

ORIGINAL RESEARCH ARTICLE

Reaching Adolescents and Youth in Burkina Faso, Guinea-Bissau and Mauritania

Solène Lardoux* and Afiwa N'Bouke

Department of demography, University of Montreal, Montreal, Canada

*For correspondence: Email: solene.lardoux@umontreal.ca; nbouke@hotmail.com

Abstract

Who are the young people reached by peer education programs and/or by youth centers? The present study intends to better know about the activities of the peer educators who are involved in organizations that promote reproductive health information and services in three West African countries. A special research tool was created to collect data to evaluate the composition and characteristics of the populations that such programs reach; therefore, to evaluate the populations left behind. We found that the typical profile of individuals in contact with peer educators or attending youth centers tended to be males aged 15 and more, schooled or highly educated, never married, and living in urban areas. We also found a relationship between peer educators' and peers' socio-demographic characteristics in rural Burkina Faso and urban Guinea Bissau. Finally, the main topics discussed included HIV/AIDS and Sexually Transmitted Infections, but omitting other aspects of sexual and reproductive health (*Afr J Reprod Health* 2013; 17[1]: 73-84).

Résumé

Quels sont les jeunes que les programmes d'éducation par les pairs et/ou les maisons de jeunes réussissent à atteindre ? La présente étude vise à mieux connaître les activités des pairs éducateurs impliqués dans les organisations qui font la promotion de l'information et des services en santé reproductive dans trois pays d'Afrique de l'Ouest. Nous avons créé un outil de recherche original qui nous a permis de collecter les données destinées à l'évaluation de la composition et des caractéristiques des populations qui participent à ces programmes, et par déduction de celles des populations qui sont laissées pour compte. Nous trouvons que le profil le plus commun des individus qui sont en contact avec les pairs éducateurs ou qui fréquentent les maisons de jeunes sont des garçons âgés de 15 ans et plus, scolarisés ou de niveau scolaire primaire ou plus, jamais mariés, et résidant en milieu urbain. De plus, nos résultats révèlent l'existence d'une relation entre les caractéristiques socio-démographiques des pairs éducateurs et des jeunes en milieu rural burkinabè et en milieu urbain en Guinée-Bissau. Enfin, les principaux sujets de discussion concernent le VIH/Sida et les maladies sexuellement transmissibles, mais les autres aspects de la santé sexuelle et reproductive sont souvent omis. (*Afr J Reprod Health* 2013; 17[1]: 73-84).

Keywords: West Africa, peer educators, youth centers, sexual and reproductive health, gender

Introduction

Investing in adolescents and youth must be a priority to reach the Millennium Development Goals. The plan for action to achieve those eight anti-poverty goals by 2015 acknowledges the need to give adolescents greater rights and power over their own lives, especially in areas where they may be exposed to sexual initiation and marriage at an early age, but also when information on sexual and reproductive health is not discussed within the family. Adolescents and youth aged 10 to 24

years represent a large percentage of the population in many developing countries as stated by the United Nations Population Fund¹. However, the internal heterogeneity of this population is generally not considered when designing programs for youth. Africa's adolescents and youth constitute a vulnerable group who may be at risk of reproductive health problems because they tend to start to be sexually active earlier, in comparison to other youths and may not be well informed or equipped to be able to protect themselves against risks associated with reproductive health, in particular STIs including HIV/AIDS². In some

places, schools offer programs that inform adolescents and youth about issues related to their reproductive and sexual rights^{3, 4}. However, in many African countries, especially in rural areas, a large percentage of adolescents and youth, more so girls, do not attend school^{5, 6, 7}. This is also the case in the three focus areas of this article, Burkina Faso, Guinea-Bissau and Mauritania. Moreover, family life and sex education in schools⁸, when delivered, is typically at the secondary school level, making its reach even more selective as the majority of African adolescents never attain this level of schooling, particularly girls. The interest of this paper is on the out-of-school programs led by peer educators and the out-of-school activities in youth centers.

