HIV / AIDS Prevention and Capacity Development in the Pacific: Peer Education and Support Program Mapping Consultancy

Republic of the Marshall Islands: Country Report

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Country Report

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1.0 Country summary

According to updated figures reported by RMI to SPC's HIV & STI surveillance unit, cumulative HIV cases (including AIDS) at the end of 2008 were 19 including seven AIDS related deaths.

In the *Republic of the Marshall Islands National HIV/AIDS Strategic Plan 2006–2009* it states that RMI is currently experiencing a concentrated/low level HIV epidemic, however complex risk behaviours and settings exist that may contribute to a generalized HIV epidemic. The existence of an emerging commercial sex trade and an active transactional sex trade, combined with the influx of international seafarers, multiple and concurrent sexual partners within Marshallese society, high rates of STIs and teen pregnancy, as well as minimal condom usage, may all impact the spread of HIV infection in the Marshall Islands.

2.0 Findings

This mapping of HIV & STI peer education programs for vulnerable populations involved: examination of national strategies, and other relevant documentation; surveying and interviewing national organisations involved in peer education; and consulting with regional organisations involved in the delivery of HIV & STI services

The following 'tight' definition of peer education has been used in this analysis:

> *the teaching or sharing of health information, values and behaviours by members of similar age or status groups*.

Peer education therefore is an education program run by, and for, members of the same peer group; and a peer is someone from the same group, in which the group members identify with each other because of certain features they have in common.

Using this definition, the information gathered is discussed with the following ten criteria in mind:

1. The project **targets a vulnerable community** in the country. The intervention is well targeted. (Basis for this comes from the national strategy and from the feedback about what the vulnerable populations are in the country.)
2. **Governance.** The peers are involved in the way things are run and the decision-making. There is **engagement with the target population** in the design, implementation and evaluation of the project. There is engagement at some levels and constant attempts are made to pursue this engagement.
3. There is obvious **support** for the peer education project at an organisational and national level.
4. **Collaborative relationship** with other organisations who are undertaking HIV peer education based activities in the country so that there is no duplication (competition) of services.

5. **Recruitment strategies** for peer educators are appropriate, systematic, ongoing and sustainable. This includes developing defined marketing strategies. There is an accepted and celebrated **exit strategy** for peer educators.
6. There is initial and follow-up education for the peer educators. There is **sustainable capacity building** of peers.
7. **Referral systems** are in place to address the needs of the target population as things arise. This includes the ability to follow-up on whether anything happened as a result of the referral (did the person actually attend for VCCT), and an ability to assess whether the referring agency is effective and provides suitable service.
8. **Evaluation**. There are set outcomes. How is the **effectiveness of the project determined?** What agreed measures are in place to assess whether this project 'makes a difference' or not, and is there a defined mechanism to report against these? It is acknowledged that this is extremely difficult, however are there attempts to do this?
9. Monitoring. A code of behaviour is defined and followed. This includes a **monitoring mechanism for the knowledge, skills and conduct of peer educators**.
10. The project makes an **obvious and tangible impact**. Things that have changed as a result of the project being in existence are able to be discussed.

2.1 The national strategy

The current national strategy covers the period from 2006–2009. A detailed analysis of this strategy with reference to peer education appears as Appendix One. A standard matrix has been used for this analysis. Highlights of the strategy are as follows:

Strengths include:

- The right for all people to access culturally appropriate information is identified strongly as a guiding principle. Reference is also made of young people with respect to testing without parental consent.
- The need to identify and target vulnerable communities is highlighted with explicit reference to particular interventions and particular populations (MSM, CSW, seafarers, young people). Young people are further identified according to specific sub-populations (unemployed, non school attendees). There is a clear outline of what interventions are to be delivered.
- There is an identification of the agencies responsible for such delivery.
- There is reference throughout the document to the engagement of the community sector with respect to the development of the national strategy and coordination of that strategy through the CPG.
- Reference is made to stakeholders, sectors and community.
- There is recognition of diversity.

Areas for improvement include:

- Partnership is described more as a relationship across organisations delivering services to PLWHA, rather than as a relationship of engagement with affected and vulnerable communities.

