PRE- AND POST-TEST SUMMARY REPORT

PEER EDUCATION OF YOUNG BAR/RESTAURANT/HOTEL/DOMESTIC WORKERS

Pre- and Post Test Knowledge on HIV, Reproductive Health, Condom use and Peer Education & Life Skills

PSI Rwanda 2010

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BACKGROUND

PSI Rwanda trained a total of 600 young bar/restaurant/hotel/domestic workers as Peer Educators (PEs) aged 15-29 of whom 51.9% were females and 48.1% were males. 14.2%, 65.9% and 17.9% were respectively 15-19, 20-24 and 25-29 years age groups. The proportion of recruited PEs was almost the same around 16% in all of the following districts: Musanze, Huye, Ngoma, Gasabo, and Nyarugenge except for Kicukiro, which was represented by 17% of participants. Regarding education level among respondents, 24.1% had primary school education, 22.5% did not complete secondary education, while 24.6% completed the secondary school education. The trainings were conducted in June and July 2010. The training sessions were evaluated by using pre- and post tests as a part of PSI Rwanda standard monitoring and evaluation (M&E) procedures. Both pre- and post-tests were taken by 555 participants.

This analysis has a two-fold purpose: 1) to describe the level of knowledge of the participants regarding HIV/AIDS, Reproductive Health, Peer Education & Life Skills and condom use prior to the training and 2) to evaluate the impact of the training by looking at differences between pre- and post test results.

Methodology

The participants filled out the 21-item questionnaire before and after the training with the same set of questions concerning comprehensive HIV knowledge, Peer Education & Life Skills, Reproductive Health and condom use. Only participants with both pre and post tests were included in the analysis (N=555). Different analyses were conducted on data aggregated per sex and district. Using the chi-square test, the differences between pre- and post-tests were examined for statistical significance.
Main findings

PSI Rwanda has been successful in reaching youth with poor knowledge on HIV. At pre-test, participants were below the national level from DHS 2005 results on comprehensive knowledge on HIV. The trainings were successful in increasing knowledge on HIV and participants were above national level after the results.

Both PSI Rwanda and DHS 2005 results show that men have greater knowledge on HIV than women. In addition, there are big differences between the level of HIV knowledge in the districts at pre- and post- test. This might be explained by other factors such as educational level or rural/urban residence.

The level of knowledge on Reproductive Health prior to the training was low; especially about when in her menstruation cycle a women is most likely to get pregnant and usage of withdrawal as a method for pregnancy prevention. The training proves very effective in increasing knowledge in these areas, as more than 75 % of both men and women have the correct knowledge about this after the training.

The training leaves convinced most men and women not to force others to agree with their ideas and not to stop his/her co-facilitator if he/she makes mistakes. During the training the participants increased knowledge on condom use around 80% among men and women.

INTRODUCTION

The pre- and post-tests are organized by PSI Rwanda in the course of training young bar/restaurant/hotel/domestic workers as Peer Educators (PEs) aged 15-24. The trainings were evaluated by using pre- and post tests as a part of PSI Rwanda standard M&E procedures. The mean of percentages of correct pre- and post test answers are usually compared in order to assess the outcome of the training. This comparison only
allows for evaluation at an aggregated level and does not give a qualitative picture of their knowledge before training or the impact of the training on specific knowledge.

Internationally, comprehensive knowledge on HIV is assessed using five measures of knowledge about transmission and prevention (UNGASS). A person with comprehensive HIV knowledge knows that a) a healthy looking person can be HIV-infected, b) that you can reduce your risk of getting HIV by having just one uninfected faithful partner and c) by using condom correctly every time you have sex and can reject the two most common local misconceptions about HIV transmission and prevention, which according to the Rwanda Demographic & Health Survey from 2005 are that d) a person can get HIV infected via mosquito-bites or e) by sharing food with someone who is infected (DHS 2005). These five indicators are included in the questionnaire and will be used to describe the participants HIV specific knowledge.

