohibitively expensive in other countries.

African leaders themselves acknowledge the increasing gravity of the pandemic. At the AIDS submit in Abuja, Nigeria in 2001 and the 1998 World Health Organization regional committee for Africa in Harare, Zimbabwe, African leaders were unanimous in their support for a coordinated campaign against HIV/AIDS, which has infected an estimated 20.8 million adults and children in the region. Every country on the continent has, to a lesser or larger degree, reported cases of the menace which every day infects about 7,500 Africans out of the global total of 16,000 (“[AIDS Spread in Africa,](#)” 2001). According to a Daily Times newspaper report (“[Spread of HIV/AIDS,](#)” 1998), it is estimated that by the end of 1997, close to 9 million children in the region born with HIV infection developed AIDS. Of that figure, no fewer than 7 million children and adults have died. Unfortunately, most vulnerable are active and productive people aged between 15 and 40 years.

In Africa, treatment of HIV/AIDS has been very difficult. It is very expensive to prolong the life of an HIV/AIDS patient. Projection of deaths and orphans that would be left has been made. UNICEF cited that by the end of year 2000, 10.4 million African children under age 15 would have lost their mothers or both parents to HIV/AIDS ([UNICEF, 2000](#)). This would be 90% of the global total of HIV/AIDS orphans (UNICEF). According to the report AIDS is wiping out much of the generation. Families are being destroyed and skilled workers cut down. The disease, according to [Adegbenjo \(2001\)](#), was said to have begun in Africa and spread, in part because of social instability, via migrant workers, refugees, and women who had few means to support themselves other than prostitution.

The situation is indeed grim, and the factors contributing to the problem include wide practice of unprotected sex, high fertility, increasing incidence of sexually transmitted diseases, and poor access to care and education. Because the situation keeps worsening, concerned authorities including govern-

ment and nongovernmental organizations are modifying the prevention style, focusing more on education, and creating awareness, particularly among the vulnerable groups in the society. And there is a general assumption that the more one advances academically, the more aware one tends to be about his or her physical and immediate environment; politically, socially, economically, educationally and religiously.

This report, therefore, seeks to examine and discuss how education can be an antidote for the spread of HIV/AIDS, to examine some theoretical analyses on origin of HIV/AIDS, and to discuss factors involved in the spread of this epidemic. The report will look as well at HIV/AIDS as a social issue and will examine alongside it the social dimension of HIV/AIDS. Education is proffered as the only durable antidote for the spread of HIV/AIDS.

### Theories of the Origin of HIV/AIDS

The debate around the origin of HIV/AIDS has sparked considerable interest and controversy since the beginning of the epidemic. However, in trying to identify where AIDS originated, there is a danger that people will use the debate to attribute blame for the disease to particular groups or individuals. Explaining this, Adegbenjo, (2001) stresses that the first cases of AIDS occurred in the United States in the early 1980s, but there is little information about the source of the disease. However, there is now clear evidence that the disease is caused by the virus HIV.

Since the discovery of HIV in the early 1980s, two questions have yet to be answered: Where did this virus originate? How did it go from being one of the smallest forms of life on record to the cause of the global AIDS pandemic? Many theories have been proposed, from the preposterous (HIV was manufactured by the Central Intelligence Agency [CIA] or the *Komitet Gosudarstvennoi Bezopasnosti* [KGB] and then introduced for the purpose of population control), to the unlikely (HIV originated from a tainted oral polio vaccine in the 1950s), to the academic (HIV originated by zoonotic transmission from an animal host). Given these explanations, we can see that there are several theoretical approaches to the

explanation, interpretation, and analysis of HIV/AIDS. It is possible to describe many emergent theoretical perspectives in understanding HIV/AIDS. Although theories on HIV/AIDS abound at present, in this report we look at the following.

### The Chimpanzee Theory

HIV is a part of family of viruses called the *lent* viruses. Lent viruses other than HIV have been found in a wide range of human primates. These other lent viruses are known collectively as simian (monkey) immunodeficiency viruses (SIV); a subscript character is used to denote their species of origin (Fritzen, 2000).

