COMMUNITY INVOLVEMENT IN THE CONTROL AND MANAGEMENT OF HIV/AIDS IN THE IMPLEMENTATION OF NATIONAL REPRODUCTIVE HEALTH PLAN IN PLATEAU STATE

BY

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DECLARATION

I hereby declare that this thesis entitled "Community Involvement in the Control and Management of HIV/AIDS in the Implementation of National Reproductive Health Plan in Plateau State" for the Award of Master's Degree in Health Education and has been written by me and is my research work in the Department of Physical and Health Education. Under the Supervision of Prof. K. Venkateswarlu. It has not been submitted elsewhere for the award of any higher degree on this topic. All sources of publications and other related studies cited in this research have been duly acknowledged through references.

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CERTIFICATION

This thesis titled "COMMUNITY INVOLVEMENT IN THE CONTROL AND MANAGEMENT OF HIV/AIDS IN THE IMPLEMENTATION OF NATIONAL REPRODUCTIVE HEALTH PLAN IN PLATEAU STATE" Banmang, Ezekiel Kumnah meets the regulations governing the Award of Master Degree of Education in Health Education (M.Ed) of Ahmadu Bello University, Zaria, and is approved for its contributions to knowledge and literary presentation.

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DEDICATION

This thesis is dedicated to God Almighty for His grace, mercy and guidance that He bestowed on me throughout the duration of this programme. It is also dedicated to my wife, Mrs. Orpha Kumnah Banmang and my children Miss Tongriyang Kumnah Banmang, Balami mBiplang Kumnah, Dorathy Kumnah Banmang and Katlibet Nathan Kumnah, who enjoyed with me the part of agonies and stress of both planned and unplanned journeys to and fro during the course of my Study.

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BANMANG, EZEKIEL, KUMNAH (BEK)

ABSTRACT

The study examined the community involvement in the control and management of HIV/AIDS in the implementation of national reproductive health plan in Plateau State. Community involvement, control and management constitute the dependent variables. While the demographic characteristics of age, gender, religion, marital status, location, ethnicity, educational qualification and income level constitutes the independent variables. As the information required to achieve this study was already available, ex-post facto research design (non-experimental) was used. In this design a questionnaire was developed and administered on a selected sample. The information thus collected was statistically analyzed to test the hypotheses of the study. Purposive sampling technique was used in each of the 3 voluntary counseling and testing centres of each senatorial district in the state. To achieve this study, a questionnaire with 43 statements in 3 sections was developed. A total of three hundred (300) subjects were selected at random from three (3) senatorial districts of Plateau State, to serve as the respondents (population) in the study. Out of the 300, 287 respondents returned their questionnaires. They included women group, religious and youth groups. The data thus collected was statistically analyzed using descriptive

statistics to test the hypotheses of the study in the involvement of the communities in the control and management of HIV/AIDS. The results are revealed below:

1. The involvement of communities in plateau state in the control of HIV/AIDS was not significant.
2. The involvement of communities in plateau state in the management of HIV/AIDS was not significant.
3. The involvement of communities in the different senatorial district of the state in their control of HIV/AIDS was not significant.
4. The involvement of communities in the different senatorial districts of the state in their management of HIV/AIDS was significant.

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LIST OF ABBREVIATIONS

AHRTAG: Appropriate Health Resources and Technologies Action Group.

AIDS: Acquired Immune-deficiency Syndrome.

ANC: Antenatal Clinic/Care.

ARH: Adolescence Reproductive Health.

BACA: Bedroom Action Committee on AIDS.

CHEWs: Community Health Extension Workers.

CODESRIA: Council for the Development of Social Science Research In Africa.

CBD: Community Based Organization.

CSWs: Commercial Sex Workers.

DACA: District Action Committee on AIDS

ELSS: Expanded Life Saving Skills

FACA: Family Action Committee on AIDS.

F.M.O.H: Federal Ministry of Health.

HEAP: HIV/AIDS Emergency Action Plan.

HIV: Human Immune-deficiency Virus.

ICPD: International Conference for Population and Development.

IEC: Information Education and Communication.

IUCD/IUD: Intra Uterine Contraceptive Device.

LACA: Local Action Committee on AIDS.

LGA: Local Government Area.

LAPC: Local AIDS Programme Coordinator.

MLSS: Modified Life Saving Skills.

MTCT: Mother-To-Child Transmission.

NACA: National Action Committee on AIDS.

NARHS: National HIV/AIDS and Reproductive Health Survey.

NASCP: National AIDS and STD Control Programme.

NDHS: Nigeria Demographic and Health Survey.

NDLA: National Drugs Law Enforcement Agency.

NEACA: National Expert Advisory Committee on AIDS.

NRH: National Reproductive Health.

NGOs: Nongovernmental Organizations.

NPC: National Population Commission.

NMDC: Nigerian Medical and Dental Council.

NUC: National University Commission.

PAC: Post-Abortion Care.

PACA: Plateau Action Committee on AIDS or Personal Action Committee on AIDS.

PID: Pelvic Inflammatory Disease

PLWHA: People Living With HIV/AIDS.

RH: Reproductive Health.

SACA: State Action Committee on AIDS.

SHMIS: State Health Management Information System.

STDs: Sexually Transmitted Diseases.

STIs: Sexually Transmitted Infections.

TBAs: Traditional Birth Attendants**.**

UNAIDS: United Nations Joint programme on HIV/AIDS.

US: United State.

VCT: Voluntary Counseling and Testing.

VCCT: Voluntary Counseling and Confidential Testing.

WHO: World Health Organization.

CHAPTER ONE

1.1 INTRODUCTION

Community involvement is a degree of collaboration required to ensure success on a particular method of implementation (Adetokunbo and Herbert, 2003). It has been observed in Plateau State that wide gaps exist in the knowledge base, awareness and motivational support for reproductive health (RH) issues, and services in the communities as well as between the served (community members, including policy makers, opinion leaders, and so on) and the servers (programme managers, health workers). This has led to weak political commitment, poor budgetary allocation and, community participation in RH programmes and services. Advocacy and social mobilization will enlist the support of policy and decision makers, community members and organizations on RH (reproductive health) issues and services. In addition, it will enhance male participation in RH (reproductive health) programmes (National Reproductive Health strategic framework and plan, 2002-2006).

Advocacy will significantly contribute to achieving the following:

- Political commitment, policy makers' and opinion leaders' support for RH programmes.
- Mobilization of the community as stakeholders

- Allocation and mobilization of adequate resources for RH activities.
- Commitment of regulatory agencies, such as National Universities Commission (NUC) Nigeria Medical and Dental council (NMDC) and Nurses and Midwifery council of Nigeria, and the legislative arm of government to support RH issues within their purview.
- Strengthen male involvement in RH programmes.
- Improve youth involvement in RH programmes
- Enhance public – private partnerships.

In 1983, the virus that caused AIDs was discovered by scientists in France and the routes of transmission were confirmed (Fact Sheets on HIV/AIDS for Nurses and Midwives, 2001). The virus became known as the human immunodeficiency virus (HIV). There are two types: HIV1, the most common type found worldwide, an HIV 2 found mostly in West Africa. The virus acts by gradually weakened the immune system, which is the body's defence (F.M.O.H. Nigeria, 2004). This results in the body not being able to resist other infections. The diseased person continues to suffer infection after infections from other microbes as a result of the reduction in the body's defences. This syndrome is referred to as AIDS. Finally the person succumbs to the overwhelming effect of the multiple infections.

Although information education and communication (IEC) can be seen as a tool for advocacy, it can also form a multi-dimensional perspective, and provide appropriate knowledge in a visible form that promotes positive social and cultural practices (National Reproductive Health Strategic Framework and Plan, 2002-2006). Donald (1988) added that in the absence of medical defences against AIDS, public education is the main weapon in the fight to limit the spread of infection.

The poor health status of Nigerians is due to low level of access to quality reproductive health information and service at all tiers of care. In

this regard, vulnerable groups, such as adolescents and the elderly, are at higher risks. In addition, access is limited by location of facilities away from the majority of users, poor staffing and deficient skills, lack of equipment and consumables, unaffordable costs and weak linkages.

Successful implementation of RH programmes demand efficiency in the skills and facilities available to execute the various activities within the programme. An inefficient healthcare delivery system, including management and service provision, has been a major setback in meeting RH needs of Nigerians. Capacity development is therefore a key strategy to planning, implementing and successfully managing RH programmes.

In this regard, training can be spread from the federal to state and local government healthcare staff. This will relate to contemporary issues, such as:

- Expanded life saving skills (ELSS), including post-abortion care (PAC) services for medical officers.
- Life saving skills, including PAC, for midwives.
- Updated family planning skills for community health extension workers (CHEWs) and other service providers.
- Modified life saving skills (MLSS) for CHEWs)

- Adolescent Reproductive Health (ARH) services, including counseling and life skills
- Management of sexually transmitted infections (STIs)/Sexually Transmitted Disease (STDs) and human Immune-deficiency Virus/Acquired Immune Deficiency Syndrome (STIs/STDs) and (HIV/AIDS).
- Programmes management, including self-assessment skills for health providers.
- Leadership and management for population and RH for relevant persons.

AIDS was almost completely unknown, especially in Africa. AIDS was identified in 1981 (UNAIDS 1998 and 2000). During the past two decades, the world has been affected by the massive infection with the human immunodeficiency virus (HIV) (Adetokumbo & Herbert, 2003) which causes the clinical syndrome of acquired immune deficiency syndrome (AIDS). The etiological agents of the disease are strains of two related retroviruses, human immunodeficiency viruses HIV-1 and HIV-2. The first AIDS case was reported in Nigeria in 1986 and the epidemic

has rapidly grown since then (National HIV/AIDS and Reproductive Health Survey (NARHS, 2003).

The adult HIV prevalence has increased from 1.8% in 1991 through 4.5% in 2001. Estimates using the 2001 HIV/Syphilis seroprevalence sentinel survey among women attending ante-natal clinic indicates that more than 3.5 million Nigerians aged 15-49 years may be infected with the virus. The epidemic in Nigeria has extended beyond the commonly classified high-risk groups, and is now common in the general population. With the adult prevalence rate at 5.8 percent in 2001, the nation is at the threshold of an exponential explosive growth of the epidemic.

Some parts of the country are worse affected than others but no state is unaffected. In some sites prevalence was higher than 10.0%. All states of Nigeria have general population epidemics of over 1%. There was no marked difference in HIV prevalence between major urban areas and sites outside major urban areas. The infection cuts across.

The infection cuts across both sexes and all age groups. However, youths between the ages 20-29 years are more infected, though in some parts of the country like in South-South and the South-West zones,

(National HIV/AIDS and Reproductive Health Survey (NARHS) 2003), there was a higher prevalence in the 15-19 year age group.

National HIV/AIDS and reproductive health survey (NARHS), 2003) has reported that an increasing number of children are now being either infected with the virus through mother-to-child transmission, or are losing one or both parents due to AIDS. By all indications, the researcher feels HIV/AIDS epidemic has continued to grow largely through heterosexual (having sexual attraction with the opposite sex, homosexual, unprotected sexual relationships, mother-to-child transmission and contaminated blood and blood products.

Nigeria has passed through several phases in her response to the epidemic. The stages included an initial period of denial, a largely health sector response, and now a multi-sectoral response that focuses on prevention, treatment and mitigation (less severe) of impact interventions and divorces coordination and implementation as distinct response components (National HIV/AIDS (NARHS), 2003). A central body is dedicated to leading and coordinating the response, while the various sectors, including civil society organizations, faith based organizations and people living with HIV/AIDs support groups focus on packing and implementing interventions based on a national action plan.

The health response which had started after the first case of AIDs was reported in 1986 was initially mounted by an adhoc National Expert Advisory Committee on AIDS (NEACA) in 1987 and supported by some state chapters set up soon thereafter. By 1988, the National AIDs and sexually transmitted diseases (STDs) control programmes (NASCP) was formally established with state counterparts there after to organize as well as to coordinate all HIV/AIDS activities at national and state levels.

In 1997, the National Council of Health formally endorsed the Multi-sectoral approach and in 2000 the federal Government of Nigeria commenced the implementation of the approach with the establishment of presidential committee on AIDS (PCA) and a National Action committee on AIDs (NACA). A 3-year HIV/AIDS emergency Action plan (HEAP) was initiated in 2001 and now being implemented. The partners implementing the plan include governmental institutions, non-governmental organizations, community based organizations, faith-based organizations and person living with or affected by HIV/AIDS (National Action Committee on AIDS (FMOH, 2002).

