

Research on

The Role of Peer service providers in Addressing Sexual Reproductive Health Services to Young People of Adama Town: The case of Family Guidance Association of Ethiopia Adama youth center

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Abstract

Worldwide, young women and men suffer from different SRH problems including; unplanned pregnancies, abortions, STDs, HIV/AIDS, female genital mutilation, infertility, sexual and gender violence. Following the Cairo, 1994 ICPD, some national and international NGOs have been starting implementing youth focused SRH programs in Ethiopia. FGAE is one of the national non-governmental organizations that provide integrated SRH services for young people its 28 youth centres. FGAE Nazareth Youth Centre of Adama town is one of the multipurpose youth centres run under central area office. The youth center provides various SRH services to young people in Adama town using clinic and outreach. The PSPs were providing various SRH services to the beneficiaries in outreach level. But there is no any research done on their output. Therefore the major objective of this study was to assess the practices and challenges of peer service providers in providing SRH services for the young people in Adama town. The research design used was descriptive survey method that employed qualitative data gathering techniques. Hence, interview, FGD and assessing records of PSPs were the data gathering instruments utilized. For this research, 32 PSPs, and four staff directly involved with PSPs were the study group. As data gathered showed all PSPs were providing similar

SRH services to the beneficiaries; SRH/IEC, counseling, FP, condom promotion and distribution, EC, referral, and FLE training were the major services. The factors that significantly associated with PSPs performance level were: age, the time allocated for service per week, number of service years before and after being PSP, the degree of involvement in the youth center activities. The PSPs had got different support from the youth center as well as from other organizations. Challenges encountered during implementations were found out absence of transportation facility, shortage of up-to-date material, resistance from the community, financial constraints and disinterests of the client were listed as the major factors. In general, we can conclude from this study PSPs were playing important role in addressing SRH services to the young people in Adama town. Hence, the researcher recommended that in order to enhance the role played by PSPs the youth center should involve them in all programmatic activities.

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List of Acronyms

- AIDS:** Acquired Immuno Deficiency Syndrome
- AHO:** Adama Health Office
- CBRHAs:** Community Based Reproductive Health Agents
- CDC:** Center for Disease Control
- CI:** Confidence Interval
- CSW:** Commercial Sex Workers
- DHS:** Demographic and Health Surveys
- EC:** Emergency Contraception
- IEC:** Information, Education and Communication
- IPPF:** International Planned Parenthood Federation
- FGAE:** Family Guidance Association of Ethiopia.
- FGD:** Focus Group Discussion
- FHI:** Family Health International
- FP:** Family Planning
- GBV:** Gender Based Violence
- HAPCO:** HIV/AIDS Prevention and Control Office
- HIV:** Human Immunodeficiency Virus
- HTP:** Harmful Traditional Practice
- ICPD:** International Conference on Population and Development
- JHU:** John Hopkins University
- MOH:** Ministry of Health
- NGOs:** Non-Governmental Organizations
- NYC:** Nazareth Youth Center
- OR:** Odds Ratio
- PE:** Peer Educator
- PLWHA:** People Living With HIV/AIDS
- PSPs:** Peer Service Providers
- RH:** Reproductive Health
- SRH:** Sexual Reproductive Health

STD: Sexually Transmitted Disease

STI: Sexually Transmitted Infections

UN: United Nations

UNESCO: United Nations Economic and Social Council

UNICEF: United Nations International Children's Emergency Fund

VCT: Voluntary Counseling and Testing

WHO: World Health Organization

YFS: Youth Friendly Services

YRHS: Youth Reproductive Health Service

Chapter I. Introduction

1.1 Background

Reproductive health (RH) is defined as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters related to the reproductive system and its functions and processes (WHO, 1997). Worldwide, young women and men suffer from a disproportionate share of unplanned pregnancies, abortions, sexually transmitted diseases (STDs) including HIV/AIDS, female genital mutilation, malnutrition and anemia, infertility, sexual and gender violence, and other serious reproductive health problems (FHI,1997).

Erikson defines adolescents, elementary and middle school age and young adult as age groups from 12-18, 6-12 and 19-40 years, respectively and young people currently account for over 30% of the world's total population (UNICEF, 2009). During 2001 the world began to focus increasing attention on the needs and problems of young people .The United Nation named 1985 the international year of youth. At the global level, the Program of Action of the International Conference on Population and Development, held in Cairo in 1994, placed great emphasis on the problems and needs of adolescents. The reproductive health needs of adolescents as a group have been largely ignored to date by existing reproductive health services (FHI, 1997).

In the same way UNICEF is concerned about youth because what happens during this period of growth and development has a profound impact on young people's health as adults and the health of their children. Moreover the middle school year and adolescents develop lifelong attitudes and behavior during this period of transition between child and adulthood (UNICEF, 2009.).

The second decade of life is a period of rapid growth and development for young people's bodies, minds and social relationships. It is the period of great opportunities, new ways of thinking about things, of new influences, of changing roles and responsibilities. The age between 15 and 24 years is a critical stage in a person's life, representing the transition from childhood to adulthood. During this period, certain decisions that have an impact on an individual's future are made, including whether to stay in school, find employment, initiate sexual relations or try drugs,

to name a few (UNESCO,2001). Millions of young Africans are at risk for unwanted pregnancies, HIV/AIDS and other reproductive health problems. The statistics are staggering: every minute, six young people are infected with HIV; of them, five live in Africa (JH University, 2002).

Young people constitutes one third of the total population in Ethiopia. Their number is estimated to grow from 20.3 million in 2000 to 27 millions in 2015.The reproductive health problem of young people in Ethiopia are multifaceted and integrated. Child bearing begins at an early age: forty-five percent of the total births in the country occur among adolescent girls and young women. Sexual violence and commercial sex work have become common phenomenon among young girls. As a result, they have become primary victims of the HIV/AIDS crises that have spread throughout the country. In general, young people are at great risk for reproductive health problems. The situation is aggravated by the overall poor socio economic, environment and harmful traditional practices. Because of the complex nature of the problems, youth reproductive health strategies demand multi-sartorial and integrated approach (Pavd., 2002).

Following the Cairo, 1994 International Conference on Population and Development (ICPD), some national and international NGOs have been starting implementing youth focused SRH programs in Ethiopia. The Family Guidance Association of Ethiopia (FGAE) is one of the national non-governmental organizations that provide integrated SRH services for young people in its 28 youth centres and 18 SRH clinics located in different branches of the country. The association is a non -profit making, voluntary based sexual and reproductive health organization that possesses a long years of experience in the delivery of a wide range of reproductive health services (FGAE, 2007).

Peer education has been used in many areas of public health, including nutrition education, family planning, and substance use and violence prevention. Use of peer education in the realm of HIV/AIDS and reproductive health stands out because of the number of examples of its use in the recent international public health literature. Because of this popularity, global efforts to further understand and improve the process and impact of peer education in the area of HIV/AIDS prevention, care and support SRH services have also increased. Questions concerning the nature of a peer and what constitutes education have a range of answers. Peer education

typically involves using the members of a given group to effect change among other members of the same group. Peer education is often used to effect change at the individual level by attempting to modify a person's knowledge, attitudes, beliefs, or behaviours. However, peer education may also effect change at the group or societal level, by modifying norms and stimulating collective action that leads to changes in programmes and policies. ” (Flanagan and Mahler, 1996).

Peer education is defined as a process, a strategy, a communication channel, and a tool. Most commonly, in terms of youth, it is viewed as a process whereby well trained and motivated young people undertake informal or organized educational activities with their peers (those similar to themselves in age, background, or interests). Peer education activities generally take place over a period of time. The goal is to develop knowledge, attitudes, beliefs, and skills needed to engage in healthy behaviors. (Youth net, 2006)

The Family Guidance Association of Ethiopia (FGAE), which is a pioneer of youth programs in Ethiopia, started its services in early 1980's with the provision of Family Life Education. It established its first youth center in Addis Ababa in 1990, with the objective of providing youth friendly reproductive health services and replicated it in a more widely geographical coverage since 1992. The Youth Centers under the eight Area Offices operate with the intention of addressing the pertinent SRH needs of young people where by vital focus given to the underserved young people in their vicinities. The target groups of intervention areas comprise of young people in the age range between 10 to 24 years of age. All Youth Centers strive for promoting awareness of young people towards SRHR through various IEC/BCC intervention activities such as youth dialogue facilitation and edutainment.

Moreover, the youth centers provide integrated SRH services to the youth including FP services, STI diagnosis & treatment, emergency contraception, HIV/AIDS related services such as testing, counseling as well as OI treatment and comprehensive abortion care among others. The Youth Centers are also exerting their efforts to strengthen young peoples' involvement in governance, SRH Communication & Promotion and program implementation. Organizing youth in clubs, associations and youth action movement for Health is believed to realize involvement of young people in the youth centres' project interventions. Similarly, Project Advisory Committee (PAC)

members selected from GOs&CBOs also play advisory role during the execution of planned activities with closer supportive follow up. Some of these youth centers have been implementing a project with the initiative of youth livelihood development.

(Taffa N. et al, 2012)

Nazareth Youth Centre (NYC) is one of the multipurpose youth centres run under FGAE central area office of the association which is located at Adama town kebeles 12. The centre was opened in 1998 with the aim of reducing socio cultural, gender, legal, religious, political and economic barriers that limit access to and utilization of SRH information, education and services among young people reside in Adama Town and its surrounding areas. The Adama youth centre provides various youth friendly services to young people so as to alleviate the SRH problems and to develop positive sexual related behaviours. Among the services provided by the centre are providing SRHIEC /sexual reproductive health information education and communication/, counselling on different youth SRH issues, HIV/VCT services, Family planning methods, STI diagnosis and treatment, Gynaecological, medical, library, recreational and training on different SRH issues are the major ones.

The youth centre employed various strategies to disseminate SRH messages and services to young people in Adama town. Facility based services through trained staff in the clinic, and community outreach level through Peer services providers /PSPs and other youth clubs; music and drama troupe, girls', SRH, mini media and library clubs. Among the voluntary youth groups, employed in the youth centre, the PSPs are the main actors in providing the SRH information, education and services to the young people in outreach level.

Through PSPs it is planned to address young people in their respective residence kebele. The main services that are provided by this youth groups are: SRHIEC, counselling, non-prescriptive family planning/FP/, emergency contraception, family life and sex education /FLE training. PSPs refer clients for those who need services beyond the level of to the nearby health institutions with full information. Furthermore, the PSPs are organizing SRH clubs in their respective living kebele after they have trained the young people on FLE training.

In Adama youth centre the PSPs are try to promote participation of adolescents/young people in governance and in the identification, development and management of programs that affect them.

They also engaged in increasing access to comprehensive, youth friendly, gender-sensitive sexuality education and to increase access to a broad range of youth friendly services. Reducing gender-related barriers and practices which affect the sexual and reproductive health and rights of young women and increasing young people's awareness on their SRHR and available services and integrated, quality, gender sensitive and youth friendly SRH services is some of the task they engaged in.

