A COMPARISON OF THE KNOWLEDGE AND ATTITUDES OF SCHOOL COUNSELLORS TRAINED IN THE "PREVENTION AND AWARENESS IN SCHOOLS OF HIV/AIDS" PROJECT AND UNTRAINED COUNSELLORS IN TANGA REGION, TANZANIA.

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A mini-thesis submitted in partial fulfilment of the requirements for the degree of Master in Public Health at the School of Public Health, University of Western Cape

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A COMPARISON OF THE KNOWLEDGE AND ATTITUDES OF PASHA TRAINED AND UNTRAINED SCHOOL COUNSELLORS IN TANGA REGION, TANZANIA.

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Abstract

A Comparison of the Knowledge and Attitudes of PASHA Trained and Untrained School Counsellors in Tanga Region, Tanzania

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In secondary schools in Tanzania, teachers are selected to take on the role of guidance and counselling in addition to their teaching duties. They are expected to be key players in supporting school youth to develop responsible sexual behaviour to avoid HIV/AIDS infections. However, it was unknown to what extent they fulfil this role or are willing and able to do so. The *PASHA* (Prevention and Awareness in Schools of HIV/AIDS) project has trained counsellors in the Tanga region of Tanzania on sexual reproductive health (SRH) and counselling skills. This study aimed to establish the effect of the training that was provided by *PASHA* on the knowledge and attitudes of school counsellors regarding HIV/AIDS. The research was conducted as a quantitative, observational KA (knowledge, attitude) study in 57 schools (37 or 32 % of the intervention schools, 20 non-intervention schools) in Tanga region, using questionnaires to compare the knowledge and attitudes of trained counsellors with those of untrained counsellors towards HIV/AIDS, sexuality and reproductive rights of their students. Questionnaires were pre-tested and then administered face-to-face over a four week period in 2007. Eighty five counsellors were interviewed, 56 of these had received in-service training as counsellors, while 29 had not received any training by *PASHA*.

School counsellors were found to be mostly young, with 47 % in the trained group under the age of 29, and 86 % in the group of untrained counsellors.

The level of knowledge of basic facts on SRH and HIV transmission was very good in both groups. Attitudes regarding students' sexuality, sexual abuse, sexual reproductive rights and stigmatization were on the overall positive and supportive to the students. Even though not statistically significant, a continuous trend towards more open-minded, progressive and rights-based views could be observed among the trained counsellors regarding early sexuality education, condom use, masturbation, pregnant girls being expelled / re-admitted. In addition, the trained group was much clearer about their roles as counsellors, which many untrained counsellors misunderstood as being responsible e.g. for tuition and for disciplinary issues. However, some reservations are still apparent among counsellors regarding the effectiveness of condoms. Surprisingly, the younger counsellors appeared to be more strict and conservative than their older counterparts. Further research will be necessary to determine if there is an association and/or if age is a confounding variable; other possible variables emerging were marital status and geographical setting.

In conclusion, this study indicates that the training provided by PASHA opened up counsellors' minds towards their students' difficulties, needs and rights regarding SRH and should therefore be continued. In future training, emphasis should be put on adolescents' rights and on advocacy of condom use for those students who do not abstain.

DECLARATION

I declare that *A Comparison of Knowledge and Attitudes of PASHA trained and untrained School Counsellors in Tanga region, Tanzania* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Dorothea Coppard 3 April 2008

Signed: 

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CONTENTS

Chapter 1: Introduction

1.1 Context and problem statement

The prevalence rate of HIV among youths (15-24 years) in Tanzania is estimated to be 4% in females and 3 % in males compared to the overall prevalence of 7.7% in females and 6.3% in males (TACAIDS, 2005). While the prevalence is lower than in the general population, youths have the highest incidence rate by far and need to be a target for prevention strategies. Research shows that young people, especially school students, have adequate basic knowledge on reproductive health, including HIV/AIDS prevention, but there is little evidence that behaviour has changed (Ministry of Education and UNFPA, 2001; AMREF, 2004; PASHA 2004-2006, Plummer et al, 2007). In addition to the efforts of the health system and mass media campaigns, the education system is ideally positioned to reach large number of youths. The strategic plan of the Ministry of Education and Vocational Training (MoEVT) tasks Biology and Civics secondary school teachers to address HIV/AIDS in the classroom as part of the curriculum, while school guidance and counselling services are being established to offer psychosocial support and to initiate and supervise peer education activities on HIV/AIDS. School guidance and counselling teachers have this role in addition to their normal teaching duties but have usually received little or no training to do so.

The *Prevention and Awareness at Schools of HIV/AIDS* (*PASHA*) project, which is implemented by the Swiss Tropical Institute on behalf of the German Development Cooperation, aims at preventing HIV/AIDS among secondary school students. One of its key interventions has been the in-service training of school counsellors. It is not known though to what extent teachers in general or

even trained school counsellors assist students and guide their behaviour, or are willing and able to do so.

Possible factors preventing them from carrying out this role might be lack of understanding of the need to do so, lack of skills to convey the messages and to counsel students, the authoritarian hierarchical structure of the society which is preventing a close relationship between teacher and students, own values based on traditions, culture and religion, fear of conflict with parents and community leaders, denial of the problem and the risks of being infected, and high workload (Visser, 2004). However, there is a lack of information on the extent to which these factors limit *PASHA* trained and untrained school counsellors from effectively educating their students about sexuality, HIV/AIDS and life skills. In fact, little attention has been given to evaluating the effect of the in-service training programme provided by *PASHA* to counsellors, even though it is important to identify gaps and thus inform efforts to strengthen the programme.

1.2 The PASHA project training programme for school counsellors

In 2001, the Ministry of Education and Culture in Tanzania decided to offer support to students through establishing guidance and counselling services in the schools. Counsellors were supposed to be part of a school committee overseeing guidance and counselling services as well as HIV/AIDS education, including peer education activities. In 2003, the *PASHA* project established in a survey that the concept of school counselling, which was meant as support for students rather than a disciplinary function, was not well understood by students and staff and

either not implemented at all or implemented without meeting critical criteria (PASHA, 2003). These criteria included involving the students in the selection of counsellors they trusted, counsellors not becoming involved in disciplinary issues and provision of confidential space. Above all, the survey made it apparent that counsellors were generally not informed about their role and had not received training. This finding is similar to that of Maluwa-Banda (1998) in Malawi, who conducted a survey on the perceptions of guidance and counselling teachers in Malawi.

Establishing counselling services in all secondary schools in the region of Tanga, Tanzania, became one of the objectives of the project in its first phase (2003-2006) as a means to achieve the overall goal of enabling school youth to make informed decisions towards responsible sexual behaviour. Besides sensitization activities and enforcing selection procedures which allow students to elect counsellors of their choice, a 2-week training programme was developed in 2004 which addressed sexual reproductive health, adolescence and gender roles and included the practice of communication and counselling skills, action planning, record keeping and networking with other service providers. The training was followed-up through annual planning and review meetings with heads of schools and short refresher-training for counsellors (three days), during which challenges and possible solutions were discussed and skills further practiced. To a limited extent, school visits and supervision activities were carried out. However, due to the large expansion of the secondary school system during the first phase (from 71 schools in 2003 to 116 schools in 2006), combined with a great mobility of teachers, a second group of new counsellors was trained in 2005 in a basic

training which, due to financial constraints, was reduced to only 1 week and immediately followed by a three day refresher course, thus still adding to eight training days. The content of this reduced training had been tightened but was otherwise the same as the initial training, using the same facilitators, to ensure a similar level of depth and quality.

It was evident during refresher training programmes that the counselling skills of the school counsellors had increased. Monitoring and evaluation concentrated on availability of trained counsellors, counselling rooms and resources as well as utilization of counselling services. No evaluation was carried out to determine counsellors' level of knowledge regarding SRH and HIV/AIDS or their views and attitudes. This motivated me to carry out this study, with the aim to *compare the knowledge and attitudes of secondary school counsellors trained by the PASHA project with those not trained, in the Tanga region, Tanzania.* The study was based on the hypothesis that the training would have a positive effect on attitudes of counsellors regarding sexuality education, gender and reproductive rights. Specific objectives of the study were

- To describe the HIV/AIDS-related knowledge and attitudes of *PASHA* trained and untrained secondary school counsellors in Tanga region, Tanzania
- To establish differences, if any, in the HIV/AIDS-related knowledge and attitudes of *PASHA* trained and untrained secondary school counsellors in Tanga region in Tanzania.

- To determine training needs with regard to HIV/AIDS among secondary school counsellors and make recommendations for future training programmes.

I decided that a quantitative, quasi-experimental study into the knowledge and attitudes of school counsellors would be the most suitable study method. In the following chapters, I will present key findings from other relevant research, before I will introduce the rationale for the selection of the study sample, results, discussion and conclusions with recommendations for future training programmes as well as recommendations regarding policies.

Chapter 2: Literature Review

2.1 The role of school-based sexuality education and HIV/AIDS

Young people are the population group least likely to be infected with the HIV-virus, while at the same time incidence in this age group is the greatest. As Lloyd (2007) argues, this risk is still increasing due to a greater time span between menarche and marriage and a frequent disconnect in developing countries between traditions and cultural practices such as initiation rites on one hand and the exposure to the modern way of life on the other hand. This is expressed also through high rates of school-dropouts due to pregnancies, and through high incidence of STI infections among youth.

Following the Alma Ata declaration (WHO, 1978), where health was defined not only as the absence of disease but broadly as the overall mental, physical and social wellbeing, the Ottawa Charter for Health Promotion in 1986 defined the prerequisites for health, such as food and shelter, education, stable eco-system and sustainable resources, income, peace and equitable conditions. It emphasizes the need for five steps for a comprehensive health promotion approach. These steps are developing personal skills, health promoting policies, an enabling environment, promotion of community participation and reorientation of health services through the processes of enabling, mediation and advocacy, which will make the achievement of such favourable conditions possible (WHO, 1998). Based on the Ottawa Charter for Health Promotion, the World Health Organization (WHO) prepared a document to provide a rationale for and assist in establishing health promoting schools, with the specific aim of preventing HIV

and AIDS (WHO, 1999). The Policy Project (2000) summarized guiding principles for public health interventions by UNAIDS, WHO and USAID, such as advocating prevention strategies and targeting those groups in the population at high risk, including youths. The assumption regarding sexuality education programmes usually is, supported by the health belief model, that if awareness and knowledge are improved, behavioural change will follow or safe behaviour will be enforced (Mullen, Hersey & Iverson, 1987). Many studies have argued for the relevance and effectiveness of school-based sexuality education programmes as a means to fight the spread of HIV/AIDS and have assessed research for evidence on the effectiveness of such programmes through meta-analysis, noting that interventions frequently improved knowledge but not necessarily behaviour (Kirby, 1995; Badcock-Walters, Kelly & Goergens, 2004: Wegbreit, Bertozzi & Padian, 2006; Okonta & Oseji, 2006; Borgia, Marinacci, Schifano & Perucci, 2005). This is what James, Reddy, Taylor and Jinabhai (2004) call "the gap between awareness and behaviour", while assuming that teachers mediate knowledge and skills effectively to the students. Very few studies have looked into the impact of prevention programmes on the teachers who are assumed to be facilitating the process. But, without teachers having the desired correct and appropriate knowledge, attitudes and skills, prevention programmes cannot have the desired effect on students.

2.2 What type of school-based interventions is effective?

The critical question to be asked is which interventions have actually been successful in improving knowledge, attitude and/or behaviour, and what common characteristics these interventions might have so that results could be replicated.

Various researchers attempted to answer this question by reviewing studies and evaluations of school-based interventions. Many of these studies, and in particular the older ones, were done in the 'Western' developed countries, mainly in the US (Kirby, et al 1994; Coyle et al, 1999; Siegel et al, 1995). While Siegel et al. (1995) concluded that the interventions achieved an increase in knowledge among students; Coyle et al. (1999) suggested that multi-component interventions led to behaviour change such as increased condom use.. But Kirby et al. (1994) argued in their review of 1994 that evidence for the effectiveness of interventions was insufficient and that many questions remained unanswered regarding the level and the quality of implementation of the programmes and the trainings conducted, as well as to whether programmes promoting abstinence were effective. Their findings suggested that fewer key messages were more effective than those coming up with complex recommendations.

Only from the late 1990s onwards, studies reviewed interventions in resource-poor countries and/or in Africa and were therefore of greater relevance for the context of Tanzania. In a review of 22 evaluations of mainly curriculum-based interventions in developing countries, Kirby, Obasi and Larris (2006) found that 73 % of these indicated positive behavioural change (delayed sex, reduced frequency, reduced number of partners, fewer unprotected sex). The authors did however encounter the problem that interventions as well as their evaluations

were difficult to compare – studies used different methodologies and the quality and duration of implementation, the age group addressed and context factors were frequently not the same and sometimes not even known. Mellanby, Rees and Tripp (2000) argued in their review, that the complexity and multiplicity of factors in the school context required very large sample sizes.