Nigeria presently benefits from a high level of political commitment and international support (National HIV/AIDS and Reproductive Health Survey (NARHS, 2003). There is a high level of

activities in all sectors: advocacy, prevention, care and support and the mitigation of the impact of the epidemic. However, there is a need to scale up activities, improve coverage, and monitor and evaluate the progress and effects of the interventions to ensure that the desired goals and objectives are achieved. It is with this in view that community participation in reproductive health programme has been emphasized as a critical strategic plan for promotion of reproductive health in Nigeria (National Reproductive Health Strategic Health plan 2002-2006). This investigation was therefore conducted to find out the extent of community involvement in the control and management of HIV/AIDS in the implementation of national reproductive health plan in Plateau state.

1.2 Statement of the Problem

The international conference on population and Development (ICPD) made a paradigm shift from the previous concept of maternal and child health care and family planning to a more comprehensive approach of reproductive health (RH) and reproductive rights in its international conference held in Cairo 1994 (Federal Ministry of Health (FMOH) 2002-2006). One of the Reproductive Health (RH) demands of the new paradigm is the prevention and management of Reproductive Tract, infections (RTIs), especially sexually transmitted infections (STIs),

including Human Immune-deficiency Virus (HIV) infections and acquired immune deficiency syndrome (AIDS). In the responses to the new reproductive health demands in 2001, the federal Government of Nigeria, through the federal ministry of Health (F.M.O.H.) developed a National Reproductive Health Policy that identified reproductive health Care needs and prescribed broad strategies for intervention to address several important Reproductive Health issues (FMOH, 2002) one of such issues is the increasing rate of HIV infection and the prevalence of other STIs.

Over half of the world's populations under 25 years of age are living with HIV/AIDS (Appropriate Health Resources and Technologies Action Group (AHRTAG), 1994) Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO), study estimates, indicate that by the end of 1999, over 30 million people would have been infected with HIV (Fact sheets on HIV/AIDS for Nurses and Midwives 2001 and Human Development Report Nigeria (2004).

More young women and men are becoming sexually active during their mid-teens (Appropriate Health Resources and Technologies Action Group (AHRTAG) 1994). In many countries, more than half of the population has unprotected penetrative sex before the age of 16 due to

emotional pressure and physical violence that is often used to force young women to have unwanted sex, usually girls.

> The role of the school in the prevention of HIV/AIDS among young people through the work of health workers, students, teachers and parents to plan and carry out sex education has so far not been emphasized. Pupils and staff living with HIV/AIDS are not protected from discrimination. There is also the absence of HIV education in the school curriculum, which contributes to the problem of not control and management of HIV/AIDS in plateau state (Appropriate Health Resources and Technologies Action Group (AHRTAG, 1994), (AHRTAG 1994) stated that other role of schools in preventing HIV and encouraging young people's healthy, sexual development can be strengthened by the following;

Developing Policy; that will help to educate students and health workers of the school (if any), teachers and parents to plan and carry out sex education. Policy should also ensure that pupils and staff with HIV are protected from discrimination and that their confidentiality is guaranteed. Training all staff, administrator, and policy makers of the school, teachers and health workers is essential. Teachers need to be confident in using participatory learning method.

Integrating HIV Education: into the school curriculum is often better than introducing it as an additional subject. The curricular should include broader health issues, such as drug use and violence, and encourage skills development. It should span several years, starting before most children become sexually active.

Setting up Extra-Curricular activities, such as school counseling services, health clubs run by and for pupils, and supporting teachers and parent discussion groups. One other problem for not involving the community is that the non-governmental organizations (NGOs) and

mission hospitals have not developed programmes to enable people living with HIV/AIDS to be cared for at home (Appropriate Health Resources and Technologies Action group (AHRTAG) 1995) which can help reduce costs and demand on in-patient facilities.

Plateau AIDS Control Agency (PACA) is a poverty eradication programme engaged in income generating activities, such as the government commitment, collaboration with institutions, such as the churches and mosques and effective training and support for both students and staff. They work with the 17 local governments of the state.

There is one (1) programme office for each of the local governments, headed by the executive chairman of the local government.

The PACA has at least 5 officers to look after its affairs. It has 15 ministries, 40 boards and parastatals, higher institutions (colleges of education, Universities, polytechniques, school of nurses and midwives, school of health technologies, (Now College of Health Technology) etcetera and non-governmental organizations (NGOs), which are its working groups.

What is also important is that the programme of control and management of HIV/AIDS should meet the needs of the people with HIV and their families, and actively involve them. If assurance of money and

medical care, for example, is given to HIV patients, fear of rejection by the family members can also be a thing of the past (Appropriate Health Resources and technologies Action Group (1995). Community involvement programmes such as bringing food, doing laundry or cultivating land for the HIV/AIDS victims increasingly encourage men and women in providing practical support for the existing community groups, which is also a step in arresting the situation.

The involvement of the local people can also stimulate the community members infected by HIV to reduce stigma and promote changes in traditions and practices that increase risk (AHRTAG, 1995). Volunteers from religions organizations or community groups are involved in providing services to the HIV patients (Appropriate Health Resources and technologies Action Group, 1995). However, no research has been reported on the nature and success of community involvement in the control and management of HIV/AIDS in the implementation of national reproductive health plan in Plateau State.

1.3 Significance of the Study

This study is justified on the following bases:

1. It is expected that community involvement in the advocacy and mobilization would promote political commitment and support of

the communities in the control and management of HIV/AIDS in Plateau state. No objective assessment has been made on the contribution of community involvement to the improvement in the political commitment and support of the communities in the control and management of HIV/AIDS. The results of the study would show whether community involvement made any impact on the political commitment and support of the communities in Plateau State in the control and management of HIV/AIDS.

2. It is expected that community involvement in the promotion of healthy reproductive behaviour would promote health – seeking behaviour of the communities in the control and management of HIV/AIDS. The study would show whether community involvement made any important impact in the health-seeking behaviour of the people in Plateau state in the control and management of HIV/AIDS.

3. It is expected that community involvement in the equitable access to quality health services of the communities in Plateau state would expand access to the control and management of HIV/AIDS. No study has been reported on the community involvement on the expansion of access to the HIV/AIDS control services of the

communities in the control and management of HIV/AIDS in Plateau state. The study will show whether community involvement made any effect on the expansion of access to the HIV/AIDS control services of the communities in Plateau State in the control and management of HIV/AIDS.

It is expected that community involvement in the equitable access to quality health services, would improve access to HIV/AIDS control services of the communities in the control and management of HIV/AIDS. This study would show whether community involvement made any impact on the improvement in the quality of HIV/AIDS control services of the communities in the control and management of HIV/AIDS.

4. It is expected that community involvement in the capacity building would strengthen capacity building of the communities in the control and management of HIV/AIDS in Plateau State. The study would be useful to provide important information that will strengthen capacity building in educating communities such as the leaflets, posters, charts, etc in he control and management of HIV/AIDS. This investigation would be of help to know whether community involvement disseminated any message on the

strengthening capacity of the communities in Plateau State in the control and management of HIV/AIDS.

5. It is expected that community involvement would promote research in the control and management of HIV/AIDS. No authentic record is known to have been kept on the community involvement to the promotion of research in the control and management of HIV/AIDS in Plateau state. Research study on reproductive health would help to provide further information for planning, modifying programmes, projects and activities. It would also help to provide the bases for employing new methods to address emerging issues towards achieving the desired targets and objectives of the communities in Plateau State in the control and management of HIV/AIDS.

1.4 Purpose of the Study

The purpose of the study was to examine the level of community involvement in the control and management of HIV/AIDS in the implementation of national reproductive health plan in Plateau state with a view to arriving at suggestions that could improve the implementation.

The Objectives were to find out whether:

1. Advocacy visits to state and local government (LG) legislators for issues concerning HIV/AIDS were conducted.
2. Advocacy meetings in support of media practitioners for HIV/AIDS control programmes were conducted.
3. In- and out-of-school youths were sensitized on the problem of HIV/AIDS.
4. Manuals on workplace HIV/AIDS ethical and human rights issues are provided.
5. HIV/AIDS sensitization of migrant workers and at major parks, seaports, border posts and barracks were conducted.
6. Seminars for maternity care staff to incorporate HIV/AIDS education into antenatal talks were conducted.
7. Sensitization seminars on HIV/AIDS for women in Polygamous homes were conducted.

1.5 Major Hypothesis

There is no significant involvement of the communities in Plateau state in the control and management of HIV/AIDS.

SUB – HYPOTHESES:

1.5.1 **Sub – Hypothesis I:**

There is no significant involvement of communities in Plateau state in the control of HIV/AIDS.

1.5.2 **Sub – Hypothesis II:**

There is no significant involvement of the communities in the management of HIV/AIDS.

1.5.3 **Sub – Hypothesis III:**

There is no significant difference among different senatorial districts of Plateau State in their involvement in the control of HIV/AIDS.

1.5.4 **Sub – Hypothesis IV:**

There is no significant difference among different senatorial districts of Plateau State in their involvement in the management of HIV/AIDS.

1.6 Basic Assumption

The following basic assumptions were made on the basis of available research evidence for the purpose of the study.

1. Community involvement in knowledge of risk involved is essential for the fruitful control and management of HIV/AIDS.

2. Community cooperation with other organizations for the promotion of health seeking behaviour is necessary for the control and management of HIV/AIDS.
3. Participation of the communities in campaign awareness would promote control and management of HIV/AIDS in plateau state.

1.7 Research Questions

This investigation was conducted to answer the following specific research questions.

1. In the advocacy and social mobilization, to what extent has community involvement in Plateau state improved political commitment and support of the communities for the control and management of HIV/AIDS?
2. In the promotion of healthy reproductive behaviour, to what extent has community involvement promoted health - seeking behaviour for control of HIV/AIDS in Plateau state?
3. In equitable access to quality health services, to what extent has community involvement expanded access to HIV/AIDS control services in Plateau state?

4. In capacity building, to what extent has community involvement strengthened capacity for the management of HIV/AIDS in Plateau states?
5. In research promotion, to what extent has community involvement promoted research on HIV/AIDS in Plateau state?

1.8 Delimitations of the Study

The research was carried out to find out the community involvement in the control and management of HIV/AIDs in the implementation of national reproductive health plan in Plateau State. This investigation was delimited to:

(a) Community involvement in the control and management of HIV/AIDs in the implementation of national reproductive health plan in Plateau State.
(b) The study was restricted to three (3) senatorial districts (Plateau Central, North and South) respectively.

1.9 Limitations of the Study

The research had the following limitations that were carefully considered during interpretation of the results.

As the researcher's questionnaire was used as its main instrument for collecting data, the researcher could not provide additional clarification on statements that were not clear to the respondents. However, efforts were made to simplify the questionnaire.

Lack of motorable roads on the part of respondents limited the coverage of the study.

The responses of the respondents were treated with due respect considering diversity in languages that existed in the state (locality) through interpretation.

OPERATIONAL DEFINITION OF TERMS

Definition of terms to avoid doubt, confusion, elimination, inconsistency and enhance the understanding of the information presented in the study.

AIDS: Acquired Immune-deficiency Syndrome a deadly disease caused by a germ (virus) called Human Immune-deficiency Virus (HIV). The germ damages the body's immune system and the ability of the body to fight infection, thereby destroying the body's power to protect itself against disease. AIDS is transmitted through contact with infected semen (through sex), body fluids and blood injection (syringes).

Access: Availability of health facilities and resources to all its Citizens.

Adolescence: The period between childhood and the onset of adulthood. It is a period of Sexual derive development of the adolescence, age period between 13 – 20 years.

Attitude: The inward and outward tendency to like or respond to situation(s) events, issues positively or negatively.

Behaviour: Observable conduct outwardly.

Blood bank: Special refrigerator in which blood is kept after withdrawal from donors until required for transfusion.

Community Involvement: The degree of collaboration required to ensure success on community participation on a particular method of health promotion.

Control: Vaccines are used to control outbreaks of diseases for yellow fever, smallpox and the elimination of poliomyelitis in the country.