METHODOLOGY

Data collection

The participants fill out the 21-item questionnaire in Kinyarwanda before and after the training with the same set of questions concerning Comprehensive HIV knowledge, Peer Education & Life Skills, condom use and Reproductive Health. The questionnaires are administered and collected by the Health Educators.

The questionnaire

The questionnaire consists of 21 questions. Questions Q001-0017 are answered by either “true”, “false” or “don't know” whereas Q0018-021 are multiple choice questions. HIV comprehensive knowledge is defined as all 5 correct answers in total for Q004-008 have been given. The questionnaire contains additional information about gender and data on age or educational level.
ANALYSIS

Pre- and post test data were collected from the participants. Only participants with both pre and post tests were included in the analysis (N=555), while the remaining (45) who completed either a pre-test or a post-test were excluded.

Results before and after the training were compared for each question and Comprehensive HIV knowledge. All crosstabs were conducted separately for men and women, and Comprehensive HIV knowledge. In addition, analysis was also conducted per district. The difference between pre- and post test results was tested for statistical significance with chi-square test.

The dummy tables in this report are showing the percentage of the total number of participants with the correct answer for the given question. If the participant gave multiple answers for the same question, the question was left blank during data entry, based on the assumption that giving multiple answers to a question with only one correct proves lack of correct knowledge.

Population

The study population consists of 555 individuals, of which 51,9% are women. Table 1a shows the study population per district and gender.
This youth peer education training was conducted among young bars, restaurants, hotels and domestic workers between the ages 15-39. The total numbers of 555 respondents were involved in pre and post tests. The table1b displays their background characteristics.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
<th>% of N&lt;sub&gt;total&lt;/sub&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N&lt;sub&gt;male&lt;/sub&gt;</td>
<td>%</td>
<td>N&lt;sub&gt;female&lt;/sub&gt;</td>
<td>%</td>
</tr>
<tr>
<td>Musanze</td>
<td>39</td>
<td>41.9</td>
<td>54</td>
<td>58.1</td>
</tr>
<tr>
<td>Huye</td>
<td>37</td>
<td>40.2</td>
<td>55</td>
<td>59.8</td>
</tr>
<tr>
<td>Ngoma</td>
<td>61</td>
<td>66.3</td>
<td>31</td>
<td>33.7</td>
</tr>
<tr>
<td>Gasabo</td>
<td>46</td>
<td>49.5</td>
<td>47</td>
<td>50.5</td>
</tr>
<tr>
<td>Kicukiro</td>
<td>59</td>
<td>62.1</td>
<td>36</td>
<td>37.9</td>
</tr>
<tr>
<td>Nyarugenge</td>
<td>25</td>
<td>27.8</td>
<td>65</td>
<td>72.2</td>
</tr>
<tr>
<td>N&lt;sub&gt;total&lt;/sub&gt;</td>
<td>267</td>
<td>48.1</td>
<td>288</td>
<td>51.9</td>
</tr>
<tr>
<td>Characteristics</td>
<td>N participants</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>----------------</td>
<td>------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>267</td>
<td>48.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>288</td>
<td>51.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>555</strong></td>
<td><strong>100.0%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>79</td>
<td>14.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td>365</td>
<td>65.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-29</td>
<td>99</td>
<td>17.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-34</td>
<td>9</td>
<td>1.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35-39</td>
<td>2</td>
<td>0.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>554</strong></td>
<td><strong>100.0%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Level of education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never been to school</td>
<td>13</td>
<td>2.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have not completed primary</td>
<td>78</td>
<td>14.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have completed primary</td>
<td>133</td>
<td>24.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have not completed post primary vocational training</td>
<td>18</td>
<td>3.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have completed post primary vocational training</td>
<td>35</td>
<td>6.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have not completed secondary</td>
<td>124</td>
<td>22.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have completed secondary</td>
<td>136</td>
<td>24.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have not completed university</td>
<td>11</td>
<td>2.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have completed university</td>
<td>4</td>
<td>0.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>552</strong></td>
<td><strong>100.0%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current in school</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current in school</td>
<td>39</td>
<td>7.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of school</td>
<td>513</td>
<td>92.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>552</strong></td>
<td><strong>100.0%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
RESULTS