- Target populations are grouped together (MSM, CSW, seafarers, non-school attendees) making it unclear as to how particular interventions should be applied to which population.
- The grouping of target populations makes it unclear as to who is responsible for particularly difficult to access groups.
- Behaviour change communication campaigns are referred to generically without detail.
- Very little reference is made to peer education**,** though it may be implicit under the broad heading of behaviour change communication.
- Consultation with particular vulnerable populations is not demonstrated, and active participation of identifiable target groups is lacking.

2.2 Organisations involved in peer education

Different organisations target different populations and undertake peer education in different ways. In RMI one organisation was identified as being involved in peer education.

2.2.1 Youth to Youth in Health

Youth to Youth in Health (Jodrikdrik nan Jodrikdrik ilo Ejmour) was formed in 1986 and is the only NGO in RMI working with young people in the area of sexual and reproductive health (SRH). 100% of its work is peer based. After revitalisation of this NGO in the last three years, the service continues to grow with current staff of 32 and approximately 50 volunteers.

The main focus of the organisation is young people (aged 0–25) including those who are marginalised as well as those in schools. However, the organisation also has contact with women, victims of rape and sexual coercion; those who are transgender e.g. Fa'afafine, Fakaleiti; those living in rural and remote areas; transactional sex workers, seafarers and their partners.

The organisation undertakes the complete range of peer education activities with young people and offers outreach to sex workers, however it is unclear what peer activities occur with other populations. Approximately 5,000 young people had been reached through peer education activities in 2008, mostly through school visits but also through outreach services, including theatre based activities.

A result of the existence of this youth service, including the presence of trained peer educators among the young population, is the 'crossover' HIV education activity that occurs with other populations, e.g. women, seafarers, school staff and parliamentarians. While this may not truly be called peer education, it is also very valuable.

Peer educators provide feedback about the success (or otherwise) of particular activities however they are not involved directly in the governance or development of projects. A steering committee oversees these aspects.

Strengths include:

1. The work of Youth to Youth in Health is well networked and collaboration between agencies occurs. This includes referral mechanisms for testing and treatment (to the hospital) and follow-up through the organisation's own clinic.
2. There is obvious support for peer education at the organisational and national levels.
3. Attempts at evaluation are made. This includes collecting pre and post workshop information; keeping track of the number of peer educators, the sessions they conduct and the number reached; and utilising most significant change stories.
4. Recruitment into peer education has been successful and ongoing. This has included continuing education for new and continuing peer educators and advanced training sourced from other agencies.
5. The youth centre that provides recreation, library, computer lab, media, tutorial services, art studio (etc) acts as a 'one-stop-shop' that eliminates barriers to accessing information about sexual and reproductive health, including HIV.

Opportunities for further development in peer education:

1. The peers are not well involved in decision-making processes, management and development of the project.
2. Acknowledging the difficulties in effective M&E there exists areas for more detailed M&E of peer education.

2.3 Regional organisations

The mapping exercise also included consultations with regional partners based in Fiji on peer education. Of the 12 regional organisations consulted, the following four raised RMI in their discussions:

2.3.1 Marie Stopes International Pacific (MSIP)

Developed initially in Fiji, the condom social marketing (CSM) program of MSIP relies upon peer distribution of condoms. Persons with previous experience in peer education (often head hunted from existing agency networks) are trained in sales and marketing and are designated as peer leaders. The training workshop is a two-day program dealing with the principles of CSM with refresher training on HIV and other STIs. The educators recruit teams of condom distributors from villages (or from vulnerable communities). This model was first developed in Fiji and is now being implemented in other countries, including RMI, where MSIP partners with local agencies and selects trained educators to become skilled in CSM. Though initially developed as a peer education program, CSM has become more of a community education and outreach project with less focus placed on engaging and developing peers as distributors and educators.

2.3.2 Secretariat of the Pacific Community (SPC) and UNFPA Adolescent and Reproductive Health Program

The Adolescent Reproductive Health (ARH) Program was implemented across the Pacific in 2001 as a UNFPA sponsored program in collaboration with SPC. UNICEF established a life

skills program in 2002 which took on a broader scope of adolescent development beyond ARH and became the Adolescent Health & Development (AHD) Program in 2005 by merging with the UNFPA-SPC project.

The life skills program utilised master trainers within existing NGOs and attached SRH to their agenda. The ARH program placed coordinators in each country but over time their role has diversified, and at times, confused as they take on a wider range of activity and responsibility.

