

Achievements and Implications of HIV Prevention Programme Among Out of School Youths: A Systematic Evaluation of HAF II Project in Kogi State, Nigeria

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ABSTRACT:

Background: The increasing number of sexually transmitted infections including HIV/AIDS among the youths in sub-Saharan Africa indicates that successive efforts towards preventing the scourge remain inadequate in the continent. Preventing the spread of HIV infection among youths aged 15 – 24 years is critical to reducing the incidence of new HIV infection. This paper therefore presents HIV prevention programme among Out of School Youths (OSYs) in Kogi State, Nigeria.

Methods: This intervention was carried out among out-of-school youths in 7 randomly selected Local Government Areas (LGAs) in the state with a total target population of 19600 OSY. One hundred and twenty (120) OSY comprising (68 males and 52 females) were recruited and trained as Peer Educators. Activities carried out included structural, behavioural and biomedical interventions using the Minimum Prevention Package for Intervention (MPPI) strategy. Data were documented using various monitoring and evaluation tools and entered in the DHIS2 platform. The data were later exported into Microsoft Excel and analysed using same.

Results: Three hundred and three community dialogues were held within the 2-years period with 672 participants and 25787 peers recruited by the peer educators resulting in 131.6% of the estimated target population. A total of 18812 of out of school youths were counselled, tested and received results for HIV. Among these, a total of 275 (1.5%) were tested positive.

Conclusion: Effective implementation of minimum prevention package for intervention in HIV/AIDS prevention programme carried out in these communities could be attributed to the dialogues held at the commencement of the project. However, there are still shortfalls in attainment of the expected results. It is therefore recommended that there be increased integration of services and decentralization of MPPI activities to primary health care centers and rural communities, stepwise supervision and monitoring of HIV prevention activities be strengthened and engagement of all tiers of governance to engender political commitment and ownership of the HIV response with a view of ensuring sustainability of these programmes.

Keywords: HIV counseling and testing, Minimum prevention package for intervention, Out of school youths

I. INTRODUCTION

Human Immunodeficiency Virus (HIV) is recognized as one of the major public health concerns for many years [1]. This problem still remains high, notably in developing countries. In 2012 the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that globally 2.3 million people were newly infected with HIV, 35.3 million people were already living with the virus and 1.6 million people died from AIDS-related causes [2-3] over a period of two decades since the emergence of the HIV and AIDS virus and this is a significant public health challenge in Nigeria. HIV has assumed a role of generalized and mature epidemic, affecting all population, groups and geographic areas of the country. Not only is the HIV and AIDS epidemic a continuing, persistent and important hitch to the attainment of future national

development targets including the Sustainable Development Goals (SDGs), it is also contributing to the reversal of some hard-won development gains of the recent past, thus- playing pivotal roles in decreasing life expectancy at birth and worsening national health systems and health indicators. Youth between the ages of 15 to 29 years contribute 60% of new HIV infections in Nigeria and they are disproportionately affected by the main drivers fuelling Nigeria's HIV epidemic especially, low risk perception, early sexual initiation, multiple concurrent sexual partners, informal transactional and intergenerational sex, lack of STI services, gender inequalities, stigma and discrimination, and inadequate health services [4].

Kogi State with a population of approximately 3.2 million has a prevalence rate of 5.8% [5], thus making it the fifth highest in the North Central zone. It is also above the national average of 4.4% [5]; a situation which is worrisome. Likewise, the proportion of men and women reporting high risk sexual intercourse is very high (19% of women and 52% of men), while 28% of men reportedly paid for sex in the past year [5]. Studies found that majority of the youth engaged in high risk sex; 13.0% of females had sex before age 15 years while 35% of their male counterparts do the same [6-7]. Spouse sharing is also a common practice in some parts of the state; a study of male and female adults found that two third of respondents (65.3%) reported spouse sharing. This category of people had an average of 3 partners per person, relative to only 2% not involved [8]. The segregation between urban and rural HIV prevalence rate in Kogi State falls between 10% for urban and 3.3 for rural [6] while the geographical distribution of the HIV prevalence according to the HSS 2012 puts Kogi State between 4.1% to 6.0% for the age group 15 to 49 years. The most hit is in the age group 30 to 34 years in the North Central Zone which the state belongs to [6].

Prevention programme planners often develop interventions that focus solely on reducing problem behaviors and funding streams for these prevention programmes often limit the ability of providers to meet young people's needs holistically. Many youth-focused HIV and AIDS interventions implemented to date in Nigeria have employed the "ABC" approach. However, there is still a significant level of unsafe sexual practices among them thus increasing their level of pre-disposition to HIV infection [4]. In Kogi State, where the intervention programme was implemented, the proportion of youths and young adults reporting high risk sexual intercourse was higher than the national average and a 2008 study found out that majority of the youths in the State engaged in high risk sex [6-7].