At pre-test, 30.3 % of men and 35.4 % of women had comprehensive knowledge on HIV. When comparing to the Rwanda Demographic & Health Survey from 2005, the level of comprehensive HIV knowledge prior to the training per district with the exception of Nyarugenge (56%) is well below the national average of 53.6% for men and 50.9% for women in the age group of 15-24. After the training, the comprehensive HIV knowledge increased to 63.3% and 62.2% for men and women respectively, indicating that the trainings were successful in increasing HIV specific knowledge of the participants (table 2). The statistical significance increase from pre-test and post-test shows the success and impact of the training on participants HIV knowledge.

Table 2 also shows the five components of the comprehensive HIV knowledge indicator separately. Generally, there is a high level of knowledge among HIV transmission and prevention prior to the training, and results for most questions increase significantly during the training to a level around 90% with correct answers. The area with the lowest level of knowledge after the training is the question about Faithfulness as a preventive method (Q005). At post test, men generally have a greater knowledge on HIV than the women.

Notably, baseline knowledge about the risks of cross generational sex in Rwanda was low: 47.6% and 44.4% of males and females respectively knew that young girls are more likely to be HIV positive than young boys in Rwanda, and 30% and 24.3% of males and females knew that men aged 30-34 are 8 times more likely to be HIV positive compared to boys aged 20-24 in Rwanda. This knowledge significantly increased as a result of the training.
Table 2: Comprehensive HIV Knowledge

<table>
<thead>
<tr>
<th>Comprehensive HIV Knowledge</th>
<th>Men (N=267)</th>
<th>Women (N=288)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test %</td>
<td>Post-test %</td>
</tr>
<tr>
<td>Performs comprehensive HIV knowledge Q004-Q008 correct</td>
<td>30.3%</td>
<td>63.3%</td>
</tr>
<tr>
<td>Rejects that a person can get HIV from mosquito bites. Q004</td>
<td>70.8%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Believes that people can reduce their chance of getting HIV by having just one sex partner who is not infected, and does not have other sex partners. Q005</td>
<td>58.1%</td>
<td>79.0%</td>
</tr>
<tr>
<td>Thinks that people can reduce their chance of getting HIV by using a condom every time they have sex. Q006</td>
<td>80.5%</td>
<td>97.4%</td>
</tr>
<tr>
<td>Believes that it’s possible for a healthy looking person to be HIV positive. Q007</td>
<td>73.4%</td>
<td>90.6%</td>
</tr>
<tr>
<td>Rejects that a person can get HIV by sharing food with a person who has AIDS. Q008</td>
<td>77.2%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Knows that in Rwanda, young girls are more likely to be HIV positive than young boys. Q009</td>
<td>47.6%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Knows that in Rwanda, men aged 30-34 are 8 times more likely to be HIV positive compared to boys aged 20-24. Q010</td>
<td>30.0%</td>
<td>79.4%</td>
</tr>
<tr>
<td>Knows that there is no cure for AIDS. Q011</td>
<td>73.8%</td>
<td>93.3%</td>
</tr>
</tbody>
</table>

