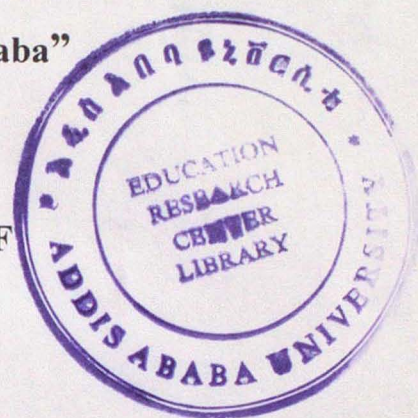


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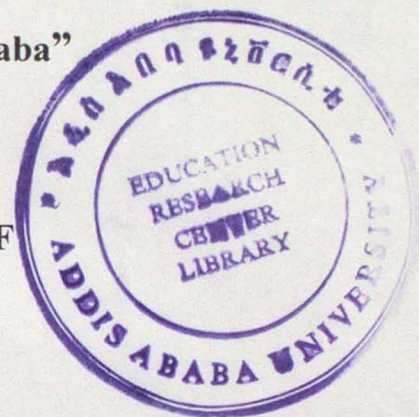
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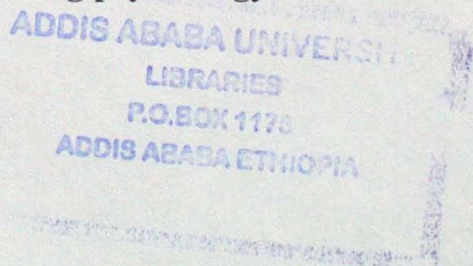
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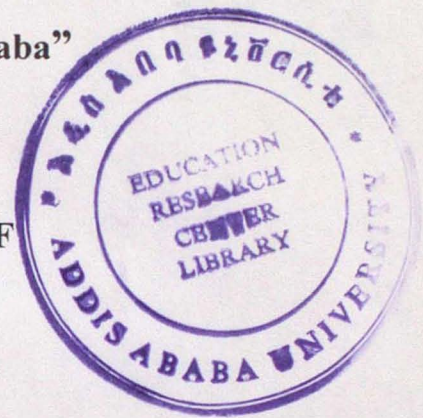


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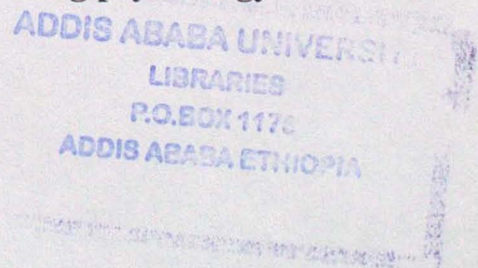
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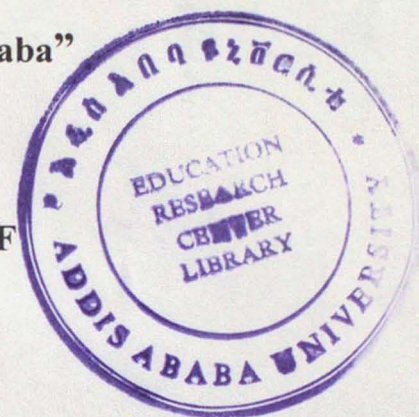


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Acknowledgement

O Allah! I confess thy help. AllhamduliLLah!

My first gratitude goes to my advisor profe. Shamim Ahmad Ansari who continuously read and provided valuable advice in the course of this research work. I would like to express my sincere appreciation and thanks to the Islamic Research and Cultural Center (IRCC) especially to the administrative staff who tolerated me for the last two years without any complain.

The next deep thanks goes to my mother Rukya Usman who extremely worried about my success starting from my early education to this thesis.

My dear wife Nessri I know how much you helped me and you dedicated every resource at your disposal for me to accomplish this program, thank you very much.

I would like to extend my gratitude to Abdu Ibrahim who becomes my honest and intimate advisor starting from topic selection till the completion of the thesis. I would also like to express my deepest appreciation to my brothers and sisters who provided moral as well a material support to the accomplishment of this work. My special thanks forwarded to Mukhtar, Yimam, Semir, Adil, Fatuma and Zemzem who read and provided valuable comments on the draft paper. Lastly I acknowledge the International Call organization (ICO) for their some financial support.

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Acronyms

P.B.U.H	peace be up on him
PLHA	Person Living with HIV/AIDS
S.W	subhanehu wetala (Glorious and exalted He is)
FGD	focus group discussion
CT	counseling and testing
STI	sexually transmitted infections
STD	sexually transmitted disease

Abstract

The main purpose of the study was to know the level of Muslim students' knowledge, attitude, stigma and discrimination, their understanding of the Islamic approach to defend the spread of HIV and to investigate their understanding and commitment to the expected role as a Muslim. The next purpose was to compare madrasa and high school students' knowledge, attitude and other variables too. For this purpose 303 students from high school (198) and madrasa (105) respondents from Addis Ababa were selected. Mainly a questionnaire was employed to gather the required information from the subjects. Using independent sample t test the obtained data were analyzed and interpreted. As a result the following major findings were observed. Though both groups have good level of knowledge, high school students have significantly better than madrasa students with some limitation. In relation to attitude, stigma and discrimination, high school students were found to have favorable attitude and less stigmatic and discriminatory behavior towards the victims. While madrasa students' attitude was negative and they were more of stigmatic and discriminators. The variation was also significant at alpha 0.01 level. Regarding the Islamic approach to the prevention strategy both groups agree to the importance but madrasa students significantly better in their understanding and commitment to this approach. Finally their understanding to the expected role was assessed and high school students were found to be more responsible. The correlation coefficient showed that strong and positive relationship among variables with the exception of prevention strategy with the other variables and it was significant for all variables.

Finally some important recommendations were forwarded so as to improve subjects (especially madrasa students) knowledge, attitude towards PLHA, orphans and the like. Out of this teaching the religious leaders, making repeated open discussion with both the clerics and madrasa students is required to improve their stigmatic behavior and unfavorable attitude. Enough attention should be given to these groups so that they may help in the process of defending and controlling the pandemic

Chapter One

Introduction

Back ground of the Study

The epidemiological pattern of HIV/AIDS has changed dramatically in the past two decades since the discovery of the disease. After being confined to North America and Western Europe the disease is now spreading through out the world with more than 90% of infected persons living in the developing world (Piot, 2001). Sub-Saharan Africa remains the worst affected region with 80% of all adults under 45 years of age being HIV positive (UNAIDS and WHO, 2003). From the estimated 42 million people who live with HIV/AIDS, the sub-Saharan continent has a lion share of 25 million, where so far 13 million people have already died from AIDS (2 million in 2003 alone). But the region shares only 10% of world population (MOH, 2004).

The prevalence of HIV/AIDS rates across the African continent vary widely. South Africa is most severely affected with more than 16% of its adult population being HIV positive. Especially the East, Central and South Africa (including Ethiopia and Burundi) accounts for more than 50% of the world's burden of HIV/AIDS, it is known that the 12 of 14 countries with the heaviest burden of HIV/AIDS are in this region. HIV/AIDS is the worst disaster over to afflict the sub region and this region has been the epicenter of the epidemic (UNAIDS, 2003). The attitude combined with lack of access to treatment services, helps to explain why an estimated 95% of men and women across Africa do not know their HIV status. (UNAIDS, 2005)

Even though the region is predominantly Muslim, the trajectory of the virus is clearly shown. In Nigeria, 6 to 10 percent of adults are infected, and between 10 to 18 percent of adults in Ethiopia are HIV positive. Both are countries in which fully half of the people practice some form of Islam. Although the HIV epidemic in Muslim Africa should have sounded a wake up call to other Islamic countries, few Islamic authorities north of the Sahara seem to have heard the alarm (Memoon, 2005).

Officially the joint United Nations Program on HIV/AIDS (UNAIDS) estimates the total HIV population of North Africa, the Middle East, and Predominantly Muslim Asia at nearly 1 million people today. At the end of 2003 UNAIDS estimated that up to 420,000 people in Mali, 180,000 in Indonesia, 150,000 in Pakistan and 61,000 in Iran had

HIV/AIDS figures based up on surveillance data: thus lack of information can be taken as a lack of infection. Although the prevalence rates of infections among Muslims may seem small (under 0.5% in North Africa) when compared with the tragedy that is unfolding in southern Africa, they stand in sharp contrast to official estimates that suggest no disease at all (Memoon, 2005).

According to the Ministry of Health (2002), the prevalence of adults with HIV infection was 6.6% which had been 7.3 in 2001, of the total population of Ethiopia. The number of orphans had been 1.2 million in 2001, and it was projected to increase 1.8 million in 2007 and if no change will be made in the situation it may be aggravated to soar up to 2.5 million in 2014. The prevalence rate of HIV in young women (15-24 age group), which indicates recent infections, is 8.6%. 537,000 of 4.7 million orphans lost either of their parents due to AIDS and 111, 903 children are infected with HIV. The number of PLHA who are in need of ARVs is 286,258. The prevalence of HIV has stabilized at higher rates in the urban areas but continues to rise in the rural areas. This is alarming because 85 % of the population lives in rural parts of the country where access to information on HIV/AIDS, CT and other care and support services is limited (MOH, 2005)

HIV/AIDS kills all human beings of all age group once they have been infected with the virus which causes AIDS. In spite of its indiscriminate nature of killing all human beings irrespective of their sex, religion, clan, and age, AIDS most likely affect people who are sexually active. The creation of awareness about the disease and related aspects is one major duty for those who are in contact with the problem.

HIV/AIDS never discriminate to infect. It affects each and every individual from any skin color, sex, age, intelligence group, religion, and/or economic level. But, the rate might be different across the world today. In view to the above facts, it looks that Muslim countries have very small proportion of HIV/AIDS infection as compared to any region or cultural groups of the world today.

People's attitude towards the nature of the disease, spreading mechanisms, PLHA and the preventing techniques should be clearly known so as to intervene in the most appropriate way to prevent the disease not to bring further damage. In addition the prevailing stigma and discrimination level should be known so that appropriate intervention mechanisms could be possible. Further more the techniques used by

individuals greatly influence the rate of transmission. Thus it is compulsory to be clear with all these variables in order to halt the further damage which AIDS is bringing to the world.

In fact there are socio cultural barriers which need closer examination when we consider HIVAIDS education, as Eyob (2000) stated "Ethiopia is a country with complex cultural diversity". Similarly a study indicated that in Ethiopian societies "children and adolescents are restricted to talk about sex issues which are secret among family members" (Hailegnaw, et al 1996).

As the influential part of the society, the role of madrasa and high school students should be put in clear pictures so as to make them participate in the battle against the disease.

As a matter of fact HIV is not the problem of some sect of a society that differentiates among peoples. It is now knocking the door of every nations and nationalities. Of course the prevalence rate may vary from country to country and hence the level of the damage it causes may be again different.

After rigorous work done across the country in the last few years, now a days there seems a relatively better achievement in creating awareness about the disease at national level, but the Muslim community, specially those who are dedicated their time to study the religion are still observed to be more of reluctant in relation to the pandemic. Probably, we may count many rationales behind this behavior. Among them: the problem of religious leaders (Imams and teachers) who do not like even to mention the name of the disease in their teachings and the world wide claims that Muslims are not the concern of HIV/AIDS. It was felt that strong Islamic convictions would prevent people from having extramarital sex, and alcoholic behavior and as a result the spread of HIV will be at least low if not stopped. But when we see the practical reality of Muslims there is a lot of non Islamic characteristics which is completely foreign and in contradiction with the very essence of the moral obligation of Islam. Labeling one self as a Muslim can not defend him/herself from the risk of HIV. Practice of Islamic principles is one of the main requirements of Islamic way of life. In fact HIV can be transmitted in different ways though the main cause is extramarital and unsafe sex. Islam also advocates both the moral and scientific means of solving a problem as far as it is in agreement with its basics tenets.

There are no previous studies addressing HIV/AIDS knowledge, attitude, stigma and discrimination and expected role of Muslim religious and high school Students in Ethiopia in general and Addis Ababa in particular. Some studies, however, have dealt with different groups of students on mixed subjects (Muslims and non Muslims). But in most of the researches the number of Muslim participants were not more than 15%. Since these researches do not represent the proportional percentage of the Muslim community hence, their finding lacks reliable information.

To the best of the present investigator knowledge, the scientific researches made by professionals were mainly confined to universities (colleges) and some industries where the number of Muslim participants were relatively small. The researcher, in spite of his effort, has not come across any research that studied students of Islamic theology (madrasa students) and formal high school students' knowledge, attitude and other related issues regarding HIV/AIDS. Hence, the present work has been made only on madrasa and high school students. For this purpose the subjects were selected from some Muslim missionary high schools (Awolia No 1 and No 2 and Abadir Mekanisa and Abadir secondary schools) and madrasa students who has been studying Islamic theology for many years and now learning modern elementary education (adult education) in Hashim Mosque Quranic school in Addis Ababa.

Statement of the Problem

The growing pressure HIV/AIDS exerts on both house hold and community is shown by the increase in elderly careers and child headed house hold in severely affected African and Asian countries.

The epidemic may harm poor countries like Ethiopia more severely than developed nations. Many families in Africa live in abject poverty crammed in to huts in the circle of drought, poverty and HIV/AIDS. For this already poor house holds the advent of AIDS can lead to a transition from poverty to extreme poverty or destitution (UNAIDS, 2005). In global scale Ethiopia hosts the third largest number of people with HIV/AIDS 16th in terms of prevalence in the year 2005 (MOH, 2004).

According to MOH, 2005 report Ethiopia responded to the epidemic as early as 1985 with the establishment of the National Task Force within Ministry of Health in 1985 which was followed by the development of National HIV/AIDS policy in 1998. The

country needed 13 years to develop a policy for such greatest harm, which shows the very reluctant response of the concerned bodies. And National strategic frame work was developed in 2000 (which means after the death of millions and the problem stretched its root deep in to the earth. This may tell us that why the problem becomes so grave and too difficult to solve or at least to reduce the risk brought to the countries over all development especially on human resource. AIDS has claimed millions of lives since its introduction and largely attacks the most productive and energetic segment of the population. Adults at their teenager and adult hood are found to be at the highest risk of the infection mainly because they are sexually hyperactive segments. Indeed being sexually hyperactive does not necessarily mean some one who belongs to this age is sexy, because many people can control them selves even if they need the pleasure as a result of their value which they submit their will to it. According to Najma (2005) religious faith can play an important role in promoting safer sexual behavior and in motivating large number of volunteers involved in HIV/AIDS care, support and prevention activities. Moreover, personal testimonies of many people living positively and productively with HIV reveal a deep reliance on inner spiritual resources for strength and will power. As it is known the majority of Ethiopian society is religious who follow one form of religion where he more or less respects the decrees of these faiths. As it was mentioned above there are significant number of Muslims in Ethiopia who practice some fundamental principles of Islam. But the dominant culture which is prevailed now in the country is not religious or it is simply secular. So people can not stick to their own values only because of wide interaction among them. As a result there seems some form of assimilation among people which prevent the practicality of religious principles in the process of solving social problems like HIV/AIDS. "Faith is the spring of sound. Through faith, our aims, desires plans and purposes are translated in to physical, social, economic, political, artistic and spiritual achievements" (ibid). Similar explanation was given by Hamuda (1975) regarding faith in this context Islam. He coined to say on the Islamic concept of religion "maintains that religion is not only a spiritual and intellectual necessity but also a social and universal need." Others argued that "behaving in accordance with religious tenets may have impacts on health and disease transmission (Ellison & Levin, 1998)

Like other heavenly religions, Islam provides us with a moral code for sexual enjoyment and health related issues. It further encourages the possession of knowledge about this worldly issues and the hereafter so that people will have the proper understanding about the world. Yet we see many Muslims being ignorant about the fact around them including HIV/AIDS and its risk in general. The silence seems deeper among the Muslim community regarding the pandemic as if it is not their business. In deed AIDS is the issue of every mankind. At present no one can skip from the danger which HIV/AIDS brought to. Today AIDS is far more than medical and biological problem. Its kingdom becomes wider and wider. That is to say HIV is a family disease which has a health, social, psychological and economic implications for all members of the immediate and extended family. In addition to the painful stress, disability and death that AIDS causes on the individual person and the family, the social and economic problems that follow are many. Such problems include divorce, family disintegration; orphaned children, poverty etc. Hence HIV/AIDS in the country is not only a health problem but also a problem affecting the socio economic development that means it has transformed currently in to a social problem.

Actually, there are many socio cultural barriers which need closer examination when we consider HIV/AIDS education. As Eyob (200) has stated "Ethiopia is a country with complex cultural diversity" Similarly a study indicated that in Ethiopian societies "children and adolescents are restricted to talk about sex issues and are secret among family members" (Hailgnaw, et' al 1996).

In such type of families children, adolescents and youths would not expected to have sufficient information about HIV/AIDS. Madrasa students fate may be more sever as the religious education teachers and fathers do not have the proper awareness and do not like to discuss about the matter openly. Thus the shortage of information that they have probably be more serious as compared with high school students. One simple fact is that discussing HIV/AIDS would involve sexual and intimate matters. So up to the researcher experience in many Muslim families discussing about AIDS and sexual issues is still a taboo. But Islam has always encouraged discussion on matters which will help the Muslims protect their health and life. Modesty in Islam does not mean that Muslims should not discuss sexual matters.

Another significant issue related to such problem is the cause and constraints to bring attitude changes among the people, particularly among the youth who are the future hopes of our society. Wondewosen (1998) explained that behavioral changes could come about through extensive information, education and communication programs.

Those who do not have sufficient information about the surrounding problems and the right attitude to the matter related to the problem will not be aware of their role and significance in the process of solving the problem.

Recently there is a better awareness towards HIV among the society. Yet very little is known whether the Muslim society specially the religious group has grown parallel or not. This is because in most of the research done in the previous years, these madrasa and high school Muslim students were not the main targets. Therefore, we don't have a clear image about Muslims' knowledge, attitude and other relevant issues towards the epidemic. Hence this piece of investigation has endeavored to investigate the following basic questions:

1. Do madrasa and high school students have adequate information about HIV/AIDS?
2. What type of attitudes do these Muslim students have towards the epidemic, PLHA, AIDS orphans and related matters?
3. Do these Muslim students clearly understand their expected role to play in the process of controlling and preventing the disease?
4. What is the attitude of these subjects towards the Islamic approach to defend the spread of HIV/AIDS?
5. Is there a statistically significant difference between high school and madrasa students in their knowledge, attitude, stigma and discrimination, prevention strategy as well as understanding their responsibility?

Objective of the study

General Objectives

The main objectives of this study was to know the level of knowledge of Muslim high school and madrasa students about HIV/AIDS, their attitudes towards the pandemic and persons living with HIV/AIDS as well as the Islamic approach to defend the virus, to investigate the level of stigmatic and discriminatory character and to know their expected role in preventing the disease and in giving care and support for the victims of the disease.

Specific Objectives

This study endeavored specifically to investigate

1. The level of knowledge of Muslim high school and madrasa students about HIV/AIDS
2. The attitudes which they have towards the pandemic, PLHA and AIDS orphans.
3. The behavior of stigma and discrimination of the two groups
4. The subjects' attitude towards the Islamic preventive mechanisms as an alternative/supplementary to the conventional techniques to prevent the disease
5. Whether these two groups do understand their general and specific roles to be played in the process of awareness creation, prevention and controlling the disease.
6. To see whether there is a statistically significant difference between high school and madrasa students in relation to the variables under study.
7. To see the level of the difference among members of the two groups taking gender and grade level as an independent variable.

Significance of the study

Individuals' knowledge and experience in some specific life tasks are the major factor for the formation of attitudes towards that or this concept. Some one who have the proper understanding and the real knowledge about something going around his/her environment is most probably expected to develop an attitude (be it positive or negative) towards that subject. Again whenever individuals know the matter under discussion and do have the objective response about it, in return they will know their share in the phenomena. The same is true in the case of the issue of HIV/AIDS. Based on their knowledge and attitude they have towards the issue under study, they are expected to have some say in the field.

Accordingly, this study will have the following social, behavioral and educational values:

1. The findings hopefully assist the concerned agencies in which area to focus in the process of teaching these students
2. Students themselves may get the chance to identify their stand towards the subject under discussion.

3. The result hopefully provides the real level of knowledge Muslim students have and gives a glimpse of their attitude which they have towards HIV/AIDS, PLHA, and AIDS orphans.
4. The paper also indicates the responsibility feeling of the subjects towards PLHA, orphans. Thus, concerned bodies may use the subjects whenever possible.
5. The paper will be a good gate to use the Muslim students' potential in preventing and controlling the pandemic.