Gallant & Maticka-Tyndale (2004) came to similar results in their analysis as earlier researchers in the US, finding significantly increased knowledge in 90 % of intervention research and some improvement in attitude, while few studies indicated behaviour change such as delayed sex or increased condom use (2 out of 11 studies).

Kirby, Laris and Rolleri (2005) asserted from their findings that sexuality education does not speed up the onset of sexual intercourse – a concern frequently expressed by parents, community members and teachers (Action Aid, 2002; Adamchack, 2005; Palmstierna, 2006; Reddy, James &McCauley, 2003), but may or may not lead to an increase in the use of contraceptive methods including condoms (Magnani et al, 2005; James et al., 2006: Reddy et al, 2003). Badcock-Walters, Kelly and Goergens (2004) came to similar results in their meta-analysis. They found a clear correlation between interventions and increased levels of awareness and knowledge, but limited change of behaviour which they assessed by applying a variety of biological and behavioural indicators. They also noted the protective effect of schooling on girls. Most studies show a negative correlation between level of education and HIV-prevalence, confirming that education can indeed be considered a 'social vaccine', where access to schooling and retention already offer some protection against early pregnancy and STIs including HIV

infections. Very interesting is a study by Stigler et al. (2006) in Tanzania which focused on mediators that might promote or prohibit the desired outcomes of programmes. It found convincing evidence that exposure to HIV/AIDS information and knowledge increase are significant mediators, as were the change of subjective social norms through peer discussions towards norms which restricted sexual activity. On the other hand, increasing self efficacy through role plays did not have any effect on the intention to be sexually active – possibly because self efficacy was not developed sufficiently despite these activities. At the same time, recent reviews of programme evaluations have demonstrated clearly that the increasingly promoted 'abstinence only' interventions that promote abstinence as the only preventive behaviour, have not been able to reduce risky behaviours, incidence of STIs or pregnancy in high income countries (Hawes, Sow & Kiviat, 2007), while little research has been done regarding their effectiveness in developing countries.

However, as studies are not standardized and use different research tools and methodologies, results are not always comparable. Almost all studies identified used questionnaires with knowledge questions on sexual reproductive health and some on attitudes and practices. Research tended to be quasi-experimental or experimental and quantitative in nature yet used very small samples that do not allow generalisation of findings. Few of the studies reported did present the tools used, again making comparison and assessment of rigor difficult. Admittedly, determining change in behaviour in cross-sectional studies is difficult being reliant on usually self-reported behaviour or intended behaviour and may – even if there is a change - not be sustained over long time periods (Badcock-Walters et al,

2004). In addition, there may be reporting or desirability bias as study participants may report behaviour that they think may be desired by the researchers.

Wegbreit, Bertozzi, DeMaria and Padian (2006) summarized that school based interventions were difficult to compare as their context was particularly complex and influenced by many, frequently un-researched factors. There is evidence that many interventions achieve an increase in knowledge, while they their impact on attitudes is not always certain and on behaviour even less so. Research has shown clearly that they do not have any adverse effects such as earlier sexual debut.

2.2.1 School-based interventions: teacher-led versus peer education

Looking into school-based interventions, one can distinguish between two common types of interventions: those which are led by the teacher(s), e.g. through everyday teaching, and those which are based on peer education. Teacher-led interventions usually refer to curriculum based teaching of factual knowledge, but may also address values and attitudes through life skills education. In South Africa, life skills education (which incorporates sexuality education, HIV/AIDS, risk behaviour etc.) was included in the normal school curriculum as a national programme and was therefore to be implemented by teachers in all schools. Visser (2005) conducted a large study assessing the life skills programme and found that the programme led to increased knowledge and some improvement regarding attitudes. She acknowledged the influence of contributing factors as a limitation of her study. These other factors could possibly be responsible for the fact that students reported increased sexual activity despite the intervention. James (2006),

who assessed the same national life skills programme, confirmed the improvement of knowledge but could not find any effect on attitude, self-efficacy or behaviour. Considering the scale of this programme, these findings are rather disappointing.

Many school-based interventions utilize both teacher-led and peer education approaches. I looked into several evaluations of such interventions in African settings. Researchers agree that teacher-led interventions improved the knowledge of students - a prerequisite to change of attitude and behaviour, but there was little indication for such change. Peer education, carried out by trained peer educators of the same age group, had better potential for change of attitude and for protective behaviour such as delayed sex or condom use. Protective behaviour was particularly pronounced in students who were already sexually active (Wolf, 1998). Where condom use was increased as a result of an intervention, it was not necessarily sustained (Agha, 2002; Agha & van Rossem, 2004). Peer educators were not as suitable as teachers to transfer knowledge and were not always good role models themselves. Studies in the UK and the US showed that peer-led education seemed least effective with students who were at high risk (Siegel et al, 1995; Oakley, 2006); I could not establish whether this would also be true in the East African context, where factors influencing risk behaviour would be different. Factors or mediators in Tanzania were investigated by Stigler et al (2006) who found peer-led discussions as having the potential to change social norms.

2.2.2 Characteristics of promising practices

Among the researchers that have conducted meta-analysis of evaluations and research of school programmes to determine whether they are effective, have also tried to identify commonalities of effective interventions. General recommendations evolving include a minimum quality standard of schooling, avoiding stand-alone interventions in favour of multi-pronged integrated approaches, linking with health services, community involvement to ensure political and cultural acceptability, needs-based programmes tailored to specific target groups, gender equality within the school context (Badcock-Walters, Kelly & Goergens, 2004; WHO, 1999; Wellings et al, 2006). Kirby, Laris and Rolleri (2005) identified in their meta-analysis seventeen characteristics of curriculum-based programmes, related to a broad content of the programme including certain skills, the development of a needs-based programme that stakeholders can input, and appropriately selected and trained implementers, usually the school teachers. Starting these programmes early, while the majority of students are not yet sexually active and sexual behaviour patterns are not yet determined, is seen as another factor making programmes more likely to succeed.

2.3 Factors influencing youth behaviour

Another question remains, why, despite their knowledge, do youths generally not adopt low risk behaviours? Studies seeking to answer this question have tended to focus on mediating factors which hinder young people to adopt safer behaviours. Factors such as poverty or gender inequity are well known and mentioned by

many researchers (Badcock-Walters, Kelly & Goergens, 2004; FHI, 2005). Other factors mentioned in the literature are the increased time between puberty and marriage; the divide between traditional and western norms and changing family structures (Adegoke, 2001). Little research though has been done to establish the extent to which cultural and traditional beliefs, values and practices influence attitude and behaviour. At the same time, behaviour is very difficult to determine – many studies collect data only on intended or reported behaviour. There is evidence that such data are not reliable and differ from actual behaviour. While females tend to under-report sexual activity, males tend to over-report. A study carried out in Tanzania in 1998 compared reported behaviour among primary school students with biological markers and found that only 39 % of girls with STI infections reported having had sex (Todd et al, 2004), which is in line with the findings of Cowan et al. (2002) in Zimbabwe. One needs to question how useful it really is to measure intended respectively reported behaviour and I would argue that researchers should not measure the effectiveness of their intervention by reported behaviour. I would expect that this measure is likely to be even less valid in countries, where sexual activity of unmarried youth and/or school students is strongly discouraged by society. Using biological markers is however only possible where large numbers of data sets are available; it is more intrusive, and resource-intensive. Visser (2005) noted in connection with her evaluation that there were likely to be a variety of unidentified factors contributing to the behavioural outcome and Gallant and Maticka-Tyndale (2004) called for more research to identify the drivers of successful programmes.

2.4 Knowledge, attitude and behaviour of youth in Tanzania

According to the Tanzania HIV Indicator Survey (TACAIDS, 2005) over 99 % of the population have heard of HIV/AIDS. Comprehensive knowledge, which includes knowledge of modes of transmission and identification of misconceptions regarding HIV as defined in the study, is however much lower at 54 – 73 % in the group of 15-19 year old. The older UNFPA study of 2001 (MoEC and UNFPA, 2001) suggests, that comprehensive knowledge among school youth is higher than in the general population, but the two studies cannot be directly compared as the questions asked were quite different.

A recently published cohort study (Stigler et al, 2006), a secondary analysis of data from 1992 and 1993 assessing the outcomes of the 'Ngao' programme with primary school children from the mid 1990s, investigated which mediators or variables may lead or not lead towards desired outcomes. It was found that increasing exposure to and knowledge of AIDS information were significant mediators to decreased intention to be sexually active in the near future and also had a positive effect on the attitudes towards people living with AIDS, as well as changing subjective norms towards ones which are more restrictive towards sexual activity. Such changes of attitude and norms signify important steps towards delayed sexual debut and support the justification of knowledge building interventions in schools, despite the fact that the study failed to assess in the follow-up whether the intended behaviour was actually put into practice. A study conducted by Matasha et al. (1998) in Mwanza region in Tanzania investigated the extent to which primary and secondary school students were already sexually active and revealed startling rates of 80 % in boys and 68 % in girls in the age

group of 12-19 years in primary schools and lower rates for girls among secondary students (48 %). These figures are much higher than the ones from the more recent Tanzanian HIV/AIDS Indicator Survey THIS 2003-2004 (TACAIDS, 2005) where 56 % of the under 19 year old claimed not to have had any intercourse yet. Considering the discrepancy between reported and actual behaviour as elaborated in Section 2.2, it is plausible that the estimates of only 44 % of under 19 year old from the THIS is a gross under-estimation and should not be interpreted as later sexual debut compared to earlier years. A large comprehensive intervention at community and school level, the 'Mema kwa Vijana', based on social-learning theory, was carried out in Mwanza region in Tanzania (AMREF, 2004). Results of this study indicated some improvement in knowledge and attitude but no significant changes in behaviour assessed, using biological outcome indicators of number of pregnancies and sexually transmitted infections (AMREF, 2004). In connection with this study it is also worrying that the intervention did not influence the perception of risk among the students. In an older study, Ndeki (1994) found a correlation between risk perception and level of HIV/AIDS prevalence of the surrounding community. Given the partial impact of the intervention on the overall goal, it is not clear whether a more prolonged intervention period would have resulted in improved outcomes. There is need for future evaluative research on health education interventions to give sufficient time before evaluating the effect.

2.5 Global research into the knowledge, attitude and behaviour of teachers

Globally, very few studies are available that provide information about the knowledge, attitudes and behaviour of teachers towards sexuality education (Visser, 2004). In early studies conducted before teacher-led interventions had been initiated, teachers reported they saw the need and their role for HIV/AIDS education in schools (Munodawafa, 1991; Kumar et al, 1995), despite not having yet introduced HIV/AIDS education themselves. Later quantitative studies confirmed supportive attitudes towards HIV/AIDS education (Dawson, Chunis, Smith & Carboni; 2001; Ayo-Yusuf, Naidoo & Chikte; 2001; Peltzer, 2000; Peltzer & Promtussananon, 2003; Adamchak, 2005; Visser, 2004; Visser, 2005) of teachers. While two of these studies found a clear link between level of knowledge and supportive attitude as well as actual teaching (Adamchak, 2005; Visser, 2004), Peltzer (2000) found only a weak association, possibly because in his sample the knowledge of teachers about HIV/AIDS was generally very poor and the questions asked were relatively few. The South African studies found insufficient knowledge about HIV/AIDS among teachers and various misconceptions, indicating a need for training. This need was reiterated by Peltzer and Promtussananon (2003), who also determined that in-service training greatly improved knowledge and the comfort to teach HIV/AIDS related topics. Regarding the South African life-skills programme, Visser (2005) noted that while teachers were committed to the programme and generally supported by school principals, large workloads and lack of teachers, limited acknowledgement of their expertise by other colleagues and non-trusting student-teacher relationships led to the programme not being implemented as planned. In most curricula, the teaching

of HIV/AIDS related topics is linked to specific subjects, but where this is not the case as it is for example regarding the school counsellors in Tanzania, the role of the subject background of teachers regarding their competence and willingness to teach HIV/AIDS is not known and requires further research.

2.6 Factors influencing attitudes and behaviour of teachers in East and Southern Africa

Kakoko, Lugoe and Lie (2006) recently conducted a quantitative study among primary school teachers in Tanzania to determine the factors that influenced primary school teachers to undergo HIV testing. The authors demonstrated convincingly more positive attitudes towards HIV testing in younger teachers and those with highly educated partners. One might assume that someone who is willing to be tested for HIV may have reflected on personal consequences in case of infection and that such openness may be more likely in more educated persons (and those with more educated partners) and younger ones. Regarding age, the findings were similar to those of Visser (2004), who conducted one of the few qualitative studies demonstrating that younger teachers are much more likely to be willing to communicate about HIV/AIDS in schools. Findings of the study indicated that strong personal experience with people living with HIV/AIDS made a big difference in the willingness to discuss HIV/AIDS. One has to be aware that Visser (2004) assessed only the willingness to teach, but not the quality or depth of teaching.

