SRHR alliance

# Effectiveness of community based strategies / models in increasing the uptake of SRH service among young people in Uganda

Final Report

Rutgers For sexual and reproductive health and rights · amref flying doctors · choice. FOR YOUTH & SEXUALITY · dance 4 life start dancing stop aids · IPPF International Planned Parenthood Federation · Simavi Basic health for all. · STOP AIDS NOW!

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*The Access, Services and Knowledge (ASK) programme is a three-year programme (from 2013 to 2015) funded by the Dutch Ministry of Foreign Affairs with the aim of improving the SRHR of young people (10 – 24 yrs.), including underserved groups. The programme which is a joint effort of eight organizations comprising of Rutgers (lead), Simavi, Amref Flying Doctors, CHOICE for Youth and Sexuality, dance4life, Stop AIDS Now!, the International Planned Parenthood Federation (IPPF), and Child Helpline International (CHI) is implemented in 7 countries, namely Ethiopia, Ghana, Indonesia, Kenya, Pakistan, Senegal, and Uganda. Operations research (OR) was identified as an integral part of activities in the ASK programme. The aim was to enhance the performance of the program, improve outcomes, assess feasibility of new strategies and/or assess or improve the programme Theory of Change.*

# Contents

**List of acronyms**

| | |
|---|---|
| AIDS | Acquired Immune-Deficiency Syndrome |
| AOR | Adjusted Odds Ratio |
| ASK | Access Services and Knowledge |
| FLEP | Family Life Education Program |
| HCT | Human Immuno-deficiency Virus Testing and Counseling |
| HIV | Human Immuno-deficiency Virus |
| OR | Odds Ration |
| RHU | Reproductive health Uganda |
| SRHR | Sexual Reproductive Health Rights |
| SRHS | Sexual Reproductive Health Services |
| STI | Sexually Transmitted Infection |
| UDHS | Uganda Demographic Health Survey |
| UNCST | Uganda National Council for Science and Technology (UNCST) |
| VHTs | Village health Teams |

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## Executive summary

The operational research was conducted to assess the effectiveness of the peer education and village health teams (VHTs) models in increasing the uptake of Sexual and Reproductive Health (SRHR) services among young people in Uganda. The two models have been adopted in the implementation of the access, services knowledge (ASK) project implemented by Reproductive Health Uganda (RHU) and Family Life Education Program (FLEP). The main objectives of the study were to: (1) ascertain whether peer education increases the uptake of SRHR services among young people; (2) ascertain whether peer education increases contraceptive use among young people; (3) ascertain whether VHTs increase the uptake of SRHR services among young people and; (4) ascertain whether VHTs increase contraceptive use among young people. The study also aimed at establishing whether the models led to increased SRHR knowledge, confidence and attitude among young people.

A quasi-experimental study design was employed targeting young people aged 10-24 years, selected from both intervention and comparison communities. The intervention communities were those where the project had trained and resident peer educators or VHTs. The comparison communities on the other hand did not have project trained peer educators or VHTs. Both intervention and comparison communities selected had no known related intervention.

One-one interviews were conducted in the local languages by young people using a structured questionnaire. A total of 368 respondents; 176 in the intervention and 192 in the comparison were interviewed for the peer education communities, while a total of 411 respondents; 207 in the intervention and 204 in the comparison were interviewed for the VHT communities.

Data was entered using EPIDATA software and later exported to SPSS for analysis. Bivariate (Chi square, T-test), and multivariate analysis (logistic regression) were conducted to compare how much more likely (or unlikely) the expected outcome was present among the exposed and unexposed group.

Our findings show that there was a statistically significant difference between those exposed to peer educators and those unexposed in relation to visiting a health facility for SRHR services. Young people exposed to Peer Educators were more likely to seek SRHR services compared to those in the comparison group; (aOR 1.6; p= 0.028). This means that there is an association between exposure to peer education and use of SRHR services. Young people exposed to peer educators were, in particular, more likely to seek HCT compared to their unexposed peers (aOR=1.9, p=0.006). However, the findings also show that

there was no difference between comparison and intervention with regard to the frequency of visiting the health facility (p = 0.512). This means that although peer education is associated with use of services, it is not associated with a higher number of visits.

In relation to use of contraceptives, we found that although peer educators were reported as important providers of contraceptives to young people (42.4% of young people received contraceptives through peer educators), they were not necessarily found to influence the actual use of contraceptives among young people (p= 0.512) We further found that there were no differences between young people in the intervention and comparison groups in relation to confidence in managing their sexuality, attitudes, and SRHR knowledge.

Regarding VHTs, our results did not suggest any difference in the uptake of services between young people exposed to VHTs and those that were unexposed (aOR 1.3, p= 0.264). This means that, two months into the intervention, exposure to VHTs does not necessarily lead to use of SRHR services among young people. The VHTs were also not found to be important providers of contraceptives to young people (13.5% of young people received contraceptives through VHTs) and were not found to have an influence on the use of contraceptive (p =0.264). However, we did find that young people exposed to VHTs were more likely to know different contraceptives; (aOR=4.8, P=0.04) and had a higher confidence in managing their sexuality compared to those in the comparison; (aOR=1.8, p=0.020).

Based on the above findings, we therefore conclude that only two months into the intervention, peer educators increased the uptake of SRHR services among young people, but did not lead to increased use of contraceptives. In addition, we did not find that VHTs increased uptake of SRHR services among young people; or increased the use of contraceptives. A clear limitation that needs to be considered is that this study was conducted only two months after the interventions were implemented. To detect changes in behaviour, research with a longer follow-up is highly recommended.

In addition, several programmatic recommendations can be made:

- Strengthen the peer education model through committing more resources especially to training of more peer educators and conducting refresher training for those that are already trained. Strengthening should also involve availing resource materials to peer educators so that they can ably guide and empower young people to seek services.

- Promote “peerness” among VHTs by recruiting and training more young people as VHTs. These should also be trained in “youth friendliness” to enable them to effectively work with young people.

# CHAPTER ONE:

# Introduction

## 1.0 Background and Rationale of the study

The 2002 Population and Housing Census show that 70% of the Ugandan population structure is below 24 years of age, and that one in every four Ugandans (25%) is an adolescent, and one in every three Ugandans (34%) are young people. These proportions were more likely to increase and the increase in the numbers of young people points to the potential to contribute positively to the socio-economic and political development of the country. However, if not well directed it can lead to consequences that may be harmful to the health status of the entire population.

In Uganda, young people are vulnerable to diverse health challenges by virtue of their level of activity, willingness to take risks, and limited information. These include reproductive health problems such as STIs/HIV/AIDS, early or unwanted pregnancy, unsafe abortion, and psychosocial problems such as substance abuse, delinquency, truancy, sexual abuse etc. Factors that predispose them to vulnerability include economic issues such as poverty, over dependence on adults, or lack of employment opportunities.

According to the UDHS 20011, teenage pregnancy rate was estimated at 25%. By the age of 16, 20 % of females have had sexual intercourse. Despite early onset of sexual intercourse among young people, contraceptive use is low. This sometimes leads to unplanned/unwanted pregnancies, unsafe abortions and related complications sometimes resulting into disproportionately high maternal mortality and morbidity. Maternal mortality is 2 to 5 times higher for the under 18 compared to older women. Utilization of antenatal, delivery and postnatal care service by young people is poorer than in the adult group and yet they are at a greater risk of obstetric complications. Children born to young people are generally prone to higher morbidity and mortality due to poor prenatal and improper childcare practices (Infant mortality among adolescent mothers in Uganda is 105/1000 live births compared to a national average of 77/1000 live births).

The Uganda HIV Sero-prevalence and behavioural survey of 2004/5 estimated that HIV prevalence among men and women aged 15-24 years is 4.9%. Fifty percent (50 %) or more of all HIV/AIDS cases occur in the ages 15-24 years[1].

[1] Uganda HIV Sero-prevalence and Behavioural Survey, 2004/2005

After 15 years of age there is a sharp rise in HIV/AIDS prevalence indicating that there is early sex and infection in this age group.

Evidence suggests that substance abuse is common in Uganda and is on the increase in most parts of the country (Annan & Brier, 2010). The most commonly abused substances are tobacco and alcohol. The use of narcotic (hard) drugs is on the increase as reported in some print media. Studies elsewhere have documented the close relationship between drug abuse, crime, violence and risky sexual behaviour with consequences of unwanted pregnancies, STI's and HIV/AIDS.

In response to aforementioned and with the aim to mitigate the enormous challenges and problems experienced by young people as in Uganda, a number of organizations including: Reproductive Health Uganda (RHU) and Family Life Empowerment program (FLEP) with support from WPF Rutgers and Simavi are implementing interventions that target young people. The implemented interventions employ diverse models to reach young people with information and services. The key models employed include but not limited to: use of peer education, engagement of Village Health Teams (VHT) to sensitize, mobilize and distribute SRHR commodities like condoms and contraceptives among others.

