Overview

Worldwide, 222 million women have an unmet need for family planning (FP), mainly because they lack access to information, education, and contraceptive services. The reproductive needs of adolescents and youth, in particular, are often overlooked, and as a result they have among the highest rates of unmet FP need.

Increasing access to FP for youth has several health benefits, including reducing rates of unwanted pregnancies, unsafe abortions, and sexually transmitted infections (STIs). Furthermore, delaying pregnancies reduces fertility rates and leads to improved maternal and child health across the population.

The adolescent fertility rate in Madagascar is particularly high at 115 births per 1,000 women aged 15–19, compared to the global average of 44 per 1,000. Young people aged 10–24 represent almost one-third of the total population of Madagascar; therefore, it is important that health services, including FP, target youth.

One approach that has proved successful in increasing FP among adolescents and youth is the use of peer educators. For example, a 2001 study in Cameroon found that exposure to peer-education is significantly associated with greater knowledge and use of FP over an 18-month period. The theory behind the efficacy of peer-led health education is that health attitudes and practices formed during youth are carried into adulthood, and that adolescents are strongly influenced by their peers, thus peer educators may act as credible role models who will have an impact on health behaviors.

Using this theoretical framework, the USAID Mikolo Project, in collaboration with the Ministry of Public Health and the Ministry of Youth and Sports, established a Youth Peer Educators (YPE) initiative. The initiative aims to improve youth education and awareness on reproductive health and FP in order to increase contraceptive prevalence rates among 15–24 year olds in USAID Mikolo intervention areas. Ultimately, the goal of the approach is to reduce the adolescent fertility rate and improve reproductive health outcomes among the youth population.
THE USAID MIKOLO PROJECT increases access to and availability of community-based primary health care, especially for women of reproductive age, children under age five, and infants living in remote areas in Madagascar. Implemented by Management Sciences for Health (MSH), with partners Action Socio-sanitaire Organisation Secours, Catholic Relief Services, Institut Technologique de l’Education et du Management, and Overseas Strategic Consulting, Ltd., the project is aligned with Madagascar’s national community health policy and specifically focuses on reproductive health; family planning; maternal, newborn, and child health; and malaria prevention and care. The five-year project serves an estimated 4.6 million people who live more than five kilometers from a health facility in 8 of Madagascar’s 22 regions, 42 districts and 506 communes.

The USAID Mikolo Project supports the Ministry of Public Health by training and supporting community volunteers to support a continuum of care under the supervision of the local health center. The community-based delivery of the service package they offer is endorsed by the World Health Organization and has been shown to be an effective way to address shortages of human resources without compromising the quality of care.

Figure 1: Evolution of young NU and RU (15–24 years old) after the YPE training sessions

THE USAID MIKOLO PROJECT - USING PEER EDUCATION TO INCREASE CONTRACEPTIVE USE AMONG YOUTH

YOUTH PEER EDUCATOR STRATEGY

1. Increase the qualitative and quantitative participation of young men and women in decision-making structures and mechanisms at the community level.

2. Increase the number of young men and women who use health care services tailored to their needs.

3. Increase the quality of services provided by community health volunteers at the community level as they adapt to the needs and concerns of youth.

4. Improve the adoption of healthy behaviors by young people, particularly regarding the age of sexual debut, marriage, and early pregnancy.

APPROACH

According to the criteria established by the USAID Mikolo Project and the Ministry of Youth, each Fokontany (village) chooses a young person who will act as a peer educator.

Pools of trainers at the district level were trained, and they in turn trained the YPEs. Training topics included leadership, peer education, youth and adolescent health, as well as the development of an action plan by Fokontany. USAID Mikolo has trained 2,639 YPEs, of whom 2,462 are active in following up a youth group, using educational material, and reporting data in a timely manner.

Each trained YPE is responsible for creating a youth group of 15 to 25 members, therefore reaching 39,600 to 66,000 youth. Each month, these YPEs educate their youth groups on postponing sexual debut, delaying first pregnancies, managing STIs, and getting antenatal care for those who have become pregnant. YPEs facilitate these education sessions through interpersonal communication materials, group discussions, and interactive activities, including sporting events.

YPE group activities are mainly concentrated at the district level through youth houses, which are meeting centers for sports and recreation. Furthermore, a doctor – likely the head of the local health center – regularly provides the youth with health care and counselling on health activities and services.

All activities carried out during the month are reported and sent to the basic health centers and then collected by USAID Mikolo staff to be entered into the central database. YPEs are evaluated twice a year, and those who perform well receive further trainings.

In addition to increasing awareness about sexual health and the use of FP, several other activities were implemented as a means to strengthen the initiative, such as advocacy and partnership development. For instance, in order to increase the participation of young men and women in the decision-making structures, advocacy meetings were held at the 506 municipalities in the project area. Additionally, awareness-raising sessions were held for project staff recruiting peer educators. Moreover, to reinforce youth knowledge and to expand to a broader audience, the project has developed standard messages, broadcast radio spots, and conducted community mobilization days around sports tournaments.

Finally, project field technicians conduct on-the-job training and supervision of community health volunteers (CHVs) every two months (as opposed to at the health center where they meet in groups). At that time, the field technicians also supervise the YPEs.
The scores obtained during two successive supervisions are collected in a grid and used to evaluate the YPEs. Those who reach more than 80% average score are called “performing YPEs” and will benefit from training in counselling for the four FP methods (FP4): the pill, condom, Depo-Provera, and natural method. They will help improve the contraceptive prevalence of young people aged 10–24 and reduce maternal and child mortality in their respective communities. They do not, however, offer injectable contraceptives, but rather refer to CHVs and/or the health center. About 2,000 YPEs will be trained in FP4 in 2017.