Teachers who perceive themselves at risk are more willing to discuss HIV/AIDS. Factors which determine individual's attitudes such as moral values play a big role together with social norms. Those teachers who feel less strongly about such values were found to be more willing to discuss sensitive issues (Visser, 2004). Visser (2004) interestingly noted also that teachers who are willing to discuss HIV/AIDS related topics with their students may not be willing to do so with the community. It is important to investigate if these assertions are valid in the Tanzanian setting. There might be differences in the type of messages teachers give, for example regarding the favoured prevention method, which could, among other variables, depend on the level of knowledge of teachers. In her evaluation of the South African national life-skills programme, Visser (2005) named level of confidence and workload as important factors.

The level of knowledge of teachers is one that will depend on the content and depth of training received. It is interesting that even though many school-based interventions focus on in-service training of teachers, very little research has investigated the effectiveness of these trainings and the factors that determine it. In the assessment of such interventions, the quality and effectiveness of training is often assumed rather than analysed, even though it is conceivable that the effectiveness will depend not only on the curriculum and resources, but also on the duration and continuation of the training, the quality of facilitation which is negatively influenced by a cascade system and the working environment. The importance of these factors has usually not been addressed in available quantitative studies.

2.7 Knowledge and attitude of teachers in Tanzania

In Tanzania, no research was found which considered the knowledge and attitudes of teachers about HIV/AIDS. In the 'Tanzanian German Programme to Support Health' KAP study (TGPSH, 2005) with primary school students, a very small number of teacher trainers were also assessed. The study demonstrated knowledge gaps and misconceptions amongst the students regarding menstruation cycle, conception and condoms which were similar to the gaps found among their teachers. Experience of the *PASHA* project with secondary school teachers which has been reported in its monitoring reports (PASHA, 2004-2006) confirms these gaps, but to a lesser extent than among primary school teachers. A qualitative study carried out by Plummer et al. (2007) in Tanzania came to the conclusion that despite many limitations, school-based ASRH-programmes may be the best way to reach Tanzanian youth at large scale, while acknowledging at the same time that problematic teacher-pupil relationships create one of the greatest barriers to ASRH programme success.

2.8 Conclusion

Many of the studies reviewed are difficult to compare, as methodologies used and contexts are different. Even though Tanzania has seen other HIV/AIDS prevention interventions at school level, such as the 'Family Life Education Programme' of the UNFPA, only one large scale intervention, 'Mema kwa Vijana', was found that had been accompanied by systematic research and been evaluated in depth (AMREF, 2004; Plummer et al, 2007.a; Plummer et al, 2007.b; Ross et al, 2007).

The effectiveness of other school-based HIV prevention interventions have generally been assessed through internal project evaluations and which did not have the quality of research, frequently remaining unpublished. In none of these evaluations was the effect measured at the level of the teachers who are being trained in all school interventions and relied on to be the mediators in the transfer of knowledge, skills and attitudes. According to Visser (2004), teachers' willingness to teach about SRH depended on their age, their personal experience and the strength of their values.

Findings from research assessing the effectiveness of school-based interventions are not very satisfactory – while knowledge on SRH topics increases among students, there is only limited improvement of attitudes and very little evidence of impact on behaviour. Even though condom use is sometimes increased, it is not necessarily sustained. One may question whether such resource-intensive school-based interventions are justified. As Wegbreit et al. (2006) argue, there is still a lack of sufficient data on whether the majority of interventions, such as school-based programmes, are able to reduce HIV incidence.

However, despite the limited proof of their effectiveness, it is generally accepted that for prevention of HIV/AIDS, school-based programmes provide the best avenue to reach a large number of young people and therefore remain essential for comprehensive HIV prevention. Many studies have clearly shown that they do not lead to increased or earlier sexual activity, but tend to have the opposite effect (WHO, 1999; Dayaratna et al, 2000; WHO, 2004; Agha & van Rossem, 2004; Wellings et al, 2006; Ross et al, 2007). Experiences made and research done have led to various policy and programme documents and toolkits offering

recommendations for interventions in schools (WHO, 2004; Commonwealth Secretariat, 2006; Lloyd, 2007). Some of these are starting the intervention at a young age (Adegoke, 2001; Maticka-Tyndale, Wildish & Gichuru, 2007), broad SRH curriculum with key messages (Kirby et al, 1994), needs-based and targeted programmes, appropriately selected and trained teachers, gender equality within the school context (Badcock-Walters, Kelly & Goergens, 2004; WHO, 1999; The Lancet, 2006; Kirby, Lars & Rolleri).

Chapter 3: Methodology

3.1 Study Design and Justification

In Tanzania, the *PASHA* project assisted secondary schools in Tanga region in establishing counselling services through implementation of adequate selection criteria and processes, sensitization, advocacy for establishing counselling rooms, through teacher training and supervision.

My research hypothesis was that due to the training received, counsellors knowledge would be greater and in particular their attitudes towards HIV/AIDS and SRH would be more rights-based, open-minded and progressive compared to those of their untrained colleagues.

I therefore did not only want to assess the immediate outcome of the counsellors' training on their knowledge and even attitudes, but also try to establish whether the training had any indirect effect on counsellors' attitudes regarding students' reproductive needs and rights, the relationship between teacher/counsellor and student and on their outlook on students' sexuality with regards to gender. Most of these topics had not explicitly been addressed in the training programme, but I expected that the content of the training, the discussions conducted combined with the practical counselling experience after the training would nevertheless result in a less conservative, more open-minded and more students'-rights focussed attitude. The study focused on counsellors' attitudes regarding sexual reproductive health education and their attitudes towards their students, in addition to determining knowledge and skills gained due to training received.

A comparative, observational KA study based on the *health belief model* (Mullen et al, 1973; Rosenstock, Stretcher & Becker, 1988) was used to establish knowledge and attitudes of school counsellors trained by the project regarding sexuality and HIV/AIDS, both generally as well as with respect to their students in comparison to school counsellors who were not trained. The health belief model developed by Rosenstock and other social psychologists was based on four constructs as conditions for an individual's change of health related behaviour: the perceived susceptibility for getting a condition, the perceived severity of that condition and its potential consequences, the perceived barriers to change of behaviour and the perceived benefits or possible consequences of changed behaviour. It was later-on acknowledged that an individual's behaviour was influenced also by other factors, and another 2 constructs were added to the health belief model (Rosenstock, Stretcher & Becker, 1988): the perceived efficacy or the individual's self assessment of his/her ability to change the behaviour, and the cues for action, that means the external influences. The development of the training programme assumes that it can address the perceptions regarding HIV/AIDS and the benefits of changing behaviour, while at the same time acknowledging that within and outside the school context there are many other factors that will influence the actual behaviour of both students and teachers.

As training of counsellors was completed in the time period 2004-2006, it was not possible to do the study with the same group of counsellors before and after the training. Instead, the study rather used 2 groups of teachers, one with teachers who never received training, and one with teachers who received the training. Due to the mentioned mobility of teachers the number of trained versus untrained

counsellors could only be roughly estimated before the study, which is why I decided to add teachers from new schools, who were likely to be untrained as counsellors, to the second group if necessary.

Using a quantitative KA study, which simplified data collection and analysis and was particularly helpful for me, as tools could be translated and interviews were conducted in Kiswahili, without the problem I would have had in a qualitative research where I would have needed a translator. At the same time it was possible through the use of scenarios and careful selection of a range of most likely options to get more information about attitudes than usually the case with simple questions, while not restricting respondents to presented options only. Basic knowledge on HIV/AIDS and reproductive health was assessed mainly through internationally commonly used questions, to be able to later-on compare the results to national and international data, such as e.g. the Tanzania HIV Indicator Survey (TACAIDS, 2005; next THIS was conducted end of 2007, analysis has not yet been completed). At the same time it was important not to make the questionnaire too long as interviews had to be conducted during school time and were administered by interviewers rather than self-administered. Therefore very detailed knowledge questions referring to the course content were not included. Also not included were questions regarding sexual practices (e.g. condom use) of teachers, despite the fact that they might have been influenced by the training, as from the findings of Plummer et al. (2007) and others I doubted the reliability and validity of the responses.

The study was funded by the project implementing agency, the Swiss Tropical Institute, as part of its project activities.

3.2 The role of the author in this research

I have been the education advisor to the PASHA intervention since its initial design, and have thus influenced the content and approach of the training for school counsellors. I have also discussed counselling practices with counsellors, heads of schools, education officers and consultants during training and monitoring activities. Regarding the actual study, I designed the questionnaire including issues that had emerged as important or critical during discussion. Project staff then assisted in engaging interviewers and selecting the schools to be included in the study. In discussing the findings I have also drawn on my own experience and observations.

3.3 Sampling

The sample frame was given by the intervention area and the schools exposed to the intervention (n=116). Schools were selected to include a comprehensive selection of variables regarding their setting, such as rural and urban, government, community and private ownership, a wide range of student numbers, co-educational and single-sex education, day and boarding schools, Schools from 4 out of 7 Tanga districts were selected, possible variances between districts were not considered. Each school was assumed to have 2 counsellors, and a sample of 37 schools with anticipated 74 counsellors was seen as sufficient. Another 20 mainly new schools were later on added to the sample as only 7 of the counsellors

from the first sample were found to have been untrained and the initial sample therefore proved to be too small to allow a comparison of the two groups of counsellors. When adding those other 20 schools, preference was given to those known to have lost trained counsellors or those who had only opened recently. According to the information received from the schools, 7 counsellors had left their schools and taken up further studies, 6 had been transferred to other schools and 6 were absent on the day of the interviews, which left a total of 85 counsellors that were interviewed.

3.4 Data Collection Methods and Strategies to Ensure Rigour

The counsellors studied were from schools in four Tanga districts, School settings and counsellor characteristics varied considerably, with school settings covering rural and urban settings, different sizes, varying school ownership (government, community or non-governmental), and some being boarding schools, while the majority were day schools. Gender, age and marital status of counsellors also varied. Due to this high number of variables and the fact that the majority of untrained teachers were found at newer schools, it was not possible to make the groups completely equal. However, care was taken to select the schools in such a way that a wide and similar range of variables was covered for the two groups of PASHA trained and untrained counsellors.

I developed a questionnaire on knowledge and attitudes with pre-determined response options, allowing one or more than one responses. I included internationally and locally used standard questions to assess comprehensive

knowledge and attitudes regarding sexuality and HIV/AIDS for better comparability (UNAIDS, 2007; TACAIDS, 2005), such as whether HIV can be transmitted by mosquito bites or by sharing food as knowledge questions, or regarding attitudes, whether a pregnant girl should be expelled from school or whether an HIV positive person should disclose their status. Some of the questions are of particular relevance for the Tanzanian context, such as the ones on expelling a pregnant girl or the boy responsible from school (according to legal regulations) or about the effectiveness of condoms, which is often doubted and frequently discussed in public.

It would have been desirable to include questions for the counsellors on real events, such as counselling experiences, to find out how they did actually counsel in a real case. However, the number of counselling events would have been too small in the case of many counsellors in the sample and too different to compare. Instead, to assess attitudes and likely practices, I developed scenarios from anecdotal experience collected previously from school counsellors and other teachers and prepared a variety of likely response options which could be categorized into desirable or undesirable options. The relevance of these questions and response options were reviewed with an experienced project officer.

The questionnaire was pre-tested at two schools for appropriateness and comprehension, translated into the local language (Kiswahili) and reviewed again. A few minor changes were made before the actual data collection.

Data were collected in face-to-face interviews by four trained interviewers (teachers) over a four week period in August and September 2007, with one interviewer per school. In addition to filling the questionnaires, interviewers

recorded other observations such as absences of counsellors. Any unexpected difficulties were reported telephonically to me so that I could advise the interviewers on how to act.

3.5 Data Analysis

Once all questionnaires had been filled, I met with all research assistants to discuss the data collection process and check whether all forms were complete. Data were entered centrally by me into Epi-Info tables. Analysis of data was done using Epi-Info Version 3.3 (2004) and Microsoft Excel (2003). All data were broken down to distinguish whether the counsellors had been trained by PASHA or not. In the analysis, the number of responses given for desirable options was compared to those that were not, such as the action taken by the teacher when a female student reported a rape. Possible association between the responses and counsellors being trained or untrained were analyzed, as well as possible correlation with age, gender and marital status. For details on the way questions were phrased refer to annexes 4 and 5.

