ORIGINAL RESEARCH ARTICLE

The Use of National Youth Service Corp Members to Build AIDS Competent Communities in Rural Edo State Nigeria

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Abstract

This paper focuses on the community component of a larger action research project on HIV Prevention for Rural Youth (HP4RY), funded by the Global Health Research Initiative (Canada). It began with ethnographic research in 10 communities selected using geographic representative sampling and random assignment to one of three research arms. Using the AIDS Competent Community (ACC) model developed by Catherine Campbell, the ethnographic research identified factors in six domains that contributed to youth vulnerability to HIV infection. This was followed by recruitment, training and deployment of three overlapping cohorts of young adults (n=40) serving in Nigeria's National Youth Service Corp (NYSC), to mobilize youth and adults in the communities to increase communities' AIDS competence over a nearly 2 year period. Monthly reports of these Corpers, observations of a Field Coordinator, and community feedback supported the conclusion that communities moved towards greater AIDS competence and reduction in youth vulnerability to HIV infection (*Afr J Reprod Health 2012 (Special Edition); 16[2]: 71-85*).

Résumé

Cet article se concentre sur la partie communautaire d'un plus grand projet de recherche d'action sur la prévention du VIH en faveur de la jeunesse rurale, financé par le Global Health Initiative (Canada). L'étude a commencé avec la recherche ethnographique dans 10 communautés choisies à l'aide d'un échantillon représentatif géographique et une attribution aléatoire à une des trois sections de recherche. A l'aide du modèle de la Communauté Compétente du SIDA (CCA), élaboré par Catherine Campbell, la recherche ethnographique a identifié des facteurs dans six domaines qui ont contribué à la vulnérabilité des jeunes à l'infection du VIH. Ensuite, il y a eu le recrutement, la formation et le déplacement de trois cohortes de jeunes adultes qui se recoupent (n=40), engagés dans le service national de jeunes, pour mobiliser les jeunes et les adultes dans la communauté du SIDA au cours de d'environ deux ans. Des rapports mensuels de ces jeunes en service national, les observations d'un coordinateur sur le terrain et une réaction communautaire ont soutenu la conclusion que les communautés ont avancée vers une meilleure compétence du SIDA et une réduction dans la vulnérabilité des jeunes à l'infection du VIH (*Afr J Reprod Health 2012 (Special Edition); 16[2]: 71-85*).

Keywords: HIV prevention, youth, community mobilization, NYSC, AIDS Competent Community Framework

Introduction

According to UNAIDS, 68% of the estimated 33.3 million people living with HIV in 2009 lived in sub-Saharan Africa (SSA). Among the countries in SSA, Nigeria's HIV prevalence is relatively low (4.6%). However, because of its large population, UNAIDS estimated the number living with HIV in Nigeria to be around 3.3 million, placing Nigeria second only to South Africa in number of prevalent infections. Considerable focus in prevention programming has been placed on youth, driven by their over-representation among those infected and the desire to reach this next

generation.[2,3,4] Prevention interventions for youth have been concentrated in two delivery settings: schools and geographically-defined communities, with a smaller number working to develop 'youth friendly' health centres. Meta-analyses[5] and systematic reviews of such interventions[6,7,8,9,10,11] have consistently come to the conclusion that their primary strength is in their ability to improve knowledge and shift attitudes in a direction that supports reducing 'risky' sexual behaviours. However, shifting sexual behaviours away from those that carry a high risk of infection to those with minimal risk has proven more difficult. As documented in the systematic reviews, only a handful of school- or community-based programmes have been able to produce such a shift[5-10].

Several researchers and theorists have suggested that a more holistic approach, addressing HIV risk and risk reduction strategies within the full range of contexts influencing the day-to-day lives of youth are needed. Within this perspective, and based on her experience in South Africa, Catherine Campbell developed a model of *AIDS Competent Communities* (ACC) that identified characteristics of communities that were supportive of changes in youth sexual behaviours.[15,16,17,18] In light of the need for effective programmes to address HIV prevention among youth in SSA, this paper describes the development, delivery and evaluation of a community-based programme designed based on Campbell's ACC model in rural communities in Edo State, Nigeria. The programme was evaluated in partnership with delivery of the school-based Family Life and HIV Education (FLHE) programme approved and mandated for delivery in Junior Secondary Schools in Nigeria as part of the *HIV Prevention for Rural Youth, Nigeria* (HP4RY) programme being delivered in Edo State.[19]

The Context

Edo State, Nigeria

Edo State is one of the eight states that comprise the south-south region of Nigeria. Communities in this state are ethnically diverse and predominantly Christian. Although the south-south region

accounts for the majority of the crude oil production (the primary source of revenue-generation in Nigeria since the 1960s), communities in this region remain highly impoverished. Edo State is the poorest and least developed of the states in the region. The regional HIV prevalence rate of 7.7% is higher than that in the country overall. Available evidence shows that HIV prevalence among youth has increased from 7% in 1995 to 13.3% in 2000 with 74.6% of the infections in adolescent females.[20] These high infection rates may, in part be related to the high rate of adolescent sexual activity and human trafficking, identified as among the highest in the country in a recent report.[21]

HIV Prevention for Rural Youth and the AIDS Competent Community Programme

The ACC programme was part of the larger *HIV Prevention for Rural Youth in Nigeria (HP4RY)* project funded by the Global health Research Initiative and delivered in Edo State between 2008 and 2012. The goal of HP4RY was to develop, deliver and test research-based interventions to reduce the vulnerability of rural youth to acquiring HIV. Two intervention models were tested, the Family Life and HIV Education (FLHE) programme delivered in Junior Secondary Schools and a combination of FLHE and the ACC community-based intervention that is the topic of this paper. Three communities with Junior Secondary Schools were selected from each of 10 Local Government Areas (LGA) from the North, Central and South Senatorial Districts of Edo State using systematic geographic sampling. Each school and community was randomly assigned to one of three research arms: receipt of FLHE; receipt of FLHE plus the ACC community intervention; and delayed receipt of FLHE after evaluation was completed. Impact evaluation data were collected using surveys and focus groups with JSS students in all schools on 3 separate occasions: before any interventions were delivered, 6 months after initial delivery, and 18 months after initial delivery. An overview of the full programme[19], a more complete description of the school programme,[22] the evaluation methodology,[23] and the results of the evaluation[24]

can be found elsewhere in this special issue. This article focuses on the development, delivery, and outcomes of using the ACC model in the 10 rural communities in the FLHE plus ACC research arm.