According to Kanabus and Allen (2001), it is now generally accepted that HIV is a descendent of SIV. Certain SIVs bear a very close resemblance to the two types of HIV: HIV-1 and HIV-2. HIV-2, for example, is said to correspond to an SIV found in the sooty mangabey monkey (SIV<sub>sm</sub>), sometimes known as the green monkey, which is indigenous to western Africa. In 1999, HIV was identified as SIV that was known to infect chimpanzees. Further, in February 1999, a group of researchers from the University of Alabama studied frozen tissue in which SIV<sub>cp2</sub> was almost identical to HIV-1. The tissue was from a chimpanzee known as pantrolodites, which was common only in west central Africa (Kanabus & Allen, 2001; Adegbenjo, 2001).

Supporting this idea and establishing the validity of this study, a similar study by Ho and colleagues of the Aaron Diamond AIDS Research Center analyzed the blood of a Cameroonian woman who died of AIDS in 1995 (CNN, 1998). Her strain of the virus was unique and fell halfway between HIV and SIV genetically. It was identical to an odd strain taken from a chimpanzee. The finding “strongly supports the hypothesis that HIV came from a simian virus” (CNN, 1998).

The results of the different researchers point to the possibility that chimpanzees were the source of HIV-1 and the virus at some point crossed from chimpanzees to human. Although it is believed that chimpanzees have transmitted the virus to man, it is still assumed that humans may have been infected from a third, as yet unidentified, primate species. (CNN, 1998; Fritzen, 2000). In either case, at least

two separate transfers into human population would have been required. The researchers suggested that HIV could have crossed over from chimpanzees as a result of a human killing a chimp and eating the meat.

### Polio Vaccine Theory

Dennis Hooper postulates that humans in the early testing of a polio vaccine in Africa in the 1950s inadvertently brought on AIDS (O'Neil, 2000). This theory seemed farfetched when it was originally introduced to public attention in a 1992 issue of *Rolling Stone* magazine (Fritzen, 2000). It suggests that an oral polio vaccine might have been manufactured from contaminated chimpanzee kidney tissue that was subsequently introduced to the African population (Fritzen, 2000).

While Hooper's theory has not been proven to have scientific merit, the time and place of the earliest cases of AIDS and the testing of the vaccine do coincide. From 1957 to 1960, polio vaccine was administered to a million people in what are now Rwanda, Burundi, and Congo. This theory challenges Hahn's pan-troglodyte zoonotic theory of origin. If Hooper's theory is correct, the simian ancestor of HIV grew in the batches of vaccine used in experimental trial. When the oral vaccine was administered to humans, the simian virus would have passed through a sore and entered the human bloodstream, evolving into HIV-1. From there, it would have been transmitted through sexual or blood contact.

### The Pathogenetical Transfer Theory

Another controversial theory contends that HIV was transferred iatrogenically, or via medical experiments. One well-published theory is that polio vaccines played a role in the transfer. This was, however, disapproved (Adegbenjo, 2001; Chireshe & Chireshe, 2003; Fritzen, 2000). These scholars also identified three of the earliest known instances of HIV infection:

- A plasma sample taken in 1959 from an adult male in what is now the Democratic Republic of Congo.

- HIV found in samples from an African American teenager who died in St. Louis in 1969.
- HIV Found in tissue sample from a Norwegian sailor who died around 1976.

### The 1930 Theory

In January 2000, the results of a study presented at the 7th annual Conference on Retroviruses and Opportunistic Infections suggested that the first case of HIV infection occurred around 1930 in West Africa. The study, according to Adegbenjo (2001), was carried out by Dr. Bette Korba of Los Alamos National Laboratory in New Mexico. The estimate of 1930 (which does have a 20-year margin of error) is based on a complicated computer model of HIV's evolution. Presently, it is not known when the emergence of HIV in humans took place. However, what is clear is that sometime in the middle of 20th century, HIV infection in humans developed into the epidemic of disease that we now refer to as AIDS.

Some researchers, led by Korba, worked out that this probably happened between 1915 and 1941. The most likely year was 1931. "The possibilities are that it was transmitted from apes to human beings near the turn of the century and remained isolated in a small population until that time, or that the virus jumped to humans in about 1930 and started spreading immediately or some years later" (Horowitz, 2000). In either case, the conclusions argue against the idea championed by Ed Hooper in his book, *The River*, that polio vaccine grown on cells from chimpanzees was the prime cause of the epidemic (Horowitz, 2000). This theory is now being tested by examination of samples of the vaccine to see if they contain HIV (Horowitz, 2000).

