

Using Peer Educators to Improve Adolescent Reproductive Health in Ghana

The Enabling Change for Women's Reproductive Health (ENABLE) project is a multi-country initiative to strengthen women's capabilities for informed and autonomous decision making to prevent unintended pregnancy and improve reproductive health. Begun in 1998 and funded by the United States Agency for International Development (USAID), ENABLE seeks to increase the capacity of non-governmental organization (NGO) networks to expand reproductive health services and promote a supportive environment for women's decision making. This summary focuses on the ENABLE project's work with NGOs in Ghana to improve young people's knowledge of sexual and reproduction health issues.



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Introduction

In response to growing concerns about the poor sexual and reproductive health (SRH) profile in sub-Saharan Africa, the Centre for Development and Population Activities (CEDPA) began a SRH sub-project in Ghana in 1998 through the USAID-funded ENABLE project. The ENABLE project aimed to bridge the SRH knowledge-practice gap and achieve behavioral change among youth in Ghana. CEDPA partnered with four non-governmental organizations (NGOs)—the YWCA, YMCA, Muslim Family Counselling Services (MFCS), and Ghana United Nations Student Association (GUNSA)—to implement activities in the selected areas. The project's goal was to provide accurate and reliable SRH information to youth through community peer educators using two models—one structured and formalized and the other unstructured and informal.

In March 2000, CEDPA conducted a study in Ghana to:

1. Evaluate the Structured and Unstructured Models that the four NGOs used;
2. Document the lessons learned from the two peer education models;
3. Provide data for measuring some benchmarks identified in the Program for Action; and
4. Recommend the appropriate peer education structure in the project areas and strategies to improve SRH service delivery.

The two models were compared with a special emphasis on their strengths and weaknesses in reaching youth. The survey team's observations and recommendations will inform the design of SRH behavioral change campaigns for youth.

Background

The ENABLE project:

- Seeks to reach in and out-of-school youth groups in urban and rural areas with information and services for SRH and related issues;
- Targets policymakers through advocacy to influence them to become more sensitive to the needs of youth and women; and
- Educates adult educators who will in turn educate peer promoters to communicate information to others in the community.

ENABLE project activities include: counseling, discussion groups, workshops, drama and music performances and the distribution and sale of non-prescriptive family planning (FP) methods.

Prior to the implementation of the ENABLE project, a 1998 initial baseline study of the project areas found that:

- Adolescents in the four project areas were engaging in risky sexual behaviors;
- There was evidence of a high incidence of sexually transmitted infections (STIs) among the youth in the MFCS and GUNSA project areas; and

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- Only 47 percent of the youth in all project areas could tell correctly when in the menstrual cycle a woman is most likely to get pregnant.

After the survey, a communication strategy was implemented to improve the SRH knowledge of adolescents and to change their attitudes and behavior. The present study compares the modalities and results from the structured and the unstructured strategies.

The project's broad **assumptions** were that a more structured peer education approach would result in:

- Improved quality of interaction among network members;
- Wider coverage;
- Greater understanding of the information provided; and
- Behavior change.

The project's **hypotheses** were that:

- No statistically significant variation existed between ENABLE project beneficiaries and non-beneficiaries in the communities where the projects would be based, and
- There was no significant difference between the SRH behaviors of the peer education beneficiaries through the Structured and the Unstructured Models.



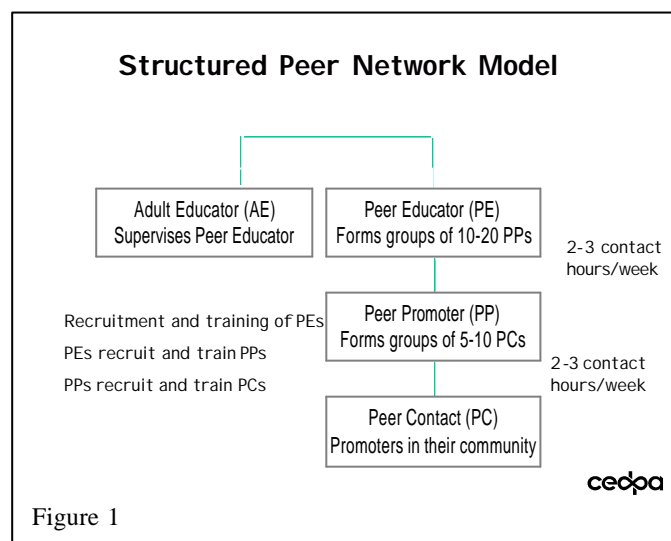
Peer Educator demonstrating proper use of a female condom.

