Response to HIV & AIDS
In Riverine Communities

Successes and Challenges of Reaching the Unreached through the Implementation of Promoting Sexual Reproductive Health & HIV/AIDS (PSRHH) Among Out-of-School Youths in the Niger Delta, South-South Nigeria

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INTRODUCTION: Peculiarities of Riverine/Niger Delta as it relates to young people and SRH/HIV and AIDS programme

The Niger Delta region consists of nine oil-producing states in Nigeria with a total land area of about 75,000 km^2 and a population of about 30 million people. The region contains the world's third largest wetland, with the most extensive freshwater swamp forest and rich biological diversity[1].

Demographic data on the age structure of the population of states in the Niger Delta region depicts that over 62% of the population is composed of young people below 30 years of age compared to over 35% of adults in the 30- to 69-year age bracket. This has implications for development planning and the financing of social services. A youthful population structure implies that many people remain outside of the working age bracket, creating an additional dependency burden for the average family or the economically active population in the Niger Delta. The magnitude of such a burden tends to be greater for impoverished families or population units that are either unemployed, under-employed or lack the benefit of full employment.

While there is little empirical data on life expectancy in the Niger Delta, the best available national estimates that by year 2000 the average life expectancy was approximately 46.8 years. It is expected that this figure may have dropped to about 43 years because of the economic deprivations, downward spiralling quality of life within the intervening years and the cumulative impact of HIV&AIDS.

Fishing and agriculture are the two major traditional occupations of the Niger Delta peoples. Today, agriculture, fishing and forestry still account for about 44 per cent of employment[2].

Generally speaking, the instability in the Niger Delta marked by high presence of militia groups and hostage taking, the high presence of oil exploring multinational companies and presence of oil terminals and refinery make the zone a highly volatile, vulnerable and conflict prone environment with significant security risks of working in local communities.

The Niger Delta–Socioeconomic Environment and Implications for HIV/AIDS Programming

(a) Poverty

Poverty is a fundamental development issue with numerous dimensions. While it varies from one setting to another in terms of the income or resources of individuals, many of the conditions that perpetuate poverty are at the communal or societal level. Poverty in the Niger Delta region manifests in many faces including exploitation, neglect and *"voicelessness".* Another dimension is that the people of this region have been excluded and disconnected from modern infrastructure, even though they are the source from which the

These children in a riverine community in the Niger Delta are trapped in a maze of poverty that threatens their very lives.

resources for transforming other parts of the country are being derived.

While poverty may seem to cause deprivation and hinder individual development, it is also the consequence of a number of social and national factors, such as poor governance and the exclusion of particular social groups, including minority ethnic groups, women and youth, from participation in decision-making on matters relating to their welfare. Other issues include poor environmental quality and high levels of pollution, conflict and lack of security, threats to health and wellbeing including HIV/AIDS, and unsustainable livelihoods and unemployment.

ActionAid Staff visiting one of the PSRHH riverine communities in the Niger Delta.

The pervasive level of poverty in the Niger Delta has raised a fundamental question known in development circles as the Niger Delta Question – ***Why is there so much poverty in the midst of plenty?*** The Central Bank of Nigeria reports indicate that the oil wealth derived from the Niger Delta region sustains the entire Federation, accounting for close to 80% of the total federal revenues from 2000 to 2004. This was earned from crude oil and gas exports, petroleum profits taxes and royalties, and domestic crude oil sales.

The overall poverty level in the Niger Delta fell from 57.9 per cent in 1996 to 42.85 per cent in 2004.[3]

(b) Environmental Degradation

High-pressure pipelines can be seen laid above ground through villages and farmlands, making these settlements vulnerable to oil spillages and the accompanying environmental hazards. Communities in the Niger Delta suffered an average of 190 spills per year between 1989 and 1996, involving on average 319,200 gallons of oil (Shell: 100 Years, 1997). Streams, rivers, lakes and ponds are polluted with oil, and much of the land is now impossible to farm. In addition, activities of oil exploring industries have permanently damaged fragile ecosystems and led to polluted drinking water and deaths from cholera. Gas flaring, gas leakages and the construction of flow stations near communities have led to severe respiratory and other health problems emanating from acid rain and polluted air (Shell: 100 Years, 1997).

The impact of the oil extracting industry on the Niger Delta Environment

The implications of this on HIV&AIDS interventions in the Niger Delta are that the capacity of individuals and communities to respond to HIV & AIDS issues; support persons living with HIV&AIDS is diminished, and malnutrition especially among children is devastating. Besides inter and intra generational poverty thrives among the people.These increases risky sexual activities among the people as a means of livelihoods. In this the people are less likely to have access to condom or knowledge of proper ways of using them. They also see prostitution as sources of livelihood in the face of millionaires from oil industries who are often far away from their own families. These contribute significantly to spread of HIV.

(c) Conflicts and Violence

The dimensions of conflict in the Niger Delta are multi-faceted, ranging from intra-communal conflicts over differences in sharing of compensations from oil companies, inter-communal conflicts over ownership of “oil space”, conflicts between communities/local governments and oil companies arising from demands or claims for compensation, and inter-ethnic feuds like the Ijaw vs. Itsekiri conflicts and Urhobo vs. Itsekiri conflicts in Delta State, the Ogoni vs. Okrika and Ogoni vs. Andoni conflicts in Rivers State, among others. There are also political conflicts between State Governments and Federal government over percentage of derivation from oil money that goes to the State Governments.

While most of these conflicts result in violent confrontations and full-scale combat with loss of lives and property, a few are settled in court.

Recently, youths in the region became actively involved in militancy with rising incidences of abduction and hostage taking involving oil workers and expatriates in the region in demand for ransoms.

The implications for HIV/AIDS interventions in the region are that these conflicts and militant activities, especially when violence is involved, have attracted military response from the Federal Government, with the corresponding influx of military presence in the region for peace keeping activities and for protection of oil facilities, life and property of community members. However, these conflicts have also resulted in increased incidences of internally displaced populations, rape, sexual violence and sexual exploitation by armed soldiers leading to increasing incidences of HIV infection and unwanted pregnancies within the affected communities.

Most of these conflicts also lead to loss of family heads and breadwinners, leaving other members of the family, especially women and girl-children, even more vulnerable to HIV/AIDS.

(d) Accessibility:

The topography of the region comprises a network of creeks dotted with small islands, and the remaining half is a lowland rainforest zone. This difficult terrain with limited land area therefore

PSRHH staff en-route to Ikpoama community in Rivers State during field support visit.

constrains people to congregate in small rural communities, over 95% of them not exceeding 5,000 persons per settlement. There are over thirteen thousand of such settlements in the Niger Delta. These are rural riverine communities which are mostly accessible by water through boats and canoes. Infrastructure and social services are generally deplorable, and vastly inadequate for a land known for its rich natural resources.

The implications of this to HIV/AIDS programming is that the riverine communities become hard to reach, experience a dearth of information, lack access to services and heightened vulnerability. Programming in this type of environment becomes challenging for field staff, and linkages with services outside the communities are constrained by transport difficulties.

(e) Religion and Culture

The people of the Niger Delta are highly religious, and have a mix of Christians who are pre-dominant, with Muslims and traditionalists.

Religion plays an important role in the lives of the people, and religious leaders are highly influential personalities at community level. However, the power of this influence has not been positively exploited for the prevention and control of HIV/AIDS in the region.

Culturally, there is a wide variation and diversity in cultures across the Delta, but the dynamics in these cultures which are deeply rooted in patriarchy that increase people's vulnerability, especially women, to the risk of HIV infection, are very similar.

(f) Politics, Governance and Human Rights

A majority of the people lacks information and technical abilities, and unemployment and underemployment rates are high.

The Delta's unstable social, economic and political situation has helped to open the door to HIV&AIDS, a devastating force reversing decades of human development and perhaps the biggest obstacle to reaching the MDGs in the Niger Delta.

The social instability and decaying social values in the Niger Delta have encouraged the spread of risky behaviours, while incorrect information about HIV&AIDS, traditional practices and poor economic conditions compound the chance of exposure to HIV. As people die in large numbers, society loses much needed human capital, productivity declines and dependency rates skyrocket.

Making matters worse is the poor quality and accessibility of basic health care services— prevention, care, support and treatment programmes are simply not available. Many people turn to unqualified but locally available caregivers.