Delimitation

The study suffered with a few limitations. This study has been done in capital city-Addis Ababa. If there had been samples from other provinces taken then there would have been different findings. The research also confined only to four high schools and madrasa students who can read and write Amharic. Female madrasa students could not be included as they did not found in Ethiopian madrasa education culturally.

Limitations

One of the limitations of this study is that there had to be proportional representation of all sub groups to have comparative congruence of information to avoid sample bias. But it has included un proportional number of male female and madrasa and high school students. In addition the problem of previous studies in related to the topic has created a gap not to compare and contrast the present finding with those of other research out comes. Further more madrasa students problem with faster and legible writing skill was the cause for not to include open ended questionnaires in the instrument used.

Operational definitions

In this research the following terms were operationally defined to fit the research purpose

High school students: those who are learning grade 9 and 10 at present

Madrasa students: those students who are studying Islamic theology in different mosques of Addis Ababa

Expected role as a Muslim: the responsibility of a Muslim in the process of defending and controlling the disease advocated by Islam

Islamic prevention strategy: the method in which Islam proposed to control the spread of HIV/AIDS and related disease

Chapter Two

2. Review of Related Literature

2.1. Prevalence and distribution of HIV/AIDS

To date around 65 million people have been infected with HIV and AIDS has killed more than 25 million people since it was first recognized in 1981. In 2005 AIDS claimed the lives of 2.8 million people and over 4 million people were newly infected with the virus. At around 17.3 million, women make up almost half of the total number of people living with the virus, and 13.2 million of which live in sub-Saharan Africa (76% of all women living with HIV). Sub-Saharan Africa remains the most affected region in the world. Two thirds of all people living with HIV are in sub-Saharan Africa where 24.5 million people were living with HIV in 2005. The vast majority of the 38.6 million people living with HIV in 2005 were unaware of their status. AIDS is among the greatest development and security issues facing the world today. The Growing epidemics are underway in Eastern Europe and Central Asia where 220,000 people were newly infected with HIV in 2005. (UNAIDS, 2006)

2.2 Mode of transmission

According to MOH, (2003) HIV can be found in large proportions of body fluids specially blood, semen, fluid from the female genitals and breast milk. It further explained that heterosexual contract to be the most common form of transmission in the country. The other mode of transmission is that of mother to child where the risk variation estimated between 15-40%. The contribution of mother to child transmission in the global HIV infection ranges between 5-10%. Infection can also occur if HIV infected blood and blood products gains entry in to the body through blood transfusion or transplanted organs or tissues, exposure of contaminated skin piercing and cutting instruments (MOH, 2003).

2.3 Knowledge and Attitude of students about HIV/AIDS

One of the most typical human trait is the capacity to be modified as a result of new learning and this capacity is the characteristics of all human beings throughout the entire life cycle (Feersing , 1979) cited in Tirusew (2001). Based on this premise (i.e. to bring attitudinal change or behavioral change) it seems that at present a great deal of information about HIV/AIDS preventive measures have been bombarded to the public at

large. There is also a research finding (Hannu, 2000) which indicates that knowledge is a major factor in the process of attitudinal change. A survey made at the University of Western Cap (Kelly, 2001) interestingly witnessed the above finding in that two-thirds of the students surveyed had changed their behavior because of what they had learned about HIV/AIDS. Similarly FGAE (1998) in a base line survey conducted on Jimma Youth cited that the level of knowledge about HIV/AIDS increases with age. There are also other research reports that revealed knowledge about HIV/AIDS is higher than other STDs among young people in both developing and developed countries (Solomon, 1990). Tilahun (1993) indicated that knowledge of AIDS of Gonder Medical College students was adequate and comparable with other college and high school students. Beyne (1997) found that although college students in general are well informed about AIDS there are gaps in their knowledge of some vital information. A relatively low level of awareness about some vital information of the risk factors and the modes of transmission of AIDS was revealed by the study. Another research done by Dagne (1999) on Jimma high school students revealed almost similar to some of the above findings, that is, according to him the students' knowledge regarding AIDS was reasonable. He further notices that but the level of awareness did not give a guarantee for the effective behavioral change (attitude change). Mustefa (2005) reported the level of knowledge about HIV/AIDS seems to be high among the respondents (wonji Shoa sugar factory workers); however, there are still a wrong interpretation and misunderstanding about HIV/AIDS transmission and its prevention.

Research findings on knowledge about HIV/AIDS and the subsequent attitude change (using HIV/AIDS preventive measures) however did not lead to similar conclusion. Among young Zimbabwean male (Kelly, 2001) greater knowledge about HIV/AIDS was often associated with unsafe sexual practices.

Simkins and Hendricks (1987) also indicated that the university students at Missouri: came up with high level of knowledge about HI/AIDS but there has been little change in using HIV/AIDS prevention measures.

Beyne (1997) concluded that students' attitude towards HIV/AIDS and their protective behavior did not match with the reality high level of knowledge they have. More over, Asshebir (1995) cited by Semahagn (2004) indicated that the change in attitude due to the

advent of AIDS is very minimal, revealing that message based AIDS education used so far is not sufficient to bring behavioral change. But according to CDS path finder (1995), HIV/AIDS prevention theorists believe that increased knowledge, along with positive attitudes and belief about HIV/AIDS will lead to positive behavioral changes, i.e. behavior that are less risky, or safer, such as use of condom, abstinence and avoiding risky situations. However, studies indicated that increased knowledge of AIDS does not always result in a positive behavior change. Here Tefera (2004) reported Jimma university students' knowledge, attitude and practice about HIV/AIDS. He concluded that 97% of the respondents have good knowledge and over 80% had favorable attitude towards prevention methods of HIV/AIDS and VCT. But 58.2% do not know that significantly healthy person can transmit HIV/AIDS.

According to Richter (1994) on the study done on HIV/AIDS knowledge and attitude among university students in Sera Leon, 20% of the respondents believed that AIDS is not actually a public threat. 2/3 of the respondents were convinced that HIV/AIDS infection posed a serious threat to them. Oyziwo (2005) reported his assessment on Nigerian students' knowledge about HIV/AIDS and the students has result of highly favorable knowledge about HIV/AIDS.

2.4. Stigma and Discrimination

2.4.1 HIV/AIDS related stigma

UNAIDS expressed AIDS-related stigma, in its annual report of 2005, as one of the greatest obstacles to people living with HIV being able to exercise their human rights. Stigma is also a major barrier in creating and implementing HIV programming. Stigma is a multi-layered process of devaluation that tends to reinforce negative connotations by associating HIV and AIDS with already marginalized groups. Stigma lies at the root of discriminatory actions that exclude people who need AIDS-related services.

UNAIDS, (2006) quoted Jonathan Mann, the previous director of the WHO Global Programme on AIDS, to identify three phases of the HIV/AIDS epidemic: the epidemic of HIV, the epidemic of AIDS, and the epidemic of stigma, discrimination, and denial. He noted that the third phase is "as central to the global AIDS challenge as the disease

itself” Despite international efforts to tackle HIV/AIDS since then, stigma and discrimination (S&D) remain among the most poorly understood aspects of the epidemic. In 2000, Peter Piot, executive director of UNAIDS, identified stigma as a “continuing challenge” that prevents concerted action at community, national, and global levels (Piot 2000). This poor understanding is due in part to the complexity and diversity of S&D, but also in part to limitations in current thinking within the field and the inadequacy of available theoretical and methodological tools (USAID, 2000).

To understand the ways in which HIV/AIDS-related S&D appear and the contexts in which they occur, we first need to understand how they interact with pre-existing S&D associated with sexuality, gender, race, and poverty. HIV/AIDS-related S&D also interact with preexisting fears about contagion and disease. Early AIDS metaphors—as death, as horror, as punishment, as guilt, as shame, as otherness—have exacerbated these fears, reinforcing and legitimizing stigmatization and discrimination.

Sexuality

HIV/AIDS-related S&D are most closely related to sexual stigma. This is because HIV is mainly sexually transmitted and in most areas of the world, the epidemic initially affected populations whose sexual practices or identities are different from the “norm”. HIV/AIDS-related S&D has therefore appropriated and reinforced pre-existing sexual stigma associated with sexually transmitted diseases, homosexuality, promiscuity, prostitution, and sexual “deviance” (UNAIDS, 2006)

Race and ethnicity

Racial and ethnic S&D also interact with HIV/AIDS-related S&D, and the epidemic has been characterized both by racist assumptions about “African sexuality” and by perceptions in the developing world of the West’s “immoral behavior.” Racial and ethnic S&D contribute to the marginalization of minority population groups, increasing their vulnerability to HIV/AIDS, which in turn exacerbates stigmatization and discrimination. (Parker, 2000)

Class

The HIV/AIDS epidemic has developed during a period of rapid globalization and growing polarization between rich and poor (Castells 1996, 1997, 1998). New forms of social exclusion associated with these global changes have reinforced pre-existing social inequalities and stigmatization of the poor, homeless, landless, and jobless. As a result, poverty increases vulnerability to HIV/AIDS, and HIV/AIDS exacerbates poverty (Parker, Easton, and Klein 2000).

Fear of contagion and disease

HIV/AIDS is a life-threatening illness that people are afraid of contracting. The various metaphors associated with AIDS have also contributed to the perception of HIV/AIDS as a disease that affects “others,” especially those who are already stigmatized because of their sexual behavior, gender, race, or socioeconomic status, and have enabled some people to deny that they personally could be at risk or affected (UNAIDS 2000; Daniel and Parker 1993). HIV/AIDS-related S&D is, therefore, the result of interaction between diverse pre-existing sources of S&D and fear of contagion and disease. According to Hussien who was quoted by Islamonline.net (2005) “stigma is largely out of fear. And this fear arises out of misunderstanding about the mode of transmission of the infection, its relation to socially unacceptable behaviors and belief that HIV is a fatal disease.”

2.4.2 HIV /AIDS related discrimination

Policy and legal contexts

HIV/AIDS-related S&D in society is commonly manifested in the form of laws, policies, and administrative procedures, which are often justified as necessary to protect the “general population” (Kirp and Bayer 1992; Manuel et al. 1990). Examples of stigmatizing and discriminatory measures include compulsory screening and testing, compulsory notification of AIDS cases, restrictions of the right to anonymity, prohibition of PLHA from certain occupations, and medical examination, isolation, detention and compulsory treatment of infected persons (Tomasevski et al. 1992; Gostin and Lazzarini 1997).

Education and schools

Children with HIV/AIDS or associated with HIV through infected family members have been stigmatized and discriminated against in educational settings in many countries. Stigma has led to teasing by classmates of HIV-positive school children or children associated with HIV (Gilborn et al. 2001). Discrimination against HIV-positive children in the USA and Brazil, including exclusion from collective activities or expulsion from school, has led to non-discrimination legislation (Public Media Center, 1995). However, less concern has been shown for young people who are perceived to be responsible for their HIV infection and who are already stigmatized and discriminated against because they are sexually active, homosexual, or drug users.

Employment and the workplace

Such discriminatory practices as pre-employment screening, denial of employment to individuals who test positive, termination of employment of PLHA, and stigmatization of PLHA who are open about their serostatus (Gostin and Lazzarini 1997) have been reported from developed and developing countries.

Religious institutions

In some contexts, HIV/AIDS-related S&D has been reinforced by religious leaders and Organizations, which have used their power to maintain the status quo rather than to challenge negative attitudes toward marginalized groups and PLHA (UNAIDS, 2004)

Community contexts

In societies with cultural systems that place greater emphasis on individualism, HIV/AIDS may be perceived as the result of personal irresponsibility, and thus individuals are blamed for contracting the infection (Kegeles et al. 1989). In contrast, in societies where cultural systems place greater emphasis on collectivism, HIV/AIDS may be perceived as bringing shame on the family and community (Panos 1990; Warwick et al. 1998). HIV/AIDS-related S&D in families and communities is commonly manifested in the form of blame, scapegoat, and punishment.

2.5. Knowledge, stigma and discrimination

According to Tedla (2005) there is a consensus that most people are much aware of the mode of HIV transmission. What contradicts their knowledge has been what they

practically do on the ground. For one thing they mix their knowledge with the wrong perception they have had about HIV and AIDS transmission, stigma and discrimination.

As Alemayehu (1997) cited by Tedla (2005) presented citing various research , the desired awareness of AIDS transmission with the required behavioral change had been thought to be better attainable by teaching formally through various mass media , anti AIDS clubs as well as using other mechanisms available in the community. The studies pronounced that the intervention programs have increased the level of knowledge in the society, but in practical terms there are no considerable changes with regard to the desired behavior appeared on the ground. So the situation necessitates the revisit of the existing programs which include policy, practical guideline and legal instruments as well as care and support intervention, information, education counseling and awareness raising programs.

Tedla, 2005) put as his finding witnessed the prevalence of stigma and discrimination against AIDS orphans, though, with varying magnitude The problem significantly pervades families, schools, peer groups and communities at large. No one denies the positive change in the knowledge of the society towards the problem of stigma and discrimination. But positive practices have not yet been considerably realized. PLHA in general and AIDS orphans in particular suffer from the negative effect of HIV/AIDS.

The provision of care and support for people affected and infected with HIV/AIDS promotes the prevention and control of HIV/AIDS.

It goes with out saying that the provision of appropriate information and education to general public regarding HIV/AIDS in an appropriate modality also contributes a lot to the prevention and control of the virus and ultimately of stigma and discrimination associated with it. Alemayehu (2004) cited by Tedla (2005)

2.6 Care and Support for PLHA and AIDS orphans

Each day, 1800 children worldwide become infected with HIV; the vast majority of them are newborns. In 2005, 9% of pregnant women in low-and middle-income countries were offered services to prevent transmission to their newborns. (UNAIDS, 2006)

In summary, the existing social, cultural and religious frameworks in Muslim countries do not provide an environment for any safe disclosure for persons who are infected.

Hence, the development of effective prevention and support services is often impeded. Containment of the HIV/AIDS epidemic in Muslim countries depends on a combination of individual and community level efforts to effect change in behavior and lifestyle to break the chain of transmission.(Meymoon 2005) There is an urgent need for developing and implementing policy and programs that provide AIDS education and awareness, prohibit stigmatization, and advocate compassion

UNESCO in its annual report (2005) very sadly expressed its regret on the problem of stigma and discrimination which replaced the expected role of society that is care and support. 'It is hard to imagine the feelings of those who have lost their loved ones, especially parents, to HIV and AIDS. Many people avoid an HIV-positive person when they find out he or she is infected. Orphans are also rejected for no good reason. People mistakenly believe that they may contract the disease just by touching or standing close to an infected person. But people who are ill or who have lost their parents are in particular need of affection and compassion in order to be able to bear their suffering more easily. A sense of rejection contributes to undermining their morale.' (<http://portal.unesco.org>) Some HIV-positive people suffer because they become an object of contempt, discrimination, mistrust, and rejection. Children who lose their parents to AIDS also suffer from discrimination and negative attitudes. Just their parents died, so AIDS orphans may feel that everybody is pointing a finger at them. (<http://www.coreinitiative.org/News>)

2.7. Islam, Muslims and HIV/AIDS

Behaving in accordance with religious tenets may have impacts on health and disease transmission (Ellison & Levin, 1998).

As far as the limited experiences of the existing Islamic organizations on fighting against HIV/AIDS and on support of persons living with the virus it could be concluded that the dominant Muslim responses to HIV&AIDS is not satisfactory and is at its infancy stage. Like many other communities, our responses as Muslims are not always shaped by the best of our religious values. (<http://PositiveMuslims.org>, 2004). Memoon, (2005) further explained this concept in the following statements "like most religions, Islam condemns homosexuality, drug use, and sex outside of marriage. Though the most important means

of protection is obviously abstinence from sex and to remain faithful to the marriage partner, however, Muslims must recognize that in many instances there is a gap between religious teaching and practice; risky behaviors that may not be allowed by Islam are indeed practiced. The main challenge is how to bridge this gap.”

The annual report of the South African Muslim Positive Association report criticized Muslims for being ignorant of the danger in the following words:

“For a long time now, Muslims have preferred to ignore the problem of HIV&AIDS or to deny that it is a reality among us. We have taken what we believe to be the ideal of Islam – no sex outside marriage and no drugs – and confused it with the reality of the Muslim world. There are indications that the reality of this pandemic among Muslims is slowly dawning upon us in many parts of Africa – such as Uganda, Mauritania and Senegal and elsewhere such as Iran, Egypt, Pakistan and Malaysia.”

The other type of response in which the Islamic world react towards the pandemic silence which is described by the association like this:

Like most traditional societies, Muslim communities are often characterized by a very loud silence when it comes to sex. When it does feature, it is often in gossip, jokes or males boasting about their ‘conquests’. Sex as a taboo or an embarrassing subject is the main context that affects any discussion of HIV&AIDS. Islam does encourage discussion on matters that will help us protect our health and life. Modesty in Islam does not mean that we should not discuss sexual matters. The Prophet (peace be upon him) said, ‘blessed are the women of the Ansar (citizens of Madinah), shyness did not stand in their way for seeking knowledge about their religion’ (Bukhari, 1996, 51, 3).

Records of the earliest Muslim community indicate that they did not feel shy about discussing sex. The Qur’an and the tradition of the Prophet have repeatedly stressed the importance of acquiring knowledge. ‘Are they equal, those who know and those who do not know?’ (Qur’an 39:9). “ibid”

The other types of response in which Muslims reflected to the disease are:

Confusion: confusion when confronted with the reality as HIV/AIDS is considered as a punishment from Allah (s.w.). It may be, but we have to know that a number of innocent Muslims are also infected by this deadly disease for different reasons of either 'halal' (permitted) or 'haram' (prohibited).

Rejecting: rejecting Muslims who are infected with HIV only because of ignorance and fear. (ibid)

Feeling sorry: feeling sorry for those people who are infected which are not acceptable by the patients.

This time, HIV/AIDS become a solid fact. It is rapidly spreading to the extent that every body in most parts of the world could sense it. By the time it became highly impossible not to observe the scourge of HIV/AIDS in every small district in the world today. The scientific findings conducted everywhere in this world are strengthening this fact.

2.7.1 Prevalence of HIV/AIDS in Muslim Countries

A survey of published journal articles containing data on HIV prevalence and religious affiliation showed that six of seven such studies indicated a negative relationship between HIV prevalence and being Muslim. Additional studies on the relationship of risk factors to HIV prevalence gave mixed evidence with respect to following Islamic sexual codes (e.g., vs. extramarital affairs) and other factors, but that benefits arising from circumcision may help account for lower HIV prevalence among Muslims (Gray, 2004). As some data showed the prevalence of HIV in predominantly Muslim countries is not that much exaggerated. But there are some indications that the virus is getting to these countries. Even some people and organizations has started to warn the Islamic world against the pandemic. According Memoon (2005), Muslim countries, previously considered protected from HIV/AIDS due to religious and cultural norms are facing a rapidly rising threat. Despite the evidence of an advancing epidemic, the usual response from the policy makers in Muslim countries, for protection against HIV infection, is a major focus on propagating abstention from illicit drug and sexual practices.

UNAIDS, at its report in 2005 described the risk of the Muslim world by providing detail data for some Middle East and North African Muslim Countries. The advance of AIDS in the Middle East and North Africa has continued with latest estimates showing that 67,000 [35,000–200,000] people became infected with HIV in 2005. Approximately 510,000 [230,000–1.4 million] people are living with HIV in this region. An estimated 58,000 [25,000–145,000] adults and children in 2005 died of AIDS-related conditions. Available evidence reveals trends of increasing HIV infections (especially in younger age groups) in such countries as Algeria, Libya, Morocco and Somalia. The main mode of HIV transmission in this region is unprotected sexual contact, although injecting drug use is becoming an increasingly important factor (and is the predominant mode of infection in at least two countries, Iran and Libya). By far the worst-affected country in this region is Sudan, where the highest infection levels found in the south. There are recent signs that HIV may be acquiring a stronger presence in the north. Even among people at special risk of infection (such as sex workers), HIV knowledge is poor and preventive behavior is rare. When surveyed, more than half (55%) of sex workers said that they had never seen or heard of a condom and fewer than 20% (17%) knew condoms could prevent HIV transmission. HIV prevalence among the women was 4.4% (Sudan National AIDS Control Program, 2004b). Similar gaps in HIV knowledge and behavior have been found among internally displaced people (Sudan National AIDS Control Program, 2004c).

