EVALUATION REPORT OF HIV/AIDS PREVENTION PROJECTS SUPPORTED BY UNICEF THROUGH FUNDING OF IRELAND AID

OCTOBER 2001
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ACKNOWLEDGEMENT

During the course of this evaluation the team met many people engaged in HIV/AIDS prevention and control in the project areas. Our work could not have been completed without the participation, co-operation and goodwill of all the project staff interviewed in the Northern and Upper East Region, Adansi West District and the Urban Project in Accra.

Each contributed to our observations and the interpretation of the project activities.

We recognise the input of the staff of UNICEF, Red Cross Society and Action Aid and extend our thanks.
1. EXECUTIVE SUMMARY

Background information

Epidemiological evidence continues to indicate that HIV infection is spreading among all age groups and both sexes in Ghana. From an initial zero prevalence of 0.2% in 1991, the HIV prevalence rate has risen to 3% by the end of 2000.

The Ministry of Health has been the lead agency for HIV/AIDS prevention activities until late 2000, when the Ghana AIDS Commission (GAC) was established to provide a multi-sectoral, national response to HIV/AIDS.

A five-year national HIV/AIDS strategic framework has been developed which focuses on five strategies: prevention of new HIV/AIDS infections; caring for people living with AIDS; creating an institutional and legal framework to enable a national response; a decentralised response, and a monitoring and evaluation framework. Promoting safer sex among the youth and other vulnerable groups have been highlighted, which is of particular importance to UNICEF.

Since 1996, Ireland Aid has supported UNICEF Ghana in the implementation of activities that aim to promote behaviour change to limit the spread of HIV/AIDS and STIs. After an evaluation of these projects in 1997, Ireland Aid provided a second round of funding for the continuation of these activities in different areas of Ghana. The programme components were:

a) Youth-to-Youth peer education in the Northern and Upper East Regions; and

b) HIV/AIDS prevention through peer education with commercial sex workers in Obuasi, Ashanti Region.

c) HIV/AIDS prevention amongst young people, including Street Children in urban Accra.

Objectives of the Evaluation

This evaluation focuses on the period of the second round of funding from Ireland Aid, from 1998 to 2000.

The purpose of the evaluation is to

- Identify the projects’ gains and achievements (intended and unintended).
- Describe the lessons and examples of ‘best practice’.
- Provide options for future developments.

Evaluation Methodology

The evaluation was undertaken from 14th to 31st May 2001 by a team of three, namely: a public health physician (team-leader), a sociologist (Ireland Aid) and a micro-credit expert (only for the Obuasi component). Various methodologies were utilised to collect information, such as the review of project documents and progress reports of the project components. In addition, there were focus group discussions with peer educators, visits to shops and pharmacies, individual interviews with staff at UNICEF, NGO partners, the staff of
Ministries at national, regional and district level. All five project components were visited by members of the evaluation team.

**Main Findings**

- **Gains and Achievements**

The logical framework of the project components, (see Annex 2) show the expected planned objectives and results. The main achievements for each project component are:

- **Youth to youth peer education component in Northern and Upper Eastern Regions.** This component had clear objectives and its educational activities were found to be in line with the project document. The project centred on talks about sexual health, using active participatory methods - some game-based - to capture the interest and attention of young people. The expected output was achieved, as a total of 514 peer educators aged between 15 – 30 years were trained between 1998 and 2000. Almost all the peer educators were retained. The peer educators in turn reached out to more than 60,000 young people in and out-of-school. An additional 20,000 adults were reached indirectly with HIV/AIDS messages.

Because of unclear financial agreements between the District Health Management Teams, the District Assemblies of Bongo, Yendi and Bawku-East and the Ghana Red Cross Society, the proposed ‘Youth Friendly Centres’ could not be completed for use before the end of 2000.

- **HIV/AIDS prevention through peer education with commercial sex workers in Obuasi, Ashanti Region.** The Obuasi programme component was managed by the Adansi West District Assembly. This was found to have been quite successful in terms of outreach, with more than 2,000 individuals contacted. However, problems with the management of loans prevented the programme resettling commercial sex workers by providing them with alternative incomes.

During its planning for the new Country Programme (2001-2005), UNICEF decided to phase out its interventions in Adansi West. Agreements have been reached with various NGOs (such as CARE International, SCF) and the District Assembly (District Response Initiative) to take over the various activities previously funded by UNICEF. It can hence be anticipated that UNICEF’s pulling out of this project component would not significantly threaten the continuation of activities.

- **HIV/AIDS prevention amongst young people, including street children in urban Accra.** This component was part of the Urban Community Based Development Project and implemented by various NGOs:

  **CENCOSAD** was responsible for a peer education programme for in and out-of-school youth in the Ga Mashie area of Accra. The programme achieved its expected output by training 252 Peer Educators, 50 counsellors and 50 supervisors who provided HIV/AIDS education to more than 12,000 young people. The educational materials used were appropriate for all young people. All the peer educators are volunteers.

  The programme was successful in retaining the majority of the peer educators. The leadership skills they obtained and the heightening of their self-esteem seem to be major factors for their
continuation in the programme. As a general point, the issue of transportation for peer educators as the project expands to hard-to-reach communities will have to be addressed.

UNICEF also collaborated with 3 other NGOs in the Urban Community-Based Development Project: the Salvation Army, Catholic Action for Street Children (CAS) and Street Girls Aid (SGAID). The HIV/AIDS component implemented by these NGOs was not based on peer education, but on classroom health education in the refuge centres of SGAID and CAS. In addition, social workers and nurses provided a health education service through health kiosks and a mobile van in the streets. All expected results emanating from these activities have been reached and even exceeded expectations, as each day about 300 children are reached in the street and the refuges where they receive information, and health services if needed.

- Key lessons learned and best practices

Several important lessons became clear during project.

Peer education as a successful intervention strategy.
- The projects supported by UNICEF are sensitive to gender issues and this has been taken into account in developing materials and in the way peer education is organised.
- The projects are also conscious of the need to develop different approaches to in-school and out-of-school youth.
- The careful selection and training of peer educators are critical to the success of the ‘peer to peer’ approach. The involvement of school authorities and parents (for in-school youth) and of community leaders (for out-of-school youth) makes it more likely that suitable candidates are selected, thus reducing the need for frequent replacements. Very few have dropped out after the training.
- Peer educators, even though young, reach out to adults and are well received by them. This demonstrates a high demand in the communities for accurate information on HIV/AIDS.
- The effective management of the project requires a critical mass of local staff working full time. The reliance on volunteer managers can create delays in programme implementation, leading to the frustration and demotivation of peer educators.

Monitoring and evaluation.
- Most projects are quite capable of maintaining process indicators but measuring the success of HIV prevention interventions is more problematic, especially in terms of its impact or effectiveness.
- Data collection in government systems was not always consistent and there is very little evidence of analysis of the data collected.

Ownership.
- Building ownership has been a strong element in all the UNICEF supported projects under review. By identifying NGO partners with strong links to the community it has been possible to get strong community support from the outset.
- Strong ownership at community level can ensure that the impact of particular project interventions is sustainable.

Sustainability.
- There is certainly evidence from the interviews conducted that peer educators will continue to reach out to their community even if external support is not available.
- Interventions which are integrated into government systems are also more likely to be sustainable.

• Future directions

Continuation of support
It is to the credit of the programme designers, namely Red Cross, Action Aid, CENCOSAD, SGAID and CAS, that the programme has been well received by the target group and community members. The high demand for HIV/AIDS and STIs education in the communities demonstrates the need to continue support for the projects. Continuation would go a long way to boost HIV/AIDS prevention and control activities for young people.

Scaling up
Building ownership at local government and national government level will be important in terms of the scaling up and the long term sustainability of the interventions. UNICEF is in a strong position to ensure that future HIV prevention activities are integrated into government structures. It is also well positioned to help build the capacity of the NGO sector to undertake effective HIV prevention activities and to play a role in co-ordinating the efforts of the various players.
In looking at supporting a District Response Initiative, UNICEF needs to consider whether it is in a position to give comprehensive support to the initiative or whether it should form a strategic alliance with other partners for this purpose.

Projects dealing with in-school youth can be institutionalised through negotiations with the educational authorities and can be scaled up in this manner. Out-of-school youth are not a homogenous group and it is important to develop a variety of strategies to reach the various sub-groups.

A key issue in scaling up is the selection of effective partners. The NGO partners that UNICEF works with have clear limits in terms of capacity, but some of them - such as CENCOSAD - are in a position to assist in the capacity building of other NGOs. Scaling up would also require a deepening of the relationship with key ministries including health and education.

Strengthening the Monitoring and Evaluation System
The difficulties encountered on the UNICEF projects with monitoring and evaluation are by no means unusual. Some NGOs involved in the project such as YPIC and CENCOSAD have particular strengths in developing monitoring systems, but ongoing support would be needed if they are to be used effectively.
2. BACKGROUND OF GHANA’S SITUATION AND RESPONSE TO HIV/AIDS

2.1 HIV/AIDS Situation in Ghana

Epidemiological evidence continues to indicate that HIV infection is spreading among all age groups and sexes in Ghana. From an initial adult sero prevalence result of 0.2% in 1991, the HIV prevalence rate has risen to 3% by the end of 2000. Though this rate is relatively low in comparison to Southern and Eastern Africa countries, the reported AIDS cases reveal disturbing disparities in the infection trends.

At the end of 31st May 2001, the National AIDS Control Programme (NACP) had reported a cumulative total of 47,444 AIDS cases. 64% are women and of those 74% are between the ages of 20-39, with the peak ages for HIV infection being 15-25 years. Children under five years old represent 2.0%, suggesting other modes of transmission including mother-to-child transmission of the HIV virus. The number of cases among 10-19 years estimated at 2.2% is rather low and justifies the focus of UNICEF's prevention activities on young people as the 'window of hope' especially in an environment where the prime mode of viral transmission is heterosexual.

With HIV infection firmly established in the country the phenomenon of AIDS orphans is increasingly coming to the fore. The NACP has projected that given the primacy of heterosexual transmission of the virus the number of children orphaned by AIDS will rise to 252,000 in 2004 and to more than 603,000 by 2014. The social and economic consequence of maternal or double parental loss on children poses a potential threat to the gains achieved under the child survival and development programmes.

2.2 The Policy environment

The Government of Ghana’s response to HIV/AIDS includes:

- Providing information, education and communication to the general public and specific target groups, such as commercial sex workers, truck drivers, the military, health workers and security services.

- Counselling for people infected with, or affected by HIV and AIDS

- Treatment and care for AIDS patients including home-based care

- Screening of blood to assure blood safety and the provision of HIV testing for suspected HIV cases, and

- Surveillance and Control.

The Ministry of Health has been the lead agency for HIV/AIDS activities until late 2000, when the Ghana AIDS Commission (GAC) was established to provide a multi-sectoral, national response to HIV/AIDS

A national HIV/AIDS and STI Policy has been developed and the final draft document has been widely disseminated among various stakeholders e.g. the donor community, people
living with AIDS, and the government structure at national, regional and district level. The document defines the government's policy on HIV/AIDS and STI in order to guide national efforts to stem the tide of the HIV/AIDS Pandemic in Ghana.

The objectives of the policy include the following:

1) Through advocacy, to create an environment conducive to ensure sustained political commitment and support for effective action against HIV/AIDS and STIs in Ghana.

2) To create conditions for behavioural change in all areas of sexual and reproductive health.

3) To provide the general population, especially among women and the youth, with a programme of information and education about HIV/AIDS and STIs.

4) To ensure that adequate attention is paid to vulnerable groups such as women and children, the youth and commercial sex workers.

5) To ensure that those infected with HIV or AIDS are provided with adequate medical and social care, including counselling.

A five-year national HIV/AIDS strategic framework has been developed. The framework provides broad guidelines for the public and private sectors, and Non Governmental Organizations to evolve specific HIV/AIDS strategic plans and activities based upon their respective strengths.

Two key interventions desired in the document and relevant to the work of UNICEF are: Prevention of new HIV infections and care and support for people living with HIV/AIDS. Promoting safer sex among the youth and other vulnerable groups have been highlighted.

2.3 The District Response Initiative

National efforts to prevent or control the spread of HIV/AIDS have not been seen as effective. However, the success of administrative decentralisation in Ghana has enabled a multi-sectoral response against HIV/AIDS at the district level. This has led to the adoption of an expanded district response to HIV/AIDS, namely the District Response Initiative (DRI). DRI involves all stakeholders in the co-ordinated implementation of HIV/AIDS interventions.

The experience on the Adansi West District formed a major component of this national initiative.
3. BACKGROUND TO THE EVALUATION

In 1996 Ireland Aid agreed to provide funding support for five HIV prevention interventions in different regions of Ghana. The interventions are projects run by different local agencies and organisations which receive their Ireland Aid support through UNICEF Ghana in Accra.

The programme logframe, reflecting the specific goals, objectives and activities for these 5 project components, is presented in appendix 2.

Regarding STIs and HIV/AIDS, the projects employ similar strategies; information, education and communication strategies, access to quality health services and access to a convenient supply of condoms. Counselling is also provided together with school/literacy education, vocational training (informal & formal) and access to credit. In Accra detailed case work aimed at re-integrating children to their family structures is done where possible. The HIV prevention strategies focus on messages of abstinence, faithfulness, condom use and effective treatment of sexually transmitted diseases.

All projects have established links to available health service providers (hospitals, clinics and pharmacy shops) particularly for sexually transmitted infections though not exclusively.

Ireland Aid’s support, though significant, has been a part contribution to these projects which have mixed funding and input arrangements.

A mid-term evaluation was performed in 1997 and numerous monitoring activities have been performed. A comprehensive baseline survey of the projects’ target populations Knowledge, Risk perception and behaviour with respect to HIV/AIDS and STIs, was carried out in 1998 though only finally published in April 2000. This study opened the opportunity for improved indicators.

3.1 Purpose of the evaluation

Though Ireland Aid has supported UNICEF Ghana in HIV/AIDS prevention activities since 1996, this evaluation will focus especially on the period between 1998 and 2000 when Ireland Aid provided a second round of funding for continued support of the five project components.

The evaluation is to inform and be of value to UNICEF, Ireland Aid, National AIDS Control Programme (and Ministry of Health), relevant local authorities and component project staff.

The purpose of this evaluation is to
- Identify the projects’ gains and achievements (intended and unintended).
- Describe the lessons and examples of best practice.
- Provide options for future developments. These would propose improvements in programme implementation and sustainable expansion and replication, while taking into account the government’s policy and strategy for HIV/AIDS and STIs, and the UNICEF 2001 – 2005 Country Programme.

The evaluation was to focus on the targeted beneficiaries and discuss with them any changes in their knowledge, perception and behaviour due to the project interventions.
The evaluation was also expected to assess the organisation, structure and management of the programme and its component projects. In particular, an analysis would be made of the programme’s capacity and efficiency, the promotion of both intra-sectoral and inter-sectoral linkages and the co-operation and involvement of relevant government ministries, such as Employment and Social Welfare, Education, Health and Sports.

The subjects of this Evaluation are the five HIV/AIDS and STI projects in the programme funded by Ireland Aid. These are:

1. The Peer Education in 12 Districts in Upper East and Northern Regions run by Ghana Red Cross Society for young people in and out-of-school. Funds have been channelled through ActionAID, Ghana.

2. The Adansi West District Assembly runs the Obuasi Commercial Sex Workers project in Obuasi, Ashanti Region. Funds have been channelled to the District Assembly.

3. Peer Education for in and out-of-school youth project in James Town, Accra, run by The Centre for Community Studies Action and Development (CENCOSAD).

4. A refuge project and centre for female Street youth in Maamobi, Accra, run by Street Girls Aid (SGAID).

5. A refuge project for male street youth in James Town, run by Catholic Action for Street children. (CAS)

3.2 Methodology of the evaluation

All the projects were visited between 14 May and 31st May 2001. The evaluation team used several methods of data collection and analysis.

The evaluation was based on in-depth interviews and focus group discussions with peer educators, outreach workers and members of the target group. Interviews were carried out with staff of UNICEF, the management of collaborating NGOs, District Assembly staff, staff in the Ministry of Health, and senior projects staff at national, regional and district level.

Background documentation was reviewed, as were reports from various levels. Health workers at the relevant health centres and hospitals were interviewed and Pharmacy Shops and Chemical shops were visited. Feedback workshops were held with peer educators, outreach staff and the management committee.

Site visits were conducted in Tamale, Yendi, Bole, Bolgatanga, Zebilla, Bawku, Navrongo, Sandema and Bongo in the Northern and Upper East Regions, in Obuasi in Ashanti Region, and Ga Mashie in Greater Accra Region. Observation was another methodology used during these field visits, such as during the visits to the Youth Friendly Centres.

The evaluation team had a debriefing meeting with the staff of UNICEF at which the preliminary findings and recommendations were discussed.
4. THE YOUTH PEER TO PEER PROJECT IN NORTHERN AND UPPER EAST REGIONS

4.1. Overview of the project

In 1993 – 94, Ghana Red Cross Society (GRCS) developed, implemented and evaluated a pilot AIDS peer group education project in Accra, with technical support from WHO and the International Federation of Red Cross and Red Crescent Societies. At the end of the project, the evaluation documented the feasibility and acceptability of the peer education approach in Ghana.

The evaluation highlighted the strong interest and commitment of both the peer educators and the young people who were reached through the project, to reduce their risk of HIV infection.

As a follow up to the Accra initiative, Action Aid Ghana and GRCS in 1995-1996 collaborated on a similar project in three Districts of the Upper East and Northern Regions. Again the evaluation report made positive recommendations which culminated in an expanded phase, this time reaching out to 12 districts in the Upper East and Northern Regions.

A tripartite agreement was established to ensure efficiency in project implementation. Responsibilities were shared with the Ghana Red Cross Society implementing, Action Aid - Ghana acting as the financial managers, and UNICEF providing technical support to the project.

4.2. Goals and targets

The goal of the project component is to reduce the incidence of HIV/AIDS amongst young people in 12 districts of the Upper East and Northern Regions.

The main objective is to promote HIV/AIDS awareness and knowledge and to promote safer sex practices among young people in the Upper East and Northern Regions of Ghana.

Specifically the project aimed to educate 20,000 young people aged 15 – 25 years on the knowledge, attitudes and skills needed to prevent HIV infection through peer to peer education.

It was anticipated that the peer educators and the participants at the education sessions would pass on HIV information to at least 50,000 other persons, two thirds of who would be aged 15 – 25 years.

4.3. Findings

4.3.1. Selection of Peer Educators
Clear criteria for the selection of peer educators exist and have been discussed and understood at all levels. They include, age, educational level of at least Junior Secondary School (JSS), ability to communicate in English (the language used in training), ability to communicate in the local language and proven commitment in GRCS activities. Additionally, the young person should not be too shy (though this is often overcome during the training) and should be of good behaviour.

Many of the peer educators who have finished school are unemployed and being a peer educator is very important for their self-esteem. “If I wasn't a peer educator I would be hanging around all day but now I have something good to do, I enjoy meeting other young people and advising them”.

The role of the peer educators has also been clearly spelt out. The peer educators know they have to work in pairs, in order to make their work easier and to support each other. Male peer educators will work with their male counterparts and female educators with their female counterparts. This arrangement is to satisfy the concerns of a traditional and conservative community that is uncomfortable with mixed sex meetings, especially if sexual issues are being discussed. The other reason for the same sex pairings is to ensure that target group members feel comfortable and participate effectively during the educational sessions. (It is significant to note that since the year 2000, some of the districts in the Upper East have experimented with mixed pairing and mixed group meetings. This arrangement did not detract from the education given and the peer educators and target group members seemed comfortable learning together.)

4.3.2. Training

A total of 222 Peer Educators have been trained in the Northern Region and 292 in the Upper East Region. It is a practice to start each year's activities with a review meeting and a Trainer of Trainers refresher workshop. This provides an opportunity for project managers and staff to interact and share lessons and experiences. An initiative was introduced in 1999 to recruit experienced and older peer educators as trainers.

There are two separate peer education training sessions each year. The first training, usually held in the first quarter, is to equip new peer educators with the skills necessary to disseminate behaviour change information among their peers. Training of new peer educators lasts for five days. A three day refresher training, this time involving the old and new peer educators is held between six and seven months after the completion of induction training. Linked to the peer education training is the development of appropriate psychosocial skills to instil in the trainees a confidence and an understanding of their self-worth. These qualities are invaluable to the peer educators, not only for the enhancement of the inter-peer communication but also for their acceptance by the community at large.

4.3.3 Peer Education Sessions

Each peer education session comprises between 12 and 15 target group members. They meet on a weekly basis for a two-hour session over a four-week period. The activities start with the target group going through the following:
i. An HIV “Risk game” using picture cards. Here participants are invited to categorise activities into high, medium and low risk for HIV transmission. This activity helps the peer educators assess the baseline levels of the target group.

ii. An HIV/AIDS snakes and ladders game. The youths are divided into two teams and correct answers to questions on HIV/AIDS allow the team to throw the dice and move on. This session is designed to encourage discussions on HIV/AIDS issues.

iii. The story of three young people, Adwoa, Kojo and Kwesi. This session allows the young people to ‘role play’ and generates issues for further discussions on HIV/AIDS.

iv. The STI Quiz and condom demonstrations. Condom demonstrations are limited to the out of school sessions as most school authorities do not allow those within the school compound, arguing that this will encourage early sexual initiation.

Recently, a pre-test and post-test exercise is carried out with the group to measure improvement in their knowledge after the four week sessions.

The peer educators had additional materials at their disposal, such as the flip charts, a question and answer booklet about HIV/AIDS and a leaflet on STIs. Most of the peer educators refer to these for assistance whenever they had to give further explanation on a difficult issue.

A number of issues arose from observation of the peer education sessions and the subsequent interviews with the peer educators:

In general the peer educators are highly motivated and enthusiastic and they have a good relationship with their peers, which enhances the peer education process. It was also observed that the peer educators handled the sessions with a high degree of self-confidence.