Within the AHD program, some coordinators are placed within the MoH, some take on a support role for lead agency NGO, and others offer technical assistance to a range of NGOs. In RMI, the NGO Youth to Youth in Health works with the AHD program to operate multiple peer education programs. Two peer educators are funded by the AHD program. It is very youth focussed and owned. However this creates significant issues for the Director who needs to take on a large responsibility for the program's activity and is unable to delegate much of that activity to the younger workers.

The AHD program has responsibility for operating youth centres, clinics, nurses, peer educators and has moved beyond ARH to encompass a full range of health issues. However, the overwhelming focus still remains ARH.

2.3.3 UNIFEM

The representative of UNIFEM identified the following organisations as working with women in RMI—Samoa maposaga o aiga (a crisis centre) and a second group called the Victim Support Group, which comprises ex policewomen.

2.3.4 UNFPA

UNFPA has also supported some pilot projects on sex worker peer education in Chuuk State FSM, Fiji, RMI (with YTYIH), Vanuatu, Solomon Islands and Kiribati. In Chuuk, Kiribati, Solomon Islands and RMI, sex worker peer educators attended training workshops to gain knowledge and skills on HIV and other STIs, promotion/distribution of condoms and the benefits of VCCT. The sex work peer education initiatives have been a response to local need. UNFPAs involvement has been technical support and a small amount of funds to run some workshops. There has also been assistance to Chuuk, Kiribati and RMI with technical support regarding grant submissions in support of sex worker peer educator programs, extending the above pilot projects.

3.0 Discussion

A low HIV prevalence coupled with the emergence of risk behaviours (transactional sex work, movement of seafarers) presents a window of opportunity in RMI that effective and well supported peer based initiatives may be able to satisfy. The experience of Youth to Youth in Health illustrates that this type of initiative continues to be hard. However, it also illustrates that this type of initiative can be effective.

The stated aim of Youth to Youth in Health is to empower young people with information, knowledge, and skills so they can make better life choices for a better quality of life.
However, as the coordinator notes in the survey, "All the YTYIH staff members have been trained to become life skills trainers however, because they are young and easily influenced, they don't always use their own skills to make good choices. They don't always follow what they preach to their peers and their peers don't always believe what they say because their actions speak otherwise. This is the challenge for the young YTYIH Peer Educators." The work is complex, however, the benefits can be great.

The importance of culture and specific cultural responsibilities are also evident. Again, as the Director noted in the survey, "No matter how educated and well trained a person is, they will never gain the trust and respect of the community if they ignore their culture."

The need is much greater than the amount of work that can be done. While Youth to Youth in Health conducts education amongst other populations, its primary focus is on young people. Hence most of the peer educators are young people. The national strategy highlights additional vulnerable populations and these are often targeted incidentally as part of the general community work of YTYIH. This cross over "community education" is very useful, but it is important that those vulnerable groups highlighted in the national strategy—MSM, sex workers, outer island residents, and people living with HIV—be targeted by dedicated peer based programs with recruitment from these target populations.

Discussions among key personnel imply that much of what is called peer education in RMI is more community education than true peer education. Capacity for development and support of true peer education is needed.

4.0 Recommendations

1. Vulnerable populations should be identified separately within the national strategy with specific interventions matched to each population. The grouping of target populations should be avoided.
2. Youth to Youth in Health should continue to be supported in its peer education initiatives among young people and sex workers in RMI.
3. Assistance with the development, implementation and adherence of protocols to increase the involvement of young people in the decision making processes of specific peer education initiatives should be undertaken. This includes governance.
4. Up-skilling in effective monitoring of peer education activities should be undertaken (acknowledging the inherent difficulty in this task).
5. Education on the importance (and implementation) of formative and summative evaluation should be undertaken among peer educators.
6. Peer education initiatives do not operate in a vacuum. Efforts in RMI illustrate the need for continued community engagement and education in broader HIV education and prevention and the impact of these on the effectiveness of specifically targeted

peer education activities. Continued general community development is warranted, even if the purpose is only to support the specifically targeted peer education.

7. Recruitment, training and support to peers from other target populations—seafarers, MSM and outer island residents—should be undertaken.
8. Although the number is small, the development of specific peer based support (and ability to network) for individuals with HIV in RMI is warranted.

