

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

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ABSTRACT

Background: HIV and AIDS continue to be huge problems especially among youths. Nearly half of the 3.1 million Nigerians living with HIV were between 15 and 24 years old. This intervention project was therefore designed to reduce the incidence and prevalence of HIV among in-school youths (ISYs) in Kogi State, Nigeria. This paper presents the achievements and implications of this intervention.

Methods: Four civil society organizations were engaged under HIV and AIDS Fund (HAF) II project to implement ISYs intervention in 6 out of the 21 Local Government Areas (LGA) in Kogi State. The project was carried out from 2014 to 2016 and implementation was done using HIV Minimum Prevention Package Intervention (MPPI). Data collected were analysed using descriptive statistics with the use of Microsoft Excel.

Results: The total number of community dialogues/advocacy held was eleven over the period of the project and 63.3% of the influencers that participated in 2014. A total of 69,248 peers were registered in this project and 65.6% were registered in 2015. Among these, a total of 54165 were reached with HIV education. A total of 9465 (27.5%) were counseled, tested and received result between 2013 and 2015; over half of this was done in 2015 (52.2%). A total of 208 tested positive and were referred for ARV while the prevalence was 2.2%. Majority (78.2%) of the registered peers were reached with MPPI.

Conclusion: The high percentage recorded in terms of peers reached with MPPI suggests that the programme was successful. This project should be sustained and extended to other LGAs not covered so as to help reduce the burden of HIV in the state.

Keywords:- HIV prevention, HAF II project, In-school youths, Minimum prevention package intervention

I. BACKGROUND

In 2013, 35.3 million people are living with HIV with 2.3 million new infections and about 39% are among young people (15-24) and young women having an especially high risk of acquiring HIV twice as high as the young men. More than two-thirds (70 percent) of people living with HIV live in sub-Saharan Africa, including 88 percent of the world's HIV-positive although this region contains a little more than 12% of the world population [1]. In Nigeria, the HIV prevalence among 15–24 years old men and women is 2.5% and 3.1% respectively [2]. Nearly half of the 3.1 million Nigerians living with HIV were between 15 and 24 years old [3]. Kogi State has an HIV prevalence of about 8.0% and also shares boundary with Benue State which has the highest HIV prevalence (12.7%) in Nigeria [4]. This geographical location predisposes Kogi State youths to be more susceptible to HIV/AIDS. Nigerian students within the age range 15-25 years accounts for more than 60% of new HIV infections. This takes place against a background in which one-third of the country's population of about 160 million are aged 10-24 years [5]. The achievement of the Millennium Development Goal 8 which was

to combat HIV/AIDS, Malaria and other diseases by 2015 has not been made possible as the prevalence of the disease continued to increase rather than decrease especially among this population. According to the information from African Development [6] gave the indices of Nigerian youth literates to be 43.25% in the North Eastern Zone, 45.15% in the North Western Zone, 69.7% in the North Central Zone, 85.3% in the South Eastern Zone, 85.65% in the South Western Zone and 90.45% in the Southern Zone, this corroborates the fact that school is the best place to capture youths for HIV and AIDS intervention as majority of them go to school. Also, research conducted by [7] showed that teachers favoured school-based sexual and reproductive health interventions for students but are not too comfortable counselling them one on one.

