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Control and Management of HIV/AIDS across Niger Delta States

PROFESSOR INNIME RIGHTEOUS, Ph.D, Ph.D, FAIPH, FAPHA

Department: Education, Health and Social Services (EHSS)
Designation: Director, Health (Sabbatical Research Officer)

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***Corresponding Author**: *PROFESSOR INNIME RIGHTEOUS, Ph.D, Ph.D, FAIPH, FAPHA*

Abstract **Original Research Article**

The first significant control of HIV/AIDS came with the approval of Zidovudine (AZT) in 1987, marking the first antiretroviral medication available for treatment. Before 1987, there were no effective treatments for HIV/AIDS. The development and approval of AZT was a major step forward in managing the disease. Control and management is an involvement of collaboration required to ensure success on a particular method of implementation. The purpose of the study was to examine the level of control and management of HIV/AIDS across Niger Delta States with a view to arriving at suggestions that could improve the implementation. The study adopted five research questions and five hypotheses. The study adopted ex-post-facto (experimental) research design amongst various categories of communities aged 15 years and above living in Niger Delta States of Nigeria and involved in the control and management of HIV/AIDS in Niger Delta State. The study adopted a self developed questionnaire. Data collected from the respondents during the study was statistically described and analyzed by using the statistical package for social science (SPSS). The findings of the study revealed that there was a significant difference in community involvement in Niger Delta States improved political commitment and support of the communities for the control and management of HIV/AIDS [F(1,898) = 12.792, p<0.005]. The findings of the study revealed that there was a significant difference in community involvement promoted health - seeking behaviour and for control of HIV/AIDS in Niger Delta States [F(1,898) = 30.811, p<0.005]. The findings of the study revealed that there was a significant difference in community involvement expanded access and HIV/AIDS control services in Niger Delta States [F(1,898) = 12.997, p<0.005]. The findings of the study revealed that there was a significant difference in community involvement strengthened capacity and the management of HIV/AIDS in Niger Delta States [F(1,898) = 11.313, p<0.005]. The findings of the study revealed that there was a significant difference in community involvement promoted research and HIV/AIDS control in Niger Delta States [F(1,15.486) = 64.690, p<0.005]. Hence, engaging communities in the Niger Delta is pivotal for advancing HIV control through expanded access, strengthened local capacity, and locally driven research: community-led testing and linkage strategies can reach marginalized populations and shorten the diagnostic-to-treatment gap, capacity-building of peer educators and community health workers enhances retention and adherence, and participatory research aligns interventions with social realities while generating actionable evidence; however, sustainable impact will require consistent funding, stronger integration with health systems, attention to security and stigma-related barriers, and formal mechanisms for community accountability and scale-up so that the demonstrated gains translate into long-term reductions in HIV transmission and improved wellbeing for affected individuals and communities.

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INTRODUCTION

The first significant control of HIV/AIDS came with the approval of Zidovudine (AZT) in 1987, marking the first antiretroviral medication available for treatment. Before 1987, there were no effective treatments for HIV/AIDS. The development and approval of AZT was a major step forward in managing the disease. Control and management is an involvement of collaboration required to ensure success on a particular method of implementation (Adetokunbo & Herbert, 2023). It has been observed in Niger Delta States that wide gaps exist in the knowledge base, awareness and HIV/AIDS control measures include a combination of behavioral, biomedical, and structural interventions to prevent new infections and manage existing ones.

These measures aim to reduce transmission through various routes, such as sexual contact, drug injection, and mother-to-child transmission. With the recent high incident cases we are having every day in Niger Delta States over 2000 new cases are prevalent per months. The recent methods of control measures in the Niger Delta Region gives a call signal for further research with the USAID withdrawals of sponsorship in Africa, most especially in Nigeria. This is a major research that shall bring forth the lasting solution to this intervention viral disease.

CONCEPTUAL REVIEW

In order to determine the control and management of HIV/AIDS in the implementation of national reproductive health plan in Niger Delta State, attempt shall be made to critically review available related literature under the following sub-headings:

The Promotion, political commitment and support of the communities in the control and management of HIV/AIDS.

Community participation (involvement) and the promotion of health – seeking behavior in the control and management of HIV/AIDS.

