# Community perceptions of *Youth to Youth in Health*: a peer education program for primary health care, Marshall Islands

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## Abstract

In the mid-1980s, the Republic of the Marshall Islands (RMI) reported an annual population growth rate of over 4 %. With 70 % of the nation's population 25 years of age and under, the Youth to Youth in Health (YTYIH) program was established in 1986 to involve young people in family planning and health promotion. Toward this end, YTYIH trains volunteer peer educators to present family planning messages using traditional Marshallese language and song, to provide confidential counselling, and to involve themselves in general community development activities. In a 1994 assessment, community perceptions of YTYIH were gathered through key informant and focus groups interviews. Although the YTYIH program challenges traditional Marshallese norms about family size and sex roles, most informants were enthusiastic about YTYIH and perceived that its health education efforts have played an important role in raising individual and community awareness about health.

## Introduction

In 1986, a peer education program called *Youth to Youth in Health* was established in the Republic of the Marshall Islands (RMI). To examine the implementation experience and the perceptions of the effects of the program, an assessment was conducted in 1994. This article describes community perceptions of *Youth to Youth in Health* gathered through interviews with key informants and focus groups.

## Background

RMI is part of Micronesia. Prior to contact with the western world, the inhabitants of these islands lived sufficiently from the land and sea and developed distinct cultures and languages[1]. The population of the Marshall Islands began to decline in the mid-nineteenth century following contact with western civilisation and the introduction of measles, tuberculosis, dysentery, smallpox, influenza, and sexually transmitted diseases[2]. This decline stabilised in the 1930s and then reversed itself after World War II when the Marshall Islands became part of the US Trust Territory of the Pacific. The World Bank noted an annual growth rate of 4.35% between 1980 to 1988 (one of the world's highest) and a total fertility rate of 7.2 children in 1988[3]. As a result, the population has quadrupled in 70 years, increasing from 9,800 in 1920 to 43,380 in 1988; the median age is 14 years[4].

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Despite a relatively high per capita income ($US1,937 in fiscal year 1992), the health situation of the RMI is worse than that of countries with comparable average income[3]. The most common diseases faced by Marshallese adults are diabetes, heart disease, hypertension, and obesity. The nation faces increasing problems with sexually transmitted diseases (affecting 4% of the adult population in 1990), alcoholism, malnutrition (affecting 2.9% of children), and high infant mortality (63 per 1,000 live births). Aside from the cancers related to US nuclear testing[5], many of RMI's health problems could be alleviated through better preventive and primary care services. However, the bulk of the nation's healthcare budget is devoted to curative services[3,6].

While Majuro, the capital, and Kwajalein, a US military base, are connected by regular air routes with Honolulu and Guam, travel among the other atolls and islands is limited. Several islands have runways that accommodate 19-seater commuter planes, but many others can be reached only by freighter or boat. Internal migration is common, with a

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general trend of movement away from the outer islands to the district centers of Majuro and Ebeye (the island community where most of the Marshallese who work on Kwajalein reside)[4].

Observers of Micronesia have reported a growing list of youth-related problems, including increased incidence of mental disorders[7], alcoholism, cigarette, and drug use[8], and suicide among young men[1,9]. Other problems include high rates of STD, teen pregnancy (over 12% of births in 1989), and a growing percentage of children unable to be accommodated by the school system (about 10% of 6-13 year old children and 36% of 14-18 year old children)[3].

Social scientists agree that these problems are due in part to the rapid westernisation that started in the 1960s and a consequent disintegration of traditional family structures, values, and activities in Micronesia. In traditional Marshallese society, youth were involved in tasks associated with subsistence living. Activities broke down along gender lines, with children learning from same-sex members of their extended family and community. Discipline of adolescents was the responsibility of older, same-sex members of the village, not parents. With westernisation, responsibility for raising children has shifted from the extended family and village to the nuclear family. New roles and mechanisms for discipline among youth have not been developed nor, as noted by Rubinstein, is there a "cultural script... for easy relations between adolescent males and their parents... At the same time, post-war changes have fostered a set of adolescent values and demands that are quite different from those of their parents, and this has further sharpened the points of intergenerational tensions."

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With 70% of the population under age 25, the problems of youth become a major issue for the nation. Appropriate health services and health education programs for adolescents, however, are lacking, most likely due to an over-emphasis on hospital-based health care rather than prevention[10].

## Youth to Youth in Health (YTYIH)

The Youth to Youth in Health (YTYIH) program was established in 1986 under the auspices of the Division of Population and Family Planning of the RMI's Ministry of Health and Environment (MOHE). Its original mission was to get youth, aged 13 to 25 years, involved in helping to slow the staggering annual growth rate by providing health education and family planning counselling to all ages, but particularly to youth. A peer education approach was adapted as it has been shown to be effective in helping youth increase knowledge, improve health behaviours, and raise self-esteem[11-20].