**RESULTS**

Results indicate that after YPE training there was an increase in the number of regular users (RU) and new users (NU) of FP in the 15–24 age group (Figure 1), which can be attributed to several factors: awareness-raising by the CHVs; the introduction of pregnancy tests in 2015; and the YPE activities. Further analysis was conducted in order to ascertain the contribution of the YPEs to this increase in FP use, which revealed that the YPEs played a significant role.

Most of the YPE training took place in July and August 2015. Before this period, the number of new FP users had a fairly stagnant growth. Figure 1 shows that after the training of the YPE, the number of NUs in the 15-24 age group increased by 1,892. However, it should be noted that during this period, pregnancy tests were also introduced into the CHVs’ service package.

Thus, this increase in FP users could be attributed to both the FP awareness-raising activities led by the YPEs and to the introduction of pregnancy tests.

Similarly, before the implementation of the YPE initiative, the number of 15–24 year-old RUs increased by 6,226 in a 10-month period. However, after the training of the YPEs, the project recorded an increase of 7,205 RUs for only four months, signifying an acceleration in the rate of FP uptake and continuation.

This analysis also examined the FP uptake after the initiation of YPE by age. It is interesting to note that, between the youth age divisions, the rate of FP uptake is higher amongst those aged 15–19 (~45% increase in NUs), compared to those aged 20–24 (~30% increase). However, when comparing all youths aged 15–24 to those over 25, the rate of uptake is slower, at 38% versus 47% (Figures 2 and 3).

On the other hand, the same analysis for RUs indicates that the increase after YPE initiation is also greater among 15-19 year olds (~39%), compared to 20–24 year-olds (~26%). However, the increase in RUs is greater amongst youth (~32%) as opposed to those over 25 (~29%) (Figures 4 and 5), which may suggest that youth in zones with YPEs are more likely to continue to use FP than those who did not benefit from a YPE.
DISCUSSION

The YPE program initiated by USAID Mikolo shows promising results in terms of uptake but especially continued use of FP among youth. This result is extremely promising, as continued FP use leads to a later onset of first pregnancy, which generally reduces a woman’s lifetime fertility rate, ultimately improving maternal and child health outcomes.1

However, the data also reveals that the project has not yet succeeded in accelerating the rate of FP uptake (NUs) among youth compared to the general population (over 25). This might be because YPEs only provide education and FP-promoting activities – not actual services.

These results suggest that, while this program helps increase awareness of FP, it may not automatically translate into increased demand. To increase demand for new uptake of FP, supply-side mechanisms must also be in place. Supply-side activities include ensuring that youth have reasonable geographic, administrative, and financial access to a range of contraceptive options. Moreover, quality of care is an important consideration and underscores the importance of engaging parents, religious leaders, and especially health providers in the initiative. For instance, if providers have negative attitudes about providing FP to unmarried youth, that might deter the youth from returning for future services.

LESSONS LEARNED

The primary target of the YPE program is all adolescents and young people aged 15–24 years (both enrolled in the sessions and non-enrolled), while the secondary targets include parents, religious leaders, and health care providers. It is possible that a generational conflict exists between young people and their parents, and if so, a parent-centered strategy should also be adopted. While increasing adolescent reproductive health education is crucial, sustained increases in FP use will require strengthened community support at different levels.

Additionally, perhaps the greatest lesson learned is that because the YPEs are not trained to distribute any contraceptive methods, the demand generated by their education activities is not being fully met, as expected. The youth participants may want to seek FP services, but having to go to a health center or a CHV, instead of a YPE, deters use.

WAY FORWARD

The USAID Mikolo Project is currently attempting to get the Ministry of Public Health’s approval to enable the peer educators to distribute FP methods, including pills and condoms. Doing so would potentially help to overcome access barriers that are preventing the youth participants from adopting FP methods.

Moreover, greater attempts to engage the wider community in this initiative may help to further increase the FP uptake rates by reducing any generational conflict between youth and their parents or other community elders. Thus, targeting opinion leaders through advocacy may help to garner further support for adolescent and youth FP use.

In addition, the data reveals that adolescents have greater rates of both new use and continued use than the youth aged 20–24. This suggests that the YPEs could adapt their activities to more specifically target the older youth, and that outreach activities to recruit participants could focus more heavily on 20–24 year olds.

Finally, supervision should be maintained as a mechanism to ensure sustained motivation and high-quality performance by the YPEs. This is particularly important if the YPEs are further trained in distributing methods, not just in education activities.

CONCLUSION

Evidence for the YPE program is positive and suggests the peer education is effective in increasing the adoption of FP by adolescents and youth as well as in increasing sustained FP use. Additional data collection and analysis should be conducted to obtain more statistically significant results that can ascertain the definitive correlation between the YPEs and FP use in Madagascar.

The YPE program can be strengthened by improving the education and activities geared towards the older youth, as well as by training the peer educators to distribute FP methods, which may further accelerate the rate of FP adoption among adolescents and youth.

Finally, the results of this study will be used to determine the possible extent of scaling up the YPE initiative across the country.

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