Structured Peer Network Model

The Structured Peer Network Model involved a three-stage process:

1. Recruit and trained peer educators;
2. Peer educators recruit peer promoters and provided them with the same training they received; and
3. After training, peer promoters recruit people from their communities (peer contacts) and discuss the same issues that they learned.

Figure 1.



The Structured Model was characterized as follows:

- Youth group formation;
- Increased regularity of group interaction;
- Use of discussion guides;
- Planned activities; and
- Systematic supervision of program activities.

Each peer educator formed a group of 10 to 20 other youth whose role was to act as peer promoters. The peer educators and peer promoters met at regular intervals (i.e., 2 to 3 hours one day a week) to systematically examine a series of RH and FP topics through discussions, role-plays, drama, games, or debates. Adult educators supervised the activities of the peer educators to ensure that the planned activities were well implemented. In the next stage, 10 to 20 peer promoters formed youth groups of 5 to 10 members called peer contacts who were youth who had not had contact with the first group, i.e. they constituted an entirely new group. These groups also set aside a day a week when they met to systematically discuss the issues learned from the peer promoters who, in turn, served as facilitators to their groups.

The Unstructured Peer Network Model

The Unstructured Peer Network Model also involved a three-stage process:

1. CEDPA developed a program with the four partner NGOs -- YMCA, YWCA, GUNSA, and MFCS;
2. The NGOs trained young people to be peer educators on SRH issues; and
3. As peer educators, young trainees informally discussed SRH issues with their friends.

The Unstructured Model involves no traceable links or feedback loops. In addition, group formation is uncommon, as activities are conducted informally.

2000 Study Features

The study's target groups were opinion leaders, project implementers, and project beneficiaries.

Data collection proceeded in three stages:

1. Consultations with major stakeholders: This involved six days of discussions between the four implementing agencies and community/opinion leaders.
2. Questionnaire design and testing: The team designed three questionnaires for quantitative data collection, held focus group discussions, produced observation guides for peer educators, and held in-depth interview guides for opinion leaders for qualitative data collection.
3. Fieldwork: The team conducted fieldwork during March 3-21, 2000.

The survey team selected a sample from the Structured and Unstructured Models. From the Structured Model, the team selected 87 peer educators (40% of the PEs trained) and 524 peer promoters/peer contacts (58% of those trained), while from the Unstructured Model, the team selected 83 peer educators (40% of the PEs trained) and 378 peer promoters/peer contacts (42% of those trained). The table below shows the targeted and actual number of respondents and the response rate (percent of those in the Targeted Group who were actually interviewed).

Table 1. Study Subjects

Type	No. Targeted	No. Interviewed	Response Rate
Peer Educators	170	205	120
Peer Promoters/Contacts	902	666	74
In-depth interview	32	19	59
Observation Sessions	8	9	112
Focus group discussions with Community Leaders	8	10	125
Discussions with key informants	41	19	46

The study's limitations were the:

- Fieldwork period, which coincided with the first national census in more than a decade;
- Large distances between project areas;
- Respondents' attitudes, which were not always cooperative;
- Range of languages in project areas; and
- Poor or nonexistent recordkeeping.

Respondents' Background

Under the Structured Model, the team interviewed a much larger sample (774 people) compared with the 96 interviewed under the Unstructured Model. Of the 774 respondents interviewed under the Structured Model, about 83 percent of the peer educators and peer promoters were 15 to 24 years old. The male to female ratio was 140:100. In terms of education, 3 percent had a polytechnic or university education, 29 percent secondary school education, 43 percent junior secondary school (JSS), 7 percent only primary, 4 percent vocational, and 3 percent no formal education. A variety of religions were represented: 27.4 percent were Catholics, 22 percent Protestants, 17 percent Muslims, and 2 percent traditional African religions.