## 1.2 Description of the community models

### 1.2.1 Peer education model

Peer Education model as adopted by FLEP involves recruitment of young people that were comprehensively trained in BCC for SRHR and service delivery and qualified as Youth Peer Educators (YPEs). The overall aim was to have YPEs engage fellow young people in dialogue about SRHR to influence behaviour change through modifying their SRHR knowledge, attitudes and beliefs. To achieve this, the project put in place a network of YPEs (10 per community; 5 females and 5 males) who conduct regular demand generation activities for SRH/HIV&AIDS services, dispense reproductive health commodities including male/female condoms and oral contraceptive pills to peers, and conduct referrals or linkages for both SRH/HIV&AIDS and wraparound services to peers. In other words, peer education by FLEP combines BCC, SRH/HIV & AIDS services demand creation and provision of services. The peer education model adopts two approaches to SRHR service delivery for young people, and these are:

**Integrated service delivery approach:** this integrates SRH/HIV&AIDS services into general service delivery plan at health facilities. The approach has

health facilities that run "youth clinic days" specifically targeting young people, while other facilities have "youth corners" where young people access SRH/HIV&AIDS information and services of their choice any day in the week.

**The outreach approach:** this approach involves taking services closer to young people i.e. finding them in their communities. Here, a team of health workers from FLEP in collaboration with those from the nearest health facility move to the community and provide community based SRH/HIV &AIDS services at a site agreed upon with the YPEs in consultation with young people. The outreaches are conducted on a weekly basis but alternating on different outreach sites, and they attract substantial numbers of young people because young people do not have to spend on transport to the distant health facilities. The outreaches are conducted in all the intervention sites included in this study.

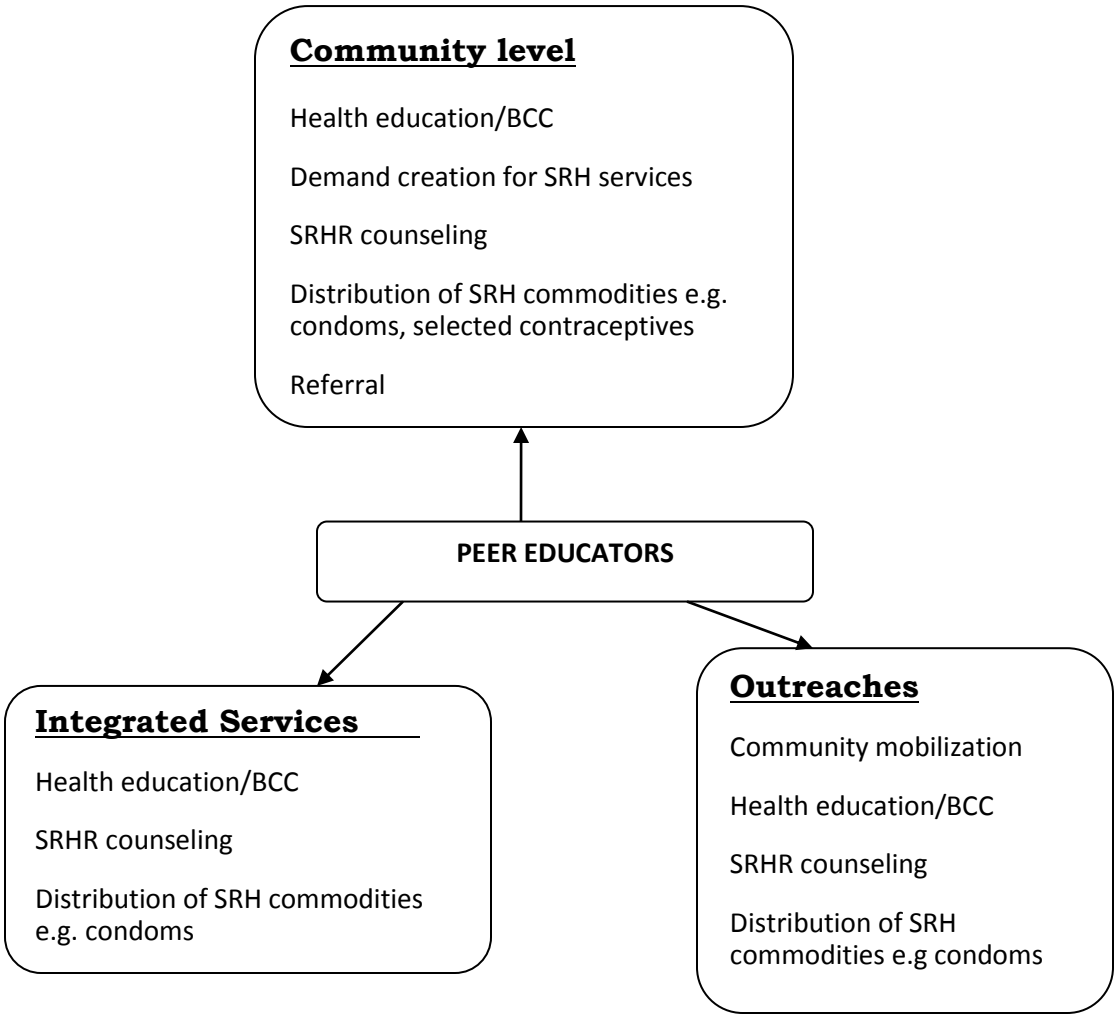
Prior to an outreach, a multimedia community mobilization campaign is conducted to inform young people on the date and venue an outreach. Mobilization involves YPEs conducting household visits to eligible peers to initiate SRH/HIV&AIDS discussions, group talk discussions and community dialogue sessions on SRH/HIV&AIDS among others. Mobilization further utilizes the existing community radios as well as existing structures including religious and local leaders.

During outreaches, young people are able to receive comprehensive SRHR information, medical services, commodities and referral/linkage services. FLEP refers to this as a "*Four Tent*" model; 1st tent is where SRHR information is provided, 2nd tent is where medical/health services is provided/received, 3rd tent is where SRHR commodities such as condoms, contraceptives are provided and 4th tent is where referral/linkage services or information is provided to young people that require services that cannot be provided on site or by FLEP.

At each of the four tents, young people are provided with a youth friendly environment that allows them to interactively engage with Peer Educators and providers in a friendly manner. It is through these interactions that young people make their SRHR decisions such as whether to test for HIV, STI or opt for a contraceptive among others.

Overall, the outreaches are preferred by young people based on the high turn up of young people seeking SRHR services that is always experienced whenever an outreach is conducted.

Flow chart showing activities of peer educators




### 1.2.2 The Village Health Team (VHT) model

In 2009, the WHO called for emphasis on community-based approaches to improving the health of populations (WHO, 2009), particularly in resource constrained communities where such approaches help bridge the formal health systems and communities (WHO, 2006). Much research suggests that health interventions that place community based approaches such as community health workers at the fore achieve better health outcomes. Therefore, the VHT model falls under the broader framework of community health workers. The VHT concept was introduced in Uganda in 20081 as part of the implementing strategy of the 2001/2006 Health Strategic Plan, although it was not rolled out

in most part of the country until 2007. The VHT are the primary village-level health contact, the equivalent of a low-level health center.

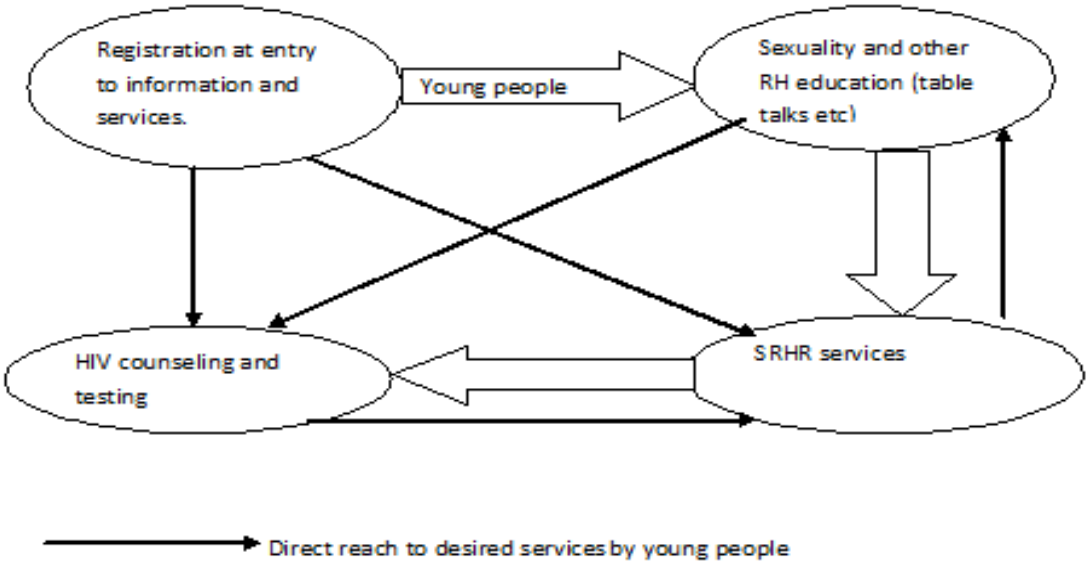
Because of their existence in the communities, a number of organizations including RHU have engaged them to reach out to community members. Under the ASK project, RHU with assistance of community leaders identified VHT members that were still in the young people age group. They also recruited other young people that were added to the existing young VHTs. All the selected were trained in SRHR in delivery of information and communication skills and commodity distribution and selected contraceptive method administration.

