Extent of Community Participation in Prevention & Control of HIV/AIDS in Akpulu, Imo State, Nigeria

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Introduction and literature review

HIV/AIDS place a huge burden on the health and national development of Sub-African nation and Nigeria is not left out. Apart from being a public health concern, it is a threat to national security, affecting and disturbing social and economic order as well as putting national survival at stake. The fight against AIDS has been given top priority by the Nigerian Government and a multi-sectoral approach to fight the problem. (United National AIDS Survey, 2008). Although various intervention programmes such as President Emergency Plan For AIDS Relief (PEPFAR), United State AIDS Intervention Programme to halt AIDS transmission, National Action Committee on AIDS (NACA) and the HIV/AIDS Emergency Action Plan developed in 2001 have been established to fight the spread of HIV/AIDS and regardless of the increase funding, political commitment and progress in expanding HIV/AIDS treatment, HIV/AIDS has output the global response.

According to USAID (2012) on global AIDS epidemic report, Nigerian represents about 50% of HIV infection worldwide having the largest number of people living with HIV with following statistics on HIV prevalence rate: among adult age (15-49 years) 3.1%; Adults and children living with HIV at the end of 2007 being 2.6 million; AIDS related deaths for both adult and children in 2007 as one hundred and seventy (170) and AIDS orphans were one hundred and twenty (120); with some states having as high as 12% while some as low as 1.2%. In some states (Benue, Imo, Delta etc) the epidemic is more concentrated and is driven by behaviour while others have been more generalized epidemics that are sustained primarily by multiple sexual partnerships in the general population, which is common in Nigeria youth and young adults with young women being at higher risk than men (USAID, 2012). In addition, the fight against HIV/AIDS has attracted much attention from the Nigerian Government and the importance of handling the problem in a multi-sectoral approach has been recognized. Participation of Non-Governmental agencies in AIDS control and prevention is encouraged. Community participation seems to be giving little or no attention. Rural areas have always been a major challenge for disease control world-wide, but involvement and active participation of communities have been identified as a key factor for success in rural communities (Opiyo, Mukabana, Kiche, Kotten, Mathenge, Killeen &Fillenger, 2007).

Community participation as defined by Vincent (2012) is the process by which individuals and families assume responsibilities for their own health and welfare and for those in the community. Community participation has helped development. By knowing the community better, community members are motivated towards solving their own problems because they will become agents (participants) of their own development. Akinlami, (2007) affirmed that there are certain ways through which individuals can participate in health care matters. Such ways include: providing labour, money or materials, and working along with government personnel among others.

A dual help in organization of health functional programmes like immunization, providing selected health care workers from the community, building health centres, cottage hospitals and health institutions, constructing roads and bridges to facilitate movement of health care personnel as well as communication, identifying real health care needs, planning, implementing and evaluating health programmes, participating in health decision making and the existence of effective mechanism for people to express demands and needs, preparing relevant information that will increase literacy and the development of the necessary institutional arrangements which will help individuals, families and communities assume responsibilities for their health and well-being, defining community health problems and priorities, contributing labour, finance and other resources, promoting self-reliance and social awareness and so on.

Cellhorn and Fulop (2007) outlined the advantages of community participation as: accomplishment in health maintenance and promotion; providing service at lower cost; participation has an intrinsic value for population groups; it is a catalyst for development efforts; participation leads to a sense of responsibility for a health project; guarantees that community felt needs are taken care of; ensures that things are done the right way; it uses indigenous knowledge and expertise; it is a starting point for con-scientization, as a result, primary health care strategies are based on effective community participation.

Akinlami (2007) noted that community participation in HIV/AIDS programme has been hampered by the following: lack of finance; community conflict; poor administrative framework; insufficient supply of skilled and experienced field workers and change agents: poor administrative resources; poor attitude of planners; administrators and community members towards self-help. Akinlami also emphasized that communities need to identify AIDS as a service health problem that needs utmost attention if they are to participate in partnership with Government, NGOs and community base organizations (CBOCs) in developing and implementing actions that will halt the spread of HIV/AIDS in the communities.

Vincent (2013) equally affirmed that communities have been seen as key factors to success of any disease control programme. Often community participation has been interpreted to mean mobilization for government resources of money, labour and materials for government planned and controlled programmes.

