HIV Prevention Programme Among Out-of-School Youths: A Systematic Assessment of HAF II Project In Nigeria

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Abstract:

Background: Sexually transmitted infections including HIV continues to be of serious public health, social, and economic concern worldwide, gaining more attention of many concerned minds, with increasing attempt to mitigate its contraction, especially among youths. With the increasing rate of pregnancy, abortion and prevailing STIs and HIV among youths, it is of no doubt that many young people are sexually active with low level of contraceptive use, and the cumulative efforts towards preventing the contraction of these infections remains inadequate. Therefore, approaches toward the prevention of the spread of sexually transmitted infections including HIV/AIDS among youths aged 15-25 years is necessary to reducing the incidence of new HIV infection. This paper therefore presents the implication of HIV minimum prevention programme among Out of School Youths (OSYs) in Nigeria.

Methods: This was an interventional project. The intervention was carried out among out-of-school youths in the six (6) geopolitical zones of Nigeria, with a total target population of 263,900 OSY. 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.

Result: A total of 3,077 community dialogues were held in this study, with 35,507 influencers participating in the process. In addition, 585,603 peers were registered, while 2,669 persons benefited from 71 income generating activities aimed at capacity building for OSY. A total of 221,787 persons were counselled, tested, and shown their results, with 10,515 persons referred for STI services. Although 1,698,649 condoms were distributed, these numbers was however below the number of condoms required during the intervention.

Conclusion: This intervention has been helpful in reducing the burden of HIV and AIDs among Out-of-School-Youths in Nigeria. Although, the effective implementation of minimum prevention package for intervention in HIV/AIDS prevention programme carried out in the 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 decentralisation of MPPI activities to primary health care centres 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 counselling and testing, Minimum prevention package for intervention, Out of school youths

I. INTRODUCTION

Over two decades ago, HIV/AIDS started in just few isolated cases and has spiralled into the most important epidemic in the trend of history. Today, HIV/AIDS has

continued to be a serious international health concern, and sub-Saharan Africa is the foremost affected region. Sub-Saharan Africa has about 25.6 million persons living with HIV, accounting for two-thirds of the recent overall world HIV infections and more than 70 percent of all AIDS-related

deaths. Sadly, more than half of the HIV-infected population in sub-Saharan Africa are women and children [1]. Sexually transmitted infections including HIV continues to be of serious public health, social, and economic concern worldwide, gaining more attention of many concerned minds, with increasing attempt to mitigate its contraction, especially among youth. With the increasing rate of pregnancy, abortion and prevailing STIs and HIV among youths, it is of no doubt that many young people are sexually active with low level of contraceptive use, and the cumulative efforts towards preventing the contraction of these infections remain inadequate. Evidences from different studies continue to confirm the existence of increasing sexual activities among the vouths globally, with those in developing countries perceived to be at greater risk, because of their low level of access to medical facilities, and other problems associated with Third World [2].

Sexually transmitted diseases (STD) defined to be a group of infectious or communicable diseases whose primary mode of transmission is sexual contact [3], remains one of the major causes of illness in the world, especially in the developing countries of the world. An estimated half a billion new curable STIs occur worldwide each year including Syphilis, gonorrhoea and chlamydia, which remains a major cause of disability and death despite being curable with antibiotics, unfortunately. Viral STIs, including herpes simplex virus (HSV), human papillomavirus (HPV), hepatitis B (HBV) and human immunodeficiency virus (HIV), are incurable and even more prevalent. Infection with multiple STIs is common, which in turn, greatly facilitates sexual transmission of HIV [4].

In the year 2008, the World Health Organisation estimated that one out of 20 teenagers contract an STI each year, and according to the international monitoring data, 70% of patients with STIs are aged between 15 and 24 years [5]. Since the first report of AIDS case in 1986 in Nigeria, AIDS

epidemic has expanded in Nigeria over the past three decades. Currently Nigeria has the second largest AIDS epidemic burden in the world [6].