3.6 Ethical Considerations

Permission to undertake the proposed study was received from the Permanent Secretary, Tanzanian Ministry of Education and Vocational Training. Ethical approval was obtained from the University of Western Cape Ethics Committee. Participation in this study was voluntary and interviewed teachers did not receive any payment or other benefits. All project schools had been informed about the

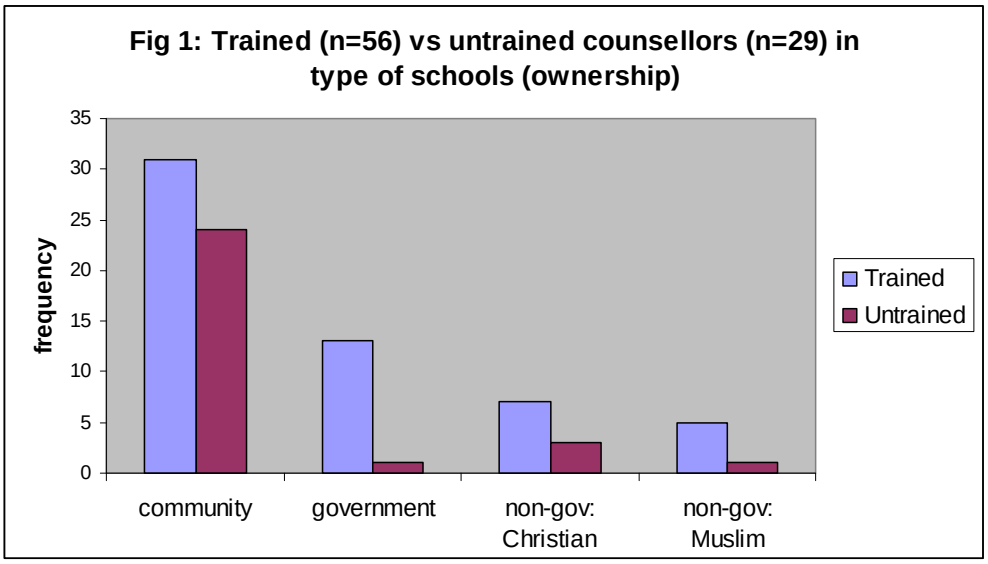
planned data collection and research beforehand and had agreed to it, but they had not been informed which schools would actually be taking part in the study. The purpose of the study was explained to all heads of schools and to all teachers interviewed. Confidentiality was assured and all questionnaires were filled anonymously. Other specific data, such as name of school, were coded. The consent form was translated into Kiswahili for better understanding and was explained by the research assistants before administration.

Chapter 4: Results and Discussion

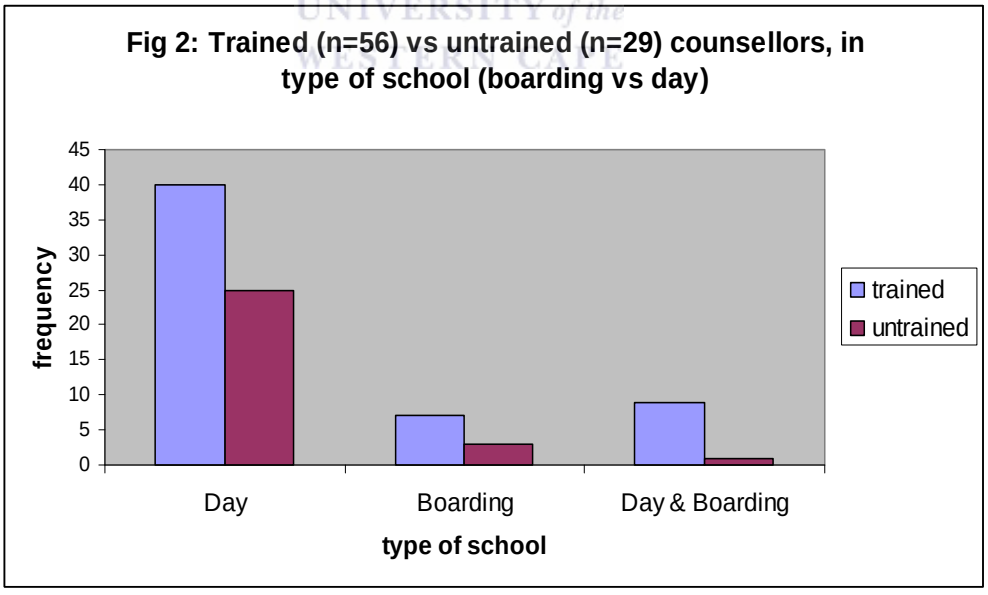
I will present the analysis and main findings from the study in this section. Data have been broken down to compare the groups of PASHA-trained and untrained counsellors. Some further associations are explored such as age and marital status. The findings and the limitations of the study are discussed

4.1 Comparison of PASHA trained and untrained counsellors with regards to school settings:

A total of 57 schools took part in this study. One of the selected schools, a boys' seminary, refused to let their school counsellors respond without the head of school being present and was therefore excluded from data collection. Figure 1 shows the relationship between type of school regarding ownership and counsellors being trained or not. While among the untrained group, the majority works in community schools (24 out of 29 or 83 %), this proportion is much smaller in the trained group of counsellors (31 out of 56 or 55 %). Few untrained counsellors were found in government schools (1 untrained compared to 13 trained counsellors, or 3 % in comparison to 23 %). This is not surprising, as most new schools are community schools where few teachers have had training opportunities.



The majority of counsellors work in day schools (Fig 2), which are the most common type of school. In schools which are both day schools and offer boarding facilities, the proportion of trained counsellors is particularly large compared to those untrained.

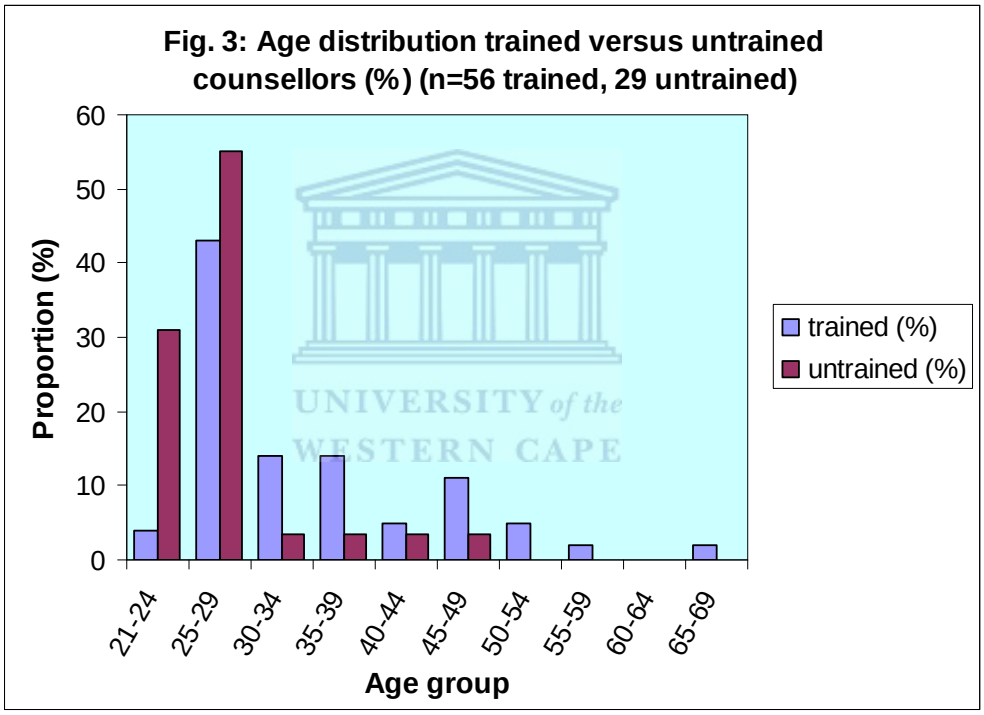


More than half (55 %) of the counsellors were found at rural schools, and most of them were working at co-educational schools (91 %); compared to 9 % who were teaching at girls' schools.

4.2 Counsellors' characteristics

4.2.1 Gender and age distribution of counsellors

The gender distribution of counsellors in this study was quite equal with 41 females and 44 males. Figure 3 shows that most counsellors are young. There was a significant difference in age distribution among the trained and untrained counsellors, with younger teachers being in the untrained stratum (86 % untrained counsellors ≤ 29 years, 47 % trained counsellors ≤ 29 years).



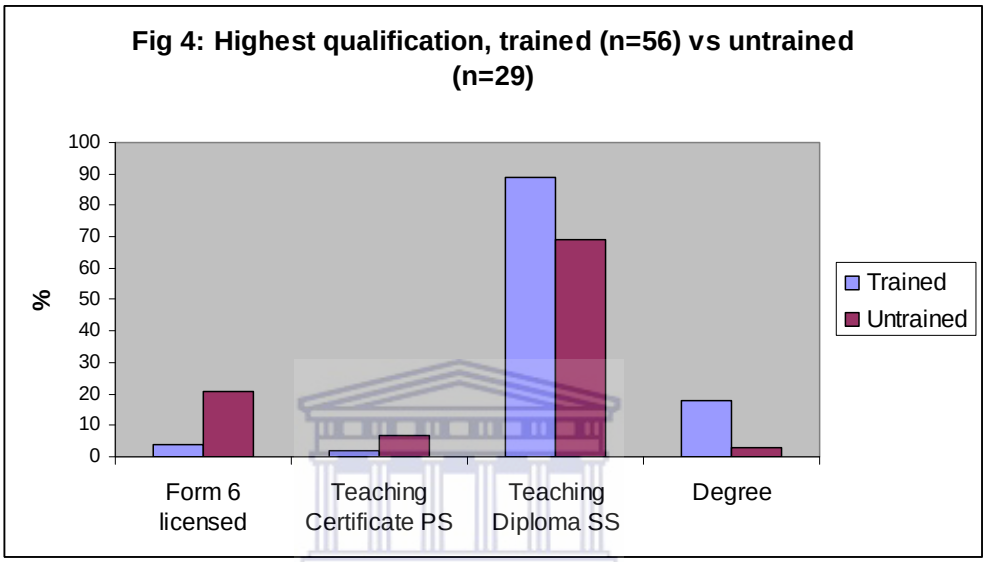
49 of the 85 counsellors were not married (58 %), 34 were married (40 %) and only 2 were separated /divorced.

4.2.2 Qualification of school counsellors

The majority of teachers had received a teaching diploma or education degree while about 12 % of the teachers were form 6 leavers who were "licensed

teachers", haven received a 'crash course' of few weeks and were now licensed to teach, an increasing phenomenon due to the rapid expansion of the number of secondary schools linked with an increasing scarcity of qualified teachers.

(Fig 4)



There was no dominance of specific teaching subjects or subject areas studied within the group of counsellors.

Of the 85 interviewed counsellors, 56 (66 %) had received at least a 2 week training for counsellors altogether, while 29 had not been trained as counsellors at all. This means that all the trained counsellors had received 2 weeks of training or more and were considered 'trained' during this study. 'Untrained counsellors' may have had some training on HIV/AIDS or SRH, but not more than 1 day of training on counselling. In the analysis, I did not distinguish between the training by other providers and the training by PASHA, as long as the training had been specifically on counselling and had lasted for at least 2 weeks in all.

Almost all counsellors (86 %) who were trained had been trained by the *PASHA* project (Table 1).

Table 1: Teachers who received in-service training as counsellors, by provider

Training Provider	Frequency	Percent
PASHA	44	86.3 %
Inspectorate	1	2 %
Other	6	11.7 %
Total	51	100 %

4.2.3. Additional training on HIV/AIDS and/or SRH

Training on HIV/AIDS and/or SRH had been provided by *PASHA*, by the School Inspectorate, by the Family Life Education Project and by NGO's. Of the counsellors who had been trained by the *PASHA* project; all had received some basic training on HIV/AIDS as part of the *PASHA* training package as well, which is reflected in Table 2. Of the counsellors that had not been trained, 3 had received some training on HIV/AIDS. In this analysis and the comparison tables further down only those teachers who had received training on *counselling* are referred to as 'trained' as the effects of the counselling training were the key interest in this study.

Table 2: Counsellors who reported having received training on HIV/AIDS, by provider

Training on HIV/AIDS			**Additional 2nd Training on HIV/AIDS**		
Training Provider	**Frequency**	**Percent**	**Training Provider**	**Frequency**	**Percent**
PASHA	36	66.7 %	**PASHA**	26	86.7%
Inspectorate	4	7.4 %	**Inspectorate**	4	13.3 %
Family Life Education	1	1.9 %	**Total**	30	100 %
Others	12	22.2 %			
Invalid response	1	1.9 %			
Total	54	100 %			

When comparing the results of the basic knowledge questions between trained and untrained counsellors it is evident that their knowledge of basic facts is very good regarding ways of transmission. There was a significant difference ($\chi^2 = 10.6$) between the percentage of trained counsellors who know where a VCT centre is (96 %) compared to untrained counsellors (72 %).

