FINAL REPORT

Agents of change

HIV AND AIDS AWARENESS CREATION PROGRAMME
TAN 0501711

ACRONYMS AND ABBREVIATIONS

AECU:	AIDS Education Coordination Unit
AFO:	Administrative and Financial Officer
AIDS:	Acquired immune Deficiency Syndrome
BTC:	Belgium Technical Cooperation
CCITWG:	Cross Cutting Issues Technical Working Group
CHMC:	Council Health Management Team
DEO:	District Education Officer
DFP:	District Focal Persons
DSCI:	District School Chief Inspector
HQ:	Head Quarters
JLPC:	Joint Local Partner Committee
LGA:	Local Government Authority
MoEVT:	Ministry of Education and Vocational Training
NMSF:	National Multi- Sectoral Strategic Framework
SCAEC:	School Counselling and AIDS Education Committee.
SRH:	Sexual Reproductive Health
TACAIDS:	Tanzania Commission for AIDS

Contents

1 BASIC INFORMATION OF THE PROJECT

Navision Code	TAN0501711
Country	Tanzania
DAC Sector and Sub sector	HIV and AIDS
National/Regional Institution in charge of Execution	Ministry of Education and Vocational Training
Agencies in charge of the Execution	HIV and AIDS Education Unit
Number of BTC International Cooperation Experts	None
Duration	48 Months
Project start	20 October 2006
End of the Project (per SA)	19th April 2013
Project Management Method	Co-Management/ Regie
Total Project Budget	Belgium: 1,549,832 € Tanzania: 56,654 €
Period covered by the project	September 2009 to 19th April 2013

2 APPRAISAL

Evaluate the relevance and the performance of the project by means of the following assessments

1. - Very satisfactory
2. - Satisfactory
3. - Non satisfactory, in spite of some positive elements
5. - Non satisfactory
X. - Unfounded

Write down your answer in the column corresponding to functions during the project execution.

	National Execution Official		**BTC Execution Official**	
Relevance	Assessment	*Remarks*	*Assessment*	*Remarks*
1. Is the project relevant compared to the National development priorities?	1	Project is in line with: • MOEVT Strategic Plan for HIV/AIDS 2008-2012 • MOEVT Guidelines for Implementing HIV/AIDS and Life Skills Education Programme in Schools (revised May 2004) including primary schools. • Tanzania Education Policy with the AIDS Education Programme in schools enhanced by circular No. 3 of 2000 stipulating the interventions and the establishment of AIDS education in schools. • MOEVT Guidelines for Implementing HIV/AIDS and Life skills Education Programme in Schools.	1	The project aimed at Mainstreaming MOEVT HIV policy. For sure it was very relevant
2. Is the project relevant compared to Belgium development Policy? Indicate your result according to the three themes below. a) Gender b) Environment c) Social economy	1	Support of HIV AIDS education and control is a key policy in Belgium a). Gender: Project main-streamed gender aspects. Both sex participate in equal numbers b). Environment: Project has little or no effect on environment c). Social Economy HIV and AIDS and poverty are interlinked and influence each other, the project then is vital for the poverty reduction.	1	Support to HIV education and control is a priority a).Gender: Majority participants were women. b). Environment: No effect c). Social economy Less AIDs means more healthy workers in an economy.

3. Were the objectives of the project always relevant?	1	The Main objective was relevant since it addresses the needs of the Tanzanian in implementing National HIV/AIDS Multi-Sectoral Strategic Framework (NMSF) 2008 – 2012 and the coming NMSF-3 which address issues concerning pupils through different innovative approaches so that we can eventually respond towards 3 zeros; Deaths zero, infection zero and stigma zero by the year 2017. The specific objective is relevant since the mission of the Ministry of Education and Vocational Training. is the empowerment by provision of skills and knowledge of HIV/AIDS to learners, teachers and MoEVT employees.	1	Yes, it has been very relevant since HIV is still an important threat in Tanzania and that no special prevention action had been taken so far in the primary school.
4. Did the project meet the needs of the target groups?		The needs were met. The project has proven the capacity of young people to transform negative community norms towards responsible behaviour change. Tanzania's National Response to the AIDS epidemic is simply incomplete without including the country's primary-school aged children.	2	The school pupils and other adolescents benefitted from the trainings, SCAECs were rejuvenated and teaching & counselling was conducted in schools. Access to health centres had still to be improved
5. According to its objectives, did the project rely on the appropriate local execution organs?	1	The project was executed by the appropriate Government organs that are the MoEVT and the Municipal/District Councils.	1	At the centre MOEVT and locally the district councils and primary schools.

	National execution official		BTC execution official	
RELEVANCE[1]	**Assessment**	**Remarks**	**Assessment**	**Remarks**
1. Did the results of the project contribute to the carrying out of its objectives[2] ? (efficiency)	**1**	The results contributed well in the achievement of the project objective. The impact of this project was witnessed across all targeted schools, demonstrating that even at primary level, children and young adolescents can positively change their own behaviour and even help change attitudes and practices among their own peers, families and communities.	**1**	Yes definitely, it has been well stated in the final evaluation report.
2. Evaluate the intermediate results (efficiency)	**1**	The intermediate results were satisfactory because they contributed to a positive achievement of the specific objective, i.e. they contributed positively to helping change behaviours and attitudes and practices among peers, families and communities. However some of the intermediate results were not appealing e.g. Some trained health officers were transfered and the project had to train others so that they could visit school to attend the referral activity for pupils.	**2**	Results were achieved significantly. It only remains a challenge the means of scaling up the positive results achieved**.**
3. Are the management methods of the project appropriated? (efficiency)	**1**	The management of the project are appropriate. The system was efficient because the project execution used already employed government staffs and outsourced implementation whenever necessary. The MoEVT policy, structure and guidelines were used. The councils by using the DFPs played a major role of coordination supervision and monitoring. The MoEVT did the facilitation and the advisory was done by BTC.	**2**	The management of the project was appropriate and followed the proposed formulation structure well. However the distances between the project districts posed a coordination problem
4. Were the following resources appropriated (efficiency)				
a. Financial means?	**1**	The financial means were satisfactory to cover most of planned activities and funds were disbursed on time.	**2**	Financial resources were put into the intended activities but fell short to achieve fully sustainable results
b. Human resources?	**1**	Human resources were sufficient in each District. In the office it was real	**1**	Implementation through district

[1] According to PRIMA, §71, pp. 19-20, it is a matter of "appreciate and measure the foreseen performances agreed during the preparation traineeships according to the 4 criteria and the indicators established during the formulation. (The 4 criteria are efficiency, suitability, respect of deadlines and quality of the personnel)".

[2] See annex 1 for further information

	National execution official		BTC execution official	
RELEVANCE[1]	**Assessment**	**Remarks**	**Assessment**	**Remarks**
		heavy for the PMT of two people but it was well managed.		council system ensured enough human resources.
c. Material and equipments?	**2**	The working materials in terms of office uses were enough. Training materials were sufficient but the furnishing of the Health club rooms did not have enough funds.	**1**	The districts and schools provided part of the resources needed. Some were supplemented by the project
5. Were the project resources optimized in order to reach the foreseen results? (efficiency)	**1**	The project resources were utilized effectively. Most of the funds were directed to beneficiaries, within the project areas.	**1**	The project resources were used wisely to implement activities planned that were identified by PMT and approved by JLPC
6. Was the project satisfactory on a cost-efficiency approach in comparison to similar interventions? (efficiency)	**1**	The project was cost efficient in terms of management but in terms of location was not cost efficient because the two execution locations were located too far from each other(about 800 km) The impact seen during Backstopping, monitoring and evaluation.	**1**	The establishment of a small team at MOEVT and use of district council systems made the project quite cost efficient.
7. According to the execution planning, assess the speed of the execution. (respect of deadlines)	**1**	The execution speed was good because there was no delay of fund disbursement. The extension of 18 months was caused by the late starting of the execution than expected.	**2**	Average speed was moderate because of some delays during project start up and the changes in the financial management modalities et LGAs level.

Indicate your global evaluation of the project by means of the following appreciations:

1 - Very satisfactory
2 – Satisfactory
3 – Non satisfactory, in spite of some positive elements
4 – Non satisfactory
X - Unfounded

	National execution official	BTC execution official
Global evaluation of the project	**1**	**1**

National execution official	BTC execution official
The project was successfully implemented since it addressed the needs of the beneficiaries, indicators which were set were achieved, and all the planned activities were implemented. The quantity and quality of the implementation was witnessed across all targeted schools, demonstrating that even at primary level, children and young adolescents can positively change their own behaviour and even help change attitudes and practices among their peers, families and wider communities.	The project had enough human, financial and material resources. The 18 months extension allowed the project to complete all the planned activities. Intermediary and final evaluations have shown good achievements.

3 SUMMARY OF THE PROJECT IMPLEMENTATION

1. Describe the Specific objectives and the Intermediate results of the project, as mentioned in the project document, as well as the implemented changes (when, how and why).

The intervention was on HIV/AIDS awareness creation programme targeting youth and adolescents in primary schools in Dar es Salaam and four selected districts in Tanzania. The Specific Objective of the project is to empower youth to practice behaviours that protect their sexual and reproductive health by increasing their age specific knowledge. All the expected results were achieved. Implementation of activities started by the project is continued by the schools and the district councils. Achievements that contributed to attainment of the Specific objective are summarised as follows:

R1. An enabling environment for HIV/AIDS programmes targeting adolescents and youth is created

A multiple, synergic approach was used to create an enabling environment for the project. Capacity of local government in HIV/AIDS programming, management, monitoring and evaluation was strengthening. At the beginning of the project there were trainings for 182 LGA primary education staff and 476 SCAEC members, which ensured ownership and sustainability of the project. Sufficient resources and infrastructure were available. Youth friendly health services and material resources were made available aiming to ensure the involvement and support of adults living with or working close to children.

R2. The capacity of the districts in HIV/AIDS programming, management, monitoring and supervision is strengthened

Resources and facilities for implementation of project activities were made available and accessible. Monitoring tools were developed and produced in collaboration with the MoEVT and the LGAs. They were used by the various stakeholders like PMT, DFPs, DSCIs CHMC and Head teachers in the implementation of the project. The project did a number of complimentary activities, both in – classroom and extracurricular, Example: 14 Arts and Sports officers, 2 from each of the 7 districts were trained; 56 teachers, two from each of the 28 schools received an initial training and a refresher course on dissemination of AIDS and ASRH education messages = using sports and arts.

R3. Teachers and School Guardians/Counsellors are trained/ skilled in HIV/AIDS and life skills education

A comprehensive Training approach was used. Comprehensive, continuous training involved all stakeholders; training of all 879 teachers, in all project schools including Head teachers; training of 113 school teacher counsellors; 56 sports and arts teachers 14 sports and arts district officers, 476 SCAEC members, 14 district school inspectors and refresher trainings by using participatory methods resulted in real understanding.. The comprehensive training contributed enormously to the knowledge, confidence and behaviour changes amongst pupils. The project directly resulted into positive behaviour amongst pupils There is also increased knowledge and behaviour change to indirect beneficiaries the out of school youths, parent and the community members in general.