- While the region is rich in natural resources and receive large chunks of federal allocations as monthly oil derivations funds for human development, the poor have been raped of social

and economic justice through large scale corruption by public office holders, leaving them poorer and more vulnerable by the day.

➲ HIV/AIDS IN THE NIGER DELTA – SOCIAL DEMOGRAPHIC CONTEXT

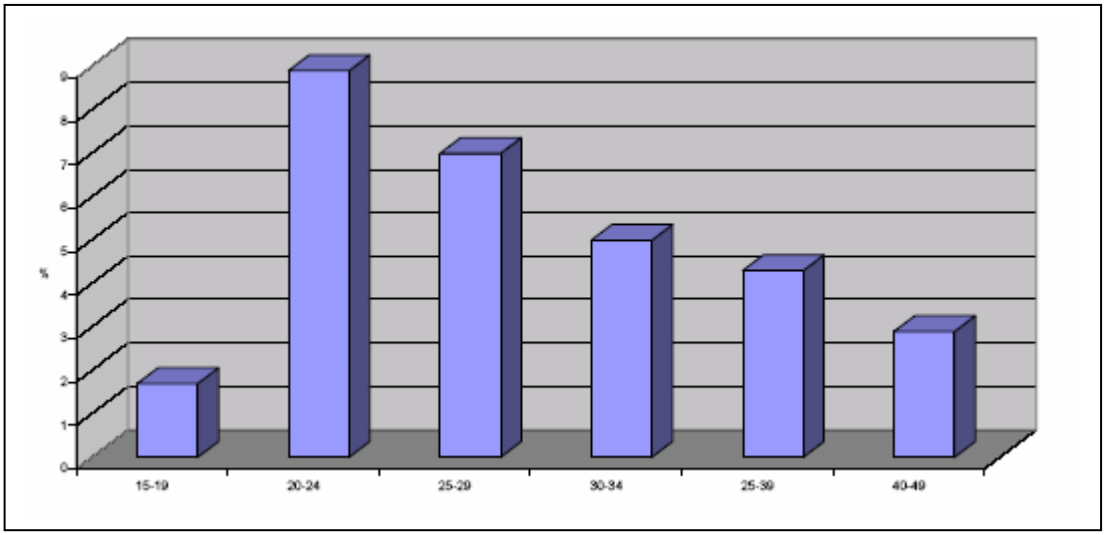
Prevalence

According to the 2005 sentinel survey, the HIV/AIDS prevalence rate in the Niger Delta Region is about 6.0%, ranking second only to North Central Zone with a prevalence rate of 6.1%. Of the over 1 million persons living with HIV/AIDS in the Niger Delta, about 10,000 are in critical need of treatment. The States where PSRHH is present have varying but unacceptably high prevalence rates of 8.0% in Akwa Ibom (second only to Benue State), 6.1% in Cross River State (down from 11% in 2003), 5.4 % in Rivers State, and 4.6% in Edo State (up from 4.3% in 2003). Although there is some indication that current efforts are having some positive impact, the Niger Delta region recorded one of the

State	Prevalence Rates - % (1999 – 2005)			
	1999	**2001**	**2003**	**2005**
Cross River	5.8	8.0	12.0	6.1
Akwa Ibom	12.5	10.7	7.2	8.0
Rivers	3.3	7.7	6.6	5.4
Edo	5.9	5.7	4.3	4.6
Niger Delta	5.5	6.6	5.4	6.0
National (Nigeria)	5.3	5.7	4.8	4.4

smallest declines, from 7.7% in 2001 to 5.8% in 2003. The South-West declined from 4.0% cent to 2.3%.

The following table statistically presents the prevalence rates in the focal States where PSRHH is being implemented in the Niger Delta Region.



HIV prevalence by age in the South-South Zone – NDHS 2003

Forces driving the epidemic

i. Behavioural Factors

Condom use is limited. Surveys have reported that the region has the largest number of people who affirmed having sex with prostitutes during the previous 12 months and the highest incidence of risky sex. There are high incidences of risky sexual behaviour among sex workers, oil workers and long distance drivers who make long stops in Port Harcourt and Warri to lift fuel and cement to other parts of the country. The age of sexual debut among adolescents is relatively low in the Niger Delta, and the high levels of stigma drive the epidemic underground.

The 2003 Nigeria Health Demographic Survey showed that the level of knowledge of HIV prevention was lower than 50% among men and women in the South-South, while rate of high risk sexual activity among men was as high as 94.5% among men with only 39% of men and 19% of women using condoms with last high risk sexual intercourse.

The survey also reported poor health-seeking behaviour for STIs with over 32% of women and 17% of men not seeking any health advice while 15% of women and 43% of men consulted traditional healers. There were also high rates of misconceptions about HIV/AIDS, with over 35% of men and 46% of women not knowing that a healthy looking person can have HIV, and about 69% of women and 54% of men believing that HIV can be transmitted by witchcraft or other supernatural means. There were also high rates of stigma reported in the survey

in the South-South, where over 67% of women and 53% of men were not willing to take care of an HIV positive family member at home, and over 78% of men and 67% of women would not even accept to buy vegetable from an HIV infected person. In addition to these statistics, only 9% of women and about 14% of men ever got tested for HIV and received their results.

ii. Economic Factors

Migration and mobility is a key economic factor driving the epidemic in the Niger Delta. Onshore/offshore migration, sex worker influx and migration from other regions facilitate the rapid spread of the virus around the Niger Delta. The oil industry activities in Rivers, Akwa Ibom, Bayelsa and Delta States, as well as the activities of the free Export Processing Zone (EPZ) in Calabar are pull forces for migration and mobility within the region.

The Niger Delta is a terminal for long distance driving corridor routes from North to South, and there is a high correlation between HIV prevalence and corridor routes used by long distance drivers.

The growing tourism industry, especially in Rivers and Cross River States attract a lot of tourists and boost sex work, as well as increase people's vulnerability to HIV/AIDS within the Niger Delta.

Growing rural-urban migration by youth in search of jobs has shifted the burden of HIV/AIDS from urban centres to rural communities as revealed by the 2005 sentinel survey.

Pervasive poverty in communities around the Niger Delta have given rise to increased incidences of child labour, inability to afford healthcare, sexual coercion and sexual exploitation of girls, with increasing vulnerability to HIV/AIDS.

The poor healthcare systems and inadequate service delivery facilities in the Niger Delta limit people's ability to access services like Prevention of Mother To Child Transmission of HIV, HIV Counselling & Testing, as well as Anti-Retroviral Therapy or even treatment for STIs and other opportunistic infections.

iii. Socio-cultural Factors

A careful examination of the Niger Delta States reveals that much effort is still needed to fully contain the spread of HIV&AIDS. Cultural factors may have to be seriously considered for much progress to occur. For instance, evidence from the 2003 NDHS reveals that people in the region are the most sexually active of any group in the country's six zones (67 per cent of men have never married, compared to nine per cent in the North-West and 22 per cent in the South-East).

In some communities in Rivers State, women who lose their husbands are not expected to re-marry, but they have the liberty to continue bearing children in the

name of their late husbands, while in yet other communities, the first female daughters of the family are expected to deliver a number of children at home for the family before getting married, if at all they get married.

Such socio-cultural practices are driving forces for the spread of HIV in the communities in the Niger Delta.

Widespread polygamy, harmful widowhood practices and strongly rooted patriarchy are other socio-cultural factors driving the pandemic that HIV/AIDS interventions have not yet addressed in the Niger Delta.

There are also religious dimensions to all these, as the pre-dominantly Catholic population are opposed to condom use, while others see the pandemic as God's judgement for sins of immorality, further fuelling stigma and discrimination against those infected and affected. Others who believe in divine healing go ahead to exercise their faith by abandoning their ARV treatments, with resultant spread of resistant strains of the virus.

iv. Gender Related Factors

The Gender Empowerment Measure (GEM), one of the human development indices (HDI) measures the extent to which women are excluded from opportunities in a given country.

The average GEM for the Niger Delta States is 0.399. Factors contributing to this low GEM include the region's oil exploratory activities, which produce men with easy money who engage in risky sexual behaviour with girls driven into prostitution by poverty. In general, women's low economic status hinders their ability to negotiate sex and other family planning issues, even with their husbands.