Of the 96 respondents from the Unstructured Model, about 88 percent of the peer educators and peer promoters were 15 to 24 years old; none was over 34 years old. The male to female ratio was 75:100. In terms of education, 7 percent of the females and 5 percent of the males had completed university, 44 percent had senior secondary education, and 40 percent of females and 27 percent males were in JSS. In this model, the majority of the respondents were Muslim (84%), followed by Christian (9%), and traditional African religions (2%).

Discussion Topics

In both models, the most common discussion topics were **STIs, HIV/AIDS** and **teenage pregnancy**. In the Structured Model, respondents also discussed **childhood diseases**, while under the Unstructured Model; **FP methods** were a common discussion topic.

Participants in the Structured Model put little emphasis on topics such as female genital cutting, nutrition, unemployment, peer pressure and sanitation/hygiene. The Unstructured Model led to little discussion on sexual abuse, childhood diseases, unemployment, and female genital cutting.

General Comparisons

The Structured Model was characterized as follows:

- Groups met 10 to 12 hours per month and those in formal education tended to meet for more hours;
- Various delivery methods were used;
- Peer educators were recruited through community/religious leaders, friends, referrals, and personal contacts;
- More methods were used to sustain interest at meetings (i.e., providing incentives, interesting topics, games/excursions, role-play, drama, debates); and
- Respondents gave high ratings for members' punctuality and cooperation.

Two important features of the Structured Model that clearly distinguished it from the Unstructured Model were a defined process for the recruitment of groups and a prescribed set of materials to study with benchmarks for assessing achievement. Unlike the Unstructured Model, which focused mainly on one-on-one interaction, the peer educators and promoters in the Structured Model had to form groups as the basis for activities. The expectation was that it would lead to extensive information dissemination among the participants, resulting in positive changes in the youth's SRH attitudes and behavior.

In implementing the model, in-school youth provided meeting sites as part of their contributions to the success of the discussions, while out-of-school youth provided other services. In the Unstructured Model, participants met in the afternoon for 30 to 40 minutes, 15 to 20 times/month, but the meeting did not involve the same groups as in the Structured Model. Group formation was the peer educators' major problem, so they often used existing groups. There was no structured recruitment.

The Strengths and Weaknesses of the Unstructured Model

The strongest point of the Unstructured Model was its inherent flexibility. Educators and promoters were free to use their own recruitment and education strategies. The facilitators largely controlled meeting times and the duration of discussions. They could choose either to contact individuals or work in groups.

Despite these advantages and contrary to expectations, the Unstructured Model was not a success. It was too loosely defined to achieve results. Although the peer education program covered many settlements, the data clearly demonstrated that very few people actually benefited from program activities. As many as 201 peer educators were trained to recruit and train others. However, in the field survey, some trained people could not be traced, indicating that they had not carried out the peer education program due to a possible lack of motivation, enthusiasm or the wrong perceptions of the training's real objectives.

The peer educator was expected to handle an unspecified number of recruits, but there was no systematic method for recruiting such people (as indicated by most respondents). Therefore, there was no systematic process for identifying people who had benefited from programs. Some contacts were with large groups and therefore members were anonymous.

In addition, since there were no incentives, few communities and groups were contacted by members of the peer education program. As the cost of inter-base movement was not paid for, peer educators felt reluctant to move, which limited the scope of people who could be contacted. For the majority of peer educators, the bottom line was the lack of financial resources to motivate and retain the potential recruits who were contacted.

The main reasons for program dropouts were found to be:

- Migration from residence for education or employment;
- Program teachings were against religion;
- Lost interest;
- Not compatible with personal views; and
- Time commitment was too much, especially for women.

Improvements in SRH Knowledge

The majority of respondents had accurate knowledge of how to protect oneself from HIV including: abstaining from sex, sticking to one partner, using condoms, avoiding sex with commercial sex workers, and avoiding the use of unclean needles.

In the Structured Model, respondents of all ages and education levels showed adequate knowledge of HIV/AIDS symptoms. For example, most males named weight loss as one symptom. Other symptoms listed by men and women included persistent diarrhea and thinning/loss of hair. No significant difference was found between knowledge of AIDS symptoms by sex or age.