In this regard the Adama youth center lacks clear documented duty and responsibility in the service the reproductive health service package the PSPs offered and the training curriculum they provided to increase their level of their knowledge in serving their peer groups. Besides, the youth center has one static clinic in which it provide reproductive health services including the role PSPs played. In this case it is difficult to understand the specific contribution of PSPs in related to the overall service rendered by the center.

1.2 Statement of the Problem

As a strategy, peer education programs train representative young people by providing information on adolescent RH or HIV/AIDS. In turn, these youth are expected to convey this information to their peers. Communication may take place in large group meetings or social events; in smaller, focused discussions; or in one-to-one exchanges between a peer educator and target youth. Peer education is considered one of many tools available to reach young people with information and skills. It is typically used in conjunction with other means of communication and information dissemination, such as media campaigns, advocacy by celebrity spokespersons, and youth-friendly services. (Youth net, 2006)

Peer education programs also have a growing role in advocacy, promoting support for the rights of young people to scientifically accurate information about RH and HIV/AIDS, and where needed, access to youth-friendly services. Peer education frequently generates demand for various health services. A comprehensive program needs to be linked or integrated with services to provide access to condoms and other contraceptives, medical care, voluntary counseling and testing (VCT), and management of sexually transmitted infections (STIs). In some cases, peer education programs may develop links with programs offering support to orphans or home and hospice care.

The AdamaFGAE youth center's peer education is often undertaken because it is thought to be an easy and convenient way to reach a large number of people with information and various SRH services, using inexpensive, volunteer staff. But when done well, peer education requires intensive planning, coordination, supervision, and resources. There are program costs inherent in each element of a peer education program – training, support, supervision, supplies, allowances – all of which require realistic budgeting and careful monitoring.

Peer educators or peer service providers/ as called by the FGAE/ have been providing the SRH services including information, education and communication to young people in Adama town since the establishment of the youth centre in Adama town. However, this type of voluntary based services hasn't got any attention till now. No study or written documents are found to be evidenced. Therefore, the basic aim of this study is to assess the practice of PSPs in addressing SRH services to their colleagues in the town. It also assesses the type of challenges encountering during the service provision.

1.3 Objective of the study

The General objective of the study is to assess the role of peer service providers of the Nazareth youth center in addressing the SRH services of the young people in Adama town

Specific objectives:

- To assess the activities of peer service providers in addressing young people's SRH issues.
- To identify the method in which the PSPs applied in disseminating SRH information and education to their peers.
- To assess the extent of PSPs involvement in the youth center to alleviate youth SRH problems.
- To assess factors influencing PSPs voluntary services
- To identify factors that enhances the role of PSPs in addressing the SRH services to young people.

1.4 Significance of the study

This research will help the youth center to recognize the SRH services given by the voluntary youth group and to improve the type of support given to this group. It also helps to identify the challenges that encounter the PSPs performance so as to design strategy for resolution of the challenges. Since there was no any endeavor to study in this issue, this research may support for those who are interested in this area as spring board for further investigation. The research will also able the youth center to incorporate necessary imputes while designing a plan. The PSP also can benefit by knowing hindering factors for better performance and will bring better achievements. It also is an opportunity for organizations working directly and indirectly with PSP to revise their strategies to address the problem of young people at Adama city.

1.5 Scope of the study

The scope of the study is delimited to youth in Adama town where FGAE youth center is found. Though the issue is very important if it applicable to other places where youth centers are established to improve the sexual behavior of the young people, but the research area can represent the active PSPs currently serves in all FGAE youth centers.

1.6 Exclusion criteria

- A. Very seriously ill and not tolerate their pain
- B. PSPs who start work for less than a year.
- C. Beneficiaries who was not volunteer to participate in the study.
- D. PSPs who is not around due to personal reasons during the study

1.7 Limitation of the study

This study was focused on qualitative aspects. In this case it may heavily dependent on the individual skills of the researcher and more easily influenced by the researcher's personal biases. Rigor is more difficult to maintain, assess, and demonstrate. The researcher's presence during data gathering, which is often unavoidable in qualitative research, can affect the subjects' responses. Issues of anonymity and confidentiality can present problems when presenting findings. Qualitative methods of data collection and analysis incorporate a wide range of

different techniques and epistemological assumption and careful selection of qualitative methods.

1.8 Ethical considerations

A letter of permission obtained from St. Merry University collage and FGAE office. Permission also obtained from each study participants after briefly describing the objectives of the study. All the FGDs were made with strict privacy after getting verbal informed consent from the respondents and assuring the confidential nature of the responses. The right of the respondents to refuse answer for few or all of the questions was respected. The study subjects also be assured that they had the right not to participate or even they could have right to quit the participation any time.

1.9 Definition of terms (concepts)

Elementary and Middle School Years - it is defined as 6 – 12 years

Adolescence: - defined as 12-18 age groups of people.

Youth: - the age group of people between 15 to 24 years.

Young people: the term used to cover the composite group of 10 to 24-year-olds

Active PSPs: Peer service providers who are working currently and regularly (monthly) submitted third report of their activities to the youth center

Supervision: purposeful and helpful or educative type of activity-monitoring and evaluation of the PSPs' activities by youth center staff.

Basic SRH training: it is the type of training which focuses on basic SRH issues to the PSPs before they are assigned to the activity

Refresher training: it is in-service training aiming at upgrading the knowledge of PSPs on sexual and reproductive health issues.

Youth-friendly health services: those that can attract youth to the facility or program, provide a comfortable and appropriate setting, and meet young people's needs

High performance: PSPs who achieved on average 80% & above of targets from the monthly planned performance.

Low performance: - PSPs who perform below 80% of their monthly target plans.

CHAPTER II. Literature Review

There are different researches finding which indicates the effectiveness of using peer approach in reaching the SRH needs of young people. Accordingly, some of the research findings will be presented here. Peer education has found many programme and project applications all around the world and, in many of them, studies have been conducted and found out that the peer-to-peer approach is natural and effective, especially in increasing levels of knowledge. What is unclear due to the scarcity of long-term studies is how much the peer education intervention has changed behavior in the long term. Nevertheless, these studies have found that peer-assisted interventions “enhance HIV knowledge and decrease risk behaviors” (Advocates for Youth Fact Sheet, n.d., p. 2 of 4).

2.1 The association between PSP service and the family

An instructive pilot study of a peer education effort which found in Ghana confirms the positive advantages of applying peer education for young people. It found that in the culture of the target group, families were a very high source of adolescent reproductive health information. Therefore, its recommendation is to include the family as part of the overall intervention. The pilot study found (Wolf, Tawfi, and Bond, June 2000, pp. 61-80): peer educators tended to reach peers of their own gender, but there was considerable crossover as well. Peer educators tend to reach peers similar to themselves, for example, by age, religion, ethnic background, social clubs, schools, and interests. Peer education can happen in many different settings, though the most common was in schools. Nearly half of the encounters involving peer educators were with their friends; young people.

In Ghana young people tend to seek advice on issues related to adolescent reproductive health from their family’s accounts (53%) while from their friends (42%). Therefore it was considered necessary to build the family into the loop of the intervention. This study underscores three valuable points: first, peer education is effective at reaching a target audience very similar to the peer educators; second, there are often other factors that also can be effective and that should be

brought into the intervention; and third, carefully setting the intervention to the context of the target audience is essential (Wolf,2000).

A process evaluation of the Youth Reproductive Health Initiative, implemented by the Reproductive Health Association of Cambodia (RHAC), indicated very positive results which being achieved and noted as recommendations for improvement peer based services. The youth reproductive health initiative was implemented as a pilot project involving a peer education programme, in Phnom Penh, Sihanoukville, and Battambang in 1999. In this initiative, high school students were trained to provide reproductive health information to their peers, both in and out of school. At the same time, health clinic services for youth were established at the same locations. These clinics were provided with a waiting room/library for youth to find access to health information in the form of books, magazines and audio-visual materials (Pathfinder, 1997).

2.2 The association between PSP service and training

A study sponsored by AIDSCAP of 21 peer education projects in ten countries in Africa, Asia, Latin America and the Caribbean identified the need for initial and reinforcement training of peer educators; continuing follow-up, support and supervision. It was clearly understood expectations of the peer educator's role; and continued incentives and motivation strategies (UNAIDS, 1999):

According to UNAIDS findings, One of the most striking lessons learned from the application of peer education is that the first beneficiaries were the peer educators themselves. Not only do they report positive changes in their own knowledge, attitudes and behaviors, but the skills they learn through the initial training and follow-up workshops provide them with real life skills that will help them as they grow and mature.

Training for peer educators needs to be an on-going process. Refresher training sessions should be offered periodically. At the same time, in order to sustain the interest of long serving peer educators, more advanced training should be offered. This can become an important incentive for young people becoming peer educators in the first place, and for their continued participation.

Continuous weekly training sessions proved to be critical for the peer educators. One long intensive training is not enough to capacitate their skill. It was found useful to ask the educators to take time to invent their own games, based on the knowledge and skills they had acquired from trainings” “It is important to hear what the educators are saying...it is equally important for them to be listening to what their groups in school are saying” (UNAIDS, 2002).

Other research also conducted in Tanzania to evaluate the youth friendliness services of the youth center. The data showed that, many youth clients were provided friendly service and offered information on HIV and abstinence from them. The study also found youth increased their SRH knowledge as a result of their exposure to a peer service provider. The majority of peer providers demonstrated proper condom use and communication skills through their assessments. Challenges to implementation included interruptions in supplies such as BCC materials and contraceptives for facilities and peer providers, community misperceptions of ASRH, heavy workload of facility staff, lack of understanding of the term YFS by youth clients, and lack of adequate monitoring and supervision of facilities and peer providers (Path finder international, 2005).

2.3 The key debates and challenges

The peer workforce and peer services currently face many opportunities and risks. There is an unprecedented opportunity for peer services to be securely funded through mental health systems. But this presents the greatest risk to peer services - that mainstream services will ‘colonise’ peer and create a workforce and services ‘in their own image’. There are fears and signs that the peer workforce in mainstream settings is poorly understood, underpaid, discriminated against and expected to work according to traditional values and ethics. There are debates among peer leaders about the risks of developing peer services within mainstream settings and professionalizing the peer workforce.

2.4 Peer Educator Performance

According to the assessment conducted in South Africa youth centers, the performance of peer educators seem to vary considerably, both between programmes and among peer educators themselves. The mean number of contacts per peer educator in a week ranged from 5 to 42.

Within programmes, there was further variability between peer educators. For example, peer educators in one youth center contacted as few as 5 young people in a week and as many as 97 young people during the same period (South Africa,2001).

In most centers, the majority of young people contacted by peer educators were in school. With the exception of Thlokomelo and Empangeni, the majority of contacts made were in a group setting, rather than individual encounter. The most common topics covered by peer educators were STIs, teen pregnancy, condoms, HIV/AIDS and family planning. Peer educators were significantly more likely to talk to boys about STIs and HIV/AIDS, compared to girls, while they were significantly more likely to talk to girls about family planning methods (South Africa, 2001).

