STRENGTHERNING PEER EDUCATORS COMPETENCIES IN EDUCATING YOUTHS ON HIV PREVENTION: A CASE OF VINGUNGUTI WARD IN ILALA MUNICIPAL COUNCIL DAR ES SALAAM

AMINA ALLY RAJABU

A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIMENTS FOR THE DEGREE IN COMMUNITY ECONOMIC DEVELOPMEN (MCED) – EXCECUTIVE OF THE OPEN UNIVERSITY OF TANZANIA

2015

CERTIFICATION

The undersigned certifies that has read and hereby recommends for acceptance by the Open University of Tanzania, a project paper titled **"Strengthening Peer Educators Competencies in Educating Youth on HIV Prevention in Vingunguti Ward in Ilala Municipal Council"** in partial fulfilment of the requirements for the award of the degree of Masters of Community Economic Development (MCED) – Executive of the Open University of Tanzania.

……..

Dr. William Palangyo

(Supervisor)

……

Date

COPYRIGHT

DECLARATION

I, **Amina Ally Rajabu** do hereby declare that, this project report is my own original work and that it has not been and will not be presented to any other institution for the award of a degree or similar awards.

…….

Signature

……

Date

DEDICATION

I would like to dedicate this work to my beloved parents Mr. Ally Rajabu and Mrs. Mariam Rajabu who laid the foundation for my education. Their efforts, encouragement, love and prayers are highly appreciated.

ACKNOWLEDGEMENT

I thank GOD - JESUS CHRIST for giving me chance, courage, and strength during my course work, community need assessment, project implementation and completing write-up.

I sincerely thank my supervisor Dr. William Palangyo, for suggestions, views, opinions and guidance throughout the period of doing this study. His professional support will always remain as my permanent assets for other works and studies in future.

My wholehearted gratitude's goes to Dr. Julius Charles from the International Training and Education Centre for Health (I-TECH) for his open ended support encouragement and counselling throughout this work.

I acknowledge the support of MYE's management in Vingunguti ward who hosted the project and allowing all peer educator and youth to participate in different stages of the project including needs assessment, project implementation, monitoring and evaluation.

I also extend my sincerely gratitude to Vingunguti LGA, community members, ten cell leaders and youths for their full participation in the project. Without their cooperation and assistance, this project would not have been completed successfully.

ABSTRACT

This project's aimed at strengthening peer educators competencies in educating youths on HIV prevention and behaviour change through training. Community assessments identified HIV prevention among youths as the major pressing need that had to be addressed and MYE as the local NGO to host the project to address the need. Training package for peer educators was developed and peer educators were trained on HIV prevention and condom use, BCC and communication skills. Following the training, peer educators were also monitored, supportively supervised and mentored with the aim of improving their performance to effectively deliver correct information to youths. Project's valuation was also conducted to measure project impact to the targeted beneficiaries. The project sustainability was ensured throughout the community need assessment, project implementation, monitoring and evaluation. LGA and community members were fully involved in identifying the most pressing community needs through interviews and meetings. MYE management were also fully involved in assessing peer educators and youths' capacity on HIV and AIDS, designing of project, development of training package and relevant project's tools. MYE management was also involved in monitoring, SSM visits and evaluation of the project. With this then, MYE' program team will continue conducting SSM and monitoring so as to keep helping the peer educators to perform better and provide correct information to youths.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF PLATES

LIST OF APPENDICES

LIST OF ABBREVIATIONS

ABCs	Abstinence, Be faithful, Condom
AIDS	Acquired Immunodeficiency Syndrome
BCC	Behaviour Change Communication
CDO	Community Development Officer
CHACC	Council HIV/AIDS Control Coordinator
EO	Education Officer
ETSDP	Education and Training Sector Development Programme
FGM	Female Genital Mutilation
FHI	Family Health International
HIV	Human Immunodeficiency Virus
HO	Health Officer
HSHSP	Health sector HIV and AIDS Strategic Plan
IEC	Information Education and Communication
IPPF	International Planned Parenthood Federation
LCD	Liquid Crystal Display
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MC	Male Evaluation
MOHSW	Ministry of Health and Social Welfare
Ms	Microsoft
MYE	Msimamo Youths Educators
NBS	National Bureau of Statistics

NGO	Non-Governmental Organization
PE	Peer Educators
PLHIV	People Living with HIV
BCC	Behaviour Change Communication
SCP	Street Chairperson
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
SWOC	Strengths, Weaknesses, Opportunities, Challenges
TACAIDS	Tanzania Commission for AIDS
TANESCO	Tanzania Electricity Supply Company
TDHS	Tanzania Demographic Health Survey
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
URT	United Republic of Tanzania
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WEO	Ward Executive Officer
WHO	World Health Organization

CHAPTER ONE
PARTICIPATORY NEEDS ASSESSMENT

1.1 Background

In Tanzania, youth are significant proportion of the population. About two thirds (65%) of the Tanzania population are youth aged below 24 years (TDHS, 2010). It is estimated that, about 1,411,829 Tanzanian are living with HIV and approximately 11.2% are youth aged 15-24 years (TACAIDS, 2013).

The majority of youth infected with HIV in Tanzania are female in which it has been reported that young women aged 15-24 account for about 45% of new infections whereas young men aged 15-24 count for only 26% of new infections (TDHS, 2010). HIV and AIDS has been reported to disproportionately affect individuals in the age group 15-49 and individuals falling into this age group are the country's most productive population. It has been shown in many studies that HIV and AIDS will have a significant impact on Tanzania's labour force in terms of reducing the size of the working age population, age and gender composition of the working population as well as skills and experiences (Mwenda, 2014), HIV/AIDS and Public Administration Tanzania Country Foresight Paper.

Risky sexual behaviours of youth aged 15-24 years remain a challenge given that heterosexual intercourse is the main mode of transmission; low condom use and low comprehensive knowledge about HIV remain a concern (TACAIDS, 2013). In Tanzania, poverty, gender inequality and lack of HIV related information among youth is exposing youth to the risks of acquiring HIV infection (Soriano, 2009). It has been estimated that at least one third of HIV positive youth may continue their

risky behaviours and continue transmitting HIV infection even after learning their HIV sero-status (Wilson, 1999).

With all these then, prevention programs among youth is very crucial so as to alleviate the situation. The importance of preventing HIV infection among youth has been a consistent message in all HIV related commitments globally and nationally. In addressing HIV prevention among youth, peer education program was one of approaches used in many countries to address HIV prevention and behaviour change among youth.

A well designed and well implemented HIV related peer education programs can improve youths' health related knowledge, attitude, skills and access to relevant health services. However, the competences of peer educators vary greatly (Adamchak, 2006). Inadequate training, supervision and lack of community support can hinder the success of the peer education programs (FHI, 2010). It is from this point of view, the researcher has identified peer educators under MYE to undertake community need assessment with a goal to establish needs, prioritize one need that can be addressed.

1.2 Profile for Vingunguti Ward

1.2.1 Location

Vingunguti ward is located within Ilala Municipality in Dar es Salaam. It is about 6 kilometres from the city centre and can be reached through Nyerere and Uhuru roads (Meshack, 2003). There are four streets in Vingunguti ward namely Mtambani, Mtakuja, Kombo, and Miembeni (Lujuo, 2001). The ward is bordered by Tabata in

the east, Kipawa in the west, Msimbazi river valley in the north and Nyerere road in the south. The Vingunguti ward covers an area of about 4.49 square kilometres, (Meshack, 2003).

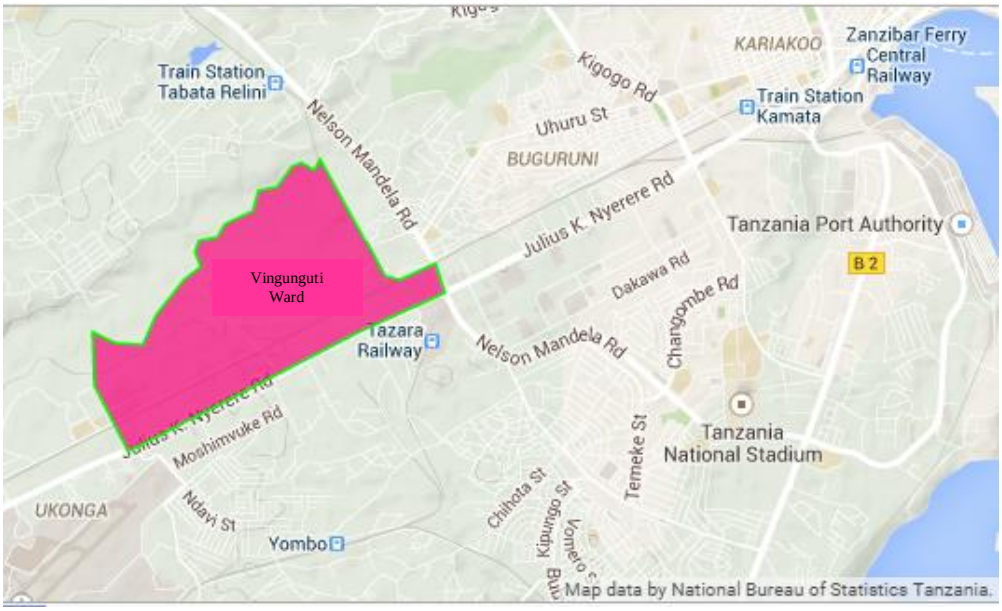


Plate 1. 1: Map showing Vingunguti location
Source: Field data, (2014)

1.2.2 Climate Condition

Vingunguti Ward is characterized by hot and humid climatic condition with an average of daily temperature ranging from 26^0 C to 35^0 C throughout the year. The climate is subjected by the southern western monsoon winds between April to October and northern western wind between November and March. The ward receives rainfall ranging from 800 mm to 1,300 mm with an average of about 1,000 mm per year (Meshack, 2003).

1.2.3 Population

The population of Vingunguti ward is increasing in each year. The count visit done in 2009 showed the total population for the four streets was 79,184 of which 40,069

were males and 39,115 females. According to (NBS, 2012), the population for the ward was 106,946. Among the total population; youth were 25,453 equivalents to 23.8%.

Table 1. 1: Population for Vingunguti Ward 1978 – 2012

Year	Youth (15-24)	Total Population
1978	4,498	18,899
1988	8,081	33,690
2002	16,404	68,923
2009	18,846	79,184
2012	25,453	106,946

Source: URT, 1978; URT, 1988, and URT, 2002 and Ward Visit count 2009, NBS, 2012.

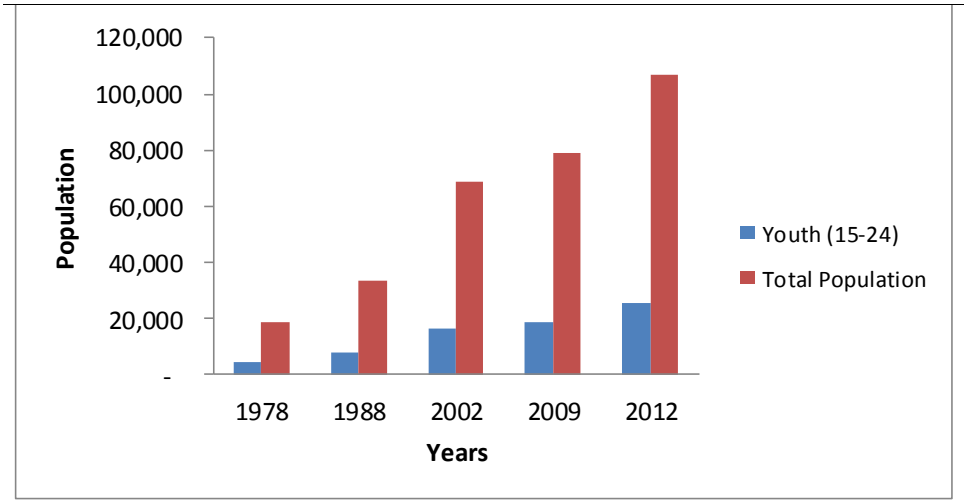


Figure 1. 1: Population for Vingunguti ward, 1978 – 2012

Source: URT, 1978; URT, 1988, and URT, 2002 and Ward Visit count 2009, NBS, 2012

1.2.4 Administrative Structure

The administrative structure of Vingunguti ward consists of Ward Executive Officer (WEO), Community Development Officer (CDO), Health Officer (HO), Council

HIV/AIDS Control Coordinator (CHACC), Education Officer (EO), and Street Chairperson (SCP). The daily activities in the ward are supervised by the respective ward's officers. HIV and AIDS activities are supervised specifically by the CHACC. Most of the meetings in the ward are chaired by the Ward Chancellor, while the WEO becomes the secretary.

1.2.5 Education

Vingunguti ward has four primary schools and one secondary school. These primary schools are Kombo, Mtakuja, Miembeni and Vingunguti primary school. The secondary school is Vingunguti secondary school. Most of the pupils in the schools come from the same ward while few of them come from the other nearby wards (field data, 2014).

1.2.6 Transport and Communication

Most people living in Vingunguti ward use mobile phones as a mode of communications. The mobile services used are being provided by the four major phone companies namely Tigo, Vodacom, Zantel and Airtel. The infrastructure available to support transportation from one place to another consists of three major tarmac roads namely Kiembembuzi, Nyerere and Mnyamani roads. Kiembembuzi road transversely the Ogelea market and Mnyamani road passes the Kwasimba market. The means of transport in the ward is public transport, motorcycles and Bajaj.

1.2.7 Ethnic Groups

(Meshack, 2003) pointed out that the Vingunguti ward was originally owed by the arab settlers who used to cultivate coconuts in the area until 1963. Later on the area

was left in the hand of former plantation labourers who were allowed by the arab settlers to cultivate rice within the area. The plantation labourers then subdivided the land into plots for selling. Currently the mostly ethnic groups in Vingunguti ward are Wazaramo and Wapemba.

1.2.8 Energy Supply

The source of power in the ward is from the National grid via the Tanzania National Electricity Supply (TANESCO).

1.2.9 Security

The ward has two police posts one in Miembeni street and the second one in Mtakuja street. Not only police force that play part in security but also in the street there are security groups responsible for protecting community properties to ensure there is peace and harmony within the area.

1.2.10 Health Facilities

There are 6 health facilities in Vingunguti ward. Among these health facilities, only 1 health facility is owned by government and the rest 5 are privately owned. The facilities are distributed in the three streets namely Mtakuja, Miembeni and Kombo. There is no health facility in Mtambani Street. The details of the health facilities are included in Table 1.2 .

Table 1. 2: Health facilities in Vingunguti Ward

SN	Name of the facility	Ownership	Location/Street
1	Arafa Dispensary	Private	Miembeni
2	Afya Bora Dispensary	Private	Mtakuja
3	Vingunguti Dispensary	Government	Miembeni
4	Allah Karim Dispensary	Private	Kombo
5	Emara Dispensary	Private	Kombo
6	Arafa-Furaha Dispensary	Private	Miembeni

Source: Field Data (2015)

1.3 The Community Needs Assessment

Community needs assessment is a systematic process of identifying community gap between the current situations their satisfaction within the service and the desired conditions (Sharma, 2000). This needs assessment was conducted in Vingunguti ward as an actual appraisal of the current situation, through getting direct information from the relevant audiences in the community.

1.3.1 Objectives of the Community Needs Assessments

The goal for conducting the community needs assessment was to systematically collect information from the community so as to identify a specific project that will effectively address the prioritized need in Vingunguti ward community.

1.3.1.1 Specific Objectives

(i) To determine different needs at various levels in Vingunguti ward community.

(ii) To prioritize one need among all needs that can be addressed in Vingunguti ward community.

(iii) To identify one local organization that supports the Vingunguti ward community towards addressing the identified need

(iv) To design an intervention that can be implemented through the identified organization and the community to address the prioritized need

1.3.2 Research Questions

(i) What are the different community needs that exist in Vingunguti ward community?

(ii) Which one need among all other identified needs that can be prioritized and addressed in Vingunguti ward community?

(iii) Which local organization in Vingunguti ward that supports the community ward in addressing the problem?

(iv) What intervention that can be implemented through the identified organization and the community to address the prioritized need?

1.3.3 Community Needs Assessment Methodology

1.3.3.1 Assessment Design

The study used both qualitative and quantitative methods to collect primary and secondary data. Primary data were collected using, interview guides for individual key respondents, structured self-administered questionnaire. Secondary data were collected through review of different studies and official documentations at different levels.

1.3.3.2 Validation of Data Collection Tools

Data collection tools were pre-tested to the targeted groups and were completed the same way as it was supposed to be. The testers were asked to think while responding to the questions and they provided their feedback and identified questions which they did not understood and proposed how to frame it to bring the meaning. Some tools were seen to be too long and some questions were repeating hence suggested to be omitted. After the completion of pre-testing improvement to the tools were made and finalised ready to be used for data collect

1.3.3.3 Study Area/Location

The study was conducted in Vingunguti ward located in Ilala Municipal Council in Dar es Salaam region. Since Dar es Salaam region has 3 municipal councils (namely Kinondoni, Temeke and Ilala), through literature review and discussion with different authorities, it was observed that there were several similar need assessments that have been conducted in Kinondoni and Temeke municipal councils. In that regard, Ilala district was purposively selected for this need assessment.

Vingunguti ward was selected randomly (from a list of 26 wards within the district) in collaborations with the district officials/authorities. Twenty six (26) small plain pieces of papers of the same size, colour and shape were made and each small piece of paper was written one name of the ward hence making 26 pieces of papers. Then the pieces of papers were folded in same size and shape so that they all appear the same. They were then put in an empty box and thoroughly mixed. Then, one person from the council authority was selected to pick up only one piece of paper and Vingunguti was finally picked up.

1.3.3.4 Study Population

Study population for this community need assessment included members of the local government leaders (WEO, CDO, HO, EO, CHACC and SCP) and community members of the Vingunguti ward, youth aged 15-24 years, peer educators and the Msimamo Youth Educators (MYE) staff. Other community member/representatives were reached using their respective Ten Cell Leaders within the study area.

1.3.3.5 Study Sample and Sampling Process

The community need assessment was performed in two main stages. The first stage involved local government and community members at large so as to identify the reasonable community need that was a priority for the community at broader perspective. The second stage was capacity assessment involved youth, peer educators and a local NGO that supports the community on the identified need. The aim of the second stage was to identify the specific capacity gap to which the project can be implemented to address.

Two main sampling procedures were employed in the study; these were purposive and stratified sampling. Purposive sampling was used to select forty (40) respondents (i.e. 6 local government leaders, 4 street chairpersons, 25 peer educators and 5 Msimamo Youth Educators (MYE) staff). Stratified sampling was used to select 140 respondents (i.e. 20 ten-cell leaders, 60 youth and 60 general community members). Therefore, the study involved a total of 180 respondents.

There were 6 Vingunguti local government leaders and all of them were interviewed for the purpose of determining the community needs. Vingunguti ward had 4 streets that formed the 4 strata of the stratified sample (i.e. Mtakuja Street, Mtambani Street, Miembeni Street and Kombo Street). Each stratum (streets) has 15 ten-cell leaders hence making a total of 60 ten-cell leaders of which, one third (1/3) of them (from each street) were randomly selected to make a total of 20 ten-cell leaders. In each selected ten-cell leader, 3 youths were selected hence making a total of 60 youths (see inclusion and exclusion criteria below). From each ten-cell leader (with 10 households each), one third (3 households) were randomly selected to make a total of

60 households. In each selected household one respondent was selected, hence making a total of 60 respondents (general community members) see figure 1.2.

The inclusion criteria for the youths to be involved in the assessment were; young people aged between 15-24 years with the ability to read and write were included in the group of youth respondents in order to determine the specific need together with the peer educators. Community member included in the study were those who knew how to read and write because the questionnaires used were self-administered. Inability to read and write was the absolute exclusion criteria for community members and other respondents from whom information was collected by using self-administered questionnaires.

1.3.3.6 Data Collection Methods

Different data collection methods were employed in the study so as to obtain important data from different sources.

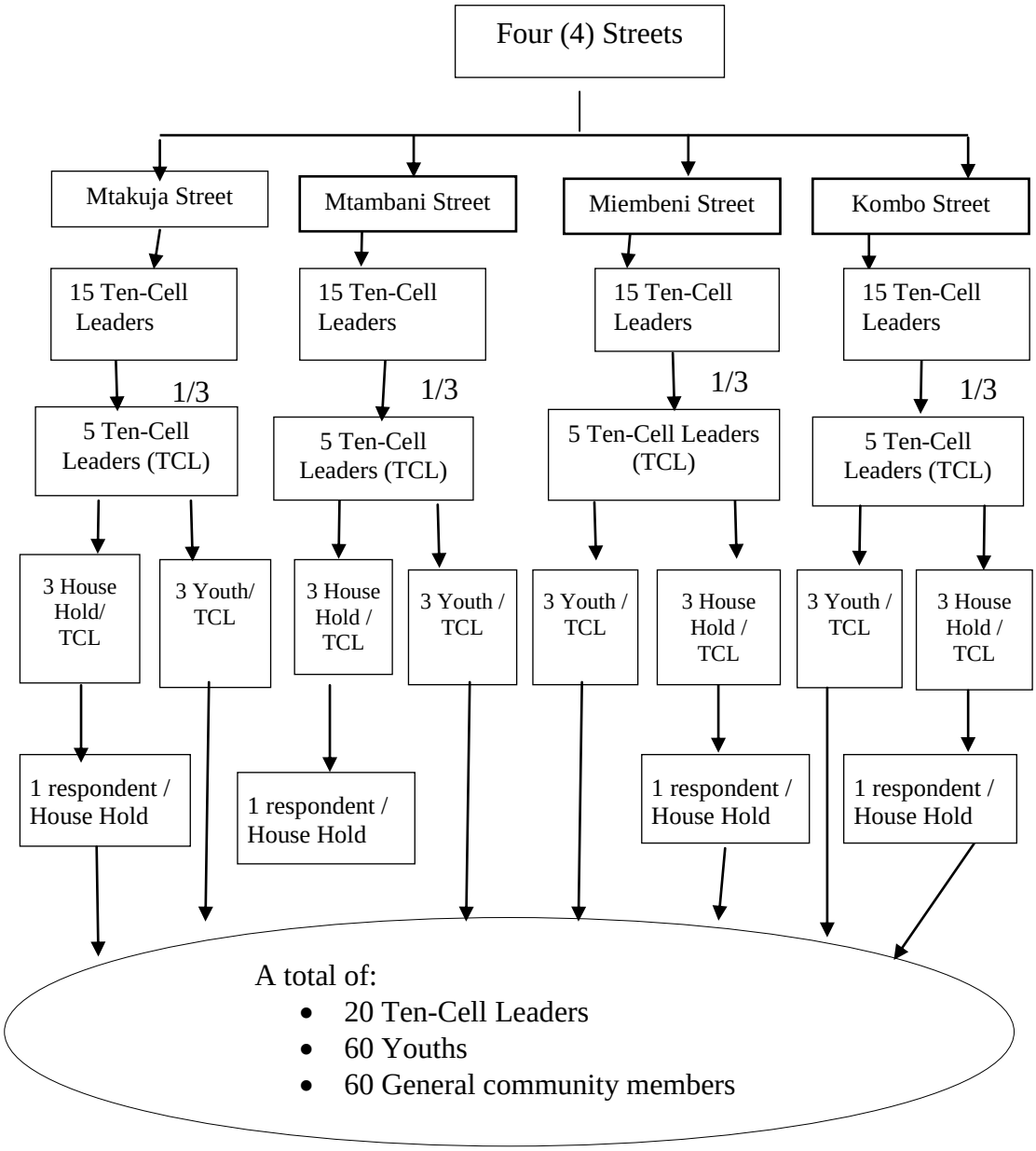


Figure 1. 2: Stratified Sampling of the Population

Source: Field data, (2014)

The data collection methods included, key respondent interviews using structured interview guide with both open and closed ended questions aimed at getting information from local government leaders and MYE staff. Other methods included

completion of structured open and closed ended self-administered questionnaires by peer educators, youths and general community members.