R4. In-school adolescents' and youth's access to curriculum and extra-curriculum HIV/AIDS information and education has improved

Creative and participatory teaching methods made the learning more effective. The project added education through arts and sports to the Ministry's existing package of primary-level interventions on HIV AIDS education. This involved studying sexual and reproductive health problems in a locality, analysing them and suggest solutions.

Using songs, games, sports and drama to address adolescent sexual and reproductive health allowed teachers and pupils to express themselves more openly. It allowed the youngsters to explore and engage with sexual and reproductive health topics more confidently. Participatory learning methods empowered the youth to take control of the learning process and young learners clearly enjoyed the lessons. Creative, participatory methods contributed to attendance rates. A total of 840 pupils were trained as peer educators and 700 pupils were trained in using arts and sports in HIV and AIDS education. Refresher courses were given..

R5. Use of ASRH/HIV/AIDS and support services by adolescents and youth has increased

Physical resources and youth friendly health services made available aimed to ensure involvement and support of those adults close to or working with the children. Health officers were trained to provide health services to the pupils. In all 28 schools health club rooms were built and furnished and they are being used not only by the schools but also by the communities around the schools. In organising the health services a gender sensitive approach was used, whereby particular attention was paid to the creation of a safe environment for girls.

R6. Information and communication to national and international stakeholders in ASRH/HIV/AIDS, including donors, about the programme results is an integrated part of the programme implementation

Development and integration of exit strategies.

Information from the Baseline studies, Backstopping missions, Best practices and Lessons learnt study were all disseminated to all the key stakeholders. The project has worked on the key recommendations given by the various reports
The key recommendations have been summarised as:

- To mainstream the project into the MoEVT -AECU.
- To involve stakeholders including TACAIDS and the MoEVT (CCITWG) in the subsequent steps after the closer of the project to develop a concrete action plan.
- To replicate tools and guidelines existing in MoEVT and those developed by the project and maximise their use..
- To share experience of the project among stakeholders within and beyond Tanzania.
- To scaling up the project to more schools integrating good practises into National policy.

2. To which extent were the intermediate results of the project reached, according to the accepted indicators?

According to the specific objective which says: To empower youth to practice behaviours that protects their SRH by increasing their knowledge of age specific sexual and reproductive health in Tanzania;

1. Knowledge of boys and girls about how to protect their SRH has been improved tremendously
2. Knowledge of boys and girls about how to protect themselves from being infected with HIV has improved
3. Use of ASRH/HIV/AIDS and support services by both boys and girls has been acquired.

R1. An enabling environment for sustainable HIV/AIDS programmes targeting youth and adolescents at primary schools is created

All the 28 schools established SCAEC and 336 SCAEC meetings were held during the project period.

R2. The capacity of the districts in HIV/AIDS programming, management, monitoring and supervision is strengthened

Training was done to 77 education staff including DEOs, DFPs, WEOs, School Inspectors, School Heads and CHMC members. All project districts had in place a focal person for the programme.

All the 7 districts have SCAEC using the standardized reporting, monitoring and supervision tools.
336 district monitoring and supervision visits have been done.

R3. Teachers and School Guardians/Counsellors are trained and skilled in HIV/AIDS and life skills education.

- Teachers in the 28 schools have been trained in ASRH/HIV/AIDS
- Guardians/Counsellors in the 28 schools have trained.
- 950 teachers received a work package with support materials
- 950 teachers have been trained in ASRH/HIV/AIDS

- 879 teachers received a work package with support materials
- 133 female teachers were selected as School Guardians/Counsellors
- 158 School Guardians/Counsellors attended refreshment trainings.

R4. In-school adolescents' and youth's access to curriculum and extra-curriculum HIV/AIDS information and education has improved.

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- 36,000 pupils have access to ASRH/HIV/AIDS support materials in the project schools.
- 28 schools established a School Health Club
- 28 School Health Clubs that have a venue of their own
- 28 School Health Clubs are equipped with a ASRH/HIV/AIDS library, sport and recreation materials
- 840 of School Health Club members have been trained as peer educators
- 6,968 girls are members of the School Health Club
- 700 boys and girls have been trained as peer educators.
- In every school the peer educators organised at least 1 to 2 peer education activities per week.
- 7 ASRH/HIV/AIDS sensitisation events have been organized in every school.
- Each of the 28 schools organised at least one ASRH/HIV/AIDS sensitisation event quarterly.

R5. Use of ASRH/HIV/AIDS and support services by adolescents and youth has increased

- 105 health staff at the village dispensary and the ward health centre were trained in adolescent and youth friendly attitudes.
- 7 village dispensaries/ward health centers has a staff trained in adolescent and youth friendly attitudes.
- 28 schools established ASRH/HIV/AIDS support and referral system.
- 36000 adolescent boys and girls use ASRH/HIV/AIDS and support services.

R6. Information and communication to national and international stakeholders in ASRH/HIV/AIDS, including donors, about the programme results is an integrated part of the programme implementation.

More than 100 people received the Publication of base-line survey results.

All the 150 people who attended the Conference on lessons learned and good practices received the publications of research results. 1000 booklets in English and 1000 booklets in Kiswahili were produced and distributed to schools and other stakeholders.

150 National and International stakeholders in ASRH/HIV/AIDS participated to lessons learned and good practices conference and received a copy of the publications, lessons learned and good practices and conference proceedings.

None of the contacted Development Partners confirmed to support the consolidation and/or expansion of the programme.

4. Describe the follow-up evaluation system established when the project was implemented

During the project, project activities were implemented directly by the project schools. Schools were being coordinated by a District Focal person. Oversight of the project was given by the JLPC, at central level the project was being coordinated by a National Project Coordinator under the MoEVT office under the AECU. Monitoring and evaluation teams consisting of DEO, DFP, WEC, DSCI, CHMT, met once in every quarter to assess the progress of project activities at school level and prepare the quarterly report.

Also twice a year the JLPC meeting was conducted and during the meeting the PMT submitted the six month progress report that was discussed by JLPC members and gave out recommendations for way forward.

Apart from JLPC meetings, there were three backstopping missions conducted by thematic experts from Belgium. The BSMs were in August 2010, August 2011 and August 2012. They assessed progress of the implementation and made recommendations majority of which were followed up and implemented by the project

At the end of the each year annually reports were made by PMT, discussed and approved by JLPC before were submitted to BTC.

Regarding financial management, the AFO posted all monthly transactions in FIT, made the monthly closure before submitting to BTC.

Financial audits were done by local and International consultants three times during project duration.

4 COMMENTS AND ANALYSIS

1. What are the major problems and questions having influenced the project implementation and how did the project attempt to solve them?

During the project implementation, challenges faced were very few because of the design of the project that most implementation is done by local institutions. PMT managed well the activities that received central support.. The few challenges encountered were dealt successfully. A summary of the challenges is described below:

i. Transfers of the trained staff

Around 15 Trained teachers, Head teachers, teacher counsellors and health officers were tranfered to non project schools and other health centers. In spite of the initiative by the PMT took to ask the DEDs/MDs not to transfer the staff working for the project. In order to keep pace with the changes, the project had to undertake retraining of staff several times to cater for the turnovers.

ii. Coverage of the project

Schools neighbouring project schools complained much for their schools to be included in the project following appreciation of the achievements in project schools. Every now and then the project had to explain that only a few schools can be included in this phase, and that a subsequent phase will be able to take in more schools, something which MOEVT still hopes will happen.

iii. Participation of DFPs

Participation of the DFPs to project activities was not up to the mark because most of them were busy attending to more pressing core duties including marking exams, Most of the coordination of schools were done from offices.

2. Which factors explain the differences in relation to the awaited results?

The achieved results were contributed by different factors as explained in the Lessons learnt and good practice report. During project implementation, there were internal and external factors that contributed positively or negatively towards achieving the project goal.

In the HIV and AIDS Awareness Creation project, some of the major internal contributing factors in achieving the positive results were the readily availability of project funds, and ability of teachers and counsellors to learn and deliver, the use of experienced focal persons who were also coordinators of HIV and AIDS of MoEVT working in the Districts, a highly committed PMT. Other factors that contributed to the success included the competence and commitment of the Technical backstopping service from BTC. Good and timely decisions made by the JLPC meetings steered the project to successes. Equipments and materials needed were simple and easily available.

3.0 Which lessons can we learn from the project experience? Please give a detailed answer on the impact and the durability of the results.

During the final evaluation of the lessons learnt and good practices, it was observed that, the project was implemented by using the existing structures and institutions such as the MoEVT officials, district council officers, use of the MoEVT guideline and learning and teaching materials, showed to be a better practice in contrast with creating new structures, systems and institutions. Using existing structures, systems and institutions increased possibilities of sustainability of the project.

3.1 Additional trainings

In the backstopping report 2010 it was recommended to organize additional trainings with the aim of “reaching out all primary school inspectors and all heads of departments and districts in order to standardize the follow-up mechanisms.” Refresher trainings were included in the programme budgeting,

3.2 Pool of TOT (district)
The presence of a pool of "Trainers of Trainers" (TOT) at the MoEVT instead of training new TOTs had a very positive impact in reaching the project objective within the short time of the project implementation.

3.3 Audiovisual materials
The backstopping report of 2010 recommended the production of audiovisual materials. Audiovisual materials are priority for ensuring a successful implementation of the programme. During the formulation of the programme this possibility had been considered, but eventually it was decided not to invest in the production of additional learning and didactic materials, but to concentrate on the use of the materials and resources that were already available at the MoEVT.

3.4 Results
In all targeted districts, the pupils, teachers and the communities were sufficiently informed and came to realisation of the problems faced by all as far as HIV/AIDS/ASRH is concerned and the necessary solutions required. As a result, School Counselling and AIDS Education Committees actively participated in prevention and awareness creation activities – mediating between schools and the wider community.

3.5 Primary pupils can be agents of change
The pilot HIV and AIDS Awareness Creation Programme (2009-13) has witnessed a gradual but paradigm shift among the community, from seeing youth as a problem or a concern, to viewing them as assets, resources and competent contributors to the fight against the spread of HIV & AIDS. This shift has in turn allowed young people to positively bring about behaviour change, of their own and the behaviour of those around them.

3.6 The study of lessons learnt and good practices
Impact studies of the project have demonstrated the capacity of young people to transform negative community norms towards responsible behaviour change/practices. The HIV/AIDS Awareness programme has been a gateway to many other social issues that can be addressed through different innovative approaches in the society to get rid of them. This was largely an achievement through the comprehensive training approach, but also the overall enabling environment and gender consideration which includes a supportive community.