Equity: Fairness in the allocation of resources with particular attention to the needs of the people.

Gonorrhea: Common sexually transmitted disease or infection of the vagina, penis or rectum, throat (goiter) and or eyes by the bacterium neisseria gonorrhea.

Heterosexual: Literally of different sexes often used to describe a person who is sexually attracted toward the opposite sex.

HIV: Human Immunodeficiency Virus. The germ damages the body's immune system and the ability of the body to fight infection, thereby destroying the body's power to protect itself against disease.

Homosexual: Literally of the same sex often used to describe a person who is sexually attracted towards a person of the same sex.

Management: Could be seen as information that decision makers and managers can use to support health programmes. It is the skillfully

management o available resources by the health authorities at all levels, from the most peripheral unit to the central office.

Morbidity: The state of being diseased as a result of discomfort from piercing of foreign bodies (objects) which cause HIV/AIDS.

Mortality: This refers to the frequency of deaths as a result of wrongful management of sex, injection (syringes) piercing of contaminated objects, etc.

Reproductive Tract Infection – have been broadly defined as sexually transmitted infections and infections that are nonsexual transmitted.

Sexually Transmitted Diseases: These include diseases of the reproductive region such as gonorrhea, syphilis, genital ulcers, such as cancroids, genital warts, herpes, etc.

Sexually Transmitted Infections: Are pelvic inflammatory diseases that causing far-reaching health, social and economic consequences. These include gonorrhea, syphilis, Chlamydia, genital herpes and trichcomoniasis are a major global cause of acute illness, infertility, long term disability and death.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

In order to determine the community involvement in the control and management of HIV/AIDS in the implementation of national reproductive health plan in Plateau State, attempt was made to critically review available related literature under the following sub-headings:

(a) The Promotion, political commitment and support of the communities in the control and management of HIV/AIDS.

(b) Community participation (involvement) and the promotion of health – seeking behaviour in the control and management of HIV/AIDS.

(c) The involvement of communities in the expansion of access to HIV/AIDS control services and the quality.

(d) Community participation and the strengthening of capacity for management of HIV/AIDS.

(e) The influence of community participation on the promotion of research on HIV/AIDS.

2.2 The promotion, Political Commitment and Support of the Communities in the Control and Management of HIV/AIDS.

The low promotion, political commitment and support of the communities for reproductive health issues and services in the control of HIV/AIDS has contributed to the weak political commitment, poor budgetary allocation and community participation in Reproductive Health Programmes (RHPs) and services in the communities of Plateau state (Federal Ministry of Health (F.M.O.H, 2002 – 2006). Anthony (1988) observed that first news of AIDS is sensationalized, stigmatizing hurrying, or distorted. First impressions are powerful and, if uncorrected, may persist and deepen into misleading beliefs and myths about AIDS. Such beliefs and myths may harm people and threaten public health by leading to denial, blame, helplessness and passivity.

One would conclude here that if adequate advocacy and social mobilization is made will enlist the support of policy and decision makers, community members and organizations on Reproductive Health (RH) issues and services. As well, it will enhance male participation in Reproductive Health Programmes (RHPs). According to Federal Ministry of Health (FMOH, 2002) adequate advocacy will significantly contribute to:

- Political commitment, policy makers and opinion leaders' support for reproductive health (RH).
- Mobilization of the community as stakeholders.
- Allocation and mobilization of adequate resources for reproductive health activities.
- Commitment of the regulatory agencies, such as National Universities Commission (NUC), Nigerian Medical and Dental Council (NMDC), Nurses and Midwifery Council of Nigeria, etc, and the legislative arm of government to support reproductive health issues within their parvenu (person of humble birth).
- Strengthen male involvement in Reproductive Health Programmes (RHPs) nationwide.
- Improve youth involvement in reproductive health programmes.
- Enhance public private partnership with other neighbours.

The PACA has the responsibility of training all the ministries, for example; Ministry of Health, Ministry of Education, board, parastatals and local government programme officers, wives of the local government chairmen, women and girls (head girls in schools), wives of pastors and imams or religious groups against poverty and AIDS empowerment and awareness of HIV/AIDS pandemic (National Action Committee on

AIDS) (FMOH, Nigeria 2002). The agency performs multisectoral activities, involving professionals and non-professionals, chaired by the local government chairman.

The youths are the most vulnerable groups Human Development Report (2004) the intervention programmes must target them. The programme must be properly packaged to influence institutions, artisans in the various trades, the stream of sexually active unemployed people who are constantly migrate in search of work. Other high-risk population likes women, young girls, Commercial Sex Worker (CSWs)/ food sale workers (FSWs) (CSWs/FSWs), and so on, must be specifically targeted with creative preventive care and support (C & S) programmes. In the age difference, the majority of Nigerians are youth (over 60 percent, 44 percent of which are 15-year-olds under) and, as the most sexually active (25 per cent of which initiate sex at the age 15 and 50, per cent at age 18) (Human Development Report (2004), they constitute the most vulnerable group.

Local Government Action Committee on AIDS (LACA). The Local projects team (LPT) at the local government level has the following officers, programme officer, monitoring and evaluation (M&E) officer, communication officer and finance officer.

Line Department

3 officers are to mine the activities of HIV/AIDS, example include

- Health
- Agriculture
- Finance
- Personnel
- Works
- Education
- Social services
- 21 staff working for the 7 departments.

From Local Government Action Committee on AIDS (LACA) then – the District Action Committee on AIDS (DACA) awareness campaign.

- Community Action Committee on AIDS (CACA) has the awareness campaign at the community level.
- Family Action Committee on AIDS (FACA) is to keep the family (father, mother and children) aware of the danger of HIV/AIDS.
- There is Bedroom Action Committee on AIDS (BACA). This involves discussion between the father and the mother as per who is the cause of HIV/AIDS between the two individuals.

Personal Action Committee on AIDS (PACA). This action generates questions on both individuals that what are the cause of the HIV/AIDS to the partner or who is the cause to help solve the problem of HIV/AIDS pandemic.

Caldwell (et al. 1989) stated that, African societies recognize as a distinct phenomena longer – term girlfriends, mistresses (and) outside wives… who partly serve in urban areas alternatives to polygamous married wives. There is no doubt about it that many African societies believe that marrying more than one wife is contributing to household productivity and as helpers on the farms Caldwell et al (1989). Because of these influences to marrying more than one partner one may be contracted with the epidemic of HIV/AIDS. Odebiyi and Vivekanada (1991) confirmed also that the Sub-Sahara African infection profile to such cultural factors as polygamy, which drives women to seek sexual fulfillment outside marriage, and high value place on children in African culture, which drives people to indiscriminate sexual activities (Human Development Report 2004). Human Development Report (2004) added that traditional practices such as polygamy, wife exchange among siblings, wife hospitality, levirate (i.e., wife inheritance), prostitution, scarification (superficial incisions or punctures in the skin), use of

unsterilized sharp objects and needles, rural to urban migration to look for white colour job (including unintended modernization and urbanization driving commercial sex trade, child labour overcrowding, and so many others can be the caused of HIV/AIDS. These can be fought successfully with excellent package preventive awareness campaigns. One might conclude here that the increasing rate of HIV/AIDS is as a result of non-steady sexual partner which contributed to the wide spread of the disease in Plateau State. Furthermore, in a randomized study of youth attitudes towards risky sexual behaviour by Mufune et al (1993), found that some group of young people in Zambia do not favour extramarital sex or multiple partners. Again, in analysis of demographic and health surveys from seven African countries by Gage – Brown and Meekers (1993) revealed that the proportions of never-married adolescents who have had sex varied enormously among countries. Premarital sexual activities was virtually absent in countries such as Burundi, where only about 4 percent of never-married females have had sex, but very prevalent in Botswana, where more than 75% of never-married women aged 15 – 24 have had sexual experience. Human Development Report (2004) described that gender status possessed severe challenges to the human rights of women and young girls. As in

most African societies, Nigerian women have a gender-ascribed role that traditionally places men above them. Although, the 1999 constitution provides citizens with the right to freedom from discrimination based on community, place of origin, ethnic group, sex, religion, or political opinion." Nevertheless, customary and religious discrimination against women persists as well as occasional religious violence and social discrimination on the basis of both religion and ethnicity. Gender inequalities, which exist within the Nigerian society, give room for the epidemic to grow. The lower status of women decrease their right to make choices (Human Development Report, 2004), including those related to their reproductive health, Human Development Report (2004), also added in that inferior status of women makes it more difficult for HIV infected women to seek care and to fight the discrimination and stigma associated with the infection.

The lower income-earning power of most women acts as a driving force for them to sale sex. As part of their survival strategy, a number of women are compelled into some form of commercial sex work example now significant problems of trafficking of young women to Europe and some African countries. (Human Development Report, 2004) to sustain

themselves and sometime their children. They are heterogeneous group propelled largely by economic factors.

2.3 Community Participation and the Promotion of Health Seeking Behaviour in the Control and Management of HIV/AIDS.

Federal Ministry of Health (F.M.O.H, 2002 – 2006) revealed that the fact that Information, Education and Communication (I.E.C) can be seen as a tool for advocacy, it can also be seen as forming a multi-dimensional perspective, and provide appropriate knowledge in a visible form that promotes positive social and cultural practices. It also added that approaches in information, education and communication (IEC) help to bring about appropriate behavioural change and improved participation in and use of Reproductive Health Services, being multi-sectoral in nature, also promotes collaboration among relevant agencies, for example (e.g.), Federal Ministry of Health (F.M.O.H), Federal Ministry of Information (F.M.O.I), media organizations and religious bodies.

The role of the community in the planning, organization, operation, control and management of HIV/AIDS should be adequately supported by health education (Adetokunbo and Herbert, 2003). This is highlighted in the Alma Ata Declaration (Adetokunbo and Herbert, 2003): Human Development Report (2004) suggested also that the commitments of

stakeholders at all levels of government and all segments of the society should be sustained in order to achieve effective community mobilization and involvement in the prevention and management of HIV/AIDS control.

> Primary Health Care is essential healthcare made universally accessible to individuals and families in the community through their full participation at a coast that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

Apart from Reproductive Health (R.H) (FMOH, 2002) stated that Information, Education and Communication (I.E.C) embraces:

- Broad-based participation in Reproductive Health Programmes (R.H.Ps)
- Cultural sensitive approaches that build upon existing approaches for information dissemination in support of reproductive health; and
- Community ownership of Reproductive Health Programmes (R.H.Ps) through involvement in planning Information, Education and Communication (I.E.C) messages.

Halfdan (1988) suggested that, government with all their sectors and people in all walks of life should in partnership act for the improvement of health, they must first understand how this can best be achieved. They must understand how to promote health, how to prevent and how to control disease, how to identify illness and treat and care for the sick and rehabilitate them as necessary.

The Council for the Development for Social Science Research in Africa (CODESRIA Bulletin 1973-2003) also confirmed that by influencing personal behaviour and lifestyles we can have hope to minimize the ravages of AIDS throughout our population. Udoh (1999) in Schneider (1958) stated that human resources make valuable contribution to the health education of children and youth. For example, a specialist physician or surgeon specialize in a body system/organ and its diseases, a psychiatrist, a beautician, a lawyer, a police officer, and so on.

Population Reports (1989) reported that preventing the spread of HIV depends on influencing people to change their behaviour. In that case there must be a reagent to act on the other to overcome the other idea to be able to achieve the expected objective. John (1988) also confirmed that absence of medical defences against AIDS, public education is the main weapon in the fight to limit the spread of infection.

The evidence seems to support the argument of the Council for the Development of Social Science Research In African (CODESRIA) Bulletin (1973 – 2003) which stated that by influencing personal behaviour and lifestyles we can have hope to minimize the ravages of AIDS throughout our population. In Africa heterosexual relationship is the main mode of transmission of AIDS and other sexually transmitted infections (NARHS, 2003). Shehu (2004) stated that major public health problems of the citizens are poor nutritional habits, smoking, heavy alcohol consumption, sexually transmitted diseases (STDS) and HIV\AIDS due to indiscriminate sexual behaviour and substance abuse. Therefore it would be suggested that educators and well meaning citizens of this Plateau state should not relent in their effort to influence people behaviour towards positive change against HIV\AIDS.