It terms of the organisation of the education sessions, a number of problems were noted:

- It can be difficult to choose an appropriate location for an out-of-school session and sometimes these were conducted in less than ideal conditions. When the meeting is held for instance in a market place or a lorry station, it usually attracts numerous passers-by and this sometimes distracts the concentration of participants.

- In some cases the peer educators did not pay attention to seating arrangements and using the conventional classroom seating was not conducive for teamwork or group discussion. This resulted in shy participants not contributing to the discussions.

- During discussion, some peer educators did not listen adequately and appeared likely to misunderstand the questions raised by group members. In some instances this resulted in didactic teaching by the peer educator, rather than building on the experience of the group through further discussions.

In terms of content the following observations were made:
In all the sessions we observed, most of the key messages about HIV/AIDS and its prevention were clearly articulated and reinforced by the peer educators. However the link between HIV infection and other sexually transmitted diseases was poorly understood. There was also limited knowledge about the other STIs and the peer educators often gave incorrect information.

There was also a constant mix-up between HIV and AIDS. Using the terms interchangeably often lead to confusing messages, particularly in relation to signs and symptoms of the disease. Some peer educators did not correctly understand Mother to Child Transmission.

The problems associated with this method of passing information on HIV/AIDS and with the specific content, could be addressed by strengthening supervision and by relevant refresher training.

The tables below summarize the achievements in terms of outreach:

Table 1: Number of Young people in the Northern Region reached through Peer Education sessions 1998 – 2000

<table>
<thead>
<tr>
<th>Target Group</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1,904</td>
<td>5,373</td>
<td>11,008</td>
<td>18,285</td>
</tr>
<tr>
<td>Female</td>
<td>1,802</td>
<td>5,231</td>
<td>10,765</td>
<td>17,798</td>
</tr>
<tr>
<td>Total</td>
<td>3,706</td>
<td>10,604</td>
<td>21,773</td>
<td>36,083</td>
</tr>
</tbody>
</table>

Table 2: Number of young people in the Upper East Region reached through Peer Education sessions 1998 – 2000

<table>
<thead>
<tr>
<th>Target Group</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1,598</td>
<td>6,832</td>
<td>8,332</td>
<td>16,762</td>
</tr>
<tr>
<td>Female</td>
<td>1,556</td>
<td>6,514</td>
<td>5,293</td>
<td>13,363</td>
</tr>
<tr>
<td>Total</td>
<td>3,154</td>
<td>13,346</td>
<td>13,625</td>
<td>30,125</td>
</tr>
</tbody>
</table>

The monitoring system was based on forms provided to peer educators on which they record the names of the peers reached.

There was also evidence that more than the required number was eager to attend the sessions and in many instances the peer educators had to restrict the number of people who could participate in each session. The impression is that many more people always turn up than each session can conveniently handle.

At the end of December 2000, the 514 trained peer educators had reached out to a total of 66,208 young people in the Upper East and Northern Regions through the peer education sessions. The project proposal had envisaged to train 750 peer educators at the end of the
three-year period who in turn will reach out to 20,000 target members. From this data it is obvious that the target set to reach out to young people on HIV/AIDS/STI behaviour change messages has been exceeded. There is however no systematic data collection to monitor those who are reached by participants of the education sessions. This shortcoming notwithstanding, anecdotal evidence exists to suggest that HIV/AIDS messages were spreading, with the active involvement of young people who have passed out from the sessions.

4.3.4 Impact on knowledge, attitudes and practices

Many of the young people interviewed individually or through the focus group discussions retained most of the information they had acquired through the sessions. Almost everyone could identify 2 modes of HIV transmission and two ways of protecting themselves from HIV infection. Invariably everyone mentioned abstinence, sticking to one partner and the use of condoms.

Almost all the out-of-school youth could demonstrate the proper use of condoms. Condom demonstration was not part of the activity for the in-school youth educational sessions. Peer educators are aware that they are trying to influence behaviour change, but acknowledge that it is difficult to measure the change. There are however examples of individuals who have changed behaviour. Some of the older target groups who are sexually active claim they now use condoms consistently. These are some remarks from young people whom we interviewed in Bawku West

“Some of us here did not want to use condoms. It was like using a raincoat to shower. Since the peer educator taught us to fix and use a condom properly, I always use it”

“Since I attended the educational sessions, I have stopped having sex. Sometimes my friends laugh at me saying if you do not have sex the sperm would be stored in you and this would disturb you; but I do not mind them”

“Sometimes the girls put pressure on the boys to have sex with them and not use condoms. They say if you trust her why don’t you want to have sex without condoms. Then we tell them you may get an STI and if you have it you are likely to get HIV quickly”

Interview with 21-year-old male in Bole

“I am still at school but also work with my father. A group of us met last year, we were about 20 boys and all of us were footballers. The peer educators showed us how to use a condom. Sometimes they burst but now I know how to use a condom properly and I advise my friends”

It is not difficult for most boys and young men to buy condoms and they are not embarrassed because each locality has its own euphemism for condoms. For example some of them go to the drug store and ask for socks, CD Cassette or Nassau Chewing gum. The drug store/chemical sellers know that they actually want condoms. A few suggested that some of the peer educators could be trained as ‘community-based distributors of contraceptives’ to help the provision of condoms and other contraceptives.
4.3.5 Referral of Sexually Transmitted Infections.

The peer educators sometimes refer cases of STI to the District Youth Organisers for medical attention. Though not part of the project proposal, this has developed logically from challenges arising during implementation. With the awareness and demystification of STI, the demand for the service has risen and the project has worked out a partnership with the local health service for referral of suspected STI cases. In some districts the peer educators accompany the clients to the health institutions. There have been a number of obstacles for young people to derive the full benefit of this innovation. According to the peer educators, one major barrier preventing access to STI health services is the “perceived high cost of STI treatment”. In addition the poor attitude of health workers to STI patients is also cited as preventing some of the referred patients from seeking proper care.

Table 3: Cases of STD Referral in the Northern Region 1998 – 2000

<table>
<thead>
<tr>
<th>Target Group</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>7</td>
<td>37</td>
<td>60</td>
<td>104</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>36</td>
<td>32</td>
<td>72</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>73</td>
<td>92</td>
<td>176</td>
</tr>
</tbody>
</table>

The numbers referred for treatment varied from district to district. In areas where the referral number was low, the peer educators indicated that people went directly to the health facility and did not need to be referred.

4.3.6 Transportation

Due to the scattered nature of the settlements in the Northern and Upper East Region, transportation presents a challenge to peer educators whose target groups live outside the district capital.

Bicycles have been given to some of the peer educators, but the agreement with the peer educators was not clear initially. While useful in helping peer educators reach the villages, there is no doubt that bicycles are also a motivational factor. However, it is not very clear to the peer educators nor the project management, whether the project will be able to continue to supply bicycles to new peer educators. It would be useful to formalise the agreement for any subsequent distribution of bicycles.

Management and coverage are issues of concern. The project must be extended into other areas in order to benefit young people in the entire region. However, the regional level would find it difficult to supervise additional districts that are far from the district capital. The structures for supervision may need to be revised if there is geographical expansion and transport issues become more acute. There may be real limits preventing coverage of the region if the project relies solely on GRCS structures.
4.3.7 Supervisions of Peer Educators

The District Youth Organiser supervises the Peer educators. Even with the support from the Assistant District Youth Organisers, it has not been possible to supervise a large proportion of the peer education sessions. A more structured approach to supervision could help identify problems at this early stage.

At present a number of the more experienced peer educators are carrying out some supervisory duties and this could be formalised. It should be possible for these experienced peer educators to observe peer education sessions and then have debriefing with the pair for peer educators at the end of the sessions, to help them identify areas whose methodology and content could be improved.

There are weekly meetings between the peer educators, the District Youth Organisers and the Assistant District Youth Organisers. These meetings are important forums for sharing of information and interacting with each other and their supervisors.

These meetings could be used as refresher training to improve the skills of the peer educators as well as addressing knotty issues that the educators encounter.

For weekly meetings to be very beneficial, each peer educator needs to collect frequently asked questions. These questions should be collated and passed on, for example, to the District Health Administration, the District AIDS Team or appropriate person or organisation, for the necessary feedback to the group. The evaluation team found a number of misconceptions that needed to be addressed and the above suggestion could be one way of correcting this.

4.3.8 Monitoring and Reporting

The report forms have been revised to take into account observations made at earlier reviews and peer educators find them easy to use. The information is disaggregated by gender. These reports have made it easy to collect and collate statistical information and for identifying the problems that have been encountered.

A summary report is assembled at the District level and sent, with a copy of the peer educator reports, to the Regional level. The peer educators indicated that they receive feedback on their reports. The filing of reports at the District level is impressive, but in a few instances there were inconsistencies in the way the summary report had been assembled.

During his supervisory visits, the project manager needs to review the reports carefully to see how the total figures are reached and raise issues with the District youth organisers.

Pre-test and post-test sessions have been introduced to try to improve the monitoring of the programme. Unfortunately there are problems with the process at the moment. The peer educators for the in-school youth claim it is cumbersome to write these test on the blackboard and would prefer to have a questionnaire to be completed by the target group.

The evaluation team witnessed one session where the peer educator combined the pre-test with a teaching session, often providing answers to questions he had posed to the group. This
can distort the test significantly. The voting process is chaotic and it is also difficult to know whether the views of the individuals involved have been captured.

There are concerns over the reports on pre-test and post-test sessions, largely because of the issues raised above and the quality of the reports is questionable. However, the introduction of pre- and post-testing has raised awareness among the peer educators of the need to monitor activities and if it can be reviewed it should provide a way of monitoring changes in information level, attitudes and risk awareness.

4.3.9 Youth Friendly Centres

The ‘youth friendly centres’ are still non-functional. However there was evidence that premises have been identified in Yendi, Bawku East and Bongo Districts. The District Youth Organiser has had discussions with the District Health Management Team and the District Assembly as to the roles of each organisation, however, the progress of work seems to have stalled. In Yendi district for instance, the District Director Health Services did not have adequate funding to complete part of the renovations and was waiting for funds from the central Government to complete the work. Given the important role this centre would play in providing a ‘one-stop shop’ to young people for their reproductive health needs, UNICEF may want to absorb the rest of renovation cost to enable the centre start operating as soon as possible.

The other centres in Bongo and Bawku District also need to be completed and made operational. It was not clear to the evaluation team what arrangements have been made regarding the sustainability of the centre. These issues need to be clearly sorted out between the District Assembly, Ministry of Health and the Ghana Red Cross Society so that roles are defined at the beginning of the project to forestall future difficulties when the centre becomes operational.

4.3.10 Project Management, Supervision and Reporting

GRCS has appointed a volunteer project manager to each region. He is assisted by a regional advisory committee with the Regional GRCS as his immediate supervisor. It would be realised that the project is benefiting from the decentralised management structure of the GRCS. At District level, the District Red Cross Committee supervises the project, which is managed by the District, and Assistant District Youth Organisers.

To maintain a gender balance, where the district Youth Organiser is a male the Assistant is a female. The two are responsible for collecting the financial and the peer education activity reports from the peer educators for transmission to Regional level.

The Project Manager collates the reports and submits them to Action Aid Ghana for transmission to UNICEF. There have been a few management problems relating to timely financial reporting.

Financial reporting from the District level on the whole seems adequate, but there is a peculiar problem in the Northern Region. This refers to the project manager who combines his work with studies as a student at the Tamale Polytechnic. As already mentioned, some of the financial returns from the District arrive at the Regional office with mistakes and it takes time to reconcile the financial statements for submission to the Action Aid office in Tamale.
Secondly, the reports from Regional level to Action Aid and UNICEF have been delayed or incomplete, leading to delays in the release of funds.

It may be useful to provide full-time project managers in both the Northern and Upper East Regions to circumvent this major bottleneck, which prevents timely flow of funds for programme implementation

**4.4 Lessons Learnt**

1. Careful selection and training of peer educators is critical to the success of the peer to peer approach. Involvement of the schoolteachers and parents in the case of in-school youth and the community leaders in the case of out-of-school youth ensured that very few of the selected candidates were found unsuitable after the training, or required replacement.

2. The initial training of the peer educators over a five-day period is short given the volume of information to be absorbed. However the weekly meetings with supervisors to review each week’s activities allow additional training for the peer educators and their existing knowledge is reinforced. This process is important, as group activities encourage the less assertive to gain confidence over time. Secondly, it is a forum where peer educators can have any misconceptions clarified on a timely basis.

3. Adults and opinion leaders are supportive of peer education activities and participate in activities in which they are involved.

4. There is a high demand for HIV/AIDS education in the communities. Well trained peer educators, even though they may be young people, have demonstrated their ability to provide HIV/AIDS education to their peers and unintended target groups such as adults.

5. Effective project monitoring requires intensive on site support and this can be obtained through the adoption of appropriate and easy to understand tools.

6. Effective project management requires a critical mass of local staff working full-time on the project. The dependence of management on volunteers is likely to create undue delays in programme implementation, which in turn may de-motivate peer educators.

**4.5 Recommendations**

1. The Ghana Red Cross and Action Aid need to discuss and streamline the management of the project at the regional level to improve the co-ordination of their activities.

2. New methods for improving the delivery of the information by peer educators have to be explored. This is vital to overcome the tendency to resort to didactic teachings. It is also essential for peer education sessions to be organised in a horseshoe shape to encourage those with special needs e.g. shy participants could be identified and supported.
3. The training for the peer educators should include aspects of listening and negotiating skills to improve their efficiency in communication. The standard of peer educators is an issue: it needs to be raised. While important, interest and motivation are not enough. Project Managers must endeavour to select new peer educators from those most likely to meet the challenges as peer educators.

4. There must be a timely and adequate supply of educational materials. At the time of review, the new peer educators had not received their supply. This can eventually lead to demotivation. UNICEF needs to review its supply system to enable the bottlenecks be removed.

5. The project needs to look at adding other reproductive health issues such as fertility management, preparation for menarche, sexual hygiene etc. to the educational component of the current programme. There is a real need for these issues to be addressed.

6. The transportation requirement for the project needs to be clearly worked out. A policy on transport support for peer educators needs to be articulated. Once the policy is in place all the different players need to adhere to the policy.

7. The role of other agencies, such as the School Health Education Programme and the Ministry of Education, should be clearly spelt out. Their co-operation must be sought. In particular the Ministry should to articulate clearly its position on reproductive health and not leave such delicate matters to the discretion of school authorities.

8. A full-time staff at the local level in both Northern and Upper East Regions should be provided for the effective management of the project. To ensure adequate supervision, the number of Assistant Youth Organisers must be increased from the current one to a maximum of three, depending on factors such as distance, population size and potential for expansion.
5.0 ADANSI WEST DISTRICT: THE COMMERCIAL SEX WORKERS PROJECT

5.1 Overview of Project

There is a realisation that, despite a high awareness of HIV/AIDS, certain groups within society are continuing to engage in very high-risk behaviour. Because of the nature of their work and their poor socio-economic status, commercial sex workers are among the most vulnerable to HIV infection. Obuasi, in the Adansi West District, is a gold-mining area and it attracts a large number of men in search of employment. The town is characterised by a high population density, high unemployment, and high cost of living and because of the predominantly male workforce, the town has also attracted a large number of commercial sex workers. In the baseline survey of attitudes in the community, slightly over 93% of the respondents were aware of commercial sex activities within the community and 66.6% described the visibility of such activities as very high.

UNICEF first became interested in working in Obuasi when they sponsored a study to look at the high drop out rate of girls in the education system. The result confirmed the fears of the District Assembly that girls who were outside the education system were vulnerable to exploitation and it raised concerns about the commercial sex worker situation in the town. UNICEF agreed to support the District Assembly and other stakeholders to address this problem.

5.2 Goals and targets.

The goal of the project as expressed in the project document approved by UNICEF and Ireland Aid in 1997, is to reduce the incidence of Sexually Transmitted Infections including HIV/AIDS among commercial sex workers and young women in Obuasi. The main objectives are:

- To increase awareness on HIV/AIDS and to increase knowledge on modes of HIV/AIDS transmission amongst commercial sex workers in Obuasi,
- To increase personal risk perception and safe sex practices among commercial sex workers in Obuasi, and
- To promote appropriate health-seeking behaviour among commercial sex workers for the treatment of STDs.

An earlier phase of the project had been evaluated in 1997 and the major findings from that evaluation were taken on board in redesigning the project. The project was due to finish in 2000 but some activities have been carried forward to the first quarter of 2001. UNICEF has indicated that it does not intend to continue funding activities in Obuasi beyond this period.

The project uses a peer education approach and a key to its success is the appropriate identification and training of peer educators. The target group was classified under several headings; hotel-based commercial sex workers, home-based commercial sex workers, street based commercial sex workers, and “invisible” sex workers. The last mentioned category consists of women who may have some other employment (e.g. hairdressers, seamstresses) but who are also involved in commercial sex activity. Peer educators were selected from these groups or from individuals who have close contact with people in these groups. Many, but by no means all, peer educators would describe themselves as commercial sex workers or former commercial sex workers.
The peer education approach is based on one-to-one discussions often in very informal settings, this helps ensure that clients are receptive and open to share their concerns and fears on HIV infection with the peer educators facilitating the process to enable the client to make healthy decisions.

The peer educators use focus group discussions and meetings with individuals in their outreach activities with commercial sex workers and other community members. The messages they carry are geared towards creating the necessary awareness about HIV/AIDS and the need to reduce the risk of exposure through behavioural change. Their activities are mainly focused on promoting safer sexual behaviour, providing access to condoms, and promoting early diagnosis and adequate treatment of STIs.

As it is difficult to identify some commercial sex workers and there are also other women with multiple partners, the target group for the project was defined as commercial sex workers and young women. It is noted however that the peer educators also reach out to young men and much of the condom distribution is to men although men were not identified as a target group in the original logical framework nor in subsequent revisions. Project staff refers to men as a secondary target group.

Outreach staff from various departments, coordinated by the assembly act as supervisors for the peer educators. Peer educators report to their supervisors orally or in writing and the supervisors then report to the management committee.

Apart from peer education the other activities in the project are; increasing access to condoms, improving access to quality STI services, and providing access to credit for commercial sex workers and single women. There was also the intention of reaching out to people with AIDS although this was not captured in the original logical framework for the project.

5.3 Findings

5.3.1 Selection of Peer Educators

The selection process starts by identifying different groups of commercial sex workers and then identifying individuals who could act as peer educators for these groups. One group that was not identified by the project was brothel based sex workers and the evaluation team found some evidence that a brothel system operated in Obuasi. The other groupings were useful ways of categorising the commercial sex workers and formed the basis for focus group discussions, which helped to identify those who have skills in leadership and communication to train as peer educators.

Overall the process of selection was excellent and the individuals chosen as peer educators had good access and were acceptable to members of the target group. Men were not selected as peer educators even though some had indicated a desire to be trained.

5.3.2 Training

In all 110 peer educators were trained; 19 home based, 30 street based, 7 hotel based, 54 invisible sex workers. 100 of the peer educators are still active (In the project document it
was planned to train 200 peer educators). Peer educators also underwent refresher training and some were also taken to Tarkwa on an exposure visit where CARE is involved in a similar project. A number of those interviewed spoke highly of this visit and in general the peer educators were very positive about the training they received. In more recent trainings the trainers have used tests before and after the training to assess its effectiveness.

5.3.3 IEC materials

Peer educators are trained to facilitate focus group discussions and to carry out individual counselling with commercial sex workers and other members of the community. The most important visual aid for many of the peer educators was the T-shirt identifying them as peer educators and the teaching aid most used was the wooden penis for condom demonstration. Many of the peer educators said that they made limited use of other educational materials. Much of the work of the peer educators is informal and unstructured and this probably accounts for the limited use made of IEC materials.

5.3.4 Outreach activities

A survey carried out in the 1997 evaluation showed that the peer educators reached out to an average of 15-20 commercial sex workers each on a regular basis. It pointed out that allowance needed to be made for possible double counting where some commercial sex workers are in contact with more than one peer educator is. With the increase to 100 active peer educators the number of commercial sex workers reached on a regular basis could be as high as 2000 if the 1997 average still holds. Unfortunately it is difficult to draw firm conclusions about the level of outreach activity from the reporting system that is in place. There is also limited information available on the nature of the outreach activity.

Some target groups have proved very difficult to reach. Initially the home-based commercial sex workers came into this category but the project has been very successful in breaking down the barriers and has developed a strong outreach system among this group. The hotel-based commercial sex workers have proved difficult to reach on a sustained basis, as they are a very transient group. The project developed several tactics for reaching out to this group including the training of security staff at the hotels. However, despite these creative responses the project staff have indicated that the current outreach activity among hotel-based commercial sex workers is very limited.

5.3.5 Supervision by outreach workers

12 outreach workers were trained and six are still active. The outreach workers were selected from the Department of Social Welfare, Ministry of Health, Information Services Department, National Mobilisation Programme and Red Cross. Each outreach worker is assigned a group of peer educators and they hold regular weekly meetings with the peer educators and report back on the progress of the project to management.

The relationship between the outreach staff and the peer educators was generally very good but a number of factors had served to undermine this relationship. These included the non-payment of allowances, the erratic supply of condoms and the delays in implementing the credit system. Peer educators tended to blame the outreach staff for these problems as the outreach staff were the point of contact between the peer educators and project management.
5.3.6 Allowances

Management agreed at the beginning of the project to give the peer educators a weekly allowance of C3000, a monthly lunch allowance of C5000 and a supply of soap and detergents, which UNICEF approved. Motivational allowances were also increased for outreach staff at the same time. UNICEF has transferred no funds for activities in 2001 and so no allowances have been paid for this period. This has led to serious demotivation of both peer educators and outreach workers. The allowance system that was established was not sustainable and as a result the overall system of supervision is crumbling.

5.3.7 Monitoring and reporting

Considerable effort was put into the development of a monitoring and reporting systems. Progress reports indicated that the collection, documentation and dissemination of relevant information for checking the progress of the project had been made simple and was understood by all the stakeholders involved in the project. The chain of processes involved daily record keeping by the peer educators through weekly updates by outreach staff and monthly compilations to the Project Co-ordinator of Adansi West District Assembly for harmonisation and onward transmission to UNICEF.