Using a community based model of integrated information and services, VHTs conduct SRHR education sessions, counseling for young people, commodity distribution of condoms, and contraceptives including administration of injectable among others. They further refer young people for different SRHR services to designated facilities providing youth friendly services.

The VHT model emphasizes provision of community based services through outreaches that are conducted in partnership with public health facilities or by RHU district based clinics. The outreaches are conducted on a daily basis with the aim of taking SRHR services to young people in their communities. Decision on the outreach site is derived at during the monthly planning meetings between RHU, health facilities and VHTs. The decision making is guided by data collected by the VHTs.

The model ensures that young people decide on the nature of service to take based on the information provided by VHTs during health talks. These services include SRHR information, HCT and FP among others as summarized below;

**Model of integrated information and SRHR/HIV services delivery targeting young People.**




From the above flow chart, upon arrival at an outreach sites, a young person can decide to begin with any of the SRHR services s/he desired to take since the service delivery process in not linear.

### 1.3 Problem statement

Overtime, the peer education model has been adopted by a number of agencies not only in Uganda but in other countries as well to reach young people and other population groups with information and services. Like other agencies, FLEP adopted the same model to reach young people with information, counseling and services with the aim of increasing the uptake of SRHR services among this age group.

RHU on the other hand adopted the use of VHTs to reach young people with SRHR information, counseling and services with aim of increasing access to information and services.

All these were done on the premise that equipped with the correct SRHR information integrated with service provision; there will be an access to SRHR services and therefore an improvement in the SRHR of young people in Uganda.

While the two partners have adopted the models for the last one year and will use the same models for the next two years of the project life, little is known whether these models are effective in increasing the uptake of SRHR services. It

is upon this background therefore, that an operational research was initiated to understand whether these models work in increasing the uptake of services.

### 1.4 Study objectives

I. To ascertain whether peer education increases the uptake of SRHR services among young people.

II. To ascertain whether peer education increases contraceptive use among young people.

III. To ascertain whether VHTs increase the uptake of SRHR services among young people.

IV. To ascertain whether VHTs increase contraceptive use among young people.

Besides the above primary objectives, the study also aimed to establish the differences in current SRHR knowledge, confidence, attitude among young people exposed to peer education or VHTs models and those that were not exposed.

### 1.5 Justification of the study

This was an operational research designed to generate evidence on the effectiveness of the models that are currently employed by the ASK project implementing partners. The findings of the study were to inform subsequent programming by gaining knowledge on what works and what does not work. Based on this evidence therefore, we would be able to know what should be replicated or avoided. In general, the research aimed at providing evidence based SRHR programming not only in Uganda, but also in other countries with a similar context.

## CHAPTER TWO:

## Methods

### 2.1 Study design

This was a quasi-experimental (intervention and comparison) study that took an implementation approach. It aimed at comparing the uptake of SRHR services among young people exposed to peer education with those not exposed. It also compared the uptake of SRHR services young people exposed to VHTs with those that were not exposed.

### 2.3 Study population

The study population were young people (10-24) in the four ASK project districts namely: Jinja, Tororo, Bugiri and Gulu. The four district were selected because this was where the two ASK project partners employing the model were implementing. RHU employed the VHT model in Tororo and Gulu, while FLEP employed the peer education model in Jinja and Bugiri.

The districts where RHU employs the VHT models share the same demographic characteristics. Both districts are rural based, with a population that shares same cultural background characterized by subsistence farmers as the major economic activity. On the other hand, the districts where FLEP employs the Peer Education model also share similar characteristics including same cultural background, language and economic activities dominated by subsistence farming. All the districts have almost the same population characteristics with young people in the age bracket 15-19 years constituting about 10% of the total district proportion (Uganda National Household Survey (2009/10).

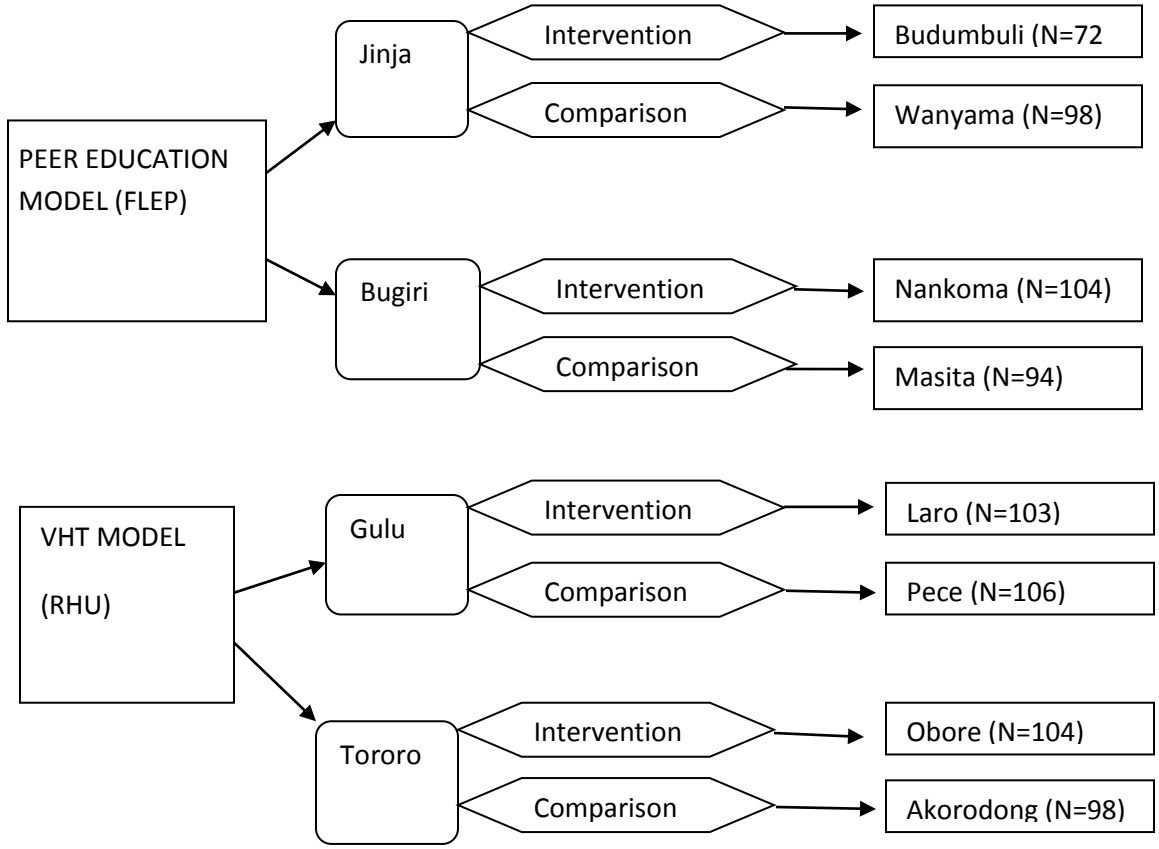
**Map of the study districts**


## 2.4 Study procedure

We selected two communities' (*cluster of villages comprising of two parishes*) in each of the two districts where the peer education model is being employed. One community per district is where FLEP is using peer education model and another community is where the model is not used. The two selected communities per district were within the vicinity of the same FLEP health facilities that provide youth friendly services. In other words, all the young people in the selected communities (intervention and comparison) had access to youth friendly services in the same health facility, and also access to outreaches conducted by FLEP. The only intervention the comparison communities did not have was peer educators. In total, we had two communities where peer education model was being employed and two communities where it was not employed.

We also selected two communities per two districts where RHU uses the VHT model and an equivalent number of communities where the model is not being used. The two communities selected per district were within the vicinity of the same RHU health facilities that provide youth friendly services, and also access to outreach sites. In other words, all the young people in the selected communities had access to youth friendly services in the same health facility and outreaches, although those in comparison communities did not have VHTs in their communities. In total, we had two communities where the model was being employed and two communities where it was not employed. The summary of the procedure is presented in the chart below.

**Summary of the study sites sampling**




We conducted a survey among a sample of young people in all the selected communities. The survey explored the current SRHR knowledge, attitudes and ASRH service seeking behavior. The survey was done in May/June 2014, after 6 months of implementation of the project. The aim was to find out if there are differences in current SRHR knowledge, attitude and uptake of SRHR services

among young people exposed to peer education or VHTs models and those that were not exposed.

