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

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ABSTRACT

Background: Considering the high burden of HIV among sex workers many HIV intervention programmes have not been very successful among them thus the HIV Minimum Prevention Package Intervention (MPPI) was introduced to reach Female Sex Workers (FSWs). This paper therefore presents achievements and implications of HIV prevention activities among FSWs in Kogi State, Nigeria.

Methods: This intervention project was carried out between 2013 and 2015 by four civil society organizations. A total of 1,413 participants were engaged and reached with the three levels of MPPI. Data were collected during peer education/cohort sessions conducted among sex workers by the peer educators and vital information on HIV counselling and testing (HCT) were documented by trained Counsellor Testers. Data were entered into District Health Information Software (DHIS) 2, exported and analyzed using excel.

Results: A total of 143 community dialogues were held during this intervention and 1,782 influencers participated. Only 11 income generation activities were held in this project and 40

participants benefitted from it. The total numbers of male and female condoms distributed were 86,445 and 4,025 respectively during the entire project year. The total percentage of persons reached with MPPI out of the registered peers was 1028 (72.7%) and only 1278 (90.4%) were counseled, tested, and received their results during this project. Among these, a total of 129 (10.1%) participants were tested positive to HIV. A total of 123 participants were also refereed for other STI services and among these, 65.0% were referred in 2014 while the remaining 35.0% were referred in 2015.

Conclusion: This intervention was a success however; only limited efforts were put on income generation activities for the participants. There is a need for more interventional efforts on the capacity building of sex workers, as only then can the efforts of other interventions be successful.

Keywords: Female sex workers, HAF II project, HIV/AIDS, Minimum prevention package intervention

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INTRODUCTION

Female sex workers (FSWs) are one of the most important groups propelling HIV epidemic in most countries in Africa [1;2]. Indeed, even when prevalence rates are generally quite low in a country, they can be very high in this group. HIV prevalence among sex workers is 13.5 times higher than among other women [2]. An estimated 37% of sub-Saharan female sex workers live with HIV [2]. Between 1% and 4% of women in several west African capital cities are estimated to be sex workers, with even higher proportions in areas were transport and employment networks increase the demand for paid sex [3;4]. Sex work in Africa takes many forms, and may be street, brothel or home-based. The exchange of sex for goods as a practice is diverse and may include the exchange of sex for food, shelter, material goods and cash. Sex work may be occasional or occur on a regular scheduled basis. Some women may identify as sex workers and others not [4]. Beyond the significant number of women who rely on sex work for employment, an even greater population of male clients (‘sex buyers’) use their services. National HIV responses in Africa have tended to ignore the needs of sex workers and have failed to protect them against HIV.

HIV prevalence among sex workers in Nigeria is very high [5]. In a recent survey among most-at- risk populations in six states in Nigeria, over half of sex workers did not consider themselves at risk of HIV infection [6]. In Lagos state, with the highest concentration of sex workers in Nigeria, only 16% of brothel-based sex workers felt they were at risk, even though each has on average 34 clients per week [6]. Despite their high-risk sexual activity, many sex workers perceive their risk of HIV infection to be low [7].

Kogi State has an approximated population of 3.2 million and was the fifth highest in the North Central zone in terms of the prevalence rate of HIV, with 5.8% of the population affected [8], a statistic that is higher than the national average of 4.4% [8;9]. Factors which precipitated these heightened prevalence rate in the State had been identified to include: multiple concurrent sexual partners, marital infidelity, high rates of unprotected sexual activity, worsening poverty levels, ignorance, low risk perception, among others [10]. The provision of a package of HIV prevention, treatment and care services to sex workers based on their needs is the basis for this pillar. Access to HIV prevention and reproductive health commodities (condoms, lubricant and contraceptives); voluntary HIV counselling and testing; treatment for HIV and other sexually transmitted and opportunistic infections; harm reduction interventions for substance abuse, and a range of social and welfare services are required to ensure a comprehensive HIV response [11]. Indeed, it is by addressing the determinants of the epidemic, the specific needs of this population, increasing the supply of services of prevention and providing care tailored to each target population, that we can hope to sustainably impact on the HIV epidemic throughout Africa. This paper therefore presents the achievements and implications of HIV prevention activities among FSWs in Kogi State, Nigeria.