During the evaluation it was clear that there were still problems with the reporting system. There are problems with the way the data is collated making it impossible in many reports to distinguish between new persons reached and repeat encounters. This makes it difficult to confirm the total number of people reached by the peer educators. There was no evidence of analysis as the reporting moved up the line and the information did not seem to be used by management at district level.

5.3.8 Impact of peer education on knowledge about HIV/AIDS and other STIs

A baseline survey was carried out in July/August 1998 in Opuasi to investigate the STD/AIDS-related knowledge, attitude and behaviour among commercial sex workers. As the study took place during the lifetime of the project it cannot be used as a baseline for the project as many of the individuals surveyed had probably already come into contact with the peer educators. It is however useful as it captures the knowledge, attitude, and behaviour at a particular point in time.

The project baseline survey noted that friends were the most important source of information for commercial sex workers HIV/AIDS and other STI. This is a useful indication that the peer education approach is an appropriate one for this target group.

The baseline survey indicated that there was a high level of knowledge about HIV/AIDS among commercial sex workers and this has been confirmed through project monitoring and was borne out by interviews conducted during the evaluation. All commercial sex workers interviewed during the evaluation were aware of HIV/AIDS and could mention at least two modes of transmission including unprotected sexual intercourse. Commercial sex workers were also aware of risk reducing behaviour such as the use of condoms. In the baseline survey all the respondents knew about condoms and 97% believed that condoms could protect them from getting AIDS. These findings were also borne out in the semi-structured interviews carried out in the course of the evaluation.
Knowledge about other STIs was more varied. In the baseline survey 98% were aware of Gonorrhoea, about a third of the respondents spoke of “white” and two persons mentioned syphilis. None of them mentioned genital warts, chlamydia or herpes. Knowledge of the symptoms was sometimes vague. Of the 29 people who admitted to having had an STI in the past, the vast majority (65%) received their treatment from a hospital or clinic.

The project has trained peer educators to increase their knowledge of STIs and to educate their peers and encourage them to seek appropriate treatment if infected. In the semi-structured interviews there was a high level of awareness of STIs among the peer educators and commercial sex workers although there was sometimes confusion about the symptoms of particular diseases. In all cases the knowledge would have given a sufficient basis for decision-making.

5.3.9 Impact of peer education on behaviour change

It is extremely difficult to evaluate whether change in sexual behaviour has taken place and even more difficult to attribute this change to a particular project intervention. The major changes that the project sought to bring about were related to reducing the risk of infection through condom usage, negotiation skills and the reduction in the number of sexual partners. Seeking appropriate treatment for STI can be seen as both a risk reduction and health promoting activity.

One of the indicators identified was a commercial sex worker correctly and consistently using condom. In the baseline survey 83% of commercial sex workers had used condoms in the past, 77% had used them in the three months preceding the survey but only 55% always succeeded in getting their clients to use condoms.

The semi-structured interviews captured interesting information on condom usage. All the peer educators interviewed were of the view that condom usage had increased among the commercial sex workers they dealt with. One woman said: “I worked for four years in this business without using condoms but then I received training and now I always use it”. Many other workers spoke of intermittent use in the past but consistent use now.

Many women spoke about the need to negotiate safer sex. In some cases a group of women support one another in this process. One of the home-based commercial sex workers said that she believes that all of the home-based women now use condoms. She insists on condom usage herself and if she turns a man away because he refuses to use a condom and he goes to the next house they will tell him that “What you were told at that house also applies here: no condom, no sex”. This is a major change in the lifetime of the project as in the past many of the home-based commercial sex workers did not insist on condom usage.

Sometimes people come to the peer educators for assistance. One peer educator said: “I once had to settle a dispute between one of my target group and her friend because he objected to the use of condoms. Anyway the boy gave in after my explanations concerning the HIV/AIDS.”

It was very difficult to get information concerning the reduction in the number of sexual partners. The only time when this arose in the interviews was when women spoke about people leaving the profession. The quarterly reports indicate that some of the peer educators had left the commercial sex business and were happily married. In the interviews there were
also indications that some people had left to take up other jobs: “Some of the girls have been
helped by projects in Kumasi to do tie and dye and other things.”

5.3.10 Access to condoms

Since the beginning of the project, condom distribution through peer educators has been seen
as an important activity. The 1997 evaluation noted that condom distribution to the peer
educators had been irregular and insufficient and that this had been a result of a management
distribution failure rather than an inability to procure condoms. In the second phase of the
project an effort was made to improve condom availability to peer educators but the supply
still remained erratic. One factor affecting supply to the project was the fact that UNICEF
was unwilling to support the purchase of condoms and therefore condom purchase had to be
done from other funding sources.

At first condoms were distributed free of charge by the peer educators but since the beginning
of 2001 peer educators had to pay ₦3000 per 100 condoms. They sell them at ₦50 on
average and therefore make a small profit from condom sales. The introduction of a cost
recovery system is an attempt to make the provision of condoms sustainable but some peer
educators complain that there is still a shortage of supply. A small number of the peer
educators have stopped distributing condoms since the charges were introduced.

All of the peer educators interviewed indicated that they now distribute less condoms and that
the change has caused problems for them as their clients were used to receiving the condoms
free of charge and now accuse the peer educators of trying to make a profit at their expense.

Many peer educators reported that they purchased condoms from drug stores when a supply
was not available from the project and that they often resold these at cost. One peer educator
said: “I have purchased them at least 15 times from drug stores when there were none in the
project”. Throughout the interviews it was always reported that condoms were available in
town even if they were not available through the project.

In the baseline survey of knowledge, attitude and behaviour among commercial sex workers
in Obuasi it was noted that only 10% of the commercial sex workers obtained their condoms
from peer educators and that 73% obtained them from drug stores. It is clear that peer
educators are not the major source of condoms for commercial sex workers and so a shortage
in supply from this source does not necessarily affect condom usage in the target group.

Peer educators may still be an important source of supply for younger people some of whom
are shy to purchase their condoms from drug stores. One peer educator reported: “I am still at
school and I sell condoms in the school even though this is not permitted. The boys want the
condoms and they don’t want to buy them in the store, they want me to supply them”. Another
peer educator said, “I find that even 14 year old boys come to me, they ask for toffee
and I give them the condoms. It is their way of asking without getting embarrassed.”

Peer educators spoke about condom distribution as an important and visible part of their
work. It is an important link between the peer educator and the community and acts as their
point of contact for conducting peer education sessions. Collection of condoms from the
project is also a time of formal or informal reporting to the supervisor.
It is very clear that the numbers of condoms distributed through the project cannot be taken as a proxy indicator of condom use as the quantity distributed is more related to supply than it is to demand and usage. Supervisors use the number of condoms distributed as an indicator of the level of outreach activity of the peer educators.

5.3.11 Strengthening STI Services

A major component of the project in Obuasi is a clinical STI service. As part of the programme to provide quality STI management, a comprehensive assessment of STI clinical services available in Obuasi was undertaken.

Doctors, Pharmacists, Medical Assistants, Nurses and Midwives were trained in treatment and counselling of STI patients. These training were based on the guidelines for the syndromic management of STIs.

Many STI clients prefer self-medication and therefore go directly to chemical sellers. In order to minimise this and improve the use of properly trained health care workers, chemical sellers were also trained in STI symptom recognition; health education with counselling and partner notification. They were also briefed on their role in the referral of clients and given forms to enable them work effectively. The laboratory technicians also received training and the laboratory was provided with basic equipment to enable it to conduct HIV antibody testing.

The review team found that subsequent to the training, most health care workers had a positive attitude towards CSWs and patients with STIs. Indeed there is a big signboard at the entrance of the hospital, which indicates that the Government Hospital provides STI Clinical Management, which in our view is a healthy development. The drugs supplied by UNICEF to the Obuasi District Hospital were to be sold and used as a revolving fund for continuing supply of STI Drugs.

Contrary to UNICEF directives, the District Director of Health Services claims he provided the drugs free of charge to the patients.

The record keeping was also not very meticulous and therefore it was difficult to ascertain the total number of patients who had the drugs for free. Another observation was that some of the drugs supplied were not fast moving items and could expire before all were used.

The team encouraged the District Director of Health Services to liaise with the STI Clinic at the Komfo Anoyke Teaching Hospital to collect these drugs, which will be put to good use since the number of patients seen at the clinic is substantial.

5.3.12 Microcredit Scheme

Background

In the course of the 1996-1997 initial project phase, the desire among the peer educators for alternative sources of income other than commercial sex work was strongly expressed. It was therefore decided to include this component in the second phase i.e. 1997-2000.
The micro credit scheme was approved as the means to deliver this service and $34,000 was made available for the purpose.

The objectives of the scheme were:

Improvement of the capacity of the peer educators to negotiate for safer sex through access to alternative sources of regular income;
Acquisition by the peer educators of the banking culture to ensure their continued access to credit funds;
Building up of savings by the peer educators.

The project proposal noted that the scheme was too small to be viable and could only be implemented on subsidy dependent basis or as a pilot scheme to test the assumption that access to funds for alternative income generating activities will actually lead to widespread practice of safe sex.

Findings

After initial problems in identifying a banking institution the Adansi West District Assembly (AWDA) managed to convince the Agricultural Development Bank (ADB) to act as the participating financial institution. It appears however that the ADB was not made aware of the draft document therefore its perception of the scheme is quite vague. Though AWDA is aware of the document, implementation of the scheme did not go quite according to the document. Instead of the group lending approach, the individual lending with guarantee approach was adopted.

Selection of beneficiaries

The 5-outreach staff members were asked to select 6 peer educators each from their groups. The criteria for selection were regular attendance at the weekly group meetings and excellence in peer education. This was probably the best way out of the situation due to the drastically reduced scale of the current scheme.

A total of 27 peer educators were selected from the 100 and asked to apply to the bank for the disbursement of the loans in September 2000. They filled in application forms designed by AWDA and presented these together with their passport size photographs to the bank. Eventually, 21 peer educators received loans of $500,000 each. Total loan fund available was $10.5 million enough for only 21 peer educators at $500,000 each (the original money had devalued greatly due to delays in starting the scheme).

Peer Educators’ Perception

The delay in starting the scheme resulted in financial losses but also led to the breakdown of trust between the peer educators and the project management. One peer educator said, “The promise of credit was used to deceive us”. Another woman said: “The council had used the money for other purposes”. In general it was felt that the management did not place high priority on resolving the problems of credit provision and that in the end it was the beneficiaries who suffered.
Peer educators who did not benefit from the scheme are very disappointed that after waiting for three years they could not benefit from a loan scheme that they had been promised. One peer educator said she was very upset about not getting the loan. She had deposited $50,000 and told all her friends that she was going to get a loan to start some business. But three people from her group including a new peer educator were given loans while older ones like her were ignored.

Another Peer educator was very disappointed. As a pioneer peer educators she has not only been very active, she reported that she has also enrolled ten people as peer educators. She was told that she would get the credit if she gave her photograph, she did not pay a deposit but one of her friends who did also has also not received the credit yet.

Those who received the loans complained about the size. Most of them were expecting amounts well above $2,000,000. Though disappointed, they are quite content that they have a source of financial assistance. A hairdresser told us: “I have been able to buy some shampoo and creams for my business. It has helped me but the amount was too small. I will be able to repay the money but I am not sure if they will give me another loan.”

Almost all of those interviewed expressed an interest in having access to credit in the future (including those who have already received loans from the scheme). One women told the interviewer: “I wanted credit because I am now a grandmother with three grandchildren and I want to finish this type of life and sell rice like I used to do when I was younger. They said that if I paid a deposit of $50,000 I would be able to get $500,000 credit. I had to go to my daughter in Somanya to get the money for the deposit which I paid to the bank.” Many of the commercial sex workers who are reached by the peer educators have also shown interest in access to credit.

Those who are yet the benefit from the scheme have high expectation that after the others have repaid, it will be their turn to receive the loans. However they have no clear information on the future of the scheme.

**Loan Conditions**

Beneficiaries were given offer letters by the bank, which stated
- an interest rate of 27%,
- a processing fee of 2%, and
- a repayment period of 12 months.

Security for the loan is AWDA/UNICEF guarantee.

All selected peer educators were made to open an account with the bank with a deposit of $50,000.

The terms of the loan as stated in the offer letter are not comprehensive enough. Even though many of the beneficiaries know they have to repay the loan within 12 months the offer letter is not clear on the frequency of repayments, whether monthly, half yearly or bullet. And this may explain the low level of repayments so far.

The 27% interest charged were well below the inflation rate of above 40% and do not show the intention to make the scheme sustainable.

*Repayment*
According to the offer letter from the bank to the beneficiaries, repayment period is 12 months. A discussion with the Project Officer of the bank showed that only one person had paid €100,000 seven months after the disbursement of the loans. However, discussions with the peer educators and the outreach staff revealed that more beneficiaries had started repaying their loans. As it is now, it is difficult to establish exactly how much has been repaid due to the absence of any monitoring and information flow.

Repayment of a loan depends on a number of factors, which relate to the mode and the purpose for which the loan was granted. In this instance the loans were granted to enable the commercial sex workers engage in income generating activities as alternative source of income. The application of the loan plays a very important role in the ability of the beneficiary to make adequate return on the loan for repayment and for self support and for reinvestment.

It became obvious that at least there is one beneficiary who will not only be unable to repay the loan but also will not benefit much from the loan.

Dalin (not real name) told us “I got credit of €500,000 from the project. I had to pay €50,000 as a deposit and I had that money from what I earn as a Commercial Sex Worker. I had a debt of €200,000 on my late mother’s funeral expenses; a woman at the village gave me the money as an interest free loan. When I received my €500,000 I paid that loan and that left me with €300,000. I go to Somanya from time to time to see my children and I gave my daughter €200,000 to trade in earrings. She is using the money she earns to feed her child and also my son. The remaining €100,000 is still in Somanya. I am leaving it behind for my daughter to buy foodstuffs during the harvest season and keep it until the lean season for resale when prices tend to be high. I have repaid €50,000 to the bank and that is from the money I earn in my business (commercial sex work).”

This story indicates that access to credit, when poorly managed, can actually deepen the trap in which commercial sex workers find themselves.

**Loan Security**

By making AWDA/UNICEF guarantee for the loans the responsibility for recovery rests on the AWDA. Although AWDA confirmed its responsibility for the recovery of the loans as the organisation conversant with the peer educators including their place of residence, there was no evidence of any efforts to enforce repayment. Only one outreach staff member was aware of the repayment effort by some beneficiaries in his group members.

**Banking Culture**

Information at the bank was insufficient to determine whether the beneficiaries have been enquiring about other services of the bank. Probably it is too early to expect such initiatives from the peer educators but this could improve with education.

AWDA is counting on the personal guarantees provided by the beneficiaries on their application forms as a last resort to retrieve the loans. Experience has shown that getting the guarantors to fulfil their obligations can be time consuming, and expensive.
Savings

Except for the €50,000 deposited by the peer educators at the time of applying for the loans, there was no evidence of savings from the beneficiaries.

Monitoring

Monitoring of the progress of the scheme was found to be minimal or absent as it was unclear the lines of responsibility for monitoring. Consequently, it was not possible to obtain reliable information that all stakeholders could agree on.

The management committee was neither aware of the exact number of peer educators who were benefiting from the scheme nor whether any repayments had been made at all.

Future possibilities

There is a possibility that in the future the commercial sex workers may be able to benefit from the District Assembly Poverty Alleviation Programme. €300,000 – €1,000,000 is the usual amount given under this fund and collateral is not needed an interest rate of 27% is charged on loans. If this scheme were made available to the commercial sex workers it would be seen as a sign of the District Assembly’s commitment to the objectives of the project.

Conclusions

i. The participating Financial Institution – Agricultural Development Bank appears to be beating a retreat from its responsibilities, denying knowledge of signing any agreement between itself and the AWDA for the implementation of the scheme. It was not ready to search for its copy of the signed agreement claiming shortage of staff. Unfortunately, AWDA could also not locate its own copy of a signed agreement. Without a signed agreement, ADB can wash its hands clean of any responsibilities for the facility.

ii. The absence of a specific individual with responsibility for this scheme within AWDA makes co-ordinating and monitoring nobody’s business. Micro credit, especially credit with education as envisaged in the draft agreement demands close supervision and monitoring for it success. The District Co-ordinating Director (DCD) should not be burdened with this task that has time and specific technical requirements.

iii. Non-briefing of the stakeholders – Outreach staff, peer educators, Management Committee members and Bank officials has left information gaps that are undermining the successful implementation of the scheme.

iv. Effectively implemented the scheme can positively contribute to attitudinal change in the beneficiaries and by extension, prevention of the spread of HIV/AIDS.
v. The current form of the scheme does not show any intent to make it sustainable. There is need to ensure that what has been started is made sustainable and expanded to make its impact felt over time.

vi. From the discussions with the peer educators – both beneficiaries and non-beneficiaries, it is encouraging to note their high expectation on the scheme. On the part of the beneficiaries, there was evidence of profitable investment and most of them expressed goodwill to repay the loans. Clearly, if the conditions of offer had been explained to the beneficiaries and their outreach staff the repayment position of the scheme would be much different from what it is now.

**Specific recommendations relating to the micro credit scheme**

i. There is need for a stakeholders meeting to discuss the concept of the scheme and clarify the functions and responsibilities of the participating organisations.

ii. Every effort should be made by AWDA to locate the signed agreement and with this ensure that the bank provides the information on the progress of the scheme to enable it better co-ordinate and monitor the scheme.

   If there is no signed agreement between AWDA and the Bank one must be signed to have a legal basis for the collaboration and operation of the scheme.

iii. Every effort should be made to find other sources of support to sustain the scheme to achieve the intended impact.

iv. The Credit with Education group lending approach is strongly recommended as that would greatly enhance and quicken the achievement of the objectives of the scheme.

5.3.13 People Living with AIDS (PLWA)

In the first phase of the project it had been planned to establish a support group for people living with AIDS (PLWA). Even though the project staff before the start of phase 2 had identified five PLWAs, no support group had been established. The project document for the second phase emphasised that establishing a support group for people with AIDS is important even if it is not a major part of it. Objectives were not clearly identified but it was intended to have seed capital to assist people with AIDS to earn an income where possible. It was envisaged that having the involvement of people with AIDS would increase the impact of prevention messages and would help address issues of prejudice and discrimination.

Baseline studies carried out in 1998 among the commercial sex workers and the wider community in Obuasi revealed very negative attitudes to people with AIDS. Among the commercial sex workers over 75% responded that PLWAs should be kept in isolation, kept in hospital or killed whereas only 16.7% responded that they should be cared for. The peer education approach in this circumstance has a dual purpose; firstly to help overcome some of the misconceptions concerning PLWAs and secondly the involvement of PLWAs could be a more powerful approach to addressing issues of prejudice and discrimination.
In the year 2000, thirty-five people with AIDS in Obuasi formed an association called “Love Life”. Staff from CARE supported them, and the District Assembly also agreed to give them assistance through the UNICEF funded project.

The assistance from the District Assembly was a once-off contribution and was in the form of food aid and allowances linked to the attendance at meetings. It is clear that this kind of support is unsustainable. Even in the past few months, CARE has been unable to maintain these payments.

It has not as yet been possible to integrate people with AIDS into the main project as peer educators nor have they been able to benefit from access to credit or to income generating activities. CARE indicated that they intend to train at least four members of the group to work in HIV prevention in the course of 2001. Under the District Response Initiative CARE also hope to receive funding for the promotion of income generating activities for people with AIDS.

It is not clear what criteria were used by the management committee in deciding to commit significant welfare support to PLWA towards the end of the project period. It appears that the decision was influenced by a desire to encourage PLWA to become involved in a research project at the hospital on herbal treatment for AIDS symptoms but this is not well documented.

It is however encouraging that the District Assembly has included support for people with AIDS in the District Response Initiative submitted for funding to UNAIDS, and that it has identified CARE, a strong NGO partner, to take the lead on this part of the initiative.

### 5.4 Project Management

The project comes under the management of the District Assembly in Obuasi and a management committee has been established. The committee is the policy making body of the project. The Project Officer in UNICEF makes regular visits to Obuasi to support the management of the project.

Youth Development Foundation (YDF) formerly YPIC was involved in management functions in the pilot phase. However in the current phase, the Assembly through the management committee is solely responsible for all management roles including monitoring and supervision. The management committee received training in project management and was positive about the experience indicating that it is helping them not only in managing this project but also in the way they manage other work at the Assembly.

The committee intended to meet monthly but this was not always possible as members of the team had many other commitments. One of the problems identified by the committee was the lack of a focal person with strong commitment, and time available, to manage the project. The project co-ordinator had too many other duties and as a result it was difficult to ensure that there was follow-up on important issues.

There have been substantial delays in accounting for funds to UNICEF and at the time of the evaluation cash advance for 2000 had not been fully liquidated hence the refusal of UNICEF to release funds for the 2001 first quarter activities. This had given rise the non-payment of allowances and the subsequent weakening of the supervisory system.
The committee expressed concerns that the commitment of the District Assembly had not been expressed through adequate budget provision for the project.

5.5 Compatibility with UNICEF and Ireland Aid Policy

UNICEF’s mandate is to promote the survival, protection and development of children. A child, as defined by the convention on the rights of the child, is anyone aged 0-18 years. UNICEF promotes the rights of women also because women are the primary care givers in society and their health and development has direct benefits for the development of children.

In the discussion with UNICEF management it was indicated that commercial sex workers are not a major target group for UNICEF. The evaluation team noted that there was no evidence that the project had been analysed from the perspective of a child focus.

The initial contact by UNICEF with Obuasi was in relation to girls dropping out of school and this was then linked to their vulnerability in the context of commercial sex work. Despite this initial focus the issue of child prostitution was never explored. The two lowest age categories in the baseline survey are; under 15 (these are clearly children) and 15-19 (many of these are probably children). If an under 18 category had been used it would have been possible to analyse information in relation to child prostitution in the baseline survey but this opportunity was missed. Similarly the monitoring system does not focus on the issue of child prostitution.