### Conspiracy Theory

The proponent of the conspiracy theory is John S. James (O'Neil, 2000). This theory views AIDS as a weapon developed by someone's germ warfare experiments and released accidentally or deliberately. Proponents have done an excellent job of collecting background information on germ warfare and how it may relate to AIDS. There are problems with the germ warfare theory. Almost all the evidence sup-

porting it concerns only the possibility that germ warfare may have happened, not whether it actually did. The key technical issue is whether anyone knew enough to have created the AIDS virus.

Other theories put forward by researchers about the origin of HIV/AIDS conclude a number of conspiracies. Some people, according to Kanabus and Allen (2001) and Adegbenjo (2001), have suggested that the CIA manufactured HIV while others believe that HIV was genetically engineered.

### **Factors Involved in the Spread of HIV/AIDS**

A number of factors are involved in the spread of HIV/AIDS; in turn, these exacerbated other problems. The conditions that prevail in some lands in Africa and in other parts of the world where AIDS is gaining ground are often related to the following factors as put forward by Adegbenjo (2001), Chireshe and Chireshe (2003), Daini (2002), and Omisakin (1988).

#### **Morality**

Because sexual contact is the primary means of HIV infection, a lack of clear moral standards evidently promotes the spread of the disease. Many feel, though, that it is not practical to advocate sexual abstinence for the unmarried. This analysis appears to be confirmed by the conduct of young people. For example, a survey in one country indicated that about a third of youths between the ages of 12 and 17 had engaged in sexual intercourse.

#### **Sexually Transmitted Disease**

The presence of a sexually transmitted disease increases the risk of HIV-1 infection two- to fivefold. Research results have shown that cases of sexually transmitted disease are more common among adolescents or youth and that there is a high tendency that people who suffer one sexually transmitted disease are likely to be prone to HIV/AIDS.

#### **Poverty**

Many countries in Africa are battling poverty, and this creates a climate favorable to the spread of AIDS. What may be considered basics in developed countries are not available in most developing lands. Large communities have no electricity and no access to clean drinking water. In rural areas, roads are inadequate or nonexistent. Many residents suffer from malnutrition, and medical facilities are minimal. All these are contributory facts to the spread of the disease.

#### **Ignorance**

A large number of those infected with HIV are unaware of it. Many do not want to be tested because of the stigma attached to the disease. "People with, or suspected of having, HIV may be turned away from health care services, denied housing and employment, shunned by their friends and colleagues, turned down for insurance coverage, or refused entry into foreign countries" (Allen, 2001; Adegbenjo, 2001, p. 55). Some have even been murdered when their HIV status was discovered.

#### **Culture**

In numerous African cultures, women are often not in a position to question their partners about extramarital affairs, to refuse sexual contact, or to suggest safer sexual practices. Cultural beliefs often reflect ignorance and denial about AIDS. For example, the illness may be blamed on witchcraft, and help may be sought from witch doctors. Supporting these explanations, Chireshe and Chireshe (2003) ascribed HIV/AIDS to social and biomedical causes. Notable among the social causes they discussed were multiple sex partners, unprotected sex, lack of self-control, not valuing one's body, teachers falling in love with schoolgirls, and women going out with "sugar daddies." The biomedical causes that Chireshe and Chireshe cited include accidents, transfusing blood from an infected person, caring for HIV/AIDS without protective equipment like gloves, and mother-to-child transmission.

## AIDS as a Social Issue

Sociological understanding of AIDS requires an appreciation of the difference between HIV, which seemingly can lie dormant in an apparent healthy person for several years, and AIDS or related conditions, which seem eventually to afflict people whose immune systems have been weakened by the virus. Unlike infectious diseases that can spread through air or water, HIV can only be spread by specific forms of bodily contact in which body fluids are exchanged or by contaminated blood being introduced into the body (Adegbenjo, 2001).

In another study (Chireshe & Chireshe, 2003), 77% of respondents ascribed HIV/AIDS to social issues. The major causes as earlier identified include prostitution, multiple sex partners, and rape. With the foregoing, we see that distinction between HIV and AIDS has been confused in representations of AIDS in the media and in many official pronouncements around the world since AIDS was first recognized (Anderson & Levy, 1985). This confusion can be considered socially significant because it has encouraged social responses to the epidemic that have little to do with AIDS as illness and a great deal to do with relationships between social groups and categories. Social responses to HIV, therefore, depend less on scientific certainties than on the social construction of the syndrome.

