THE OPEN UNIVERSITY OF TANZANIA

&

SOUTHERN NEW HAMPSHIRE UNIVERSITY

MASTER OF SCIENCE IN COMMUNITY ECONOMIC DEVELOPMENT

(2005)

BEHAVIOUR CHANGE COMMUNICATION FOR YOUTH OUT OF SCHOOL

THE CASE STUDY OF CHAWAKUA

KARAMA, ZAYNAB MARO

BEHAVIOUR CHANGE COMMUNICATION FOR YOUTH OUT OF SCHOOL:

THE CASE STUDY OF CHAWAKUA

BY

KARAMA ZAYNAB MARO

A PROJECT PAPER SUBMITTED IN PARTIAL FULFILLMENT FOR THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN COMMUNITY ECONOMIC DEVELOPMENT IN THE SOUTHERN NEW HAMPSHIRE UNIVERSITY AT THE OPEN UNIVERSITY OF TANZANIA

2005

SUPERVISOR'S CERTIFICATION

I, Felician Mutasa certify that, I have read this Project and accept it as scholarly work for review. I therefore recommend it to be awarded the Degree of Master of Science in Community Economic Development (CED).

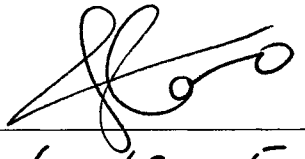
Signature Mutasa

Date 30/09/05

STATEMENT OF COPYRIGHT

DECLARATION BY THE CANDIDATE

I Karama, Zaynab Maro of Riverside Shuttle,Car Hire and stores Ltd. P.O.Box 28 Arusha, do hereby declare that, the work of this project paper presented for fulfillment of the Degree of Masters of Science in Community Economic Development(CED) is based on my own efforts and solely done by myself except where quoted for learning purpose. It has never been presented at any other Institution for similar purpose.

Signature 

Date 30/09/2005

DEDICATION

To the memory of my precious family, my father, the late sir Karama Rashid Maro, my beloved mother Mwanahawa bint Muya and my lovely son, Rashidi.

To my beautiful daughters Fatma Karama Maro and Mwanahawa Rashid.

ABSTRACT

This report is about the evaluation of the Behavior Change Communication for the youth of six selected wards of Arusha Region. Chawakua, is an organization conducting the projects against HIV/AIDs. They answered my request to work for them during my studies and asked me to monitor and evaluate one of their projects; The Behavior Change Communication to youth out of school.

The project is developed to continue support of a series of reproductive health interventions aimed at improving the quality of care in Arusha District initiated by the Ministry of Health under National Aids Policy and with a methodology proposed by the World Health Organization (WHO).

These interventions are to improve the quality of care focused on adaptations in six wards, training providers, and increasing the range of condom use methods offered. Evaluation of the Behavior Change Communication project showed that the interventions improved services but did not increase demand among underserved populations.

It is concluded that the intervention's impact would continue to be low unless the project reaches community members and create more demand for services.

ACKNOWLEDGEMENTS

This research would not have been possible without the efforts of many people and institutions that generously joined the activities and supported the achievement of the objectives established.

I want **Chawakua** to be recognized for providing the institutional background to carry out this work. I would like to express special thanks to the founders of this NGO and the whole **Chawakua** team for the administrative support given.

Additionally, the support of Instructors Mr. Michele Adjibodou and Mr.Felician Mutasa was vital to reaching participants in different areas. Michele created this idea to me and Felician stood by my side by giving educational sessions, technical as well as logistical support. They were the creators and initiators of this project they offered orientation and valuable opinions, and they supported the follow-up of the project activities.

I also want to express our gratitude to all instructors who were responsible for delivering their educational materials to all students. All the instructors sympathized with me in class after my tragedy.

My special gratitude is to my all Mighty God who made it possible for me to finish this course though he decided to test me in the hardest way by taking my beloved mother

and the same week he took again my dearest friend who happened to be my first born and only son.

He later gave me a beautiful granddaughter from the same son during my course period and I became a mother again and her name is Baby Hawa.

I share my sincere appreciation with my daughter Fatma who encouraged me and some of my friends to continue with this course despite from my tragedy , and many thanks to them because I have managed to finish my studies.

Without forgetting the CED crew, my fellow colleagues in the programme, thank you.

TABLE OF CONTENTS:

Supervisor's Certificate i
Statement of Copyright..... ii
Declaration Certificate..... iii
Dedication..... iv
Abstract..... v
Acknowledgement..... vi
Table of Contest..... viii

CHAPTER 1: CBO BACKGROUND

1.1 Background..... 1
1.2 Chawakua's accomplishment..... 1
1.3 mission..... 3
1.4 vision..... 3
1.5 goals..... 3
1.6 Objective 5
1.7 Source of Funding 5
1.8 Clients characteristics..... 5
1.9 Baseline survey..... 6
1.10 Assignment..... 6
1.11 Organization chart..... 7
1.12 Problem statement..... 8
1.13 Objectives/activities to accomplish at the end of project..... 9
1.14 Youth talk 9
1.15 Sports Rallies 9
1.16 Site Visit Meetings in wards 10
1.17 Teen Safaris and Enter-Education..... 10

1.18 Peer educators.....10
1.19 Life planning skills.....10
1.20 Participatory Community Mobilization..... 11
1.21 Peer educators to refresher..... 11
1.22 TOT refresher course to VET-C Teachers..... 11

CHAPTER II: LITERATURE REVIEW

2.0 Theoretic Review 12
2.1 Empirical Review..... 22
2.2 Policy Review.....33
2.3 Overall goal of the HIV/Aids Policy in Tanzania.....34
2.3.2 U.N.Education/Children Rights.....37
2.3.3 UNFPA policies.....39

CHAPTER 111: RESEARCH METHODOLOGY

3.0 Research Design.....45
3.1 Research Approach and Strategy..... 48
3.2 Sampling Technique..... 51
3.3.0 Data Collection..... 52
3.3.1 Primary Data Collection..... 53
3.3.2 Secondary Data Collection.....53
3.3.3 Data Collection for Youth Talk.....54
3.3.4 Data Collection for Sports Rally.....55
3.3.5 Data Collection for Site Visit Meeting..... 57
3.3.6 Data Collection for Enter-Educate/Drama 58

3.3.7 Data Collection for Teen Safari for Peer Educators..... 59
3.3.8 Peer Education Training..... 60
3.3.9 Data Collection for Life Planning Skills..... 61
3.3.10 Data Collection for Community Mobilization..... 63
3.3.11 Data Collection for Peer Educator Refresher..... 64
3.3.12 Data Collection for TOT Refresher to VET-C-..... 65

3.4.0 Data Analysis..... 66
3.4.1 Primarily Data Analysis..... 67
3.4.2 Secondary Data Analysis..... 68
3.4.3 Data Analysis for Youth Talk..... 70
3.4.4 Data Analysis Sports Rally..... 71
3.4.5 Data Analysis Site Visit..... 71
3.4.6 Data Analysis for Teen Safari.....72
3.4.7 Data Analysis for Enter-Educate..... 72
3.4.8 Data Analysis for Peer Educator Training.....73
3.4.9 Data Analysis for Life Planning Skills.....74
3.4.10 Data Analysis for Community Mobilization..... 76
3.4.11 Data Analysis for Peer Educator Refresher.....77
3.4.12 Data Analysis for TOT Refresher Course to VET-C-Teacher.....78

CHAPTER IV: FINDINGS AND CONCLUSION

4.0 Data Findings..... 80

4.1 Data Findings for Youth Talk..... 82

4.2 Data Findings for Sports Rally.....

4.3 Data Findings for Teen Safari..... 84

4.4 Data Findings for Site Visit..... 85

4.5 Data Findings for Enter-Educate..... 86

4.7 Data Findings for Peer Educators..... 88

4.8 Data Findings for Life Planning Skill.....90

4.9 Data Findings for Community Mobilization..... 91

4.10 Data Peer Educator to Refresher..... 92

4.11 Data Findings for TOT Refresher Course to VET-C-Teachers.....93

4.2.0 Recommendation Introduction..... 94

4.2.1 Recommendation for Youth Talk..... 94

4.2.3 Recommendation for Sports Rally..... 95

4.2.4 Recommendation for Site Visit..... 95

4.2.5 Recommendation for Enter-Educate..... 97

4.2.5 Recommendation for Teen Safar for peer educators..... 97

4.2.7 Recommendation for Peer Educators Trainings.....98

4.2.8 Recommendation for Life Planning Skills..... 99

4.2.9 Recommendation for Community Mobilization..... 100

4.2.10 Recommendation for Peer Educators to Refresher..... 100

4.2.11 Recommendation for TOT Refresher to VET-C-Teachers..... 102

4.4. Conclusion..... 103

CHAPTER V: IMPLEMENTATION OF ASSIGNMENT

5.0 Develop Monitoring and evaluation..... 105

5.1 Incorporating input from the field..... 108

5.2 Need of a targeted area..... 108

5.3 Planned budget..... 109

5.4 Indicators..... 109

5.5 Implementation Mechanism for Future work..... 110

5 6 Output and Deliverables of the BCC Components..... 112

5.18 References..... 113

APPENDICES

Appendix A, Table of Meetings..... 124

Appendix B, List of 164 participants who filled questionnaires..... 126

Appendix C, Request letter to **Chawakua**..... 131

Appendix D, Response letter from **Chawakua**..... 132

Appendix E, Copy of **Chawakua** Registration Certificate.....133

Appendix F, Evaluation Results..... 134

Appendix G, Original Questionnaire..... 135

Appendix H, Pictures..... 142

Appendix I, some of the processed data..... 144

LIST OF ABBREVIATION

AIDS.....**Acquired Immune Deficiency Syndrome**

AMREF.....**African Medical Research Foundation**

ARV.....**Antiretroviral**

DAC..... **District AIDS Coordinators**

GDP.....**Gross Domestic Product**

HAART.....**Highly Active Antiretroviral Therapy**

HIV.....**Human Immunodeficiency Virus**

NACP..... **National AIDS Control Programme**

NGO..... **Non-Governmental Organization**

CBO.....**Community Based Organisation**

PLHA.....**People Living with HIV/AIDS**

TACAIDS.....**Tanzania Commission for HIV/AIDS**

CHAWAKUA .....**Women's against spread of HIV/Aids Arusha**

BCC.....**Behavior Change Communication**

HIV .....**Human Immunodeficiency Virus**

OVI.....**Objective verifying Indicators**

HOO.....**Hinchey of Objectives**

MOV.....**Means of Verification**

PE.....**Peer Educators**

FHI.....**Family Health International**

M&E.....**Monitoring and Evaluation**

IPs.....**Implementing Partners**

3.4 Data collection techniques 47
3.4.1 Interview 47
3.4.2 Participant observation 47
3.4.3 Key informant interview 48
3.4.4 Informal discussions 49
3.4.5 PALISEP meeting 49
3.5. Data analysis 49

CHAPTER FOUR

4.0. Findings and Recommendations 53
4.1. Economic activities 53
4.2. Major problems in the area 53
4.3. Equal chances to boys and girls 54
4.4. Problems in pre-school and primary school enrolment 54
4.5. Importance of sending children to pre-school 55
4.6. Awareness of PALISEP CBO 55
4.7. PALISEP achievements 55
4.8. Number of existing primary schools in Loliondo ward 57
4.9. Number of existing pre-school in Loliondo ward 58
4.10.Livestock contribution since year 2000 59
4.11.Conclusion 66
4.12.Recommendations 68

CHAPTER FIVE

5.0. Project Proposal - Implementation of assignment 69
5.1. Introduction 69
5.2. Name of the project 72
5.2.1 Problem Statement 72
5.2.2 Project Rationale and Justification 73

HBC.....**Home Based care**

M&E.....**Monitoring and Evaluation**

UMATI.....**Umoja wa Malezi Tanzania**

VCT.....**Voluntary Counseling and Testing**

VETA.....**Vocational Education Training Authority**

LPS.....**Life Planning Skills**

IEC.....**Information Education Communication**

OVC.....**Orphans Vulnerable Children**

NSSF.....**National Social Security Fund**

STIs.....**Sexual Transmitted Infections**

STD.....**Sexual Transmitted Diseases**

OCAT.....**Organization Capacity Assessment**

ASRH.....**Adolescent Sexual Reproductive Health**

TOT.....**Training of trainers**

CHAPTER 1: BACKGROUND

1. Historical Background of Chawakua:

Chawakua is a Swahili acronym for the Association of Women Fighting against HIV/AIDS in Arusha. The association was established in 1992 and registered with Country Agreement of Government of Tanzania under the Ministry of Home Affairs, on June 24th, 1994, with registration number SO 8153. The organization has 45 members in the three Districts, of Arumeru, Monduli and Arusha Municipality. The organization is steered by board members who are selected during annual general meeting. Up to date the society has implemented different activities in Arusha Region concerning HIV/AIDS and Sexual transmitted diseases, the guiding principles of Chawakua are based on volunteerism and participation.

Chawakua, in its' 12 years life time has worked with at-risk groups in Arusha Region to contribute to the Government of Tanzania's Goal of reducing the prevalence of sexually transmitted infection (STIs) including HIV/AIDS among youth and women. Because of its commitment and experience to HIV/AIDS prevention in Arusha, **Chawakua** was selected as a coordinating local NGO of 27 NGOs of Arusha Region (Arusha Cluster HIV/AIDS Intervention).

1.2 Chawakua's accomplishments:

- Between 1995 and 1998, **Chawakua** worked closely with traditional Birth Attendants, bar workers and youth in Sexual Reproductive Health with the support from USAID through Family Health International (FHI) where after increasing knowledge, enhanced them to use the delivery medical instruments, e.g., glove, spirit and also referred pregnant women who had normal delivery problems to hospitals. Bar workers become peer educators and gave HIV/AIDS education to their customers.

- From 1998 to 2004 the organization has focused in out-of-school youth vulnerable to Peer pressure and social stress. **Chawakua** gained experience building relationships with valuable stakeholders, in implementing youth oriented projects and fostering synergies of scope which strategically positions it as a key player in raising sexual health awareness and reducing HIV/AIDS among out-of-school youth in Arusha Municipal.

- **Chawakua** implemented the project BCC and LHDS funded by Bill and Melinda Gates Foundation through African Youth Alliance, which took place in 2002 to 2004 in six wards of Arusha Municipality:

Although African Youth Alliance (AYA) has not yet conducted an impact evaluation, **Chawakua** has observed significant qualitative positive changes, and has continually monitored and documented the process and quality of its intervention. Youth in the

pilot wards can openly discuss issues on ASRH, and uses of condoms have increased from 500 to 2000 pieces per month. Parents show appreciation in their children behavioral change, e.g. The following activities were done to support to the project:

- Ngarenarok parents are supporting the football team which was initiated by Chawakua,
- Ward leaders from 6 six wards have supported peer educators by providing the space in their offices where they can meet with there peers groups,
- The Municipal Government have been supplying cartons of condoms to distribute to the youth.
- **Chawakua** peer educators have been invited by the Government to participate in workshop out side Arusha Region.
- Enter educate activities has kept youth busy and changed the behaviour of 5 drug addicts, who now are doing small business also we have found shelters for 2 street children.

1.3 Mission:

The mission of **Chawakua** is "to have a community of people who are not infected with HIV/Aids and STIs.

1.4 Vision:

Chawakua is a non-governmental organisation motivated by volunteerism spirits, participatory process and effective partnerships focus Arusha as a region with improved

poverty condition of women and youth infected, affected and vulnerable to HIV/Aids through access to information and high quality health, social and economic services.

1.5 Goals:

Chawakua has three main goals/targets identified as relevant for the organisation to carry out its mission as well as achieving its long-term objectives of improving poverty status of women and youth infected, affected and vulnerable to HIV/Aids in Arusha region. The following goals will be achieved by **Chawakua** over the coming five years:

1) hnReduce spread of HIV/Aids/STIs among women and youth affected and vulnerable to HIV/Aids/STIs in Arusha region in five years.
2) Improved standard of living of women and youth affected and vulnerable to HIV/Aids/STIs in Arusha region in five years.
3) Increased access to health services for women and youth infected, affected and vulnerable to HIV/Aids/STIs.

1.6 Objectives:

1. Increased access to ASRH information among high-risk youth.
2. Increased access to ASRH services in supplying condom to high-risk youth
3. Increased access to VCT services
4. Increased access to income generating activities by the high-risk youth.
5. Increased support to HIV/AIDS infected people and orphans

1.7 Source of funding:

1) Annual fee paid by membership.

2) 10% of any income which any person receives through Chawakua, e.g. workshop allowances and salaries.
3) Grants/donations from members, individual charity ,government institutions and inside and outside donors)
4) Organized fund raisings and pageants.

1.8 Clients Characteristics:

1. Youth aged from 6 to 24 years old.
2. Women and orphans within Arusha Region

1.9 Baseline Survey:

The proposed project areas are Levolosi, Ngaranarok, Sekei, Unga Ltd., Daraja Mbili, and Sombetini, all are located around Arusha municipality. Levolosi is famous for her bars, guest houses and nightlife and provoking prostitution, these results in high transmission of HIV/Aids/STIs. Ngaranarok and Unga Ltd., is known for her high density, it is the most highly populated areas in Arusha region and is also famous for its squatters and it needs dramatic change.