UNICEF has indicated that it is interested in exploring the issue of child prostitution in Ghana and intends to fund a survey. There is no doubt that the network of peer educators and commercial sex workers in Obuasi would have been a useful base for exploring this difficult issue.

There was no analysis of children as clients of commercial sex workers either. The baseline indicates that many youth have either paid or been paid for sex but the analysis does not allow us to see how many of the youth are under 18. (In the survey of out-of-school youth; 33.3% of those out of school but in apprenticeships etc have either paid or been paid for sex, 48.6% of the unemployed out of school youth have either paid or been paid for sex). Peer educators are in contact with sexually active children but the project has never asked them to focus on this area or to report specifically on children.

It is also clear from both the baseline survey and from the in-depth interviews, that the majority of the commercial sex workers have dependent children and the health and development of these children could have been explored in the project.

It would appear that UNICEF has not explored ways of ensuring that the project is more compatible with its primary focus on children.

Ireland Aid principles and policies underline the importance of considering women in the development response and improving their status, opportunities and rights and it recognises that their status in society makes them particularly vulnerable to HIV/AIDS. In its strategy on HIV/AIDS the effectiveness of targeting prevention programmes at high-risk groups is recognised. Ireland Aid renews its commitment to support programmes aimed at commercial
sex workers, youth, migrant populations and other high-risk groups. The current project is therefore compatible with Ireland Aid policies and strategies on HIV/AIDS.

From a human rights perspective Ireland Aid states that: Respect for the rights of people living with HIV/AIDS will be supported at a community level. Ireland Aid will encourage initiatives promoting an awareness of the rights of individuals living with HIV/AIDS at grassroots level. The support to people with AIDS in the Obuasi programme can be seen to be compatible with this approach.

5.6 Sustainability Issues

It is recognised in the project document that when dealing with the poorest in society, and with sometimes-transient groups, such as commercial sex workers, sustainability becomes very difficult. Nevertheless it is important to examine the project and to see whether its design and implementation has fostered sustainability.

The project document sees the issue of sustainability as being one of ownership. It notes that the project is entirely funded externally by Ireland Aid but that the District provides staff for the outreach and health activities. The document expresses the hope that the District Assembly, with the Ashanti Goldfields Company (AGC), could take over the project funding eventually. It notes that AGC are represented on the management committee of the project but at a low level and their involvement is limited and financially non-existent.

Unfortunately four years later, at the time of this evaluation, the situation remains unchanged. Ashanti Goldfields Company still has minimal involvement in the project and there is little evidence that the District Assembly itself is willing to commit meaningful funding to the project.

On the other hand a number of NGOs are active in the District and others are likely to become active in the near future and these will be able to support some HIV/AIDS activities. The District, in common with all the other districts in Ashanti Region, will also have access to funding from the District Response Initiative supported by UNAIDS. The experience it has gained to date in the UNICEF funded project should leave it in a good position to co-ordinate the District Response Initiative and to develop worthwhile plans.

5.7 Recommendations

UNICEF has already decided to withdraw from the project in Obuasi and this has influenced the recommendations that are made in this report.

1. As part of an exit strategy UNICEF should continue to have dialogue with the District Assembly and with UNAIDS to ensure that the positive outcomes of the project are consolidated in the District Response Initiative.

2. In dialogue with the District Assembly, UNICEF should ensure that the credit fund is set up in a sustainable manner that will meet the needs of the peer educators.

3. The District Assembly needs to reflect on the management problems that have arisen in the course of the UNICEF funded project and consider what measures need to be
taken to ensure that these problems do not resurface under the District Response Initiative.

The issue of a focal person for the project needs to be addressed, as does issues of prompt and complete accounting for project funds. Any monitoring and reporting structures should be embedded in the normal structures of the District Assembly and not dependent on external funding.
6.0 PROJECTS FOR IN AND OUT-OF-SCHOOL YOUTH IN ACCRA

6.1 Overview of the Urban Community Based Development Project

In the Country Programme of co-operation between the Government of Ghana and UNICEF of 1996-2000, one of the projects was the Urban Community-Based Development Project. The HIV/AIDS activities in Accra are a component of the activities supported by the urban project, which focused on specific poor urban areas and street children in Accra.

The main objectives of the Urban Community-Based Project were;
- to improve access to basic services for urban poor and street children, and
- to improve the capacity of the municipal authority and NGO counterparts to protect and counsel children in need of special protection.

The major strategies adopted were
1) service delivery to street children working and staying in different areas of the city and urban poor children in Ga Mashie and Maamobi and
2) strengthening the capacities of partner NGOs and co-ordinating agencies to enable them to improve their services and co-ordinating role.

Services for urban poor and street children in Accra are mainly carried out by NGOs. In the period 1998-2000, the urban project supported four NGOs in the delivery of services. These four NGOs are the Centre for Community Studies, Action and Development (CENCOSAD), Street Girls Aid, The Salvation Army and Catholic Action for Street Children (CAS). Due to accounting problems since 1999, UNICEF stopped its collaboration with CAS in the year 2000 but continued working with the other three NGOs. All four NGOs have strong ties with each other, meet regularly and provide complementary services for the same target group in poor areas of Accra.

Though these NGOs delivered various kind of services to the target group such as health care, education, vocational skills training and literacy training, they also included activities to increase knowledge, change attitudes and practices to prevent HIV/AIDS/STIs, as well as STI treatment. The strategies used varied from NGO to NGO. CENCOSAD relies on youth-to-youth peer education using participatory training methods including group discussions, brainstorming, group work and role-plays. SGAID and CAS used general health education in the classroom for children visiting the refuge and group discussions with the whole class involving teachers and Salvation Army nurses.

The Salvation Army, SGAID and CAS also used one-on-one counselling by social workers and nurses for cases involving treatment for STIs. The Salvation Army was instrumental in providing health information, condom distribution and STI treatment for street youth visiting the refuges or mobile health vans.

Ireland Aid funds were mainly utilized for HIV/AIDS preventive activities, but the collaboration with these NGOs needs to be seen in a wider context.
6.2 Findings CENCOSAD: Peer education for in and out-of-school youth in Ga Mashie

6.2.1 Purpose of collaboration with CENCOSAD

CENCOSAD’s Programme for HIV/AIDS Prevention and Awareness Creation aims to promote attitudinal and behavioural change related to HIV/AIDS and other STIs, for in and out-of-school youth in Jamestown. The methods used are peer education, providing access to condoms and appropriate health services and counselling.

CENCOSAD is a Ghanaian NGO. Its mission is the empowering and enabling of poor communities and their residents to realise their own development. It promotes this through an integrated approach of participatory action – research, monitoring and evaluation; capacity building and training; networking and resource mobilisation.

The Programme for HIV/AIDS Prevention and Awareness Creation started in 1998 and is funded by UNICEF. A Communities Reproductive Health Project funded by DFID through Save the Children Fund, is also implemented by CENCOSAD. Strong links have been created between the two projects and the peer education approach is common to both.

Between 1998 and 2000, UNICEF also supported CENCOSAD in other areas, such as skills and entrepreneurial training for young single mothers. During the period of training, a holistic approach was adopted, meaning that the young mothers also received information on child caring practices, access to early childhood care and information on STI/HIV/AIDS prevention.

6.2.2 Selection of peer educators

Careful selection and training of peer educators is critical to the success of the peer education approach. CENCOSAD used clear criteria in the selection of peer educators. For the selection of peer educators in schools, the teachers played a major role. For the selection of candidates who would be reaching out to out-of-school youth, the communities have been involved in the selection and screening of peer educators, counsellors, and supervisors. The youth are usually selected from among members of community-based organisations, such as environmental groups. Opinion leaders are used to launch the programme in communities and to ensure their continuing support.

6.2.3 Training of peer educators.

In general the selected youth have successfully completed their training and are working as peer educators. There were few examples of selected candidates being found unsuitable at a later stage.

The training programme is the same for in and out-of-school peer educators. They also join together for the refresher training and quarterly meetings.

The initial training of peer educators takes place over a five day period and the major topics covered are general reproductive health issues, STIs, HIV/AIDS, teenage pregnancy, values, steps to attitudinal change, counselling, assertiveness, family planning, confidence and self
esteem. Three-day refresher training takes place after six months and there is also a one-day quarterly meeting with a conference format that reviews progress and reinforces the earlier training.

The training was highly appreciated by the peer educators. In addition to providing them with information it also increased their self-confidence. Some peer educators felt that the initial training was too short, but most of those interviewed appreciated the opportunity of practising for a number of months and then coming back for refresher training. They found the refresher training also very relevant as it allowed them to discuss issues from their own experience as peer educators.

The programme has trained over 120 students to act as peer educators in reproductive health issues in six Junior Secondary Schools in the programme area. Sixty-eight of the peer educators are girls. Each school also has teachers trained as supervisors (in all 30) and counsellors (also 30) and all teachers in the schools have been sensitised towards the programme. Parents have been very supportive of the programme.

The programme has trained 141 youth to act as community peer educators in the Ga Mashie area, especially to reach out-of-school youth. 18 Counsellors and 18 supervisors have also been trained to support the community peer educators.

**Godfred, a counsellor, talks about his work.**

> I am 23 and I graduated from Accra Polytechnic as a mechanical engineering technician but I am not working now. My friends were in the Society for Educational and Environmental Development (SEED) and they suggested to me that I should become a peer educator. When I contacted CENCOSAD they trained me straightaway as a counsellor.

> The role of the counsellor is a bit different to that of a peer educator as we do a lot of one-to-one counselling. If a person has a problem they are taken away from the main group to talk to a counsellor. One of the issues I deal with is teenage pregnancy. I work closely with the peer educators and sometimes if I find that a girl would prefer to talk to another girl, I refer them to a female counsellor but I find that many girls are happy to talk to me and they don’t feel shy.

**6.2.4 Peer education sessions**

The peer education approach is relevant to both in and out-of-school youth. One of the teachers said: “Children find it difficult to approach us and they are much more comfortable discussing these issues with their own friends”. The peer education approach has been accepted by school authorities and by parents and is also positively regarded by community groups.

Community peer educators usually work as a male/female pair. They use group discussion, home and church visitations, sporting events, sanitation exercises in the city and film shows to reach their target groups.

Peer educators also organise group discussions, individual counselling, drama activities, debates, sporting events and games. For the last four years there are also 9 Stop AIDS clubs in the schools, which have organised talks to share information on reproductive health issues.
Peer educators have access to some educational materials such as photocopies of a training manual and some leaflets from the Ministry of Health.

**Case Study: Tony - a peer educator**

**I am thirteen years of age. My teachers selected me and I was really happy, I spoke to my parents and they agreed that I could be trained as a peer educator. The training took place over five days and we discussed all sorts of issues concerning reproductive health.**

When I came back to the school I started a Stop AIDS club with 10 boys and 5 girls. I like having a mixed group but sometimes the boys can be disruptive when there is no teacher present. I can handle the situation and even the boys who are disruptive are really interested in learning about HIV/AIDS and they will ask me questions afterwards. Each week I choose a topic for the club on some aspect of reproductive health or HIV/AIDS and I prepare it in advance.

I also talk to my classmates during free periods and because people know that I am a peer educator they come to me with their questions. If I am asked a question and I don’t know the answer, I discuss it with one of the teachers who is a supervisor. Also sometimes if I find a student who has a problem I can bring that student to a teacher counsellor. Some of the students I talk to are sexually active and they raise the issue of condom availability. I give them information but I am not allowed to promote condoms at school. My main advice is abstinence.

I look forward to the quarterly meeting with CENCOSAD as it is an opportunity of meeting with other peer educators and discussing the work we are doing.

Since 1998 the peer educators reached about 5,000 in and out-of-school youth in the Ga Mashie area.

One of the issues discussed with the peer educators in semi-structured interviews and in focus group discussions, was how they defined their target group. For the in-school youth the target group consisted of their classmates, though they also reached out to their peers in the wider community. For the out-of-school youth a deliberate attempt was made to reach out to existing groups, including environmental clubs, sport associations and groups of apprentices. Peer educators also reached out to their group of friends. There was strong evidence that peer education has become so much a part of their lives that they use all types of opportunities to pass on the messages concerning HIV/AIDS and STIs.

**Case Study**

Nyamekye, a community peer educator, talks about his work

I am twenty years of age and unemployed; sometimes I get casual work loading and unloading. I completed secondary school, but as my father is dead I didn’t have any support to continue my education. I am the eldest of three boys and I live with my aunt. I was involved with an environmental group, the Society for Educational and Environmental Development (SEED) and they selected me to be a peer educator. I was trained over a year ago and I enjoy
being a peer educator, it gives me something to do every day and prevents me from getting bored. I have a regular group of young women apprentices but I also talk to a lot of individuals. People in the area know that I am a peer educator and they come to me, especially for condoms. I get some condoms from the project and I buy some myself. Condoms are easily available locally though some people are shy to buy them. I meet regularly with other peer educators, counsellors and supervisors and then we have a quarterly meeting with CENCOSAD. The meetings help keep us motivate, but we don’t get any other incentives.

In discussions with the out-of-school youth, they identified a number of groups who may not be reached by their work, especially the disabled and the youth from the North of the country which have settled in Accra for economic reasons. Most of the youth from the north speak their own language and socialise together. The disabled are unlikely to be found in the social network of the peer educators. The peer educators indicated that these groups could be better reached if peer educators would be selected from these groups as well.

6.2.5 Supervision of peer educators

The supervision system is an important element in maintaining programme quality. In the case of the in school youth, teachers supply the immediate supervision and in the case of the out-of-school youth, it is provided by other youth who have been trained as supervisors. In some cases, peer educators have been promoted to the supervisory level. There was a very positive, supportive relationship between the peer educators and their supervisors. A strong link was also made between the supervisors and the project management structure in CENCOSAD. Peer educators, counsellors, and supervisors spoke highly of the staff in CENCOSAD.

Julie, a supervisor talks about her work

*I am 22 and I am still a student. I hope to be a teacher when I finish my studies. They trained me as a supervisor and I spend a lot of time with the peer educators watching the way they approach their clients. I notice if they are giving out incorrect information and I talk to them afterwards to correct the situation. I also advise them on their own behaviour because it is important that peer educators are seen to practice what they preach.*

6.2.6 Monitoring and reporting mechanism

A simple reporting format is in place for peer educators, counsellors, and supervisors and additional information is captured through informal discussions and meetings. The report format captures the main activities that the peer educator has carried out during the month. It notes the number of males and females targeted, the topics discussed and any problems that occurred. The interviews indicated that there was feedback from the supervisors and project management on the reports submitted and the problems encountered. The form serves its purpose well, but it doesn’t differentiate between new clients and repeats and so there may be a problem in arriving at the total number of people reached by the project.

Peer educators write reports for their supervisors, but much of the reporting is verbal. During monthly monitoring visits, CENCOSAD collects the reports and later compile quarterly, mid-year and end of year reports.
6.2.7 Access to condoms

Peer educators for out-of-school youth are involved in condom distribution. The condoms are available from the project for which a nominal fee is charged. Once a person is known as a peer educator they are approached for condoms. Condoms are also widely available from drug stores in the area.

When asked about indicators that could be used to measure the impact of the programme, the peer educators referred to increased demand for condoms and increased condom usage among their peers. They also indicated that female condoms are now being purchased, indicating an increased awareness by women who are reducing their exposure to risk.

6.2.8 Impact on Knowledge, Attitudes and practices

In interviewing the peer educators and while observing a peer education session, it was clear that the peer educators have grasped the basic messages in relation to HIV/AIDS and its prevention. The issue of STIs was more problematic. Though peer educators seemed to have a reasonable understanding of STIs, they sometimes found it difficult to deal with the questions that were asked. A number of misconceptions about STIs arose in the interviews with members of the target group. One woman said: “I know about gonorrhoea, only men can get it.”

In 1998 a baseline survey on HIV/AIDS and other STIs was conducted for in- and out-of-school youth in Accra. The survey was not finalised until April 2000. CENCOSAD indicated that the absence of baseline data had been problematic, but they were initially unhappy with the survey process: “It was not participatory and we were not involved in the preparation and design. We still don’t have the final report and there is no sense of ownership.” Nevertheless CENCOSAD indicated that the quality of information provided by the survey is good and should be helpful in their future work.

The survey indicated that friends were an important source of information on HIV/AIDS and STIs; a peer education approach therefore is a good response to this finding. The survey also found a high level of awareness about HIV/AIDS, but less awareness about STIs. It remains to be seen how a project such as this could systematically capture information in relation to knowledge and behavioural change, for comparison with the baseline information.

6.2.9 Skills training

UNICEF supported CENCOSAD to promote a number of pilot micro-initiatives relating to poverty reduction and environmental improvement. These included an environmental sanitation programme aimed at improving housing conditions, drainage systems and alley paving. However, this component was phased out in 1999. However, skills training to improve the income of single mothers is continuing.

The objective of the skills training component is to equip 100 unskilled, unemployed, young single mothers with skills, entrepreneurial training, counselling and guidance in dressmaking, catering, hairdressing and tie and dye/batik. The programme also seeks to educate these single mothers on STIs and HIV/AIDS prevention.
At the end of 2000, 100 mothers had been trained. Thirty have been provided with training in batik and tie and dye during a six-week workshop. Seventy mothers have been enrolled in longer-term training in catering, dressmaking and hairdressing. CENCOSAD has contracted out the skills training, but CENCOSAD staff continue to provide support in entrepreneurial training and counselling.

Gladys is a catering trainee.

I have two boys, they are four and two years of age, but I have broken up with their father. I heard of the training programme through a friend who works with CENCOSAD and I was called for interview and then was selected. I was asked to pay a personal contribution of US$60,000 and my brother gave me this money, I don’t know if they are going to refund it to me. The project paid my tuition fee of US$350,000.

Initially we were made to understand that at the end of our training we would be provided with equipment free of charge so that we could set up on our own, but now we have been told that we will have to repay US$950,000 for the equipment over a two year period. I have really benefited from the project and I have learnt a lot but it will be difficult to repay the money, as I have to take care of my children at the same time.

6.2.10 Compatibility

CENCOSAD’s activities are in conformity with the objectives of the Urban Community Based Development Project. It is worth noting however that CENCOSAD’s target group is youth in general (most of the out-of-school youth are over 18) and there is no specific focus on street children or on the poor. However, the project is in an area where there is a high level of poverty.

6.2.11 Sustainability

The major costs in the peer education programme are related to the training of the peer educators and the production of materials. No allowances are paid to peer educators, counsellors, or supervisors apart from the cost of attending the quarterly meeting. The structure has been kept to a minimum, thus reducing overheads, and it is possible that project activities would continue even in the absence of external funding.

CENCOSAD, just like the other NGOs in this project (SGAID, the Salvation Army and CAS) have a number of sources of funding and are not solely reliant on UNICEF.

6.2.12 Management of the Project

CENCOSAD has a structure which is able to support the peer education and skills training programme. Communications with UNICEF have improved over the years and there is a clear process for approving workplans and budgets on an annual basis.

CENCOSAD managers need to consider its overall aim in supporting a peer education programme. Is it hoping to give long term support to peer education in a particular community, or is it testing a methodology that will have a wider application? Given the nature of CENCOSAD and its emphasis on action research, it would seem to be in a
particularly strong position to develop a methodology and set of ‘best practice’ guidelines to be used by other NGOs in the sector. CENCOSAD already has close contact with a number of other NGOs and would be in a position to disseminate information to them.

6.2.13 Lesson Learnt

1. Reaching the entire community with consistent messages is particularly important, because individual behaviour change cannot be sustained unless the social environment encourages healthy behaviour. Secondly, parents and community members who have participated in the planning of the youth programme in Accra are willing to defend the programme and deal with the other adults who want the programme to stop.

2. Working through existing community-based organizations allows individuals with common social networks to be reached with HIV/AIDS prevention messages. However, some vulnerable groups may not be reached because they do not belong to any social network and are not easily identifiable. One example are the youth from the North which have migrated to Accra, who do not speak the local language and are a floating population.

3. Community-based groups with little or no previous HIV/AIDS experience can be mobilised to support HIV/AIDS prevention in their communities if the process is kept simple.

6.2.14 Recommendations

1. CENCOSAD sees its role as testing a methodology and developing a ‘best practice’ model. Therefore it must ensure that more effort is put into documenting the experience and developing appropriate IE&C materials.

2. CENCOSAD must look at appropriate linkages (e.g. with the Ministry of Education) to ensure that these methodologies are disseminated in a way that will allow them to be institutionalised.
6.3 Findings: STREET GIRLS AID. Female street youth and refuge project in Maamobi, Accra

6.3.1 Purpose of the collaboration

The purpose of the collaboration between UNICEF and Street Girls Aid is to provide female street youth in difficult circumstances, with access to adequate maternity services, other reproductive health services and help them to protect themselves against HIV/AIDS and STIs.

SGAID started in 1994 when a refuge centre was opened for pregnant street girls in Maamobi, close to the Urban Aid Clinic run by the Salvation Army. UNICEF has supported SGAID in the running of the refuge centre, antenatal and post-natal care, delivery services, child care and nutrition education, counselling and vocational skills training and literacy training. Most activities are implemented in close collaboration with the Salvation Army and Catholic Action for Street Children. In 1996, CAS and Street Girls Aid (SGAID) conducted a survey on street children and counted at least 10,000 children living and working in the streets of Accra.

The activities of SGAID take place in the streets or in the refuge. At SGAID, the refuge centre offers residential care for 40-45 pregnant girls in the last month of pregnancy until 3 months after the delivery. In all, 120 girls per year can be offered residential care. During the period at the shelter the social workers visit their family home to ascertain the social circumstances and try to reunite the girls with their families. All girls working and living on the streets can attend the shelter during the day and are offered vocational skills training, literacy training and health education. There are 8 field workers who support the activities of the centre.