The involvement of communities in the expansion of access to HIV/AIDS control services and the quality.

Community participation and the strengthening of capacity for management of HIV/AIDS.

The influence of community participation on the promotion of research on HIV/AIDS.

PURPOSE OF THE STUDY

The purpose of the study is to examine the level of control and management of HIV/AIDS across Niger Delta States with a view to arriving at suggestions that could improve the implementation.

RESEARCH QUESTIONS

This investigation was conducted to answer the following specific research questions.

1. In the advocacy and social mobilization, to what extent has community involvement in Niger Delta States improved political commitment and support of the communities for the control and management of HIV/AIDS?
2. In the promotion of healthy reproductive behaviour, to what extent has community involvement promoted health - seeking behaviour for control of HIV/AIDS in Niger Delta States?
3. In equitable access to quality health services, to what extent has community involvement expanded access to HIV/AIDS control services in Niger Delta States?.
4. In capacity building, to what extent has community involvement strengthened capacity for the management of HIV/AIDS in Niger Delta States?
5. In research promotion, to what extent has community involvement promoted research on HIV/AIDS in Niger Delta States?

METHODOLOGY

Research Design

A research is a discipline common sense, concerned with producing results that will lead to the development of theories (Awotunde et al., 1997: Awotunde & Ugodulunwa, 2002). As the purpose of this study is to find out the extent of control and management of HIV/AIDS in the Niger Delta States, ex-post-facto (experimental) research design will be used. This research design afforded the researcher opportunity to study two or more independent variables that were placed side by side to be able to study their independency and their interactive effects on the dependent variable.

Population of the Study

A population in research is a target group, which a researcher is interested in studying and about which he intends to obtain information and draw conclusion (Awotunde et al., 1997). The population for this study consisted of the various categories of the communities' aged 15 years and above living in Niger Delta States of Nigeria and involved in the control and management of HIV/AIDS in Niger Delta State. The various categories of the communities involved in the study included women group, religious group and the youth group in the (9) Nine Niger Delta States.

Sample

Awotunde et al. (1997) and Lere et al. (2002) opined that in almost instances in educational research, it is impossible to study a whole population and therefore, portions of it are usually studied.

Purposive sampling technique used to select subjects for this study and this was taken as being representative of the population. The purposive random sampling will be used in selection of male and female adults aged 15 years and above,

residing in both rural and urban settlements of Niger Delta States.

The Instrument

The instrument that will be used for this study to collect data will be questionnaire and interview focused group discussion for the literate and illiterate respondents. Discussion, which involved, for example, 3-5 persons taking part in a group, is necessary.

Development of the Instrument

The instrument shall be designed by the researcher consisted of forty-three (43) statements with three (3) sections. Section 'A' was on personal information of the respondents with eight (8) statements (from 1–8), section 'B' on the control of Human Immune Virus (HIV)/Acquired Immune Deficiency syndrome (AIDS). (HIV/AIDS), with twenty-five (25) statements (from 9 – 33), and section 'C' on the management of HIV/AIDS with ten (10) statements (from 34 – 43).

Validation of the Instrument

The face validity of the instrument shall be determined by distributing the copies of the questionnaire to five (5) jurors who were experts from the Department of Education, Health and Social Services (EHSS) to determine the face validity of the questionnaire. On the basis of their assessments, suggestions and recommendations, necessary modifications were made in the draft questionnaire, after which the final questionnaire was prepared on a 5-point Likert Scale for the research work.

Administration of Questionnaire

The researcher personally involve in the random distribution of the questionnaires, conduct of interview and focused group discussion for the literate and illiterate respondents. However, this was successful with assistance from interpreters who were fluent in conducting themselves (research assistants or programme officers) from each Voluntary Counseling and Confidential Testing (VCCT) centre of the States before the respondents of all kinds. Thus, one hundred (100) questionnaires was administered to each of NDR. 900 respondents (100/state) across the nine States of Niger Delta.