According to progress report on Global Response to the HIV\AIDS epidemic (2003 the increasing effectiveness of HIV\AIDS advocacy efforts by non-governmental organizations (NGOs); people living with HIV\AIDS (PLWHA), United Nation (UN) agencies diplomats, faith-based groups, business leaders, labour organizations, and a wide array of other actors, continue to reflect in the growth of political commitment and available resources for HIV\AIDS programmes. All efforts by these

groups of individuals are to salvage the lives of people against the ravages experience in the epidemic in the promotion of health-seeking behaviour in the control and management of HIV\AIDS.

Adetokunbo and Herbert (2003) propagated that health education was used to be practiced as one-way process with the health professional transmitting technical information and advice to individuals and to the community. They should be dynamic which means is diverse in nature. This statement therefore agreed with Adetokunbo and Herbert that health practices should not be done by only professionals but also with the general populace as determination of health is expected by every soul. The fact that the above mentioned by Adetokunbo and Herbert produced ready-made packages of ideas and plans based on the preconceived notions of the health workers, such programmes did not always take into consideration traditional beliefs and practices of the local community nor did it benefit from its innate wisdom and accumulated experience. In this case everybody should be carried along to achieve a positive health-seeking behaviour. The people's beliefs and practices of the local man.

Appropriate Health Resources and Technologies Action Group (AHRTAG) 1995) agreed on programmes that will encourage men and women participation especially in providing practical support such as

bringing food, doing laundry, or cultivating land for the sake of promoting health expectancy of the populace. This group further contains that community participation help volunteers from religious or community groups too often involve as inexpensive way to increase service capacity. These partners act as active motivator in maintaining their involvement against those that are passive. As part of wider involvement, stronger community link, organize meetings and workshops with local healers. This gives valuable opportunities for sharing knowledge and perception about HIV\AIDS in the health-seeking behaviour in the control and management of HIV\AIDS.

The group further agreed that meeting with local non-governmental (NGOs) and community leaders, including those from the religious, traditional organizations; to discuss their perception of the epidemic and possible ways to support families and provide community education will go a long way in promoting health-seeking behaviour.

Adetokunbo and Herbert (2003) explained that the community members must be consulted, they must be persuaded and they must be given responsibility in the decision-making under the technical and professional guidance of health workers. The plan for involving people's participation must not be imposed but at every step the people must

participate in devising the strategies, which are most compatible with their needs and resources. In some cases, the sole responsibility lies with individuals and families. The role of the health workers (personnels) is to provide guidance, for example, personal hygiene, nutrition, and social habits. In these cases, the individuals must learn and then do the things themselves.

Appropriate Health Resources and Technologies Action Group (AHRTAG), 1995) stated that the greatest problems of people living with HIV are poverty and lack of medical care, and not only HIV illnesses, fear of rejection (discrimination by members of the family) is also common. Indeed, relation with chronic disease is sometimes being silence about the treatment of such patient by the relations. Involving people living with HIV means that they can take part as careers and educators, not simply as patient or clients, to have easy involvement of the populace. Family should be provided with care, nutrition foods and medical treatments. Their capacity to cope needs to be assessed and plans made with the family members. When such are not provided women and older girls are likely to be withdrawn from education. If there is not enough money for school fees, home care and prevention programmes, need to reduce these pressive by providing economic, legal

and employment support, and promoting equal responsibilities for caring in the home (AHRTAG, 1995).

Appropriate Health Resources and Technologies Action Group (AHRTAG, 1994) believed that community participation in the control and management of HIV\AIDS can not be achieved without the involvement of the youth. Their involvement could include initiatives ranging from introducing sex education in schools, to working with young people in religious organizations, sports or youth clubs, using the media, and making family planning services more accessible. In these ways different needs and project staff should be cleared about with whom they are going to work. The young people should be allowed to involve actively. The young (youth) should be ensured that activities are relevant and useful to them. They should be given opportunities to open up on their needs and problems and what is already being done.

The programmes of the youth (both women and men) should relate to specific issues, beliefs and need for information and skills identified by young people themselves. These issues or needs could include discussion about sexuality and relationship, and broader concerns about their education, families or careers. These groups of association (AHRTAG, 1994) are of the view that young people need much more

than sex and reproduction. They need opportunities to question whether sex is the best or only way to express their feelings, to feel valued or to explore relationships. Which can contribute to the promotion of health – seeking behaviour. They need to be taught where to find information and support. They need to develop skills to make decisions, communicate them to others, dealt with conflicts and stand by their decisions under pressure from their group.

Appropriate Health Resources and Technologies Action Group (AHRTAG) 1994) concluded that behaviour of the young people are being influenced by their families, friends and others with whom they have regular contact. Their environment too is greatly affected by the mass media, legislation, policies and economic issues as well as cultural and religious norms about appropriate behaviour.

According to the view of Adetokunbo and Herbert (2003) Mass Media have the advantage of reaching large numbers of people who may not have direct contact with the health workers in the appropriate change in the promotion of health-Seeking behaviour. These messages can be repeated over and over again serving as reminder and reinforcement. They advanced that materials read in the newspapers or heard on the radio carries more authority than information that is obtained from local

sources in some communities. For these reasons, views and concerns of parents, policy makers, health workers, community and religious leaders should be explored and to gain their support for youth programmes. One of such concerns and views is the media mentioned above which can play an important part in raising awareness about young people's need and influencing public opinion and providing consistent messages.

Population Reports (1989) has this to say that prostitutes can be recruited as AIDS educators. They can find and talk with their peers more effectively than outsiders and can help to change attitudes in their peer group. For example, Prostitutes in Australia, Burkina Faso, the Dominican Republic and many others have been trained to talk to their colleagues about AIDS and in some programmes distributes condoms (Population Reports 1989). The report also contained that in Cameroon, after a pilot project of peer counseling and free condoms, the percentage of prostitutes using condoms at least half the time rose from 28 percent before the project to 95 percent six months later and then declined to 72 percent a year later. One may not hasited that prostitutes in Plateau state will need skills training to learn how to convince clients and boyfriends to use condoms and how to refuse to have intercourse with them, unless they do. They need to know how to use condom correctly if they must

have sex. All effort is to reduce the high risk of HIV/AIDS Pandemic in Plateau State.

Adetokunbo and Herbert (2003) contributed that some members of the community tend to be rigid in their views for change, while others tend to be more receptive to new ideas. Therefore, it is worthwhile identifying such innovators, encouraging them using them as instrument of change within their communities. They said that priority should be given to the education of children especially school children because they tend to be more receptive than adults are who in the process of their education would be prepared to accept and test new ideas. At home they can influence their parents. School programmes specially developed AIDS curricula with accompanying teaching materials help both teachers and students (Population Reports, 1989).

Programmes are needed to teach men facts about AIDS, dispel false beliefs, and motivate them to use condoms with both prostitutes and their steady sexual partners. Peer education, group discussion and counseling are promising approaches but have been infrequently used. Evidence on behaviour change among homosexual men is mixed. For example, in San Francisco, in 1994, prospective studies of 411 men, 40 percent of HIV- positive men were having incentive anal intercourse with

two or more partners in six months risky behaviour has been decreased. By 1987, that percentage had decreased to 5%. Among men who remained uninfected, receptive anal intercourse with two or more partners in six months decreased from 15 percent in 1984 to 3 percent in 1987. Similarly, changes have been reported in other United State (US) cities, Australia, Canada, Mexico, the Netherlands, Switzerland, and the United Kingdom (UK). These changes have occurred mostly among men in long – term studies who usually received counseling which help in the promotion of health – seeking behaviour in the control and management of HIV/AIDS.

2.4 The Involvement of Communities in the Expansion of Access to HIV/AIDS Control Services and the Quality

Federal Ministry of Health (F.M.O.H, (2002 – 2006l) suggested that the poor health status of the communities in Plateau State could be due to low level of access to quality reproductive health information and services and at all tiers of care. For this reason, vulnerable groups, such as adolescents and the elderly, are at higher risk. Again, access is limited by location of facilities to the majority of users; poor staffing and deficient in skills, lack of good equipment and consumables, unaffordable costs and linkages are some of the lapses in view.

Attention should be given to ensuring basic reproductive health service converge through the National Health Insurance schemes (NHIS) and provide sector occupational health programmes. Promised there should be made available in the community. This effort should be community driven in determining the scope, timing and costs for these services in order to ensure sustainability. Consideration should be given to deferral and exemption schemes that have an impact on cost recovery and subsidization policies. Attention should also be given to ensuring basic reproductive health (RH) service coverage through the National Health Insurance Schemes (NHIS) and private sector occupational health programmes (F.M.O.H. 2002).

According to Appropriate Health Resources and Technologies Action Group (AHRTAG, 1995) in most countries there are now significant numbers of people with human immune-deficiency virus (HIV) – related illnesses. The burden on health services is growing. For instance, in 1992 developing countries spent a total of United State (US) $340 million on health care for people with human immune-deficiency virus (HIV), up to one third of some national budgets. One study (AHRTAG, 1995) in Zambia reported that up to half of all patient days in medical wards of a central hospital were accounted for by people with

human immune-deficiency virus (HIV) – related illness. All is an attempt to find out expansion of access to HIV/AIDS control services and the quality.

The importance of health to humanity cannot be over-emphasized, Health services, non-governmental organizations and mission hospitals have developed programmes to enable people with chronic illnesses to be cared for at home. According to Appropriate Health Resources and Technologies Action Group (AHRTAG 1995), many people with incurable illnesses often prefer or choose to be cared for or even die at home. This is because hospital care is not always available or accessible. Families cannot afford transport or medical costs, or to stay with the sick person while they receive treatment.

Community-based care including home-based care programmes aimed at:

- Ensure that people receive basic nursing care as well as social and emotional Support;
- Training volunteers, families and people with human immune – Deficiency virus (HIV) in basic nursing care and infection control;
- Mobilize other people to provide supports;
- Reach sick people who are not using health services;

- Provide advice or money for income generation;
- Integrate care with human immune – deficiency virus (HIV) education;
- Reduce pressure on hospital in-patient facilities.

Adetokunbo and Herbert (2003) still observed that many communities in developing countries do not benefit fully from modern knowledge and technology that could have protected and restored their health. To them communities do not have access to simple remedies of proven efficiency, or where the services are provided. Many people also fail to make appropriate use of them. Individuals and communities often lack the essential knowledge on how to keep healthy, how to recognize dangerous signs in the individual and hazardous situations in the environment, and how to mobilize resources to solve health problems.

In their study (Adetokunbo and Herbert, 2003) stated great advances in biomedical sciences have made available many effective technologies for the prevention, diagnosis and treatment of diseases throughout the world, as the health sector is in crisis. On the other hand, even the most affluent developed countries cannot afford to make all these technologies available to all the people who need the various interventions. With annual spending of US $1000 – 3000 per head of

population, the developed countries cannot afford to provide universal access to all modern health technologies. In some countries, they said rationing takes the form of long waiting lists, for example, in the United Kingdom (U.K) in others, the services are rationed on the basis of ability to pay, in the United States of America (U.S.A) for example. The situation is even worst in developing countries, for example, the poorest countries spending less than US $20 per head per annum. It is obvious that it would be inappropriate for a poor man to have access to health facilities that are highly privatized. In that case, access can only be provided to the buguals (the rich ones) while the poor have less privilege of access to these services.

The Alma Ata Conference in 1978 of all African countries set the philosophical basis for the global vision of health development on the basis of social justice. The aim (Slogan) was 'Health for All'. It was firmly agreed in principle that it is the responsibility of the governments to ensure or expand access for all their citizens, the highest level of health on the basis of available resources.

Ideally, access to health services in Plateau state is expected to include:

- Equitable – that is fairness in the allocation of resources with particular attention to the needs of the poor.
- Value for money – carefully selecting the most cost effective intervention and managing services efficiently.
- Stewardship – responding to the needs of the people with transparency and accountability.

2.5 Community Participation and the Strengthening of Capacity for Management of HIV/AIDS.

An inefficient healthcare delivery system, including management and service provision, has been a major setback in meeting the Reproductive Health (RH) needs of the people of Plateau state (Park, 1997 (F.M.O.H), 2002-2006). Capacity development is therefore a key strategy to successful planning, implementing and management of RH programmes. Efficiency in the skills and facilities available to execute the various activities within the programme. Strengthening capacity must be a response to results of a needs assessment. Capacity building may involve personnel development (including provider knowledge and skills), provision of materials, equipment and services for effective administration of programmes. Capacity building also includes making the service users friendly and sustainable.

