

Achievements and Implications of HIV Prevention Programme among General Population: A Systematic Evaluation of HAF II Project in Kogi State, Nigeria

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ABSTRACT

Background: HIV/AIDS has over the past two decades become a significant public health challenge in Nigeria and it is necessary to address these challenges and strengthen the national response towards ensuring we reach our set national response targets. This paper therefore presents achievements and implication of HIV prevention programme among the general population in Kogi State, Nigeria.

Methods: The intervention project was conducted between the year 2013 and 2015 and a total of 84206 participants between the ages of 15-49 years were reached during this intervention. Activities carried out included community dialogues, condom distribution, HIV/AIDS education and HIV counselling and testing among others. Data were documented using various monitoring and evaluation tools and entered in the DHIS2 platform. The data were exported into Microsoft Excel and analysed using Excel.

Results: A total of 62 community dialogues were held during this intervention and 4,084 influencers participated in these dialogues. The year 2015 witnessed an increase in the number of peer educators registered in virtually all of the communities, with 59,197 peers alone registered in 2015 representing 70.3% of the total number of peer registered. A total of 82.6% of the registered peers were reached with complete HIV education and among these, 65.1% were reached in 2015. A total of 35621 (56.6%) of the registered peers were reached with all the three stages of MPPI and 55368 (84.9%) were reached with only HCT. Among these, 1273 (2.3%) were tested positive to HIV

Conclusion: This project enhanced and contributed immensely to the skills development of the peer educators and their cohorts which spread across the communities. However, challenges highlighted in this project should be fashioned into any future HIV intervention programme in the state.

Keywords: HIV/AIDS, HAF II project, Minimum prevention package intervention, General population

INTRODUCTION

HIV/AIDS has over the past two decades become a significant public health challenge in Nigeria, casting a long shadow of severe epidemic affecting all population groups and geographic areas of the country, thus constituting an impediment to national development policy targets particularly the Millennium Development Goals (MDGs), whilst also contributing to the decreased life expectancy and worsened national health indicators. As such, no state is exempted from its scourge. ^[1] In 2010, 4.1% national prevalence of HIV was reported for Nigeria. ^[2] According to the study, North Central Zone (7.5%) was the highest, and South-South region (6.5%) was next. ^[2] In relation to location, there were similar trends in all the region with North-Central and South-South regions as having topmost urban prevalence of HIV (8.2% each) while South-South regions top the rural prevalence of HIV (4.2%). ^[2-6] Kogi State for several years flirted with a prevalence rate over and above the national average of 4.4% (NPC, 2008). This is shown by the sentinel surveys of 2005, 2007, 2008 and 2010 which stood at 5.7%, 5.5%, 5.1% and 5.8% (NPC, 2008). However, in 2012 this prevalence rate was reported to have dropped to 1.4%. ^[7]

The reach of HIV epidemic in Kogi State, prior to specific interventions geared towards increased HIV prevention, was as disconcerting as the epidemic was widespread, due to the occurrence of sexual networking among general population, ^[8] These coupled with a significant level of unsafe sex practices among the general population such as 'spouse-sharing' ^[9] pre-disposed them to contract HIV from already infected persons, which in turn helped spike the local data to 12.45% for male and 14.08% of female testing positive to HIV. ^[10] These unsafe sex practices were however not limited to married members of the general population alone, as sexual behavior among the general population in Kogi State

whether married or unmarried is high. Women of reproductive age, women with special needs including widows, women in separated marriages and single mothers, are known to actively participate in sexual activities oft-times unsafe. ^[9] Furthermore, young women, youth and the young adults (15-45 years old) across the 21 Local Government Areas (LGAs) of Kogi State are highly sexually active with the proportion of youths and young adults reporting high risk sexual intercourse being higher than the national average. A 2008 study reported that a majority of the youths in Kogi State engaged in high risk sex, such as casual unprotected sex, multiple sexual partners, transactional sex and concurrent sex. ^[11-12]

As a result of the continued rise of the epidemic within the state, there were calls for increased HIV preventive interventions. ^[8] These calls were made with the aims of fostering the adoption of safer sexual behaviors and promoting of social norms and values such as good health seeking behavior for prompt treatment of STIs, reduction in the number of sexual partners, increase in condom use, limiting sexual intercourse to one HIV negative partner, reduction in sexual violence and drug abuse, reduction in teenage pregnancy among young girls, improve access to quality HIV services, referral and follow up services on HIV counseling and testing (HCT) and strengthen mechanism for care and support services. This paper therefore presents HIV prevention programme among general population in Kogi State, its achievements and implications for programming.