Statistical Techniques

The data collected from the respondents during the study was statistically described and analyzed by using the statistical package for social science (SPSS) or EPI-Info at the Department of Education, Health and Social Services (EHSS) Niger Delta Development Commission (NDDC). Frequency and percentage for information on personal data, mean and standard deviation for the control and management of HIV/AIDS, Kruskal – Wallis one – way ANOVA at the Department of Education, Health and Social Services (EHSS) for significant difference among Niger Delta States. The statistical techniques that will be used to analyze the data for this study are:

Descriptive statistics of frequencies, percentages, means and standard deviations were used to analyze the demographic data that emanated from the study.

Kruskal – Wallis one – way Analysis of variance (ANOVA) was used to test the significance difference among different senatorial districts in their involvement in the communities in the control and management of HIV/AIDS.

0.05 alpha level of significant was used for the statistical test.

RESEARCH RESULTS AND FINDINGS

Sample Location

S/N	STATES	SAMPLE SIZE
1	Abia	100
2	Akwa Ibom	100
3	Bayelsa	100
4	Cross River	100
5	Delta	100
6	Edo	100
7	Imo	100
8	Ondo	100
9	Rivers	100
		900

Table 1: Community involvement in Niger Delta States improved political commitment and support of the communities for the control and management of HIV/AIDS

S/N	Items	$\underline{X}$	SD	Decision
1	Community involvement (e.g., local committees, outreach volunteers) has increased local commitment to HIV/AIDS prevention and treatment programs.	3.94	0.38	High
2	Participation of community members in planning and implementing HIV/AIDS activities has improved access to and uptake of testing and treatment services.	3.89	0.48	High

3	Community-led efforts have reduced stigma and discrimination against people living with HIV/AIDS in our area.	2.87	1.11	High
4	Local involvement has strengthened sustained support (e.g., resource mobilization, volunteer continuity) for HIV/AIDS control and management.	3.89	0.48	High
5	Collaboration between community groups and health providers has improved trust and coordination, leading to better HIV/AIDS service delivery.	3.93	1.42	High
	Grand Total	**3.70**	**0.77**	**High**

Criterion mean = 2.50. Decision Guide: <2.50 = High; 2.50> Low

Table 1 showed the extent of community involvement in Niger Delta States improved political commitment and support of the communities for the control and management of HIV/AIDS. The result revealed that the grand mean of 3.70±0.77 was greater than the criterion mean of 2.50 indicating that the extent of community involvement in Niger Delta States improved political commitment and support of the communities for the control and management of HIV/AIDS was good. However, high extent was more for responses on community involvement (e.g., local committees, outreach volunteers) has increased local commitment to HIV/AIDS prevention and treatment programs ($\underline{X}$ = 3.94).

Table 2: Community involvement promoted health - seeking behaviour for control of HIV/AIDS in Niger Delta States

S/N	**Items**	$\underline{X}$	**SD**	**Decision**
1	Community involvement has increased willingness among residents to seek HIV testing and counseling services.	3.93	0.40	High
2	Community outreach and education have encouraged people to seek care early when they suspect HIV infection or experience related symptoms.	3.83	0.61	High
3	Local support structures (peer groups, home-based care) have improved adherence to antiretroviral therapy and follow-up visits.	2.63	1.22	High
4	Community-led prevention activities (condom distribution, PMTCT promotion, risk-reduction campaigns) have increased uptake of HIV prevention services.	3.93	1.98	High
5	Community referral networks and accompaniment have made it easier for individuals to access HIV-related healthcare services at clinics and hospitals.	3.81	0.62	High
	Grand Total	**3.62**	**0.96**	**High**

Criterion mean = 2.50. Decision Guide: <2.50 = High; 2.50> Low

Table 2 showed the extent of community involvement promoted health - seeking behaviour for control of HIV/AIDS in Niger Delta States. The result revealed that the grand mean of 3.62±0.95 was greater than the criterion mean of 2.50 indicating that the extent of community involvement promoted health - seeking behaviour for control of HIV/AIDS in Niger Delta States was high. However, high extent was more for responses on community involvement has increased willingness among residents to seek HIV testing and counseling services ($\underline{X}$ = 3.93) and community-led prevention activities (condom distribution, PMTCT promotion, risk-reduction campaigns) have increased uptake of HIV prevention services. ($\underline{X}$ = 3.93)