1.3.3.7 Data Processing, Analysis and Presentation

Collected data were processed and analysed using different methods based on nature of the data. For quantitative data, dummy tables were drawn, then using completed questionnaire, tallying and counting were performed to obtain tables of results. For qualitative data, coding of the responses was performed so as to obtain common themes whenever possible. This was then followed by developing dummy tables, tallying and counting so as to obtain tables of results. All the important data from the tables of results were then entered into Ms Excel 2010 for analysis and summarization. Different data presentations were through pie charts, histograms, bar charts and line graphs.

To complete identification of the community needs, after obtaining different tables from the local government leaders and general community members, the needs were summarized and presented back to the local government and Ten-Cell leaders (community representatives) for prioritization of one need that was taken further for project implementation and identification of one local NGO that would host the project.

1.4 Community Needs Assessment Findings

1.4.1 General Community Members and Local Government Authority

A total of 6 local government leaders and 80 community members (20 ten-cell leaders and 60 general community members) were interviewed in order to get general information of the Vingunguti ward as well as initiate the process of

identifying and prioritizing community needs. Among the 80 community members interviewed, 39 (49%) were males and 41 (51%) were females.

Majority of the community members were in the age groups 38-43, 26-31 and 32-37 years, see Figure 1.3.

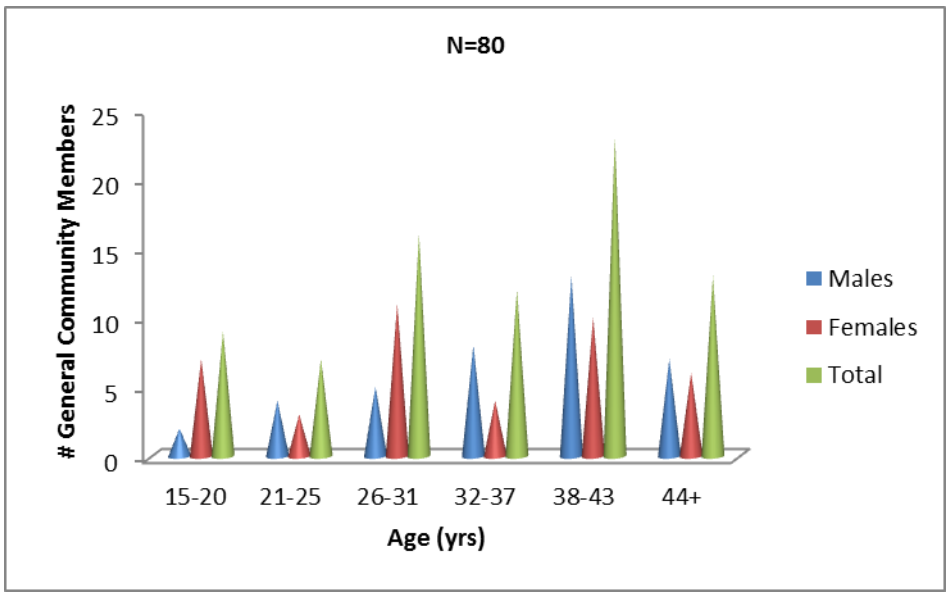


Figure 1. 3: Age - Sex Distribution of the General Community Members

Source: Field data, (2014)

As for the level of education, majority of Vingunguti community members were primary school leavers followed by secondary school leavers. Few of them were still in school and some were college leavers, see Figure 1.4.

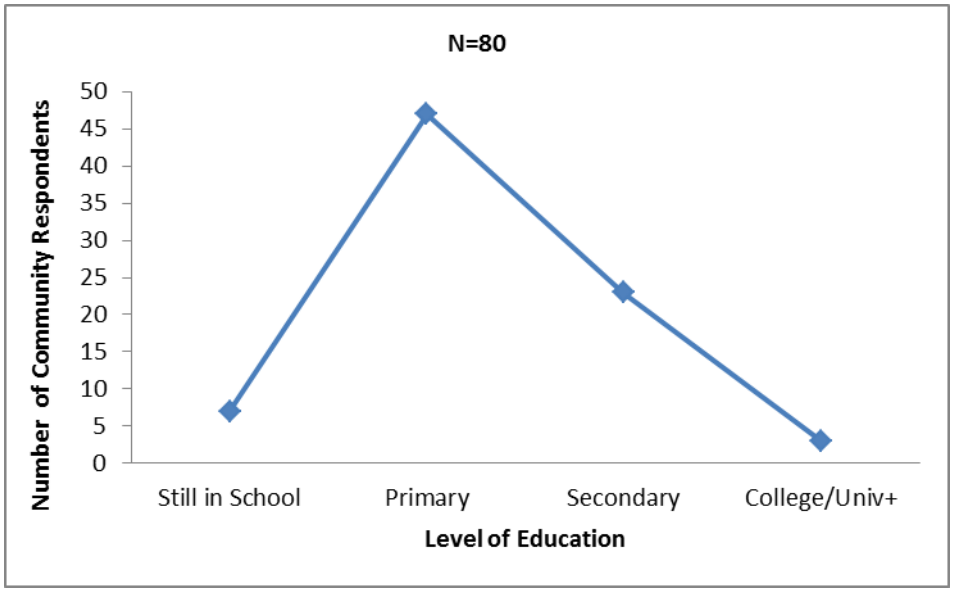


Figure 1. 4: Level of Education for Vingunguti Ward Community

Source: Field data, (2014)

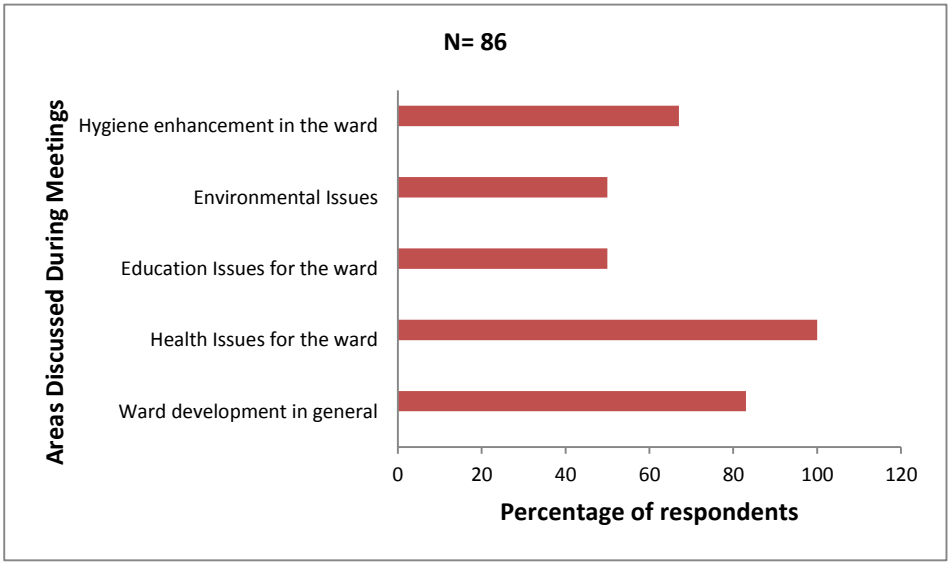


Figure 1. 5: Issues that LGA discuss with community

Source: Field data, (2014)

All local government leaders and community members revealed that there are meetings conducted between the general community and local government leaders to discuss several issues that are important and that face the Vingunguti ward

community. The issues that are discussed during the meetings were identified as hygiene enhancement in the ward, environmental issues, education issues, health issues for the ward, and ward development in general. These are summarised in Figure 1.5.

Data from 6 local government leaders and 80 community members interviewed collectively revealed that the most pressing needs for the Vingunguti ward community were inadequate safe and clean water, unplanned streets, poor drainage system, HIV and AIDS among youths, prostitution among young female, drug abuse among youths and inadequate collection of domestic waste. The identified needs are summarized in Figure 1.6.

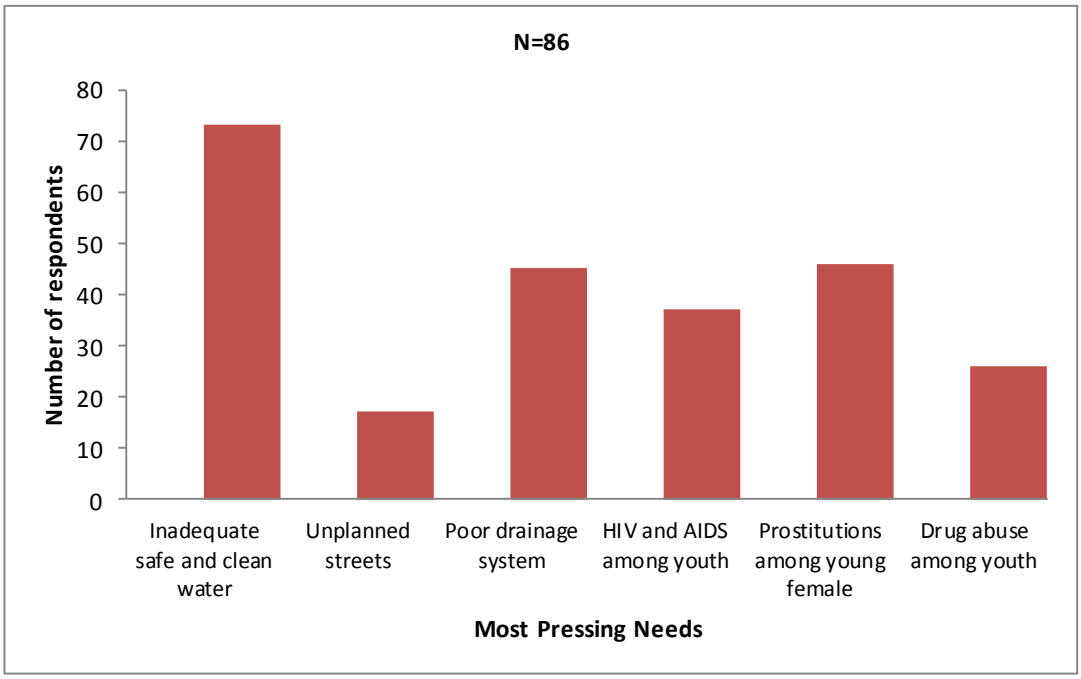


Figure 1. 6: Most Pressing Needs for Vingunguti Ward Community

Source: Field data, (2014).

1.4.1.1 Validation Meeting

Following the identification and summarization of the most pressing needs from the local government leaders and the general community members, a half-day meeting was conducted so as to validate and prioritize the needs. The meeting involved all the 6 local government leaders and the 20 ten cell leaders hence making a total of 26 members. The identified needs were presented to the members and each member was given a piece of paper and a pen to list down the needs from the first to the last according to his/her opinion. The pieces of papers were then collected and analysed the needs from number 1 to 7 according to what came out from the members. A summary table was then developed indicating the needs' score as per number of respondents as well as the ranking position per need. These findings are summarized in Table 1.3.

Table 1. 3: Scoring and Ranking of the Community Needs

Pressing Need	Local Government	General community	Score	Ranking
Inadequate safe and clean water	6	54	60	1
Drug abuse among youth	6	50	56	2
HIV and AIDS among youths	4	41	45	3
Poor drainage system	5	32	37	4
Inadequate collection of domestic wastes	2	33	35	5
Prostitutions among young female	2	32	34	6
Unplanned streets	3	1	4	7

Source: Field data, (2014)

1.4.1.2 Prioritisation Process

Development of a scoring and ranking summary table of the most pressing needs was then followed by a joint discussion involving the local government leaders, the ten-cell leaders and the researcher to prioritize one most pressing need that could be addressed by the researcher through developing and implementing a project while considering the capability of the researcher. Criteria for the selection or prioritization were set and they were four; availability of enough funds to implement the project, presence of a local NGO that to some extent also supported towards addressing the specific need, time-frame that was within the duration that the researcher was assigned and whether the need was reasonable to be implemented at that particular time. Therefore, a table (see table 1.4) was created indicating the pressing needs arranged according to the ranking results against the criteria set.

Table 1. 4: Prioritisation Process of Pressing Needs for Project Implementation

Pressing Need	Fund Available	NGO Dealing with the Issue	Enough Time for Implementation	Reasonable	Total Score
Inadequate safe and clean water	0	0	0	1	0
Drug abuse among youth	0	1	0	1	2
HIV and AIDS among youths	1	1	1	1	4
Poor drainage system	0	0	0	1	1
Inadequate collection of domestic wastes	0	0	1	1	2
Prostitutions among young female	0	1	1	1	3
Unplanned streets	0	0	0	0	0

Source: Field data, (2014)

Although the ranking process identified inadequate safe and clean water as the first most pressing need that needed to be addressed, its implementation was considered not possible following the prioritization process because it needed a lot of funds, it needed a lot of time hence against the researcher's duration of stay in the community and there was no local NGO currently dealing with the issue. HIV and AIDS among youths were then selected as the priority to be addressed because something sustainable could be done to address the issue within the time-frame that the research stayed within the community.

There was a local NGO that was dealing with similar issues within the community and the intervention was considered to be less expensive and the researcher's budget was well fitting into the budget. It was further appreciated that some other pressing issues could to some extent be addressed while implementing HIV and AIDS intervention; these other pressing needs were prostitution among young females and drug abuse among youths. The prioritization process findings are summarized in Figure 1.7.

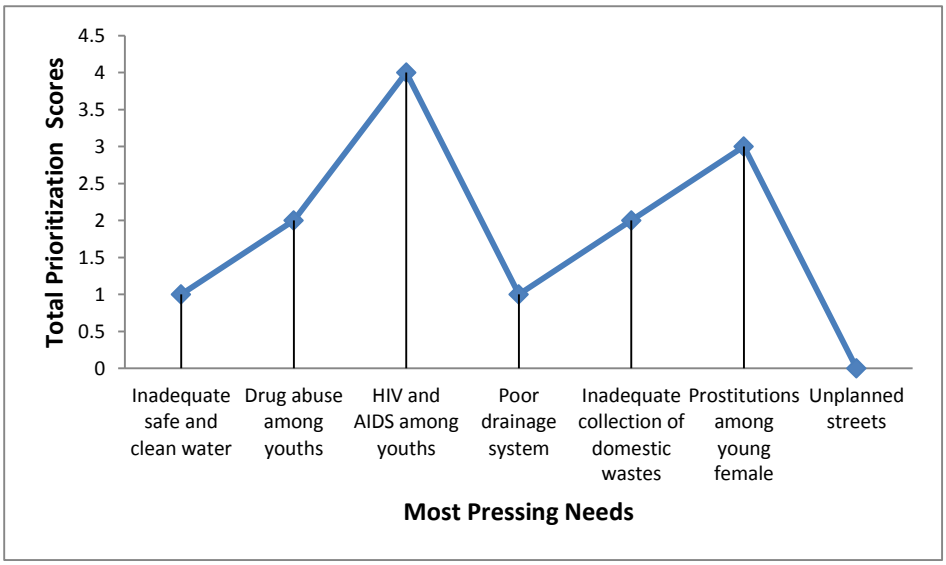


Figure 1. 7: Results of the Needs Prioritization Process

Source: Field data, (2014)

Therefore, the community representatives prioritized HIV and AIDS among youths as the need to be dealt with and addressed within the time and researcher's capabilities. It was also revealed that Msimamo Youths Educators (MYE) was the only local non-governmental (NGO) that supports the Vingunguti community in addressing several youths' issues, HIV and AIDS being one of them. It was further revealed that, MYE works with peer educators (PE) in addressing several youths' needs within the Vingunguti community.

It was then agreed that, more information was needed from the MYE organization, peer educators and youths themselves so as to determine the actual gaps in HIV and AIDS among youths that can be dealt with through the project implementation. For this reason then, questionnaires were developed so as to collect information from the MYE leadership, peer educators and youths within the community. The results of this process for peer educators and youths are described in the section below.

1.4.2 Peer Educators and Youths

1.4.2.1 Socio-Demography

A total of 25 peer educators from MYE NGO and 60 youths from Vingunguti ward community were interviewed using self-administered questionnaires. Among the 25 peer educators 18 (72%) were males and 7(28%) females while among the 60 youths, 32 (53%) were males and 28 (47%) females (see Figure 1.8).

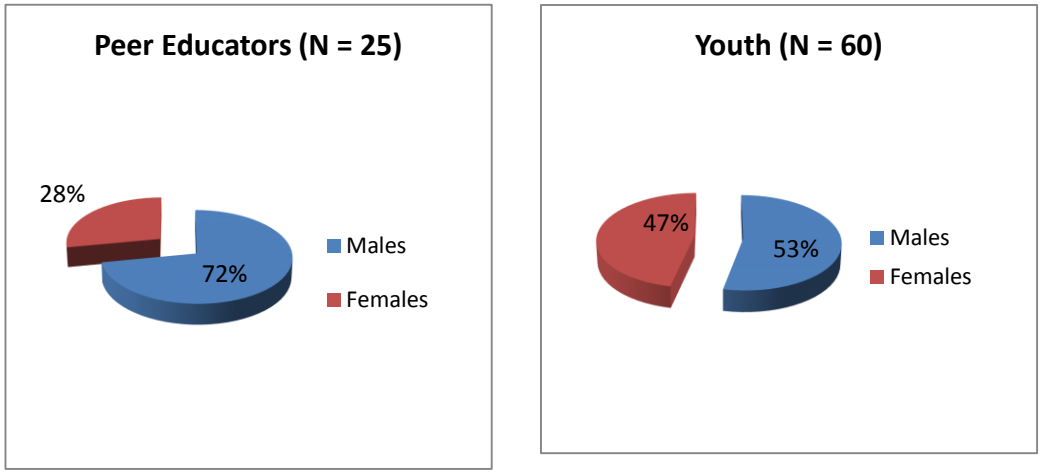


Figure 1. 8: Sex Distribution of Peer Educators and Youths

Source: Field data, (2014).

Majority of the peer educators were in the age group 20-22 years while majority of the youths were in the age group 17-19 years; Figure 1.9 clarifies this.

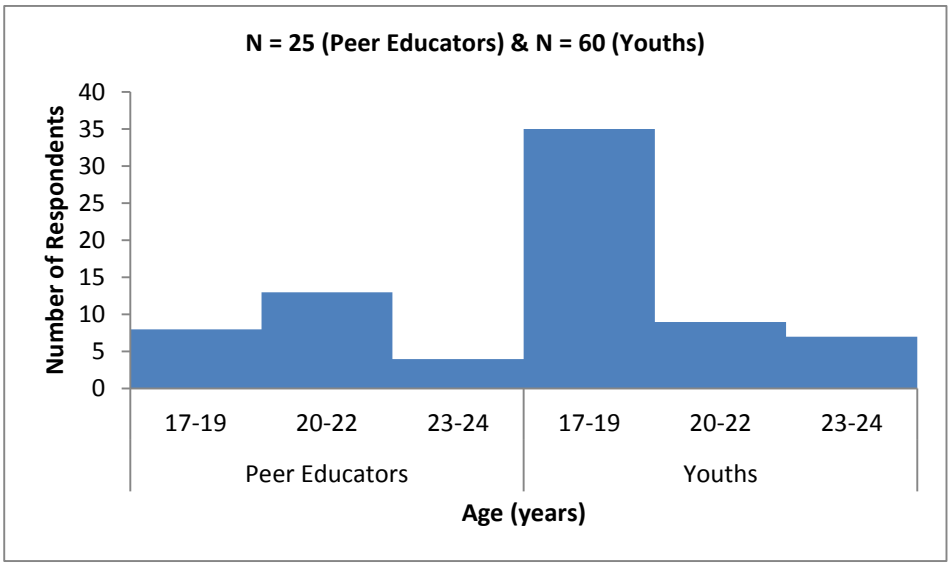


Figure 1. 9: Age Distribution for Peer Educators and Youths

Source: Field data, (2014)

Majority of the peer educators 17 (68%) and youths 47 (79%) were single. Only 6 (24%) of peer educators and 8 (13%) of youths were married. Cohabiting couples were found in 2 (8%) of peer educators and 5 (8%) of the youths; Figure 1.10.

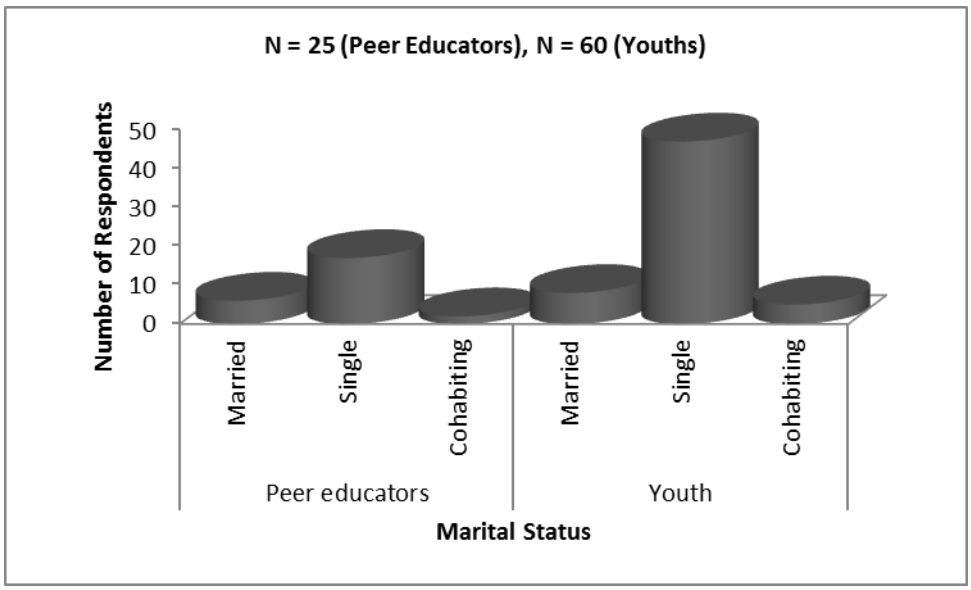


Figure 1. 10: Marital Status for Peer Educator and Youths

Source: Field data, (2014)

Peer educators who had secondary school education were 14 (56%) and 6 (24%) of them had primary school education while 15 (25%) and 26 (43%) of youths had secondary and primary school education respectively. One (4%) of peer educator and 18 (30%) of youths were still studying while 4 (16%) of peer educators and only 1 (2%) of youths had college and/or university education; see Figure 1.11.