MATERIALS AND METHODS

Study Design and Scope

This was an intervention project carried out among FSWs in Kogi State, Nigeria. Four Civil Society Organizations (CSOs) were involved in this study namely; Africa Health Project (AHP), Rural Women Empowerment and Youth Development Foundation (RWEYDF), Dual Communication Initiatives (DCI) and Development of Female Gender Initiative (DEGENDER). The scope of the project was limited to increased adoption of safer sexual behaviours, good health seeking behaviour for prompt treatment of STIs, and consistent and correct use of condom.

Study Area

The project was carried out in randomly selected eleven out of the twenty-one local government areas (LGAs) in Kogi State. Kogi, State, central Nigeria was created in 1991 from portions of eastern Kwara and western Benue states. The state has a projected population of 4,153,089 in 2014 with 20 Local Government Areas. The Male population in the state is 2,101,463 and Female population is 2,051,626. Kogi is bordered by the states of Nassawara to the northeast; Benue to the east; Enugu, Anambra, and Delta to the south; Ondo, Ekiti, and Kwara to the west; and Niger to the north. Abuja Federal Capital Territory also borders Kogi to the north.

Target Population
The target population for this intervention are female sex workers in Ankpa, Adavi, Dekina, Kogi, Lokoja, Idah, Omala, Olamaboro, Okene, Ofu and Yagba East LGAs.

Sample size
The estimated sample size for this intervention was 952 sex workers

Description of Intervention
The CSOs were engaged by Kogi State Agency for the Control of AIDS and funded under the HIV and AIDS fund (HAF) II project of the World Bank. This intervention was carried out between 2013 and 2015. The CSOs reached FSWs with the three levels of MPPI which are structural, behavioural and biomedical interventions and activities under each of the intervention are discussed below;

Structural Intervention
Structural Intervention was concerned with promoting community-led interventions that sought to create enabling environment for access to information and health services for FSWs. Also, the project sourced for alternative means of livelihood for sexual workers by engaging in community-based programs to rehabilitate these women as well as assist them to exit sex work by building their capacities, teaching them about the management of their finances, conducting feasibility studies before starting any business, marketing strategies, as well as customer relationship. Advocacy visits were made to stakeholders at the community level particularly the hotel managers and other gate-keepers.This intervention also addressed structural barriers within the community such as cultural believes and practices as well as policies and legislation that hinder FSWs and their clients from accessing and utilizing appropriate HIV prevention, treatment and care services.

Dialogue session with stakeholders

Dialogue sessions were held with stakeholders to report to the gatekeepers on the progress of the project in their community and to solicit support where the challenges encountered are within their power. The participants of this meeting are the representatives of the traditional rulers, the police, health workers at the general hospitals and ART clinics, brothel owners, local action committee on AIDS coordinators and other stakeholders visited in the advocacy. Bi-annual dialogue sessions of FSWs with hotel managers and the police were also conducted. The bi-annual dialogue sessions held controlled the challenges of FSWs activities with hotel managers and the police. The meeting was conducted to bring the community leaders and police very close. A lot of issues were discussed about FSWs right and their relationship with community and police.

Special event; *Ladies night*

This was a programme specifically for the sex workers and their patrons. It brought myriads of interventions to their door step. From research we discovered that the management of most brothels usually organize shows; a sort of night club on weekly or monthly basis. This is a time when lots of risky behaviours are perpetuated by this group. It was in this knowing that we organized this special event tagged; “Operation know your status and stay safe” This event provided a holistic and comprehensive services to the

FSWs and their numerous patrons.Major services provided in the event were HIV sensitization messages, STIs prevention, HCT, condom messaging and demonstration andlife building skills. A combination of these services yielded the expected result.

Capacity Building

A five-day training programme on "make-up" was organized for some selected FSWs in Lokoja in form of capacity building. A consultant who has a beauty and make-up saloon was hired to facilitate this training. The participants were selected from all the project sites. The sex workers were thought different types of make-up and saloon style for the period of the training in Lokoja. The participants were ushered expertly and systematically into their own world through self appraisal and began to see things they never thought of before. Among others, they were taught about the management of the training, marketing strategies, modes of advertising products, ways of making customers and customer relationship. All these opened up a new world view to understanding the issue of make-up to them. Crucially and very important, they were taught time management as well as business feasibility study in any community. Practical sessions were held to give each of them the opportunity to demonstrate on how to do make-up.