Table 3: Comparison of correct responses of trained and untrained counsellors regarding knowledge

Knowledge questions	**counsellors trained at least 2 weeks**		**untrained counsellors**		
	% of correct responses	*Frequencies in brackets (total 56)*	% of correct responses	*Frequencies in brackets (total 29)*	$\chi 2$ (uncorrected)
Which diseases are sexually transmitted?					
a) HIV	100	*(56)*	100	*(29)*	
b) Malaria	2	*(1)*	-	-	
c) Diarrhoea	-	-	-	-	
d) Syphilis	98	*(55)*	100	*(29)*	
Is it possible for a girl to get pregnant the first time she has sex?	100	*(56)*	97	*(28)*	1.95
Can a healthy looking person be HIV positive?	100	*(56)*	100	*(29)*	-
Can a person get the HIV virus through mosquito bites?	100	*(56)*	100	*(29)*	-
Can a person get the HIV/AIDS virus by sharing food with a person who has AIDS?	98	*(55)*	100	*(29)*	0.52
Do you know of a VCT centre that a student could go to?	96	*(54)*	72	*(21)*	10.6
Do you know where a student could get STI treatment or contraceptives?	96	*(54)*	93	*(22)*	0.47
A correctly used condom greatly reduces the possibility of…					
a) unwanted pregnancy	100	*(56)*	93	*(27)*	-
b) transmission of HIV	96	*(53)*	86	*(25)*	3.9
c) transmission of STDs	96	*(54)*	86	*(25)*	0.2
d) pleasure gained from sex (those who ticked this option)	25	*(14)*	31	*(9)*	13
e) none of the above	-	-	-	-	-

Looking into the counsellors' attitudes concerning their students' sexuality and reproductive rights, results for both strata of counsellors are similar. There was no clear difference in counsellors' attitude on condom education (91 % of trained counsellors in favour, versus 83 % of untrained counsellors), whereby 91 % of the trained counsellors felt that students should learn that condoms protect against HIV, while only 83 % of the untrained counsellors felt the same. A possible

association between female and male counsellors and this attitude was investigated but no such association found. An association was found between marital status of counsellors, where unmarried counsellors where more supportive towards such education (Fig. 5).

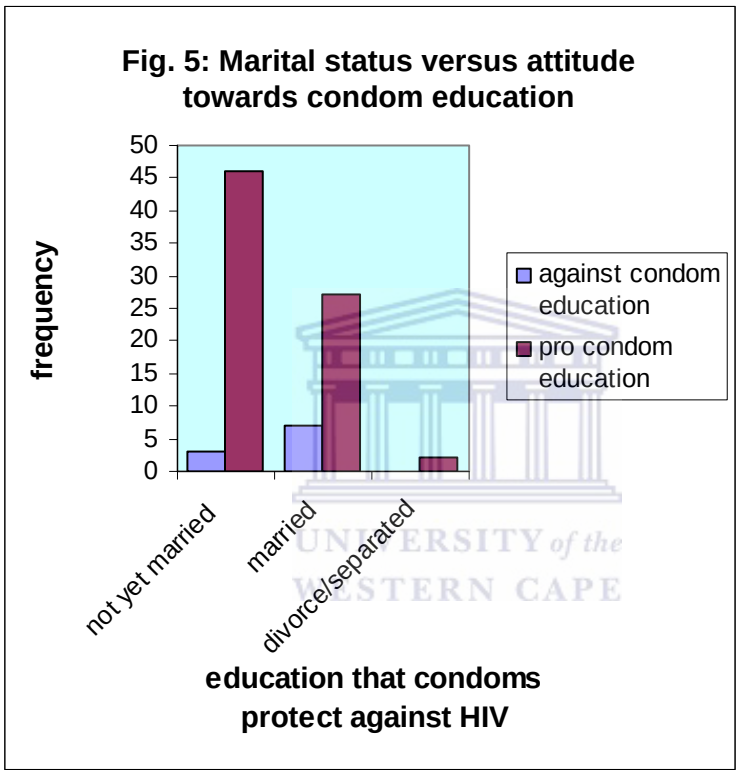


Table 4: Comparison of attitudes regarding students' sexuality and reproductive rights of trained versus untrained counsellors

Attitude towards students' sexuality and reproductive rights	**counsellors trained at least 2 weeks**		**untrained counsellors**		$\chi 2$ (uncorrected)
	% of responses agreeing with: *Frequencies in brackets (n= 56)*		% of responses agreeing with: *Frequencies in brackets n= 29)*		
Sexuality education at what level?					
a) as early as possible (Std. 1)	39	*(22)*	31	*(9)*	
b) from Standard 5 primary school	55	*(31)*	55	*(16)*	
c) at secondary schools	5	*(3)*	14	*(4)*	
d) not at all	-	-	-	-	
Education on contraception - yes	96	*(54)*	86	*(25)*	
Education prevention STI, HIV – yes	98	*(55)*	97	*(28)*	
Education condom protect against HIV – yes Reasons for 'disagree', coded*: (frequencies)*[1] - *Such education encourages sex (6)* - *Too young (2)* - *Condoms not good method (2)* Reasons for 'agree', coded: - *Protection against STI/HIV (49)* - *Students sexually active (18)* - *Students need to know (11)* *Preventing pregnancies (10)*	91	*(51)*	83	*(24)*	-
Do many student have an urge for sex - yes	89	*(50)*	79	*(21)*	OR = 2.17, $\chi 2$ 1.6
Masturbation is wrong - yes	36	*(20)*	83	*(24)*	$\chi 2$ 16.9
School girl should be able to say no - yes	96	*(54)*	100	*(29)*	
For boy to mature needs sex - yes	0	*(0)*	3	*(1)*	
For girl to mature needs sex - yes	4	*(2)*	0	*(0)*	
Pregnant school girl to be expelled – yes Frequency of reasons[2]: - *Bad example (18),* - *sex illegal (15),* - *cannot take care of baby (12),* - *girl to be punished (11)* Other reasons given coded into: - *other girls would follow example (3)* - *medical reasons (2)* - *will not focus on studies (2)* - *will be stigmatized by others (1)*	20	*(11)*	24	*(7)*	-

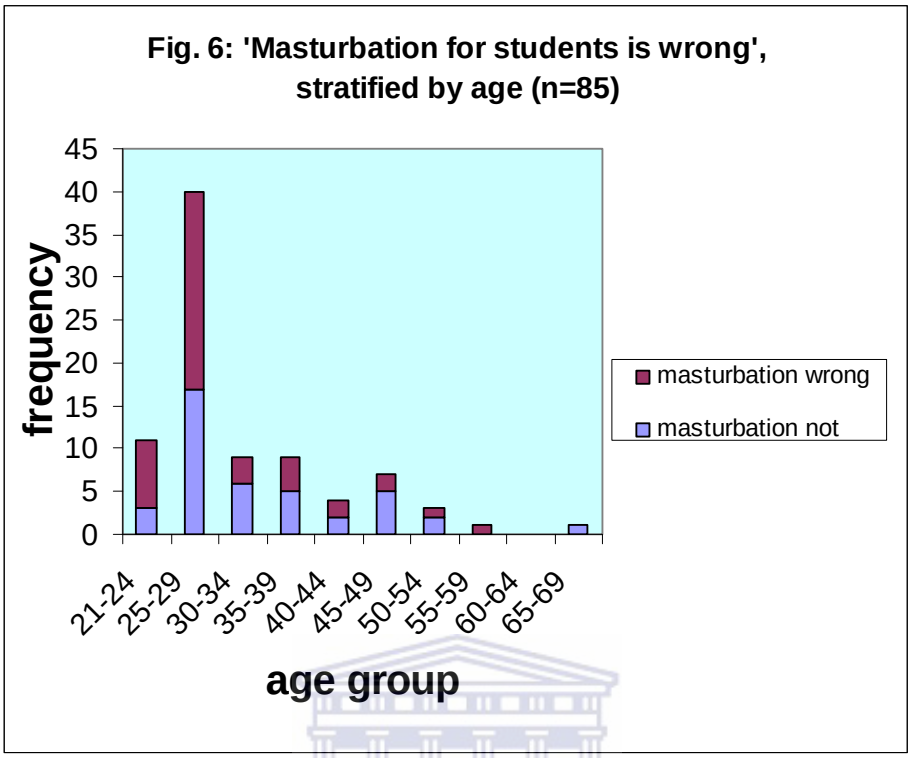
[1] distribution of reasons very similar between trained and untrained counsellors, therefore no disaggregation

[2] distribution of reasons very similar between trained and untrained counsellors, therefore no disaggregation

Should pregnant girl be allowed back after delivery – yes	81	*(45)*	72	*(21)*	$\chi 2$ 0.99
Should the boy who made the girl pregnant be expelled – yes Frequency of reasons for 'agree'[3]: - *will be bad example (18)* - *sex illegal (18)* - *fair that both boys and girls expelled (18)* - *should be punished* Other reasons given coded into: - *boy needs to help with baby/responsibility (2)* - *will cause more pregnancies (1)* *as warning to others (1)*	27	*(23)*	35	*(10)*	-

Both groups of counsellors favoured early sexuality education at primary school from Standard 5 or earlier, including education on contraception and STI/HIV prevention. There was an insignificant difference regarding counsellors' belief, that students have strong sexual urges, and there was no association found between sex of counsellor and this belief. There was however a significant difference in their attitude towards masturbation, where 83 % of untrained counsellors felt this was wrong while only 36 % of the trained counsellors agreed with this statement (Table 4). An association was present between age and attitude towards masturbation; with younger teachers being most opposed (Fig. 6, $\chi^2 = 7.8$).

[3] distribution of reasons very similar between trained and untrained counsellors, therefore no disaggregation



A negative association can be found between counsellors' age and the agreement to expel a pregnant school girl (Fig. 7, $\chi^2 = 6{,}08$).

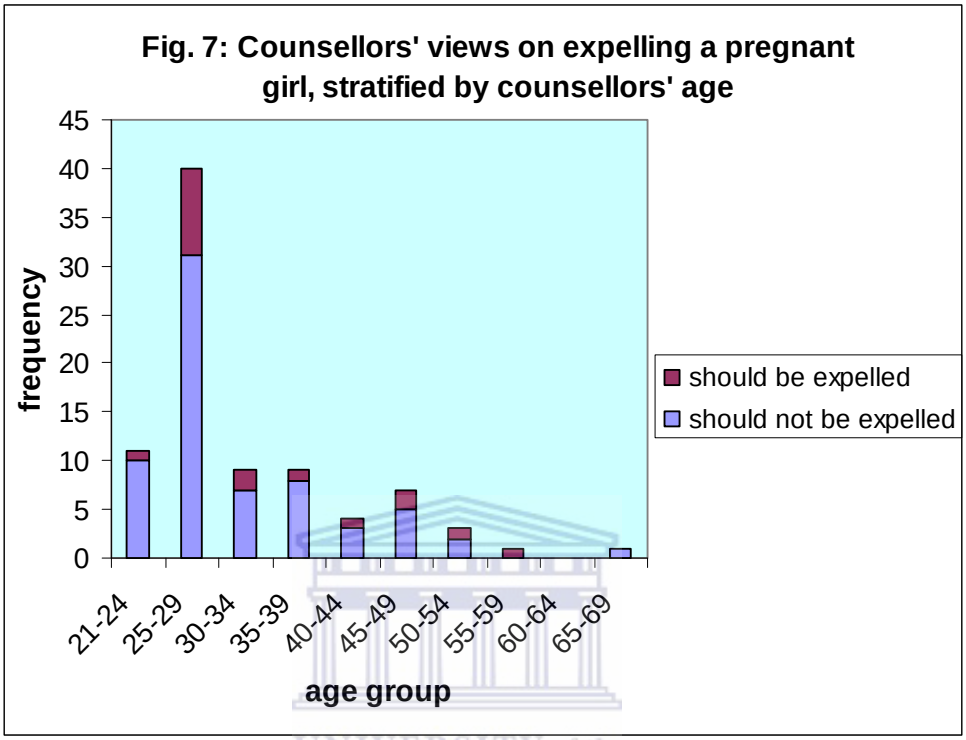


Table 5: Comparison of attitudes related to HIV status of trained versus untrained counsellors

Attitude regarding HIV status	**counsellors trained at least 2 weeks**		**untrained counsellors**	
	% of responses	*Frequencies in brackets (n= 56)*	% of responses	*Frequencies in brackets (n=29)*
could HIV$^+$ people tell others their status – yes Frequency of reasons for 'agree'[4]: - *so that s/he cannot infect others (63)* - *to receive treatment (61)* - *to get community support (61)* - *so that family be prepared for death (19)* 'Other' coded into (frequencies)[5]: - *for communities to learn more about care (1)* - *for communities to realize extent of prevalence (1)* - *to understand HIV/AID is a normal disease (1)* *for caretakers to be protected (1)*	75	*(42)*	76	*(22)*
Should HIV$^+$ children be allowed in school - yes	98	*(55)*	96	*(27)*
Do you know of AIDS death in community - yes	98	*(55)*	79	*(22)*
Do you know of AIDS death in school - yes	30	*(17)*	21	*(6)*
Should HIV$^+$ teacher be allowed to teach - yes	98	*(55)*	100	*(28)*
If a student was worried to be HIV infected, what would you do?				
a) counsel, look at options	91	*(51)*	93	*(27)*
b) tell student to pray and not to worry	22	*(39)*	58	*(17)*
c) tell others to prevent spreading	2	*(1)*	7	*(2)*
d) tell student to go for VCT	98	*(55)*	93	*(27)*
e) others 'Others' coded into (frequencies)[6]: - *advise to face reality after getting VCT results (4)* - *involve parents (2)* - *advise to be busy (2)*				

[4] distribution of reasons very similar between trained and untrained counsellors, therefore no disaggregation
[5] because of small numbers no disaggregation according to trained / untrained
[6] because of small numbers no disaggregation according to trained / untrained

- *provide information (1)* - *advise to abstain (1)* - *find out reasons for worry (1)* - *be empathetic (1)*				

Attitudes related to HIV status were again very similar between trained and untrained counsellors (Table 5). With few exceptions, counsellors felt that both HIV^+ teachers and students should remain in school. About three out of four felt that infected people should expose their status, the main reason given that they could then not infect others, but also that they could then get treatment and be supported by the community. Less untrained counsellors knew of AIDS deaths in their community. A number of additional options were listed of what they would do if a student was worried about being HIV^+.