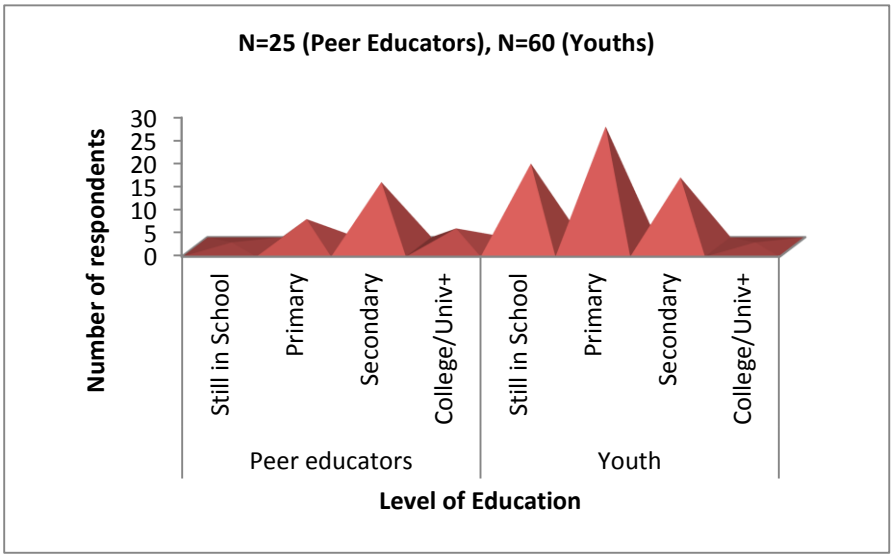


Figure 1. 11: Level of Education for Peer Educators and Youths

Source: Field data, (2014)

1.4.2.2 Meetings between peer educators and youths

All 25 (100%) peer educators and 56 (93%) of youths revealed presence of meetings among themselves to discuss on HIV and AIDS-related issues. The main agendas that they discuss when they meet were identified as HIV and AIDS in general, Stigma and discrimination in HIV, Risky behaviours for HIV infection, effects of prostitution and the use of illicit drug use in relation to HIV transmission. Apart from HIV and AIDS issues, other issues that they also discuss included general body hygiene and environmental sanitation. In order to facilitate the discussion with

youths, peer educators revealed that different approaches were being used to deliver important messages to youth. The approaches that were being used included; sports and play/games with key messages, focus group discussions, one on one discussion, drama and role plays.

1.4.2.3 HIV and AIDS Knowledge among Peer Educators and Youths

Findings from peer educators on issues that they felt not comfortable or competent discussing with youths were almost in line with what was found in youths when they were asked to identify issues or topics that they needed to learn more. The issues that youths needed to learn more included HIV in pregnant women, HIV in discordant couples, HIV prevention, entrepreneurship in youths and correct use of condoms.

All 25(100%) of peer educators had significant knowledge on HIV and AIDS while only 11(44%) of them had patch knowledge on different methods to prevent HIV infection. Majority of youths, 58(97%), 51(85%), 43 (72%) and 49(82%) had understanding on the meaning of HIV and AIDS, modes of HIV transmission, signs and symptoms of HIV/AIDS and myths/misconception respectively. It was also revealed that only 19(32%) and 23(38%) of youth answered correctly on the risk behaviours for HIV transmission and different methods to prevent HIV infection respectively. Table 1.5 summarises the findings on this area.

Table 1. 5: Correct Knowledge on HIV/AIDS among PE and Youths

HIV and AIDS Knowledge	Number of Respondents who Correctly Answered	
	Peer Educators N=25	Youths N=60
Meaning of HIV and AIDS	25 (100%)	58 (97%)
Modes of HIV Transmission	25 (100%)	51 (85%)
Risk Behaviours for HIV Transmission	10(40%)	19 (32%)
Signs and Symptoms of HIV and AIDS	25 (100%)	43 (72%)
Myths and Misconceptions in HIV and AIDS	25 (100%)	49 (82%)
Methods to Prevent HIV in Youths	11 (44%)	23 (38%)

Source: Field data, (2014)

1.4.2.4 Challenges Faced by Peer Educators in Educating Youths

Peer educators admitted that educating youth was not an easy task and that they were facing several challenges when discussing with youths. The challenges that peer educators were facing when discussing with youth were identified as difficulties for youth to change behaviour, inadequate training and refresher trainings in the area of HIV and AIDS, inadequate communication skills for peer educators, instructing youths on the correct use of condoms and inadequate Information Education and Communication (IEC) materials for provision of health education to youths. Majority of the peer educators had patchy training on HIV and AIDS related issues and most of them had very long time since they had received the trainings without refresher trainings. Peer educators identified sessions or topics that they felt and didn't feel comfortable discussing with youths. These topics are summarised in Table 1.6.

Table 1. 6: Areas that PEs Felt/Didn't Feel Comfortable Discussing with Youths

Felt Competent discussing with youths	Didn't feel comfortable discussing with youth
HIV Transmission	HIV prevention
Stigma and Discrimination	Demonstration of correct condom use
Gender and HIV	Behaviour change in youth
Illicit Drug use and HIV	

Source: Field data, (2014).

1.4.2.5 Youths' Risky Sexual Behaviour

Youths who admitted to have ever had sexual intercourse at least in the past three months were 43(72%); Out of these, 22(51%) reported to have had sexual intercourse with more than 1 partner and 32(74%) of them did not use condoms. Those who did not use condoms during sexual intercourse had several reasons for that. Reasons provided were condoms render no sexual pleasure 11(34%), not user friendly 27(84%), feeling ashamed to buy or ask for condoms 12(38%), tedious steps of using the condoms 23(72%), possibilities of the condom to slip and get lost into the vagina 19(59%) and partners' refusal to use condoms 25(78%).

1.5 Discussion and Conclusion on Needs Assessment

Involving the community was the best way that made identification and prioritization of community needs. The study appreciated the participatory community needs assessment towards development and designing of the project towards addressing the prioritized need. The needs that were identified in a participatory approach were inadequate safe and clean water, unplanned streets, poor drainage system, HIV and AIDS among youths, prostitution among young female, drug abuse among youths and inadequate collection of domestic waste. Among all other identified needs by the

Vingunguti ward, the community then prioritized HIV and AIDS among youths as a need that needed to be addressed. Through participatory approach, the community also identified one local NGO that was supporting the community in the area of HIV and AIDS in youths.

Capacity assessment of the local NGO revealed that youths and peer educators had almost similar social-demographic characteristics; there were no differences in their age, marital status and level of education. Peer educators act as role models to youths hence fasten learning process to take place. The capacity assessment discovered that, peer educators and youths had adequate knowledge on differences between HIV and AIDS, modes of HIV transmission, signs and symptoms of HIV/AIDS, myth and misconception in HIV and AIDS.

However, there were some areas in HIV and AIDS in which peer educators and youths had little understanding. Majority of youths had little knowledge and understanding on the risk behaviours for HIV transmission. Majority of peer educators and youths had little knowledge on HIV prevention approaches and methods. This signified that something needed to be done so as to impart knowledge and understanding to peer educators that will enable them transfer knowledge and skills to youths and appreciate the processes of behaviour change among youths.

The Vingunguti peer educators were discovered to be facing challenges in effectively discussing and imparting knowledge and skills to youths particularly in the area of HIV prevention, demonstration of correct use of condoms, and processes for behaviour change. To a greater extent, these challenges affected the effectiveness of

peer educators within the Vingunguti ward in delivering some aspects of HIV-related knowledge and skills to youths. This is in line with what was found to youths; among the areas that youths thought they needed some more understanding included HIV prevention and correct condom use. It was clear from the study that youths were practising unsafe behaviours that predispose them to HIV infection; these included multiple sexual partners and lack of condom use.

1.6 Recommendations Following Needs and Capacity Assessments

MYE's peer educators' capacity needed to be built on area of HIV prevention, condom use, behaviour change and communication skills. This signified that an intervention in the form of training was necessary to peer educators in order to strengthen their knowledge and skills' capacity to discuss with youths along the areas of HIV prevention, condom use and behaviour change. Apart from training also close monitoring, supportive supervision and mentoring helped them to strengthen their competencies in their work with youth. They gained confidence, technical skills in communication, correct information on HIV prevention these helped them to smoothen their work. Since peer educators were considered as role models and agent of behaviour change among youth, increase their competencies in HIV prevention will also transfer the knowledge and skills to youth and lastly youth will change their HIV risky behaviours and lead to decrease in HIV prevalence rates among youth in Vingunguti ward.

CHAPTER TWO

PROBLEM IDENTIFICATION

2.1 Background to Research Problem

HIV infection among youths is an important proxy indicator for determining trend in HIV incidence and prevalence. The overall change in HIV prevalence among youths from 2007/08 (2.4%) to 2011/12 (2.0%) is equivalent to 17% decrease during the past 5 years.

Although much has been done and achieved in the fight against HIV and AIDS, there is still a long way to go in preventing HIV transmission among youths. Many youths are still at risks because of high risks sexual behaviours and they do not feel that they are at risks of contracting HIV infection hence they do not see reasons for changing their behaviours. It is challenging for many youths to practice abstinence (differing sex until marriage) and they feels reluctant to use condom consistently due to loss of sexual pleasure, condom failure and feeling of embarrassment when attempting to purchase condoms. Furthermore, youths face difficulties in obtaining clear and correct information on HIV transmission and prevention.

In addressing HIV prevention through risk behaviour change among youth globally and nationally, different approaches have been deployed including the capacity building for peer educators so that they can impart knowledge and skills to youths. Peer educators have been described as a core pillar in HIV prevention and have been found to be effective at improving knowledge and promoting attitudinal and behavioural change particularly among youths.

Peer education strategy is associated with decreased in risky behaviour; this is because youth share information with each other and one acts as a facilitator of the discussion, they discuss and learn about particular topic together. Peer educators help to empower youth to take action because its implementation is of participatory manner.

In order for them to be on the driving seat of influencing youth towards changing their risks behaviours, peer educators need to be more knowledgeable and skilled enough to respond to the quarries from youth during the discussions. They also need to be open minded, good listeners and with good communication skills.

Peer educators in Vingunguti ward were found to have inadequate knowledge and skills on some components of HIV prevention, communication skills, skills for demonstration of correct use of condoms and social behaviour change communication (BCC). This situation rendered challenges for peer educators to fully play their roles in influencing youths towards HIV prevention. With this then an intervention that was aligned towards equipping the Vingunguti ward peer educators with knowledge and skills was of paramount importance. The intervention was critically supposed to be in the form of training so as to impart knowledge and skills to peer educator so that they become competent and confident enough to discuss with youths on the areas of HIV prevention in general, behaviour change communication, demonstration of correct use of condoms and effective communication skills.

Without this intervention, the peer educators' incompetence and lack of confidence would continue to exist; youths will continue missing the knowledge and skills on

HIV prevention and behaviour change and HIV transmission among youth would continue to rise. A lot of youths would be HIV infected and die from AIDS hence the productivity of the community would have also been compromised. This would increase poverty at family and community levels.

2.2 Project Description

2.2.1 Target Community

This project targeted peer educators from MYE in Vingunguti ward, Ilala municipal council in Dar-es-Salaam region. Peer educators were part and parcel of the community and they participated in the initial participatory need assessment as community members. The initial need assessment identified the most pressing community needs and community representatives prioritize one need in a broader perspective (HIV and AIDS among youths).

Secondly, peer educators and youths were involved in identification of the specific problems or issues in the area of HIV and AIDS in youths whereby the specific challenges in delivering correct HIV prevention messages to youths were clearly pointed out among themselves. These specific needs consequently led to development of the project with the intervention to strengthen knowledge and skills to peer educators so that they can deliver correct HIV prevention information to youths competently and confidently.

Thirdly, the peer educators were actively involved during execution of the project through interactive training, supportive supervision and mentoring when practicing

their skills in empowering youths. The close collaboration with youth and peer educators in identification of the problems and implementation of the project involved other community members (parents and guardians) since they had to provide permission to them so that they can participate in their HIV and AIDS related sessions (peer educators and youths interactions).

It was extrapolated that the correct HIV and AIDS related information provided through implementation of the project to peer educators and consequently to youths did not just end there but also disseminated to the rest of the community members hence empowering the entire Vingunguti community. In this therefore, peer educators and youths act as ambassadors.

2.2.2 Stakeholders

The main/primary stakeholders of the project were peer educators of the Msimamo Youth Educators (MYE). Other stakeholders for the project were youths, the MYE leaders, ten-cell leaders, local government leaders and rest of the community members. The role of community members was to identify and prioritise needs for Vingunguti ward, identify one local organization that addresses the prioritized need, allow their children (youths and peer educators) to attend discussion sessions among them for learning purposes.

Apart from participating in identifying and prioritizing community need, local government leaders also acted as a bridge between the researcher, community members and the local non-governmental organization (NGO). Additionally, the

local government leaders identified the local NGO that is working towards addressing the identified need and they participated too in addressing the identified need.

Ten cell leaders also acted as a bridge between the researcher and community members and youths, participated in the identification of community needs and represented the entire community in the process of prioritizing one need that was used to develop a project. Importantly, ten cell leaders distributed and collected all the self-administered questionnaires from the respective households they were leading.

As a local NGO that hosted the project, MYE participated in the planning, implementation, monitoring and evaluation of the project. They also allowed their peer educators and other supporting staffs to participate fully in the project. Since they involved in the execution, monitoring and evaluation of the project, MYE facilitated to ensure sustainability of the project by incorporating some of the project activities into their work plans and budget so that they can be implemented further in the long run. Generally, the stakeholders' concerns were how the problem of HIV infection among youths can be addressed using the project designed and how could the designed project be made sustainable.

2.2.3 Project Goal

To strengthen peer educators competencies in educating youths on HIV prevention

2.2.4 Project Objectives

The project's specific objectives were,

(i) To determine the capacity of MYE in enabling peer educators to deliver knowledge and skills on HIV prevention information to youths.

(ii) To determine strategies for addressing the identified capacity gaps for MYE, peer educators and youths.

(iii) To strengthen peer educators' knowledge and skills on different approaches for preventing HIV transmission.

(iv) To strengthen peer educators' knowledge on behavior change communication

(v) To strengthen peer educators' knowledge and skills on effective communication skills.

(vi) To improve peer educators' performance according to set standards.

2.2.5 Hosting Organisation Profile

Msimamo Youth Educators (MYE) was founded in 2011 and got full registration in 2012. It focused on supporting marginalised youth and children.

2.2.6 Organization Vision

To create a healthier and safer, society where children and youths are living happily.

2.2.7 Organization Mission

To educate and empower children and youths to overcome criminality, use of drugs and prostitution in disadvantaged communities.

2.2.8 Organization Leaders

The MYE's management team includes Program Director, Program Manager and Treasurer. These form the decision making team for the organization. Other MYE's

staffs include Program coordinator, project assistant and a driver. Figure 2.1 summarises the MYE's organogram

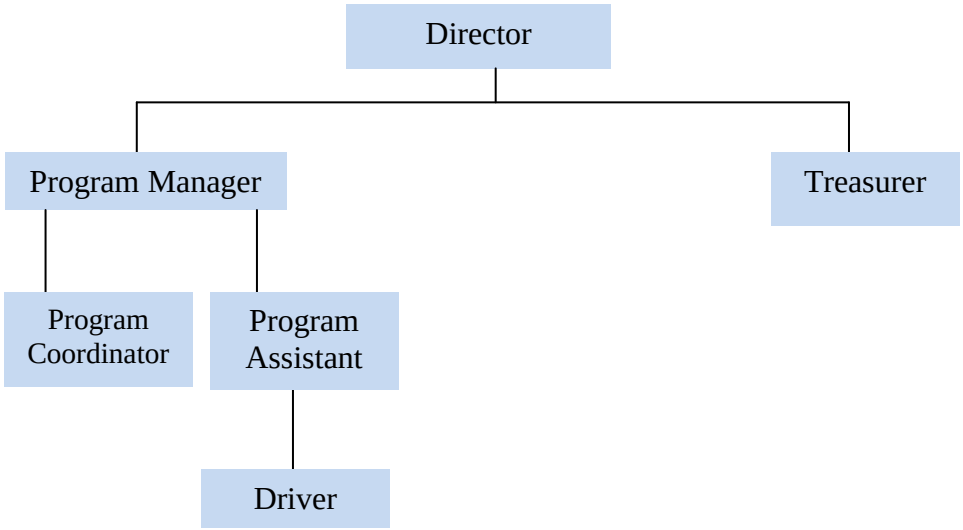


Figure 2. 1: MYE's Organization Structures (Organogram)

Source: Field data, (2014)

2.2.9 Organization SWOC Analysis

During capacity assessment it was found that the major challenges that MYE's faced were; there were no HIV and AIDS training package for peer educators, SSM tools and M and E tool to track performance of peer educators at field. Mentoring was not done to ensure peer educators performed according to a set standards.

The SWOC analysis of the host organization showed the existence of many strength and opportunities that are available to support the implementation of the project to the targeted beneficiaries. This project supported the MYEs' to address the detailed weaknesses to smoothen the project implementation and peer educators were trained. Below (Table 2.1) is the SWOT analysis table showing some strength, weaknesses, opportunities and threats of the host organization (MYE).

Table 2. 1: SWOC Analysis for Msimamo Youths Educators Organization

Strength	**Weaknesses**
Availability of 25 peer educators Good accountable program manager and coordinator	Lack HIV and AIDS training package Lack of SSM tools Lack of M & E tools Mentoring is not done to peer educators
Opportunities	**Challenges**
Acceptance of community members Acceptance by LGA Youth accepted to learn and participates in activities.	Budget constraining to run training to peer educators.

Source: (Field data, 2014).

2.2.10 Researcher's Involvement

The researcher was involved from the first stage of identification of the problem, designing project, implementation, monitoring, SSM and evaluation and handing over a project to the MYE. At the first stage researcher conducted the following:

(a) Capacity assessment was done to MYEs' by a researcher to identify gaps that needed to be addressed. Following the assessment, researcher presented identified gaps to MYEs' staffs, training to peer educators was agreed, and training package, M & E and SSM tools were developed by a researcher and draft was presented in a meeting between researcher and MYEs'. Inputs were provided and schedules were planned for the implementation.

(b) Researcher in collaboration with MYEs' program manager they conducted training to peer educators, after the training they did Monitoring visits, and SSM to identify challenges that peer educators faced in their work with youth.

(c) In collaboration with researcher, MYEs' program manager and coordinator they did project evaluation and measured the impact of project to the beneficiaries.

CHAPTER THREE

LITERATURE REVIEW

3.1 Introduction

This part provides information on what others did for the similar problem. It summarizes on how the problem was identified, the existence of the problem, magnitude of the problem, and benefits for solving the problem.

3.2 Magnitude of the Problem

Young people are at the centre of the global HIV and AIDS epidemic, in regard to new HIV infections (Monasch et al., 2006). In December 2013 HIV prevalence rate among youths in Tanzania was 11.2% while Dar es Salaam was 6.8% (TACAIDS, 2014).

3.3 Theoretical Review

Constructivism learning theory was applied in this study. As far as the theory is concerned, learning should engage and expand experiences of the leaner. Students learn by doing and should be allowed to construct, create and actively enquire. In this study peer educators were made to actively participate and engage critical thinking skills and analyse challenges that are encountered during their work with youths. Different facilitation skills were used such as group discussion, brainstorming, role plays and lecturing so as to broaden peer educators minds and for effective learning. Also Constructivism learning theory emphasises on collaboration between mentor, learner-based environment and encouragement of participants (mentees) reflection

through experimental learning (Crotty,1997).Facilitators have been assumed as a co-explorer who encourages peer educators to rise up questions, challenges students' ideas and formulates to get conclusions. As far as constructivism principles concerned, active learning problem based learning, collaboration; discovery learning, deeper understanding and higher performance were all applied in the implementation of the project.

Youths are still at higher risk of contracting HIV infection due to risky sexual behaviours, (Campbell, et al., 2002)., (Visser, 2007). Most youths do not feel that they are at risk of contracting HIV infection hence they see no reasons for behaviour change. Youths who understand that they are at higher risk of becoming infected with HIV also see few reasons for changing their behaviour because of beliefs that HIV is inevitable. Many youths fail to adhere to the concept of abstinence until marriage, do not use condom in each and every act of sexual intercourse of the mentality of loss of sexual pleasure and the feeling of embarrassment when buying condoms.

The use of peer educators has been found to be effective at improving knowledge and promoting attitudinal and behavioural change among youths, (Brieger, et al., 2001); (Ali, et al., 2004), and such interventions were significantly associated with decreased risky behaviours, (Li, et al., 2010); (DiClemente, 2000). Previous studies in Africa have shown that teachers and parents are frequently reluctant to discuss sensitive sexual issues with students and children respectively since they are usually bound to cultural and social inhibitions, (Oshi and Nakalema, 2005)., (Visser, 2005).

Peer education was considered as the best approach to be used in order to reach youths based on the rationale that they have a strong influence on individual behaviours, (Population Council, 2000).

As members of the target group, peer educators are assumed to have a level of trust and comfort with their peers that allow more open discussions on sensitive sexual issues (Campbell and MacPhail, 2002). Similarly, peer educators are thought to have good access to hidden populations that may have limited interaction with more traditional health programs (Sergeyev, et al., 1999).

Although peer education is known to be the most effective approach in changing youths' behaviour, peer educators face different challenges, (Sulumo, 2010). Peer educators lack knowledge and skills on HIV and time to respond to the challenges. In addressing those challenges (Adamchak, 2006) and (Hooks, et al., 1998) revealed that ongoing training and supportive supervision are important for the maintenance of quality services provided by peer educators (Medley, et al., 2009) stated that, for peer educators to become effective in delivering information to youths he/ she should be sensitive, open minded a good listener and a good communicator.

(Adamchak , 2006) stated that global researches on the benefits of peer education show that this approach can positively influence youths attitudes and knowledge about HIV and AIDS, influence youths to decrease their number of sexual partners and increase their use of condoms and other contraception, reach youths' groups with education and health materials, such as brochures and condoms, increase the use of

sexual and reproductive health services by vulnerable young people, and improve community norms about youth and sexual behaviour.

3.4 Empirical Literature

Different researchers conducted similar studies and used different approaches in identifying the actual problems pertaining peer educators challenges in providing effective education to youths. Medley, et al., (2009) and (Michaelson, 2012) used systematic literature reviews and meta-analysis in which data were searched using pre-specified terms and additional articles were identified on website and international organizations. Al-Iryani (2011) identified the problems in peer education through conducting baseline survey to obtain information from youths and peer educators and consequently he designed and implemented HIV prevention and education among youth through peer educators.

In many researches, the intervention to strengthen peer educators knowledge and skills to educating youths on HIV matters related to prevention was attained through training, supportive supervision and mentoring (SSM). Agha and Van Rossem (2004), (Gao, et al, 2002) and (Welsh, et al., 2001) pointed out that training of peer educators is the effective means of building their capacities they did not specify and detail the type of training peer that educators received (Broadhead, et al., 2006) and (Morisky, et al., 2006) reported that peer educators received a onetime training course that ranged in length from few days to two months but there was no details on exact topics or themes that entailed in the peer educators training. Although (Asamoh, 1994) mentioned that supportive supervision and mentoring visits to peer

educators were done following the training, but he did not indicate the level of supportive supervision and the specific areas that were covered.