Programs to improve youth sexuality and reproductive health have existed for a number of years in different institutions such as schools; community youth service clubs (in and outside of school), youth associations and youth centers. The objectives of those programs are generally to provide accessible reproductive health information and services to youth, to reduce the incidence of sexual and reproductive health related problems among youth, lower the transmission and prevalence of STI/HIV, decrease the prevalence of unintended pregnancies among adolescents, delay the onset of sexual activity among youth, prevent sexually experienced youth from suffering negative consequences of sexual activity, improve knowledge of sexuality and reproductive health, promote safer sex behaviours and increase contraceptive use among sexually active adolescents^{9, 10, 11, 12, 13, 2}.

Feedback, on which subgroups of youth are being reached (versus not reached) by programs and how successfully, is critical information for program effectiveness. Results of several evaluation studies are of different kinds according to the sites. For instance, a study shows that clinic users in a youth centre in Lomé, in contrast to those in other facilities, are significantly younger and less likely to be married; never pregnant youth are more likely than ever-pregnant youth to be visiting the youth centre¹². According to a situation analysis of the Zimbabwe National Family Planning Council's Youth Centres, very few youth below the age of 15 years are reached through the

youth centres¹⁴. Moreover, a study evaluating a peer-based adolescent reproductive health intervention in Cameroon shows that older, in school, and male adolescents have greater knowledge of contraception than their younger, out-of-school, and female peers¹². Adolescents who meet with a peer educator are more likely to be currently using modern contraceptives than those who do not have such a contact. Finally, an evaluation of a reproductive health education program in Nigeria and Ghana (The West African Youth Initiative) indicates that peer education is not effective in the out-of-school setting².

One weakness in youth programs is the absence of clear objectives¹⁴. Another limitation is the lack of distinction between groups of youth that may be different in terms of needs and characteristics and therefore may require special means from the rest of the population¹⁵; for instance the programs target a wide age range from 10 to 24 years^{16, 11}. Only a few programs acknowledge that services should sometimes be specific to sub-groups or that strategies to reach most of the youth population should take into account socio-demographic characteristics in order to serve groups that may be more vulnerable^{17, 18}. Another challenge is the lack of consistent record keeping of program activities, which if accomplished could provide a foundation for improvement of training of peer educators, operations of youth centers and budget allocation. Moreover, youth centers are built to offer facilities for recreational and sport activities and to be places for counseling services but the frequency of organization of activities for youth in centers is unequal across countries and regions. In addition, associations' representatives and their teams of peer educators may not be aware of the percentage of youth that attend activities or interact with peers^{9, 19, 20, 14}.

Previous research has focused on the evaluation of youth centers^{19, 20, 14}; however, the impact of peer education programs for adolescents and youth has been less studied^{21, 22, 23}. The children's peer culture presents at least three advantages²⁴: the importance of sharing and social participation; attempts to deal with confusions, concerns, fears, and conflicts in the daily lives and resistance to and challenging of adult rules and authority. Female and male peer educators are generally

recruited in schools and youth associations and they take an oral and written test that determines their level of motivation and commitment to the program¹³. Peer educators are trained to deliver their messages on reproductive health through a mixture of techniques. Certain factors may facilitate discussions between peers and peer educators including similarities such as sharing the same neighbourhood; the connection of peer educators in the youth clubs and associations; the choice of peers who would be naturally acceptable as sources of information and help^{12, 25}. The role of peer educators may be facilitated and reinforced by discussions between parents and adolescents or a communal approach in rural areas¹⁸, as well as education sessions to adolescents led by peer educators through meetings arranged by the village leaders²⁶. As for the age range of peer educators, it may be of 18 to 22 years¹⁰, there may be “youth coordinators” who are generally older (mid to late twenties) and supervise the “youth promoters” (10 to 24 years old)²⁰. But we are not aware of a study that did compare peer educators’ characteristics to the peers’ characteristics.