In 2016, about 36.7 million people were living with HIV all over the world, with 1.8 million new infections in 2016. In Nigeria 3,200,000 people were living with HIV in 2016, with about 220, 000 new infections recorded, and 160, 000 AIDS-related deaths. The most vulnerable groups however continue to include sex workers with a prevalence rate of 14.4%, men who have sex with men (23%), and people who inject drugs (3.4%) [7].

HIV/AIDS epidemic has recorded a severe and rapidly growing rate in Nigeria, characterised by an adult prevalence rate in the range of 3.6%–8.0%, generalised and driven primarily by heterosexual transmission.

Adult HIV prevalence in Nigeria increased from 1.8% in 1991 to 5.8% in 2001 and declined to 5.0% in 2003 [8]. A cross sectional study of 350 out-of-school youth aged 15–24 years in Nigeria reported by Adebiyi & Asuzu [9] recorded figures of no condom use as high as 56.5% of the total 74.9% that had ever had sex, while 29.0% of them reported they used condoms. Their commonest reason for non-condom use was that it reduces sexual enjoyment. These factors contribute to

the increasing spread of sexually transmitted infections and HIV/AIDS, especially among youths [10].

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that 3.5 million Nigerian adults and children were living with HIV/AIDS by the end of 2001. Among sex workers in Lagos, HIV prevalence rose from 2 percent in 1988–89 to 12 percent in 1990–91. By 1995–96, up to 70 percent of sex workers tested positive. Current projections show an increase in the number of new AIDS cases from 250,000 in 2000 to 360,000 by 2010. As a result of the epidemic, the crude death rate in Nigeria was about 20 percent higher in 2000 than in 1990. In 2001 alone, 170,000 adults and children died of AIDS. At the end of 2001, UNAIDS estimated that 1 million children orphaned by AIDS were living in Nigeria [11].

Young people, especially women 20–24 years old, are increasingly vulnerable. Other affected groups include sex workers and people with tuberculosis. Low levels of condom use, especially among mobile populations, a high prevalence of untreated sexually transmitted infections, poverty, stigma and discrimination, low rates of literacy, poor health status, low status of women, prevalence of polygamy and low perceptions of risk among vulnerable groups have contributed to the rapid spread of the epidemic [8].

However, HIV prevalence in Nigeria is relatively higher in some high burden states, such as Abia (7.3%), Akwa Ibom (10.9%), Anambra (8.7), Bayelsa (9.1%), Benue (12.7%), and Edo (5.3%), with the lowest reported condom use among young people aged 15-19, and especially young women who had sex with non-marital partners without the use of condoms [12].

II. METHODOLOGY

STUDY DESIGN AND SCOPE

This was an interventional project conducted among out of school youth across the six geo-political zones of Nigeria. The HIV Programme Development Project was designed with the aim to increase demand for HIV counselling and testing (HCT) and utilisation of prevention measures as a way to reduce the incidence of new infections, while ensuring a reduction is risky sexual behaviour among OSY.

STUDY AREA

This intervention was carried out in the six geo-political zones of Nigeria

STUDY POPULATION

The targeted population for this study are Out-of-School youths which were randomly selected in different states from the six geo-political zones of Nigeria which are the North East, North West, North Central, South East, South West, and South-South. 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.

SAMPLE SIZE

A total of 263,900 Out-of-School youths was estimated as the sample size for this intervention. The project adopted a purposive sampling technique; youth groups in each of the geo-political zones were identified using a community participatory approach, peer educators were selected by nomination of qualified persons who were acceptable by the youth community.

DESCRIPTION OF INTERVENTION

The minimum prevention package intervention (MPPI) was adopted in the implementation of this project. Project interventions are categorised under the three components of MPPI which structural, behavioural, and biomedical interventions are. Activities carried out under each of the components are summarised below;

STRUCTURAL INTERVENTION

This area of the intervention included promotion of community-based interventions aimed at creating adequate access to information and services among Out-of-School youths. This level of intervention focused mainly on income generation activities (IGA), community dialogues, and advocacy. Activities organised under this approach include community dialogues, outreaches, sensitisation and awareness creation across all the project states with the aim of sensitising stakeholders on the HIV/AIDS situation around them, and to recruit community volunteers to be trained as peer educators. The session attracted a number of influencers, who also participated in various awareness programs. They were introduced to the basics of HIV and AIDS, which includes the mode of transmission as well as how untreated HIV becomes AIDS. The interventions gathered the targeted communities' stake holders together, and enlighten them about the proposed project, and then outline routes that would allow for the project success. Advocacy visits were made to health facilities and community stakeholders to strengthen ties and ease referrals within the states. 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 meeting.