MATERIALS AND METHODS

Study Design and Scope

This was an intervention project carried out among general population in Kogi State, Nigeria. Five civil society organizations (CSOs) namely Neighbours without Borders (NEBO), Youth and

Women Empowerment Project (YAHWEP) and Global Hope for Women and Children Foundation (GLOHWOC), Rural Poverty Reduction and Empowerment Initiative (RPREI) and New Generational Destiny Initiative (NGDI) were engaged by Kogi State Agency for the Control of AIDS and trained to provide sustainable HIV prevention among General Population. The project was conducted between the year 2013 and 2015.

Study Area

The project was carried out in seven out of the twenty-one Local Government Areas (LGAs) in Kogi State. Kogi State was created on 27th August, 1991, and has its headquarters situated in Lokoja. The state occupies an area of 28,312.6 square kilometers. It shares common boundaries with ten (10) states and the Federal Capital Territory (FCT). To the North; it shares boundaries with Niger, FCT, and Nassarawa, to the West by; Kwara, Ekiti, Ondo, Edo, and Delta, while to the East by; Benue, Anambra and Enugu states. Kogi state is made up of 239 wards, in 21 LGAs and 3 Senatorial districts (Kogi state Ministry of Health, 2010). The state has a population of 3,478,029 according to the 2006 census, with Males making up 46.8% of the population and females 53.2%.^[12] The major indigenous ethnic groups in the state are: Igala, Ebira and Okun-Yoruba.

Study population

The study populations for this intervention are male and female between the age of 15-49 years in Olamaboro, Adavi, Kogi, Mopa-Amuro, Ogori/mangogo, Bassa, Omala local government areas (LGAs).

Sample size and Sampling Technique

The estimated sample size for this project was 108,000 and the project adopted a convenient sampling technique in selecting participants. This implies that participants were selected based on their availability and consent to participate in this project.

Project Activities

The minimum prevention package intervention (MPPI) was adopted in the implementation of this project. The three components of MPPI were structural, behavioural and biomedical interventions. The strategies used for this intervention were peer education, community outreach and peer education plus (Use of role model). Activities under each of the category are summarized below;

Structural Intervention

Advocacy visits were made to traditional gate-keepers within the communities to seek their support, and ensure that all hands are on deck to drive out the epidemic. Community outreach activities were also organized in all the intervention communities. Community members were sensitized on the basic fact of HIV/AIDS; meaning of HIV/AIDS, modes of transmission, symptoms of HIV/AIDS, prevention of HIV/AIDS and other sexual and reproductive issues. Mobilization was also made to create an enabling environment for the ease of access to HIV prevention and care services to address structural barriers within the community such as cultural believes and practices that hinder people living with HIV from accessing and utilizing appropriate HIV prevention, treatment and care services.

Behavioural Intervention

Trained peer educators carried out peer cohort session among their recruited peers using the MPPI model. Behavioural change communication was employed to attempt to influence a change in behavior in order to reduce risk of HIV infection. Behaviors such as risky sexual practices of spouse sharing, multiple sexual partners, non-use of condoms and poor health seeking behaviour. Community outreaches were carried out in all the intervention communities with particular focus on condom messaging and distribution. The outreaches were carried out by peer educators and peers. Community members were sensitized on HIV/AIDS and other sexual and reproductive health issues. Fliers

and posters that informed people about HIV/AIDS transmission as well as condoms were distributed. The activity witnessed turnout of community members. Peer educators, peers recruited and some members of the project team together with band group moved round the communities sensitizing onlookers, passers-by, and community members on HIV and AIDS prevention with melodious songs and as well distributing condoms, posters and fliers to people.

