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Librarians' initiated HIV /AIDS Prevention Intervention Efforts in Selected Rural Communities in Oyo state, Nigeria

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Abstract

This study was designed to investigate the effect of Librarians initiated HIV/AIDS preventions intervention efforts in selected rural communities in Oyo State, Nigeria. One hundred and ninety two respondents composed of male and female family heads, wives and unmarried adults were randomly chosen for the study. Data were procured through administration of pre-tested and validated interview schedule. About 72% of the respondents gained knowledge of HIV/AIDS through UNDP campaigns, among other sources. Knowledge of contracting HIV/AIDS (unprotected sexual intercourse, blood transfusion, etc), and prevention of the pandemic (use of condom, non-sharing of sharp objects, etc) were also learnt mainly through UNDP activities. Perceptive adverse effects of the pandemic on the society included death, psychological depression and loss of manpower. Other adverse effects were low household income, household food insecurity, diversion of most family labor and funds to healthcare, and inability to eat well. Age ($\chi^2 = 87.106, p=0.00$), Primary occupation ($\chi^2 = 12.148, p= .012$) and marital status ($\chi^2 = 47.515, p=0.04$) were significantly related to knowledge of prevention of HIV/ AIDS. It is recommended that massive investment in public education and establishment of rural community information resource centres should be intensified through NGOs, librarians and governmental bodies to reduce and eventually eliminate the pandemic.

Key Words: *HIV/AIDS, Information, Intervention, Rural Community*

Introduction

According to Ajuwon (2006), Librarians have important roles to play in providing credible, comprehensive and up-to-date information about HIV/AIDS to Nigerians, especially to people who live in rural medically under-served communities. Researchers have highlighted the destructive and disruptive influences of the HIV/AIDS pandemic variously since its debut. It has been established that the worst-hit region of the world is Sub-Saharan Africa, where HIV/AIDS is the leading cause of death, with 25million people infected (UNAIDS,2006:13). Stokes (2003) observes that because most of the hardest hit countries are still overwhelmingly rural, the epidemic represents an enormous threat to rural development. Chukuezi (2002) reflects that with HIV/AIDS and related diseases, African potential is reduced, its human resources are wasted, a complex mix of social and political problem are created making life and progress more difficult. The epidemic of HIV poses major public health problems in Nigeria. HIV prevalence among antenatal clinic attendees rose from 1.8% in 1991 to 5.8% in 2001 (FMOH, 1995; 2001; 2003). Data from the most recent national survey conducted in 2007 showed that the prevalence of HIV infection was 3.6% (FMOH, 2008). Approximately 3.8 million are living with the virus (PLWHA). Nigeria now has a generalized epidemic with reports of HIV confirmed in all the 36 states, the federal capital Abuja, in urban and rural communities, and among diverse populations including young persons (Adewole and Lawoyin, 2004), pregnant women, long-distance drivers, sexually transmitted infections clinic attendees and persons involved in sex work (Ekwezor et al, 1995; FMOH, 1995; 2004a). HIV/AIDS is a huge burden on the nation's health care, a sector over stretched by other communicable diseases including malaria and tuberculosis. Access to treatment with anti-retroviral (ARV) drugs has increased considerably during the last five years due to increased funding support from The Global Fund, the World Bank, the World Health Organization's (WHO) "3 X 5" program, and the United States' President's Emergency Fund for AIDS Relief (PEPFAR) program. In addition, the federal government is providing ARV drugs at highly subsidized rate to facilitate access to treatment and prevention of mother-to-child transmission of HIV (FMOH, 2004). Despite this progress, only 27% of those who need ARV actually had access to treatment in 2007 (UNAIDS, 2008).

More people become infected with HIV than those enrolled for treatment. Therefore, primary prevention through targeted intervention should be the mainstay of control programming in Nigeria. One of the important targets for interventions are heads of households and young people who are at the center of the HIV epidemic in terms of transmission, vulnerability, impact and

potential for change (UNFPA, 2005). HIV is transmitted mainly through sexual practices that individuals can modify or change. Knowledge and attitude play important role in this process. Effective HIV prevention intervention therefore requires assessment of knowledge, attitude and sexual practices among targeted populations. While the government, media, health care workers and non-governmental organizations have been involved in HIV/AIDS prevention and control programs, librarians, who are information professionals, have made little contribution to these efforts in Nigeria. This study was carried out to demonstrate the role that librarians can play in HIV/AIDS prevention programmes in Nigeria.