The program has since expanded its mission to promote healthy behaviours in general, cultural pride, and youth leadership skills. Toward this end, youth are trained to 1) write and perform skits, songs, and drama that present health education messages using traditional Marshallese language, music, and dance; 2) provide group health education through schools; 3) provide confidential counselling to youth on issues of family planning and health; and 4) contribute to other health and development activities in their communities. The program admits that its peer-education activities conflict with a number of traditional norms by involving girls and boys in co-ed, rather than segregated activities; by allowing open discussion of sex and its consequences; and by placing youth in a teacher, rather than a learner, role.

In Majuro, YTYIH peer educators concentrate on outreach in school and community programs, counselling and referral. In 1993, demands from an even younger cohort led the program to invite youth ages 8 to 12 years to join in the outreach activities on Majuro. YTYIH began developing chapters at Outer Island sites in the 1990s; 15 such chapters are presently operating. At the Outer Island sites, peer educators are linked with the Health Assistants (locally trained health workers who staff the government-sponsored Outer Island Dispensaries) in their communities and work to supplement their efforts by providing outreach, conducting health education programs in the schools, assisting in the clinic (taking blood pressure, counselling, maintaining records, etc.), and helping develop the community-at-large, e.g., cultivating gardens. About 340 youth have completed the training since the program's inception in 1986.

The program has evolved organisationally, as well. In 1989, YTYIH incorporated as a non-profit, non-governmental organisation (NGO) and began receiving substantial grants from overseas churches and foundations enabling it to hire

full-time peer educators on staff. At the same time, the program maintains its connection with the MOHE. The director of YTYIH also directs the MOHE Division of Adolescent Health.

## Method

The 1994 assessment explored the implementation experience of the program, gathered community perceptions on the program, and helped the program develop tools to use in self-assessment in the future[21]. This paper reports on the results of key informant and focus group interviews used to obtain community perceptions.

Key informant surveys involved one-on-one interviews with individuals from government, churches, business, and the YTYIH program itself. For the most part, selection of specific key informants was based on the positions held by the individuals, e.g., the first author asked to meet with administrators and staff of specific government agencies and with business and church representatives knowledgeable about the program. These informants, in turn, identified other individuals who they thought would provide additional insights for the researcher. These interviews lasted 60 to 90 minutes, with the interviewer taking notes and verbatim quotes from the informants. Altogether, 15 individuals were involved in the key informant surveys.

Ten focus groups were also conducted, each involving between two and fourteen individuals grouped by segment of the population. Focus groups have been used successfully as qualitative tools in social research, allowing researchers to interview a number of people at the same time on their individual perceptions and to gauge the level of agreement among group members on specific issues[22-23]. The seven focus groups on Majuro were comprised of YTYIH staff, YTYIH active Majuro members (those who completed the peer educator training and are currently involved in the delivery of YTYIH services), YTYIH active Outer Island members (visiting Majuro for training), former YTYIH members (those who completed the peer educator training but are not currently involved in the delivery of YTYIH services), youth who were not members of YTYIH, parents of active YTYIH members, and parents of youth who were not members of YTYIH. To assess the Outer Island component of the program, the team conducted focus groups on Wotje, an atoll about 300 miles northwest of Majuro. The three focus groups on Wotje involved YTYIH active members, youth who were not members of YTYIH, and a group of parents. Altogether, 57 individuals participated in the focus groups.

A similar interview schedule was used in both the key informant surveys and the focus groups: 1) What do you see as the problems of youth in the Marshall Islands? 2) How well are programs addressing these problems? 3) What are your perceptions of YTYIH regarding its activities, strengths, and impact? and 4) How can YTYIH be improved? Both types of interviews were transcribed. Ethnograph, a program for the computer-assisted analysis of text-based data, was used to categorise and count the responses[24].

Qualitative methods were used because our pretest experience suggested that our target population was unfamiliar with written surveys and found them intimidating. Although most of the nation's reading and writing is done in English, the level of comprehension of written English is uneven. Translating surveys to Marshallese did not help as Marshallese is an oral language with no standardised spelling. Thus, we chose to gather data through individual and group interviews.

## Results

This section gives a summary of the findings, with illustrative quotes. Because responses from the key informants and the focus groups were quite similar, information is reported by "question" rather than by whether data were provided by a key informant or a focus group participant. Where meaningful, specific information is provided about the respondent (e.g., if the respondent were a parent or an MOHE official).