Biomedical Intervention

This employed the use of HIV counseling and testing, referrals for ART and STIs services. The HIV tests were done within in the communities and were carried out by the trained HIV counselor testers. During the outreach, Peer educators and their peers as well as other community members were advised to partake in the exercise for them to know their HIV status. The clients were counseled and tested after which the results were provided to them. HIV tests were done in private under HCT tents within the community. Only one client was attended at a time to ensure privacy of the client. Data documentation during the counseling and testing was done using the client intake form. Those who tested positive, needed STIs services or PTMCT were referred to appropriate health care facilities for further services.

Data collection procedure

Data were collected by peer educators who were recruited from community based organizations (barbing, tailoring, patent medicine and hair dressing associations), religion organizations (Christian association of Nigeria and Muslim associations). A total of 1760 peer educators were recruited and trained for 3 days to build their capacity and improve their proficiency in carrying out effective HIV prevention intervention activities among their peers in their various communities. Peer education manuals were developed and used as training guides. The focus of the training included the following: life skills, general knowledge of HIV/AIDS,

sexually transmitted infections, HIV prevention and access to help, gender and sexuality. Other focus of the training are peer education characteristics and qualities, gender and HIV/AIDS, risk perception including HIV/ AIDS stigma. Each modules and topics were presented using discussion, group works, role plays and various exercises and energizers. Also, pre and post-test evaluation of participants at the point of entry and at the end of training was conducted to measure the impact of the training on the trained peer educators.

Monitoring and Evaluation

Data were collected using various data collection and data reporting tools. Desk review of the collated data from the trained peer educators was conducted monthly to ensure data quality for effective compliance to project goals and objectives.

Statistical Analysis

Data were entered on DHIS 2, checked for completeness, accuracy, errors and other inconsistencies to identify any possible data quality errors, exported and analyzed using Microsoft Excel.

Ethical Issues

Prior to the commencement of the research, the proposal was subjected to a two-stage review and ethical approval to conduct the research was obtained from the National and the State Ethical Review Committee, Federal Ministry of Health, Nigeria after an in-depth review of the proposal for compliance with ethical guidelines. Also, permission was obtained from the leaders of the identified groups where necessary. The criteria for selection of samples included voluntary declaration of participation in the study and the ability for transmission of information. The HIV client intake forms were kept safe place to avoid access to unauthorized persons. Those that tested positive were referred for appropriate treatment.

RESULTS

The findings are presented based on the levels of intervention: structural, behavioural and biomedical interventions.

The overall target population reached during this intervention was 84206 given a target reached of 78.0%.

Structural Level

A total of 62 community dialogues were held during this intervention and 4,084 influencers participated in these dialogues. Out of the 62 community dialogues, 48 were held in 2014 while only 14 were held in 2015. Majority (68.8%) of the influencers that participated in community dialogue did so in 2014 while 27.6% did so in 2015.

Table 1: Structural – level intervention

Period	Number of community dialogues held	Influencers participating in community dialogue
2014	48 (80.0%)	2,809 (68.8%)
2015	14 (20.0%)	1,275 (31.2%)
Total	62	4,084

Behavioral Level

Table 2: Number of peers registered and reached with HIV education and male condoms

Period	Number of Peers registered	Persons reached with complete HIV education out of registered peers	No of condoms distributed to females	No of condoms distributed to males
2014	25,009 (29.7%)	22,768 (34.9%)	8,954 (19.1%)	58,697 (31.3%)
2015	59,197 (70.3%)	42,469 (65.1%)	38,043 (80.9%)	127,761 (68.1%)
Total	84,206	65,237	46,997	187,761

Biomedical Level

Table 3 presents information on the number of persons counselled, tested and got result (CTR). A total of 55,368 (84.9%) persons were CTR. Among these, 35621 (56.6%) were registered peers reached with HIV education in behavioural intervention.