Appendix One

Analysis of peer education within the national strategy

Country: Republic of Marshall Islands Strategy Document: *National HIV/AIDS Strategic Plan 2006-2009*						
Does the Strategic Plan include Guiding Principles which highlight the importance of:	The rights of all people to access education & prevention services	All people, regardless of age, gender, religion and race, have free and equal access to accurate awareness information and education about HIV/AIDS, and how to prevent HIV/AIDS in their own language. All people have equal access to affordable and confidential testing, treatment and counseling. All people have rights, including people living with HIV/AIDS, which are protected by government, legislation and through community support.				
	Partnership and engagement with the affected community (i.e. vulnerable groups)	All communities are encouraged to preserve partnerships between government, health providers, churches, NGOs, private sector and civil society to educate the community about HIV/AIDS and provide care and support to people living with HIV/AIDS.				
	Engagement of young people and their right to access education & prevention services.	All adolescent youth (aged 12-19) have the right to access testing without parental consent.				
Does the Strategy highlight the importance of Identifying and targeting vulnerable populations? Refs	Page 13 - 2.1.5 Conduct Second Generation Surveillance among most-at-risk-populations to provide evidence for program development and policy formulation Page 22 - 7.1 To reduce the risk amongst all vulnerable people of RMI, especially youths (school & non-school attendees), unemployed youth, commercial and transactional sex workers, low socio-economic groups, pregnant mothers & their children, and seafarers. Page 25 - 2.1.4 To develop BCC campaigns to reach vulnerable groups e.g. sex workers, MSMs, and non school attendees Page 26 - 5.1.1 Develop a CTR protocol with an emphasis on most-at-risk-populations, including men-who-have-sex-with-men, sex workers and seafarers					
Does the Strategy highlight the importance of peer education as an intervention?	Page 20 - 4. To increase education on prevention methods including abstinence, faithfulness, condom use and doing less risky sexual activities Page 20 - 4.1.2 Train school principals, teachers, PTA, church leaders, peer educators on HIV and sexual health education.					
Vulnerable Groups	Population	Youth 15-24	Seafarers	Women	MSM	Outer Island

Country: Republic of Marshall Islands Strategy Document: *National HIV/AIDS Strategic Plan 2006-2009*						
identified in Strategy and associated Prevention Strategies/Actions identified in Strategy	Intervention	(School & Non schooled) unemployed		(including Commercial & transactional SW)		residents
	Public service announcements	YES				
	Outreach workshops using theatre, song, media *WUTMI, YTYIH, PTA, Churches, AKTS Inc, MOE, MOIA, Businesses, traditional leaders, youth, CARE Program, Mission Pacific*	YES				
	Periodical HIV/STD education *MOH, MOE, Health promotion & Human services, Churches, NGOs*	YES	YES			YES
	Train the trainers re BCC strategies *Reproductive Health, SPC, CDC, UNFPA*	YES	YES	YES	YES	YES
	Develop BCC campaigns *YTYIH, WAM, WUTMI, Mission Pacific*	YES	YES	YES	YES	YES
	Social marketing of condoms at Clubs, bars, youth clinics *Health Education, YTYIH*	YES				
	Develop new IEC materials in various languages to reach all target groups *Reproductive Health, Health Promotion & Human Services, International volunteers, Mission Pacific*		YES	YES		YES
	Develop a CTR protocol *MOH, YTYIH*		YES	YES	YES	
Does the strategy highlight the importance of partnership/engagement with vulnerable	Preface: As part of the process to develop the Ministry of Health's National HIV/AIDS Strategic Plan for 2006-2009, a community planning workshop was held in April 2005, with fifty-nine participants from government sectors, the community, churches, non-governmental organizations (NGOs) and youth gathering to set priorities and create a plan for addressing HIV infection in the Marshall Islands.					