Although still very low, HIV prevalence in women attending antenatal clinics in Morocco doubled between 1999 and 2003, when it reached 0.13%. Among sex workers and prisoners, prevalence was considerably higher, at 2.3% and 0.8%, respectively. In Tunisia since young people in particular have poor HIV knowledge and limited access to condoms, such trends could put them at risk of acquiring HIV. (UNAIDS, 2005)

After the 1998 outbreak of Nosocomial infections at Benghazi Children's Hospital, Libya reported an almost tenfold increase in infections in young men in the early 2000s. As many as 80% of the almost 10,000 HIV cases officially-reported by end-2004 have been reported since the turn of the century—and the majority of those infections appear to be the result of injecting drugs (UNAIDS/WHO update, 2005).

UNAIDS in its annual report of 2004 explained the bad situation in Muslim countries specially Middle East and North Africa. In this region HIV prevention programmes and services remain sporadic. Knowledge of AIDS is generally poor, and preventive practices are rare, even among populations most at high risk of becoming infected. Substantive efforts are clearly needed to introduce more effective HIV prevention strategies in the Middle East and North Africa.

Others warn the magnitude of AIDS epidemic problem in the Asian region to be increasingly significant. The increase has to be controlled in the time, otherwise religious, social and economic development in the region will be hindered and disparities within and between ASEAN Member Countries will increase accordingly (islamonline.net.or, 2005)

The continent of Africa, particularly the southern region, continues to have the highest HIV/AIDS incidence and prevalence rates globally (WHO, 2004). The number of HIV-positive adults range from 6 -10% in Nigeria, and 10 - 18% in Ethiopia; both countries have a majority of residents who are Muslims. By the year 2010, 40% of the African population, where the disease burden is highest, will be Muslim (Sigmon, 2004). Some Muslim countries, such as Sudan and Nigeria already show evidence of an explosive epidemic. In the Eastern Hemisphere, countries like Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan, which were part of the former Soviet Union, face a young and rapidly growing epidemic. (Memoon, 2005)

2.7.2 Prevention strategies in Islam

To date, there is no adequate treatment for AIDS, nor there any satisfactory immunization methods, such as vaccine. The only remaining option for the prevention and control of the spread of the AIDS virus is two radical changes in personal and social habits of sexual behavior. Considerable progress has been made in controlling the spread of AIDS through blood transfusion and the use of needles. There are certain preventive methods relating to the isolation of patients and the infection of babies through their mothers, which are still shrouded in controversy. According to Sigmon (2004), the current course of the epidemic is unlikely to change unless the people affected, and those at risk, make a concerted effort to adopt preventive measures

The most effective method of prevention in today's permissive society is the education and training of the individual to avoid the hazards of indulging in promiscuous sexual relationships and to promote certain moral principles that would lead to the necessary balance, health and stability in the life of members of society. Such measures represent the cornerstone of the Islamic approach to the prevention and control of AIDS.

Islam seeks to teach its followers to build their lives and behavior on faith in God and observation of His laws and guidance. It instills in every individual a constant and positive heeding of God and a profound sense of responsibility for every action and towards all members of society. It demands commitment towards others. (Badri, 2000)

Accurate information about HIV and AIDS will help to control the spread of the disease in our communities. It will also reduce the fear and discrimination against people who become HIV positive. Information will also help us to challenge any myths surrounding the disease. The disease is therefore largely avoidable by changes in personal behavior, in other words by voluntary choice. (Memoon, 2005, Badri, 2000)

In general the Islamic prevention strategy can be categorized in to two which can be labeled as the do's and the don'ts types. The Do's type of Islamic preventive strategies of HIV/AIDS and other sexually transmitted infections (STIs) are permissibly ordered ('halal') and really recommendable that includes: marriage, fasting, supplication, dressing veil ('hijab') and others. On the other hand, the Don'ts type of prevention strategies are strictly forbidden ('haram') and ordered not to reach such activities that includes: sexual intercourse (premarital sex, adultery, rape and other illegal sexes (vaginal, oral, and/or anal), masturbation, etc...); dressed but half-naked type of dressing of girls; any type of mixed both sex gatherings; uncontrolled eye gaze; pornography, music, video, and theaters; use of drug, alcohol, and other intoxicants; etc...

We will see the strategies in some further depth so that it will be clear in the process of preventing the pandemic in our society.

2.7.2.1 The Do's Type of HIV/AIDS Prevention Strategies

They are compulsory, recommendable and permissible in order to lead a life that is full of physical, mental and spiritual fulfillments. Some are discussed as follows:

Marriage:

This is a positive and effective means to protect individuals, especially young people, from indulging in illicit sexual activity that could lead to infection with the AIDS virus. The teachings of Prophet Mohammad urge Muslims to make marriage affordable and easy for all members of society. He said: "When a man comes to you seeking marriage, and you are happy with his religious and moral integrity and honesty, give him your daughter; otherwise immorality and corruption would spread among you all". Transmitted by 'Sahi-al Bukhari'

In another tradition the prophet (p.b.u.h) is reported to have said that a person escapes so many evils through marriage. Rather, if any one wants to leave this world with a clean record, without any blemishes on the chastity of his character, it is possible only through marriage. "Whoever wishes to meet God with a clean record should marry gentle and chaste women". When Sharif Ahmed, (1987) interprets this tradition he wrote "the words used in the hadith (tradition) suggest that through marriage God also protects man from other sins in addition to those related to sex, and that marriage becomes the means of guidance and salvation of man."

It is also our own observation that the unmarried people who are not in a position to gratify their sexual urge law fully, become involved in various sins voluntarily. As against them, those who would remain confirmed bachelors and wish to live a clean life, free from lewdness, are compelled to pass a life of such struggle that any thing may tilt the balance any moment and they may be involved in sin (illegal sexual intercourse). (Sharif Ahmed, 1987)

Sex outside marriage, chastity before marriage, and all other related evils must be vehemently discouraged and fidelity during marriage must be upheld at all cost (Hammudah, 2003). Accordingly, as an institution, marriage is a good safe heaven that prevents believers from contracting sexually transmitted infections (STIs), including HIV/AIDS and related social evils.

Fasting:

Fasting is an institution in Islam that encourages self-consciousness and self-discipline on the part of the followers (Hammudah, 2003). It is considered as the second recommendation of the prophet (p.b.u.h.), next to marriage. The best solution to ensure the young people piousness is to simply marry them off as soon as they can afford it or else tell them to fast so that they can curb their yearnings. As it is narrated by Alqama the Prophet said 'He who can afford to marry should marry, because it will help him refrain from looking at other women, and save his private parts from committing illegal sexual relation; and he who cannot afford to marry is advised to fast, as fasting will diminish his sexual power' (Sahih al-Bukhari).

Indeed it is not mere preaching to recommend fasting as preventing techniques. According to Badri (2000) police records of theft and house breaking, car accidents, drunken aggression, and similar crimes show an obvious decline during this month (Ramadan) in all countries of the Islamic world. It is during this month that many Muslims generate the necessary will and motivation to change their lives by stopping to take alcohol, drugs or smoking or to abstain from promiscuity and opt for a tranquil life of marriage.

Notice that fasting is not only held in Ramadan. Of course it is obligatory upon every healthy and matured Muslim, but there are many days and months throughout the year optionally to be fasted so that one can save him/her self from every possible temptations toward sexual desire.

Prayer ('*Salat*')

The practicing Muslim has to offer at least five times daily prayers. The well known Muslim psychologist Malik Badri explains how prayers serve as a preventing mechanism for HIV/AIDS:

Though each prayer may take only a few minutes, it is a relaxing and highly spiritual and contemplative ritual which at times takes the faithful into a divine journey of tranquility and closeness to God.... These prayers are

nicely distributed during the day and early dark hours of the night, so that the Muslim can carry out his daily business and other responsibilities, but after every few hours he has to extract himself from this world of the here and now to the spiritual world. During these blessed times he is consciously and unconsciously reminded of his Islamic ethical standard and moral responsibility. Prayers properly performed therefore, give the faithful a very strong will power against fornication and the unsanctioned temptations of the flesh as well as the strength to abstain from drugs and alcohol. "... establish regular prayer: for prayer restrain (one away) from shameful and evil deeds..." ve.29:45 (Badri, 2000)

In other Qur'anic verse, God said that 'O' You who believe! Seek My help with patience and prayer: surely, Allah is with those who are patient.' (2:153) And also, 'Surely the getting up at night for prayer is most effective for controlling the self and most suitable for reciting the Qur'an as well; ...' (v. 73:6).

In general, it must not be forgotten that Islam is the true submission to God almighty. Thus, both the five daily prayer and fasting are aimed at implanting to feelings of inner peace and security, responsibility towards others and mutual responses.

Dressing Veil ('hijab'):

According to Hamuda (2003) in Islam, women are enjoined to cover their heads and breasts, not to display their beauty before other men except their husbands or such relatives with whom their marriage is prohibited, hide their jewelry and not to put on jingling (ringing) ornaments when they go out of their homes. They are ordered to dress veil starting from their age of puberty. The minimum requirements are for entire body, with the exception of the face and the hands. In addition, the veil should not be forming fitting (tight), sheer (transparent) or so eye-catching as to attract undue attention or reveal the shape of the body. The following two verses of the Holy Qur'an will give us clear and tangible information on the women's dressing. God almighty ordered: "Likewise enjoin the believing women to lower their gaze and guard their modesty; not to display their beauty and ornaments except what normally appears thereof; let them draw their veils over their bosoms and not display their charms except to their husbands, their fathers,

their fathers-in-law, their own sons, their stepsons, their own brothers, their nephews on either brothers' or sisters' sides, their own womenfolk, their own slaves, male attendants who lack sexual desires or small children who have no carnal knowledge of women..." (V.24:31).

In one tradition, the Prophet Muhammad (p.b.u.h.) is quoted as saying: "...If the woman reaches the age of puberty, no part of her body should be seen but this --- and he pointed to his face and hands."

Hence, through proper use of veil Muslim women could save their male counterparts from getting through evil deeds and themselves from forced rape and unnecessary contacts with others, eventually of the community at large.

Male Circumcision:

The majority of Muslims believe that male circumcision is obligatory and it should be done before the individual become sexually active. The prophet is reported to have said "Five practices are characteristics of the Fitra (nature): circumcision, shaving the pubic region, clipping the nails and cutting the moustaches short." Transmitted by Tirmizi

Circumcision has been identified as a practice apparently decreasing HIV transmission (Bailey, Plummer, & Moses, 2001; Weiss, Quigley, & Hayes, 2000; cited by peter Gray 2001).

In the world today, forty studies provide evidence that male circumcision protects against all sexually transmitted diseases, and that circumcised men are 2-8 times less likely to become infected. Most studies appreciate benefits arising from circumcision that account for lower HIV prevalence among Muslims (Hawa, 2001). Thus, circumcision, as practiced by Muslims, would be the most immediately effective intervention for reducing HIV transmission since it is done before men are sexually active.

In answering the question raised by many people that concerns '*how male circumcision protects from HIV infection?*' epidemiological evidence points that the inner surface of the foreskin is a likely point of entry for uncircumcised men. It also contains Langerhans' cells that act as HIV receptors. The inner mucus surface of the foreskin is rich in

Langerhans' cells. During intimate relations, the whole inner surface of the foreskin is exposed to vaginal secretions, providing an increased area for HIV transmission. (Gayle& Hill, 2001)

2.7.2.2 The Don'ts Type of Preventive Strategies

The don'ts types of Islamic prevention strategies are unnatural, illegal, and shameful activities that are treated as strictly forbidden or non-recommendable in Islam that every Muslim should refrain to do so. The following are some of such strategies:

Illegal Sexual Intercourse:

All type of illegal sexual intercourses are strictly forbidden for every Muslim men and women. Thus, every Muslim should not only refrain from them, but also should take care of everything that lead to approaching such unnatural, illegal, and shameful deeds. The following are some of the illegal sexual intercourses that are common in the world today.

Premarital Sex

It is currently became common even among high school students, may be because of lack of child rearing practices, absence or lack of parents' guidance, peer pressure, and media defaults.() In Islam, premarital sex is strictly forbidden. It is declared to be social crime and a criminal offence (v.24:2). According to Sharif (1987), virginity and chastity are still highly held virtues, particularly in Muslim females, whereas any unsanctioned sexual relationship is still considered sinful. Thus, if someone commits this criminal offence and proven guilty, he/she should be punished. God said 'the woman and the man guilty of adultery or fornication flog each of them with a hundred stripes: let not compassion move you in their case, in a matter prescribed by God, if you believe in God and the last day: and let a party of the believers witness their punishment.' (v.24:2).

Adultery

This is a very serious sin in Islam and the punishment is also sever for its negative impact on the social value of a society. The Apostle of God (p.b.u.h.) Said: "The blood of a Muslim man who testifies that there is no god but Allah and that Muhammad is Allah's Apostle should not lawfully be shed except only for one of three reasons: a man who

committed fornication after marriage, in which case he should be stoned; ...". (Abu Dawd)

The Prophet (p.b.u.h) said, "Seven people will be shaded by Allah under His shade on the day when there will be no shade except His. Out of them is a man who refuses the call of a charming woman of noble birth for an illegal sexual intercourse with her and says: I am afraid of Allah" (Sahih al Bukhari). As a result of such values Muslims were significantly less likely to have engaged in sex with a prostitute (Rakwar et al, 1999).

Rape

Home is the best environment for Muslim women. Even the nearest relatives are enjoined not to enter the private rooms of any man or woman without permission; especially in the morning, at noon and at night. People are also forbidden to enter houses other than their own without seeking permission. (Qura'n 24:27-8)

In addition, if a Muslim woman necessitates to go out of home she has to wear veil and lower her gaze, neither disclose nor ringing out her ornaments to gain attention, neither speak loudly nor in emotion swinging way, not allowed to use perfume, and has to go with a male who can not marry her due to their blood relationship. According to Islamic ethical standards and moral responsibilities, all these are proactive actions to save oneself from rape and related evils (Hamuda, 2003).

Whereas, in the world today, commercial factors are behind the increase of rape and related crimes. Design of clothes, for example, by international houses that reveal the attractive curves of women's bodies' results in many rape and related crimes. Because crimes against those women who exaggerate in revealing their private body parts for the sake of public approval and attraction is pervasive here and there (Najma, 2005). In South Africa high levels of sexual violence have been compounded by the growing HIV/AIDS epidemic. According to the South African Police Service, 37,711 rape cases were reported to the police between January and September 2001. According to a study by the University of South Africa (UNISA), one million women and children are raped annually (<http://www.irrinnnews.org/AIDSreport>, November 13, 2006). Almost half of PLHA are women. Some have become infected through sexual violence and exploitation. It is

estimated that one in three women worldwide will be raped or abused in their lifetime (ibid). This shows that rape is becoming rampant and serves as one of the main means of transmission of the virus. Thus, enough attention should give to it.

Sex during Menstruation

Medical science has proven the serious health ramification that involves sexual intercourse during menstruation. It is scientifically proven that menstruation can carry the AIDS virus in sufficient amount to infect others (John, 2002): Accordingly, Islam ordered believers to refrain from sex during that period because it is known that sexual intercourse during menstruation increases the probability of infection with the virus. 'They ask you about menstruation. Tell them: This is a discomfort; therefore, keep away from women (do not have sexual intercourse) during their menstrual periods and do not approach them until they are clean again. When they have cleansed themselves then you may approach them in the manner Allah has enjoined for you. Surely Allah loves those who turn to Him in repentance and keep themselves clean.' (Qura'n. 2:222)

Homosexuality:

Along with other evils, Islam also forbade it very strictly and prescribed for this abominable deed most sever punishment , relenting not in the least in making it deterrent (Sharif, 1987). The prophet subscribed capital punishment for this crime "whoever is found involved in sodomy, put him to death, both the active and passive one" (Transmitted by Tirmizi). Professor Opendra Narayan of the John Hopkins Medical School cited by Badri (2000) has openly indicted the excessively rampant promiscuity of the early homosexual group for the development of HIV/AIDS. He describes them as follows:

These people have sex twenty to thirty times a night....A man comes along and goes from anus to anus and in a single night will act as a mosquito transferring infected cells on his penis. When this is practiced for a year, with a man having three thousand sexual intercourses, one can readily understand this massive epidemic that is currently upon us (Leo Bersani in crimp, 1991:197).

Accordingly the danger of new sexual epidemics is only triggered by rampant fornication and not by the limited promiscuity expected to be practiced in any average, morally clean society (Badri, 2000)

In the world today, homosexuality is the source and the major way of HIV transmission. This is, therefore, the prohibitions against homosexual sex could reduce the risks of, for example, unprotected anal sex eventually of HIV infections.

Uncontrolled Eye Gaze:

Woman by her form, carriage, embellishments and airs rouse up man's passion. Islam has suggested a very effective device toward this trial...lowering eye gaze and if the passion of some one who have a wife rose up the prophet suggested that the man should go to his wife, and discharge his upsurge where it rightly belongs (Muhammad, 1987). Allah (s.w.) ordered both male and female believers to lower their eye gaze. It is stated in the Qur'an as: 'Enjoin the believing men to lower their gaze and guard their modesty; that is chaster for them. Surely Allah is well aware of their actions. Likewise enjoin the believing women to lower their gaze and guard their modesty...' (v.24:30-31)

In Islam, both men and women are instructed to lower their gaze when they come in contact to each other. Because, seeing leads to love. Uncontrolled eye gaze might also lead to illegal and unnecessary contact, eventually of contracting of the AIDS virus.

Media, Pornography, Music, Video, and Theater:

Theaters, Video films, Television films and movies which show lots of violence, including all illegal sexual intercourses such as rape crime, premarital sex, promiscuity, and adultery are totally prohibited by Islam. Most of the movies revolve around sexual and violent episodes. Such presentation work as stimuli for imitation by the youth eventually risk of HIV infection. Hence it should be avoided. Islam does not allow all these things unless they are proved to be decent and free of immorality.

Use of Drug, Alcohol, and Other Intoxicants:

The UNAIDS 2004 Report on the Global AIDS Epidemic notes that in 'much of the North African and Middle East region HIV infection appears concentrated among injecting drug users'. "It is quite right to say that the alcoholic drink is one of the major causes which have annihilated the independence, freedom, natural wealth and resources of the nations, because it diminishes the mental power and the sense of understanding of

the addicted people who are led to sell their precious resources and their national and spiritual wealth and honor to a cup of wine". (Najma, 2005)

Accordingly, all intoxicants are strictly forbidden in Islam to save the human generation. God Almighty said: 'O believers! Intoxicants and gambling, dedication to stones (paying tribute to idols) and divination by arrows (lottery) are the abomination of Satan's hand work: Get away from such (abomination), that you may prosper. Satan's plan is (but) to excite enmity and hatred between you, with intoxicants and gambling, and to hinder you from the remembrance of Allah and from prayers: Will you not abstain?' (Qur'an 5:90-91). Regarding the use of drugs, the Prophet (p.b.u.h) said, "All intoxicants are prohibited." (Sahih al-Bukhari)

In summery, Islam as a complete way of life has numerous prevention strategies through which Muslims can save themselves and the whole community at large from the scourge of HIV/AIDS and related pandemics. Of course these strategies serve mainly to defend the spread of the virus through illegal sexual intercourse which cover 87% of the cause for infection. Hence using all these preventive measures can surely decrease the spread and prevalence of the virus in our society along with the rest techniques. Accordingly, other usual measures like blood transfusion, using infected needle and similar materials and vertical transmission (mother to child) which contribute the rest for 13% should be given enough attention in the process of halting the pandemic.

2.7.3 Muslims' Proper Responses toward PLHA and AIDS orphans

2.7.3.1 Persons Living with HIV/AIDS

Kindness and consideration of others are important social responsibilities. A wide circle of relationship begins with the husband, wife, parents, children, and other relatives, then moves to neighbors, friends, orphans, widows, needy community members, fellow Muslims, fellow human beings, animals, trees, and plants (Esack, 1999).

Sheikh Selman (2005) summarized the social responsibility of the Muslim society in the following words : "The individual member of the society work together to fulfill the general needs of society as well as the individual needs of its members and that they work

together to protect society from harm". Thus each member of society has a right, and also has responsibilities towards others.

Indeed not all cases of HIV and AIDS are contracted through needle exchange or sexual intercourse, and second, regardless of the route of transmission, once a person is infected, he/she should not be treated as a criminal but should be considered as a patient who is suffering from a disease. Just as patients who are afflicted with any disease deserve the provision of clinical care and support from their family and the society, patients suffering from HIV/AIDS have all the rights to the same services, support and compassion (Memoon, 2005). Here the Prophet's concern to the poor, patients and the needy in general comes, as he said "whoever relieves a human being from a grief of this world, God will relieve him from a grief on the day of Judgment" (Transmitted by Muslim). In another message to all mankind the prophet addressed the following: "All created beings are the family of Allah so the most loved one of Allah is the one who shows kindness to his family" (Abdulhamid, 1983).