6.3.2 Antenatal and post-natal care, and delivery services

Pregnant girls receive antenatal care at the nearby Urban Aid Clinic run by the Salvation Army. They can also deliver their babies in this clinic. Those with complications are referred to Korle-Bu Teaching Hospital or Maamobi Polyclinic. Their babies are also taken care of at the Urban Aid Clinic, particularly for minor ailments, and they receive the childhood immunisation regime. In total, 400 girls were provided with antenatal care at Urban Aid Clinic between 1998 and the year 2000 (in 1998: 141 girls, in 1999: 106 girls, and in 2000: 153 girls).

6.3.3 Social Education and Counselling

In addition to the children coming to the refuge centres, social workers of both CAS and SGAID move to the areas where the children live and work, to counsel them, befriend them and provide them with health information, including on STI/HIV/AIDS. This way, social workers from Street Girls Aid and CAS reach about 300 children daily. This is one of the most important activities of the NGOs working with street children. Children with emotional problems find someone to listen to them and provide advice on various matters. One objective of the counselling is also to see if children could be reunited with family members. It has not been easy to rehabilitate some of the girls nor link them up with their families. Of the average number of 125-130 girls staying in the SGAID refuge each year, about 30 will go
back to their families. The experience is that it is very difficult to trace the families of the children. Many have run away because of divorce, abuse or parental neglect and are unwilling to return home. Others are unwilling to disclose the whereabouts of their parents.

6.3.4 Health Education, Including HIV/AIDS Awareness and Prevention

Health education is part of the counselling in the streets. Social workers provide the education and try to reach the street girls whilst they are working. The difference between this and the other projects is that no peer educators are used. Health education is also provided to girls coming to the refuge, through classes held by qualified health staff from the Salvation Army. Through this approach in the refuge and in the streets, a total of 870 street girls are reached each year with HIV/AIDS education.

6.3.5 Skills Training

The refuge has a training centre where the girls learn cookery, sewing, hair dressing, batik and tie and dye. In the year 2000, 25 girls completed their apprenticeship in dressmaking, hair dressing, batik and tye and dye making. This training has helped to improve the image of the girls among their family members.

The NGO CAS has provided sponsorship to 40 of the SGAID girls for various forms of long term vocational skills training. The girls look forward to the sponsorship and those who are fortunate to receive it are appreciative. For instance 19 year old Gladys Agyeiwah has received sponsorship and is currently attending Prampram Women’s Training Institute where she is learning to be a Caterer. She is happy because, as she says “I did not want to go back to the village and become pregnant, I want to get a vocation”.

6.3.6 Lessons Learnt

1. One of the aims of the SGAID Project is to provide support for pregnant girls and make an effort to reunite them with their families. However, due to poor support from their homes when they are back (limited financial, parental support) have made it difficult to get most of the girls back to where they came from. Unless there is a general improvement in the economy, many of the young girls will continue to move from rural areas to the urban areas to face the difficulties of street life.

2. Despite the HIV/AIDS education, some of the street girls supplement their income by engaging in commercial sex. This has also been confirmed by the baseline survey on street youth in Accra. They therefore put themselves at risk of HIV infection. The support to street girls needs to take the economic opportunities into account to reduce the need for them to continue to engage in high risk practice for survival.

6.3.7 Recommendations

The Street Girls Aid Programme continues to provide a needed service for the many disadvantaged girls on the street. There is the need for UNICEF to continue to support the programme. Without external assistance the programme will collapse and many of the street girls will be in greater hardship.
The sponsorship programme needs to be reviewed so that many more girls benefit from it, as most of them cannot obtain help from their families to learn a trade or engage in any meaningful income generating activities.
6.4 Findings for Catholic Action for Street Children (CAS): A refuge project and Centre for Male Street Youth in James Town.

6.4.1 Purpose of the collaboration

The purpose of the collaboration between UNICEF and Catholic Action for Street Children (CAS) is to provide vulnerable male street youth with access to a non-resident refuge and to provide access to vocational skills training, literacy training, health services and health education.

CAS started in Jamestown in October 1992. Just like SGAID, CAS offers street youth (mainly boys) a place of contact with people they are comfortable with and a place where they feel safe. The difference with SGAID is that CAS does not provide residential care- only a house of refuge during the daytime. In addition, CAS has a variety of activities aimed at ameliorating the youth’s living conditions, raising their self-esteem and, eventually getting them off the streets.

CAS field workers now operate in more than 4 suburbs of Accra and provide street corner education on general health problems including HIV/AIDS as has been discussed already under SGAID.

Originally CAS operated a house of refuge in James Town where many urban poor children can be found. Since 1999, a new house of Refuge has been acquired in Laterbiokorshie, a more organised residential set up than in James Town, but more difficult to reach for the target group. Therefore, CAS has established mini–refuge centres, which are wooden kiosks or rented premises where field workers meet the children.

6.4.2 Health Education, Including HIV/AIDS Awareness and Prevention

As in SGAID, health education is part of the activities of social workers in the streets, and also in the refuge. In addition, CAS has a number of health kiosks where street children can receive medical care for minor problems.

Between 40 – 50 Street Children visit the mini refuges daily and receive education on health, including HIV/AIDS. In the streets, social workers meet children on a daily basis and health education is usually one of the topics of discussion. However, monitoring the content of the sessions has been weak.

The health kiosks are located in strategic parts of town and they serve as meeting points to treat small problems and to provide health education. On a daily basis, about 200 children are provided with health information and treatments if necessary for wounds, rashes etc.

UNICEF also supported the Salvation Army with outreach immunisation and health education. The Outreach clinic schedules about 20 outings per month. A mobile van moves into Ga Mashie, Maamobi and other areas where many street children reside. The team immunises during the day, and provides health information on various issues such as family planning, breast-feeding, malaria, personal hygiene STIs and HIV/AIDS in the evening. The nurse provides health care when needed and refers complicated cases to the hospitals.
Through the outreach activities of the Salvation Army, many thousands mothers and children are reached every year.

6.4.3 Sponsorship for formal and non-formal education

CAS has developed a sponsorship scheme to increase access to education for street children. Some children show interest in learning another skill by visiting the refuge centres regularly to participate in literacy and vocational skill demonstration classes. Children who are interested can be sponsored to follow a long term training of about 3 years in a new skill, or they can return to the formal education system.

This initiative will take them off the street by providing them shelter, pocket money, and the basic equipment. There is an intensive follow-up required by the social workers employed by CAS and they visit the children at least once a month at their home or educational environment. 85% of these sponsored children complete the training and use it for their future living.

In 1999, CAS sponsored 250 children, out of which the Irish Government has sponsored 35 children, all less than 18 years of age. Half of the sponsored children are boys, half are girls.

6.4.4 Recommendation

Since the beginning of 2000, UNICEF ended its support for CAS due its failure to account for advances provided since 1998. Consequently UNICEF has requested an audit firm to do a financial audit for the period 1998 to 2000. The conclusions of the auditors revealed various shortcomings in the management and accounting for funds provided to CAS by UNICEF. UNICEF has been advised not to enter in a new agreement with CAS until it implements the recommendations of the audit firm to improve its financial management.
7.0 SPECIFIC EVALUATION ISSUES

7.1 Relevance

The youth-to-youth peer education project seeks to improve young people’s knowledge, attitudes and behaviour and their access to the services and condoms they need to protect themselves against HIV/AIDS/STIs and other reproductive health problems. The importance of the project to the target group is evidenced from surveys around the world, which indicate that the majority of new HIV infections are in this age group.

As the only visible programme currently serving the needs of both in and out-of-school youth in the target districts, the project must be retained and expanded to reach many more young people.

7.2 Impact

The impact of the project during the last three years has been beneficial to the communities. It is too early yet to quantify the impact on the long-term objective of reducing the incidence of STIs and HIV/AIDS among the vulnerable population groups in Ghana. However, given the data obtained from the monitoring reports and also from the activities of the peer educators, there are indications that many communities members are being reached with the same consistent message; this should lead to behaviour change. Community leaders, teachers and opinion leaders recognise that this is a good programme that must be continued.

7.3 Effectiveness of the Project

The peer-to-peer education projects for young people have been highly effective in the two regions, in Obuasi and in Accra. These are the only projects in the areas working to reduce the spread of HIV/AIDS among young people in a structured format. The project has enhanced the capacity of young people to discuss sexual and reproductive health issues, which hitherto had been regarded taboo by adults.

Community leaders have approved of the programme. On many occasions church leaders, opinion leaders and others have invited peer educators to give talks to their members.

7.4 Sexually Transmitted Infections Management

Generally there is access to STI management, based on the government guidelines for the syndromic approach. The basic drugs for treatment of STIs are available.

However, health workers find it difficult to provide patients with adequate counselling on STIs. Two factors are responsible for this: the first is a lack of privacy in the consulting rooms, and secondly the sheer workload that the few health workers have to deal with. Had the proposed three ‘youth friendly centres’ been operational as at the time of this review, they could have served as counselling centres on HIV/AIDS/STIs for young people.

7.5 The HIV Prevention Package including Information, Education and Communication (IE&C) materials and strategy.
The HIV Prevention package is adequate, since its main thrust is information on how HIV/AIDS/STIs are transmitted.

The available IE&C materials are appropriate for all the sites and have been extensively used by the peer educators. However, the timely supply of materials to the various projects is becoming a source of anxiety, particularly for the newly-trained peer educators. There are few ‘take home’ IE&C materials for target groups - limited handouts are obtained from the National AIDS Control Programme. These are the HIV/AIDS Questions and Answers Book, the booklet on Sexually Transmitted Infections (STIs), and the leaflet on what everyone should know about HIV/AIDS.

UNICEF has organised a material development workshop with the peer educators. The developed materials are with the printers and when available will provide target groups with a ‘take home’ resource. In the meantime, the possibility of reinforcing the HIV/AIDS message using other channels as the mass media must be explored. All regional capitals have radio stations that broadcast in the local language as well as in English. These stations could provide a service to the general public by carrying out specific HIV/AIDS educational messages targeted at the youth in particular.

### 7.6 **Voluntary Counselling and Testing Services (VCT)**

When properly carried out VCT helps break the vicious cycle of stigma and denial surrounding HIV/AIDS. The benefits: giving opportunity for people to know their HIV status, and helping people with HIV/AIDS feel confident enough to be open about their infection and become involved in the fight against the epidemic. If combined with proper counselling, voluntary testing will contribute to adoption of risk reduction behaviour.

Unfortunately, HIV testing facilities and counselling are far from adequate.

Counselling services, both pre and post-testing, are not available in most health institutions outside the big cities, and testing without prior counselling is still commonplace in Ghana. Given these limited facilities for proper HIV testing and proper counselling, a VCT strategy should not be introduced now as more harm than good may be caused.

Before introducing a VCT system, quality services must be made available with the assurance that the health care system can sustain such a system. There should be a review of the current HIV testing and counselling services to ascertain how it can be improved.

### 7.7 **Socio-Cultural Aspects of the Programme**

The components of the projects are socially acceptable to the communities in which they are set. The educational materials, even though in English, are suitable for use by the peer educators - all of who are literate in the English language. The peer education session manual is the outcome of a series of participatory workshops attended by community members and leaders and religious organisations. The result is that the materials are sensitive to cultural and religious needs. There is no evidence of complaint about their content.

### 7.8 **Participation and Ownership**
Local agencies and key programme personnel have involved community organisations and beneficiaries in guiding and implementing the programme and its components. This is particularly evident in the programme being implemented by CENCOSAD. Some leaders in the community are actively involved in the supervision of the programme and interact with the peer educators.

Numerous volunteers continue to work in the programme: firstly because they are members of an existing organisation e.g. Red Cross; secondly, the programme has improved the self-esteem of many of the young people and enhanced their leadership skills. One gets the impression that this is more important to the volunteers than any monetary reward.

CONCLUSIONS

To a large extent the activities supported by Ireland Aid have been very successful. The project has provided over 60,000 young people with preventive education on HIV/AIDS/STI, in the project areas in Northern and Upper East regions, in Obuasi and in Accra. These young people have retained the information given; they are knowledgeable about how HIV is transmitted and can name the key prevention methods - abstinence and the use of condoms. They are also able to pass on the information to their friends.

Several challenges associated with the design and implementation of HIV/AIDS education, such as the selection, training supervision and motivation of the peer educators, have been well addressed and a response been institutionalised.

It is to the credit of the programme designers, namely Red Cross, Action Aid and CENCOSAD, that the programme has been well received by the target group and by community members. This has led to the high demand for education on HIV/AIDS/STIs in the project areas. The Street Girls AID Project has also allowed pregnant girls to have support during difficult periods of their life. The skills training component has provided a new way of life for the young girls.

A major drawback has been the occasional delays in the supply of the educational materials to the peer educators. UNICEF internal arrangements relating to purchasing and supply have been largely responsible for these delays. Any future project expansion would have to take necessary steps to eliminate this bottleneck.

There is a huge demand for HIV/AIDS education. The continuation of these projects would greatly boost HIV/AIDS prevention and control activities among young people.
8: BEST PRACTICE AND FUTURE DIRECTION

8.1. Introduction

Experience from two decades of the epidemic has generated a considerable body of good practice and UNAIDS stresses the need to have a response based on Best Practices learned. For UNAIDS, Best Practice means accumulating and applying knowledge about what is working and not working in different situations and contexts. A number of elements of Best Practice are relevant to the work of UNICEF in Ghana.

8.2 Effectiveness of Interventions:

The working paper of the WHO Commission on Macroeconomics and Health (CMH) stresses the need to prioritise high impact preventive interventions. It points out that several key elements in the chain of transmission of HIV have proven to be amenable to intervention and that such interventions interrupt transmission relatively rapidly. The CMH working paper suggests three public health criteria for prioritising preventive interventions, in order of importance these are: centrality to the epidemic, amenability to change, and cost-effectiveness. (CMH p.8)

In terms of centrality to the epidemic, unprotected sex with multiple partners is clearly the most important factor in promoting transmission. One of the most effective interventions to interrupt heterosexual transmission is peer-group interventions among sex workers. Each infection prevented “upstream” among female sex workers prevents all “downstream” ones, except in situations where the transmission risk is high from other risk behaviours. (CMH p.15)

Interventions targeted at high-risk heterosexual males can also be effective in interrupting heterosexual HIV transmission. (CMH p.14) Many men in occupations involving long absences from steady partners practice unsafe sex with multiple partners, but not all of them do. One effective strategy for intervention with this target group has been through workplace peer education. (CMH p.18)

The improved management of bacterial sexually transmitted diseases is seen by CMH to be an intervention with some evidence of effectiveness in interrupting heterosexual HIV transmission.

The CMH working paper also identifies interventions with limited evidence of effectiveness. These include mass media education (which, although effective in increasing knowledge of HIV/AIDS and creating an environment conducive to other interventions, has by itself had little effect on behaviour) (CMH p.23). Also, school-based programmes for youth (there is little evidence that general school-based interventions for youth reduce HIV or STI incidence). (CMH p.23)

The CMH working paper notes that there is a lack of advocacy for the most effective interventions and that there is too little spent on HIV prevention interventions. It argues that the lack of priority accorded the most effective interventions has contributed to the epidemic. (CMH p.54)
UNICEF is supporting a series of interventions in Ghana, some of which are likely to be effective in terms of HIV prevention, while others are likely to be significantly less effective. The interventions in Obuasi (Ashanti Region) target Commercial Sex Workers and to a lesser extent their clients; these have the potential for high impact in terms of HIV prevention. Limited progress has been made with workplace peer education among the miners in Obuasi, although in principle this could also be an effective intervention.

8.3 Building Ownership:

“Building ownership” is seen as an important element of Best Practice in designing effective interventions. A life skills programme in Namibia reports “An important lesson learned is that building the “ownership” of the activity in the communities where it takes place is a key component of success. Building such ownership is not only a matter of goodwill and openness, but also of organizational structure.” (UNAIDS (a) p. 19).

This has been a strong element in all the UNICEF-supported projects under review. By identifying NGO partners with strong links to the community it has been possible to get strong community support from the outset. Potential areas of difficulty, such as sex education in schools and girls acting as peer educators, have been overcome by building community ownership of the intervention. Ownership occurs at many levels and of particular significance is the sense of ownership by the target group whether this is in-school youth, out-of-school youth, or commercial sex workers. Again this is strongly developed throughout the projects.

Ownership at government level is also important and major attempts have been made to ensure that the Obuasi project is ‘owned’ by the District Assembly. Building ownership at local government and national government level will be important in terms of the scaling up and the long term sustainability of the interventions.

8.4 Peer Education and other interventions with young people:

UNAIDS notes that: “Increasingly, young people are being appreciated as a resource for changing the course of the epidemic. They are responsive to HIV prevention programmes and are effective promoters of HIV prevention action. Investing in HIV prevention among young people is likely to contribute significantly to a more sustainable response to HIV/AIDS. Several lessons have been learned over the past years that can be applied to planning effective actions to focus more on young people in the HIV epidemic.” (UNAIDS (a) p.9)

The same document outlines a number of priority actions and these include: supporting peer and youth groups in the community to contribute to local and national responses to HIV/AIDS; improving the quality and coverage of school programmes that include HIV/AIDS and related issues, and expanding access to youth-friendly health services.

Lessons from best practice in peer education with youth include the need to recognise gender differences and to take these into account in designing interventions (UNAIDS (a) p.13) and the need to have different strategies for targeting in-school and out-of-school youth (UNAIDS (a) p.17).

The projects supported by UNICEF are sensitive to gender issues and this has been taken into account in developing materials and in the way peer education is organised. The projects are also conscious of the need to develop different approaches to in-school and out-of-school youth, but this may need to be developed even further. Projects dealing with in-school youth
can be institutionalised through negotiations with the educational authorities and can be scaled up in this manner. Out-of-school youth are not a homogenous group and it is important to develop a variety of strategies to reach the various sub-groups. Existing projects have been particularly successful in reaching vocational groups such as apprentices.

UNICEF has a particular focus on young people and is therefore drawn to support projects with a direct impact on this target group. The CMH working paper cautions that this is unlikely to have a significant impact on HIV prevention, at least in the short term. It is however appropriate as an element in a longer term sustainable response to HIV/AIDS. If UNICEF is to position itself as an agency influencing HIV prevention while focusing on the needs of children, then it should intervene at a number of levels including national policy level. It also needs to play an advocacy role in relation to a number of specific groups. These include AIDS orphans and young people living with HIV/AIDS and also children involved in prostitution. The numbers in these groups may be relatively small in Ghana compared to some other countries.

8.5 Interventions with Commercial Sex Workers:

As already indicated, there is a strong rationale for peer education programmes directed at safer sexual behaviour among women in prostitution. The working paper of the WHO Commission on Macroeconomics and Health recognises these interventions as having a particularly high impact.

The same report notes however that: “there is a lack of advocacy for these interventions as such interventions involve programmes in partnership with the poorest, most marginalized and most stigmatised groups”. (CMH p.53). Given the experience UNICEF has gained in Obuasi, it is to be hoped that they will play an advocacy role for these interventions in the future.

It has already been noted that the programme in Obuasi has strong ownership by the peer educators and commercial sex workers and has the support of key staff at District level.

In other projects with commercial sex workers, such as the Transex project in Papua New Guinea, one of the lessons learnt has been that: “training to diminish moralistic and judgmental attitudes among staff proved to be successful… the project showed that the development of meaningful relationships with target groups is a key issue, requiring time and empathy.” (UNAIDS (b) p.52)

The project in Obuasi has been particularly strong in this respect and is clearly in line with best practice elsewhere. It has successfully broken down the barriers and suspicion between local government staff and commercial sex workers. Meaningful relationships have been developed over time and judgmental attitudes of project staff and health workers have been dealt with through training.

In the Obuasi project there is very close contact between the peer educators and their colleagues and this close contact has been respected by the project. This is in keeping with best practice as it has been noted that: “If peer educators are separated from their colleagues with special privileges, the value of the approach may be lost.” (UNAIDS (b) p.17)
In India, the Sonagachi project recognises that the commitment and active involvement of the sex workers themselves is dependent on “treating the sex worker as a whole person, encouraging her to recognize and express her needs and treating her in a fully ethical manner. Meeting the felt needs of the sex workers has encouraged them to commit themselves to HIV prevention.” (UNAIDS (b) p.86)

This has also been true in the Obuasi project and the credit support was seen as meeting the felt needs of the commercial sex workers. Unfortunately this element of the project was not well handled and this tended to undermine the commitment of the sex workers. Supporting health care can be seen as another example of treating the commercial sex worker as a whole person. But other opportunities for reaffirming this, such as understanding the commercial sex worker as a mother and family person, were not explored by the project.

In many other projects with commercial sex workers, an important element has been the development of sex worker organisations. For example: in the Sonagachi project in India it is noted that: “Organization has been the key to empowering the sex workers of Sonagachi. Several influences converged to encourage the sex workers of Sonagachi to organize themselves.” (UNAIDS (b) p.71). In Obuasi the commercial sex workers are organised by project staff, but there is little evidence of self-organisation in any formal way. This may be partly because of the reluctance of many to define themselves as commercial sex workers.

Self-organisation is often seen to be important for the sustainability of commercial sex worker projects. In the case of the SHAKTI project in Bangladesh it is stated that: “There is now a vision of sustainability through a sex worker-run project that has evolved due to the efforts of the sex workers themselves to band together for strength and safety.” (UNAIDS (b) p.124).

### 8.6 STI Management:

The West African Project to Combat AIDS has concluded from its analysis of STI control strategies that: “The syndromic control of STIs in populations with high-risk behaviours is feasible within existing primary health care services on a drug cost-recovery basis.” (UNAIDS (a) p.82) It recognises a number of elements that are necessary for the success of this approach. These include:

- Assessment of health-seeking behaviours
- Community-based activities to stimulate use of STI services
- Appropriate training at the field level of health care workers
- Consistent supervision
- Advocacy at central (Ministry of Health) level
- The syndromic approach included in all health school curricula
- Use of generic drugs
- Planning and managerial capacity-building must be built into projects, to improve the procurement, distribution, and use of essential drugs.