3.7 Lessons learnt and Good practices
The success of the program draws on the fact that, the majority of the pupils have changed their behaviours, which were putting them at risk of being infected with HIV. From the findings, it is clear that many have been able to learn beyond the awareness level – to life skills, capable of confronting various social and psychological issues. They have used their skills to transform their societies and are eager to go on and on, until most negative social norms are changed. The major success is that the majority of pupils decided to abstain or delay their sexual rendez-vous ; some were saying; "W*e have learnt that our sexual organs should be protected until marriage*".

4.0 According to you, how was the project perceived by the target groups?

Generally all the beneficiaries: pupils, teachers, SCAEC members and the community around the project schools have been overwhelmed by the project. The target group feels privileged to participate in the project by the fact that many other neighbours did not receive the benefits of behaviour changes being observed in the target group following the intervention.

5.0 Did the follow-up evaluation or the monitoring, and the possible audits and controls have any results? How were the recommendations taken into account?

- During the project duration a number of monitoring and controls were done that resulted into achievement of the expected results, these include:
- 2 Backstopping missions from thematic experts from BTC Brussels which assisted the project in re-planning to address the existing situation.
- 1 Backstopping mission from BTC Brussels that was very intensive to suffice the need for a Mid-term review. Hence the MTR was cancelled.
- 2 audits were conducted by external firms.
- All the above made several useful recommendations that were agreed by PMT or proposed to JLPC meeting for approval. The project implemented all the key recommendations except a few. In order to be able to implement the recommendations, several budget changes were made to accommodate the changes.

6.0 **Which are your recommendations for the consolidation and the appropriation of post-project period (policy to be followed or implemented, necessary national resources, makes target groups aware of their responsibilities, way to apply the recommendations**

- The project has been piloting a MOEVT curriculum on HIV AIDS awareness to primary schools. The lessons learnt during implementation will help the Ministry to review and fine tune the curriculum. For example: its important to introduce and promote Arts and sports in HIV AIDS as extra curriculum activity.
- The MOEVT and the Local Government Authorities are urged to maintain the structures and resources created by this project as much as possible. For example, they should continue using the health club rooms for the intended purpose, and they should refrain from transferring teachers and counsellors from the project schools. The schools should be encouraged to continue training Peer educators each year to replace the pupils that have completed school.
- The district should ensure that SCAECs continue to be active and 'keep the candle burning in the schools and the communities.
- The government and especially the district councils should allocate the resources needed for scaling up of the project to more schools in order to consolidate the successes and 'spread the news' to more schools and communities.
- The Ministry can promote parts of the programme especially the arts and sports component to private and corporate companies for sponsorship just like it is done to football in Tanzania.

7.0 Conclusions

In spite of the short duration of the project which is a normal case with donor projects the project made great achievements within the time and financial constrains.
The project used existing structures for implementation from central level to grassroots level. At national level the PMT was located within the MOEVT, while at lower level primary schools and their communities were the implementers and beneficiaries. The district councils were instrumental in the horizontal coordination of the project schools (4 in each district) and vertically to the PMT at MOEVT. The project received overall supervision from a partners committee (JLPC) that brought together key players at national level and some representation from the intermediate and ultimate beneficiaries.
The project received relevant backstopping and monitoring support from BTC internally or through external firms. This helped the project to assess performance and review the strategies and plans for better performance.
It is a widely accepted fact that the project resulted into great changes in the knowledge, skills attitude and behaviours among the pupils in the project schools and the communities surrounding the schools.
The level of achievement of results encourages the various stakeholders to consider the up calling of the project to cover more schools and give time to the government to find sustainable modalities for policy change and relocate more funds for the interventions in primary schools.
The project wishes that the Belgian government will still consider funding an up scaling project by any other way possible. Many thanks are given to all who made this project a success.

National execution official	**BTC execution official**
Name:	Name:
Signature:	Signature:

5 ANNEXES

Annex 1 Results summary
Annex 2 Situation of receipts and expenses
Annex 3 Disbursement rate of the project
Annex 4 Personnel of the project
Annex 5 Subcontracting activities
Annex 6 Equipments
Annex 7 Trainings
Annex 8 Agent of Change leaflet

ANNEX 1. Result Summary (according to Logical framework)

Intermediate result	Project Indicators	Indicator foreseen or realized	Progress
Specific Objective: To empower youth to practice behaviours that protects their SRH by increasing their knowledge of age specific sexual and reproductive health in Tanzania.	Knowledge of boys and girls about how to protect their SRH has improved. Knowledge of boys and girls about how to protect themselves from being infected with HIV has improved Use of ASRH/HIV/AIDS and support services by both boys and girls .63% of pupils agreed to have been using the services.	Base-line survey report. Research report on lessons learned and good practices. Focus group discussions with students. Referral reports. Health facility reports. Reports of social support services.	The targeted group 7 to 13 pupils has demonstrated that they can positively change their own behaviour and even help change attitudes and practices among their peers, families and wider community. 79 % of pupils appear knowledgeable on how to avoid becoming infected. Support services available in all 28 schools.
R1. An enabling environment for sustainable HIV/AIDS programmes targeting youth and adolescents at primary schools is created.		All 28established a SCAEC and meet quarterly. The members of SCAEC played an important role in ensuring local ownership and support of the project. Minutes for SCAEC meeting and annual working plans and reports available.	The members of SCAEC became involved in awareness rising, helping to address concerns of some parents ensuring children felt they could be more open about sensitive topics.
R2. The capacity of the districts in HIV/AIDS programming, management, monitoring **and evaluation is strengthened.**	Number of districts with a Programme Focal Person. Number of trained DEOs, PFPs, WEOs, School Inspectors, School Heads and CHMC members. Number of districts and SCAEC using the standardized reporting, monitoring and supervision tools. Number of district monitoring and supervision visits.	All 7 districts have a Programme Focal Person. 77 members of the District Officers have been trained on HIV/AIDS and ASRH. (DEOs, PFPs, WEOs, SCIs School Heads and CHMC members.) All 7 districts got and used the standardized reporting, monitoring and supervision tools. Quarterly district	Trained Local Government Authorities and school committees ensure ownership and sustainability. Interviews done showed very positive respond to the project. The head teachers say the pupils are very competent and confident while one of the DEOs say he will encourage the Government Authorities to

		monitoring and supervision visits were done by district Officers and head teachers.	allocate resources from the council Budget to continue the programme when BTC stops.
R3. Teachers are trained and skilled in HIV/AIDS and life skills education.	Number of schools where teachers have been trained in ASRH/HIV/AIDS. Number of teachers trained in ASRH/HIV/AIDS. Number of teachers who received a work package with support materials. Number of schools disposing of trained School Guardians/Counsellors. Number of female teachers who were selected as School Guardians/Counselors. Number of School Guardians/Counsellors who received an intensive training. Number of female School Guardians/Counsellors who received an intensive training. Number of School Guardians/Counsellors who attended refreshment trainings. Number of female School Guardians/Counsellors who attended refreshment trainings.	In the 28 schools all teachers have been trained in ASRH/HIV/AIDS. All 879 teachers received a work package with support materials (teacher counsellors and sports and arts teachers). 28 schools dispose trained School Guardians/Counsellors. 65 female teachers were selected as School Guardians/Counsellors. 133 School Guardians/Counsellors received an intensive training. 65 female School Guardians/Counsellors who received an intensive training. 113 School Guardians/Counsellors who attended refreshment trainings. 65 female school Guardians/Counsellors attended refreshment	Teachers are ready and very much willing to orient others in HIV/AIDS/ASRH knowledge and skills. It has been realized that when teachers are trained/ oriented can perform well in giving youths knowledge and skills on HIV/AIDS and ASRH
R4. In-school adolescents' and youth's access to curriculum and extra-curriculum HIV/AIDS information and education has improved.	Number of school pupils that have access to ASRH/HIV/AIDS support materials. Number of schools that established a School Health Club. Number of School Health Clubs that have a venue of their own.	36,523 of pupils have access to ASRH/HIV/AIDS support materials. 28 schools established a School Health Club. 28 of School Health Clubs have a venue of their own 28 School Health Clubs	

	Number of School Health Clubs that are equipped with a ASRH/HIV/AIDS library, sport and (re)creative materials. Number of School Health Club members who have been trained as peer educators. Number of girls who are member of the School Health Club. Number of girls who have been trained as peer educators. Number of peer educators who organised at least 1 peer education activity per year. Number of School Health Clubs that received arts/sport workshops. Number of arts/sport workshops that were organised. Number of ASRH/HIV/AIDS sensitisation events that have been organized. Number of schools that organised at least one ASRH/HIV/AIDS sensitisation event.	are equipped with a ASRH/HIV/AIDS library, sport and (re)creative materials. 840 School Health Club members have been trained as peer educators. 350 girls are members of the School Health Club. 350 girls have been trained as peer educators. All peer educators in the 28 schools organised at least more than 1 peer education activity per year. 700 School Health Clubs received arts/sport workshops 2 arts/sport workshops were organised each 5 days. More than 14 ASRH/HIV/AIDS sensitisation events have been organised. 28 schools organised at least one ASRH/HIV/AIDS sensitisation event.	
R5. Use of SRH/HIV/AIDS services by adolescents and youth has increased.	Number of health staff at the village dispensary and the ward health centre trained in adolescent and youth friendly attitudes. Number of village dispensaries/ward health centers with staff trained in adolescent and youth friendly attitudes. Number of schools that established an ASRH/HIV/AIDS support and referral system. Number of adolescent boys and girls using	105 health staff at the village dispensary and the ward health centre trained in adolescent and youth friendly attitudes. More than 28 village dispensaries/ward health centers with staff trained in adolescent and youth friendly attitudes. 28 schools established an ASRH/HIV/AIDS support and referral system. 36,523 adolescent boys and girls using	The setup of referral system allowing pupils to be referred to health professionals and professional visiting schools to give some of the knowledge which teachers cannot give like ARVS, CD4 etc. couldn't be achieve in most of the districts.