## 2.6 Sampling

### 2.6.1 Sampling of communities

Sampling was done in close partnership with the implementing partners during a planning workshop. During this period, purposive sampling method was agreed to be adopted in the selection of communities. This aimed at ensuring that we select communities where there were active peer educators or VHTs that were already selected and trained by the respective partner implementers. We further ensured that intervention and the comparison communities shared common demographic characteristics like location, economic status and cultural background as earlier described in the selection of the study population. In all the intervention communities selected, there was an average of ten peer educators in each of the FLEP intervention communities sampled, and an equal number of VHTs in each of the RHU intervention communities selected.

We further ensured that there were no ongoing SRHR interventions that employed the same models assessed by this study. This was ensured by the implementing partners themselves who are on the ground and were therefore aware of communities that had or did not have related interventions. In this case, any community that was reported to have some intervention was reported by the implementing partner and therefore left out during the selection process. All this aimed at minimizing bias, and also explain any attribution that may arise during the analysis.

### 2.6.2 Sampling of respondents

A household listing for each community was done with the help of Peer Educators, VHTs and local leaders. The household listing generated a list of households in which it was known that there was a young person 10-24 irrespective of gender, schooling status or marital status. Upon completion of the household listing, systematic sampling method was employed to select households from where individual respondents were selected. In each household, as many as two eligible young people would be eligible for interviewing, as long as they were not of the same gender. Selection of more than one respondent would be randomly done by assigning numbers to the eligible respondents and then select only two for interview. Important to note

was that the household list in intervention had more females than males, and this partly explains why females formed a bigger part of the sample.

### 2.7 Sample size

The sample size was calculated using a web-based sample size calculator (http://www.surveysystem.com/sscalc.htm) as follows. We set the desired confidence level at 95% and the confidence interval at 5%. We further estimated the total population of young people in the two communities (intervention and comparison) per district was 400. Based on these parameters, the calculator gave sample size 196 young people per district. This was slightly increased to 200 young people per district to cater for possible none response rate.

### 2.8 Data collection

A structured questionnaire comprising of mainly closed ended questions was employed to collect data from young people. This was administered through one-on-one interview method. Interviewing was done by young people that were recruited from the implementing partners and trained by the study team. All the interviews were conducted in the local dialects of Lusoga, Luo or English.

### 2. 9 Data Management

All questionnaires were corrected for errors in the field. A computer file was created using EPIDATA version 3.02 to resemble the lay-out of the questionnaire to minimize errors by the data entry clerks. Data audits using frequency distributions and cross tabulation were performed to detect missing values and out-of range and illogical values. All the missing values were hence forth excluded in the analysis.

For data cleaning, range and consistency checks were run for each variable to identify inadmissible values. Data cleaning yielded a small number of unusable and out of range questionnaires, reducing the sample to 779 from 800 interviews translating into 97.3% percent of initial target.

### 2.9.1 Data analysis

Data was entered in the EPIDATA version 3.02 and exported to STATA 13 for analysis. Bivariate (Chi square, T-test), and multivariate analysis (logistic regression) were conducted to compare how much more likely (or unlikely) the expected outcome was present among those exposed to peer education or VHTs and those that were unexposed group.

## 2.10 Ethical approval and clearance

All the study materials; questionnaires and consent forms were approved by the Uganda National Council for Science and Technology (UNCST). The study protocol was also reviewed and approved by RHU and FLEP management. It was further reviewed and approved by Rutgers WPF that supports the project and the study.

Each respondent interviewed in the study provided written informed consent prior to commencement of the interview. Parental consent was also obtained for all respondents below 18 years, in addition to the young person himself/herself providing informed consent. The questionnaires and consent forms were stored separately in order to ensure no identifying information could be linked.

## 2.11 Quality comparison measures

We undertook a number of quality comparison measures including the following:

ASK project implementing partners were oriented on the study design and their roles clearly agreed to ensure the flow of the study. The partners' roles included; informing their staff about the study and the study procedure, and how the staff was involved in the study, selection of intervention and comparison communities, participation in the development of household listings, support to the lead researcher in identifying data collectors and provide the required information in time.

A team of 28 (7per district) Research Assistants (young people) that were knowledgeable in participatory research methods and conversant in the local dialect were recruited to collect data.

Research assistants underwent rigorous training that covered aspects such as: introduction to the study objectives, study methodology, research ethics as well as imparting skill/techniques through role playing/mock interviews.

All the data collection tools were translated in the local dialects (Lusoga and Luo and then back translated in English to ensure that we do not loose meaning during the translation process.

All tools were pre-tested to ensure their comprehensivity.

Research assistants were closely supervised through spot-checks and observation of the data collection processes.

## CHAPTER THREE

## Study findings on Peer education model

### 3.1 Introduction

The study findings presented in this chapter are divided into two main sections. In the first section, we present the demographic characteristics of study participants, the second part we present findings for the peer education model in relation to their effectiveness increasing uptake of services.

### 3.2 Socio-demographic characteristics of participants

The key demographic characteristics of the study participants presented in the tables below include age, gender, marital status and sexual activity of the young people studied. Tables 3.1 below give a summary of respondent's key demographic variables.

**Table 3.1: Socio demographic characteristics of the study participants**

| Variable | | Comparison | % | Intervention | % | P-value |
|---|---|---|---|---|---|---|
| | | n=192 | | n=176 | | |
| **Sex** | Boy | 111 | 57.8 | 71 | 40.3 | 0.001 |
| | Girl | 81 | 42.2 | 105 | 59.7 | |
| **Age** | 10-14years | 47 | 24.5 | 36 | 20.7 | 0.468 |
| | 15-19years | 79 | 41.2 | 68 | 39.1 | |
| | 20-24years | 66 | 34.4 | 70 | 40.2 | |
| **Marital status** | Never married | 152 | 79.2 | 128 | 72.7 | 0.266 |
| | Currently married | 38 | 19.8 | 45 | 25.6 | |
| | Divorced | 1 | 0.5 | 3 | 1.7 | |
| | Widowed | 1 | 0.5 | 0 | 0.0 | |
| **Ever had sexual intercourse** | No | 75 | 39.7 | 112 | 36.4 | 0.514 |
| | Yes | 114 | 60.3 | 189 | 63.6 | |

As shown in table 3.1 above, the study participants in the intervention and comparison shared almost similar demographic characteristics such as age, marital status and sexual activity. However, there were more females study participants in the intervention group; 59.7% vs 42.2% in comparison, while there were males in the comparison than the intervention; 57.8% vs 40.3%; p-value 0.001. The mean age of the respondents was 18.1 years, (sd; 3.607).

### 3.3 Effectiveness of Peer Education in increasing the uptake of SRHR services

The first objective of this study was to ascertain whether peer education increases the uptake of SRHR services among young people. In this section, therefore we present analysis of data based on peer education intervention program. We analysed this based on data collected from peer education communities. In our analysis, we compared outcomes i.e. utilisation of SRHR services and contraceptive use among participants exposed to Peer Education (intervention) with those not exposed (comparison). We also compared other intermediate outcomes including knowledge, attitude and confidence among participants exposed to Peer Education with those in the comparison group. This section therefore presents data based on young people's knowledge of SRHR, attitudes towards uptake of SRHR, confidence in managing own sexuality, uptake of SRHR services and contraceptive use.

#### 3.3.1 Utilisation of SRHR services by young people in peer education programs

To establish SRHR service utilisation, we asked participants whether they have visited a health facility to seek SRHR services in the previous 12 months preceding the study. The aim was to determine whether young people exposed to Peer Educators were more likely to seek SRHR services compared to those in the comparison group. In table 3.2 we present a summary of results based on analysis by comparing the intervention and the comparison group.

**Table 3.2: Young people who visited a health facility for SRHR services in the last 12 months**

| **In the previous 12 months, have you visited a health facility for services on reproductive and sexual health?** | | | | | | |
|---|---|---|---|---|---|---|
| | **Comparison** | | **Intervention** | | | |
| | **Frequency** | **%** | **Frequency** | **%** | **P-value** | **Adjusted P-value** [1] |
| **Yes** | 116 | 60.4 | 130 | 73.9 | 0.006 | 0.028 |
| **No** | 76 | 39.6 | 46 | 26.1 | | |

[1] Calculated with a multivariate logistic regression analysis which adjusts for gender

As presented in table 3.2 above, the findings show a statistically significant difference between the two groups in relation to visiting a health facility for SRHR services. The findings show that young people exposed to Peer Educators were more likely to seek SRHR services compared to those in the comparison group; (p-value=0.006). We further conducted multivariate analysis while controlling for gender since there were differences in gender between the samples. The results still show that there was still a significant difference in relation to seeking SRHR between young people in the intervention and comparison group. Young people in the intervention were more likely to seek SRHR services than those in the comparison group; (aOR 1.6; p-value 0.028). This means that there is an association between exposure to peer education and use of SRHR services.