Some of the most challenging issues faced by women in the communities where we work include poverty, sexual violence, ignorance, stigma and discrimination against HIV positive women (more than with men who are always thought to be victims infected by women), lack of skills and power to negotiate safe sex, and lack of access to resources. Where ignorance, stigma and discrimination prevail, women with HIV and AIDS are shunned, filled with guilt and often deny the truth, even at the risk of spreading HIV to others. Children and wives who experience the illness or death of loved ones, and who must suddenly fend for themselves, are often disinherited, subjected to abandonment, abuse and exploitation, thereby aggravating their vulnerability to poverty and HIV/AIDS.

A gender-based community-level participatory analyses of the felt needs of women living with HIV/AIDS in the Niger Delta region of Nigeria also revealed some key issues of concern to them including lack of access to information, poor access to education for their young daughters who are often withdrawn from school to care for the sick parents, lack of freedom of association and voice in

the community, lack of safe and satisfying sex as they lack power to negotiate safer and enjoyable sex, poor access to comprehensive treatment, care and support, dependence on male spouses and lack of access to sustainable livelihood, victimisation by customary norms and practices that increase vulnerability, and above all, they are ignorant of available laws and policies that protect their rights.

It is evident in the Niger Delta, like in other parts of the country, that women are increasingly more at risk of HIV infection, and bear the brunt of the AIDS epidemic. Across the region, women are most disproportionately affected by HIV than anywhere else in the country, and the gap continues to grow. In most States, women are being infected with HIV at earlier ages than men. The differences in infection levels between women and men are most pronounced among young people (aged 15–24 years). Recent population-based studies suggest that there are on average 36 young women living with HIV for every 10 young men. While contextual analyses around the country depict HIV and AIDS with a woman's face, National and State strategic frameworks for addressing HIV/AIDS and poverty do not have women-focused interventions to address their practical and strategic needs.

The vulnerability of women in the Niger Delta as the key driving force of HIV & AIDS in the region is summed up in Stephen Lewis' Statement as follows: *"If women's sexuality … wasn't under assault, if women were able to say no, if women weren't subject to predatory attacks by men, or predatory behaviour generally, then you would have a disease in Africa called AIDS. But you wouldn't have a pandemic"*[1].

v. Biological Factors

Though not peculiar to the Niger Delta, it is worth noting that by reason of the male and female reproductive anatomy, women are more pre-disposed to infection through sex than men. Subsequently, these women are more likely to transmit the infections to their children for poor quality of, or outright lack of prevention of mother–to-child transmission services.

vi. Political factors

There are political factors driving HIV/AIDS pandemic in the Niger Delta. Some of the conflict situation and activities of militia groups that eventually lead to military interventions are politically motivated. Apart from the high rate of corruption that diverts HIV/AIDS funds to individual pockets, most state governments are yet to fully prioritise healthcare on their development agenda.

Many state governments pay lip service to HIV/AIDS, and go ahead to hijack HIV/AIDS activities funded by donors just to score political points. Most state budgets will confirm that most of the states in the region make very minimal contributions to fighting HIV/AIDS. However, huge loans are collected from the World Bank in the name of HIV and AIDS Funds (HAF) but again, are mismanaged

1 Stephen Lewis, UN Special Envoy for AIDS in Africa

and sunk into unsustainable projects by various low-performing and under-funded State Action Committees on AIDS.

Politically motivated conflicts and government's response (through their actions or inactions) have always led to large numbers of internally displaced populations especially of women, girls and children, who become highly vulnerable to HIV infection.

vii. Geographical Positioning

The cross-border location of the Niger Delta which shares both land and maritime boundaries with Cameroon with easy access to Equatorial Guinea by sea coupled with the notoriously weak borders puts this region, especially Cross River, Akwa Ibom, Bayelsa and Rivers States at risk of HIV infection due to cross-border mobility, migration and sexual activity.

The riverine location of most of the communities in the Niger Delta also means they are cut off from easy access to information and services that could help them fight or survive the scourge of HIV/AIDS.

➲ PSRHH Implementation in the Niger Delta Region/South South Zone

Background: Promoting Sexual & Reproductive Health and HIV/AIDS Reduction (PSRHH) in Nigeria, also known at the grassroots as "Make We Talk", is a 7-year partnership programme of the Federal Government of Nigeria, the UK Department for International Development (DFID) and the United States Agency for International Development (USAID) managed by Population Services International and implemented in Nigeria by Society for Family Health (SFH), ActionAid Nigeria (AAN) and Crown Agents.

The PSRHH is an innovative programme initiative that seeks to combine the benefits of products social marketing with communication for social change strategies for the implementation of integrated community-based sexual/reproductive health projects that respond to the country's increasing poverty levels and HIV/AIDS infection.

The programme basically targets poor and vulnerable populations that are most at risk including out-of-school youths, female sex workers, transport workers, and uniformed service men. Programme strategies included Peer Education (Plus), Working with Influencers, Policy Advocacy, Product Distribution (Social Marketing) and Institutional Capacity Building for SFH/CSOs/CBOs towards effective community-level programme delivery.

However, a key strategy adopted by ActionAid International Nigeria (AAIN) in achieving the programme goal is engaging and collaborating with Civil Society Organisations (CSOs) across the six geo-political zones of Nigeria.

Sites: There are 28 PSRHH intervention sites across the Zone including Etim Edem, Esuk Utan, Marina 1, Marina 2, Eburutu Military Barracks, Akim Police Barracks, Bedwell by Nelson Mandela street, all in Calabar – Cross River State; Ikot Ekpene, Offot and Ekpenyong in Akwa Ibom State, Oluku, Forestry 1, Forestry 2, Aduwawa and Ogida barracks in Benin City of Edo State; Eme Barracks, Aviele, Angle 90 and Jattu Junction in Auchi, Edo State, and Alesa (Refinery), Trailer Park, Eagle Cement (factory site), Okogbe (junction town), Ikpoama (adjoining to the Sea Port), Bori camp (military barracks), Post 3 (truck terminal), Nonwa Tai and Rumuocholu communities in Rivers State. More sites are still being identified for scale up.

Programme activities at these sites are being managed by Society for Family Health (SFH) Regional Teams and ActionAid International Nigeria-supported civil society organisation (CSO) partners including Youth Fate Renaissance in Port Harcourt Region, Community Partners for Development in Calabar Region, Lift Above Poverty Organisation, Benin, and Justice, Development and Peace Commission, Auchi, both in Benin Region.

Context: The sites where the programme interventions are located were chosen based on assessment of risk of exposure and characteristic risky behaviour of target populations, and they are made up of junction towns where long distance drivers stop over and a lot of night activities are going on with transactional sex as part of social and economic life of the population at these sites.

Military, police and prisons barracks made up of residential quarters of mobile and regular uniformed service officers, their families and a busy commercial area where young people and

other community members are engaged in income yielding economic activities especially restaurants and sales of provisions are also descriptive of some of our sites.

Some urban communities made up of diversity of ethnic groups, usually ruled by a traditional authority, with a busy motor park characterised by a beehive of economic activities ranging from hawking to sale of electronics, provisions and motor spare parts. Sometimes these sites include a market with booming economic life, surrounded by residential homes.

In Port Harcourt Region, there are some unique sites including the Post 3 community which are commercial hubs for livestock and farm produce from the Northern part of the country. Most of these sites are predominantly Muslim Hausa in composition, with few Igbos and Rivers State indigenes who are involved in other commercial business activities. There are large numbers of female sex workers in these sites, who are not resident in brothels, but reside in personal apartments within the community. Long distance truck drivers plying the North South Route patronise the several female sex workers in the site, and there is low level of literacy among the inhabitants.

Some sites are in rural communities like Okogbe, Ikpoama, Rumuocholu, Nonwa Tai in Rivers State, etc, and are some few kilometres from the City. These rural sites house a large number of young people who work or do businesses in town, and sometimes have brothels for female sex workers who transact sex in town at night. These community has a traditional ruler and a community youth association. There is an organised Hausa community embedded among the predominantly Ikwerre population, with a Hausa Chief who oversees this migrant population.