I noticed a possible association between school setting and counsellors wanting HIV^+ persons to disclose their status, with 83 % of counsellors from rural schools saying so, versus 66 % at urban schools, while there was no difference between the trained and untrained group.

Table 6: Comparison of other attitudes of trained versus untrained counsellors

Other attitudes	**counsellors trained at least 2 weeks**.		**untrained counsellors**	
	% of responses	*Frequencies in brackets*	% of responses	*Frequencies in brackets*
If a girl told you a male teacher proposing sexual relationship, what would you do				
a) speak to head of school	5	*(3)*	38	*(11)*
b) tell girl not to tell lies	2	*(1)*	10	*(3)*
c) speak to the teacher	59	*(33)*	93	*(27)*
d) speak to parents, advise to remove girl	4	*(2)*	5	*(17)*
e) advise girl to say no and avoid being with teacher	100	*(56)*	100	*(29)*
f) discuss options with girl, let her decide	55	*(31)*	14	*(4)*
g) nothing	-	-	-	-
h) others 'Others' coded into (frequencies): - *make girl understand implications (10)* - *speak to teachers as group (2)* - *counsel the teacher (2)* - *support and guide girl if she becomes involved (1)* - *as a child she needs to be guided/told (1)*				
Rape scenario (by neighbour) – how do you feel				
a) this is the way men are	16	*(9)*	31	*(9)*
b) Neighbour raped, unacceptable	95	*(53)*	97	*(28)*
c) neighbours important, must have good reasons	-	-	-	-
d) such men should go to prison	95	*(53)*	97	*(28)*
e) others 'Others' coded into (frequencies): - *I feel very bad, disgusted (15)* - *Not all men are like that (4)* - *Neighbour and community need to be educated (2)* - *I worry that student could be traumatized (2)*				
Rape scenario (by neighbour) – what would you do				
a) speak to head of school	29	*(16)*	69	*(20)*
b) tell girl not to tell lies	4	*(2)*	3	*(1)*
c) the way things are – avoid neighbour	5	*(3)*	17	*(5)*
d) counsel girl, let her decide	66	*(35)*	82	*(24)*
e) report case to police	34	*(19)*	76	*(22)*
f) others 'Others' coded into (frequencies): - *Advise for medical check, VCT (27)* - *Speak to parents (11)*				

- *Offer psychosocial support (7)* - *Advise to be busy with peers (1)* - *Advise to report to police (1)* - *Advise to avoid future risks (2)* - *Get legal assistance (1)*				
What is the role of a counsellor				
a) help students find solutions to problems	98	*(55)*	100	*(29)*
b) offer tuition	34	*(19)*	59	*(17)*
c) discipline students that misbehave	21	*(12)*	45	*(13)*
d) give students SRH and HIV/AIDS education	87	*(49)*	86	*(25)*
e) not sure	4	*(2)*	7	*(2)*
f) others 'Others' coded into (frequencies): - *provide lifestyle guidance (15)* - *offer activities for staff and/or community (7)* - *initiate peer education, clubs (5)* - *offer education sessions (5)* - *answer questions (5)* - *help students (4)* - *collaborate with other teachers (3)* - *answer students' questions* - *record keeping of counselling sessions (3)* - *offer health services, VCT (2)* - *provide life skills (2)* - *provide study skills (2)* - *offer career guidance (1)* - *involve parents (1)* - *create conducive school environment (1)*				

I compared counsellors' attitudes towards a few specific scenarios. They were asked how they felt about the scenario, and/or what they would do. Reacting to a male teacher proposing sex to a female student, trained and untrained counsellors responded distinctly differently. More than a third of untrained counsellors opted to involve the head of school, almost all of them wanting to approach the teacher involved, while on the other hand only 14 % versus 55 % of trained counsellors intended to discuss the options with the girl and let her make the decisions. Some other options were named and coded, the most frequent one was making the girl understand the implications of such a relationship. Concerning a rape scenario,

both groups expressed the same feelings and judgements, other options named and coded were the statement that not all men behaved like that, and one counsellor expressed the worry that the girl might be traumatized. The group of untrained counsellors mentioned more frequently different actions such as counselling, reporting the case to the police and speaking to the head of school. The only action named frequently for this scenario by the trained group was counselling. Both groups mentioned a large number of other options for action, in particular the advice to go for a medical check up (n=27) and to involve the parents (n=11).

In the perception of the counsellor's role clearly more untrained counsellors considered themselves responsible for the tuition of weak students (59 % versus 34 %) and for disciplining bad behaviour (45 % versus 21 %). Many other roles were listed, the most frequent ones were the provision of lifestyle guidance (n=15), offering activities for staff and/or the community (n=7) and initiation of peer education or clubs (n=5) (Table 7).

4.3 Discussion

The purpose of this study was to determine the effect of the training by the *PASHA* project on the knowledge and attitudes of the school counsellors, based on the research hypothesis that counsellors trained by the project would have better knowledge and more open and students-rights oriented attitudes. To summarize, knowledge of both trained and untrained counsellors was very good and attitudes were overall supportive, with a distinct trend to being less judgemental and more

open-minded in the trained group, which does support the hypothesis, even though the differences were not statistically significant.

Heads of schools and counsellors were very willing to participate in the study. The great majority of counsellors who had received any training as school counsellors had received this training by the project (86 %). The possible influence of other training providers was not considered here. It is interesting to note that the majority of counsellors were young, and many of them still unmarried (58 %), which might well influence their attitudes. In the group of untrained counsellors respondents were even younger (86 % ≤ 29 years) than among the trained ones (47 % ≤ 29 years). This represents a limitation in the comparability of the groups, as age could be a confounding variable, a possibility which I did not investigate any further and which would require additional research. This would be useful as Visser (2004) also noted age as an important factor in the attitude and motivation of teachers and it could have implications for the selection and training of future counsellors. One should also need to investigate if besides age, qualification might also be an important variable, as the youngest teachers tend to be the least qualified such as Form 6 leavers.

Knowledge of basic facts on HIV/AIDS transmission was in both groups very good and better than in the general population, as given in the THIS study (2005), and almost all supported SRH education at primary school level (presently in primary schools in Standards 5, 6, 7), and many already much earlier than that. This might be because they had experienced the realities at school level, with many even young students being sexually active and dropping out of school due to

pregnancy. The only differences in knowledge were found in where to find a VCT centre. This could be due to lack of experience as many of these teachers were very young and probably new at their schools, or simply, because many of the schools where untrained teachers are found are located in very remote places where such facilities do not exist. The majority of counsellors agreed that students should learn that condoms protect against HIV infections. This is particularly positive as many doubts about the safety of condoms exist in Tanzania and neither the Catholic nor the Muslim faiths condone their use (own observations). Support for condom education was greater among the group of unmarried counsellors, which might be related to their personal situation. Trained counsellors supported condom education more than those untrained, without this difference being statistically significant. The perception that many students have strong sexual urges was also more pronounced among the trained group. Interesting was the finding that approximately one quarter of the teachers stated that condoms reduced the pleasure of sex, which could imply that they are not very positive about using them themselves. It is worrying that approximately one out of four counsellors felt that condoms did not offer protection – the proportion being again greater in the group of untrained counsellors. This is worrying as it is then unlikely that these counsellors would promote the use of condoms for young people convincingly and is in contrast to the counsellors wish to give the education that condoms prevent HIV infections. It would be interesting to extend the interviews to find out more about this contradiction. Worldwide, and also in Tanzania, the use of condoms is considered one of the key prevention strategies in

the fight against HIV/AIDS, and in Tanzania, the generally accepted key message for young people is ‘abstain, delay or use a condom’.

In contrast to the existing education policy that forces pregnant girls to leave school, all counsellors were more human- and reproductive rights oriented, with all but one stating that a girl should always be in the position to refuse sex, the majority opposing the expulsion of pregnant girls from schools and equally of the male students who impregnated the girl, and supporting re-admission after delivery. This trend was stronger among the trained group. There appears to be an association with age, with almost all younger counsellors disagreeing with the expulsion of girls.

Counsellors did oppose stigmatization of HIV^+ children or teachers, and all but one of the trained counsellors had known people who had died from AIDS-related causes – the number in the untrained group being smaller. However, reasons for these findings cannot be concluded. About three out of four counsellors in both groups wanted HIV^+ people to disclose their status, reasoning that in such a way infections of others could be prevented and the community could then support those infected. It seems that they are not aware of the great danger of stigmatization of those disclosing their positive status, unless they gave greater priority to their own protection against infections. There seemed to be an association between rural setting and counsellors wanting HIV^+ people to disclose their status, but it could also be a confounding variable.

It is my experience that teachers who have exercised their profession for a number of years usually know of male teachers who have sexual relationships with girl

students. There was a difference in what trained counsellors intended to do in such a case, with more than half of them wanting to speak to the teacher involved and to counsel the girl so that she made her own decision, while most untrained would speak to the teacher and many of them to the head of school, but very few would let the girl make her own decision. This is against the principles of counselling as they are also taught in the training, which demand that the client must be supported to make his/her own decision. On the other hand it appears very positive, that almost all untrained teachers suggested taking the initiative to speak to the teacher concerned – which, however, should only be done with the consent of the girl according to the mentioned principles of counselling. The same applies to involving the head of school; here again; the girl would need to give her consent. The survey questions did not provide any information whether the counsellors were aware of this or not. Regarding the rape scenario, again untrained counsellors would want to involve the head of school and also report the case to the police – both might be very sensible steps, if done with the consent of the girl. In this case, the majority of the untrained group – more than of the trained group – intended to counsel the girl. Many also would advise to go for a medical check or VCT, as another important point.

No association between attitudes and sex of the counsellor was found.

Concerning their understanding of their role as a counsellor, all but one counsellor understood that they should help students to find solutions to their problems, and the majority also saw SRH education as their responsibility. Counsellors also mentioned other aspects of their role, such as providing life-skills education, initiating peer education, offering education sessions etc., but some also

misunderstood their role, especially among the untrained group. 59 % of untrained counsellors felt they needed to offer tuition, which is clearly not their role, compared to still a surprising proportion of 34 % in the trained group. Almost half of the untrained group thought they needed to discipline misbehaving students versus 21 % in the trained group, which again is opposed to their role as a supportive counsellor. It is also surprising that even in the trained group; two counsellors said they were unsure about their role.

While there are hardly statistically significant differences in the *individual* attitudes between trained and untrained counsellors, there seems to be a pattern of *collective* attitudes characteristic for each group. Overall the study findings show a consistent trend of trained counsellors having more *progressive* views and attitudes towards students' sexuality and their reproductive rights, and a better understanding of their role as counsellor, than the untrained group. This is surprising as untrained counsellors tend to be younger and one would assume them to be less *conservative* and appears to be in contrast to the findings of Visser (2004) and Kakoko et al. (2006), who describe the young teachers as those most willing to teach SRH – however, I did not assess counsellors' willingness to discuss SRH, but rather whether their attitudes towards SRH would be different. Visser (2004) argued that one determinant of teachers' willingness to discuss SRH openly with students was how strong their moral values were. Those with very strong values were less willing to discuss SRH openly. I assessed a number of such moral values (e.g. regarding masturbation, condom use, rape, gender inequity) and the majority of counsellors seemed to have not so strongly pronounced values. This trend was greater in the group of trained counsellors. If

the findings of Visser (2004) findings are true also in the Tanzanian context, counsellors would be likely to be willing to discuss SRH issues openly with their students.

4.4 Limitations of this Study

The findings of the study indicated no clear difference between the two groups of teachers regarding knowledge, but some consistent trends regarding attitude. The knowledge questions could have been more meaningful if they had included in-depth knowledge.

The findings of this study do not allow conclusions into the causes for these attitudes and it needs to be emphasized that counsellors' reports on intended behaviour and views of scenarios may not reflect their actual practice. However, actual practice is very difficult to observe due to the fact that counselling sessions are confidential and generally, clients would not be willing to be observed. The validity of some of the data collected especially regarding attitudes may be questionable, as counsellors might have answered questions to "please" the researcher (desirability bias). The probability for this effect was minimized by explaining the purpose of the study, ensuring anonymity, not informing the counsellors beforehand of the intended interview to avoid 'preparation', by using interviewers who were from outside the school and the intervention context and the lack of financial benefits.