We further asked those that have visited a health facility on the number of times they had visited in the previous 12 months. The aim was to establish and compare the frequency of visiting a health facility for services among both groups. The findings show that there was no difference between comparison and intervention when looking at the frequency of visiting the health facility (p-value = 0.512). This means that although peer education is associated with use of services, it is not associated with a higher number of visits.

### 3.3.2 Nature of services sought by young people

We further explored the nature of services sought by young people by asking them a question on the type of services accessed. Young people who visited a health facility mentioned a range of services that they sought. The findings show that the main SRHR services sought were HCT services, STI testing and treatment, obtaining condoms and health education. We further compared the

services sought by young people in both the intervention and comparison, and the findings are presented in table 3.3 below.

**Table 3.3: Nature of SRHR services sought by young people in the 12 months prior to the study**

| Type of SRHR service accessed [1] | Comparison | | Intervention | | | |
|---|---|---|---|---|---|---|
| | Frequency | % (yes) | Frequency | % (yes) | P-value | Adjusted p-value [1] |
| Pregnancy test | 27 | 14.1 | 35 | 20.1 | 0.123 | |
| HCT | 94 | 49.0 | 111 | 63.1 | 0.006 | 0.006 |
| STI screening | 40 | 20.8 | 46 | 27.1 | 0.165 | |
| Contraceptive | 14 | 7.3 | 18 | 10.5 | 0.278 | |
| Condoms | 19 | 9.9 | 21 | 12.6 | 0.421 | |
| Safe male circumcision | 8 | 4.2 | 8 | 4.8 | 0.785 | |
| Antenatal | 4 | 2.1 | 12 | 7.6 | 0.013 | 0.058 |
| PMTCT | 3 | 1.6 | 6 | 3.8 | 0.185 | |
| Post abortion | 3 | 1.6 | 6 | 3.4 | 0.245 | |
| Health education | 36 | 18.8 | 27 | 15.8 | 0.475 | |
| Counseling on sexual based violence | 6 | 3.1 | 7 | 4.0 | 0.658 | |
| Counseling on growing up | 12 | 6.3 | 20 | 11.5 | 0.076 | |

[1]Multiple responses allowed

[2] Calculated with a multivariate logistic regression analysis which adjusts for gender

It is evident from table 3.3 above that access to HCT and antenatal care services were significantly associated with the exposure to peer education with their p-values less than 0.05. However, other services were not significantly associated with the intervention since there p-values were greater than the statistical value of 0.05.

We further conducted multivariate analysis while controlling for gender since there were differences in gender between the samples. The results show that after adjusting for gender young people exposed to peer education were still more likely to seek HCT services compared to those in the comparison

(aOR=1.9, p=0.006). However, this was not the case when it comes to antenatal services..

### 3.3.3 Contraceptive use among young people

One of the key components of the ASK project is to increase access and use of contraceptives among young people. In this study, therefore, we explored whether peer education increases contraceptive use among young people. Our findings did not show any significant difference between young people in intervention and comparison group with regard to contraceptive use (p-value= 0.512). This means that the intervention has so far had no effect on the use of contraceptives among young people. We further sought to establish whether young people obtain contraceptives they were using from peer educators. We therefore asked those who reported to be using contraceptives where they get the contraceptives from and the findings as presented in table 3.4 below.

**Table 3.4: Where young people get contraceptive they are currently using**

| | **Comparison** | | **Intervention** | |
|---|---|---|---|---|
| **Currently using a contraceptive** | **Yes** | **%** | **Yes** | **%** |
| **Where do you get the contraceptive method you are currently using** | | | | |
| Healthfacility/Pharmacy/drug shop/VHTs | 55 | 84.6 | 38 | 57.6 |
| Peer educator | 10 | 15.4 | 28 | 42.4 |

The findings in table 3.4 show that majority of young people get contraceptives from other sources including health facilities/pharmacies/drug shops and not peer educators. However, it should be noted that 42.4% of the young people in the intervention group get contraceptives from peer educators implying that peer educators have a role in distributing contraceptives.

### 3.3.4 Young peoples' knowledge about SRHR

We asked participants some knowledge questions on SRHR and HIV with the aim of establishing their knowledge levels. We then analysed data for any differences in the knowledge among the intervention and comparison. The findings in table 3.5 below compare the knowledge levels between the two groups.

**Table 3.5: Knowledge on HIV and among young people**

| | Comparison | % | Intervention | % | P-value | Adjusted p-value |
|---|---|---|---|---|---|---|
| HIV can be prevented by correct and consistent use of a condom during sex | | | | | | |
| False | 18 | 9.4 | 34 | 19.3 | 0.006 | 0.867 [1] |
| True | 174 | 90.6 | 142 | 80.7 | | |
| It is possible for an HIV infected mother to pass on HIV to her baby during pregnancy, child birth or during breast feeding | | | | | | |
| False | 42 | 21.9 | 35 | 19.9 | 0.639 | |
| True | 150 | 78.1 | 141 | 80.1 | | |
| The risk of HIV transmission from mother to child can be reduced by a mother taking special drugs from a health facility during pregnancy | | | | | | |
| False | 30 | 15.7 | 32 | 18.2 | 0.527 | |
| True | 161 | 84.3 | 144 | 81.8 | | |

[1] Calculated with a multivariate logistic regression analysis which adjusts for gender

In table 3.5 above, it is clear that knowledge levels across the analysed variables did not significantly vary between young people in the intervention and comparison groups. Majority of young people in both groups appeared to have correct knowledge on HIV and AIDS. The only variations appeared on HIV prevention by correct and consistent condom use. Majority of young people in the comparison group 174(90.6%) said it was true that HIV can be prevented by correct and consistent use of condoms compared to 142(80.7%) of their counterparts in the intervention group p-value =0.006. However, we did not find any differences in a multivariate analysis after controlling for gender since the p value associated with the adjusted odds ratio (aOR= 0.9) was P=0.867.

### 3.3.5 Contraceptive knowledge

Young peoples' contraceptive knowledge was established by asking participants the contraceptive method they know (how it is looks and used). The responses

were categorised as "*spontaneous*", "*prompted*" or "*do not know*". We then analysed data for any differences in knowledge among the intervention and comparison. The findings in table 3.6 below therefore, compare the knowledge levels between the two groups.

**Table 3.6: Contraception methods spontaneously known by young people**

| Contraceptive method | Comparison | | Intervention | | |
|---|---|---|---|---|---|
| | Frequency | % (yes) | Frequency | % (yes) | P-value |
| Pill | 55 | 49.1 | 62 | 54.9 | 0.387 |
| Emergency contraception | 21 | 29.9 | 20 | 29.9 | 0.985 |
| Male condom | 131 | 79.4 | 104 | 75.4 | 0.402 |
| Female condom | 50 | 96.2 | 49 | 87.5 | 0.78 |
| IUD | 8 | 13.3 | 14 | 20.0 | 0.312 |
| Injectable / Depo-Provera | 26 | 33.3 | 22 | 27.8 | 0.456 |
| Foam tablets/ jelly/ cream | 1 | 1.9 | 2 | 3.4 | 0.623 |
| Norplant | 10 | 16.9 | 17 | 23.3 | 0.369 |
| Male sterilization | 5 | 8.5 | 3 | 4.7 | 0.395 |
| Female sterilization | 4 | 7.0 | 10 | 14.3 | 0.193 |
| Withdrawal | 51 | 52.0 | 55 | 54.5 | 0.733 |
| Calendar method/safe days | 63 | 58.9 | 58 | 55.8 | 0.648 |
| Tradition | 4 | 10.5 | 4 | 8.7 | 0.776 |

It is evident from table 3.6 above that there was no difference in knowledge on contraceptive methods among young people exposed to the peer education intervention with those in the comparison. The findings suggest that there is no association between exposures to peer education and spontaneous knowledge on contraceptives.

### 3.3.6 Young people' attitudes towards uptake of SRHR services

In order to understand attitudes of participants towards SRHR services, we asked some attitudinal questions that relate to seeking SRHR services. We then compared attitude responses of both young people in the intervention and comparison groups. Table 3.7 below gives a summary of the key attitudinal responses young people gave on key variables regarding contraceptive use to prevent pregnancy and seeking SRHR services.

**Table 3.7: SRHR attitudes among young people**

| | Comparison | % | Intervention | % | P-value | Adjusted P-value |
|---|---|---|---|---|---|---|
| Young people like you should be allowed to use contraceptives to prevent unplanned pregnancy | | | | | | |
| Agree | 162 | 84.4 | 138 | 79.3 | | |
| Disagree | 30 | 15.6 | 36 | 20.7 | 0.132 | |
| Young people like you do not need to seek SRHR services (STI screening, sexuality counselling, pregnancy test, SMC) because they are "healthy" | | | | | | |
| Agree | 37 | 19.3 | 73 | 41.5 | | |
| Disagree | 155 | 80.7 | 103 | 58.5 | 0.000 | 0.001 [1] |

[1] Calculated with a multivariate logistic regression analysis which adjusts for gender

In table 3.7 above, it is evident that young people in both intervention and comparison groups favour the use of contraceptives to prevent pregnancy since there was no difference observed between the two groups (P-value= 0.132). However, we found a significant difference between young people in the intervention and comparison group in relation to attitude towards believing that young people are "healthy" and thus don't need to seek SRHR services. The findings show that young people in the intervention group were more likely to agree to the statement that young people do not need to seek SRHR services since they are "healthy"; p-value =0.00. After controlling for gender, young people in the intervention group were still more likely than the comparison group to agree to the statement (aOR =2.1; p-value =0.001) as indicated in table 3.7 above.