2.5 The association between PSP and Motivation

Peer education is often undertaken because it is thought to be an easy and convenient way to reach a large number of people with information using inexpensive volunteer staff. But when done well, peer education requires intensive planning, coordination, supervision, and resources. There are program costs inherent in each element of a peer education program – training, support, supervision, supplies, allowances – all of which require realistic budgeting and careful monitoring (youth net, 2006).

A study in Kenya concludes that volunteers who are supervised more frequently tend to meet with more clients. The research record done in Kenya generally shows that paid workers perform better than volunteers. When agents are paid, supervision can be rigorously exercised, programs can be standardized and designed to cover populations, and service quality can be maintained. Community based distribution programs that use volunteer workers are more complex to manage (MOH, 2004).

An assessment of CBRH services conducted in Ethiopia during 2002-2003 had shown that Volunteers' agents had supervisors. Only 58% of the respondent said that the supervision they received was adequate. In the same study, a significant proportion of the agents (48%) recommended that supervision should be more frequent to ensure improved and efficient

provision of family planning services. Most observers agree that the quality and intensity of volunteers' training is the most important single determinant of program quality and impact. Training generally works better when it is competency based, incremental and practical (FHI, 1999).

2.6 The role of PSP in RH & HIV/AIDS/

Meaning of Peer Education and Type of Activities

Peer education is a popular concept that variously refers to an approach, a communication channel, a methodology, a philosophy, and/or an intervention strategy. The English term *peer* refers to "one that is of equal standing with another; one belonging to the same societal group especially based on age, grade or status." The term *education* (v. educate) refers to the "development," "training," or "persuasion" of a given person or thing or the "knowledge" resulting from the educational process (Merriam Webster's Dictionary 1985). In practice, peer education has taken on a range of definitions and interpretations regarding who are a peer and what is meant by education (e.g., counseling, facilitating discussions, mobilizing for advocacy, lecturing, distributing materials, making referrals to services, and providing support (Shoemaker et al. 1998; Flanagan et al. 1996).

The study conducted in Albania indicated that peer education typically involves training and supporting members of a given group to effect change among members of the same group. Peer education is often used to effect change at the individual level, with the aim of modifying a person's knowledge, attitudes, beliefs, or behaviors. Peer education may also effect change at the group or societal level by modifying norms and stimulating collective action that contributes to individual change as well as changes in programs and policies. The literature on peer education uses various terms to describe those working in peer-led programs, including peer educator, peer service providers, peer leader, peer supporter, and youth peer educator.

While peers are meant to be similar in basic characteristics to those in their target audience, some programs find it more advantageous to use "peers" who are slightly older, or otherwise different, from their audience. Finally, peer education is considered one of many tools available to reach young people with information and skills. It is typically used in conjunction with other means of

communication and information dissemination, such as media campaigns, advocacy by celebrity spokespersons, and youth-friendly services. (Youth net, 2006)

Another study conducted among PSP service in Addis Ababa, indicated that the activities in peer education programs vary widely in the type and frequency of activities, the number and intensity of contacts, and the frequency of follow-up. Settings include schools, universities, clubs, churches, street settings, workplaces, barracks, or wherever young people gather. Peer education frequently generates demand for health services. A comprehensive program needs to be linked or integrated with services to provide access to condoms and other contraceptives, medical care, voluntary counseling and testing (VCT), and management of sexually transmitted infections (STIs). In some cases, peer education programs may develop links with programs offering support to orphans or home and hospice care. Often, natural connections can be fostered with existing community health and development programs. (FHI, 2005).

2.7 The association between PSP and Youth Reproductive Health Problems

A field research conducted in Meskan and Mareko district indicated that the reproductive health crisis facing young people arises basically from the increase of early and premarital sexual behavior resulting in problems of teenage pregnancy, unsafe abortions and /STI- HIV /AIDS.

The extent of sexual activity, pregnancy, and their health and social consequences among young people of fertile age is only now being recognized as a major health and social problem in many countries. Motherhood at a very young age entails a risk of maternal mortality that far exceeds the average, and the children of young mothers tend to have higher level of morbidity and mortality. Early childbearing continues to be an impediment to improvements in the educational, economic and social status of women in all parts of the world (Path Finder, 1999).

2.8 The association between PSP and Teenage Sexual activity

The study conducted in Debark, Northwest Ethiopia indicated that in Ethiopia, the median age at which women age 25 – 49 first had sexual intercourse is 16. Three in ten women in this age group have had sex by age 15, two in three by age 18, and more than 80 percent by age 20. There is gradual increase in the proportion of young women who have ever had sex. This increase is more pronounced among experienced compared with nearly one in four women age 16 year, 27

percent of women age 17year, and about one in two women age 18 and 19. The percentage of women who have ever had sex increases gradually from 70 percent among women age 20 to 84 percent among women age 24, with the largest percent increase between age 19 and 20. On the other hand, men initiate sex an average of four years later than women (Pan G., 2002).

For urban adolescents, pregnancy is mostly extra marital and almost always ends up in early marriage are one of the cultural traditions that expose young women to reproductive health problems. The 1990 Family and Fertility survey revealed that 34 % of women were married before age 15(CSA, 1993).In Ethiopia, marriage by Abduction is also widely practiced; at the national level, 69 % of the respondents reported knowing that the marriage by abduction took place in their area (National Committee for HTP, 1998).

Unwanted pregnancy is one of the greatest problems a young girl can face. Pregnancy may endanger her health, her chances for education and marriage, and many of her hopes and plans for the future. Her family may even disown her. Many adolescents are too young, too poor, or too inexperienced to care for a child. Consequently, some young women turn to abortion. Where abortions are performed by unskilled providers in unsafe conditions, the risks of serious health complications and deaths are great (Pop. IntProg., 1995).

For urban adolescents, pregnancy is an extramarital and almost always ends up in abortion. In developing Countries, up to 60% of pregnancies in teenage are unwanted.(UNFPA,1998). More than half of all young women (54%) have at least one child by the time they are 20 years old. Another study show that 28% of pregnancies recorded at Yaoundé maternity hospital are among adolescent girls , representing 70 % of all gynecological complication cases. (Cameroonian researcher, 2004).Ethiopia has one of the highest rates of infant and maternal mortality in the world. The data show that the children born to mother in their teens have substantially greater risk of dying young (UNESC,2001)

According to the World Health Organization, Ethiopia has the fifth largest number of maternal deaths. The maternal mortality ratio (MMR) in Ethiopia was estimated at 673 deaths per 100 000 live births in the year 2005, and unsafe abortion was estimated to account for 32% of all maternal

deaths in Ethiopia. The restrictive laws on abortion before May 2005, in Ethiopia have been revised to include four legal grounds in which abortion can be made available, (rape and incest, lethal congenital malformation, physical health and mental health), which contributes to an increase in induced abortion, even though it is not as expected. Recently in 2008, an estimated 382,000 induced abortions were performed in Ethiopia, and 52,600 women were treated for complications of such abortions. There were an estimated 103,000 legal procedures in health facilities nationwide 27% of all abortions.

Nationally, the annual abortion rate was 23 per 1,000 women aged 15-44; the abortion ratio was 13 per 100 live births. Unsafe abortion is still common and exacts a heavy toll on women in Ethiopia. It also shows that almost 58,000 women sought care for complications of induced or spontaneous abortion. Forty-one percent had moderate or severe morbidity, such as signs of infection that were likely related to unsafe abortion. (GEREZGIHERBURUH 2011).

The evidence linking PSPs role and HIV/AIDS is not as clearly documented. Dutercent studies in the United States of America and Africa suggest a complex dynamic relationship between the two. Sexually transmitted Infections (STIs) are a major health problem among young people worldwide. Sexually transmitted infections affect people in both developing and industrialized countries. Those aged 20-24 is at highest risk of infection. STIS have important repercussion on reproductive health and have been shown to increase the risk of infection with the AIDS virus. The fact that relation prior to marriage tend to be unprotected increases the risk of unwanted pregnancy and STIs, including HIV/AIDS, among youth. Young people are increasingly at risk of being infected with STIs. Of the estimated 333 million new cases of STIs that occur in the world every year, at least 111 million occur to youth under age of 25.

The presence of STIs in the body increases a person's chance of contracting HIV by two to five times. This is especially true of any STIs that produce sores or weeping lesions, such as herpes, syphilis, or cancroids. Sexually active youth are at substantial risk not only for HIV but also for other STIs because they tend to have multiple sex partners, to engage in unprotected sex and among young women to have older men a sex partner (UNESC, 2001).Report from different countries; show that young people are the most victims of AIDS. Of the over 60 million people

who have been infected with HIV in the past 20 years, about half became infected between the ages of 15 and 24. Today, nearly 12 million young people are living with HIV/AIDS. Young women are several times more likely than the young men to be infected with HIV (UNESCO,2001)

In a nationwide survey among young adults aged 15-29 years, knowledge about contraception was found to be as high as 90% and 87% for condoms and pills, respectively. But when it comes to practice, only 15% of the males used condom and 39% of the females used pills (Eshete F, 1995). Other study conducted in south Ethiopia indicated, reported condom use rate during the first sexual intercourse was 13.5%, while it was 27.6% during their recent one. Study conducted in rural town of Ethiopia revealed that, 65.7% of sexually active group reported to have used some form of modern contraceptive in the past. The evidence demonstrates that early sexual activities coupled with none or low FRM use causes unintended pregnancies, which in most cases end up with illegal abortion (Gebresilassie A, 1995).

In a study conducted in USA indicated that young people are increasingly at risk of abusing substances. The substances used by youth are usually those readily available, including alcohol, tobacco, pharmaceuticals, volatile solvents, illicit drugs and other psychoactive substances. Experimentation with drugs often begins at childhood or adolescences. In developed world, during the last quarter of century, drugs have invaded the society especially the Youth. Presently it is also in rapid spread in the developing world including our country due to urbanization and exposure to western life style. Large number of Youth somehow decides daily whether or not to use drugs without adequate knowledge (UNESCO,2001).

In a rapid assessment of the situation of substance abuse in selected urban areas of Ethiopia, the age at first use was found to be in 44.9% cases at less than 15 years and 34.6% at the age of 15 to 19 years (Andualem M., 2002).The study conducted in South Africa health policies at the national and clinic levels need to be more youth friendly, and youth friendly services need to be more carefully evaluated. Young people's concerns are rarely included in health policies, either because young people are not seen as a separate group with special needs or because cultural norms limit open recognition of adolescents' reproductive health needs. Health care providers

need to know how national health policies and regulations affect young people's care, as well as what specific and detailed protocols, guidelines, and standards for treating young people exist.