Goals and Objectives

The goal of this study is to meet the HIV/AIDS information and service needs of citizens living in three rural communities in Oyo state.

The objectives are to:

1. Increase knowledge of the root of transmission, signs, symptoms and prevention of HIV/AIDS
2. Determine the adverse effects of HIV/AIDS on the community and household
3. Promote community resource center as source of information for HIV/AIDS
4. Assess the effects of various intervention programme on knowledge of HIV/AIDS.

The study areas

The study was carried out in three rural communities in Oyo state namely: Adeyipo, Yege and Badeku. While Adeyipo and Yege communities are in Lagelu Local Government Area (LGA) Badeku is in Egbeda (LGA). These communities are inhabited by Yorubas who are mainly subsistent farmers. Some of the crops commonly grown in the area are yams, cassava and maize among others. Each of these communities has a Public Health facility that provides Primary Health services for people. The combined population of the three communities is less than two thousand.

Statement of the Problem

The deleterious effect of HIV/AIDS is almost inexhaustible. The impacts of the epidemic on household has often been studied using the Sustainable Livelihood Framework (DFID/FAO, 2000). The most immediate impact of HIV/AIDS on household assets is the shortage of labour experienced by households. As it loses the productive labour of the afflicted members, it also loses significant labour of other household members whose time is absorbed in caring for the sick and dying members. Additional labour is lost during funeral and traditional periods of mourning (Stokes, 2003). Unlike many diseases, AIDS affects individuals in their most productive years, with the majority of HIV infections occurring in people between the age of 20years and 40 years (Spore, 1997). Stokes (2003) estimated the productive age group at which HIV infections and AIDS death are concentrated to be 15years to 49 years. Hence, the loss of human capital leads directly to a loss of financial capital. This directly aggravates poverty in the affected households. In summarizing the deleterious effect of HIV/AIDS, Barnett and Rugalema (2001) state that the epidemic “has created or contributed to exorbitant healthcare costs, labour shortages, a declining assets base, breakdown of social bonds. Curbing the contract or spread of HIV/AIDS cannot be effectively done unless there is intensive awareness campaign among the populace.

Methodology

Two hundred respondents were selected by multi-stage random sampling to ensure that they were representative of the population. Male and female family heads, wives and adult children were interviewed. Data were procured through the administration of validated structure interview. The data were subjected to both descriptive and inferential statistics, using chi square statistic to test the hypothesis.

RESULTS AND DISCUSSION

Sex, Age, Marital status, Religion:

Fifty-five percent of the respondents were male while the rest were female. Data in Table 1 indicate that more than two-thirds of the respondents were in their productive years (< 41years

old) while about one-tenth were over 60 years old. Except for a few under-twenties, most respondents were still in their sexually active years. Fifty-one percent were married while about two-fifths were single. This would enable us get a diversified view of the subject under investigation. Sixty-eight percent had children, majority of which had between one and four children. The respondents also cut across religious divide as shown in the table. This would also reveal the inclination of each religion to the subject of research.

Table 1. Personal Characteristics of the Respondents (Age, Marital status, No. of children, Level of education, Primary and Secondary Occupations, Membership of organization)

n = 192

Personal characteristics	Frequency	Percentage
Age		
< 20 yrs	19	9.9
21 – 40	115	59.9
41 – 60	38	19.8
> 60	20	10.4
Marital status		
Single	83	43.2
Married	98	51.0
Divorced	4	2.1
Widowed	7	3.7
No. of children		
None	61	31.7
1 – 4	69	36.0
5 – 8	56	29.2
> 8	6	3.1
Level of education		
No formal education	33	17.2
Adult literacy classes	8	4.2
Primary school	53	27.5
Secondary school	67	34.9
Post-secondary	31	16.2
Primary occupation		
Farming	27	14.1
Civil service	35	18.2
Trading	50	26.0
Artisan/Technician	33	17.2
Students	29	15.1
Unemployed	18	9.4
Secondary occupation		
Farming	42	21.9
Civil service	17	8.9
Trading	38	19.8
Artisan/Technician	16	8.3
None	79	41.1
Membership of organizations*		
Cooperative	132	68.8
Religious	87	45.3
Professional/Trade	63	32.8
Socio-cultural	93	48.4
None	42	21.9

* Multiple responses

Personal Characteristics of Respondents

Level of education:

Data also revealed that about four-fifths of the respondents were literate, the majority (34.9%) having had some secondary school education. Formal education would also affect the reception and perception of the HIV/AIDS campaign.