	ASRH/HIV/AIDS and support services.	ASRH/HIV/AIDS and support services	
R6. Exit strategies for the consolidation and expansion of the programme are developed and implemented.	Publication of base-line survey results Publication of research results on lessons learned and good practices. Number of national and international participants to end-of-programme conference. Number of national and international stakeholders in ASRH/HIV/AIDS having received a copy of the publications (base-line survey, lessons learned and good practices, conference proceeding). Number of donors supporting the consolidation and/or expansion of the programme.	Base-line survey publication done and disseminated. Publication of research results on lessons learned and good practices done and Disseminated. 150 national and international participants to end-of-programme conference. 150 national and international stakeholders in ASRH/HIV/AIDS received a copy of the publications (base-line survey, lessons learned and good practices, conference proceeding). The government of Belgian have pledged for Tz.shs.171,000,000/=	Baseline has not been disseminated Done during the conference and lessons learnt disseminated

ANNEX 2: EXPENSES

Project Budget and Cumulated Expenses from 1st April to 31st March, 2013

Description of Budget Heading	Financial Mode	Total Cost Belgian Contribution (Euro)	Cumulated Expenses (Euro)
A: HIV AND AIDS AWARENESS CREATION PROGRAMME			
TOTAL PART A			
01 Creation of enabling environment (Sub Total)		**117,950**	**117,869**
01 Start-up activities at district level	Cogest	2,870	2,857
02 Start-up activity at village level	Cogest	17,080	17,072
03 Establishment/activation SCAEC	Cogest	57,000	56,943
04 Capacity Building SCAEC	Cogest	41,000	40,997
02 District management capacity building		**93,560**	**93,410**
01 Reporting, monitoring and supervision tools	Cogest	3,500	3,464
02 Training DEO, School Inspectors, School Heads, CHMT	Cogest	27,060	27,002
03 Reporting, monitoring and Supervision	Cogest	63,000	62,944
03 Teacher training and capacity building		**146,440**	**146,380**
01 Training teachers	Cogest	69,580	69,555
02 Activation School Guardians/Counselors	Cogest	28,000	28,017
03 Intensive training School Guard/Counselors	Cogest	23,310	23,249
04 Refreshment training School Guard/Counsel	Cogest	25,550	25,559
04 Youth HIV/AIDS information and education		**729,690**	**729,118**
01 Support materials	Cogest	27,600	27,550
02 School Health Clubs	Cogest	203,550	201,715
03 Peer education trainings	Cogest	275,240	276,126
04 Arts/sport workshops	Cogest	184,300	184,763
05 ASRH/HIV/AIDS sensitization event	Cogest	39,000	38,964
05 Use of ASRH/HIV and support services		**48,625**	**49,478**
01 Training Health Staff	Cogest	18,625	18,583
02 Referral System	Cogest	30,000	30,895
06 Information and communication		**72,717**	**65,846**
01 Base-line survey	Regie	25,000	24,508
02 Lessons learnt and good practices	Regie	40,217	38,586
03 End-of-programme conference	Cogest	7,500	2,752
Z GENERAL MEANS		**340,850**	**290,687**
01 Staff salaries		**131,250**	**117,063**
02 National Programme Coordinator	Regie	25,600	24,195
03 Administrative and Finance Officer	Regie	58,400	53,784
04 Technical staff - driver	Regie	14,800	11,592
05 Other staff costs	Regie	32,450	27,492
02 Investments		**37,500**	**37,406**

01 Vehicle	Regie	26,700	26,653
02 Office equipments	Cogest	9,700	9,667
03 Equipment IT	Cogest	1,100	1,086
03 Operational Costs		**73,100**	**72,793**
03 Maintenance vehicles/fuel	Cogest	44,900	44,978
04 Telephone, fax and e-mail	Cogest	6,200	5,010
05 Office materials	Cogest	22,000	22,805
04 Audit, monitoring and evaluation		**99,000**	**62,759**
01 Monitoring and evaluation	Cogest	37,000	14,612
02 Audit	Cogest	30,000	16,685
03 Backstopping BTC (Technical and Admin.)	Cogest	32,000	31,462

ANNEX 3: Disbursement rate of the project.

Source of financing	Cumulated budget (Euro)	Real cumulated expenses (Euro)	Cumulated disbursement rate	Comments and remarks
Direct Belgian Contribution	1,549,832	1,492,788	96%	**This report covered up to 31st March, 2013.**
Contribution of the Partner Country	56,654	In-kind	Not measured	.

ANNEX 4 : Personnel of the project

Personnel type (title, name and gender)	Duration of recruitment (start and end dates)	Comments (recruitment periods, profile relevance …)
1. National Programme Coordinator • **Name:** Mrs. Hyacintha Musaroche • **Gender:** Female **2. Administrative and Finance Officer** • **Name:** Mr. Ainesa S. Kinjofu • **Gender:** Male	March, 2009 to April, 2013 July, 2009 to April, 2013	

ANNEX 5: Summary of Consultancy – Intellectual work

Name	Profession	Address	City	Country	Consultancy fee
1. Michael Angulile	Consultant		Dsm	Tanzania	Euro 1,000
2. Dr.Fidelis Owenya	Consultant	Box 72401	Dsm	Tanzania	Euro 4,000
3. P. Hezron	Education Officer/monitoring	Box 9121	Dsm	Tanzania	Tzs. 6,307,000
4. Franael Munisi	Education Officer/Counselor	Box 9121	Dsm	Tanzania	Tzs. 6,890,000
5. Macfadyne Sawaya	Consultant	Box 4910	Dsm	Tanzania	Tzs. 4,200,000
6. A.S.Rajabu	Consultant Co.	Box 19877	Dsm	Tanzania	Euro 15,980
7. Issai Seng'enge	Consultant	Box 35074	Dsm	Tanzania	Tzs. 8,000,000
8. Dr. Bennet Fimbo	Consultant	Box 76100	Dsm	Tanzania	Tzs. 6,085,000
9. HERA/ AEDES	Consultancy	Brussels	Brussels	Belgium	Euro 26.266

ANNEX 6 : List of the Equipments Acquired During the Project Purchased Under Regie

Equipment type	Budget-Euro	Actual-Euro	Remark
Motor Vehicle – Mitsubishi Pajero (Regie)	**26,700**	**24,195**	

Annex 7. Trainings/Workshops

Training type	Country, Institution, Duration	Name or number of trained people	Dates of the trainings	Subject, content and level
Capacity building to SCAEC members		7 Districts 476 SCAEC Members	March 2010	
Training of District Education Officers (DEOs), District Chief School Inspectors (DCSI), CHAC) and Ward Executive Officers		7 Districts 77 persons (comprised of DEOS, Chief School Inspectors, CHACS and WEO)	March, 2010	
Training of Teachers		7 Districts 879 Teachers	March, 2010	
Training of TOTs for Peer Education and Counselling		20 Officers	May, 2010	
Peer Education trainings Pupils		28 Primary Schools 840 pupils	May, 2010	
Districts Health Staff		105 health staff surrounding the project schools	June, 2010	
Training of Teacher Guardians/Counselors in Peer Education		7 Districts 113 School Guardians/Counselors	June, 2010	
Training of Peer Educators pupils		28 Schools 840 Peer Educators pupils	July, 2010	
Refreshment training to School Guardians/Counselors Teachers		7 Districts 113 School Guardians/Counselors	October, 2010	
Refreshment training to School Guardians/Counselors in counselling Pupils		7 Districts 840 School Guardians/Counselors	December, 2010	
Refresher training to Districts Health Staff		14 health staff surrounding the project schools	May, 2011	
Refresher Training of Teacher Guardians/Counselors in Peer Education		7 Districts 113 School Guardians/Counselors	June, 2011	
Arts/sport trainings 1st training		7 Districts 98 Persons (Districts	September, 2011	

		sport officers and school teachers)		
Arts/sport trainings		700 Arts/sport pupils	October and November, 2011	
Advocacy of HIV HIV/AIDS Education in Schools for Education Officers		56 Officers	January, 2012	
Evaluation of Arts /sport training		56 officers	January, 2012	
Refresher training for teacher counselors		133 Teacher counsellors	February/March, 2012	
Sport and arts refresher training to teachers		70 teachers	April, 2012	
Refresher training sport and arts for pupils		700 teachers	April, 2012	
Workshop for production of IEC materials phase 1, 2 , reviewing and pre-testing		90 Teachers, pupils and education officers	May – September, 2012	

Annex 8. Agent of Change leaflet

AGENTS OF CHANGE

LESSONS FROM A PILOT HIV & AIDS AWARENESS PROJECT IN PRIMARY SCHOOLS IN TANZANIA

Ministry of Education
and Vocational Training

BTC TANZANIA

Report compiled/edited by Marleen Bosmans (HIV/AIDS Mainstreaming Expert, BTC), Hyacintha Musaroche (National Project Coordinator, MoEVT), Anna Patton (Communications Officer, BTC)
All photo credits: BTC/Anna Patton, unless otherwise specified
Design and layout by Petra Balenovic

Dar es Salaam, October 2012

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
(A)SRH	(Adolescent)sexual and reproductive health
BTC	Belgian Technical Cooperation (Belgian development agency)
DEO	District Education Officer
DSI	District School Inspector
GoT	Government of Tanzania
HIV	Human Immunodeficiency Virus
LGA	Local government authorities
MoEVT	Ministry of Education and Vocational Training
MoHSW	Ministry of Health and Social Welfare
PLHA	People/Person living with HIV or AIDS
SCAEC	School Counselling and AIDS Education Committee
STI	Sexually transmitted infection
TACAIDS	Tanzania Commission for AIDS
TDHS	Tanzania Demographic and Health Survey
THMIS	Tanzania HIV and Malaria Indicator Survey

CHILD, ADOLESCENT, OR YOUTH?

The United Nations defines youth as persons between the ages of 15 and 24.

Adolescents are generally defined as those between 10 and 18 years old.

A child is any person under the age of 18.

This project targeted primary school pupils, meaning children aged 7 to 13. However, some Tanzanians are already in their mid-teens when they complete primary school.

TODAY'S LESSONS TOMORROW'S TASKS

This booklet presents the results of a project on HIV & AIDS awareness piloted in 28 primary schools in Tanzania. It highlights lessons learned and makes recommendations for scaling up activities to many more schools.

The impact of this project was witnessed across all targeted schools, demonstrating that even at primary level, children and young adolescents can positively change their own behaviour and even help change attitudes and practices among their peers, families and wider communities. Particular features of the project design contributed to these results, including:

- Alignment with Tanzanian systems
- Focus on an enabling environment
- Comprehensive training approach
- Using arts and sports

Funded by the Government of Belgium and implemented by the Ministry of Education and Vocational Training (MoEVT) with support from BTC – the Belgian development agency, this intervention was the first of its kind in Tanzania. As such, the experience of the project team, teachers, students, school committees and local government officials may offer valuable lessons for health and education stakeholders in Tanzania and beyond.

It is hoped that this booklet and the accompanying report* will encourage serious consideration of the need to invest in HIV & AIDS education in primary schools and to mainstream it within national policy.

*This booklet is based on an independent evaluation of the pilot project, carried out in July 2012. The full evaluation report can be obtained on request from the Ministry of Education and Vocational Training.

“Investing in adolescents and youth in HIV&AIDS and reproductive health issues has a multiplier effect in the national response to the epidemic. Yet in many cases, a large proportion of adolescents are left out of national HIV&AIDS strategies, since their age brackets focus on 15-49 year olds. The majority of primary school pupils are left to fumble around with adolescence, not knowing to whom they can ask questions, as parents are normally shy, and teachers and other adults assume pupils do not need sexual and reproductive health education. As such, they are prone to being misled.