Al-Iryani (2011) stated that, designs intervention for HIV prevention among youths in the community, the theory of diffusion of innovation has to be taken on board. The intervention started with pre-training to peer educators for 10 days using the peer educators training and life skills package. Pre training was then followed by a 2 days pre field training before the initiation of peer educator's sessions and outreach activities. Targeting youth at the community level, he conducted indoor peer education session outreach activities with pre and post-tests.

The indoor peer education was conducted in such a way that peer educators did five hours sessions in the course of two days where ten HIV messages and two life skills were covered by peer educators. The peer educators used posters, one for each message. Schools were the site for peer education session after school hours. During community outreach peer educators focal point mobilized youths and families through home visit to encourage families to allow youths to participate. The outreach peer education activities were conducted in bus stops and homes with the aim of equipping the hard to reach youths with necessary HIV prevention knowledge and skills. Many of these studies did not mention any monitoring and evaluation in the course of the implementations.

3.4.1 Lessons Learnt from the Literature

The approach of using peer educators will help to effectively change youths' risky behaviours that predispose them to HIV infection. It has also been learnt that

equipping the peer educators with adequate knowledge and skills on HIV and AIDS related matters as well as providing supportive supervision and mentoring after the training enhances competences and confidence to the peer educators. The approaches were incorporated in the designing and implementation of the project where by training on HIV prevention, condom demonstration, behaviour change communication (BCC) and Effective communication skills was provided to MYE's peer educators. This project went further and implemented monitoring and evaluation that were not well described by other researchers. The monitoring and evaluation for this project involved developing relevant tools, actual monitoring and evaluation of peer educators while interacting with youths and re-assessing the youths on the knowledge and skills on behaviour change and HIV prevention-related matters.

3.5 Policy Review

To achieve the objective of controlling the spread of HIV and AIDS is to promote youths' friendly services and positive sexual behaviour change through peer education and strengthening guidance and counselling services (URT, 2010). The rationale behind peer education is that peers can be a trusted and credible source of information. They share similar experiences and social norms and are therefore better placed to providing relevant, meaningful, explicit and honest information. Young people are trained to offer information and services on issues of sexual and reproductive health based on the basis that most young people feel more comfortable receiving information from people of the same age group rather than from adults.

Peer education increases young people's access to sexual and reproductive health education subjects which are often not fully addressed by parents and schools and reaches vulnerable and marginalized young people who may not be in schools. By means of appropriate training and support, the young people become active players in the educational process rather than just passive recipients or messengers (IPPF, 2007).

However, successful peer education programmes require intensive planning, coordination, supervision and resources. Moreover, for peer education programmes to work they must motivate the peer educators and make them feel valued members of the organization. This instils a feeling of ownership, which shows in their work and which young educators pass onto their peers (FHI, 2010).

Peer educators need ongoing training from the member associations, or the organization undertaking the peer education programme, on the specific issues they will be teaching. The training should be adapted to the peer educators' needs and experiences and it should relate directly to the objectives and type of activities planned in the programme (Adamchak, 2006).

Before starting the training, it is recommended to inform parents and other important stakeholders, including teachers about the purpose of the training, including the contents of the curriculum. This can be done through a letter or by organizing a special meeting. It is also advisable to obtain the parental/guardian consent for very young peer educators (URT, 2010).

Before beginning the training, a group assessment should be undertaken to determine peer educators' own knowledge levels, needs and strengths. This helps determining the content of the training and the techniques that are best suited for the group. It is advocated that, immediate evaluation of the training should involve the trainer, coordinator, trainees and senior management in appraising the training needs and objectives achieved.

Use pre and post-tests to determine whether peer educators have acquired the necessary knowledge and skills. Evaluation forms at the end of the training are also a useful tool to identify strengths and weakness of the training, and possible topics for refresher and follow-up training.

If some of the participants have shortcomings at the end of the training, the coordinator can decide whether the individuals have the skills necessary to be a peer educators and whether additional training can be organized for them. If not, the coordinator can talk to the individual about the potential for other types of work within the organization, (FHI, 2010).

Supporting and supervising peer educators is particularly important aspect of programme implementation since it provides the opportunity for peer educators to receive feedback, technical support and enable them to express their thoughts and concerns about their work and the programme as a whole.

CHAPTER FOUR

PROJECT IMPLEMENTATION

4.1 Introduction

This chapter provides detailed information on what was originally planned after the participatory community needs assessment at the Vingunguti ward, the actual implementation of the project that addressed the one most pressing need and reports on what was exactly accomplished. The participatory need assessment identified and prioritized HIV/AIDS issues among youths and MYE as a local NGO that can be involved to address the issue through the use of peer educators. The chapter is divided into three main parts namely; expected project outputs and products, project planning and project implementation.

4.2 Project Outputs

The project started in November 2014 and ended in July 2015 with Community need assessment, and ended up with project evaluation and report writing. As stipulated earlier in chapter II, there were six objectives that were planned to lead into the actual activities for the actual implementation of the project.

The major outputs/products that were planned for the projects were in terms of completion of identification of one most pressing need and identification of host organisation, capacity/knowledge and skills assessment for MYE, peer educators and youths, identification of gaps, completion of several meetings, production and sharing of assessment findings, agreement on appropriate interventions, completion

of development of appropriate training materials and tools, completion of training to peer educators, completion of supportive supervision and mentoring to peer educators and completion of knowledge and skills assessed post intervention.

The major planned indicators for the project were in terms of assessment results, meeting minutes, developed training materials and tools, training reports, number of supportive supervision and mentoring visits, number of peer educators supervised and mentored, supportive supervision and mentoring reports, and project monitoring and evaluation report. The objectives with their major planned outputs and indicators for the projects are summarized in Table 4.1.

Table 4. 1: Objective, Planned Outputs and Indicators for the Project

Objectives	Expected Output	Indicators
To conduct community need assessment to identify one most pressing need in Vingunguti ward.	One most pressing need identified	Assessments result
To determine the capacity of local NGO in enabling peer educators to deliver knowledge and skills to youths	MYE's capacity assessment conducted Capacity gaps identified	Assessment results
	Peer educators capacity assessment conducted Capacity gaps identified	Assessment results
	Youths' knowledge and skills assessment conducted	Assessment results
To determine strategies for addressing the identified capacity gaps for MYE, peer educators and youths	Meeting conducted Assessment findings shared Appropriate intervention agreed	Meeting minutes
	Appropriate training materials, SSM tools and M&E tools developed	Training materials SSM, M&E tools
	Meeting conducted Training materials and associated SSM and M&E tools developed	Meeting minutes
To strengthen peer educators' knowledge on behaviour change communication	Training conducted 25 peer educators trained	Training report
To strengthen peer educators' knowledge and skills on effective communication skills	Training conducted 25 peer educators trained	Training report
To improve peer educators' performance according to set standards	25 peer educators monitored, supported and mentored and evaluate	Monitoring and evaluation report

Source: Field data, (2015)

4.3 Project Planning

Considering the six objectives that were set, several activities were planned so as to accomplish each objective and consequently implement the project as a whole. Under this section of implementation, there were four (4) main sub-sections namely; the implementation plan, planned inputs, staffing pattern and planned budget. In addition, the sub-section detailed planned activities, planned timeline, and people responsible to undertake each activity as well as the resources needed so as to accomplish each planned activity.

4.4 Implementation Plan

In order to accomplish project's objectives, specific activities were planned for each objective. People responsible, resources needed and the timeframe for the completion of each planned activity were identified. Following prioritization of HIV and AIDS among youths as the most pressing community need that needed to be intervened and identification of MYE as a local NGO that could host the project, the researcher then planned to assess capacities for MYE, peer educators and youths along the issue of HIV and AIDS among youths.

This aimed at identifying gaps that would raise the need of establishing an intervention. After identification of capacity gaps to peer educators, researcher and the program team from MYE's agreed to conduct training to peer educators. It was also extrapolated that the specific training needs would necessitate adaptation of specific and focused training materials from different national and international sources. The developed training materials were planned to be used to train the pre-

existing MYE's peer educators so as to strengthen their capacities on delivering HIV and AIDS-related knowledge and skills to fellow youths within the Vingunguti ward community.

The project also planned that to supportively supervise and mentor the trained peer educators so as to identify challenges that would still be encountered and consequently mentor them with the aim of enhancing their competences. As part of participatory project implementation, several meetings with MYE's staff and peer educators were planned to be conducted so as to discuss project's progress, successes and challenges that would prompt different ways to strengthen the implementation towards achieving the intended goal and objectives.

Project's monitoring and implementation was also planned as a very important activity in the implementation. Monitoring and evaluation was planned to target the project's progress as the implementation continues as well as at the end of the project so as to ensure the intended changes are attained as originally planned and generally determine successes or failure of the project. This was also planned to determine which parts of the project's implementation would have been and that which wouldn't had been completed and consequently hand over to MYE for continuation and sustainability. Table 4.2 details the planned activities for each objective, people responsible, timeframe and resources needed for each activity.

Table 4. 2: Actual Project Implementation Planning

Objective 1: To identify one most pressing need in Vingunguti ward			
Planned Activities	**Timeframe**	**Resources Needed**	**Person(s) Responsible**
Conduct community need assessment to identify most pressing needs in Vingunguti ward.	November 2014	Time, Fuel Stationaries	Researcher
Conduct validation meeting to prioritize one most pressing need and identify one local NGO that can host the project for implementation	November 2014	Time, Fuel Stationaries	Researcher, Ten cell leaders, LGA
Objective 2: To determine the capacity of local NGO in enabling peer educators to deliver knowledge and skills to youths			
Assess MYE's capacity on enabling peer educators with HIV prevention knowledge and skills	December 2014	Time Fuel Stationaries	Researcher
Assess peer educators' capacity in delivering HIV prevention knowledge and skills to youths	December 2014	Time Fuel Stationaries	Researcher MYE's program manager MYE's program coordinator
Assess youths' knowledge and skills on risky behaviour, HIV prevention and condom use	December 2014	Time Fuel Stationaries	Researcher MYE's program manager MYE's program coordinator
Objective 2: To determine strategies for addressing the identified capacity gaps for MYE, peer educators and youths			
Planned Activities	**Timeframe**	**Resources Needed**	**Person(s) Responsible**
Conduct meeting with MYE and peer educators to share the capacity assessment findings and agreed on the appropriate intervention	December 2014	Time Venue Fuel Stationaries	Researcher MYE's program manager

			MYE's program staff
Develop appropriate training materials and their associated SSM and M&E tools for peer educators	January 2015	Time Internet Stationaries	Researcher
Conduct meeting with MYE to share the developed materials and SSM and M&E tools for their inputs	January 2015	Time Venue Fuel Stationaries	Researcher MYE's program manager MYE's program staff
Communicated with MYE's program manager and coordinator to mobilize peer educators (PE) for the training	January 2015	Air time	Researcher and Program manager
Objective 3: To strengthen peer educators' knowledge and skills on different approaches for preventing HIV transmission			
Planned Activities	**Timeframe**	**Resources Needed**	**Person(s) Responsible**
Train 25 peer educators on different approaches for preventing HIV transmission	February 2015	Time Venue Fuel Stationaries Printing Training supplies	Researcher MYE's program manager MYE's program coordinator
Objective 4: To strengthen peer educators' knowledge on behaviour change communication			
Planned Activities	**Timeframe**	**Resources Needed**	**Person(s) Responsible**
Train 25 peer educators on behaviour change communication	February 2015	Time Venue Fuel Stationaries Printing Training supplies	Researcher MYE's program manager MYE's program

			coordinator
Objective 5: To strengthen peer educators' knowledge and skills on effective communication skills			
Planned Activities	**Timeframe**	**Resources Needed**	**Person(s) Responsible**
Train 25 peer educators on effective communication skills	February 2015	Time Venue Fuel Stationaries Printing Training supplies	Researcher MYE's program manager MYE's program coordinator
Conducted 3 meetings with peer educators and MYE's staff on status of the project, successes, challenges and way forward.	March – May 2015	Time Fuel Stationaries Printing	
Objective 6: To improve peer educators performance according to set standards.			
Planned Activities	**Timeframe**	**Resources Needed**	**Person(s) Responsible**
Conduct monitoring visits to 25 peer educators	March – June 2015		
Conduct quarterly supportive supervision and mentoring to 25 peer educators	March – June 2015	Time Fuel Stationaries Printing	

Source: Field data, (2015)

4.4.1 Inputs

The investments that were planned for the project implementation were mainly time (and funds/money (a total of 1,844,920 TZS) from capacity assessment to final monitoring and evaluation of the project.

4.4.2 Staffing Pattern

The project did not hire any staff to accomplish the implementation. The researcher had planned to complete most of the activities in a participatory manner by involving the main stakeholders from the beginning of the project implementation. The stakeholders for the project implementation included the ten-cell leaders, MYE's staff, peer educators and the youths within the Vingunguti ward community. With this plan therefore, there was neither planned staff salary nor planned benefits at the end of the project. Only few stakeholders were paid allowances to accomplish some tasks for the project implementation.

There were no formal job descriptions for each staff but just a list of tasks that each stakeholder played role in. Only MYE's staff and the researcher had planned supervisory roles in the project implementation. The roles that stakeholders were planned to play were;

Ten-cell leaders; distributes and collected back the questionnaires to youths in their respective houses of leadership with the aim to assess youths' knowledge and skills on HIV prevention, risk behaviour and use of condoms.

MYE's staff; actively participated in the planning meetings, development of training materials, training of peer educators, holding meetings with researcher and pee

educator to discuss project progress, supportive supervision and mentoring of peer educators and project monitoring and evaluation.

Peer educators; participate in the capacity assessment, training (as trainees), supportive supervision and mentoring (as supervisee and mentees) and involved during project monitoring and evaluation.

Youths; as interviewee, they participated in the knowledge and skills assessment before the intervention and thereafter during the monitoring and evaluation of the project. They were also involved during ongoing implementation of the project by participating as (trainees) during routine sessions with the trained peer educators.

4.4.3 Budget and its Justification

As described in the staffing pattern part, there was no planned staff hiring for the project hence there were neither planned salary nor benefits costs pertaining the implementation of the project. In addition, there were neither planned equipment costs, start-up costs, recurring operating expenses, professional nor outsourced service contract that were needed.

The costs that were planned to be incurred for the project implementation included allowances for some stakeholders for some tasks, direct expenses like internet use, stationaries, printing training materials/documents, and transport for the researcher, hiring of venues for meetings and training.

All the expenses that pertained to project implementation, and monitoring and evaluation were taken care of by the researcher. Neither the local NGO nor any

member of the community incurred any cost. The total amount that was planned to be spent during project implementation, and monitoring and evaluation was 1,844,920 TZS. The planned expenses for the project are summarized in Table 4.3. Appendix 13 indicates the full spreadsheet detailing the budget categories and budget line items as well as their respective cost.

Table 4. 3: Summary of Planned Total Budget for Project

SN	Budget Categories	Total Cost for the Category
1	Personnel (Salaries and Wages)	0
2.	Fringe Benefits (Percentage of Salary)	0
3.	Consultants	0
4.	Travel and Per Diems	1,259,600
5.	Direct Costs	256,600
6.	Equipment	-
7.	Sub-contract/Sub-agreements	-
8.	Training	628,720
9.	Indirect Cost	-
10.	Fixed Fee	-
Grand Total for the Project		**1,844,920**

Source: Field data, (2015)

4.5 Project Implementation

This sub-section describes the actual implementation of the project. It is divided into two (2) main parts namely; the project implementation report and the project implementation Gantt chart. The actual project implementation report details the implementation process, outlined activities carried out to accomplish each objective and resources used for the implementation. It also details the accomplishments/achievements of project goal and objectives while comparing to the planned project work and objective stated earlier. The project implementation Gantt chart summarizes and depicts the narrative and outline in the project implementation report.

4.5.1 Project Implementation Report

4.5.1.1 Implementation Process

The implementation process details step-by-step of the implementation, particularly describing the activities that were executed so as to achieve each of the intended objectives. The main activities included, conducting capacity assessment, writing assessment report, meeting with MYE and peer educators to discuss and agree on the intervention, development/adaptation of training materials for peer educators, meeting with MYE to share the materials and training implementation modalities, actual implementation of training of peer educators, supportive supervision and mentoring of peer educators and meetings with MYE and peer educators do discuss on project's progress.

4.5.1.2 Activities Implemented to Accomplish each Objective

The objectives and their respective detailed activities are described below,

To determine the capacity of local NGO in enabling peer educators to deliver knowledge and skills to youths Soon after the participatory prioritization of the one most pressing community need (HIV and AIDS among youths) and one local NGO (MYE) that could host the project, an assessment was done to MYE, peer educators and youths in order to determine their capacities. Capacity assessment for MYE based on the ability to host project and actively participate in implementing the intervention.

Since peer educators were the ones who directly interact with youths and discuss on HIV related issues, they were assessed on their capacities in terms of knowledge and skills on HIV prevention and condom use, and behaviour change. Youths were also

assessed on knowledge and skills in HIV prevention and condom use, and risky behaviour that could predispose them to HIV infection.

Information from all the three groups of stakeholders was collected using structured questionnaires. Information from MYEs management was obtained through one-on-one interview with the researcher. Information from peer educators and youths was obtained through self-administered questionnaires. For peer educators, the questionnaires were distributed to them from MYE's offices; they filled the questionnaires and returned back.

The questionnaires were then collected by the researcher for processing and analysis. Questionnaires for youths were distributed using selected ten-cell leaders who distributed to respective houses with youths; they then went back to collect the filled questionnaires from youths and submitted to MYE's offices where the researcher picked them for processing and analysis.

To determine strategies for addressing the identified capacity gaps for MYE, peer educators and youths; following capacity, knowledge and skills assessment, the researcher then conducted a meeting to present the results to MYEs management and program staffs and the peer educator. The gaps identified from the assessment was clearly communicated and collaboratively strategized the best ways to address the gaps. The assessment identified that youths had challenges in behaviour change because they were still practicing risky behaviour that predisposed them to HIV infection.

Youth also were found to have little knowledge and inadequate skills on correct condom use. Challenges on the side of youth were extrapolated from challenges that peer educators had in smooth and effective delivery of the knowledge and skills to youths. Most of the peer educators were found to be lacking adequate knowledge and skills on HIV prevention, correct use of condoms, processes of behaviour change and effective communication skills.

Peer educators were not at all become trained, and this was again extrapolated as due to lack of funds on the side of MYEs as a local NGO. It was then agreed from the meeting that the capacity of peer educators needed to be strengthened through training on specific session so as fill the gaps that they had.

Since there were no existing training materials for the particular gaps, the researcher had to develop to suit the identified gaps and the target audience. The materials were adapted from different national and international sources. The sources ranged from pre-existing related national and international training packages to national and international guidelines and policies. The researcher's cost on the training material development process was in terms of time and funds especially during searching the materials from the internet, going to the Ministry of Health and Social Welfare (MOHSW) to obtain different documents and contacting other stakeholders in the relevant areas.

The training materials consisted of three modules namely; HIV prevention (including correct condom use and demonstration), Behaviour Change Communication (BCC) and Effective Communication Skills. The researcher had also to buy penile and

pelvic models for the demonstration of correct use of male and female condoms during the training.

Condoms were obtained from nearby health facilities for free. At the end of the project, the researcher left the penile and pelvic models to MYE's offices so that peer educators can continue using. The researcher then conducted a half day meeting with MYE's staff to share the developed materials for their inputs and buy in. This was followed by participatory development of the timetable/schedule to achieve the training to peer educators

To strengthen peer educators' knowledge and skills on different approaches for preventing HIV transmission, knowledge on behaviour change communication and effective communication skills; these were achieved through implementation of the actual training using the developed training materials. A total of 25 MYE's peer educators were trained and the training took place on February 7, 14 and 21, 2015. The researcher communicated with the MYE's program manager who then communicated with the peer educators in order to mobilize them for the training.

Important logistics were prepared in advance; these included venue, printing of materials, buying pens, notebooks and pencils and other training related supplies. The training was on HIV prevention (including correct condom use and demonstration), behaviour change communication and effective communication skills.

Although there were three (3) different sessions, they were not delivered in a single sitting but the three sessions were spread through three weeks. Each session was

delivered once a week, during Saturday. This gave enough chances for peer educators who were still in schools to participate fully. Two hours and half were spent in each Saturday for the session.

The sessions were collaboratively facilitated by the researcher and program manager from MYE see Plates 4.1 - 4.10. The sessions contained mixed methodologies for delivering; these included lecturing, brainstorming, buzzing, small and large group discussions and demonstrations.

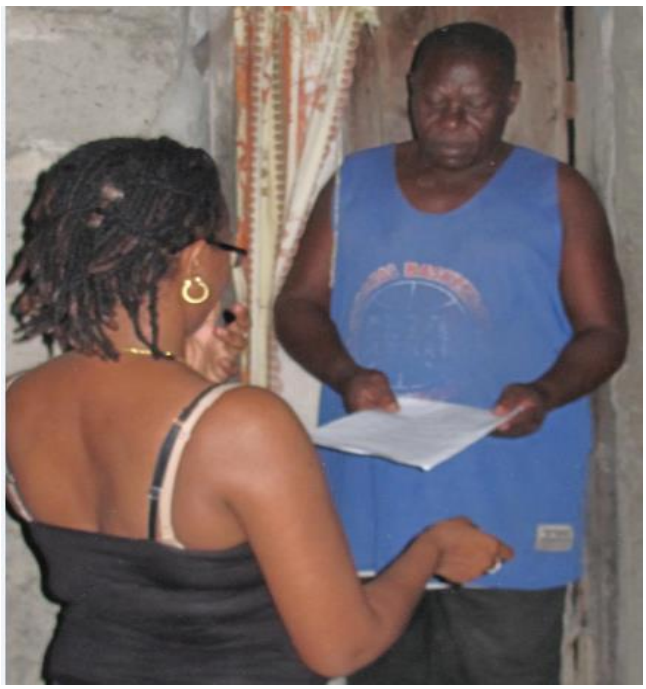


Plate 4. 1: The Researcher Providing Questionnaires to one of the SCP

Source: Field Data, (2014)

Plate 4. 2: Peer Educators on Small Group Discussion in the Class

Source: Field data, (2015)

Plate 4. 3: Peer Educators Preparing for a Role-Play During the Training

Source: Field Data (2015)

Plate 4. 4: Training Participant Doing Plenary Presentation after Discussion

Source: Field data, (2015)

Plate 4. 5: MYE's Program Manager Leading a Session During the Training

Source: Field data, (2015)

Plate 4. 6: The Researcher Demonstrating the use of Male Condom

Source: Field data, (2015)

Plate 4. 7: Peer educators doing Return Demonstration use of Male Condom

Source: Field data, (2015)

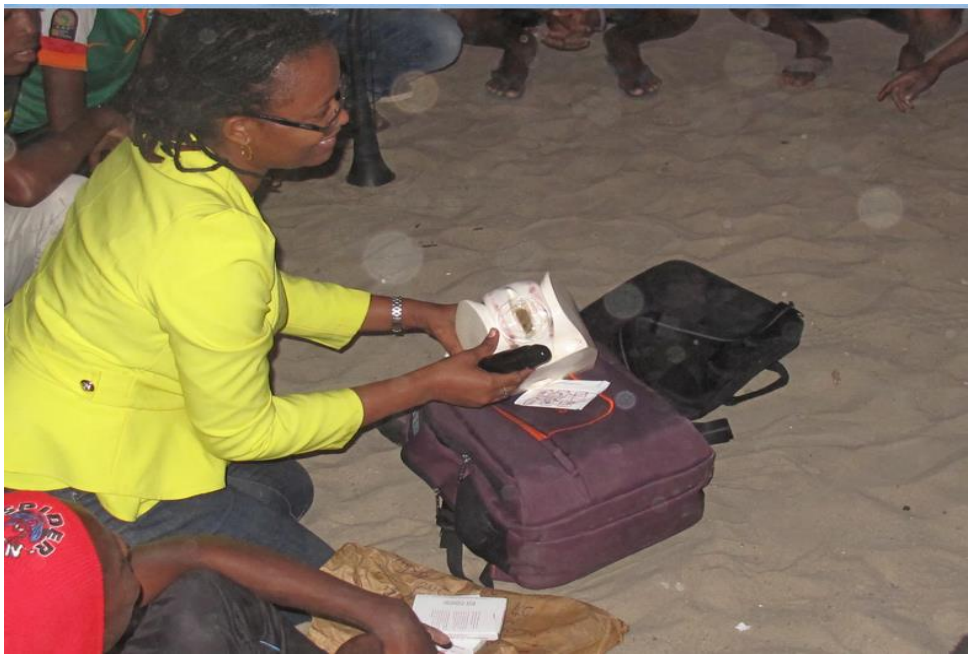


Plate 4. 8: The Researcher Demonstrating on How to use Female Condom

Source: Field Data, (2015)

Plate 4. 9: Peer Educators Doing Return Demonstration on use Female Condom

Source: Field data, (2015)

Plate 4. 10: The Researcher Doing a Summary Discussion with Peer Educators

Source: Field data, (2015)

After being trained, the peer educators started applying the knowledge and skills by practicing with youths through their routine activities. As originally planned, peer

educators were then visited for monitoring and followed by supportive supervision and mentoring.