Clear policies at all levels can help facilities provide consistent and equitable services for young adults and recruit and maintain a young clientele, but regulations should be flexible enough to allow clinics to adapt their services to young people's needs. While an increasing number of programs are trying to provide more youth-friendly services, few such efforts are being evaluated, and most formal evaluations are focusing on public sector or NGO-sponsored clinics rather than on youth centers or school-clinic partnerships. Further work will help determine whether youth-friendly services are cost effective and whether investing in them significantly improves young people's reproductive health.

Program managers and policymakers can undertake several strategies to improve access to reproductive health care for young adults and to enhance the quality of their care. A wide array of changes, including addressing the social norms that keep young people from getting care, must be made at all levels to recognize and meet young people's reproductive health care needs.(Eschon, 2002). Health care facilities need be aware of and address the full spectrum of young people's reproductive health care needs. Preventive care, such as contraception and services for preventing, diagnosing, and treating STIs, can be combined with maternal care, including prenatal, postnatal, and post abortion care, to improve outcomes for both types of services. To meet the diverse needs of youth effectively, programs need to use a variety of interventions (Senderowitz, 1997).

The other study done in USA indicated that health care providers need education and training to help them better understands and meets young people's reproductive health needs. Providers' interest in working with youth and their ability to develop respectful relationships with their young clients are key to ensuring that adolescents will seek care. Youth-adult partnerships can help bridge the gap between young people and health providers. Staffs that are trained to deal with young people can provide effective counseling to help young people make informed choices about abstinence, contraceptives, STI prevention and treatment, and pregnancy care.

Young people's reproductive health needs vary widely, depending not only on individuals' age, sex, and marital status, but also on their social and economic situation. Each group's specific preferences and needs should be considered when services are designed. Involving young people in developing, implementing, and evaluating programs can help ensure that their needs are met. Community members and family members also need to be educated about reproductive health issues and consulted (within limits, due to issues of confidentiality) to ensure that programs are supported and accepted.

Youth-friendly services are designed to make health care more acceptable to young adults by improving the quality of existing health services, including making care more accessible. Improving the acceptability of health services has several important benefits:

- Encouraging youth to obtain primary and secondary health care, such as laboratory tests and treatment for STIs;
- Allowing young people to meet with providers who can address their specific health needs and strengthening their relationships with public-sector health services; and
- providing a low-cost approach to increasing adolescent use of existing clinical services (FOCUS on Young Adults 2001)

Youth-friendly services are usually offered through health facilities by staffs that provide services in the clinic, but such services may also be offered in the workplace or at schools, by peer educators or by community outreach workers, or through the private sector, including private providers, pharmacies, and other retail outlets. Young respondents in South Africa said the most important factors influencing their choice of a clinic were staff attitudes, the clinical environment, the contraceptive methods available, and operating hours (Transgrud 1998).

2.9 Theoretical Frameworks Used in Peer Education

Peer education programs draw on various theoretical approaches to help shape interventions. Individual cognitive theories and theories of collective action and group empowerment – drawn from the fields of health psychology, health education, and public health – explain why people adopt new behaviors and provide a rationale for peer-based approaches. Below are a summary of

the major theories and models of behavior change particularly relevant for peer education (FHI, 2005).

2.10 Advantages /Benefits / and Disadvantages of Peer Education

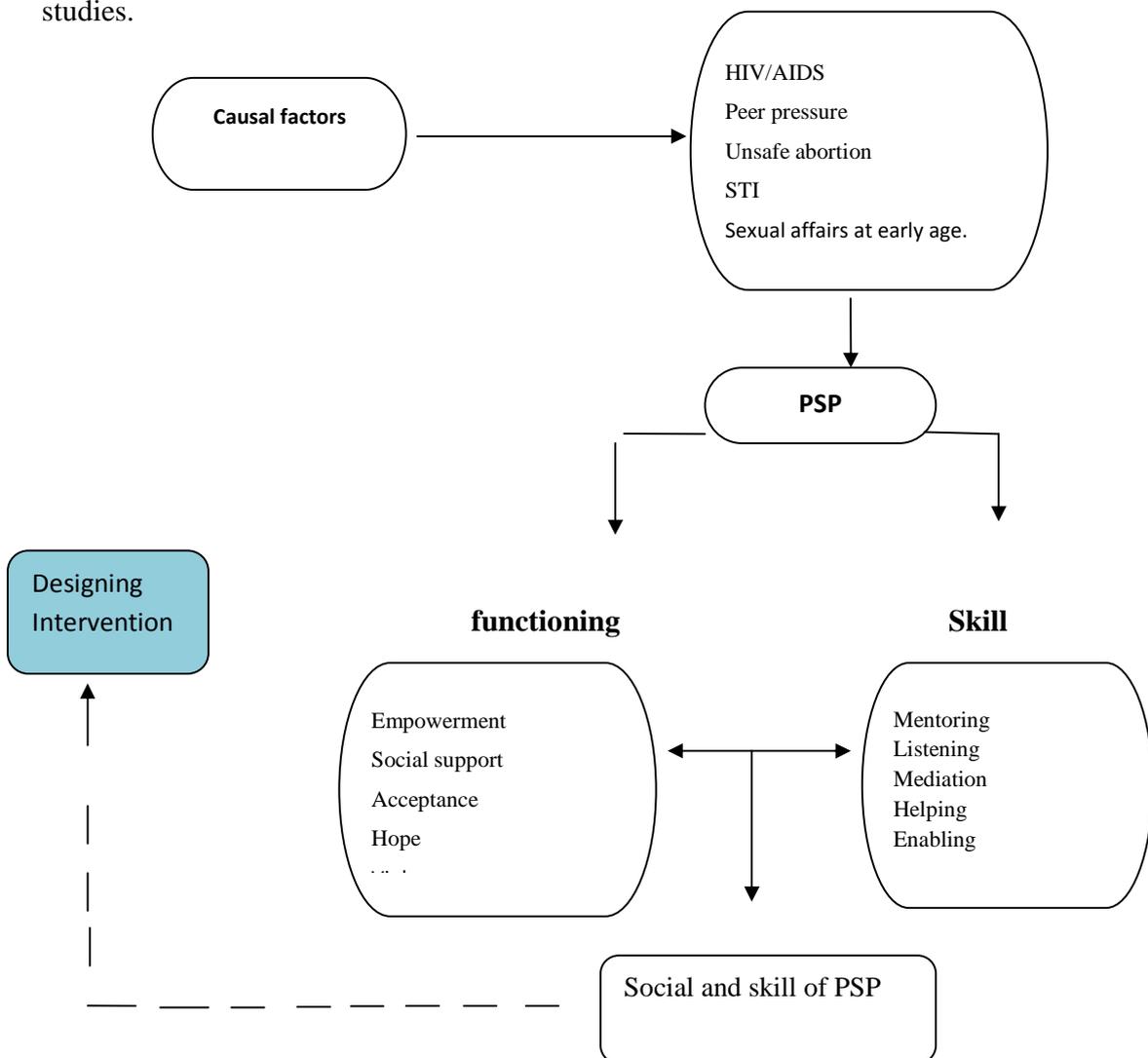
Peer education has many advantages and disadvantages as well, according to the literature founded Path finder has listed some advantages of peer education as listed below: They build on evidence that young people already get a lot of their information from their peers. Mostly peer service provider offer different services to those similar to themselves in age, background and interests. Peer programmes can help change social behavior and are relatively inexpensive comparing with other program. Peer educators often gain long-term benefits from their experiences. These include an ongoing commitment to responsible reproductive health behavior, leadership, job training and experience (Pathfinder International, 1997).

In addition, save the children has also listed some advantages and disadvantages of peer education. The peer based service enables the active participation of young people; suits the sensitive nature of sexual and reproductive health work, as children and young people can discuss issues at their own level. This facilitates active learning, where children and young people learn for themselves and each other rather than being taught. They also can be adapted to meet the specific needs of marginalized children and young people, promotes messages that reflect the realities of the lives of children and young people (Save the Children, 2004)

According to the organization, Save the Children, the followings are the disadvantage of peer education. The PSPs are tends to focus on awareness-raising rather than helping children and young people to change their behavior. It demands a lot of resources, including the time, skills and money to select, train and manage educators. It can be difficult to sustain PSP due to a high turnover due to various reasons. The links PSP have with other partners in sexual and reproductive health and HIV and AIDS services can be difficult to monitor, in terms of assessing the impact it brought on people's attitudes and behavior. (Save the Children, 2004)

2.11 Conceptual framework

This framework maps the pathways through how PSP became committed to volunteerism service because of causal factor for reproductive health problems. Moreover, the framework draws attention to different skill and social problems of PSP while engaging in their volunteer services. In the end the result will lead us in designing an intervention concerning skill and social problems of PSP which is the shaded area and will be left for other researchers for further studies.



2.12 Basic Research Questions

Investigation into the problem involves answering the following basic research questions:

- To what extent the service of PSPs brought a change through addressing the exact SRH needs of young people in the target area?
- What are the challenge they face by the youth center /FGAE/ so as to implement their tasks?
- What are the factors that affect the voluntary services of PSP while serving in the community?
- What are the factors that motivate the PSPs to provide SRH services to their peers voluntary?

Chapter III Methodology

3.1 Introduction

This qualitative research has its own set of strengths but it also has its disadvantages. With qualitative research it was easier to gain a better understanding of the target market because the types of questions that are asked during the research process begin with the word why. What is a much more powerful word than when, how much? With the understanding of why then they could reach out to even more people. Qualitative designs are naturalistic to the extent that the researcher does not attempt to manipulate the activity or its participants for purposes of the evaluation.

Qualitative methods are particularly well suited to exploration, discovery and inductive logic. Qualitative research approach is inductive to the extent that the researcher attempt to make sense of the situation without imposing pre-existing expectation on the setting. Inductive design begins with specific observation and builds towards general pattern.

3.2 Design of the study

The research design employs qualitative data gathering techniques. Qualitative methods permitted the researcher to study selected issues, cases and events in depth and detail.

3.3 Study Population Area

The study was conducted in Oromia region, Adama town at FGAE youth center from January to May 2014. The study includes client attending the clinic for reproductive health service, girls club, reproductive health clubs, music clubs, drama clubs talk show clubs, PSP, Salsa club, question and answer club and staff members.

3.4 Data sources

The population of this study was the active PSPs who were providing SRH services to young people in FGAE, Nazareth youth centre's staff members who were providing various support to the PSPs to facilitate their voluntary based service provision, the beneficiaries, young people, of Adama town, young people served by PSP and the youth canter's different club members.

3.5 Sample and Sampling Procedure

In FGAE Nazareth youth centre, there were 35 PSPs but during the study, 32 were active PSPs and eight full time staff members, out of them four were working in directly related to PSPs. Since the number of staff members and PSPs were so small, all of them were included in the study. Therefore, the researcher had taken all the seven full time staff members, 15 Drama club members, 16 Music club members, 11 Talk show club members, 15 SRH Club members, 14 Girls club members, and all 32 active PSPs based on available sampling methods .