Globally, neglect of younger children means that the institutions representing them, such as education bodies, are also left to tackle the issue with minimal support from other national and international organisations. In its fourth decade, HIV&AIDS has revealed that it is an ever-changing epidemic, generalised in most cases but also concentrated within vulnerable populations – including young people and adolescents.”

DR BENNETT FIMBO, HEALTH EDUCATION AND HEALTH PROMOTION SPECIALIST. AUTHOR OF PROJECT EVALUATION

WHAT DID WE LEARN?

1. **A multiple, synergetic approach is essential**
   - An overall enabling environment is needed to empower young people
   - Trained LGAs and school committees ensure ownership and sustainability
   - Physical resources including books help ensure issues are given the space and attention they deserve
   - More work is needed to guarantee accessibility of youth-friendly health services

2. **Being thorough contributes to knowledge, confidence and behaviour change**
   - The combination of project activities appears to bring about positive behaviour change among pupils
   - Comprehensive, ongoing training involves all stakeholders and results in real understanding
   - Indirect beneficiaries also report increased knowledge and behaviour change

3. **Creative, participatory methods make learning more effective**
   - Arts and sports allow young people to engage with sexual and reproductive health topics more confidently
   - Creative, participatory methods have additional benefits such as improving school attendance

WHY THIS PROJECT?
A REMINDER OF THE CONTEXT

HIV & AIDS AMONG CHILDREN AND YOUNG ADOLESCENTS

Despite the recent decline in national prevalence in Tanzania (from 7% in 2004 to 5.7% in 2008), an estimated 2.2 million people are still living with HIV or AIDS. Higher than average prevalence (over 9%) is recorded in (semi-) urban areas, with a rise in new infections in rural areas.

There are big gaps in data on children and young adolescents – globally, statistics refer to categories of 15-49 years, or under 5 years, with no figures for the years in between. However, it is estimated that up to 10% of PLHA in Tanzania are children, while UNICEF puts the number of under 15 year-olds living with HIV or AIDS at 160,000 (2009).

Even when not infected by the disease, children are particularly vulnerable to its effects. Baseline data gathered at the start of the project found a substantial number of pupils (22.8%) lived or had lived with an infected person. Nationwide, more than one million children have lost one or both parents to AIDS.

Sources: TACAIDS; THMIS; UNAIDS *et al.;* Chediel & Rajabu

WHAT DO YOUNG PEOPLE KNOW? HOW AT RISK ARE THEY?

Despite some confusion, primary school pupils are usually knowledgeable on the basics of HIV & AIDS. But they do not automatically apply that knowledge to real life situations.

Baseline surveys carried out in the project schools found that learners were generally knowledgeable about HIV & AIDS, though with variations: pupils in Dar es Salaam were more knowledgeable than those from the other (rural)

districts, and the incidence of misconceptions about HIV & AIDS was higher among girls than boys.

Most of the pupils questioned (79%) appeared knowledgeable on how to avoid becoming infected, but responses to other questions revealed some confusion. For example, about a third of pupils said HIV positive teachers should not teach, with the main reason given that they might infect others.

A third of the country's population are aged 10 to 24, when most become sexually active. In one study (TDHS 2010), 11% of young women and 8% of young men said they first had sex before turning 15; 6% of schoolgirls (primary and secondary combined) drop out of school each year due to pregnancy (MoEVT). Project baseline data found that 4% of the pupils targeted by the project had started having sex. With 80% of new HIV infections in Tanzania caused by heterosexual relations (TACAIDS, 2009), young people are clearly vulnerable.

Risky sexual behaviour among youth has been decreasing – for example, the proportion of girls aged 15-19 having sex with more than two partners dropped from 5 to 2% from 2004-2010 (TDHS 2004/2010). But condom use is still very low: in other studies, less than a third of young people report having used a condom when they first had sex (THMIS 2007-8).

> *"Globalisation is a major challenge in the development of our pupils especially those in Std III and IV, because many of them have seen a lot of things and have even tried... You know pupils like to try. So when you talk to them they know already – some of them know from the media. So this project is important to put things in the right perspective to ensure our primary school pupils and even communities are able to avoid HIV infection and other STIs."*
>
> DISTRICT EDUCATION OFFICER, KARATU DISTRICT

79%
of pupils questioned appeared knowledgeable on how to avoid becoming infected.

WHAT EDUCATION AND CARE IS PROVIDED TO YOUNG PEOPLE?

Existing GoT education policies cover ASRH education including HIV & AIDS awareness. But authorities often lack sufficient material and financial resources dedicated to these topics. Some counselling, testing and care services are available, but may be inadequate, and children and young adolescents may be unaware or reluctant to make use of them.

HIV & AIDS education has been integrated in the national primary education curriculum since 2000. Prior to that, the Ministry of Education had established four intervention areas within primary schools: skills-based HIV and AIDS prevention education; peer education; guidance and counselling services; and establishing School Counselling and AIDS Education Committees (SCAEC).

But the quality of HIV & AIDS education still varies widely. Using a "carrier subject" approach, teachers of Science, Personality and Sports, and Civics are required to introduce HIV & AIDS topics during their lessons. Without specific training, however, this does not always happen. Often teachers feel uncomfortable dealing with a delicate subject which they do not consider their field. The project baseline study found that training of teachers was lacking, and

some of them complained of inadequate teaching and learning materials. Peer education had had some impact, but was sometimes not well understood.

Two counsellors are assigned per primary school (one male and one female), who can refer pupils to health services where necessary, while School Counselling and AIDS Education Committees should ensure involvement and support of the wider community in HIV & AIDS education.

Our baseline data indicated that guidance and counselling in the schools examined was inadequate. Only 63% of the pupils questioned agreed that such services were available. In some cases SCAEC members had been appointed but not trained and not given clear responsibilities, thus making such committees inactive. Furthermore, a significant number of pupils (48%) said they would not go for voluntary counselling and testing, because they were afraid of bad results.

Recently, some Tanzanian schools were found to be identifying infected children by – illegally – requiring them to wear a red ribbon, suggesting continued ignorance among teachers and parents of how best to care for the physical and psychological needs of PLHA.

48%
of pupils said they would not go for voluntary counselling and testing, because they were afraid of bad results.

PROJECT FEATURE *| ALIGNING WITH TANZANIAN SYSTEMS*

WHAT
Using existing MoEVT guidelines, tools, materials and resource persons, while bringing additional innovations where relevant.

WHY
International donors including Belgium are committed to the Paris Declaration, which states that development aid should focus on strengthening national policies and their implementation. BTC, taking the approach of "critical alignment", worked with MoEVT – the National Project Coordinator was based within the ministry, and rather than developing new material or hiring external consultants, we worked to develop and reinforce what existed already, for example further developing policy guidelines, or activating and training the MoEVT-established School Counselling and AIDS Education Committees. Valuable experience from other programmes and other countries (such as ensuring an enabling environment, using arts and sports, supporting peer educators) were added to the MoEVT's package of tools and policies.

THE PROJECT FACTS AND FIGURES

28
schools targeted in seven districts of Dar es Salaam, Coast, Arusha and Kilimanjaro regions for the pilot project.

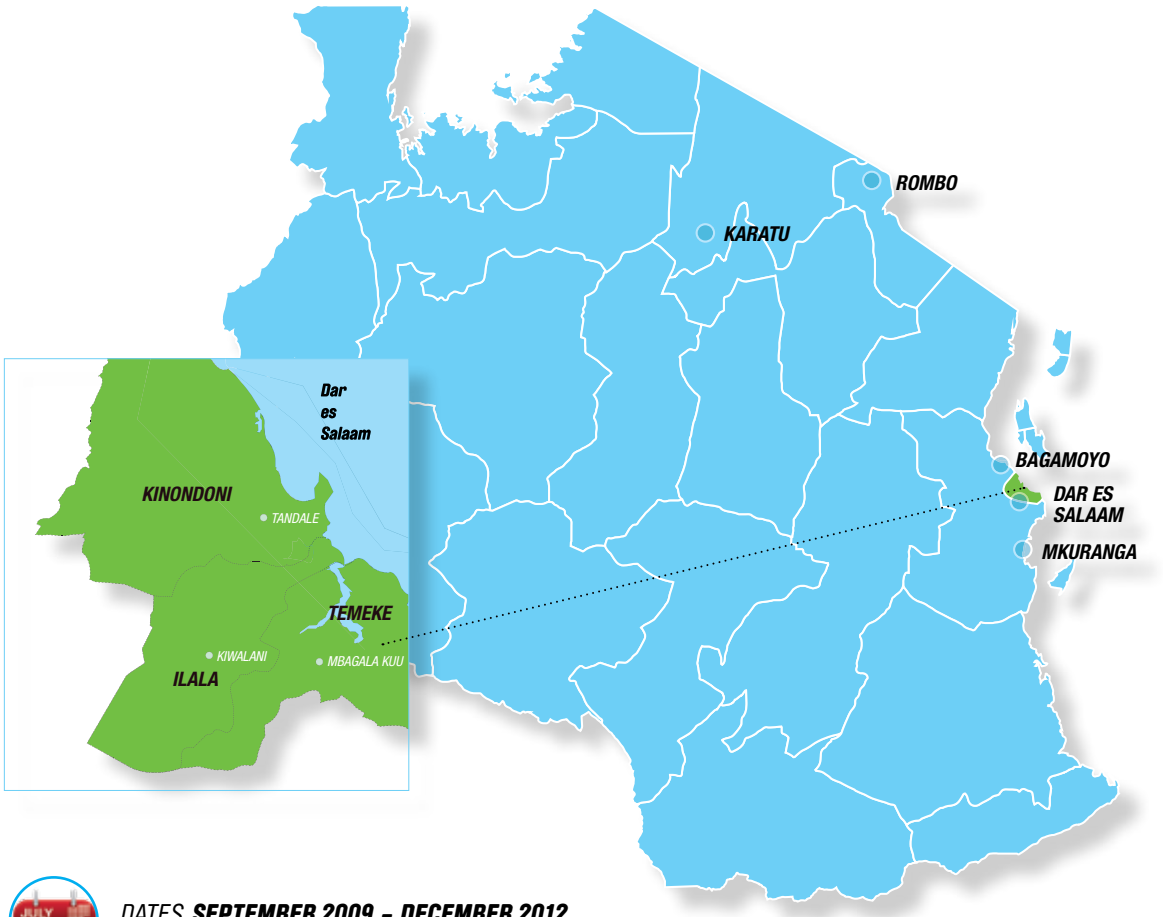
The Ministry of Education recognises the need to direct HIV & AIDS education at children from the earliest stages, as clearly reflected in current policies. But the necessary structures and resources to implement those policies need strengthening to become fully effective.