Table 2 shows the number of peer registered by peer educators as well as those contacted during this intervention. The year 2015 witnessed an increase in the number of peer educators registered in virtually all of the communities, with 59,197 peers alone registered in 2015 representing 70.3% of the total number of peer registered. The total number of peers registered represents 78.0% of the estimated target population (108,000). A total of 82.6% of the registered peers were reached with complete HIV education and among these, 65.1% were reached in 2015. Table 2 also depicts the distribution of male condoms during the course of the intervention. More condoms were distributed in the year 2015 than in the preceding year.

Those tested positive and referred were 1,273 (2.3%) persons. Out of the number referred, 92.6% were males, and only 7.4% females (Table 4). A total of 516 persons were referred for STIs services; more females (356) than males (160) were referred for these services.

Table 3: HIV Counseling and Testing

Period	Number of persons counseled, tested and received result		Total	No of persons tested positive	Number of persons tested positive and referred for ART		Total
	Female	Male			Female	Male	
2014	10,119	8,555	18,674	184 (14.5%)	88	77	165
2015	16,224	20,470	36,694	1,089 (85.5%)	6	1102	1 108
Total	26,343	29,025	55,368	1,273	94	1 179	1273

Table 4: Biomedical Intervention

Period	No of persons referred for STI	No of persons currently receiving STI services	No of persons going for STI follow-up
2014	194 (37.6%)	183 (34.8%)	153 (32.3%)
2015	322 (62.4%)	343 (65.2%)	320 (67.7%)
Total	516	526	473

Coverage of MPPI, HCT and Prevalence of HIV

A total of 35621 (56.6%) of the registered peers were reached with all the three stages of MPPI and 55368 (84.9%) were reached with only HCT. Among these, 1273 (2.3%) were tested positive to HIV (Fig. 1).

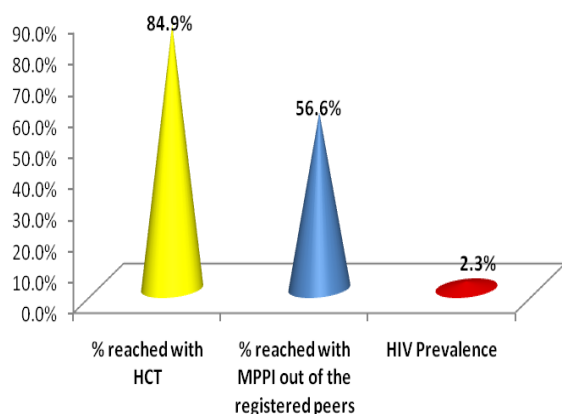


Figure 1: Coverage of MPPI, HCT and prevalence of HIV

DISCUSSION

The structural level activities were embarked upon to ensure that community members in the selected sites across the state were sensitized about HIV/AIDS, as well as other such topics such as HCT, STI management, and the need to avoid discriminating against those diagnosed with HIV and AIDS. Although Eno et al., [13] did note that the respondents in their study (also conducted in Kogi State) were empathetic with the plights of people living with HIV. However, it is important to make people realize that the issue of stigmatization goes beyond empathy. Stigma and discrimination against persons living with HIV and AIDS is widespread in Nigeria, [14] and often influences the use of HIV related prevention and care services; whilst adversely affecting the psychological, sexual and physical health of such individuals. [15-16] Social support particularly from the individual's family has been known to influence the health outcomes of HIV infected individuals. [17] It is noteworthy to also point out that the afore-mentioned structural level activities yielded fruit, as observed in the number of community dialogues held, as well as registration of peers and HCT coverage.

The number of peers registered as observed rose on a yearly basis, with each year witnessing an increase in peer registration than in the preceding year. This is of course bound to have an impact on the awareness of the population as touching

HIV and AIDS, as well as the need for behavioral modification in a bid to stay healthy, and increased usage of hospitals rather than TBAs in the case of pregnant women. An increase in the rise of peers plays a very crucial role in this area as it helps to improve the condom use among the community members and consequently reduce the risk of HIV transmission even further. As Eno et al., [13] notes, it is not that the people are not aware of the reality of HIV and AIDS or its modes of transmission, however as other studies notably Osagbemi [9] have pointed out, the sex negotiation skills of community members are weak. PEPFAR [18] notes that condom use with non-marital partners was generally low (49%) across Nigeria, with the least use in the North-East, North-Central and North-West zones.