Supportive supervision and mentoring was done once per month (Friday) by the researcher in collaboration with MYE's staff (the program manager and the coordinator). Supportive supervision and mentoring tools were used to execute the exercise.

Communications were made earlier enough to inform peer educators about the visit while they were conducting sessions with youths. The supportive supervision and mentoring tools addressed issues through two main approaches namely; observation on what and how they communicated with youths and interviews with individual peer educators. The aim of supportive supervision and mentoring was to identify things that peer educators were doing well and challenges that they were still encountering.

At the end of the day the researcher and MYE's staff met to compile the SSM report and provided immediate feedback to the peer educators on what they had as strengths and areas that needed improvement. Moreover, the researcher and the MYE's staff mentored the peer educators on the best ways of doing based on the identified gaps. A total of ten supportive supervision and mentoring visits were conducted and all the 25 peer educators were successfully supervised and mentored. In addition to supportive supervision and mentoring visits, the researcher also conducted regular monthly meetings with MYE's staff together with peer educators to discuss about general/overall progress of the project while putting forward challenges encountering

the execution of the project. The meeting then discussed the best way forward in tackling the challenges. A total of six meetings were conducted and all the 25 peer educators actively participated.

To monitor and evaluate the project outputs, outcomes and indicators; Monitoring and evaluation of the project output, outcomes and indicators were performed during implementation and at the end of the project. Detailed original monitoring and evaluation plans and their respective actual implementation are described in chapter five.

4.5.1.3 Resources Used

Resource used for the implementation of the project mainly included funds and human resource in terms of time. The funds were used for printing training materials and other documents, buying penile and pelvic models for demonstration, communication expenses, allowances for some supporting people, and travel expenses for the research (meals and fuel). Other direct costs included venue expenses for the trainings and various meetings.

Originally, the researcher had planned to incur some expenses for printing HIV related information education and communication (IEC) materials and distribute them to peer educators but unfortunately the budget following implementation did not allow.

4.5.1.4 Accomplishments

The project achieved most of the planned activities in relation to the goal and objectives. What was not achieved for the project was the printing and distribution of HIV-related IEC materials to the trained peer educators. With this therefore, the project goal was met and all objectives achieved. Following community needs assessment, prioritization and recommendations several project goal and objectives were outlines and activities planned. The accomplishments are stipulated as follows;

A meeting was conducted to present the findings from the capacity assessment for MYE, peer educators and youths. The researcher presented the findings to MYE and peer educators. Collaboration of the researcher, MYE and peer educators then came out with a strategy on how to address the identified gaps and the modalities on how to implement the project. It was agreed that focused training materials for pee educators be developed. It was also agreed to conduct supportive supervision and mentoring to peer educators following training and their practice with youths.

Focused training materials were successfully developed for peer educators. These materials based on the gaps identified from peer educators and included HIV prevention (including condom demonstration), behaviour change communication and effective communication skills.

Supportive supervision and mentoring tools were developed that assisted during the supportive supervision and mentoring sessions. Monitoring and evaluation tools were developed to assist in the overall project monitoring and evaluation. These aimed at monitoring day-to-day project progress, mid-term and end of project evaluation.

A meeting was conducted to share the developed training materials with associated tools. The meeting was between the researcher and MYE management. The MYE management provided their inputs that farther enriched the materials and tools for smooth project implementation. Training materials were then finalized ready for the trainings.

Three days trainings were conducted and 25 peer educators successfully trained on HIV prevention (including condom demonstration), behaviour change communication and effective communication skills. Monitoring visits were conducted on weekly basis aimed at tracking routine project progress and ensuring what was intended was happening according to what was planned. The process used prepared monitoring tools that collected routine data which was analysed and conclusion drawn.

Four supportive supervision and mentoring visits were done and 25 peer educators were supportively supervised and mentored successfully. The visits were conducted once per month and supervisees and mentors used the prepared tools to achieve the intended deliverables. Out of the visits successes and challenges were identified and actions taken to address the gaps. The peer educators were visited while having their routine sessions with youths.

The project was successfully evaluated; this was done mainly in a formative ways. Tools for evaluation were used to accomplish the activity and a report written and presented to the stakeholders.

4.5.1.3 Implementation Gantt Chart

Table 4.4 below summarises project's implementation in terms of activities implemented, timeframe, resources that were needed to accomplish the activities and the person(s) who were actually responsible for the successful completion of the activities.

Table 4. 4: Project Implementation Gantt chart

ACTIVITIES	Time Line									Resource needed	Person Responsible
	2014		2015								
	November	December	January	February	March	April	May	June	July		
Conducted community need assessment to identify most pressing needs in Vingunguti ward.										Travel expenses (meals & fuel) Stationary,	Researcher
Conducted validation meeting to prioritize one most pressing need and identify one local NGO that can host the project for implementation											Local Government Authority (LGA), Community Members representatives (Ten-cell leaders)
Conducted capacity assessment for MYEs, peer educators and youths to determine gaps and design appropriate intervention											Researcher, youth and peer educators and MYEs
Conducted meeting with MYE and peer educators to share the capacity assessment findings and agreed on the appropriate intervention											Researcher, youth and peer educators and MYEs
Developed appropriate training materials and their associated SSM and M&E tools for peer educators (from other training packages, guidelines and policies)										Travel expenses (meals & fuel/fare)	Researcher

Conducted a meeting with MYE's staffs to share the adapted training materials and agree on venue, dates, and time and implementation modalities for the training.										Venue, stationaries	Community representatives
Communicated with MYE's program manager and coordinator to mobilize peer educators (PE) for the training										Stationary, Travel expenses (meals & fuel/fare)	Researcher
Conducted training to 25 peer educators on HIV prevention, condom use, behaviour change communication and effective communication skills.										Stationaries, Travel expenses (meals & fuel)	Researcher, Program manager from MYEs
Conducted Monitoring Visits to 25 peer educators											
Conducted supportive supervision and mentoring visits to peer educators										Stationaries, Travel expenses (meals & fuel)	Researcher, MYEs staff
Conducted 3 meetings with peer educators and MYE's staff on status of the project, successes, challenges and way forward.											
Conducted evaluation to the project										Travel expenses (meals & fuel/fare)	Researcher, Program manager and program coordinator from MYEs'
Wrote project implementation report										Airtime	Researcher

Source: Field data, (2015)

CHAPTER FIVE

PARTICIPATORY PROJECT MONITORING, EVALUATION AND SUSTAINABILITY

5.1 Introduction

This chapter is divided into three parts namely; monitoring, evaluation and sustainability. Monitoring part explains how the project was monitored based on the standards and indicators set to ensure efficiency and effectiveness of the project.

Evaluation part elaborates how the assessment was done to measure whether the project achieved its outcomes and it is on track. Indicators were set and considered as a bench mark used to measure project performances. The sustainability part describes how community members, peer educators and MYE's were involved to ensure sustainability to be in place even after departure of the researcher.

5.2 Participatory Monitoring

Monitoring was done to gather information that was needed to track and report on project progress towards achieving its goal and objectives. Monitoring helped the MYE's program manager and the researcher to analyse situation in the field, identify existing challenges and solve them timely.

Monitoring information system such as monitoring plans and tools were developed before the start of the project. Monitoring tools were designed to systematically select, watch, collect and record information on the progress of the project. The main focus of monitoring tools was to track whether peer educators and youths performed

according to the project's set standards. The collected information from monitoring visits were compiled, report produced and shared with MYE's program staff for discussion and decision making.

Monitoring was then followed by supportive supervision and mentoring visits that aimed at closely supervise and mentor peer educators on how they perform well and areas that need improvements. The overall aim of supportive supervision was to enhance peer educators performance according to project's set standards. All 25 peer educator were successfully supervised and mentored. Table 5.1 and 5.2 indicate the details of project monitoring plan and information for monitoring project operations respectively.

Table 5. 1: Project Monitoring Plan

Project goal: Strengthening peer educators knowledge and skills in educating youth on HIV Prevention

Planned Activities	Targets	Indicators	Source of data	Methodology	Timeframe		Responsible
					Planned	Actual	
Specific Objective 1: To determine the capacity of local NGO in enabling peer educators to deliver knowledge and skills to youths							
Assess MYE's capacity on enabling peer educators with HIV prevention knowledge and skills	1 capacity assessments conducted.	Number of assessments conducted	Assessment report	Field interview Probing and visits	December, 2015	December, 2015	Researcher
Assess peer educators' capacity in delivering HIV prevention knowledge and skills to youths	1 capacity assessments conducted.	Number of assessments conducted	Assessment report	Field interview Probing and visits	December, 2015	December, 2015	Researcher
Assess youths' knowledge and skills on risky behaviour, HIV prevention and condom use	1 capacity assessments conducted.	Number of assessments conducted	Assessment report	Field interview Probing and visits	December, 2015	December, 2015	Researcher
Specific Objective 2: To determine strategies for addressing the identified capacity gaps for MYE, peer educators and youths							
Conduct meeting with MYE and peer educators to share the capacity assessment findings and agreed on the appropriate intervention	1 meeting conducted	Number of meetings conducted	Meeting minutes	Document review	December, 2015	December, 2015	Researcher, MYE program manager, and management staff
Develop appropriate training materials and their associated SSM and M&E tools for peer educators	1 package of training materials, 1 SSM tool and 1 M&E tools developed	Number of packages of training materials, SSM tools and M&E tools	Package of training materials, SSM and M&E tools	Document review	December, 2015	January, 2015	Researcher
Conduct meeting with MYE to share the developed materials and SSM and M&E tools for their inputs	1 meeting conducted	Number of meetings conducted	Meeting minutes	Document review	January, 2015	January, 2015	Researcher, MYE program manager, and management staff

Specific Objective 3: To strengthen peer educators' knowledge and skills on different approaches for preventing HIV transmission							
Conduct training for 25 peer educators on different approaches for preventing HIV transmission	25 peer educators trained	Number of peer educators trained	Training report	Field visits Document review	February, 2015	February, 2015	Researcher and MYE program manager
Specific Objective 4: To strengthen peer educators' knowledge on behaviour change communication on HIV prevention							
Conduct training for 25 peer educators on behaviour change communication on HIV prevention	25 peer educators trained	Number of peer educators trained	Training report	Field visits Document review	February, 2015	February, 2015	Researcher and MYE program manager
Specific Objective 5: To strengthen peer educators' knowledge and skills on effective communication skills							
Conduct training for 25 peer educators on effective communication skills	25 peer educators trained	Number of peer educators trained	Training report	Field visits Document review	February, 2015	February, 2015	Researcher and MYE program manager
Specific Objective 6: To improve peer educators' performance according to set standards							
Conduct weekly monitoring visits to 25 peer educators.	25 peer educators monitored 14 monitoring visited 625 youths actively participate in the discussion	Number of peer educators monitored. Number of monitoring visits conducted Number of youths actively participating in the discussion	Monitoring visit report	Field visits Document review	March-June, 2015	March-June, 2015	Researcher, MYE program manager, and program coordinator
Conduct monthly supportive supervision and mentoring to 25 peer educators	25 peer educators supervised and mentored 4 SSM visits conducted	Number of peer educators supervised and mentored Number of SSM visits conducted	SSM visit report	Field visits Document review	March-June, 2015	March-June, 2015	Researcher, MYE program manager, and program coordinator

Source: Field data, (2015)

Table 5. 2: Information for Monitoring Project Operations

Categories	What to Monitor		What record to keep	Who collects Data	Who uses data	How to use information	What decision can be made
	Program Activities	**Indictors**					
Program Work Plan	Assess MYE's capacity on enabling peer educators with HIV prevention knowledge and skills	Capacity gaps identified	Assessment report	Researcher	Researcher and MYE's Program manager	Getting prior information on what activities will be implemented where, when and to whom	Arrangements for the implementation of project's activities, preparing resources needed for the project's activities
	Assess peer educators' capacity in delivering HIV prevention knowledge and skills to youths	Capacity gaps identified	Assessment report	Researcher and MYE's Program manager			
	Assess youths' knowledge and skills on risky behaviour, HIV prevention and condom use						
	Conduct meeting with MYE and peer educators to share the capacity assessment findings and agree on the appropriate intervention	Strategies to address gap identified	Meeting minutes	Researcher	Researcher and MYE's Program manager	Building aware on the identified gaps and design appropriate intervention to address the gaps	Implementation of the intervention (project) address the gap
	Develop appropriate training materials and their associated SSM and M&E tools for peer educators	Training materials, SSM,M and E tools developed	Training materials and SSM, M&E tools	Researcher and MYE's program manager	Researcher, Peer educators and MYE's management and program team	Training peer educators, and measuring program performance	Refresher training, changing of implementation approaches
	Conduct meeting with MYE to share the developed materials and SSM and M&E tools for their inputs		Meeting minutes	Researcher and MYE's Program manager			
	Train 25 peer educators on different approaches for preventing HIV transmission	Peer educators increased knowledge and skills on different approaches for HIV prevention	Training and monitoring reports	Researcher, MYE's Program manager, and Program Coordinator	Researcher, Peer educators, MYE's management and program team, and LGA	Measure the progress of the project towards objectives	Changing the implementation approaches
		Increased youths' awareness on correct and consistent use of condoms	Monthly and mid-term evaluation reports				
		Decreased number of youths with multiple sexual partners	Annual assessment report				

	Train 25 peer educators on behaviour change communication	Peer educators increased understanding on behaviour change processes	Training and monitoring reports	Researcher, MYE's Program manager, and Program coordinator	Researcher, Peer educators, MYE's management and program team, and LGA	Measure the progress of the project towards objectives	Changing the implementation approaches
		Increased youths awareness on HIV infection risky behaviour	Monthly and mid-term evaluation reports				
	Train 25 peer educators on effective communication skills	Improved communication skills among peer educators	Training and monitoring reports				
		Improved active youths' participation on HIV prevention discussion with peer educators					
	Conduct monitoring visits to 25 peer educators	Peer educators performing according to project's set standards	Monitoring and SSM reports	Researcher, MYE's program manager, and program coordinator	Researcher, Peer educators, MYEs management and program team, and LGA	Measure the progress of the project towards objectives	
	Conduct SS and mentoring visits to 25 peer educators						
	Conduct project's evaluation						
Costs	Conduct expenditures monitoring	Budget, funds on hand and expenditures	Activity expenditure report	Researcher and MYE's program manager	Researcher and MYE's program manager	Tracking expenditures so as to align with planned budget	Adding or cutting some program activities or looking for other source of funds

Source: Field data, (2015)

5.3 Participatory Evaluation

Participatory project evaluation measured project outcomes and helped researcher and the MYEs program manager to calibrate the implementations process and deliverable based on the original plans. The purpose for conducting project evaluation was to check how effective the project was, how well things were done by peer educators and youths, and whether project objectives were met. Evaluation plan was developed and performance indicators were set to measure whether project archived its intended outcomes.

Evaluation questions were established to assess the projects' outcomes to the targeted beneficiaries. Table 5.3 details how the project planned to be evaluated, type of questions used during evaluation, means of verification of where that information was collected and methods used to collect information.

It was not possible to conduct summative evaluation since the long term goal of project was to decrease the prevalence of HIV among youths. It was not possible to observe, verify and measure the change (impact) within a short period. The immediate goal of strengthening peer educators competencies in educating youths on HIV prevention was achieved as shown in Table 5.4.

5.3.1 Participatory Evaluation Methods

Methodologies used during evaluation process were; review of relevant documents such as reports produced by MYE's program team, beneficiary assessment report, interview and observation in field visits while peer educators were practising in the field.

Table 5. 3: Project Evaluation Plan

PROJECT IMPLEMENTATION			EVALUATION				
Project Goal: To Strengthen peer educators competencies in educating youths on HIV prevention							
OBJECTIVES	**OUTPUT**	**OUTCOME**	**QUESTIONS**	**SOURCE OF DATA**	**METHODS OF DATA COLLECTION**	**RESPONSIBLE PERSON**	**TIME FRAME**
To determine the capacity of MYEs in enabling peer educators to deliver knowledge and skills on HIV prevention information to youths	MYE's capacity assessment conducted	Capacity gaps identified	What capacity did MYE possess that enabled peer educators to deliver HIV prevention information to youths?	MYE's Management team and assessment report.	Interview Field visit Desk review of documents	Researcher	December, 2014 to January, 2015
	Peer educators capacity assessment conducted		What knowledge and skills capacity on HIV prevention did peer educators possess?	Peer educators, MYE's Management team	Interview Field visit Desk review of documents	Researcher MYE's program manager MYEs program coordinator	
	Youths' knowledge and skills assessment conducted		What knowledge and skills on HIV prevention did do youths possess?	Youths	Interview Field visit	Researcher MYE's program manager MYE's program coordinator	
To determine strategies for addressing the identified capacity gaps for MYE, peer educators and youths	Meeting conducted Assessment findings shared	Strategies for addressing the gaps identified Training material and SSM and M&E tools developed	Which strategy that could be used to address gaps identified by youth peer educators and MYE?	MYE's management team MYE's program staffs Peer educators	Interview Desk review of documents	Researcher MYE's program manager MYEs program coordinator Peer educators	December, 2014 to January, 2015
	Training materials developed		What type of training materials that were developed				

	SS &Mentoring tools, and M&E tools developed		What did the training materials and tools contain? How were the training materials and tools developed?				
To strengthen peer educators' knowledge and skills on different approaches for preventing HIV transmission	25 peer educators trained	25 peer educators demonstrate knowledge and skills on different approaches for HIV preventions	Did peer possess adequate knowledge and skills on different approaches for preventing HIV transmission?	Peer educators Youths	Interview Observation Demonstration Return demonstration	Researcher MYE's program manager MYEs program coordinator	February, 2015
			Do peer educators know correct steps for using condoms?	Peer educators Youths			
	625youths received correct information on different approaches for preventing HIV transmission	Increased youths' knowledge on different approaches for preventing HIV transmission, correct and consistent use of condoms	Are youths aware of the different approaches for preventing HIV transmission?	Youths	Interview	Researcher MYE's program manager MYEs program coordinator	
			Do youths know/recognize the correct steps of condom use?	Youths			
		Increased number of youths who correctly and consistently use condoms	Do youths use condoms correctly and consistently?	Youths			

		Decreased number of youths with multiple sexual partners	To what extent do youths engage in sexual relationship with multiple partners?	Youths			
To strengthen peer educators' knowledge on behaviour change communication	25 peer educators trained	Increased peer educators' knowledge on behaviour change communication	Do peer educators understand the processes of behaviour change?	Peer educators	Interview	Researcher MYE's program manager MYEs program coordinator	February, 2015
To strengthen peer educators' knowledge and skills on effective communication skills	25 peer educators trained	Increased communication skills among peer educators	Do peer educators demonstrate effective communication skills?	Peer educators	Interview, questionnaire	Researcher MYE's program manager MYEs program coordinator	
		Increased number of youths who communicate interactively with peer educators	Do youths communicate interactively with peer educators?	Youths Peer educators	Interview Observation		February, 2015
To improve peer educators' performance according to set standards	25 peer educators monitored, supportively supervised and mentored, and evaluated	Peer educators performed according to project's set standards	Were peer educators monitored, supportively supervised, mentored and evaluated for improvement of their performance?	Peer educators MYE's program manager MYE's program coordinator	Interview Observation	Researcher MYE's program manager MYEs program coordinator	March - June 2015

Source: Field data, (2015)

Table 5. 4: Actual Project Evaluation

GOAL/OBJECTIVES	PERFORMANCE INDICATOR	EXPECTED OUTCOME	ACTUAL OUTCOME
To Strengthen peer educators competencies in educating youth on HIV prevention	Increased peer educators' knowledge and skills on HIV prevention, BCC and communication skills	Increase in peer educators' knowledge and skills on HIV prevention, BCC and communication skills	Increased peer educators' knowledge and skills on HIV prevention, BCC and communication skills
		Acquisition of HIV prevention knowledge and skills among youths	Youths acquired knowledge and skills on HIV prevention
		Decrease in HIV infection risky behaviour among youths	Decreased number of youths with multiple sexual partners
		Decrease in HIV prevalence among youths population	It was not possible to be measured since it is a long term impact
To determine the capacity of MYE in enabling peer educators to deliver knowledge and skills on HIV prevention information to youths	Assessment conducted	Identified capacity gaps	Capacity gaps identified
To determine strategies for addressing the identified capacity gaps for MYE, peer educators and youths	Assessment findings shared	Identified strategies to address the gaps	Strategies to address gap identified
	Appropriate training materials, SSM tools and M&E tools developed	Develop training materials, SSM tools, monitoring and Evaluation tools	Training materials, SSM,M and E tools developed
To strengthen peer educators' knowledge and skills on different approaches for preventing HIV transmission	25 peer educators with knowledge and skills on different approaches for preventing HIV transmission	Increase in peer educators' knowledge and skills on different approaches for preventing HIV transmission	Increased peer educators' knowledge and skills on different approaches for preventing HIV transmission
		Increase in youths' awareness on correct and consistent use of condoms	Increased youths' awareness on correct and consistent use of condoms

		Decrease in multiple sexual partners among youth	Decreased number of youths with multiple sexual partners
To strengthen peer educators' knowledge on behaviour change communication	25 peer educators with knowledge and skills on behaviour change communication	Increase in peer educators' understanding on behaviour changes processes	Increased peer educators' understanding on behaviour changes processes
	625 of youth received correct information on risky behaviour for HIV infection	Increase in youths' awareness on risky behaviour for HIV infection	Increased youths' awareness on risky behaviour for HIV infection
To strengthen peer educators' knowledge and skills on effective communication skills	25 peer educators trained on effective communication skills	Improvement in communication skills among peer educators	Improved communication skills among peer educators
	625 youths actively participated in discussion on HIV prevention with peer educators	Improvement active participation of youth in HIV prevention discussion with peer educators	Improved active participation of youth on HIV prevention discussion with peer educators
To improve peer educators' performance according to project's set standards	25 peer educators monitored, supportively supervised, mentored and evaluated according to project's set standards	Peer educators perform according to set standards	Peer educators performed according to set standards

Source: Field data, (2015)

5.4 Project Sustainability

The project activities were expected to continue functioning even after the researcher concluded the implementation. This is due to the fact that most of the projects' activities were conducted in a very participatory approach; community members and other stakeholders actively participated in the activities right from the needs assessment to project implementation and evaluation.