Table 1 Demographic characteristic of club members

No	Category	M	F	TOTAL
1	Drama club members	9	6	15
2	Music club members	10	6	16
3	Talk show club members	6	5	11
4	SRH Club members	8	7	15
6	Girls club members	14	0	14
7	PSP	17	15	32
8	Salsa club members	8	7	15
9	Quaestion and answer club members	5	5	10
10	Staff members	6	1	7
	Grand total	83	52	135

FGD with PSPs and different club members also used to triangulate the information gathered. The face-to-face involvement of the researcher was ensured that, the conversation was always on track, and encouraged participants' engagement without one individual dominating the meeting. When participate were stimulated to discuss, the group dynamics was generate new thinking about a topic which was result in a much more in-depth discussion. The researcher was modified some point of discussion which was prepared before the session to make the topic more suitable for the purpose of this research. The study population personnel were provided to think to the researcher better to handle the direction of discussion, and improve the quality of output.

3.6 Semi structured interview

It was helped to maximize the reliability and validity of the service the PSP offered. It was also more semi structured because the researcher had a clearly specified set of research questions that was to be identified. The semi structured interviews were conducted with the youth centers staffs and with club members. The main purpose of the interview items were to gather information from beneficiaries on the extent to which the PSPs services were reached at grass root level.

3.7 Observation

Observation provided the researcher to yield direct information about the nature of the beneficiaries of the service in the youth center environments. Participant observation helped the researcher to watch and understand both PSPs reaction and the availability of basic reproductive health services.

3.8 Methods of data analysis and interpretation

All completed interview questionnaires were checked for inconsistencies and missed points. Analysis of data from qualitative source through FGDs was made by summarizing the concepts into different themes after recording; transcribing and translating into English all discussion points.

3.9 Conceptualization

Identifying and refining important concepts was a key part of the iterative process of this qualitative research. Conceptualizing begun with a simple observation that was interpreted directly and then put back together more in meaningful manner for further explanation. This excerpt showed how the researcher first was alerted to a concept by observations in the youth center, and then refined his understanding of this concept by investigating its meaning.

3.10 Examining Relationships and Displaying Data

Examining relationships was the centerpiece of the analytic process, because it allowed the researcher to move from simple description of the people and settings to explanations of why things happened as they did with those people in that setting. The process of examining

relationships was captured to show how different concepts are connected, or perhaps what causes are linked with what effects.

3.11 Validity of the study

The result of this study should be understood within the context of Adama city FGAE youth center in which the study was carried out.

- **Accuracy:**-Accuracy was assured by reviewing and checking the instruments which was semi structured and FGD questions. All data were recorded and notes were taken in order not to miss any valid information.
- **Credibility:** - assured by the development of early familiarity with the culture of participants before starting the study. The use of a wide range of participants in the study was benefited the study in getting individuals view points and experience.
- **Transferability:**- The study result was transferred to concerned body through disseminating research findings by presenting power point presentation to the youth center staffs and PSP. The role of the researcher was presenting the findings and responding to the question raised by the attendants to the youth centers staffs to utilize the finding of this research.
- **Resource availability**The researcher observed the clients of the clinic while working in the clinic and the clinic staffs and volunteers facilitated to get the target groups for FGD. Target groups were available and professionals on the area to get advice and guidance including the needed materials for reference.

Chapter IV - Result

In this chapter presentation, analysis and interpretation of data collected from PSPs, beneficiaries, and staff were analyzed, interpreted and presented. Procedurally first demographics of the subjects were presented then the analyses of the responses to the FGD and interview items were followed.

Table 2 Demographic characteristics of PSPs

Variables	Alternatives	Male	Female	Total	%
Ages in years	15-19	6	7	13	40.6
	20-24	12	7	19	59.4
Educational level	< Grade 8	3	2	5	15.6
	Grade 9-10	7	8	15	46.9
	11-12	8	4	12	37.5
Ethnicity	Amhara	7	9	16	50
	Oromo	9	1	10	31.3
	Others	2	4	6	18.8
Religion	Christian	13	13	26	81.3
	Muslim	2	1	3	9.3
	Protestant	2	1	3	9.3
	Other	2	1	3	9.3
Marital status	Single	17	12	29	90.6
	Married	1	2	3	9.4
	Divorced	0	0	0	0
Occupation	Student	14	9	23	71.9
	Par time workers	4	5	9	28.1
Currently living	With parents (Mother and father)	10	6	16	50
	With other family	3	4	7	21.9
	Alone	5	4	9	28.1

Based on age classification, majority of the respondents were between ages of 20 – 24 which accounts 59.4. In the case of educational level, 46.9% accounts 9 – 10 grades. Concerning ethnicity, majority of them, 50% were Amhara, 31.3 % Oromo and the rest were from other ethnic group. Majority of the respondents, 81.3%, equal number of male and female, were Christians and the rest 18.7% were the followers of other religions. Most of the respondents, 90.6% were single at the time of the study and the rest 9.4% were married.

Concerning their occupation the majority of the respondents, 71.9% were students and the rest 28.1% were engaged in different occupations. Out of the total, half of respondents, 50% were living with their parents whereas 21.9% and 28.9% live with other family members and alone respectively.

4.1 Socio Economic characteristics of PSPs’ parents

The socio economic characteristics of PSPs’ parents was analyzed into three groups for the sake of convenience / parental education, occupations and economic status/

4.1.1 Parental education

Table 3 Profile of parental education

Variables	Father		Mother	
	frequency	%	Frequency	%
Educational level				
Cannot read and write	5	15.6	5	15.6
Grade 1-6	3	9.4	8	25
Grade 7-12	11	34.4	8	25
Diploma and above	5	15.6	2	6.3
not alive	8	25	9	28.1

As the table shown above equal number of PSPs father and mother, 15.6%, had no formal education, and still equal number of their parents, 9.4% were found between grade 1 to 6 whereas 34.4 % of fathers compared to 25% of mothers were between grade 9 to 12 the rest 15.6% of father compared to 6.3% mothers were diploma and above educational level.

4.1.2 Parental Occupation

PSPs' parents occupations shown in Table 3 below indicated different for each of the parents /father and mother/

Table 4 Profile of parental occupation

Variables	Father		Mother	
	frequency	%	Frequency	%
Occupation				
Civil Servant	10	31.3	5	15.6
Private employee	1	3.1	1	3.1
Trader	6	18.8	1	3.1
House wife			14	43.8
not alive	8	25	9	28.1
Others	7	21.9	2	6.3

As the Table indicated above, significant number 10 (31.3%) of respondents replied that their fathers were engaged in civil servant whereas the large number of their mothers, 14(43.8%) were engaged in households, the rest 18.8% of their father compared to 3.1% of mother were trader, but 21.9% of fathers as compared to 6.3% of mothers were engaged in different occupations.

4.1.3 Parental Economic Status

The PSPs' parents' economic level as one of the socio economic characteristics collected and analyzed in the table below.

Table 5 Profile of parental economic status

Variables	Father		Mother	
	frequency	%	Frequency	%
Monthly income				
Less than 300 Birr	1	3.1	6	18.8
300-599 Birr	8	25	3	9.4
600-999 Birr	9	28.1	3	9.4
1000 Birr and above	6	18.8	1	3.1
Lives with the income of the father			10	31.3
Not alive	8	25	9	28.1

As the Table indicated above, 3.1% of the father compared to 18.8% of the mother earning monthly income of less than Birr 300. The monthly income of fathers was higher than mothers 2, 46.7% of fathers compared to 12.5% of the mother earning monthly income of more the Birr 600. But significant numbers of mothers, 10(31.3%) were depending on the income of their husbands. This parental education, marriage status and income had indirect impact on effective performance of PSPs.

4.2 SRH services provided by PSP of the youth Center

PSPs were providing different SRH services to the young people in Adama town. All PSPs were replied that as they were providing SRHIEC/sexual reproductive health information, education and communication, counseling, FP services /Family planning, condom promotion and distribution, EC distribution /emergency contraception and referrals.

On the other hand 81.8% of PSPs were providing FLE training /Family Life and Sex education training to their peers groups. In addition, some of PSPs, 9.3% were replied as they were providing library and mini media services in the youth center. The PSPs were requested to report in which SRH services they were most successful? the majority of them, 34.4% were successful in providing SRHIEC to their peers. Regarding success in SRH services, compared to IEC service the counseling services were reported to be the second position.

4.3 Analysis of Data obtained from FGD

SRH problems found among young people

According to the group discussion result, the following SRH problems were listed based on their prevalence rates those were, HIV/AIDS, unwanted pregnancy, abortion, substance and drug use and STI. Study participants were asked about the number of their lifetime partner, and risk factors that exposed the young people to HIV/AIDS. They point out that based on biological, gender and cultural points of view, females are more susceptible than males to HIV infection. Most participants responded that HIV/AIDS is a disease highly associated with poverty. One respondent indicated that,

“I believed that socially, young women face higher risks. When they have sexual relations, it tends to be with older men, increasing the likelihood that their partners are already infected. Some adolescent girls are attached to “sugar daddies”, much older, relatively well-off (usually married) men who support them in exchange for sex”.

Another respondent said that, *“I usually less experienced in or confident about sexual relationships and sometimes unknowingly put myself at risk. The reason for this is due to low awareness about the dangers of STIs”.*

The respondent indicated that, some of their friends who are sexually active adolescent girls, had partners 2-10 years their senior who provides them with gifts, such as soap, perfume, meals out and jewelry. Some poor girls exchange sex for money for school fees or to help their families. Once girls were engaged in such tasks, they continue their relationships with teachers, drivers, shopkeepers or even policemen. Besides, they have little power to negotiate the use of condoms.

Most participants reflected that married youths were at risk of acquiring the infections. Marriage does not always protect young women against HIV infection. Since a much higher percentage of young men than young women become sexually active early, young women are likely to marry an already sexually experienced man. Most participants indicated that there is still lack of information and skill among young people to protect themselves from different reproductive health problems. One participant said that

“Sex is a taboo topic in my families; I do not get sufficient information to refuse premarital sexual practices or negotiate safer sex practices. While I have heard about the current status of HIV/AIDS, but I had low chance to protect myself from sexual practice due to no support from my family although they are health professionals”.

4.4 Unwanted Pregnancy and Attempted Abortions

In FGD conducted with girls club, some of them reported they had experienced unwanted pregnancy at some point in their lives. And point out that, education should be started before the age of 14, when young people become sexually active. One participant indicated that

“Once I faced unwanted pregnancy due to lack of detailed information about contraception and its side effects, in this case I forced to consult my friend and she advised me to attend unsafe abortion. After I went through this process, I bleed too much and obligated to spend some time in hospital”.

The participant indicated that, there is a low interest among some health professionals to deal sympathetically with teenagers requiring contraception for prevention of unwanted pregnancy. They added that, it is important to provide information and education for the community to take away the stigma of teenage sexuality, so that adolescents are not afraid to ask for contraception. The respondent added that, some of contributing factors for this problem include, lack of reproductive health rights, low access to IEC/Contraceptives, Gender Bias, Sexual Violence and Poverty

Drug abuse

The respondent indicated that some young people are able to use recreational or prescription substances like “Chat” without ever experiencing negative consequences or addiction. From their experience, substance use causes problems at work, home, school, and in relationships, feeling isolated, helpless, or ashamed.