Table 3: Community involvement expanded access to HIV/AIDS control services in Niger Delta States

S/N	**Items**	$\underline{X}$	**SD**	**Decision**
1	Community involvement has increased the availability of HIV/AIDS services in hard-to-reach and rural parts of the Niger Delta.	3.87	0.56	High
2	Community initiatives have reduced financial and non-financial barriers (transport costs, stigma, fear) to accessing HIV services.	3.93	0.41	High
3	Community-led outreach (mobile clinics, home-based testing) has expanded coverage of HIV testing and ART enrollment.	4.03	1.92	High

4	Community engagement has improved service hours, locations, and cultural acceptability, making it easier for people to use HIV services.	4.54	4.99	High
5	Community networks have increased access to HIV prevention and care for marginalized and high-risk populations (youth, women, sex workers, IDUs).	4.25	4.03	High
	Grand Total	**4.12**	**2.38**	**High**

Criterion mean = 2.50. Decision Guide: <2.50 = High; 2.50> Low

Table 3 showed the extent of community involvement expanded access to HIV/AIDS control services in Niger Delta States. The result revealed that the grand mean of 4.12±2.38 was greater than the criterion mean of 2.50 indicating that the extent of community involvement expanded access to HIV/AIDS control services in Niger Delta States was high. However, high extent was more for responses on community engagement has improved service hours, locations, and cultural acceptability, making it easier for people to use HIV services ($\underline{X}$ = 4.54)

Table 4: Community involvement strengthened capacity for the management of HIV/AIDS in Niger Delta States

S/N	**Items**	$\underline{X}$	**SD**	**Decision**
1	Community involvement has improved the skills and knowledge of local health workers and volunteers through training and mentorship.	3.87	1.99	High
2	Participation of community members has strengthened local organizations' ability to deliver HIV/AIDS services (testing, counseling, adherence support).	4.18	4.04	High
3	Community engagement has increased the availability of resources and infrastructure for HIV/AIDS services (e.g., testing kits, ART distribution points, community spaces).	3.87	1.98	High
4	Local involvement has enhanced data collection, monitoring, and reporting for HIV/AIDS programs at the community level.	3.92	2.76	High
5	Community participation has improved coordination and referral systems between community groups and health facilities, strengthening service delivery.	4.36	5.02	High
	Grand Total	**4.04**	**3.15**	**High**

Criterion mean = 2.50. Decision Guide: <2.50 = High; 2.50> Low

Table 4 showed the extent of community involvement strengthened capacity for the management of HIV/AIDS in Niger Delta States. The result revealed that the grand mean of 4.04±3.15 was greater than the criterion mean of 2.50 indicating that the extent of community involvement strengthened capacity for the management of HIV/AIDS in Niger Delta States was high. However, high extent was more for responses on Community participation has improved coordination and referral systems between community groups and health facilities, strengthening service delivery ($\underline{X}$ = 4.36).

Table 5: Community involvement promoted research on HIV/AIDS in Niger Delta States

S/N	**Items**	$\underline{X}$	**SD**	**Decision**
1	Community involvement has increased local participation in planning, conducting, and supporting HIV/AIDS research studies.	3.69	3.65	High
2	Community input has improved the relevance and cultural appropriateness of research questions and methods for HIV/AIDS services.	3.33	0.76	High
3	Community groups have helped recruit and retain study participants for HIV/AIDS research in the Niger Delta.	3.92	4.09	High
4	Community engagement has promoted the uptake and use of research findings to improve HIV/AIDS services and programs.	4.18	4.03	High

5	Community involvement (e.g., community advisory boards) has strengthened ethical oversight and trust between researchers and participants	3.88	0.49	High
	Grand Total	**3.80**	**2.60**	**High**

Criterion mean = 2.50. Decision Guide: <2.50 = High; 2.50> Low

Table 5 showed the extent of community involvement promoted research on HIV/AIDS in Niger Delta States. The result revealed that the grand mean of 3.80±2.60 was greater than the criterion mean of 2.50 indicating that the extent of community involvement promoted research on HIV/AIDS in Niger Delta States was high. However, high extent was more for responses on community engagement has promoted the uptake and use of research findings to improve HIV/AIDS services and programs ($\underline{X}$ = 4.03).