Even though the sample size selected was estimated large enough to be representative, due to the large number of variables some of the differences in

responses would require a larger sample size for verification and generalizability for other Tanzanian regions and contexts, to verify that some of the identified variables really do play a role. Some of these variables that appeared to be associated with attitude were age, marital status and geographical setting (rural versus urban). These possible associations were not stratified according to trained or untrained counsellors as I felt that it would require much larger sample sizes to determine if these variables are indeed associated with certain attitudes. As explained earlier, samples for both groups were not completely the same, with untrained counsellors being younger and sometimes located at more remote – usually community - schools.

For the purpose of this study the training of counsellors was assumed standardized. However, there was some variety in length, content and intensity of content dealt with and in the number of training attended. While some counsellors attended only one, others attended two or, in a few cases, even three training programmes. Nevertheless, all trained counsellors in this study had received at least 8 days of training so that differences should have been small, and all of them had also received some training on HIV/AIDS. If counsellors had received training on SRH or HIV/AIDS only, by other providers, but not on counselling, they were still considered 'untrained' – even though this definition would have had its limitations as it could well have influenced their knowledge and attitudes. To give a clear response to whether the PASHA-training achieved its aim, the study should be repeated with much larger sample sizes to explore possible confounding factors and associations. At the same time, it does appear that even untrained school counsellors do have quite a supportive attitude – this may be to a

greater awareness and changing attitude among teachers in general, due to the influence of the pandemic in itself and through media and various other campaigns.

Chapter 5: Conclusions and Recommendations

A number of conclusions for the future training of school counsellors can be drawn from this study. The basic knowledge counsellors had of facts on HIV transmission and other SRH issues was very good, nevertheless I would not suggest to completely exclude this from future training as discussions always show the great need and interest of teachers to clarify myths and misconceptions. With respect to the content of the training, more emphasis should be put on discussing the effectiveness of condoms – also as a contraceptive for adolescents. It is apparent that many counsellors still have reservations regarding condom use both for themselves as well as for adolescents.

The topic of stigmatization will need more attention for deeper understanding, as the link between exposure and stigmatization does not seem to be clear. An effective strategy to strengthen the understanding could be the consequent involvement and sharing of experiences of people living with HIV/AIDS during the training.

Human rights and gender issues should also receive more attention, especially with regards to the vulnerability of girls. Counsellors overall are quite sensitive and aware of students' needs and rights. Training has to stress the need to support students even if they have not made good choices, such as e.g. a girl fallen pregnant, rather than enforcing punishment. Over a long time period counsellors might thus contribute to a paradigm shift in schools away from an institution which simply aims to transfer knowledge to one offering a conducive and health promoting environment for learning and developing responsible young adults who

have learnt to make well informed decisions. Altogether, counsellors still need to be clearer about their role, as well as their limitations. The extent of the tasks that some of them listed is not realistic for a school counsellor who at the same time is a practicing teacher.

It appears that very young teachers may not necessarily be the best suited to be counsellors as their views and attitudes appear to be 'less mature' or 'more conservative' than those of slightly older ones.. It would be important though to look deeper into the effect of age not only regarding the attitudes of counsellors concerning HIV/AIDS, SRH and reproductive rights, but also regarding the motivation and willingness to become involved. From these findings, one would then need to decide whether age should be a factor to consider in the selection of school counsellors.

It would be interesting to explore if the students, who are of course of ultimate interest for a school based intervention, actually perceive their counsellors in a similar way as the counsellors presented themselves, and if they perceive the trained counsellors more open-minded and less threatening than the untrained ones. This would be a prerequisite for counsellors' acceptance and effective utilization. It would also be important to know whether students see their counsellors as role models, especially regarding their behaviour.

I agree with Visser (2005) and Plummer et al. (2007), who convincingly argue that one of the biggest problems for teacher-led HIV/AIDS programmes in schools is the non-trusting relationship between teachers and students. This is a problem that the PASHA programme has tried to minimize as much as possible –

by sensitizing heads of schools and school staff, ensuring that the students can select the counsellor themselves, and by putting emphasis on trust and confidentiality in the training of the counsellors. The results of my study give an indication that school counsellors, if trained well, have the potential to contribute towards a school setting with reduced gender-based sexual abuse which is conducive to promote the health of young people.

It would be very interesting to observe whether the counselling practice of trained counsellors is similar to that of untrained ones or, whether it is different. I would expect that trained counsellors would use a more appropriate counselling process, would be less judgemental and assist the students in exploring different options for decision making. Due to the confidentiality of counselling sessions, this is however difficult to do.

At school level, it will be critical that the school communities perceive human rights violations as such, e.g. teachers having sexual affairs with female students, and school communities reacting to such offences appropriately rather than ignoring the issue.

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Annex I**:**
Consent Form

Information on the research:
This questionnaire is part of a research for the Masters thesis of Dorothea Coppard, Education Adviser to the PASHA project at the Ministry of Education and Vocational Training. The aim of this research is to find out *the Effectiveness of the PASHA training on the knowledge and attitudes of school counsellors regarding HIV/AIDS*. Questionnaires have been prepared for school counsellors and for students. Data will be collected in September 2007 from 37 schools in Tanga region. They will be used as part of the Masters thesis and forwarded to the School of Public Health, University of Western Cape, Private Bag X17, Bellville 7435, South Africa. The research is supervised by Ehi Igumbor, School of Public Health, University of Western Cape, Private Bag X17, Bellville 7435, South Africa (Email: eigumbor@uwc.ac.za).

The findings from this study will help to improve future training programmes for school counselors.

Dorothea Coppard can be contacted on +255-75 444 1865. Correspondence can be sent to Dorothea Coppard, PASHA project, c/o GTZ, P.O. Box 1519, Dar es Salaam or pasha@africaonline.co.tz.
The research assistant ……. can be reached using the same address.

I, ……. (name) agree to participate in a research conducted by Dorothea Coppard and her research assistant ……
I understand that:

1. The participation is voluntary and I can decide not to take part or to leave any time I wish to do so.

2. If I decide to withdraw from the study or not to take part at all, this will not have any consequences for me whatsoever.

3. The names of the participants will remain confidential.

4. Any information from the questionnaire may be used for the Masters thesis, but without names of participants. Personal information will not be shared with others. It will therefore remain confidential.

5. I have not received any payment or other benefit from taking part in this research.

…….. (Date)

……	……	……
Signature	Signature	Signature
Participant	Research assistant	Dorothea Coppard

Annex II

Fomu ya kukubali kushiriki katika kujibu Dodoso la utafiti.

Utangulizi kuhusu utafiti husika

Dodoso hili ni sehemu ya utafiti unaofanywa na Dorothea Coppard ikiwa ni kazi maalum katika Shahada ua Uzamili. Mtafiti ni mshauri wa mradi wa PASHA, Wizara ya Elimu na Mafunzo ya Ufundi, Tanzania.
Lengo la utafiti huu ni kujua kiwango cha ufanisi wa mafunzo yaliyokwisha tolewa na Mradi wa PASHA kwa walimu washauri na wanasihi shuleni kuhusiana na elimu dhidi ya UKIMWI.
Madodoso yameandaliwa kwa ajili ya walimu washauri na wanafunzi.
Takwimu hizi zitakusanywa Augusti au Septemba 2007 kutoka shule za sekondari 37 mkoani Tanga. Taarifa ya utafiti itatumika katika kuandika kitabu cha shahada ya uzamili, ambacho kitatumwa chuo kikuu cha Western Cape Private Bag X17, Bellville 7435, South Africa. Msimamizi wa Dorothea katika masomo yake ya shahada ya Uzamili anaitwa Bwana Ehi Igumbor, eigumbor@uwc.ac.za, School of Public Health University of Western Cape, Private X17 Bellville 7435, South Africa.

Matokeo ya utafiti huu yatatumika katika kuboresha mafunzo kwa walimu washauri na unasihi.

Dorothea Coppard anaweza kupatikana kwa Anuani zifuatazo: PASHA Project, C/o GTZ, P.O.BOX 1519, Dar es Salaam au pasha@africanonline.co.tz simu ya mkononi +255 754 44 18 65.
Mtafiti msaidizi kwa ajili ya ukusanyaji wa takwimu _____ anaweza pia kupatikana kwa anuani hizo hapo juu.

Mimi _____(jina kamili) nakubali kushiriki katika kutoa taarifa kwa mtafiti Dorothea au kwa msaidizi wake.

Ninafahamu kwamba:

1. Ushiriki wangu ni wa hiari na kwamba nina uhuru wa kuendelea au kutoendelea kutoa taarifa wakati wowote endapo nitajisikia kufanya hivyo.
2. Endapo nitaamua kutoshiriki katika zoezi hili la utafiti, uamuzi wangu huo hautakuwa na madhara kwa namna yeyote kwangu.
3. Majina ya washiriki wote yatabaki kuwa ni siri.
4. Taarifa zote zitakazotolewa katika dodoso zitatumika kwa lengo la shahada ya uzamili na taarifa hizo hazitatolewa kwa mtu yeyote: yaani taarifa zote zitabaki kuwa ni siri.
5. Sijapata malipo au takrima yeyote kama kishawishi cha kunifanya nikubali kushiriki katika utafiti huu.

…….(tahere)

_____	_____	_____
Sahihi	Sahihi	Sahihi
Mshiriki	Msaidizi wa utafiti	Dorothea Coppard

Annex III

Data Collection Tools

School Counsellors QUESTIONNAIRE

- to be administered by research assistant through face-to-face interviews -

Research assistant, please fill in the code:

D		S		C	

SECTION I: School data

Research assistant, please fill in these school data **before** the interview: *Please tick*

A. School type:

government	community	Non-government
		Religious: Christian
		Religious: Muslim
		Other

B.

Day school	Boarding school

C.

Co-educational	Girls only	Boys only

D. Setting:

Urban (regional or district capital)	Rural

E. Size of school (number os students)l

0 - 200	201 - 500	501 - 1000	More than 1000

General Instructions:
All questions should be answered. Where respondents choose the option 'other', request the respondent to specify and note in the space provided.

SECTION II: Demographic data

1. **What is your sex?**
   (Tick one response)

male	

female	

2. When were you born?
(Fill in the date)

Day	Month	Year		*Age(yrs)*

3. What is your marital status?
(Tick one response)

Not yet married	01	
Married	02	
Widowed	03	
Divorced/separated	04	

4. Training

I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII
Qualification	**Subjects studied**	**Subjects taught**	**Years teaching experience**	**INSET on HIV/AIDS**	**when**	**duration**	**By whom**	**INSET on Counselling**	**when**	**duration**	**By whom**

I: Qualification:
1 Form 6 years
2 Certificate
3 Diploma3
4 Degree

II: Subjects studied (2)
1 Biology
2 Other sciences or maths
Civics,
4 Geography, history
5 Languages

III: Subjects taught
1 Biology
2 Other sciences or maths
3 Civics
4 Geography, history
5 Languages

IV: Experience

V: In-service training
Yes= 1, No=0

VI and X: when
2006 = 1
2005 = 2
2004 = 3
Before 2004 = 4

VIII and XII: by whom
PASHA = 1
MoEVT/Inspectorate = 2
FLE = 3
Others = 4

VII and XI: duration
1 – 2 days = 1
3 – 4 days = 2
5 days – 1 week = 3
8 days – 2 week = 4
More than 2 weeks = 5

SECTION III: Knowledge

5. Which of the following are sexually transmitted diseases? *(Tick as many responses as you think are correct)*

a)	HIV/AIDS	
b)	Malaria	
c)	Diarrhoea	
d)	Syphilis	

		Yes	No	Don't know
6.	Is it possible for a girl to get pregnant the very first time she has sex?			
7.	Can a healthy-looking person be HIV-positive?			
8.	Can a person get the HIV virus through mosquito bites?			
9.	Can people get the HIV/AIDS virus by sharing food with a person who has AIDS?			
10.	Do you know of a VCT centre that a student could go to?			
11.	Do you know where a student could go for STI treatment or contraceptives?			

12. **A correctly used condom greatly reduces the possibility of….?** *(Tick as many responses as you think are correct)*

Unwanted pregnancy	1	
Transmission of HIV	2	
Transmission of STDs	3	
Pleasure gained from sex	4	
None of the above	5	
Don't know	6	

Section IV - Beliefs and Attitudes

13. At what level do you think should students receive sexuality education in school, including contraception and prevention of HIV and STI's?