Programme Delivery: The community level interventions were expected to increase knowledge and attitudes conducive to safer sexual and reproductive health practices among poor and vulnerable groups (including abstinence and delayed sexual debut among young people), increase access (availability & affordability) to safer sex products and services among poor and vulnerable populations (that are sexually active), and improve the enabling environment for reproductive health behaviour change in Nigeria, among other expected outputs.

To achieve the above programme goals, the Peer Education Plus (PEP) model was adopted which clearly identified and defined the most at risk populations to be targeted in the programme including general characteristics, size, distribution, social organisations. The model had three distinct phases corresponding to entry, implementation and community handover.

During the entry phase a participatory needs assessment and stakeholder analysis was conducted including identification of influencers and gatekeepers with analysis of influences on behaviour change including barriers. This was followed by an intensive intervention phase which included selection, training and support of peer educators who carried out a structured programme of group education with peers. The intervention phase also included working with influencers and advocacy to remove barriers to behaviour change including need for

service improvement and policy change. This whole process was driven by a cadre of trained field staff who trained and supported peer educators and also carried out advocacy work.

The final and most crucial phase of the programme has been the community-handover phase which encourages the emergence and strengthening of community based organisations to continue with peer education activities, to be monitored, supported and mentored by CSO Partners, ActionAid International Nigeria and SFH Regional teams.

In the South-South Zone (Niger Delta), a number of community based organisations have emerged so far from some sites. The capacities of these CBOs were built by the CSO partners and SFH Regional teams with support from the ActionAid International Zonal Programme Advisor (ZPA) and Programme Support Unit (PSU).

Areas for capacity building included:

- Development of CBO Constitution;
- Leadership Development;
- Organisational Management and Administration;
- Financial Management;
- Participatory Programme Design, Management;
- Participatory Monitoring and Evaluation;
- Basic Communication and Documentation;
- Gender Mainstreaming;
- Book Keeping;
- Membership/Volunteer Recruitment & Retention.

Capacity building workshops for CBOs emerging from PSRHH programme sites in the South-South Zone.

About 34 surviving community-based organisations emerged from the process so far in the South-South zone including the following as shown in the table below:

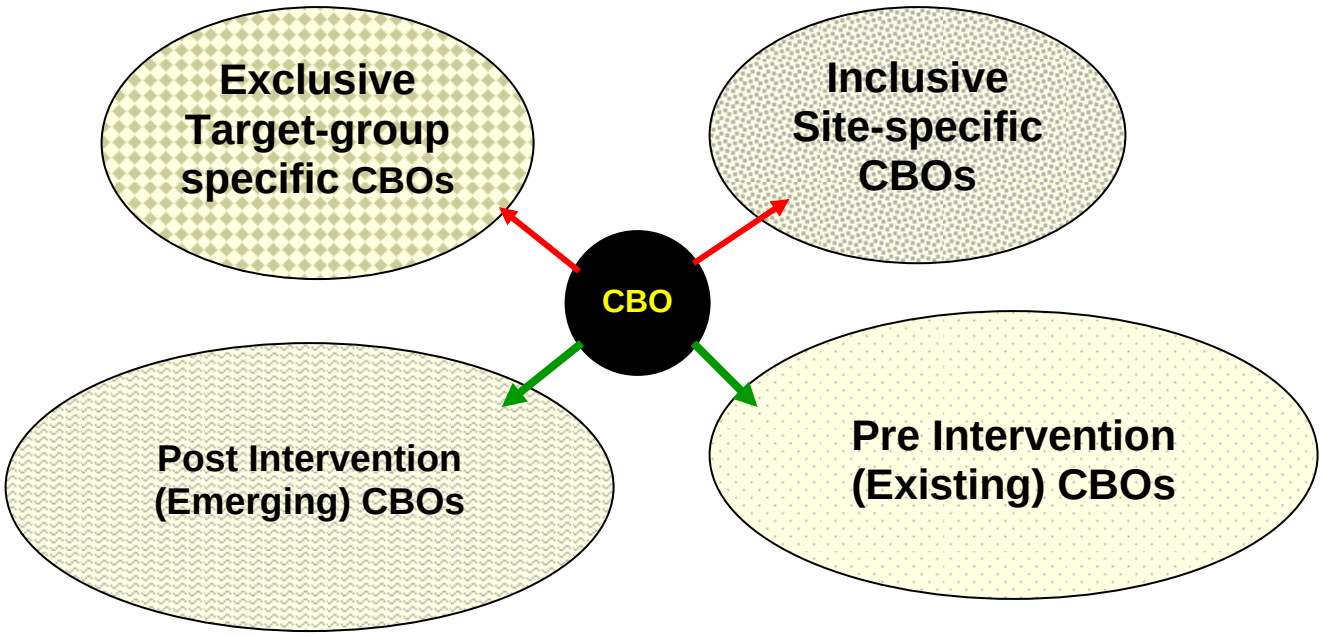
S/N	Emerging CBOs	Target Group Being Reached	Site	Region
1	AP United Girls Against HIV/AIDS	Female Sex Workers	Alesa	Port Harcourt
2	Camp Youth Health Club, Bori Camp	Male & Female Out-of-School Youths	Bori camp	Port Harcourt
3	Youth Transformation Association, Eleme	Male & Female Out-of-School Youths	Trailer Park	Port Harcourt
4	Eagle Cement Organisation on AIDS	Male, Female Out-of-School Youths & Transport Workers	Eagle Cement	Port Harcourt
5	Okogbe Youth Action Committee on AIDS	Male, Female Out-of-School Youths & Transport Workers	Okogbe	Port Harcourt
6	Ikpoama Community Action Committee on AIDS (Youths & FSWs)	Male, Female Out-of-School Youths & Female Sex Workers	Ikpoama	Port Harcourt
7	Arewa Society Against HIV & AIDS	Male, Female Out-of-School Youths & Transport Workers	Alesa	Port Harcourt
8	Image Changers Association	Male, Female Out-of-School Youths & Transport Workers	Trailer Park	Port Harcourt
9	Rumuochiolu Organisation for Positive Health	Male Out-of-School Youths	Rumuochiolu	Port Harcourt
10	Youth Health Organisation	Male Out-of-School Youths	Nonwa-Tai	Port Harcourt
11	Nonwa Motorcycle Health Organisation	Transport workers	Nonwa-Tai	Port Harcourt
12	Community Health & development Association	General Population	Oluku	Benin
13	Motorcycle Dealers on Aids Eradication (MODAE),	Male Out-of-School Youths	Forestry 1	Benin
14	Forestry Okada Riders Against Aids (FORAA)	Transport Workers	Forestry 2	Benin
15	Aduwawa Safe Health (ASH) Club	Male, Female Out-of-School Youths	Aduwawa	Benin
16	Eme Barracks Action Committee on AIDS	Male, Female Out-of-School Youths & Uniformed Service Men	Eme Barracks	Benin
17	Aviele Action Committee on AIDS (ACACA)	Male, Female Out-of-School Youths, FSWs & Transport Workers	Aviele	Benin
18	Angle Ninety Action Committee on AIDS	Male, Female Out-of-School Youths & Transport Workers	Angle 90	Benin
19	Character Changing Ladies (CCL)	Female Sex Workers	Cuts across all selected sites in Region	Benin
20	Youths against HIV/AIDS	Male, Female Out-of-School Youths	Jattu Junction	Benin

S/N	Emerging CBOs	Target Group Being Reached	Site	Region
21	Drivers Against AIDS	Transport Workers	Jattu Junction	Benin
22	Police Action Committee on AIDS	Uniformed Service Men	Jattu Junction	Benin
23	The United Health Club Of Ogida	Male, Female Out-of-School Youths	Ogida Barracks	Benin
24	Progressive Youth Club, Etim Edem	Male, Female Out-of-School Youths	Etim Edem	Calabar
25	Calabar Tipper Drivers Multipurpose Cooperative Society Ltd	Transport Workers (Tipper & boat transporters)	Marina - Calabar	Calabar
26	Marina Youth Foundation (MYF)	Male & Female Out-of-School Youths	Marina 1-Calabar	Calabar
27	Youth Awareness Club (YAC), Eburutu Barracks	Male & Female Out-of-School Youths	Eburutu Barracks - Calabar	Calabar
28	HIV & AIDS Control Association (HACA)	Uniformed Service Men – (Police)	Akim Police Barracks - Calabar	Calabar
29	Dynamic Youth Association, Offot	Male &, Female Out-of-School Youths	Offot – Uyo	Calabar
30	Legend Youth Association, Ekpenyong	Male &, Female Out-of-School Youths	Ekpenyong - Uyo	Calabar
31	Golden Sisters Association, Offot	Female Sex workers	Offot - Uyo	Calabar
32	Goodland Association	Transport Workers	Offot - Uyo	Calabar
33	Future Hope Youth Association Ikot Ekpene	Male &, Female Out-of-School Youths	Ikot Ekpene	Calabar
34	Life Concern Men Association	Transport Workers	Ikot Ekpene	Calabar

Besides capacity building and mentoring support, CBOs were also linked with other organisations, state institutions like the State Action Committees on AIDS (SACAs) and other donor partners that could provide additional support for their sustainability.