The organizations that can promote community participation include: The RED Cross; Save The Children Fund; Rotary Club; Oxford Committee For Famine Relief; Alcoholic Anonymous; Young Men Christian Association (YMCA); Boy's Brigade; World Council of churches and United Nations Organization (Demehin, 2008) among others.

HIV/AIDS can be controlled and prevented at the grass root level; this can be done by considering the socio-economic and cultural contact of the community. Emphasis on community based strategies peculiar to the community must be made. In specific terms, communities can participate in the control of HIV/AIDS by creating awareness on HIV/AIDS, promoting control practices, AIDS treatment seeking behaviour and support; as well as care for AIDS victims. Success in any of these control programmes depend on a greater extent of community participation in HIV/AIDS prevention and control in Akpulu, Ideato North L.G.A, ImoState.

Research questions

Two research questions guided this study:

i. What is the extent of community participation in creating HIV/AIDS awareness in Akpulu?
ii. What is the extent of community participation in HIV/AIDS promoting control practices in Akpulu?

Methodology

The design adopted for the study was survey research design to examine the extent of community participation in HIV/AIDS prevention/control in Akpulu, Ideato North Local Government Area of Imo State. Ejifugha (2008) defined survey design as a research style of finding out the current status of a phenomenon from a population who should supply the required information and to whom the information is generalized. A sample survey is the fraction of population (Vincent, 2013). The researcher adopted the sample survey because it helps in obtaining relevant information about the issue being treated. Also Xiaohui&Yukai (2014) used survey research design to ascertain the effectiveness of school-based education on HIV/AIDS in India. This justified the use of similar design inn a study of similar nature.

Accessible population of the study consisted of an estimatedthree thousand two hundred and thirty four (3234) adults from the four randomly drawn villages from the five (5) existing villages in Akpulu. Using the "rule of thumb" (Rick, 2006), the sample for the study consisted of three hundred and twenty three (323) adults i.e. 10% of the estimated population drawn from the four villages. Multi-stage which is a form of cluster sampling procedure was adopted for the study. During the first stage, four villages were drawn from the five existing villages through simple random sampling technique. By balloting with replacement, each of the villages was given equal opportunities of being drawn. In the second stage, sixteen kindred were selected, four kindred from each village. Then using cluster sampling, five families each was used in each of the four kindred of the study thus making a total of eighty families/houses from each village. Adults from the families were interviewed.

The main instrument for data collection was a structured interview schedule. The instrument was made up of two sections (A & B). Section A contained four patterned questions that answer the extent of community participation in creating awareness while Section B contained thirteen questions that expose the extent of community participation of HIV/AIDS in prevention and control. The questions were close ended and patterned into four (4) - point scale of very often, often, rarely and not at all. The point scale were ranged between (70-100) was rated high (69-50) moderate, (44-40) low, and below (40) very low. The data collected were analyzed manually using mean deviation. A mean score of below 2.5 was considered low extent, a mean score of 2.5 - 3.49 was considered moderate extent while a mean score of 3.5 and above were considered high extent.

A total number of 323copies of the questionnaire were distributed a copy got lost and two were incorrectly filled which gave a return rate of 99.1%. Based on this return rate, the responses were tailed and put into frequency distribution tables and analyzed manually using mean deviation.

The presentation of result was organized using the research questions of the study.

Section A

What is the extent of community participation in creating HIV/AIDS awareness in Akpulu?

Table 1. Mean Responses of community participation in HIV/AIDS awareness

S/N	ITEM	VERY OFTE	OFTEN	RARELY	NOT AT ALL	MEAN	DECISION
1.	Mounting of billboards on the road	60	70	100	90	2.31	Low
	Mounting of posters in (a) Churches	84	77	80	79	2.51	Moderate