### 3.3.7 Young peoples' confidence to manage their own sexuality

We also looked at young people's confidence in relation to believe in their own abilities to be able to manage their sexuality. We noted that the level of confidence influences the behaviour that young people adopt especially safe sex practices. In table 3.8 we present a summary of results based on analysis of peer education intervention sites.

**Table 3.8: Young people confidence to manage their sexuality**

| | Comparison | % | Intervention | % | P-value |
|---|---|---|---|---|---|
| Imagine that someone wants to force you to have sex. How confident are you that you resist him/her? | | | | | |
| Not confident | 80 | 41.7 | 86 | 48.9 | 0.066 |
| Confident | 112 | 58.3 | 90 | 51.1 | |
| Imagine that you will have sexual intercourse in future. How confident are you that you will use a condom every sexual intercourse with a partner you do not know his/her HIV status to prevent HIV? | | | | | |
| Not confident | 92 | 47.9 | 86 | 48.9 | 0.149 |
| Confident | 100 | 52.1 | 90 | 51.1 | |
| Imagine that you will have sexual intercourse in future. How confident are you that you will use contraceptives to prevent pregnancy | | | | | |
| Not confident | 105 | 55.0 | 85 | 48.3 | 0.463 |
| Confident | 86 | 45.0 | 91 | 51.7 | |
| Imagine that you want to seek services (testing or treatments) for SRHR condition/diseases. How confident are you that you seek services without any fear? | | | | | |
| Not confident | 30 | 16.1 | 32 | 18.2 | 0.356 |
| Confident | 156 | 83.9 | 144 | 81.8 | |

As indicated in table 3.8 above, our analysis of data based on the peer education intervention sites revealed no statistically significant differences between young people in the intervention and comparison group. In other words, young peoples' confidence in managing their own sexuality; negotiating safe sex, preventing pregnancy and seeking SRHR services among others was not associated with whether one was exposed to peer educators or not.

## CHAPTER FOUR:

## Study findings on the VHT model

### 4.1 Introduction

The study findings presented in this chapter are divided into two main sections. In the first section, we present the demographic characteristics of study participants; in the second part we present findings for the VHTs model in relation to their effectiveness increasing uptake of services among young people.

### 4.2 Socio-demographic characteristics of participants

The key demographic characteristics of the study participants presented in the tables below include age, gender, marital status and sexual activity of young people. Table 4.1 below gives a summary of respondent's key demographic variables.

**Table 4.1: Socio demographic characteristics of the study participants**

| | | Comparison | % | Intervention | % | P-values |
|---|---|---|---|---|---|---|
| | | n=204 | | n=207 | | |
| **Sex** | Boy | 80 | 39.2 | 71 | 34.3 | 0.301 |
| | Girl | 124 | 60.9 | 136 | 65.7 | |
| **Age group** | 10-14years | 62 | 30.4 | 56 | 27.3 | 0.662 |
| | 15-19years | 84 | 41.2 | 83 | 40.5 | |
| | 20-24years | 58 | 28.4 | 66 | 53.2 | |
| **Marital status** | Never married | 166 | 81.4 | 144 | 69.6 | 0.027 |
| | Currently married | 34 | 16.7 | 51 | 24.6 | |
| | Divorced | 4 | 2.0 | 11 | 5.3 | |
| | Widowed | 0 | 0.0 | 1 | 0.5 | |
| **Ever had sexual intercourse** | No | 113 | 55.7 | 76 | 37.3 | 0.000 |
| | Yes | 90 | 44.3 | 128 | 62.8 | |

With regard to study participants as shown in table 4.1 above, there were no major differences in relation to participants' age and gender. However, more participants in the comparison were not married compared those in the intervention group; 81.4% vs 69.6% (p-value= 0.027), and more participants in the intervention were sexually active; 62.8% vs 44.3% (p-value =0.000). Overall, a significant proportion of the study participants were aged between 15-19 years. The mean age for the respondents was 17.4 years (sd.3.837).

### 4.3 Effectiveness of VHTs in increasing the uptake of SRHR services

Like in the peer education analysis, to establish SRHR service utilisation in communities using the VHT model, we asked participants a series of questions on SRHR knowledge, attitude and health seeking. The aim was to determine whether there were differences in the project outcomes (SRHR knowledge, attitude, confidence and service uptake) among young people exposed to VHT with those that are not exposed.

#### 4.3.1 Utilisation of SRHR by young people

To establish SRHR service utilisation, we asked participants whether they have visited a health facility to seek SRHR services in the previous 12 months preceding the study. The aim was to establish whether young people exposed to VHTs were more likely to have sought services compared to those in the comparison group. In table 4.2 we present a summary of results based on analysis by comparing the intervention and the comparison group while controlling for gender.

**Table 4.2: Young people who visited a health facility for SRHR services in the last 12 months**

**In the previous 12 months, have you visited a health facility for services on reproductive and sexual health?**

| | **Comparison** | | **Intervention** | | | |
|---|---|---|---|---|---|---|
| | **Frequency** | **%** | **Frequency** | **%** | **P-value** | **Adjusted P-value** [1] |
| **Yes** | 102 | 50.0 | 136 | 65.7 | 0.001 | 0.264 |
| **No** | 102 | 50.0 | 71 | 34.3 | | |

[1] Calculated with a multivariate logistic regression analysis which adjusts for marital status and sexual intercourse

As presented in table 4.2 above at a bivariate analysis, the findings show that young people exposed to VHTs were more likely to have visited a health facility seeking for SRHR services compared to those in the comparison group (p-value = 0.001). However, when controlling for marital status and sexual activity since there were more unmarried people in the intervention group and more sexually active in intervention group, our findings show that there was no longer a difference in the uptake of SRHR services between young people exposed to VHTs with those in the comparison group (aOR 1.3, p-value 0.264). This means that exposure to VHT does not necessarily lead to use of SRHR services among young people.

We further asked those that have visited the health facility on the number of times they had visited in the previous 12 months. The aim was to establish and compare the frequency of visiting health facility for services among both groups. The findings show that there was no difference between comparison and intervention when looking at the frequency of visiting the health facility (aOR=0.8, p-value =0.688). This means that there was no association between the frequencies of visiting a health facility for SRHR services and being exposed to VHT.

### 4.3.2 Nature of services sought by young people

Young people who visited a health facility for SRHR services mentioned a range of services that they sought. Data indicate that the common SRHR services sought by young people were HCT, STI Testing and treatment, information about condoms and health education.

**Table 4.3: Nature of SRHR services sought by young people in the 12 months prior to the study**

| Type of SRHR service accessed[1] | Comparison | | Intervention | | | |
|---|---|---|---|---|---|---|
| | Frequency | % | Frequency | % | P-value | Adjusted P-value[2] |
| Pregnancy test | 19 | 9.3 | 28 | 13.5 | 0.180 | |
| HCT | 81 | 39.7 | 104 | 50.2 | 0.032 | 0.302 |
| STI | 37 | 18.1 | 41 | 19.8 | 0.666 | |
| Contraceptive | 19 | 9.3 | 39 | 18.8 | 0.006 | 0.095 |
| Condoms | 23 | 11.3 | 39 | 18.8 | 0.032 | 0.212 |
| Safe male circumcision | 7 | 3.4 | 15 | 7.2 | 0.086 | |
| Antenatal | 2 | 1.0 | 14 | 6.8 | 0.002 | 0.021 |
| PMTCT | 2 | 1.0 | 1 | 0.5 | 0.554 | |
| Post abortion | 4 | 2.0 | 7 | 3.4 | 0.372 | |
| Health education | 34 | 16.7 | 41 | 19.8 | 0.410 | |
| Counseling on sexual based violence | 13 | 6.4 | 21 | 10.1 | 0.165 | |
| Counseling on growing up | 12 | 5.9 | 13 | 6.3 | 0.866 | |

[1] Multiple responses allowed

[2] Calculated with a multivariate logistic regression analysis which adjusts for marital status and sexual intercourse

It is evident from bivariate analyses in table 4.3 above that access to HCT, condoms and antenatal care services were significantly associated with the exposure to VHTs with their p-values less than 0.05. However, other services were not significantly associated with the intervention since there p-values were greater than the statistical value of 0.05.