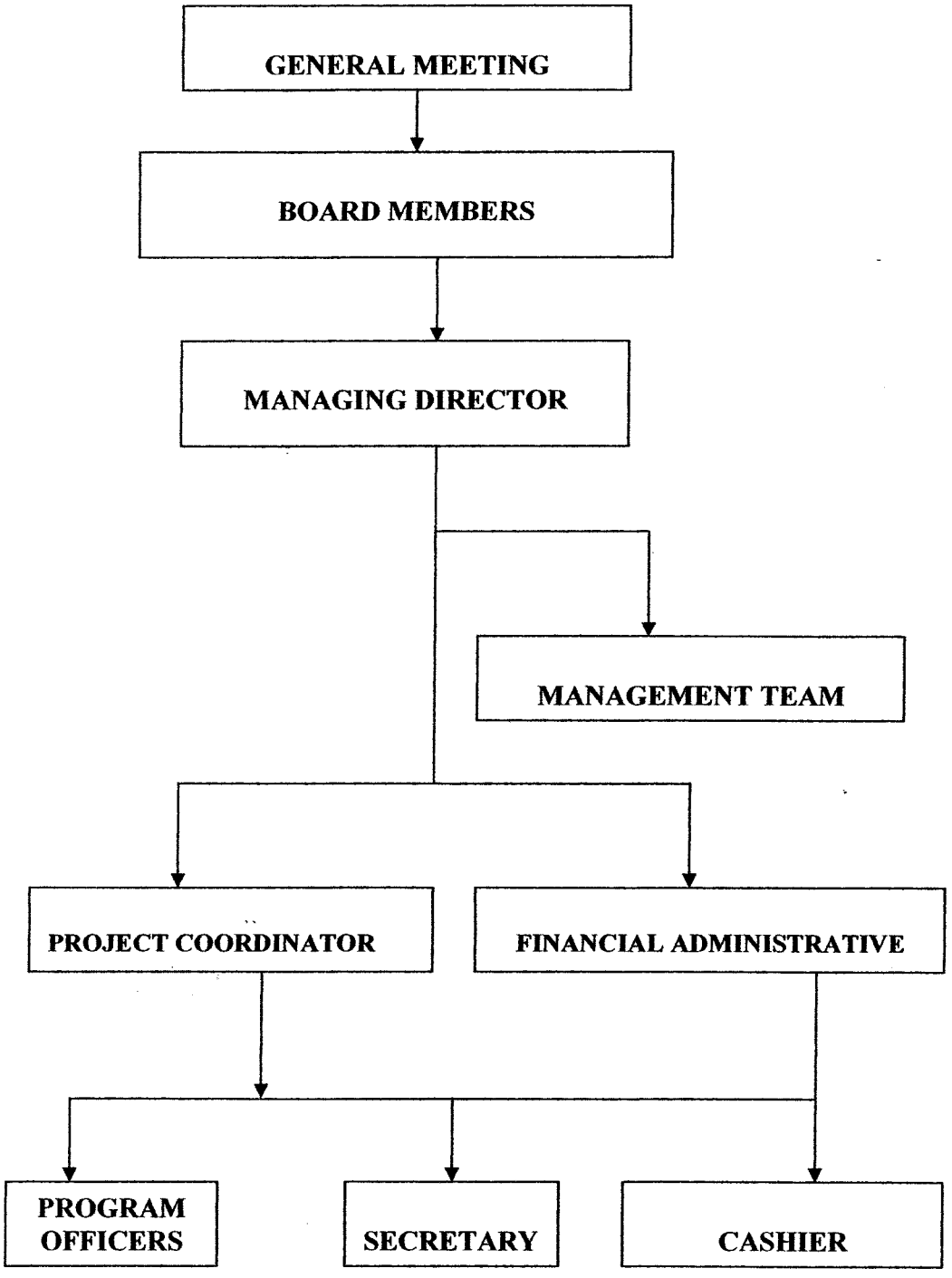
Sekei ward is also heavily populated and has large hotels, such as Novotel Mount Meru and Oasis, these areas are attracting many tourists; this means it is attracting prostitution too. Daraja Mbili and Sombetini are with densely populated with many out of school and unemployed youths.

1.10 Assignment: Develop monitoring and evaluation plan

The following is the plan of my activities to this project:

1. To measure the progress (quantitatively and qualitatively) towards achieving the intervention goals.
2. To collect relevant data and information on the design and implementation process in order to improve or modify implementation process plan.
3. To share experience by assessing strength, weakness, opportunities and threats and make recommendation for future activities.
4. To enable the community, programme staff and others to analyse their situations, abilities and skills.

ORGANIZATION CHART



1.12 Problem statement:

Arusha is a growing municipal town and a centre of five districts with a population of 1,288,088 people. (National census document 2002). Arusha Municipal consists of major

National parks like Ngorongoro, Serengeti, Manyara and Tarangire. There are big tourist companies, big hotels of five star levels, and luxurious lodges.

Additionally Arusha is an International town with United Nations (UN), Tribunal court activities going on and Arusha International Conference Centre (AICC). The town and the business outcomes attract young girls to flow to town and due to the economic situation, life becomes difficult and they fall into the trap of prostitution as a means of survival.

Arusha Municipal also serves two (2) Regions (Arusha and Manyara) this is because of the mining activities which are taking place in the Manyara Region, where by Arusha Municipal is a market centre; it consequently brings people from all over African Region.

The majority of the residents in the targeted area and neighborhoods are jobless. In general, they are people with low incomes, low education, and poor nutritional status. Some tradesmen with high incomes are also found in the areas, but they are not typical. The basic infrastructure and services are poor and sometimes parents are using their young girls in commercial sex work so that they can make earnings.

Each tribes e.g., Maasai, Meru, Iraques of Arusha Region has their own norms, traditions, and cultural beliefs. There is belief that causes young girls to practice sex at young age from 8 years to 15 years old. Other tribes' young men of peer age can share women; however other believes that a sister can serve his brother in-law sexually if her sister has travelled. These beliefs lead to poor parent child communication in most of the families. These behaviours contribute to STIs HIV/AIDS infection, unwanted pregnancies, and sterility it also increases number of orphans and street children.

Chawakua has observed that the most pressing problem to the youth is unemployment of youths between 20 to 24 years old which forces them, especially girls to involve themselves in commercial sex and young men to work in mining areas where most get HIV/AIDS infection, and some become drug addicts, pick pockets and street children. This means Arusha youth and women desperately need accurate health information, quality health services and viable economic alternative.

1.13 Objectives/activities to be accomplished at the end of this project are:

1.13.1 Youth talk:

Peer education builds on the reality that people tend to congregate and talk with other people similar to themselves. Peer education programs are those, which train and deploy as educators people similar in age, place of residence, occupation or interest area to those who are targeted to receive the designated education: One way of reaching youth by peer educators, graduate educators and drama group is through youth talk activities

1.13.2 Sports rallies:

Chawakua is experienced in organising sports tournaments to youth and at the same time it is delivering information of ASRH/LHDS and LPS. In this activity youth will gain in three aspects, empowering them in their talents, building their bodies physically and thirdly to spend their idol time in sports.

1.13.3 Site visits meetings in wards:

The purpose of these meetings will be to discuss the problems encountered by youths in the wards and search for possible solution. Some people like small gathering compared to discuss their issues as opposed to large gathering bearing in mind African taboos and myths.

1.13.4 Teen safaris and enter – Educate Drama Performances:

Chawakua has an ongoing program where the out-of-school youth are involved in international, national and regional events to entertain audiences through poems, drama, songs, music and dancing passing on messages on HIV/AIDS/STIs.

1.13.5 Peer Educators:

Chawakua will conduct a three days Peer training to 40 LPS trained youth, they will be selected by LPS,TOT and youth, to be recruited as youth advocacy and share the knowledge with peers and families.

1.13.6 Life planning Skills Training:

Life planning skills (LPS) is a youth development program that combines sexuality education with effective skill building while preparing young people for the future. The program is age-appropriate, focuses on specific pregnancy and HIV/AIDS prevention goals, and utilizes participatory training methodologies, which allow young people to learn by practising and not theoretical.

1.13.7 Participatory Community Mobilization and Advocacy:

Participatory community mobilization is a dynamic approach designed to facilitate social change regarding a public health issue by involving various stakeholders in the identification of root causes of their problems and to plan, implement, and evaluate appropriate and culturally sensitive solutions. Projects facilitated by community devised solutions are often more successful than solutions identified and implemented by the outside.

1.13.8 Peer educator to refresher:

The project will include parents as Secondary beneficiaries in this program to break the ice/dilemma of parents in communicating with their youth on sexual issues. Parents being the first teachers in most of the families, they need to be sensitized on how to identify sexual values and share with their children and support them to make right decisions about adolescent sexual behaviours.

1.13.9 TOT Refresher course to VET-C Teachers

Chawakua project assistants and I will continue to link with TOT teachers of VET-C for monitoring the activities of integrating ASRH/LHDS into VET-V curriculums In order to share experience with TOT VET-C teachers. Chawakua will conduct 6 quarterly meetings and see how the activities are been done and to get the data' for the students reached.

CHAPTER II: LITERATURE REVIEW

The main objective of this literature review exercise is to look to what has been done in the past, what similar devices exist that we can share ideas from and to scan existing literature documenting key aspects of Behaviour Change Communication as detailed below. This review draws extensively on a companion bibliographic review and policies which has drawn together a variety of literature search techniques including searches of journal databases and various internet search systems that collated from journal articles.

2.0 Theoretical review

Behavior Change Communication is the process of using communication approaches and tools to foster positive change in behavior, as well as in knowledge and attitudes around HIV/Aids, STI s sexuality. Behavior Change approaches recognize that presenting facts alone does not ensure behavior change, and are designed to accommodate the stage of behavior adoption of an individual or group and to cultivate skills integrally needed to enable and sustain change.

The Problem:

"In many societies, adolescents face pressures to engage in sexual activity. Young women, particularly low-income adolescents, are especially vulnerable. Sexually active adolescents of both sexes are increasingly at high risk of contracting and transmitting STIs, including HIV/AIDS, and they are typically poorly informed about how to protect themselves". 1994 International conference on population and development programme

of action, paragraph 7.403. "Effective information, education and communication (IEC) are prerequisites for sustainable human development and pave the way for attitudinal and behavioral change. This begins with the recognition that decisions must be made freely, responsibly and in an informed manner, on the number and spacing of children and in all other aspects of daily life, including sexual and reproductive behavior." ICPD Programme of Action, Paragraph 11.12.

Facts on Young people:

Nearly half of the world's populations are under 25. Young people between the ages of 10-24 which is = 30% of world population 60% of all young people live in Asia, 15% in Africa, 10% in Latin America and the Caribbean, 15% in developed region. By 2020, 87% of young people are expected in developing countries, majority will be sexually active. 1994 ICPD programme of action paragraph 8.10

Young People and Poverty:

Number of youth with the age of 15-24 in the world surviving on less than a dollar a day in 2000 was estimated to be 238 million; on less than $2 a day = 463 million. Countries with the largest headcount of youth in extreme poverty (77% of 238 million) are India, China, Nigeria, Pakistan, Bangladesh, DPR Congo, Vietnam, Brazil, Ethiopia, Indonesia and Mexico. An estimated 130 million children between the ages of 6-11 entering adolescence don't go to school of which nearly 60% are female. In the Eastern

Asia/Oceania region, 58 million adolescents are out of secondary school of which 30 million are girls" 1994 ICPD programme of action paragraph 8.15.

Young People and Education World:

Bank global survey found that 48% women in Asia have had sexual intercourse by the time they turn 20, whether within or outside of marriage. Consequences: - unwanted/teen pregnancy, early child bearing, abortions, STIs and HIV infections.

Young People and Sexual Behavior:

Sexual violence against girls and young women in the form of rape – including "date" or "acquaintance" rape, sexual assault, incest, commercial sexual exploitation and sexual slavery. An estimated 200,000 – 250,000 women and children from South East Asia are trafficked every year. 1994 ICPD programme of action paragraph 9.16

Behavior change communication:

Interventions aim to provide people with information and skills that help them maintain or adapt behaviors and practices that can improve their quality of life, recognizes that presenting facts alone does not ensure **behavior change**. Knowledge reduces risks; delays sexual activity, research has consistently shown that accurate knowledge about sexuality and reproductive health do not promote early sexual activity, but help young people make informed decisions about their own life.

HIV/AIDS was being transmitted to about 6 million people annually in Africa by the end of the 1990s. The death rate is doubling every 4 years. About 3.5% of the economically active population has already died. It seems increasingly likely that less affected countries are merely at an earlier phase of the epidemic. The Behavior Change Plan identify four age groups for youth, 6-10, 11-15, 16-20 and 21-24 year olds and indicates-that different approaches need to be developed for each age group. It also recognizes that as less than half the child/youth population is in school, out-of-school youths will be addressed with appropriate approaches.

HIV infection increases rapidly between the ages of 11 and 19, especially among girls of 15 to 19 years, who are five times as likely to become infected as boys. Girls in the 20-24 age groups are twice as likely to be infected as boys. Peak infection occurs between 15 and 24 years, which implies that 15-year-old girls with AIDS are infected before or during puberty. There are 10% more women among the newly infected with HIV than men, largely as a result of women's vulnerability and inequality before the law.

The need to target youths, who are among the most vulnerable groups to HIV/AIDS, is urgent. Prevention of sexual transmission is the main strategy in behavior change communication."1994 ICPD programme of action paragraph 15.6

Unexplained lack of behavior change in the face of devastating effects of HIV/AIDS:

The HIV/AIDS pandemic is devastating the young people. This is in addition to the high

rates of other STIs, early pregnancies, induced abortion, school dropout and early marriages. Globally, more than half of the new HIV cases occur among young people 15-

24 years. The incidence rates are estimated to be 4-6% among young women and 2-3% among young men. In Sub-Saharan Africa, the rates are comparatively higher, estimated at 6-11% among females and 3-6% among males (UNAIDS 2002).

In Tanzania, the initial peak for HIV infection is among 15-19 years old in females and 20-24 years in males (UN HIV/AIDs report of 1999). In Uganda HIV prevalence was until 2000 highest among young people 15-24, with females 3-6 times more infected than the males (STD/ACP 1997, 2000). Data from AIDS Information Center (AIC) in Uganda indicate that among youth 15-24 year, the prevalence rates have declined from 11% among males and 29% in females in 1992 to 2.5% and 12.1% respectively in 1999.

This notwithstanding, the rates are still unacceptably high. In addition these data may not adequately reflect the overall national HIV Prevalence status. Besides, the high impact interventions and other factors linked to these the declining trends, in the surveillance sites are yet to be systematically evaluated and documented. There is evidence that the youth engage in sex at very early ages with a large number having multiple or concurrent sex partners some studies have reported first intercourse as early

as 13 years (UDHS 2000/1, Mulindi et al, 1998). These reports indicate a significant period of sexual activity before marriage that exposes young people to the risk of HIV infection and other STDs.

With no vaccine or cure, education, has and continues to be the main intervention in prevention of HIV/AIDS. Education campaigns have provided information on HIV transmission and prevention, mainly emphasizing condom use, reduction in sexual partners, abstinence and delaying the age of sexual debut. They have been supported in terms of research, by surveys reports, which have been used to evaluate the impact of the AIDS education and information on behavior change.

While a major finding from these surveys is that there is considerable knowledge about the risks of certain behaviors, evidence seem to suggest that there has been little behavior change (Carael etal 1997, UNAIDS 2000). Apart from the problems entailed in the "risk group" strategy, this survey report have limitations in their assumptions, conceptualization and design it also assumes that individuals execute their preferences or choices regardless of societal pressures around them (Poppen and Reisen 1997). In the design and implementation, it furthermore assume that respondents understand or have thought about the issues they are questioned about, while there is a tendency to link attitudes expressed in verbal responses to the behavior of a respondent.

A fundamental problem could be that assumptions used for interventions and evaluation

may be wrong. It is for example, assumed that knowledge is linearly associated with change of attitude and behavior . The assumption that increased knowledge helps people take rational actions in health is based on the analytical model of the concept of self-agency, a phenomenon closely tied to the development of biomedical knowledge.

In the way it has been promoted in HIV/AIDS education and evaluations, there has been a tendency to ignore that the individual exists within complex social contexts. Yet, over the years there has been conflicting messages, controversies among different stake holder's even dissenting voices, making the context for intervention to promote sexual behavior change and prevent HIV/AIDS among young people even more complicated.

The wide spread knowledge of the magnitude, causes and effects of HIV/AIDS demonstrated to exist in the community by **Chawakua** studies is expected to bring a realization that there is a health crisis. Behavior change should be a quick and obvious result that would lead to a resolution of the health crisis. Just now, "to the outsider these communities are living through health crises. There is a high level of observable human suffering. But to the community the situation is very difficult but normal crises by their very nature are short term phenomena and are to be resolved quickly to allow normalcy to resume.

The community needs resources and know-how to resolve the crises. The community has neither the resources nor the know-how. Hence, the community cannot deal with the

situation as crisis. Innovations of interventions to resolve the crisis will require adopting the community pace of resolving difficult situations and then provide support to quicken it. 1994 ICPD programme and Millenium development goals programme of action programme 10.9.