According to Jonathan (1988) strengthening capacity building requires the active participation of two persons therefore the chain of transmission can be broken by a change in the behaviour of either infected or the non infected person. For that reason, the proper focus of prevention is behaviour, not infection status. To prevent human immune deficiency virus (HIV) we must inform and educate so as to obviate the adoption of risk behaviour or to help people with such behaviour to abandon it or modify. He said here that the medical personnel must be well informed and supportive. But the behaviour involved in acquired immune – deficiency syndrome (AIDS) transmission must be private, hidden from others, or frankly by disapprove of by many societies.

Not everywhere is at equal risk of human immune deficiency virus (HIV) infection, so information and education like any health intervention, should be especially targeted where it is most needed. Therefore we need to discover more about the private behaviour of people in passing messages. Jonathan (1988) suggested that this must be done carefully, with empathy and sensitivity, otherwise vital information will be hidden and nothing useful will be learned. Working with the people must be intended to educate its dismal failure.

Tolerance and avoidance of discrimination against those who are infected with Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), they and others need help to stop risk behaviour (Jonathan 1988).

Donald (1988) observed that strengthening capacity in reproductive health can be the risk of infection by sexual intercourse can clearly be avoided by life – long celibacy (state of living unmarried vow) or by restricting intercourse to a mutually monogamous (Married to only one) relationship with an infected person. Such advice is not sufficient to meet the needs of everyone. The risk can further be reduced by reducing the number of partners and by the use of condom of high quality during intercourse. Donald (1988) further added that if one must have sex, for example the prostitute must provide sterilized equipment during sex to render them less of a risk to others. For those who are infected, they should be advised to reduce the risk of infecting their sexual partners by abstinence (abstaining for example from sex) or the correct use of condom. Donald (1988) continued that other procedures which involve penetration of the skin, including tattooing (putting a mark or design on the skin), acupuncture (the incision or introduction of fine, hollow tubes into edematous tissue for the purpose of withdrawing fluid or insertion of

needles into the parts of the body), and penetration of the skin for cosmetic treatment, are a potential means of transmission of HIV and should always be carried out with sterile equipment.

Testing all blood donors for HIV antibodies can markedly reduce the risk of infection. Similar precautions are necessary in respect of donations of tissue for transplantation and of sperm for artificial insemination (Donald 1988). Screening of donors together with proper treatment has eliminated the risk of HIV infection.

Other methods of transmission are from infected patient, to people nursing them. They have involved either injury with an infected needle or gross contamination of the skin or mucous membranes of the nurse. In this case, the health worker was untrained and did not wear gloves. “Therefore, Donald (1988), said that sound hygienic medical and nursing practices and extreme care in handling sharp instrument and disposing of them are the keys to risk reduction.

The strengthening of capacity for RH services requires meaningful improvements such as:

- Institutionalization of skills by updating RH components of curricula for training all cadres of healthcare personnel, including Traditional Birth Attendants (TBAS).

- Development and utilization of improved curricula to update the training of service providers and pre-service training of nurses and midwives and medical officers in particular.
- Available of job aids.

In response to these issues, training can be conducted from federal to state and local government healthcare staff. This will further relate especially to issues such as management of HIV\AIDS (FMOH, 2002).

Government information programmes for the general public are necessarily highly visible and so must be widely acceptable. In some areas, fear of objections has prevented open discussion of sexual practices, use of explicit language, and particularly condom promotion (Population Reports, 1989). These lessen the motivational nutrients of strengthening of capacity for management of HIV\AIDS. In Ethiopia, many HIV/AIDS prevention campaigns on radio, television and other media encouraging abstinence, monogamy and condom use are not appropriate to this group (youth) except for the message on condom use (Swart-Kruger and Richter 1997).

The cost of reaching most of the public with education campaign is expensive relative to other public health expenditures. For instance, in Australia, 97 percent of the population saw AIDS messages during the

1987 television campaign (Swart-Kruger and Richter 1997). The fact that many television stations did not charge for airtime, the campaign cost &3.4 million (US) (148). During the second media campaign in the UK, just 90 percent of all adults saw at least one television ad (advert), but the campaign cost £3 million (US $6.1 million). To reach wider populace and to limit costs, the UK AIDS programme is focusing on press advertising. Similarly, Plateau state can organize programmes use various mass media to reach the general public. Such mass media as those on television, major newspapers and Magazines because these reach the largest audiences with authority and legitimacy (AHRTAG, 1994).

There are radio and various print materials such as brochures, leaflets, and posters to strengthening the capacity for management of HIV\AIDS in Plateau state. Teachers of various institutions of learning, religious bodies community groups, private organizations, individuals and the like can develop methods towards strengthening capacity for the control of HIV\AIDS.

Strengthening of capacity for the management of HIV\AIDS is sometimes due to limited distribution of networks. Many languages are spoken and many people cannot read. For example, in Uganda, over two

million leaflets and posters with the Slogan “Zerograzing” and “Love carefully” were distributed in 1987, up from 2000 in 1986 (“Zerograzing” is a phrase borrowed from agriculture and in this context means to stay with one sexual partner) (Population Report 1989). Community programmes organized through Churches and local political groups have been important information sources in rural areas. In addition, there should be television and radio aired talk shows and public service announcements in several languages.

2.5.1 Strengthening Sustainability of Reproductive Service

National Reproductive Health Strategy Frame Work (F.M.O.H, 2002-2006) mentioned that elements of sustainability of reproductive health (RH) services can include supervision and management and evaluation (M&E) and management information system. When the major weakness in the health system in Plateau state, like the ones mentioned below, staff, fund, facilities and equipment are checked corrected and improved activities towards delivery of quality RH services will be achieved and managed properly. Such data should be obtained and possessed guidance for the management of the health programmes (Adetokunbo and Herbert 2003). It continuous that monitoring and

evaluation should be built into the family health services using simple but informative educators (Adetokunbo and Herbert, 2003). Programme managers should monitor the processes (services provided, activities of the health personnels), the outputs (utilization and performance of services), and impact (change in health status of women and children morbidity and mortality rate (Adetokunbo and Herbert 2003).

According to Jonathan (1988) also observed that strengthening capacity building requires the intervention of two persons so that the chain of transmission can be broken by a change in the behaviour either in infected or the non-infected person.

The reason for weak monitoring and evaluation (M&E) could include:

- Poor record keeping and non-availability of the state Health Management Information Service (SHMIS) forms at facility level.
- Lack of tools for M&E
- Lack of motivation of staff due to poor and irregular wages and or incentives; and
- Poor logistics support, including poor or lack of means of transportation and communication.

To strengthen the process for supervision and monitoring and evaluation, the following actions can be taken:

- Tools for M&E and supervision for all components of RH should be developed using the state guidelines for supervision, monitoring and evaluation developed by the Federal Ministry of Health (F.M.O.H).
- Capacity of the units responsible for supervision and M&E at the federal state and local government area levels should be strengthened with regards to staff training on supportive supervision skills and provision of means of transportation (example vehicles, boats (where necessary) motor cycles, bicycles, etc).
- A work plan should be developed to include regular supervisory and monitoring and evaluation visits, especially at facility, state and local government levels.
- Annual and mid-term review of RH projects and activities, including RH services, should be conducted.
- For specific RH programmes and projects, mid and end of term evaluation of performance should be conducted (including impact evaluation) and the stakeholders.

- Quality within the private sector should be monitored and enforced.

2.5.2 Strengthening the Referral System.

F.M.O.H, (2002-2006) admitted that weak referral system diminishes or assumes the access to quality of care without access to quality of care in RH services for routine and emergency situation. Currently, the referral system is well defined, however, there is poor implementation and monitoring and evaluation. Adetokunbo and Herbert (2003) stated that most of the problems are presented at this level but more difficult cases will be referred for more detailed evaluation and for more skilled care. World Health Organization (WHO) cooperates with member state in the strengthening and reorientation of their health services, with particular reference to the primary health care services (Adetokunbo and Herbert, 2003). Based on the Alma Ata Declaration that was adopted in 1978 conference, the inefficient in the referral system have been poor staffing of health facilities, insufficient knowledge of and information about referral guidelines, inadequate supplies and materials, poor documentation, weak communication and transportation system and the unfriendly activities of caregivers. In an effort to meet up the

demand, F.M.O.H. recently recommended resuscitating the referral system by initiating the development of guidelines for referral and designing a standardized tool for effective referrals (2-way referral form). This referral system will involve the following actions or responses.

- Reawakening the interest of all stakeholders in the referral system.
- Producing and distributing national guidelines on referrals and referral forms.
- Supporting communities to participate in the process of referrals by sustaining availability forms and establishing revolving funds to support the costs of referrals.
- Strengthening the decision-making capacity of care providers (including Traditional Birth Attendants (TABs) for timely referrals.
- Providing quality service delivery at all centres.

2.5.3 Management of Information System by the Community in the Promotion of Reproductive Health.

Park (1997) and Adetokunbo and Herbert (2003) observed that information is needed for day-today management of the health system. The information system should b tailored according to the management needs of the individual health services. This includes collection,

classification, transmission, storage, retrieval, transformation and display of information. They added that design services that are equitable and to monitor performance of health services. It should also measure inequalities in health status and inequalities in access to health care. Adetokunbo and Herbert (2003) stated that resources available to the health authorities should be skillfully managed at all levels, from the most peripheral unit to the central office at the headquarter of the Ministry of Health. Training in management is essential for health workers, especially those who are placed in positions of authority and supervision. Adetokunbo and Herbert (2003) added that appropriate supervision of staff is an important aspect of the management of health services. This can be performed by the leader of each group or subgroup. Experience has shown that the best results are obtained if feedback is positive, not only blaming when things go wrong but also praising and rewarding good performance. National Immunization Policy (NIP, 2003) and Adetokunbo and Herbert (2003) concluded that in order to ensure that injection safety activities are carried out properly, it is imperative that trained and competent personnel at all level of the health system are identified to monitor and mange injection safety issues. These included the safe disposal and destruction of use injection equipment.

Management issues include not only health safety training and supervision of practices, but also equipment requirement, calculation, budgeting and monitoring. The status of injection safety shall be regularly assessed in order to identify the problems and the areas to be improved upon.

Plenum Press (1997) contributed that health promotion activities are crucial in any sexually transmitted disease (STD) and human immune-deficiency virus (HIV) (STD/HIV) prevention and control programme. It involves a number of objectives informing the public about STDs (HIV) how they are transmitted, and their long-term effects (especially pelvic inflammatory disease (PID) promoting primary preventive sexual behaviour (stable monogamy; reduction of number of sex partners, safe sex practices, use of barrier contraceptives methods, including condoms, diaphragms and spermicidal, sexual abstinence). Peggy (1988) added that a media-based health education component of an AIDS control programme directed particularly at women, which helps dispel the notion that AIDS is a disease of homosexual men only.

2.5.4 Improving Logistics and Supplies.

If logistics support for Reproductive Health (RH) services which will include materials needed for services (particularly family planning

(FP) commodities, drugs and supplies) at times equipment and appliances are functional, and materials are replenished based on forecasting, stock level assessment and inventory will enhance logistics support for reproductive health (RH) service, these will promote client's satisfaction. This can be strengthened by institutional arrangements and procedures and processes for purchasing and distributing materials (FMOH, 2002).

Supporting the Health Information System

Strengthening of the State Health Management Information System (SHMIS) will improve the quality and quantity of data collected in an integrated manner from all levels of healthcare, for analysis through collection, collation and processing of data with respect to Reproductive Health (RH) Services by critical performance audit and evaluation. In response to the above, State Health Management Information System (SHMIS) forms should be mass-produced and distributed to all health facilities – public and Private institutions. Again, the responsible units for data management at all levels (local government areas (LGAs), State, Federal deserves strengthening through health data information management training as may be necessary for the appropriate staff, and the supply of data management training as may be necessary for the appropriate staff, and the supply of data management hardware and

software. Record keeping habits and processes of the facilities should be supported, which include ensuring regular submission of data forms to all tiers of governments (FMOH, 2002).