Community members and other stakeholders were involved in identification of most pressing needs, prioritization of the one most pressing need. They also participated in identification of local NGO that would host the implementation of project towards addressing the prioritized need.

MYE' management and program team were also involved from assessing capacity gaps within the organisation, to peer educators and youths as well. They also participated fully during the development of different documents (training materials, SSM and M&E tools), monitoring of regular activities, coordination and implementation of meetings for peer educators. They were also part and parcel of monitoring, SSM and Evaluation team.

After the training, peer educators developed action plan for implementation of their usual sessions with youths. In their action plan they all agreed to establish peer educators' network for them to meet at least once per month to discuss their successes and challenges faced in their work. The reports for meetings and all other

activities were compiled and submitted to MYEs' program manager for reference and working on the recommendations.

It was agreed by MYEs' program manager that the peer educators' action plans will be incorporated into the organisation work plan so as to support them as needed. Therefore, although the researcher initiated and engineered the project, close involvement of MYE's management team and community members rendered the project sustainability in the long run.

CHAPTER SIX

CONCLUSION AND RECOMENDATION

6.1 Introduction

This chapter contains two sections that are conclusion and recommendation. Conclusion part narrates the summary of key findings of participatory assessment, literature review, and project's objectives, implementation, participatory monitoring, evaluation and sustainability. In the recommendation part, the researcher has provided recommendations on the key areas that other researchers and program developers can go about on how to strengthen peer educators' competencies so as to become more effective in imparting knowledge and skills to youths.

6.2 Conclusion

Participatory community needs assessment done to the Vingunguti ward community was very successful as it intended to identify the most pressing need. The needs assessment prioritized HIV and AIDS among youths as the most pressing need that had to be addressed, and identified MYE as the local organization that could host the implementation of the project to address the prioritized need. Participatory capacity assessment to MYE revealed that peer educators faced challenges on knowledge and skills in areas of HIV prevention, correct condom use, behaviour change communication and communication skills.

The other major finding was that MYE as a local organization had no pre-existing related HIV/AIDS training package for their peer educators. These major findings

necessitated development of a focused training package and consequently train the per educators on the pinpointed areas.

The project had six objectives namely; to determine the capacity of MYE in enabling peer educators to deliver knowledge and skills on HIV prevention information to youths, determine strategies for addressing the identified capacity gaps for MYE, peer educators and youths**,** strengthen peer educators' knowledge and skills on different approaches for preventing HIV transmission, behaviour change communication and effective communication skills, improve peer educators' performance according to projects' set standards.

The researcher collaborated with MYE to develop training package, SSM, and monitoring and evaluation tools for peer educators and project monitoring. Training sessions to peer educators were spread across three week and took place only on Saturdays of each week and each session took approximately 2 and a half hours.

After the training peer educators were provided with SSM and monitoring visits that aimed at ensuring all challenges faced by peer educators at the field are addressed so as to maintain the correct information provided to youths. The visits were timed in such a way that the actual interactions between the peer educators and youths could be appreciated.

The project outcomes revealed following project evaluation were in two categories namely; peer educators and youths categories. The outcomes in peer educators were;

increased peer educators' knowledge and skills on different HIV prevention approaches, increased understanding of behaviour changes processes, improved communication skills and performance according to projects' set standard.

Outcomes in youths included; increased youths' awareness on correct and consistent use of condoms, decreased proportion of youths with multiple sexual partners, increased youth awareness on HIV infection risks behaviours, and increased youths' active participation in HIV prevention discussion with peer educators.

6.3 Recommendations

Many studies showed that, youths are at higher risks of contracting HIV infection due to lack of knowledge and skills on HIV prevention which consequently predisposes them to risky behaviours. To influence behaviour change among youths, peer educators have greater inspiration on individual behaviours since not only that they act as role models to youths but also educating them on HIV related issues. To be more competent and effective, peer educators need to be trained, monitored, supportively supervised and mentored regularly. The use of participatory method throughout the project life cycle is very important since it helped the target beneficiaries, community members and LGA to feel ownership of the project.

This project can further advanced to the establishment of peer educators forums where youths and peer educators can meet and discuss on HIV and AIDS related issues. This will also help youths and peer educators to build not only their confidence but also increased their knowledge on HIV prevention and become aware on risky behaviours that make them prone of HIV infection.

REFERENCES

Adamchak, S. (2006). Youth peer education in reproductive health and HIV/AIDS: Progress process and programming for the future. Youth issues Paper 7.

Ali, M., Bhati, M. and Ushijima, H. (2004): Reproductive health needs of adolescent males in rural Pakistan: An exploratory study. The Tohoku Journal of Experimental Medicine. (204)1: 17 – 25.

Brieger, W., Delano,G., Lane, C., Oladepo, O. and Oyediran, K. (2006). West African youth initiative: outcome of a reproductive health education program. Journal of Adolescent Health. 29(6): 436 – 446.

Broadhead, R., Volkanevsky, V., Rydanova, T., Rybakova, M., Borch, C., Fullerton, A., et all. (2006). Peer driven HIV interventions for drug injectors in Russia: First year impact results of a field experiment. International Journal of Drug Policy, 17(5): 379 – 392.

Campbell, C. and Mzaidume, Z. (2001). Grassroots participation: Peer education and HIV prevention by sex workers in South Africa. *Am J Public Health.* 91(12): 1978 – 1986.

Cohen, L. (2011), Research Methods in Education.7th ed. London and New York: Routledge

Cornish, F. and Campbell, C. (2009). The social conditions for successful peer education: A comparison of two HIV prevention programs runs by sex workers in India and South Africa. The American Journal of Community Psychology. 44 (1)123 – 135.

Cornish, F. and Campbell, C. (2009). The social conditions for successful peer education: A comparison of two HIV prevention programs runs by sex workers in

India and South Africa. The *American Journal of Community Psychology*. 44(1) 123 – 135.

Dornyei, Z. (2007). *Research Methods in Applied Linguistics, Quantitative, qualitative and Mixed Methodologies*. Oxford University Press, Oxford.

FHI. (2010). Evidence Based Guideline for youth peer education. Family Health International. USA

Fishbein, C. and Ajzen, Z (1975). *Belief, attitude, intention and behaviour, An introduction to theory and research*. Wesley.

Foster, S. and Buve, A. (1995). *Benefits HIV screening of blood Transfusions in Zambia: How to make them work better, Lancet (372)*. London School of Hygiene and Tropical Medicine, London, UK.

Freire, P. (1970). *Pedagogy of the oppressed*. New York.

Gao, Y. Shi, R. Lu, Z, Qiu, Y. Niu, W. and Short, R. (2002). An effective Australian Chinese peer education program on HIV/AIDS and STDs for University students in China. *Journal of Reproductive Medicine*. 11 (1): 7-12.

Harden, V.(2012). *AIDS at 30*: *A History*. Potomac Books Inc. (294)324.

Holden, S. (2004). *Mainstreaming HIV/AIDS in development and humanitarian programmes*. Oxfam GB.

IPPF. (2007). Included Involved Inspired: A framework for youth peer education programme. Parenthood federation. London., UK

Joint United Nations Program for HIV and AIDS (2014). The Gap report

Juma, M. (2002). Poverty Assessment Based on Access to Basic Infrastructure and services in some selected Unplanned Settlements in Dar es Salaam: The Case

of Vingunguti, Tandale and Manzese. *Unpublished Dissertation*. Dar es Salaam.

Kallings, L. (2008).The first postmodern pandemic: 25 years of HIV/AIDS. *Journal of Internal Medicine*. 263(3).

Kothari C. (2009). *Research methodology: Methods and techniques*. New Delhi Wiley Eastern.

Kothari, C. (1999). *Research methodology: Methods and techniques*. New Delhi Wiley, Eastern.

Lujuo, R. (2001). Assessments of Community Infrastructure Provision in Informal settlement: The case of Vingunguti Miembeni. Dar es Salaam City, *Unpublished Dissertation*, Dar es Salaam, Tanzania.

Mahongo, S. (1999). *Sea level measurement and analysis in the Western Indian Ocean. National Report*. Tanzania Fisheries Research Institute. Tanzania.

Mbonile, M. (1993). Migration and structural change in Tanzania: The case of Makete District. Liverpool University press, Liverpool.

Medley, A. O' Relly, K. Schmid, G. and Sweet, M. (2009). *Systematic review of the efficacy of peer education in reducing HIV sexual risk behaviour in developing countries*: A systematic review and Meta- analysis. AIDS Educ Prev. 21(3):181-206

Meshack, M. and Lupala, J. (2003). Conflicts in Community Managed Projects: The Case Of Community Based Organization in Tanzania, Dar es Salaam, Tanzania.

Monasch, R. and Mahy, M. (2006). Young peoplethe Centre of the HIV epidemic in Preventing HIV/AIDS: A Systematic Review of the Evidence in Developing Countries.

Population Council, (2002). Peer Education and HIV/AIDS: Past Experience, Future Directions.

Sergeyev, B. Oparina, T. Rumyantseva, T. Volkanevskii, V. Broadhead, R. Heckathorn, D. et al. HIV Prevention in Yaroslval: A Peer driven International and Needle Exchange. *Journal of Drug Issues*. Russia 29 (4).

Sharma A., Lanum, M. and Suarez, Y. (2002). A community needs assessment's guide: A brief guide of how to conduct needs assessment. Loyola University., USA.

URT. (2010). Reproductive Child Health Section. Ministry of Health and Social Welfare. Dar Es Salaam., Tanzania.

Visser, M. (2007). HIV/AIDS prevention through peer education and support in secondary schools: South Africa. SAHARA. 4(3).

Welsh, M., Puello, E., Meade, M., Korne, S. and Nutlley T.(2001). Evidence of dif-fusion from a targeted HIV/AIDS Intervention in the Dominican Republic. J Biosoc Sci., 33(1):107-119.

APPENDICES

Appendix 1: Interview Guide for Government Authority

1. When did you start living in Vingunguti ward? _____

2. For how long have you been working with Vingunguti local government authority?

3. What are the main socioeconomic activities for the Vingunguti Ward?

4. What are the problems facing Vingunguti ward in general?

5. What is the most pressing need among the above mentioned need?

6. Do you have enough resources to address you're most pressing needs? a) Yes b) No

If yes, mention the available resources

7. Do you conduct meetings with your community members? (a)Yes (b) No
   If yes, how often?

8. What do you normally discuss?

9. Are there any strategies to address the identified pressing needs?

   (a)Yes (b) No
   If yes, what are the strategies?

10. What are the anticipated challenges in addressing the most pressing needs?

11. Are there any available local NGOs supporting each of the identified most pressing
    If yes, how do you collaborate with the NGOs
    If no, why?

Appendix 2: Questionnaire for Community Members

1. What is your age? _____

2. What is your sex? (a) Male

   (b) Female

3. What is your marital status? (a) Married (c) Cohabiting

   (b) Single (d) Widow

4. What is your Education?

   (a) Primary Education (c) College/University+

   (b) Secondary Education (d) Others (mention)_____

5. Which street do you stay? (a) Mtakuja (c) Kombo

   (b) Miembeni (d) Mtambani

6. For how long have you been staying in Vingunguti ward? _____

7. What are the problems facing the Vingunguti ward community?

   _____

   _____

8. Among the problems mentioned above, what are the most pressing needs?

   _____

   _____

9. Do the local government leaders conduct meetings with the community?

   (a)Yes

   (b) No

   If YES, how often?_____

10. What do you normally discussed?

    _____

    _____

11. Do you know any organization(s) that support(s) each of the most pressing mentioned above?

    (a) Yes

    (b) No

12. How local government in your community do helps towards address the most pressing need?

    _____

    _____

13. Do you participate (as a community member) in addressing the most pressing issues mentioned above?

    _____

    _____

    If YES, explain how?

    _____

    _____

    If NO, why?

    _____

    _____

14. What are your opinions on the best approach that can be used to address the most pressing issues?

    _____

    _____

Appendix 3: Interview guide for MYE Organization

1. When was the organization formed?
2. How many staff does the organization has?
3. Briefly describe the organization of MYE
4. What are mission and vision of MYE?
5. What is (are) the goal(s) for the organization?
6. What is (are) the objective(s) for the organization?
7. What is the source of funds for the organization?
8. What approaches do you use in addressing HIV and AIDS among youths?
9. What strength does the organization has towards addressing HIV and AIDS issues in youths?
10. What opportunities for the organization do you think are there to address to address HIV and AIDS among youth?
11. What challenges does the organization face/anticipate in addressing HIV and AIDS among youths?
12. How do you involve the community members in addressing HIV and AIDS among youth?
13. Do you collaborate with the local government authority in addressing HIV and AIDS among youth?
    a) Yes
    b) No

    13 a) If YES, how?

    13b) If No, why?

Appendix 4: Questionnaire for Peer Educators

1. What is your age? _____

2. What is your sex? (a) Male

   (b) Female

3. What is your marital status? (a) Married (c) Cohabiting

   (b) Single (d) Widow

4. What is your Education? (a) Primary Education (c) College/University+

   (b) Secondary Education (d) Others (mention)___

   Which street do you stay? (a) Mtakuja (c) Kombo

   (b) Miembeni (d) Mtambani

5. How do you meet with youths?

   _____

   _____

6. What do you normally discuss with youths?

   _____

   _____

7. What do you normally discuss with youths?

   _____

   _____

8. Which approaches do you use in communicating with youths?

   _____

   _____

9. What challenges do you normally face when discussing

   _____

   _____

10. Have you ever received any HIV and AIDS related training? (a) Yes (b) No

    If yes, what did the training cover /topics?

    _____

    _____

    When was the training? _____

    If no, how do you manage discussing with youth on HIV & AIDS matters?

11. Which sessions on HIV and AIDS do you feel comfortable discussing with youth?

    _____

    _____

12. Which sessions on HIV and AIDS do you feel uncomfortable discussing with youths?

    _____

    _____

13. Who influenced you to become a peer educator?

    _____

    _____

14. Have you ever had sex in the past 3 months? (a) Yes (b) No

    If yes, with how many partners? _____

15. Did you use condom? (a) Yes (b) No

    If yes, why? _____

    If no, why? _____

16. What is the meaning of;

HIV _____

AIDS _____

17. What is the difference between HIV and AIDS?

_____

_____

18. What are the modes of HIV transmission that you know?

_____

_____

19. Among the modes you have mentioned, which is(are) the most common mode(s) that contribute(s) more in HIV transmission?

_____

_____

20. What are the risk behaviours that contribute to HIV infection among youths?

_____

_____

21. What are the symptoms and signs of HIV that you know?

_____

_____

22. Can HIV be transmitted through,

		(a) Yes	(b) No
(i)	Mosquito bite?	------	------
(ii)	Sharing eating utensils?	------	------
(iii)	Shacking hands?	------	------
(iv)	Hugging?	------	------

23. Can HIV be cured? (a) Yes (b) No

If yes, mention the cure _____

24. Can HIV be treated?

If yes, mention the treatment_____

25. What are the different methods that can be used to prevent HIV in youth?

_____

_____

26. Do you think disclosing one's HIV status is important? (a) Yes (b) No

If yes, why? _____

If no, why? _____

Appendix 5: Questionnaires for Youths

1. What is your age?_____
2. What is your sex? a) Male b) Female
3. What is your marital status? a) Married c) Cohabiting
   b) Single d) Widow
4. What is your Education? a) Primary Educationc) College/University+
   (b) Secondary Education (d) Others (mention)_____
5. Which street do you stay? (a) Mtakuja (c) Kombo
   (b) Miembeni (d) Mtambani
6. Have you ever had sex in the past 3 months? (a) Male (b) Female
7. If YES, with how many partners? _____
8. Did you use condom? (a) Male (b) Female

If YES, why? _____

If NO, why? _____

9. In which other situations that you would use condom when having sexual intercourse?

   _____

   _____

10. In which other situations that you would not use condom when having sexual intercourse?

    _____

    _____

11. Have you ever heard of HIV and AIDS? a) Yes b) Female
12. If yes What is the meaning of

HIV_____

AIDS_____

13. Have you ever tested for HIV?

    If YES, Why did you decide to test? _____

    If NO, why? _____

14. What are the modes of HIV transmission that you know?

    _____

    _____

15. Among the modes you have mentioned, which is (are) the most common mode(s) that contribute(s) more in HIV transmission?

    _____

    _____

16. What are the risk behaviours that contribute to HIV infection among youths?

    _____

    _____

17. Can HIV be transmitted through, (tick appropriate)

    (a) Mosquito bite

    (b) Sharing eating utensils

    (c) Hugging

    (d) Shacking hands

18. What are the symptoms and signs of HIV that you know?

    _____

    _____

19. Can HIV be cured? a) Yes b) No

If YES, mention the cure _____

20. Can HIV be treated? a) Yes b) No

If YES, what is the treatment? _____

21. What are the different methods that can be used to prevent HIV in youth?

_____

_____

22. What are the steps for correct use of female/male condom?

_____

_____

23. Do you meet with peer educators and discuss HIV and AIDS related issues?

(a) Yes (b) No

24. If YES, what HIV and AIDS related issues do you discuss?

_____

_____

25. What issues in HIV and AIDS that you wish to learn more?

_____

_____

Appendix 6: Training Manual for Peer Educators

Session 1 - HIV Prevention

Total Session Time: 130 Minutes

Objectives: By the end of this session, participants will be able to:

- Outline the meaning of HIV prevention
- Explain goals of HIV prevention programs
- Explain risk factors for contracting HIV infection
- Describe major prevention methods used to reduce HIV infection
- Explain general principles for targeted HIV prevention messages
- Describe HIV 'prevention for positives'

SESSION OVERVIEW

Steps	Time	Activity/Method	Content	Resource Needed
1	15 minutes	Presentation	Introduction, Learning Objectives	Laptop, LCD/Overhead Projector, Flipchart stand and flipcharts, Markers
2	10 minutes	Presentation, Buzzing	Meaning of HIV Prevention	Laptop, LCD/Overhead Projector, Flipchart stand and flipcharts, Markers
3	10 minutes	Presentation	Goals of HIV Prevention Programmes	Laptop, LCD/Overhead Projector, Flipchart stand and flipcharts, Markers
4	30 minutes	Presentation, Group Discussion	Individual, Community and Society Risk Factors that Increase Vulnerability to HIV Infection	Laptop, LCD/Overhead Projector, Flipchart stand and flipcharts, Markers
5	30 minutes	Presentation, Group Discussion	Prevention Methods used to Reduce HIV Infection	Laptop, LCD/Overhead Projector, Flipchart stand and flipcharts, Markers
6	30 minutes	Presentation, Group Discussion	Condom use for preventing HIV transmission	Laptop, LCD/Overhead Projector, Flipchart stand and flipcharts, Markers
7	05 minutes	Presentation	Principles for Targeted HIV Prevention Messages	Laptop, LCD/Overhead Projector, Flipchart stand and flipcharts, Markers
8	05 minutes	Presentation	Tips on Discussing HIV Prevention in Youths	Laptop, LCD/Overhead Projector, Flipchart stand and flipcharts, Markers
9	10 minutes	Presentation, Buzzing	Prevention for Positives	Laptop, LCD/Overhead Projector, Flipchart stand and flipcharts, Markers

	SLIDE CONTENT	TRAINER'S NOTES
Slide 1	**Session 1: HIV prevention**	**INTRODUCE** session 1 to participants. **TELL** participants that this session is scheduled to take 2 Hours (120 minutes). **ENCOURAGE** active participation, tell them to be free to ask question at any time during the session. **LET** participants answer each other's questions whenever they know the answers.
Slide 2	**Introduction** Despite evidence of declining new HIV infections in many parts of the world, HIV infection remains a major public health problem especially among youth in low and middle income countries. Many adolescents and youths engage in sexual intercourse, often times with multiple sex partners and without condoms. It is therefore very important to talk/discuss about HIV prevention among youths so as to reduce its transmission	
Slide 3	**Learning Objectives (1)** By the end of this session, participants will be able to: • Outline the meaning of HIV prevention • Explain goals of HIV prevention programs • Explain risk factors for contracting HIV infection • Describe major prevention methods used to reduce HIV infection • Condom use for preventing HIV transmission	**READ** or **ASK** participants to volunteer reading the learning objectives. **ASK** participants if they have any questions on the objectives and clarify accordingly
Slide 4	**Learning Objectives (2)** • Explain general principles for targeted HIV prevention messages • Describe HIV 'prevention for positives.	

Slide 5	**Activity - Buzzing**	**ASK** participants to buzz in pairs about 'the meaning of HIV prevention' **ALLOW** them to buzz for 3 minutes **INVITE** few pairs to share their responses in plenary **RECORD** their responses on flip chart **SUMMARIZE** their responses using the content of the next slide
Slide 6	**Meaning of HIV Prevention** HIV prevention refers to the practices done to prevent the spread of HIV. This can be done by individuals and/or community as a whole. Prevention includes; Practices directed at those who are HIV negative to prevent them from getting infected. Practices directed at those who are HIV positive to prevent them from being re infected and infecting others.	
Slide 7	**Goals of HIV Prevention Programmes (1)** To prevent a person from becoming HIV positive by promoting the "ABCs". • Abstinence. • Being faithful to one partner who is HIV negative. • Correct and consistent use of condom. To prevent those who are already HIV positive from getting new infections and from infecting others	**EXPLAIN** to participants that HIV prevention can take several forms. Prevention can help to; • Keep the uninfected individuals from being infected. • Keep the HIV infected individuals stay well • Increase the comfort of those living with the later stages of the disease. • Enable HIV infected individuals to not infect others and avoid acquiring new infections.
Slide 8	**Goals of HIV Prevention Programmes (2)** To enable those who are unaware of their HIV status to stay healthy Counselling and testing to know sero status and to preserve health	**EMPHASIZE** to participants that it is important to first think about the impact of HIV and AIDS on several levels, in order to make prevention interventions as effective as possible.