In the present study we intend to better understand the groups of youth who do not benefit from the programs, as well as to present a simple tool, called “coverage exercise”, that allows peer educators and associations’ representatives to have a better idea of the characteristics of the population that they reach and to keep track of the activities they organize^{27, 16}. We test three main hypotheses. First, the most vulnerable adolescents and youth are the younger girls, married, less educated, living in rural areas, and are less reached by programs. Second, peer educators organize activities and exchanges with peers to talk about a variety of topics in relation to reproductive and sexual health. Third, the peer educators tend to be in contact with people that share common socio-demographic characteristics.

Data and Methodology

Data were collected in 2006 with a diagnostic instrument, the “coverage exercise”, developed by researchers at the Population Council in order to offer youth-serving organizations a sustainable monitoring and evaluation tool that recognizes the

internal diversity of adolescent populations and lives^{27, 16}. This tool is original because it is designed in such a way that the peer educators and other service providers can collect the data on a regular basis. In particular, it provides information at two levels. First, on the characteristics of the individuals who are in contact with peer educators or who attend youth centers regarding their age, place of residence, gender, schooling status, highest education level, living arrangements, work and marital status. Second, the coverage exercise collects information on the type of activities and topics of discussion between peer educators and peers, as well as some socio-demographic characteristics of the peer educators. UNFPA teams volunteered to participate to this exercise in the three countries.

In Burkina Faso and Guinea Bissau (regions of the islands are not included), one of the authors worked with 20 associations from both countries and selected from each association one to three peer educators who could understand French and were available to come to a training session in the capital city and to collect the data. Although the representation of associations is not exhaustive we consider that the 20 associations are representative of the activities for youth on reproductive health, in each country. In Burkina Faso, the associations run programs that target 10-24 year-old young males and females. However, several associations target specific groups such as the schooled boys and girls, the unschooled in urban and rural areas, the young with HIV, or the most vulnerable. In Guinea Bissau, there are associations that aim at organizing sensitization activities about hygiene and against delinquency and sexual abuse, as well as activities to protect the environment. Their activities and modes of interaction are mainly group discussions, plays, video projections, training, activities to promote literacy, distribution of condoms, and organization of paid activities.

In Burkina Faso, the data collection lasted one month (July-August 2005) with 34 peer educators from 20 associations (16 in urban and four in rural areas) among which nine associations received support from UNFPA. In Guinea Bissau, the data collection lasted one month (January-February 2006) with 39 peer educators from 20 associations (15 in urban and five in rural areas) among which

ten associations receive support from UNFPA. In Mauritania, data collection lasted one week (end of November-beginning of December 2005) and was conducted by 20 interviewers in the 18 youth centers (in urban areas only).

In Guinea Bissau and Burkina Faso, peer educators registered every exchange they had with someone regarding sexual and reproductive health. This may have been through organized activities, personal interview, as well as informal interactions. In Mauritania all individuals who came into the youth center are recorded.

Strength and limits of the methodology

The strength of the coverage exercise methodology lies in the possibility to deconstruct 'adolescent youth' from a homogenous whole, and identify groups according to some socio-demographic characteristics and therefore identify those who may be the most vulnerable (Annex 1). The comparison of percentages of individuals may suggest that some groups are underrepresented.

In Guinea-Bissau and Mauritania the data were collected during the school-year while in Burkina Faso it happened during the summer school vacation that is also the rainy season, a period when the youth may be less mobile and may have to work in the fields. In Mauritania, the data collection lasted shortly since the data collection was conducted by interviewers. Moreover, special events, the Independence Day and the World AIDS Day, were celebrated; a good thing is that we were able to record activities and attendance to the youth center during those special occasions, but there our results may overestimate the practice of some activities.