Scientific evidence and research experience shows that care for people living with HIV virus including nutritional assessment, home based care, counseling, education, treatment literacy and follow-up has a significant impact on the health of patients particularly on their ability to stay on treatment and on the effectiveness of the treatment using the minimum prevention package for intervention (MPPI) strategy [9]. In line with the overall goal of the programme to reduce the risk of HIV infections in the Kogi State by scaling up prevention interventions and to increase access to and utilization of HIV counseling, testing, care and support services in Kogi State, this paper therefore presents achievements and implications of HIV prevention programme conducted among out of school youths (OSYs) in Kogi State, Nigeria.

II. METHODOLOGY

Study Design

This was an interventional project conducted among out of school youth in Kogi State. Three civil society organizations (CSOs) namely Rural Poverty Reduction and Empowerment Initiative (RPREI), New Hope Agency (NHA) and Environmental Development and Family Hope Foundation (EDFHO) were engaged by Kogi State Agency for the Control of AIDS and funded under the HIV and AIDS Funds (HAF) II of the World Bank to implement this intervention.

Study Area

Kogi State was created on 27th August, 1991. It is made up of a part of the old Kabba Province (that remained in Kwara) and the one that was part of Benue State. Kogi State has its headquarters situated in Lokoja, the state is situated in the North Central geo-political Zone of Nigeria. It has a total land area of 28,313.53 square kilometers and a population of over 3 million people. The State economy is agrarian in nature with majority of the inhabitants practicing farming and other ancillary trades. The State has three major ethnic groups namely: Igalas, the Ebiras and the Yorubas (Okun), it is bordered by the following States: Enugu (South East), Benue (East), Nasarawa (North East), Ondo (South West), Edo (East), Anambra (South) and Ekiti (South-West). It has a land mass of 30,354.74 square kilometers.

Study population

The target population for this intervention are out of school youths in seven local governments areas in Kogi State. The LGAs are Yagba West, Kabba-Bunu, Adavi, Kogi, Idah, Lokoja and Ankpa LGAs. The participants are youths who had never attended school or were not enrolled in a school as at the time of this intervention. Some of them had at one time or the other acquired some forms of education but dropped out of school due to various reasons, they were either learning trade or apprentice artisans.

Sampling

The project adopted a purposive sampling technique; youth groups in each of the selected local government areas were identified using a community participatory approach, peer educators were selected by nomination of qualified persons who were acceptable by the youth community. The total estimated population was 19,600. One hundred and twenty (120) OSY comprising (68males and 52females) were trained as Peer Educators in the selected project implementation communities.

Data collection procedure and project activities

The minimum prevention package for intervention (MPPI) was adopted in the implementation of this project. A quantitative data collection method was used and community-based outreaches were carried out in order to assess the targeted beneficiaries within the project community. At least three strategies were utilized to reach the targets reported; these activities can be grouped into structural, behavioural and biomedical intervention. Activities conducted were as follows:

1. Structural Intervention- Advocacy and Coordination Meeting

Advocacy visits were made to health facilities and community stakeholders to strengthen their ties and ease referrals within the state. In strengthening and supporting institutions to strategically linking HIV prevention intervention through the project, series of meetings were held and linkages were promoted through meetings between staffs of the medical centre and the project team that enhanced collaboration and experience sharing and also conducted community dialogue meetings to keep the groups abreast with Tuberculosis (TB) management, care and support; effective networking and leveraging of ideas and support were encouraged.

2. Behavioural Intervention– Peer educators’ recruitment and training

This focused mainly on the recruitment of peer educators through a snow balling of peers in artisan and apprenticeship settings. Some of these were also recruited from youth development organisations within the selected communities. Peer educators were trained in HIV prevention modules suitably communicated by professionals in health. Peers recruited were also intimated on the requirement and importance of cohort sessions in which each peer educator was expected to reach at least 10 peers in 6 to 9 training sessions within 2 to 3 months using the HIV prevention modules.

3. Biomedical Intervention– Use of Condoms, and HIV Counselling and Testing (HCT)

Major aspect of this project are the biomedical interventions which quantifies the uptake of the other two components of the intervention in the quantity of male and female condoms distributed, number of individuals counselled tested and received results for HIV, number of individuals referred for HCT and STI treatment including those referred for antenatal as may be required. Demand was created for the update of HIV prevention services in the communities; testing and counselling, abstinence and Sexual and Behavioural Change Communication messages, use of condom and other prevention messages. The HCT was carried by trained HIV Counsellor Testers. During the testing, counselling services were provided to clients and basic information on HIV and AIDS were also provided to the clients.