BEHAVIOURAL INTERVENTION

This aspect of the intervention includes change in behaviour targeted at influencing beneficiaries to embrace healthy behaviours that support the reduction of risks of contracting HIV infection. Such behaviours include reduction in partner number, consistent and correct condom use for sexual engagements. Condoms (Male and Female) were also distributed to the participants. This intervention was carried out by Peer Educators selected among the Out-of-School youths. The selected Peer Educators then further recruited peers among the OSY who they reached out to during cohort session using MPPI. The Peer Educators were members of the targeted populations who had been previously selected, trained, and supported to educate members of their group about HIV and related topics, condom use and distribution, and lubricant use.

BIOMEDICAL INTERVENTION

The biomedical intervention level was aimed at increasing access to HIV prevention, treatment, and care services. HIV counselling and testing were provided to the participants by trained counsellor testers, and referral were made for those who tested positive and other STIs treatment.

HIV COUNSELLING AND TESTING (HCT)

HIV counselling and testing availed one the opportunity to take a comprehensive individual risk assessment and to accurately refer for more intensive services. This entails three distinct components: risk assessment and counselling before the blood or oral sample is taken, testing of the sample, and counselling and referral with the test results. These three components were properly followed in this project. The implementing organisations trained ad hoc tester and peer educator volunteers who conducted mobile HIV/AIDS counselling for OSY during peer sessions.

REFERRAL, TRACKING AND ESCORT SERVICES

Several referrals were made for STIs and HIV/AIDS for care and treatment in various health care facilities by Ad-hoc testers and trained volunteers. Clients diagnosed with HIV and other STIs were tracked and escorted to the health facilities for care/treatment.

DATA COLLECTION

Data collection was done with the use of various data collection and reporting tools. HCT was documented using clients intake form. Data were collected using peer-to-peer sessions by the peer educators. Also collected were the numbers of OSY who received support services, and those who completed referrals. The data collected were from various activities carried out under enrolment pattern, structural and socio-economic intervention and positive health dignity and prevention.

DATA ANALYSIS

Data collected were entered into DHIS2 platform and exported into Microsoft excel. The results were analysed using Microsoft Excel, by comparing frequencies and percentages, with careful presentation in tables.

ETHICAL CONSIDERATION

The proposed project proposal was subjected to reviews and ethical approval to conduct the research was obtained from the National and State Ethical Review Committee, and Federal Ministry of Health, Nigeria, prior to the commencement of the intervention. Permission was also 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. RESULT

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

STRUCTURAL INTERVENTION

The table below shows the summary of structural interventions carried out during the project duration. A total of 3,077 community dialogues were held during the intervention, with the majority held in the South South (33.1%), and the least was recorded in the North East (2.6%) (Table 1). A total of 35,507 influencers participated in the community dialogues, out of which 29.2% were recorded in the South-South. 71 IGAs were held, and the highest number of people that benefited was recorded in the South West (94.0%). No IGA was conducted in the North East, North Central, and North West.

Interventi	East	Centra	West	East	West	South	Total
on		1					
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	
Number of	0	4	0	11	0	284	299
individuals	(0%)	(1.3%)	(0%)	(3.7%)	(0%)	(95.0%	
referred for)	
IGA							
Number of	0	0	0	22	24	25	71
IGA held	(0%)	(0%)	(0%)	(31.0%	(33.8%	(35.2%	
)))	
Number of	0	0	9	31	2510	119	2669
persons	(0%)	(0%)	(0.3%)	(1.2%)	(94.0%	(4.5%)	
that)		
benefited							
from IGA							
Number of	80	496	493	374	616	1018	3077
community	(2.6%)	(16.1%)	(16.0%	(12.2%)	(20.0%)	(33.1%	
dialogues)))))	
held							
Influencers	495	6837	4685	3794	9339	10357	3550
participatin	(1.4%)	(19.3%	(13.2%)	(10.7%	(26.3%)	(29.2%)	7
g in)))))	
Communit							
y dialogues							