Guiding Frameworks: Theory and Praxis

A combination of three theoretical and praxis frame-works contributed to development of the community-based programme. These were the *AIDS Competent Community* (ACC) framework[15-18], best practices from reviews of community-based programmes,[8] and peer educator/leader models and best practices[7].

Catherine Campbell developed the *AIDS Competent Community* theoretical framework in response to the difficulties that young people in South Africa had in actualizing the gains they made in school-based HIV programming in their day-to-day lives[15,16,17]. ACC is based on the premise that vulnerability to HIV is rooted in communities of daily life. Targeting a group in a community (e.g., youth) with prevention programming designed to change individual behaviour can produce, at best, only limited change. To effect change, communities of daily living must support such change through actively decreasing the social, cultural, political and economic conditions that produce and maintain vulnerability within the community. To develop interventions to accomplish such change, communities are located along continua in six domains which individually and collectively identify areas in which the local environment contributes to vulnerability to HIV. The ends anchoring each continuum signify poor and excellent AIDS competency and a community's location on each helps to identify areas for 'intervention work.' As communities improve in each of these areas they become more supportive of both risk-reduction and improved treatment of community members infected and affected by HIV and AIDS. The six domains are:

- *Awareness of AIDS and knowledge related to HIV transmission and acquisition.*
- *Critical thinking and awareness of how social and cultural factors such as gender norms,*

sexual scripts, and power relations influence HIV spread or prevention.
- *Community solidarity and commitment to addressing the threat posed by HIV and AIDS.*
- *Confidence among community members in their ability to take action against HIV and AIDS.*
- *Social networks that support change.*
- *Services and resources that support HIV prevention, treatment and care.*

The ACC model was used to guide the content of the intervention programme in each community.

Best practices identified in a systematic review of community-based programmes conducted as part of a WHO-sponsored initiative[8] guided intervention form and mode of delivery. Six best practices were applied. The first was to maximize acceptance and the possibility of sustainability by designing the programme to fit the mandate, programmatic work, and infrastructure of existing institutions. Second, was to insure local organizations had ownership of the intervention. Third, the programme had to rely on local resources and not require outside support. Fourth, programme facilitators had to be selected based on motivation and 'people' skills, and it was essential to provide training and support for their tasks. Fifth, besides programme delivery, there was a need to develop local capacity to sustain the programme. Finally, the interventions needed to be delivered and evaluated in the 'real world' setting of communities, with no special measures taken to supplement, manage or control operations from the outside.

The third theory-praxis dimension that guided the programme was scholarship and best practices related to peer educators or leaders. For guidance in this area we turned to a recent systematic review of peer educator/peer leader programmes targeting HIV prevention in low resource/income countries.[7] Peer-led programming is grounded in the social psychological theories of group interaction and influence. Members of groups, especially groups of youth, exert a strong influence on each other, create and enforce behaviour norms, and group members learn from each other. Group norms and behaviours are most likely to change when change is led by liked and trusted group

members.[7,12,25,26,27] There are now national and international organizations of peer leaders and peer leadership programmes, specifically targeting HIV prevention among youth[7]. However, the paucity of scientifically rigorous, formal evaluations of peer led interventions has hampered efforts to identify whether and how such interventions can effect change.[28] Maticka-Tyndale and Barnett[7] developed a list of best practices and limitations based on a systematic review that used the guidelines developed in the WHO consultation referenced above.[29] The most successful peer-led programmes were built based on research within the community to identify appropriate areas to target, as well as the language and mode of delivery, entry points and influential stakeholders and constituents. This is consistent with the ACC model which requires identification of starting points on each of the six continua. Community involvement in the form of acceptance and support from those in power, use of traditional social structures to deliver the intervention, and direct involvement of community members in setting the direction for the peer led programme and involvement in programme delivery coincided with best practices in community-based programmes.

However, the review identified two limitations in peer-led interventions. Peer leaders selected from within closely bound local groups could potentially contribute to concerns about confidentiality and disclosure of private information to other peers or community members as well as to power-struggles among group members. A second was that close peers were not necessarily credible as experts since they shared the same formal and informal education as their peers.

Together, the action research framework, the ACC model, and best practices from reviews of community-led and peer-led interventions guided the development of the community-based programme, the selection, training and supervision of facilitators, and the delivery of the programme. It also set the framework for the data collected through daily activity logs, monthly summaries, field observations, and final self- assessments by facilitators and feedback from community members and youth.

Methods

This section briefly reviews methods used to establish entry points and baseline positioning of communities on the six ACC continua, methods for delivering the community programme, and methods for evaluation. The entire HP4RY project was reviewed and cleared by ethics review boards in three Canadian universities (University of Windsor, Western University, York University) and one Nigerian university (University of Benin). Work in communities was also reviewed and approved by the Edo State NYSC Directorate.

Brief Ethnographies

Brief ethnographies were conducted in each community to establish the starting point of communities in each ACC domain and entry points and gatekeepers in each community. As part of selection of research sites for the full HP4RY project, the project team members met with leaders of participating communities to review the full range of research and intervention procedures and objectives. Permission to conduct these in the community was obtained as well as cooperation, assistance and support. In the 10 communities assigned to be part of the ACC intervention, community leaders assisted in the selection of three (males and females) university educated Ethnographic Research Assistant (ERA) from each community. These ERAs received training in the ACC model and in ethnographic methods of data collection including informal interviewing, group interviewing, observation and field notes. They were provided with a template listing information they were expected to obtain and a list of topics for discussion in interviews and conversations and to guide their observations. These included information about the physical, social, cultural, political, health service and economic context as well as specific information about sexual norms, scripts, socialization, and youth behaviours, awareness and knowledge and beliefs related to HIV and attitudes towards those infected and affected. Data collection spanned 3 months. Interviews and field notes were transcribed with both verbatim transcriptions of interviews and field notes and summaries used to develop

community profiles, starting points on the ACC domains, factors contributing to vulnerability, and lists of potential locations and groups that could be used as entry points for the intervention. These were used to develop training materials and delivery guidelines for the programme facilitators.