Because the peer educators collect the data about their own activities, in Burkina Faso and Guinea-Bissau, there could be a bias of over-evaluation of their activities. However, all peer educators who collected the data for the present study were carefully trained to use the data collection tool but also to be aware of the aims of such a study. Associations' representatives were asked to name one to three peer educators who organized activities on reproductive health for adolescents and youth, knew French (read and write) and were serious. To offset the bias of

selection of peer educators, we compare the characteristics of the peer educators and of those of the peers with whom they are most in contact.

Data analysis

We use descriptive statistics to analyze data and stratify the analysis by place of residence, gender and age. In order to better understand the relation between characteristics of the peers and of the peer educators, we use the multiple correspondence analyses (MCA). The MCA is a method for analyzing the relationships within more than two categorical variables. One can see it as a generalization of the principal component analysis (PCA) where the variables are categorical. The variables of interest are age, gender, marital status, place of residence, and number of years of experience as a peer educator. In the MCA, if two modalities of the same variable are close, it means that individuals, who have one of the modalities and those with the other, are broadly similar in terms of the other variables. If two modalities of two different variables are close, this may mean that in general the same individuals have one and another modality.

Results

In Burkina Faso, 34 peer educators report that contacts with a total of 6216 individuals over the one-month period include at least one exchange during the period of the data collection about reproductive health issues. Among the total of 6860 contacts, 9% are repeats (i.e. individuals can have an exchange with the peer educator more than once during the data collection). On average, a peer educator has 50 contacts (i.e. exchanges) per week.

In Guinea-Bissau, 39 peer educators reported they had exchanges with a total of 7265 individuals and 8167 contacts of which 11% are repeats of individuals who talked with the peer educator more than once. On average, peer educators had 52 contacts per week. In Mauritania, 5452 individuals attended a youth center during the week of data collection and interviewers recorded 8115 contacts. The majority (82%) of individuals came to the center more than once in

the week, and almost 37% of them attended the youth center every day. On average, each one of the 20 interviewers recorded 450 contacts per week and per youth center, with differences across youth centers.

Characteristics of individuals

We present in Table 1, the characteristics of individuals who had at least one exchange with a peer educator (Burkina Faso and Guinea-Bissau) or who came at least once to a youth center (Mauritania) during the data collection period.

The majority of individuals who are in contact with a peer educator or go to a youth center in all three countries are males. In Burkina Faso, the percentages of males and females are very close to those observed in Guinea-Bissau (56% of individuals are males in Burkina Faso, and 57% are males in Guinea-Bissau). In urban Mauritania, male attendance is of 83%. Thus, young males seem to be more exposed to reproductive health programs than females in Burkina Faso and Guinea-Bissau, and to a greater extent in Mauritania.

Table 1: Distribution of peer educators' and youth center's beneficiaries (%) by their characteristics and place of residence (*Sources:* ECBF-2005, ECGB-2006 and ECM-2005)

Characteristics (individuals, % in column for each characteristic)	Place of residence of peer educator's beneficiaries						Place of residence of youth center's beneficiaries
	Urban		Rural		Total		Urban
	Burkina Faso	Guinea Bissau	Burkina Faso	Guinea Bissau	Burkina Faso	Guinea Bissau	Mauritania
Gender							
Males	57	55	55	62	56	57	83
Age group (years)							
< 10	0	0	0	0	0	0	4
10-14	7	7	3	8	7	7	28
15-19	32	37	20	37	30	37	42
20-24	34	30	31	29	33	30	15
25-29	15	16	24	18	16	17	5
30+	12	10	22	8	14	9	5
Marital status							
Never married	73	84	60	78	71	82	89
Engaged	6	2	5	1	6	1	3
Married	18	11	30	18	20	13	7
Other ¹	3	3	5	3	3	3	1
Highest education level							
None	25	6	35	5	26	5	2
Primary	18	30	21	42	19	33	37
Secondary or higher	57	60	44	49	55	57	58
Koranic school	0	5	0	2	0	4	3
Had a paid activity in the previous month	42	24	43	27	42	25	20
Total (Number)	5280	5185	936	2080	6216	7265 ²	5452
Total (% in row by country)	85	71	15	29	100	100	100

Notes: ¹ Separated, divorced, widowed (and cohabiting just in Guinea Bissau);

² Includes 33 missing values for the variable "marital status", 44 missing for the "highest education level" and 3 missing values "had paid activity".