For Out of School Youth:

The ministries responsible for youth development affairs, in collaboration with Local Government Councils, NGOs and Faith Groups shall develop participatory HIV/AIDS, sexual and reproductive health education programmes for the out of school youth. The youth should be given correct information including the prevention strategies including promotion of correct and consistent use of condoms, abstinence and fidelity, and voluntary counseling and testing. Girls should also be encouraged to avoid unwanted pregnancies. Having been empowered with information, the youth should be encouraged and supported in developing their own strategies.(Carael etal 1997,UNAIDS 2000).

For Adults:

The Government, Local Government Councils, NGOs, CBOs and Faith Groups shall develop IEC programmes to promote safer sex practices including fidelity, abstinence, correct and consistent use of condoms according to well informed individual decision.

For Drug substance abusers:

Government agencies dealing with drug substance abuse in collaboration with Tanzania Commission for HIV/AIDS (TACAIDS),NGOs and faith groups shall strengthen their preventive activities and implement targeted IEC and counseling services for drug substance abusers.(Carael etal 1997,UNAIDS 2000).

For PLHAs (People living with HIV/Aids):

PLHAs shall be encouraged to adopt healthy behavior which enables them to live positively with HIV/AIDS. Facilities and services shall be made available to make it easy for them to make such health behavior changes.(Carael etal 1997,UNAIDS 2000).

For Media Institutions:

Sustained public information and creation of awareness is paramount in the control of the epidemic. Therefore the role of the media is very important. The media including folk media, in collaboration with other relevant organizations shall play a leading role in educating the public on HIV/AIDS.

The media should be actively involved in investigating the practical challenges in the control of HIV and the responses by different sectors in the society, including the private sector. Scientific publications regarding trends in epidemiological surveillance and research intervention activities to promote safe practices shall be disseminated in professional journals and through the mass media. 1994 ICPD programme and Millennium goals programme of action 10.9.

For Community Involvement:

The community is the key in curbing the HIV/AIDS epidemic. The community should be fully informed about HIV/AIDS and the real life challenges in its prevention and care. The communities shall be encouraged and supported to develop appropriate approaches to reduce HIV infection and care for the PLHAs and orphans in their localities.

TACAIDS will encourage all sectors, local government councils, faith groups, NGOs and CBOs to mobilize communities to plan and implement their community based HIV/AIDS control activities.

For Condoms:

There is overwhelming evidence about the efficacy and effectiveness of condoms when used correctly and consistently in the prevention of HIV transmission. Good quality condoms shall be procured and made easily available and affordable. The private sector shall be encouraged to procure and market good quality condoms so that they easily accessible in urban and rural areas.

Prevention and Management of Sexual Transmitted diseases:

STIs shall be targeted for early diagnosis, treatment, prevention and control because of their role in facilitating HIV/AIDS transmission. This shall include partner notification, counseling, and validating syndromes management of STIs on regular basis.

a) Public information and awareness on STIs shall be enhanced so

that people take measures to avoid STI and seek early treatment.

b) Health care providers of all cadres shall be trained in order to acquire the necessary knowledge and skills for prevention, early diagnosis and case management of STIs.

c) Counseling and partner notification shall be part of care in accordance with the guidelines for the management of STIs.

The community is the key in curbing the HIV/AIDS epidemic. The community should be fully informed about HIV/AIDS and the real life challenges in its prevention and care. The communities shall be encouraged and supported to develop appropriate approaches to reduce HIV infection and care for the PLHAs and orphans in their localities. TACAIDS will encourage all sectors, local government councils, faith groups, NGOs and CBOs to mobilize communities to plan and implement their community based HIV/AIDS control activities.

Gender Issues in Relation to HIV/AIDS:

In Tanzania, the main mode of HIV transmission is through heterosexual intercourse. Therefore, addressing issues of gender equity and promoting equal participation of men and women in negotiating safer sexual practices is highly desirable, and women have the right and should be encouraged to say NO to unsafe sex.

Men and women should be accorded equal status, equal opportunities for education, access to reproductive health education, and access to health care services, leadership and advancement in all spheres. Although policy exists in this regard, HIV/AIDS demands more vigorous translation of the policy to practical activities at all levels.

(a) Power relations in traditional and customary practices that inhibit equal participation of men and women in preventing the spread of HIV/AIDS shall be addressed by all sectors.

(b) Customary practices and cultural institutions that provide opportunities for public awareness shall be utilized as for empowerment and dissemination of IEC on reproductive health, HIV/AIDS.

(c) Community programmes shall address the issues of multiple sex partnership and the issues of gender and reproductive rights in relation to the spread and transmission of HIV/AIDS

(d) Integrated, quality and user-friendly reproductive health services shall be made accessible to men, women and the youth.

e) Existing inheritance laws shall be reviewed and harmonized. Efforts shall be made to influence customary laws and practices to become gender sensitive.

2.1 Empirical Review:

Youth behavior change programme in Tanzania is not a new phenomenon in our country;

There are a number of NGOs delivering these services. An on going ISHI programme is well known to almost all Tanzanians, its theme is to encourage our youth to change behavior especially in using condoms during sexual intercourse, a culture which is new to Tanzanians. The following are some of institutions working on the same project behavior change communication; this is to emphasis the empirical review:

2.1.2 The ISHI programme in Dar es Salaam, Tanzania use a slogan "usione soo sema nae" which means do not feel shy talk to your partner, to use condom. The main emphasis is prevention of HIV-infection through behavior change, promotion of STD-care and condom use for targeted groups of people with focused educational messages. The promotion of behavior change will focus not only on the individual behavior, but will equally focus on the collective behaviors, and the norms and the values of the community. In order to achieve this, it is necessary to give first priority to children and youth and to start addressing norms and values right from school entry, gradually making it more specific as the child grows. This program at the moment is burned by Tanzania Parliament they felt it doesn't portray the actual meaning.

2.1.3. "Moving with purpose" One of the best ways to really understand issues is to discuss them with people your own age. It is a film where teenagers work with each

other to understand their sexuality and to learn about HIV/AIDS and other issues of reproductive health. Using drama and video to focus on the problems facing them, AYA provides young people with skills and access to services that will help them lead healthier lives. This is just one aspect of a wide ranging project, in which young people of all ages will discuss, debate and advocate so that they get a clearer understanding of sexual health issues and the spread of HIV/AIDS thus leading to change of behavior.(This slogan has been burned by the parliament at this moment)

2.1.4 "U.S.A. SILVER RING THING" – As televised by "Star TV in its HIV/AIDs programmes, in this project, youth promise not to engage in sexual acts until their marriage time, they wear silver ring to show their commitment. It is a programme of behaviour change for youth, as stated recently in the American Broadcast; it mobilises youth to change their normal behaviour which promotes the spread of HIV/AIDS by engaging in early sexual intercourse before getting married. Statistically 20% of the youth in U.S.A. are involved in Sexual intercourse before their 15^{th} birthday. *"Silver ring thing"* expressed difference of behaviour change it encourages youth to come out and announce their faith of not engage in sexual act before marriage, though they confess to be not easy to be recognised not to have done sexual intercourse to that age, they are being laughed by their fellow age mate.

2.1.5 "UNFPA (United Nations Population Funds) is working in some areas of the world dealing with behavior change communication for a number of years now.

UNFPA, is the world's largest international source of funding for population and reproductive health programmes. Since they began their operations in 1969, the Fund has provided nearly $6 billion in assistance to developing countries.

UNFPA works with governments and non-governmental organizations in over 140 countries, at their request, and with the support of the international community. They support programmes that help women, men and young people:

- Plan their families and avoid unwanted pregnancies
- Undergo pregnancy and childbirth safely
- Avoid sexually transmitted infections(STIs) - including HIV/AIDS
- Combat violence against women.

Together, these elements promote reproductive health-a state of complete physical, mental and social well being in all matters related to the reproductive system. Reproductive health is recognized as a human right, part of the right to health. UFPA also helps governments in the world's poorest countries, and in other countries in need, to formulate population policies and strategies in support of sustainable development. All UNFPA-funded programmes promote women's equality.

UNFPA's Strategic Approach:

It matches with BCC programme we are researching with **Chawakua** and other NGO"s in Tanzania there strategies are as follows:

UNFPA's strategy for promoting adolescent sexual and reproductive health through the effective use of information, education and communication (IEC), behavior change communication (BCC) and advocacy initiatives, consists of the following main elements:

- Promotion of the rights of adolescents to reproductive health education, information and appropriate care.

- Designing and implementing programmes to meet the special needs of youth. Such programmes include support mechanisms for the education and counseling of adolescents and young people in areas of gender relations and equality, responsible sexual behavior, family life, reproductive health, prevention of STIs and HIV/AIDS and violence against adolescents.

- Sensitizing communities about the information needs of adolescents, including initiatives aimed at parents, religious and political institutions, community leaders, schools, mass media and peer groups
- Building a supportive environment for community-based IEC and advocacy programmes

- Establishing youth-to-youth peer education programmes and building networks

- Strengthening the interpersonal communication skills of youth service providers, including peer educators

- Utilizing multi-media, including the Internet, to inform and build support for adolescent sexual and reproductive health programmes

- Designing peer education training programmes suitable across regions

Promoting the health and rights of young people is a continuing struggle. Many governments still lack youth policies or services tailored to the specific needs of adolescents. The world's population contains 1.2 billion adolescents between the ages of 10 and 19, the largest youth cohort in history. Nearly 90 per cent of them live in developing countries.

UNFPA reports that over the past decade there have been major changes in how and what kind of information is made available to adolescents and young people. Increasing numbers of countries now recognize that the provision of information through the mass media is a cost-effective and popular means of getting health messages to young people.

Out of 151 countries responding to UNFPA's Global Survey of progress made over the past decade in implementing the goals of the ICPD, 133 (88 per cent) now provide adolescents with access to information on reproductive health issues.

Specifically, information efforts encompassed the following measures:

- 72 countries initiated national IEC/advocacy campaigns aimed at youth
- 46 countries launched national education strategies
- 38 countries initiated peer education programmes
- 37 countries utilized the media, including national TV and radio
- 32 countries provided special counseling services to youth
- 27 countries established youth associations
- 26 countries promoted youth-focused NGOs

Impressive gains have been made by governments, NGOs and community groups in influencing behavior change among youth. A total of 139 countries (92 per cent) reported having adopted one or more measures to promote responsible, safe reproductive health behavior among vulnerable groups, especially youth. Of these, 94 countries launched national IEC/BCC campaigns.

Though constraints remain, especially opposition from conservative religious and political groups, the majority of countries have advanced the reproductive and sexual health agenda for young people by utilizing information technology, the media and non-formal communication channels, such as traditional and modern dance, drama and music.

2.1.6. Meeting Development Goals:

UNFPA's work is guided by the Programme of Action adopted by 179 governments at the International Conference on Population and Development in 1994. The conference

agreed that meeting people's needs for education and health, including reproductive health, is a prerequisite of sustainable development.

The main goals of the Programme of Action are:

- Universal access to reproductive health services by 2015
- Universal primary education and closing the gender gap in education by 2015
- Reducing maternal mortality by 75 per cent by 2015
- Reducing infant mortality
- Increasing life expectancy

These goals were refined and amplified in 1999. One of the most important additions concerned HIV/AIDS:

- HIV infection rates in persons 15-24 years of age should be reduced by 25 per cent in the most-affected countries by 2005 and by 25 per cent globally by 2010.

Reaching the goals of the Programme of Action will be critical for reaching the Millennium Development Goals-global targets set by world leaders in 2000 to halve extreme poverty by 2015.

2.1.7. Improving Reproductive Health:

Reproductive health is a means to sustainable development as well as a human right. Some 350 million couples lack adequate means to plan their families or space their children. Each year, half a million women in developing countries die during pregnancy

or in childbirth. Investments in reproductive health save and improve lives, slow the spread of HIV/AIDS and encourage gender equality. These in turn help to stabilize population growth and reduce poverty. Investments in reproductive health extend from the individual to the family and from the family to the world.

UNFPA promotes a holistic approach to reproductive health care that includes: access to a range of safe and affordable contraceptive methods and to sensitive counseling; prenatal care, attended deliveries, emergency obstetric care and post-natal care; and prevention of sexually transmitted diseases including HIV/AIDS.

2.1.8. Supporting Adolescents and Youth:

Today the world has the largest youth generation ever the first generation of young people to grow up with HIV/AIDS. There are more than a billion people between 15 and 24.

UNFPA works to ensure that adolescents and young people have accurate information as well as non-judgmental counseling, and comprehensive and affordable services to prevent unwanted pregnancy and sexually-transmitted infections including the HIV infection that leads to AIDS.

2.1.9. Preventing HIV/aids:

Each day 14,000 people-half of them aged 15 to 24-are newly infected, and add to the epidemic's staggering impact on health and on the social and economic stability of

nations. In some parts of sub-Saharan Africa, young women are now up to six times more likely than young men to be infected with HIV.

Prevention, the centerpiece of UNFPA's fight against the disease, is being integrated into reproductive health programming around the world. Prevention includes promoting safer sexual behavior among young people, making sure condoms are readily available and widely and correctly used, empowering women to protect themselves and their children, and encouraging men to make a difference.

2.2.20. Promoting Gender Equality

Women can and must play a powerful role in sustainable development and poverty eradication. When women are educated and healthy, their families, communities and nations benefit. Yet gender-based discrimination and violence pervade almost every aspect of life, undermining women's opportunities and denying them the ability to fully exercise their basic human rights.

For more than 30 years, UNFPA has been in the forefront of bringing gender issues to wider attention, promoting legal and policy reforms and gender-sensitive data collection, and supporting projects that empower women economically. The Fund aims to improve the status of women at every stage of their lives.

2.2.21. Securing Reproductive Health Supplies

Without the essential commodities-from contraceptives to testing kits to equipment for emergency obstetric care-the right to reproductive health cannot be fully exercised. In

many places, condoms are urgently needed to prevent the further spread of the deadly HIV virus.

The mandate of UNFPA in this area is to provide the right quantities of the right products in the right condition in the right place at the right time for the right price. This complex logistical process involves many actors, including the public and private sectors. UNFPA takes a lead role in reproductive health commodity security, coordinating the process, forecasting needs, mobilizing support and building logistical capacity at the country level."

This is the major empirical review compared to our local NGO, but it shows how the world cares and used the same measures to eliminate the pandemic.

2.2.22 Journey of life brief description: "Journey of Life" is an entertainment education radio soap opera sponsored by USAID and the National Office of Population. The purpose of the show was to teach the facts about family planning and HIV/AIDS, as well as to provide a clear, simple plan regarding how to go about adopting healthy beliefs and behaviors and communicating these healthy ideas to family and friends.

WHAT WAS DONE: In order to track the effects of "Journey of Life during its 26 week episode run, face-to-face interviews were conducted every other week with one unmarried male under age 18, one unmarried female age 18, one unmarried male over age 19, one unmarried female over age 19, and one married couple under age 30. These

persons were representative of our target population. Each participant was interviewed on their thoughts, perceptions, and behaviors regarding Journey of Life episodes, and the impact of the episodes on their lives. In addition, each case study participant kept daily diaries on their thoughts and feelings regarding Journey of Life, and the issues it raised (e.g., family planning, HIV/AIDS). In addition to these face-to-face interviews, at least three significant others of each participant were interviewed, in order to get a well-rounded view of each case study participant.

QUESTIONS ASKED: How did listeners respond to the soap opera? Has it made an impact on their lives? What can be improved? What specific feedback did they have about the show?

Show Feedback: "Journey of Life," Season One was a huge success; with producer objectives met or exceeded. According to listener feedback the radio show was entertaining, popular, valuable, easy to relate to, and effective as motivating significant change in listener's lives. Following are examples of typical statements made about "Journey of Life" by people who managed to watch the play.

Gained new knowledge:

Listeners learned a lot about HIV/AIDS prevention, family planning, treatment of AIDS patients, various ways to get AIDS, and need to change from traditional ways. The following are people's comments:

- My scope of knowledge of preventive methods of sexually transmitted diseases is much wider now.
- I have learnt much about FP. Previously, I was curved in traditional beliefs that children meant wealth. Now I am better off. I feel I have to apply FP when I get married.
- I know now that AIDS is transmitted through sexual intercourse, I know its effects on the economy and of its distribution pattern between urban and rural parts of the country. It also empowered me to look at it deeply and helped me to evaluate myself on the role I personally play to prevent and control the spread of HIV/AIDS.

Changed behaviors:

The two most common behavior changes were stigma reduction toward HIV+ persons and increased community involvement to help protect community members from negative health threats. These are some their observations:

- "If I were invited to participate in such community symposium before the beginning of the program, I believe I would say that it was none of my business. Now I feel that I must be concerned about such social problems.

- The main behavior change I see is in the way we look at AIDS patients. Before being informed about the disease, we used to avoid those we know to have AIDS. But now, we are caring for AIDS patients and treating them as we would any other person".

2.2 Policy Review:

The Tanzania national policy on HIV/AIDS provides for a framework for leadership and coordination of the National Multi-sectoral response to the HIV/AIDS epidemic. The UN Convention on the Rights of the Child must be upheld ensuring that all children have access to education, treatment, counseling, property and shelter, recreation and social support and be protected against discrimination, child abuse, incest and rape.