Given the fact that HIV/AIDS is a disease that affects human beings in a society and that it can be contracted through human interaction (mostly sexual), sociologists have seen it as an issue that needs to be handled sociologically. Suffice it to say that to many sociologists, HIV/AIDS is a social issue and should be handled as such.

## Education as an Antidote to HIV/AIDS

In each society, whether pre- or postindustrial, there is an education system; however, the objectives, methods, and contents of the systems may differ. The education system of each society should mirror the total society; hence, educational institutions might be conceived as a microscopic reflection of the society.

In all societies, education is a means by which society ensures its stability. It is through the educational system that young members of the society are taught the expected behavior of the society. The internalization of expected behaviors ensures harmony among members. Education is therefore viewed as a social control mechanism.

Given the role of education as expatiated above, and considering the fact that there is no curative treatment for the spread of HIV/AIDS and that HIV/AIDS is very common among a vulnerable group (adolescents) across the world today, efforts should therefore be directed toward a serious education of the people, particularly adolescents, about this dreaded disease.

From various definitions of education as given by Akinpelu (1981); Babarinde (1999); Bamisaiye (1990); Omokhodion and Dosumu (2000), and Oni (2001), it could be argued that for an individual to live in society and interact with his fellow men as expected, he should be prepared by educators in an environment that nurtures him to meet this expectation. Education then plays the role of preparing and nurturing individuals to live in society and thus be able to perform specific functions for society. Education is recognized as an institution of society that can provide adequate information or knowledge on how problems affecting society can be ameliorated.

From the above brief account of the functions of education in society, one is tempted to assert that without education there is no society. This assertion reveals once again that education is a socially significant institution of society.

HIV/AIDS as a social issue could therefore be brought into education with the aim of bringing about a change in behavior within the society. This could be done by exposing to students to what HIV/AIDS is all about and explaining the modes through which one can contract HIV/AIDS and how it can be prevented. There is also the need to explain what to do when one contracts it. Because HIV/AIDS is a killer disease, without trying to curb its spread, the whole human race is in danger. At the moment, there are several gaps in knowledge on interaction programs on HIV/AIDS across the world.

Public and private schools have the responsibility to ensure that young people understand the nature of

the HIV/AIDS epidemic and the specific actions they can take to prevent HIV/AIDS infections, especially during adolescence and young adulthood. Schools should therefore serve as channels for educating adolescents about HIV/AIDS. In doing this, information should be integrated into relevant subjects such that all students would be exposed to HIV/AIDS education consistently for an appreciable period, thus ensuring the desirable impact on risky sexual behavior. However, given the fact that integrating AIDS education into existing curriculum intervention implies change in policy that often takes time to accomplish, other short-term solutions must be explored. Teachers should be trained to expose HIV/AIDS knowledge to students, and some of the students should be trained as peer educators. This will help students to learn better if they open up to their peers, if not to the teachers.

Much has been said about sex as a major cause of HIV/AIDS. Other modes of spread such as using infected needles for injection, taking of unscreened blood, and use of infected clippers at the barber's should be stressed. Students should be made aware of all modes of spread so that they can resolve to at least prevent themselves from getting infected with HIV/AIDS. In a way too, they could help get the message across to society by educating, even if verbally, people within their immediate environment.

As suggested earlier, Most AIDS prevention programs undertaken to date have relied primarily on educational messages about the disease and recommendations to use condoms if sexually active outside a monogamous relationship. Efforts to combat the continued spread of HIV infection will be more successful if prevention programs take into greater account factors related to the relationship context of sexual behavior, substance use, and other situational antecedents surrounding sex, strategies for modifying sexual behavior repertoires, and sexual schema and scripts. Because there is now considerable reason to believe that interventions that provide explicit sexuality education related to AIDS are effective and that certain individuals are at high risk for HIV infection, such skills as correct condom use, sexual negotiation and assertiveness, and sexual behavior decision-making produce reduction and not increase in high-risk sexual activity. This also agrees with

Choi and Coates (1994), that those intervention programs should be preceded by qualitative educational research that identifies the sexuality lifestyle issues confronting members of the intervention target population. This also agrees with the results of Stout and Kirby (1993) cited in Adegbenjo (2001), as well as Dawson (1986) and O'Brien (1997) that contraception education as an area in human sexuality education in schools rarely produces increases in teenage sexual behavior.