The interventions in Obuasi and in the peer education projects targeted at youth, have had some success in understanding health-seeking behaviours and stimulating the use of STI services. The services have become more sensitive to the particular needs of both commercial sex workers and youth. It has however been much more difficult to ensure that the other elements outlined above have been addressed in a coherent manner. If UNICEF is to
influence the overall issue of STI management, it will need to negotiate with many stakeholders, at national and district level, on an ongoing basis.

### 8.7 Monitoring and Evaluation:

Measuring the success of HIV prevention interventions can be very problematic. In the UNAIDS case study on Female Sex Worker HIV Prevention Projects, the authors note: “When screening numerous projects……this issue loomed largest. Most projects are quite capable of maintaining process indicators, i.e. the number of condoms given out, the number of meetings held or peer educators trained. Measures of impact or effectiveness, however, are often less well developed. In some cases, data are collected which could be used to demonstrate impact, but there are no project personnel available with the skills to analyse and disseminate the results.” (UNAIDS (b) p.12)

The difficulties encountered on the UNICEF projects with monitoring and evaluation are therefore by no means unusual. Some NGOs involved in the project such as YPIC and CENCOSAD have particular strengths in developing monitoring systems but ongoing support would be needed if they are to be used effectively. Data collection in government systems was not always consistent and there is very little evidence of analysis of the data collected.

If UNICEF is to support pilot approaches in the future, it needs to pay particular attention to monitoring systems so that these pilots can be properly assessed. If it is supporting already proven approaches then less sophisticated monitoring systems would be adequate.

### 8.8 Scaling up:

The CMH working paper concludes that: “The experience of the first two decades of the HIV epidemic has taught us that control of the epidemic is possible if the highest impact interventions are implemented at scale. The rapid and widespread implementation of such interventions must be given the highest priority. Too much time and effort has been wasted on insufficient and often ineffective action. It is past time to act decisively and effectively.” (CMH p.57)

There is little evidence that the issue of scaling up has been adequately addressed in UNICEF-supported projects. If UNICEF wishes to move to a more programmatic approach to HIV prevention, it will have to develop strategies for scaling up effective interventions and this should be addressed in future project documentation.

A key issue in scaling up is the selection of effective partners. The NGO partners that UNICEF works with have clear limits in terms of capacity, but some of them such as CENCOSAD are in a position to assist in the capacity building of other NGOs. Scaling up would also require a deepening of the relationship with key ministries, including Health and Education. It would also require a coherent strategy for support at district level with the possibility of replication in other districts.

The long-term impact of the projects supported by UNICEF will be dependent on the ability to scale up these interventions, either with continued support by UNICEF or through advocacy with other key institutions such as government ministries and UNAIDS.
8.9 **Sustainability:**

Sustainability is a difficult issue to address in HIV prevention programmes. There is no doubt that most HIV prevention initiatives are heavily dependent on external support. In the long term sustainability is closely linked to ownership and to the institutional arrangements adopted.

Strong ownership at community level can ensure that the impact of particular project interventions is sustainable. Evidence from the interviews conducted indicates that peer educators will continue to reach out to their community, even if external support is not available.

Interventions that are integrated into government systems are more likely to be sustainable. This can be achieved by ensuring that HIV prevention is included at all stages of government planning and budgeting. Mainstreaming HIV prevention activities into existing programmes of both governments and NGOs can help ensure sustainability by building on existing strengths.

Ensuring a co-ordinated response is also important for sustainability as individual interventions are seen as part of a coherent approach and are not identified with a particular external support agent.

In documenting a female sex worker HIV prevention programme in Cote d’Ivoire, the author notes: “An extremely important lesson is the value of co-operation between different organizations in order to get the greatest value out of existing resources. The programme allows co-ordination between local communities, government programmes, NGOs, and international organizations that reflects the strengths of each. Such co-ordination avoids duplication of effort and provides the best guarantee of sustainability.” (UNAIDS (a) p. 76)

UNICEF is in a strong position to ensure that future HIV prevention activities are integrated into government structures. It is also well positioned to help build the capacity of the NGO sector to undertake effective HIV prevention activities and to play a role in co-ordinating the efforts of the various players.

8.10 **Issues to be considered by UNICEF in developing a future response.**

In looking towards the future, UNICEF is faced with a number of challenges. It clearly has achieved some success in its intervention with Commercial Sex Workers in Obuasi, but it is not clear how it will build on this success. One option is to negotiate with UNAIDS to ensure that the Commercial Sex Worker component in Obuasi is fully supported in the District Response Initiative. There may also be the possibility of advocacy for similar interventions elsewhere in the country. If UNICEF is supporting a District Response Initiative in the Northern Region, it could ensure that Commercial Sex Workers are targeted as a specific group in areas such as Bole and Tamale.

The work with Commercial Sex Workers could be given a stronger Child Rights perspective if UNICEF used its existing contacts to explore the area of child prostitution. This was not developed in the Obuasi project, though there was some evidence of the existence of child prostitution in the area.
In looking at supporting a District Response Initiative, UNICEF needs to consider whether it is in a position to give comprehensive support to the initiative or whether it should form a strategic alliance with other partners for this purpose. If UNICEF sees its particular focus as child-centred interventions, then this can only be seen as an aspect of a more comprehensive District Response Initiative. If UNICEF is to develop a particular expertise in this area, it must consider from the outset ways of ensuring that international best practice in this area is taken into account throughout the development of the programme. It is also important to be clear whether UNICEF is supporting a pilot approach at District level with a view to scaling up in the longer term.

As an international organisation, UNICEF’s great strength is its ability to influence policy at national level, while having a more direct influence on programme implementation at the lower levels. Future interventions should consider linking the experience gained at District level with policy development at national level and also linking to the wider UN family to ensure that all programme developments are informed by international best practice. In this way UNICEF will be able to bring its considerable strengths to bear on HIV prevention in Ghana.
This report represents an initial contribution to the evaluation design of UNICEF Ghana’s HIV/AIDS and STI Programme. Feedback and further input from UNICEF and the component projects are needed to finalise the evaluation.

Although Ireland Aid’s contribution to the programme and its component projects represents a part contribution with additional input coming from other sources, it is impractical to evaluate only those aspects supported by Ireland Aid. Clearly the planned evaluation needs to coordinate with and involve UNICEF and the implementing organisations at least (apparently CENCOSAD is planning an evaluation for 2001). However the National AIDS Control Programme and the relevant local authorities need to be consulted since lessons learnt and recommendations regarding improvements in implementation and building sustainability and are of direct concern to them.

The proposed evaluation is informed by guidelines developed by the Organisation for European Co-operation and Development (OECD) for project and programme evaluation. These require the application of standard intervention logic in project/programme design, monitoring, review and evaluation.

Since initial funding by Ireland Aid, the programme and its components have undergone changes which have resulted in improved logical frameworks, clearer and more specific indicators and baseline data (although this was collected almost mid-programme).

In order to develop the design for this evaluation, the existing logframes and additional information contained in periodic reports, monitoring visits and the mid-term evaluation have been used to propose an overall programme logframe and component logframes. It is important that the component projects and UNICEF study and comment on these to ensure that the evaluation is well directed. Amongst other things, additional indicators may be suggested.

Terms used in the logframes are defined in the glossary.

It was not clear what resources are available for the evaluation. Consequently input is required regarding composition of the evaluation team and scope of the evaluation.

Evaluation of UNICEF Ghana’s HIV/AIDS and STI Programme supported by Ireland Aid

Ireland Aid has supported five separate but related HIV prevention interventions in Ghana through UNICEF Ghana. These represent all of UNICEF Ghana’s specific HIV prevention activities and are seen as its HIV/AIDS and STI programme. After almost five years of support an end-of-funding-period evaluation is to be performed in March 2001. This report describes the design of that evaluation.

1. UNICEF Ghana’s HIV/AIDS and STI Programme

Ghana has a mixed HIV1 (92.8%) and HIV2 infection picture with relatively low prevalence rates as demonstrated in the annual HIV Sentinel Surveillance conducted by the National AIDS Control Programme. The 1999 report shows no significant rise and concludes that it is too early to comment on the trend for HIV prevalence.

In 1996 Ireland Aid agreed to provide funding support for five HIV prevention interventions in different regions of Ghana at the request of UNICEF Ghana as part of it’s Bilateral Aid. The interventions are
projects run by different local agencies and organisations which receive their Ireland Aid support through UNICEF Ghana in Accra.

These HIV interventions represent the specific HIV/AIDS & STI activities undertaken by UNICEF Ghana and, for the purposes of this evaluation, are considered to be UNICEF’s HIV/AIDS & STI programme. The programme logframe is presented in appendix 2.

Since then there have been significant changes in the management structures and systems of these projects, their target populations and activities. Some changes were prompted by Ireland Aid while others were internal project decisions or UNICEF initiated. This has not been without difficulty and continued support by Ireland Aid is evidence of commitment and flexibility in their approach to such support.

In the programme environment there have been important changes in both the Government of Ghana’s approach to HIV/AIDS and within UNICEF:

- The Government of Ghana, guided by its National HIV/AIDS and STI Policy, the Strategic Framework for HIV/AIDS and STI (draft) and supported by UNAIDS has moved to decentralise responsibility for HIV/AIDS to District Assemblies in such a way that it is considered by all sectors and therefore mainstreamed. Local Authorities have thus far had little to do with HIV/AIDS or health delivery
- UNICEF has produced its Master Plan of Operations and Programme Plans of Operation 2001-2005. In this rights based approach HIV/AIDS is mainstreamed into its five programme areas.

Ireland Aid has, since supporting these HIV prevention interventions, developed two key documents: An HIV/AIDS Strategy for the Ireland Aid Programme (January 2000) and their Health Sector Strategy and Guidelines for the Bilateral Aid Programme (March 2000). These were based upon Ireland Aid’s experiences in supporting HIV/AIDS programmes and projects.

The five HIV/AIDS and STI projects in the programme are:

1. A youth peer to peer project in Upper North and North East Regions run by Ghana Red Cross Society.
2. A commercial sex worker and single women peer to peer project in Obuasi, Ashanti Region, run by the Adansi West District Assembly.
3. A peer to peer in and out of school youth project in Jamestown, Accra run by The Centre for Community Studies Action and Development (CENCOSAD).
4. A refuge project and centre for male street youth in Jamestown, Accra, run by Catholic Action for Street Children CAS.
5. A refuge project and centre for female street youth in Maamobi, Accra, run by Street Girls Aid (SGA).

A narrative summary of the projects is presented in appendix 1 and their logframes appear in appendix 2.

Regarding STIs and HIV/AIDS, the projects employ similar strategies; information, education and communication strategies, access to quality health services and access to a convenient supply of condoms. Counselling is also provided together with school/literacy education, vocational training (informal & formal) and access to credit. In Accra detailed case work aimed at re-integrating children to their family structures is done where possible.

The HIV prevention strategies focus on messages of abstinence, faithfulness, condom use and effective treatment of sexually transmitted diseases.

All projects have established links to available health service providers (hospitals, clinics and pharmacy shops) particularly for sexually transmitted infections though not exclusively.

Ireland Aid’s support, though significant, has been a part contribution to these projects which have mixed funding and input arrangements.
A mid-term evaluation was performed in 1997 and numerous monitoring activities have been performed. A comprehensive baseline survey of the projects’ target populations was carried out in 1998 though only finally published in April 2000. This study opened the opportunity for improved indicators.

A number of assumptions have been identified. These influence the success of the project but are, strictly speaking, conditions/factors not directly affected by the intervention. The evaluation must assess the extent to which the assumptions have been realised and what effort, if any, was made to encourage the realisation of the assumptions.

2. Background to the evaluation

The evaluation is to inform and be of value to UNICEF, Ireland Aid, National AIDS Control Programme (and Ministry of Health), relevant local authorities and component project staff.

The evaluation aims to:
- Identify the projects’ gains and achievements (intended and unintended).
- Describe the lessons and examples of best practice. Lessons for future donor

The evaluation will focus on the targeted beneficiaries, therefore indicators must be measured and reference made to the findings of the baseline studies. Clearly this requires measurement of changes in knowledge, attitude (particularly perception of risk) and behaviour as a consequence of the intervention. Despite the difficulties that this may present, there is consensus that this timely opportunity should not be missed to understand what approaches and mix of approaches work.

The gap between awareness and knowledge on the one hand and behaviour on the other is well recognised. In this scenario interventions aimed at achieving behaviour change need to be evaluated to demonstrate this change so that successful practices (or combination of practices) can be identified. Findings can be compared to those of the baseline study and can be compared between projects.

The evaluation must assess the organisational structure and management of the programme and its component projects with particular reference to capacity, efficiency and the promotion of both intra-sectoral and inter-sectoral linkages and co-operation and involvement of relevant government ministries such as Employment Creation and Social Welfare, Education, Health and Sports.

Although external evaluators will be recruited, stakeholders will be involved in providing input into the evaluation design and as participants in a workshop to discuss preliminary findings, conclusions and recommendations. To this end it will be valuable to co-ordinate this evaluation with any plans by component projects to perform evaluations in the near future.

3. Evaluation Issues

3.1 General Evaluation Issues

These issues have a direct relation to specific levels in the intervention logic and logical framework. Successes and failures need to be explained, constraints identified and best practices highlighted. Comparisons between component projects will be useful.

3.1.1 Relevance

Asses whether this programme and its components correspond with needs and aspirations of the beneficiaries.

Are the Results, Purposes and Objectives at programme and component levels relevant to the needs of the target populations?
3.1.2 Impact
Consider the impact of the programme towards achieving the long term Programme Objective.

Has there been, or is there likely to be a change towards achieving the Overall Programme Objective as a consequence of achieving the Programme Purpose? This may include unintended gains.

3.1.3 Effectiveness
Evaluate the extent to which the Programme Purpose has been achieved as a consequence of the programme.

Assess to what extent the Component Purposes have been achieved and how these contribute to realising the Programme Purpose.

3.1.4 Efficiency
Have the inputs (means) been utilised as planned have the Component Results been achieved?

3.2 Specific Evaluation issues
3.2.1 Sexually transmitted infections management:
Assess access to proper quality STI management based on the government guidelines for the syndromic approach – diagnosis, drugs, condoms and counselling.

Are the STI data reliable and what could be done to improve this situation?

3.2.2 The HIV prevention package:
Is the HIV prevention package adequate? In particular is STI prevention and management built into the HIV prevention message?

Is the time right for the introduction of voluntary HIV counselling and testing services?

Is there opportunity to raise the priority of mother to child transmission (presently referred to as parent to child transmission) considering non-retroviral drug practices such as good obstetrical care and vitamin A supplementation?

3.2.3 Supportive Information Education and Communication (IEC) materials and strategy:
Assess whether the available IEC materials are appropriate for the specific sites and available to the public as take home materials.

Is there an IEC strategy to support the peer to peer approach and other communication efforts? Are there opportunities to engage mass media and employ participatory production processes?

3.2.4 Care for and involvement of People Living With HIV/AIDS:
Increasingly there appears need to consider care and involvement of PLWA in HIV prevention interventions. Are there opportunities for this?

3.2.5 Income generating activities:

There appears clear opportunity and desire for small enterprise development as an important way out of the poverty trap, a significant factor in promoting HIV spread. Linking vocational training and micro credit provision with the establishment of successful small enterprises seems to be a logical next step in the project areas.

Examine the activities in the programme and consider how these could be improved.

3.2.6 Networking:

Evaluate the networking between organisations and agencies doing similar work and those doing complementary work both in the local project setting and in other parts of the country and consider how this could be improved.

4. Compatibility and Sustainability

4.1 Compatibility

Asses whether the Programme is compatible with the strategic goals of Ireland Aid. This should include the promotion of human rights, equity, democracy, and poverty alleviation.

Furthermore is the programme consonant with Ireland Aid’s Health Sector Strategy and Guidelines for the Bilateral Aid Programme (March 2000) and the HIV/AIDS Strategy for the Ireland Aid Programme (January 2000)?

4.2 Sustainability

4.2.1 Policy Environment

Is the Programme operating in a supportive policy environment? Consider the changing policies of NACP (& MOH) and UNICEF’s new country programme.

4.2.2 Economic and Financial Feasibility

Without the continued support of Ireland Aid, are there funds to support the continuation or indeed expansion of the Programme or its component projects?

This must consider the relevant local authorities (who are expected to take responsibility for HIV/AIDS soon), the implementing organisations and other potential sources.

4.2.3 Institutional Capacity

Consider the capacity of the implementing organisations and UNICEF to maintain and develop the intervention. In areas where the local authorities are likely to play a larger role comment on their capacity to do so.

Comment on whether additional categories of personnel are needed – in the office and in the field.

Pay specific attention to the capacity to provide technical support and how this may be achieved.

4.2.4 Socio-Cultural Aspects
Are the component projects socially and culturally acceptable to the communities in which they are set?

This is of particular importance in the Obuasi, Upper North, North East and Jamestown peer to peer projects, the acceptability by key groups in associated social systems – parents, teachers and close relationships.

What possibilities are there to address any problems in this area?

4.2.5 Participation and Ownership
To what extent are local agencies, community organisations and beneficiaries involved as participants in guiding and implementing the programme and its components?

Of particular value is understanding what motivates and retains (or otherwise) the numerous volunteers in the programme.

4.2.6 Gender
Asses to what extent the needs and roles of men and women are recognised in planning and implementation of the programme.

5. Methodology
All relevant documents are to be reviewed. These include, amongst others, original proposal documents, periodic project and programme reports, reports from monitoring visits, mid-term evaluation, data from the NHIS (including reports from local health services), relevant reports and surveys from MOH, NACP policy and strategy reports, Ireland Aid HIV/AIDS and health strategies, UNICEF plans 2001-2005, the baseline study (1998) and any associated research such as the Exodus Study (1999).

Site visits will be performed to all areas, project staff interviewed and a sample of sessions observed for quality and content. Local health services will be visited as will a sample of other service providers such as pharmacy shops and drug sellers.

Personal interviews will be performed involving key informants, resource persons and a sample of peer educators, beneficiaries and second generation peer contacts as described in the component project documents.

Similarly focus group discussions will be held for beneficiaries and peer educators.

6. Evaluation Team
Three consultants are proposed to complete the evaluation.

Two public health consultants with particular expertise in HIV/AIDS programmes and a good understanding of communication strategies and techniques. One will cover Obuasi and the Upper North and North East while the other will cover the Accra components.

It is suggested that one be an external international consultant and the other be a national level in country expert.

The third should have expertise in small enterprise development and income generation projects to evaluate all such activities in the programme.
7. Mission and Reporting

7.1 The Evaluation Mission
The total mission duration is estimated as 18 days for both public health consultants broken down as follows:
Preparation: 3 days
Initial briefing with stakeholders: 1 day
Field work: 7 days
Feedback Workshop: 2 days
Finalisation: 5 days
Small enterprise expert: 7 days
Total consultancy days: 36 + 7 = 43

Preliminary findings and draft recommendations are to be presented to a wide stakeholder workshop. This should be a two day workshop involving at least UNICEF, component project staff (and volunteers/peer educators), NACP & MOH, local authorities and UNAIDS.

The workshop is to discuss the key findings, propose recommendations based on those findings and identify important lessons for future HIV/AIDS & STI interventions.

7.2 Final report format
Executive Summary
UNICEF Ghana’s HIV Prevention Programme
The environment, description of the intervention (s), history, changes in the environment and the programme itself.
Assumptions
Background to the evaluation
Purpose, methodology, limitations and other relevant details.
Evaluation Issues
4.1. General Evaluation Issues
4.1.1. Relevance
4.1.2. Impact
4.1.3. Effectiveness
4.1.4. Efficiency
4.2. Specific Evaluation Issues
4.2.1. Sexually Transmitted Infections Management
4.2.2 The HIV Prevention Package
4.2.3 IEC Materials and Strategy
4.2.4 Care for and involvement of People Living With HIV/AIDS
4.2.5 Income Generating Activities
4.2.6 Networking
Compatibility and Sustainability
5.1. Compatibility
5.2. Sustainability
5.2.1. Policy Environment
5.2.2. Economic and Financial Feasibility
5.2.3. Institutional Capacity
5.2.4. Socio-Cultural Aspects
5.2.5. Participation and Ownership
5.2.6. Gender
Conclusions and Recommendations
To include suggestions for operational improvements and developmental lessons learnt. These must be based on findings and clearly separated from them while findings must be supported by empirical evidence as much as is possible. Additional chapters/sections may be included as the evaluation team sees fit.
ANNEX 2: Logframes for UNICEF Ghana HIV/AIDS & STI Programme

This presents the overall UNICEF HIV/AIDS & STI Programme (funded by Ireland Aid). Objectives and Results represent the intended end of programme state.