* p<.05; ** p<.01; *** p<.001

Table 3 shows comprehensive HIV knowledge per district. There are big differences between the level of knowledge among districts, both prior to and after the training: Pretest scores vary from 4.3% to 56.0 % for men and 17.0 to 53.8 % for women, and posttest scores from 54.1% to 76.9% and 52.8% to 72.2% for men and women respectively. At pre-test, the district with the highest HIV knowledge among men was Nyarugenge while the lowest score (4.3%) was found in Gasabo district. Among
women, the highest HIV knowledge was 53.8% in Musanze district at pre-test, while the district with the lowest knowledge (17.0%) was Gasabo. At post-test, Musanze had the highest score (76.9%) among men, and Huye had the lowest (54.1%). Women’s HIV knowledge increased the most (72.2%) in Musanze district while Huye was lagging behind (54.5%). Worth noting are the non-significant differences traceable between pre-test and post-test results in Huye district, both among men and women. According to program staff, the problem with non significant differences in pre-test and post-test results in Huye may have resulted from the wrong completion of the questionnaire. A short discussion the research staff has had with youth centers coordinators and youth services staff as they were supposed to oversee the implementation of this activity pointed out that the participants’ low level of understanding and of education as the leading cause of the unexpected and non-significant results. It seems that they did not pay attention while responding to multiple choice questions since it is a matter of ticking a number or a letter. This could have happened in other districts without necessarily impacting the results but in Huye the problem was much accentuated. Another factor we believe can lead to non-significant results between pre- and post-test results is that even health educators do not understand the end use of data collected from peer education evaluation; they might do it for the sake of it. This may be one of the reasons that explain the lack of strictness on the completion of data collection tools.
Table 3: Comprehensive HIV Knowledge by District

<table>
<thead>
<tr>
<th>Comprehensive HIV Knowledge by District</th>
<th>Men N= 267</th>
<th>Women N=288</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Musanze</td>
<td>41.0</td>
<td>76.9</td>
</tr>
<tr>
<td>Huye</td>
<td>35.1</td>
<td>54.1</td>
</tr>
<tr>
<td>Ngoma</td>
<td>23.0</td>
<td>68.9</td>
</tr>
<tr>
<td>Gasabo</td>
<td>4.3</td>
<td>60.9</td>
</tr>
<tr>
<td>Kicukiro</td>
<td>37.3</td>
<td>57.6</td>
</tr>
<tr>
<td>Nyarugenge</td>
<td>56.0</td>
<td>60.0</td>
</tr>
</tbody>
</table>

* p<.05; ** p<.01; ***p<.001

Table 4 below shows the results for questions on Reproductive Health. The results show that the level of knowledge among participants prior to the training is very low for some questions, especially about when in her menstruation cycle a woman is most likely to get pregnant (Q018) and withdrawal as a method for pregnancy prevention (Q017). The training is very effective in increasing knowledge in these areas, as more than 75% of both men and women have the correct knowledge about this after the training.
Table 4: STIs & Reproductive Health

<table>
<thead>
<tr>
<th>STIs &amp; Reproductive Health</th>
<th>Men N= 267</th>
<th>Women N=288</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
<td>Sig.</td>
<td>Pre-test</td>
<td>Post-test</td>
<td>Sig.</td>
</tr>
<tr>
<td>Believes that pains during sex, sores, itching or unusual discharge from the vagina or penis are typically symptoms of sexually transmitted infections (STIs). Q012</td>
<td>54.7 83.5%</td>
<td>***</td>
<td>54.5 87.2% ***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Believes that a man or a woman can be infected with an STI WITHOUT having visible symptoms</td>
<td>68.9 86.5%</td>
<td>***</td>
<td>68.4 85.8% ***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Believes that without treatment, an STI can be healed. Q014</td>
<td>74.9 93.6%</td>
<td>***</td>
<td>75.3 93.1% ***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Believes that having an STI can greatly increase the risk of HIV transmission during unprotected sex. Q015</td>
<td>75.3 94.4%</td>
<td>***</td>
<td>75.7 94.8% ***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Believes that a girl can get pregnant the first time she has sex. Q016</td>
<td>76.0 97.8%</td>
<td>***</td>
<td>77.4 96.2% ***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Believes that it’s possible for a girl to get pregnant if the boy withdraws before ejaculation. Q017</td>
<td>22.1 79.8%</td>
<td>***</td>
<td>28.5 79.5% ***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knows that a woman is most likely to get pregnant in the middle of her menstruation cycle. Q018</td>
<td>21.0 75.7%</td>
<td>***</td>
<td>29.5 82.3% ***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knows that withdrawal is the least effective contraceptive method. Q019</td>
<td>39.3 71.9%</td>
<td>***</td>
<td>43.1 80.9% ***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Believes that the only family planning method that provides protection against HIV is condom. Q020</td>
<td>61.8 87.3%</td>
<td>***</td>
<td>68.4 89.9% ***</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p<.05; ** p<.01; *** p<.001