In Burkina Faso like in Guinea-Bissau, more than 60% of individuals in contact with a peer educator are between the ages of 15 to 24 year-old. The most represented age group in Burkina Faso is the 20-24 year-olds and slightly younger in Guinea-Bissau where it is the 15-19 year-olds. In urban Mauritania, 42% who come to the youth centers are 15-19 years. A striking result is the presence of individuals over 25 years in the three countries that are also served by peer educators. In contrast, very few youth under age 14 seem to be reached by the peer educators' services, and only 4% of individuals under age 10 are attending youth centers in Mauritania.

The majority of individuals who are in contact with a peer educator in Burkina Faso (71%) and Guinea-Bissau (82%) are unmarried. In Mauritania, the unmarried increases to almost 90 percent of attendees at the youth centers. There is some difference between urban and rural areas in Burkina Faso and in Guinea-Bissau, even though never married persons still prevail. The majority of attendees have a secondary or higher education level: 55% in Burkina Faso, 57% in Guinea-Bissau and 58% in urban Mauritania. In Burkina Faso, 26% of individuals in contact with peer educators have not been to school (25% in urban and 35% in rural areas), while in the other countries the percentages are much smaller.

We tested whether there is a difference between gender and age groups, in each area and for all our variables of interest that are schooling status, highest education level, living arrangements, work and marital status (results not shown but available upon request from the authors). In Burkina Faso, 42 % of individuals (47 % of males and 36 % of females) received money in exchange for labour. Results of the chi-square test of independence between these two variables are significant (at the level of 0.05) only in urban Burkina Faso. Therefore the percentages of youth who had a paid activity in urban area differ among young males and females, by age groups; oldest youth participate more in a paid activity. In Guinea-Bissau, 25% (respectively 29% and 19 % of males and females) received payment and like in Burkina Faso differences across gender and age groups are significant in urban areas only. In Mauritania, almost 20 % (21% of boys and 13% of girls) had a

paid activity in the previous month. In general, more males than females had a paid activity in the previous month.

In the three countries, the percentages of married or engaged youth are very low and are greater among youth of 20-24 years. However, the highest percentage married is in Burkina Faso, particularly among youth aged 15-24 years; most likely because of the activities of the association that works with married adolescents, PSADO (*Promotion de la Santé Sexuelle et Reproductive des Adolescents*). In urban Mauritania too, the percentage married is high among females of 15-24 years. But in the three countries, the groups of females and males aged 10-14, 15-19 and 20-24 years that participate in the activities are unmarried, in-school and living with both parents or with other persons (i.e. partner, other relatives or alone). Differences of percentage across age groups and gender exist for the never married in rural and urban areas, except in rural Guinea Bissau, as well as with regards to youth in school, for all countries. As expected, more males than females are in school and percentages are higher in the urban areas and the capital.

With regards to living arrangements, in urban Burkina Faso, slightly less than 60 percent of young males and females live with both parents, about 10 percent with their mother only and 5 percent with their father alone, the remaining having other types of living arrangements (i.e. alone, partner, other relative). In rural Burkina, the youth are more evenly distributed across those categories, and less live with parents; we observe the same in Guinea Bissau. In urban Mauritania over 60 percent of youth live with both parents.

The percentages of youth who live with both parents significantly differ in urban and rural Burkina Faso, urban Guinea Bissau and in Nouakchott. Among those living with their mother alone, there are differences across gender and age groups in urban Burkina Faso, urban and rural Guinea Bissau and in other urban places in Mauritania. For the youth who live with their father alone, the differences are only significant in urban Burkina Faso. Finally, individuals in the category of living arrangements "others (alone, partner, other relative)" differ by gender and age group in urban Guinea Bissau and Mauritania.

