Report
Impact Evaluation - Amplify Project
Sexual and reproductive health
SignHealth – Deaf Child Worldwide – IDEO.org

Prepared by: Yahoska Berrios

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INTRODUCTION

A human rights framework to Sexual and Reproductive Health rights emphasizes the need to maintain one’s sexual and reproductive health, access to accurate information (seek, receive and impart information related to sexuality) and a choice of safe, effective, affordable contraception.

Currently young people in sub-Saharan Africa face various sexual and reproductive health risks such as unplanned pregnancy and sexually transmitted infections – including very high levels of HIV prevalence. According to Global Health Observatory data from 2015, the region is severely affected and accounts for 70% of people living with HIV worldwide (Renzaho AMNI, Kamara JK. 2017). In addition, other studies show a high prevalence of syphilis, gonorrhoea, bacterial vaginosis, trichomoniasis and herpes.

In recent decades, Uganda has made tremendous progress in fighting HIV/AIDS and has reduced prevalence in the general population from 15% in the early 1990s to 7% in 2014. Nevertheless, some sectors of the Ugandan population are more affected than others. Prevalence is higher in urban areas than in rural areas (8.7% vs 7%), higher in adult women than in adult men (8.8% vs 4.3%) and among young people aged 14-24 years the prevalence of HIV/AIDS is significantly higher among young women than young men (4.2% vs 2.4%).

In addition, persons with disabilities (especially deaf girls) have a greater HIV risk given vulnerability to sexual violence and low literacy levels that limit knowledge on health-related issues including HIV and/or AIDS (Chireshe, Rutondoki & Ojwang 2010; United Nations Human Rights, World Health Organization and United Nations Programme on HIV/AIDS 2009). Research published by Public Reproductive Health Matter (2017) showed that among people with disabilities, deaf women were most at risk of being raped or experiencing sexual violence. Data obtained via interviews showed that 66% of deaf women participants reported having been raped once or multiple times, in contrast with 16% of women with other physical disabilities. All rape incidences took place during adolescence or pre-adolescence. Perpetrators were often family members or family friends.

Whilst Uganda has a National Adolescent and Young People’s Health Policy, as a priority to achieving the Sustainable Development Goals, sexual and reproductive health is still poorly addressed especially with regards to meeting deaf young people’s sexual needs and the gap in SRH education.

THE CONSULTATION PROCESS

Prior to the development and implementation of the Amplify project, Deaf Child Worldwide conducted a consultation to explore deaf young people’s knowledge of SRH, and their experiences of accessing information and support, in order to influence the design and development of an SRH project and ensure that it is planned in a way that deaf young people feel is effective and accessible. The consultation involved the delivery of full-day focus groups with deaf young people in three different locations; Kampala, Masaka and Jinja.

Results showed that the main barriers to obtaining sexual and reproductive health information for deaf young people were:

1. Communication barrier
2. Education gap
3. Deaf young people’s isolation (hard to reach)
4. Lack of knowledge on family planning methods
5. Lack of information about pregnancy and childbirth
6. Lack of funds for transport

The consultation identified that while deaf young people consider that health clinics are the best source of SRH information, in practice, most of them usually obtain their information via friends.

The consultation showed a significant difference in sexual and reproductive health knowledge between deaf young people in the different cities. Deaf young people in Kampala were quick to see the bigger picture when asked about SRH and had good awareness of funding, lobbying decision makers, and networking with other NGOs and organisations. Their experiences on previous projects has clearly done a huge amount to increase their confidence and aspirations - it was good to see this influencing their interaction and ability to share their views so clearly. In contrast, the youth in Masaka and Jinja seemed less aware of their rights and found it more difficult to understand questions and share their views.

THE PROJECT – “AMPLIFY”

Amplify was an initiative funded by the Department for International Development (DFID) and managed by IDEO.org, Triple line and IMC Worldwide. AMPLIFY aims to create a new model for international development that places high value on creativity, innovation and human centred solutions.

Under this initiative, SignHealth in collaboration with Deaf Child Worldwide and the Ugandan National Association of the Deaf was one of the local organisations selected by IDEO.org to deliver a disability inclusion project aimed at transforming the way deaf young people access sexual and reproductive health information through training peer leaders, health workers and educators.

The project was implemented in three districts of Uganda: Masaka, Kampala and Jinja.

- The objectives of the project were:

  1. Increase the ability of deaf young people to make informed choices on their sexual and reproductive health
  2. Increase support, aspirations and hope in the future of deaf children and youth by the families
  3. Improve the acceptance and inclusion of deaf young people in their communities

The expected outputs and activities planned were the following:
### Stage of development

1. **Prototyping phase (Jan to March 2018)**
2. **Design phase (April, May and June 2018)** this was led by IDEO.
3. **Pilot phase (July 2018 - May 2019)**