Programme Delivery

Programme Facilitators: Members of the Nigerian National Youth Service Corps (NYSC) were used as programme facilitators. By statutory law the Federal government of Nigeria mandates all graduates from tertiary institutions who are 30 years of age or younger to participate in one year of service in the NYSC. Corpers are placed in states outside their place of origin. Those who complete their service are awarded certificates of completion as proof of their service. The certificate is required to gain entry into gainful employment or to further their education. The goal of the service year is to build and increase Corpers' knowledge of other peoples' culture in Nigeria and to facilitate mutual and respectful interactions through the reduction of negative stereotypes. It is also aimed at encouraging young graduates to take up permanent jobs and residence outside their place of origin, promoting inter-ethnic marriage and strengthening national cohesion. Forty Corpers from three overlapping cohorts participated in this programme between August 2009 and June 2011. They provided nearly two years of continuous programming in each participating community.

All Corpers participate in a compulsory one month, government-run orientation. HP4RY team members and staff spread information about the programme and reviewed applications from Corpers being trained at the state camp located at Okada in Ovia North Local Government Council of Edo State. The government training included learning about the language, norms, and beliefs of the people of Edo State. In addition, various nongovernment organizations ran workshops and information sessions on specific topics. For example, UNICEF ran workshops on peer leadership and the HP4RY programme ran a workshop on youth sexuality and HIV/AIDS. These contribute to Corper training and also

helped them become familiar with the programmes of these organizations. Following training, Corpers are assigned to different work settings and organizations based on requests from organizations and applications from Corpers. Assignments may include schools with inadequate staffing, nongovernment organizations for programme and service delivery, government offices or local government councils.

The Corpers participating in HP4RY were all single, recent university graduates, primarily from Ibo and Yoruba speaking groups, with a few from the north and middle belt of Nigeria. They were selected based on their motivation to participate in this programme and their 'people skills.' Their standard one-month training was followed by additional training at the project headquarters in Benin City that focused on youth sexuality, HIV/AIDS, the ACC model and strategies for community mobilization to increase AIDS Competence. They were provided with a pay supplement (the Federal Government 9000 Naira/month was supplemented with an additional 10000 Naira), a furnished room in their assigned community, and a transportation allowance. Accommodation and per diem were provided during training. Corpers remained in their communities for their 1 year of service, with some remaining behind to bridge to and orient the new, incoming Corpers.

Programme Delivery

The work of Corpers was monitored by a Field Coordinator who also provided direct support through telephone and site visits and indirect support and information sharing through a newsletter that included success stories, programming advice, response to questions, and suggestions for dealing with challenges. For the first few months, the Field Coordinator provided Corpers with specific guidelines and work plans. These focused on becoming involved in the community, gaining community buy-in, and building core youth groups to work with them. Once these tasks were accomplished, consistent with the action research model, Corpers developed their own work plans in collaboration with local community members that addressed local contexts

and community positioning on the ACC continua. Thus, while programming and delivery methods were based on a common theoretical framework and best practice guidelines, they were specific and unique to each community. Corpers reported their work monthly to the Field Coordinator who provided them with feedback and encouragement.

A small budget was made available to support activities in each community. This was accessed based on submission and approval of a plan and budget. Activities in communities became more diverse and complex as communities advanced towards greater AIDS competency. During the last months of the programme, Corpers concentrated on insuring the programme was supported within the community and on turning it over to the core group of youth in the community.

Programme Evaluation

Four forms of monitoring and evaluation were conducted. First were the monthly activity logs submitted with daily field notes to the Field Coordinator. These, together with telephone contacts and monthly visits by the Field Coordinator provided for ongoing monitoring and process evaluation. At the end of their service, each cohort of Corpers collectively participated in debriefing sessions. At the end of the programme, Corpers completed evaluation questionnaires. These provided Corpers' assessments of the programme, the performance of the project staff and team members, the progress of their communities, and a self assessment of their own performance and challenges. When the last group of Corpers had completed their service, the Ethnographic Research Assistants conducted structured interviews with community leaders and adult and youth community members to obtain feedback on and evaluation of the programme. All questionnaires and results are available in the report on the community programme evaluation[29]. Finally, the impact of the community programme was evaluated as part of the full HP4RY evaluation using questionnaires and focus groups with Junior Secondary School students[23] with results reported in Arnold et al.[24] in this special issue.

Results

Ethnographic Profile of the Communities

The ten rural communities participating in the intervention shared a profile common to many rural communities in Edo State. All were accessible by road although many roads were in poor repair and some were not tarred. This made transport outside the community difficult and expensive, often beyond the reach of many residents. Government hospitals were difficult to access although five of the communities had health centers and one shared a centre with a neighboring community. Only one community had piped water with the remainder relying on either common or private boreholes or drawing their water from local streams and rivers. All but one community had electricity. Sanitation was mainly pit toilets or the bush. All ten of the communities had functional formal western primary and secondary schools since this was a criterion for participation in HP4RY. However, these schools were poorly resourced. In only one school did students each have their own desk and chair and in two there were no desks or chairs for any students. Students shared desks and chairs in the remaining seven schools. In four schools there were no books at all; in five, students shared books; and in only one were there enough books for each child to have his or her own. The mean student/teacher ratio was 54 students for each teacher. A requirement for participation in HP4RY was the presence of at least one government teacher for a core subject that carried the FLHE programme. However, only one of the 10 schools had government teachers for all three core subjects (English, Social Studies and Integrated Science). Five had teachers in two of these subjects and there was one school with only one and another with no government teachers in any of the core subjects. Where government teachers were missing, subjects were either carried by someone hired from the community who might or might not have training as a teacher, by a Corper specifically assigned to the school for teaching (i.e., not part of the ACC programme), or the subject was not taught by a designated teacher.