While some of these CBOs emerged as target-specific CBOs reaching out to members of other target groups e.g. sex workers, uniformed service men, etc, some were broad-based and more inclusive, working across a range of target groups within the sites.

Also, another variation in the types of CBOs present in the sites are those that emerged newly as a product of the PEP model (post –intervention CBOs), and those that existed prior to the intervention and were eventually bought into by the programme, such as the case with the Tipper Drivers' Multipurpose Cooperative Society in Mariner, Calabar.



THE CHANGE AGENT ROLE OF CBOs IN the PSRHH SITES:

These CBOs have assumed key paramount roles as agents of social change in their various communities beyond the mandate of HIV/AIDS issues. Some key roles and responsibilities of the CBOs towards ensuring the sustainability of the programme in their various sites include, but not limited to:

- Carrying out advocacy and community mobilisation (creating enabling environment);
- Creating awareness on HIV/AIDS & other health-related issues in the sites using a variety of approaches including community theatre and rallies;
- Providing counselling and referrals for care and support services, FP and STI treatment;
- Reducing HIV/AIDS-related stigma in the community;
- Increasing access to services and ensuring accessibility of HIV/AIDS, Family Planning & Maternal Child Health Commodities in communities through non-traditional outlets;
- Reinforcing positive (non-risky) behaviour (e.g. No-Condom-No-Sex Policy Among Female Sex Workers);
- Scaling up interventions even beyond initial target communities (e.g. FSWs CBO like Character Changing Ladies reaching out to other brothels in Benin);
- Transforming into a key community development agency beyond HIV/AIDS – e.g. Aviele community action committee on AIDS carried out advocacy and got the local government's attention and commitment to provide a health centre in the community, with the community providing land, though government is still to make real its pledge to the community.

CHALLENGES OF APPLYING PSRHH FRAMEWORK IN THIS CONTEXT

In implementing the PSRHH PEP model in the communities in the South-South, a number of challenges were encountered and some key innovative approaches adopted in addressing them including:

➲ Challenges in Programme Acceptability:

A. Low Initial Community Acceptance – While some communities have had some form of ad hoc interventions by either public or private sector agencies, these created precedence that made communities less enthusiastic and uninterested in whatever packages the PEP model had to offer. Some of these communities had a very low perception of their risk, and other target groups and stakeholders perceived the programme as economically disadvantageous (e.g. brothel owners and sex workers thought the programme was going to "spoil" business for them) as they felt that any intervention creating awareness on HIV/AIDS was intended to discourage sex.

B. Low Initial Parental Acceptance – Most parents and guardians including shop owners for whom the out-of-school youths worked or were attached to as apprentices also had concerns about the programme. While some felt that it was time consuming and was taking away a lot of "productive time" from their wards, with little "economic benefits", others felt it was promoting condom use and promiscuity among young people, which was going to increase their vulnerability to teenage pregnancies and HIV & STI infection. As such, they were reluctant to release their wards to facilitate peer education sessions or attain training sessions.

C. Slow Initial Stakeholder Buy-In – In the Niger Delta where multinational companies have been carrying out activities as part of their corporate social responsibility with the aim of creating community acceptance for their presence in the communities rather than meeting felt needs of communities, they approach development work with attractive "community-relations" lobbying budgets during the entry process. Also, given situations where communities were used to the top-down approach to development programmes, **PSRHH's participatory rights-based approach came as a paradigm shift.** This delayed community buy-in even after intensive advocacy, as some community leaders were more interested in "what is in it for me".

This barrier was overcome by selecting key influencers and training them to drive the process, and selling the programme concept to the wider community. These influencers worked hand-in-hand with CSO partners and field teams to drive the project.

➲ Challenges with Accessibility

A. Difficult Riverine Terrain & Access to communities – While some communities are located offshore and accessible only by boat, others located on land were far from urban centres. Some programme staff working in riverine communities had to contend with floods and high tides, heavy rains and difficult means of transportation. Yet because these communities were so vulnerable, they could not be excluded

simply because they were hard-to-reach. As a matter of fact, most interventions by other agencies are concentrated within the urban centres, denying these riverine communities of access to information and services.

B. **Difficulties in Accessing Care & Support Services –** Given that PSRHH was not a service delivery programme, programme staff and peer educators were left with the option of referring clients and those who needed services including HIV counselling and testing, prevention of mother to child transmission (PMTCT), anti-retroviral therapy (ART) and psychosocial support through support groups. However, those referred were unable to access these services for a number of reasons – they were either too far from the communities, or community members were too poor to afford transportation and service charges to access them. This in itself constituted a draw back in the referral system.

C. **Difficulties in Accessing HIV/AIDS, Maternal Child Health and Family Planning Commodities -** Just like care and support services, most HIV/AIDS commodities like condoms and Lubrica were found mostly in the cities. Where these products were available in some sites, they were in very limited quantities and at exorbitant prices. The distributors of these commodities further seized the opportunity of demand creation by the PSRHH programme to make big profits on the products.

➲ **Challenges in Technicalities of Programme Content and Delivery**

A. **Time Management in Deploying Participatory Methodologies -** Participatory Methodologies were used in deploying programme activities to enhance learning and assimilation. This has usually been time consuming, for instance when conducting monitoring and evaluation, capacity building or focus group discussions, and even peer facilitation, etc. If not properly managed, participants may become tired and lose concentration.

B. **Capacity of CSOs, CBOs & PEs to Deploy PSRHH Strategy -** PSRHH delivery and deployment in the communities has been heavily dependent on the capacity of CSO partners and Peer Educators to roll out the strategy. For CSOs, capacity was viewed in terms of number of staff available to PSRHH, qualification, programming skills and ability to communicate fluently both with community members and the PSRHH implementing partners (ActionAid Nigeria & SFH). In the case of the PEs, ability to read and write English was very important.

While some CSO partners had difficulties motivating and retaining peer educators, some of the PEs had difficulties in forming and sustaining peer groups. Although partner and peer educators selection were done with this in view, however, some fell short of the required competencies and so posed challenges in programme delivery and documentation.

Where CBOs emerged, they had very weak capacity to implement programmes and manage organisations.

C. **Low Literacy Level of Target Communities –** Most community members involved in the programme either as peer educators or influencers were usually of low

educational background, therefore posing challenges in understanding and deploying training modules.

➲ Challenges in Motivation for Behaviour Change

A. Socio-cultural Barriers – Some communities had deeply entrenched patriarchal cultures and practices that made behaviour change difficult. Cultures where first daughters had license to bear children for the family outside of wedlock and where widows were encouraged not to re-marry seemed counterproductive, and slowed down behaviour change.

Also, some religious teachings that discouraged the use of condoms saw the programme as promoting promiscuity, and therefore opposed it at community level.

B. High Community Expectations – In most Niger Delta communities, development is about "sharing oil proceeds", and as long as a programme has no direct financial benefits to community leaders or gatekeepers, they are either not interested or they even go further to sabotage its success. Because of the high levels of poverty, most youths who were selected as peer educators expected to be paid for their time and much more, to be "employed" by the CSOs or donor partners.

In some sites, the programme ran into competition with other donor-funded programmes that came in newly and were offering a lot more financial incentives than PSRHH was able to afford if PEP had to remain a cost effective model.

On the other hand, when peers in the groups realised that their peer educators were getting more allowances than they (peers), every peer then wanted to become a peer educator or drop out of the peer groups.