### Budget

<table>
<thead>
<tr>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning &amp; induction of Peer leaders in 3 locations</td>
<td>Peer leaders are trained and available to support deaf young people in the 3 locations of the project.</td>
<td>Increased ability of deaf youth to make informed choices on their health</td>
</tr>
<tr>
<td>Training of selected peer leaders (in Leadership &amp; Group Dynamics &amp; peer support basics)</td>
<td>Peer leaders are trained and available to support deaf young people in the 3 locations of the project.</td>
<td>Increased ability of deaf youth to make informed choices on their health</td>
</tr>
<tr>
<td>Consultation with DYP on SRH materials, review &amp; modification of available resources</td>
<td>Information materials are developed on SRH</td>
<td>Increased support and aspirations and hope in the future of deaf children and youth by the families</td>
</tr>
<tr>
<td>Club/Interactive sessions with DYP in and out of school</td>
<td>Defe young people access information session in an inclusive and interactive manner</td>
<td>Increased support and aspirations and hope in the future of deaf children and youth by the families</td>
</tr>
<tr>
<td>Introducing and facilitating SRH packages in Schools and health centres in the 3 project locations</td>
<td>SRH information is facilitated at schools and health centres</td>
<td></td>
</tr>
<tr>
<td>Conducting gender based mentoring sessions/retreat for DYP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication training for DYP with limited SL skills and literacy</td>
<td>Defe young people receive communication training</td>
<td></td>
</tr>
<tr>
<td>Check-ups/sessions with DYP &amp; SL interpretation at health centres</td>
<td>Defe young people access health check ups with the support of an interpreter</td>
<td></td>
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<tr>
<td>Training guide for peer leaders in delivery of SRH tools,</td>
<td>Peer leaders are trained on SRH tools and how to disseminate the information</td>
<td></td>
</tr>
<tr>
<td>Organise exposure and exchange learning trips with DYP and hearing counterparts for each location</td>
<td>Defe young people socialise with hearing peers and exchange learning</td>
<td></td>
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<tr>
<td>Identification &amp; testing communication boards with selected families in each location</td>
<td></td>
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<tr>
<td>Orientation/consultative meetings with parents representatives (peer groups in the 3 project locations)</td>
<td>Communication board are created, tested and used by families</td>
<td></td>
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<tr>
<td>Reproduction and sharing of communication boards for families</td>
<td></td>
<td></td>
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<tr>
<td>Training (including communication guide) for parents leaders for follow-up of families of Deaf Children &amp; Young People</td>
<td>Parents, leaders and mentors are trained in communication</td>
<td></td>
</tr>
<tr>
<td>SL communication packs for families (home pack including SL brochures on where to seek services)</td>
<td>Families access SRH and communication information packs</td>
<td></td>
</tr>
<tr>
<td>Family check in (communication support by volunteers DYP and mentor/buddy parents)</td>
<td>Family receives communication support by volunteers</td>
<td></td>
</tr>
<tr>
<td>Piloting communication boards/SL for parents in selected schools</td>
<td>Schools access communication boards</td>
<td></td>
</tr>
<tr>
<td>Mentoring sessions and linking parents to other development projects/partners (biannually in each location)</td>
<td>Parents receive information on how to link with other projects</td>
<td></td>
</tr>
<tr>
<td>Yaka events - Conducting Community Outreaches/awareness camps on deafness</td>
<td>Yaka events are conducted to raise awareness on deafness and</td>
<td>Improved acceptance and inclusion of DYP in their communities</td>
</tr>
<tr>
<td>YAKA promotional branded materials (including T-shirts, posters, Banners, stickers and fliers)</td>
<td>Yaka events are promoted at a national scale</td>
<td></td>
</tr>
<tr>
<td>Promoting YAKA Booths/participation in national events (opportunities for YAKA branding )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conducting Music, Dance, drama/guerrilla theatre and inclusive talent development competition activities</td>
<td>Guerrilla theatre is used to raise awareness on deafness and SL</td>
<td></td>
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<tr>
<td>Deaf awareness and communication training for community leaders and service providers</td>
<td>Community leaders and service providers access training on deaf awareness and communication</td>
<td></td>
</tr>
<tr>
<td>Supporting Networking and information with other partners including business &amp; CSOs working with young people in project locations</td>
<td>Deaf young people role models are connected with other partners, business and CSOs</td>
<td></td>
</tr>
<tr>
<td>Compiling a documentary/publication on successful DYP role models</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family/community vests on rights issues of DYP</td>
<td>Families receive monitoring support by project staff</td>
<td></td>
</tr>
<tr>
<td>Technical Review meetings with project team</td>
<td>Project staff review project constantly and make changes according</td>
<td>Project Monitoring and Learning</td>
</tr>
<tr>
<td>Biannual monitoring visits with DCW</td>
<td>DCW conducts biannual monitoring visits</td>
<td></td>
</tr>
<tr>
<td>Project reporting and Review</td>
<td>Report and project reviews are develop to a high standard and on time to demonstrate performance and impact</td>
<td></td>
</tr>
</tbody>
</table>
The pilot phase budget was $153,160 of which $75,325.8 was spent on project activities (60.7% of the total budget).

THE EVALUATION

The purpose of the evaluation was to review and analyse the project’s relevance, effectiveness, efficiency, sustainability and impact. As well as identifying lessons learned and recommendations for modification/improvements in design and methodologies used.

According to the evaluation plan, the key objectives were:

- To assess the project delivery quality, identify expected and unexpected impacts and guide the direction of future projects.
- To increase the capacity of delivery organisations to evaluate impact of their work and open spaces for deaf young people to provide feedback.
- Reflect the strengths of the partnership between SignHealth and DCW and identify areas to improve.

Use of the findings:
- Contribute to broader evidence base: inform future practice by the organisations and others outside the organisations.
- Inform decision making aimed at improvement: changing or confirming policies and practices
- Lobby and advocate: demonstrate achievements

Evaluation principles:

Impartiality: The evaluation process should be impartial, this contributes to the credibility of evaluation and the avoidance of bias in findings, analyses and conclusions.

We are aware that this is hard to achieve when the evaluation is internal, therefore we have established control measures to ensure that we hold each other accountable in the process.

Control measures are:
1. Agree a plan which is based on research on the ground
2. Agree on plan that clearly establishes roles and responsibilities from both organisations
3. Allow spaces for peer review

Credibility: Credibility requires that the evaluation should report successes as well as failures. It is important to understand that we are not fishing for success stories. We are open minded and understand that learning can come from both success and failure and therefore we need to be faithful to our findings.