The AIDS epidemic has also provided a graphic illustration of how ignorance can turn to fear and fear to prejudice and ostracism that crimp the flow of compassion and love for our neighbors when they need it the most. Education is the antidote. It can show us that AIDS is not a personal threat but a call to awaken our faith and put it to work in making a positive difference in the lives of those who suffer from this disease.

Education can also be a means to stopping the spread of the disease. Half of new infections across the world today are people who are 25 years old or younger. A way to help our young people avoid infection is by offering AIDS prevention education. While educational resources include presentations on the nature of the virus, caregiving topics, prevention, and personal experiences in living with AIDS, in addition, spiritual and theological issues surrounding the epidemic should be integrated into the school syllabus.

The education sector also has a vital role to play in prevention activities, because AIDS prevention messages and education must begin at an early age. These messages are most effective when they reach primary school children. One of the most cost-effective ways is to include these messages in the curriculum in some form. Education establishments and staffs are also potential resources for outreach into broader communities.

Government, particularly in Africa, should also encourage promotion of HIV/AIDS nursing practice for the provision of educational, therapeutic, and supportive interventions. The goals of nursing care are to prevent infection; promote client, family, and community adaptation to HIV infection and its sequelae; and to ensure continuity of care by collaborating with others.

Nursing practice in HIV/AIDS should include in its curriculum a complex knowledge base and range of skills that include pathophysiology, learning principles, family dynamics, grief and loss, coping with chronic illness, care of immunocompromised clients, risk assessment, and risk reduction. Use of research results should also be essential in maintaining an adequate knowledge base in an evolving field such as HIV/AIDS nursing. Nursing practice is multifocused and occurs in an array of settings including primary care, acute care institutions, communities, and schools. The goals of nursing practice would therefore be achieved in collaboration with the client, other health care professionals, and community-based organizations.

Specifically, the HIV nursing practice course or curriculum should focus on the treatment and care of people with HIV including diagnosis and treatment, combination therapies, diagnosis and treatment of opportunistic infections, occupational health and safety issues, and the role of medical personnel in the continuum of care of those with HIV.

### Conclusion

In this report, theories of the origin of HIV/AIDS have been examined. The factors involved in the spread of the deadly disease have also been discussed. HIV/AIDS as a social issue was also discussed. The report ultimately presented education as a durable solution to the spread of the epidemic, and stressing that HIV/AIDS awareness, education, and prevention among the vulnerable groups (adolescents) should be reinvigorated.

It is time to recognize that the HIV/AIDS debate is over as an academic exercise and as a practical matter. This long debate may have been constructive at first because it obliged scientists to give careful consideration to the epidemiological and clinical data they were gathering, but it has become a dangerous diversion. The doubt that it has fostered carries the potential for great harm: it can lead those at high risk of infection to ignore prevention messages, and it can keep those who are infected from benefiting from recent advances in therapy. The debate should cease, and all energies should be directed toward developing a universally accepted, effective vaccine against

HIV and curative treatments for those who are infected.

With the foregoing, it is evident that curtailing the HIV epidemic poses enormous challenges for behavioral sciences research and nursing practice in the development of effective HIV prevention models. The complex psychological, social, cultural, and biological determinants of sex also create unusual challenges for HIV primary prevention. HIV prevention efforts through education and nursing practice are likely to be the most successful when they draw on relevant areas of human sexuality research including those related to the interpersonal relationship context of sex. Going by this explanation, we see that there is no universally accepted drug to deal with the deadly disease, and even in countries where there are drugs for it, they are still very expensive. Therefore, the only durable and curative drug is prevention, which can best be achieved through education, including education in nursing practice. The form of the education should concentrate on adolescents, most of whom are students. So, with respect to HIV/AIDS, we need to intensify classroom health education on HIV/AIDS not only to avert and reduce the spread of the virus in the community but also to make people sufficiently conscious so that a wolf is not hailed when there is no wolf.

Nurses have made major contributions to the care of people affected by the epidemic. HIV/AIDS nursing practice education should be reinvigorated where it exists and should be put in place and in proper shape where it does not exist, particularly in African countries (Ogurie, 2002).

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