The level of literacy was low in all the communities. Although many youth and adults

were not necessarily fluent in Standard English, each community had people competent in pidgin-English to facilitate communication with non-indigenes. Subsistence-farming was the primary mode of economic activity with women also involved in petty trading in local markets. Community members spoke of poverty as encouraging girls and women to exchange sex as a survival strategy to support themselves and their family members. For married women, survival was also tied to their ability to produce children, especially sons. For example, in one community a woman reported that "young people have sex because of money and entertainment while married women have sex to have children" (married female).

Traditional heads or rulers held considerable power and authority and remained pivotal to the daily running of the communities. Their authority was expressed in control of community land, including its distribution; in presiding over disputes; in insuring people held steadfast to cultural beliefs and practices; and in functioning as custodians of the peoples' way of life. The traditional institution of rule perpetuated hierarchical power structures, gender relations rooted in patriarchy and paternalistic processes that promoted and enforced a double standard. In the area of sexuality, men were typically allowed and expected to have multiple sex partners. Women did not have the right to negotiate their sexual relationships, especially if they were married. For example, a young married male in one of the communities commented that "because we are married and she belongs to me, it is my right to have sex with her". Such gender and power imbalances contributed to vulnerability to HIV infection among both men and women.

Placement on ACC Continua at Baseline

The Ethnographic data provided specific information related to the first, second and sixth ACC domains. In all cases, communities ranked at the very lowest end of each continuum.

Awareness and Knowledge Related to HIV and AIDS

Misconceptions and misinformation about HIV/AIDS (especially about condoms) were common. For example, HIV was seen as witchcraft or "night disease." It was seen as "not real." Condom use was not common. Common beliefs were that the "condom gets stuck in the vagina" and that available "condoms do not fit properly." Patent medicine dealers noted that condoms remained so long in their stores that they got damaged and exceeded their expiry date. Overall, awareness and knowledge were very low in all communities, with only the occasional individual found who had even basic factual information.

Social and Cultural Factors Influencing HIV Spread

Based on interviews and conversations with youth, at least some youth were sexually active in all communities. Despite this, practices, norms and values restricted talk about sex. Across all communities, adults and young people expressed a discomfort in talking about sex, sexuality, and HIV/AIDS. This silence helped perpetuate common beliefs and taboos related to sexuality. For example, sex was considered an essential ingredient to serious relationships. Denial of sexual relations was believed to have a negative effect on the body with sexing/sex believed "to serve as food to the penis and vagina" (unknown individual). Sex was also seen as a rite of passage to adulthood, especially for young men.

Teenage pregnancy was common, with pregnant girls typically dropping out of school. In one community, a key informant commented that marriages only occurred once a young woman was pregnant. In others, the preference was for youth, especially young women, to remain celibate. For young women, pregnancy could be seen either as a misfortune or a triumph. It was a misfortune as it became an additional burden to the teen mother and her family. It was a triumph as it proved a girl's fertility and desirability as a wife and potentially even provided economic gain or marriage with the child's father. Sexual exchange was common, with males expected to provide gifts and females expected to reciprocate with sex. Young women used this exchange as a way to access material goods and often negotiated for the best gains possible.[30]

Patriarchy and associated normative and hegemonic practices perpetuated gender differences and dynamics that disempowered females and made them passive as against males who were dominant and aggressive. Accordingly, females played sex at the demand of their male partners, such that individual agency was non-existent for them. If a female did not consent to play sex, she was either coerced or forced, with the threat that "I will kill you" if you tell anyone. In addition, females were unable to negotiate sex. Sexual intercourse was a way of showing intimacy, and without sex they could lose their boyfriend.

Community Commitment, Confidence, Solidarity and Social Networks of Support

Evidence from the ethnographic research placed all communities at the very lowest end of cotinuua in the third through fifth domains related to community commitment, confidence, solidarity and social networking to support reduction of risk and provision of support to those facing HIV transmission risk and those infected and affected by AIDS. There was no evidence of community commitment to addressing the threat of HIV and AIDS. If anything, denial that AIDS was a salient concern predominated. When the issue of HIV and AIDS was raised during the ethnographies there was general lack of confidence in communities that they could address the threat. Social networks were not supportive of change in behaviours associated with established cultural practices and people infected and affected (PLWHA) experienced stigmatization and isolation rather than support.

Access to Services, Treatments and Programmes

The community profile already documented the paucity of health services and the poor resourcing of schools in these communities that comprise the sixth ACC domain. These placed communities on the low end of the continuum in this domain. Ethnographic data also pointed out the reluctance of rural inhabitants to get tested for HIV. There was a concerted effort not to disclose HIV status to family members, friends, and peers. Persons living with HIV/AIDS lived in fear due to the discrimination and stigma they experienced from their family members, friends and community at large. In some communities, PLWHA experienced isolation in social events, while in others they were quarantined. In fact, some PLWHA reported "smuggling" their medication into their residences to keep it hidden from others.

Traditional healers were the primary health providers in most communities and at times were referred to as the village doctors. They provided treatment for a vast array of diseases, including sexually transmitted infections and spleen disease. The ethnographic research assistants (ERAs) observed that they practiced their profession in ways that increased the possibility of exposure to HIV. For example, razor blades and needles were used for multiple clients without sterilization. Other observations included commercial cutting of nail by itinerant nail cutters, often migrants from the north, who use unsterilized tools for all their clients.

The brief ethnographies helped to place communities along continua for the six domains of AIDS competency and provided information about community structures, gatekeepers, and youth to facilitate Corpers in beginning their work.