Usefulness: To have an impact on decision-making, evaluation findings must be perceived as relevant and useful and be presented in a clear and concise way.

Participation: Spaces for participation should be open, voluntary, language appropriate and accessible.

Confidentiality and consent: Every person taking part in the evaluation was clear that their involvement in the project is not in danger as a result of the views they express in the participatory activities.
THE METHODOLOGY

The evaluation was conducted in a transparent and participatory manner. The objectives were explained to all the participants by the evaluation team and participation was voluntary and consensual.

The methodology incorporated; desk-based consolidation of quarterly report results, data gathering by SignHealth staff using structured questionnaires, three focus group discussions with deaf young people in Masaka, Jinja and Kampala, four interviews with parents of deaf children and two interviews with members of staff of the Naguru Youth Centre (drop-in clinic) in Kampala.

The evaluation design allowed us to obtain a mixture of quantitative and qualitative information.

Considering sexual and reproductive health is a sensitive topic, we provided both a personal and confidential space (through our questionnaire) for young people to answer questions about their knowledge, opinions and behaviours regarding SRH as well as focus group discussion for those who felt more able to share their experiences.

The data collection phase took place from the 24th April to the 20th May 2019.

- Data collection instruments

Structured Questionnaire

A structured questionnaire was used to collect individual data. It comprised six sections (you can find the complete questionnaire in the annexe section of this report): personal background; sexual behaviours; knowledge and use of family planning methods; knowledge of HIV and sexually transmitted diseases; condom knowledge and attitudes; sexuality and gender norms. The questionnaire was field tested prior to data collection for cultural and deaf appropriateness and clarity and was administered in Ugandan Sign Language. This activity was led by peer leaders and supported by a SignHealth project officer

Focus group discussion

Three focus group were conducted in the three project locations, each taking approximately 3 ½ hours.

Participants

Masaka – 11 participants - 7 female, 6 males – ages 21-31
Jinna – 11 participants - 5 female, 7 male – ages 18-27
Kampala 12 participants - 6 female, 6 male – ages 21-27

The focus group had 5 sections: sources of information; SRH knowledge; sexual ideology and gender; behaviour change; what worked best/ what can improve. They were conducted in English with the support of two Ugandan Sign language interpreters and one Kenyan Sign Language Interpreter. They were led by DCW staff and organised by SignHealth. Each focus group has the participation of two peer leaders.

The first three sections of the focus group was delivered with all deaf young people together. The final two section, however, in which we asked more personal questions, the group was divided by gender.
Dividing the group by gender allowed us to create a more comfortable and open space for deaf young people to share personal views without feeling intimidated. The focus group for girls was led by Yahoska Berrios (IEIEA) and Rose Nyagwoka (Programmes officer) with the support of a female interpreter. The focus group for young men was delivered by Richard Mativu (Senior Technical advisor).

Parent interviews

Four interviews were conducted with parents of deaf children (two mothers and two fathers, children age 5 - 12). Two were conducted in Kampala and two were undertaken in Jinja. Each interview took between 30 minutes to one hour and was conducted in English by DCW’s International Evidence, Information and Evaluation Advisor with support from Ugandan language interpreters.

The interviews were focused on how the project and the project’s materials (especially the communication boards) have been useful to improve communication among the family.

Health worker interviews

Two interviews were conducted with staff from the Naguru Youth Centre in Kampala (one female psychologist and one male social worker). The questionnaire had four sections: background information; experience and training in SRH services; experience providing SRH advice and consultation to deaf young people/ focused on contraception; engagement with SignHealth. Each interview took 30 minutes and was conducted in English by DCW’s International Evidence, Information and Evaluation Advisor.

Most significant change stories were planned but unfortunately due to restricted time we couldn’t collect this information. The focus group took longer than expected and the long distance that young people have to travel from home to the venue meant that we had to prioritise the focus groups.

- Performance against plan

According to SignHealth quarterly and final reports all activities planned for both the prototype phase and the pilot were delivered successfully.

The main activities included:

1. The ‘guerrilla theatre’ - Impromptu drama to attract attention from the community and generate discussions and interest in deaf young people’s issues. Guerrilla theatre was conducted at national and community level in all three project locations. The performances were mainly written by the young people, this allowed an opportunity for them to bring their agenda forward and discuss the issues they consider of most relevance. They had support from the project team when required.

The guerrilla theatre was also a central feature in the community outreach events called “YAKA”. YAKA events were characterized by mixture of community mobilization and awareness activities including dance and drama, sports and talent shows. These helped to showcase the skills of deaf young people and break the stigma and exclusion. YAKA events were also instrumental for identification of deaf children that have been previously hidden by their parents. Meeting points: The meeting points were periodical meetings in all three locations of the project for deaf young people to have an open space to talk about SRH. These meeting points were led by the peer leaders who were in closer contact with the project staff and supported the planning and delivering operations of the YAKA events and the guerrilla theatre.
SRH materials design: With the support of IDEO designers a deaf friendly SRH booklet was created to support health workers, community educators and teachers to facilitate information about SRH to deaf young people. According to SignHealth final report, these improved packages have not only simplified the delivery of SRH education in schools, but have eased communication between health providers and deaf young people. Health clinics who benefitted from these booklets include Naguru Health Centre in Kampala, TASO in Jinja and Masaka Regional Referral Hospital.

SRH Training: Deaf youth have been trained in SRH with a focus on HIV/AIDS, family planning and STDs at the health facilities. Peer leaders have received extra training on how to use the SRH materials and how to communicate the messages they contain. In addition the peer leaders received training in leadership and communication skills to be able to engage meaningfully with other deaf young people.

Communication boards: Communication boards are a visual tool which can be used as a sign language dictionary. Their main feature is that each word is drawn on an individual magnet, allowing the user to move words around the board to create sentences. The objective of this communication board is to facilitate communication among deaf children and parents.