The rights of children in Tanzania are defined in the UN Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child, both of which Tanzania is a signatory, and more specifically in the Children's Protection and Adoption Act *[Chap. 5:06],* the Education Act *[Chap. 25:04]* the Guardianship of Minors Act *[Chap. 5:08],* among other statutes. In Tanzania persons under the age of 18 are minors according to the Legal Age of Majority Act *[Chapter 8:07].* World Health Organization (WHO) defines those between the ages of 15 and 24 years as young people. The provisions of these national and international instruments apply to all children including those living with and affected by HIV/AIDS.

Clause 2.2.1 Overall goal of the HIV/aids policy from Tanzania's National Policies:

Clause: 3.1. Introduction

The overall goal of the National Policy on HIV/AIDS is to provide a framework for leadership and coordination of the National multi-sectoral response to the HIV/AIDS epidemic. This includes formulation, by all sectors, of appropriate interventions which will be effective in preventing transmission of HIV/AIDS and other sexually transmitted infections, protecting and supporting vulnerable groups, mitigating the social and economic impact of HIV/AIDS. It also provides for the framework for strengthening the capacity of institutions, communities and individuals in all sectors to arrest the spread of the epidemic. Being a social, cultural and economic problem, prevention and control of HIV/AIDS epidemic will very much depend on effective community based prevention, care and support interventions. The local government councils will be the focal points for involving and coordinating public and private sectors, NGOs and faith groups in planning and implementing of HIV/AIDS interventions, particularly community based interventions. Best experiences in community based approaches in some districts in the country will be shared with the local councils.

In most parts of the world, HIV is primarily a sexually transmitted infection (STI). Development of a supportive environment requires national and community-wide discussion of relationships, sex and sexuality, risk, risk settings, risk behaviors and

cultural practices that may increase the likelihood of HIV transmission. A supportive environment is also one that deals, at the national and community levels, with stigma, fear and discrimination, as well as with policy and law. The same issues apply in parts of the world where unsafe injection of illegal drugs is the chief source of new infections. The AIDS epidemic forces societies to confront cultural ideals and practices that can contribute to HIV transmission.

Effective BCC is vital to setting the tone for compassionate and responsible interventions. It can also produce insight into the broader socioeconomic impacts of the epidemic and mobilize the political, social and economic responses needed to mount an effective program. FHI's pragmatic BCC approach, based on sound practice and experience, focuses on building local, regional and national capacity to develop integrated BCC that leads to positive action by stimulating society-wide discussions. BCC is both an essential component of each program area and the glue between the various areas. However, society-wide change is slow; changes achieved through BCC will not occur overnight. This document outlines FHI's BCC strategy for HIV/AIDS. The overall goal of the HIV/AIDS policy is to control the spread of HIV/AIDS in Tanzania and to mitigate its impact to the point where it is no longer of public health, social and economic concern. In order to achieve the overall goal, a number of **specific objectives** must be achieved.

The rights of children and young people will be upheld in regard to protection from

HIV infection. If children have HIV/AIDS, these rights must extend to freedom from discrimination in all spheres of life and the right to full access to health care, education and welfare support. Children of both sexes must be brought up in ways that develop responsible behavior and a sense of responsibility towards themselves and others. Children-and young people should have access to knowledge and life skills needed to avoid HIV infection.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together seven UN agencies in a common effort to fight the epidemic the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses to the epidemic of its seven cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners governmental and NGO, business, scientific and lay man.

Clause 2.2.2 U.N. Education/Children Rights:

Foster (1990) asserts that the role and challenge of educators is firstly to determine what role if any they should play as educator in curtailing the spread of HIV/AIDS and secondly to develop the type of strategies that can accomplish their goal. The strategies should result in reduced fear, elimination of inappropriate behavior in students, teachers and their families.

Foster (1990) in a later work considered a comprehensive HIV/AIDS policy including ethical and legal considerations. Critical issues for consideration include:

- Rights of access to education
- Non discrimination in employment and education
- Confidentiality and disclosure of information
- Non exclusion of student, teachers and other support staff within institutions.

Through collaboration the United Nation Educational Scientific and Cultural Organization (UNESCO) World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS and Education International issued a joint statement launching Global School Health Initiative aimed at empowering the world teachers "to promote health and to enable them to address priority health issues such as HIV infection and related discrimination". Part of the mission is to get the involvement of teachers in developing HIV/AIDS policy, education programmed and training materials through partnership between departments of education and health.

The International Guidelines on HIV/AIDS and Human Rights make reference to children and HIV/AIDS. A thrust of the initiative dealing with children is the inclusion of HIV/STD prevention in schools and vulnerable children guided by the United Nations convention on the Rights of the child.

You will find that both **Chawakua** and Tanzania's policy in HIV/Aids for youth are integrating with United Nation and many others countries in the world. The major objective is preventing and educating how to protect our youth.

It is reported that from as early as May 1991 the World Health Organization listed 583 laws and regulations dealing with HIV infection and AIDS from different countries in addition to 179 laws from the United States. The United States adopted the approach that the HIV/AIDS issue was distinctive enough to be given treatment as a specific area of law. Some countries have made amendments to existing laws or where they have introduced laws it relates to broad areas such as discrimination.

Nonetheless HIV/AIDS must be recognized for its impact on social and economic development of not just a specific country but globally. The legal response must therefore be appropriate, all circumstances considered.

Clause 2.3.3 United Nations Population Funds Policies concerning youth and women.UNFPA Mandate and Youth UNFPA work in the area of adolescents and youth

guided by the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination against women and youth (CEDAW).

Clause 2.3.4 UNFPA Mandate and Youth UNFPA work in the area of adolescents and youth:

1) to ensure that population, poverty eradication and development policies respond to the needs of adolescent girls and boys, with particular focus on their sexual and reproductive health
2) To promote girls' rights, gender equality and equity including supporting girls' empowerment, sensitizing boys, and eliminating gender-based violence and harmful traditional practices that jeopardize girls' health and well-being.
3) To strengthen youth participation and leadership and support their contributions in family, community, and national decision-making processes, and at all levels of development programming intended for their benefit, in line with their civic roles and responsibilities in fostering positive social Youth UNFPA work in the area of adolescents and youth.
4) To promote and protect the rights of adolescents to sexual and reproductive change and democratic values.
5) UNFPA Mandate and health as an integral part of their well-being and development through policy and legislative dialogue, awareness raising and community mobilization

6) To expand access for young people to sexual and reproductive health information, education (in and out of school), and services, and acquisition of life skills.
7) To advocate for increased commitments and resources for adolescent sexual and reproductive health and youth development generally.
8) To develop national capacity for youth-friendly, effective programmes.

Clause 2.3.5 UNFPA Mandate and Youth UNFPA Priority Groups:

10 to 24 years age group timely interventions for education, reproductive health and rights. Girls as priority concern areas to address early marriage, early pregnancy, STIs/HIV/ AIDS, harmful traditional practices, violence, sexual abuse and incest, sexual exploitation. Married adolescent girls less educated, less aware of own bodies and reproduction health issues, isolated, pressured to bear children early.

Clause 2.3.6 Specific Objectives of the Policy

a) Prevention of transmission of HIV/AIDS

I) To create and sustain an increased awareness of HIV/AIDS through targeted advocacy, information, education, and communication for behavior change at all levels by all sectors. This hinges on effective community involvement and empowerment to develop appropriate approaches in prevention of HIV Infection, care and support to those infected and affected by the epidemic including widows and orphans.

ii) To prevent further transmission of HIV/AIDS through:

(a) Making blood and blood products safe, and

(b) Promoting safer sex practices through faithfulness to partners, abstinence, non-penetrative sex, and condom use according to well informed individual decision. The key issue of moving from abstinence or condom use to another strategy depends on testing in between

(c) Early and effective treatment of STIs in health facilities, with special emphasis on high risk behavior groups, and early diagnosis of HIV infection through voluntary counseling and testing

b) HIV Testing

I) To promote early diagnosis of HIV infection through voluntary testing with pre-and-post test counseling. The main aim is to reassure and encourage the 85 - 90% of the population who are HIV negative to take definitive steps not to be infected, and those who are HIV positive to receive the necessary support in counseling and care to cope with their status, prolong their lives and not to infect others.

ii) To plan for counseling training and accreditation of training programs in Tanzania to ensure that counseling in HIV/AIDS abides by a common code of practice

6.0 HIV TESTING

6.1. Objective

The main objective is to outline the ethical conditions in testing for HIV for surveillance of the epidemic, diagnosis, voluntary testing and research.

6.2. Testing for HIV/AIDS

I) For voluntary HIV testing, pre-and-post test counseling shall be done to enable test results to be communicated to the person tested or, in the case of minors, to parents or guardians. The main aim is to reassure and encourage the 85 - 90% of the population who are HIV negative to take definitive steps not to be infected, and those who are HIV positive to receive the necessary support in counseling and care to cope with their status, prolong their lives and not to infect others.

ii) For unlinked HIV testing, no pre and post-test counseling shall be required. For blood donors who wish to know their test results, provision shall be made for follow up voluntary HIV testing with pre- and post test counseling.

6.7. Pre-marital HIV Testing

Pre-marital testing shall be promoted and made accessible and affordable all over the country. Like all other testing it should be voluntary with pre- and post–test counseling

6.8. Research Involving HIV Testing

All research proposals shall seek ethical clearance from the Research and Ethics Committee of the hosting institution or sector. TACAIDS shall be informed of such research findings for the record and/or dissemination. Approved research proposals shall be registered with TACAIDS. Research involving international collaborators shall obtain ethical clearance from the Institutions from which the foreign collaborators are based and also from the relevant national research institutions and sectors. All authors shall give consent, in writing, to the publication of the research report.

6.9. Surveillance for HIV

For the purpose of surveillance, one highly sensitive and specific test will be recommended depending on the accuracy of desired results. However, confirmation may be applied according to research needs and such other needs as referral for early diagnostic testing and early treatment for opportunistic infections.

7.2. Community Based Care and Support Services

Comprehensive response to HIV/AIDS has been shown to be effective in the control of the epidemic. This includes prevention, care and support to patients with HIV/AIDS in the communities including home based care.

However, it must be appreciated that at he household level, caring for an AIDS patient is very costly in human, time and financial terms. The need for support from the community is paramount.

7.3. Tanzania Government shall establish cooperation and collaboration with:

a) Interested individuals, organizations, agencies or bodies in promoting community based care for AIDS patients and orphans.

b) The Government shall encourage the collaboration of religious communities in providing spiritual care and material support for PLHAs. Spiritual care is a component of holistic care.

c) All public claims of cures for HIV/AIDS by traditional and faith healers or other care providers shall be discouraged until such claims are authenticated and approved by government agencies.

d) All importation and manufacture of modern and traditional remedies for HIV/AIDS shall be promoted and approved by relevant government agencies.

e) The Government shall expedite rapid drug trials and registration of efficacious modern and traditional remedies.

f) Modalities for establishing a special trust fund for complementing community initiatives in supporting and caring for those infected and affected by HIV/AIDS shall be developed.

CHAPTER III: RESEARCH METHODOLOGY

3.0 Research Design

The Behavior Survey Strategy methodology is a monitoring and evaluation tool designed to track trends in HIV/AIDS-related knowledge, attitudes and behaviors in subpopulations at particular risk o f the infection, such as female sex workers, injection drug users, and youth. Based on classic HIV and sexually transmitted disease (STD) serologic surveillance methods, BSS consist of repeated cross-sectional surveys conducted systematically to monitor changes in HIV/AIDS/STD risk behaviors

Objective: To describe the trends in AIDS knowledge and sexual behavior in six wards of Arusha Municipality and a Comparison of one ward.

Design: Analysis of data collected in representative surveys.

Methods: Analyses were stratified by age group. In order to assess whether there had been changes in the levels of knowledge and high risk sexual behavior over the eleven months period, surveys were tested across several indicators, based on robust estimates of variance and dialogue.

The purpose of this evaluation was to review progress against the programs objectives. The evaluation sought to understand the process by which the achievements had been made and draw conclusions and recommendations for future innervations. It is hoped

that the sharing of the extracted lessons will make a positive contribution to stakeholders, Chawakua Organisation, staffs, municipal of Arusha. Aya Pathfinder International and any other interested donors for future planning.

Specifically, the evaluation exercise was undertaken to address the following issues as outlined in the terms of reference:

a) To measure the progress (qualitatively and quantitatively) towards achieving each of the intervention goals as outlined in the program's design document.

b) To collect relevant data and information on the design and implementation process in order to improve or modify, implementation process plans.

c) To share experience by assessing strengths, weakness, opportunities, threats and make recommendation for future activities.

d) To find out whether resources (human/materials) are being used efficiently and effectively for the service of the community and the satisfaction of all stakeholders.

e) To enable the community, programme staff and others to analyse their situation, abilities and skills, understand which socio – economic variable

influence programme progress in monitoring the program so as to take further action to improve them.

f) To analyse the inputs (sources, time, systems process methodologies approaches and strategies out (quantitative), effects and outcomes of the program and the impact for future **Chawakua** youth.

g) To exercise my training skills and find ways of reducing poverty among my fellow Tanzanians, in this way we will reduce HIV/Aids pandemic.

I led my research team to develop a logical framework for the first phase of the research project to achieve the objectives stated above. Phase two of the project on mapping of reality has achieved all the above mentioned and expected objectives:

A Behavior Change communication strategy is best designed in a participatory fashion, including members of target populations, organizations planning to work with us and stakeholders. Designing a BCC strategy is more than a matter of developing messages and media materials for dissemination. It was necessary to find the right mix of approaches to involve target population that is, to get their attention and to promote and enable action. This project will be conducted only once in this year because it is a study research. The survey will end in my 3rd semester. 164 out of school youth are targeted in this project. A total 6600 people are planned to be reached by this intervention but only 164 will be interviewed. The following behavior changes are expected from this project:

a) Reduction of prevalence of HIV/Aids

b) Reduction of incidence of STIs

c) Reduction of rate of unwanted pregnancies and unsafe abortion

d) Increase of contraceptive prevalence

e) To reduce the proportion of first sex that just happened or is forced or coerced.

The person in control of this survey will be me and assisted by the six project assistants who are in charge of each selected ward. This gives them control of understanding their clients living there.

3.1. Research Approach and Strategy

The following is my project designed BCC strategy which includes the following:

a) Clearly defined BCC objectives

b) An overall concept or theme and key messages

c) Identification of channels of dissemination

d) Identification of partners for implementation (including capacity-building plan)

e) A monitoring and evaluation plan

A) Clearly defined BCC objectives

This Project Behavior Change Communication has set objectives to be fulfilled during and after evaluation. The research team has made use of these objectives as shown on terms of reference:

1) Youth talk
2) Sports rally
3) Site visit meetings
4) Teen safari for peer educators
5) Enter- educate
6) Peer educate training
7) Life planning skills
8) Peer educator for refresher
9) Community Mobilization
10) TOT Refresher course to VET – C Teachers

B) An overall concept or theme and key messages

Messages will be delivered through mass media for example, television or radio spots; articles in periodicals; or material in brochures, posters, flip charts, and pictures, by health workers, peer educators, counselors, or other trained personnel. Additional means of delivery include musical or dramatic performances and community events.

Peer education (or peer facilitation) is a cornerstone of all interventions with target populations.

This study managed to have found that peer education has an overwhelmingly positive impact on STI or HIV incidence and risk behaviors. Peer educators can help reach specific groups, model safe behaviors stimulate community discussions and provide referrals to appropriate services.

C) Identification of partners for implementation (including capacity-building plan)

In developing a BCC strategy, it was important to identify key partners who can help design and implement its components. Our partners include government counterparts, media outlets, local traditional entertainers, members of target populations and other program implementers, religious leaders, and stake holders.

D) Identification of channels of dissemination

Development of specific communication support materials was based on decisions made about channels and activities. They can include:

- Print materials for peer educators, such as flip charts and picture codes
- Print materials to support health workers on specific care issues
- Television spots for general broadcast
- Promotional materials about the project, for advocacy
- Radio or television soap opera scripts

E) Conduct pre-testing

Pre-testing was done to ensure that themes, messages and activities reach the intended target populations. It was important to pre-test at all three stages with all audiences for whom the communication was intended, both primary and secondary. Pre-testing was done of themes, messages, prototype materials, training packages, support tools and BCC formative assessment instruments.

Pre-testing of media, messages and themes evaluated the following:

- Comprehension
- Attraction
- Persuasion
- Acceptability
- Audience members' degree of identification

The development of different educative video films, posters, brochures, booklets and newsletters to increase the knowledge and acquisition of quality information on HIV/AIDS and STIs to youth and the community was done during this project life. 50 teaching films in Kiswahili were developed so that more youth can receive ASRH/LHDS and HIV/AIDS and STIs knowledge and also **Chawakua** printed 500,000 different IEC/BCC materials during this project and distributed them.