Early sexual debut, non-consensual sex, unprotected sex and multiple sex partners were prevalent sexual risk behaviours predisposing to HIV/AIDS among young people [8]. Socio-cultural practices like alcohol usage, use of pornography, blood swearing covenants, vulnerable sexual practices, cultic practices, early marriages, circumcising females and not circumcising the males all make them more susceptible to HIV [9]. A study carried out by [10] revealed that most youths are involved in unprotected sex despite their awareness of the efficacy of condom and its use. A 2008 study also noted that most youths in Kogi State engaged in high risk sexual activities, such as casual unprotected sex, multiple sexual partners, transactional sex and concurrent sex, with 13.0% of the female youth population having had sex before attaining the age of 15 years while 35% of their male counterparts reported likewise [11]. In addition, the proportion of men and women reporting high risk sexual intercourse in the state is very high (19% women & 52% men), while 28% of men were reported to have paid for sex on several occasions in the year prior to the report [11]. A study carried out by [12] identified that peer education is an effective intervention approach among in-school youths. Adeomi et al., [12] stated this because the knowledge of the study group increased as compared to the control group as it regards HIV/AIDS. Population Council made available the report of various interventions carried out by several non-governmental organizations on youths with focus on HIV reduction [13]. The interventions included education, voluntary counselling and testing, free provision and distribution of condoms. It was found out that behavioural change intervention produced the best result as it reduced the prevalence of HIV and AIDS among the population. As World Bank [14] has reported that education is associated with the actualization of most of the millennium development goals, it is highly imperative to address the impact of HIV and AIDS in the educational sector in Nigeria. Hence this article presents the achievements and implications of HIV prevention programme carried out among in-school youths (ISYs) in Kogi State, Nigeria.

II. METHODOLOGY

2.1 Study Design and Scope

This was an intervention project designed to reduce the incidence and prevalence of HIV among in-school youths in Kogi State. The project was carried out between 2014 and 2016.

2.2 Study Area

Kogi State was created in 1991 from the eastern part of the then Kwara State and western part of the then Benue State. The state occupies the central part of Nigeria and it is unique for serving as the belt for the two major rivers in Nigeria; Niger and Benue, Lokoja is the capital of the state and here the two rivers meet, hence the appellation 'Confluence State'. The state occupies an area of 28, 312.6 square kilometres. It is bounded by ten states and the Federal Capital Territory (FCT). To the north; Niger, FCT and Nassarawa, to the west; Kwara, Ekiti, Ondo, Edo and Delta, while to the east; Benue, Anambra and Enugu States. Kogi State is actually the only Nigerian State that shares boundary with as much as ten States. The state contains 239 wards in 21 local governments and 3 senatorial districts. The population as at 2006 was 3, 478,029. Males make up 46.8% and females 53.2% (National Population Commission, 2006). The state consists of three main tribes which are Igala, Ebira and Okun-Yoruba. There are also other minority tribes like Nupe, Ogori, Bassa-komo, Bassa-Nge, Egbira-koto among others. The state is highly heterogeneous due to its location. Agriculture is the main occupation of its inhabitants.

2.3 Study Population

The study population was in-school youths from ages 15-24 years in Kogi State. Youths who were enrolled in the selected schools in the state for at least a year prior to the study and were between the ages of 15-24 years were selected and all those who did not fall within the inclusion criteria were excluded.

2.4 Sample size

The estimated target population was 34,362 in school youths. The sample was selected in 6 out of 21 Local Government Areas (LGAs) in Kogi State. The 6 LGAs included are Ankpa, Kabba/Bunu, Idah, Lokoja, Adavi and Kogi.

2.5 Description of the Project

A total of four civil society organizations (CSOs) were engaged to implement HIV in-school youths (ISYs) interventions these are Environmental Development and Family Health Organization (EDFHO), New Hope Agency (NHA), Youth and Women Empowerment Project (YAHWEP) and Africa Health Project (AHP). These CSOs through the Kogi State Agency for the Control of AIDS (KOSACA) under the HIV and AIDS fund (HAF) II project intervention reached ISYs through direct social services to promote normative change. The CSOs focused on a unified structured approach, working closely with community stakeholders and school heads. The CSOs also used well defined and proven methodologies to reach the ISYs with the aim to improve their wellbeing and to remain relevant in a healthy and socially supportive environment. Emphasis was placed on heightening the perception of self-efficacy to prevent HIV, mobilization of communities to change social, cultural norms and value to ones that minimize their vulnerability to HIV. The CSOs also strategically integrated all HIV and health services to achieve maximal and efficient synergy in the prevention of HIV through a well detailed monitoring and evaluation plan. This was possible through advocacy visits, community leaders' dialogues, peer review meetings, free HIV counseling and testing (HCT), outreaches and referral services. The participating stakeholders were; PLHIV (support groups), community groups, KOSACA, CSOs HIV team, local government officials and traditional rulers.