Table 1: Summary of structural interventions carried out across the six geo-political zones

BEHAVIOURAL INTERVENTION

The number of condoms distributed was recorded to be highest in the South West with 44.3% and 48.6% female and

male condoms respectively (Table 2). The total number of condoms distributed was 94621 female condoms and 1604028 male condoms. However, out of the totalled 3147392 male and female condoms required for the intervention duration, only 1698649 condoms were distributed representing 54% of the condoms required. A total 585603 peers were registered during the intervention. While 520072 peers were contacted in the old month, 259903 of them were contacted in the new month. Out of the 84116 lubricants required, with the highest percentage for South-South (81.7%), a total of 7447 lubricant was distributed, representing 8.9% of lubricants required.

Behaviou	North	North	North	South	South	South	Total
ral	East	Central	West	East	West	South	
Interventi	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)	
on							
Number	5432	102257	99304	92179	89412	197019	585603
of peers	(0.9%)	(17.5%)	(17.0%	(15.7%)	(15.3%)	(33.6%)	
registered)				
No of	7578	100507	61338	50844	101807	197998	520072
peers	(1.5%)	(19.3%)	(11.8%	(9.8%)	(19.6%)	(38.1%)	
contacted)				
in the							
month -							
old							
No of	2609	54888	29044	34108	30737	108517	259903
peers	(1.0%)	(21.1%)	(11.2%)	(13.1%)	(11.8%)	(41.8%)	
contacted)				
in the							
month -							
new							
Total	10187	155395	90382	84952	132544	306515	779975
Number	22700	400962	165240	212010	407467	1727014	2147202
Number	32790	490863	105348	313010	40/46/	1/3/914	314/392
10	(1.0%)	(15.6%)	(5.5%)	(9.9%)	(12.9%)	(55.2%)	
condoms							
required	2012	2200	0000	7200	21010	41001	04/01
INO OI	3913	2280	8228	(7.70)	31019	41891	94621
condoms	(4.1%)	(2.4%)	(8.7%)	(7.7%)	(32.8%)	(44.5%)	
formalo							
- Temate	21766	124722	00715	242702	222620	770402	1604029
NO Condomo	31700	134733	90713	(15.20())	323020	(19402	1004028
Condoms distributed	(2.0%)	(8.4%)	(5.7%)	(15.2%)	(20.2%)	(48.0%)	
mala							
- mate	25670	127012	08042	251092	254620	921202	1609640
Total	55079	157015	96945	231082	554059	821295	1098049
Number	65	6491	6417	2395	18	68730	84116
of	(0.1%)	(7.7%)	(7.6%)	(2.8%)	(0.0%)	(81.7%)	
lubricants							
required							
Number	0	314	1697	111	0	5325	7447
of	(0.0%)	(4.2%)	(22.8%	(1.5%)	(0.0%)	(71.5%)	
lubricants)				
distributed	1						1

 Table 2: Summary of behavioural interventions carried out across the six geo-political zones

BIOMEDICAL INTERVENTION

Data on number of persons, who were counselled, tested and received result (CTR) are presented in table 3. A total of 221787 out of school youths were counselled tested and received results during the project; South South recorded the highest percentage of CTR activities (32.3%) during the project. On the number of persons referred for STI services, 10515 persons were referred and 46.7% of the people referred were from North Central. The data available also showed that a total of 7452 persons were receiving STI services with over half of the total number (59.0%) from the North Central as well. However, only 2242 persons were recorded to be going for follow up, with the highest number recorded in the North West (66.7%). A total of 268782 Out of the 585603 peers registered were reached with MPPI, and 131019 of the samples size reached were referred for HCT. A total of 893 pregnant women were referred for antenatal