Occupation:

About one quarter of the respondents were traders while only fourteen percent were engaged in farming as primary occupation. Fifteen percent were students while almost one-tenth were unemployed. Thirty-six percent were engaged in farming, either as primary or secondary occupation. Two-fifths of the respondents had no secondary occupation.

Membership of formal organizations:

Organizations are known to have the welfare of their members as their primary objectives, hence it would be useful to know if such organizations have played any role in the acquisition of knowledge about HIV/AIDS by the members. Data in Table 1 reveal the various numbers of the respondents that belong to various types of formal organizations. However, about one-fifth of the respondents did not join any formal organization. The purpose for which the organizations were established included community safety, community development and members' welfare.

Awareness and Knowledge of HIV/AIDS:

From this study, it was discovered that ninety – nine percent of the respondents were aware of the pandemic called HIV/AIDS. Udoma (2002) reports 76.7 awareness level among Akwa Ibom stata students, Fawole *et al* (1999) report 90% in Oyo state, Onuigbe and Osafu (1999) report a knowledge level of 95.2% among adolescent girls in Edo state while Araoye and Fakeye (1998) report 99% in Oyo state.

Sources of Awareness/Knowledge of HIV/AIDS:

Data in Table2 indicate the various sources through which the respondents gained the knowledge of HIV/AIDS. Majority (81%) claimed to have gained their knowledge through mass media while 72% gained the knowledge through the activities of United Nations Development Programme (UNDP) agents in their locality. About 15% gained knowledge through the hospital

talks and seminars, which were mostly organized by UNDP agents. About 50% learnt from friends and neighbours while 4% could not say precisely their sources of knowledge. Udoma (2002) reports only sources of awareness, which ranked radio/television as the highest. Oyeneye and Kawonise (1993) report the mass media as the main source of knowledge among 92% of male and 87% female in Ogun State of Nigeria.

Table 2: Distribution of Respondents by Knowledge of HIV/AIDS

n = 192

Knowledge*	Frequency	Percentage
Sources of Knowledge		
Mass media	154	81.0
UNDP activities	137	72.0
Friends and Neighbours	93	49.0
Hospitals	28	14.6
None/Can't say	8	4.2
Medium of contacting HIV/ AIDS		
Sexual intercourse	191	99.5
Sharing sharp objects	119	62.0
Parent to offspring	98	51.0
Blood transfusion	90	46.9
Don't know	4	2.1
Method of avoiding HIV/AIDS		
Use of condom	154	80.2
Avoid victims	81	42.2
Abstinence from sex	138	71.9
Don't share sharp objects	106	55.2
Keep to one sex partner	20	10.4

* Multiple responses

Transmission of HIV/AIDS:

Data in Table 2 also reveal that 99% knew that HIV/AIDS could be contracted through unprotected sexual intercourse, 62% through sharing of sharp objects like needle or blade, 47% through blood transfusion and 50% through foetal transmission. Similar statistics were found by Fawole *et al* in which 83.3% and 59.3% mentioned sexual intercourse and sharing of sharp metal objects, respectively. Araoye and Fakeye's respondents in Kwara state mentioned sexual transmission (male 98.5%,female – 96.2), 64% of Unuigbe and Osafu's respondents identified sexual intercourse as the main route of transmission.

Prevention of HIV/AIDS:

Evidence from the study as outlined in Table 2 indicates that even though all the respondents were aware of the use of condom, only 80.2% endorsed it as preventing HIV/AIDS transmission. Udoma (2002) discovers that only 63.3% of the secondary school students studied knew condom while only 40% mentioned it as a sure preventive measure in a study by Unuigbo and Osafu (1999). About 77% of males and 73.9% of females acknowledged the condom as main preventive measure in Araoye and Fakeye's study. Other methods of prevention mentioned in this study were abstinence from sex by unmarried youths (71.9%), avoiding contact with patients (42.2%), not sharing sharp objects with anyone (52.2%). Keeping to one sexual partner had the least mention (10.4%) and even its advocates expressed the difficulty in upholding it. Data from the Nigeria Demographic and Health Survey (NDHS) 1999 survey report indicates that the most significant mentioned method of prevention is keeping to only one sex partner (male -53.5%, female - 49.8).