Other activities such as training for parent’s leaders as mentors have not been mentioned in SignHealth final report. During the evaluation we had the opportunity to interview a few parents who have been involved in training and even though they consider the training useful, particularly in improving their Sign Language skills and improving communication with their deaf children, they themselves had not received education on SRH and they considered their children (ages 5-10) too young to receive this information.

SignHealth is also planning the production of a video to demonstrate the impact of the project and the value of their peer to peer approach.

RESULTS

- Participant demographics

The characteristics of the study’s participants are summarized in Table 1. A total of 35 deaf young people participated in our study. Of whom 51% were young women and 49% young men, 6% were aged between 15-19, 60% were aged between 20-24 and 34% older than 24. The average age of participants was 24. Most participants had technical level education having finished primary and secondary education.
Table 1 – Association between sexual behaviour and demographics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>People interviewed</th>
<th>Ever had sexual intercourse</th>
<th>Had sexual intercourse since engagement in the project</th>
<th>Used family planning method</th>
<th>Participated in the decision on which family planning method to use in the last intercourse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (no.)/ %</td>
<td>no. %</td>
<td>no. %</td>
<td>no. %</td>
<td>no. %</td>
<td>no. %</td>
</tr>
<tr>
<td>All</td>
<td>35 100%</td>
<td>34 97%</td>
<td>28 80%</td>
<td>26 74%</td>
<td>28 80%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>18 51%</td>
<td>17 94%</td>
<td>16 89%</td>
<td>14 78%</td>
<td>16 89%</td>
</tr>
<tr>
<td>Male</td>
<td>17 49%</td>
<td>17 100%</td>
<td>12 71%</td>
<td>12 71%</td>
<td>12 71%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>2 6%</td>
<td>1 50%</td>
<td>1 50%</td>
<td>0 0%</td>
<td>0 0%</td>
</tr>
<tr>
<td>20-24</td>
<td>21 60%</td>
<td>21 100%</td>
<td>19 90%</td>
<td>15 71%</td>
<td>19 90%</td>
</tr>
<tr>
<td>24+</td>
<td>12 34%</td>
<td>12 100%</td>
<td>8 67%</td>
<td>11 92%</td>
<td>9 75%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>3 9%</td>
<td>3 100%</td>
<td>3 100%</td>
<td>3 100%</td>
<td>2 67%</td>
</tr>
<tr>
<td>Secondary</td>
<td>8 23%</td>
<td>7 88%</td>
<td>7 88%</td>
<td>4 50%</td>
<td>7 88%</td>
</tr>
<tr>
<td>Technical</td>
<td>18 51%</td>
<td>18 100%</td>
<td>12 67%</td>
<td>15 83%</td>
<td>14 78%</td>
</tr>
<tr>
<td>University</td>
<td>6 17%</td>
<td>6 100%</td>
<td>6 100%</td>
<td>4 67%</td>
<td>5 83%</td>
</tr>
</tbody>
</table>

- **Sexual behaviours and sources of information**

The study found that the majority of the participants in the study were sexually active, with 34 out of 35 reporting having had sex.

74% of participants affirmed to having safer sexual practices as a result of the project. Increasing fidelity, abstention from sex, and use of condoms are the most mentioned behavioural changes. Survey results show that 20% of participants declared that they had not had sex since their involvement in the project.

Participants were asked what the main reasons for abstaining from sex were, to which the most popular answers were: fear of HIV/ AIDS; fear of pregnancy, and considering sex before marriage as not appropriate.

One of the outcomes most mentioned by young people, as a result of their participation in the project, was an increase in knowledge with regards to family planning methods, HIV/AIDS and other sexually transmitted infections. Nevertheless, it is important to analyse if knowledge is adequate and comprehensive as well as how much of that knowledge has translated into behaviour change.
All the young people interviewed knew where and how to access condoms, pills and birth control implants. However, participants stated they did not have knowledge of:

- How these methods work
- The common secondary effects and how to mitigate them
- When it is necessary to see a doctor
- What factors to take into account to decide which method is more appropriate for their body and lifestyle

Only 34% of the participants had ever in their lives discussed sex-related matters with their parents. During the focus groups they expressed feeling more comfortable talking about sex-related matters to friends, although they recognise their friends often do not have the right answers.

34% sought advice from The AIDS Support Organization (TASO) – a Ugandan non-governmental organisation with a broad reach funded by a myriad of sources including Ugandan Ministry of Health, DFID and DANIDA. 49% obtained sexual education information from friends and peers and only 17% have ever discussed SRH matters with doctors. During the focus group deaf young people expressed that they knew about these places before getting involved in the project but they didn’t have the confidence or interest to visit them.

Communication was not considered a barrier to accessing birth control methods. 38% have used sign language to express their request, 52% writing and 9% have communicated via hearing friends. Nevertheless, communication is a significant barrier to obtaining more profound education on SRH.

During the focus groups, only a few participants (peer leaders) could explain how pregnancy happens and they had many doubts and concerns with regards to infertility, cervical diseases, menstruation, how to deal with menstrual cramps, and how to properly use sanitary towels.

Some girls stated that the pills and injection provided by medical centres caused them abdominal pain and nausea and because they didn’t know how to obtain advice on what to do to avoid this, they decided to stop using them.

One resounding piece of feedback was the need to deliver more comprehensive training on SRH - especially about menstruation, pregnancy and how family planning methods work. Young
people expressed that they would prefer if the training were delivered by a deaf person or an interpreter with deep knowledge of SRH and sign language who could understand their questions and address them directly.