Behavioural Intervention

This influenced beneficiaries to adopt healthy behaviours, whilst reducing their risk for HIV infection. Such behaviours include partner reduction, correct and consistent use of condom, good health seeking behaviour for prompt treatment of STIs, treatment referral, follow-up and HCT. Individual level behavioural change communication was achieved through cohort session of peer to peer education. It was at this level of intervention that condoms (both male and female) were promoted as well as lubricants, in a bid to ensure an upturn in access to and the use of condoms. Sex workers' peers were engaged to carry out peer influenced behavioural change communication and peer-to-peer education sessions in the selected FSWs sites.

Peer sessions

The peer cohort sessions was a monthly program carried out by PEs with their peers or cohorts registered into the project. A total of 152 PEs were recruited and trained to provide peer education to their colleagues who are also sex workers. Each of the PEs has a minimum of 8 and maximum of 12 members in their cohort. They meet at least 2 times or at most 3 times in an interval of 15 days or 10 days respectively in a month to discuss HIV and other related issues including sexual and reproductive health as contained in their training manual. After a minimum of 6 contacts, the peers were provided with HCT and graduated having completed the modules in the manual. The participants were taught about meaning of HIV and AIDS, HIV modes of infection and transmission, HIV prevention, HIV counseling and testing, as well as issues revolving round stigma and discrimination. Other areas of focus during the peer-to-peer education included the human anatomy, the reproductive system, stages of human development, self-esteem and other life skills, value system, use and importance of condoms and getting treatment for STIs.

Focus Group Discussion Session on Condom

Focus Group Discussion sessions on condom messaging and demonstration were held in all projects sites by the project team in conjunction with the trained peer educators and

the LACA officers from each LGA. Each peer educator brought along their selected cohort members whom they have started meeting at cohort sessions. Condoms were freely distributed to all participants and all other interest individuals.

Biomedical Interventions

The biomedical level of interventions was approached along two lines, the first being with regards toincreasing access to HIV services for FSWs, while the second pertained to mobilizing an enabling environment for FSWs to gain acceptance within the communities they belong and have access to HIV prevention, treatment and care services. It is within this level that the issues pertaining to the strengthening of the referral system to provide quality STIs treatment and increase the uptake of HCT services for sex workers and their clients.

HIV Counselling and Testing (HCT)

Mobile HCT services were carried out for all peer educators and their cohorts as well as other members of the community. Those tested positive were referred to health facilities for care and support while others were counselled to adopt a non-risky behavioural style of life.

Data Collection, Monitoring and Management

Data were collected during peer education/cohort sessions by the peer educators among FSWs involved in the peer session. Information on HCT were documented by trained HIV Counsellor Testers using the HIV Client Intake Form and referral forms for those who need further services such as STIs and Antiretroviral Therapy. All activities were monitored by implementing organizations Monitoring and Evaluation Officers especially the peer sessions in collaboration with the Service Support Organization (SSO). Reports were entered in the relevant reporting templates which were transmitted on to the DHIS 2 platform. The project manager, monitoring and evaluation (M&E) officers and other technical staff were saddled with programme coordination. They were provided with five days training on MPPI & DHIS.

Community Engagement and Project Sustainability

Community engagement activities were carried out across project site to encourage community involvement. Community engagement session was successfully running with hotel managers, community leaders and FSW leaders.

Data Analysis

Data were entered into District Health Information Software (DHIS) 2 and was checked for completeness, accuracy, errors and other inconsistencies to identify any possible data quality errors, exported and analyzed using excel.

Ethical Issues

Prior to the commencement of the intervention, 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. 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 tests were done under HCT tents within the community, with only one client attended to at a time to ensure privacy of the client. The HIV client intake forms were kept in a safe place to ensure confidentiality. 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 target reached during this intervention was 1413 as against 952 which was an estimated sample size. This gave a target reached of 148.4%.

Structural Intervention

Out of the 143 community dialogues held, 84 (58.7%) took place in 2015 while 59 (41.3%) took place in 2014. A total of 1,782 influencers participated in the community dialogue. Among these, 67.6% participated in 2015. In addition, three income generation activities were held in 2014 and only 5 people benefitted while in 2015, 35 people (87.5%) benefitted from the eight income generation activities (Table 1).

Table 1: Structural intervention

Period	Number of community dialogues held	Influencers participated in community dialogue	Number of IGA held	No of persons that benefited from IGA
2014	59 (41.3%)	577 (32.4%)	3 (27.3%)	5 (12.5%)
2015	84 (58.7%)	1205 (67.6%)	8 (72.7%)	35 (87.5%)
Total	**143**	**1,782**	**11**	**40**

Behavioural Intervention

The total number of male condoms distributed was 86, 445 out of which 34,437 (38.1%) were distributed in 2014 while 56,033 (61.9%) were distributed in 2015. Also for female condoms, a total of 4025 condoms were distributed and most (73.7%) were distributed in 2015. On the number of peers registered, only 520 (36.8%) peers were registered in 2014 while 893 (63.2%) were registered in 2015. Most (74.9%) of the lubricants distributed during this intervention were distributed in 2014 while 156 (25.1%) were distributed in 2015 (Table 2).