2.6 The Influence of Community Participation on the Promotion of Research on HIV/AIDS.

Funding or promotion of research in Reproductive Health (RH) services provides further information for planning, modifying programmes, projects and activities. It will help to provide the basis for employing new methods to address emerging issues towards achieving the desired targets and objectives (Federal Ministry of Health (F.M.O.H, 2002 – 2006).

Population Reports, (1989) stated that research also helps programme managers to develop appropriate messages, design materials, and choose media so that the programme and all its products will be meaningful, persuasive, and appealing to the intended audience.

Due to research findings reported in the Journal of Science (Health and Fitness, 2004) researchers into the HIV/AIDS epidemic recently announced the successful unraveled the structure of an anti-body that neutralizes the human immuno-deficiency Syndrome (AIDS) disease.

Research has also shown (Donald, 1988) that the risk of infection is related to the frequency with which the person injects and with which he or she shares equipment with others (Donald, 1988). Population Reports (1989) also confirmed that research helps to develop appropriate messages, design materials and choose programme and all its products that are meaningful, persuasive and appealing to the intended audience.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The purpose of this study was to find out the extent of community involvement in the control and management of HIV/AIDS in the implementation of national reproductive health plan in Plateau State. To achieve this purpose the research design, population, sample, sampling techniques (procedures), the instrument, validation of instrument, analysis and statistical techniques (methods) are described in this chapter.

3.2 The Research Design

A research is a discipline common sense, concerned with producing results that will lead to the development of theories (Awotunde, P.O., Ugodulunwa, C. & Ozoji, E.D., 1997 & Awotunde, P.O. & Ugodulunwa, C.A., 2002). As the purpose of this study was to find out the extent of community involvement in the control and management of HIV/AIDS in the implementation of national reproductive health plan in Plateau State, ex-post-facto (non-experimental) research design was used as the information required was already on ground (available). This research design afforded the

researcher opportunity to study two or more independent variables that were placed side by side to be able to study their independency and their interactive effects on the dependent variable.

3.3 The Population

A population in research is a target group, which a researcher is interested in studying and about which he intends to obtain information and draw conclusion (Awotunde et al 1997). The population for this study consisted of the various categories of the communities' aged 15 years and above living in Plateau State of Nigeria and involved in the control and management of HIV/AIDS in Plateau State. The various categories of the communities involved in the study included women group, religious group and the youth group in the 17 Local Government Areas of the State. The population of the State has been zoned into three (3) senatorial districts:

(a) Plateau Central Senatorial district, comprises of Bokkos, Kanam, Kanke, Mangu and Pankshin Local Government (Pankshin as Headquarter).

(b) Plateau North Senatorial district, comprises of Barakin Ladi, Bassa, Jos East, Jos North, Jos South and Riyom Local Government (Barakin-Ladi as Headquarter) and

(c) Plateau South senatorial district comprises of Langtang North, Langtang South, Mikang, Quan-Pan, Shendam and Wase Local Government (Shendam as Headquarter).

3.4 The Sample

Awotunde, P.O., Ugodulunwa, C. & Ozoji, E.D. (1997) and Lere, M.M., Dadughun, S.I. & Bulus, H. (2002) opined that in almost instances in educational research, it is impossible to study a whole population and therefore, portions of it are usually studied.

Purposive sampling technique used to select subjects for this study and this was taken as being representative of the population. The purposive random sampling was used in selection of male and female adults aged 15 years and above, residing in both rural and urban settlements of Plateau Central senatorial district, Plateau North senatorial district and Plateau South senatorial district used for the study. Thus, voluntary counseling and Testing (VCT) Centre of each senatorial zone headquarters were used for this study.

3.4.1 Sampling Techniques (Procedures)

Awotunde et al (1997) stated that sampling is a process or activity in which a portion, segment or part (also known as sample) of a population is carefully selected as taken as being representative of the population. A sample drawn at random is unbiased in the sense that no member of the population has any more chance of being selected than any other member. Purposive or non-probability sampling was also used. This is where each element in a population was chosen at random and has

a known, non-zero chance of selection (Awotunde et al 1997, Osuala, 2001and Lere et al. 2002). To select 100 respondents from the 3 (women, religious and youth group), the researcher distributed the questionnaires to those groups present at different designated days. Thus Plateau Central Senatorial districts on Mondays, Wednesdays and Fridays, Plateau North Senatorial on Tuesdays, Thursdays and Saturdays and Plateau South Senatorial on Mondays, Thursdays and Saturdays respectively. All respondents (15 years and above) living in Plateau State at the time of the study serve as subjects for this study irrespective of gender, religion, marital status, location, ethnicity educational qualification and income level. Women group were assigned a day for the awareness, religious group as well as the youth group (at different designated days). In addition three hundred (300) respondents (subjects) are expected from the three (3) senatorial districts headquarters (Voluntary Counseling and Testing (VCT)) headquarter centres. The technique was successful with assistance from interpreters who are fluent in conducting themselves (research assistants or programme officers).

3.5 The Instrument

The instrument used for this study to collect data was the questionnaire and interview focused group discussion for the literate and

illiterate respondents. Discussion, which involved, for example, 3-5 persons taking part in a group, is necessary.

3.5.1 Development of the Instrument

The instrument was designed by the researcher consisted of forty three (43) statements with three (3) sections. Section 'A' was on personal information of the respondents with eight (8) statements (from 1–8), section 'B' on the control of Human Immune Virus (HIV)/Acquired Immune Deficiency syndrome (AIDS). (HIV/AIDS), with twenty five (25) statements (from 9 – 33), and section 'C' on the management of HIV/AIDS with ten (10) statements (from 34 – 43).

3.5.2 Validation of the Instrument

The face validity of the instrument was determined by distributing the copies of the questionnaire to five (5) jurors who were experts from the Department of Physical and Health Education, Community Medicine, Veterinary Medicine, Physiology and Sociology of Ahmadu Bello University, Zaria, to determine the face validity of the questionnaire. On the basis of their assessments, suggestions and recommendations, necessary modifications were made in the draft questionnaire, after which

the final questionnaire was prepared on a 5-point Likert Scale for the research work.

3.6 Administration of Questionnaire

Three (3) Voluntary Counseling and Testing (VCT) Centres were used for the administration of the questionnaires in the three (3) senatorial districts of Plateau State. The researcher was personally involved in the random distribution of the questionnaires, conduct of interview and focused group discussion for the literate and illiterate respondents. However, this was successful with assistance from interpreters who were fluent in conducting themselves (research assistants or programme officers) from each Voluntary Counseling and Confidential Testing (VCCT) centre of the zones before the respondents of all kinds. Thus, three hundred (300) questionnaires were administered to the 300 respondents randomly selected from the three (3) senatorial districts in the state. A total of 100 copies of questionnaires were administered to each of the 3 senatorial districts in Plateau State.

3.7 Statistical Techniques

The data collected from the respondents during the study was statistically described and analyzed by using the statistical package for

social science (SPSS) at the Institute for Agricultural Research (IAR) Ahmadu Bello University, Zaria. Frequency and percentage for information on personal data, mean and standard deviation for community involvement in the control and management of HIV/AIDS, Kruskal – Wallis one – way ANOVA at the Institute for Agricultural Research (IAR) Computer Centre, Ahmadu Bello University, Zaria for significant difference among communities from different senatorial districts of Plateau state. The statistical techniques that were used to analyze the data for this study are:

1. Descriptive statistics of frequencies, percentages, means and standard deviations were used to analyze the demographic data that emanated from the study.
2. Kruskal – Wallis one – way Analysis of variance (ANOVA) was used to test the significance difference among different senatorial districts in their involvement in the communities in the control and management of HIV/AIDS.
3. 0.05 alpha level of significant was used for the statistical test of level of confidence.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

The purpose of the study was to find out community involvement in the control and management of HIV/AIDS in the implementation of national reproductive health plan in Plateau state.

To achieve this purpose, the data collected was statistically analyzed, the results of which are presented and discussed in this chapter.

4.2 Results

Information about the demographic characteristics of the respondents are shown in table 1.

4.2.1 TABLE 1: Demographic Characteristics of Respondents

CHARACTERISTIC	FREQUENCY	PERCENT	VALID PERCENT	CUMULA-TIVE PERCENT
1. **Age:**				
(a) 15 – 19 years	26	9.1	9.1	9.1
(b) 20 – 24 years	41	14.4	14.4	23.5
(c) 25 – 29 years	45	15.8	15.8	39.3
(d) 30 – 34 years	67	13.5	23.5	62.8
(e) 35 years and above	106	37.2	37.2	100
Total	285	99.3	100	
Missing system	2	.7		
Total	287	100		
2. **Gender:**				
(a) Male	177	61.7	62.1	62.1
(b) Female	108	37.6	37.9	100
Total	285	99.3	100	
Missing system	2	.7		
Total	287	100		
3. **Religion**				
(a) Christianity	240	83.6	83.9	83.9
(b) Islam	36	12.5	12.6	96.5
(c) Traditional	5	1.7	1.7	98.3
(d) Others	5	1.7	1.7	100
Total	286	99.7	100	
Missing system	1	.3		
Total	287	100		
4. **MARITAL STATUS**	101	35.2	35.2	35.2
(a) Single	168	38.5	38.5	93.7
(b) Married	13	4.5	4.5	98.3
(c) Widowed	5	1.7	1.7	100
(d) Divorced	287	100		
Total				
5. **Location**				
(a) Rural	183	63.8	63.8	63.8
(b) Urban	104	36.2	36.2	100
Total	287	100	100	

6. **Ethnicity**				
(a) Birom	67	23.3	23.4	23.4
(b) Jarawa	14	4.9	4.9	28.3
(c) Hausa	14	5.2	5.2	33.6
(d) Yoruba	9	3.1	3.1	36.7
(e) Igbo	11	3.8	3.8	40.6
(f) Mwaghavul	66	3.8	23.1	63.6
(g) Ngas (Angas)	32	23.0	11.2	74.8
(h) Angkwai	18	11.1	6.3	81.1
(i) Others	54	6.3	18.9	100
Total	286	18.8	100	
Missing system	1	.3		
Total	287	100		
7. **Highest Education Qualification**				
(a) Master's Degree	3	1.0 5.6	1.0	1.0
(b) Bachelor's Degree	16	18.1	5.6	6.6
(c) NCE/Diploma	52	35.9	18.1	24.7
(d) O'Level cert. G.II SSCE, NECO	105	27.5	35.9	60.6
(e) Prim. School Cert.	79	5.9	27.5	88.2
(f) Quranic education	17	2.4	5.9	94.1
(g) Adult education	7	2.1	2.4	96.5
(h) Traditional education	6	1.0	2.1	98.6
(i) Apprenticeship/ Craftsman	3	.3	1.0	99.7
(j) Never attended	1	100	.3	100
	287		100	

8. Income Level				
(a) Less than N100,000.00 per Annum	106	36.9	39.1	39.1
(b) N100,000.00 - N200,000.00 per Annum	74	25.8	27.3	66.4
(c) N200,000.00 - N300,000.00 per Annum	39	13.6	14.4	80.8
(d) N300,000.00 - N400,000.00 per Annum	27	9.4	10.0	90.8
(e) N400,000.00 and above per annum	25	8.7	9.2	100
Total	271	94.4	100	
Missing system (value)	16	5.6		
Total	287	100		

Table 1 shows that more than 60% (173) of the respondents were 30 years and above in age. 177 (61.7%) of them were males and 108 (37.7%) females. Most of them (240, 83.6%) were Christians. They were mostly either married (168, 58.5%) and Single (101, 35.2%). Most of them (183, 63.8%) were from rural areas. The dominant tribes were Birom (67, 23.3%), Mwaghavul (66, 23%) and others most of them had had either Secondary (103, 35.9%) or Primary School (79, 27.5%) education. The income level of most

people (180, 62.7%) ranges from N100,000.00 to N200,000.00 per annum.

4.3 Major Hypothesis

There is no significant involvement of the communities in Plateau State in the control and management of HIV/AIDS.

4.3.1 Sub-Hypothesis 1:

There is no significant involvement of communities in Plateau State in the control of HIV/AIDS.

In order to test sub-hypothesis I, mean score of responses to statements on the control of HIV/AIDS through the involvement of the communities in Plateau State were computed. As the responses were on a 5 point Likert Scale, a mean score of 3.5 and above was considered as significant involvement of the communities in Plateau State. Results regarding the involvement of communities in Plateau State in the control of HIV/AIDS are shown in table 2.