2.6 Baseline survey

Baseline survey was conducted in selected secondary schools in Lokoja LGA in May 2014 to assess the knowledge of young men and women, their perception and practice with regards to issues related to sexual health including HIV/AIDS. The assessment was aimed to provide information in order to improve the content and quality of programme interventions in sexual health, offered to young men and women. Qualitative and quantitative approaches were used for data collection and purposive sampling method was used in selecting respondents.

2.7 Advocacy and Coordination Meeting

Following the findings and recommendation from the baseline, teams from the CSOs paid advocacy visits to different community actors who are principals of various schools, the local government chairmen, traditional rulers of the selected towns and health facilities in the locality. This gave the organizations an opportunity to familiarize themselves with the communities and the facilities. In designing an effective mechanism for project implementation in the communities, the CSOs through coordination effectively created an enabling environment for a successful project implementation that aided the various visits and intervention.

2.8 Intervention Activities/Strategies

The Minimum Prevention Package Intervention (MPPI) was used for the implementation of the programme. These strategies were organized into three levels of interventions which were; structural, behavioural and biomedical.

2.8.1 Structural Intervention

2.8.1.1 *Community dialogue*

The CSOs conducted community dialogue in communities where the project was implemented. Various community stakeholders were selected ranging from community chiefs, market women and men, youth leaders, Motorcycle riders' association representatives, religious leaders etc. In implementing effective community dialogue, everyone was given a voice and space through which they could articulate their feelings and concerns and collectively came up with answers that are pertinent and meaningful.

2.8.1.1 *Community Sensitization*

In strengthening and supporting institution to strategically linking HIV prevention intervention through the project, the CSOs conducted series of meetings and promoted linkages through meeting 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 HIV/AIDS and TB management, care and support. Also, the CSOs encouraged effective networking and leveraging of ideas and support.

2.8.2 Behavioural Intervention

2.8.2.1 *Recruitment of peer educators*

Following the advocacy for a smooth project take off was identification of the right category of people to aid the propagation of HIV prevention intervention, hence the enrollment of peer educators (PEs) on the

project. The PEs were identified, enrolled and registered for the project. This was successful through school visit, local government headquarters visit and community.

2.8.2.2 Peer session meeting

The trained peer educators carried out peer/cohort sessions (meetings) with their peers in their various communities and schools to enhance support for prevention of sexual transmission messages for effective compliance towards reaching the project goal and objectives. The meetings were done within the range of 2–3 months with the frequency contact ranging between 6 to 9 times. The intervals of meeting days ranged between 10 to 15 days.

2.8.2.3 Peer education training

ISYs were trained as Peer educators in selected secondary schools. There was emphasis on sexual transmission prevention strategy which was designed to focus specifically on unmarried youth engaging in unprotected sex and multiple sexual partnerships.

2.8.3 Biomedical Intervention

HIV Counseling and Testing (HCT)

The CSOs conducted a stakeholder’s forum in the communities to sensitize and conduct HCT. The HCT was conducted by trained Counsellor Testers and data were documented using HIV client intake form. During the testing, counseling services on HIV were also provided to clients.

2.9 Monthly Monitoring and Evaluation visit to project sites

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

2.10 Data Analysis

Data were collected using various but uniform data collection and reporting tools. The data were collected from various activities carried out under structural intervention, behavioural intervention and biomedical interventions. The data were entered into DHIS2 platform and exported into Microsoft excel. The results were analyzed using Microsoft Excel by comparing frequencies and percentages. They were carefully presented in tables and chart.

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 71830 given a target reached of 209.0%.