There are many Muslims who are affected by AIDS. These people are someone's sons or daughters, brothers or sisters: they are part of the Muslim community. We cannot shun people living with HIV or AIDS. Any person with AIDS should be given attention, care, love and affection, so the person can lead his/her life with dignity. We also have no right to judge or condemn people. It is up to the Almighty to forgive or punish. AIDS and HIV are all around us, inside our Mosques and in many of our homes. We know the Prophet Muhammad (p.b.u.h) said: "Have compassion towards those who are on earth and the One who is beyond will have compassion towards you." (Abdel Halim, 2003)

Islam is a religion that is full of compassion, love and mercy. The Prophet Muhammad (p.b.u.h) reminded Muslims that: "You will not enter into paradise until you believe, and you will not believe until you love one another." (Transmitted by Tirmizi)

In another tradition, it has been said, "Allah shows compassion only to those of his servants who are compassionate" (Transmitted by Ibnu Majah). Lastly, he has warned careless believers where their neighbor is in trouble "who so ever goes to sleep satisfied

while being aware that his neighbor is hungry does not believe in me". Thus, giving care and support for the patients, for those who lost their partner as a result of the pandemic and the victims in general is an Islamic obligation of Muslims ordered by God almighty and His messenger.

2.7.3.2 AIDS Orphans

In 2005, it was estimated that there were a total of 4, 885,337 orphans aged 0-17 years; of which, 744,100 were AIDS orphans. Of the total number of AIDS orphans, 529,777 were maternal, 464,506 paternal, and 250,195 dual orphans. The estimated number of orphans in urban areas has been greater than that of in rural areas up to 2003; however, beginning in 2004, the number of orphans in rural is expected to exceed that of in urban areas (MOH, 2006).

Bjorn Ljungqvist, head of UNICEF Ethiopia said the scale of the crisis was daunting. The warning came as UNICEF launched a global campaign focusing on the enormous impact of HIV/AIDS on children. Worldwide, fewer than five percent of HIV-positive children receive treatment and millions of children who have lost parents to the disease go without support (PLUSNEWS, 25th October, 2006). If the fact is like this, what does Islam say about the crisis? And how is the Muslims response where a large number of the victims (orphans) belong to them? The social ethics of Islam is found up on a real sense of solidarity and brother hood (Hamuda, 2003). According to Fatuma (2005) more than 22 Qura'nic injunction as well as many prophetic tradition discuss about the treatment that orphans are worthy. It indicates that Islam gives more emphasis to orphaned children. Allah (S.W.) says:"... Help one another in righteousness and piety, but help you not one another in sin and rancor ..." (5: 1-2) "... righteousness is the quality of one who..., and who gives his wealth, in spite of his love for it, to the kinsfolk, orphans, the poor, the wayfarer those who ask, and to free slaves..." (Quran 2:177)

There are a number of verses in the Qura'n and prophetic tradition that encourage taking care of the orphan and inspire the believer to do so. God almighty says the following:

“There fore, treat not the orphan oppressively and repulse not the beggar” (Qura’n 193:9)

“And do good to parents, kinsfolk, orphan and the poor.” (Qura'n 4:36)

“Have you seen the one who denies the judgment? That is the one who repulses the orphaned (harshly) and urges not on the feeding of the poor”. (Qura’n 1-3)

The prophet (p.b.u.h) reported to have said: "The best house among the Muslims is one which contains an orphan who is well treated and the worst house among the Muslims is one which contains an orphan who is badly treated." (Transmitted by Ibn majah)

“He who invited an orphan to his food and drink, Allah will grant him (in reward) the paradise provided he would not commit any sin which is not pardonable (e.g. Unbelief, polytheism etc)" (Abdulhamid, 1983).

" I and the care taker of the orphan will enter paradise together like this, raising (by way of illustration) his fore-finger and middle finger jointly, leaving no space in between" (Sahih al- Bukhaari). In the above Quranic verses and the prophet’s tradition we did not find the cause for the orphanage. Hence it is clear that AIDS orphans deserve all the care support service urged by Islam regardless of the reason for parental loss.

2.8 Expected Role as a Muslim

In developed countries, a majority of the population is aware of the modes of transmission for HIV infection, whereas in the developing countries, misconceptions about the disease and its causes are rampant. Most persons residing in Muslim countries assume that all HIV infections are transmitted only through immoral sexual behaviors and are unaware that it can also be transmitted inadvertently through mother-to-child, accidental pricking of skin and contact with contaminated blood (as in the case of health care professionals) or the possibility of an innocent spouse getting infected by the husband who may have acquired HIV through sexual or drug related contact with other infected persons. Therefore, due to lack of education, expression of compassion towards HIV/AIDS patients is perceived as tolerance towards the practices that lead to acquiring the infection (Memoon, 2005). Such attitude may prevent people from doing what Islam

put on their shoulder. According to Kamil (1998) we need to have compassion for people with HIV, no matter how they were infected. The moral quality of those who say that some people deserve this bad fate needs to be questioned. For people infected with HIV, while fate has not been good to them, there should be no Muslim who gives thanks for their suffering. That goes against the values of our religion, Islam.

As the influential group of the society the youth, especially who are in school and madrasa, seem more responsible to fight such attitude. They should preach the concept of mercy and compassion for the mass in different occasions. Islam appreciates its nation as the best nations revealed for they enjoin with good and prohibits from evil (Quran, 3:110). Thus the youth who are the hope of the nation has to organize themselves in a way that helps them to fulfill their responsibility in the process of defending and controlling the pandemic. It is well known fact that their interaction with the family, siblings, peers and other relatives makes them more influential and important. Thus, they should feel responsibility and act accordingly. Particularly their role in creating the proper awareness about the way it transmits and attitude towards PLHA and AIDS orphans is very important.

UNDP Kyrgyzstan program manager Ekaterina quoted by plus news on 25th October 2006, said that religious leaders have a role to play in warning against dangerous behavior that can cause HIV/AIDS to spread...such as having unprotected sex or using intravenous drugs. And they can encourage people to have positive attitudes toward the people who have HIV/AIDS or who are at highest risk of contracting the disease. This includes sex workers and drug users. She further explained the importance of multi sector approach to the HIV/AIDS problem and hence this is one approach. Indeed "all sectors of the society have a responsibility for fighting the HIV/AIDS epidemic threat. Sixty percent of Kyrgyz population is rural. And Islamic leaders have a great influence. They are like opinion-makers" Ekaterina cited by UNAIDS, (2004). In Mauritania, Imams, preachers and other Muslim clerics have agreed to press home the message that individuals must practice fidelity in marriage. They are also outspokenly opposed homosexual relation ship. In our country too madrasa students and their teachers influence seems more considerable in shaping peoples' attitude towards different life

aspects. They teach Islam in different Quranic schools, mosques and houses of the Muslim community. These people are; preachers (Khatibs), Qadis (judges), and Imams of the Muslim society. Their understanding of their responsibility is very useful. As one Kyrgyz National University students said people listen carefully to Imams talking about AIDS. "I think Muslim clerics' work to inform the youth about HIV/AIDS is great because a lot of young people come to the mosque, and for them clerics are persons of authority,". Another person of the participant said: "they are listened to attentively. I think imams do use full and proper work. As for me when the clerics told me about this disease I listened with great interest and attention" (UNAIDS, 2004). Using this acceptance, the young clerics have a lot to do in defending and controlling the disease by mobilizing and teaching the mass.

2.8.1 In Care and Support for PLHA and AIDS orphans

As we have seen above when dealing with individuals in a state of distress such as an illness or catastrophe, even with those who were sinners or criminals, Islam very forcefully preaches mercy, brotherly love, sympathy and an optimistic attitude. Visiting sick people, praying for them and raising their morale and hopes for improvement are some of the deeds highly recommended by Islam (Abdulhamid, 1983). Failing to care for the sick incurs the displeasure of God (Badri, 2000).

In the well-known hadith qudsi narrated by the prophet quoted by Abu Hurayrah, and authenticated by al-Bukhari, God says that in the Hereafter, the following moving words to one Muslim who had not cared for a sick acquaintance during his lifetime on earth:

"Allah, the Lord of Honor and Glory, will say in the Day of Judgment: O son of Adam! I was sick and you did not visit me! The man will submit and say: My Lord! How is it that I visit You and You are the Sustainer of the Universe? And God will reply, didn't know that My servant so and so was sick and you did not bother to visit him? Didn't you realize that if you had visited him you would have found me with him?"

The prophet has warned against unreasonable fear from infection which prevents a Muslim from caring for a sick brother or sister. (Badri, 2000)

All these discussions indicate our fellow brothers and sisters that the level of their responsibilities in which Islam put on their shoulder. To prevent the pandemic from further expansion, and reduce the crisis which the youth, who is the backbone of any civilization, should understand their values and messages in life so that they will use in their solution to the psychosocial problems of the society. Many argue that the present day Muslim should strive much to defend their people from the harm of HIV/AIDS and other related disease. Indeed we have discussed above the place where Islam gives to piety that is kindness to patients and orphans and the poor as well as the needy in general. We should try to imagine the feelings of those who have lost their loved ones, especially parents, to HIV and AIDS.

Chapter three

Methods

3.1 Sample

High School Students

The samples of this study were driven from four Muslim missionary high schools in Addis Ababa. These schools were selected using purposive sampling method. The basic rational to choose these schools were that students in these schools were almost Muslims, though there were very few students from other religious groups. Thus getting only Muslim students has become easy for the study. The schools which were chosen for collecting sample population were Awolia no 1 found in Asko, Abadir Meknaisa; Mekanisa, Abadir secondary near G.Wingate, Awolia no 2 in AyerTena. As the study was endeavored to conduct on Muslim samples only, these schools provided good number of Muslim students.

In the academic year 2006/2007 the above four selected secondary schools had a total of 565 (275 male and 290 female) students in grade nine and ten.

The above two grade level students were selected purposely. As preparatory students were expected to be aware of the issues under study, they were exempted from the study. This is because of the reason that they were exposed many years of education through different media including the three or four years of civic education which incorporate issues about HIV/AIDS and related aspects. . Again the preparatory students' present assumption is that they are first year first semester and second semester college or university students Thus preparatory students were not the subject of this study. Regarding the selection of students from the schools, every school has two class rooms for grade 9 and 10 having on average 30-37 students. To select the participants the researcher had chosen one class room from every school and grade level randomly. That is a total of 8 class room students who were attained class at that specific day (where data was collected) participated in the research.

Out of the students' total population, the samples selected were as follows:

Table 3.1 High school students' characteristics

Grade	Male	Female	Total
10	50	54	104
9	51	55	106
Total	101	109	210

A total of 210 students were randomly selected. The students sample were randomly selected from Mekanisa Abadir (n=55); Awolia number 1 (n= 50). The sample of Awolia number 2 (n= 53) and Abadir secondary school (near G.Wingate school) is (n= 52) students.

Madrassa students

In addition to the above, another sample group of students were also selected from the 3 mosques of Addis Ababa (Anwar, Noor and Ababora) for the pilot study. In these mosques though there were many such students (young Muslim clerics), as a matter of fact most of them can not read and write Amharic. This is because they dedicate most of their time to the study of their religious courses. Thus, they write and read Arabic as their own language and not any other local language. But those who were included in this study were attending classes prepared just for them only and reached up to grade four level. Some of the pilot groups again participated in the major study. For the sake of convenience and to be confident on their capacity to read the questionnaire and write whatever required from them the researcher included the upper two classes only (grad 3 and 4). Before selecting the respondents the researcher visited the school and contacted the school principal in order to get the consent from his side. Then the school administrator introduced the researcher and urged students to participate in the research work. In addition he elaborated the objective of the research. As the researcher understood the conservative nature of the participants, forming rapport with them and their teachers was very important. After giving wide explanation about the goal, significance of the research as well as the responsibility of the researcher to keep confidential whatever the individual response could be, the consent was attained. Accordingly, grade 3 and 4 students only were taken as a sample for the study. In the two classes we have got the sum of 130 students. As a matter of fact we did not get any female madrasa student (there is no female cleric in

the present Muslim community of Ethiopia). Hence, the participants of this group were only male young clerics (madrassa students).

Table 3.2 Characteristics of Respondents

N0	Status	High school students	Madrassa students	Total
1	Number of participant	210	130	340
2	total	210	130	340
3	Age range	15-20	21-30	

As shown in the table above 210 number (101 male and 109 female) subjects have been participated in the study. The mean and mode ages of secular students were 16.08 and 16 respectively. All madrassa students were above twenty years age with mean and mode of 25 and 26 respectively as well.

Table 3.3 Respondents' profile by grades that completed the questionnaire properly.

Grade	Male	Female	Total
10	48	54	102
9	46	50	96
4	51	-	51
3	54	-	54
Total	199	104	303

As indicated in table 2, 198 (94 male and 104 female) students of grade 9 and 10 from the secular schools and grade 3 and 4 of madrassa students completed the questionnaire properly. 12 students from high school group were discarded as their result could not be taken as reliable source of information. This might be due to negligence or loss of interest to respond properly. Some others returned the questionnaire with out filling. Such questionnaires are also discarded from the research. Similarly, 25 students from the religious group have been discarded as they

could not respond the questionnaires properly. Hence a total of 303 respondents were taken for the analysis.

3.2 Instrument

For this study three types of instruments were prepared and employed for data gathering. These were questionnaire, unstructured interview and focus group discussion. Effort has been made to make the whole items of the instrument as relevant as possible, with the help of experts' opinion.

Questionnaire development

Two types of questionnaire were prepared for the study. Before the development of the questionnaires many related literature were reviewed. Moreover previous studies and the instruments were also analyzed. After much reading and critical analysis of the previous questionnaires; the researcher collected items from them and from other sources. The objective and the ways the questionnaires were developed as follows:

1. To measure the over all subjects knowledge about HIV/AIDS that is cause, nature and way of transmission 25 closes ended questions were prepared. This was done taking in to consideration the difficulty of madrasa students to write faster and legibly about the issue expected from them.
2. So as to describe the two major groups level of attitude towards AIDS, person leaving with HIV/AIDS, AIDS orphans and, stigma and discrimination, attitude toward Islamic prevention strategy as well as expected role to be played in prevention and care and support as a Muslim, 62 items were prepared and distributed to the pilot study (17 items for attitude, 15 items for each of the rest variables). Out of these 42 items were made ready for the final study, almost all subjects returned the questionnaire and after verification, 89% of the subjects (303) response was used for interpretation. likert 4 scale points was used to differentiate the subjects response about the variables under study.

Unstructured Interview

1. Unstructured interview items on knowledge towards the nature, transmission, protective mechanisms were designed for selected individuals from the subjects.

2. 6 unstructured interview questions on attitude towards PLHA, AIDS orphans, stigma and discrimination, expected role were also developed for selected individuals among the study group.

Focus group discussion

To get further information some unstructured items of the focus group discussion were carried out in two high schools and one in another place. A total of three groups participated in the focus group discussion having 20 members.

3.3 Pilot study

The objective of the pilot study was to test and improve instruments so that it will be relevant to measure the intended variables. Further more it also aimed at find out any ambiguities, omissions and misunderstandings of the items. It also serves to create rapport in the study areas (sites).

Before the administration for pilot study the test was given to the advisor and two master graduates from the department of psychology. They were required to give their reaction on each item of the instrument. Based on their comment some improvements were done .Then, the originally English instrument made for forward and backward translations to Amharic and English. The subjects for pilot study were 40 students from both groups and sex from Awolia no1 and Abadir meknanisa and medrasa students from their respected school. Accordingly, 10 girls and 10 boys from grade 9 and 10, 20 male students from madrasa had participated in the pilot study.

On the basis of the pilot study the instruments were improved. Items which were found to have poor inter-item correlations were rephrased and improved. Items that were detected as confusing to the subjects to respond to during survey testing were either cancelled or rephrased and made to fit subjects' level of understanding. Further more, the final Amharic version was given to one post graduate language student and two BA graduates so as to improve the language used to express issues or identify and correct vague terminologies. Reliabilities for all scales were computed using crombach's alpha reliability coefficient. The reliability coefficient of the scales for madrasa students were .75 for knowledge, 0.76 for attitude, .75 for stigma and discrimination, .74 for prevention strategy and .76 for expected role items. While the reliability of the scales for high school students were 0.76 for knowledge, .75 for

attitude, .77 for stigma and discrimination, .75 for prevention strategy and .77 for expected role items.

3.4 Procedure of data collection for the main study

As indicated above the 5 school principals were agreed with the researcher to allow him collect data from the respected schools and madrasa. In all schools selected classes were adjusted and students were made to sit far apart as much as possible in order to respond the items independently.

Three assistant researchers who were oriented about the objectives of the questionnaire helped the researcher in the data collection. Every necessary and possible explanation was given for respondents in addition to what was written as an instruction. Respondents were also told not to spend much time on each item to read repeatedly as most of the items were non cognitive variables.

The data gathered through interview and focus group discussion was conducted by speaking with respondents face to face. Of course the necessary rapport was made before conducting interview and focus group discussion. This helped to create conducive environment for respondents to feel free and express their feeling openly.

3.5 Scoring

Response to the level of knowledge of the items were given for subjects as scale value ranging from three (3) for those who correctly answered the question, 2 for those who did not have information about the question (said I don't know) and 1 to those who wrongly answered subjects.

For the scoring of the rest variables two approaches were used: i.e. one for the positively worded items and other for the negatively worded items. A positive item carried out the weights 1,2,3,4 for the response categories of strongly agree, agree, disagree and strongly disagree respectively. However, for negative items a weight of 4,3,2,1 was assigned for the response categories of strongly disagree, disagree, agree and strongly agree respectively. Finally all the positive and negative items scores were added to obtain the score for the subscale or total score.

The minimum possible score obtained for a total knowledge question could be 15 and the maximum score could be 45. Similarly, the minimum possible score for total attitude score could be 13 and the maximum score was 52. Moreover stigma and discrimination has a minimum score of 9 and maximum score of 36. Besides there are

scores for each sub-scale (variables). The highest score in the subscale or total scale shows that the individual respondent possesses high knowledge, or has positive attitude or the like. Here undecided or uncertain has no value (was not incorporated in the response category) because most of the time people tend to avoid decision if they feel that it has some responsibility. These scores entered SPSS (statistical package for social science) and analyzed on the basis of the research objectives mentioned on the first chapter.

The interview and focus group discussion results were also included in the analysis whenever relevant.

3.6 Statistical Analysis

To interpret and analyze data collected basically quantitative method was used. But in order to incorporate data obtained from FGD and interview qualitative method of analysis was also used. Independent sample test was computed to see whether students of different sections (high school and madrasa) and sex do have difference in the different variables outcomes. In order to check the relationship among variables Pearson product moment correlation was also employed. For the overall analysis simplicity the statistical package SPSS version 12.0 was used.

Chapter four

Result and Analysis

This chapter has tried to analyze the already collected data. The analysis has done in the following procedure.

In the first place the simple descriptive statistics has been applied to compare the mean using standard deviation of the total population. That is, the mean description of the various variables has taken comparing the observed mean with expected mean. Then the comparison of the various categories of the two major subjects (high school and madrasa students) is taken. Here the five dependent variables, knowledge, attitude, stigma and discrimination, Islamic prevention strategy, and expected role as a Muslim are taken independently. And independent t-test was used to check the over all hypothesis of no difference in the mean of the different groups.

In the next phase, some specific items were (whenever important) discussed separately as their response indicated some unique feature of the groups. It also showed the real gap to be filled by the users of the research out come.

Finally, the two major groups mean score comparison was held. To this effect independent sample t-test was computed to see whether or not there is a statistically significant difference between groups across the various variables.

Regarding the approach, results have been presented in tabular form, which is followed by statistical interpretation and the second phase results have been discussed and analyzed in relation with previous findings if any.

4.1 Knowledge of students about HIV/AIDS

Knowledge of High School Students

Table 4.1.1: Descriptive statistics of knowledge score for high school students

variable	No of items	Observed mean	Standard deviation	Minimum score	Expected mean	Maximum score
Knowledge of HIV/AIDS	15	39.92	2.98	30	37.5	45

Here the mean score of students on the knowledge of HIV/AIDS is taken as a criterion variable. As a result the students score lies between 30 and 45 where 30 indicates that the

student had missed all the items showing that he/she was not informed about the pandemic specially the way it transmits at the time of the study. And a full 45 score shows that the student had been able to answer all the items designed to measure his/her knowledge of HIV/AIDS.

Accordingly, when we examine the knowledge score that the students of high school got, we find the observed mean score for the total population to be 39.92 with standard deviation and standard error of the mean to be 2.98 and .2119 respectively. The result indicated in the table above shows that the mean of the sample was greater than the mean of the population (37.5) for the knowledge of students regarding HIV/AIDS and its transmission way. This indicates that most students scored above the mean of the population.