C. Demand for Service Delivery - Programming for behaviour change is always challenging as people do not see tangible benefits and so feel that they are labouring in vain. Also because the communities were used to service delivery projects from oil companies, they expected health centres and schools to be built for them. It was difficult for them to understand and appreciate that the changes being advocated by PSRHH had to do with people's ways of life and their attitudes to sexual and reproductive health.

D. Low Participation of Female Out-of- School Youths – In some sites, the participation of female out of school youths was extremely low, about 50% of male participation. Most girls were shy to join groups, were lowly motivated to participate in the programme, and were more likely to be restrained from programme activities by parents or guardians than their male counterparts.

➲ Challenges in Programme Sustainability

A. High Dependence on PSRHH

One of the challenges faced especially at the end of each phase that saw the emergence of CBOs was the absolute dependence of these CBOs and peer educators on the sponsorship support of PSRHH. They only carried out activities when supported or funded, and some of the youths and leaders of these groups actually expected some allowances from PSRHH.

They left the issue of paying rents for their office accommodation entirely to PSRHH, and made no efforts to mobilise additional resources apart from what PSRHH provided.

There was little willingness for volunteerism, and most of the community members wanted some form of compensation even for using their premises or open spaces for sensitisation activities.

There were big challenges of resource mobilisation and funding by other donor agencies mostly because these groups were nascent, and no funders were ready to work with new groups with little experience and capacity. This compounded their dependence on PSRHH.

B. **Low Community Ownership –** Most communities felt they were not responsible for the success of the programme, and made little or no contributions to sustain it. This was particularly true of communities that were transitional, made up of external settlers who were not indigenes, though there were tribal affiliations and associations that bonded the various component tribes together e.g. the Northern Arewa Forum that brought together all Hausa indigenes at the site, etc.

C. **High Rates of Attrition and Mobility of Peer Educators –** Most of the youths who participated in the programme were highly mobile. While those who were apprentices moved on after completing their apprenticeship terms, others who were awaiting admission into higher institutions entered school, posing serious challenges to the peer education process. This was particularly true of peer educators in transitional sites, and those in the barracks who moved when their parents or guardians were transferred to other locations.

D. **Hostile Environment and Human Insecurity –** Sometimes, conflicts broke out in project communities and affected programme delivery. In Oluku community in Benin, for example, communal conflicts halted the programme for almost one year before CSO partner resumed work in the community.

At Bori Camp Barracks in Port Harcourt, a car bomb blast by militant groups in the Niger Delta in conflict with Federal Government over the arrest and detention of a notable leader of a militia group in the region led to the expulsion of all civilian populations within the barracks for security reasons, leading to the loss of all female sex worker groups, most out of school peer educators and influencers at the site.

Sometimes, conflicts and violence erupted in communities when project staff were visiting, leading to high insecurity of project vehicles and staff.

INNOVATIONS ADOPTED IN OVERCOMING CHALLENGES

1. **Promoting Programme Acceptability** – To increase programme acceptability within target communities, the initial community inertia was overcome by intensive advocacy efforts and open community meetings which clearly spelt out programme benefits to the communities.

   To overcome parental resistance and unwillingness to allow their children participate in the programme, the involvement of parents as influencers in the peer education process eventually softened the ground. These adult influencers were not only trained to influence other youths and community members to be involved in the programme, but also served as advocates to other parents as well as supervisors of peer education activities of the young people involved. When the youths now had the support of their parents and adult influencers, they become more committed and involved as well.

   While the use of influencers' strategy was equally useful in breaking the barrier of slow stakeholder buy-in, we also trained and involved community members in the initial baseline survey using Participatory Monitoring & Evaluation (PM&E) then sharing results with communities. This helped the communities to access their risk of HIV and to appreciate the need for the programme in the community.

Community member (Influencer) being trained to facilitate PM&E process at Auchi

2. **Increasing Access** – To increase access of hard-to-reach communities to programme benefits, programme staff went by boats to communities to facilitate peer sessions and implement other programme activities.

   To overcome the hurdle poor access to care and support services, programme staff created linkages with other service providers and agencies that were able to take these services to programme sites where they were needed. Even at that, most riverine sites still lacked access to vital care and support services. Some times, HIV counselling and testing services were taken to the site, and at other times, HIV/AIDS Support groups of people living with HIV/AIDS also visited to provide care and support to those who tested positive during HIV Counselling and Testing.

   To bridge the gaps that limited access to HIV/AIDS, maternal child health and family planning products, Society for Family Health (SFH) regional teams, CBOs and CSO partners took products to sites on almost daily basis, and

other non-traditional outlets like patent medicine vendors were identified and products stocked in their shops to make them accessible to the communities. Some of these vendors were trained as peer educators and others as influencers, making them reproductive health advocates at community level, given their high influence in communities where they are seen as “small doctors”.

While Family planning commodities could not be distributed over the counter, some community-based service providers were identified and trained by SFH product detailers to provide FP services and referrals.

3. **Adaptation of Contents and Delivery** - To bridge the capacity gaps, the zonal programme advisor provided regular mentoring support to both the CBOs and CSO partners, and various capacity building training activities were organised as the need arose to enable partners (CSOs & CBOs) deploy the strategy effectively.

To address challenge of low literacy level of peer educators and influencers, the training modules were adapted and pre-tested several times till low literacy pictorial versions were arrived at and used. Peer education sessions were made to be as participatory and interactive as possible, and note-taking was discouraged so that group members who could not write would not lose self esteem and feel excluded. This worked. Not withstanding, while no literacy requirements were made for peer group members, peer educator selection took into consideration minimal literacy requirements to enable them follow on with training and interpretation of modules to their peers. Local content and contexts were adapted as much as possible.

4. **Increasing Motivation for Behaviour Change** – To reduce opposition by religious groups, we involved religious leaders through advocacy and some capacity building, which changed their perceptions about HIV/AIDS, and gave the programme a leeway to change risky behaviour patterns within the communities.

   To handle the problem of high community expectations with respect to monetary rewards, non-monetary incentives were introduced, and peers, instead of being given money for coming to or attending sessions, they were given gifts like cups, cosmetics (for girls), key holders, etc, branded with “Make We talk” – the brand name of PSRHH in the communities. They seemed to appreciate these more than monetary incentives and this worked well for PSRHH.

   Apart from motivational gifts, branded t-shirts were also given to peer educators who, giving them a sense of identity. Most of them were very proud of these, and this also helped to promote visibility of the programme at the sites.

   In all the sites, we promoted and encouraged recreational and entertaining activities like quiz competitions, snooker, football and boat regatta competitions among the peer educators and peers. These activities attracted high levels of participation among community members who were then reached with behaviour change communication materials and messages during the events.

To increase the participation of female out of school youths, we separated male youths from female peer education groups, and increased non-monetary incentives for the girls such as adding skills acquisition training to their activities as well as increasing female influencers' involvement in the programme. This more than doubled the participation of female out of school youths in some sites.

Youths participating in snooker, boat regatta and quiz competitions as a way of increasing motivation.

5. **Increasing Sustainability –** To address the problems of over dependence on PSRHH and low community ownership, programme staff sought increased community involvement. Through advocacy, some communities donated office accommodation to the CBOs that emerged from the process, while PSRHH just contributed furnishing. This took off the burden of rents. Also, in most communities, CBOs were supported on counterpart funding basis, and they were expected to raise a percentage of funds required to run programmes while PSRHH supported the balance. This also worked in a number of cases, and reduced complete dependence on PSRHH.

   Apart from building the capacity of these CBOs on resource mobilisation and financial management, linkages were created with other funding agencies and government agencies like SACAs in the states where they were. As a result, some succeeded in writing proposals and attracting grants that were helpful in scaling up their work and replicating the programme in other communities outside of PSRHH support.

   To address the challenge of attrition and high rate of mobility of peer educators, the CSO partners and emerging CBOs kept training and re-training other peers to replace peer educators who moved out of the sites, and selecting peers who were not most likely to move, especially those who had strong family ties at project sites.

   To increase community ownership, the CBOs were handed back to the communities at the close-out phase during an exit community meeting, and the CBOs became accountable to the community rather than to PSRHH.