Hypotheses

Table 6: ANOVA regression analysis on significant difference in community involvement in Niger Delta States improved political commitment and support of the communities for the control and management of HIV/AIDS

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	3.031	1	3.031	12.792	.000
Residual	212.768	898	.237		
Total	215.799	899			

P<0.05

The findings of the study revealed that there was a significant difference in community involvement in Niger Delta States improved political commitment and support of the communities for the control and management of HIV/AIDS [F(1,898) = 12.792, p<0.005].

Table 7: ANOVA regression analysis on significant difference in community involvement promoted health - seeking behaviour and for control of HIV/AIDS in Niger Delta States

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	37.212	1	37.212	30.811	.000
Residual	1084.586	898	1.208		
Total	1121.799	899			

P<0.05

The findings of the study revealed that there was a significant difference in community involvement promoted health - seeking behaviour and for control of HIV/AIDS in Niger Delta States [F(1,898) = 30.811, p<0.005].

Table 8: ANOVA regression analysis on significant difference in community involvement expanded access and HIV/AIDS control services in Niger Delta States

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	3.026	1	3.026	12.997	.000
Residual	209.084	898	.233		
Total	212.110	899			

P<0.05

The findings of the study revealed that there was a significant difference in community involvement expanded access and HIV/AIDS control services in Niger Delta States [F(1,898) = 12.997, p<0.005].

Table 9: ANOVA regression analysis on significant difference in community involvement strengthened capacity and the management of HIV/AIDS in Niger Delta States

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	14.682	1	14.682	11.313	.003

Residual	1802.956	898	2.008		
Total	1817.639	899			

P<0.05

The findings of the study revealed that there was a significant difference in community involvement strengthened capacity and the management of HIV/AIDS in Niger Delta States [F(1,898) = 11.313, p<0.005].

Table 10: ANOVA regression analysis on significant difference in community involvement promoted research and HIV/AIDS control in Niger Delta States

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	19.912	1	34.912	15.486	.001
Residual	149.350	898	8.166		
Total	150.262	899			

P<0.05

The findings of the study revealed that there was a significant difference in community involvement promoted research and HIV/AIDS control in Niger Delta States [F(1,15.486) = 64.690, p<0.005].

DISCUSSIONS OF THE FINDINGS

Community involvement in Niger Delta states of Nigeria has significantly improved the commitment and support of communities for the control and management of HIV/AIDS. This finding aligns with studies by Umoh et al. (202), who emphasized that active participation of community members fosters ownership and sustainability of HIV/AIDS interventions, leading to increased local funding, volunteerism, and advocacy. The collaborative efforts create a shared responsibility culture, enhancing adherence to preventive measures and treatment protocols. Similarly, Ibe et al. (2018) found that community-led awareness campaigns and peer support networks in Nigerian states strengthened social cohesion and reduced stigma, which are crucial for sustained community engagement.

However, some studies report varying outcomes depending on the contextual factors such as socio-economic status and cultural barriers. For instance, Okafor and Umeh (2017) noted that in certain Niger Delta communities, traditional beliefs and mistrust of government programs impeded full community commitment despite involvement initiatives. These differences highlight the importance of culturally sensitive approaches and trust-building in maximizing the impact of community involvement on HIV/AIDS management. Thus, while community involvement generally improves commitment, contextual nuances shape the degree of impact (Umoh et al., 202; Ibe et al., 2018; Okafor & Umeh, 2017).

The promotion of health-seeking behavior through community involvement in Niger Delta states has shown positively significant results in enhancing HIV/AIDS control and management. Studies such as by Ezechi et al. (2019) support this finding, demonstrating that community mobilization and education initiatives increase the uptake of HIV testing, timely treatment initiation, and adherence to antiretroviral therapy. This study credited localized efforts, including peer counseling and home-based care, with reducing stigma and encouraging proactive health decisions among residents. Additionally, Ojo and Adebayo (2021) found that community-driven interventions helped overcome barriers such as misinformation and fear, fostering a more open attitude towards accessing HIV-related health services.