The Structured Model respondents showed higher levels of HIV/AIDS transmission knowledge than those in the Unstructured Model.

In the Structured Model, respondents' HIV transmission knowledge was generally high irrespective of their education. Even among the male and female respondents without formal

education, there were very high scores for knowledge of transmission through sexual intercourse, sharing of needle/blade and from mother to child. Perhaps education was not necessarily an issue, since nearly all the male and female respondents in the Structured Model had at least primary education and nearly a third had attained second cycle education or higher.

The data indicate that one's educational status did not influence the amount of knowledge gained. Whether a person was illiterate or had higher education, his/her knowledge of HIV transmission was about the same. This might have been due to the generally high level of HIV/AIDS knowledge observed in a number of surveys in Ghana due to various government and NGO programs running in the country (e.g. GDHS 1998).

Age also had no significant influence on knowledge of the transmission mode. Between 70 and 90 percent of the respondents in all the age groups demonstrated an adequate knowledge about how HIV is transmitted.

In the Unstructured Model, the survey team found inconsistent and often incomplete knowledge of condom use. For example:

- More than one-third of the men did not agree that condoms can be a family planning method;
- Almost two-thirds of the men said condoms were only to prevent HIV, not pregnancy;
- About half of the females did not know to check the condom's expiration date;
- Less than one-quarter of the respondents with JSS and second cycle education agreed that condoms could be used to prevent HIV; and
- Two-thirds of females aged 20-24 and all females aged 25-29 had witnessed a demonstration of condom use, compared to only about one-third of males aged 20-24.

The top two reasons stated for a lack of knowledge on condom use were the lack of a penis model for a demonstration and that the facilitator and members were too shy to conduct the demonstration. A small number of people said that they already had adequate knowledge.

In terms of the HIV/AIDS transmission knowledge gained through the discussions, half of the male and a third of the female respondents in the Unstructured Model rated the knowledge gained as excellent.

HIV/AIDS Misconceptions

For planning and policy purposes, decision makers should take note that the survey found many people held misconceptions about HIV/AIDS transmission. Following are some respondents' misconceptions:

- Some respondents thought that HIV/AIDS could be transmitted from mosquitoes and insect bites, casual contact, sharing of clothing with infected persons, and stepping in the urine or stool of infected persons.

- Both males and females in all the age groups did not believe that breastfeeding and kissing were known modes of HIV transmission.
- Some respondents thought that AIDS can be cured. Despite the national HIV/AIDS educational campaigns and claims that the discussions had given them adequate knowledge on this issue, some respondents from Accra, Aflao Agbozume, Denu, and Koforidua expressed the notion that AIDS can be cured.
- Some respondents from Accra, Aflao Agbozume, Denu, and Koforidua claimed to know of a vaccine that provides protection against the virus that causes AIDS.
- Some males (11%) and females (16%) reported that people who wash carefully after sex are not exposed to HIV. This misperception appeared striking despite more positive attitudes expressed on the condom's ability to reduce the infection risk and also the confirmation that one could get HIV the first time one had sex with an infected person.

Misconceptions about transmission modes such as mosquito or other insect bites were higher among both males and females resident in the three Volta settlements and four Accra suburbs than in Koforidua and Kumasi. The fact that Accra residents reported insect bites as transmission sources is intriguing considering that HIV/AIDS educational campaigns on radio and television are more frequent in Accra than in other parts of Ghana. Accra residents are also known to have greater access to the media than those in the other areas.

Such misconceptions about HIV/AIDS have serious implications for various levels of programming, including peer promoters, the public education system, home-based care for people living with HIV/AIDS (PLWHA), and the national campaign designed to reduce the spread of HIV/AIDS. Any future HIV/AIDS education strategy will have to take these issues into consideration.

Negative Attitudes Towards PLWHA

While the majority of males and females indicated without hesitation that AIDS existed and some knew PLWHA in their communities, attitudes were generally negative towards PLWHA and persons who are HIV positive. Respondents believed that PLWHA were bad people who deserved the disease. In the Unstructured Model, even though the majority of respondents showed quite a positive attitude towards PLWHA, 39 percent of the males and 27 percent of the females had poor or very poor attitudes towards PLWHA. These attitudes were particularly high among the few respondents aged 15-19 years and those with only JSS education. Sadly, the peer educators and peer promoters have been trained to educate others and therefore are likely to have more positive attitudes towards PLWHA than the general public.