   To further create an enabling environment that posed less risk to human security, CSOs were trained in conflict participatory vulnerability analysis in Port Harcourt by the Human Security in Conflicts & Emergencies unit of the ActionAid Nigeria Governance Team. It is hoped that this will go a long way to enable them build capacity of communities to prevent as well as respond to conflict situations in their sites. To ensure the continuity of CBOs beyond project timeframe, the CBOs were networked into coalitions at regional levels. This had two advantages – it provided a mechanism for peer mentoring and peer motivation of the CBOs, and created opportunities for continuous peer support and shared learning.

EXPERIENCES AND LESSONS LEARNT

SOME EXPERIENCES & SUCCESS STORIES:

- Aviele Community Action Committee on AIDS (ACACA), one of the CBOs that emerged from the PSRHH intervention in Aviele Community in Auchi, Edo State, facilitated the emergence of a Local Government Action Committee on AIDS in Esako West LGA, Edo State, and is advocating for construction of a health centre in the community. The community has donated land for the project, and the LGA Chairman has approved and pledged his support for the project in principle.

- At Eme Barracks, Eme Barracks Action Committee on AIDS in Auchi (Edo State) is now catalysing HIV/AIDS response in the barracks, and the military authorities in-charge of the barracks have granted the CBO a building to be used as an office within the Barracks.

- In Benin, the Character Changing Ladies – a Female Sex Workers' CBO is now reaching out to other brothels in the State not being reached by the PSRHH programme

- The Oluku Community Health & Development Association in Oluku Community which emerged after many months of conflict within the community is now reaching out to PLWHAs and providing VCT support & referrals in collaboration with the GHAIN Project.

- In Port Harcourt, Ikpoama Action Committee on AIDS, Eagle Cement Organisation Against AIDS, Okogbe Action Committee Against AIDS, Trailer Park Image Changers Association and Arewa Society Against HIV/AIDS successfully won grants for scaling up the PSRHH PEP model in their communities and environs through SACA.

- In Calabar, Marina Youth Foundation successfully partnered with OIC/USAID to build entrepreneurial skills of youths in their community.

- In Ikot Ekpene (Calabar Region), Nonwa Tai, Rumuchiolu, Okogbe and Ikpoama (Port Harcourt Region), communities provided office accommodation for the CBOs that emerged, demonstrating ample community support and sustainability.

Participatory Monitoring & Evaluation findings in the programmes sites have shown that the programme is making tremendous impact in the lives of individuals and entire communities including:

- *Increased level of confidence and self esteem among peer educators (PEs);*

- *Reduced incidences of teenage pregnancies and abortion reported among female Out-of-School Youths within the sites;*

- *Reduced incidences of abortion among female sex workers as a result of improved condom negotiation skills;*

- *Reported increase in condom use by peers (across all target groups), also corroborated by the reported increase in sales of condoms/ Lubrica by patent medicine vendors in all sites;*
- *Increased parental support for participation of youths in "Make We Talk" intervention;*
- *Increased health seeking behaviour amongst male and female Out-of-School Youths (OSYs) and FSWs towards STI treatment in the few cases of infection;*
- *Reduced incidences of stigmatisation of female sex workers (FSWs) has created an enabling environment for behaviour change among this group;*
- *Most northern community members in the sites in Port Harcourt now freely discuss sexual and reproductive health (SRH) issues, and now more confidently demand condoms unlike before;*
- *Decreased drug and alcohol use among Out-of-School Youths (OSYs) and FSWs in sites.*

KEY LESSONS LEARNT

In implementing the PSRHH programme in the Niger Delta Riverine Communities, we learnt some vital lessons:

- Involvement of key influencers enhanced community participation in “Make We Talk” intervention;
- Quiz competition among peer educators and peers spurred interest in programme;
- Use of picture code manuals by peer educators and improved facilitation skills led to better participation by peers;
- Edutainment activities with token prizes created more visibility and interest for “Make We Talk” at sites;
- Informal relationships by programme staff with peer educators and their peers go a long way to build trust for programme and implementers;
- Behaviour change is most sustainable when communities are directly involved in planning and implementing programmes that target them;
- Building the institutional and programmatic capacity of CBOs as change agents to design, implement, monitor and evaluate HIV/AIDS initiatives at community-level are critical to the success of behaviour change communication for HIV/AIDS prevention, care and support;
- Linking up CBOs with other sources of funding and collaboration is key to the success and sustainability of community-based initiatives in resource poor settings.

RECOMMENDATIONS AND CONCLUSIONS

Based on our experiences and lessons from the programme, we wish to recommend that those intending to implement the PEP Model in riverine communities should:

- Explore non-monetary ways of motivating and providing incentives to community-based participants towards sustainable development programme engagements;
- Evolve CBO models that best meet needs of your programme vis-à-vis community needs;
- Engage more with communities that are more indigenous and non-transitory as they provide an environment that will better support sustainability and community ownership of the programme

CASE STUDIES

MAKE WE TALK

IMPACTING LIVES

YAKUBU UMAR KOGI – PEER EDUCATOR
Alesa, Port Harcourt Region.

Yakubu Umar is a trained peer educator based at Alesa in Port Harcourt Region where he undertakes casual jobs in loading petroleum tankers and runs a small film house where tens of young people patronise daily to watch cable news and international sporting leagues from Europe and South America via satellite networks to which Yakubu has subscribed.

Initially, it was difficult convincing Yakubu to join the programme but after much pressure by the PSRHH programme staff who found in him latent potentials for peer education, Yakubu decided to give the programme a trial. He accepted to be trained as a peer educator, and he has been quite zealous and influential among his peers at the site. In fact, he is a real Make We Talk Ambassador, and is making a difference at the site.

After his training as a peer educator, Yakubu used his film house as bait for attracting young people to join his peer education group. Every peer educator knows that this is the most challenging aspect of their work – convincing their peers to form a group that meets regularly to discuss sexual and reproductive health issues. To overcome this challenge, Yakubu fixed his peer facilitation sessions about one and half hour before the commencement of European Championship football leagues. Every young person who comes in 1 – $1^{1/2}$ hours before the match to participate in the Make We Talk Peer facilitation session will watch the match free of charge. It worked the magic for Yakubu, and he soon started having more than 30 young people attending his peer education sessions, so he got another trained peer educator to pair with and split the group for easy facilitation and better participation. Now, his group meets twice a month for peer education sessions at the site.

Incidentally, Yakubu plays snooker as a pass-time activity (hobby), so he assisted the field team in organising a snooker competition with the support of other peer educators at the site in order to reach out to more youths with the key reproductive health messages around issues of HIV/AIDS and STIs. The games were successful, and Yakubu volunteered to coordinate and co-referee the competition.

Yakubu (left) coordinating and refereeing the Make We Talk snooker competition organised by peer educators at Alesa, Eleme.

On how the programme has affected his life and others around the site, Yakubu says:

"Before this programme came to Alesa, I used to have over 4 girlfriends, and I was not using condoms. Now, I don't chase women again, and have cut down the number of girlfriends to just one, and I am now using condoms consistently."

In Alesa, my peers now see me as an example, and they say, 'If Yakubu can keep off from women, then this is serious…It means we too can stay off…' Now, when my friends feel any symptoms of STIs, they come to ask me what to do. Before, they used to go for herbs, but now, they go to hospital for STI treatment.

Two of my friends confided in me that their girlfriends had been getting pregnant often, and I invited them to join my peer education group. One of them who had vowed never to use condoms on religious grounds; when he saw pictures of STIs in our picture code manuals, he changed his mind, and now uses condoms.

In Alesa, my peers see me like a small doctor in the community because of what I now know from the Make We Talk programme. People now direct people to me for advice and I counsel them and tell them how to protect themselves from HIV/AIDS, STIs and pregnancy.

I think this programme is really helping us, and we want to see it continue, so we have formed the ***Alesa Youths Empowering People on HIV/AIDS*** *to continue educating the community on HIV and other health matters.*

YAKUBU DURING A PEER EDUCATORS' TRAINING SESSION AT ALESA

MAKE WE TALK

IMPACTING LIVES

Angel styling a client's hair in his hair salon

ANGEL – PEER EDUCATOR
Eagle Cement Site, Rumuolumini, Port Harcourt.