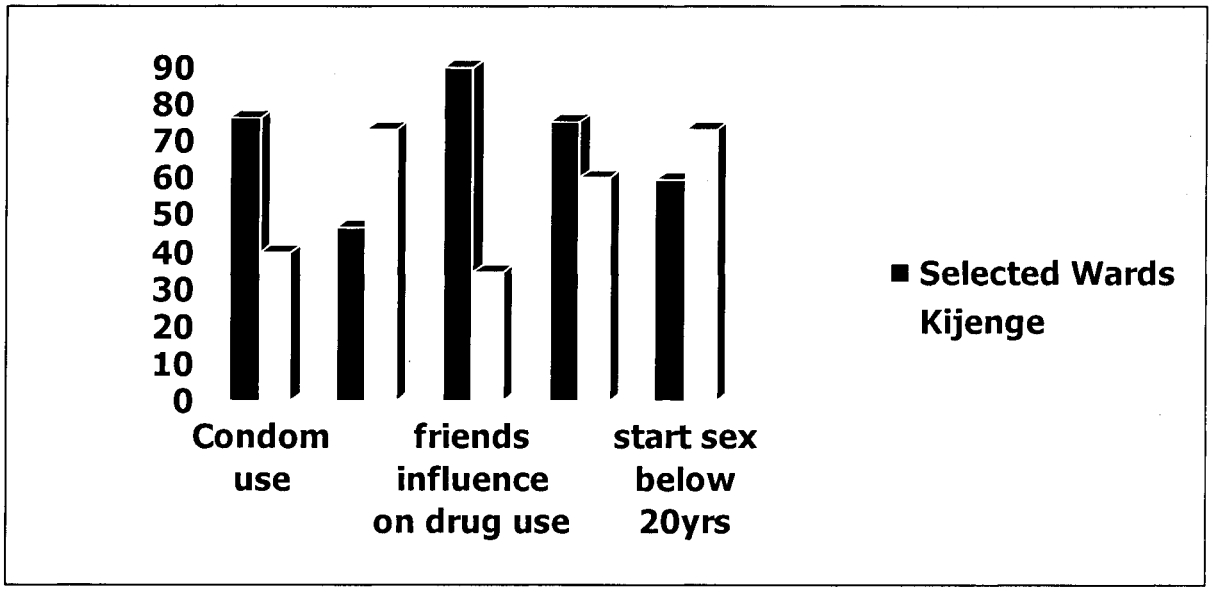
Among developed materials, **Chawakua** with the support of the government promoted and distributed condoms to youth in need. Counseling to the women, and youth was done, 20 sessions was done to all six wards of targeted six wards including Kijenge non participating ward. Material distributed including T-shirts, brochures, leaflet concerning ASRH skills, radios given by VODACOM Tanzania Ltd. for youth to listen messages concerning HIV/Aids strategies.

3.2. Sampling Technique

Comparison designed technique was applied in this study. Kijenge Ward which in non-participating was used to compare to the six other wards, which are Sombetini, UngaLtd., Ngarenarok, Sekei, Daraja Mbili and Sanawari.

Site visit to the comparison group were as equal as to the other selected six wards this makes this survey to be both longitudinal and comparison sampling. To get the result comparatively all the ten objectives were to b e tested at the same time as the selected six reached wards. Though Kijenge was not among reached wards, but in collecting data and interviews both groups were reached equally.

3.2.2 Comparison technique six reached wards and un-reached Kijenge ward



3.3.0 Data Collection

Data was collected for both the diagnostic phase and the end line evaluation through focus group discussions (FGDs), in-depth interviews, and statistics using quantitative and qualitative methods. The FGDs and interviews were conducted with the target population to evaluate their knowledge of ASRH and attitudes about reproductive health, as well as their access to and satisfaction with services.

164 questionnaires were administered, process indicators used were youth trained, meetings conducted on ASRH and survey on condom uses. The design of the **Chawakua** youth behavior change progrmme is based on the matched comparison technique on which data for a representative sample of youths of Kijenge ward which is not participating ward in this programme.

The baseline data ruled out before and after evaluation technique and because the reforms were not applied randomly to youth which ruled out an experimental evaluation design in which the sample of youths studied in the evaluation would be random and therefore can be district wise representative.

3.3.1 Primary Data Collection:

Chawakua stakeholders meeting with me and my team was done in initial stages, Stakeholders include policymakers, opinion leaders, community leaders, religious leaders and members of target populations, including PLHA. Their active participation at appropriate stages of BCC strategy development was very essential as it helped to

obtain guidance and commitments to the process and to develop coordination mechanisms. While tailored primary research, it allowed for specific research questions to be explored directly, administrative data collected for other purposes present a useful source for secondary analysis. From this primary data I managed to identify the targeted population which is youth out of school.

3.3.2 Secondary Data Collection:

We decided to change behavior by using the objectives mentioned above to be used as a means of reaching our targeted goal. We decided to increase condom use among sex workers and clients who are our primarily population in order to adapt and maintain appropriate behaviors.

By doing this we sought the help of policy makers in this case are ward leaders, head of religions and even peace keepers who are police, people providing services, such as health workers, private practitioners, pharmacists' counselors and social service workers, without forgetting local communities and families. This is expected to create resource linkage across community-based activities e.g. a church or mosque leaders who becomes a member of the project co-ordination committee will definitely bring in some aspect(s) of church or mosque resources to bear on the project.

The entrenchment objective was achieved in four steps: reconnaissance visits, opinion leaders meetings, community meetings and follow-up leaders meetings.

3.3.3 Data Collection for Youth Talk

Six youth talks meetings were conducted with each ward hosting one meeting which involves all peer educators, LPS graduators and other untrained youth from within and outside the wards. During the talks, peer educators were encouraged to exchange experiences from each ward regarding to the discussed ASRH topics. More specifically, the goal of these talks was to evaluate the impact in ASRH/LHDS and the topic discussed includes; drug abuse and communication skills, relationships, condom use, STDs and physical change. All the six youth talk meetings were composed of 658 youth (348 males and 310 female) and youth were transparent to discuss their personal issues.

The sample of fifteen youth was taken randomly from the six wards (Levolosi, Ngaranarok, Sekei, Unga Ltd, Daraja Mbili, and Sombetini). Out of twenty five youths (12males and 13female) interviewed on the condom use, 76% were strictly using condoms in every intercourse compared to Kijenge ward, were the response to condom use was 40%.

The same sample consisting of twenty five youth (12males and 13female) from the six wards indicate that 60% are not engaged in drugs/alcohol while in Kijenge ward the same number indicate 40% are not engaged in drugs/alcohol.

Assistance program officers seek assistance from different companies/offices and contributions in terms of material or money for the winners of these competitions.

Friendly matches' competitions on netball are organised among netball teams in wards V/S netball girls in the drama group

There was a failure to undertake considerable measure for treatment, whereby 4% from the selected wards have got their treatment from hospitals while 12% from Kijenge got treatment from hospital. The failure to pursue treatment from hospital was considered to be expensive and secretive.

3.3.4 Data Collection for Sports Rallies

Through sports the organisation has reached more people of different age group thus it is one of the ways of reaching parents with the knowledge of ASRH/LHDS.
Ward leaders from all the six wards were left with the task of finding girls to form netball team so that they can have more girls during the next meetings.

The purpose of these competitions was to reach more young people with the ASRH/LHDS messages as well as to encourage youth to participate in a positive activity rather than remaining idle in the streets hence in doing so no behaviour change will take place. The friendly football competitions takes place in four wards (Levolosi, Unga Ltd, Sekei, and Ngarenarok).

Drug abuse, relationship and physical change have been explained in detail and all the youth have been given chances to give their opinion, all of them have shown the

behaviour of the youths who have been in use of drugs, and have explained the consequences facing it and promised that they will stop using drugs.

Peer education programs are effective ways of passing accurate information to youth (information provision and knowledge building).**Chawakua** organisation facilitated sensitisation and awareness creation session on early marriages, condom use, drug abuse, relationship and physical change. People reached from all six wards (Levolosi, Unga Ltd, Sekei, Sombetini, and Ngarenarok) were 1250, out of which there are 780 were males and 470 were females.

During the matches **Chawakua** distributed messages which emphasized the importance of using condoms at every sex act or to have honest relationship and impacts of drug use on daily life to all who attended the festival.

Through sports the organisation has reached more people of different age group thus it is one of the ways of reaching parents with the knowledge of ASRH/LHDS

3.3.5 Data Collection for Site visit Meetings

Chawakua conducted meetings for the trained post-graduate, peer educators and untrained youth in each of the six wards of the project site whereby 470 youth (240 males and 230females) attended. The purposes of these meetings were to discuss the problems encountered by youths in the wards and search for possible solutions.

For instance the youth of Unga Ltd ward shared reasons that they had heard other youths explaining their good reasons for not using condoms. They explained that some

youth stated that they doubt the safety of condoms and because of this, they abstain from sexual intercourse. However, others stated that, they practiced sex without condoms.

Peer educators from the Sekei ward requested that the MIS data collection forms be given to the outreach youth so that they can also evaluate themselves on how well they have been teaching.

The LPS graduate educators and the peer educators of Levolosi ward formed a club which meets twice a week to refresh themselves on what they have learnt during the LPS training. They requested brochures containing LPS doctrine to give to their fellow youths.

Youth from Ngarenarok ward discussed ways involving more girls in spreading the ASRH message.

The ward netball team, involved girls between ages 10-24 years old. Darajambili and Sombetini ward are still working with the community to gain more experiences. In addition to the benefit of educating youth, these site visits meetings provide an opportunity for **Chawakua** staff to evaluate the failure and successes following the LPS training.

Chawakua organisation facilitated sensitisation and awareness creation session on early marriages, condom use, drug abuse, relationship and physical change. People

reached from all six wards (Levolosi, Unga Ltd, Sekei, Sombetini, and Ngarenarok) were 1250, out of which there are 780 were males and 470 were females.

3.3.6 Data Collection Enter Educate/Drama Performance

Different youth were questioned on drug abuse. From the wards they were found out fifteen youth (7males and 8females) which is equivalent to 26.7% were using drugs/alcohol and on the other hand data from Kijenge ward shows that out of fifteen youth 40% were/are using drugs.

The group had performed accordingly during the football matches and each show had a message relating to ASRH and HIV/AIDS/STDs. The first show was carrying a message about early marriage, the other second about drug abuse, the third about condom use, the fourth about relationship/communication, and the fifth about physical change.

Most of the audience have showed a good response on the message which the group have delivered, this was evaluated by the way they behaved during the shows as they were all quiet and listening as the show goes on. Adults who attended have also asked the group to perform during the ward meetings, because they believe it is a good way to receive strong messages. These tend to collect street children which are among the targeted coming group of the following project.

In the case of relationships, youth who had started sexual intercourse below the age of 20years were 74.3% out of the 15 youth from the selected wards; compared to Kijenge ward all of the 15 interviewed youth (7males, 8females) had started sexual intercourse at the age below 20 years. Out of which 26.7% from the selected wards have conceived in this early years from the selected wards and 40% from Kijenge ward have noticed the same case. The number of youth using sexual protective measures was observed to be 66.7% from the selected wards while in the Kijenge ward 53.3% responded on the use of sexual protective measures.

The observation shows that first sex was still worse according to the data from 15 youths which indicates that 46.7% of total youths, who wanted to have sex voluntarily and it was their first time were33.3%. In Kijenge ward the same sample indicates that 73.3% who had sex for the first time and from their initiation were 20%.

3.3.7 Data Collection for Teen Safari for Peer Educator:

The Assistance Program Officers and Program Officers organized youth talk in the form of picnic at Momela Arusha National Park. Debate was opened in order to explore many issues involving drug addiction. After debating, youths were given time to share experience with drug users and drug addicts.

The debate was led by the Levolosi peer educators who hosted the youth talk. 133 youth between the ages of 6 – 25 years participated, and 16 VET-C TOT teachers assisted supervise the trip in order to learn the ways in which the youth talk benefit youth.

Various aspects concerning ASRH were discussed like condom use for safe sex and many youths were interested about the topics, since they were not sure on the safety of condoms, the impact of early marriage and the case of youth to start sex below the age of 19years was discussed and also the ways in which youth can avoid the first sex to be 'just happened', 'coerced' or 'forced' have been discussed in details.

The effects of drugs have been discussed and youth who were already or still in drug using were given the chance to explain what they feel after using drugs and if they benefit from it or not. After the youth who have used or using drugs accomplish to explain their feeling, other youth were given the chance to give their opinion.

3.3.8 Data Collection Peer Educator Training

Chawakua has an ongoing program where the out-of-school youths are involved in national and regional events to entertain audiences through poems; drama, songs, music and dancing passing on messages on HIV/AIDS/STDs.

Chawakua have continued to use folk media to disseminate HIV/AIDS/STDs messages, these include Radio 5 in Arusha, Radio Clouds and radio Triple A, News from Majira and Arusha Times of Arusha.

Developmentally adolescents between the ages of 14-25 are more likely to be influenced by peers' behaviours and hence advice therefore peer education is more appropriate for this age group and not for all ages.

"The importance of the 'fit' of the communication approach to the behaviour change objective cannot be over-emphasized." Using these methods to convey HIV/AIDS/STDs prevention information is likely to be successfully where most of the people are illiterate or low-literate, because unlike most modern prevention campaigns that distribute literate or use methods that "require communities to 'participate' in ways that are often incomprehensible to them", folk media is often incorporate an oral tradition.

3.3.9 Data Collection for Peer Educator Life Planning Skills

Peer education builds on the reality that people tends to congregate and talk with other people similar to themselves. Peer education programs are those which train and deploy as educates people similar in age, place of residence, occupation or interest area to those who are targeted to receive the designated education.

Peer educators reported significant gains in knowledge about HIV transmission and about where STIs services can be attained. Most of the peer educators also intend to delay their first or subsequent sexual encounters and to use condoms when they are sexually active.

It is expected that when the peer educators will be trained, each will reach at least 10 youths per month per ward, through one to one outreach and a minimum of 300 per month in each ward through the organised educational programs such as drama, video shows, games and peer led LPS activities to include condom demonstrations. The number of people to be reached through this strategy does not include the large numbers of youth to be reached through rallies and festivals.

Twenty five (14males, 11females) peer educators were selected from all six ward (Levolosi, Ngaranarok, Sekei, Unga Ltd, Daraja Mbili, and Sombetini) and were trained to be peer educators. Twenty youths were selected from wards and five from drama group and trained for three days to be peer educators. This training aimed to empower youths so that they can reach more young people on ASRH/LHDS and HIV/AIDS messages.

All the youths who participate in the LPS trainings have been recruited as youths advocate and encouraged to share their knowledge and skills with their peers, families, and siblings. The selected youths have provided with additional training on the key ASRH facts, leadership, and advocacy skills, as well as peer education methodologies

including how to identify youths who need information, where they can be reached, how to get and maintain their attention, how to use educational materials and equipments, and how to conduct life panning skills training activities.

All peer educators have been equipped with appropriate resources and encouraged to conduct youths outreach activities aimed at provision of accurate ASRH information to youths, to reinforce messages and provide condoms to those youths who graduated from LPS. They will organise video shows, stage dramas, distribute materials, recruit additional youths for LPS trainings, and refer youth to youth friendly services – all these in place where youth congregate identified during the PLA.

Review of the data collected from 20 youths (11males and 9 females) shows that all of them who have accomplished ASRH/LPS expect to have good relationship with their parents and friends than before they have got LPS and ASRH training. Their behaviour will change and now they are free to talk to their parents and friends. The same sample of data has revealed that 65% of youth are free to talk to the people who are at the same age. However, they all recommend parents to be open on the issues concerning ASRH and HIV/AIDS, so that they can have more from their parents.

3.3.10 Data Collection for Community Mobilization

The awareness levels may measure as high as 90%-95% in regarding to the entire community leader. The awareness of the general population is known to be a

prerequisite, but in itself not sufficient to lead to behavior change. When adequate awareness levels are reached there is need to rapidly move from sensitization to behavior change promotion.

Out of twenty community leaders attended, 67% of them have openly discuss with their children about the causes and spread of HIV/AIDS, STDs and the effect of drugs, and the ways to protect themselves. These results show over estimated planned of 30% from the indicators shown earlier. Customs shows it is a difficult task for them to discuss sexual related matters with children.

In this process, community members become social change agents themselves, furthering policy goals and minimizing backlash or opposition. Consistent with this participatory social change philosophy, **Chawakua** has participated in AYA Participatory Learning Action (PLA) activities which were carried out in Arusha Municipality. Each AYA partner has facilitated PLA activities to its target audience in the community.

Participatory community mobilization is a dynamic approach designed to facilitate social change regarding a public health issue by involving various stakeholders in the identification of root causes of their problems and to plan, implement, and evaluate appropriate and culturally sensitive solutions. Project facilitated by community devised solutions are often more successful than solutions identified and implemented by the outside experts such as AYA.

3.3.11 Data Collection for Peer Educator to Refresher

Peer educators show that they are able to link the message about ASRH, LHDS and HIV/AIDS to youths. 25 peer educators were asked on the ways youth can protect themselves from being affect with HIV/AIDS and 84% of them have showed they are well knowledgeable.