Slide 9	**Activity – Group Discussion**	**DIVIDE** participants into 3 groups **ASK** participants that they will be discussing on the "risk factors that make people vulnerable to acquiring HIV infection at different levels" as follows; **Group I:** Risk Factors at Individual Level **Group II:** Risk Factors at Community and Society Levels. **Group II:** Risk Factors at Community and Society Levels **INSTRUCT** participants that each group should select a chairperson to lead the group and a recorder who will write group's responses and present in plenary **PROVIDE** flipchart and marker pens to each group for recording their responses **ALLOW** ten minutes for the discussion **INVITE** group I to present their responses in plenary **LET** other participants contribute and/or ask questions for clarifications from the group **INVITE** group II to present their responses **LET** group III present by adding on responses that were not mentioned/discussed by group II **SUMMARISE** the discussion by using the next slides
Slide 10	**Risk Factors that Increase Vulnerability to HIV Infection (1)** These factors can be divided into 3 main categories • Individual Factors • Community Factors • Societal Factors	**EXPLAIN** to participants that HIV is an infection that impacts individuals, communities, and society as a whole. Any efforts to understand and prevent HIV must consider the individual as well as the community and society in which they live. Each level has a different set of factors to consider

Slide 11	**Risk Factors that Increase Vulnerability to HIV Infection (2)**	**MENTION** to participants that; **Individual level contains** person's knowledge, attitudes, beliefs, age, gender, health status, education level, and economic status **Community level contains** Social influences of friends, peers, social norms ("how things should be done"), cultural/religious beliefs, traditions, taboos, and fashion. It can also include a person's living and working conditions, including his or her physical environment and access to services, education, and information. **Societal level contains** Culture, religion, social action, economy, government policy, political stability, and infrastructure.
Slide 12	**Risk Factors that Increase Vulnerability to HIV Infection (3)**	**ELABORATE** to participants that there are three sources of vulnerability that can affect any of these levels: unsafe behavior (e.g. unprotected sexual intercourse with an HIV positive person), power issues (e.g., one partner in a relationship dominating decisions about sexual activities; inability for one partner to negotiate the use of a condom during sex), and health-service issues (e.g., inadequate HIV testing and counselling services). **PROVIDE** the following example to participants; A young man may want to use a condom (individual), but he may be influenced by his peers to have unprotected sex (community) and his church may disapprove of condom use altogether (community). The Ministry of Health provides affordable condoms but not at the district clinic near his village (societal).
Slide 13	**Individual Risk Factors for Acquiring HIV Infection (1)**	**ELABORATE** more to participants that; **Multiple sexual partners and Unprotected sexual intercourse,** with infected partners predispose one from contracting the HIV infection.

Slide 14	**Individual Risk Factors for Acquiring HIV Infection (2)**	**Presence of other STIs especially the ulcerative ones,** increases chance of HIV infection to an individual **Alcohol and/or drug use,** impair decision making as well as negotiation skills, which can lead to taking greater risks such as having unsafe sex. Age, Adolescent women are more susceptible to HIV infection because their genital tract is not mature and the skin is more delicate. **Male circumcision (MC),** may significantly reduce risk of HIV acquisition to the male partner. Because MC does not replace other interventions but complements them, it is still necessary to use condoms and other prevention methods. MC does not prevent HIV transmission to female individuals. **Viral load**, The amount of HIV in a person's blood (viral load) can affect the ability of that person to transmit the virus to another person.
Slide 15	**Individual Risk Factors for Acquiring HIV Infection (3)** Lack of knowledge on HIV status (sero-status)	**ELABORATE** more to participants that **Lack of knowledge of sero-status** Being unaware of individual's HIV sero-status can prevent ones from making informed decisions about their sexual behaviour and about how to protect themselves and their sexual partners. It can also prevent access to ART and other clinical care that could improve an individual's health and quality of life.
Slide 16	**Community and Societal Risk Factors for Acquiring HIV Infection (1)** Lack of knowledge and social acceptance about: HIV and AIDS Condoms and other HIV prevention methods. • Poverty • Migration for employment • Loss of social support and cohesion.	

Slide 17	**Community and Societal Risk Factors for Acquiring HIV Infection (2)** Poor access to: • STI screening and treatment • Counselling and testing services • Care for people living with HIV (PLHIV)	
Slide 18	**Activity – Group Discussion**	**DIVIDE** participants into groups of four or five **INSTRUCT** participants to choose one person from the group to record and one person to present in plenary **ASK** participants to discuss about possible prevention methods directed to one of the risk factor chosen from earlier list and record their responses on flipcharts **PROVIDE** flipcharts and marker pens for each group **ALLOW** participants 15 minutes for the discussion **RECONVENE** the class for presentation **ASK** few groups to present on one risk factor that they identified and a prevention method that might reduce that risk factor **ASK** all other participants to ask questions and contribute to the presentations **LET** participants also ask questions if they have and clarify accordingly **SUMMARISE** the discussion using the next slides.
Slide 19	**Prevention methods used to reduce HIV infection (1)** • Behaviour Change Communication (BCC) • HIV Testing and Counselling and linkage to care HIV care • HIV treatment for prevention • Ensuring availability and provision of condoms • Provision of HIV prevention to youth	**ELABORATE** to participants **Behaviour Change Communication:** this is a simplest way of sending different messages towards changing behaviours that can cause transmitting of HIV from one individual to the other. **HIV testing and counselling and link to care**: the provision of HTC services to the individuals is very important due to when they test negative they will be in a position to assess and modify their risks behaviours to help them stay un infected. When they are infected they will take steps to protect their own health and prevent HIV transmission to others and being linked to care and treatment.

Slide 20	**Prevention methods used to reduce HIV infection (2)**	**HIV treatment for prevention Preventing Mother to Child transmission:** the provision of ART to pregnant woman reduces the risks of HIV transmission to infants during pregnancy, labour, delivery and breast feeding as well as preventing infection to their spouses and community at large. **Treatment of PLHIV with ART:** This lower the amount of HIV virus in their body and can reduce their risks of transmitting HIV to others **Ensuring availability and provision of condoms**: condoms need to be available and accessible to people who are living with or at risks of getting HIV. Condoms when used correctly are effective in preventing sexual transmission diseases including HIV. **Provision of HIV prevention for key vulnerable population:** this can help to reduce risks behaviours and play important role in HIV prevention to high risks and vulnerable populations such as refugees, prisoners, sex workers and drug users
Slide 21	**Prevention methods used to reduce HIV infection (3)** • STI screening and Treatment • Voluntarily Medical Male Circumcision (VMMC)	**ELABORATE** to participants **STI screening and Treatment:** Sexual Transmission infection increases individual risks of acquiring and transmitting HIV. Therefore screening and treating STI may reduce risks for HIV infection. **Voluntary Medical Male Circumcision** has been proved to reduce the risk of acquiring HIV to male partners. **Post-exposure prophylaxis** is aimed at provision of medicines to people who have been exposed to HIV. This includes healthcare workers accidentally exposed to blood, blood products and fluids from patients while providing care. It also includes non-occupational exposure to HIV such as rape.

Slide 22	**Activity on condom myths and personal feeling (1)**	**DIVIDE** participants into two groups **ASK** each group to take two pieces of papers and one paper to write false and the other paper True**.** **TELL** the participants that you will read the statements and they have to choose whether it is correct or incorrect. Participants to respond by rising up the paper if it is true they have to take up a true paper and if it is false- false paper**.** **START** by reading the following statements. Condoms don't work very well. [False statement] **If used consistently and correctly, condoms are effective in preventing both the transmission of STIs including HIV, and** The male condom can come off and get lost inside the woman. [False statement] **If put on correctly, a male condom is very unlikely to come off. Even if it does, it will remain within the vagina and can be removed with the fingers, it cannot 'get lost' within the women. The same applies for the female condom.** Most condoms are too small for African men. [False statement] **The latex used to make condoms is very flexible and can stretch to several times the size of even the biggest penis.** Using two condoms at the same time offers greater protection. [False statement] **Using two condoms at the same time creates greater friction during sex, which may result in the condoms breaking or slipping off. Only one condom should be used at a time.**

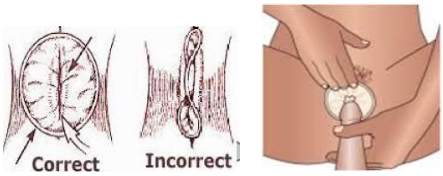
Slide 23	**Activity on condom myths and personal feeling (2)**	Using two condoms at the same time offers greater protection. [False statement] **Using two condoms at the same time creates greater friction during sex, which may result in the condoms breaking or slipping off. Only one condom should be used at a time.** The HIV germ is so small that it can pass through the condom. [False statement]. **Tests have shown that neither semen nor HIV can pass through the material used in making condoms.**
Slide 24	**Condom preventing HIV transmission** • Condom allow people to engage in safe sex with siginificantly reduced risks of body fluids being exchanged. • When condom used correctly and consistently can prevent a risk of contracting HIV and other sesual transmitted infections. • To effectively reduce the risks of HIV transmission condoms should be used when having virginal,oral and anal sex	

Slides 25	**Activity (1)** Demonstrate how to correcly ope, use and despose condome.	**DIVIDE** participants into groups of four or five **EACH** participants to be provided with two condoms **ASK** participants to place condom on the demonstrator while describing the steps to the group. **DISCUSS** with participants the danger of putting on condoms incorrect **LET** most of suggestions came from participants **GROUP may identify resistance to condom use as a major topic and possibly one member of the group refused to handle the condom. Take it as a concern and continue with discussion you will deal with it later.**
Slides 26	**Activity (2)** Demonstrate how to correcly ope, use and despose condome.	**GIVE** each group condoms and range of lubricants from water based to oil based (Vaseline, Cooking oil) **ASK** them to blow up the condom like a balloon and apply lubricants and tie a knot in end**.** **SET** a stop watch and see how long it takes for the condoms with oil based lubricant to degrade and break. **EXPLAIN** oil based is bad for condoms and water based is good. **WHEN** condom tear of come off during sex STOP, if continue you will be putting yourself and partner expose to HIV infection, Go to nearby health facility of speak with any medical professional to discuss exposure.

Handout 1: Comparisons Of Male And Female Condom

Male condom steps	**Female condoms steps**
Buy /get condom	Buy /get condom
Store the condom	Store the condom
Show interest in using it	Show interest in using it
Agree to have sex	Agree to have sex
Agree to use condom	Agree to use condom
Hug and kisses	Hug and kisses
Foreplay	Press the inner ring into 8 shape and insert into the vigina,ensuring that the outer ring stays outside the virginal opening.
Erection and lubrication	Hugs and kisses
Carefully open the condom	Foreplay
Put the condom at the tip of the penis	Erection and lubrication
Roll the condom down to the base of the penis	Penetration,ensuring that the outer ring stays outside the virginal opening
Add lubrication	Intercourse
Intercourse	Orgasm
Orgasm	Male withdraw penis
Hold condom at the base of the penis	Remove the condom from virginal
Withdraw the penis	Dispose of the condom
Dispose the condom	

Handout 2: Steps in Using Male and Female Condoms

/N	Steps in Using male Condom	Steps in Using female Condom
.	 Read expire date and how to use it	 Read expired date and how to use it
.	 Erection	  Careful open, it can be placed to vagina l up to 8 hrs before
.	  Open careful	 Press the inner ring to 8 figure
.	 Pinch the tail to expel any air and	 How to insert into the vagina,
.	 Roll the condom down to the base of the penis	 outer ring stays outside the vaginal opening
.	 Hold the condom at the base of the penis, with draw the penis and tie a knot in end to stop it leaking	 How to withdraw the condom, and tie a knot in end to stop it leaking
.	 Dispose of condom safely	 Dispose of condom safely

Handout 3: Do's and Don't When Using Male and Female Condoms

Do's	Don'ts
Before Sex	
Make sure you are using a good quality of condom	Don't open pack with teeth
Keep condom in a coll and dry place	Don't fill with water to check for wh
Make sure you use the correct size condom incorrect can cause to tie off or come off	Don't pull the condom on
Before opening the packat chack the use by date	Don't dispose in a toilate
Use for vaginal,anal and oral sex	Don't re use
Move the condom to one side inside the packet and carefully tear the edge	Don't wash out
Make sure the condom is not inside out	Don't pass used condom for a frientc
Place the condom over the tip of the penis	Don't store condom in direct sunligh on rough surphase as it mau damage before use
Tight squeeze the air out before rolling the condom down to the base of the penis	Don't use condom that has had a stap packet
If it comes off place a new condom	Don't use an expired condom
After Sex	
Withdraw the penis while it is still erect, hold the base of the condom during withdraw.	
Remove the condom from the penis/Vagina making sure you do not spill any fluid.Tie a Knot in end to stop it leaking	
Dispose of condom safely	

Slide 27	**Principles for Targeted HIV Prevention Messages** All prevention interventions should: • Consider the context of the individual • Recognize areas of vulnerability • Focus on risk reduction by promoting behaviour change • Ensure that consistent HIV and AIDS prevention messages are used • individual, community, and societal levels • Include "prevention for positives" messages	**TELL** participants that; Interventions and messages will be different depending on the individual and situation. For example, the questions you ask a woman getting tested for HIV as part of a prenatal checkup will be different from the questions you ask when a young, unmarried male presents with genital ulcers. **EXPLAIN** that prevention messages are not just for those who are HIV negative, but also for people living with HIV. "Prevention for positives" messages promote healthy lifestyle choices for people living with HIV to maintain health and reduce risks of other illnesses.
Slide 28	**Tips on Discussing HIV Prevention with Youths** Provide a comfortable environment to talk about sexual behaviour in order to discuss behaviour change: • Encourage protection for themselves • Encourage protection of sexual partners • Discuss disclosure to sexual partners and significant others • Encourage partner testing • Reinforce positive behaviour • Promote partner negotiation • Encourage regular testing, if HIV negative and sexually active	**EXPLAIN** to participants that all individuals should take steps to protect themselves from HIV infection or re-infection and other STIs. If a person tests HIV negative, it is important to reinforce behavior that will help that person remain HIV negative.

Slide 29	**Activity - Buzzing**	**ASK** participants to buzz in pairs on the issues that can be considered in 'prevention for positives' **ALLOW** them to buzz for 3 minutes **LET** few pairs to share their responses to the class **RECORD** the responses on flip chart **ALLOW** other pairs to contribute on what has been shared by other pairs **SUMMARIZE** the discussion using the next slides
Slide 30	**Prevention for Positives** Other issues in prevention for positives include those that can take place within healthcare settings such as; • Encouraging HIV positive youth to adhere to ART or other treatment • Encouraging individuals to seek regular care, monitor health, and prevent / treat opportunistic infections • Discussing reproductive choices (family planning, desire for children) • Provision of counselling on positive living and sustaining healthy behaviour • Practice safer sex to prevent re-infection and infection of others • Identify and reduce risky behaviours	Prevention for positives aims at enabling HIV positive individuals maintain healthy lives by reducing the risk of becoming ill with Other illnesses, including other STIs, different strains of HIV Encouraging HIV positive individuals to reduce the risk of infecting others is an important part of controlling the spread of HIV **EXPLAIN** to participants that doctors, nurses, Counsellors, pharmacists, and lab staff should use their strengths and different areas of expertise to provide care to the patient in a safe, confidential, and nonjudgmental environment. This is very important in order to: **Discuss reproductive choices.** Many HIV positive individuals still would like to conceive or are interested in hearing about family. Provide the client with referrals on sources for additional social support or other services for positives.

Session 2: Behaviour Change Communication

Total Session Time: 120 Minutes

Objectives: By the end of this session, participants will be able to;

- Define the terms "behaviour", and "behaviour change"
- Describe the stages of behaviour change
- Identify barriers to positive behaviour change on HIV and AIDS
- Describe approaches of behaviour change communication and link to stages of behaviour change
- Explain the meaning and role of BCC in HIV prevention.
- Identify factors that hinder effective BCC in HIV and AIDS prevention
- Outline the roles of peer educators in HIV prevention among youth

Session Overview

Steps	Time	Activity/Method	Content	Resource Needed
1	15 minutes	Presentation	Introduction and Learning Objectives	LC LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens D/Overhead Projector
2	5 minutes	Buzzing, Presentation	Definitions of Behaviour and Behaviour Change	LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens
3	25 minutes	Activity, Experience Sharing, Presentation	Sages of Behaviour Change: Sharing experience on behaviour Change, how and why it happened	LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens
4	30 minutes	Activity (Group Work), Presentation	Barriers to Positive Behaviour Change on HIV/AIDS, Behaviours, Attitudes and Practices that Have to be Encouraged, Risk Behaviour, Attitudes and Practice that Have to be Changed	LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens
5	5 minutes	Presentation	Definition of Behaviour Change Communication	LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens
6	20 minutes	Presentation	Effective Role of BCC in HIV and AIDS prevention	LCD/Overhead Projector, Laptop, Flip Charts, Marker

				Pens
7	5 minutes	Presentation	The Link Between Stages of Behaviour Change and BCC Approaches	LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens
8	15 minutes	Presentation	Roles of Peer Educators on HIV and AIDS Prevention Among Youths	LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens

	SLIDE CONTENT	TRAINER'S NOTES
Slide 1	**Behaviour Change Communication (BCC)**	**INTRODUCE** session 2 to participants. **TELL** participants that this session is scheduled to take 2 Hours (120 minutes). **ENCOURAGE** active participation, tell them to be free to ask question at any time during the session? **LET** participants answer each other's questions whenever they know the answers.
Slide 2	**Introduction** Behaviour change communication (BCC) entails using communication approaches and tools with a view to empowering youth with skills and capabilities to enable them promote and manage their own health and development. BCC also helps foster positive change in youth's behaviour, as well as in their knowledge and attitudes, besides motivating them to collaborate with their families, educational institutions, health service providers and communities.	
Slide 3	**Learning Objectives (1)** By the end of this session peer educators will be able to • Define the terms "behaviour", and "behaviour change" • Describe the stages of behaviour change • Identify barriers to positive behaviour change on HIV and AIDS • Describe approaches of behaviour change communication and link to stages of behaviour change	**READ** or **ASK** participants to volunteer reading the learning objectives **ASK** participants if they have any questions on the objectives and clarify accordingly

Slide 4	**Learning Objectives (2)** • Explain the meaning and role of BCC in HIV prevention. • Identify factors that hinder effective BCC in HIV and AIDS prevention • Outline the roles of peer educators in HIV prevention among youth	**READ** or **ASK** participants to volunteer reading the learning objectives **ASK** participants if they have any questions on the objectives and clarify accordingly
Slide 5	**Activity: BUZZ** What is the meaning of the following 'Behavior' and 'Behavior change'	**ASK** participants to buzz in pairs on the meaning of '*behavior*' and '*behavior change'* **ALLOW** 2 minutes for them to complete buzzing **LET** few pairs to present on what they have come up with **SUMMARIZE** the discussion using the next slide
Slide 6	**Definition of Behaviour and Behaviour Change (1)** **Behaviour** is a range of observable actions and reactions performed by an individual in conjunction with oneself or his/her environment, that includes others around as well as the physical environment	
Slide 7	**Definition of Behaviour and Behaviour Change (2)** **Behaviour change** refers to any transformation or modification of human behaviour It may also refer to a broad range of activities and approaches which focus on the individual, community, and environmental influences on behaviour	**PRESENT** the meaning of both behaviour and behaviour change as in this slide **GIVE** the following examples of HIV/AIDS – related behaviour that needs to be changed • Early sexual intercourse • Multiple sexual partners • Unsafe sexual intercourse (not using condoms to partner(s) with unknowing HIV status) • Excessive alcohol use – impairing judgement on the use of condoms • Stigma and discrimination to PLHIV

Slide 8	**Activity:** Sharing experience on 'behaviour change	**ASK** participants to share on any change of behavior that they have experienced (e.g. abstinence to Sexual intercourse) let them volunteer **ASK** each volunteer on <u>how and why</u> they changed that behavior **ALLOW** 3 to 4 volunteers to share their experiences on behaviour change **RECORD** their responses on flip chart **SELECT** one behaviour and using the next slide, then take the class through the stages that one passes through to achieve the desired behavior change
Slide 9		**TELL** participants that there are 5 main stages of behaviour change, namely; **Pre-contemplation:** lack of awareness of risk, or no intention to change risk behaviour **Contemplation:** beginning to consider behaviour change without commitment to do anything immediately **Preparation:** a definite intention to take preventive action in the near future **Action:** modification of behaviour, environment or cognitive experience to overcome the problem Maintenance**:** the stabilisation of the new behaviour
Slide 10	**Activity: Group Work (1)**	**DIVIDE** participants into three manageable groups **ASSIGN** the following questions to the groups as indicated; • **Group I -** What are the barriers to positive behaviour change on HIV and AIDS? • **Group II -** What risks behaviours, attitudes and practices have to be changed? • **Group III -** What behaviors, attitudes and practices have to be encouraged?

Slide 11	**Activity: Group Work (2)**	**ASK** each group to record their responses on flip chart and select one person among themselves who will present to the plenary **SUMMARISE** the discussion using the next slides **ALLOW** 10 minutes for participants to complete their assignments **ASK** each group present their responses (using the selected person per group) in plenary **ALLOW** other to ask questions and contribute to what has been presented
Slide 12	**Barriers to Positive Behaviour Change on HIV & AIDS (1)** • Lack of knowledge on HIV and AIDS • Misconceptions regarding HIV/AIDS and other STDs • The fear that AIDS might be caused by witchcraft or sorcery • Many adults are wary of their youth being given sex education for fear that it will encourage them to be immoral • Some youths do not use condoms because they label them as ineffective, liable to burst, laced with HIV and either too big or too small for African youths • Stigma to HIV/AIDS	
Slide 13	**Barriers to Positive Behaviour Change on HIV & AIDS (2)** • AIDS is largely seen as self-inflicted through promiscuity and unprotected sexual encounters • In many African areas, it is convinced that there is a relationship between AIDS and illicit/illegal/ unlawful/ dishonest sex. • Gender imbalance girls do not participate as much as boys in project activities • Inability of girls for cultural reasons to bargain for safe sex • Cultural and religious beliefs • Poverty • Lack of supportive political will	

Slide 14	**Behaviours, attitudes and practices that should be encouraged to youth (1)** • Abstinence • Being faithful to uninfected sexual partner • Consistent and correct use of condoms • Avoiding stigmatisation and discrimination • Respect and compassion for PLHIV • Provision of care and support to PLHIV and the affected	
Slide 15	**Risk behaviours and attitudes that need to be changed to youth (2)** • Multiple sexual partners • Unprotected sex • Gender based violence ,rape and sexual coercion/intimidation • Beliefs like AIDS is witchcraft and people with HIV are losers • Harmful traditional practices like female genital mutilation (FGM) and early marriage • Stigmatisation and discrimination	
Slide 16	**Behaviour Change Communication (BCC)** Behaviour change communication (BCC) is an interactive process of any intervention used to support individuals' ability to adopt and maintain new positive behaviours. BCC aims at; developing communication strategies, increasing knowledge**,** Stimulating dialogue BCC ensures that people are given accurate and timely information about HIV and AIDS in their preferred language or medium.	