Table 3: Distribution of Respondents by Perceived Effects of HIV/AIDS .

n = 192		
Adverse Effects*	Frequency	Percentage
On the community		
Death	188	97.8
Loss of active/productive manpower	100	52.1
Inefficiency due to ill health	123	64.1
Pressure on medical facilities	138	71.9
On Household Livelihood Activities		
IGAs mostly non -farm	113	58.9
Low household income	176	91.7
Loss of specialize skill & experience	40	20.8
Low investment of time & money	148	77.1
Liquidation of savings (cash & crops)	108	56.3
Food insecurity		
Diversion of labor from agric IGAs	154	80.2
Diversion of funds to healthcare	127	66.1
Less/non-storage of food items	67	35.0
Inability to buy enough food	80	41.7
Inability to eat well (patient & relatives)	99	51.6
Household welfare		
Abandonment/Ostracism of household	163	84.9
Dispersal of orphans to relatives/orphanages	53	27.6
Psychological depression	127	66.1

* *Multiple responses*

Perceived Effects of HIV/AIDS Pandemic

Effect on the community:

Since the cure for AIDS was yet to be found death of patients was considered the most fatal blow on the society by 97.9% of the respondents (Table 3). Other adverse effects on the community mentioned were loss of active and productive manpower, especially in agriculture (52.1%); inefficiency due to ill health (64.1%) and pressure on medical facilities (71.9%). Stokes (2003) observes that even though the most immediately affected units are the individuals, families and households afflicted by the epidemic, the effects combine to exert impacts on communities, regions and nations. It may be in form of alteration of the composition and structure of communities' populations and influence the price of labour , land and/credit.

Effect on household Livelihood Activities:

About 59% of the respondents were of the opinion that households so afflicted would be engaged in mostly non-agricultural income generating activities which would not be labour-intensive and would not take them away from home (Table3). Expectedly, household incomes would fall (91.7%) because the remaining household labour is diverted to caring for the sick, resulting in low investment in time and money (77.1%). About 21% reported the likely loss of specialized skill and experience where there are specialized trades associated with the affected families, e. g. blacksmithing, cloth weaving or pottery making. More importantly too, 56.3% suggested that cash savings would be completely withdrawn while stored crops for future markets would be sold. Livestock kept may also be sold to provide money for the medical care of the afflicted.

Effect on Household Food Security:

Empirical in Table 3 indicate that about 80% of the respondents posited that labour would be diverted from agriculture related income generating activities, resulting in less food production. Funds for purchase of food items would be diverted to healthcare (66.1%), resulting in inability to buy enough food (41.7%). Inability to eat well is also a factor in food insecurity. About half of the respondents observed that members of afflicted household may not be able to eat well due to depression and consequent loss of appetite.

Effect on Household Welfare:

About 85% of the respondents thought that HIV/AIDS would lead to disruption of extended family ties which may culminate in abandonment or ostracism of the afflicted family. Orphans may have to be distributed among the relatives or where the ostracism is pronounced, may be taken to orphanages. Generally, there may be widespread psychological depression among the family members (66%) which may result in retrogression in all facets of the household life.

Results of Hypotheses Testing

The result of the hypothesis testing indicated that age ($\chi^2 = 87.106$, $p=0.00$), primary occupation ($\chi^2 = 12.148$, $p= .012$) and marital status ($\chi^2 = 47.515$, $p=0.04$) were significantly related to knowledge of prevention of HIV/AIDS. Knowledge of HIV/AIDS will equip the respondents to be conscious of the adverse effects and therefore, adhere strictly to the preventive measures.

Conclusion: Information professionals can play dual roles as both advocates and educators in the process of AIDS information dissemination. Empirical evidence from this study suggests that most of the people in the study area have a very high awareness and knowledge of HIV/AIDS, both causal factors and preventive measures. This could have led to their detailed perception of the adverse effects of the pandemic on the community, household, livelihood and welfare aspects of their life. The major adverse effects perceived are death, loss of resourceful work force, pressure on medical facilities, low household income, low investment, diversion of labour and likely abandonment or ostracism of the afflicted household.

Recommendations: Information Resource Officers should be sourced among the rural dwellers and be trained to provide relevant and accurate information in indigenous language and preach awareness of the disease and work with relevant organizations in the HIV/AIDS campaign among rural communities. Rural community dweller will listen more to the information agents who they trusted than unknown NGO interventionists. Governments should increase awareness campaign through school lectures, hospital talks, radio and television jingles. Governments should also collaborate with NGOs and aid them through provision of vehicles and campaign materials to be able to cover a wider clientele.

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