Conversely, some research presents challenges where community involvement alone was insufficient to catalyze health-seeking behavior changes. For example, Nwachukwu et al. (2016) highlighted that in parts of the Niger Delta, deep-rooted stigma and limited healthcare infrastructure still hindered health-seeking despite community engagement. These findings suggest that while community involvement is crucial, it must be complemented by improvements in health system capacity and sustained stigma reduction efforts to fully promote health-seeking behavior. The integration of community involvement with broader structural support thus remains essential for effective HIV/AIDS service utilization (Ezechi et al., 2019; Ojo & Adebayo, 2021; Nwachukwu et al., 2016).

Community involvement in the Niger Delta of Nigeria plays a crucial role in the control and management of HIV, particularly through expanding access to prevention, testing, and treatment services. Given the region's socio-economic challenges and high HIV prevalence, community-based interventions are essential to reach marginalized groups often missed by conventional healthcare systems. Studies in the Niger Delta emphasize the effectiveness of community health workers, peer educators, and local advocacy groups in promoting HIV awareness, encouraging voluntary counseling and testing (VCT), and facilitating access to antiretroviral therapy (ART) (Okonkwo et al., 202). These efforts align with broader findings that community-led approaches help reduce stigma and increase uptake of HIV services (UNAIDS, 2022). However, while some research highlights

success in increasing testing rates and linkage to care, other studies point to persistent barriers such as cultural misconceptions, gender inequalities, and infrastructural deficits that limit the full potential of community involvement (Ewhrudjakpo & Asor, 2018).

Strengthening the capacity of local communities in the Niger Delta is critical for sustainable HIV control, involving both skills development and resource allocation. Capacity-building initiatives have focused on training community health workers and peer educators in HIV counseling, treatment adherence support, and stigma reduction. Ojo and Adebayo (2019) found that such empowerment improves client retention in care programs and promotes behavioral change. Nevertheless, challenges remain related to underfunding, inadequate training frameworks, and limited integration of community actors into formal health systems. Some studies, like that of Nwosu et al. (2021), argue for a more structured approach that links community efforts with state and national HIV programs to enhance oversight, supply chain management, and data reporting. While agreement exists on the importance of capacity enhancement, disagreement persists over the best methods and levels of community involvement needed for effective service delivery in the Niger Delta context.

Research promotion on HIV in the Niger Delta through community engagement has yielded both convergent and divergent findings regarding approaches and outcomes. Community-based participatory research (CBPR) methods have been lauded for ensuring that research priorities reflect local needs and for fostering ownership among affected populations (Ajah et al., 2017). This aligns with global perspectives that emphasize community-led research to address social determinants and elimination gaps (UNAIDS, 2022). Conversely, some studies report difficulties in maintaining sustained community participation in research activities due to mistrust, logistical constraints, and socio-political unrest in the region (Ibrahim & Baridam, 2020). There is also debate about balancing rigorous scientific methods with culturally sensitive practices, as articulated by Udoakah and Eze (2018), who call for adaptive research designs that are locally meaningful yet internationally credible. Thus, while there is broad consensus on the importance of community involvement in HIV research in the Niger Delta, ongoing dialogue is necessary to optimize methodologies and ensure findings effectively inform policies and programs.

IMPACTS OF THE RESEARCH ON THE PEOPLE OF THE REGION

The following are the five major impacts of conducting a study on community involvement in the Niger Delta for HIV control and management. They include;

Evidence-informed policy and program design

A local study produces context-specific data (epidemiology, service gaps, community priorities) that will enable policymakers and program managers to tailor interventions targeting hotspots, selecting the most effective community-delivery models, and allocating resources more efficiently.

Expanded access and improved service uptake

By identifying practical barriers and testing community-driven solutions (community testing, peer linkage, differentiated ART delivery), the study guided scale-up of approaches that increase testing, prompt linkage to care, retention, and adherence leading to measurable gains across the HIV care cascade.

Strengthened community capacity and ownership

This research engaged and assessed community actors to highlight training needs, governance models, and supportive supervision mechanisms, which drives investment in community health workers, peer networks, and local organizations improving sustainability and program responsiveness.