3.1 Structural Interventions

Structural interventions are presented in table 1. The total number of community dialogues/advocacy held was 11 over the period of 2014-2015. Out of the 11 dialogues, just over half (54.5%) was held in 2015 while the remaining 45.5% was held in 2014. Data on the influencers that were involved the community dialogues were also presented in table 1. A total of 412 influencers participated. Majority (63.3%) of the influencers that participated in community dialogue did so in 2014 while 36.7% did so in 2015.

Table 1: Structural Interventions

Period	Number of community dialogues (%)	Influencers participating in comm. Dialogue (%)
2014	5(45.5)	261(63.3)
2015	6(54.5)	151(36.7)
Total	11	412

3.2 Behavioral Intervention

Data on condom programming was shown in table 2. A total of 24 pieces of female condom were distributed and all were distributed in 2015. Male condoms were majorly distributed in 2015 (51.1%) with (49.0%) distributed in 2014. Table 2 also contained data on peers registered by the PEs. A total of 69,248 peers were registered in this project and 65.6% were registered in 2015. Among these, a total of 54165 were reached with HIV education (Table 2)

Table 2: Behavioural Intervention

Period	Number of peers registered N (%)			Number of persons reached with HIV Education N (%)			Number of condoms distributed	
	Female	Male	Total	Female	Male	Total	Female Condom (%)	Male Condom (%)
2014	11712 (31.9)	11126 (33.6)	22838 (33.0)	9031 (30.5)	8592 (35.0)	17623 (48.2)	0 (0.0)	22751 (49.0)
2015	24458 (67.6)	21952 (66.4)	46410 (67.0)	20620 (69.5)	15922 (65.0)	36542 (51.8)	24 (100.0)	23718 (51.1)
Total	36170	33078	69248	29651	24514	54165	24	46469

3.3 Biomedical Interventions

Data on number of persons, who were counseled, tested and received result (CTR) are presented in table 3. A total of 9,465 were CTR between 2014 and 2015; over half of this was done in 2015 (52.3%). Among these, 208 persons were tested positive showing HIV prevalence of 2.2% (Fig 1). On the number of persons referred for STI services, a total of 5 persons were referred and all 5 were referred in 2015. The data available also showed that a total of 4 persons received STI services with all 4 receiving STI services in 2015 as well. This was similar for the number of persons that went for STI follow-up. Four persons went for follow-up and all 4 did so in 2015. Selected items from the biomedical interventions were presented by gender in table 3.

Table 3: Biomedical Interventions

Period	No CTR (%)			No tested positive (%)	No referred for STI services (%)	No of received STI services (%)	No went for STI follow-up (%)
	Female	Male	Total				
2014	2659 (55.1)	2380 (51.3)	5039 (53.2)	94 (45.2)	0 (0.0)	0 (0.0)	0 (0.0)
2015	2167 (44.9)	2259 (48.7)	4426 (46.8)	114 (54.8)	5 (100.0)	4 (100.0)	4 (100.0)
Total	4826	4639	9 465	208	5	4	4

3.4 Coverage of MPPI, HCT and Prevalence of HIV

The percentage of persons reached with MPPI out of registered peers was 72.8%. The total percentage reached with HCT was 27.5% while the prevalence of HIV was 2.2% (Fig. 1).

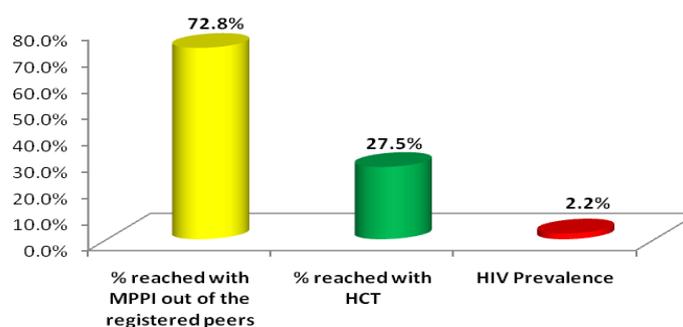


Figure 1: Coverage of MPPI, HCT and Prevalence of HIV

IV. DISCUSSION

The use of structural intervention in this project especially the community dialogue has contributed immensely to the success of this project. More community dialogues were done in 2015 as against more