Peer education is a good method to disseminate the right information among young people. The peer educators can also give advice to their friends on sexual matters. Instead of negative peer pressure, peer education can lead to positive peer pressure among young people, which can lead to safer sexual behavior. The peer educators also plan, implement and evaluate their own activities. This increases 'ownership' and will increase the effect of the program. However this alone will not be enough. If young people have the knowledge and adopted a safe attitude, then they should also be able to carry out safe sex and better decisions. Therefore it is important that there are also youth friendly clinics where they can get treatment and counseling.

During the training, they learn the technical facts about STDs and HIV/AIDS, but also about how to communicate with peers about these sensitive subjects and they receive a life skills training. The training is presented by different people, by for example a nurse who explains the technical facts and by other peer educators about the role of peer educators, etc. After the training, the peer educators are supposed to disseminate the

information they have learned. This can be done by informal talks or by organizing activities in the community or in schools.

3.3.12 Data Collection for TOT Refresher Course to VET – C Teachers

Prevention of AIDS among young people with community involvement concern not only understanding AIDS disease in its social, cultural, economic and political contexts, but also community organizations as well as factors that promote sustained community support. This is the area where social science can make a substantial contribution towards prevention of HIV/AIDS.

Given the data collection above, interventions, whether diagnosis, treatment or prevention at individual or societal levels cannot depend on knowledge of a single disease agent. Rather, it should depend on interpreting meanings and subjective worlds of the affected people and their realities and of local practices in which are embedded both risks and preventive measures. This implies various forms of collaboration, linkages and partnerships including interdisciplinary, researchers/practitioners researchers/community groups as well as a broad based involvement of varied stakeholders.

The forms of collaboration mentioned here can be ensured through a participatory action research as elaborated further below.

3.4 Data Analysis

Analyses were stratified by age/gender group in order to assess whether there had been changes in the levels of knowledge and high risk sexual behaviour. Quantitative study draws on data for a sample of 3,240 reached, only 164 were interviewed in this project 76 were females and 88 males. 25 youths interviewed o the condom use, and 76% were strictly using condoms in every intercourse compared to Kijenge ward, were the response to condom use was only 40%.

During the project research data were collected by research team of six project assistants and me. Data analysis are used to analyse the process of project evaluation which will later on be recorded as it has been done here for future use of the organisation in comparison to the intervention done later or earlier whether it is of use and how and who will be using. The beneficiaries of this evaluation will be the following:

1) Youth out of school,
2) Women and Orphans
3) Agencies
4) Firms
5) Volunteers
6) Interested groups
7) Chawakua and other NGO's
8) Municipal Council of Arusha

It will be used to improve and strengthen BCC Programme and make difference in people. This will be seen in the findings how people have benefited from this programme and some changes will be shown from behaviour after the intervention.

3.4.1 Primary Data Analysis:

In the data analysis we found out that most sero-positive individuals are unaware of their status until the infection expresses itself in overt physical symptoms such as weakness, weight loss, opportunistic infections, and even then some uncertainty may remain. Women often learn of their sero-positive status through an antenatal check-up, i.e. after they have already added a pregnancy.

Because of the difficulties in collecting valid and precise data on sexual behavior, changes in sexual behavior are not easy to detect. Hence, it is not surprising that some studies of sero-positive individuals make no effort to assess changes in sexual activity in response to knowledge of their status. In the qualitative data we observe no intention among HIV-positive women to modify their sexual behavior. In contrast, a comparable qualitative study of men and women conducted after notification of their sero-positive status, some individuals stopped having sex, others reported a reduction in multiple partners, and some men indicated that they had stopped casual sex.
These changes are not quantified, and, furthermore, those individuals who stopped having sex found this difficult to sustain for emotional reasons.

3.4.2 Secondary Data Analysis:

Tape recordings and field notes were transcribed using a word processor, with a number assigned to each line. The themes originally considered for the analysis include:

- Attitudes and knowledge about sexual and reproductive health services
- Needs and demands for contraceptive services
- Knowledge of sexual and reproductive rights

In addition, the interviewees brought up the following topics:

- Barriers and access to health care
- Knowledge about sexually transmitted infections, including HIV/AIDS
- IEC strategies in the community
- Community organization and participation

Participants' gender and ethnicity were taken into consideration during data collection and analysis, as well as during the educational interventions, as these characteristics can influence individuals' opinions. More inquiring was necessary to obtain information from women and girls.

Researchers collected socio-demographic data on all participants, and recorded observations of behavior and gestures during the focus group discussions to provide further contextual information for analyzing transcripts. Results are presented without

individual identifiers in separate sections for women, and youth, as there were substantial differences in the results among the groups.

Quantitative data were entered into SPSS and researchers analyzed routine service statistics for each group to determine statistical trends in the indicators listed above. Additionally, Kijenge ward results provided a comparative framework for the analysis.

Out-of-school youths consist mostly of young men and women who have had little or no schooling. They constitute over 50% of the youth between the ages of 15 and 19. Young women are by far the majority in this group.

Out-of-school youths are hard to reach and difficult to target. They have little access to information, and are often intimidated and lack self-confidence. They are rarely given the opportunity to learn about health issues and even in the rare instances where sensitization sessions are held, they are not specifically invited, made welcome and involved in discussion:

3.4.3 Data Analysis for Youth Talks

The youth talks are specifically designed to take youth out from bad behaviours like prostitution, pick pocketing, drug addiction, and overall sexual risk- takings which may lead to unwanted pregnancies, STDs and HIV/AIDS.

It was observed that conducting of youth talks in the ward office would not be enough to accommodate more than fifty (50) youth thus it was suggested to ask for venue at Museum Azimio la Arusha and VIA VIA.The participation of girls was changing from day to day whereas, at the beginning there were few girls and the number was increasing after their parents educated and notified the success outcomes of the previous meetings.

Silence amongst communities on HIV/AIDS issues, is still a hindrance factor for dissemination of proper messages to targeted groups.

3.4.4 Data Analysis for Sports Rallies:

Involving in sports creates different attitudes to youth. The time used by them to unnecessary activities will be replaced by sports, so the organisation used this approach to welcome more youth and in friendly manner to join sports.

Apart from engaging in sports exercises like football, netball, basket, volley ball, the organisation (**Chawakua**) had organized friendly competitions in all types of sports. The purpose of these competitions was to reach more young people with the ASRH/LHDS messages as well as to encourage youth to participate in a positive activity rather than remaining idle in the streets hence in doing so no behaviour change will take place. The friendly football competitions takes place in four wards (Levolosi, Unga Ltd, Sekei, and Ngarenarok).

Assistance Program Officers seek assistance from different companies/offices and contributions in terms of material or money for the winners of these competitions.

Friendly matches' competitions on netball are organised among netball teams in wards V/S netball girls in the drama group.

Chawakua organisation facilitated sensitisation and awareness creation session on early marriages, Condom use, Drug abuse, Relationship and Physical change. People reached from all four wards (Levolosi, Unga Ltd, Sekei, and Ngarenarok) were 1250, out of which there are 780males and 470females.During the matches **Chawakua** has distributed messages which emphasize the importance of using condoms at every sex act or to have strong relationship and impacts of drug use on daily life to all who attended the festival.

Through sports the organisation has reached more people of different age group thus it is one of the ways of reaching parents with the knowledge of ASRH/LHDS.

3.4.5 Data Analysis for Site Visit Meetings:

The focus groups discussions revealed commendable competence among the peer educators on proper youth entry skills and dissemination of appropriate condom use messages. The peer educators reported to have organised youth talks to emphasize among them the importance of condom use during first sex, last sex and consistently. However the data collected revealed a relatively low achievement as from fifteen youth (7males, 8 female) interviewed from the six wards 33.3% that condom does not help in the protection of STDs/HIV/AIDS.

The data still reveal that most of the youths are not in confidence of being not affected by STDs/HIV/AIDS which is hazardous for their future relations and existence in good health. The data shows that out of the fifteen youths 26.7% believe they are in endangered of being affected by STDs/HIV/AIDS, comparing with the same sample for Kijenge ward 46.7% revealed they doubtfully on endangered of being affected.

3.4.6 Data Analysis for Teen Safari for Peer Educator:

Many youths who have registered for Safari have not reported due to some reasons, but the major reason was the failure to pay contributions for bus fair and entry fees. The total number of youth attended who were 133 (82male, 51female) was near a half of the total number who have registered which was 295.

Drug abuse has continued to be the threatening habit to many youths under twenty years. Research shows that many youths are using drugs out of their own will because they did not have the opportunity to be advised on the effect of drugs at proper time.

3.4.7 Data Analysis for Enter-Educate:

The drama group has been invited to different talent shows involving youths from all wards of Arusha Municipality. This enabled the group to reach many youths with the knowledge of ASRH/LHDS also advocate AYA to youth of Arusha.

The group performed during the football friendly matches but it was very difficult to reach many people.

The performances were not as effective as it could have been because there were not the budget for hiring speaker and the generator. Having proper audio equipment attracts a far greater number of people to the performance

The group had performed accordingly during the football matches and each show had a message relating to ASRH and HIV/AIDS/STDs. The first show was carrying a message about early marriage, the other second about drug abuse, the third about condom use, the fourth about relationship/communication, and the fifth about physical change.

Most of the audience have showed a good response on the message which the group have delivered, this was evaluated by the way they behaved during the shows as they were all quiet and listening as the show goes on. The adults who attended have also asked the group to perform during the ward meetings, because it is a good way to receive a strong message.

3.4.8 Data Analysis for Peer Educator Training:

Review of the data collected from 20 youths (11males and 9 females) shows that all of them who have accomplished ASRH/LPS expect to have good relationship with their parents and friends than before they have got LPS and ASRH training. Their behaviour will change and now they are free to talk to their parents and friends. The same sample of data has revealed that 65% of youth are free to talk to the people who are at the same

age. However, they all recommend parents to be open on the issues concerning ASRH and HIV/AIDS, so that they can have more from their parents.

Peer education builds on the reality that people tends to congregate and talk with other people similar to themselves. Peer education programs are those which train and deploy as educates people similar in age, place of residence, occupation or interest area to those who are targeted to receive the designated education. Peer educators reported significant gains in knowledge about HIV transmission and about where STIs services can be attained. Most of the peer educators also intend to delay their first or subsequent sexual encounters and to use condoms when sexually active.

It is expected that when the peer educators will be trained, each will reach at least 10 youths per month per ward, through one to one outreach and a minimum of 300 per month in each ward through the organised educational programs such as drama, video shows, games and peer led LPS activities to include condom demonstrations. The number of people to be reached through this strategy does not include the large numbers of youth to be reached through rallies and festivals.

3.4.9 Data Analysis for Life Planning Skills

All trained out-of-school youths were very active and aware of the importance and need to understand many changes taking in their life during this early age, the importance and ways for protecting themselves and their friends.

To measure their understanding on the topics discussed twenty youths (12males, 8 females) were asked different questions about life planning skills, 75% said that their now know how to negotiate safe sex by using condoms with their partner, while 25% almost girl said they are not sure if their partner will respond in case they want to use condom. 85% of the interviews know the ways which cause the spread of HIV/AIDS and how to protect themselves. This was discovered during focused group discussions on changes taking place to youths and their effects if they are not well Given Information about sexuality and the ability to communicate and act responsibly in sexual situations are basic programmatic offerings that must be provided to young people.

In order for adolescents to comprehend their physical and emotional change development, understand sexual issues, manage relationships and peer pressures, know how to protect themselves and their partners, be able to identify signs of illness and pregnancy and how and where to seek help, they need a fundamental knowledge of sexuality, reproductive health and ways or skills to manage relationship and social pressures. Ideally, this education and information provides skills for carrying out health intentions, such as decision-making, personal communications, negotiating safe sexual practices and an ability to express important

Life planning skills is a youth's development program that combines sexuality education with effective skill building while preparing young people for the world of

work (future). This program is age appropriate, focuses on specific pregnancy and HIV/AIDS prevention goals, and utilizes participatory training methodologies which allow young people to learn by doing rather than through lectures.

The program evolved from delinquency and substance abuse prevention programs that demonstrated the linkage between lack of certain skills (assertiveness; communication, and decision making skills and low self-esteem) and risk taking behaviours including substance use;succumbing to peer educators influence and aggressive behaviour. The LPS program was then adopted to deal with ASRH issues by organisations such as Advocacy for Youths.

3.4.10 Data Analysis for Community Mobilization:

Community leaders have supported the implementation of the strategies and the team noted that awareness campaigns were well on their way using a variety of media approaches. However, it appears to exit a tendency to repeat awareness campaigns to the communities and sensitize the population for the same old messages of abstinence, faithfulness and condom use.

The few attended parents have remained on the need for their daughters to participate on ASRH and ward leaders were left with the task of educating other parents on the importance of girls to have the same chance as boys on other events. Also the parents

were emphasized to be free to talk to their children on ASRH/LHDS, HIV/AIDS and drug abuse.

Chawakua organises a series guided group discussions with parents and community members to solicit ways in which they can support youth to protect themselves from HIV/AIDS,STIs, unwanted pregnancies/births, coerced/forced sex and other sexual exploitation. 78% of the interviews community members got information on HIV/AIDS prevention through a combination of radio/TV programs and CHAWAKUA initiatives of organizing video screening sessions. 37% of the respondents admitted to have shared information on HIV/AIDS with their friends and neighbours. Community leaders were encouraged to make ASRH supportive statements in their speeches; to include ASRH into community development agenda, to allocate resources to ASRH from district resources; and to advocate for programs supporting out-of-school youth. This communication for change training will be completed by additional focused advocacy trainings conducted by UMATI supported by UNFPA.

3.4.11 Data Analysis for Peer Educator to Refresher:

Peer educators show that they are able to link the message about ASRH, LHDS and HIV/AIDS to youths. 25 peer educators were asked on the ways youth can protect themselves from being affect with HIV/AIDS and 84% of them have showed they are well knowledgeable. Peer education is a good method to disseminate the right information among young people. The peer educators can also give advice to their

friends on sexual matters. Instead of negative peer pressure, peer education can lead to positive peer pressure among young people, which can lead to safer sexual behavior. The peer educators also plan, implement and evaluate their own activities. This increases 'ownership' and will increase the effect of the program. However this alone will not be enough. If young people have the knowledge and adopted a safe attitude, then they should also be able to carry out safe sex and better decisions. Therefore it is important that there are also youth friendly clinics where they can get treatment and counseling.

3.4.12 Data Analysis for TOT Refresher Course to VET-C Teachers

The discussions conducted during the sessions revealed most of the VET-C teachers are very familiar with the strategies to fight against HIV/AIDS/STIs and drug abuse. The time spent to train VET-C teachers as TOT was very short according to the syllabus which is in the facilitators' manual books hence the decision was made to provide another refresher training course for 10days to the same 20 VET-C teachers. At the end of the training teachers were provided with Facilitators' Manual books, Participants manual book, leaf lets and different brochures.

A six days workshop was conducted to twenty (12males, 8females) VET-C teachers of Arusha Municipality. The purpose of the workshop was to empower VET-C teachers with the knowledge of ASRH/LHDS and HIV/AIDS/STIs so that they can integrate the subject in their school curriculum. This can provide them with the content and skills to

provide the information to not only their students but also other interested teachers at their centers.

The purpose of the workshop was the result of the sensitization workshop which was done to few VET-C leaders and the four days workshop conducted to 20 VET-C teachers in the previous year. **Chawakua** has provide technical support to the trained teachers as they return to their centers to share ASRH information and skills with other teachers and as they provide ASRH and life-planning skills education to their students. Adapt/adopt and produce relevant support materials for their use in training teachers and for teacher's use because they provide information to the students.

CHAPTER IV: FINDINGS AND CONCLUSIONS

4.0 Data findings

Overall findings targeted to inadequacy of funds which has resulted in failure of payment to teen safaris, rewards to winning teams, and un-able to start micro-enterprises projects to youth. The poor participation of girls, improper use of condoms, lack of will power to convince sex partner to use condoms, are among the following findings.

Attitude towards Condom Use: Condoms were the least used means for HIV/AIDS prevention in all six wards. Knowledge of-condoms were low among male youths and very low among female youths. To some extent, condoms are still associated with prostitutes or at least with immoral behavior. Very few men and women had ever seen a condom and proper condom use was almost entirely absent. A minute number of men actually bought and used condoms. In youth talk, 2 out of 22 men in a focus group discussion had used condoms. School youths had a much better understanding of condoms and in many schools pupils had even had a condom demonstration. Teachers reported that pupils are open to using condoms.

Proper use of condoms is very limited. The fact that condoms can only be used once and then have to be disposed was not known to many people and using one condom for each round of sex was not obvious to either men or women. This has raised confusion

on many levels. Some young men, particularly unemployed, wash condoms and use them several times over. Sometimes they even share them among each other. One young man told a story about how he got drunk one night and wanted to have sex. To be safe, he thought he would use three condoms. When he was half way through the sexual act, he said he thought to himself: "Do you eat sweets wrapped in paper?" He threw the condoms out, feeling "cheated." Inaccurate, and/or inadequate information on condoms can easily backfire and discourage or alienate people from using them.

In Youths questionnaires, the reliability of condoms was questioned and some youths were concerned that condoms may appropriate for certain but not all sexual practices. Attitude is-directly linked to knowledge or the absence of knowledge. The fact that many youths have largely an abstract knowledge of HIV/AIDS explains why they blame the HIV positive partner for transmitting the HIV virus rather than themselves for engaging in high risk sexual behavior.