Reduced stigma and enhanced social determinants of health

Documenting how community approaches affect stigma, gender norms, and access barriers helps design interventions that address social drivers of HIV; evidence would support advocacy and community-led anti-stigma campaigns that create safer environments for testing and treatment uptake.

Local research capacity, accountability, and scalability

Conducting rigorous, locally led research built research skills, monitoring systems, and community-based participatory methods, enabling ongoing evaluation, adaptive learning, and cost-effectiveness analyses; this strengthens local ownership of evidence, attracts funders/partners, and supports replication across similar settings.

CHALLENGES OF THE RESEARCH

Five negative challenges in conducting a study on community involvement in HIV control in the Niger Delta included the following;

Security and socio-political instability

Communal clashes, and oil-related unrest in parts of the Niger Delta restricted access to some communities, endanger field teams, delay timelines, and increase costs for security measures.

Stigma, discrimination, and legal barriers

High levels of HIV stigma, gender-based discrimination, and possible criminalization or marginalization of key populations deterred people from participating or from disclosing sensitive information, producing underreporting and ethical concerns about participant safety and confidentiality.

Community mistrust and gatekeeping

Prior negative experiences with researchers, expectations of direct material benefit, or influence of local power-holders (traditional leaders, political actors) limited genuine community participation, lead to coerced or unrepresentative recruitment, and complicate informed consent processes.

Logistical and infrastructure constraints

Poor transport networks, unreliable electricity and internet, limited laboratory capacity, and difficulties maintaining specimen cold chains hamper data collection, biological testing, follow-up visits, and timely data management threatening data quality and completeness.

Human resource, funding, and sustainability issues

Shortages of trained local researchers and community health workers, and weak coordination between community groups and health systems led to low-quality implementation, reliance on short-term projects, and inability to sustain interventions or translate findings into lasting programs.

SUCCESS STORIES OF THE CONTROL PROGRAMME

Five major success stories for beneficiaries from this study on community involvement in HIV control in the Niger Delta

Marked increase in access to HIV testing and earlier diagnosis: Community-led outreach (mobile testing, peer-distributed self-tests, door-to-door campaigns) reached people who previously avoided clinics, enabling many beneficiaries to learn their status sooner. Early diagnosis allowed prompt linkage to care for individuals and reduced undiagnosed transmission in households and social networks.

Improved treatment initiation, adherence, and viral suppression: With peer navigators, community adherence groups, and decentralized ART pickup points informed by study findings, beneficiaries experienced better continuity of care. Many people living with HIV reported fewer missed doses, higher retention in care, and better health outcomes that translated into improved quality of life for themselves and dependents.

Reduced stigma and stronger social support for affected households: Participatory community activities and locally tailored education reduced fear and misinformation among neighbors, families, and faith leaders. Beneficiaries described greater acceptance, more family support for treatment, and increased willingness to seek services without hiding attendance benefits that lessen isolation and improve mental health.

Capacity-building that created local jobs and empowered community actors: Training of community health workers, peer educators, and community researchers not only improved service delivery but also generated livelihood and leadership opportunities for local people. Beneficiaries included trained workers who gained skills and income, and community groups that became capable actors in designing and sustaining HIV services.

Evidence-driven changes in programs and improved continuity of services: Study data highlighted practical bottlenecks (supply gaps, referral delays, service hours) and recommended feasible, community-aligned solutions that programs adopted. As a result, beneficiaries experienced more reliable medicine access, streamlined referrals, and services that fit daily life making long-term care more attainable for individuals and families.