The pilot project designed by BTC together with MoEVT was the direct result of this need. Launched in 2009, the 'HIV & AIDS Awareness Creation Programme Targeting Youth and Adolescents in Primary Schools' aimed to help reduce AIDS and other sexual and reproductive health (SRH) problems by educating and empowering youth to protect themselves.


Marko Balenovic

STARTING TOO YOUNG? THE CASE FOR PRIMARY-LEVEL INTERVENTION

Primary-aged pupils must be considered a key target group for HIV & AIDS awareness and adolescent sexual and reproductive health (ASRH) issues. Firstly, only 36% pupils go on to attend secondary school (UNESCO, 2011), so education-based initiatives must focus on primary level to be effective. Indeed, Tanzanians sometimes complete primary school late: among the project schools, some pupils were as old as 17. Secondly, ASRH among children does not mean introducing sex education or other "adult" topics prematurely. MoEVT material and curricula are carefully tailored to each age group (for example, the youngest children learn about keeping clean and healthy) . Peer education is done by older pupils (Standard 5-7) only.



DATES ***SEPTEMBER 2009 – DECEMBER 2012***

28 SCHOOLS
7 DISTRICTS
DAR ES SALAAM > Kinondoni, Ilala & Temeke
COAST > Bagamoyo & Mkuranga
ARUSHA > Karatu
KILIMANJARO > Rombo

PARTNERS ***MINISTRY OF HEALTH AND SOCIAL WELFARE, PRIME MINISTER'S OFFICE – REGIONAL ADMINISTRATION AND LOCAL GOVERNMENT, MINISTRY OF FINANCE, TACAIDS***

IMPLEMENTED BY ***MINISTRY OF EDUCATION AND VOCATIONAL TRAINING; LOCAL GOVERNMENT AUTHORITIES***

BUDGET ***EUR 1,606,486***

WHAT DID WE DO?

In each district

- Training district education staff to ensure their capacity and motivation to monitor in-school activities.
- Training district health staff to work with youth, and setting up a referral system to help young people to access health services.
- Reviewing Science, Personality & Sports, and Civics syllabuses to identify HIV & AIDS sub-topics.
- Developing teaching guides and monitoring tools.

In each school

- Training all teachers in HIV & AIDS awareness and life skills.
- Activating and training existing School Counselling and AIDS Education Committees (SCAEC).
- Training teacher-counsellors in HIV & AIDS, life skills and peer education facilitation.
- Training teachers, officers and pupils in HIV & AIDS awareness through arts and sports.
- Training pupils as peer educators.
- Building and furnishing dedicated health club rooms.

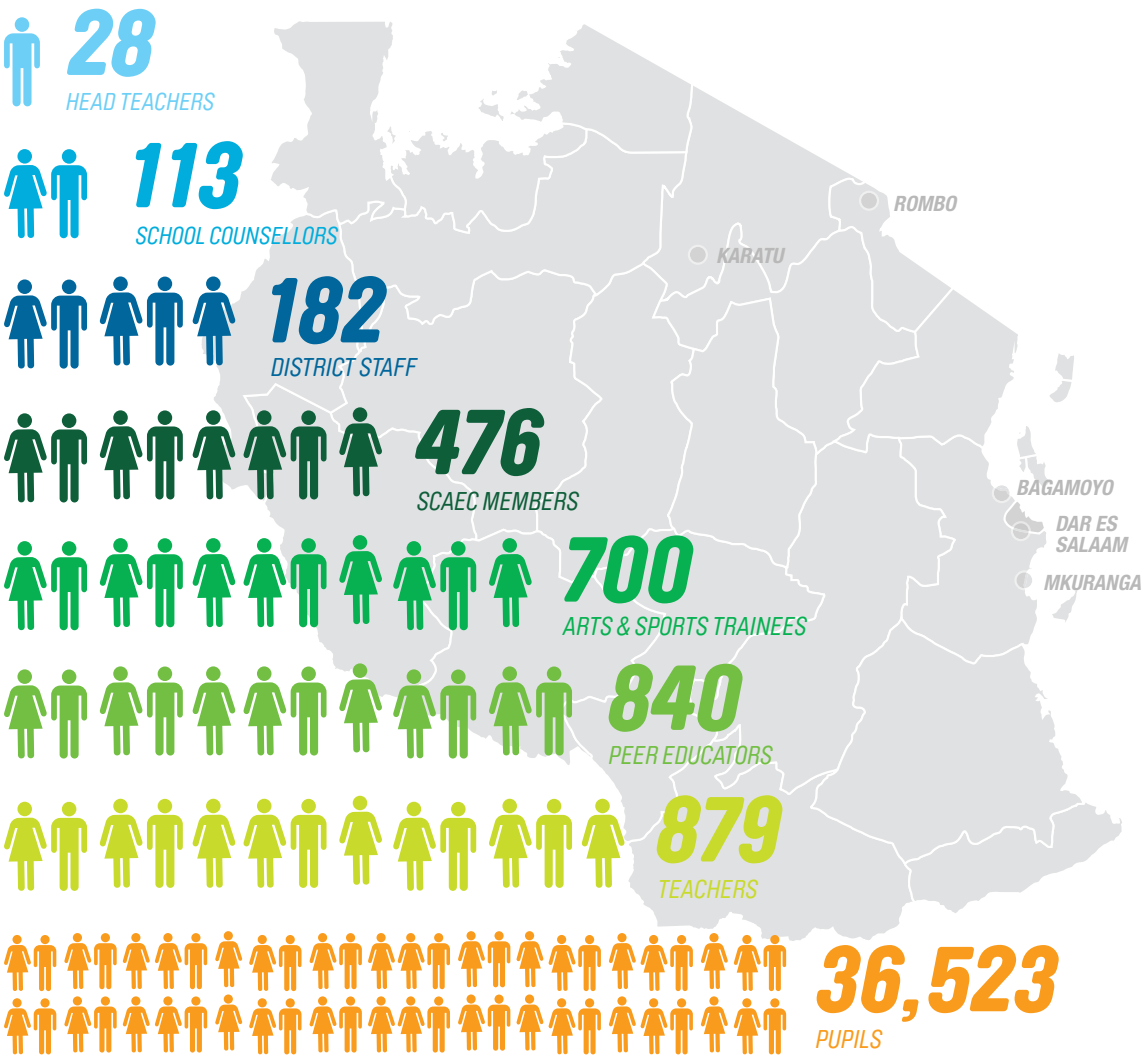
GUIDELINES ON HIV & AIDS EDUCATION IN PRIMARY SCHOOL

AS OF OCTOBER 2012

The project aimed to support MoEVT in implementing its existing policies. We therefore used and added to existing MoEVT guidelines, including:

- **Training guide for School Counselling and AIDS Education Committee (SCAEC)**
- **Training guide for Teacher-Counsellors in Peer Education Facilitation**
- **Training guide for Pupils in Peer Education Std. 5, 6 and 7**
- **Guides for teaching HIV/AIDS in classrooms Std. 1, 2, 3, 4, 5, 6, and 7**
- **Training guide for Trainer of Trainers (ToT)**
- **Training guide for Teachers in the use of arts and sports in HIV/AIDS Awareness *(produced by the project)***

WHO DID WE REACH?



INDIRECTLY: PARENTS, OUT OF SCHOOL YOUTH, COMMUNITY MEMBERS

LESSONS LEARNED

LESSON 1 | A MULTIPLE, SYNERGETIC APPROACH IS ESSENTIAL

- **An overall enabling environment is needed to empower young people**
- **Trained LGAs and school committees ensure ownership and sustainability**
- **Physical resources including books help ensure issues are given the space and attention they deserve**
- **More work is needed to guarantee accessibility of youth-friendly health services**

In what context can young people best learn about sexual and reproductive health? What do they need in order to feel empowered to protect themselves? These were fundamental questions behind the project design. It aimed to create an enabling environment – one that is conducive to learning, understanding, and feeling able and permitted to change one's behaviour.

The project included a number of complementary activities, both in-classroom and extracurricular; aimed to ensure sufficient resources and infrastructure were available; and sought ways to gain involvement and support of those adults close to or working with the children.

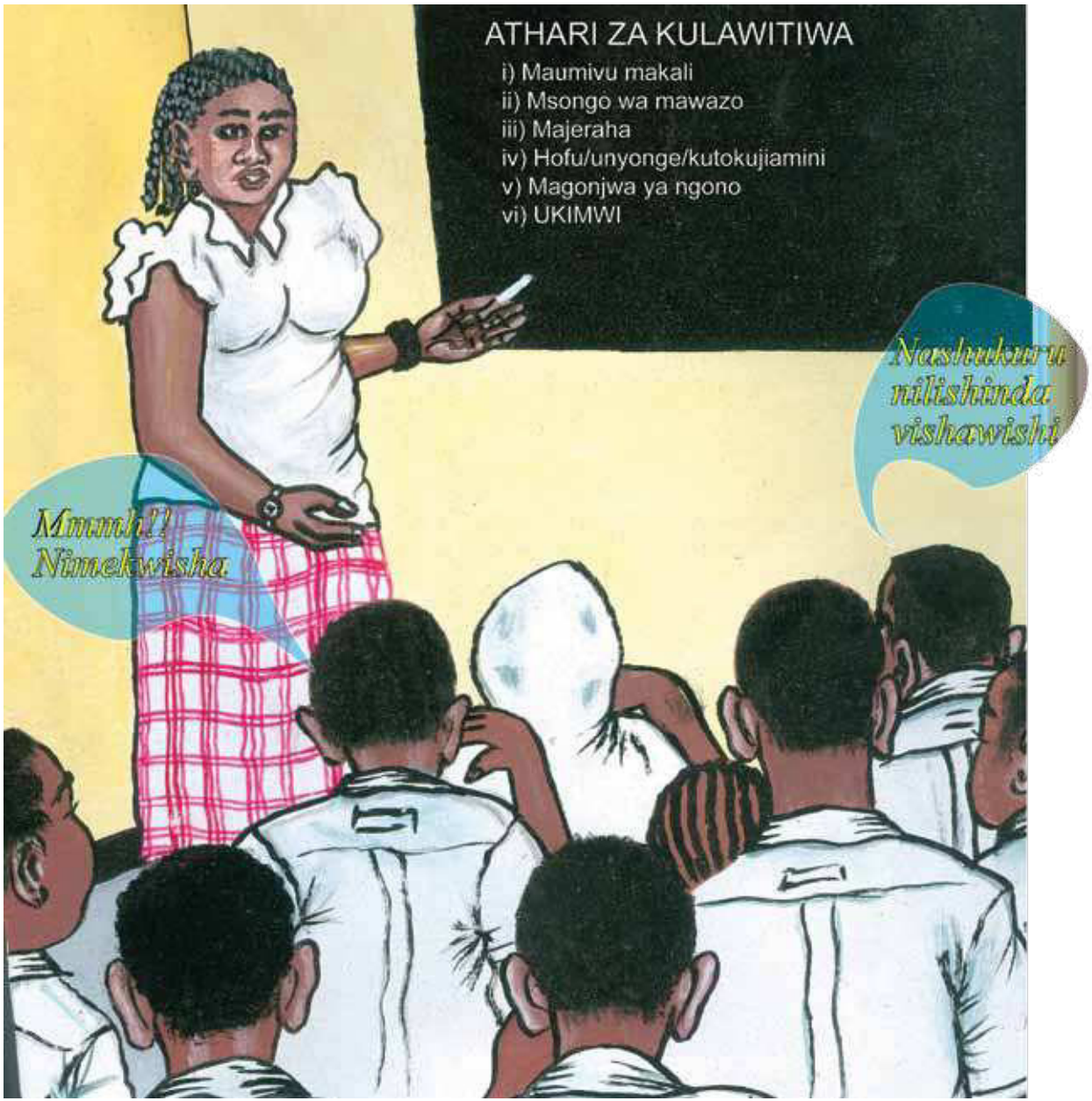
PROJECT FEATURE | FOCUS ON AN ENABLING ENVIRONMENT

WHAT

Ensuring quality facilities and resources are available and accessible.