4.5 Challenges faced by PSP while providing the service

PSPS described the major activities they were performing to tackle the SRH problems of the young people. According to their response, the first major activity was creating awareness on different SRH issues, Promotion of ABC according to the target group/i.e., A for youth, B for married people & C for CSWs/. After they created the awareness, they were providing personal preference SRH services as counseling, FP services, E.C, condom distribution, referral for those who need other services; FLE training and organizing different SRH clubs were major activities/ services they were providing to the young people. While providing this services, majority of them replied that they were not welcoming by the community while distributing condom and oral contraceptive pills, this is due to some people understood them as they are initiating the young people to have pre-marital sexual practices. Due to this, even some times they are beaten.

One participant from PSP indicated that

“I focused on helping all individuals to make informed choices about sexuality and reproduction, and to have a safe and satisfying sexual life, free of violence and coercion but some peer like to reject my service and asked me to leave them very soon”.

Their service also extended to help all couples to have the best chance of having a healthy infant and women to avoid unwanted pregnancy and to address the consequences of unsafe abortion. The PSPs added that, lack of time (most of the PSPs were students), unfavorable environment for working situations, unfriendliness of recording and reporting keeping formats were listed as the major ones. No feeling of volunteerism, economic problem, lack of interest, lack of confidence were also mentioned as the secondary causes of problems they were encountered. lack of experience in the PSPs when they are new, capacity, wideness of the working area, Shortage of contraceptives were also listed as tertiary level. One PSP indicated that

“I usually got to our kebele when there is meeting related to young person, When I asked meeting facilitator to give me at least 10 minute to transfer message about reproductive issues, I faces lack of cooperation from Kebele Administration and negatively react to my volunteer service ”.

Participants reflected the methods by which these gaps would be narrowed. Accordingly, organizing PSPs in pair, updating the information of PSPs every time, enhancing the confidence of PSPs so as to provide SRH services to their peers well. Creating feeling of competition among PSPs, motivating the best performer on achievement bases were good strategies to minimize the gap. Furthermore, evaluating the PSPs activities by PSPs themselves, conducting monitoring and supervision regularly, giving serious attention during recruitment process, Provide training for low performed PSPs, Conduct discussion with clubs were described as possible solutions to narrow gap among the PSPs.

4.6 Type of beneficiaries and major approaches to address their SRH needs

PSPs were asked to list down the type of target beneficiaries that they addressed more; accordingly, in terms of age they said that, it was young people (10 -24 years), in terms of sex they treated both sexes, in terms of educational level primarily they were focusing on out of school youth then in school youth, in terms of economic background; focusing on poor and marginalized youth whereas in terms of marital status, they were focusing on single then married youth as a secondary client.

The approach they utilized to address those target group were through coffee ceremony, youth dialogue, question and answer contests, using short drama play, using model youth as a testimony, networking and partnership with other clubs, maintaining of confidentiality of clients information so as to develop trust with the beneficiaries.

6.7 Motivational Factors

Major motivational factors that initiated PSPs to provide voluntary services were described during the group discussion: the prevailing condition of SRH among the community, seeing the joyful faces of the satisfied client, getting acceptance from the community, developing trust from the client, seeing behaviorally changed young people, the development of skill by their beneficiaries to cope different problems for their future life were the major factors that motivate PSPs to provide voluntary services to their peers. One respondent indicated that

“I usually seek non monetary motivation because it improves my self-confidence, that it enhances my self-discipline, and reward myself for reaching goals, and

challenge to stretch beyond my perceived limits to serve the young peoples freely”.

4.8 Challenges of PSPs

PSPs tried to list down the major challenges encountered during the SRH service provision, accordingly, uncooperativeness of some of the of kebele leaders, lack of transport problem /bicycle problem/, lack of awareness from the community, inadequacy of training, minimum of incentives from the youth center, the training methodology was not updated, lack of supportive supervision in the youth center, time shortage/unable to get ample time. The idea PSP recommended to alleviate the challenges encountered during service provision include, strengthen net working with different clubs, conduct inter PSPs training, conduct experience sharing with other youth centers or organizations, recruiting committed PSPs, updating the teaching materials, making the kebele leaders to be cooperative, provide bicycle as much as possible and improves the incentives given.

4.9 Analysis of Data obtained from staff interview

Strategy utilized by the youth center to solve SRH problem

Most of the respondents agreed that the SRH problems of the young people in Adama town were: unintended pregnancy, unsafe abortion, STI, GBV /gender based violence (psychosocial problems, harassment, sexual exploitation, sexual violence and rape)

The youth center head said that

“Currently I observed that many young girls seek abortion service repetitively, this indicated that there is unsafe sexual practice which leads to the expansion of STI and this needs immediate intervention”

The strategies by which the youth center utilized to solve these problems were: awareness creation, provide SRH services in facility & outreach level, at facility level it was provide in the clinic/by professional service providers/ and outreach level /by voluntary based PSPs and referral services to health institutions for those clients who needs further intervention were the strategies

by which the youth center addressed the SRH problem of the young people in Adama town and all respondents provide equal emphasis.

4.10 Tasks of PSPs in outreach Level

According to the respondents, the major SRH services provided by PSPs in outreach level were: SRHIEC, Counseling, FP services, E.C. distribution, Condom promotion and distribution, FLE training, and referral services. Most of the staff agreed that some PSPs were providing different services in the youth center. Accordingly, IEC in the library and recreational areas, peer counseling, serving clients in waiting area and recording were the major services of the PSPs in the youth center compound.

Voluntary Services

Most respondents were agreed on the existence of performance difference among the PSPs on which the difference was recorded: differences in commitment, experience, capacity, in efficient utilization of time, motivation, in the meaning of voluntarism were the major causes listed by them.

As respondents replied, there were factors that motivates PSPs to provide voluntary services such as understanding of the existing SRH situation of their environment, interest of preventing their peers from different SRH problems, /solving the youth problem through youth creates motivation/, the program itself motivates them, considering young people problems as their own, matter of commitment to voluntarism and observing the satisfied clients were the major motivating factors enumerated by similar number of respondents.

Most respondents agreed that the PSPs were provided the following supports in the youth center: training, materials /like bicycle, uniform, stationery, transport allowance and supportive supervision.

Most the respondents were agreed on the existence of performance difference among the PSPs on which the difference was recorded: differences in commitment, experience, capacity, in efficient utilization of time, motivation, in the meaning of voluntarism were the major causes listed by them. One Respondent said that

“I usually hear a complaint from PSP that the monthly taxi fare the youth center provides them doesn’t cover their transport expense while providing the service; in this case, they usually lose their interest of volunteer based services in this case they obligated to remain from home to home service which leads to low performance”.

As respondents replied, there were factors that motivates PSPs to provide voluntary services, among this, understanding of the existing SRH situation of their environment, interest of preventing their peers from different SRH problems, /solving the youth problem through youth creates motivation/, considering young people problems as their own, matter of commitment to voluntarism and observing the satisfied clients were the major motivating factors enumerated by similar number of respondents.

Most respondents agreed that the PSPs were provided the following supports in the youth center: training, materials /like bicycle, uniform, stationery, transport allowance and discussion challenges during monthly review meetings were mentioned by most respondents whereas supportive supervision mentioned only one respondent. One respondent said that

“I usually use the bicycle I got from the center and in this case I able to reach most clients through home based services”.

4.11 The role of PSPs

Most respondents were agreed that PSPs had played significant role in reaching young people on SRH services. The basic facts to say this were; The type of information given through PSPs creates internal motivation to the beneficiaries to use the services, besides, youth to youth / Y2Y/ approach was the best approaches to addressing many young people through different approaches for SRH service & referral. The PSPs themselves become testimony for the services Young people now utilize safer sex practice due to the PSPs, due to their contribution some changes which were observed by their beneficiaries like decreased substance users and unsafe abortion.

Three respondents said that,

“In our previous referral service, most of the case we refer to the clinic were to check pregnancy test due to unsafe sex, cases related to un safe abortion and counseling service related to substance abused. In our follow up we observed that those young people were started new life. Besides, our referral slip indicated that such types of problem is already minimized”.

4.12 Challenges faced by PSPs

According to the respondents, the challenges of PSPs were divided into two-external and internal factors, among the external factors, Lack of transport /bicycle/, unwillingness of the beneficiaries to give their time for IEC, Attitudinal problem among the community to be served by PSPs, lack of cooperation among the kebele leaders, un able to involve in the youth center program were the major ones. Whereas the internal factors include, Knowledge and skill gap, unable to utilize various approaches on provision of SRH services, some of PSPs become fade up, lost the feeling of volunteer rather searching for some incentives.

The respondents were also their suggestions by which the PSPs challenges could be solved: Increase the awareness level of the community, avail transport facility for PSPs, involving PSPs in the youth center different program, PSPs should utilize different approach for service delivery , provide incentives for best achievers, conduct close monitoring and supportive supervision, increase monthly transportation allowance; these were replied by three of the respondents. One respondent said that,

“I usually try to give IEC service for young people found in the school, but most of them replied as my service is time wasting and has no benefit to change their life, in steady they ask for DSTV at youth center compounds to enjoy themselves”.

CHAPTER V. Discussion

The researcher organizes the discussion section by classifying under five sub titles systematically answer the basic research questions listed at the introduction part.

5.1 Major SRH services provided by the PSPs:-As data gathered from service providers and shown in the analysis part, all PSPs were providing similar SRH services to their peer groups found in Adama town. Sexual reproductive information and education through different communication channels, counseling on different sexual and reproductive health issues, Family planning methods like pills and condom, condom promotion and distribution as the method of prevention and control of HIV/AIDS and STI/ sexually transmitted infections/, Emergency contraception distribution to those girls who conducted unplanned sex with the partners or due rape and other reasons.

PSPs also provided referral services to their peers when the case of their clients became beyond the limit of their services. In addition, most of PSPs were providing Family life and sex education /FLE/ training which takes seven or eight half days /four full days/and has a package of information on basic ASRH issues, these include: concepts, components, and rights SRH, definition and formation of family, STI/HIV/AIDS, Bio-psychological changes during adolescence, concepts and benefits of FP methods, gender based violence, concepts of life skill and communication skills, basic skills of counseling and different approaches of IEC.

As the PSPs mentioned the above services were the major services in addition to these some of the PSP reported that they were providing library and mini media services in the youth center and in their living area. As it is revealed in the literature part the activities of PSPs compared to South Africa, it was almost similar. In South Africa, the most common topics covered by peer educators were STIs, teen pregnancy, condoms, HIV/AIDS and family planning. Peer educators were significantly more likely to talk to boys about STIs and HIV/AIDS, compared to girls, while they were significantly more likely to talk to girls about family planning methods (South Africa, 2001).