ACC Facilitators: The National Youth Service Corps

Using youth corps members as ACC facilitators fit with the best practices associated with peer-led interventions and countered some of their limitations.[7] To the youth in the community the age and status as 'single' made Corpers 'near' rather than 'close' peers, i.e. not the same age nor from within local peer groups, but close enough in age and sharing the status of single to be seen like older brothers, sisters or near peers. Youth looked to them as mentors and role models. Since they were not members of the community, both youth and adults were more comfortable in discussing sexuality and sharing information about their sexual practices with them and their pledge of confidentiality was believed. In most communities both a male and a female Corper were present at all times. This facilitated exchange of gender sensitive information and respected and

accommodated cultural norms that prohibited women from engaging in conversations on sex with men. Corpers' educational level and the knowledge about sexuality and HIV/AIDS that they gained in their training gave them credibility as experts on these matters. Monitoring and support from the Field Coordinator provided them with someone to share successes and challenges and help to deal with difficult situations.

Entering and Gaining Trust in Communities

The first step in the community programme was to gain entry and acceptance in the community and develop relationships of trust with community leaders and members. The ERAs facilitated entry into the community by working with the first cohort of Corpers for the initial 2 months of their residence in the community. After this, each cohort performed this function for subsequent cohorts. This involved familiarizing Corpers with the community and how to meet their own day-to-day needs, and introducing them to traditional rulers, elders and other stakeholders such as leaders of faith-based organizations and school principals.

Building rapport with community members began with house to house visits, this 'put a face' on the Corpers and initiated conversations about HIV with adults and younger family members. Rapport and trust were built and lines of communication opened through the assistance that Corpers provided with everyday activities such the processing of cassava (the staple food in many communities) and school work and through participation in youth recreational activities such as soccer, dancing and cooking. Corpers built and expanded their social networks through visits to social spots where youth congregated and socialized, through membership in faith-based organizations, and with the help of youth living in the same house or residential area. Through connections to youth and women leaders, who were members of the council of elders and chiefs, they were able to identify, recruit and form core groups of youth. These core group members became the local ACC teams. They worked with the Corpers and took responsibility in identifying, designing and implementing activities aimed at

enhancing the AIDS competence of their communities.

Raising Awareness and Building Accurate Knowledge of HIV Transmission

The first of the six ACC domains is awareness and knowledge. Strategies to build awareness and knowledge included seminars, group presentations (including to faith-based communities), drama, debate, poems and songs, and house-to-house visits. These focused on conveying information about the nature of the infection, transmission, and prevention, concentrating on dispelling myths and misconceptions and replacing them with factual information. With time, the youth and adults were also able to participate in discussions of sexuality and shifted to an understanding that HIV was present in Nigeria and in their communities (i.e., HIV is real), was not caused by witchcraft, nor was it a punishment for sins. They also came to recognize that it is preventable and treatable, although not curable.

In teaching about prevention, Corpers focused on safer sex practices for those who were unable to abstain from sexual activity. They spoke about and showed condoms and carried out skills training on the correct use of condoms, using bananas and carved wood replicas of the penis. On some occasions, resource people from neighboring communities or the local government council HIV/AIDS resource person was invited to give talks with public rallies held in the markets and other public places. Through these strategies, Corpers and core group members were able to provide youth and adults alike with accurate information. As people acquired accurate knowledge, they became more willing to engage in other activities aimed at building AIDS Competent Communities.

Over the period of Corpers' activities, they commonly reported that "we have succeeded in increasing the awareness of HIV. Many community members are discouraged from using itinerant commercial nail cutters and a majority of women are promoting the use of one needle or razor per person in body-cutting, A majority of the people who did not know anything about HIV are now aware of and have knowledge of HIV/AIDS.

Some of the hair dressers now embrace the use of bleach to clean their needles."

Developing Critical Thinking

The second domain in the ACC model is critical thinking. Corpers focused on developing critical thinking skills among youth that would help them break away from local beliefs and normative practices that perpetuated sexual risk behaviours. The common strategies used included drama, debate and moonlight dances, all of which actively engaged youth in thinking, discussing and deliberating norms, behaviours and consequences. Through these activities, youth became aware of the consequences of risky behaviours. Individual agency gradually evolved to replace unquestioning subservience to the dominance of community control in determining sexual and other practices.

Corpers facilitated the formation of in- and out-of- school youth groups to develop scripts for plays, to get individuals willing to play the roles in the scripts, to organize rehearsals, and to make presentations to the public, including adults and youth. Composing, participating in, and even viewing such dramas and engaging in discussions afterwards helped youth to develop a critical eye towards HIV/AIDS within the context of their social, cultural and economic contexts. Youth who had not started playing sex spoke of choosing not to start, while those who were sexually active spoke of practicing safer sex through using condoms.

Corpers in some communities documented increases in condom use from their conversations with patent medicine dealers, who noted that before Corpers' activities, the demand for condoms was minimal but since these activities began, demand had increased. Accordingly, through critical thinking, youth were able to reject the abundant myths about condoms and became aware that condom use is an effective way to prevent HIV infection.

Building Solidarity, Cohesiveness and Commitment among Community Members

Solidarity and commitment among community members in addressing HIV and AIDS is the third domain. This is meant to replace and guard against segmentation of community members into those who see themselves as 'safe' and those who are looked down upon because they are infected or seen to be courting infection through 'bad' behaviour. Promoting such solidarity inevitably requires conversations about sexuality and cultural norms.

As the Corpers became known in the community as people who could be trusted and who had considerable knowledge about HIV and AIDS, parents, adults and youth approached them for ever more information and with specific questions. Gradually, more community members began to work together to support youth in their efforts to come together in a way that would reduce their vulnerability to HIV infection. For example, in most of the communities elders gave land, space, and, in some cases, buildings or rooms for Corpers and community youth to build youth friendly centers. Youth collectively worked together to gather building materials from local sources to erect these centers. In one community, the Corpers and youth developed a public library. These activities were community-centered and community supported since only minimal seed grants were provided to assist in the areas of refreshments and documentation of events through photography.