In an attempt to see whether or not there could be variation in the knowledge score of high school students' across gender regarding HIV/AIDS mean comparison was made and there were significant knowledge difference regarding the subject under study.

Table 4.1.2: T-test of mean comparison for knowledge of high school students regarding HIV/AIDS across gender

Variable	gender	N	Standard deviation	Mean	t obtained	df	Significant (2-tailed)
Students knowledge of HIV/AIDS	Male	94	3.337	39.3085	-2.81	196	.000
	female	104	2.508	40.4808			

As can be observed in table 4.1.2 the mean score of girls was greater than the mean score of boys. This difference was also supported by t-test result, which indicated that there was a significant knowledge difference at 0.05 level in between the two study groups. This variation might happen due to different situations which made girls more accessible to information regarding the disease. Especially, girls today, has got good level of attention in relation to HIV/AIDS.

Table 4.1.3: T-test of mean comparison for knowledge of high school students regarding HIV/AIDS across grade

Variable	Grade	N	Standard deviation	Mean	t obtained	df	Significant (2-tailed)
Students knowledge of HIV/AIDS	9	96	2.962	39.4167	-2.35	196	.020
	10	102	2.936	40.4020			

In the same way so as to examine whether or not there is significant difference between the two grades level students' score in relation to knowledge mean comparison was made using independent sample t test, and the table shows that there is statistically significant difference at alpha 0.05 level. Hence we can conclude that grade ten students' knowledge about the pandemic and its mode of transmission was found to be better than that of grade nine students.

Further analysis was made to observe if any different result were happened or not across the schools where the subjects come from using one way analysis of variance (ANOVA). The mean comparison has given almost similar out come for all schools. In other words high school students' difference in their information level in relation to the pandemic across different schools was found to be almost in an equal status.

Frequency table for special items

Here some items seemed a bit different from the total items result. Hence we discussed them one by one to have detail information about students' level of information about the issue under study.

Table 4.1.4: Frequency table for selected Knowledge Questions (high school students)

		Frequency	Percent	Valid Percent	Cumulative Percent
Question no. 6	Correct	30	15.2	15.2	15.2
	I don't Know	20	10.1	10.1	25.3
	Incorrect	148	74.7	74.7	100.0
	Total	198	100.0	100.0	
Question no. 13	Incorrect	43	21.7	21.7	21.7
	I don't know	45	22.7	22.7	44.4
	Correct	110	55.6	55.6	100.0
	Total	198	100.0	100.0	
Question no. 14	Incorrect	38	19.2	19.2	19.2
	I don't know	42	21.2	21.2	40.4
	Correct	118	59.6	59.6	100.0
	Total	198	100.0	100.0	

As shown in the above table students who responded for question number 6, limited the life span of HIV/AIDS patients to three years only. Out of 198 students who responded the questionnaire properly, 30 students believe that the patients could not live longer than three years. Other 20 students do not have any information about how long a person can live with HIV. In other words 25.3% of our sample students have either wrong or lack proper information about the life span in which a person can live with HIV/AIDS.

Here again high school students' response for question number 13 is also a bit different from the expected one. Accordingly, 21.7% (43) of respondents wrongly understood the issue of using drugs with injection as one of the main cause of HIV transmission. The other 45 students (22.7%) reported that they did not have any information about this issue. This means 88 students or 44.4% of the respondents were not well informed about the risk of taking drug with injection for HIV/AIDS. In Ethiopia the use of drug through injection does not seem much contributor for HIV transmission and it also has less attention in the mass media and public lectures related to HIV/AIDS. Thus, this could be one factor for certain high school students that made them answer the question wrongly.

The last very unexpected response come for question number 14. This item simply asks whether saliva and sweat contact transmit HIV or not. 38 students (19.2%) answered saying, yes it did. Other 42 (21.2%) students responded that they did not know whether it transmits or not. A total of 80 students or 40.4% of the group either had wrong understanding or did not have any exposure to the objective reality about the way the virus transmits from one person to another.

Madrasa students score for knowledge

Table 4.1.5: Descriptive statistics of results of knowledge regarding HIV/AIDS (N=105)

Variable	No of items	Observed mean	Standard deviation	Minimum score	Expected mean	Maximum score
knowledge of HIV/AIDS	15	32.55	4.5676	15	30	45

In the same way, the observed mean of the sample (32.55) was greater than the mean of the population (30) for madrasa students' information related to HIV/AIDS. This may tell us that most madrasa students had good understanding about the disease and the way it spreads.

Independent sample t test was carried out in order to see whether or not there is a significant difference between grade 3 and grad 4 students with regard to their knowledge scores. The observed result indicated the absence of significant difference across the two groups taking 95% confidence interval of the difference. Hence we can conclude that the information difference between the two graders was not that much observable.

Here again we could observe some of the results of madrasa students were very unexpected. Using frequency distribution table bellow, we describe the following few items. Such in-depth looking may help us to clearly observe in which specific area the subjects lack information regarding the epidemic

Table 4.1.6: Frequency table for selected knowledge questions (madrasa students)

		Frequency	Percent	Valid Percent	Cumulative Percent
Question no. 2	Incorrect	56	53.3	53.3	53.3
	I don't know	20	19.0	19.0	72.4
	Correct	29	27.6	27.6	100.0
	Total	105	100.0	100.0	
Question no. 4	Incorrect	41	39.0	39.0	39.0
	I don't know	37	35.2	35.2	74.3
	Correct	27	25.7	25.7	100.0
	Total	105	100.0	100.0	
Question no. 13	Incorrect	27	25.7	25.7	25.7
	I don't know	45	42.9	42.9	68.6
	Correct	33	31.4	31.4	100.0
	Total	105	100.0	100.0	

As shown in the above table the analysis suggested that there were significant proportion of students who had wrong information about the presence of curable vaccine for HIV/AIDS. Accordingly, 53% of the respondents answered the question wrongly, while other 19% did not know whether the disease had curable vaccine or not at the time of the study. In general 72.4% of the sample group for this study had either wrong or no information about the existence of curable medicine for the disease.

The next question that needs to be discussed was item number 4 which. This question was asked whether a person could differentiate HIV infected person just by looking at his physical appearance or not.

From the above table, it could be said that 41 students (39%) responded positively. That means, they claimed that they had the ability to differentiate the infected person just by looking at his/her physical appearance. The other 37 subjects (35%) did not know the impossibility or possibility of identifying a person with the virus. Thus 73.3% of the

study group lacked proper information regarding difficulty of identifying the infected person by simple observation.

The last item which seemed poorly answered by the students of Islamic theology was the item which dealt with the relationship between taking drugs through injection and HIV/AIDS risk. According to the table, 68.6% of the group did not have proper information in relation to the matter. This may indicates the very big information gap among the madrasa students about the way HIV transmits from the infected to the normal person.

Independent sample t test results of knowledge score between madrasa and high school students

Table 4.1.7: Mean comparison for knowledge score of madrasa and high school students regarding HIV/AIDS

Variable	Student type	N	Standard deviation	Mean	t obtained	df	Significant (2-tailed)
Students knowledge of HIV/AIDS	High school	198	2.982	39.9242	16.9	303	.000
	Madrasa	105	4.5762	32.5524			

An independent sample t test was carried out so as to observe whether or not there is a significant difference between high school and madrasa students with regard to knowledge of HIV/AIDS scores.

As table 4.1.7 shows, the result of the analysis suggested that there was significant difference between the two groups with respect to their score on knowledge questions. According to the result, the mean score of high school students ($\bar{X}$ =39.92) was significantly higher than the mean score of madrasa students ($\bar{X}$ =32.55). That is high school students were found to have higher level of information about the disease and its transmission. However, the low result of madrasa students' indicates their lack of information about the issue under discussion.

4.2 Attitude score of respondents

In order to examine the subjects' attitude towards the disease, infected peoples, and orphans who lost their parents due to the disease, the researcher developed 13 items. As it

was indicated in the previous chapter, the value for each item varied from minimum score one to maximum score four. Accordingly, the minimum and maximum expected score range from 13 to 52 respectively. The higher the score the positive or favorable and the lower the score the negative will be the attitude of the respondents. Here again simple descriptive statistic is used in order to report the result obtained. Some specific items also dealt independently so as to identify important intervention area.

Table 4.2.1: Descriptive statistics of high school students' attitude towards PLHA, AIDS orphans, and AIDS

Variable	No of items	Observed mean	Standard deviation	Minimum score	Expected mean	Maximum score
Attitude items	13	40.62	4.608	13	32.5	52

According to the above table the observed mean (40.62) exceeds the expected mean (32.5) score. This may help us to generalize that the majority of high school students had favorable attitude towards PLHA, AIDS orphans and realistic view of the pandemic.

Table 4.2.2: Mean comparison for attitude scores between grade 9 and grade 10 students

Variable	Grade	N	Standard deviation	Mean	t obtained	df	Sig(2-tailed)
Attitude items	9	96	4.37	40.10	-1.54	196	.126
	10	102	4.79	41.11			

According to the table, grade 10 students scored a mean of 40.11 with standard deviation 4.79. While grade 9 students score a mean of 4.1 and the standard deviation was 4.37. Like the above cases, here is also independent sample t-test was employed so as to check whether or not there is a significant variation in the attitude of the two grade students. As the table made it clear, there is no significant difference between the two grade students regarding their attitude towards PLHA.

Table 4.2.3: Mean comparison for attitude score for Male and Female students

Variable	Gender	N	Standard deviation	Mean	T obtained	df	Significant (2-tailed)
Attitude items	Male	94	4.80	39.61	-3.0	196	.003
	Female	104	4.24	41.54			

In an attempt to see the probability of difference between the two groups, mean comparison was made as usual. According to the above table, girls' mean score found to be better and this was supported by independent sample t-test. Thus, the result suggested the significant variation in the two groups mean for attitude scores. Such result also helps us to say that female students are more sympathetic for the people in trouble especially in relation to HIV/AIDS. In other words, female students' attitude seemed to be more positive and favorable towards PLHA.

Here again some specific items have been discussed independently so as to look students' attitude in some more depth. Bellow the selected items were presented.

Table 4.2.4: Frequency of selected attitude items (for high school students)

		Frequency	Percent	Valid Percent	Cumulative Percent
Item no 14	Strongly Agree	37	18.7	18.7	18.7
	Agree	26	13.1	13.1	31.8
	Disagree	80	40.4	40.4	72.2
	Strongly disagree	55	27.8	27.8	100.0
	Total	198	100.0	100.0	
Item no 26	Strongly Agree	47	23.7	23.7	23.7
	Agree	50	25.3	25.3	49.0
	Disagree	58	29.3	29.3	78.3
	Strongly disagree	43	21.7	21.7	100.0
	Total	198	100.0	100.0	
Item no 36	Strongly Agree	27	13.6	13.6	13.6
	Agree	49	24.7	24.7	38.4
	Disagree	63	31.8	31.8	70.2
	Strongly disagree	59	29.8	29.8	100.0
	Total	198	100.0	100.0	

As the above table, some items deserve to be discussed independently. From such examples item 14 is presented. And 63 students (31.8%) reported to have a belief that AIDS patients (regardless of the cause for the infection) to be transgressors of God's rules and regulations. This means that the mentioned respondents associate the disease only with illegal sexual behavior or the patients with those who did not keep the moral conduct (avoiding fornication and adultery) ordained by God. Thus these groups may have a negative attitude towards peoples living with HIV/AIDS in this aspect. As a result, they may not be considerate about these peoples overall situation or problem.

The other response which attracted the writer's attention was that of item no 26. As it might be clear, the above and this item has strong correlation ($r = .849$). But high school students in large proportion expressed their belief that HIV being a punishment for promiscuous behavior. Indeed we know many genuine and ethical peoples were the

victim of the pandemic. According to the frequency table result from the total population 97(49%) of them reported to have said HIV is the cost to be paid by some immoral people. This may indicate the students negative attitude towards infected people be it by their promiscuous behavior or any other possible reason. Of course in general the majority of students may be labeled as positive (as their mean score indicated) towards the people who are suffering out of AIDS, but such deep investigation may express many students negative attitude especially in some aspect of life. The other sensitive item observed by the researcher was item number 36. This item clearly challenged the attitude of respondents regarding children who lost their family as a result of the disease. And many students (78, 38.4%) have a negative perception for the orphans. This could be the result of students feeling that consider AIDS orphans as a burden over the society.

Madrassa students' attitude towards PLHA, AIDS orphans and HIV

Table 4.2.5: Descriptive statistics of attitude score for madrasa students

Variable	No of items	Observed mean	Standard deviation	Minimum score	Expected mean	Maximum score
Attitude items	13	28.57	5.719	13	32.5	52

The result indicated in the above table showed that the mean of the sample (28.5) was lesser than the expected mean of the population (32.5) with respect to madrasa students' attitude towards PLHA, AIDS orphans and AIDS. This indicates that most madrasa students scored below the mean of the population. Closer examination of the overall attitude result of madrasa students, as indicated in the above table showed that most of them have negative attitude towards the victims of the disease and have irrational view towards the virus itself. The finding may help us to generalize that many of these students are not in a position to accommodate the victims of the disease and did not have realistic view about the epidemic at the time of the study.

Table 4.2.6: T-test of mean comparison for attitude score variation of madrasa students towards the victims of the pandemic across grade

Variable	grade	N	Standard deviation	Mean	t	Df	Significant (2-tailed)
Attitude items	4	51	5.113	27.76	1.411	103	.161
	3	54	6.189	29.33			

In an attempt to determine variation in attitude score of madrasa students across grade, mean comparison yielded no significant difference for the independent variable between the two graders. As the SPSS result, that the mean score of grade 3 students (29.33) were greater than that of grade 4 students (27.76). The standard deviations were found to be 5.11 and 6.18 for grad 3 and 4 students respectively.

In depth investigation in to madrasa students’ attitude score, some items revealed the following results.

Table 4.2.6: Frequency table for selected attitude items (for madrasa students)

		Frequency	Percent	Valid Percent	Cumulative Percent
Item no 2	Strongly Agree	74	70.5	70.5	70.5
	Agree	15	14.3	14.3	84.8
	Disagree	6	5.7	5.7	90.5
	Strongly disagree	10	9.5	9.5	100.0
	Total	105	100.0	100.0	
Item no 14	Strongly Agree	68	64.8	64.8	64.8
	Agree	13	12.4	12.4	77.1
	Disagree	13	12.4	12.4	89.5
	Strongly disagree	11	10.5	10.5	100.0
	Total	105	100.0	100.0	
Item no 29	Strongly Agree	54	51.4	51.4	51.4
	Agree	20	19.0	19.0	70.5
	Disagree	19	18.1	18.1	88.6
	Strongly disagree	12	11.4	11.4	100.0
	Total	105	100.0	100.0	
Item no 36	Strongly Agree	51	48.6	48.6	48.6
	Agree	30	28.6	28.6	77.1
	Disagree	18	17.1	17.1	94.3
	Strongly disagree	6	5.7	5.7	100.0
	Total	105	100.0	100.0	

To start with item number 2, which tests respondents' attitude towards prostitutes in relation to HIV/AIDS, the majority of the group agreed that HIV/AIDS to be a proper punishment for the prostitutes. According to the above table around 85% of the respondents had a negative feeling about prostitutes. They believed that the disease is the punishment for bad behavior of prostitutes. The mean comparison for this item indicated the clear difference between the population mean (2.5) and the sample mean (1.54).

Similarly, the majority of student of Islamic theology (81, 77.1%) agreed that AIDS patients as being rebels against God's rules and regulations which in this case committing adultery and fornication. The conclusion was supported by students' sample score which was found to be 1.69. Thus we can say that madrasa students had a negative feeling about people living with HIV/AIDS.

The other item which expressed most students' unfavorable view was item number 29. This item considered HIV/AIDS as the issue of immoral people. The sample mean for this item was found to be 1.9, while the expected mean was 2.5 indicating the overall negative impression which madrasa students had towards the victims of the disease. The frequency table showed the number of respondents who expressed their negative feeling towards the victims to be 74 or 70.5 %. Similarly AIDS orphans were considered by the majority of respondents (81, 77%) as a burden over the society. The observed mean was 1.8 which is far inferior to the expected mean. In general, we can generalize that the unfavorable attitude of madrasa students towards AIDS victims was clearly observed.

T-test of mean comparison for attitude score of madrasa and high school students (independent sample t test was used)

Table 4.2.7: Mean comparison for attitude score of madrasa and high school students

Variable	Type of student	N	Standard deviation	Mean	T	Df	Significant (2-tailed)
Attitude items	High school	198	4.608	40.62	19.884	301	.000
	Madrasa	105	5.719	28.57			

In an attempt to see whether or not there is a variation in attitude score between madrasa and high school students, mean comparison was made. Accordingly, the mean score of high school students clearly exceeded the mean score of madrasa students as the above table show. And there were a significant variation at alpha .01 level. This means that high school students had better and positive attitude towards HIV patients, orphans and objectively favorable attitude towards the disease as compared with that of madrasa students who were found to have negative feeling towards those who were victimized by the pandemic.

4.3 Students stigma and discrimination score

Descriptive statistic of High school students' behavior in relation to stigma and discrimination

Table 4.3.1: High school students' stigma and discrimination score

Variable	No of items	Observed mean	Standard deviation	Minimum score	Expected mean	Maximum score
Stigma and discrimination	9	29.95	3.673	9	22.5	36

In order to measure subjects' behavior regarding stigma and discrimination 9 items were developed. The scoring was similar to that of attitude items. According to table 4.3.1 high school students observed mean is greater than that of the population mean telling us that the majority of the subjects did not stigmatize and discriminate those who become victims of the disease. In general we could say that high school students were well aware about the problem of stigma and discrimination. And this could be associated with their positive attitude towards the patients and orphans who lost their parents as a result of the disease.

T-test of mean comparison for behavior variation of high school students regarding stigma and discrimination across grade

Table 4.3.2: Mean comparison of stigma and discrimination across grade

Variable	Grade	N	Standard deviation	Mean	t	df	Significant (2-tailed)
Stigma and discrimination	9	96	3.607	29.98	.11	196	.913
	10	102	3.751	29.92			

According to the above table the mean score of the two grade students seem almost equal indicating the similarity of their behavior in relation to stigma and discrimination. The independent sample t test also affirmed the absence of variation between the two groups score at .05 level.

T-test of mean comparison for behavior variation of high school students regarding stigma and discrimination across gender

Table 4.3.3: mean comparison for stigma and discrimination score of high school students across gender

Variable	Gender	N	Standard deviation	Mean	t	df	Significant (2-tailed)
Stigma and discrimination	Male	94	3.972	29.29	-2.44	196	.015
	Female	104	3.285	30.55			

Here again the result of mean comparison was employed so as to see whether or not there is a significant variation between male and female students of high school students regarding their behavior in relation to stigma and discrimination. As table 4.3.3 showed that there were significant difference between the groups' mean score and the t test result confirmed the variation at 0.05 level of significance (df=196, t =1.96). Thus we can conclude that female high school students were more sensitive to people who faced the challenge of HIV/AIDS. In other words the attitude of female high school students about stigma and discrimination seemed more sympathetic than that of male students in the same school.

Descriptive statistic of Madrasa students' behavior in relation to stigma and discrimination

Table 4.3.4: Madrasa students' stigma and discrimination score

Variable	No of items	Observed mean	Standard deviation	Minimum score	Expected mean	Maximum score
Stigma and discrimination	9	20.99	4.94	9	22.5	36

The result of the above table showed that the mean of the sample (20.99) was smaller than the mean of the population (22.5) with respect to the behavior of madrasa students regarding stigma and discrimination. This indicated that most students of the group had a tendency to discriminate and stigmatize AIDS patients in different ways.

Just for deeper looking in to the items, the following items were selected and discussed independently. And all the selected items were related to the behavior of avoiding the infected peoples.

Table 4.3.5: Frequency of selected stigma and discrimination items (for madrasa students)

		Frequency	Percent	Valid Percent	Cumulative Percent
Item no. 1	Strongly Agree	54	51.4	51.4	51.4
	Agree	18	17.1	17.1	68.6
	disagree	21	20.0	20.0	88.6
	Strongly disagree	12	11.4	11.4	100.0
	Total	105	100.0	100.0	
Item no. 3	Strongly Agree	53	50.5	50.5	50.5
	Agree	27	25.7	25.7	76.2
	disagree	16	15.2	15.2	91.4
	Strongly disagree	9	8.6	8.6	100.0
	Total	105	100.0	100.0	
Item no. 11	Strongly Agree	36	34.3	34.3	34.3
	Agree	37	35.2	35.2	69.5
	disagree	19	18.1	18.1	87.6
	Strongly disagree	13	12.4	12.4	100.0
	Total	105	100.0	100.0	

To start with items number 1 which suggest special classroom for the infected student, (72, 68.6%) of the total sample population advocate the preparation of special classroom for infected students. Regarding preference to sit with HIV positive students, again 80 or 76.2 % of the students reported their preference to sit with normal student. Other 69.5 % of the respondents expressed their discomfort to eat with the infected person indicating the avoidant behavior that they posses. Thus the above selected items further tell us the extent of stigmatization and discrimination of madrasa students to be serious.