In addition to the peers' socio-demographic characteristics, the analysis of the results provides information on the activities organized by peer educators, the places where the exchanges take place and the topics of discussion in relation to reproductive health.

Places of exchange and activities

In Burkina Faso, males and females in urban and rural areas meet peer educators in their neighborhoods (30%) and/or in the peer educator's locality (18%), and in youth centers (12%). One association provides services by phone only and the calls are anonymous. In Guinea-Bissau, interactions take place in school (29%), in the peer's neighborhood (28%), and few exchanges are in youth centers (2%). In these two countries, clinics are barely attended by peers (3% in Burkina Faso and 1% in Guinea-Bissau). In Mauritania, data collection is limited to the youth centers.

In urban and rural Burkina Faso, the majority of contacts between peer educators and young boys and girls take place in group discussions (41%) and individual discussions (17%), during question-and-answer sessions (11%), and video projections (10%). These activities are also frequent in Guinea-Bissau, respectively 36%, 18%, 17%, and during counseling (11%).

In Mauritania, we observe that group discussions are rare and the majority of youth (64%) who come to the center do not have interaction via a conversation and/or counseling with a peer or with a resource person. Fewer females attend youth centers, but we find that when they come they are more in contact with a resource person than males, in all age groups. Moreover, the percentage of contacts with a resource person or a peer increases with age. The majority of the activities are organized by the youth themselves since most of the time no counselor is present to animate an activity. In contrast, there is one center in Nouakchott that receive UNFPA funding as a pilot youth center and our results show that this particular center attracts several associations and concentrates almost all activities, mainly soccer for males

(56%) and drama for females (31%), while other youth centers have very little to offer.

Topics of discussion

The main topics that peers and peer educators discuss are HIV/Aids, STIs (sexually transmitted infections), condoms, family planning, drugs, abortion, family and social problems, children's rights and traffic. Other topics discussed minimally, include female genital mutilations, pregnancy, emergency contraception, delinquency, gender questions, hygiene/sanitation, life skills, and marriage (results not shown).

There are significant gender differences in discussion topics in Burkina Faso and Guinea-Bissau; girls are more likely to receive education on abortion, as well as on family and social problems. In contrast, boys discuss more on HIV/Aids, STIs, condoms and drugs. For age differences, we find that peer educators educate the youngest on children's rights or traffic and hygiene/sanitation, and the oldest on HIV/Aids and drugs. In the youth center in Mauritania, among the few boys and girls who talked with a resource person or a friend, HIV/Aids is the most cited topic and there is no significant gender difference; moreover, the youngest (below age 15) discuss mostly about physical activities while the oldest talk more about HIV/Aids.

In Burkina Faso where the most cited topics of exchange are HIV/AIDS, STIs and condoms, peer educators in rural areas discuss more often on HIV/Aids, STIs and family planning than on children's rights or traffic, condoms, family and social problems which are topics more often discussed in urban places. In Guinea-Bissau, exchanges are essentially on HIV/AIDS and drugs. In addition to these topics, peers in urban areas of this country discuss mostly about STIs while in rural areas, they talk mostly about condoms and abortion.

Comparison of peer educators' and peers' characteristics

Finally, we analyze characteristics of peer educators (Table 2) and we compare their characteristics and those of the peers (Figure 1).