Country: Republic of Marshall Islands Strategy Document: *National HIV/AIDS Strategic Plan 2006-2009*	
groups? Refs .	Overview: The National HIV/AIDS Strategic Plan 2006-2009 for the RMI was developed using various processes including multisectoral consultations, symposiums and discussions with those that actively work with HIV/AIDS issues in government and civil society organizations. This plan is the first attempt by the Government and civil society to create a national strategy on HIV. The coordination of HIV/AIDS activities will be lead by the Ministry of Health and driven by the Community Planning Group (CPG), which will be re-convened and invigorated with the support of the Ministry of Health and the Centers for Disease Control and Prevention. One of its functions of the CPG will be to inform the Ministry of Health, which in turn will keep Government leaders apprised of the program's needs and progress. Page 9: Each culture, individual and each community is distinctive, and so responses to HIV/AIDS will be distinctive as well. Bringing different agencies and community is necessary in order to have a plan that is acceptable and appropriate to the needs of the country. Page 13: 3. To revitalize the Community Planning Group (CPG) and include representatives from diverse sectors of society
Does the strategy highlight the importance of training for peer workers? Refs.	Page 20: 4. To increase education on prevention methods including abstinence, faithfulness, condom use and doing less sexual activities. 4.1.2 Train school principals, teachers, PTA, church leaders, peer educators on HIV and sexual health education.

Appendix Two

Summary of interview: Youth to Youth in Health

Youth to Youth in Health (YTYIH), founded in 1986 to address SRH issues, employs 32 FTE staff and 50 volunteers. The interviewee identified a documented definition of peer education as "Peer to Peer Approach….in Marshallese our organization's name is Jodrikdrik nan Jodrikdrik ilo Ejmour (Youth to Youth in Health)" and a personal definition as "Sharing of information and skills amongst peers."

100% of the programs activities are devoted to PE, utilising the services of all staff. The following target groups were identified: Marginalized young people, Young people attending school, Women, Sex workers (commercial and transactional), Those who are transgender e.g. Fa'afafine, Fakaleiti, Victims of rape and sexual coercion, People living in rural / remote communities, Seafarers, and Partners of seafarers. Additional groups were identified as: Young people affected by substance abuse, parliamentarians, parents, school officials and teachers, traditional leaders, taxi drivers, travellers, students going abroad for education, partner agencies and groups.

A full range of peer activities are conducted: Direct one-on-one education, Group based education, Education sessions (e.g. in schools), Telephone information service staffed by peers, Social support activities, Advocacy on behalf of the target population, Advocacy for peer education, Condom and resource distribution by peers to peers, Resource production, Theatre / role play education, Media production, Knowledge training, Skill training (e.g., in communication), Training for trainers of peer educators. In addition sports tournaments, youth field days, retreats, picnics, and alcohol free parties are conducted. A variety of videos, songs, stories, art, and music tapes have been produced.

The project targets young people from 0 to 25 years and seeks to empower young people with information, knowledge, and skills so they can make better life choices for a better quality of life.

The YTYIH program was established by a Marshallese woman named Darlene Keju-Johnson who worked for the Ministry of Health Adolescent Health at the time in 1986. In the 1980s the Ministry of Health was faced with the challenge of slowing down the birth rate and finding a solution to the rapidly growing population. Darlene saw that the Youth to Youth approach would work for the Marshall Islands. In 1989 YTYIH became a chartered NGO and Darlene continued her mission until she died in 1996. The program has remained the only youth program established in the Marshall Islands.

The passing of its Founder, Mrs. Darlene Keju-Johnson, embedded great sadness amongst YTYIH staff and PEs and it seemed the program also died with Darlene. However Darlene's husband, Mr. Giff Johnson, and devoted YTYIH Advisors and Peer Educators continued with their efforts and in 2006 hired a new Program Director (Julia M. Alfred). The program was revitalized and the trust of the community was regained and funding commenced. Positive feedback and success stories were routinely collected from program users and recorded and used. Program Managers wrote progress and activity reports and submitted to donors and supporters.

Success is measured by collating indicators such as Number of users by age, gender, residence, education status, employment status, clinical results, purpose of visit, number attended workshops/seminars/focus group meetings. Use is also made of "Most significant change" stories and
Pre and post test results.

The interviewee believes as the only chartered youth to youth program, the Marshall Islands has greatly benefited from its activities. Every summer another 50 YTYIH members are recruited so currently thousands of Marshallese citizens have a relationship with YTYIH since its establishment in 1986. Volunteers are peers of the of the target population.

It is estimated that more than 5,000 youths in schools and out of schools, parents, teachers, parliamentarians, community members, sex workers, seafarers, taxi drivers, travellers were targeted in 2008. The program is primarily funded from regional donors (UNFPA, UNICEF, SPC, AusAID, UNESCO), RMI government, private sector, and other international donors. Annually the program operates on approximately US$300,000, though insufficient given the increasing demand.