As usual mean comparison was made in order to see whether or not there is an observed variation between grade 3 and 4 madrasa students regarding stigma and discrimination. As a result the t test at alpha .05 level has revealed a significant difference between the two groups. The critical value for t was found to be ($t=1.98$, $df=103$) smaller than that of the obtained t value (2.01). This indicates the relatively better performance of grade 4 students.

T-test of mean comparison for behavior variation of high school and madrasa students regarding stigma and discrimination

Table 4.3.6: Mean comparison for stigmatic behavior for high school and madrasa students

Variable	Type of student	N	Standard deviation	Mean	t	df	Significant (2-tailed)
Stigma and discrimination	High school	198	3.673	29.95	17.85	301	.000
	Madrasa	105	4.945	20.99			

In the same way, in order to examine the level of the difference of the major groups of the study regarding their position in stigma and discrimination, an independent sample t test was administered. The mean comparisons for the two subjects were held and their difference became significant at 0.01 level. Accordingly, the mean of high school students was found to be 29.95 with standard deviation and standard error of the mean to be 3.673 and 0.261 respectively. While madrasa students mean score was found to be 20.99 with standard deviation and standard error of the mean 4.94 and 0.483 respectively. Thus, we can conclude that high school students score for stigma and discrimination implies their good feeling towards PLHA and AIDS orphans. While madrasa students can be labeled with those people who discriminate and stigmatize the victims of the disease.

4.4 Results for Islamic prevention strategies

In order to measure subjects' attitude towards the Islamic prevention strategy for the prevention and control of the disease, 10 items were developed. The items were totally in agreement with the principle of Islam and believed to prevent and control the pandemic by Islamic scholars and researchers. Thus respondents' commitment and conviction for the strategy was measured using the items and the scoring was similar with the previous variables.

Descriptive statistic of high school students' score for Islamic prevention strategy

Table 4.4.1: descriptive statistics for high school students' response regarding the Islamic prevention strategies of HIV/AIDS transmission

Variable	No of items	Observed mean	Standard deviation	Minimum score	Expected mean	Maximum score
Islamic prevention strategy	10	29.83	4.56	10	25	40

The result in the above table showed that the mean of the sample (29.83) was greater than the mean of the population (25) with respect to the Islamic approach to halt the spread of HIV/AIDS. The result told us that most of the students have a belief that an Islamic approach to the prevention of the disease was important or acceptable. Further more the finding seemed to indicate that a large number of respondents considered the new approach, if properly applied, to be help full in fighting and controlling the disease from bringing further damage.

T-test of mean comparison of high school students' score for Islamic Prevention Strategy across grade

Table 4.4.2: Mean comparison of high school students regarding the Islamic prevention strategy across grade

Variable	Grade	N	Standard deviation	Mean	t	df	Significant (2-tailed)
Islamic prevention strategies	9	96	4.153	28.64	-3.681	196	.000
	10	102	4.664	30.95			

As usual, the mean comparison was employed so as to see if any variation between the two graders in their score to the prevention strategy items exists or not. According to table 4.4.2 the mean score for grade 9 students was found to be 28.64 with 4.153 standard deviation and 10th graders scored a mean score of 30.95 with standard deviation of 4.664. Hence the possible conclusion could be that 10th grade students appreciate and support the use of the Islamic approach to defend the spread of HIV. The independent sample t-test also conducted and revealed a significant variation between the two grade students.

T-test of mean comparison for Islamic prevention strategy score variation of high school students across gender

Table 4.4.3: Mean comparison of high school students regarding the Islamic prevention strategy across gender

Variable	Gender	N	Standard deviation	Mean	t	df	Significant (2-tailed)
Islamic prevention strategies	Male	94	4.89	29.32	-1.5	196	.136
	Female	104	4.81	30.29			

In an attempt to see whether or not there is a variation in the perception of high school students regarding Islamic prevention strategy to stop the spread of the pandemic, mean comparison was made and there were no significant variation between male and female students. The t-test also affirmed the variation to be non significant at .05 level. This may help us to generalize that the two groups of students agreed up on the importance and significance of this approach to defend the generation from further attack of HIV/AIDS.

Madrasa students’ score to the Islamic approach to the prevention of HIV/AIDS

Table 4.4.4: Descriptive statistics for the prevention strategy

Variable	No of items	Observed mean	Standard deviation	Minimum score	Expected mean	Maximum score
Islamic prevention strategy	10	33.11	3.16	10	25	40

As clearly put in the above table the mean score of madrasa students is taken to be 33.11 which was greater than that of the expected mean for the population (25). The implication to the result indicated that the majority of the student of Islamic education has positive concern to the prevention strategies proposed by the religion to defend HIV and other related disease.

In respect of their difference, there was no significant variation between the two grade levels. Hence the simple conclusion for the result is that madrasa students' attitude towards the Islamic prevention strategy seemed almost similar and positive.

Table 4.4.5: Mean comparison for high school and madrasa students regarding prevention strategy proposed by Islam

Variable	Type of student	N	Standard deviation	Mean	t	df	Significant (2-tailed)
Islamic prevention strategies	High school	198	4.56	29.83	-6.588	301	.000
	Madrasa	105	3.16	33.11			

As it was made for the other variables here also mean comparison was made to identify the possible difference between the two major groups (high school and madrasa students) in relation to the strategy for the prevention of AIDS with the assumption of the general hypothesis two tailed. The t-test result indicated the variation to be highly significant at 99% confidence interval. According to the table shown above, the mean score for madrasa students was found to be 33.11 while for high school students' it was 29.83. As a result we could generalize the madrasa students' attitude for the prevention mechanisms advocated by the Islamic principle was more positive as with students in high school.

4.5 Results for Expected Role Items

As it was discussed in the previous chapter, 10 items were developed and administered in order to identify the subjects' role as a Muslim in care and support which should be provided to PLHA, AIDS orphans and the victims in general. The items were developed based on the Islamic principles of giving care and support for those who need it

regardless of the cause for their problems. The result for high school students were presented in the table bellow

Table 4.5.1: descriptive statistics for expected role items of high school students'

Variable	No of items	Observed mean	Standard deviation	Minimum score	Expected mean	Maximum score
Expected role as a Muslim	10	32.86	2.84	10	25	40

According to the above table high school students scored an observed mean of 32.86 while their expected mean was 25 which lead us to a conclusion that these students had better knowledge and understanding of their role which is expected from them as a Muslim citizen. When we observe their grade difference in their commitment to the role in which they are expected to provide for the victims and the society in general, there were no difference between the two grade students, and hence there is no need to repeat their independent mean score here.

Table 4.5.2: Mean comparison of expected role items between high school students across gender

Variable	Gender	N	Standard deviation	Mean	t	df	Sign. (2-tailed)
Expected role as a Muslim	Male	94	3.24	32.23	3	197	.003
	Female	104	2.31	33.43			

Likewise, an independent sample t test was done on expected role scores of high school students to find out a possible variation across groups in this sphere. Accordingly the independent sample t test carried across the two gender family indicated a statically significant difference on expected role understanding. ($t = 1.960$ $df = 197$), $p < 0.05$

As the table indicated male students scored an observed mean of 32.23 with standard deviation and standard error of the mean to be 3.24 and .334 respectively, while female students scored a mean of 33.43 with standard deviation and standard error of the mean to

be 2.31 and .226. Hence, we can conclude that female understanding of their role in which Islam put on their shoulder appeared better than that of their counter part.

Table 4.5.3: Descriptive statistics of madrasa students for expected role items

Variable	No of items	Observed mean	Standard deviation	Minimum score	Expected mean	Maximum score
Expected role as a Muslim	10	24	4.019	10	25	40

As shown in the above table the mean score for the total population was 25. While the sample mean was found to be 24. This indicated that madrasa students' commitment to the role that they are expected to play in all direction against HIV/AIDS seems inferior.

In respect of grade level influence on students' expected role score we have seen almost no significant difference between 3rd and 4th graders. Hence due to the similarity of the score we can conclude that the two grade students did not have understanding difference in relation to the role that is expected from them in the process of defending and controlling the problem of HIV/AIDS.

As usual an independent sample t test was employed to examine the variation between the two major groups (high school and madrasa students) on the role that is expected from a Muslim to defend and control the prevailing problems related to the pandemic.

Table 4.5.4: Independent sample t test of expected role items for madrasa and high school students

Variable	Student type	N	Standard deviation	Mean	t	df	Significant (2-tailed)
Expected role as a Muslim	High school	198	2.846	32.86	13.86	301	.000
	Madrasa	105	4.019	24			

Accordingly the overall t test result showed that there was a statistically significant difference between the two groups with regard to the underlying construct at 0.01 level. In general the table clearly showed that high school students scored a mean of 32.86 as compared with madrasa students who got a mean of 24 indicating the superior responsibility feeling of high school students.

4.6 Inter correlation result of the variables

Table 4.6.1: inter correlations among the independent variables

	Knowledge	attitude	stigma and discrimination	prevention strategy	expected role
knowledge	1				
Attitude	.647(**)	1			
stigma and discrimination	.687(**)	.783(**)	1		
Prevention	-.159(**)	-.191(**)	-.199(**)	1	
expected role	.604(**)	.738(**)	.744(**)	-.147(*)	1

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

The test for significance of correlations for $N=303$ with $df = N-2$ is made at alpha 0.05 and 0.01. Non directional t test revealed that highly significant correlations have been noticed between attitude and stigma and discrimination items i.e. $r_{xy} = .783$ indicating the influence of one over the other being remarkable. Once again attitude and expected role items also showed a strong positive relationship. Hence the two characters may be influenced each other strongly. Strong and positive correlations have been observed between the knowledge items with stigma, attitude and expected role variables and it was significant at alpha 0.01 level with the prevention strategy. The prevention strategy has significant and negative correlations with all the rest variables and the significant comes at 0.05 level with expected role and it is the weakest as compared with the other variables.

4.7 Data obtained from interview and focus group discussion

To supplement and validate the data gathered from questionnaire, unstructured interviews were made with one counselor and some students from both groups. In addition focus group discussion was also made.

To start with, the Ethiopian Muslim supreme counsel for Islamic affairs staff member and counselor was contacted. The purpose was to have information on which they have done on the subjects under study. For this purpose I asked her what the organization has done till now regarding the subjects under study. According to her the organization has prepared many work shops and trainings for Imams and some university and high school students in order to increase their awareness towards the disease. But there were no training or workshop for madrasa students (young clerics). This shows us that these groups were forgotten and their significant role has been denied. Most of the trainings were held for imams. However the behavior change in which these Imams brought as a result of these workshops and trainings were not that much satisfactory. Most of the Imams were rigid and they don't like even to mention the name of the disease during the weekly sermon. Hence their students (madrasa students) seem to have similar attitude with them. Note that madrasa students spent most of their times with these imams in different mosques of Addis Ababa.

Regarding students she felt sorrow for students' reluctant behavior towards the disease though they have the knowledge, they do not seem much concerned. In fact the training was not consecutive and it was not intensive or not for many students. According to the informant there is problem of responsibility feeling among both imams and high school and university students too. But affirmed students feeling to be in a better position as compared with the Imams.

Regarding students response for interview item (do you think HIV to be the problem of Muslims), most of the participants believe HIV to appear as a problem for every society. However, they insisted its insignificant prevalence as compared with others. For the question what are the major preventive methods to the pandemic, almost all the participants found to be ready to teach if they got the opportunity. Indeed their interests vary. Madrasa students typically advocate teaching about abstinence and fidelity for marriage partner. High school students proposed besides these two other transmitting

ways to be thought. Regarding the current status of HIV in Ethiopia both groups explained their fear that it may cause to deteriorate the country's over all situation. According to Madrasa students' view the expansion of bars, night clubs and prostitution may endanger the society in general and the youth in particular. But they claimed the vast majority of the victims to be non Muslims. Almost none of the interviewed and participants of in the FGD faced infected person. However, many of high school students has the experience to meet with PLHA. In relation to their role, almost all of them are ready to teach and participate in the battle against the disease.

In the FGD session both group participated and almost all their comment was similar with that of their response for the questionnaire with the exception of some madrasa students, who were found to be more stigmatic. As one of the participant said, "even though I know eating with infected person does not transmit HIV, I don't feel comfort to do that".

Due to the similarity of other opinions and suggestion made by respondents, it becomes irrelevant to repeat it here.

Chapter Five

Discussion

In the previous chapter we have been discussing the obtained result in simple reporting form. Here we discussed the present result with some detail in the light of the previous findings if any.

Knowledge of Respondents about HIV/AIDS

According to the present research Muslim students' knowledge about HIV/AIDS and its transmission found to be in a good condition. Particularly high school students' score to the knowledge items is satisfactory in general terms. Indeed there were some misinformation and confusions among these students. While the madrasa students scored above the mean indicating the presence of good level of information about the disease. But the mean comparison showed a significant difference between the two groups. The confusion and lack of information in some aspect of the pandemic largely prevailed in the madrasa students. Further more the selected items for independent interpretation (using frequency table) clearly indicated the information gap prevailed between the two groups. Generally speaking the two groups scored above the expected mean witnessing the fair level of information that the respondents acquired. In this regard other research findings also showed similar results. According to Solomon (1990) knowledge about HIV/AIDS is higher than other STDs, among young people in both developing and developed countries. Tilahun (1993) indicated the knowledge about HIV/AIDS of Gonder Medical College students to be in comparable with other high school students. Another research finding which seems similar with the present findings was done by Dagne (1999) on Jimma high school students. Further study is also done by Beyen (1997) on college students revealed the satisfactory level of information. But it also reported that there were gaps about some vital information of the risk factors and mode of transmission among high school students and madras students. As the selected items clearly put the information gap among madrasa students was more serious than that of high school students. Some research findings like FGAE, (1998) argued that the level of knowledge about HIV/AIDS increases with age. But the present finding resulted in opposite ways. As it was reported in the methods chapter the madrasa students' age was far superior to that of high school students. The finding also reflected the better performance of the

younger high school students. Probably we may count many reasons for their difference. One simple reason could be the age group compared here is not in the same type of educational background. The high school students have been learning for many years about the nature of the disease and its means of transmission in the class rooms. In addition, in many of our high schools we observed anti HIV/AIDS clubs that teach students about the nature of the virus, the mode of transmission and how to prevent and control it. Moreover high school students have much exposure to the teachings about the disease through different mass media including radio, television, leaflets, journals etc. While the madrasa group of students did not get all these access for many years. This is probably because most of them were in remote rural areas in studying their subject matter for many years in which it was impossible to get any information about the disease and related issues. Even after coming to Addis they might not get enough access to the media, anti- AIDS programs like panel discussions, workshops and the like.

Another possible reason for their lower performance in relation to knowledge questions could be their negligence towards the real problem. The outcome of many research conducted in Muslim countries showed that the Muslim community in general still is not well aware of the risk of HIV/AIDS. For example UNAIDS, (2004) declare the observation of recent signs that HIV may be acquiring a stronger presence in North Africa (which is dominantly Muslim society). Even among people at risk of infection (such as sex workers), HIV knowledge is poor and preventive behavior is rare. Similar gaps in HIV knowledge and behavior have been found among internally displaced people in Sudan (SUDAN, 2004). In Tunisia since young people in particular have poor HIV knowledge and limited access to condom, such trends could put them at risk of acquiring HIV (UNAIDS 2005).

In general in many Muslim countries the information gap about HIV/AIDS is clearly manifested. The reflection may also be observed in our country's Muslim society too. Even though madrasa students have scored an observed mean greater than expected mean, their lack of information specifically towards those items discussed independently denoted the gap. As we discussed above the other possible interpretation could be that they might associate the disease with promiscuous behavior and they consider the

infected people as a sinner. Thus avoiding such type of people may be preferred by the madrasa students and thus aggravate the information gap prevailed among them.

Their knowledge regarding the presence of curable vaccine may indicate their misunderstanding of ART. While their claim to differentiate the carrier just by looking towards his physical appearance, could be the result of associating the disease with typical weight loss. This finding corresponds with Tefera (2004) who reported 58% of his respondents who did not know the significantly healthy person can transmit HIV. The other response for drug using through injection clearly shows the information gap that these young clerics have. This could be due to the lack of information about the use of drug through injection. Even some of them do not know the nature of drug itself. The South African Positive Muslim Association criticized the Muslim world in general regarding their knowledge and denial of the existing reality in the following words: "For a long time now, Muslims have preferred to ignore the problem of HIV/AIDS or to deny that it is a reality among us. We have taken what we believe to be the ideal of Islam – no sex outside marriage and no drugs – and confused it with the reality of the Muslim world. There are indications that the reality of this pandemic among Muslims is slowly dawning upon us in many parts of Africa – such as Uganda, Mauritania and Senegal – and elsewhere – such as Iran, Egypt, Pakistan and Malaysia." As it was repeatedly discussed above drug is one of the main root of HIV transmission especially in the Muslim world. Now a days drug using is becoming common in Ethiopia too. The researcher has observed many shisha (type of drug which is smoked in group or independently) and Kat houses where many young men and women chew and smoke together in single room. In fact it is not clear whether these people are using other types of drugs or not. But we can guess the eventual development of the culture in to using another type of drugs. In addition, as the gatherings were among young men and women, this may lead to uncontrolled and unsafe sexual intercourse eventually contracting HIV/AIDS.

Attitude of respondents towards PLHA, AIDS orphans and AIDS

The descriptive statistics result obtained from the items which attempt to measure the prevailing attitude towards PLHA, AIDS orphans and the pandemic itself of high school

students found to be positive. That is high school students have favorable feeling towards PLHA, AIDS and AIDS orphans. Examining their grade level did not give a significant variation between the two graders. This could be because of the absence of marked life experience among students of grade 9 and 10. Thus the similarity of their attitude could be attributed to the similarity of their experience in life. There is a significant difference between male and female students score for the attitude items. Accordingly girls scored better than male students for the variable. Hence, as result girls seems to have more positive attitude towards PLHA, AIDS orphans. The result may be caused by girls' exposure to people with the problem. As it is well known in most cultures it is females who look after the patients at home as well as in clinics and hospital. In addition it is them who face the problem of orphan children and practically observe the real situation happened to the victims of HIV/AIDS. Therefore, they may develop sympathetic behavior to these people. Furthermore the class room education related to HIV/AIDS most probably will have a significant contribution for overall high school students' good attitude formation towards PLHA and AIDS orphans. Other findings done in high school and university students agree with the present findings. Beyene (1997) reported that students' attitude towards the disease to be favorable. Ibrahim (2006) also reported defense college students' positive attitude towards PLHA and AIDS itself. Oyziawo (2005) also reported Nigerian students as highly favorable to wards AIDS and PLHA.

Regarding madrasa students attitude, their mean score was found to be less than the expected mean indicating their negative attitude towards PLHA, AIDS orphans and AIDS. In other words most madrasa students feeling did not seem appropriate or positive. As many research findings indicated one's attitude could be the reflection of his/her knowledge about HIV/AIDS. The present research also witnessed the strong and positive relationship between the two variables. Even though the writer of this paper has tried a lot so as to find previous research works carried on the madrasa students' knowledge and attitude in relation to HIV/AIDS, it was almost impossible to get it. Thus it becomes difficult to compare the present study with previous findings. Yet one thing to mention here is that the young clerics attitude generally seemed almost similar with the general Muslim society. Many reports explained Muslims (who live in different parts of the

world) attitude towards AIDS and PLHA to be negative. According to United Nations News agency IRIN (2003), HIV is still a taboo subject in staunchly Islamic Mauritania, but awareness of the disease is growing. Here one madrasa leader quoted as the best example "the problem of AIDS is happening allover the world. It's right for young people, women and men, who have some problems with HIV/AIDS to go to health service but not to Muslim clerics. Doctors know about this disease more than Imams. In my opinion, it is not right when clerics talk about AIDS. I don't support this idea." Erasianet partener, 2004)

These people associate HIV/AIDS with promiscuous behavior thus they don't have the sympathy for those affected by the pandemic as they count them as a sinner. According to Badri (2000) though the association of contentious ethical and moral issues with HIV risk behavior exists in all society, it is much more pronounced in the Muslim world. Thus most of these clerics may consider accepting the victims and the disease as an encouragement for the immoral activities of some people. Consequently, they prefer to avoid the patients due to their inappropriate judgment of all the patients. Furthermore these subjects clearly responded their negative attitude towards PLHA by considering all patients as transgressor of God's border. 77.1% of the respondents approve this belief. Another 77% of this group considered AIDS orphans to be the burden over the society which indicated the negative feeling they have towards the orphaned children due to AIDS. This is exactly against the principle of Islam which strongly urge people to support orphans regardless of the cause for being orphan. But the reason for such contradiction could be the above misunderstanding about the disease and its association only with illegal sexual intercourse.