4.2 TABLE 2: Means and Standard Deviation of Responses on the Control of HIV/AIDS

LOCATION	**NO. OF STATEMENT S**	**MEAN SCORE**	**MEAN OF STANDARD DEVIATION**
Combine districts	25	3.14	1.178

Table 2 shows that the mean score for the involvement of communities on the control of HIV/AIDS was 3.14 $\pm$ 1.18, which is less than 3.5. Therefore, the involvement of Plateau State communities in the control of HIV/AIDS was not significant. Therefore, the hypothesis was accepted.

4.3.2 Sub-Hypothesis 2:

There is no significant involvement of the communities in Plateau State in the management of HIV/AIDS.

As the responses were also on a 5 point Likert Scale, a mean score of 3.5 and above was considered as significant involvement of the communities in the State. Results regarding the involvement of communities in the state in the management of HIV/AIDS are shown in table 3.

4.3 TABLE 3: Mean and Standard Deviation of Responses on Management of HIV/AIDS

LOCATION	NO. OF STATEMENTS	MEAN SCORE	MEAN OF STANDARD DEVIATION
Combine districts or zones.	10	3.18	1.156

Table 3 shows that the mean score for the involvement of communities in the management of HIV/AIDS was 3.18 $\pm$ 1.16, which is less than 3.5. Therefore the involvement of Plateau State communities in the management of HIV/AIDS was not significant. Therefore, the hypothesis was accepted.

4.3.3 Sub-Hypothesis 3:

There is no significant difference between different senatorial districts of Plateau State in their involvement in the control of HIV/AIDS.

In order to test sub-hypothesis 3, mean scores of responses from each senatorial district on the control of HIV/AIDS were computed, the results of which are shown in table 4.

4.4 TABLE 4: Means and Standard Deviation of Responses on

the Control of
HIV/AIDS BY DISTRICT

LOCATION	NUMBER OF STATEMENTS	MEAN SCORE	MEAN OF STANDARD DEVIATION
Plateau Central Senatorial District (PCSD)	25	3.42	1.133
Plateau North Senatorial District (PNSD)	25	3.02	1.138
Plateau South Senatorial District (PSSD)	25	3.06	1.211
Combine districts or zones	25	3.14	1.178

Table 4 shows that the responses from all the districts were less than a mean of 3.5 indicating that there was no significant involvement of these districts in the control of HIV/AIDS. However, table 4 shows differences in the responses from the different senatorial districts. To find out if these differences were significant, the responses were analyzed by using one-way Analysis of variance (ANOVA), the results of which are shown in table 5.

4.5 TABLE 5: One-Way Analysis of Variance (ANOVA) for

Differences among the Different Senatorial districts on the Control of HIV/AIDS

	SUM OF SQUARES	df	MEAN OF SQUARES	F	SIGNIFI-CANT
Control					
Between Group	6.531	2	3.265	6.923	.001
Within Groups	99.047	210	.472		
Total	105.577	212			

Table 5 shows significant difference among districts in their involvement in the control of HIV/AIDS. Scheffe Post-hoc showed that the significant difference among districts in their involvement in the community in the control of HIV/AIDS was due to greater involvement (M = 3.42 ± 1.13) of Plateau Central senatorial district compared to Plateau North (M=3.02 ±1.14) and South senatorial district (M=3.06±1.211).

4.3.4 Sub-Hypothesis 4:

There is no significant difference between the different senatorial districts of Plateau State in their involvement in the management of HIV/AIDS.

To test sub-hypothesis 4, mean scores of respondents from different districts were computed on the involvement of communities in the management of HIV/AIDS, the results of which are shown in table 6.

4.6 TABLE 6: Mean and Standard Deviation of Responses on Management of HIV/AIDS by District

LOCATION	NUMBER OF STATEMENTS	MEAN SCORE	MEAN OF STANDARD DEVIATION
Plateau Central Senatorial District (PCSD)	10	3.45	1.144
Plateau North Senatorial District (PNSD)	10	2.92	1.108
Plateau South Senatorial District (PSSD)	10	3.16	1.143
Combine districts or zones	10	3.18	1.155

Table 6 shows that the mean score for the involvement of communities on the management of HIV/AIDS was 3.18 ± 1.16, which is less than 3.5. Therefore, the involvement of communities in Plateau state in the management of HIV/AIDS was not significant. However table 6 shows differences in the responses from the different districts. To find out if these differences were significant, the responses were analyzed by

using one – way Analysis of variance (ANOVA), the results of which are shown in table 7.

4.7 TABLE 7: One-way Analysis of Variance (ANOVA) for Differences between the different Senatorial Districts on the Management of HIV/AIDS

	SUM OF SQUARES	df	MEAN OF SQUARES	F	SIGNIFI-CANT
Management					
Between Group	11.682	2	5.841	8.799	.000
Within Groups	165.955	250	.664		
Total	177.636	252			

Table 7 shows significant differences among districts in their involvement in the management of HIV/AIDS. In the management of HIV/AIDS, the difference was mainly due to greater involvement of Plateau Central senatorial district (M=3.45±1.14) compared to other districts and due to Plateau south senatorial district (M=3.16±1.14) than Plateau North senatorial district (M=2.92±1.11).

4.4 Discussions

Control of HIV/AIDS

The results of this study showed insignificant involvement of the communities in political commitment and support for the control of HIV/AIDS. This finding is in line with the report of Federal Ministry of Health (F.M.O.H; 2002 – 2006), which stated that weak political commitment, poor budgetary allocation and community participation in reproductive health programmes (RHPs) and services led to poor involvement of the communities in the control of HIV/AIDS. This was also in agreement with the finding of John (1988) who confirmed that absence of medical defense against AIDS, and public education is the main cause of spread of infection. This evidence seems to support the argument of the Council for the Development of Social Science Research In Africa (CODESRIA, Bulletin, 1973 – 2003), according to which by influencing personal behaviour and lifestyles we can have hope to minimize the ravages of AIDS throughout our population. This is related to that of Population Report (1989), which stated that preventing the spread of AIDS depends on influencing people to change their behaviour. In Africa, heterosexual relationship is the main mode of transmission of AIDS and other sexually transmitted infections (National HIV/AIDS and Reproductive Health Survey (NARHS), Nigeria, 2003).

The results of these study also showed insignificant involvement of the communities in the promotion of health seeking behaviour in the control of HIV/AIDS. This finding supports the report of Adetokunbo and Herbert (2003). According to which health practices should not be done by only professionals but also with the general populace. This is also in line with the view of Appropriate Health Resources and Technologies Action Group (AHRTAG; 1995), according to which programmes should encourage participation of men and women, especially in providing practical support, such as bringing food, doing laundry, or cultivating land for the sake of promoting health expectancy of the populace. It is perhaps because of this reason that Adetokunbo and Herbert (2003) suggested that community members must be consulted persuaded and be given responsibility in the decision-making, which contributed to the greater involvement of the communities in Plateau state. This result also justifies the views of Appropriate Health Resources and Technologies Action Group (AHRTAG; 1995), which stated that the greatest problems of people living with HIV are poverty and lack of medical care and not only HIV illnesses, fear of rejection (discrimination) by members of the family, was also common.

The result of the study also showed insignificant involvement of the communities in the expansion of access to the control and management of HIV/AIDS. This finding supports the view of the F.M.O.H (2002-2006) which suggested that the poor health status of the communities in Plateau state could be due to low level of access to quality reproductive health information and services at all tiers of care. Moreover, access is limited by location of facilities to the majority of users. Poor staffing and deficient in skills, lack of good equipment and consumables, unaffordable costs and linkages are some of the lapses in reproductive health services. This view is in line with AHRTAG, (1995) according to which hospital care is not always available or accessible. Family cannot afford transport or medical costs, or to stay with the sick person while he or she receives treatment. This finding also supports AHRTAG (1995) and Adetokunbo and Herbert (2003), which reported that many communities in developing countries do not benefit fully from modern knowledge and technology that could have protected and restored their health. To them communities do not have access to simple remedies of proven efficiency, or where the services are provided. Individuals and communities also fail to make use of them. They often lack the essential knowledge on how to keep healthy, how to recognize

dangerous signs in the individual and hazardous situations in the environment, and how to mobilize resources to solve health problems.

Management of HIV/AIDS

The result of the study showed insignificant involvement of the communities in the management of HIV/AIDS. This finding is in accordance with that of Park (1997) and F.M.O.H., (2002 – 2006), according to which an inefficient healthcare delivery system, including management and service provision, has been a major setback in meeting the Reproductive Health needs of the people of Plateau State. This study also supports population Reports (1989) which stated that fear of objections have prevented open discussion of sexual practices, use of explicit language, and particularly condom promotion. These lessen the motivational nutrients of strengthening of capacity for management of HIV/AIDS.

The study showed insignificant involvement of the communities in the strengthening the referral system in the management of HIV/AIDS. This finding supports Adetok2unbo and Herbert (2003) and F.M.O.H., (2002 – 2006) which supported that weak referral system diminishes or assumes the access to quality of care in RH services for routine and emergency situation. Management information system must include measuring inequalities in health status and inequalities in access

to health care. The data collecting instrument must be designed to take note of groups and sub-groups, especially vulnerable groups whose access to services is restricted by geographical, economic, social and cultural factors. This includes usual demographic indicators (age, sex and marital status) as well as socio-economic indicators (race, ethnic origin, occupation, residence) and other social variables (Adetokunbo and Herbert, 2003).

This study showed significant difference among districts in the involvement of the communities in the control of HIV/AIDS due to greater involvement (M=3.42 $\pm$ 1.13) of Plateau Central Senatorial district compared to Plateau North (M=3.02 $\pm$ 1.11) and Plateau South Senatorial district (M=3.06 $\pm$ 1.21). The greater involvement of the communities was probably due to political commitment and support of the communities in the control and motivational support (F.M.O.H., 2002 – 2006) for reproductive health (RH) issues and services. The communities in Plateau Central senatorial district were well informed educated and communicated (F.M.O.H, 2002 – 2006). Not only that, they were provided appropriate knowledge in a visible form that promotes positive social and cultural practices. The greater involvement of the communities of Plateau Central Senatorial district was also due to greater effectiveness of HIV/AIDS advocacy efforts by non-governmental organizations (NGOs) people living with HIV/AIDS

(PLWHA), United Nation (UN) leaders, labour organizations and a wide array of other actors in the community. This finding also supports AHRTAG, (1994) and Adetokunbo and (Herbert, 2003) which stated that behaviour of the young should not be over influenced by their families, friends and others with whom they have regular contact. The study also suggested that provision of access to quality reproductive health information and services and at all tiers of care to vulnerable groups are some of the differences experienced in the risk infection of HIV/AIDS epidemic.

The study also showed significant difference between different senatorial districts in their involvement in the provision of access to quality reproductive health in the control of HIV/AIDS.

This study showed significant difference among the different senatorial districts in their involvement in the management of HIV/AIDS. F.M.O.H. (2002 – 2006) observed that inefficient healthcare delivery system, including management and service provision, has been a major setback in meeting the Reproductive Health (RH) needs of the people of Plateau state. There was greater involvement ($M=3.5 \pm 1.14$) of Plateau Central Senatorial district compared to other districts and also due to Plateau South Senatorial district ($M=3.2 \pm 1.14$) than Plateau North

Senatorial district (M=2.92 $\pm$ 1.11). Communities in Plateau Central were able to strengthened their capacity building by personal development by (provider knowledge and skills), provision of materials, equipment and services for effective administration of programmes. Capacity building should include making service users friendly and sustainable.

The result also showed insignificant difference between different senatorial districts. It is in line with Population Report (1989) which explained that explicit languages, and particularly condom promotion helps motivational nutrients of strengthening of capacity for management of HIV/AIDS. Various print materials such as brochures, leaflets and posters are used to strengthen the capacity for management of HIV/AIDS in Plateau central Senatorial district and South Respectively. There was distribution of networks in the languages people can read and understand. For example, in Uganda, over two million leaflets and posters with the Slogan "Zerograzing" and Love carefully "were distributed in 1987, up from 2000 in 1986". It is a phrase borrowed from agriculture and this context mean to stay with one sexual partner. The involvement of communities in Plateau Central and South Senatorial in the management of HIV/AIDS was also due to programmes organized through churches

and local political groups in rural and urban areas. As well, provision of television and radio aired talk shows and public service announcements in several languages.