Contact is made through face to face and peer educators are generally recruited through peers, by parents, and using the media to advertise.

The Executive Director reviews all activity proposals and works with Program Managers to develop work plans. The Board of Directors regularly meet to be informed on progress, funding and policies.

After an activity, the participants are allowed time for feedback and recommendations. These are considered in the development of work plans and the program has a Project Coordinating Committee (stakeholders) who meet quarterly and at the end of the year to plan activities.

It was reported that there is still a great deal of myths and misinformation shared with young people. Access to RH/STI/HIV information and services is still very limited especially in the outer islands. One significant innovation is that YTYIH has recently opened its Ebeye Youth Center (urban outer island) to increase access to RH/STI/HIV services and plans to expand and revitalize the outer island chapters.

This YTYIH in health one-stop-shop model is cited as an example of best practice. It reduces barriers that limit access to information and services for target audiences. It is a youth center that provides recreational, library, computer lab, media, and tutorial services, art studio, as well as clinical services. The clinic is open Monday to Saturday from morning until 9:00 pm. It is the only clinic that provides evening and weekend RH services for the most vulnerable population groups, free of charge.

However, there are concerns. All the YTYIH staff members have been trained to become life skills trainers however, because of their youth they are subject to peer pressure and therefore don't always use their own skills to make good choices. A challenge for these young PE is their capacity to be able to model appropriate behaviour and to maintain their credibility as educators.

A significant lesson learnt is the primacy of confidentiality and trust. Consequently all YTYIH staff members must take an "oath". However as a youth organization managed and operated by young people who are still in their development stage, issues and challenges can occur with confidentiality.

The project has developed the following resources: TV shows, a movie, a book, brochure/booklets.

The organisation is included in the National HIV/AIDS Strategy, it is a part of the National AIDS Committee, and it partners with the SPC and AHD to form what it considers a peer network. The organisation collaborates with the MoH, MoE, general community and schools. The organisation refers target group members to the local hospital and clinic for testing, but is only able to follow-up those who access the clinic.

The interviewee believes that they have the support of the organisation and the MoH to be involved in peer education.

Training for PE was conducted in July/August 2008, through the 23rd Summer Youth Health Leadership Training Seminar and in November 2008 by officers of the SPC. In addition two AHD Peer Educator Trainers attended the Adolescent Reproductive and Sexual Health Workshop in Japan, a one-month course offered by JICA.

The following education and training skills were identified as critical for effective peer education:

- The Pacific Star Life skills training
- Puberty
- Reproductive health system and how it works
- Signs and symptoms of STIs and treatment
- Prevention of STI and HIV
- Contraception and available methods
- How to approach the different vulnerable groups.
- Referral and follow-up.

Vulnerable groups currently not being adequately targeted included: high school students, sex workers, trans-genders, seafarers/sailors, juveniles or young prisoners under the age of 25 years. For the high school students, the Peer Educators' time in the school is limited by the school schedule and in some schools the information allowed to be presented is limited, especially in private schools. There was identified a need for training curriculum that can target some of the concerns of private schools (e.g. Catholic) concerning contraception and condoms. The SDA schools are considered the most difficult to work with. Peer education within church groups was considered a particular challenge. With respect to sex workers, condoms may not be accessible as some bars do not make them readily available. Some parents tell their children not to visit the youth health centre, therefore there needs to be a program for educating or motivating parents to assist their child.

The PE are seen as role models and people tend to forget that they are also young people with struggles and problems which places a lot of pressure on them when they make a mistake. The PE at YTYIH commenced their involvement as participants in YTYIH activities and were empowered to become PE. Working for YTYIH provides an environment where they can continue to develop their life skills, enabling them to cope with the problems of daily life.

There is still a lack of support from the government in terms of sharing of funds and resources. Government agencies are still very territorial and remain sceptical that an organization operated and manage by young people can be successful and produce results.

One integral component of peer education is an understanding of culture. Despite the level of training and education, PE will never gain the trust and respect of the community if they ignore their culture. There are a number of issues a young person must be aware of concerning their culture before outreaching into the community, e.g. identifying the traditional leaders (landowners), the appropriate protocols and presentation of their mission to the traditional leaders. They must know what is acceptable attire and what they should bring to them when they meet with traditional leaders. Similarly, PE should become better acquainted with protocols for visiting and meeting with parliamentarians or government leaders.