Angel is a trained peer educator at Eagle Cement site in Port Harcourt region, and facilitates a group of 10 peers who meet twice a month to discuss issues around sexuality and HIV/AIDS. He is into showbiz, and does barbing as an income generating activity. He spoke with the Make We Talk (MWT) Team on how the programme has impacted on lives at Eagle Cement site in Port Harcourt Region:

"Being in showbiz exposed me to so many girls. Before this programme, I never used to use condoms, but now, I cannot do without them. Even in my hair salon, I now give out free condoms to my clients because I always seize the opportunity when they come in to discuss safer sex.

At Eagle Cement, there used to be a very high rate of teenage pregnancy among the little girls due to their interaction with the trailer drivers. Each week, we used to hear of at least 2-3 incidents of aborted foetuses dumped in cartons around rubbish heaps at the site, either by these young girls or by sex workers. But now, all that has changed because people are getting more enlightened about use of condoms and contraception. Since May/June 2005, we have not heard of any such case.

This young teenager at Eagle Cement is 16, and has an 18-month-old baby ... and there are many of such cases at the site. Now, the rate of teenage pregnancy is reducing due to "Make We Talk"

On the impact of the programme on Angel, he says:

"I used to be a heavy smoker before this programme but because of what we learnt about the danger of drug abuse, I have stopped smoking because I have to practice what I preach. People now look up to me and expect so much from me, so I have to be a good example of what we are teaching other young people like us.

Angel also feels that the programme has brought peace to the community between drivers and female sex workers:

"Before this programme, there was always fighting between the trailer drivers and these hustling girls. They were always fighting when the girls wanted them to use condoms but now, the drivers are more aware about condoms due to this programme, and the fighting has reduced.

Before, condoms used to go out of stock here a lot because vendors said that the product was not moving fast in the market but now, even if you buy one trailer of condoms [exaggerated], they will finish them within a very short time, and there are condoms everywhere now even in the midnight, unlike before. At first, people used to complain that they were not getting enough satisfaction from using condoms but since Lubrica was introduced here by the Make We Talk people, most of our friends don't complain about condoms again as such, and I think it a good thing.

Port Harcourt Region

MAKE WE TALK

IMPACTING LIVES

actionaid

"Before Make We Talk came to Ikot Ekpene, I did not believe that AIDS was real…But now I believe"

UDEME ESSIEN AKPAN
PEER EDUCATOR
Ikot Ekpene Site
S.S. ZONE

Miss Udeme Essien, popularly known among her peers as U-D *[you-dee]*, is a 24-year old peer educator based at Ikot Ekpene, Akwa Ibom State, one of the sites where the Community Partners for Development (CPD) is implementing its 2nd cycle of PSRHH intervention with the support of ActionAid International Nigeria. She is an apprentice-seamstress at Ikot Ekpene in her 2nd year of training. Udeme joined the Make We Talk programme in June 2006 after the open community meeting.

Ikot Ekpene is the third metropolitan city in Akwa Ibom after Uyo (the capital city) and Eket (where oil exploration takes place). It is along a major highway lining the west and east to the south and towards the borders with Cameroon. The town is host to many commercial activities, with thriving drug and sex markets. Brothels are open to lots of young people and transport workers who patronise sex workers on a regular basis.

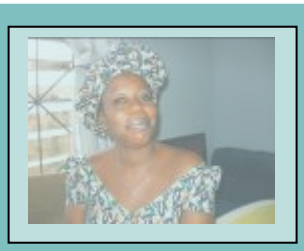
When Udeme joined the programme in 2006, she did not believe that HIV/AIDS was real. She says she thought it was just one of these rumours fabricated by condom manufacturers to sell their products. Most of her peers at Ikot Ekpene felt the same, and many were engaged in multiple partnering and unprotected sex, including Udeme. Udeme said she was even more worried when her friends and a lot of people in the community believed that one could get the virus by sharing toilets, utensils or shaking hands with someone who was infected. For her, it was a mixture of fear and disbelief.

Now, Udeme is happy that she joined the Make We Talk programme, which she describes as a life saver. Today, a youth CBO made up of Peer Educators has emerged from the site known as Future Hope Youth Association, and Udeme is the vice President.

On how PSRHH has benefited her personally, Udeme says:

"Before this Make We Talk programme was introduced in this town, I did not believe that HIV was real. I thought it was just rumour…but now, I believe after we were thought for over seven months along with other peer educators by CPD.

"There is really a remarkable reduction in the number of youths roaming our streets at night due to what they have learnt from this Make We Talk programme"…[Eno].



Mrs Eno Essien, a key female influencer in the programme at Ikot Ekpene is the Mistress of Udeme, and confirms that the programme has changed a lot of things among youths in the site, including those learning tailoring in her fashion design training centre, whom Udeme has influenced tremendously. She has been very supportive of the programme, and encourages her apprentices to participate in peer sessions. Even her training centre is made available for peer sessions whenever Udeme wanted to hold a session. Mrs Eno usually supervises and ensures that sessions hold as scheduled, and that the youths are actively participating in the peer sessions. She says there is a remarkable reduction in the number of youths roaming the streets at night due to what they have learnt from the *Make We Talk* programme.

Udeme (Left) and a member of her peer group – Mercy Oku (Right) after a Make We Talk peer group session at Ikot Ekpene

Mercy Oku is one of the beneficiaries of Udeme's influence. This 20-year-old peer of Udeme is also a co-apprentice with Udeme in Mrs Eno's Fashion designing training centre at Ikot Ekpene, and she recounts how the Make We Talk programme has influenced her life:

"Before this programme came, I did not know much about HIV/AIDS but now, Udeme has taught us about HIV/AIDS and how to protect ourselves. I have also learnt not to stigmatise or discriminate against those who are HIV positive.

Before now, I used to have many boyfriends, but after Udeme taught us, I decided to abstain from sex all together. It was not easy, as it resulted in fights and quarrels as each of my boyfriends thought I have gotten someone else and decided to dump them. But I have made up my mind. Even if I want to have sex now, it will only be with one person, and that person has to go for an HIV test first before we can start having sex…and even with that, I will insist that we use condom to protect myself..

Also, I used to be afraid of using condoms because I thought they could tear and enter into my body, but now I know that they are safe and can protect me from pregnancy, HIV and STIs.

I am glad that I joined this programme".

PICTURES

Peer Educators participating in mid-term review of PSRHH in South-South with Zonal Programme Advisor facilitating .

Influencers analysing the causes and effects of teenage pregnancy in Offot and Ekpenyong communities during Influencers' training at Uyo

Zonal Programme Advisor on mentoring support visit to JDPC Auchi

Peer Educators reaching out-of -school youths and community members with HIV/AIDS messages using community drama in Port Harcourt .

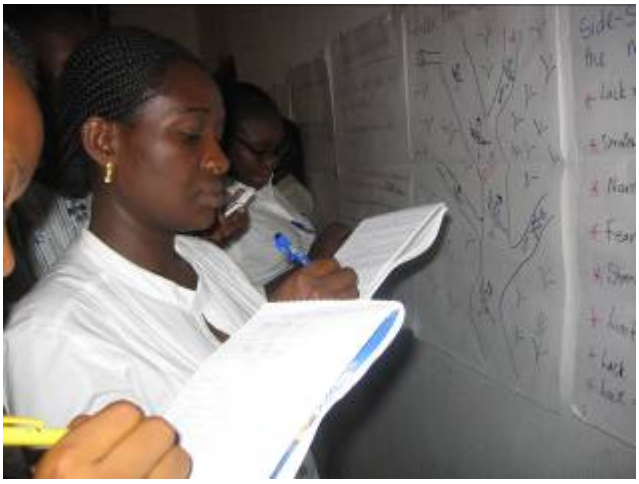
Reaching out-of-school youths and community members with HIV/AIDS messages using road shows in Port Harcourt .

Right: Community Leader giving out prizes to participants during quiz competition at Aviele, Benin Region

Marina Youth Foundation, Calabar – one of CBOs that emerged from site now operates video games in its office to reach youths with HIV/AIDS messages – ActionAid ZPA on mentoring support visit with Calabar Field Team (left photo)

Training Community members on Participatory Monitoring & Evaluation of PSRHH in their communities at Benin.

Boat regatta in Ikpoama – It's both learning and fun for peer educators.



Building the capacity of SFH Field Team & CSOs on Gender Mainstreaming into PSRHH in South-South

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