Over time, the attendance in youth organized events/activities such as soccer, drama, debate or dancing increased and attendance was more diverse in terms of age and social standing. Gradually communities began to come together to work collectively on combating HIV and AIDS in their community rather than seeing it as an issue of only some people (people who broke with community norms) and began to openly talk about HIV, AIDS and sexuality. The youth friendly centres became safe places for youth to congregate, spend time, socialize and work on projects.

Building Empowerment, Motivation, and Confidence

The fourth domain is empowerment, motivation and confidence to act to reduce risk and vulnerability. Delivering talks in faith-based organizations, to specific groups such as bike riders, in hair salons and barber shop, contributed

to females becoming more empowered and knowing they have the right to say 'no' and to report cases of forced sex or rape. Another activity aimed specifically at empowering female youth was vocational skills training as an alternative income generating activity to the exchange of sex for gifts. Female youth received training in beading, making soap and preparing snacks such as buns and cakes, using indigenous made ovens. The training in one community involved more than twenty female youth. The Corpers reported that some of the youth who were able to raise the initial capital brought their products to the community and neighboring markets feeling satisfied and happy to generate their own income. Such economic autonomy empowered them to participate in decision making in their families, engage in social networking, and gain sexual autonomy.

Building Social Networks

The fifth ACC domain is the presence of social networks that support change. Several such networks were built in communities. The core youth group was a social network for its members and expanded outward to include a wider range of youth in each community. In communities where skills training was conducted, the young women participating in the skills training became a supportive social network for each other. Most challenging for the Corpers, however, was building a social network of people living with HIV and AIDS. The Corpers and core youth groups facilitated community –wide activities which deconstructed the false perceptions of HIV and AIDS in order to reduce or eliminate fear and stigmatization of PLWHA.

Corpers also worked to enhance social acceptance and support networks for PLWHAs. Over the course of the ACC programme, more PLWHAs disclosed their HIV status and sought treatment and care. In one community, PLWHAs became members of support groups in the General Hospital located in a neighboring community and through this found other PLWHAs in their own community. They began to 'keep an eye out for one another.' If one of them failed to attend clinic, others went out in search of what may have

happened and to ensure he/she returned for treatment. In cases where a member was seen to engage in risky behaviours, they would counsel them on the implications of such acts and work closely with the person to help them change to lower risk behaviours. The women obtained capital in the form of interest free loans from such groups to start businesses or to purchase the needed farm seedlings for their farms. These support networks had a major impact on the quality of life and health of PLWHAs, helped to decrease stigmatization, and made HIV and AIDS more visible in the communities, acting against denial and opening lines of communication.

Promoting Accessibility to Services and Resources

The final domain was increasing accessibility to relevant services. Prevention programming was developed within the communities through the FLHE training of teachers and activities of the Corpers and core youth team members. As demands for condoms increased, patent medicine dealers increased their supplies. However, with the paucity of diagnostic and treatment services available in the participating communities, activities in this area involved linking individuals with institutions in neighboring communities and advocating for certain services to be brought to the communities. For example, the Corpers succeeded in making people aware that in most cases HIV testing was free where it was available. Community members were given information on where they could be tested, and the testing centers were alerted to expect a potential increase in the demand for testing. In addition, in one community that was distant from any testing facilities, research team members and staff facilitated having a non-governmental organization, the Global HIV/AIDS Initiative Nigeria (GHAIN), which brings testing to communities based on request, bring testing to the community. In addition, as already discussed, when available, PLWHAs were linked with support services in neighboring communities.

Corpers also taught hair and nail salon owners simple methods of sterilizing their equipment so community members had access to safe

procedures. To make information more accessible, youth erected signs carrying messages on HIV prevention and transmission. These signs ranged from the simple use of cardboard to full road signposts. The language used was simple and messages were expressed in ways that facilitated community members getting the correct message.

In one community, PLWHAs organized public rallies and announced their HIV status as a way to show that it is not possible to visibly identify someone who is HIV positive. Communities also became linked with peer education training programmes at the local government council headquarters, and the AIDS officer visited the communities to give public talks and demonstrations of condom use and to promote safe sex practices and reduce risky behaviours.

Evaluation Results

Monthly Field Reports

Monthly field reports documented increases in activities in communities over the span of the project with core youth group members taking increasing responsibility for them. By the end of the project, every community had a youth friendly centre on land or in space allocated by village heads where youth could come together in a risk-free setting for a variety of activities. Evidence of movement towards decreased vulnerability and in-creased action by individuals included increased condom sales, increased HIV testing in neighboring testing centres, increased visibility of PLWHAs and linking of PLWHAs to support groups where they were accessible, and increasingly open conversations in the community about HIV, AIDS and sexuality. Movement of all communities along each of the ACC continua towards greater levels of competence was documented.

Corper Self Assessments

Twenty-five Corpers from across all 10 communities completed self-assessment evalua-tions[29]. They consistently rated every aspect of the programme positively. They reported that they felt well trained, competent, and supported in their work. They listed gains to themselves as a result of participation in this project including improved

knowledge, ability to address an important issue, enhanced expertise, and development of valuable relationships. Satisfaction with the progress of their communities towards greater competence was high as well as with the way community members worked together. The main barriers they identified to carrying out project activities were communication and language difficulties (recall that Corpers cannot be indigenes of the communities where they serve), transportation and distance, cultural differences, and insufficient resources. In addition, barriers to increasing competency among community members included discomfort talking about HIV/AIDS, misconceptions, lack of participation and expectations of monetary gains for participation[29].

Assessments by Community Members

Two hundred and forty community members from across the 10 communities completed evaluation surveys[29]. All reported satisfaction with Corpers' activities in their communities and were particularly complementary of the dedication, commitment and friendly approach of the Corpers, their ability to organize youth, and they believed that the programme had led to changed behaviours. The large majority indicated there was nothing they disliked about the programme. For the few who did list dislikes, four themes emerged. First, Corpers did not speak the local language. Second, that Corpers were not always available or reliable. Third, that Corpers' activities were not always well organized, and finally that Corpers talked about sex and sexuality. Community members were asked to assess progress along the ACC continua. In each case they rated the community as progressing in a positive direction and credited this to the activities in which Corpers involved them. In particular, all community members felt they had been helped to stay safe from HIV, to become interested in helping others stay safe, learned how to practice safer sex (including condom use), and were better able to talk about sex and sexuality matters, including with children. Suggestions for improvements to the programme included continuing the programme, keeping Corpers in their community, providing more materials, expanding the

programme and providing better accommodations and rewards for the Corpers[29].