Monthly Monitoring and Evaluation visit to project sites

Desk review of the collated data from the trained PE was conducted to ensure data quality for effective compliance to project goals and objectives.

Data Analysis

Data collected were entered on DHIS2 platform, exported into Microsoft Excel and analysed using same. Data were analysed using descriptive statistics and presented in tables.

Ethical Consideration

Prior to the commencement of the programme, 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 participants included voluntary declaration and the ability to disseminate information. Informed consent was obtained from all participants in the study; this included statements of assurance of confidentiality of the all information collected from the participants.

III. 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 25787 given a target reached of 131.6%.

Structural Intervention

Table 1, shows the summary of activities in terms of structural indicators carried out during the entire project duration. Total number of community dialogues held during the time of the project was 203; majority (96.6%) were held in 2015 which was the second and final year of the project. With regards to community influencers who were included in the community dialogues, 672 participated; out of which most (57.3%) were recorded in the first year of the project (2014).

Table 1: Structural Intervention indicators

Year of Assessment	Indicators	
	Numbers of community dialogues held N (%)	Number of Influencers who participated in community dialogue N (%)
2014	7 (3.4)	385 (57.3)
2015	196 (96.6)	287 (42.7)
Total	203	672

Behavioural Intervention

A total of 25787 peers were registered during this intervention. A comparison of number of peers registered and those reached with HIV education were higher in 2015 than 2014; about 61.0% of the total number of peers reached with HIV education within the period of the project was in 2015, about 65.0% of the total numbers of peers registered were in 2015 (Table 2).

Table 2: Behavioural Intervention indicators

Year of Assessment	Indicators	
	Number of peers registered N (%)	Number of peers reached with HIV education N (%)
2014	10187 (39.5)	6791 (38.9)
2015	15600 (60.5)	10663 (61.1)
Total	25787	17454

Biomedical Intervention

A comparative analysis of these activities showed a great improvement in 2015 over 2014. Over 68.0% of total male condoms were distributed in 2015 and 18812 of out of school youths were counselled, tested and received results for HIV. Among these, a total of 275 (1.5%) were tested positive. A total of 357 of the participants reported to be currently receiving STI services while 166 persons were referred for STI management (Table 3).

Table 3: Biomedical Intervention indicators

Year of Assessment	Project Indicators						
	Number of Female condoms distributed n (%)	Number of male condoms distributed n (%)	Number of persons counselled, tested and Received results for HIV n (%)	Number of person tested positive to HIV n (%)	Number of persons currently receiving STI services n (%)	Number of persons referred for STI management n (%)	Persons referred for antenatal n (%)
2014	0 (0.0)	6997 (31.9)	1543 (8.2)	129 (46.9)	0 (0.0)	0 (0.0)	12 (0.0)
2015	313 (100.0)	14934 (68.1)	17269 (91.8)	146 (53.1)	357 (100.0)	166 (100.0)	29 (100.0)
Total	313	21931	18812	275	357	166	41

Coverage of MPPI, HCT and Prevalence of HIV

A total of 15505 (88.8%) out of the registered peers of 17454 were reached with all the three stages of MPPI and 18812 (96.0%) of the sample size reached were reached with only HCT. Among these, 275 (1.5%) were tested positive to HIV (Fig. 1).