As a result, messages are not internalized, knowledge is ignored or dismissed, and does not translate into behavior change. In Levolosi, Mr. James Kiwale, Ward leader, argued that even actors are not abiding by the messages they communicate through plays addressing HIV/AIDS. HIV/AIDS messages are viewed as a nuisance, he added, and when they recommend pre-marital abstinence, young people laugh it off.

Attitudes toward "faithful partner" prevention strategy is ambivalent and the concern was raised over trusting one's partner: "I have a [girl] friend who lives in a village about five miles from here," said a young man. "I go there, perhaps every two weeks. How can I know what she does when I am not there?" Another one said: "They are very smart. They attract you in all ways and tell you they are healthy. What can we do?" And another: "How can we live without eating?" referring to the difficulty of being faithful to one partner or resorting to abstinence. All these tools were received from focus groups. Youth talks are among focus group.

4.1 Data Findings for youth talk

Different youth were questioned on the drug abuse, and from the wards they were found out of fifteen youth (7males and 8females) 26.7% were using drugs/alcohol and on the other hand data from Kijenge ward shows that out of fifteen youth 40% were/are using drugs.

On the case of relationships, youth which have started sexual intercourse below the age of 20years were 74.3% out of the 15 youth from the selected wards where as at Kijenge ward all of the 15 interviewed youth (7males, 8females) have started sexual intercourse at the age below 20 years. Out of which 26.7% from the selected wards have got pregnancy in this early years from the selected wards and 40% from Kijenge ward have noticed the same case.

Ward	Youth Reached		Topic Discussed
	Males	Females	
Levolosi	60	45	Physical Change
Ngarenarok	76	31	Drug abuse and Condom use.
Sekei	45	63	STIs and Physical Change
Unga Ltd	81	34	Communication
Sombetini	56	62	STIs and Relationship
Daraja Mbili	71	75	Drug and Alcohol Addiction
Total	348	310	
Comments	Youth have been transparent to discuss their personal issues. Participation of girls during the meeting had been increasing.		

The number of youth using sexual protective measures had observed to be 66.7% from the selected wards while in the Kijenge ward 53.3% responded on the use of sexual protective measures.

The trend of first sex was still worse according to the data from 15 youths which indicate that 46.7% of total youths, the first sex were just happened with 33.3% wanted. From Kijenge ward the same sample indicates that 73.3% first sex was just happened with wanted of 20%.

From Kijenge ward the same sample indicates that 73.3% first sex was just happened with wanted of 20%.

4.2 Findings for Sports Rally

Over 47% of the past trained peer educator have left the place they live, other have leave the task due to their reasons and the new one were not in good experience of revealing the actual facts about the impact of drugs, misuse/not use of condoms. Due to that reason most of the youths said that they have got messages about condom from their friends who made them still doubtful of its safety.

Despite the efforts done by **Chawakua** 20% of the youths, from the sample of fifteen youth from the six wards have get/give pregnancies in the early years. This have been explained by the victims themselves, and their reasons is not knowing the better or right way of protecting themselves from unwanted pregnancies.

4.3 Findings for Teen Safari

The peer educators have shown a good knowledge on ASRH and drug abuse. They collaborated accordingly on the discussion and brighten their colleagues about all the matters discussed. Out of twenty youths (14males and 6females) who were already or still using drugs interviewed the data shows that 80% of the youths have engaged on drugs after being convinced by their friends and only 20% was due to their own willing. Also all the twenty youths clarify that drugs have not yet give any solution on their problems and they agreed to give up using.

On the other side the VET-C TOT teachers have promised to direct their students at the **Chawakua** centre for counselling and they ask our organisation leader to conduct seminar for their students at least once in every three months. They confessed of their ignorance in family health planning and that their students know a little about the topics discussed

Table for Teen Safari findings

Activity Accomplished	Planned	Achieved	% Achieved	People Reached		Messages Discussed
				Males	Females	
Teen Safari	295	133	45%	82	51	Condom Use Drug Abuse Relationship Physical Change

4.4 Data Findings for Site Visit

The data still reveal that most of the youths are not in confidence of being not affected by STDs/HIV/AIDS which is hazardous for their future relations and existence in good health. The data shows that out of the fifteen youths 26.7% believe they are in

endangered of being affected by STDs/HIV/AIDS, comparing with the same sample for Kijenge ward 46.7% revealed they doubtfully on endangered of being affected.

Site visit is a daily routine to wards participants for project assistants who happen to be co-researchers.

Table: Site Visits Conducted in Wards.

Activity	Ward	People Reached		Message Discussed
		Males	Females	
Site Visit	Levolosi	71	57	Drug Abuse, Physical Change and Relationship
	Daraja Mbili	30	22	Condom Use
	Sombetini	27	34	Communication
	Ngarenarok	52	67	Forced Sex and Early Pregnancy
	Unga Ltd	36	38	Earl Marriage and Condom Use
	Sekei	24	12	Relationship
Total		240	230	

4.5 Data Findings for Enter -Educate.

The drama performances have been video taped and recorded. These recording will be used for project outreach activities in the newer wards, schools, and by other NGOs. To improve the quality of their performances, the drama group has been provided with uniforms and relevant/appropriate equipment such as drums to attract many youths. Most of the population are "primarily listeners and speakers rather than read and writers" and are more likely to respond positively to an approach that "embodies many of the activities, beliefs and customs" of their way of life. Communication through enter-educate reach broader audiences with messages that are tailored to meet the community norms and needs.

Table 4: Enter Educate

Activity Accomplished	Planned	Achieved	% Achieved	People Reached		Messages Discussed
				Males	Females	
Enter Educate	295	133	45%	82	51	Condom Use Drug Abuse Relationship Physical Change

4.6 Data Findings for Peer Educators

Peer education programs are effective ways of passing accurate information to youth (information provision and knowledge building). Peer education programs are more effective in changing the behaviour of peer educators than their target youths (This is postulated to be because of the fact that they receive a good sexuality education, and take their knowledge and skills are then reinforced by supportive supervision and refresher training).

Developmentally adolescents between the ages of 14-25 are more likely to be influenced by peers' behaviours and hence advice – therefore peer education is more appropriate for this age group reasons which drive more youth to engage in drugs are considered to be friends, poverty and idleness as the data shows that 40% is friends influence, and 20% poverty and idleness.

The number of youth using sexual protective measures had observed to be 66.7% from the selected wards while in the Kijenge ward 53.3% responded on the use of sexual protective measures. The trend of first sex was still worse according to the data from 15 youths which indicate that 46.7% of total youths, the first sex were just happened with 33.3% wanted. From Kijenge ward the same sample indicates that 73.3% first sex was just happened with wanted of 20%.

4.6 Findings for Peer Educators Training

Peer education programs are effective ways of passing accurate information to youth (information provision and knowledge building).

Peer education programs are more effective in changing the behaviour of peer educators than their target youths (This is postulated to be because of the fact that they receive a good sexuality education, and take their knowledge and skills are then reinforced by supportive supervision and refresher training).

Developmentally adolescents between the ages of 14-25 are more likely to be influenced by peers' behaviours and hence advice and therefore peer education is more appropriate for this age group and not for all ages.

Table for Peer Educators Findings

Activity Accomplished	Planned	Achieved	% Achieved	People Reached		Material Distributed
				Males	Females	
Peer Educator Training	25	25	100%	14	11	2,814

Reasons which drive more youth to engage in drugs are considered to be friends, poverty and idleness as the data shows that 40% is friends influence, and 20% poverty and idleness.

Peer educators are more influential in their circle of friends/peers and not with all youth in a given school or community. Peer educators may be as effective but are not more effective in educating youth about sexual and reproductive health than adult educators. Peer education programs are plagued by issue of youth turn over and issue related to incentives (this may not be different than other programs using adult volunteers who lack sufficient income to sustain their livelihood while carrying out volunteer work).

4.7 Data Findings for Life Planning Skills

There is lack of trained persons and training manual for STIs management.

There is irregularity in the supply of STD drugs and total lack of female condoms.

Although **Chawakua** tried to meet many out-of-school youths, but there is a difficult in reaching high mobile population with HIV/AIDS prevention and education message.

Another factor noticed during the discussion is a wide spread of the acceptance of multiple sex partnership.

Table for: Life Planning Skills findings

Activity Accomplished	Planned	Achieved	% Achieved	People Reached		Material Distributed
				Males	Female	
LPS Training	430 youth	330 youth	76.7%	173	157	1008

Life planning skills is a good way of preparing youths to understand the changes that will take place in their bodies and how to manage and take right decision.

Life planning skills help youth to utilize strategies which are implemented for the fight against unwanted pregnancies, HIV/AIDS and also prepare youth to manage relationship

4.8 Data Findings for Community Mobilization

Many communities underestimate the impact of the epidemic on their own community because AIDS for a long time remains an invisible disease. When community leaders are asked about AIDS in their community, the answer often masks their uncertainly. In most cases, very few people are actually tested and thus uncertainly about the extent of HIV-infection prevails.

Because of the prevailing stigma, people with HIV/AIDS often hide from the public's eye. Thus, the need for improved care and support remains hidden. Participatory diagnostics within the community will provide insights into the magnitude of the problem locally. When communities are asked to identify reasons why they find it difficult to avoid risk behaviors, they mention socio-economic reasons such as unemployment among youth, poverty leading to survival sex by women and girls, unequal gender relations, and even sexual abuse. There is need for multi-sector support from those structures/departments / organizations that address such broader development issues.

Development actions will create a positive environment for behavior change as they bring hope for the future and can contribute to income generating opportunities for women and youth. Additionally, they will be first steps towards mitigating the development impact of AIDS in the rural/agricultural system.

HIV/AIDS prevention and control activities in many communities were centered on biomedical approach and information, education and communication (IEC) messages. The underlying models predicted behavior change subsequent to increased awareness about the disease and risk. Nevertheless, minimal behavior change has occurred despite repeated use of these approaches. Lack of action on social determinants is now believed to be one of the major reasons why the epidemic keeps growing despite impressive awareness efforts in community. Addressing social dimension of development is very challenging since they touch society's deep cultural norms and values. Discussion of issues on sexual relationships is taboo to many communities in societies.

4.9 Data Findings for Peer Educator to Refreshers

A study of youths networks found that young peoples' risk behavior occur in clusters of small groups of friends who have significant influence on each other.

Youths sexual networking also indicate that members of the small group go outside the circle and may have sex with 'rich men' and 'rich women' (sugar daddies and sugar mommies) thus bringing the risk to their networks. There is also a clear link between

young people's newfound freedom, entertainment, alcohol and drug consumption with unsafe sex and accident.

Table for Peer Educator to Refresher findings

Activity Accomplished	Planned	Achieved	% Achieved	People Reached		Material Distributed
				Males	Females	
Peer Educator Refresher Course	40	40	100%	20	20	2,814
Comments	The goal was met.					

Testing is a way of HIV prevention but a lot of (young) people do not want to recognize that they have been in a risky situation. At the same time people are less afraid of AIDS and tend to have more un-safe sex. Even if we agree that it is important to offer information and services to young people, there is still much debate on how prevention messages should be carried out. At a seminar on capacity building a young girl and out-of-school defended HIV prevention in the schools, there was a youth panel in which they discussed the following statement:

4.10 Findings for TOT Refresher Course to VET-C Teachers

Most of the VET-C teachers have not stayed at their current colleges for many years; the interview revealed that 75% have stayed between 1 to 2 years.

Most of the VET-C colleges have not included LPS, ASRH, or HIV/AIDS/STDs in their syllabus. Data shows that 50% of the VET-C colleges are not teaching LPS, HIV/AIDS, and STDs in their colleges.

Table for Refresher Course to VET-C TOT findings

Activity Accomplished	Planned	Achieved	% Achieved	People Reached		Material Distributed
				Males	Females	
VET-C TOT	20	20	100%	11	9	720
Comments	Most of the participants were new, not the same attended the first training, who attends this time majority were volunteers and part time in VET-C. This was because the few permanent teachers in VET-C were not ready to attend continuously for six days.					

Also 50% of the students have asked their teacher about the place where they may have counseling about HIV/AIDS/STIs. In 11 out of the 20 VET-C colleges there are organizations which conduct seminar about LPS, ASRH, drug abuse and HIV/AIDS/STIs.

4.2.0 Introduction

Recommendation is given according to planned activities observations, most of it were produced from focus discussion groups and meetings.

4.2.1 Recommendations for youth talk

1) **Chawakua** in collaboration with government health departments, and other NGOs based on the same objectives should look at more potential way of identifying ways to break the silence amongst parents to openly discuss the issues concerned HIV/AIDS prevention.

2) **Chawakua** with ward leaders should have to conduct more youth talks in all wards of municipal so that they can reach many youths. This can be easily achieved by the ward leaders to arrange the days of extra talk apart from the scheduled days due to the fact that other wards are located far away from the proposed venue (Museum Azimio la Arusha and VIA VIA).
3) Ward leaders through their ward meetings have to emphasize and encourage parents to openly discuss with their children on how they can prevent themselves from the pandemic disease.

4) **Chawakua** staffs and Health department have to emphasize the importance of hospital treatment for the STDs affected youth as most of the youth are taking their treatment either in pharmacy or from traditional doctors.

4.2.3 Recommendations for sports rally

1) **Chawakua** recommend the ward leaders to reserve the open spaces which most of them have been taken for private purposes to be left for youth to have play grounds. Most of wards in Arusha have no pitches and this brings the constraint on the operation of other sports like volleyball and netball whereby the organisation is enforced to ask for pitches from schools/colleges.

2) Businessman and private companies are encouraged to participate during the events by contributing in term of money or material for prizes so as to encourage more people to attend the events.

3) **Chawakua** staffs, other NGOs in collaboration with the government police force should have the tendency to pass at the grounds which have shown the attitude of having many youths engaged in drugs and try to help them by explaining on the impact of drug.

4.2.4 Recommendation for Site Visit

1) **Chawakua** staffs should consult respective ward leaders and re-discuss the issue of paying honorarian to peer educators to reward and motivate them for their good job of providing ASRH, HIV/AIDS/STDs and drug abuse education to benefit youths in their respectful wards.

2) The **Chawakua** organisation should collaborate with the ward leaders and select youths to be trained for the purpose of becoming peer educators to replace the gap left by the peer educators who are not in the wards or are not providing services. This will help the youths to have proper information about condoms, safe sex, the impact of drugs, the consequences of early pregnancies, and to understand their physical changes.

3) **Chawakua** staffs should undertake regular visits to all of the selected six wards (Levolosi, Ngaranarok, Sekei, Unga Ltd, Daraja Mbili, and Sombetini) to asses the performance of the peer educators, and left them with brochures containing messages about the effect of unsafe sex, early pregnancies, drug abuse, early birth etc.

4) **Chawakua** organisation in collaboration with ward leaders should explore a possibility of identifying and training the peer educators to break the silence of the community to openly discuss issues pertaining to HIV/AIDS. Parents should be encouraged to openly discuss with their children on how they can prevent themselves from the pandemic disease.

4.2.5 Recommendations for Enter-Educate

1) **Chawakua** organisation leaders have to pass to businessmen, companies and other people to seek for money to buy or hiring the speaker and the generator which usually attracts many people.

2) **Chawakua** organisation leader have to try to talk to the popular radio station in Arusha Municipality to develop a local youth variety show including testimonials, questions and answers sessions and role plays focusing on AYA behavioural goals.

3) In order for people to get more information, other NGOs have to establish their art groups with the same purpose, also this will be a challenge for the existing one. More importantly, the peer educators will be organisers of LPS graduates into youth advocates in the community and key link between these larger groups of project. Peer educators will organise at least two rallies in which all project participants (including LPS graduates) will be mobilised to partake and support an educational theme including the world AIDS day.

4.2.6 Recommendations for Teen Safari for Peer Educators

1) **Chawakua** organisation leaders should make the arrangement for their Safari for at least three month before the planned date in order to give chance for more youths to participate. Also the organisation should have the specific time during each year for their Safari, as it may help the youth make proper preparations earlier.

2) The organization should give extra efforts on informing youths on the impact of drug abuse by make close ties with the parents and school teachers to talk with their children/students friendly so that they can understand well.

4) The government health department should make sure that the selling of drugs is strictly prohibited and reactions must be taken to the people who are involved in the production and distribution of drugs.

4.2.7 Recommendations Peer Educator Training

1) In light of the issues about peer educators, **Chawakua** have to use LPS as the base sexuality education strategy and have to reinforce the messages from those programs with messages from the peer educators (PEs). The youth have been viewed as educators rather than as blanket peer educators since all the youth in the community do not see them as their friend/peer.

2) **Chawakua** have to provide support and supervision to peer, and organise refresher training after every six months where peer educators will share experiences, correct misinformation, reinforce messages, renew commitments, and stay involved and engaged in the promotion of sexual health.
3) **Chawakua** have to work with the peer educators to develop an outreach plan including average number of youths to reached by each peer educator per month, number of activities to be organised in the community (video shows, drama, LPS

activities, etc) and resources (educational materials, equipment and technical assistance from staffs) that they will need to carry their activities effectively.

4) **Chawakua** have also to work with peer educators to develop activity recording and monthly reporting forms suited for low literate youth.