One of the major differences with South Africa is there seem to be sex preference but here the PSPs provide the service to all sexes in the same ways without any sex preference. In addition, the activities carried out by PSPs are almost similar to the activities listed by IPPF. According to the organization, most of the peer educators' activities were grouped under the four categories: Promotion, information, education and communication (IEC, Counseling); Community distribution of services, merchandise and referrals; advocacy and special activities (IPPF, 2004) /further information please see in the literature part/.

According to the data gathered from FGD, the source of individuals' performance differences were analyzed, accordingly the major sources of the difference were: not focusing on their duty, lack of time /most of the PSPs were students, unfavorable environment and working situation, recording and reporting were listed as the major ones. No feeling of volunteerism, economic problem, lack of interest, lack of confidence were mentioned as the secondary causes of differences on performance level of them. Lack of cooperation on the Kebele Administration, lack of experience in the PSPs /when they are new, capacity and ability difference among PSPs, wideness of the working area, shortage of contraceptives (some times), were listed as tertiary level by which performance difference among the PSPs were observed.

The reasons of performance difference among the PSPs were also listed by staff. Accordingly, it was due to differences in commitment, experience, capacity, in efficient utilization of time, difference in motivation, difference in the meaning of voluntarism were the major causes listed by them. The other association was seen between the PSPs performance level and type of PSPs involvement in the youth center different program activities. As it was indicated in the discussion, those PSPs who had involved in youth centers' planning, implementation, overall activities and didn't have any involvement have significant association with PSPs performance level.

Youth involvement is one of the key factors that enhanced peer educators performance. This idea is supported by IPPF. According to the organization, Peer educators' participation in the process of planning and developing activities is essential to a program's success. Not only does it give the peer educators a sense of ownership of and responsibility to the program, but it also increases their autonomy and management skills (IPPF, 2004)

FHI also enhanced this idea. According to FHI, meaningful youth involvement is critical for peer educator retention, motivation, and productivity. Youth involvement refers to the degree of empowerment and decision-making that youth are able to assume through established organizational mechanisms. Opportunities for meaningful involvement require adequate training and supervision that can increase youths' decision-making skills and proficiency in carrying out their responsibilities (FHI, 2006).

In general, most successful interventions, of any kind, call for the inclusion of all stakeholders to be involved through all phases of the project development and implementation. This holds conducive environment for applications of peer education. Peer educators need to be involved in all aspects of project development for several reasons: first, to ensure that the intervention is properly set in the context of the target population; second, to ensure that the “language of youth” is properly used in all communication efforts; and third, to ensure that the peer educators have a vested interest, a sense of ownership, in the overall effort. (De la Cruz, 2010).

The performance level of PSPs also viewed from the beneficiaries responses. According to the data collected from the beneficiaries, using the semi structured interview, out of the total beneficiaries interviewed, most of them were replied that they got different SRH services and confirmed that the source of their SRH services was FGAE/ Family Guidance Association of Ethiopia) and out them, the lion share services were taken by PSPs, services. Therefore, the PSPs played important role in addressing the SRH services to the young people in Adama town. They took the highest ratio compared to other sources of addressing the SRH services, like mass media, health institutions, and other clubs.

As the PSPs revealed, the type of SRH services provided for the beneficiaries were various, accordingly, most of them said that they got SRHIEC services, counseling services, FP services, condom services and Emergency contraception service, and some of beneficiaries replied FLE training and referral services respectively. This shows that PSPs had provided various services to alleviate SRH problems of young people based on their interests. Concerning the frequency of getting the PSPs services, most of the beneficiaries replied that they got them more than one time. It shows that the contact of PSPs with the beneficiaries is not only one shot, rather it is repetitive activity.

5.2 The strategies by which PSPs were providing SRH services and its quality:-As data collected revealed, most of the target beneficiaries of PSPs were clearly identified in terms of age, sex, marital status, economic level & educational status. Accordingly, as most of the respondents replied, they had served young people (10 to 24 years of age), both sexes were their target /no sex discrimination/, both single and married young people were equally served. In terms of economic background most of them, served all level but some of them focused on the poor and average economic classes. Concerning the education level, they focused on both in school and out of school youth groups. This idea also confirmed during focus group discussion, all above mentioned list of target groups were similar but slightly explanation difference was seen in terms of educational level. According to the FGD, PSPs were primarily focused on out of school youth then in school youth were served as secondary clients. In terms economic level, they revealed that mostly they have focused on the poor and marginalized youth and unmarried young people were primary focused compared to married youth.

Concerning the mechanism by which the PSPs employed to address the SRH services, they utilized different methods. Accordingly, group discussions, youth dialogue, one to one, compared to other strategies, and were used by large number of respondents. Home visit and distribution of different IEC materials were the most utilized strategies. As discussed during FGD, in addition to the above methods, PSPs were utilized different strategies depending up on the situation and the interests of the beneficiaries. Coffee ceremony, question and answer contest, short drama play, using model youth as testimony were approaches used by the PSPs to address the services.

Establishing strong networking and partnership with other RH clubs, establishing trust through maintaining confidentiality of client's information were also the mechanism by which the PSPs address SRH services to the beneficiaries at grass root level. According to the data collected from the PSPs, most of the PSPs had got positive feedback from the beneficiaries after they have provided the services. The beneficiaries were also asked to mention how they have got the SRH services given by the PSPs. Accordingly, the majority of the respondents, said that the services were adequate.

Furthermore, the beneficiaries compared the type of services given by the PSPs and other organization or clubs peer educators, out of the beneficiaries who got peer educators/PE/, most of them said there was a difference between the PE &PSPs. Hence the PSPs were providing different SRH services using different strategies in a better approach as it is explained by themselves and confirmed by the beneficiaries.

5.3 Factors that Motivate PSPs to provide voluntary Services:-In FGD conducted, most PSPs were interested in their voluntary services. Most of the PSPs were providing voluntary services before being PSP. A large number of PSPs provided this type of services more than one year and this has great effect in the performance level. Factors that influence most PSP to be interested them to provide such services were, the training they had got from the youth center, the skilled they had developed, and the incentives they had got from the youth center were some of the major factors that enabled them to involve in the program.

The above idea also was confirmed by Staff, as it was collected data through staff interview. There were factors that motivate PSPs to provide voluntary services. Understanding of the existing SRH situation of their environment, interest of preventing their peers from different SRH problems, /solving the youth problem through youth/, the program itself motivates them. Considering young peoples' problems as their own, matter of commitment to voluntarism and observing the satisfied clients were the major motivating factors enumerated

PSPs also showed their interest to continue in such voluntary based service provision; accordingly, most of the PSPs, had reported that they were interested to continue such type of service. The major reasons that made them to continue were, it gave them internal satisfaction when they had served people voluntarily, to be change agent, they enjoyed with volunteerism, and since they had got basic training they had to apply. PSPs also very much interested to inform their close friend to join this service if she/he is interested.

In general, PSPs were motivated in their voluntary services. As it is revealed in the FGD, the major motivational factors that initiated them to provide the services were, the prevailing condition of SRH among the community, seeing the joyful faces of the satisfied client, getting

acceptance from the community, developing trust on the client, observing some behavioral changes among the served young people and developing skills for future life.

5.4 The supports of different organization to the PSPs so as to implement their tasks:-Peer service providers of the youth center mentioned that they got different supports from different organizations like respective kebele administrations and schools were the major organization that provided support. In the other hand, some of the respondents said that they got support from religious organization. In addition, some PSPs also reported that organizations like CBO /community based organizations, Red Cross Society and other clubs organized in the town were providing the support.

PSPs were getting different supports from different organizations. One of the major supports given to them was in the provision of training that enhance their capacity of service provision. Accordingly, most of the respondents replied that they were provided different trainings from other organizations. SRH related topics, skills on how to address SRH services to the beneficiaries, life skills, club management and other non SRH health related issues were the main topics of the trainings given by these organizations.

According to the data obtained from PSPs, the youth center was one of the major sources of support that enabled them to provide the services. Types of supports provided from the youth center were: moral support, material support, training support monthly transport allowance. Besides, PSPs also mentioned that monthly review meetings conducted in the youth center was very supportive and most of them confirmed this idea. The issues of discussion during the meeting were: success stories/best practices/, challenges encountered during the reporting period, and plan modification based on previous achievements.

In general, the existence of different supports given to the PSPs from the internal, youth center, and external, from different organization, enhanced their achievement level. Especially, the review meetings conducted every month help them to gain experiences from other peers solves challenges faced during service implementation period. Conducting review meetings on regular

basis is an excellent opportunity to see whether the PSPs were meeting the goals set forth in his or her work plan, and to address any questions or problems the peer service providers may had.

According to literature reviewed, the support of PSPs should not be only from the organization but also from the community and stakeholders. This idea is confirmed by save the children. In addition to the support of the program coordinator of the organization, peer educators need the support of the community. This can be accomplished by holding periodic meetings with a coalition of direct stakeholders.

The community can also show its support by making money or in-kind donations to the program. Peer education relies heavily on part-time peer educators and coordinators, working in new and demanding roles and often in difficult environments. Close supervision and support help peer educators deal with stress, burnout and other psychological aspects and create a forum for sharing successes and ideas. It also prepares them to deal with resistance and public criticism, should it arise. Motivating the peer educators helps build commitment, reduce turnover and improve sustainability (Save the Children, 2004).

5.5 The prominent challenges encountered PSPs in addressing SRH services to their peers:-

The major challenges that encountered the PSPs in addressing the SRH services (as they planned) were various. As it was indicated in FGD, the problems that hindered them not to access to all the targeted beneficiaries were: shortage of time, clients disinterest, inadequate training they gained, wideness of the target area, personal problems and other factors were the major ones

In addition to the above mentioned factors, PSPs were asked to list down the major challenges encountered while they were implementing their activities, accordingly, absence of transportation facility, shortage of up-to-date IEC material, resistance from the community, financial constraints and disinterests of the client were listed as the major factors.

Similarly, the issue of differences among the PSPs were raised and discussed. According to the discussants, the reasons of differences among the PSPs were: due to lack of focusing on their

duty, shortage of time /most of the PSPs are students, unfavorable environment and working situation, problem of recording and reporting properly, lack of feeling of volunteerism, economic problem, lack of interest, low capacity or ability/lack of confidence, lack of cooperation on the Kebele administration, high turnover of PSPs, lack of experience in the PSPs /when they are new, wideness of the working area, shortage of contraceptives /sometimes/ were the major ones.

Furthermore, the major challenges encountered during the SRH service provision were discussed during the focus group discussion. Accordingly, uncooperativeness of some of the of kebele leaders, transport problem /bicycle problem/, Lack of awareness from the community, inadequacy of training, minimum of incentives from the youth center, the training methodology is not updated, lack of supportive supervision in the youth center, time shortage/unable to get adequate time/.