Table 2: Characteristics of peer educators (PE) (Sources: ECBF-2005 and ECGB-2006)

Characteristics	Burkina Faso (BF)				Guinea Bissau (GB)			
	Urban		Rural		Urban		Rural	
	Males	Females	Males	Females	Males	Females	Males	Females
Median age (years)	25	23	31	26	25	24	30	25
Years of experience as PE (median)	6	3	6	4	4	2	9	7
Marital status								
Never married/Single	11	11	2	1	11	12	4	4
Engaged/married or separated	4	1	2	2	3	2	2	1
Reported contacts								
Number	3346	2513	539	461	2769	3002	1214	1182
% (in row by country)	49	37	8	7	34	37	15	14
Total PE (number)	15	12	4	3	14	14	6	5

Results show that the median age of the male and female peer educators together is of 24.5 years in Burkina Faso and of 25 years in Guinea-Bissau. In the two countries, female peer educators are slightly younger than males, and peer educators are younger in urban than in rural areas. This may explain why female peer educators are less experienced in Burkina Faso and Guinea-Bissau, and why the median of the years of experience as peer educator is smaller in urban areas (this median of 4 years is also the median at the national level).

Male and female peer educators have never been married, and have secondary or higher education level. The multiple correspondence analyses (MCA) include the place of residence, age, gender and marital status of peers and peer educators as well as the number of years of experience of the latter. The MCA for Burkina Faso can explain 77.2% of the total inertia in the first two dimensions. Results show that only in rural Burkina Faso, there is a relationship between the characteristics of peers and those of peer educators. There, peers of 10-24 years who have never married, mostly talk with peer educators of 20-24 years, who are also unmarried. Female peer educators of 15-19 years are the least experienced with less than 4 years of experience. Peers of 30 years and more are the peers who are married, engaged or separated. However they do not seem

to be so much in contact with the peer educators who are 30 years and older, who live in urban area, are married, engaged or separated, and have more than four years of experience.

In Guinea-Bissau, the MCA can explain 42.2% of the total inertia in the first two dimensions. Results of the MCA show that urban Guinea-Bissau is the only place where there is a relationship between the characteristics of peers and those of peer educators. Youth of 15-29 years, who are never married, are generally in contact with female peer educators of 20-24 years who have less than 4 years of experience. Results show that individuals of 30 years or more are the same as those married, engaged or separated. Peer educators of the same age group live in rural area and have more than four years of experience.

Discussion

The cross cutting findings of the present study are the following. First, programs are reaching very few 10-14 year-olds young males and females (especially in rural Burkina Faso and Nouakchott), and are attaining more individuals over 25 years old than might be warranted. Second, fewer females participate to the programs than males, especially in the Mauritanian youth centers. Third, in general married adolescent females are absent from the programs, whereas they may be

Annex 1: Summary of main stages of a coverage exercise

Five main phases constitute the stages to elaborate a coverage exercise¹. A first step consists in the identification and selection of the programs and the organizations and associations to include in the study. Secondly, the institution that coordinates the project chooses a person who will be responsible for the overall management of the coverage exercise that is the project coordinator. The partners –project coordinator and the responsible for the organizations (or the units in the case of a coverage exercise in a single organization) agree on the goals of the coverage exercise and guarantee the participation of peer educators or other service providers to the data collection. At the third step, peer educators are nominated by the responsible of the organizations. They follow a training workshop in order to learn how to use the data collection forms and to understand the goals of such an exercise, that the data collection for the coverage exercise should be like a photography of what they are doing in their daily activities (one can tell them that, for instance, it will allow others to understand what their work consists of). For the one-to-one activities, peer educators use activity registers and group activity registers for group activities. Those two kinds of activity registers include the names of specific activities, topics of discussion as well as the names of different kinds of meeting places that are adapted to the local context of the peer educators' fieldwork. Finally, project assistants may be chosen to be present on the field and bring support during the data collection with a supervisor that coordinates all.

The two last steps concern the data entry and analysis, and the dissemination workshop. The workshop consists in the restitution of the results of the coverage exercise to the peer educators and to the organizations' representatives, as well as to the donors, government agencies and policy makers. The aim of such a dissemination workshop is to present the results to all participants and discuss strategies for improving program performance and increasing coverage, or strengthening the programs that seem to be reaching their targets. The workshop is also a good time to discuss with interested parties about the adoption of the coverage exercise for managing and monitoring their future work.