Some peer leaders seemed to, in general, have more technical knowledge of SRH than the rest of the deaf young people, especially with regards to the physiological process surrounding pregnancy, general information about HIV/AIDS, and where to access support and information. However, they had many doubts and concerns about infertility, intrauterine diseases, and permanent contraception.

- **Use of family planning methods**

Of those who were sexually active only 76% have used any type of contraception. According to the survey, condoms are the contraception most commonly used (65%). However, this figure does not correlate to the information found in the focus groups when participants were asked what family planning methods they actually used. The most mentioned types of contraception were injection, implants, and withdrawal method.

Some participants specified that they do not consider condoms to be a safe family planning method because they worried they could split during intercourse. 26% of participants expressed that they have experienced a condom split or break during sex. Participants (both male and female) also mentioned that they do not trust in the quality of the condoms provided by the health centres. Participants in Jinja and Masaka also mentioned that they do not trust their and their partner’s ability to use the condoms properly as they have never seen a demonstration on how to use them.

In addition, during the sex-disaggregated sessions of the focus groups, participants stated that although most of them had used condoms, they preferred using other methods because condoms reduce sexual pleasure. Female participants stated (on occasion) they had tried to suggest to their partners that they should use condoms but their partners had refused. Male participants confirmed the statement above and stated that they did not enjoy using condoms.

The results of the focus group correlate to the results of the survey (see table 2). There is misinformation regarding how many times a condom can be used with 15% of respondents saying that condoms can be used more than once or being unsure about it. There are also low levels of trust from deaf young people regarding a condom’s ability to protect them from pregnancy (with only half believing they are effective against this), and HIV and STIs (with only a third believing they are effective against both of these).

**Table 2: Knowledge and attitudes towards condoms**

<table>
<thead>
<tr>
<th>Knowledge and attitudes towards condoms</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms are an effective method of preventing pregnancy</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>Condoms should not be used more than once</td>
<td>85%</td>
<td>15%</td>
</tr>
<tr>
<td>A girl can suggest to her partner that he uses a condom</td>
<td>88%</td>
<td>12%</td>
</tr>
<tr>
<td>A boy can suggest to his partner that he uses a condom</td>
<td>79%</td>
<td>21%</td>
</tr>
<tr>
<td>Condoms are an effective way of protecting against HIV/AIDS</td>
<td>31%</td>
<td>69%</td>
</tr>
</tbody>
</table>
Condoms can be used in steady loving relationships 62% 38%
If a girl suggests using a condom it means that she doesn’t trust him 31% 69%
Condoms reduce sexual pleasure 86% 14%
Condoms are an effective way to protect against STIs 34% 66%

The focus group data (Table 3) shows that only 28% of girls use condoms as their main method of contraception. In comparison, 76% of boys (Table 4) reported condom use as their main method of contraception despite dissatisfaction and lack of trust in condoms as an adequate form of contraception.

Gender disaggregated use of family planning methods

*38% of girls used the morning after pill.

The morning after pill is easily available in Uganda. It is available over the counter or through TASO.

The most positive feedback about the methods used were for the injection and the implant. The girls mentioned that the injection and implant methods were the easiest to use as they only needed to be thought about every three months. With the exception of possible weight fluctuation, the girls surveyed said they had not been informed about the possible side-effects or long-term consequences of using these family planning methods.

According to the survey, 48% of participants knew about Intrauterine devices (IUD), 14% about vasectomies, and 26% about female sterilisation. However this knowledge was only to a superficial level.

Another method widely mentioned during the focus group was the safe day’s period method, also known as the rhythm method for natural family planning. Some girls said they had decided to use the safe day’s method because their partners refused to use condoms while implants,
pills and injections caused them pain. However, when asked to explain how the method worked those surveyed weren’t sure how to make the calculation of their ovulation cycle to identify which days in the month were the pregnancy safe days. Some used rosary beads to calculate their cycle and identify fertile days; however those with irregular periods struggled to calculate exact safe days increasing the risk of unwanted pregnancy.

Not one male participant understood the safe day’s method but none of them said they used it.

80% of participants said they had participated in the decision-making process for which family planning method to use. Of those who had participated in the decision-making process, the majority expressed that they had discussed contraception with their partners before having intercourse.

The above results demonstrate an evident gender disparity regarding who has decision making power over their own sexual practices. Results in the chart show that 18% of participants consider it is only men’s authority to decide when the right moment to have sex is. This is worrying as it means that deaf young girls might feel pressure to become sexually active before they feel emotionally ready. Having the perception that the decision of when is the right time to have sex is largely controlled by men raises concerns in terms of views of consent, as it undermines girl’s decision-making power over their own sexual practices.

During the focus groups, comments like “Girls sometimes say they don’t want to have sex, but they don’t mean it, they just want to be courted”, and, “if when you approach a girl at the beginning [and] she doesn’t show interest in you, you have to keep trying, don’t give up” arose. These kind of responses need to be taken extremely seriously and they reflect the need to raise awareness about consent. Misconceptions about girls not being completely honest when they say they are not interested in a sexual relationship may put them in risk of harassment or even abuse.

Another red flag in terms of gender disparity is that 45% of the participants think only women should be responsible for regular use of contraception. This imposes a disproportionate economic burden linked to the task of visiting the health centre, pharmacy or shop.
- **HIV/AIDS knowledge, testing and prevention**

93% of the participants say they now know about HIV compared to 73% during the consultation led by DCW in 2017. This represents a 20 percentage point increase in knowledge as a result of the project. Results from the survey show 71% expressed feeling concerned about catching HIV during previous sexual relationships.

100% of the participants have been tested for HIV and 47% said they do it periodically. 90% said that they know how and where to get support if they are HIV or STI positive - government health clinics being the most popular place to obtain support (65%), followed by TASO (14%) and private clinics (11%).