PSPs reflection:-To alleviate the above mentioned problems, PSPs put recommendations to the youth center. Accordingly, avail transport facility like bicycles, provide financial support, improve monthly transport allowance, establish internet café services, and provide community awareness, equipping PSPs with adequate and current information, conduct discussion with PSPs challenges were the possible solution by which the PSPs challenges will be minimized.

Possible recommendations were also identified during the FGD, according to the discussants, in order to alleviate the challenges faced the PSPs during service provision, the youth center should organize PSPs in groups, updating the information of PSPs every time, making confident the PSPs so as to provide SRH services to their peers well. Creating feeling of competition among PSPs, and motivating the best performer on achievement bases was recommended as one of the best solution. Evaluating the PSPs activities by themselves, conducting monitoring, provide supportive supervision at field level on regular bases will enhance the PSPs performance level. Provide great attention during the PSPs recruitment process and provide training for low performed PSPs were also important points raised during the discussion.

On the beneficiaries' perspective, out of the respondents who had got SRH services from PSPs the majority of respondents were provided their suggestion on which the PSPs can improve their services. Accordingly, the following recommendations were given: Out of them relatively the large number of respondents, recommended PSPs should apply different approaches to address

the services. Whereas, significant number of respondents said that they were doing well, keep it up. Other group of respondents recommended that they would have adequate knowledge and information. Furthermore an equal number of respondents said that PSPs would do more than presently done. Relatively few number of beneficiaries said PSPs should promote their services in a large scale / they have to address the services to a large group of the people.

Similarly, the possible remedies for the challenges encountered during the services provision were raised during the staff interview. According to the respondents, the possible remedies were: PSPs should use their time efficiently as well as they should be Patient and committed. In addition, they should strengthen networking with different clubs and should conduct intra PSPs experience sharing to enhance their knowledge and to develop confidence. Furthermore, conduct experience sharing with other youth centers or organizations, recruiting committed PSPs, updating the teaching materials, making the kebele leaders to be cooperative, provide bicycle as much as possible, improves the incentives given were the major remedies to solve the challenges.

As it was recommended by the respondents, IPPF also provided focus on the ongoing support given to the service providers. Accordingly, ongoing support and supervision are essential for any peer education program as these create the opportunity both for peer educators to express their thoughts and concerns about the program, as well as for addressing the peer educators' performance. More specifically, support and supervision mechanisms are ways of providing peer educators with updated information, giving them feedback about their activities, providing technical support for creating new activities, ensuring that the group dynamic is working, and helping the educators resolve problems(IPPF, 2004)

According to IPPF, conducting supportive supervision on different approaches could enhance peer educators performance. Observing activities and making field visits are good way to supervise and provide support to peer educators. While the peer educators are conducting the activities, the coordinator can identify whether they need additional training related to specific information or skills (IPPF, 2004).

Other less formal ways to offer support to peer educators include, friendly team environment and atmosphere among peer educators; additional didactic materials for the use of peer educators (i.e. a peer educator manual); network of adults who provide additional information and respond to

questions; help with presentations and activities; financing for activities and supplies; emotional support; opportunities for personal and professional development and for goal-setting. Availability of supervisors to help peer educators, handle difficult experiences; social support from communities in maintaining ties with project collaborators and other peer educator programs; assistance negotiating with adults and help in resolving problems between peer educators and intermediaries, guardians and parents(IPPf, 2004)

Chapter VI. Conclusion and Recommendation

6.1 Conclusions

Based on the research findings the following conclusions can be drawn:

1. PSPs were providing similar SRH services to their peer groups found in Adama; SRHIEC, Counseling, Family planning, condom promotion and distribution emergency contraception distribution, referral services, Family life and sex education /FLE/ training at the outreach level. In addition, PSPs were providing different services in the youth center compound /IEC in the library and recreation areas, peer counseling and serving clients in the waiting areas
2. PSPs were playing important role in addressing SRH services to the young people in Adama town. As the data analyzed from the beneficiaries, out of the channels of getting SRH services, the type of services rendered by PSPs were the highest. Out of the beneficiaries who had got SRH services, most of them confirmed that the source of their SRH services wereFGAE and out them, the lion share of PSPs were great.
3. PSPs had differences significantly on performance level. This was identified based on geographical location they cover, experience they had and means of transportation they use, accordingly, those with small geographic coverage and use bicycle as means of transport perform better comparing with others.
4. The performance level of PSPs had significantly associated with PSPs age, number of time allocated for the voluntary services, the number of service years before and after being PSP; and the involvement level of PSPs in the youth center different programmatic activities.
5. The target beneficiaries of PSPs were identified in terms of age, sex, educational status, marital status and economic level.

6. The major strategies by which the PSPs addressed the SRH services to the young people were: group discussion, youth dialogue, one to one, home visit, and distribution of different IEC materials were the most utilized strategies. In addition to this, coffee ceremony, question and answer contest, short drama play, model youth as testimony, networking and partnership with other RH clubs, establishing trust through maintaining confidentiality of client's information were utilized.
7. PSPs were mostly interested in providing voluntary services to their peer group. The major factors that motivates them were, the prevailing condition of SRH among the community, seeing the joyful faces of the satisfied client, getting acceptance from the community, developing trust on the client, observing some behavioral changes among the served young people, developing skill for future life.
8. PSPs were supported by the youth center and other organizations; the support was given from internal organization, the youth center, and external organizations like Kebele administrations, schools, CBOs and clubs organized in a town. Mostly, the types of supports were: training, materials support, moral support & discussions during monthly review meetings, monthly incentives from the youth center and training on different topics and cooperation to provide the service in outreach level from external organizations.
9. PSPs were challenged by different problems in executing their activities. To mention the major ones, transportation problem, capacity problem, lack of experience specially when they were new, resistant from the community, unable to get support in the field /no supportive supervision from the youth center/, low motivational incentives and problem commitment were seen on some PSPs were the major problems listed by all groups of the respondents /during PSPs questionnaire, FGD& staff interview/

10. To alleviate the above challenges, different groups provide their own possible recommendations. Among the listed suggestions: avail transport facilities, awareness creation to the community, provision of intensive training to the new PSPs, provide field support, arranging intra PSPs training, improve the monthly incentives, were the major ones listed by all groups.

6.2 Recommendations

Based on the study results the following are recommended.

- The PSPs were providing various SRH services to solve the youth SRH problems. Therefore, the concerned organization should enhance this type of services.
- The youth center should redefine the selection criteria of getting the best fit. Age, the level of commitment, the type of voluntary service experience should be taken into consideration.
- The youth center should encourage PSPs to allocate ample time for this type of services.
- PSPs should involve in all programmatic activities of the youth center / in planning, implementation and over all execution of the youth center program/. This in turn creates a sense of belongingness on the youth center program.
- The youth center, FGAE, should improve the type of material incentives /such as providing bicycle/ to the PSPs so as to enhance the type of services given to the young people.
- The youth center should design and conduct regular supportive supervision so as to strengthen the performance level of the PSPs.
- The youth center should organize different community awareness creation workshops so that community resistant will be minimized.
- The youth center should strengthen the network and partnership with pertinent organizations so that they can provide different supports to the PSPs.
- If the organization, FGAE, conducts this type of research in large scale, in all youth center, it may give a total picture of the youth program of it.

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Appendix A; Data Gathering Tools

I. Questions designed for PSPsFGD

Consent format for focus group discussions.

Date of FGD: _____

Venue: _____

Time started: _____ Time ended: _____

Facilitator/moderator name: _____ Sig. _____

Introduction:-

You are all welcome. First of all we are happy that you could make time to us. We are here to collect information about the role of PSPs in addressing SRH services to young people in Adama. Its aim is to gather data on performance of PSPs and to identify major challenges during activities implementation.

You have been randomly selected to participate in this discussion hence you are expected to provide us vital information and experience to share with us on this subject. There is no right or wrong answer. All comments, both positive and negative are welcome. We would like to have many points of view and to be open discussion, so feel free to express your opinion honestly and openly. In order not miss any point of the discussion; we use a tap recorder. Your name as well as address is not recorded in this interview to protect your confidentiality.

Individuals are free to decide on whether or not to participate in the discussion. We also encourage members to feel free to say any thing concerning the topic of discussion, because your information is very important to evaluate and improve the program. Again, we would like to confirm to you that all your comments are confidential and used for research purpose only.

Thank you very much again. (The facilitator asks participants to introduce themselves at this stage and then introduce your self.)

1. Would you please list the main SRH problems of young peoples in this town/ Adama/?
2. To what extent these problems pronounce list according to the prevalence rate?
3. Please mentions the major activities you perform to tackle these SRH problems
4. Please list the activities in order / based on the number of beneficiaries you addressed/

5. What are the main strategies you employed to address SRH services to your peers?
6. What are the major reasons of difference among the performance of PSPs?
7. Is there a mechanism to narrow the gap between the PSPs performance
8. What motivates you to provide voluntary services to your peers?
9. What are the major challenges you face during service provision to your clients
10. What suggestion you provide to solve these challenges

Thank you for your cooperation

II. In-depth interview for staff

St. Marry University Department of social work Post Graduate program

This question is designed to collect data for post graduate thesis on the title of practice and challenges of PSPs in addressing SRH services to the young people FGAENYC. Therefore, I requested you to fill the questions in which the correct response on your own.

1. Would you please mention the main SRH problems of young people in your target area?
2. What are the main strategies you are utilized to alleviate these SRH problems?
3. Would you list the type of services the PSPs are providing in their local areas/ please list down based on their performance
4. Are there services in the youth center compound provided by PSPs? If so, please list down
5. Is there any performance difference among PSPs service provision? If yes, please mention the reason why it occurs?
6. Would you please mention the type of support you are providing for success of PSPs?/like training, supportive supervision, material support, etc./
7. In your opinion, do the PSPs play role in addressing SRH services to young people? Please describe basic facts to argue this idea
8. Would you please describe the reason why PSPs are motivated to provide voluntary services to their peers?
9. What are the major challenges faced the PSPs during service provision and what are the causes for it?
10. If you say they have problems, what is your suggestion to solve the problem?

Thank you for your cooperation

II. In-depth interview for Beneficiaries

Introduction and consent

INFORMED CONSENT

Hello. My name is _____ and I am part of a team of people who are carrying out a study on “*Practices and Challenges of PSPs in addressing SRH services to the young people in Adama* “. We would very much appreciate your participation in this survey. I would like to give you a self administered questionnaire and it will take you about 20 minutes. Your answers will remain confidential, and we will not be taking down your name or address, so your answers will be anonymous. Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this study since your views are important.

1. Would you mention the main SRH problems of young people in your target area?
2. What are the main causes of SRH problems according to your perspective?
3. Would you list the type of services the PSPs are providing in their local areas/ please list down based on their performance
4. Are there services in the youth center compound provided for clients are meets the demand of the clients?
5. What is your main reason of choosing FGAE youth center for getting service?
6. Does the youth center maintain confidentiality?
7. What would like the approach of of the service providers in serving the clients?
8. Do you have further comments in improving the service of the youth center?

Thank you for your cooperation