Impact Evaluation

Detailed results of the impact evaluation are provided in Arnold et al.[24] in this special issue. In brief, the ACC programme in communities was found to enhance the impact of school programming in decreasing youths' reliance on myths rather than factual explanations related to HIV and AIDS. For male students, attitudes related to sexuality (e.g., the urgency to be sexually active) and condoms became more supportive of delaying sex, respecting their partners and using condoms when they were exposed to the community programme. For female students, initiation of sexual activity and for those who were already sexually active, continuing to engage in sex were less likely not only when the FLHE programme was in schools but even more so among those who were in communities with the ACC programme. Students reported that Corpers were involved in teaching about HIV and AIDS in their schools and in running the HIV/AIDS clubs. Schools with teachers trained in FLHE but without Corpers running ACC programmes in communities did not have such clubs. When asked whether they would like to have Corpers working with them on HIV and AIDS related issues, well over 80% of students across all schools replied that they would either like them to be working in their schools on such issues or both in their schools and their communities. These results support the benefits of combining school and community programming.

Limitations

Despite the noteworthy gains in all six of the ACC domains and the positive results of the impact evaluation, there are limitations to forming a definitive conclusion about the effectiveness and efficacy of this programme. The nature of the action research framework and of the programme produced unique programming in communities and required the use of qualitative and process data for evaluation. Such data are subjective, and consist of predominantly self reports. The only

'objective' data that were collected were incidence of HIV testing at local testing centres, purchase of condoms, and attendance at events organized by Youth Corps members. Testing centres and patent medicine dealers both reported substantial increases and events organized by Corpers were attended (compared to no such events prior to the programme). However, reports of behaviour changes and articulation of new attitudes are subjective, with no objective measures available to substantiate such claims.

The results reported here are based on field notes and monthly reports of the Youth Corps members who were delivering the programme, observations of the Field Coordinator, and reports of community members to ethnographic research assistants in post-programme interviews. While this triangulates three different sources of information, that information remains subjective and non-quantifiable.

In addition, the project took place in only 10 communities. Although these were spread across 10 different local government areas and three Senatorial Districts, and were selected to maximize their representativeness of rural communities in Edo State, the sample is small and exclusively rural. Whether the programme and its outcomes would be replicated in other communities, in more urban communities, or communities in other states cannot be known and requires further research.

Youth Corps members were selected based on their interest which presents the limitation that not all Youth Corps members would necessarily be suitable for this programme. It is also unknown whether another group of Corpers would obtain the same results.

Finally, the programme was designed to be relatively unique to each community. Although the ACC framework was the same in all cases and certain activities were taught during the training programme, Youth Corps members were directed to work with their communities to develop plans, activities and content that met the specific needs and dynamics of each community. Thus, this is a non-standardized programme. Some would see this as a limitation since it cannot be 'packaged' and delivered in exactly the same form with the same content in all locations and it is nearly

impossible to ascertain precisely which part of the programme had an effect. However, the flexibility and specificity to each community is precisely what is required in the ACC model and is a characteristic of action research.

Conclusion and Way Forward

The experience of delivering a community-based programme based on the AIDS Competent Community model supports the conclusions drawn by Campbell and others[12-18]. The ethnographic research showed the role of communities in creating and maintaining environments that contribute to HIV vulnerability among youth and the importance of working with communities to effect change. Corpers' activities depicting the movement of communities towards greater AIDS competency were documented, as were behavioural changes among a wide array of community members. The general pattern saw a shift toward safer sexual practices, increased willingness to be tested for HIV, increased HIV testing, and improved support and treatment for PLWHAs. Students in Junior Secondary Schools benefited in improved abilities to recognize and reject myths about HIV and AIDS and to move away from attitudes and behaviours linked with greater risk of exposure to infection.

This project also supports the best-practices identified in systematic reviews of community-based[7] and peer-led[6] programming as beneficial guides for programme development. Particularly important for replication, feasibility and sustainability of a community-based programme is that this project demonstrated that locally-driven programming could be effectively facilitated by members of the National Youth Service Corps, a resource that is available to communities across Nigeria. The model for Corper-facilitated community-programming was developed and implemented to minimize costs and maximize community-ownership and responsibility. Although communities and Corpers at times pushed for more resources and input from the Field Coordinator and project team, when these were not forthcoming, they demonstrated the capacity to creatively solve problems and either produce the required resources or find alternative ways to deliver programming.

Although the programme dealt with sensitive matters such as sex and gender inequality, community feedback at the end of the programme was universally positive with the main criticism that the programme could not continue indefinitely. Similarly, although many of the Corpers were somewhat skeptical of their ability to effect change at the beginning of the programme and initially found their communities to be difficult places to live and work, as each cohort approached the end of their term they expressed reluctance to leave and pride in their accomplishments. Perhaps one of the most important testaments to the impact of the programme on Corpers themselves is the following statement from a Corper:

> *Apart from the fact that this is a study, we're touching lives. It's not just the priests and pastors that do it. I really want to say, 'God bless you for conceiving such an idea.' It gives me joy to see people empowered with right information. The relevance of our lives is hinged on this unequivocal credence that man is here for the sake of other men.*

This programme has not only helped communities to move towards greater AIDS competence, but has also met the goals of the NYSC programme in Nigeria in building understanding and ties across ethnic and regional groups and empowering the emerging generation of leaders of Nigeria with confidence, dedication to a worthy cause, and skills that will contribute to building a stronger nation.