influencers that were involved in 2014. This showed that number of influencers had little to do with the dialogues. Community dialogues have also been used by the German government in collaboration with the Nelson Mandela to fight the scourge for HIV/AIDS among youths [15]. The community dialogues done in this study were vital to facilitate the acceptability of the various interventions and it certainly helped in generating the necessary response from the target population. This agrees with the Guidelines for Conducting Community Dialogue put forward by the National AIDS Commission of Malawi [16]. Condom programming and peer educators were the major behavioural interventions carried out by the CSOs. These are similar to the Geração Biz program done in Mozambique. Trained peer educators were used to reach young people and condoms were also distributed [17]. In this project, all condoms were distributed in 2015. On the peer educators more were registered in 2015. The percentage for peers increased substantially from 2013 to 2015. The data in this section generally suggests that more was done in 2015 than any other year. The high coverage of condom programming in this study is in variance with the notion put forward by [18] in their study among youths in Ekiti state, Nigeria, where they compared in-school youths and out-of-school youths, it was showed that condom use was less among the ISY population. In this study, though coverage was high, it might not translate to use. However, it is a step in the right direction should these population engage in risky sexual behaviour. Peer-led approach was also used in a similar program, USAID/Ethiopia In-School Youth HIV Prevention Program [19]. Peer education presents a good opportunity for young people such as the target population in this study to help develop and make effective informed decisions on issues relating to HIV/AIDS. The biomedical intervention revealed that there were three major interventions with data on receipt of STI services and follow-up coming from the health centres. Just as it was noticed in the structural and behavioural interventions, more was done in 2015 as more persons were referred for STI and ARV in 2015. This was with the exception of HCT where more than half were counseled, tested and got result in 2015. In a study conducted by [20] among eight secondary schools in Kenya, it was shown that only 24.7% of respondents had undergone HCT which is comparable to 27.5% covered in the current study.

V. IMPLICATIONS FOR PROGRAMMING

The results of this intervention have great implications for programming. Series of strategies could be used to sustain the success stories recorded in this programme. The challenges could in similar way be surmounted. Positive reaction to HIV prevention messages among community members as well as eager participation in community dialogue meeting could be encouraged as a way of ensuring the success of similar programmes in the future. This could be done by continuous engagement of community leaders and gatekeepers. Generally, proper community entry is expected to facilitate the implementation of a programme such as this; hence the success recorded. This will also go a long way in ensuring stakeholders support for the programme. The major challenges documented during this study was shortage of HIV testing kits, difficulty in getting facilities to help with kits and lack of IEC materials, this should have inadvertently affected the HCT coverage of 27.5%. To avoid such problems in future, there should be a strong support from the government to help compliment the efforts of donor agencies. This will go a long way to help reach a larger set of beneficiaries and by so doing reduce the burden of the disease. One of the reasons why there was shortage of HIV testing kits was the fact that there was an unprecedented large turnout of people. This could be planned for in future. Appropriate measures could be put in place to checkmate having more people than the resources available.

VI. CONCLUSION

The high percentage recorded in terms of peers reached with MPPI suggests that the programme was successful. Behavioural change intervention on HIV and HIV counselling and testing services needs to be intensified in the state especially in the local government areas not covered in the current project so as to reduce the burden of HIV in the state. The government could sustain this project or similar projects through the contribution of materials, finance and enabling environment for organizations and donors. More interventions should be done by using peers as it tends to have more impact as shown in during this project.

VII. ACKNOWLEDGEMENT

The evaluation team wishes to acknowledge the World Bank and the National Agency for the Control of AIDS (NACA) for making available the funding for the conduction of the evaluation programme, the dissemination of results and the writing up of the article.

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