**" ... the problems of youth ... were primarily in the areas of health (including high rates of suicide, sexually transmitted diseases, and teen pregnancy) and boredom (school drop-out, unemployment even if they graduate, substance abuse, crime, and gang activity). "**

**Problems of Youth.** Many of the participants were quick to enumerate the problems of youth in the RMI. They were primarily in the areas of health (including high rates of suicide, sexually transmitted diseases, and teen pregnancy) and boredom (school drop-out, unemployment even if they graduate, substance abuse, crime, and gang activity). These perceptions did not differ among participants (i.e., youth, parents, MOHE officials, etc. provided similar answers to this question) and are consistent with government health statistics and reports by external agencies.

**Programs for Youth.** A number of youth groups and activities were identified. Most participants felt, however, that these groups were too limited to have an impact on the problems of young people. For example, there are not enough schools to accommodate the nation's youth, so many do not attend or drop-out before completing high school. Sports groups exist but are limited in facilities, equipment, and coaches. Church groups are popular but

respondents noted that they usually met only once a week and were usually not involved in activities that had a broad community impact. Again, there was a high degree of sameness in answers to this question regardless of category of respondent.

**Perceptions of YTYIH.** The majority of the respondents had a high opinion of YTYIH, even the 23 focus group participants who were not affiliated with the program in any way. Program strengths fell into three general categories: 1) benefits accrued to youth who become peer educators; 2) the impact of YTYIH on raising awareness about health in the community; and 3) benefits to Outer Islands with YTYIH chapters.

Respondents reported significant benefits to youth who completed the training and joined the program. These benefits included increased knowledge about health, expanded skills, increased confidence and purpose, and improved health behaviours, e.g. quitting drinking and/or smoking. Parents, in particular, expressed pride in their children's performance during outreach programs. An informant from the Ministry of Health and Environment said "I appreciate the program's capacity to interest youth in health and prompt them to pursue further education and health careers. I see YTYIH members as tomorrow's health leaders and I seek them out as employees." A representative of the church noted that YTYIH members were more successful than other youths and work to improve themselves. He said that other youths looked look up to YTYIH members.

Informants from the private sector noted that YTYIH helped get kids active and involved. Examples of their comments included:

"YTYIH is a positive organisation for young people. It shows young people that they can do something; the program counters what I call the *'majok'* (I'm afraid) syndrome of the Marshall Islands. The *'majok'* syndrome is counterproductive and leads to suicide among youth. YTYIH is a step in the right direction. Kids get practice expressing themselves and being leaders. Members become good role models for other kids. The program showcases the best parts of both (Marshallese and Western) cultures."

"Right now, YTYIH doesn't reach enough people. But even if they only impact the top 2-3% of youth, these are our future leaders for the Marshall Islands. YTYIH helps these youth deal with changes and think about the future, not just live for today."

Respondents felt that peer education was an effective means of reaching and communicating with youth. Parents of participants and non participants alike reported that, due to YTYIH, community awareness of health has been raised. Parents said:

"If we really listen to the words of the songs about health, then you can learn something. Even my granddaughter sings about condoms, pills, IUD, and Norplant."

"My daughter comes home and shares health messages with us. She told me to get more exercise!"

Several informants felt that YTYIH played a significant role in the 41% decline from 1988 and 1992 in the nation's fertility rate noted by the WHO consultant in 1993[25]. A government official felt that YTYIH's messages about family planning were having an impact and felt that they had helped lower the birth rate (although she admitted to problems with under-reporting of births).

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YTYIH's Outer Island program is somewhat different from the Majuro program in that YTYIH members there are affiliated with Health Assistants and are more likely to be involved in community development projects such as gardening. Parents also liked the fact that YTYIH helped keep their children from migrating to the district centers. An MOHE official reported:

"Their Outer Island outreach is excellent, especially going to where the young people are and where we can reach them. Then it will spread to the other islands and within a short time it will reach all the young people in the Marshall Islands. Taking the video (to record YTYIH programs) to the Outer Island is also very effective."

On Wotje, the chair of the local council said:

"The (Wotje) Council has had an ordinance for many years against drinking but it was not enforced. When YTYIH came, the amount of drinking here decreased because of the YTYIH rules. These rules affected members, but also non-members. The Council has a lot of respect for YTYIH because they are making a serious contribution to the island. It is also good because it helps keep our children on Wotje."

**Perceptions of the Program's Weaknesses.** The major weakness of the program noted by the focus group members and key informants was its lack of resources. In Majuro, respondents felt that YTYIH needed to conduct more outreach, provide more services in the schools, and increase access to counselling. Youth, parents, and community leaders mentioned a need for a Youth Health Center in the downtown area. They felt that youth were reluctant to seek family planning and counselling services at Majuro Hospital. They

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**" It is the malady of our age that the young are so busy teaching that they have no time left to learn. "**

*Eric Hoffer (1902)*