Table 2: Behavioural intervention

Period	Female condoms distributed	Male condoms distributed	Peer registered	Lubricant distributed
2014	1058 (26.3%)	33379 (38.6%)	520 (36.8%)	466 (74.9%)
2015	2967 (73.7%)	53066 (61.4%)	893 (63.2%)	156 (25.1%)
Total	**4,025**	**86,445**	**1413**	**622**

Biomedical Intervention

A total of 1278 (90.4%) sex workers were counseled, tested, and received their results. Among these, a total of 129 participants were tested positive to HIV. A total of 123 participants were also refereed for other STI services and among these, 65.0% were referred in 2014 while the remaining 35.0% were referred in 2015 (Table 3).

Table 3: Biomedical Intervention

Period	No counseled tested and received result	No of persons tested positive	No of persons referred for STI	No of persons receiving STI services	No going for STI follow-up
2014	530 (41.5%)	58 (45.0%)	80 (65.0%)	54 (55.7%)	45 (51.7%)
2015	748 (58.5%)	71 (55.0%)	43 (35.0%)	43 (44.3)	42 (48.3%)
Total	**1278**	**129**	**123**	**97**	**87**

Coverage of MPPI, HCT and Prevalence of HIV

A total of 1028 (72.7%) of the registered peers were reached with all the three stages of MPPI and 1278 (90.4%) were reached with only HCT. Among these, 129 (10.1%) were tested positive to HIV (Fig. 1).

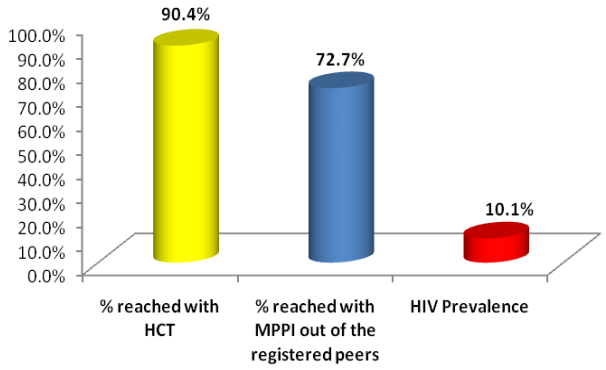

Figure 1: Coverage of MPPI, HCT and Prevalence of HIV.

DISCUSSION

The structural level interventions employed during this intervention include advocacy visits to community gate-keepers and community dialogues particularly in the hot-spots of FSW activities as well as capacity building for FSWs. This may be attributed to the fact that structural conditions contribute to the drastically elevated rates of HIV infection among sex workers compared to the general population of women of reproductive age [2;12]. Widespread stigma and discrimination towards sex workers contribute to their exclusion and discourage health service access [4]. Human rights abuses and violence aimed at sex workers, mostly at the hands

of clients and law enforcement officers occur commonly and contribute to disempowerment and reduce their ability to negotiate condoms (among other effects), particularly where sex work is criminalised [13-18]. All or most aspects of sex work are criminalised in the majority of sub-Saharan African countries, leaving sex workers with little to no recourse to report violence and abuse, and often acting as a direct barrier to accessing HIV prevention, treatment and care services.

As regards the income generating activities and capacity building of the FSWs, these were embarked upon to provide the sex workers trainings on vocational skills and savings which were hoped will reduce their dependence on commercial sex activity. This is due to the belief as captured by [19] on the subject of HIV prevalence in Nigeria that the epidemic in Nigeria is driven by transactional sex, low risk perception, high risk behavior and sexual networks amongst FSWs and their clients, multiple and concurrent partnerships, poor STI management and vulnerability, which all arise from economic challenges.

At the individual level of intervention wherein condom and lubricant distribution is embarked upon, it is noteworthy to state that although the total number of (male and female) condoms distributed slightly exceeded the 60% target for condom use in both years amongst FSWs, however condoms distributed were short of the estimated target population for the intervention, highlighting that this is a step in the right direction as this undoubtedly would promote the message of condom usage among FSWs and their clients, as well as the use of water-based lubricants as against other harmful petro-chemical substances that many of them were fond of using in place of lubricants. These, if supported with continued encouragement and provision of condoms and lubricants would in time become a main-stay of the sexual lives of the FSWs as well as their clients within the state, whilst also helping to reduce the prevalence of HIV even further.