	Market places	50	77	101	92	2.27	Low
	Town union halls	40	60	115	105	2.11	Low
	Village halls	20	30	130	140	2.00	Low
3.	Use of local languages to create HIV/AIDS awareness for:						
	Market men & women	69	67	89	95	2.34	Low
	Age grade members	66	61	96	97	2.30	Low
	Town union members	8	75	121	116	1.92	Low
	Kindred members	4	60	115	141	1.77	Low
	Church members	118	90	64	48	2.81	Moderate
	Youth members	80	82	78	80	2.51	Moderate
	Village members	80	87	77	76	2.53	Moderate
4.	Use of resource persons to create awareness on HIV/AIDS in:						
	Town union meetings	32	50	118	120	1.98	Low
	Youth meetings	50	68	103	99	2.22	Low
	Church meetings	70	102	98	50	2.60	Moderate
	Kindred meetings	38	62	67	153	1.93	Low
	Village meetings	40	90	89	101	2.22	Low
	Grand Mean					**2.25**	**Low**

Section B

What is the extent of community participation in HIV/AIDS promoting control practices in Akpulu?

Table 2. Mean responses of community participation in HIV/AIDS prevention practices

S/N	ITEM	VERY OFTEN	OFTEN	RARELY	NOT AT ALL	MEAN	DECISIONS
1.	Advising unmarried member from premarital sexual	122	101	69	28	2.99	Moderate

	activities						
2.	Advising married adults from extra marital sexual activities	64	61	98	97	2.29	Low
3.	Emphasizing abstinence from sexual intercourse	40	60	120	100	2.13	Low
4.	Advising members to avoid unprotected sex	18	51	126	125	1.88	Low
5.	Advising members especially youths to avoid seductive environment	20	45	125	130	1.86	Low
6.	Encouraging members with HIV/AIDS to go for treatment	68	58	97	100	2.28	Low
7.	Emphasis on consistence use of condom	40	62	108	110	2.10	Low
8.	Insisting that members go for HIV/AIDS voluntary counseling and testing	28	75	110	107	2.17	Low
9.	Advising members to accept only screened blood	40	60	101	119	2.07	Low
10.	Advising members to desist from sharing skin piercing objects like razor blade, needles etc.	50	60	101	109	2.16	Low

11.	Placing laws against female circumcision, scarification and tattooing	62	61	119	78	2.33	Low
12.	Placing law against alcohol and drug use which contribute to HIV/AIDS high risk behavior	-	-	158	162	1.49	Low
13.	Minimizing disco parties which catalyzes sexual activities	8	42	100	170	1.65	Low
	Grand Mean					**2.11**	**Low**

Discussion of findings

Research Question 1 sought to ascertain the extent of community participation in creating HIV/AIDS awareness in Akpulu? Result from table 1 reviewed that the awareness is low in grand mean with a mean score of 2.25. The table shows moderate community participation in mounting of posters in churches, use of local languages to create HIV/AIDS awareness for church members, youth members and village members. The table also shows moderate community participation in use of resource person to create awareness on HIV/AIDS in church meetings. The table shows low community participation in mounting of billboards on the road, mounting of posters in market places, town union halls and village halls. Use of local languages to create HIV/AIDS awareness was low for market men and women, age grade members, town union members and kindred members. Also use of resource person to create awareness on HIV/AIDS was low in town union meetings, youth meetings, kindred meetings and village meetings. It is a welcome development that the community members can participate through use of local languages to create awareness for church members, youths and village gathering. This could be so because most CBOs target youths meeting, churches and village gatherings in HIV/AIDS awareness programme. Also National Action Committee on AIDS (NACA), 2006 conducted a study on effective practices in getting religious community committed and involved in the fight against HIV/AIDS in Umuahia, Abia State, Nigeria. The study turned out to be effective breakthrough as most church members became aware of HIV/AIDS. The findings of this study especially on moderate community participation in churches could be as a result of mandatory testing of HIV/AIDS to all intending couples before sacrament of marriage could be performed by the church leaders. Also community leaders could easily reach out to community members in churches, youth meetings and village gathering than any other place. The community members may consider that market may not be adequate to create awareness. Use of billboards and posters are effective tools of sending messages across. Fortunately, youth meetings are not

neglected in the target group area of community participation in AIDS awareness. This may likely be because this is a vulnerable group that needs HIV/AIDS awareness programme of their sexual activities.

For any community participation disease control programme to be successful and effective their awareness level must be high (Osoba, 2008 and Roodie, 2008). There is need for the community to have clear understanding of their health problem if effective community participation could be achieved.