[2]

We conducted multivariate analysis while controlling for marital status and sexual activity since there were differences in between the samples. The results did not show any association between exposure to VHT and HCT and condoms, except antenatal services (aOR=5.9, p=0.021). This means that young people exposed to VHT were more likely to seek antenatal services compared to those unexposed.

### 4.3.3 Contraceptive use among young people

To establish contraceptive use, we asked the sexually active young people whether they were currently using any form of modern contraceptives. Our findings show that there was no significant difference in contraceptive use between young people exposed to VHT with those in the comparison group (p-value =0.264). We further asked young people that were currently using contraceptives where they obtain contraceptives from. The aim was to determine where whether young people access contraceptives from VHTs or other sources. Our findings indicate that majority of young people obtain contraceptives from other sources rather than VHT as presented in table 4.4 below.

**Table 4.4: Where young people get contraceptive they are currently using**

| | **Comparison** | | **Intervention** | |
|---|---|---|---|---|
| | Yes | % | Yes | % |
| Where do you get the contraceptive method you are currently using? | | | | |
| Health facility/Pharmacy/drug shop/peer educators | 56 | 93.3 | 83 | 86.4 |
| VHTs | 4 | 6.7 | 13 | 13.5 |

The findings in table 4.4 above show that most young people using contraceptives obtain them from other sources and not from VHTs. This implies that very few young people using contraceptives access them from VHTs.

### 4.3.4 Young peoples' knowledge about SRHR

In the analysis of data from the VHT intervention sites we found no statistically significant differences in young peoples' SRHR knowledge across the measured variables since all the p-values were above 0.05. As table 4.5 below indicates,

knowledge on the measured variables was equally high in both intervention and comparison groups.

**Table 4.5: Knowledge on HIV and among young people**

| | Comparison | % | Intervention | % | P-value |
|---|---|---|---|---|---|
| HIV can be prevented by correct and consistent use a condom during sex | | | | | |
| False | 31 | 15.2 | 22 | 10.6 | 0.167 |
| True | 173 | 84.8 | 185 | 89.4 | |
| It is possible for an HIV infected mother to pass on HIV to her baby during pregnancy, child birth or during breast feeding | | | | | |
| False | 41 | 20.1 | 34 | 16.4 | 0.335 |
| True | 163 | 79.9 | 173 | 83.6 | |
| The risk of HIV transmission from mother to child can be reduced by a mother taking special drugs from a health facility during pregnancy | | | | | |
| False | 43 | 21.1 | 46 | 22.2 | 0.778 |
| True | 161 | 78.9 | 161 | 77.8 | |

### 4.3.5: Contraceptive knowledge

We asked young peoples' some questions on contraceptives they know (how it is looks and used). The aim was to determine their knowledge levels on contraceptives. The responses were categorised as "*spontaneous*", "*prompted*" or "*do not know*". We then analysed data for any differences in the knowledge among the intervention and comparison. The findings in table 4.6 below therefore, compare the knowledge levels between the two groups.

**Table 4.6: Contraception methods spontaneously known by young people**

| Contraceptive method [1] | Comparison | | Intervention | | | |
|---|---|---|---|---|---|---|
| | Frequency | % | Frequency | % | P-value | Adjusted p-value [2] |
| Pill | 73 | 79.3 | 113 | 92.6 | 0.004 | 0.04 |
| Emergency contraception | 25 | 53.2 | 35 | 54.7 | 0.876 | |
| Male condom | 161 | 98.8 | 167 | 96.5 | 0.187 | |
| Female condom | 86 | 92.5 | 107 | 87.0 | 0.196 | |
| IUD | 36 | 63.2 | 44 | 63.8 | 0.944 | |
| Injectable / Depo-Provera | 74 | 81.3 | 95 | 88.0 | 0.192 | |
| Foam tablets/ jelly/ cream | 10 | 34.5 | 10 | 24.4 | 0.357 | |
| Norplant | 29 | 60.4 | 58 | 80.6 | 0.016 | 0.944 |
| Male sterilization | 19 | 50.0 | 27 | 47.4 | 0.801 | |
| Female sterilization | 23 | 54.8 | 34 | 52.3 | 0.804 | |
| Withdrawal | 18 | 45.0 | 34 | 51.5 | 0.515 | |
| Calendar method/safe days | 19 | 38.8 | 29 | 34.1 | 0.588 | |
| Tradition | 19 | 79.2 | 34 | 79.1 | 0.993 | |

[1] Multiple responses allowed

[2] Calculated with a multivariate logistic regression analysis which adjusts for marital status and sexual intercourse

The findings in table 4.6 above indicate that there was no statistically difference regarding the knowledge on contraceptive methods since the p-values are greater than 0.05. However, more young people in the intervention exhibited higher knowledge of the pill and Norplant compared to those in the comparison (p-value =0.004, and 0.016). We further conducted multivariate analysis while controlling for marital status and sexual activity since these differed in the sample. The results show further that young people exposed to VHTs were more likely to know the contraceptive pills compared to those in the comparison (aOR=4.8, P-value=0.04). However, this was not the case for Norplant since the p-value was greater than 0.05 (aOR=1.0, p-value=0.944).

### 4.3.6: Young peoples' attitudes towards uptake of SRHR services

We asked participants some SRHR attitude questions and then teased out data on the basis of influence of VHTs. We found that significant differences existed

in attitude between young people in the intervention and comparison groups as presented in table 4.7 below.

**Table 4.7: SRHR attitudes among young people**

| | Comparison | % | Intervention | % | P-value | Adjusted P-value [1] |
|---|---|---|---|---|---|---|
| Young people like you should be allowed to use contraceptives to prevent unplanned pregnancy | | | | | | |
| Disagree | 68 | 33.5 | 41 | 19.8 | 0.007 | 0.019 |
| Agree | 135 | 66.5 | 166 | 80.2 | | |
| Young people like you do not need to seek SRHR services (STI screening, sexuality counselling, pregnancy test, SMC) since they are "healthy" | | | | | | |
| Disagree | 119 | 58.3 | 92 | 44.3 | 0.016 | 0.001 |
| Agree | 85 | 41.7 | 115 | 55.6 | | |

[1] Calculated with a multivariate logistic regression analysis which adjusts for marital status and sexual intercourse

From the table above, we found that young people in the intervention group were more likely to agree to the statement on using contraceptives to prevent unplanned pregnancy compared to their peers in the comparison group; p-value =0.007. However, the findings also show that young people in the intervention group were more likely to agree to the statement that young people do not need to seek SRHR services since they are "healthy" ; p-value =0.016. After controlling for sexual activity and marital status, the differences remained as more young people in the intervention group favour the use of contraceptives to prevent unwanted pregnancy (aOR=1.6, p-value=0.019). Likewise, more young people in the intervention group agreed to the statement that young people do not need to seek SRHR services since they are "healthy" (aOR=2.1, p-value=0.001).

### 4.3.7 Young peoples' confidence to manage their own sexuality

Analysis of data in the VHT intervention sites revealed that there were no statistically significant differences across key confidence indicators. The only difference exists on whether young people were confident to use contraceptives to prevent pregnancy in future with more young people in intervention likely to

say that they are confident to use contraceptives as illustrated in table 4.8 below.

**Table 4.8: Young people confidence to manage their sexuality**

| | Comparison | % | Intervention | % | P-value | Adjusted-value [1] |
|---|---|---|---|---|---|---|
| Imagine that someone wants to force you to have sex. How confident are you that you resist him/her? | | | | | | |
| Not confident | 69 | 33.8 | 63 | 30.6 | 0.508 | |
| Confident | 135 | 66.2 | 143 | 69.4 | | |
| Imagine that you will have sexual intercourse in future. How confident are you that you will use a condom every sexual intercourse with a partner you do not know his/her HIV status to prevent HIV? | | | | | | |
| Not confident | 67 | 32.8 | 76 | 36.8 | 0.689 | |
| confident | 137 | 67.2 | 130 | 63.1 | | |
| Imagine that you will have sexual intercourse in future. How confident are you that you will use contraceptives to prevent pregnancy | | | | | | |
| Not confident | 79 | 38.9 | 53 | 25.6 | 0.014 | 0.020 |
| Confident | 124 | 61.1 | 154 | 74.4 | | |
| Imagine that you want to seek services (testing or treatments) for SRHR condition/diseases. How confident are you that you seek services without any fear? | | | | | | |
| Not confident | 67 | 33.2 | 51 | 24.8 | 0.171 | |
| Confident | 135 | 66.8 | 155 | 75.2 | | |

[1] Calculated with a multivariate logistic regression analysis which adjusts for marital status and sexual intercourse

As presented in table 4.8 above, results showed that young people in the intervention group were more likely to be confident to use contraceptives as a measure against unplanned pregnancy compared to their counterparts in the

comparison group; p-value= 0.014. After controlling for sexual activity and marital status, the results further show that young people in the intervention group compared to the comparison were more likely to use contraceptives as a measure against unplanned pregnancy (aOR=1.8, p-value=0.020).