High prevalence of HIV was recorded among sex workers in this intervention. Today, the female sex workers (FSW) constitute the sub group most affected by HIV/AIDS in Nigeria [20-21]. In an integrated biological and behavioural surveillance (IBBS) survey carried out by the Federal Ministry of Health [22-23] comprising five and eight states of the federation (e.g. Lagos, Kano, Edo, Anambra and Cross River) including the FCT, different HIV prevalence among female sex worker was noted in these states and such has been largely attributed to the varying use of condom and alcohol consumption by the sex workers [23]. The prevalence of HIV/AIDS among sex workers in Nigeria was approximately 25% in 2012 while prevalence among people 15–49 years old in the country in 2011 was around 4% [24].

Implications for Programming

At this level, community-led interventions sought to create both enabling environments for access to information and services for FSWs thus increasing access to information, and health services as well as alternative sources of income so that the number of FSWs in the state could reduce. This was done in a bid to not only sensitize FSWs and their clientele about HIV and AIDS, but also to mobilize for HCT, and the need to avoid discriminating against those diagnosed with HIV and AIDS. Stigma and discrimination against persons living with HIV and AIDS is widespread in Nigeria [25], and often influences the use of HIV related prevention and

care services; whilst adversely affecting the psychological, sexual and physical health of such individuals [26]. Social support particularly from the individual's family may also influence the health outcomes of HIV infected individuals [27].

A programme of such magnitude as HAF II, particularly in terms of its financial cost as well as its objectives to which this cost is matched portends a lot for the future of health sector programming in the Kogi State specifically and the country as a whole. While it is not untrue that Nigeria as a whole as a developing nation in sub-Saharan Africa has in recent years witnessed the influx of intervention activities channeled particularly towards its health sector conducted by many local and international organisations most of their activities were channeled more towards mother and child health care issues and other such, with little emphasis being placed on HIV and AIDS, and even lesser on how FSWs are affected by the scourge of the epidemic. This challenge is even more disturbing when viewed as Kogi dilemma given the peculiarity of issues such as the incidence of transactional sex, risky sex, and the prevalence of HIV amongst FSWs in the state, among others. It is thus important to note that such initiative that portends much good for the health of members of the public as occasioned in the capacity-building of the FSWs in the HAF II should not be allowed to go the way of majority of interventions which often die natural deaths after a short-while. Hence sustainability of such intervention is a key to reducing the number of FSWs in the state, as well as reducing the prevalence of HIV even further.

An important aspect of this project, is that the HIV/AIDS Fund II initiative takes the FSW discourse beyond basic HIV prevention, HCT, care and treatment, but also seeks to provide alternative means of livelihoods for these FSWs through capacity building. While these may undoubtedly incur more costs than just the provision of basic services or face challenges in the form of brothel owners who fear they may be on the losing end in a few years, it is nonetheless worthy of emulation not only because it shows the FSWs that they are cared for by the society at large, but also that there are other ways by which they can survive and earn their daily bread. Importantly, the introduction of HCT services to the communities within this intervention has helped this special community to begin to take cognizance of their state of health at large, and HIV statuses in particular. This will however only continue to work if such interventions are not only continued, but also followed up by other programmes geared towards ensuring proper monitoring to ensure the smooth running of the HIV referral links and follow-up for STI management. Also, such programmes aimed at improving the referral process can be built on the success of the HAF II.

Challenges

Some brothel owners tactically limited intervention activities among sex workers in their brothels because of the perception that the primary aim of the project was to reduce the number of sex workers in the state. Another challenge was that some participants including the peer educators who travelled during the Christmas and New Year period were lost to follow-up, they did not return to the brothel. Hence, similar future interventions among FSW as a matter of fact should plan ahead to prevent any form of lost to follow-up.

CONCLUSION

The impact of this intervention on the participants is commendable but only limited efforts were put into their financial capacity building through income generating activities. The participants took ownership and see their contributions valuable to the success of the programme. However, some of the participants were still afraid of receiving HIV counseling and testing due to their perceived susceptibility to the virus. Hence this type of intervention should be sustained among sex workers in the state through provision of package of HIV prevention, treatment and care services based on their needs.

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