37% expressed that the peers had encouraged them to get tested for HIV, 14% were encouraged by their partners, 17% by their families and 20% by health workers.

Some young people expressed that even though they had been tested themselves and know they are HIV negative, they still feel at risk as they don’t know the HIV status of their partner. They expressed it was sometimes a challenge to convince their sexual partners to get tested. A girl in Masaka expressed “I cannot convince my partner to come with me to the clinic, he is scared of the results but we don’t use condoms either, that makes me very worried”. Other participants advised her to talk to other men in the peer group and ask them to talk to her partner to convince him to get tested.

Some participants were also worried about catching HIV from oral sex. No one knew about dental dams and the fact that it is possible to use condoms for oral sex. They mentioned asking their peers, and even health workers, but the response was to abstain from oral sex. An answer which they find unrealistic.

- **Available health services**

Two interviews were conducted with health providers to identify which services were available for deaf young people, their adequacy, how services are provided and what conditions are met to ensure health providers understand deaf young people’s needs.

Established in November 1994, as a voluntary activity by a Swedish gynaecologist and several volunteer counsellors, Naguru Teenage Information and Health Centre (NTIH) in Kampala Uganda is a pioneer in providing youth-friendly adolescent sexual reproductive health services and information targeting young people aged 10–24 years.

The offer the following SRH services:

1. Contraceptive counselling
2. Antennal care
3. Maternity care
4. Postnatal care
5. HIV/ AIDS counselling and testing
6. Other STIs testing, counselling and treatment
7. Gynaecological exams
8. Pregnancy testing
9. General reproductive health education

Both staff expressed they are trained constantly on SRH by the organisation, in both cases they have received refresher training no longer than three years ago. SignHealth and the Naguru centre staff worked together to create a deaf friendly SRH manual which service providers can use to facilitate information to deaf young people. Both interviewees said they had very little sign language knowledge so when a deaf young person visited the clinic they relied heavily on the manual. One of the interviewees expressed that the
manual was helpful but that it didn’t address all the problems deaf young people faced or provide all the information they wanted to know. They have both been trained by SignHealth to efficiently communicate with deaf young people, however they still face difficulties when answering deaf young people’s questions,

“deaf young people are just like hearing young people, they are sexually active and have many questions. We sometimes rely on interpreters if we have the help of SignHealth but otherwise we need to communicate by writing and pointing at the images in the manual”.

“I don’t think the communication is fully effective, you need a lot of patience to explain things because even with the interpreters we sometimes struggle. I think young people leave with still many questions and unclear ideas”.

Both interviewees considered they had learned a lot from SignHealth, especially on how to engage with deaf young people. They said that without SignHealth they would not have been trained on deafness or any other disability and, while the centre has an obligation to receive all people without discrimination, they would have struggled to support deaf young people before.

Both the interviewees have prescribed contraception to deaf young people involved in the project in the last year. They provided a range of options including condoms (female and male), pills and injections. They provided this to sexually active people aged between 15 to 24. For minors, aged between 10 to 15, they required parental consent.

A form of consent is also required, from the sexual partner when prescribing contraception to young females in a steady relationship, even when these are older than 15. Although this is considered a form of advice to foster communication between sexual partners, it can be sometimes problematic when male sexual partners refuse to use condoms or to attend to the clinic.

Both of the interviewees said that usual procedure to prescribe contraception would include a conversation to know more about each individual patient, their sexual practices and previous medical history, in order to know what method of contraception is best for them. However, communication barriers between staff and deaf young people make this due diligence process more complicated and often contraception is prescribed without much consideration. The centre staff and SignHealth have organised information workshops in which they have provided general SRH information to deaf young people as a group. Most of the SRH information that deaf young people know has been obtained in this way.

Although this is beneficial as a first step training, individual sessions to discuss personal circumstances are needed and communication support is needed to ensure that deaf young people have all the information required to make informed choices about their sexual and reproductive health.

- Parental involvement and communication with family

Four interviews were delivered to assess how the project has improved communication between parents and deaf young children (ages 5-12).

According to the project’s plan, the communication support activities are delivered in order to achieve the second objective of the project to increase support, aspirations and hope in the future of deaf children and youth by the families.”

The communication support activities include the creation and distribution among families of communication boards – a type of Ugandan Sign Language dictionary board with words placed on individual magnets that allow the user to move them across the board to create sentences.
Parents were asked how the communication was within their families and consequently their hopes for the future of their deaf children. Both mothers stated they have used the board to learn sign language and even though they work and therefore have very little time to spend with their children, their communication has improved: they use sign language and both have very high expectations and hope for the future of their children.

Fathers on the other hand rely on the mother or sibling to communicate with their child. One father said that he makes sure that the hearing sibling attends all the training and learns sign language so that she can support her deaf brother.

It is important to note, however, that all the parents interviewed were parents of deaf children rather than young people. The parent benefiting from communication support were families that are not linked to other SRH activities related to the project – making it unclear how this part of the project follows the logic of the intervention.

Although the project planning process did not follow traditional methods, and activities were selected in an “evolving project manner”, the inclusion of this activity makes little sense with the rest of the project, and therefore did not contribute to the project’s main topic (Sexual and reproductive health).

For instance, the assumption that by merely improving communication between parents and deaf children will lead to parents talking more openly about SRH with their deaf children, contradicts all the previous evidence that demonstrates that the reason why parents and young people do not talk about sex is based on cultural norms and customs.

During the focus groups deaf young people were asked if they would talk to their children about SRH to which the majority answered no, as they don’t consider it to be a comfortable topic of conversation between parents and their children. From those who answered yes, they said they would have such a conversation at an appropriate age (18+) which is later than the mean age of sexual initiation which is 16 (Renzaho AMNI, Kamara JK. 2017). In addition, this assumption contradicts the main theme of this project which is that peer leaders, health workers and community educators are better placed to provide SRH information to deaf young people.