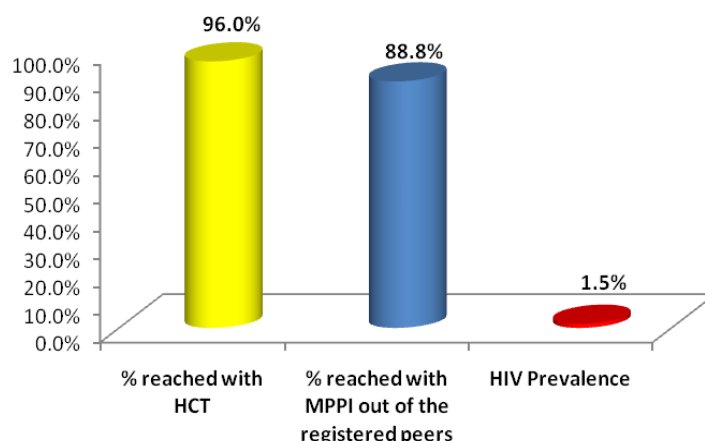


Figure 1: Coverage of MPPI, HCT and Prevalence of HIV

IV. DISCUSSION

The minimum package of intervention for HIV prevention has been proven to be a successful strategy among the most at risk populations (MARPs) as reported in a study carried out among injection drug users in Burma [10] and female sex workers in Benue State Nigeria (Songu, 2013). In accordance the recommendation of UNICEF [11], community mobilisation, outreaches, advocacy and partnership for monitoring are very important for a successful HIV prevention programme especially among out of school youths who are mobile and vulnerable to infection. This study also confirms that the best prevention strategy is an expanded response which simultaneously reduces vulnerability, risk behaviour and the impact of the infection [11] like the multi-pronged approach of MPPI. Therefore, having as many as 203 community dialogue meetings has been considered as one of the winning strategies for sustainability in HIV prevention programming like this. More people participated in the community dialogue meetings held in 2014. The decline in the level of participation at the community dialogue meeting may be attributed to the fact the community dialogue activities are majorly carried out at the inception of any project activities to gain access into the community through the gatekeepers. Hence, many of the participants would have been reached in the meetings held in 2014, therefore the 2015 data was just a mop-up of the remaining stakeholders who were involved in the programme. This is confirmed in the report of a HIV prevention programme in Zimbabwe [12], which showed a gentle decline in recruitments made for outreaches by implementers as the year turned over.

Behavioural data from this evaluation revealed a general increase in the number of peers reached in 2015 compared to those reached in 2014. This has only revealed an improved programme output. In comparison with the size estimation of the target population, more peers were registered and reached with MPPI. Restless Development [12] noted that the model of youth/peer-led delivery of sexual and reproductive health services and information was one of the major drivers in ensuring that youths had access to these information and services. This is a major indicator for a scale-up in registration and recruitment of peers for an improved and impactful behavioural intervention component of the MPPI. Regarding distribution of both male and female condoms, all the female condoms distributed were done in 2015. More male condoms were distributed in 2015 than in 2014.

Biomedical intervention in this project included HIV Counselling and Testing (HCT), receipt of results, referral and treatment of Sexually Transmitted Infections (STI) and referral for antenatal care. Over 90% of the peers were counselled, tested and received result in 2015. These outlined indicators are quite germane to the assessment of the success of this HIV prevention programme. However, the number of peers that came for the HCT was relatively low compared to the population size estimation. All the peers who were referred for further services (ARV and STI treatments) were reached in 2015; this could be attributed to better structuring of the MPPI strategy and monitoring of its implementation. Despite the success attributed to this project, it should be however noted that the HCT aspect of this programme have achieved below expectation. This results revealed a significant gap in the programme implementation and a need for a more holistic and comprehensive HIV prevention programming.

Implications for Programming

An in-depth analysis of the evaluation of the HIV prevention programme in Kogi state has revealed some gaps in the programming and implementation process. These are confirmed by the listed challenges which the programme faced at different points in the implementation process, this included: the delays in the World Bank bureaucratic processes which reduced the effectiveness of implementation agencies in delivering the first

and second semester results of the programme, poor ownership of HIV and AIDS interventions implementation leading to the non-release of funds from the State Government for HIV and AIDS, improper coordination of the line ministries working on the project, lateness in the introduction of re-DHIS 2.15 reporting tool and inadvertent lateness in the training of the personnel responsible for uploading the data, dearth of qualified personnel for key programme areas such as Monitoring and evaluation, poor quality leadership, commitment and self-sacrifice from stakeholders and the government in the achievement of results and lateness in the provision of recording tools and HCT materials.

In view of the above mentioned short falls in the programming process, the following can be recommended for improved programming of future HIV and AIDS prevention programmes in order to control the burden of the problem. More integration of services and decentralization to PHCs at rural communities, strengthening of Monitoring and Evaluation of HIV and related interventions, aggressive scaling up of prevention activities in a cost-effective manner and scale up of ART programme as a prevention strategy and to stem more AIDS-related deaths. There should be more engagement at all levels to engender political commitment and ownership of the HIV response (including State and LGA levels) with a view of ensuring sustainability through increased funding, brainstorming and synthesizing of ideas for alternative/innovative ways of mobilizing resources for the HIV response at all levels. The State Government should take ownership of the programme by providing ARV drugs, requisite infrastructure, adequate staffing and the capacity building of health care providers at the primary health care level.

V. CONCLUSION

Effective implementation of the minimum prevention package for intervention in the prevention of HIV prevention programme in Kogi State showed significant achievements and improvement in the year 2015 when compared to 2014. However, relating the number of people involved in HCT to the total estimated sample size, there is a little shortfall in the attainment of the expected results. This could be attributed to programmatic bottlenecks, which when given the necessary attention could be easily overcome. It is therefore recommended that there is increased integration of services and decentralization of MPPI activities to primary health care centers and rural communities, stepwise supervision and monitoring of HIV prevention activities be strengthened and engagement of all tiers of governance to engender political commitment and ownership of the HIV response (including State and Local Government Area (LGA levels) with a view to ensure the sustainability of this programmes.

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