Logframe for UNICEF Ghana HIV/AIDS & STI Programme

<table>
<thead>
<tr>
<th>Overall Programme Objective: Reduced incidence of STIs and HIV/AIDS among vulnerable population groups in Ghana.</th>
<th>Indicators for Overall Programme Objective:</th>
<th>Sources of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>• STI incidence rate is reduced in areas and in age/sex groups representing a high proportion of vulnerable people.</td>
<td>• HIV infection prevalence rate is stable or dropping especially in areas and age/sex groups representing a high proportion of vulnerable people.</td>
<td>• National Health Information System.</td>
</tr>
<tr>
<td>Sources of verification</td>
<td>• Periodic surveys to validate data from NHIS.</td>
<td>• Periodic HIV sero-prevalence surveys.</td>
</tr>
<tr>
<td>Programme Purpose: Reduced HIV and STI transmission amongst women and youth in three areas of Ghana (selected areas of Accra, Obuasi &amp; 12 Districts of Upper North and North East) with special emphasis on street youth in Accra and Commercial Sex Workers in Obuasi.</td>
<td>Indicators for Programme Purpose:</td>
<td>Sources of verification</td>
</tr>
<tr>
<td>• Reduced incidence of STIs amongst the target groups.</td>
<td>• Number of commercial sex workers resettled.</td>
<td>• Attendance figures for STIs at local health services. (This is likely to be a poor source since reduced attendance may not reflect reduced incidence at this stage)</td>
</tr>
<tr>
<td>• Number of street children re-integrated into families.</td>
<td>Sources of verification</td>
<td>• Personal interviews and focus group discussions to compare STI incidence to baseline survey results.</td>
</tr>
<tr>
<td>Assumptions</td>
<td>Projects’ records.</td>
<td>Assumptions</td>
</tr>
<tr>
<td>Routinely collected data for STI diagnosis is unreliable and the baseline study was a good reflection of STI incidence.</td>
<td>The STI attendance data is reliable and reflects STI incidence.</td>
<td>Government gives HIV/AIDS a high priority for all sectors.</td>
</tr>
<tr>
<td>Result 1</td>
<td>(Component 1)</td>
<td>Supporting GRCS, in and out of school youth in 12 districts of Upper North and North East Regions have the knowledge, attitudes, behaviour and access to services to protect themselves against HIV, STIs and other reproductive health conditions.</td>
</tr>
<tr>
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<tr>
<td>Result 2</td>
<td>(Component 2)</td>
<td>Supporting Adansi West District Assembly, Commercial Sex Workers and single women in Obuasi are knowledgeable about STIs, HIV/AIDS &amp; reproductive health, have access to suitable RH services and have appropriate attitudes &amp; life skills and alternative sources of income to protect themselves against HIV, STIs and other reproductive health conditions.</td>
</tr>
<tr>
<td>Result 3</td>
<td>(Component 3)</td>
<td>Through CENCOSAD, in and out of school youth in Jamestown are have the knowledge, attitudes behaviour and access to services to protect themselves against HIV, STIs and other reproductive health conditions.</td>
</tr>
<tr>
<td>Result 4</td>
<td>(Component 4)</td>
<td>By backing CAS, particularly vulnerable male street youth access a non-resident refuge and support so that they are protected against HIV, STIs and other reproductive health conditions.</td>
</tr>
<tr>
<td>Result 5</td>
<td>(Component 5)</td>
<td>By providing support to SGA, female street youth in particularly difficult circumstances access adequate maternity services and support to protect themselves against HIV, STIs and other reproductive health conditions.</td>
</tr>
</tbody>
</table>

**Assumptions**
Data available on street children from NGOs adequately analysed and published so that planning is evidence based.

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<table>
<thead>
<tr>
<th>Indicators for result 1</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>♠ 80% of targeted youth are able to identify 2 modes of HIV transmission (knowing unprotected sexual relations as the major mode) and 2 modes of protecting oneself from HIV infection, including condom use.</td>
<td></td>
</tr>
<tr>
<td>♠ 80% agree that they would be at risk of HIV infection if they have unprotected sex and 50% say they would ask a partner to use a condom.</td>
<td></td>
</tr>
<tr>
<td>♠ 70% know how to use condoms properly and can access them.</td>
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<tr>
<td>♠ 30% increase in reported use of condoms during last sexual contact amongst non-monogamous youth. ~ refer to baseline study.</td>
<td></td>
</tr>
<tr>
<td>♠ Young people targeted by the project seek help promptly for STIs from a reliable service provider.</td>
<td></td>
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</tbody>
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<tr>
<th>Indicators for result 2</th>
<th></th>
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<tbody>
<tr>
<td>♠ CSW (and some single women) rely less on commercial sex for income and some leave the business altogether.</td>
<td></td>
</tr>
<tr>
<td>♠ Target group access quality health services promptly.</td>
<td></td>
</tr>
<tr>
<td>♠ CSW are correctly and consistently using condoms: 65% by December 2000.</td>
<td></td>
</tr>
<tr>
<td>♠ Increasing proportion of CSWs and single women knowledgeable of modes of transmission of HIV. (65% by Dec 2000)</td>
<td></td>
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<thead>
<tr>
<th>Indicators for result 3</th>
<th></th>
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<tbody>
<tr>
<td>♠ Increasing number of targeted youth can name three modes of transmission of HIV with sexual intercourse being the most important and can describe how to protect themselves.</td>
<td></td>
</tr>
<tr>
<td>♠ Youth have convenient access to condoms and use them properly.</td>
<td></td>
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<tr>
<td>♠ For STIs, youth easily access quality health services</td>
<td></td>
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</tbody>
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<tr>
<th>Indicators for result 4</th>
<th></th>
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<tbody>
<tr>
<td>♠ Youth visiting the refuge and those reached in the street have adequate knowledge of STIs and HIV/AIDS including options to protect themselves.</td>
<td></td>
</tr>
<tr>
<td>♠ Street youth have easy access to condoms and use them properly.</td>
<td></td>
</tr>
<tr>
<td>♠ Street youth access health services promptly when needed, especially for STIs.</td>
<td></td>
</tr>
<tr>
<td>♠ Children apply the training they have received to make income and adopt a safer lifestyle.</td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th>Indicators for result 5</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>♠ Increasing number of street girls have adequate knowledge of health issues and options to protect themselves and their babies: STIs, HIV, reproductive health, child health issues.</td>
<td></td>
</tr>
<tr>
<td>♠ Targeted street girls access health services promptly especially for STIs and MCH problems.</td>
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</tr>
<tr>
<td>♠ Street girls conveniently access and use condoms correctly and consistently.</td>
<td></td>
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<tr>
<td>♠ Increased level of improved child care and health practices adopted by street mothers (exclusive breast feeding, complementary feeding and reproductive health).</td>
<td></td>
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<tr>
<td>♠ Increasing number of street girls making money using newly acquired skills.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Sources of</th>
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<table>
<thead>
<tr>
<th>Verification Result 1</th>
<th>Verification Result 2</th>
<th>Verification Result 3</th>
<th>Verification Result 4</th>
<th>Verification Result 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal interviews and focus group discussions with sample of targeted youth.</td>
<td>Sample of CSWs and single women (not only peer educators) who have been involved with the project. Perform personal interviews and focus group discussions.</td>
<td>Personal interviews and focus group discussions with in and out of school targeted by the programme.</td>
<td>Interviews and focus group discussions.</td>
<td>Interviews and focus group discussions.</td>
</tr>
<tr>
<td>Attendance figures at local health services.</td>
<td>Attendance figures for STIs at local health services providers and extent of use of referral card system. Attendance should increase initially.</td>
<td>Attendance data from local health services</td>
<td>Attendance data for STIs.</td>
<td>Attendance figures from local health service providers.</td>
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<tr>
<td>Activities for Result 1</td>
<td>Activities for Result 2</td>
<td>Activities for Result 3</td>
<td>Activities for Result 4</td>
<td>Activities for Result 5</td>
</tr>
<tr>
<td>1. Using acceptable peer to peer approaches and focussing on STI, HIV/AIDS and life skills, for in and out of school youth, reach 20 000 youth directly and a further 50 000 indirectly.</td>
<td>1. Use peer to peer techniques targeting single women and CSWs to equip them with appropriate knowledge, attitudes skills and behaviour. Support this with IEC strategy.</td>
<td>1. Target in and out of school youth in Jamestown using peer to peer approaches provide education and counselling focussing on STIs, HIV/AIDS and life skills.</td>
<td>1. Provide a day refuge and counselling for mainly male street children.</td>
<td>1. Provide a residential refuge and counselling service for female street youth for crisis care and access to health services including maternity care.</td>
</tr>
<tr>
<td>2. Promote provision of and access to quality RH services.</td>
<td>2. Provide CSWs and single women with convenient access to quality condoms.</td>
<td>2. Organise reliable access to condoms for the target group.</td>
<td>2. Provide health education and health services especially for STIs and HIV/AIDS.</td>
<td>2. Arrange for health education &amp; counselling and access to health services and supplies (especially for STIs) for street girls.</td>
</tr>
<tr>
<td>3. Facilitate access to condoms where needed.</td>
<td>3. Facilitate and promote provision of and access to quality STI health services.</td>
<td>3. Provide health education and access to quality health services for STIs.</td>
<td>3. Arrange for formal and informal, academic and vocational training for the street youth.</td>
<td>3. Offer training in literacy and vocational skills for those girls in the refuge and on the streets.</td>
</tr>
</tbody>
</table>

Logframe for Programme component 1: Peer to Peer project Upper North and North East
<table>
<thead>
<tr>
<th>Component 1 Objective&lt;br&gt;Reduced HIV and STI transmission amongst women and youth in three areas of Ghana (selected areas of Accra, Obuasi &amp; 12 Districts of Upper North and North East) with special emphasis on street youth in Accra and Commercial Sex Workers in Obuasi.</th>
<th>Indicators for Component 1 objective&lt;br&gt;Reduced incidence of STIs amongst the target groups.&lt;br&gt;Number of commercial sex workers resettled.&lt;br&gt;Number of street children re-integrated into families.</th>
<th>Sources of verification&lt;br&gt;Attendance figures for STIs at local health services. (This is likely to be a poor source since reduced attendance may not reflect reduced incidence at this stage)&lt;br&gt;Personal interviews and focus group discussions to compare STI incidence to baseline survey results.&lt;br&gt;Projects’ records.</th>
<th>Assumptions&lt;br&gt;Routinely collected data for STI diagnosis is unreliable and the baseline study was a good reflection of STI incidence.&lt;br&gt;The STI attendance data is reliable and reflects STI incidence.&lt;br&gt;Government gives HIV/AIDS a high priority for all sectors.&lt;br&gt;Ghana remains stable and standard of living continues to grow.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component 1 Purpose&lt;br&gt;Supporting GRCS, in and out of school youth in 12 districts of Upper North and North East Regions have the knowledge, attitudes, behaviour* and access to services &amp; condoms to protect themselves against HIV, STIs and other reproductive health conditions.</td>
<td>Indicators for component 1 purpose&lt;br&gt;80% of targeted youth are able to identify 2 modes of HIV transmission (knowing unprotected sexual relations as the major mode) and 2 modes of protecting oneself from HIV infection, including condom use.&lt;br&gt;80% agree that they would be at risk of HIV infection if they have unprotected sex and 50% say they would ask a partner to use a condom.&lt;br&gt;70% know how to use condoms properly.&lt;br&gt;30% increase in reported use of condoms during last sexual contact amongst non-monogamous youth. ~ refer to baseline study.&lt;br&gt;Young people targeted by the project seek help promptly for STIs from a reliable service provider.</td>
<td>Sources of verification&lt;br&gt;Personal interviews and focus group discussions with sample of targeted youth.&lt;br&gt;Attendance figures at local health services.</td>
<td>Assumptions&lt;br&gt;GRCS has the capacity to absorb the inputs and implement the plan.&lt;br&gt;The environment is such that GRCS adult and youth volunteers will be willing to continue to give considerable unpaid time to project activities over a three year period.</td>
</tr>
<tr>
<td>Component 1 Result 1&lt;br&gt;Using acceptable peer to peer approaches and focussing on STIs, HIV/AIDS and life skills for in and out of school youth, 20 000 people aged 15-25 yrs are reached directly and a further 50 000 indirectly.</td>
<td>Component 1 Result 2&lt;br&gt;Quality reproductive health services are provided for and accessible by youth in the districts.</td>
<td>Component 1 Result 3&lt;br&gt;Young people can access condoms when needed.</td>
<td>Assumptions&lt;br&gt;The peer approach works in HIV prevention promotion.&lt;br&gt;Supplies of condoms and STI drugs are reliable.&lt;br&gt;Mass media and leadership promote a climate in which STI and HIV prevention activities are accepted and encouraged.</td>
</tr>
</tbody>
</table>

* This includes life skills such as assertiveness and safer sex options.
<table>
<thead>
<tr>
<th>Activities for component 1 Result 1</th>
<th>Activities for component 1 Result 2</th>
<th>Activities for component 1 Result 3</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Train peer educators in peer to peer approaches and a four module course to be used covering knowledge, attitude (including risk perception) and behaviour (including safe sex practices and assertiveness/life skills): Y1-174, Y2 &amp; Y3-288 each.</td>
<td>☐ Train service providers in the syndromic management of STIs and in providing youth friendly services.</td>
<td>☐ Establish reliable source of enough quality condoms.</td>
<td>The set of four educational activities undertaken on a peer education basis are adequate to develop the appropriate knowledge, attitudes (particularly perception of risk), &amp; skills/behaviour to prevent HIV (&amp; STI) infection in youth.</td>
</tr>
<tr>
<td>☐ Peer educators to train 20 000 people (15-25 yrs) each completing the four module process and</td>
<td>☐ Establish youth friendly corners in clinics and hospitals</td>
<td>☐ Explore and put in place systems of convenient access.</td>
<td>Community members and school authorities will accept and approve explicit HIV/STI education to youth, including condom knowledge and skills</td>
</tr>
<tr>
<td>☐ Peer educators and participants influence a further 50 000 of which 2/3 are 15-25yrs</td>
<td>☐ Establish Youth Centres</td>
<td>☐ Encourage recognition and early presentation of STIs as part of the peer education sessions and other contacts.</td>
<td>Local health service providers agree to collaborate in offering quality STI treatment and youth friendly services.</td>
</tr>
<tr>
<td>☐ Provide regular support and supervision: ADYOs and DYOs meet weekly and monthly with RYO.</td>
<td>☐ Provide refresher courses for peer educators at least annually.</td>
<td>☐ Supply and distribute supportive IEC materials</td>
<td>Peer educators, ADYOs &amp; DYO have access to sufficient transport to cover the districts.</td>
</tr>
<tr>
<td>☐ Supply and distribute supportive IEC materials</td>
<td>☐ Check stocks and record of stocks.</td>
<td>☐ Personal interviews and focus group discussions.</td>
<td></td>
</tr>
</tbody>
</table>

**Sources of verification**
- Project manager reports.
- Reports from ADYOs, DYO and RYO.
- Interview a sample of people who have been through the training provided by the peer educators.

**Sources of verification**
- Personal interviews and focus group discussions with youth reached by the programme.
- Examine the STI services offered by clinics and hospitals and interview pharmacy shops.

**Sources off verification**
- Check stocks and record of stocks.
- Personal interviews and focus group discussions.

- Condom supply is adequate and reliable.
- Young people have convenient and non-embarrassing access to condoms.

- 2/3 of community leaders and parents interviewed express approval of the project.
- 2/3 of trained peer educators are retained for at least one year. (an indication of acceptability of and commitment to the project)
- 20 000 young people are reached each having completed the four module course.
- Each person reached influences and informs about 3 others to reach an additional 50 000 people.
Logframe for Programme component 2: Peer education project for commercial sex workers and single women in Obuasi

**Component Objective**
Reduced HIV and STI transmission amongst women and youth in three areas of Ghana (selected areas of Accra, Obuasi & 12 Districts of Upper North and North East) with special emphasis on street youth in Accra and Commercial Sex Workers in Obuasi.

**Indicators for Component objective**
- Reduced incidence of STIs amongst the target groups.
- Number of commercial sex workers resettled.
- Number of street children re-integrated into families.

**Sources of verification**
- Attendance figures for STIs at local health services. (This is likely to be a poor source since reduced attendance may not reflect reduced incidence at this stage)
- Personal interviews and focus group discussions to compare STI incidence to baseline survey results.
- Projects’ records.

**Assumptions**
- Routinely collected data for STI diagnosis is unreliable and the baseline study was a good reflection of STI incidence.
- The STI attendance data is reliable and reflects STI incidence.
- Government gives HIV/AIDS a high priority for all sectors.
- Ghana remains stable and standard of living continues to grow.

**Component 2 Purpose**
Supporting Adansi West District Assembly, Commercial Sex Workers and single women in Obuasi are knowledgeable about STIs, HIV/AIDS & reproductive health, have access to suitable RH services and have appropriate attitudes & life skills and alternative sources of income to protect themselves against HIV, STIs and other reproductive health conditions.

**Indicators for component purpose**
- CSW (and some single women) rely less on commercial sex for income and some leave the business altogether.
- Target group access quality health services promptly.
- CSW are correctly and consistently using condoms: 65% by December 2000.
- Increasing proportion of CSWs and single women knowledgeable of modes of transmission of HIV. (65% by Dec 2000)

**Sources of verification**
- Sample of CSWs and single women (not only peer educators) who have been involved with the project. Perform personal interviews and focus group discussions.
- Attendance figures for STIs at local health services providers and extent of use of referral card system. Attendance should increase initially.

**Assumptions**
- AWDA has the capacity and will to run the project.
- Income generating ventures are successful, sustainable and grow.

**Component 2 Result 1**
Using peer education techniques and supported by other IEC strategies, reach 10 000 commercial sex workers and single women (altogether) are reached directly and trained in knowledge, attitudes, skills and safe sex behaviour. A further group is reached indirectly by CSW benefiting from the project.

**Indicators for Result 1**
- Number of peer educators and outreach staff trained: increasing

**Component 2 Result 2**
CSWs and single women have convenient access to enough quality condoms.

**Indicators for Result 2**
- Local supply sources have adequate quantities of quality

**Component 2 Result 3**
Quality STI management services are provided for CSWs and single women and actively promoted.

**Indicators for Result 3**
- Quality management of STIs offered at local health facilities:

**Component 2 Result 4**
CSWs and single women access Grant Credit Assistance to fund alternative ways of making a living.

**Indicators for Result 4**
- Increasing number of Single Women's Clubs formed.

**Assumptions**
- Supplies of condoms and STI drugs are reliable.
- Credit scheme is enough to establish alternative source of income.
- The peer educator drop out rate is manageable.
annually according to workplans.

- Retention rate of peer educators (an indication of relevance and commitment)
- Number of contacts made between peer educators and targeted CSWs and single women and estimated number of secondary contacts. To increase annually: 50 contacts per year by December 2000.

condoms.
- Total numbers of condoms distributed by peer educators: Increase from year to year.
- Increasing proportion of target group easily access and use condoms consistently and correctly: 65% by December 2000.

- Doctors, Lab Techs & Nurses able to identify and treat STIs correctly.
- Logistics and essential drugs supplied and available.
- Referral Cards System working.
- CSWs and single women understand the link between STIs and HIV, can recognise STIs and seek help promptly at health facility: 80% by December 2000.
- Pharmacists, Chemical Sellers and TBAs can recognise STIs and refer to health facility.
- An initial increase in clients seeking treatment for STIs at local health facilities and referral card used commonly.
- Growing number of CSWs who have benefited from the Credit Assistance.
- Growing number of CSWs who have benefited from the Credit Assistance.

Sources of verification
- Interviews and focus group discussions with CSWs and single women.
- Project records and reports.

Sources of verification
- Check stock records of local suppliers.
- Interview/FGD a selection of CSWs and Single Women. They are to demonstrate use.

Sources of verification
- Examine the STI management system at local health facilities. Exit interviews will provide a more accurate picture.
- Interview and focus group discussions with CSWs and single women.
- Interview a selection of Pharmacists, Chemical Sellers and TBAs targeted by the project.
- Examine STI attendance rates at local health facilities.

Sources of verification
- Project records.
- Examine records kept by local lending institution administering the scheme.
### Activities for component 2

#### Result 1
- Peer educators are selected amongst CSWs and single women and trained in peer education techniques and, focusing on HIV/AIDS, STIs and reproductive health are trained so that they can promote
  - Knowledge (including link between HIV and STIs)
  - Attitudes, especially perception of risk.
  - Behaviour: the life skills, safe sex options and condom demonstration and use.
- Peer educators have contact with a target of 50 other CSWs annually and these in turn inform/influence others.
- Develop and implement an IEC strategy to complement peer education.
- Hold weekly report back, problem solving and weekly planning sessions. Identify need to improved/new communication techniques and content.

#### Result 2
- Train all peer educators to demonstrate the use of condoms and supply the training materials. (see Result 1) and supply condoms.
- Establish a reliable source of quality condoms.
- With CSWs and single women, establish access outlets which are acceptable and convenient. These will include peer educators.

#### Result 3
- Train Doctors, Lab Techs and Nurses in proper diagnosis and management of STIs.
- Train TBAs, Pharmacists and Chemical Sellers to recognise STIs and refer to health facility.
- Establish the Referral Card system for CSWs.
- The link between STIs and HIV clearly explained in the peer contacts (Result 1).

#### Result 4
- Establish a rotating credit scheme with a local lending institution to be accessed by project CSWs and single women.
- Establish Single Women’s Clubs providing advice and access to credit.
- Monitor the performance of the scheme.

### Assumptions
- The communication strategy and techniques used continue to develop to suit audience, need for new content and changing environment. Perhaps suitable institutional links are needed.
- The atmosphere is such that CSWs and single women can freely participate in the project without fear or discrimination.
- Health service providers collaborate to offer quality STI management and convenient access for CSWs and single women.
- Women repay the credit.
- The peer approach is acceptable to CSWs and single women.

<table>
<thead>
<tr>
<th>Means</th>
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<tbody>
<tr>
<td>Costs</td>
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Logframe for Programme component 3: Accra (Jamestown) peer to peer project for in and out of school youth.

<table>
<thead>
<tr>
<th>Component Objective</th>
<th>Indicators for Component objective</th>
<th>Sources of verification</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced HIV and STI transmission amongst women and youth in three areas of Ghana</td>
<td>- Reduced incidence of STIs amongst the</td>
<td>- Attendance figures for STIs at local health services. (This is likely to be a poor source</td>
<td>Routinely collected data for STI diagnosis is unreliable and the baseline study was a good</td>
</tr>
</tbody>
</table>
(selected areas of Accra, Obuasi & 12 Districts of Upper North and North East) with special emphasis on street youth in Accra and Commercial Sex Workers in Obuasi.

<table>
<thead>
<tr>
<th>Component 3 Purpose</th>
<th>Indicators for component 3 purpose</th>
<th>Sources of verification</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through CENCOSAD, in and out of school youth in Jamestown have the knowledge, attitudes behaviour and access to services to protect themselves against HIV, STIs and other reproductive health conditions.</td>
<td>Increasing number of targeted youth can name three modes of transmission of HIV with sexual intercourse being the most important and can describe how to protect themselves. Youth have convenient access to condoms and use them appropriately. For STIs, youth easily access quality health services.</td>
<td>Personal interviews and focus group discussions with in and out of school targeted by the programme. Attendance data from local health services.</td>
<td>CENCOSAD has the capacity to implement the project. Peer educators are retained ~ drop out rate is manageable. Data from health services is reliable.</td>
</tr>
</tbody>
</table>

### Component 3 Result 1
Focussing on HIV/AIDS, STIs, reproductive health and life skills, education and counselling is provided for in and out of school youth using peer education and appropriate IEC materials.