Biomedical Intervention	North Fast	North Central	North West	South Fast	South West	South South	Total
mut venuon	Last	Central	mest	Last	mest	Journ	
	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)	
No of	1990	39583	17005	38886	52938	711385	221787
persons	(0.9%)	(17.8%)	(7.7%)	(17.5%)	(23.9%)	(32.2%)	
count, test &							
result (prev)							
No of	411	4906	3570	167	50	1411	10515
persons	(3.9%)	(46.7%)	(34.0)	(1.6%)	(0.5%)	(13.4%)	
referred for							
STI							
No of	254	4393	1595	95	313	802	7452
persons	(3.4%)	(59.0%)	(21.4%)	(1.3%)	(4.2%)	(10.8%)	
receiving							
STI services							
No of	211	51	1495	43	4	438	2242
persons	(9.4%)	(2.3%)	(66.7%)	(1.9%)	(0.2%)	(19.5%)	
going for							
STI follow-							
up							

Dersons	3622	67500	21/18/	27628	60253	70205	268782
reached with	(1.20)	(25.1%)	(8,00/)	(10.20)	(25.89/)	(20.5%)	208782
reached with	(1.5%)	(23.1%)	(8.0%)	(10.5%)	(23.8%)	(29.5%)	
MPPI in the							
quarter							
No of	1321	36004	11126	24744	9443	48381	131019
persons	(1.0%)	(27.5%)	(8.5%)	(18.9%)	(7.2%)	(36.9%)	
referred for							
HCT							
Pregnant	31	497	185	7	0	173	893
persons	(3.5%)	(55.7%)	(20.7%)	(0.8%)	(0.0%)	(19.4%)	
referred for							
antenatal							
Number of	75	9	25	0	0	0	109
svringes	(68.8%)	(8.3%)	(22.9%)	(0.0%)	(0.0%)	(0.0%)	
needles	()	()	(()	(,	(,	
distributed							
Manulaurof	90	26	105	0	0	1200	1501
Number of	80	20	185	0	0	1290	1581
syringes	(5.1%)	(1.6%)	(11.7%)	(0%)	(0%)	(81.6%)	
needles							
required							

 Table 3: Summary of behavioural interventions carried out across the six geo-political zones

IV. DISCUSSION

The HIV Prevention Programme among out of school vouths in Nigeria was effected using the minimum prevention packaged intervention (MPPI) divided into structural, behavioural and biomedical interventions. FMH [13] reported that the combination of these three intervention strategies is necessary in order to achieve a comprehensive HIV prevention intervention. In this study, many community dialogues were held, thus serving as a medium via which the purpose of the project was communicated to the stakeholders in the community. Structural Intervention therefore could be said to have paved access for the implementation of the two other intervention strategies. The community dialogues held were used in educating out-of-school youths and important stakeholders about HIV prevention programme. According to the findings of this study, the structural intervention which included the community dialogue attracted greater number of influencers in the South-South zone as compared to the North East zone which recorded the least. This difference could be attracted to the fact that more than times twelve of the community dialogues held in the North East took place in the South-South. This observation is similar to the report of Ademola et al, [14] in Plateau state, Nigeria, where it was reported that the difference recorded in the number of influencers that participated in the community dialogues held in the three project years could be attributed to the difference in the number of community dialogues held.

The behavioural intervention strategies recorded the highest number of peers registered in the South-South zone. This is believed to be responsible for the highest number of male and female condoms distribution recorded in the South-South geographical zone when compared with other zones. The behavioural strategies employed during the study were aimed at influencing the beneficiaries to adopt healthy behaviours, so as to reduce their risk of HIV infection. More than half of the people reportedly receiving STI services are from the North Central, which could be attributed to the fact that the majority of people referred for STI were also recorded in this zone.

V. CONCLUSION

This intervention has been helpful in reducing the burden of HIV and AIDs among Out-of-School-Youths in Nigeria. Although, the effective implementation of minimum prevention package for intervention in HIV/AIDS prevention programme carried out in the 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 decentralisation of MPPI activities to primary health care centres 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.

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