Table 5 shows the questions regarding Peer Education & Life Skills. During the training, many are convinced not to force others to agree with their ideas (Q001) and not to stop his/her co-facilitator if he/she makes mistakes (Q002). The training is also effective in educating about life skills, as 82.4% of men and 85.8% of women correctly states the three types of life skills at post test, which is almost double as many as prior to the
training. For both questions increase at post test is considerable and very significant with p<.001. There are very significant differences between the results of the pre-test and of the post-test.

Table 5: Peer Education & Life Skills

<table>
<thead>
<tr>
<th>Peer Education &amp; Life Skills</th>
<th>Men N= 267</th>
<th>Women N=288</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td>Rejects that because a trained peer educator knows what is best, he/she should try by all means to force everyone to agree with his/her ideas. Q001</td>
<td>20.6 %</td>
<td>76.0 % ***</td>
</tr>
<tr>
<td>Rejects that a good peer educator should stop or correct his co-facilitator in the middle of a session, if he or she has made a mistake. Q002</td>
<td>22.8 %</td>
<td>76.0 % ***</td>
</tr>
<tr>
<td>Mentions ‘Ability to communicate, ability to make decisions, and Interpersonal skills’ as the three types of life skills. Q003</td>
<td>57.3 %</td>
<td>82.4 % ***</td>
</tr>
</tbody>
</table>

* p<.05; ** p<.01; ***p<.001

Table 6 below shows the six components of the condom use knowledge indicators. Apparently there is a low level of knowledge in using condom correctly prior to the training, and results for most questions increase significantly during the training to a level around 90% with correct answers. At post test, both men and women have increased performance on condom use correctly to a level of 80%. This is very significant with p<.001.
### Table 6: Condom use Knowledge

<table>
<thead>
<tr>
<th>Condom use knowledge</th>
<th>Men N=267</th>
<th></th>
<th></th>
<th>Women N=288</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
<td>Sig.</td>
<td>Pre-test</td>
<td>Post-test</td>
<td>Sig.</td>
</tr>
<tr>
<td>Performs condom use knowledge. Q021 correct</td>
<td>%</td>
<td>%</td>
<td></td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>36.7</td>
<td>81.3</td>
<td>***</td>
<td>34.4</td>
<td>80.9</td>
<td>***</td>
</tr>
<tr>
<td>Mention to check expiration date on condom package Q021</td>
<td>%</td>
<td>%</td>
<td></td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>56.6</td>
<td>88.0</td>
<td>***</td>
<td>57.3</td>
<td>89.9</td>
<td>***</td>
</tr>
<tr>
<td>Mention to open condom package using fingertips. Q021a</td>
<td>%</td>
<td>%</td>
<td></td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>61.0</td>
<td>92.5</td>
<td>***</td>
<td>63.2</td>
<td>94.1</td>
<td>***</td>
</tr>
<tr>
<td>Mention to verify if condom is not inside out, put in on erect penis while pinching the tip; Q021c</td>
<td>%</td>
<td>%</td>
<td></td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>63.7</td>
<td>94.4</td>
<td>***</td>
<td>61.1</td>
<td>93.8</td>
<td>***</td>
</tr>
<tr>
<td>Mention to unroll condom completely ;Q021d</td>
<td>%</td>
<td>%</td>
<td></td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>69.7</td>
<td>92.5</td>
<td>***</td>
<td>67.4</td>
<td>92.7</td>
<td>***</td>
</tr>
<tr>
<td>Mention to hold condom when removing it, while penis is still erect Q021e</td>
<td>%</td>
<td>%</td>
<td></td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>68.5</td>
<td>92.5</td>
<td>***</td>
<td>66.0</td>
<td>92.0</td>
<td>***</td>
</tr>
<tr>
<td>Mention to dispose in a trash bin. Use each condom only once Q021g</td>
<td>%</td>
<td>%</td>
<td></td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>71.5</td>
<td>96.6</td>
<td>***</td>
<td>76.0</td>
<td>95.5</td>
<td>***</td>
</tr>
</tbody>
</table>

* p<.05; ** p<.01; ***p<.001

### MAIN FINDINGS

At pre-test, 1 out of 3 participants had comprehensive knowledge on HIV. The participants were below national level of around 50% for the same age group from the Rwanda DHS (2005). At post-test, 2 out of 3 had comprehensive HIV knowledge, which shows that the trainings were successful in increasing knowledge on HIV.