National Reproductive Health Strategy Framework (F.M.O.H., 2002 – 2006) mentioned that element of sustainability of Reproductive Health (RH) Services should include supervision and management and evaluation (M & E) and management information system. The contribution merges with sub-hypothesis 4 of no significant difference between the different senatorial district in their involvement in the management of HIV/AIDS. Programme Managers were monitored (services were provided, activities of the health personnels), the outputs (utilization and performance of services) and impact (change in health status of women and children morbidity and mortality rates were felt.

In the other hand, F.M.O.H, (2002 – 2006) admitted that weak referral system diminished or assumed the access to quality of care in the involvement of communities in Plateau North Senatorial district (M=2.92 $\pm$ 1.11) compared to other factors of management of HIV/AIDS in the area. There was poor implementation and monitoring and evaluation. The Alma Ata Declaration adapted in 1978 Conference, that the inefficiency in the referral system have been due to poor staffing of

health facilities, insufficient knowledge of and information about referral guidelines, inadequate supplies and materials, poor documentation, weak communication and transportation system and the unfriendly activities of care givers. The inability to be involved in the community was also due to decision-makers and managers cannot develop a management information system (MIS) Park (1997) and (Adetokunbo and Herbert, (2003). They advanced that collection, analysis of data and interpretation of findings for making decision; monitoring trends and evaluation of programmes are not regularly followed. They added that measuring inequalities in health status and inequalities in access to health care were some of the insignificant involvement of the communities in the management of HIV/AIDS in Plateau State. Adetokunbo and Herbert (2003) further added that the insignificant involvement of the communities was that the resources available to the health authorities are not managed skillfully at all levels.

Donald (1988) observed that significant difference existed in the involvement of the communities in the management of HIV/AIDS was probably because there were so many polygamous homes (marrying more than one) relationship (partner) sexual steady partners.

It could be observed here that there was no research carried out in respect of community involvement in the management of HIV/AIDS that contributed to the low level of involvement of the communities. Further information for planning, modifying programmes, project and activities will help to provide the basis for employing new methods to address emerging issues towards achieving the desired targets and objectives (F.M.O.H, (2002 – 2006) and Population Report (1988) which stated that research helps programme managers to develop appropriate messages, design materials and choose media so that the programme and its products will be meaningful, persuasive and appealing to the intended audience. Due to research findings reported in the Journal of Science, Health and Fitness (2004) researchers into the HIV/AIDS epidemic recently announced the successful unraveled the structure of an anti-body that neutralizes the human immuno-deficiency syndrome. Research has also shown that the risk of infection is related to the frequency with which the person injects and with which he or she shows equipment with others (Donald 1988).

The major hypothesis that states: there is no significant involvement of the communities in Plateau State in the control and management of HIV/AIDS in the implementation of national

reproductive health plan was therefore was accepted. The result of this study showed that political commitment, motivational support, knowledge of how to improve on individual health related services contributed to the low control and management of HIV/AIDS in Plateau State.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary

It has been observed that there are differences in the knowledge base, awareness and motivational support for reproductive health (RH) issues, and services in the communities of Plateau state between the served (community members, including policy makers, opinion leaders etc) and the servers (programme managers, health workers). This has led to the weak political commitment, poor budgetary allocation and community participation in RH (reproductive Health) programmes and services.

This study therefore attempts to examine the extent of community involvement in the control and management of HIV/AIDS. To achieve this purpose, a questionnaire was developed which consisted of 43 statements with three (3) sections. In order to validate, 5 jurors professional experts from the Department of Physical and Health Education, Community Medicine, Veterinary Medicine, Sociology and Physiology, vetted the questionnaire for the face validity. On the basis of their assessments and suggestions, the final questionnaire was restructured and prepared on a 5 point Likert scale. The questionnaire

was administered on a total of 300 respondents, out of whom 287 responded.

The study showed that some of the problems perceived by the respondent were lack of knowledge base, awareness and motivational support for reproductive health issues and services. The study further revealed that the problems identified were not new.

Furthermore, the study showed significant differences among communities from different senatorial districts of plateau state in their involvement in the control and management of HIV/AIDS. These significant differences were mainly due to greater involvement (M= 3.42$\pm$1.13) of plateau Central senatorial district compared to Plateau North senatorial district (M= 3.02 $\pm$ 1.11) and plateau south senatorial district (M= 3.06 $\pm$ 1.21).

Advocacy and social mobilization will enlist the support of policy and decision makers, community members and organizations on reproductive health issues and services. In addition, it would enhance male participation in RH programmes (National Reproductive Health Strategic Framework and Plan (Federal Ministry of Health (F.M.O.H, 2002 – 2006).

However, no studies have been reported on the extent of mobilization and involvement of communities in different parts of Plateau State in RH programmes. This study was therefore conducted to find out the extent of community involvement in the control and management of HIV/AIDS in Plateau state.

The results of this study showed that: there were significant differences among communities from different senatorial districts of Plateau State in their involvement in the control and management of HIV/AIDS.

1. The involvement of Plateau State communities in the control of HIV/AIDS was not significant.
2. The involvement of communities in Plateau State in the management of HIV/AIDS was not significant.
3. The involvement of communities in the different senatorial districts of the state in their control of HIV/AIDS was not significant.
4. The involvement of communities in the different senatorial districts of the state in their management of HIV/AIDS was significant.

5.2 Conclusions

In view of the limitations of this study, the following conclusions are drawn from the results presented and discussed in chapter 4.

1. Community in Plateau State was not significantly involved in the control and management of HIV/AIDS. There was no knowledge base, awareness and motivational support for reproductive health issues and services.
2. Involvement of communities in the management and control of HIV/AIDS significantly different from each other, perhaps due to the input they received. Plateau central Senatorial District made use of supports received from government, non-governmental organizations and mass media.
3. Communities from Plateau Central Senatorial District were significantly more involved than other senatorial districts in Plateau State in the control and management of HIV/AIDS as these districts receive supports from government, non-governmental organizations (NGOs) and mass media.

5.3 Recommendations

Based on the results of this study, the following recommendations are made to increase the involvement of communities in Plateau State in the control and management of HIV/AIDS.

1. There is need to improve knowledge base, awareness and motivational support for reproductive health issues and services.
2. People should be educated not to discriminate on against HIV/AIDS victims.
3. Government should provide free medical care most especially to those who have opened up and tested positive with HIV.
4. Government voluntary counselling and testing centres should be built in every local government headquarters of the state for the voluntary counselling and confidential testing patients.

Recommendations for Further Studies

This study found significant differences among communities from different senatorial districts in their involvement in the control and management of HIV/AIDS. It is clear that these differences affect control and management of HIV/AIDS. It is therefore suggested that studies on the differences among communities less significantly involved in the control and management of HIV/AIDS be conducted.

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QUESTIONNAIRE ON THE COMMUNITY INVOLVEMENT IN THE CONTROL AND MANAGEMENT OF HIV/AIDS IN THE IMPLEMENTATION OF NATIONAL REPRODUCTIVE HEALTH PLAN IN PLATEAU STATE

This questionnaire contains three sections. Sections 'A' is on personal information of the respondents, section 'B' human immune-deficiency virus (HIV) and acquired immune-deficiency syndrome (AIDS) and section 'C' on Management of HIV/AIDS.

SECTION A: PERSONAL INFORMATION

Please tick (√) against each statement that most appropriate to you.

1. Age:

   (a) 15 - 19 years ( ) (b) 20 - 24 years ( )

   (c) 25 - 29 years ( ) (d) 30 - 34 years ( )

   (e) 35 years and above ( )

2. Gender:

   (a) Male ( ) (b) Female ( )

3. Religion:

(a) Christianity ( ) (b) Islam ( )

(c) Traditional ( ) (d) Others (specify):

_____

4. Marital Status:

(a) Single ( ) (b) Married ( )

(c) Widowed ( ) (d) Divorce ( )

5. Location:

(a) Rural ( ) (b) Urban ( )

6. Ethnicity:

(a) Birom ( ) (b) Jarawa ( )

(c) Hausa ( ) (d) Yoruba ( )

(e) Igbo ( ) (f) Mwaghavul ( )

(g) Angas ( ) (h) Ankwai ( )

(i) Others (specify): _____

7. Highest Educational Qualification:

(a) Masters Degree ( )

(b) Bachelor's Degree/HND ( )

(c) NCE/Diploma ( )

(d) Ordinary Level Certificate
Grade II, SSCE, NECO ( )

(e) Primary School Certificate ( )

(f) Qur'anic education ( )

(g) Adult education ( )

(h) Traditional form of education ( )

(i) Apprenticeship/Craftsman ( )

(j) Never attended ( )

8. Income Level:

(a) Less than N100,000.00 per annum ( )

(b) N100,000.00 – N200,000.00 per annum ( )

(c) N200,000.00 – N300,000.00 per annum ( )

(d) N300,000.00 – N400,000.00 per annum ( )

(e) N400,000.00 and above per annum. ( )

SECTION B: CONTROL OF HIV/AIDS

All the statement in section 'B' and 'C' are to be responded on the 5 points Likerts Scale. The key further abbreviation is given below:

SA = Strongly Agree

A = Agree

UD = Undecided

D = Disagree

SD = Strongly Disagree.

Please tick (√) the column against each statement that best represent your feeling.

		SA	A	UD	D	SD
9.	Visits are conducted in your area to make you aware of the problems regarding HIV/AIDS control programmes.					
10.	The visits are at least once a week					
11.	Meetings are conducted in your area to make you aware of the control and prevention measures of HIV/AIDS.					
12.	Time meets are conducted at least in one community.					
13.	In Junior Secondary School (JSS 1 (in-coming students) are sensitized in your community (Local Government Area (L.G.A).					
14.	In Senior Secondary School (SSS) out-gone students (LGA) are sensitized.					
15.	Only female students in-and-out-of school are screened.					
16.	Only male students in-and-out-of school are sensitized.					
17.	Both male and female students in-and-out-of school are screened.					
18.	Information, Education and Communication (I.E.C) (Manuals) are disseminated (supplied) in workplace on Ethical and human rights issues involve in HIV/AIDS.					
19.	Information, Education and Communication (I.E.C) supplied at least once a week.					
20.	HIV/AIDS sensitization is conducted in respect of migrant workers in different Communities in the L.G.A.					

21.	Migrant workers are sensitized at least once a month.					
22.	Seminars are conducted to sensitize maternity care to include HIV/AIDS education in antenatal talks.					
23.	Seminars are conducted at least once a month.					
24.	Routine sensitization and mobilization are conducted to make people understand the effect of commercial sex workers (CSWs) regarding safer sex practices.					
25.	Routine checks are conducted at least once a week.					
26.	Sensitization seminars are conducted concerning problems of HIV/AIDS regarding women in Polygamous homes.					
27.	Sensitization seminars are conducted at least once a month.					
28.	Teams are established in your Community in respect of mobilization process.					
29.	At least two teams are established in each Community.					
30.	Public awareness messages and policy information are disseminated in respect of blood concerning safety and blood (donors)					
31.	Voluntary counseling and confidential testing (VCCT) centre in each zone.					
32.	At least one voluntary counseling and confidential testing (VCCT) centre in each zone.					
33.	Guidelines are produced and disseminated to home-based care in respect of health care providers.					

SECTION C: MANAGEMENT OF HIV/AIDS.

The following statements relate to management of HIV/AIDS Managements. Please (√) the appropriate column against each statement, which best describes your opinion or feelings.

		SA	A	UD	D	SD
34.	Drugs used are produced and supplied for the management of HIV/AIDS.					
35.	Testing kits are procured and distributed regarding HIV infection diagnostic.					
36.	Testing kits are procured and distributed at least once a year.					
37.	Community Volunteer mobilizers are trained.					
38.	At least two (2) community mobilizers are trained in one Community.					
39.	Training is conducted at least once a month.					
40.	Community action groups are established (formed).					
41.	At least two (2) Community action groups are formed in each Community.					
42.	Health care providers are provided for the problem of patient counseling regarding home-based c are.					
43.	Training is conducted at least once a week.					