4.2.8 Recommendations for Life Planning Skills

1) **Chawakua** in collaboration with other stake holders and the government department should have the regularity of arranging various life planning skills at different period of the year so as many youth can be reached with the messages about physical and emotional development.

2) **Chawakua** have to recruit more trained persons so that they can arrange more seminars on life planning skills which can help many youth to be reached with the messages of ASRH, drug abuse, relationship and HIV/ADS/STDs.

3) The government should make sure that there is regular supply of STDs drugs and female condoms are available wherever they needed and at affordable price so that women can turn from the habit of being decision takers in relationships and be decision makers as well. Also there is a need for the government to establish STDs departments in all large hospitals.

4) **Chawakua** and other stake holders should emphasize the importance of having single partnership as one of the main strategy for the protection of HIV/AIDS and other STD.

4.2.9 Recommendations for Community Mobilization

1) Community leader actions for behavior change should start immediately and be independent of external support. Based on initial actions by the community. the action committee could request support for improved condom distribution, support for the diffusion process and for increased mitigation activities and improved services.

2) **Chawakua** and other stake holder like UMATI, Marie Stops and government organizations emphasis should be put on social mobilization combined with focused IEC, improved health services, availability of condoms and targeted interventions.

3) **Chawakua** staffs and peer youths have to conduct more PLA activities including community resource mapping (clinics. churches. bars. markets. kiosks. vocation training centers, video parlor and any other place where youth congregate and receive information); and PLA activities with youth aimed at identifying why adolescents engage in sexual risk taking and what will work to make them protect themselves.

4.2.10 Recommendations for Peer Educators to Refresher

1) Through PLA techniques, CHAWAKUA, UMATI, Marie Stopes and other AYA implementing partners have to try to understand the sub-culture of both in and out-of-school youths including their sexual networks so as to identify influential persons in each network and the potential for empowering sub-cultures to adopt protective behavior.

2) **Chawakua** and other stake holders have to promote behavior change action: Different groups (men, women and youth) separately make vulnerability assessment and decide on actions to reduce the vulnerability. Each group also decides to create more supportive environment for behavior change. Promote awareness about the epidemic; IEC campaigns continue with old messages – abstinence, faithfulness and condom use. Given quite high general awareness about these preventive measures, a rapid movement to promoting behavior change is recommended.

3) The way HIV/AIDS is portrayed by various stake holders should change. The image should be more positive. The emphasis should make clear that infected people are living with HIV/AIDS and not dying with it. Strategies that aim to make people have safe sex through focusing on the 'dangers' of sexual relations will contribute to create a climate of prejudices and the stigmatizing of people living with HIV/AIDS. This will accomplish the exclusion and marginalizing of

people who consequently will go underground and are not being reached. The challenge we identify is raising awareness on the necessity of preventing HIV/AIDS without using the everlasting tool of frightening people for the 'dangers' of sexual relations. This is not empowering. Strategies for HIV prevention should promote free choice and provide opportunities instead of forcing changes of behavior.

4.2.11 Recommendations for TOT refresher course to VET –C Teachers

1) **Chawakua** and other stake holders have to pass in various VET-C centers so that they can train the students about LPS/ASRH and HIV/AIDS.

2) The government through the ministry of Education should make sure the curriculums of the VET-C colleges are including LPS and ASRH. CHAWAKUA and other organization may contact the heads of academic department for them to prepare short term syllabus for the VET-C colleges.

3) Various stake holders have to look for the importance of having special days for counseling with VET-C students. Stake holders should be from different fields in order to collect a lot of ideas suitable for youth from various ministries. Interested parties should be encouraged to contribute for the benefit of our youth and National at large.

4.4 Conclusion

It needs number of years to ascertain the real results of behavior change. Even though this will not give us set back and see our youth get destroyed we will start delivering support by means of educating them and with **Chawakua** we will continue this programme for the coming five years. Feedback by that time will be certain. To monitor the course of a BCC strategy properly, it is necessary to establish effective information-gathering systems. These include reports, site visits and reviews of materials. Reporting tools and protocols must be standardized to ensure consistency.

Chawakua organization should collaborate with the ward leaders and facilitate sensitization and awareness creation sessions on early marriages, condoms use, drug abuse relationship and physical body changes; these will increase the course of HIV/Aids reduction. For the youth development of initiatives and micro-enterprises projects at the district and ward level including the religious leaders, school teachers, and the National Youth Office, at the Strategic Planning Exercise of the National Youth Programme so that youth should be trained in entrepreneurships to increase income of youths.

To conclude, behavior change strategies that do not address socio-cultural norms Including early sexual behavior, alcohol and drug abuse, bar and disco culture ritual cleansing and wife inheritance, etc. but only hinge on sexual behavior per se are not likely to be effective, particularly among youths.

This may also explain why behavior change is reported to be very difficult to measure. If behavior was also measured in terms of changing patterns in alcohol consumption, frequency of bar visits, unfaithfulness of sexual partners etc., perhaps a more accurate picture of behavior change would emerge.

However, **Chawakua** succeeded in creating awareness in BCC to youths of Arusha and was rewarded with a certificated and trophy by the Municipal Council of Arusha in worlds Aids Day. Empirical review

Chawakua must establish linkages with:

1) Multilateral organizations like UNDP, UNAIDS, WHO, UNFPA projects to mitigate the socio-economic impact of HIV/Aids through Micro-Projects.
2) Local NGOs working in the district in HIV/Aids related work, including ANGAZA, TACAIDS and ISHI Tanzania.

CHAPTER V: IMPLEMENTATION OF ASSIGNMENT

5.0 Project Implementation

Develop Monitoring and Evaluation Plan

The purpose of this study is to strengthen community strategies to improve quality of care services first implemented as part of **Chawakua** project of behavior change communication. That intervention focused on health facilities, and the accompanying organization interventions were found to be insufficient, because there is no one person responsible for monitoring and evaluation and monitoring and evaluation was never done since the initiation of the NGO, 1992. Groups that do not regularly attend health facilities, such as adolescents, men, and women with older or no children, remained out of reach. To reach these target audiences and improve community demand for services, **Chawakua** implemented a community education intervention focusing on sexual and reproductive health and rights.

As a researcher from CED programme my implementation agenda is to prepare plan for monitoring and evaluation, which needs to be drawn up during the initial stage of behavior Change Communication strategy design. The information to be gathered for BCC should be linked to the program's overall monitoring system.

Monitoring is part of the ongoing management of communication activities, and it usually focuses on the process of implementation. The following will closely be monitored:

Reach:

The plan is to reach 6600 youth at the end of this project in an expectation of reaching Youth who are expected to fill questionnaires are in this program each to reach ten other youth, and the other ten to reach another ten and to repeat until the population of 6600 reached in Arusha Region.

Coordination:

Communication in reaching youth by means of delivering education in ASRH, Condom use, parent to child talk, youth talks delivering materials which will communicate their ideas in order to get the delivered messages and broadcasting radios and drama groups will all be communicated to the selected youth in this eleven months project time.

Scope:

Meeting points as well as in easily visible places such as the posting referral lists of local sites in **Chawakua** offices, local market stalls, bars, video parlors and pharmacies. Provide handouts of referral service lists and what to expect from each services youth during trainings and during outreach. Communication will effectively integrated with the necessary range of audiences, the Behavior change communication issues will have to meet the targeted group who are out of school youth from the

selected six wards of Arusha. Services delivered should be supervised and the targeted youth should benefit.

Quality:

Channel used will be to raise awareness of reducing HIV/Aids/STIs and Reproductive Health to the community. To promote behavior change through education, blood screening as well as condom distribution. We also have to use media channels to reach the community. Moral support to the targeted youth should be encouraged and without forgetting spiritual support to the effected and affected especially women and youth. Empowerment of youth out of school and orphans in different skills to become self employment by offering them advises how to acquire loans from microfinance's and join micro-enterprise sectors. All out-of-school youth participating in **Chawakua** trainings, outreach, or receiving materials will be given a set of information related to service seeking including ways to identify symptoms of STIs, at least two service points where they can find treatment of STIs, partner notification and treatment skills, one VCT site in the municipality, and where to get information about service delivery issues.

Feedback:

Peer educators will collect responses from target populations to help identify changes that may have to be made in the environment or aspects of communication and services that may need to be addressed. Measurable changes in behavior and environment in this period of this project will be very difficult. When changing behavior, the individual,

behaviors, at least under certain circumstances. Understanding where the majority of a group is in the change process is crucial when designing a BCC strategy.

Periodic focus-group discussions and in-depth interviews will also help BCC programme to assess the perceptions of target populations which are been organized and hosted by peer educators have been a big success for this project which make peer educators reach more targeted youth also keeping in touch of peer and know what is going on in the wards. Many youth who were drug addict, prostitutes, who started sex at early age and even those who had aborted, at youth talk they are usually ready to share experience with other youth.

The M&E Plan will also include monitoring and support supervision schedule done by **Chawakua**. The M&E schedule will be accompanied by development of monitoring, supervision and reporting tools specially suited at risk and low-literate youth in 3 District. The objectives of these tools will be to supervise quality of implementation of project activities (are activities leading to an actual learning commensurate with behavior change); whether activities are being implemented as planned and budgeted; ensure documentation of project experiences and youth reached as well as effectiveness of strategies being used. Forms to be developed include those to be filled by PEs during their outreach activities on a daily and/or monthly basis.

The ultimate goal of any HIV prevention program is to reduce the number of new infections. Evaluating the impact of HIV/STI interventions on reducing HIV transmission is, therefore, an essential part of overall prevention and control efforts.

However, this type of program assessment remains an elusive goal for most AIDS control programs because of the prohibitive costs and methodological difficulties associated with field-based program impact evaluation. As a consequence, the important question of the extent to which program effects may lead to reductions in HIV transmission is usually not answered by intervention programs.

5.1 Incorporating Input from the field:

Participatory community mobilization is a dynamic approach designed to facilitate social change regarding a public health issue by involving various stakeholders in the identification of root causes of their problems and to plan, implement, and evaluate appropriate and culturally sensitive solutions. Projects facilitated by community devised solutions are often more successful than solutions identified and implemented by the outside.

Stigmatization was hardly mentioned during my interview, I observe it as a norm and it needs objectives to be dealt with.

Poverty eradication being the main target of all programmes in our African countries in this project is deficit because there were no exercises of empowering youth in order to employ themselves or sensitize them in forming groups and seek consultancy in getting microfinance help.

5.2 Need of a Targeted Area

Arusha being an attractive town due to different business carried out such as United Nations offices (UN), Tribunal court offices, Arusha International Conference Centre

(AICC) have been attracting girls from nearby Districts and others from other part of Tanzania to come to Arusha and involve them in commercial sex work. The town is also serving 2 Region of being Manyara and Arusha itself. The mining is taking place in Manyara Region and the selling centre is done in Arusha Municipal consequent brings people from all over Africa. Lack of employment to young people has caused poverty situation to most of the families hence advanced have been taken by young girls and sometimes parents using their young girls in commercial sex work so that they can make their earning.

Chawakua has observed that the most problem to youth is accessibility of employment to young people between 20 to 24 years old which forces these young people especially girls to involve themselves in commercial sex workers and young men to work in mining areas where most get HIV/AIDS infection, and if they miss all these then they become drug addicts, pick pockets or what ever unwanted behavior faces them, this means Arusha youth and women desperately need accurate health information, quality health services and viable economic alternatively.

From these observations, **Chawakua** therefore want to continue with the project of "Behaviour Change Communication" to the previous pilot wards for enter educate activities and also expand the LPS/LHDS activities in other 6 wards of Arusha Municipal and other near by District of Arusha Region.The proposed project **Chawakua** will be operating in 16 wards of three districts in Arusha Region so that to

bring access of information and high quality to health, social and economic services to youth at risk and other marginalized groups.

Chawakua will implements its activities in 12 wards of Arusha Municipality and four wards of Arumeru and Monduli Districts.

In the five implementing years, the project will use variety of complementary strategies aiming to address core sexual and reproductive health needs to youth at risk and others design as support strategies to reinforce specific messages, promotes specific behaviors and/or services. These will include life planning skills (LPS), peer education, and enter-education. The project will strive to use participatory teaching methodologies, and material production that are appropriate for the sex, age, sexual activity status, culture, and literacy levels of youth and women in Arusha. **Chawakua** will conduct different training during the life span of the project, hence **Chawakua** members and youth will be identified and trained as TOT so that to enable them facilitate the project training.

5.3 Planned Budget

Considering the above statement **Chawakua** respectively requests the support of US $ 599,955.52 so that to improve the quality of ASRH and well being of risk youth in Arusha Region.

Indicators:

1) Reduce prevalence of STIs and HIV/Aids among youth at risk

2) By the end of the project to have reached at least 50% of young female commercial sex workers with information and education ol LPS.
3) At least 30% of sexually active youth should report good uses of condoms in every sexual act by the end of the project
4) 30% of orphans to receive in kind and cash support from the communities.
5) By the end of the project at least more than 30% of drug addict youth will be reached with counseling information, and education on ASRH/STIs/HIV/Aids.
6) Reduce number of youth who are drug addict by 20 percent by the end of the project.

5.5 Implementation Mechanism for Future Work:

a) Involve children and youth in terms of child participation;

b) Prioritize stigma and discrimination and raise awareness of how this affects children and the links with poverty;

c) Target faith based organizations since for many South Africans, faith or religious beliefs play a major role in our sense of personal identity, thought processes, moral judgments and perceptions of disease. Traditional and faith based leaders have an enormous amount of influence through the spoken, broadcast and spoken word, ceremonies, and traditions, and can therefore

play an integral role in determining how communities respond to the challenge of BCC

d) Target risk (vulnerability) factors in where BCC suffer from self discrimination, family situations where children and youth are abused and community networks where children and youth are marginalized;

e) Target protective factors which promote the use of extended families and communities as protective networks;

f) Increase the levels of information that challenge negative attitudes and stereotypes;

g) Promote awareness of BCC in terms of their rights to access basic services (education, health, welfare, legal) particularly in rural areas and increase understanding and non-acceptance of barriers to access;

h) Provide tools for early recognition of Behavior change communication and publicize avenues to access community and social support structures

i) Provide assistance and information around succession and financial planning, obtaining birth certificates etc. before children are orphaned. In conjunction with the relevant authorities, increasing knowledge about how to access relevant social security e.g. foster care grants;

j) Highlight good practice where social support networks or circles of support are functioning and provide information to assist BCC when a particular component of the 'circle' is non-functional;

k) Realize that BCC are not a burden for the education sector alone, but for all sectors (health, welfare, social development);

l) Campaign for community involvement and dialogue in addressing cultural prejudices and inequalities with regard to BCC

m) Recognize that contextual factors play a significant role in determining a response to the epidemic, including socio-economic, gender, education, locality, resource and HIV/AIDS related delivery factors

n) reinforce and strengthen existing positive media initiatives like opera and cinemas

o) Ensure that any intervention is sustainable.

5.6 Output and Deliverables of the BCC Component will be:

- Utilizing data from the BCC evolution research and also its commissioned research and evaluations
- It will also focus on in -depth analysis of critical issues such as HIV/AIDs
- Analytical reports on surveys and censuses
- Updating relevant indicators
- **Chawakua** Annual report and its quarterly reports.
- A communications strategy with an interactive element to facilitate ongoing feedback from stakeholders

The **Chawakua** monitoring website with links to the national website will be used as part of the monitoring mechanism.

- A communications strategy with an interactive element to facilitate ongoing feedback from stakeholders

The **Chawakua** monitoring website with links to the national website will be used as part of the monitoring mechanism.

REFERENCES

An introduction to sexual health-International Federation of Red Cross and Red Crescent societies, 1995

Assessment and Monitoring of BCC Interventions: Reviewing the Effectiveness of BCC Interventions. Arlington, VA: AIDSCAP/Family Health International, 1996 [published in English and French].

Behavior Change Communication for the Prevention and Treatment of STDs. Arlington, VA: AIDSCAP/Family Health International, 1997.

Behavior Change through Mass Communication: Using Mass Media for AIDS Prevention. Arlington, VA: AIDSCAP/Family Health International, 1996 [published in English and French]

Bertrand, Jane E. Communications Pre-testing. Chicago: Community and Family Study Center, University of Chicago, Media Monograph 6, 1978.

Cabanero-Verzosa, Cecilia. Communications for Behavior Change: A Toolkit for Task Managers. World Bank Human Development Department. Washington, DC: The World Bank, 1996.Communications Framework for HIV/AIDS: A New DirectionUNAIDS/Pennsylvania State University, 1999.

Draft an inventory of successful income-generating activities for youth and initiatives for AIDS home care handbook, World Health Organizatio, 199AIDS: working with young people: Aggleton P,Rivers, and Warwick

Evaluating the Impact of Development Projects on Poverty, A hand book for Practitioners, by Judy I. Baker, The World bank Washington,D.C.

How to Conduct Surveys, A step – by-step Guide, by Arlen Fink and Jacqueline Kosecoff. Kalichman S, Hospers H.Efficacy of behavioural –skills enhancement HIV risk-reduction interventions in community settings AIDS 1997; (suppl A): S] 91-S199. Kalichman S,Rompa D,Coley B.Lack of positive outcomes