Both PSI Rwanda and DHS 2005 results show that men have greater knowledge on HIV than women. In addition, there are big differences between the level of HIV knowledge in the districts at pre and post test. This might be explained by other factors.
such as educational level or rural/urban residence, or these differences may be attributed to participant recruitment.

The level of knowledge on Reproductive Health at post test improved considerably especially when it comes to the period of fertility and usage of withdrawal as a method to prevent pregnancy. The knowledge increased in these areas, as more than 75% among both men and women scored high after the training.

After the training most men and women are convinced not to force others to agree with their ideas and not to stop his/her co-facilitator if he/she makes mistakes. During the training both men and women increased their knowledge on condom use at the level of 80%.

RECOMMENDATIONS

Programmatic implications

The results show, that the trainings are effective in increasing knowledge of participants, especially regarding HIV and Reproductive Health. There are big differences between the districts, which might be explained by rural/urban dichotomy, differences in educational level or difference in motivation to learn about these topics. These regional differences could be explored further given that PSI Rwanda has outreach to youth in many districts of the country. In addition, further knowledge on this would be valuable in terms of planning and conducting training.

Gender differences in especially HIV knowledge both prior to and after the training calls for increased focus on how to improve outreach to girls in Peer Education trainings as well as other parts of PSI Rwanda’s interventions on HIV prevention among youth.

When entering the data, it is clear that many participants give multiple answers for the same questions. This calls for attention when the Health Educators explain how to fill in
the questionnaire, regardless of whether or not this exercise of analyzing the results will be put in to practice on a regular basis. Moreover, it should be stressed that more than one answer for the same question is not a correct answer and should not count as such when calculating the correct percentage on each test.

In order to ensure data quality for pre- and post-tests results, Research, Monitoring and Evaluation department, or at least people who will analyze the data, should be involved in the designing of data collection tools. A specific supervision, rigorous guidance, and explanations are required when the participants are not skilled enough to fill in the pre-and post-test questionnaire. There should also be held a session to explain correctly the use of these tools of data collection to health educators as it has been observed that some questionnaires were not properly filled to allow analysis.

Health educators have to be well trained in the area of HIV/AIDS and reproductive health prior to going to the field. Further refresher training is also recommended when it is found that a long time has elapsed without going through this exercise of peer education training. This calls for PSI youth team to design a simplified module which covers all the topics on HIV, reproductive health, condom use and peer education life skills with methodological support to guide health educators in their activity.

The recruitment process of peer educators should be done carefully to make sure that all people meet the pre-defined criteria of the target group to avoid those who can sneak in and bias the data since this can also be the source of knowledge discrepancies in some districts.

**Program evaluation**

The pre and post tests provides an opportunity for increased qualitative program monitoring and evaluation, given that the data are collected on a regular basis and is already a part of the routine procedures of the youth team. However, costs and benefits should be considered before implementing this for future trainings: are the results worth
the extra work to analyze them – or, is it just extra work? Given the usefulness of the results for programmatic decisions, these types of trainings should be systematic and follow-up closely to ensure quality, thus improving targeting the right population.

If PSI Rwanda decides to proceed with analyzing the pre- and post-tests data, the test should be reviewed in terms of content, design, and translation. The design of the test could be improved by using tick-boxes for education- and gender questions. This would ease data entry and improve the quality of data. Importantly, the data collection tools should be harmonized and reformatted across the programs that conduct pre- and post-tests; this allows quick data cleaning and analysis.