Lardoux S. and C. Meyers. How to conduct a coverage exercise: a rapid assessment tool for programs and services. 2006, 38 p. <http://www.popcouncil.org/pdfs/CoverageExerciseGuide.pdf> (also available in French, Portuguese and Spanish).

numerous in rural areas where the average age of marriage is much younger than in urban areas (one program in Burkina Faso is addressing the needs of this population). Fourth, the distribution between rural and urban programs is unbalanced, with far more urban than rural ones. Fifth, programs are tending to reach youth with higher educational levels than the national average. Thus, with the previous findings, our first hypothesis that vulnerable youth (younger girls, married, less educated, in rural areas) might be under represented in those programs is confirmed.

Another of our findings is that HIV/AIDS is the principal issue raised when reproductive health topics are discussed. However, in Mauritania, discussion of reproductive health during exchanges is rare. Results do not confirm our second hypothesis that peer educators organize activities and exchanges with peers to talk about a variety of topics in relation to reproductive and sexual health. Finally, although peer education programs might intend to reach youth who have approximately the same characteristics as peer educators, only in rural Burkina Faso, and to a

lesser extent in urban Guinea Bissau, is there a relationship between the characteristics of peers and those of peer educators. Therefore our third hypothesis that peer educators tend to be in contact with people that share common socio-demographic characteristics is not confirmed in all regions.

Our analysis raises some questions in relation to the efficiency of programs since we find that some topics on reproductive and sexual health are more discussed than others. Moreover, in addition to the information on the topics discussed, it would be interesting to know the quality of the information that peer educators distribute to their peers. Our results show differences across gender and age groups however we do not have enough information to study more in details those differences, in the three countries in terms of the exchanges or activities related to reproductive health.

The present study did not intend to measure the reasons for the low access of youth to the reproductive health services and programs²⁸ nor the perception of the usefulness of youth programs²⁹. Rather, it allows us to present several

socio-demographic characteristics of the youth who are in contact with programs on reproductive health, and to define sub-groups that may share common behaviors and needs. One challenge that program makers face is the difficulty of matching the specificities of a program with the needs of the individuals who use the services, and to attract those who do not.

We suggest the following recommendations, in particular to community workers and members of funding institutions. First, at training sessions for peer educators, indicate the importance of the various topics in relation to sexual and reproductive health, and recall the meaning of family planning, prenatal care, early pregnancies, adolescents' unwanted pregnancies, early first sexual intercourse, dangers of clandestine abortions, and female genital cutting. For instance, in Burkina Faso preliminary results of the present study, UNFPA members suggested to reorient the content of messages toward a better treatment of aspects related to reproductive health, in particular to insist on adolescents' unwanted pregnancies and early first sexual intercourse, and not only about HIV/AIDS. The Reproductive Health Project in the Northern region of Guinea-Bissau organized workshops for peer educators to broaden the reproductive health topics that are comfortable discussing. Second, results of the present study show that program planners should take into account the internal diversity or the complexity of youth, and not assume that one strategy will meet the needs of many. The different and multiple needs of youth based on their gender, social status, economic situation, levels of education, ethnicity and place of residence, require specific approaches for program execution and implementation. For example, in Mauritania, the fact that there is such an imbalance between girls and boys is the proof that there is a need for gender-specific actions to give girls greater access to the youth centers. Moreover, younger boys may feel excluded by older males who are present in the youth centers. Therefore, the nature of the support should differ between girls and boys since they may face economic pressures and social isolation as well as engage in risky behaviors differently. Since youth programs are often school based and urban concentrated, future programs

should be better adapted to rural areas and to populations of underserved youth such as those who are not in school and/or not living with one or both parents²⁷. Therefore, associations, in cooperation with the government, should develop alternative projects and structures regarding the elaboration of new strategies that can cover the most vulnerable youth groups that have not yet been enough reached by peer education programs.

Contribution of Authors

The first author conceived the study and collected the data, both authors analyzed the data and prepared the manuscript. The two authors of the article approved the manuscript.

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