It appears that some respondents were obsessed with the principle of 'positive self, negative other' (Abane 1995). Thus, AIDS belongs to others and not them. Such an attitude is not good for the program's future.

Knowledge of Protection and RH Practices

The majority of respondents in the Structured Model, both male and female, had accurate knowledge of the main methods of protection against HIV/AIDS that specialists normally suggest such as abstaining from sex, sticking to one partner, using condoms, avoiding sex with commercial sex workers, and avoiding the use of unclean needles/blades. Although differences emerged in the answers given according to the respondents' education level, the differences are not great enough to warrant serious attention.

A worrying aspect is the small percentage of males and females who still felt nothing should be done to protect oneself against infection. About one-third of females with secondary education and about a quarter of males with higher education thought nothing should be done to prevent infection. This view was consistent in people of different ages and educational levels. Clearly, the educational campaign needs to reach to address this factor.

In terms of the respondents' reproductive health practices, the survey team found that four main contraceptive methods were used—abstinence, condoms, rhythm method, and withdrawal. Abstinence was the most cited method, however less than a third of the males and females were using abstinence. The other methods were used less frequently. Long-term methods were rarely used. Educational level did not have a major influence on method choice, but religion did.

In general, respondents had a high SRH knowledge but did not see the need to take measures to protect themselves against sexually transmitted infections that could put their health or life at risk.

Community Dynamics

The team also conducted 19 in-depth interviews to discuss:

- Problems facing young people in the community;
- Strategies for solving the problems facing young people;
- Teaching SRH to young people;
- Service provision to young people; and
- Their views on RH and knowledge of the program activities.

Poverty and unemployment were the economic problems perceived as facing youth, while the social problems were teenage pregnancy, sexuality, and STIs.

Mandate to Teach SRH to Youth

While most parents and guardians (85%) interviewed in Ghana said that young people should be given SRH education (GSMF 1999), the problem has been determining who should teach SRH. In this study, parents, teachers, and church leaders were most commonly named as appropriate

SRH teachers, while NGOs (such as the four implementing agencies) were rarely mentioned. Unfortunately parents, teachers, and church leaders rarely undertake the task of teaching SRH.

Observations

Based on the survey results, the team had several observations:

1. Running both models—structured and unstructured—concurrently created confusion in some areas as to the participants' specific roles (i.e., peer educator, promoter, or contact).
2. Staff were more committed at sites that paid allowances and had a permanent office equipped with books and TVs.
3. Paying some people and not others created problems in the program. Peer promoters lacked the motivation to form their own groups at sites where their work was considered voluntary and the peer educators were paid allowances.
4. Peer promoters without formal education or less than secondary school often lacked the confidence to form their own groups.
5. Program sustainability was a problem in some areas.
6. This ENABLE sub-project did not fully meet its ultimate objective—to train a crop of people who assisted others to change their behavior.

Recommendations

1. If the unstructured system is to continue, roles and responsibilities need to be explained thoroughly to the project staff to avoid confusion.
2. Offices should be established at all sites.
3. Both peer educators and peer promoters should be given some remuneration.
4. There should be in-service training for both peer educators and peer promoters.
5. The scope of issues discussed should be expanded to cover background variables on problems that youth face, such as individual characteristics and community dynamics.
6. Each agency should be required to present an activity plan or program that is geared towards achieving sustainability.
7. When selecting individuals without formal education or only basic education as peer promoters and peer contacts, they should receive extra training in communication skills and self-confidence.
8. Since parents, teachers, and church leaders rarely teach SRH to youth, NGOs should increase advocacy efforts to promote themselves as credible alternatives and conduits to supplement SRH education in the schools.
9. To meet its ultimate objective—to train a crop of people who assist others to change their SRH behavior—a follow-up intervention should investigate what methods will make people change their SRH behavior to a less risky, more life-affirming state.