Research Question 2 sought to ascertain the extent of community participation in preventing/controlling HIV/AIDS practices? Table 2 reveals that community participation in HIV/AIDS prevention and control is generally low with a grand mean score of 2.11. The table shows moderate participation for control of HIV/AIDS only on advising unmarried members from premarital sexual activities. There was absolute low participation on control/prevention of HIV/AIDS on placing laws against alcohol and drug use which contribute to HIV/AIDS high risk behaviour, advising members to avoid unprotected sex and minimizing disco parties which catalyze sexual activities. Low participation was also on insisting for periodic HIV/AIDS voluntary counseling and testing, advising members to desist from sharing skin piercing objects (like razor blade, needles etc), placing laws against female circumcision, scarification and tattooing. There was no emphasis on consistence use of condoms and abstinence from extra marital sexual activities. Community does not encourage infected members to seek for medical help through the use of antiretroviral drug therapy.

This does not go well for HIV/AIDS control. When individuals are not aware that they are HIV positive, control and prevention practices are jeopardize. Since they do not know they are positive and are thus unaware they are likely to transmit the virus to others. In the absence of an increase in HIV testing up-date, HIV infected persons would only become aware of their status when they become symptomatic, which can limit the potential benefit of antiretroviral treatment (UNAIDS, 2012).

If the community does not encourage positive treatment seeking behaviour of infected members, there is risk of infecting other members as well as shortening their lives. Antiretroviral drugs therapy is believed to improve general health and quality of life of HIV positive victims as well as increase survival time by between 4 and 12 years (Idu&Obinna, 2008). Antiretroviral drugs are free in Owerri, Imo State of Nigeria in Government hospitals. However, some of these centres are far from the rural communities (Akpulu). Community levels need to be more actively involved in treatment emphasizing abstinence, avoid sexual marital sex, multiple sex partners, delay in sexual debut as correct and consistent use of condom are the key behaviours that can present or reduce the likelihood of sexual transmission of HIV/AIDS. Low community participation in the area of avoiding seductive environment, seductive communication, and making laws against alcohol and drug use, female circumcision, tattooing, scarification as well as disco parties will increase spread of HIV/AIDS in the community. Bandura (2007) opined that alcohol, and drug use is creating a lot of problem in the environment in terms of sexual activities. If there are no sanctions or control on these activities particularly among youths, community effort in HIV/AIDS prevention may be jeopardized. Community participation in prevention/control practices must address these socio-cultural and environmental characteristics that may prevent individuals from HIV/AIDS infection. There is absolute need for positive action to check socio-cultural forms that might heighten the risk behaviours that expose the people to HIV/AIDS.

Conclusions

Based on the result, it was observed that the extent of community participation on HIV/AIDS awareness was low with a mean score of 2.25. Creation of awareness on HIV/AIDS by the communitywere low on mounting of billboards, posters in market

places, town unions and village halls alsoin the use of local languages in reaching market men and women, age grades, town unions and kindred members. Community participation in HIV/AIDS prevention/control is generally low with a mean score of 2.11. Community participation was only moderate on advising unmarried members from premarital sexual affairs. There was absolutely no emphasis on the use of protective device (condom) for sexual intercourse, HIV/AIDS voluntary counseling and testing and antiretroviral drug therapy for infected members.

Recommendations

Based on the findings the following recommendations were made:

1. There is need for Local, State and Federal Government to strengthen community actions by providing fund and technical support vis-à-vis sponsoring media programmes aimed at educating the general public on the ways of preventing and controlof HIV/AIDS.
2. Communities should come up with measures to control certain socio-cultural norms that predispose the people to high risk behaviours.
3. The communities, NGO's, CBO's and Government should target HIV/AIDS awareness and preventive programmes for unmarried members in the rural communities.
4. Empowerment programmes for People Living With HIV/AIDS (PLWHA) should be initiated in the communities with the help of community leaders.
5. Communities should encourage voluntary counseling and testing of every member of the community.
6. During August meeting, community members should organize health educators to sensitize and enlighten parents on the prevention/control of HIV/AIDS through talks and inter-active sessions.

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