WHY

Resources – material and human – consolidate learning. Books for every pupil was therefore one prerequisite. A dedicated health club – a special building – was constructed in each school, creating a safe space for counselling as well as the physical infrastructure for peer educator /arts and sports groups' meetings. Schools were expected to establish a clear, fixed timetable for all activities. And the project worked not only with teachers, but also trained other adults working with youth, including district health officials. Working more intensively with each school's SCAEC helped involve and earn the support of the wider community.



Original illustration by Peter Leonard (2012)

Information material produced by the project. The text on the blackboard reads: "Effects of Rape: Pain; Stress; Injuries; Fear/Weakness/Low self-esteem; STIs; HIV. The speech bubbles read: "Oh! I'm done for" and "Thank goodness I've beaten temptation"

17
SCAEC members in every school

The members of the School Counselling and Education Committees (SCAEC) played an important role in ensuring local ownership and support of the project. Though SCAECs had been set up previously, the project expanded their membership in each school to 17, so that each committee included two religious leaders (one Christian, one Muslim) and two PLHA (one male, one female) as well as village leaders, pupils, and teachers. Members were trained in HIV & AIDS topics; their responsibilities – mediating between school and community – clearly outlined. As a result, SCAECs in the project schools became much more involved in awareness-raising, helping to address concerns of some parents and ensuring children felt, for example, that they could be more open about sensitive topics.

One target of the project was to set up a referral system allowing pupils to be directly referred to health professionals, who have also been trained in working with youth. However, by late 2012 this system was still not functioning as expected; for example, even after training, health officers were not visiting schools as planned. Improving linkages between the ministries involved (MoEVT, MoHSW, PMO-RALG) would help ensure more accessible health services.

Other aspects of the enabling environment approach were much more successful. Teachers were reported to be giving close support to peer educators; in non-project schools, according to district officers and school inspectors, this was not the case. The "carrier subject" method of teaching initiated by the Ministry showed that it functions well given an appropriate, supportive environment. For instance, availability of books and other learning materials is a basic factor in learning. Provided to every pupil in Standard 5-7, books were confirmed by evaluators to be accessible to all – and widely used. Insisting on their availability reinforces the message among pupils and teachers that this is an important subject, and has even been shown in some cases to encourage a reading culture and to develop reading and comprehension skills.

> *"This programme through its books has improved the performance of my pupils. My pupils are able to explain very well on what they have read and their level of understanding is very high."*
>
> HEAD TEACHER, BAGAMOYO

Construction of health club rooms in each school has also had a significant impact. Said one head teacher in Mkuranga: "People in the community see that this programme is serious, because it has an office." Health clubs, which are also open to people outside the school, have successfully attracted the interest of the wider community, who now come voluntarily to make use of the services.

Finally, the positive, open approach to HIV & AIDS to which all activities contribute has in some cases improved attitudes towards those infected by the disease. Not only do PLHA experience less discrimination; schools also take a more proactive approach to helping pupils. For example, they may require parents/guardians of infected children to disclose their status to teachers, so they can assist them with managing medication, not give them hard work and provide food for them on time.

LESSON 2 | BEING THOROUGH CONTRIBUTES TO KNOWLEDGE, CONFIDENCE AND BEHAVIOUR CHANGE

- **Surveys suggest the project directly led to positive behaviour change among pupils**
- **Comprehensive, ongoing training involves all stakeholders and results in real understanding**
- **Indirect beneficiaries also report increased knowledge and behaviour change**

How does one ensure a solid understanding of HIV & AIDS and related issues among all pupils and adults? While MoEVT policy had been to train only a few teachers in each school, the project insisted on a comprehensive training programme that included all teachers, as well as health and education officials in working with youth. Training was also ongoing. For example, teachers, school guardians, and counsellors attended refresher sessions on HIV & AIDS and ASRH in the second and third years of the project.

Interestingly, even this rather intensive training schedule did not appear to raise problems of time management. Rather, it ensured motivation of learners and availability of multiple "experts" in each school. This had a significant impact on the overall quality of teaching and learning.

> *"At first I was just aware of the disease partially and could teach without confidence. I was only using my general knowledge which I got when I was at college but after a series of trainings I can say now I am an expert in HIV & AIDS…the same applies to the pupils… I am telling you they are very competent and confident. They can stand out to the crowd and talk about HIV and AIDS and you will be surprised."*
>
> TEACHER, BAGAMOYO

PROJECT FEATURE *| COMPREHENSIVE TRAINING APPROACH*

WHAT

Training all teachers in every school including head teachers; training several school counsellors; refresher training; training of districts, SCAEC, school inspectors and peer educators; and all training using a participatory approach.

WHY

Under existing MoEVT guidelines, a limited number of teachers are trained in HIV & AIDS awareness, and only two counsellors per school. This project recognised the need for all teachers to feel competent and confident to teach ASRH topics, and also for head teachers to be involved so that they would support project activities. Refresher courses are needed for sustainability and to counter high staff turnover. Training of district officials responsible for planning and monitoring education policies is vital in creating an enabling environment for prevention and care, and also ensures they take their roles seriously.

> *"Before this project even though we were teaching about HIV &AIDS, it was not effective, we did not know the subject well, and we were feeling shy to talk to pupils about these issues."*
>
> TEACHER, ROMBO

Teachers became more confident in talking about HIV & AIDS and ASRH, and report that they are now comfortable to raise such issues spontaneously, something which does not always happen in non-project schools.

Sufficient attention to awareness-raising is ensured by insisting on a specific timetable for all activities. One district official explains: "This programme shows that it is serious because it demands a school to formulate a timetable which involves the training days for the pupils". For example, one day per week may be assigned for peer educators to conduct discussions, and another day for arts and sports groups to perform.

Greater attention to HIV & AIDS education also has an impact on related subjects. Preventing and dealing with the disease requires a set of life skills that are equally relevant to other aspects of adolescent life: sexual health in general, dealing with puberty, taking responsibility, standing up for one's rights, and so on.

> *"Through this education, we have learnt how to respect our reproductive organs responsibly...we have been taught that at this age while at school we should use our reproductive organs for going to the toilet and not otherwise….because if we use otherwise we might conceive or get infected with HIV or other STIs."*
>
> PEER EDUCATOR, BAGAMOYO

The comprehensive approach described above resulted in high levels of specific knowledge among pupils, as shown by responses to open-ended questions. That knowledge covers HIV prevention but also STIs in general, as well as broader life skills. And unsurprisingly, knowledge comes hand in hand with increased confidence, witnessed in the manner in which children and young adolescents now talk about such issues.

Knowledge reported by pupils appears to have made them more able to identify risk situations and strong enough to avoid them. For example, the end of project evaluation found that in Rombo, the DEO had not heard of any girl becoming pregnant since the project started in the four schools despite personally enquiring about it; in focus group discussions with Rombo teachers, respondents also said they had not seen any pregnant school girl since the project started in 2009. Karatu and Mkuranga head teachers also reported significant reduction in pregnancy rates in their schools. These observations are backed up by pupils' own responses regarding their behaviour.

> *"Nowadays if a person tells me, take some money or a lift, I would tell him, "Wait for a while, I am going to put on some clothes", then I don't come back."*
>
> PUPIL, ROMBO

"WHAT HAVE YOU LEARNED FROM THIS PROJECT?"

(Sample number = 776)

Spontaneous multiple responses	**Total %** *(N=776)*	**Male %** *(N=370)*	**Female %** *(N=388)*
How to protect myself	34.9	38.9	32.2
Avoid temptations	33.8	33.8	34.3
Not to stigmatize	24.6	26.2	23.2
Knowledge of STIs	15.7	15.9	15.7
Avoid risk behaviour	15.2	14.6	21.4
HIV & AIDS	14.8	12.2	17.8
Avoid sugar mammy/daddy	13.8	14.6	12.9
Abstinence	8.9	7.6	10.3
Confidence & self-determination	8.4	9.5	7.7
Avoid truancy & risk groups	5.9	8.1	3.9
Avoid pregnancy & early marriages	5.5	5.1	6.2
Avoid night walks	4.8	3.2	6.4
Avoid alcohol & drugs	3.6	3.8	3.6
Life skills	3.2	4.1	2.6
Reproductive health	2.7	3.8	1.5

> *In the previous time many pupils used to go for traditional night dances…….the problem is that when they go there they meet with other people from the village who tempt them to engage into sexual intercourse…..sometimes young girls are raped by adults especially when they are drunk. But after this education we are thankful that many have been educated and they don't go anymore.*
>
> PEER EDUCATOR, MKURANGA

"HAS THE KNOWLEDGE GAINED CHANGED YOUR BEHAVIOUR?"

(Sample number =776)

Behaviour change	Frequency	Percent
Yes	752	96.91
No	13	1.68
No response	3	0.39
Don't know	8	1.03
Total	**776**	**100**

"WHAT KIND OF BEHAVIOUR HAVE YOU CHANGED?"

(Sample number =776)

Type of change	Mentioned %	Not mentioned %
Abstinence	46.5	53.5
Delaying sexual debut	58.9	41.1
Having one sexual partner	1.9	98.1
Using protection	0.8	99.2
Avoiding night dances	7.7	92.3

> *After the training I came to know that it is like any other disease…..therefore, I started to educate others, especially when I find them sitting at the jobless corners ('vijiwe') where they often ask questions.*
>
> FEMALE PLHA, MKURANGA

The knowledge and confidence expressed by teachers and pupils is also apparent among communities outside the schools. For example, PLHAs interviewed said they are more confident about their status; stigma and discrimination is less of an issue. As one woman in Mkuranga, a member of a School Counselling and AIDS Education Committee (SCAEC), explains: "After being involved in this committee, we had training on HIV & AIDS. I was convinced that other people should know about my status, that I am HIV infected. Earlier I was afraid to do so, but after the training I came to know that it is like any other disease."