References

1. UNAIDS. *AIDS Report on the Global AIDS Epidemic*. New York: UNAIDS; 2010.
2. Monasch R, Mahy M. Young people: the centre of the HIV epidemic, in Ross D., Dick B. & Ferguson J.(eds.), *Preventing HIV/AIDS in Young People. A Systematic Review of the Evidence from Developing Countries*. Geneva: WHO; 2006.
3. UNAIDS/WHO. *AIDS Epidemic Update: December, 2005*. Geneva: WHO; 2005.
4. World Bank. *Education and HIV/AIDS: a Window of Hope*, Washington, DC: World Bank; 2002.
5. Johnson B, Carey M, March K, Levin K, Scot-Sheldon L. *Interventions to reduce sexual risk for the human immunodeficiency virus in adolescents, 1985-2000*. A*rchives of Pediatrics & Adolescent Medicine*. 2003; 157(4): 381-388.

6. Gallant M, Maticka-Tyndale E. School-based HIV prevention programmemes for African youth. *Social Science & Medicine.*2004; 58(7): 1337-1351.

7. Maticka-Tyndale E, Barnett JP. Peer educators: A synthesis of the research. *Evaluation and Programme Planning.* 2010; 33: 98-112.

8. Maticka-Tyndale E, Brouillard-Coyle C. The Effectiveness of Community Interventions Targeting HIV and AIDS Prevention at Young People in Developing countries. :In Ross D, Dick B, Ferguson J, editors. *Preventing HIV/AIDS in Young People: A Systematic review of the evidence from developing countries.* Geneva: WHO; 2006.

9. Kirby D, Obasi A, Laris BA. The effectiveness of sex education and HIV education: Interventions in schools in developing countries. In: Ross D, Dick B, Ferguson J, editors. *Preventing HIV/AIDS in Young People: A Systematic review of the evidence from developing countries*. Geneva: WHO; 2006.

10. Magnussen L, Ehiri J, Ejere H, Jolly P. Interventions to prevent HIV/AIDS among adolescents in less developed countries: Are they effective? *International Journal of Adolescent Medicine & Health*. 2004; 16: 303-23.

11. Speizer I, Magnani R, Colvin C. The effectiveness of adolescent reproductive health interventions in developing countries: a review of the evidence. *Journal of Adolescent Health.* 2003; 33(5): 324-348.

12. Aggleton **P,** Campbell **C.** Working with young people— towards an agenda for sexual health. *Sexual and Relationship Therapy*. 2000; 15: 283–296.

13. Michielson K, Bosmans M, Temmerman M. Reducing HIV/AIDS in young people in sub-Sahara Africa; gaps in research and the role of theory. *Africa Focus*. 2008; 21(1): 31- 43.

14. Kiirya KS. Scaling-up responses to HIV/AIDS using the Community-led HIV/AIDS Initiative (CHAI) Strategy in Uganda: Lessons Learned. *International Conf AIDS*. 2004 Jul 11-16.

15. Campbell C. *Letting them die: why HIV prevention programmemes often fail.* Oxford: James Currey. Bloomington: Indiana University Press; 2003.

16. Campbell C, Foulis CA, Maimane S, Sibiya Z. The impact of social environments on the effectiveness of youth HIV prevention: A South African case study. *AIDS Care.* 2005; 17 (4): 471-478.

17. Campbell C, MacPhail C. Peer education, gender and the development of critical consciousness: Participatory HIV prevention by South African Youth, *Social Science and Medicine.* 2002; 55 (2): 331-345.

18. Lamboray J L, Skevington S. Defining AIDS competence: A working model for practical

purposes. *Journal of International Development.* 2001; 13(4): 513-521.

19. Onokerhoraye A, Maticka-Tyndale E. HIV Prevention for Rural Youth in Nigeria: Background Overview. *African Journal of Reproductive Health.* 2012; 12(6): 25-38.

20. Family Health International. *Nigeria HIV/AIDS Behavioural Surveillance*. 2003.

21. Okonofua FE, Ogbomwan S, Alutu AN, Okop K, Aghaghowa E. Knowledge, attitudes and experiences of sex trafficking by young women in Benin City, South-south Nigeria. *Social Science and Medicine*. 2004; 59(6): 1315-1327.

22. Dlamini N, Okoro F, Ekhosuehi UO, Esiet A. Combating Youth Vulnerability to HIV/AIDS: Evaluating Teacher Delivery and Responses to Family Life and HIV Education in Edo State, Nigeria. *African Journal of Reproductive Health.*2012; 12(6): 86-102.

23. Dlamini N, Maticka-Tyndale E, Omorodion F, Anucha U. What does a decolonizing/ decentralizing methodology in examining sexual lives entails? A critical reflective case study. *African Journal of Reproductive Health.* 2012; 12(6): 55-70.

24. Arnold R, Maticka-Tyndale E, Tenkorang E, Holland D, Gaspard A, Luginaah I. Evaluation of School- and Community-Based HIV Prevention Interventions with Junior Secondary School Students in Edo State, Nigeria. *African Journal of Reproductive Health.* 2012; 12(6): 103-125.

25. Fee N, Youssef M. *Young people, AIDS and STD prevention: experiences of pee approaches in developing countries*. Geneva, World Health Organization, GlobalProgrammeme on AIDS; 1993.

26. Shiner M.   Defining peer education. *Journal of Adolescence.* 1999; 22: 555-566.

27. Turner G, Shepherd J. A method in search of theory: peer education and health promotion. *Health Education research: Theory and Practice.* 1999; 14(2): 235-247.

28. Kim C, Free C.   Recent evaluations of the peer-led approach in adolescent sexual heatlh education: A systematic review. *International Family Planning Perspectives.* 2008; 34 (2): 89-96.

29. HP4RY. *Corper Programme Evaluation*. University of Windsor: Ontario, Canada. 2011.

30. Barnett JP, Maticka-Tyndale E, the HP4RY team. The gift of agency: Sexual exchange scripts among Nigerian youth. *Journal of Sex Research.* 2010; 48: 349-355.

31. Ross DA, Dick B, Ferguson J. (Eds).   Preventing HIV/AIDS in Young People: A Systematic Review of the Evidence from Developing Countries. Geneva: WHO. 2006..

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