Conclusions

- Evaluation objective 1: To assess the project delivery quality, identify expected and unexpected impacts, and guide the direction of future projects.

The project delivery quality is evaluated by the extent to which the activities delivered by SignHealth contributed towards the achievement of the long term outcomes.

Outcome 1. Increase ability of deaf young people to make informed choices on their health.

Evaluation indicator 1. Are deaf young people receiving adequate information about SRH in the language of their choice and through which they can clarify their doubts and understand the information fully?

Access to SRH information has certainly improved for the deaf young people that participated in the project but there are still many challenges before we can be sure that they receive adequate SRH information.

The theatre and the YAKA events were a great way to engage deaf young people and create support networks which they can reach when needed for information or support. Nevertheless, major improvements still need to happen regarding the quality of information deaf young people receive.
Although the peer to peer approach has proven successful in reaching deaf young people and developing their confidence to open up and talk more freely about SRH, misconceptions and misinformation are still evident.

More work needs to be done to ensure that peer trainers are well informed and trained on SRH issues. They need specialised knowledge on SRH to be able to respond to their peers’ needs and questions. For peer leaders to have this knowledge they need to be trained by certified medical professional. One of the staff of Naguru youth centre recommended a ten days training to cover all SRH related matters.

In addition, peer leaders need to have effective communication skills to ensure the message is conveyed properly.

More work is needed with service providers to ensure they have sufficient communication skills to attend the needs of deaf young people.

Evaluation indicator 2. Are deaf young people aware of the available services to access to information about SRH?

The data reflects that deaf young people were generally aware of where to access SRH information. Government health clinics and TASO were the most common medical centre used by deaf young people.

Evaluation indicator 3. Are deaf young people more confident to access these services?

Lack of confidence does not seem to be what stops deaf young people from accessing these services. Most of the participants in the evaluation who had reached for SRH services have felt generally comfortable and not judged. They describe their experience to be generally pleasant however communication barriers make it difficult for them to get the most out of these services.

Strategic thinking needs to be done to identify how this barrier can be overcome. Innovative initiatives such the SAFAids SRH app are bringing attention to the role of technology to bridge the gap between young people and access to SRH information. If a technology friendly approach is not viable within the Ugandan context, other types of youth friendly visual communication methods should be used to ensure that young people get the most from available SRH services.

Evaluation indicator 4. Are deaf young people having safer sexual practices?

Improvements in access to SRH services (especially HIV testing), living healthier lives, protecting oneself, and avoiding high-risk behaviours were generally reported by young people. However, the small scope of the evaluation and the lack of baseline (which would enable comparison between increase in knowledge and level of change participants experienced) limits this evaluations ability to state with scientific certainty that behaviour change has happened as a result of the intervention.

In addition, data collection methods for this evaluation have been anecdotal. We are reliant on deaf young people’s willingness to share their opinions and experiences and have to trust in the transparency of the answers. Although deaf young people have participated in the evaluation on a voluntary basis and have been informed that their feedback does not affect their future participation in other projects there is a power relationship that needs to be taken into account and understood when analysing their answers: i.e. the possibility that deaf young people respond based on behaviours they think they should have rather than ones they actually have.
Furthermore, the short-term nature of the project (1 year pilot) does not provide enough sustained data to guarantee behaviour change moves from trial phase to consistent healthier practices. Human beings and societies are complex, and are moulded by cultural and gender norms (especially sexual practices and relationships), therefore it should be clear that behaviour change does not happen in the short term.

Outcome 2. Increased support, aspiration and hope for the future of deaf children and youth by their families.

Evaluation indicator 5. Are parents communicating more effectively with deaf children and young people?

As mentioned before, all the parents interviewed were parents of deaf children (ages 5-10) rather than young people. Therefore, although parents seemed more positive with regards to having improved their communication with their children and as a result being more positive about their children’s potential, the parents were not linked to other SRH activities related to the project.

While parents were generally very positive about the support received from SignHealth, in particular the support their children received at school, they felt their children were too young to be involved in an SRH project and they were not aware of the main objectives of the project.

From a programmatic perspective it seems that the activities involving parents do not contribute to the main scope of the project: to transform the way that deaf young people access sexual and reproductive health information.

Outcome 3. Improved acceptance on inclusion of deaf young people in their communities.

This outcome was only evaluated from an SRH perspective.

Evaluation indicator 6. Are service providers deaf aware and able to meaningfully engage with deaf young people?

There is no doubt that since the project health service providers feel more confident than before in engaging with deaf young people. They are aware that deaf young people have equal needs to their hearing peers, as well as equal rights to demand such services.

The evaluation reflects that despite improvement has happened, more work needs to be done to improve health providers’ ability to communicate effectively with deaf young people. At the moment, the information they can provide to deaf young people is superficial without the support of interpreters.

In addition to improving their sign language and communication skills, health providers need to work with SRH specialists to develop a training curriculum which is more comprehensive.

- Evaluation objective 2: To increase the capacity of delivery organisations to evaluate impact of their work and open spaces for deaf young people to provide feedback.

SignHealth has been actively involved in all the stages of the evaluation. They facilitated a trial of the questionnaire with deaf young people and had the opportunity to feed back on it. The responses of the questionnaire allowed them to have qualitative information with regards to how deaf young people have change their current practices. They were also encouraged to use such information for the development of their final report to IDEO.
We also held a meeting with representatives of DCW, peer leaders and SignHealth staff to share lessons learned during the data collection process and draw conclusions and recommendations for future evaluations.