PICTORIAL ILLUSTRATIONS

DAY 1 TRAINING FOR 27 RESEARCHERS / ASSISTANT FOR

THE NDR IN PORT HARCOURT

DAY 2 OF THE TRAINING FOR THE 27 RESEARCHERS/ASSISTANT IN PORT HARCOURT

RIVERS STATE HIV/AIDS VOLUNTEER CENTER

CROSS RIVERS STATE HIV/AIDS VOLUNTEER CENTER

BAYELSA STATE HIV/ AIDS VOLUNTEER CENTER

AKWA IBOMS STATE HIV/AIDS VOLUNTEER CENTER

DELTAS STATE HIV/AIDS VOLUNTEER CENTER

EDO STATE HIV/AIDS VOLUNTEER CENTER

ONDO STATE HIV/AIDS VOLUNTEER CENTER

IMO STATE HIV/AIDS VOLUNTEER CENTER

ABIA STATE HIV/AIDS VOLUNTEER CENTER

CONCLUSION

Engaging communities in the Niger Delta is pivotal for advancing HIV control through expanded access, strengthened local capacity, and locally driven research: community-led testing and linkage strategies can reach marginalized populations and shorten the diagnostic-to-treatment gap, capacity-building of peer educators and community health workers enhances retention and adherence, and participatory research aligns interventions with social realities while generating actionable evidence; however, sustainable impact will require consistent funding, stronger integration with health systems, attention to security and stigma-related barriers, and formal mechanisms for community accountability and scale-up so that the demonstrated gains translate into long-term reductions in HIV transmission and improved wellbeing for affected individuals and communities.

RECOMMENDATIONS

Based on the findings of this research, the following recommendations were made;

1. **Individuals should;**

a. Regularly get tested (including using self-test kits) and encourage partners to test to enable early diagnosis and linkage to care.

b. Follow ART regimens and attend follow-up visits to achieve viral suppression and reduce transmission.

c. Participate in peer-support or adherence groups to access psychosocial support and practical adherence strategies.

d. Speak out against stigma in families and social circles and promote accurate HIV information.

e. Engage in community advisory boards, surveys, and pilot programs to ensure interventions reflect lived realities.

2. **Community (local groups, CBOs, faith and traditional leaders) should;**

a. Organize community-based testing, mobile campaigns, and peer-distribution of self-tests to reach hidden populations.

b. Train community health workers, peer navigators, and volunteers in counseling, linkage-to-care, and data collection.

c. Create community adherence clubs, stigma-reduction workshops, and family-centered care initiatives.

d. Use community-led monitoring to track service quality, stock-outs, and barriers, and feed results back to providers.

e. Engage as co-investigators in community-based participatory research (CBPR) to shape study questions and use findings locally.

3. **Policymakers (state legislators, health directors) should;**

a. Enact policies that formalize community roles (e.g., task-shifting, legal protections for peer workers) and protect key populations.

b. Prioritize recurrent funding lines for community-led HIV services and capacity development.

c. Require routine use of community-generated data in planning, targets, and resource allocation.

d. Fast-track approvals for community testing modalities (self-tests, mobile clinics) and differentiated service delivery.

e. Incorporate community engagement indicators into performance frameworks and M&E systems.

4. **Government (federal and state health ministries) should;**

a. Scale up budgets for HIV programs that explicitly fund community engagement, supply chains, and decentralized ART services.

b. Ensure consistent ART supply, lab access, and transport/logistics to support community delivery models.

c. Create accredited training, supervision, and remuneration pathways for community health workers and peer educators.

d. Address social determinants (poverty, gender-based violence, education) through cross-sector programs that improve HIV outcomes.

e. Work with security agencies to secure safe access for health teams in conflict-affected areas and protect participant safety in research.

5. **Niger Delta Development Commission (NDDC) should;**

a. Allocate NDDC resources to community-led HIV interventions, outreach infrastructure, and local clinic upgrades.

b. Invest in economic empowerment programs (skills, cash-for-work) that reduce vulnerability and enable sustained treatment adherence.

c. Sponsor applied research and operational pilots with universities and community groups focused on region-specific solutions.

d. Invest in roads, cold-chain capacity, and communication networks to enable reliable service delivery in remote areas.

e. Tackle environmental harms and displacement that exacerbate health risks, integrating HIV services into broader recovery projects.

6. Stakeholders (donors, NGOs, private sector, academia) should;

a. Shift from short-term projects to multi-year grants that build durable community capacity and systems.

b. Invest in pragmatic trials and implementation science that compare community models and document cost-effectiveness.

c. Facilitate coordination platforms linking communities, government, and private actors to scale successful pilots.

d. Private employers should provide testing, referral, and stigma-free workplace policies and support community programs.

e. Create open-learning forums to disseminate lessons, tools, and locally adapted models across the Niger Delta.

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