## CHAPTER FIVE:

## Synthesis and Discussion

### 5.1 Introduction

In this study, the critical answers that we sought to know was whether Peer Education increases the uptake of SRHR services and contraceptive use among young people. We also sought to know whether VHTs increase the uptake of SRHR services and contraceptive use among young people. Besides, we desired to establish whether there was any difference in SRHR knowledge, attitude and confidence between young people exposed to the interventions with the unexposed. Our outcome of interest therefore was the use of SRHR services, contraceptive use, knowledge, attitude and confidence. We therefore analyzed our data by comparing the number of young people that reported visiting a health facility for services in both the intervention and comparison groups. .

Methodological limitations

Before describing the results, there are several methodological limitations that need to be highlighted. As stated earlier, this study was conducted only two months after the interventions (peer education and VHT) were implemented. This may explain the differences, or the lack of, in the perceived effect of peer education interventions on behavioural determinants and contraceptive use and VHTs on uptake of services, behavioural determinants and contraceptive use. Secondly the difference in one item of SRHR knowledge and attitude each showing higher knowledge and positive attitudes among the comparison in some aspects could be because there was no use of validated scales and sum scores in analysis. Therefore conclusions were based on just one item and therefore likely to be less reliable. Lastly there was a likelihood of contamination because some young people in the comparison communities can be exposed to peer education or VHT through other uncontrolled interactions and this can greatly affect the findings.

### 5.2 Peer educators and uptake of SRHR services among young people

Peer education is a widely used approach for promoting sexual and reproductive health (SRHR) and preventing HIV especially among young people. Under the ASK project, peers education was adopted to reach young with SRHR information to influence behavior change, and encourage them to seek SRHR services and adopt the use of contraceptives. Peer educators were also

trained to distribute some contraceptives to young people in their respective communities.

In this study we found that young people exposed to peer education were more likely to visit a health facility for services than those that were not exposed. In other words, peer educators positively influence the uptake of services among young people in rural Uganda, especially HCT. However, the frequency of visiting a health facility was not related to the exposure to peer educators. We further found that although peer educators were important providers of contraceptives to young people, they were not found to influence the actual use of contraceptives among young people. However, this can partly be attributed to the fact that the study was conducted only two months after the intervention was implemented, yet actual behavior change is likely to need more time.

The results suggest that, only two months into the intervention, peer educators have contributed to the use of SRHR services among young people in the intervention communities. The results of this study are comparable to other studies of peer education interventions in diverse settings. Studies have shown that peer education programs succeed in creating an environment for uptake of services. In a study conducted in Vietnam, Ngo et al. (2013) found a nearly five-fold increase in the percentage of clients who sought various SRHR services such as HCT as a result of exposure to peer-based education and integration of HIV and SRHR for young people aged 15-24. Their study also highlighted the benefits of peer-based education regarding knowledge on SRHR services. In a related study, Michielsen et al. (2012) conducted a non-randomized control trial to determine the effectiveness of a peer-led intervention in Rwanda. Their study found that although the peer-intervention did not effectively alter risk behavior, it significantly reduced enacted stigma. In an earlier study Okonofua et al (2003) conducted formative research in Nigeria that consisted of community participation, peer education and access to services, the study found that peer education increased the health seeking behavior for STIs among young people. In other earlier studies conducted in Cameroon by James-Traore T *et al (2002)* that evaluated peer health education program, results showed increased use of modern contraceptive methods among participants versus comparison youth. Similar findings were reported by Brieger WR *et al.*(2001) where an evaluation of a peer education programs in schools and out-of-school settings in Ghana and Nigeria showed an increase in the proportion of youth reporting use of modern contraception methods.

In a study by Michielsen et al. (2012) to determine the effectiveness of a peer-led intervention in Rwanda, it was found that although the peer-intervention

did not effectively alter risk behavior, it significantly reduced enacted stigma towards the uptake of SRHR services including contraceptives among young people. The reduction in stigma by the peer education interventions therefore could be the reason why our results show that young people exposed to peer educators were more likely to seek SRHR services, especially HCT, compared to those in the comparison group in this study. This was further affirmed that peer educators refer young people for services during their regular interaction. For example, data obtained from the implementers database show that a total of 381 young people were referred for services by peer educators in the first five months of the project, and this number is likely to increase as the project implementation progresses.

### 5.3 VHTs and uptake of SRHR services among young people

Our results do not suggest any difference in the uptake of services between young people in the intervention and the comparison group as far as the VHTs model was concerned. This means that exposure to VHTs was not necessarily related to the use of SRHR services among young people. The VHTs were also not found to be important providers of contraceptives to young people and were not found to have an influence on the use of contraceptives.

The lack of the lack of perceived effect VHTs in this study can be attributed to a number of factors. First, as earlier reported, the study was conducted two months after the intervention was implemented, and this could have affected the anticipated outcomes. Secondly, lack of effect could have been due to lack of "peerness" among VHTs in terms of personal characteristics i.e. age, interest, communication style, circumstances and experiences among others because most case VHTs are adults. The absence of "peerness" therefore may create a gap between young people and VHTs making their interaction less effectives. Therefore VHTs could be effective in working with the adults and not young people. Thirdly, VHTs limited influence on young people could also be attributed to their busy schedules since they are not engaged with young people only, but also with other community health interventions.

Attempt to compare our findings with related studies did not yield much because there are almost no published studies on the VHT model with regard to their effectiveness in increasing access to SRHR services among young people. The only study though not specific to young people was conducted by Ashaba et al (2012) and the findings showed that VHTs were expected to perform a wide range of functions including home visits, environmental

sanitation, provision of water supply, first aid and treatment of simple and common ailments, health education, nutrition and disease surveillance, maternal and child health and family planning activities, communicable disease control, community development activities, referrals, record-keeping, and collection of data on vital events. These findings highlight the fact that with such workload, the VHTs may have less meaningful time with young people and therefore less likely to influence change.

## CHAPTER SIX:

## Conclusions and recommendations

### 6.1 Conclusion

- Overall, peer educators increase the uptake of SRHR services among young people since young people exposed to peer education were more likely to visit health facilities for services, especially HCT, than those that were unexposed. We therefore conclude that, only two months into the intervention, peer educators are already effective in increasing the uptake of SRHR services among young people.

- Apparently, there is no evidence to suggest that peer educators lead to increased use of contraceptives among young people. However, peer educators increase access to contraceptives among young people since close to half of the young people using contraceptives accessed them from peer educators. Actual behavior change is likely to need more time.

- Two months into the intervention, peer educators were found not to have improved the empowerment of young people to manage their sexuality. The level of confidence among young people to effectively manage their sexuality did not differ between young people exposed peer education and those that were not. Therefore, there is, as yet, no evidence to suggest that peer education leads to young people's improved confidence to manage their sexuality. This was the same with regard to SRHR knowledge and attitudes. Actual change in determinants of behavior is likely to need more time.

- The VHT model was not related to an increased uptake of SRHR services among young people; neither did it lead to increased use of contraceptives. This is because there was no difference exhibited with regard to uptake of services and use of contraceptives between young people exposed to VHTs and those that were not exposed. Likewise, only a tiny proportion of the young people using contraceptives reported accessing them from VHTs.

- The VHT model did not lead to improved empowerment of young people in managing their sexuality. The level of confidence among young people to effectively manage their sexuality did not differ between young people exposed to VHTs and those that were not. Therefore, there is apparently no evidence to suggest that VHT model lead to improved confidence

among young people. This was the same with regard to SRHR knowledge and attitudes except for knowledge on selected contraceptive methods.

- This study was conducted two months into the peer education and VHT models intervention. This means that the study was conducted at a time when not all the planned intervention activities were implemented, and this could have partly affected some findings and conclusions.

## 6.2 Recommendations

Based on the findings presented and the conclusion above, the following recommendations can be made;

- We recommend the strengthening of the peer education model. This can be done through committing more resources especially to training of more peer educators and conducting refresher training for those that are already trained. Strengthening should also involve availing resource materials so that peer educators can guide "informed" youth towards service providers. Emphasis should also be placed on empowering peer educators to building the competencies and confidence of young people to effectively manage their sexuality. This will enable young people to adopt positive SRHR practices that will match the SRHR services being accessed by young people.

- There is a need to recruit and include more young people as VHTs to promote "peerness". These should also be trained in "youth friendliness" to enable them to effectively work with young people. The training should also be able to make VHTs appreciate the SRH needs of young people.

- The project should assess how both peer educators and VHT manage the contraceptive component in the process of executing their duties. The fact that majority of young people currently using contraceptives obtain them from health facilities despite the existence of peer educators and VHTs is an indication of existing gaps in the distribution processes. The assessment findings can then be used for project improvement.

- We further recommend research with a longer follow-up since behavior requires more time to change. Additional in-depth research is needed to understand why VHTs were limited in providing services to young people, as well as establishing the percentages of young people referred for outreach and integrated services.

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