- Evaluation Objective 3. Reflect the strengths of the partnership between SignHealth and DCW and identify areas to improve.

The Amplify project was an opportunity for SignHealth to trial new approaches and develop a strong network of deaf young people.

The human design approach they have used has allowed more direct participation of deaf young people in decision-making platforms and therefore, improved accountability. This is a significant strength for SignHealth as they are slowly developing deaf young people’s leadership skills, ownership of the project and confidence. This was evident during the evaluation.

Deaf Child Worldwide has on this occasion contributed as a technical advisor. Supporting SignHealth with reviewing quarterly financial and narrative reports, offering suggestions on how to communicate their impact in a clearer way and providing support on how to manage the reporting and support process for safeguarding causes of concern. In addition, Deaf Child Worldwide are also leading the evaluation process which will provide meaningful inputs to consider for both SignHealth and Deaf Child Worldwide if a new project is agreed.

If a future intervention is to happen, it is important that gender awareness and empowerment is placed at the core of any future project. Despite the outstanding skills demonstrated by deaf girls involved in the project they are mainly exercising secondary leadership positions such as vice-chair, or vice-representative.

SRH is a topic that is heavily moulded by cultural and gender norms. Young women and young men feel SRH issues in different ways and have different views, experiences and needs. As mentioned in the introduction, the prevalence of HIV in young girls is still significantly higher than in young boys, as is their risk of sexual abuse and violence. Therefore any intervention that aims at improving SRH access to young people in Uganda cannot stay at the margins of addressing unequal gender norms and their consequences.

SignHealth’s efforts to address this by encouraging deaf girls to be part of the peer leaders group are a promising start; however more work needs to be done to ensure that the project empowers young girls, such as:

1. Guaranteeing equal representation at project management staff level
2. Delivering gender disaggregated training to ensure girls have the confidence to ask sensitive questions
3. Working with the young boys, especially the group leaders, about their responsibility for acting to prevent the replication of unequal gender norms that negatively affect girls and put them at risk.

Safeguarding – Deaf Child Worldwide’s Child Protection and Safeguarding policy sets out our commitment to safeguarding children and young adults at risk from harm. Everybody has a responsibility to prevent harm and promote the wellbeing of children and those affected by deafness. We are accountable for everything we do, both to our partner organisations and to the deaf children and young adults at risk we work with.

Safer organisations require openness, constant monitoring and oversight of practice.

Any new development of a project of this kind will come with the requirement of adhering to a set of minimum standards for child safeguarding and child protection as an integral component
of programme delivery. This will also place greater emphasis on improving the capacities of SignHealth staff to respond to safeguarding concerns.

**Recommendations**

For the delivery of future training:

Specialised training for peer leaders should involve in its planning process:
- Deaf young people, to ensure that their concerns are answered.
- TASO
- SRH-based organisations
- Specialist medical practitioners
- Deaf trainers – Senior Lead trainers

The training should include:
- Gender awareness training sessions
- Training on menstrual health, cervical diseases, fertility, and contraception for both boys and girls
- Awareness raising about individualised medical attention for SRH
- Training sessions with regards to consent, freedom of choice, and rights and entitlements
ANNEXES

Questionnaire

Complete questionnaire

../Data collection tools\Questionnaire Final.pdf

Analysed results from the survey can be found in the following link:

https://docs.google.com/forms/d/1ZXvXsqGNDtEbBAUATe5b9EaF4-Ho1cgKOzJxpV72Wo/edit#responses

Data spreadsheet: \Ndcslonsan1a\shared\Deaf Child Worldwide\East Africa\3. Uganda\1. Current Partners\SignHealth\AMPLIFY - IDEO.ORG 2017\Evaluation\Results\Row data\Signhealth Evaluation. Responses from the survey.xlsx

Focus group

Masaka youth evaluation – responses: \Ndcslonsan1a\shared\Deaf Child Worldwide\East Africa\3. Uganda\1. Current Partners\SignHealth\AMPLIFY - IDEO.ORG 2017\Evaluation\Results\Row data\Focus group - Masaka Results.docx

Jinja youth evaluation – responses: \Ndcslonsan1a\shared\Deaf Child Worldwide\East Africa\3. Uganda\1. Current Partners\SignHealth\AMPLIFY - IDEO.ORG 2017\Evaluation\Results\Row data\Focus group - Jinja Results.docx

Kampala youth evaluation – responses: \Ndcslonsan1a\shared\Deaf Child Worldwide\East Africa\3. Uganda\1. Current Partners\SignHealth\AMPLIFY - IDEO.ORG 2017\Evaluation\Results\Row data\Focus group - Kampala Results.docx

Health Staff interviews

\Ndcslonsan1a\shared\Deaf Child Worldwide\East Africa\3. Uganda\1. Current Partners\SignHealth\AMPLIFY - IDEO.ORG 2017\Evaluation\Results\Questionnaire for service providers. Female respondent.xlsx

\Ndcslonsan1a\shared\Deaf Child Worldwide\East Africa\3. Uganda\1. Current Partners\SignHealth\AMPLIFY - IDEO.ORG 2017\Evaluation\Results\Questionnaire for service providers. Male respondent.xlsx

Evaluation plan

\Ndcslonsan1a\shared\Deaf Child Worldwide\East Africa\3. Uganda\1. Current Partners\SignHealth\AMPLIFY - IDEO.ORG 2017\Evaluation\Signhealth Evaluation Plan.doc

Amplify – Prototype logframe

\Ndcslonsan1a\shared\Deaf Child Worldwide\East Africa\3. Uganda\1. Current Partners\SignHealth\AMPLIFY - IDEO.ORG 2017\Full Application\AMPLIFY - Disability Inclusion - Looking Forward -SU-DCW-UNAD FINAL AGREED.xlsx