

School-Based Peer Education Programs Popular in Ghana

Even so, focused, well-developed programs are needed to reach more youth in schools.

From 2001 to 2004, a school-based peer education program on HIV/AIDS operated in 90 schools across Ghana. Called “Strengthening HIV/AIDS Partnership in Education” (SHAPE), the program was implemented by nine local civil service organizations (CSOs) with funding and technical assistance from World Education, a U.S.-based nongovernmental organization. Trained peer educators provided in-school youth with information about how to avoid or reduce risk-taking behavior, delay the onset of sexual activity, and for youth already sexually active, change behavior to reduce the risk of HIV infection.

The peer educators, often working through school clubs, presented basic facts about HIV/AIDS and other sexually transmitted infections, life skills, human anatomy, substance abuse, gender and sexuality, and care and support of people living with HIV/AIDS (PLWHAs). The program allowed the CSOs to choose materials, recommend topics and activities, and train the peer educators. The CSOs also trained a patron at each school to support the peer educators.

In 2004-2005, YouthNet evaluated the impact of SHAPE, looking specifically at the differences in key indicators of HIV/AIDS and reproductive health knowledge, attitudes, and behavior – the focus of this brief. The evaluation also sought to measure participation in peer education activities, messages discussed, and other information sources. The results of this evaluation will be used to inform and improve the subsequent SHAPE 2 program as it expands to more schools.

Methods

The evaluation used an experimental-control post-test design, comparing results from 10 schools that participated in SHAPE (intervention sites) and 10 comparable schools that did not participate in SHAPE but may have participated in other peer education programs (control sites). About 1,600 students from each of the two sets of schools completed valid survey questionnaires. Of the 3,223 completed questionnaires, 43 percent were from junior secondary schools (JSS) and 57 percent from senior secondary schools (SSS). The mean age of the students surveyed was 14-15 for the SHAPE and non-SHAPE students in JSS and 16-17 for those in SSS. Boys were slightly older than girls.

Results

A significantly higher percentage of SHAPE than non-SHAPE students attended a meeting or educational session taught by a peer educator – among girls, boys, and both age groups (see table). Even so, knowledge and most attitudes were not significantly different between the intervention and control sites.

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Select Indicators of HIV Knowledge, Attitudes, and Behaviors of JSS and SSS Students

	Junior Secondary School (JSS) Students				Senior Secondary School (SSS) Students			
	Females		Males		Females		Males	
SCHOOL:	SHAPE	Non-SHAPE	SHAPE	Non-SHAPE	SHAPE	Non-SHAPE	SHAPE	Non-SHAPE
	N=355	N=227	N=337	N=453	N=448	N=489	N=485	N=429
Percent attended educational sessions with a peer educator in last 12 months	75% *	59%	73% *	55%	67% *	56%	55% *	46%
Ways to avoid HIV/AIDS sexual transmission (number correct out of 6) #	4.1	4.2	3.7	3.8	4.5	4.3	4.3	4.3
Misconceptions about HIV/AIDS transmission (number rejected out of 4) #	3.7	3.6	3.7	3.6	3.8	3.9	3.8	3.9
Believe have control over risk and protective behaviors (number out of 7) #	4.0	3.9	4.3	4.3	4.2	4.3	4.6	4.5
Positive attitudes about sex and condom use (out of 8) #	4.6	4.5	4.8	4.7	5.7	5.6	5.5	5.5
Percent ever had sexual intercourse +	NA	NA	NA	NA	6% *	17%	25%	27%

* p < 0.05 # Mean + Asked of SSS students only

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Knowledge of HIV/AIDS was high among both groups. There were no significant differences in average knowledge scores on such questions as ways to avoid sexual transmission of HIV/AIDS and misconceptions about transmission (see table). However, a higher percentage of girls in the intervention groups did know that the only way to avoid unwanted pregnancy and sexually transmitted infections (STIs) is through abstinence (e.g., 76 percent in intervention sites vs. 65 percent in control sites for JSS girls) and that condoms are the only family planning method that also protects against STIs (e.g., 31 percent vs. 22 percent for SSS girls). There were no differences for boys.

Attitudes about love and sex were similar among students in SHAPE and non-SHAPE schools, including survey responses about risk and protective behaviors and condom use (see table). Attitudes did not differ significantly between SHAPE and non-SHAPE schools on such complicated issues as whether using a condom is a sign of not trusting your partner and the degree of control over using condoms.

Significantly fewer girls from SHAPE schools reported ever having sexual intercourse, 6 percent compared to 17 percent from control sites. However, there was no significant difference in the percentage who had ever had sexual intercourse among those who had actually participated in SHAPE activities and those who had not. In contrast, among boys, the percentage reporting ever having sexual intercourse was about the same in the SHAPE and non-SHAPE groups (25 percent and 27 percent).

SHAPE students generally reported more positive attitudes about PLWHAs than did the control group, with fewer differences between girls and boys. A higher percentage of SHAPE students felt PLWHAs should be treated like everyone else and students with HIV should be allowed to continue classes. A significantly higher percentage of SHAPE students felt that teachers with HIV should be allowed to continue teaching, 51 percent (girls) and 59 percent (boys) compared to the control group (39 percent, girls; 49 percent, boys). Nonetheless, about seven of ten students from both SHAPE and control sites would feel worried going to school with a person who had HIV.

Conclusions and Implications

The study found that a high percentage of students in both SHAPE and non-SHAPE schools have attended peer education programs, suggesting that programs appear to be operating in the other schools. Even though the percentage attending peer education programs was higher in SHAPE schools, the differences in the measures studied were not great. The *marginal impact* of the SHAPE program over and above that of other peer education programs did not seem significant.

One difference was that girls in SHAPE schools were less likely to have had sexual intercourse. However, it is not likely that this difference in behavior can be attributed to the SHAPE program given that there were few significant differences in knowledge and attitudes between students in SHAPE and non-SHAPE schools. Moreover, those students who actually participated in SHAPE activities were about as likely to have had sex as those who did not.

SHAPE students appear to be more tolerant of PLWHAs than non-SHAPE students. In all four comparisons, for example, students in SHAPE schools were more likely to say that a student with AIDS should be allowed to continue studying and these results were significant in two of four comparisons (JSS boys and SSS girls). However, fear and stigma of attending school with someone infected did appear high among both groups. The program could put more effort into developing tools for greater acceptance and tolerance of PLWHAs.

A strong comprehensive peer education program needs to devote considerable support and monitoring to ensure that peer educators convey correct information regularly on all topics designed for discussion. They also need to address sensitive issues such as thinking that condom use is a sign of not trusting one's partner.

— Susan Adamchak and Barbara Janowitz

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