Members of SCAEC who are religious leaders also noticed the difference, as one in Karatu explained: "It was hard to talk about HIV and AIDS in public especially for us Muslims. But after we attended training we actually got power to speak to our people".

LESSON 3 | CREATIVE, PARTICIPATORY TEACHING METHODS MAKE LEARNING MORE EFFECTIVE

- **Arts and sports activities allow young people to explore and engage with sexual and reproductive health topics more confidently**
- **Creative, participatory methods may contribute to attendance rates**

Teaching young people about sexual and reproductive health through artistic expression has been shown to be an effective way to restore learners' dignity and to improve awareness of their rights (Bosmans et al., 2012).

The project added participatory education through arts and sports to the Ministry's existing package of primary-level interventions. This involved guiding students to research their own sexual and reproductive problems, to analyse them and to suggest solutions. Using drama, games or music, pupils are able to express themselves freely on sensitive subjects, even in public. Through the performances they design, young people also involve the audience, asking them to suggest solutions to what they observe - meaning their messages also reach parents, neighbours and out of school youth.

With such teaching methods, pupils learn quickly; they engage with discussions about HIV & AIDS because they reflect what is really taking place in the communities.

"Because pupils like drama, they would always come to school and they wouldn't like to miss classes – because they would also miss the drama."

PEER EDUCATOR, TEMEKE

PROJECT FEATURE | USING ARTS AND SPORTS

WHAT
Using drama, song, games and sports to address adolescent sexual and reproductive health.

WHY
Persisting cultural taboos make it difficult to openly discuss delicate subjects like sex, but using drama or song allows teachers and pupils to express themselves. Participatory learning methods empower young people to take control – and young learners clearly enjoy the lessons.

Like the arts and sports modules, peer education (for Standard 5-7 only) also puts the pupils themselves at the centre of the learning process. Peer educators – one boy and one girl in each stream, chosen by his or her classmates – are trained by counsellors. Then, using material provided and guided by counsellors, peer educators prepare sessions which they deliver on a regular basis

> *This project has had dual effects on the pupils – first it has empowered them to fight HIV & AIDS without fear, and secondly, ability to answer / express themselves well and correctly in other academic subjects.*
>
> HEAD TEACHER, BAGAMOYO

to their classmates. The increased confidence expressed by peer educators since the project began ("We are now able to speak openly to anybody about the disease", said one interviewee in Karatu) is accompanied by a willingness to share what they have learned, both inside and outside of school. Said one head teacher in Rombo: "Our peer educators have become competent in educating others".

Using such approaches also appears to have contributed to higher attendance rates, since pupils are much more motivated to attend those classes, and therefore less likely to skip school. Truancy was reported to have dropped in the seven districts by DEOs and head teachers from project schools.

Better attendance – also thanks to fewer dropouts due to early pregnancies – may have been a factor in improved overall performance. Academic performance improved over the course of the project in many of the targeted schools, as reported by the DEO in Rombo and the DSI in Kinondoni. Head teachers from Kwangao Primary School (best performing in Rombo District) and Hekima Primary School, Kinondoni (one of the best performing in Kinondoni District), and various teachers also reported similar impressions.

CONCLUSION

EVEN AT PRIMARY AGE, CHILDREN CAN BE AGENTS OF CHANGE

The end of project evaluation in 2012 confirmed that results already witnessed in certain schools applied almost across the board. In every district, project schools demonstrated positive changes that set them apart from non-project schools.

A comprehensive training approach, applied within an overall enabling environment, was shown to be successful in increasing knowledge and confidence, in contributing to behaviour change, and in engaging young people and those working with them to deal with HIV & AIDS in a more open, proactive way. The programme also brought additional benefits, appearing to contribute to improved attendance and academic performance.

At the heart of these changes are the enthusiastic learners themselves. The increased confidence of pupils in dealing with HIV & AIDS has been remarked on frequently by teachers and government staff. During in-classroom and extracurricular activities, young people speak out, able to express themselves. The way in which pupils in our evaluation survey spoke about life situations is indicative of the maturity and confidence they have developed, helping them to avoid risky behaviour and environments. This sense of empowerment is particularly evident among girls, who appear to take to their roles as peer educators with a natural flair.

Not only are pupils clearly capable of changing their own behaviour, they have also demonstrated the ability to inform and influence others to do the same. SCAEC members reported that pupils from the project schools, especially those trained as peer educators, tend to share what they have learned, for example among other siblings attending non-project schools, and even parents. Parents and neighbours also learn through school performances and through the research which pupils are encouraged to do in their community. The result of this has been reported behaviour change among adults, for example in making use of the health club rooms or deciding to go for HIV testing.

Discussing ASRH and HIV & AIDS topics at this young age still meets some resistance. Teachers report that sometimes parents complain that their children are taught things not relevant to their age. However, their complaints seem to reflect inadequate understanding rather than outright rejection of such education. As one Bagamoyo head teacher says: “We explained to [the parents] about the programme and its importance. In the end, they understood, and even pupils tell us that their parents can now speak about the disease openly.”

> *“Most of the parents have become more willing to be tested.”*
>
> TEACHER, MKURANGA

> *“Parents have also got educated about night events and have realised they are not good for their children.”*
>
> TEACHER, MKURANGA

Information material produced by the project. Original illustration by Peter Leonard (2012)

FROM PILOT TO POLICY: NEXT STEPS

> *This project has proven the capacity of young people to transform negative community norms towards responsible behaviour change. Previously I was not convinced about this approach – but now I have seen it work. But if the project just stops, these benefits will simply disappear over time. Every new generation of children deserves to be given the attention that this project gives to adolescents' sexual and reproductive health, and I strongly recommend that Tanzanian policy-makers find ways to continue it.*

DR. BENNETT FIMBO, HEALTH EDUCATION / HEALTH PROMOTION SPECIALIST. AUTHOR OF END OF PROJECT EVALUATION

National policy-makers are ready to support the project's continuation, including those at the highest levels of MoEVT and at TACAIDS, the government body responsible for coordinating the national response to HIV & AIDS.

Many of those involved in the project have also expressed clear support for its continuation and expansion. Teachers in one Temeke school, for example, have on their own initiative given informal training to teachers in neighbouring non-project schools. District staff, too, say they hope the project can continue.

But activities cannot be properly expanded, nor sustained long term, without continued input of resources. As the project draws to a close, the project team is therefore working to ensure good practices will be continued and that the project will be expanded beyond the 28 pilot schools. One achievement to date is accreditation by MoEVT of tools and guidelines produced by the project (for example, the 'Training guide for Teachers in the Use of Arts and Sports in HIV/AIDS Awareness').

> *I will try to encourage the Local Government Authorities to allocate resources from the Council Budget in order to continue this programme when BTC stops funding.*

DEO, KARATU

> *"Tanzania's National Response to the AIDS epidemic is simply incomplete without including the country's primary school-aged children. At this young age, they have the great potential to develop the knowledge and skills necessary to avoid HIV risk factors and to influence others to emulate: they are the change agents and role models. When I watched their wonderful performances, I was moved – the kids were really assertive, and confident of what they were doing.*
>
> *Scaling up this project nationwide will require significant investment, but I believe it will be money well spent, and I fully support that investment."*
>
> MORRIS LEKULE, NATIONAL RESPONSE DEPARTMENT, TACAIDS. MEMBER OF PROJECT STEERING COMMITTEE

We recommend to policy-makers, project partners and potential partners the following next steps:

1. MAKE THE MOST OF CURRENT MOMENTUM AND ENTHUSIASM

- **Involve project stakeholders** in discussions on next steps and continue to work with partners (including TACAIDS) and relevant bodies of MoEVT (Cross-Cutting Issues Technical Working Group) to develop a concrete action plan.
- Maximise use of and reproduce **existing tools and guidelines** used and developed by the project.
- **Share experience** of project among stakeholders within and beyond Tanzania.

2. SCALE UP THE PROJECT TO MORE SCHOOLS BY INTEGRATING GOOD PRACTICES INTO NATIONAL POLICY

- Open discussions with policy-makers and relevant bodies (e.g. Tanzania Institute of Education) on integrating project good practices into **national policies and guidelines**. Starting points should be the next Primary Education Development Plan and the National Multisectoral HIV Prevention Strategy.

3. FIND NEW SOURCES AND MEANS OF FUNDING

As a result of donor harmonisation, Belgium is now limiting support to Tanzania to two sectors only (natural resources management and local government reform). The end of the current project will mark the end of Belgian aid to the education sector, and MoEVT will appeal for support from elsewhere in scaling up the project. Given the global drop in financial support for HIV & AIDS interventions, and Tanzania's continued dependence on outside finance – of HIV and AIDS spending, 97% is donor-funded – this will be a challenge. MoEVT will seek to:

- **Obtain support of other donors and/or private partners.**
- Find innovative ways to **reduce costs without reducing impact.** For example, make use of the existing pool of trained teachers in project schools to train others in their districts; investigate the option of them also assisting with HIV education in teacher training colleges.

4. *MONITOR IMPLEMENTATION AND ENSURE LONG-TERM SUSTAINABILITY*

- Ensure that **responsibility** for HIV & AIDS awareness through primary education is clearly mandated to an institution with the capacities to monitor its effective implementation. TACAIDS (National Response Department) and MoEVT (Cross-Cutting Issues) take the lead in the meantime.
- Build on results from future activities and use these to **continuously improve** the quality of intervention.
- Continue to **share and exchange lessons learned** with stakeholders outside Tanzania.
- Continue to monitor HIV and AIDS targets in Tanzania's medium and long term **development plans.**

NOTES

The lessons learned described in this booklet are based on an independent evaluation, using a combination of structured questionnaires, in-depth interviews and focus groups, carried out in July 2012. Evaluators visited two schools in each of the seven project districts, interviewing a total of 776 pupils (Standard 5-7, age range 11-17 years). At those 14 schools, the SCAEC chairman, both SCAEC religious leaders, teachers and peer educators were also interviewed. Head teachers from 26 of the 28 schools were interviewed. While non-project schools were not a target of the evaluation, district officials confirmed "a very big difference" between project and non-project schools in their districts.

At local government level, all District Education Officers, School Inspectors, Ward Education Coordinators, Council HIV and AIDS Coordinators, and District Focal Persons were interviewed. At the national level, the following institutions were consulted: Ministry of Education and Vocational Training (MoEVT), BTC, Tanzania Commission for AIDS (TACAIDS), and the Ministry of Health and Social Welfare through the National AIDS Control Program (NACP) and the Reproductive Health Section.

The full evaluation report (Dr Bennett Fimbo,'Lessons Learnt and Good Practices From the HIV & AIDS Awareness Creation Programme', August 2012) is available on request from the Ministry of Education.

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