Majority of the youths in Kogi State engaged in high risk, casual unprotected sex, with multiple sexual partners. [11-12] As a result, it was noted that over 50% of all new HIV infections occurred among these young people who fell between the ages 15 and 24, [19] this consequently makes those within this age-group a priority for any serious attempt at HIV prevention. However, it is also important to note that whilst this group is important as well as Most-at-risk within the general population, the practice of spouse-sharing also makes for increased spread of the epidemic, particularly given the tendency of members of the general population to shun the use of condoms. As such, there is not only the need to preach the use of condoms via individual level BCC or community dialogues, but also to promote its use by distributing it to community members. The promotion of condoms, (both male and female) as well as lubricants, is in a bid to ensure an upturn in the access to and the use of condoms among community members, particularly among the sexually active young people. One key aspect of the biomedical level intervention is in the uptake and continued patronage of HCT services within the communities. As the NDHS statistic of 2008 has it, about

85.5% of women aged 15 to 49 years in Kogi State have never tested for HIV, and only 34.5% of these women know where to access the services, 87.7% of men of the same age group never tested for HIV. [12]

Implications for Programming

The involvement of stakeholders and community gatekeepers through various advocacy visits/meetings enhances project ownership, support and sustainability. Peer education strategy still remains the best dependable approach and a sustainable strategy towards preventing or reducing the spread of HIV and other STIs especially among in and out of school youths. Distribution and use of both male and female condoms is a key to HIV prevention. However, only male condoms were distributed in this project. This could be as a result of lack of supply of female condom due to financial constraint. Other similar studies in the state should ensure female condoms programming. Community participation makes project implementation easier, and builds confidence towards project sustainability and engagement of key decision makers facilitate smooth community entry and community acceptance. Although there has been a significant increase in HIV awareness and prevention statistics, and a decrease in HIV prevalence over the years, however, there is still a need to ensure that availability, use and monitoring of HCT services within communities in order to ensure the gradual decline of the prevalence of HIV within the state, given that the prevalence statistic garnered from this project is slightly higher than the State's previously documented of 1.4% HIV prevalence rate. [20] The State Government should take ownership of the programme by providing ARV drugs, requisite infrastructure, adequate staffing and the capacity building of health care workers. Also, there should be more integration of services & decentralization to PHCs and rural communities, scaling up of prevention activities in a cost-effective manner as well as a better strengthening of Monitoring and Evaluation of HIV and

related interventions. Furthermore, engagement and synthesizing of ideas for alternative ways of mobilizing resources at all levels to engender political commitment should be increased. It is only then, that programming efforts might indeed begin to yield astounding results.

Challenges

Despite the successes and achievements recorded during the project implementation, the project however witnessed some constraints which include high financial expectation/remuneration by peer educators. Most of the PEs postulated that their peers are demanding for money because the peer session usually take the time they would have used to make money. Mobilizing peer educators for activities was tasking as it demanded extra cost especially transportation and communication and time for the mobilization as against the budgeted amount/resources. Other major challenges faced during the duration of the programme include: late supply of condoms, and HCT kits, lack of peer educator plus manual, poor referral linkage of HIV positive clients to adherence and support groups, late release of funds, inadequacies in the motivation of volunteers and non-programme staff, dearth of qualified personnel for key programme areas such as M&E among others. It is nonetheless important to state that the outcomes of this programme show that other programmes fashioned after this model will turn out much better, if given better support. Thus, for any such programme in the mold of this initiative to be successful, the challenges highlighted within this paper should be taken care of, so as to reap maximum results.

CONCLUSION

This project enhanced and contributed immensely to the skills development of the peer educators and their cohorts which spread across the communities. The level of achievements recorded in this project showed the programme was a success. However, challenges highlighted in this project should

be fashioned into any future HIV intervention programme in the state.

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