### Component 3 Result 2
Access to condoms is provided for in and out of school youth.

### Component 3 Result 3
Appropriate health education and counselling is provided together with access to adequate health services (especially for STIs).

### Assumptions
- Condom and STI drug supplies are reliable.
- Mass media and leadership promote a climate which encourages and supports HIV prevention activities.

### Indicators for Result 1
- Increasing number of youth (in and out of school) reached by peer educators.
- Number of peer educators trained and active compared to drop out rate.
- Growing number of functional youth clubs involving at least 75 youth in year one and 150 in years two and three.
- IEC materials provided are adequate and appropriate for target group ~ those reached by structured peer contacts and others.

### Indicators for Result 2
- Condom stocks are adequate and supply system is reliable.
- Distribution figures increase year on year and estimated as sufficient by end 2000.

### Indicators for Result 3
- Numbers of in school and out of school youth reached by health education and counselling. Majority of target group reached by end 2000.
- Local health services are offering proper STI management and youth friendly service.

### Sources of verification

<table>
<thead>
<tr>
<th>Source of verification</th>
<th>Result 1</th>
<th>Result 2</th>
<th>Result 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Result 1</td>
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<tr>
<td>Result 2</td>
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<tr>
<td>Result 3</td>
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</tr>
<tr>
<td>♦ Project records.</td>
<td>♦ Check stocks, supply and distribution records.</td>
<td>♦ Project records</td>
<td>♦ Visit local health services.</td>
</tr>
<tr>
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</tr>
<tr>
<td>♦ Inspect IEC materials that are available.</td>
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</tbody>
</table>

### Activities for component 3

**Result 1**
- Select and train in and out of school peer educators, counsellors and supervisors. In year 2000, 120 peer educators, 30 counsellors and 30 supervisors trained.
- Peer educators contact in and out of school youth focussing on STI, HIV/AIDS, reproductive health and life skills. Establish Health clubs/youth clubs as part of this activity: Clubs to
  - Provide adequate support to peer educators (including IEC materials)
  - Recruit support of community leaders and community based organisations.

**Result 2**
- Secure a reliable source of quality condoms.
- Organise a system(s) of convenient access by both in and out of school youth.
- Demonstrate how to use condoms (Result 1).

**Result 3**
- Social Workers provide counselling on the streets to children.
- Provide counselling and health education in collaboration with Salvation Army and utilising the Health Kiosks and outreach clinics.
- Collaborate with CAS and SGA social workers in delivering counselling and health education services.
- Working with Salvation Army, arrange for youth friendly access to health services, especially for STIs.

### Means

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<tr>
<th>Means</th>
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### Costs

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<th>Costs</th>
<th>Costs</th>
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</thead>
</table>


### Logframe for Programme component 4: Accra (Jamestown) male street refuge project.

**Component Objective**
Reduced HIV and STI transmission amongst women and youth in three areas of Ghana (selected areas of Accra, Obuasi & 12 Districts of Upper North and North East) with special emphasis on street youth in Accra and Commercial Sex Workers in Obuasi.

**Indicators for Component objective**
- Reduced incidence of STIs amongst the target groups.
- Number of commercial sex workers resettled.
- Number of street children re-integrated into families.

**Sources of verification**
- Attendance figures for STIs at local health services. (This is likely to be a poor source since reduced attendance may not reflect reduced incidence at this stage)
- Personal interviews and focus group discussions to compare STI incidence to baseline survey results.
- Projects’ records.

**Assumptions**
- Routinely collected data for STI diagnosis is unreliable and the baseline study was a good reflection of STI incidence.
- The STI attendance data is reliable and reflects STI incidence.
- Government gives HIV/AIDS a high priority for all sectors.
- Ghana remains stable and standard of living continues to grow.
By backing CAS, particularly vulnerable male street youth access a non-resident refuge and support so that they are protected against HIV, STIs and other reproductive health conditions.

<table>
<thead>
<tr>
<th>Component 4 Result 1</th>
<th>Component 4 Result 2</th>
<th>Component 4 Result 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>A day refuge and counselling services are provided for mainly male street youth in Jamestown.</td>
<td>Health education and health services focussing on HIV/AIDS, STIs, reproductive health and life skills are provided for street children in and out of the refuge.</td>
<td>Training is provided for street children: Informal (literacy), formal academic and vocational.</td>
</tr>
</tbody>
</table>

**Purpose**
- Youth visiting the refuge and those reached in the street have adequate knowledge of STIs and HIV/AIDS including options to protect themselves.
- Street youth have easy access to condoms and use them properly.
- Street youth access health services promptly when needed, especially for STIs.
- Children apply the training they have received to make income and adopt a safer life style.

**Indicators for Result 1**
- Numbers of street youth using the day refuge: Attendance at the refuge is sustained or increases throughout the project.
- Number of street youth attending health education and counselling sessions at the refuge.
- Number of children managed as one on one social work cases.

**Indicators for Result 2**
- Number of health education and life skills sessions organised and total attendance: At least 25 street children daily receive health education classes ~ this includes those reached by the SGA project.
- Number of children attending mobile clinics for advice and/or care for STI, HIV and other health issues increases.

**Indicators for Result 3**
- Number of street children benefiting from the training offered. This increases throughout the project.

**Sources of verification**
- Result 1: Project reports, Social worker reports
- Result 2: Project training reports, Attendance figures at the clinics
- Result 3: Project reports

**Activities for component 4 Result 1**
- Establish a non-residential refuge mainly for male street youth.
- Provide counselling for those who use the refuge and together with CENCOSAD, Salvation Army and SGA, offer counselling on

**Activities for component 4 Result 2**
- Collaborating with Salvation army nurses and social workers, provide education and counselling on STIs, HIV/AIDS, reproductive health and other health issues. Utilise the refuge, Salvation Army clinics and CAS Health Kiosks.
- Offer informal literacy training and demonstrations for street youth at the refuge. Encourage as many as possible to participate.
- Identify those who are capable and keen to enter formal school education, secure places

**Assumptions**
- A good working relationship with CENCOSAD, SGA and Salvation Army.
- Health service providers willing to collaborate.
- Appropriate IEC materials exist or can be readily produced.

**Assumptions**
- CAS has the capacity to absorb the inputs and implement the project.
- Conduct interviews and focus group discussions.
- Visit supply points for condoms.
- Attendance data for STIs.
- Examine income generating activities.

Condom supply and drugs for STIs is reliable.
the street for youth. This is to include crisis
counselling, life skills and protection against
STIs/HIV and associated reproductive health
conditions (eg parenthood).

- Exploit possibilities for re-integrating youth
back into their families.

- Analyse available data on street youth, their
life stories and future perspectives to better
understand their needs and risks in their lives
for planning purposes.

- Working with Salvation Army, offer
adequate quality health services (especially
STI management) which can be conveniently
accessed by the street youth. Promote
appropriate health seeking behaviour.

- Arrange for reliable supply of quality
condoms and convenient access by street
youth.

- Ensure adequate supply of appropriate IEC
materials.

### Logframe for Programme component 5: Accra (Maamobi) female street youth refuge project.

<table>
<thead>
<tr>
<th>Component Objective</th>
<th>Indicators for Component objective</th>
<th>Sources of verification</th>
<th>Assumptions</th>
</tr>
</thead>
</table>
| Reduced HIV and STI transmission amongst women and youth in three areas of Ghana (selected areas of Accra, Obuasi & 12 Districts of Upper North and North East) with special emphasis on street youth in Accra and Commercial Sex Workers in Obuasi. | - Reduced incidence of STIs amongst the target groups.  
- Number of commercial sex workers resettled.  
- Number of street children re-integrated into families. | - Attendance figures for STIs at local health services. (This is likely to be a poor source since reduced attendance may not reflect reduced incidence at this stage)  
- Personal interviews and focus group discussions to compare STI incidence to baseline survey results.  
- Projects’ records. | - Routinely collected data for STI diagnosis is unreliable and the baseline study was a good reflection of STI incidence.  
- The STI attendance data is reliable and reflects STI incidence.  
- Government gives HIV/AIDS a high priority for all sectors.  
- Ghana remains stable and standard of living continues to grow. |

<table>
<thead>
<tr>
<th>Component 5 Purpose</th>
<th>Indicators for component purpose</th>
<th>Sources of verification</th>
<th>Assumptions</th>
</tr>
</thead>
</table>
| By providing support to SGA, female street youth in particularly difficult circumstances access adequate maternity services and support to protect themselves against HIV, STIs and other reproductive health conditions. | - Increasing number of street girls have adequate knowledge of health issues and options to protect themselves and their babies: STIs, HIV, reproductive health, child health issues. | - Interviews and focus group discussions.  
- Attendance figures from local health service providers.  
- Examine income generation activities and | - SGA has the capacity to implement the project and continues to afford HIV/AIDS a high priority. |
Component 5 Result 1
A residential refuge and counselling service for female street youth is provided for crisis care, access to health services and pre & post natal care.

Component 5 Result 2
Education, counselling and access to health services and supplies (including condoms) is provided particularly for STIs, HIV/AIDS, reproductive health for street youth in the refuge and on the streets.

Component 5 Result 3
Literacy training, demonstrations and vocational training is available to refuge in-mates and youth on the streets.

Assumptions
Condom and STI drug supply is reliable.
Health services provided are sustained.
The vocational training and any associated support is enough to establish an income generating project/activity.

Indicators for Result 1
- Number of girls utilising the refuge.
- Number of girls utilising the maternity services offered and accessed by the refuge. Ante natal education and counselling, including STIs and HIV. Contraception. Delivery in a labour ward. Post natal education and care.
- Number of street girls managed as one on one social work cases.

Indicators for Result 2
- Number of sessions held for street girls covering STIs, HIV/AIDS and aspects of reproductive health.
- At least 25 street children daily receive health education classes ~ this includes those reached by the CAS project.
- Number of girls treated and counselled: At least 140 street girls treated and counselled in 2000.
- Increasing MCH consultations (immunisations etc): To reach 3000 consultations 2000 for mothers, their babies and street children.
- Number of condoms distributed.

Indicators for Result 3
- 135 street children in the sponsorship scheme by end 2000 developing the knowledge and skills to manage a safer self sustaining life style.
- Number of children attending the other trainings offered. This increases throughout the project.

Sources of verification
- Project records

Sources of verification
- Project reports

Sources of verification
- Project records
<table>
<thead>
<tr>
<th>♦ Salvation Army clinic records</th>
<th>♦ Clinics’ records</th>
</tr>
</thead>
<tbody>
<tr>
<td>♦ Social worker reports</td>
<td>♦ Condom supply and distribution records</td>
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</table>

84
<table>
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<tr>
<th>Activities for component 5 Result 1</th>
<th>Activities for component 5 Result 2</th>
<th>Activities for component 5 Result 3</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Establish a residential refuge for female street youth offering crisis intervention and care for pregnant street girls.</td>
<td>□ In partnership with Salvation Army and CAS, provide health education and counselling on STIs, HIV/AIDS, reproductive health and common health problems for youth on the street.</td>
<td>□ Make available literacy training and demonstrations to street youth especially those associated with the refuge.</td>
<td>Atmosphere is such that street girls feel comfortable to use the refuge.</td>
</tr>
<tr>
<td>□ For street girls visiting or residing at the refuge, in collaboration with Salvation Army, ensure pre and post natal medical care is provided including immunisation and management of common conditions. Establish a working referral system to next level of health care.</td>
<td>□ Establish convenient access to health services and supplies for street youth, poor women and their babies working with Salvation Army nurses and CAS Health Kiosks. This includes outreach immunisation.</td>
<td>□ For girls in the refuge and others identified by the social workers, offer informal vocational training and sponsored formal vocational training.</td>
<td>Working relationship with CAS, CENCOSAD and Salvation Army is good and maintained.</td>
</tr>
<tr>
<td>□ Analyse available data on street girls, their life stories and future perspectives to better understand their needs and risks in their lives for planning purposes.</td>
<td>□ Set up a system of supply and convenient access to condoms.</td>
<td>□ Provide advice and, where possible, support for establishing income generating projects.</td>
<td>Referral hospital and formal training institutions collaborate.</td>
</tr>
<tr>
<td>□ Where possible, attempt to re-integrate youth into their family structures.</td>
<td>□ Supply adequate quantity of appropriate IEC materials.</td>
<td></td>
<td>IEC materials are available or can easily be produced.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Means</th>
<th>Means</th>
<th>Means</th>
<th>Assumptions</th>
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<td>Costs</td>
<td>Costs</td>
<td>Costs</td>
<td>Atmosphere is such that street girls feel comfortable to use the refuge.</td>
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<td>Working relationship with CAS, CENCOSAD and Salvation Army is good and maintained.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Referral hospital and formal training institutions collaborate.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>IEC materials are available or can easily be produced.</td>
</tr>
</tbody>
</table>
ANNEX 3 DOCUMENTS CONSULTED:


5. Factors contributing to teenage pregnancy and school drop out among adolescents in Adansi West District, Ghana. Dec 1995


16. Results from a baseline survey on STD/AIDS for in and out of school youth in the Northern and Upper East Regions John K. Anarfi and Lawrence A. Knanne.


19. Female Sex Worker HIV Prevention Projects, UNAIDS Case Study, November 2000. (UNAIDS (b))

ANNEX 3  LIST OF PEOPLE MET

SANDEMA PEER EDUCATORS AND DISTRICT YOUTH ORGANIZERS

1. Rebecca Ayukorok - ADYO
2. Hafiisu Hamidu - P.E.
3. Anyeana Vitus - P.E.
4. Amadu Iddrisu Seimu - P.E
5. Alhassan Ayanu - P.E
6. Moses A. Achumboro - DYO
7. Anyogbire Benjamin - P.E
8. Aengpoe Albert - P.E
9. Akanpoi Regina - P.E
10. Abodeem Mavis - P.E
11. Matilda Akundare - P.E
12. Akaba Bridget - P.E
13. Nsoh Faustina - P.E
15. Wilberforce Atekiya - P.E
16. Gabriel Anaba - P.E

BOLGA

1. Abonaba Ignatius
2. Ali Memuna
3. Nsoh Timothy
4. Yusuf Ahmed Agama
5. Mohammed Zobeiru Rufai
6. Atude Peter
7. Asunnaya Abu Solomon
8. Adongo Napoka Ophelia
9. Bukom Doe Monica
10. Aviisah Philomena
11. Grace Dedo
12. Joel Agorinya
13. Peter Ayukah
14. Jahiru Humu
15. Badii Regina
16. Baba Starling
17. Gilbert Agama (DYO)
18. Adam Memunatu
19. Gladys Adugbire (A.D.Y.O.)
20. Anthony Awiah D.O.
BONGO DISTRICT

1. Akom Solomon
2. Akaribo Cletus
3. Aloyale Francis
4. Akanmdim Joseph
5. Ernest A. Afari
6. Ayimayimah Kenneth
7. Asingbe Peter
8. Gabriel Ayamya
9. Afibila Williams
10. Giba Dorothy
11. Akom Victor Atambila
12. Debra (Avonbano) Kurshan, Peace Corps
13. Ayampa Alexis ADYO
14. Ananga Charity D.Y.O.

IN SCHOOL PEER EDUCATORS YENDI SECONDARY SCHOOL

1. Salifu Y. Fulera
2. Abdulai Taihatu
3. Abdulai K. Kojo
4. Mohammed Sikena
5. Sadik Shai Zuwera
6. Jumah Thomas

Yendi Senior Secondary Schools; all were educators before entering the school
### NORTHERN REGION & UPPER EAST REGIONS
#### DISTRICT YOUTH AND ASSISTANT DISTRICT YOUTH ORGANISERS

<table>
<thead>
<tr>
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<td>1</td>
<td>Chilala Osman</td>
<td>Bawku</td>
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<td>2</td>
<td>Abdull-Rahman S. Fuseni</td>
<td>Yendi</td>
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<td>3</td>
<td>Osman Issakahu</td>
<td>Yendi</td>
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<tr>
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<td>Montana Adam</td>
<td>Damongo</td>
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<td>Damongo</td>
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<td>6</td>
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<td>7</td>
<td>Braimah I. Alhassan</td>
<td>Bimbilla</td>
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<td>8</td>
<td>Tindana Dorurugu</td>
<td>Bimbilla</td>
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<td>Abik D. Kombian</td>
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<td>Avuyem Florence</td>
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<td>Gabriel Anaba</td>
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<td>Martha Akwegre</td>
<td>Novrongo</td>
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<td>Issah Ibrahim</td>
<td>Bolga</td>
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<td>Gilbert Agana</td>
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<td>18</td>
<td>Atugba Agamba</td>
<td>Walewale</td>
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<td>19</td>
<td>Alhassan Asaana</td>
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<td>Abdul-Rahman Yussif</td>
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<td>22</td>
<td>Alhassan Husein</td>
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<td>Bugri Sophia</td>
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<td>24</td>
<td>Ali Dawuo Nadia</td>
<td>Tamale</td>
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<tr>
<td>25</td>
<td>Imoro Mohammed Polo</td>
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</tr>
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<td>26</td>
<td>Jacob Ndego</td>
<td>Tamale</td>
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</tbody>
</table>

### YENDI SENIOR SECONDARY SCHOOL

Mr. A.B. Cockra Hussein  
Mr. Thomas Jumas  
Abdulai K. Kojo  
Amidu Seidu Musah  
Bernard K. Ofori  
Isahaku M. Shanni  
Awolu Zakaria  
Muhammed Koji Amino  
Alhassan Husein  
Ibrahim Zakari Buaery  
Alhassan Ganiyu  
Joseph Kojo Awuni  
Sulemana Fusheini  

Assistant Headmaster  
Peer Educator  
Peer Educator  
Target Group  
Target Group  
Target Group  
Target Group  
Target Group  
Target Group  
Target Group  
Target Group
<table>
<thead>
<tr>
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<th>YEAR JOINED</th>
<th>PROGRAMME</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Abdul-Rahamani S. Fushein DYO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Osman Issahaku T.O.T.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Abdulai A. Budalli P.E.</td>
<td>April 2000</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Alhassan I. Bawa P.E.</td>
<td>April, 2000</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Inusah Iddrisu P.E.</td>
<td>October 2000</td>
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<td>8.</td>
<td>Issah Mohammed Amin P.E.</td>
<td>January 2001</td>
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<tr>
<td>10.</td>
<td>Abdulai Abukari P.E.</td>
<td>1998</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Alhassan Adam P.E.</td>
<td>April 2000</td>
<td></td>
</tr>
</tbody>
</table>
## ANNEX 5  PEER EDUCATION ACTIVITY REPORT

### PRETEST QUESTIONS

District:……………….Region …………….: Number of participants…………..

Venue of meeting:..........Month: ............Year:.................................

NB: The questions below must be answered before the START of the first meeting with a new target group.

Target group: (underline one)   1) In school – Males  2) In school – Females  
3) Out of school – Males  4) Out of School – Females

<table>
<thead>
<tr>
<th>Question</th>
<th>Response (Number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Mention the main mode of the spread of HIV (indicate only the number of participants who mentioned sexual intercourse)</td>
<td></td>
</tr>
<tr>
<td>2 In order to preference, show how you can protect yourself from the AIDS virus. (Let 1 = first choice, 2 = second choice and 3 = third choice.)</td>
<td>Abstinence</td>
</tr>
<tr>
<td></td>
<td>Faithfulness</td>
</tr>
<tr>
<td></td>
<td>Condom</td>
</tr>
<tr>
<td>3 Do you believe you are at risk of catching the AIDS Virus?</td>
<td></td>
</tr>
<tr>
<td>4 As an unmarried person, would you always use condom when you have sexual intercourse.</td>
<td></td>
</tr>
<tr>
<td>5 How many participants are able to demonstrate correct condom use.</td>
<td></td>
</tr>
<tr>
<td>6 What should be done for PLWHA (Let 1 = first choice, 1 = second choice and 3=third choice)</td>
<td>Kill</td>
</tr>
<tr>
<td></td>
<td>Imprisoned</td>
</tr>
<tr>
<td></td>
<td>Loved</td>
</tr>
<tr>
<td>Parents/Community members</td>
<td></td>
</tr>
<tr>
<td>7 What do you think about the HIV/AIDS peer education Project</td>
<td>Must stop</td>
</tr>
<tr>
<td></td>
<td>Must continue</td>
</tr>
</tbody>
</table>

Date:………………………….  
Name of Peer educator(s):

Please check that you have fully completed the form and your completed form to your District or Assistant District Youth Organiser not more than two days after the education session.
**PEER EDUCATION ACTIVITY REPORT**

**HIV/AIDS PREVENTION PROJECT**

**PRETEST QUESTIONS**

District:………………..Region ……………..: Number of participants……………….

Venue of meeting:………..Month: …………..Year:……………………………….

NB: The questions below must be answered before the START of the first meeting with a new target group.

Target group: (underline one)   1)  In school – Males  2) In school – Females  
3)  Out of school – Males  4) Out of School – Females

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<td><strong>Parents/Community members</strong></td>
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<td>Must stop</td>
</tr>
<tr>
<td></td>
<td>Must continue</td>
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</tbody>
</table>

Date:………………………….  
Name of Peer educator(s):………………………………..  
………………………………..  
………………………………..  
………………………………..

Please check that you have fully completed the form and your completed form to your District or Assistant District Youth Organiser not more than two days after the education session.
NAME OF GROUP: ........................................................................................................

ACTUAL LOCATION OF GROUP: .............................................................................

DAY OF MEETING ........................................................................................................

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Name of Peer Educators

1. .................................................................

2. .................................................................

Date:.........................................................