The great difference between the two subjects (madrasa and high school students) regarding attitude, probably have many factors. Even though many researchers argue the negative attitude people have with the presence of high level of knowledge, knowledge affects ones attitude. Hannu (2000) indicated that knowledge is the major factor in the process of attitudinal change. Hence high school students' satisfactory level of knowledge may help them to have realistic view towards the issue under study. Further more as we previously discussed modern education curriculum has a portion for the

proper information dissemination among students and influence students to have positive attitude about the victims of the disease. There are also many exposures for high school students which may help them to build the proper imagination about the victims of the pandemic. They have easy access to discuss with teachers, peers and other knowledgeable persons which help them in the process of positive concept formation regarding the disease. In contrast, the madrasa students do not have much of the privileges which may support them in the process of shaping their attitude in the proper direction. If they have, it is their teachers (madrasa clerics) who do not have proper understanding towards the nature of the problem and is more of conservative attitude towards the victims. These people again have been far away from the realistic life of cities for many years as most of them were in rural areas for their study. As a result, their negative attitude could be the result of their experience which was not exposed to deal with HIV/AIDS and related matters.

Stigma and Discrimination

Generally speaking high school students' behavior in relation to stigma and discrimination was found to be in favor of the desired one i.e. they do not stigmatize or discriminate. As the observed mean indicated most of these students seems to have better understanding to the bad side of S&D and are not with those who stigmatize and discriminate the victims. The grade level influence was almost negligible on the students score on S&D. While there was gender difference in the behavior related to S&D. According to the independent sample t-test for comparison of mean, female students obtained significantly better score indicating their positive tendency towards the victims or their stand against stigma and discrimination. The reason for girls' better performance may be similar with that of the above reason given for their positive attitude. Here again it is females who carried the burden of the problem in most of the cases and thus they may have better sympathy for the infected and the victims in general.

The madrasa students scored sample mean less than their expected mean. This indicated that most of these students stigmatize and discriminate in one or another form. When we discussed some specific items, the stigmatic and discriminatory character of these

subjects seemed more serious. In other words more than 70% of the respondents explained their agreement or preference to detach themselves from the victims in simple day to day activities like sitting together in the class room. Another 69.5% of the respondents aggressively preferred not to eat with infected friend. Here the finding supported by Gilborn et al. (2001) who said "Stigma has led to teasing by classmates of HIV-positive school children or children associated with HIV". The UNAIDS, 2004 report also expressed the poor understanding of stigma and discrimination and its bad effect on the victims of the pandemic. The report quoted "In some contexts, HIV/AIDS-related S&D has been reinforced by religious leaders and Organizations, which have used their power to maintain the status quo rather than to challenge negative attitudes toward marginalized groups and PLHA (UNAIDS, 2004). Anyhow the main finding of the research is that the group responded for stigmatic and discriminatory behavior that they have.

As to high school students' response, the reason could be the same with the previous reasoning. But the result of this study is inconsistent with Tedla (2005). According to him though people are much aware of the mode of HIV transmission, they still contradict in their practice (stigmatize and discriminate). The study also negates Allemayhu's (19997 which similarly documented the difference of peoples' knowledge and their behavior in relation to stigma and discrimination. Yet the report goes inconsistent with the result of madrasa students. Tedla (2005) specifically concluded that the presence of stigma and discrimination against AIDS orphans though, with varying magnitude. He further explained the extent of the problem to be significantly pervaded families, schools, peer groups and community at large. Other research findings also both contradict and assert the present research findings. That is when it support for the madrasa students result in effect it is contradicting the high school students result. According to UNAIDS (2000)...S &D remained among the most poorly understood aspects of the epidemic.

Others associate being stigmatic and discriminatory with fear and this fear arises out of misunderstanding about the mode of transmission of the infection, its relation to socially unacceptable behaviors and the belief that HIV is a fatal disease. (WHO, 2003)

Islamic prevention strategy

Using the usual observed mean comparison with that of expected mean, high school students reported to have the trust on the Islamic prevention strategy to defend HIV/AIDS from further expansion. Further detail observation show that grade 10 students have better confidence on the prevention mechanism that Islam advocates. While the difference between male and female students show non significant difference. Hence both groups (male and female high school students) do have almost similar belief on the strategy as a means to halt the spread of the virus.

The same result was obtained for madrasa students' perception of the prevention strategy forwarded by Islam. But one thing here is that the agreement level has a significant variation between high school and madrasa students. This is to say that madrasa students' score found to be greater than that of high school students. This could be because of madrasa students have more knowledge and experience about the general Islamic teachings as they have been studying it for many years exclusively. The other possible reason may be that high school students may expect other preventive strategies like using condom and being one to one. The madrasa students probably consider the Islamic strategy as the only alternative. This was observed specially during focus group discussion. I.e. they don't accept using condom for the purpose of preventing HIV. Indeed similar attitude have been observed in different Muslim countries. In these countries Muslim clerics agreed to teach the public about the virus within the frame work of Islamic law. According to Eruasianet partner post report (2004) Islamic scholars in Kyrgyzstan agreed to defend the spread of HIV/AIDS using the Islamic approach. Similarly, in Mauritania and the Indian Jamu-kashmir Muslim religious scholars agreed to teach the Islamic way of preventing HIV/AIDS like fidelity to one's family, avoiding any extramarital heterosexual and homosexual activities. But they opposed to teach the use of condom considering it as an encouragement for adultery and fornication.

The well known Muslim scholar Bedri (2000) also advocated the Islamic prevention strategies. He said "The most effective method of prevention in today's permissive society is the education and training of the individual to avoid the hazards of indulging in promiscuous sexual relationships and to promote certain moral principles that would lead to the necessary balance, health and stability in the life of members of the society. Such

measures represent the cornerstone of the Islamic approach to the prevention and control of AIDS.”

Another popular group who advocate the Islamic prevention strategy and agree with the present research finding is that the South African positive Muslims Association. It says “We know that HIV is mainly transmitted through unprotected sex with an infected person. The most important means of protection is obviously abstinence from sex and to remain faithful to your partner in marriage and not to have any sex before or outside such a relationship” (<http://positiveMuslim.org>, 2004)

In order to compare the students result with other objectively done research outcomes, the writer tried a lot but it was very difficult to find. Almost all researches done in the past dealt with the usual or conventional strategies of the 3A's. Indeed there is unanimous agreement on the strategy of abstinence and being faithful for one's partner. Yet the controversy arises in other methods like using condom and being one to one and polygamous.

Expected role of respondents

Students observed mean for their expected role response was found to be greater than that of expected mean score. In general high school students' score indicated their readiness to fulfill what is expected from them. Further investigation showed that the absence of difference between the two grade level. In respect of gender difference there was a significant variation. This is to say that girls understanding and commitment to participate in the process of defending and controlling the spread of the virus found to be superior to that of male students. In other words the significant difference between the two groups tell us that girls were more ready and feel responsibility to involve in care and support for the victims, teaching and the like activities. Overall conclusion is that high school students feel responsibility towards the problem and they were ready to do what is expected from them.

Regarding the result obtained from madrasa students, it was found to be lower than what is expected. This may help us to conclude that these students seemed indifferent towards the problem and its risk. In other words they don't seem comfortable to deal with HIV/AIDS and the victims probably due to their belief that made HIV/AIDS to be the problem of promiscuous people. This was also observed at the time of filing the

questionnaire where some of the students were not interested to file. This was as some informant told the researcher; they consider it as a dirty talk which includes sexual and related issues and they preferred to “refrain” from such activity.

Here again the researcher has tried a lot so as to find any related research out comes, but unfortunately, it was almost impossible to get it. Most of the available materials are generally written materials which have been discussed in the review of related literature part. But the researcher has interviewed a counselor in the office of Ethiopian Supreme Counsel for Islamic affairs, who work in the department VCT. According to her the organization in which she was working has given many training and workshops so as to create awareness and mobilized the university students and Imams (Muslim clerics) so that they teach the mass during prayer time. The counselor repeatedly blamed the attitude of these Imams due to their rigidity and uncooperativeness to teach the mass about the disease. Hence, they do not like to call the name HIV/AIDS, and associate the disease only with illegal sexual intercourse and alcoholism. She further explained that unfortunately they don't want to condemn Kat and 'shisha' house in which many youngsters and adults stay for longer hours. As the researcher himself observed in those rooms male and female youngsters chew chat and smoke 'shisha' together almost every day. Especially in the week ends there appear a large number of customers come to these houses from different parts of the society. But the imams, according to the counselor do not denounce this culture, most probably due to absence of clear information about the reality. Accordingly most of the subjects of this research learn from these Imams or clerics in Addis and most probably follow their line of thinking. So we can generalize that one possible reason for the young clerics indifference to accomplish their role towards preventing and controlling the risk of HIV/AIDS, is the influence of their teachers in Addis Ababa. This may be different in some Islamic countries where the Imams and the secretariat office for HIV/AIDS work together. The best example for such cooperation is the Indian Jamu-Kahsmir clerics who participated in teaching the mass during Friday sermon and other times whenever appropriate. Their agreement was boasted by Mohammad Amin health official of the region, he said “Islamic scholars have helped us in a big way to spread the anti AIDS message, and I can proudly say that 90%

of the populations in Jamu-Kashmir know about the disease". The Mauritanian Imams also agreed to teach about HIV/AIDS in agreement with the Islamic code of conduct.

Correlation among variables

As the Pearson product moment correlation result indicated there were positive and strong relationships among variables with the exception of prevention strategy with the other variables. Thus we can conclude that respondents' knowledge has significantly affected their attitude as well the stigmatic and discriminatory behavior. Again subjects' responsibility feeling has been significantly and positively affected by the knowledge and attitude they have. The prevention strategy proposed by Islam has strongly supported by madrasa students though they have lesser knowledge as compared with high school students. Thus the correlation result indicated a negative relation ship between this variable and other variables. While high school students though they accept the strategy they were significantly lower than that of madrasa students. This might be because of madrasa students' inaccessibility to other options except to support the strategy in which they know it well. In addition some high school students could be doubt full on the strategy while madrasa students accept it with full confidence and scored the maximum. As a result of this discrepancy the correlation result for this variable showed considerable difference from the other variables.

To conclude, with the exception of prevention strategy all variables showed significant positive correlation among themselves which indicated the interdependence of the variables.

Chapter six

Summary, Conclusion and Recommendations

Summary and conclusion

The main objective of this study was to know the level of Muslim high school and madrasa students' knowledge about attitude towards, stigma and discrimination, Islamic prevention strategy and understanding of their expected role as a Muslim towards HIV/AIDS. For this purpose 198 high school students from different Muslim mission schools in Addis Ababa and 105 madrasa students who were pursuing religious education in different mosques in Addis Ababa and now learning basic education in some of the school there in have participated. In order to support the variables to be studied, different literatures and researches have been reviewed. So as to collect data from the subjects, the main instrument used was questionnaire. In addition some interviews were made with selected individuals from both groups as well as one VCT counselor at the Ethiopian Muslim Supreme Counsel for Islamic Affairs. Furthermore focus group discussions were made to support the collected data using the questionnaire and interview. After the administration of the instruments, data collected was analyzed in line with the purpose of the study using the appropriate statistical methods. As a result the following major findings were observed:

High school students' knowledge about the modes of transmission of HIV/AIDS was found to be satisfactory albeit with some confusions or misunderstanding. These misunderstanding were specially observed in some specific areas like how long one can live with HIV/AIDS, the use of drug through injection and the transmission of the virus via sweat and saliva. But overall performance for the knowledge questions indicated the students' level of knowledge pertaining to the pandemic to be in a good condition. Here there was a variation among students knowledge score across grade and gender. The scores of 10th graders and female students were found to be significantly different from their counter parts. In other words the observed mean for both of these groups was greater than that of their parallels.

Like high school students, the observed mean score of madrasa students for knowledge question witnessed the groups over all performance to be in a good situation. Although the two mean scores (the sample and the population) vary significantly the mean

difference did not show such observable difference. That is the observed mean was not far away from the expected mean. Comparison of the two grade level showed no difference between them; hence, a similarity in knowledge scores was observed. Some items interpreted independently gave the typical information gap which these subjects had. Accordingly, subjects' information regarding the possibility of differentiating the infected person, for example, has clearly indicated the knowledge gap prevailing among this group. Other issues like drug use and the presence or absence of curable vaccine were areas where the information gap seemed more serious. Therefore, the overall mean comparison for the two major groups of the study has told us the significant difference between them regarding the disease and its mode of transmission.

The research finding also indicated the overall high school students' attitude towards PLHA and AIDS orphans to be positive. Here in the focus group discussion high school students expressed their sympathy to the victims. Indeed there were some negative feelings towards the victims by some of the students as well. These students considered the victims specially the infected persons to be transgressors of God's border. Other significant portion of the respondents from this group saw HIV to be the right punishment for promiscuous people. Here again grade and gender difference was observed. According to the findings, grade 10 students seem to have more favorable attitude as compared with 9th graders. Similarly female students' feeling was more positive than that of male subjects. While the madrasa students observed mean witnessed their negative attitude towards the victims and the disease itself. A comparison in the differences between the two grades was made and it was non significant. But the selected item analysis gave us a result of negative feeling these people had towards PLHA. Even the FGD results also provided their unfavorable attitude towards the victims.

The general mean comparison for the two major groups has obviously indicated a significant disparity between the two subjects concerning the attitude they had towards PLHA and AIDS orphans.

Here once again high school students' score for stigma and discrimination score inform us their stand against it. In other words they were found to be non stigmatic and non discriminatory towards the victims of the disease in general. For this variable the grade

level difference was negligible, but still female students were found to be more considerate than male students. The variation was significant at alpha 0.05 which point out females' superior achievement for stigma and discrimination items.

The madrasa students observed mean score has denoted their undesirable behavior in relation to stigma and discrimination. In other words they were reported to be stigmatic and discriminatory. For some cases, their tendency to avoid the victims seemed more serious. In the interview and FGD the participants affirmed the results obtained from questionnaire. Thus the stigmatic behavior was observed in all source of information.

Hence the overall mean comparison of madrasa and high school students score showed significant variation between the two groups. That is high school students were found to have better understanding about the problem of S&D, whereas madrasa students still have negative perception and hence discriminate the victims of the disease.

The result of prevention strategy for high school and madrasa students was found to be in a good condition. I.e. both groups' over all performance regarding the items were greater than the expected mean. When we compare grade 9 and 10 students, the latter scored significantly better than the former. The variation between female and male students was found to be non significant. This is to say that the perception of the two groups towards the prevention strategy was almost similar and positive. The mean comparison for madrasa and high school students gave a significant difference between the two major subjects of the study. Thus, madrasa students scored a mean of 33.11 which was greater than that of high school students (29.83). The conclusion for the result obtained was that madrasa students have more positive attitude towards the Islamic approach to prevent and control the virus from bringing further damage on the society. The focus group discussion participants from both groups strongly advocate the implementation of this method.

The overall performance of high school students expected role items indicated the maturity of their understanding in relation to the responsibility they shoulder. They have got an observed mean which is greater than the population mean. The FGD and interview result also clearly indicated the feeling of responsibility that the students

harbour in giving care and support, creating awareness among the mass and concern for AIDS orphans, to be satisfactory. As usual the feeling of responsibility among girls was significantly better than that of their counter parts and there were no difference across grade level comparison.

The responsibility feeling of madrasa students was found to be poor or unsatisfactory. During FGD session most of the participants expressed that they never attended any gathering related to HIV/AIDS. Most of them had never seen any person infected by the virus. They believed that their responsibility is to give advice for the infected person if they face him/her. Some others prefer to keep away from such discussion and were not comfortable at the time of discussion. In general the overall attitude of this group towards the disease indicated the absence of sympathy to the infected peoples. This was affirmed by them during FGD session.

As to the relationship among variables there was a strong and positive relation ship. Above all we have observed the influence of respondents' attitude towards the victims to be stronger over stigmatic and discriminatory behavior. Generally speaking the result of this study showed the interdependence of the variables studied with the exception of the prevention strategy proposed by Islam.

Recommendation

As it was clearly observed from the findings there is a gap in all aspects of the pandemic in relation to knowledge, attitude, stigma and discrimination and for other variables too. Generally in order to fill the gap regarding awareness of madrasa students as well to make high school students fully aware, additional concern is required.

For high school students it could be enough to teach the already ready made books in further details. But the madrasa students need urgent intervention to develop their level of awareness about the virus, to shape their attitude towards PLHA, and AIDS orphans, stigma and discrimination as well as to increase their responsibility feeling. Probably the school in which they are learning modern education could serve as the center for teaching about the reality of AIDS.

For the madrasa students, teaching their teachers (Sheikhs) will have a great contribution. Both the students and the Sheikhs are the opinion makers of the society. Thus enough

attention should be given to them at its top priority. Repeated open discussion with these religious leaders must be adjusted.

In order to improve the madrasa students' attitude the correct Islamic conception of the disease should be thought using different stages. Indeed this can be done by the Ethiopian Muslim Scholars Association (Ulema council). Consecutive workshop, symposiums as well as discussion stages should be prepared. In this regard the Supreme Counsel should have to play the major role in coordinating and organizing such programs. In fact every body who have concern with HIV/AIDS should take in to consideration of the role of theses people as they are the most influential group of he society. They can be a good asset in the prevention and control of the spread of the disease if they properly understand the nature of the problem and its danger on our society. Thus special emphasis is immediately required for madrasa students by all concerned agents.

But the present study obviously did not represent all madrasa and high school students from every corner of the country due to many limiting factors. Thus we can not generalize the research result for all Muslim students living in the country. In order to have clear and objective information about their status in relation to the disease further studies are strongly needed so that it will be clear where the exact area of interventions is.

Reference

1. Abdalati Hammudah (2003): Islam in Focus. Dar Al-Elm Printing and Publishing Co. K.S.A. Jeddah.
2. Abdella Yusuf Ali (1946) the holly Qur'an Text, Translation and Commentary. Qatar Printing press
3. Abdel Halim Mustafa (2003). [http://www.islamonline.net/English/News/2003-12/01/article 08..shtml](http://www.islamonline.net/English/News/2003-12/01/article%2008.shtml).
4. AbdulHamid Siddique (1983), selection from Hadith and edition, Islamic book publishers Sufat Kuwait
5. AIDS update (2000). An annual overview of AIDS. University of North Florida, Jacksonville
6. Alemayehu Bishaw (1997). Evaluation of Relevant the Elementary School. Second Phase curriculum in developing students' knowledge
7. Bedri, Malik (2000): AIDS Crisis: A Natural Product of Modernity's Sexual Revolution, 3rd ed., Medeena Books, Kuala Lumpur, Malaysia.
8. Beyene Petros (1997), "AIDS and college students in Addis Ababa: a study of knowledge, attitude, and behavior", Ethiopian Journal of Health Development, 2, 4:115-123
9. Bukhari, Muhammad ibn Ismail (1996). The English Translation of Sahih Al Bukhari with the Arabic Text, trans. Muhammad Muhsin Khan, 9 vols. Alexandria, VA: al-Saadawi Publications.
10. Castells, M. 1996. The Network Society. Oxford: Blackwell Publishers, Inc
11. ———. 1997. The Power of Identity. Oxford: Blackwell Publishers, Inc.
12. ———. 1998. End of Millennium. Oxford: Blackwell Publishers, Inc.
13. Castro, R. et al. 1998a. "Family responses to HIV/AIDS in Mexico," Social Science and Medicine 47(10):1473-1484.
14. CDC Path finder, 1995. HIV/AIDS and college students
15. Dagen Admasu (1999), Sexual Behavior Associated Problems and Risk Factors Among High School Students in Jimma. Unpublished MA thesis AAU.