Slide 17	**Effective role of BCC in HIV and AIDS prevention (1)** Increases Knowledge on HIV and AIDS • Stimulates community dialogue • Promotes appropriate attitude change • Reduces stigma and discrimination • Creates demand for information and services • Improves skills and sense of self efficacy	**EXPLAIN** to participants the details on each of the bullets mentioned on the slide as follows **Increases Knowledge** *on HIV and AIDS* - to ensure youth are given the basic facts about HIV and AIDS in a language that they can understand and relate to their living and practice. **Stimulates community dialogue**, dialogue by encouraging community and national discussions on the basic facts of HIV and AIDS and the underlying factors that contribute to the epidemic, such as risk behaviors, risky cultural practices related to sex and sexuality, and marginalized practices (e.g. drug use).
Slide 18	**Effective role of BCC in HIV and AIDS prevention (2)**	**Promotes appropriate attitude change:** attitude change about topics like perceived personal risk of HIV infection, belief in the right to and responsibility for safe practices and health supporting services, provision of compassionate and non-judgmental services, open mindedness concerning gender roles, and the basic rights of those vulnerable to and affected by HIV and AIDS. **Reduces stigma and discrimination** through communication about HIV prevention and AIDS mitigation that addresses stigma and discrimination and attempts to influence social responses to them. **Creates demand for information and services** by encouraging individuals and communities to demand information on HIV and AIDS and appropriate services. **Improves skills and sense of self efficacy** by focusing on strengthening new skills and behaviors, such as condom use, negotiating safer sex, and safe injection practices. This can contribute to a sense of confidence in making and acting on decisions.

Slide 19	**Activity: Group Discussion**	**DIVIDE** participants into two groups **ASSIGN** the following questions as indicated below – **Group I –** What are the factors that may hinder effective BCC in HIV and AIDS prevention? – **Group II –** What are the general approaches to behaviour Change **ASK** each group to record their responses on flip chart and select one person who will present in plenary **ALLOW** 10 minutes for the participants to complete the activity **ASK** each group to present in plenary **ALLOW** others to ask questions and contribute to each presentation **SUMMARIZE** the discussion using the next slides
Slide 20	**Factors that may hinder effective BCC intervention** • Messages that stigmatize those who are infected/affected with HIV • Messages that are not properly structured to address sensitive cultural practices like FGM and early marriage • Cultural/societal norms that marginalize women/girls in respect to owning property • Lack of adequate and proper information • Inappropriate use of media channels that are not available to the community • Glorification of sex in advertisements • Easy access to pornography by the youth on the internet, TV and magazines • Use of language that is not target audience specific	

<table>
<tr><td>Slide 21</td><td>Approaches to BCC
Encourage awareness and value change
Promote benefits of the new behavior
Reduce the costs involved in adopting new behavior (including financial costs and barriers to access), foster social support, and teach relevant skills necessary for the behavior change.
Reward and support change
Continue support of behavior change</td><td></td></tr>
<tr><td>Slide 22</td><td>The Link between stages of behaviour change and BCC approaches<table><tr><th>STAGE OF CHANGE</th><th>BCC APPROACH</th></tr><tr><td>Pre-contemplation</td><td>Encourage awareness and value change</td></tr><tr><td>Contemplation</td><td>Promote benefits of the new behaviour

Reduce the costs involved in adopting new behaviour (including financial costs and barrier to access), foster social support, and teach relevant skills necessary for the behaviour change</td></tr><tr><td>Preparation for Action</td><td>Personalize risks and benefits, deliberate decision-making, increase self-efficacy and self-esteem and perception of positive change among peer group</td></tr><tr><td>Action</td><td>Reward and support the change</td></tr><tr><td>Maintenance</td><td>Continue supporting the behaviour change</td></tr></table></td><td></td></tr>
<tr><td>Slide 23</td><td>Role of peer educators on HIV and AIDS prevention among youth (1)
Build HIV and AIDS awareness among youths
Encourage positive living and adhere to appropriate treatment for those who have infection
Reduce risky sexual behavior amongst youth
Promote more youths to knows their HIV status
Create greater openness about HIV/AIDS and sex</td><td>EXPLAIN to participants on the details of some bullets on the slide as follows;

Build HIV and AIDS awareness among youths this will increase knowledge that will make youth know more about HIV transmission and prevention/control of the epidemic.

Encourage positive living and adherence to appropriate treatment, positive living encourages Youth with HIV prevent themselves from re infections and infecting others. Adherence to treatment reduces viral load in HIV infected individuals hence decreasing chances of infecting others (treatment for prevention).</td></tr>
</table>

Slide 23	**Role of peer educators on HIV and AIDS prevention among youth (2)** • Support reduction of stigma and discrimination	**Reduce risky sexual behavior amongst youth,** reducing risky behavior promotes prevention and reduces chances of HIV infection among youths **Promote more youth to know their HIV status,** knowing their HIV status will help those who are HIV negative maintain their status and prevent themselves from being infected while those who are HIV positive will protect themselves from being re- infected and not infecting others. **Create greater openness about HIV/AIDS and sex** openness about HIV/AIDS promotes HIV prevention and control. Youth can educate themselves on HIV transmission and how they can protect themselves. For those who are already HIV infected, openness helps them disclose their status hence making others aware and prompt to HIV testing. **Support reduction of stigma and discrimination,** Stigma and discrimination causes HIV infected individuals hide their HIV status hence increases chances of infecting others and being re-infected. Therefore youth has to be supported to reduce/eliminate stigma and discrimination so as to influence free expression of HIV status and promote negotiation for condom use.

Session 3 - Communication Skills

Total Session Time: 120 Minutes

Objectives: By the end of this session, participants will be able to;

- Define the term communication
- Describe types of communication
- Explain communication processes
- Explain effective communication
- Describe characteristics of effective communication
- Explain barriers of effective communication and how to overcome them
- Demonstrate effective communication skills

Session Overview

Steps	Time	Activity/Method	Content	Resource Needed
1	15 minutes	Presentation	Introduction, Learning Objectives	LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens
2	05 minutes	Presentation	Definition of communication	LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens
3	10 minutes	Presentation, Buzzing	Importance of Communication, Types of Communication	LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens
4	15 minutes	Demonstration	Non-verbal Communication	LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens
5	15 minutes	Presentation	Components of Communication Process	LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens
6	05 minutes	Presentation, Brainstorming	Definition of Effective Communication	LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens
7	15 minutes	Presentation, Brainstorming	Effective Communication Skills Useful to Youth	LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens

8	20 minutes	Presentation, Role-play	Active Listening	LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens
9	20 minutes	Presentation, Discussion	Common Barriers to Effective Communication	LCD/Overhead Projector, Laptop, Flip Charts, Marker Pens

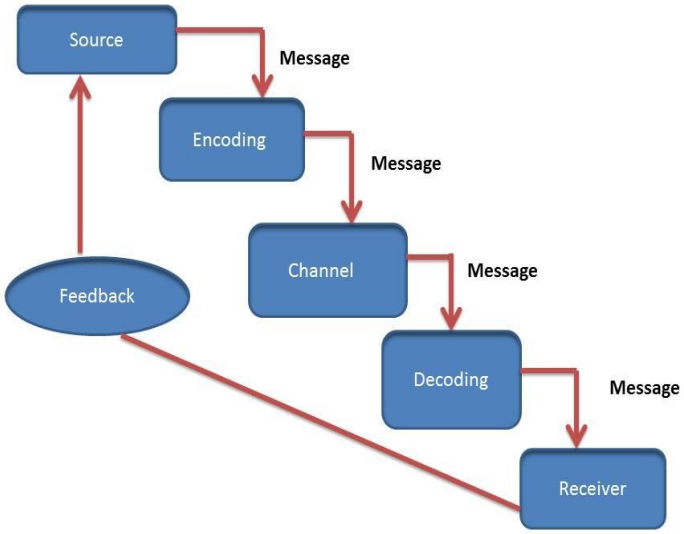
	SLIDE CONTENT	**TRAINER'S NOTES**
Slide 1	**SESSION 3: COMMUNICATION SKILLS**	**INTRODUCE** session 3 to participants. **TELL** participants that this session is scheduled to take 2 Hours (120 minutes). **ENCOURAGE** active participation, tell them to be free to ask question at any time during the session. **LET** participants answer each other's questions whenever they know the answers.
Slide 2	**Introduction** Communication is a dynamic process through which we convey a thought or feeling to someone else. How it is received depends on a set of events, stimuli, that person is exposed to. How you say, what you say, play an important role in communication The process of communication is actually what allows us interact with other people; without it, we would be unable to share knowledge or experiences with anything outside of ourselves. Common forms of communication include speaking, writing, gestures, touch and broadcasting	

Slide 3	**Learning Objectives (1)** By the end of this session participants will be able to, • Define the term communication • Describe types of communication • Explain communication processes • Explain effective communication • Describe characteristics of effective communication • Explain barriers of effective communication and how to overcome them • Demonstrate effective communication skills	**READ** or **ASK** participants to volunteer reading the learning objectives. **ASK** participants if they have any questions on the objectives and clarify accordingly
Slide 4	**Definition of Communication** **Communication** refers to the process of transmitting ideas, knowledge, experience, and feelings from one person to another though speech, signals, writing or behavior	
Slide 5	**Importance of Communication** Communication is necessary for; • Sharing knowledge and experiences • Building relationships • Motivating others • Informing and teaching • Persuading and inspiring • Entertaining • Giving or receiving directions and feedback	**EMPHASIZE** to participants that communication helps to develop a good working relationship between youth and peer educator; • Youth better understand recommendations from peer educator • Youth feel respected and understood • Youth feel motivated to adopt change of behaviour.

Slide 6	**Types of Communication** Communication can either be; - Verbal (through spoken words) -7-11% - Non-verbal - 89-93% Non- verbal communication may be through • Gestures (smiling, leaning forward, nodding) • The way we stand • The way we sit • Facial expressions • Eye contact • Silence	**TELL** participants to buzz in pairs on the importance of communication **INFORM** each pair to write down their responses on a piece of paper or notebook **ALLOW** 2 minutes for the buzz **LET** few pairs share their responses to the class and others to contribute/add on what has been presented **WRITE DOWN** the responses on the flip chart **SUMMARISE** their responses/discussion using the next slide
Slide 7	**Exercise: Guess the Message (1)**	***Advance Preparation*** Prepare 6 sets of note cards with each emotion (Anger, Fear, Sadness, Pain, Impatience and Happiness) written on it. **Instructions** **INFORM** participants that this activity involves interpreting non-verbal communications

Slide 8	**Exercise: Guess the Message (2)**	**TELL** them that one person will be selected as a timekeeper, one person as recorder and 6 people will be actors **EXPLAIN** to them that each of the actors will act out an emotion, and the rest of the group needs to figure out which emotion they are acting out **ALLOW** 10 minutes for the exercise to take place **EMPHASIZE** to participants that this exercise will give participants an introduction to non-verbal communication through the interpretation of emotions. **ASK** six volunteers to be "actors" who will portray one of the emotions given to them on the card. **EXPLAIN** to participants that volunteer actors will come in front of the group to act out an emotion. **DISTRIBUTE** the 6 emotion cards to each of the actors

Slide 9	**Exercise: Guess the Message (3)**	**HAVE** each of the "actors" take an emotion card and tell him/her not to share it with the audience. Clarify to each actor what is the meaning of the word each one has. **EXPLAIN** that the volunteers will act out the given emotion using non-verbal communication and without talking. The audience will guess what emotion the volunteer is acting out. **COMPARE** the audience guesses to the actual emotion after each volunteer acts out his/her emotion. **ASK** the volunteers to be seated after all they have completed their emotion acting. **CONDUCT** a large group debrief and discussion with the following questions:
Slide 10	**Exercise: Guess the Message (4)**	**ASK** the volunteers – (Was it difficult to try to express a feeling without words? Was it difficult to determine how to express the emotion without a verbal explanation to the audience)? **EMPHASIZE** to all participants that; Youth will use both verbal and non-verbal communication to express their feelings and emotions. Sometimes when it is difficult to express them with words, they may use non-verbal communication. This is why it is very important to be aware of and observe non-verbal communication that the youth may be using. As a peer educator, it is also necessary to be aware and conscious of the non-verbal communication you are communicating.

<table>
<tr><td>Slide 11</td><td colspan="2">Components of Communication Process (1)
 
</td></tr>
<tr><td>Slide 12</td><td>Components of Communication Process (1)
The message is the key idea that a sender want to communicate. It must be ensured that the main objective of the message is clear

The sender/encoder is a person who sends the message. A sender may use symbols or words to convey the message and produce the required response.</td><td>EXPLAIN to participants;
The sender can be a peer educator who has to discuss with the youth on ways of HIV prevention

The receiver can be both Peer educators or youth, so communication is a two way process

The channels are the voice of the speaker, or it could be a letter, or a brochure, banner or any other IEC materials.</td></tr>
<tr><td>Slide 14</td><td>Components of Communication Process (2)
The receiver is a person for whom the message intended

The channel is the media or means through which the information is being sent

Feedback is the response from the receiver indicating that the message has been received</td><td>Feedback can differ among youth and can be either negative or positive. Peer educator need patience to handle negative feedback</td></tr>
</table>

Slide 15	**Activity - Brainstorming**	**TELL** participants to brainstorm on the meaning/definition of 'effective communication' **ALLOW** the brainstorm to continue for 2 minutes **ASK** few participants to volunteer and give the responses on the definition of effective communication **RECORD** their responses on a flip chart **SUMMARIZE** the discussion using the next slide
Slide 15	**Effective communication** **Effective communication** refers to the ability of listening and understanding others, to read and interpret body language and to know the best ways to get point across.	
Slide 16	**Activity: Brainstorm** 	**ASK** participants to brainstorm on; "What are effective communication skills that would be useful when discussing with youth on HIV prevention" **ALLOW** few minutes for participants to respond **WRITE** down their answers on flip chart

Slide 17	**Effective Communication Skills Useful to Youth (1)** • Active listening/reflective listening • Demonstrating a caring and respectful attitude • Praising and encouraging • Speaking clearly and simply at a level the • youth can understand • Encouraging youth to ask questions • Attending • Paraphrasing	**EMPHASIZE** to participants that a good peer educator uses effective communication skills as indicated on the slide **ASK** participants to give examples of what each of the verbal communication skills look like, using the background information below to guide the discussion. Examples may include the following statements • "Sounds like you are feeling down today." • "I'm glad you stopped by so we can talk. I care about you and how you feel." • "I know. It is really hard to think about getting tested for HIV. I can understand why you are hesitant."
Slide 18	**Effective Communication Skills Useful to Youth (2)** • Reflection of feeling • Summarizing • Asking checking questions to check for understanding • Self-disclosure • Interpreting • Confrontation	**EMPHASIZE** that effective communication is more than just providing information or giving advice. It involves asking questions, listening carefully, trying to understand youth's concerns or needs, demonstrating a caring attitude, and helping to solve problems. **EXPLAIN** that • Good communication starts when the peer educator sees youth quickly and talks to him or her in a respectful manner. • Effective communication is not only needed for relaying information about HIV and AIDS, it is critical to encourage youth to learn about prevention such as to access and correctly use condoms, abstain from sex etc.

Slide 19	**Characteristics of Active Listening** **S** - Sitting squarely **O** - Open position **L** - Learning forward **E** - Eye contact **R** - Relaxed	
Slide 20	**Activity: Roleplaying**	**REVIEW** the SOLER behaviour to demonstrate active listening **INSTRUCT** participants to work in pairs and sit facing one another. **TELL** each pair to decide who will be a "listener" and who will be the "speaker". **TELL** the one who will role-play as a listener to follow the SOLER behaviour's and encourage the other person to speak. **ALLOW** 10 minutes and let the speaker give the listener feedback about the effectiveness of his/her listening **INSTRUCT** the pair to then change the roles (listener becomes the speaker and vice versa) **ALLOW** another 10 minutes, and let the speaker offer feedback to the listener **DEROLE** the participants to the usual situation

Slide 21	**Activity – Group Work**	**DIVIDE** participants into manageable groups **INSTRUCT** them to list down the possible common barriers to effective communication **LET** each group select a recorder who will write down the group responses on a flip chart and consequently present in plenary **PROVIDE** a flip chart and a marker pen to each group
Slide 22	**Activity – Group Work**	**ALLOW** 15 minutes to complete the activity **LET** the recorder from the first group present the responses in plenary **ALLOW** other presenters come forward and present only barrier that did not appear in the previous presentation (this will shorten time for presentation) **LEAD** a brief discussion on all the barriers mentioned and how they can affect effective communication **SUMMARISE** the discussion using the next slides
Slide 23	**Barriers to Effective Communication (1)**	**EXPLAIN** to participants that; **Noise** can make verbal communication difficult since the message cannot be received with the intended clarity **Inappropriate medium**, for example, if you decide to use radio or TV to communicate and the intended audience do not have Radio or TV then the communication will not be effective **Language differences** if the message is expressed in a language that the intended person do not understand then the communication will never be effective and it will be difficult to understand

Slide 24	**Barriers to Effective Communication (2)**	**Poor listening skills,** in order to effectively communicate the intended person need to also be a good listener. If s/he is a poor listener then it will be difficult to understand hence ineffective communication. **Distractions** if someone is in the communication procedure, distraction of any means will cut-down the flow of information hence there will be lack of concentration and consequently ineffective communication **Personal Factors** include lack of interest, jumping to conclusion without waiting for the whole message, lack of knowledge on what is being communicated, being selective on what is being communicated, and allowing more argument and debating

Appendix 7: Timetable for the Training

Day 1: Saturday January 19, 2013

TIME	TOPIC	RESPONSIBLE
08:00 – 08:30	Arrival and Registration	Reseacher / Program Coordinator
08:30 – 09:30	Opening	Program manager
09:30 – 12:30	HIV prevention	Program manager
12:30 – 12:45	Daily evaluation	Reseacher
12:45 – 01:00	Closure	Reseacher

Day 2: Saturday January 26, 2013

TIME	TOPIC	RESPONSIBLE
08:00 – 08:30	Arrival and Registration	Reseacher / Program Coordinator
08:30 – 09:30	Opening	Program manager
09:30 – 12:30	Behaviour Change Communication	Program manager/Researcher
12:30 – 12:45	Daily evaluation	Reseacher / Program Coordinator
12:45 – 01:00	Closure	Reseacher

Day 3: Saturday February 2, 2013

TIME	TOPIC	RESPONSIBLE
08:00 – 08:30	Arrival and Registration	Reseacher / Program Coordinator
08:30 – 09:30	Opening	Program manager
09:30 – 12:30	Communication skills	Reseacher
12:30 – 12:45	Final Evaluation	Reseacher
12:45 – 01:00	Closure	Reseacher

Appendix 8: Daily Evaluation for the Training

Please check one:

☐ Day 1

☐ Day 2

☐ Day 3

1. What did you enjoy most about today?

2. What did you learn today that you will use in your work?

3. What did you not understand?

4. Other comments/Questions?

Appendix 9: Final Evaluation for the Training

Please complete the following evaluation table by ticking the column of your choice.

Key: 1 = Poor/ Not useful 4 = Very good/ Very useful

2 = Fair/ May be useful 5 = Excellent/ Essential

3 = Good/ Useful

Session	**1**	**2**	**3**	**4**	**5**
1.					
2.					
3.					

Please complete the following:

Which days did you attend this training?

Day 1 ___ Day 2 ___ Day 3 ___

What part of the training was the most useful for your work?

What part of the training was the least useful for your work?

Please list three things from the workshop that you will apply in your work:

How could the workshop be improved?

Any other comments?

Appendix 10: List of Participants for the Training

S/No	NAME	SEX	STREET
1	Joseph Lameck	Male	Mtakuja
2	Agnes Leonald	Female	Mtakuja
3	Godwin Mukono	Male	Miembeni
4	Yassin Ally	Male	Kombo
5	Makrina David	Male	Miembeni
6	Judith Mukono	Female	Mtakuja
7	Alice Daniel	Female	Mtakuja
8	Getrude Lutengano	Female	Miembeni
9	Mary Malick	Male	Miembeni
10	Gladys Mzava	Female	Kombo
11	Leonora Mwasinga	Female	Kombo
12	Edwin Chrispin	Male	Kombo
13	Mvungi Massawe	Male	Mtakuja
14	Martin Kaoneka	Male	Mtakuja
15	Alex Peter	Male	Kombo
16	Devota Massaka	Female	Miembeni
17	John Kingu	Male	Miembeni
18	Hamfrey Daniel	Male	Mtakuja
19	Samwel Frank	Male	Kombo
20	Said Abdallah	Male	Kombo
21	John Paul	Male	Miembeni
22	James Beatus	Male	Mtakuja
23	Henry Moses	Male	Miembeni
24	Ramsey Gabriel	Male	Kombo
25	Seleman Salum	Male	Miembeni

Appendix 11: Project Monitoring Tool

Name of peer educators:	
Supervisee Name	
Date:	

Topic covered	Presentation methods	Successes	Gap	Way forward
Number of youth reached	Male	Female	Total	

Appendix 12: Supportive Supervision and Mentoring Tool

Supervisee Name:
Supervisor Name:

Date :

Select focus area for SSM visit:

□ Condom Demonstration

□ Communication Skills

□ HIV prevention Methods

□ Behaviour Change Communication

Gaps Identified during Monitoring Visits	Current status	Area Mentored	Action Points

General successes of SSM Visits

General challenges

Summary of action

Appendix 13: Detailed Project Budget

BUDGET CATEGORY	UNIT COST	# OF UNITS	FREQUENCY	AMOUNT
PERSONEL				
	0	0	0	0
CONSULTANTS				
	0	0	0	0
TRAVEL AND PERDIEM				
Fuel	1,800	250	1	849,600
Allowance for Ten cell leaders	10,000	26	1	260,000
Allowance for researcher	10,000	1	15	150,000
OTHER DIRECT COST				
Printing community need assessment tools	200	5	1	1,000
Photocopying community need assessment tools	80	80	1	6,400
Printing capacity assessment tools	200	2	1	400
Photocopying capacity assessment tools	80	180	1	14,400
Printing monitoring tools (SSM, monitoring and evaluation)	200	2	1	400
Photocopying tools (SSM, monitoring and evaluation)	80	50	1	4,000
Stationaries (pens, photocopy papers and document wallet) for assessments	50,000	1	1	50,000
Modem Recharge	12,000	1	15	180,000
TRAINING				
Photocopying Training manual	80	38	2	6,080
Photocopying Training Handouts	80	26	1	2,080
Photocopying Training tools	80	27	3	6,480

Photocopying Training Schedule	80	1	1	80
Printing training manual	200	38	1	7,600
Printing training Handouts	200	2	1	400
Printing training tools and schedule	200	3	1	600
Printing training Schedule	200	27	1	5,400
Hiring LCD projector	80,000	1	3	240,000
Penis Model	15,000	4	1	60,000
Venue	50,000	1	3	150,000
Stationaries (Flipcharts, pen, notebook, pencil, marker pen and ream)	150,000	1	1	150,000
TOTAL COST				**1,844,920**