16. Daniel, H. and R. Parker. 1993. *Sexuality, Politics and AIDS in Brazil*. London: Falmer Press
17. Esack, Farid (1999). *On Being a Muslim – Finding a Religious Path in the World Today*. Oxford: One world
18. El-Awady, Nadia (2002): *AIDS: Stigmatize or Show Mercy*. In Islam Online; Health and Science Edition.
19. Eyob Lema (2000). *Predictors of HIV/AIDS Related Sexual Behavior of High school Adolescents Based on the Classical Health Behavior model*. Jimma Town (unpublished MPH thesis)
20. Ellison, C. G., & Levin, J. S. (1998). The religion-health connection: Evidence, theory, and future directions. *Health Education and Behavior*, 25(6), 700–720
21. Fatuma Habib (2005). *Problems of orphans children and their mitigating mechanisms with in the Muslim community: the case of Awelia Children's Home (AA)* Unpublished senior essay. AAU
22. FGAE (1998). *A base line survey report on knowledge, attitude and practice of sexuality and reproductive health among Jimma youth, research and evaluation unit, A.A.*
23. Gayle, H. D., & Hill, G. L. (2001). Global impact of human immunodeficiency Virus and AIDS. *Clinical Microbiology Reviews*, 14(2), 327–335.
24. Gray, Peter B. (2004): 'HIV and Islam: Is HIV Prevalence Lower among Muslims?', In *Social Science and Medicine*, 58: 1751-6.
25. , L. et al. 2001. *Making a Difference for Children Affected by AIDS: Baseline Findings from Operations research in Uganda*. Washington, DC: Population Council.
26. Gostin, L.O. and Z. Lazzarini. 1997. *Human Rights and Public Health in the AIDS Pandemic* New York: Oxford University Press.
27. Hailegnaw Eshete (1996). *The Programme of HIV/AIDS in Ethiopia*. *Ethiopian Journal of Health* vol.10.3
28. Hanu, S.(2000).*Disability and persons with disabilities in Ethiopia: Definition of terms, statistical information and Rational for attitude change* Addis Ababa Ministry of Education

29. Hubley, John (2002): The AIDS Handbook: A Guide to the Understanding of AIDS and HIV, 3rd ed. fully revised, Macmillan Publishers Limited.
30. Ibrahim Yemer Assen (2006). A comparative study of knowledge, attitude and practice about HIV/AIDS and VCT among Defense University Students. Unpublished MA thesis AAU
31. Irfan, Hwaa (2001): AIDS and Circumcision. Unknown publisher
32. Jacksonville, AIDS up date (2000): annual overview of acquired Immune Deficiency
33. Kegeles, S.M. et al. 1989. "Perceptions of AIDS, the continuing saga of AIDS-related stigma," AIDS 3(suppl.1):S253-S258
34. Kelley, LM; Eberstadt, N. Behind the veil of a Public health crisis: HIV/AIDS in the Muslim world. NBP Special Report: The National Bureau of Asian Research. 2005
35. Kelly, M.J. (2001) Challenging the challenger: understanding and expanding the response of Universities in Africa to HIV/AIDS. Lusaka: working group on higher education
36. Kirp, D.L. and R. Bayer (ed.). 1992. AIDS in the Industrialized Democracies. New Brunswick, NJ:
37. Manuel, C. et al. 1990. "The ethical approach to AIDS, a bibliographical review," Journal of Medical Ethics 16:14-27.
38. Memoona Hasnain (2005); Cultural Approach to HIV/AIDS Harm Reduction in Muslim Countries
39. MOH, (2004). AIDS in Ethiopia. A disease prevention and control department AA
40. _____(2003). National HIV/AIDS counseling training manual. January, 2003 AA
41. _____ (2002). AIDS in Ethiopia, fourth edition, disease prevention and control department.
42. Muhammad ibnu Issa (Tirmizy) (latest publication, 19994) Sunan atTirmizy (Arabic) Darul Fiker publisher.

43. Muahmmad ibnu Mazyd (ibnumajah) (latest publication, 19994) Sunan ibnu Majah (Arabic) Darul Fiker publisher
44. Muhammad, Najma (2005): Tackling AIDS Through Islam? Cape Town, South Africa
45. Muhammad Zafeeruddin Nadvi (1987). Modesty and chastity in Islam. Islamic Book Publisher Kuwait
46. Muslim Ibnu Hajaj Ibnu Muslim (2000). Sahih, trans. Abdul Hamid Siddiqi, 4 vols. New Delhi: Kitab Bhavan
47. Mustefa Reshid (2005), Knowledge and Attitude of Factory Workers towards Voluntary Counseling and Testing for HIV: the case of Wonji-Shoa Sugar Factory. Unpublished MA thesis AAU
48. Oyziwo, (2005). HIV/AIDS knowledge, attitude and belief among university of Botswana undergraduate students. <http://www.nesu.edu/nesu/aern/aids.htm/>
49. . PANOS. 1990. The 3rd Epidemic: Repercussions of the Fear of AIDS. London: Panos Institute
50. Parker, R. 2000. "Administering the epidemic: HIV/AIDS policy, models of development and international health in the late-twentieth century," in Globalization, Health and Identity: Lynne Rienner Publishing, pp. 39-55.
51. Parker R.G., D. Easton, and C. Klein. 2000. "Structural barriers and facilitators in HIV prevention
52. Piot, P. 2000. Report by the Executive Director. Programme Co-ordinating Board. Joint United Nations Programme on AIDS. Rio de Janeiro. 14-15 December.
53. Positive Muslims (2004): HIV, AIDS and Islam: Reflections Based on Compassion, Responsibility and Justice, Positive Muslims Organization, Cape Town, South Africa.
54. . Rakwar, J., Lavreys, L., Thompson, M., Jackson, D., Bwayo, J. & Hassanali, S., et al. (1999). Cofactors for the acquisition of HIV-1 among heterosexual men: Prospective cohort study of trucking company workers in Kenya. AIDS, 13(5), 607-614.
55. Richter D.L., 1994. HIV/AIDS knowledge and attitude among university students in Seraleon. Aegis.com/iad 1994/PDOSS

56. Semahgn Mengistu (2004), knowledge, attitude and behavior of hearing impaired young people about sexual and reproductive health issues
57. Shiek Salman Al-Awudah (2005). Social responsibility in Islam
(<http://www.islamtoday.com>)
58. Sigmon, M. Africa. Mission Network News. Delivered at the International Coalition for Religious freedom Conference on Religious Freedom and the new millennium. 2004. <http://www.pubmedcentral.gov/redirect3>.
59. Simkins, L. and Hendick, c. (1987), "attitude towards AIDS, Herpens and Toxic Shock syndrome: two years later: "Psychological report . vol 59 (9), 88-89
60. Solomon G.(1990). Sexual Behavior and Knowledge of AIDS and Other STDS on High School Studetns. Ethiopian Jorunal of Health Development, 4(2), 123-131
61. Sudan National AIDS Control Program, 2004c.
62. Suleyman ibnul Ashass (abuDaud) (latest publication, 19994) Sunan AbiDaud (Arabic) Darul Fiker publisher
63. Tedla Diressie (2005), stigma and discrimination against AIDS orphans in Addis Ababa and Awassa. Unpublished MA thesis AAU.
64. Tefera Belachew (2001). Knowledge, attitude and practice about HIV/AIDS and VCT among students of Jimma university, Ethiopian Journal of Health Science vol.14 special issue pp, 43-52
65. Tirusew Tefera (200) Human Disabilities: developmental educational psychological principles . AAU.
66. Tilahun T.(1993). College Students' Attitude and Knowledge of AIDS. Ethiopina Journal of Medical Journal 31(4), 233-237
67. Tomasevski, K. et al. 1992. "AIDS and human rights," in AIDS in the World, ed. J. Mann, D.J.M. Tarantola, and T.W. Netter. Boston, MA: Harvard University Press.
68. USAID (2000),. Policy project Ethiopia: community and personal perception of Risk and vulnerability to HIV/AIDS, AA. Future group international and united management constants. Science vol.58 no.3 march 2004. pp.95-108.
69. USA .Public Media Center 1995

70. UNAIDS, (2005). AIDS in Africa. Three scenarios to 2025
71. UNAIDS, UNICEF, USAID (2004) children on the Brink of a joint report of new orphan estimates and framework for action.
72. UNAIDS, (2006), overview of the global AIDS Epidemic (Report on the Global AIDS Epidemic)
73. Warwick, I. et al. 1998. "Household and community responses to AIDS in developing countries," Critical Public Health 8(4):291-310.
74. UNESCO (2005), annual report on global AIDS <http://portal.unesco.org>
75. Wondwossen kebde (1998) The Attitude and Practice of Adolescent Students about HIV/AIDS. Senior Essay AAU, Addis Ababa (unpublished)
76. <http://www.islamonline.net/English/family/2005/02/article07>.
77. <http://www.irrinnews.org/AIDS> report, November 13, 2006
78. <http://www.medicalnewstoday.com/medicalnews.php?newsid>
79. <http://www.coreinitiative.org/News>, 2005
80. <http://www.positiveMuslims.org> 2004
81. <http://www.erasianetpartner> , 2004

Appendix I

Addis Ababa University

Department of Psychology

The objective of this questionnaire is to collect information regarding HIV/AIDS among Muslim students of both traditional and modern education centers in Addis Ababa

To indicate your reaction to the statements

Dear respondents:

You are kindly requested to give your genuine response for each statement. In responding the questionnaires please follow the instructions bellow

1. Since every respondent give their opinion for each statement based on their experience and/or understanding, there is no right or wrong response to any of these statements.
2. The information provided will be kept confidential and no one will be affected by it. For this reason your name and specific address should not be written in any place in the questionnaire.
3. To indicate your reactions to the statements here are the following scale and check mark () in the box of the appropriate letter corresponding to the statement.

SA = strongly agree

AG = agree

DA = disagree

SD =strongly disagree

Please respond all the items.

No	Items	SA	AG	DA	SDA
1	There should be special classroom for HIV positive students				
2	Prostitutes deserve the HIV punishment				
3	I prefer to sit with HIV negative student rather than positive one.				
4	Helping him/her self is the responsibility of the career				
5	It is not correct to give care and support for infected prostitutes				
6	I should threat AIDS orphans as my own brothers and sisters				
7	I would never shake the hands of a positive people if I know his positives ness				
8	I do have no mercy for those people who got HIV from their homosexual behavior				
9	Islam doesn't order us to give care and support for AIDS patients				
10	Teaching about HIV/AIDS is definitely my responsibility				
11	I can not feel comfort to eat with HIV positive friend				
12	I can not help AIDS orphans as they are the offspring of promiscuous people				
13	AIDS is the problem of poor countries only				
14	AIDS patients are transgressors of Allah's border				
15	AIDS should be thought in mosques and madrasas				
16	To give love and affection for PLHA is one of the righteous deeds in Islam				
17	AIDS is not the problem of Muslim societies				
18	Organizations should have the right to fire employees if they have AIDS				

19	AIDS is the problem of commercial sex workers				
20	I don't have to worry about AIDS patients				
21	I must openly discuss with anyone about the risk of HIV/AIDS				
22	AIDS is not my problem				
23	In Muslim countries like Saudi Arabia and Iran AIDS is not a problem.				
24	I feel shame on to speak about condom				
25	Night clubs must be closed as they are the center of trial for the youth				
26	Indeed AIDS is a punishment for promiscuous behavior				
27	Marriage can serve as a preventive strategy for HIV transmission				
28	I will never take un tested blood though I am in dare need of it				
29	AIDS is the issue of immoral people				
30	People regularly keep prayer are not susceptible to HIV risk				
31	Women proper dressing is very important mechanism to halt the HIV danger				
32	PLWHA. are hopeless people as they can not live longer				
33	Those youngsters who fast can control their lust feeling				
34	Avoiding extramarital sex is the best way to defend HIV transmission				
35	Intoxicants and alcohols do have significant contribution to HIV transmission				
36	AIDS orphans are the burden over the society				
37	pornographic films and theaters aggravate HIV transmission				
38	I don't want to hear any thing in relation to HIV/AIDS				

39	Cooperating with those who try to halt HIV transmission is my Islamic obligation				
40	I do have no responsibility for PLWHA				
41	It is my responsibility to fight against HIV/AIDS				
42	Giving care for AIDS orphans may encourage promiscuous people to be more careless				

Attitude items = 2,5,8,14,20,22,26,29,32,36,38,40,42

Stigma and Discrimination items = 1, 3, 7, 11, 13, 17, 18, 19, 23

Islamic prevention strategy items = 24, 25, 27, 28, 30, 31, 33, 34, 35, 37,

Expected role items = 4,6,9,10,12,15,16,21,39,41

Knowledge measuring questions

Please answer the following questions by making the sign ✓ on the space provided

No	Questions	Response		
		Yes	No	I don't know
1	Mosquitoes, louse and mice don't transmit HIV			
2	Curable vaccine is available though it is very expensive			
3	Using public toilet may be dangerous because it may cause HIV			
4	I can recognize HIV positive peoples just by looking towards their appearance			
5	AIDS do not capture old people			
6	A baby from HIV positive mother surly be HIV positive			
7	Condom never protect HIV/AIDS			
8	Serious coughing, sneezing and using the same spoon and glass transmit HIV			
9	Sleeping together with AIDS patients cause HIV			
10	HIV do not transmit among homosexuals (from male to male or female to female)			
11	HIV positive peoples can not live more than 3 years			
12	AIDS is only a sexually transmitted disease			
13	Using drug with injection does not have any relation with HIV transmission			
14	HIV can be transmitted through saliva and sweat contact			
15	AIDS never transmit from the mother's milk to her child			

Thank you, in advance

Unstructured interview guide items

1. Can you mention some activities of your organization in relation to HIV/AIDS?
(to the counselor only)
2. Can you tell about HIV/AIDS and its major means of transmissions?
3. What are the major preventive methods?
4. What do think about the current situation of HIV/AIDS in Ethiopia?
5. Do you think HIV to be the problem of Muslims?
6. What do you feel about the AIDS orphans?
7. Do you have clear conception about stigma and discrimination in relation to HIV/AIDS?
8. Have you ever done something to defend the spread of HIV/AIDS
9. Do you have any occasion that you helped a PLHA?
10. What was your response when you saw the AIDS patient at first?
11. What should be Muslims response towards HIV/AIDS?

Focus group discussion guide items

1. Can we say that HIV/AIDS is the problem of promiscuous people?
2. What is the cause of HIV/AIDS transmission
3. Should AIDS patients be avoided from the day today activities
4. How do you see the Islamic prevention methods which focus on previous steps
(avoiding any possible occasion that leads to extramarital sex)
5. What should be done to defend the spread of the disease
6. What is your role as Muslim?

ተ.ቁ	ጥያቄ	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም
1	የወጣት ጥያቄ ቁጥር	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም
2	የወጣት ጥያቄ ቁጥር	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም
3	የወጣት ጥያቄ ቁጥር	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም
4	የወጣት ጥያቄ ቁጥር	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም
5	የወጣት ጥያቄ ቁጥር	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም
6	የወጣት ጥያቄ ቁጥር	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም
7	የወጣት ጥያቄ ቁጥር	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም
8	የወጣት ጥያቄ ቁጥር	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም
9	የወጣት ጥያቄ ቁጥር	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም
10	የወጣት ጥያቄ ቁጥር	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም
11	የወጣት ጥያቄ ቁጥር	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም
12	የወጣት ጥያቄ ቁጥር	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም
13	የወጣት ጥያቄ ቁጥር	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም
14	የወጣት ጥያቄ ቁጥር	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም
15	የወጣት ጥያቄ ቁጥር	የሰነድ ቁጥር	የሰነድ ቀን	የሰነድ ስም

መመሪያ 1 የሚከተሉትን ጥያቄዎች በተሰጠው ክፍት ቦታ ላይ የ ራይት ምልክት (✓)

አድራሻ ----- የት/ት ደረጃ ----- ጾታ ወንድ ----- ስም ----- ት/ቤት -----
 ነው፡ መዋገድ ተቀባይ የሆኑትን ስሞች በሰነድ መመሪያዎችን በሰነድ መመልከት
 አድራሻዎችን ማረጋገጥ አለባቸው፡፡ ሌሎች ስሞች ላይ ጥናትና ምርመራ ማካሄድ ሀሳብ ሊሰጥ
 መሆኑን ማረጋገጥ አለባቸው፡፡ ስሞች ላይ ማረጋገጥ አለባቸው፡፡ ስሞች ላይ ማረጋገጥ አለባቸው፡፡

ጥላላ

በአዲስ አበባ የሚገኝ
 የድህረ ምረቃ ትምህርት መርኅ ግብር
 የትምህርት ላይክሎጂ ክፍል

ተ.ቁ	ዓረፍተ ነገር	በእስ	እስ	አልስ	በአልስ
1	ኤች አይቪ ለያዛቸው ተማሪዎች ልዩ የመማሪያ ክፍል መዘጋጀት ይኖርበታል				
2	ለሴተኛ አዳሪዎች ኤች አይቪ እንደቅጣት ተገቢያቸው ነው				
3	ኤች አይቪ ከያዘው ተማሪ ይልቅ ካልያዘው ተማሪ ጋር መቀመጥ እመርጣለሁ				
4	ኤች አይቪ የያዘው ሰው እራሱን መንከባከብ የራሱ ሀላፊነት ነው				
5	በኤድስ የተያዙ ሴተኛ አዳሪዎችን መንከባከብና መርዳት ተገቢ አይደለም				
6	በኤድስ ወላጆቻቸውን ያጡ ህጻናትን እንደራሴ ወንድሞችና እህቶች መንከባከብ ይኖርብኛል				
7	በኤችአይቪ መያዙን ያወቅኩትን ሰው እጅ በፍጹም አልጨብጥም				
8	በግብረሰዶማዊነታቸው (ሊዋጥ) ምክንያት በኤድስ ለተያዙ ሰዎች ምንም ርህራሄ የለኝም				
9	ለኤድስ ህመማን ድጋፍና እንክብካቤ እንድናደርግ ኢስላም አያዘንም				
10	ስለኤድስ ማስተማር በርግጥ የኔ ሀላፊነት ነው				
11	በኤድስ ከተያዘ ጓደኛዬ ጋር አብሮ መብላት ምቹት አይሰጠኝም				
12	በኤድስ ወላጆቻቸውን ያጡ ህጻናት የሴሰኛ(ባለጌ) ሰው ልጆች ስለሆኑ ልረዳቸው አልፈልግም				
13	ኤድስ የድሀ ሀገሮች ችግር ብቻ ነው				
14	የኤድስ ህመማን የአላህን ወሰን የጣሱ ናቸው				
15	በመስጊዶችና መድረሳዎች ስለኤድስ ትምህርተ መሰጠት ይኖርበታል				
16	ለኤድስ ህመማን ድጋፍና እንክብካቤ ማድረግ በኢስላም ከሚወደዱ በኋላ ስራዎች መካከል ነው				
17	ኤድስ የሙስሊሞች ችግር አይደለም				

18	ድርጅቶች በኤድስ የተያዙ ሰራተኞችን የማባረር መብት ሊኖራቸው ይገባል				
19	ኤድስ የሴተኛ አዳሪዎች ችግር ብቻ ነው				
20	ስለኤድስ ህመማን መጨነቅ አይኖርብኝም				
21	ስለኤድስ አስከፊነት ከማንኛውም ሰው ጋር በግልጽ መወያየት አለብኝ				
22	ኤድስ የእኔ ችግር አይደለም				
23	እንደ ሳውዲያሪያና ኢራን ባሉ መስሊም ሀገሮች ኤድስ ችግራቸው አይደለም				
24	ስለኮንዶም መወያየት ያሳፍረኛል				
25	የምሽት ዳንስና ጭፈራ ቤቶች ወጣቶችን ስለሚፈታተኑ መዘጋት ይኖርባቸዋል				
26	ኤድስ ለሴቶች (ዝመታ) ባህሪ የመጣ ቅጣት ነው				
27	ጋብቻ የኤች አይቪን ስርጭት ለመግታት አማራጭ መንገድ ሆኖ ያገለግላል				
28	ያልተመረመረን ደም የቱንም ያህል ቢያስፈልገኝ አልወስድም				
29	ኤድስ ግብረገብነት የሌላቸው ሰዎች ጉዳይ ነው				
30	ሰላታቸውን በወቅቱ የሚሰግዱ ሰዎች ለኤችአይቪ አይጋለጡም				
31	ሴቶች በተገቢው መንገድ መልበሳቸው ኤድስን ለመከላከል አስፈላጊ እርምጃ ነው				
32	ከኤችአይቪ ኤድስ ጋር አብረው የሚኖሩ ሰዎች ረዥም እድሜ ስለማይኖሩ ተስፋቢሶች ናቸው				
33	ጾም የሚያዘወትሩ ወጣቶች ስጋዊ ስሜታቸውን ለመቆጣጠር ይችላሉ				
34	ከጋብቻ ውጪ የግብረሰጋ ግንኙነት አለመፈጸም ኤድስን ለመከላከል ብቸኛው መንገድ ነው				
35	የአልኮል መጠጦች ኤችአይቪን በማስፋፋት ረገድ ጠንከራ አስተዋጽኦ አላቸው				