As early as possible, from Std 1	1	
From standard 5 in primary schools	2	
At secondary schools	3	
There should not be such education in school	4	
Other, please specify	5	

14. Should students receive education on contraception?
(Tick one response)

Agree	
Disagree	

15. Should students receive education on prevention of sexually transmitted diseases and HIV?
(Tick one response)

Agree	
Disagree	

16a) Should students be taught that condoms protect against HIV/AIDS?
(Tick one response)

Agree	
Disagree	

16.b) State briefly why you think this:

---

17. Do you think many of your students have an urge to have sex?
(Tick one response)

yes	
no	

18. Masturbation is wrong and girls and boys shouldn't seek to satisfy themselves in this way
(Tick one response)

Agree	
Disagree	

19. A school girl should always be able to say no, when asked to have sex.
(Tick one response)

Agree	
Disagree	

20. Do you agree that for a boy to mature properly he needs to have sex before marriage?
(Tick one response)

Agree	
Disagree	

21. Do you agree that for a girl to mature properly she needs to have sex before marriage?
(Tick one response)

Agree	
Disagree	

22. Should a school girl who becomes pregnant be sent away from school?
(Tick one response)

Agree	
Disagree	

23. If you responded with 'agree', why did you say so?
(Tick as many responses as you think are correct)

It is illegal to have sex when you are a student	1	
The girl should be punished	2	
The girl will be a bad example if she stays at school	3	
The girl will not be able to take care of the baby at school;	4	
Other (*please specify)*	5	

24. Should a girl who becomes pregnant be allowed to return to school after she has given birth?
(Tick one response)

Agree	
Disagree	

25. Should a school boy who makes a girl pregnant be sent away from school?
(Tick one response)

Agree	
Disagree	

26. If you responded with 'Agree', why did you say so?
(Tick as many responses as you think are correct)

It is illegal to have sex when you are a student	1	
The boy should be punished because he is the father	2	
The boy will be a bad example if he stays at school	3	
It is only fair that both the girl and the boy are expelled	4	
Other reason (please specify)	5	

27. Should HIV infected people tell others about their status?
(Tick one response)

Agree	
Disagree	

28. If you answered with 'agree', can you explain why you think HIV infected people should tell others about their status? *(Tick as many responses as you think are correct)*

So that the community can support the HIV infected person	
So that the HIV infected person cannot infect others	
So that the HIV infected person can receive medical treatment	
So that family members can prepare for the death of the person	
Other reason (please specify)	

29. Should children who are infected with the AIDS virus be allowed to go to school with other children? *(Tick one response)*

yes	
no	

30. Do you know of anyone who died of AIDS in your family or your community?
(Tick one response)

yes	
no	

31. Do you know of anyone who died of AIDS from your school – teacher, student, another staff member?
(Tick one response)

yes	
no	

32. If a teacher has the AIDS virus but does not feel or look sick, should he or she be allowed to continue teaching in the school?
(Tick one response)

yes	
no	

33. If one of your students was worried to be HIV positive, what would you do? *(Tick as many responses as you think are correct)*

Counsel the student to look at options	1	
Tell the student to pray and not to worry	2	
Tell everyone so that nobody can be infected by the student	3	
Tell the student to go for VCT	4	
Other (please specify)	5	

34. If a girl student told you that a male teacher is trying to have a sexual relationship / love affair with her, what would you do*? (Tick as many responses as you think are correct)*

Speak to the head of school about the problem	1	
Tell the girl that she should stop telling lies	2	
Speak to the teacher mentioned by the students	3	
Speak to the parents of the girl and advise them to remove the girl from the school	4	
Advise the girl to be strong, not agree to the relationship and avoid being alone with the teacher	5	
Discuss with the girl what options she has and let her decide what to do	6	
Nothing because you can not do anything	7	
Other reason (please specify)	8	

35. A girl student tells you the following story:

I was alone at home yesterday. Our neighbour came for a visit and asked me for some water. He started telling me how much he liked me. He then started touching me and feeling my body. I did not like it and got up. He followed me and kept touching me. I tried to get out of the house but he would not let me get out. I was scared to shout because I did not know what would happen. He pushed me into one of the rooms onto the floor, pulled my clothes aside and had sex with me. It felt terrible. When he was finished he warned me not to tell anyone because he is a well known person in the community. When my parents came home, I was crying but I did not tell anyone why. I am scared and do not know what to do.

35.a. How do you **feel** about the behaviour of the neighbour?

This is the way men are	1	
The neighbour raped the girl and such behaviour cannot be accepted	2	
Good relations with neighbours are important so I am sure he had good reasons for his behaviour.	3	
Such men should be put in prison	4	
Other (please specify)	5	

35.b. What would you **do**? (*tick one or more responses)*

Speak to the head of school about the problem	1	
Tell the girl that she should stop telling lies	2	
This is the way things are in our community. I will tell the girl that she should not worry about the neighbour and get out of his way in the future	3	
Counsel the girl and help her to find out what she considers the best solution	4	
Report the case to the police	5	
Nothing because it did not happen at school	6	
Nothing because you can not do anything	7	
Other (please specify)	8	

36. Which of the following do you think is the role of a school counselor? (*tick one or more responses)*

To help students to find a solution to problems they have	1	
To offer tuition to students that do badly academically	2	
To discipline students that behave badly	3	
To give students information about sexuality and HIV/AIDS	4	
I am not sure	5	
Other (*please specify*)	6	

THANK YOU VERY MUCH

Annex IV

Dodoso kwa walimu wa ushauri na unasihi shuleni

Dodoso hili litaongozwa na mtafiti msaidizi kwa kuendesha mahojiano ya ana kwa ana na mwalimu mshauri shuleni

Mtafiti msaidizi, anza kwa kujaza alama mficho katika visanduku hapo chini kadri ya maelekezo uliyopewa

D		S		C	

Maelekezo ya jumla

Ni muhimu sana kuuliza maswali yote na uhakikishe kila swali limepata jibu lake. Endapo mtoa majibu atatakiwa kutoa majibu ya ziada, basi jaza maelezo ya jibu lake kwenye nafasi iliyoachwa wazi.

SEHEMU I: Taarifa za Shule:

A.

Aina ya shule (Weka alama ya V katika jibu husika)		
Serikali	Wananchi	Si ya Serikali
		Dini ya Kikristo
		Dini ya Kiisilamu
		Nyingine eleza

B.

Kutwa	Bweni

C.

Mchanganyiko	Wasichana	Wavulana

D. **Eneo**

Mjini	Vijijini

E. **Idadi ya wanafunzi shuleni**

1-200	201 - 500	501 - 1000	Zaida ya 1000

SEHEMU II: Takwimu za kuzaliwa

1. Wewe una jinsi gani?
(Weka alama ya (v) kuonesha chaguo la jibu lako)

Mwanamke	
Mwanamume	

2. Ulizaliwa lini?
(jaza tarehe, mwezi na mwaka wa kuzaliwa)

Tarehe	Mwezi	mwaka

umri (miaka)

3. Hali yako ya ndoa ikoje?
(jibu moja tafadhali)

Sijaoa/kuolewa	01	
Nimeoa/nimeolewa	02	
Nimjane	03	
Tumeachana kwa talaka / tumetengana	04	

4. Mafunzo

I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII
Kiwango cha elimu	Masomo uliyosoma	Masomo unayofundisha	Miaka ya uzoefu kazini	Semina kuhusu VVU/UKIMWI	Lini	Muda wa mafunzo	Semina liendeshwa na ani?	Mafunzo ya huduma za ushauri na unasihi	lini	Muda wa mafunzo	Mafunzo yalitolewa na nani.

Alama mficho kuhusu swali Na. 4 hapo juu

I: Kiwango cha Elimu 1 kidacho cha 6 2 cheti 3 Stashahada 4 Shahada	**II: Masomo uliyosoma** 1 Elimu ya viumbe hai (biologia) 2 masomo mengine ya sayansi au hisabati 3 Uraia 4 Jiografia, Historia 5 Lugha	**III: Masomo unayofundisha** 1 Elimu ya viumbe hai (biologia) 2 masomo mengine ya sayansi au hisabati. 3 Uraia 4 Jiografia, Historia 5 Lugha	**IV: Miaka (Kazini)**
V, IX: Mafunzo kazini **Ndiyo =1,** **Hapana =0**	**VI, X: Lini** 2006 =1 2005 =2 2004 =3 Kabla ya 2004 =4	**VIII,XII: Yalitolewa na nani** PASHA =1 MoEVT, Wakaguzi =2 FLE =3 Taasisi nyingine yeyote =4	
VII,XI: Yalichukua muda gani siku 1 – 2 =1 siku 3 – 4 =2 siku 5 – wiki 1 =3 siku 8 - wiki 2 =4 zaidi ya wiki 2 =5			

Sehemu ya III: Maarifa

5	Ni magonjwa gani kati ya haya huambukizwa kwa njia ya ngono?		
	e) VVU/UKIMWI	1	
	f) malaria	2	
	g) kuharisha	3	
	h) kaswende	4	

		ndiyo	hapana	sijui
6	Inawezekana msichana akapata mimba kwa kufanya ngono mara yake ya kwanza			
7	Je mtu anayeonekana kwa macho kuwa ana afya nzuri anaweza kuwa na VVU?			
8	Mtu anaweza kupata VVU kwa kuumwa na mbu?			
9	Mtu anaweza kupata VVU kwa kula pamoja na mtu mwenye UKIMWI			
10	Je unajua vituo vinavyotoa huduma ya kupima VVU kwa hiari ambavyo wanafunzi wanaweza kwenda?			
11	Je unajua wanafunzi wanaweza kwenda wapi kwa matibabu ya magonjwa ya ngono au huduma ya uzazi wa mpango?			

12. Matumizi sahihi ya kondomu yanapunguza uwezekano wa……..? (weka alama ya v kwa majibu unayofikiri ni sahihi) Unaweza kujaza zaidi ya jibu moja)

mimba zisizotarajiwa	1	
maambukizo ya VVU	2	
Maambukizo ya magonjwa ya ngono.	3	
Kufurahia tendo la ndoa	4	
hakuna jibu sahihi hapo juu	5	
Sijui	6	

Sehemu ya IV – imani na mitazamo mbalimbali

13. Unafikiri ni kiwango gani wanafunzi wanapata shuleni elimu inayohusu kujamiana uzuiaji wa mimba, VVU na magonjwa yangono?

Mapema iwezekanavo, kuanzia darasa la kwanza	1	
Kuanzia darasa la tano katika shule za msingi	2	
Wakiwa shule za sekondari	3	
Haitakiwi elimu ya aina hiyo shuleni	4	
Mengineyo, tafadhali eleza	5	

14. Je ni lazima wanafunzi wapate elimu inayohusu uzazi wa mpango?
(jibu moja)

Nakubali	
Nakataa	

15. Je ni lazima wanafunzi wapate elimu inayohusu uzuiaji wa magonjwa ya ngono na VVU
(Jibu moja)

Nakubali	
Nakataa	

16a) Je ni muhimu wanafunzi wafundishwe kuwa kondomu zinazuia maambukizo ya VVU/UKIMWI?
(Jibu moja)

Nakubali	
Nakataa	

16.b) Eleza ni kwa nini unaamini/unafikiri hivyo?

18. Je unafikiri wanafunzi wengi wanahisia kali za kufanya ngono?
(Jibu moja)

Ndiyo	
Hapana	

19. Kupiga punyeto si njia sahihi na wavulana au wasichana hawatakiwi kutumia njia hii katika kujiridhisha wenyewe
(Jibu moja)

Nakubali	
Nakataa	

Mwanafunzi wakike daima awe na uwezo wa kusema HAPANA anapoombwa kufanya ngono
*(*Jibu moja*)*

Nakubali	
Nakataa	

20. Je unakubali kuwa ili mtoto wa kiume apevuke sawasawa anahitaji kufanya ngono kabla ya ndoa?
(jibu moja)

Nakubali	
Nakataa	

21. Je unakubali kuwa ili mtoto wa kike apevuke sawasawa anahitaji kufanya ngono kabla ya ndoa?
(jibu moja)

Nakubali	
Nakataa	

22. Je ni lazima mwanafunzi wa kike anayepata mimba afukuzwe shule
(jibu moja)

Nakubali	
Nakataa	

23. Kama jibu lilikuwa ni kukubali kwa nini unasema hivyo?
majibu mengine unayofikiri ni sahihi

ni kinyume cha sheria kufanya ngono ukiwa mwanafunzi	1	
msichana lazima aadhibiwe	2	
msichana atakuwa mfano mbaya kama ataendelea kubaki shuleni	3	
msichana hataweza kumlea mtoto shuleni	4	
Mengineyo, (eleza)	5	

24. Je mwanafunzi wa kike aliyepata mimba aruhusiwe kurudi shuleni mara baada ya kujifungua?
(jibu moja)

Nakubali	
Nakataa	

25. Je mwanafunzi wa kiume aliyempa mimba mwanafunzi wa kike afukuzwe shule?
(Jibu moja)

Nakubali	
Nakataa	

26. Kama jibu lako ni kukubali kwa nini umesema hivyo?
(Chagua majibu mengi unayofikiri ni sahihi na uweke alama ya V)

ni kinyume cha sheria kufanya ngono ukiwa mwanafunzi	1	
lazima aadhibiwe kwa sababu yeye ni baba	2	
mvulana atakuwa mfano mbaya kama ataendelea kubaki shuleni	3	
Ili kuondoa dhana ya upendeleo ni vyema mvulana na msichana wote wafukuzwe shule	4	
sababu nyinginezo, tafadhali eleza	5	

27. Je ni lazima watu wanaoishi na VVU waambie wenzao hali zao
(jibu moja)

Nakubali	
Nakataa	

28. Kama jibu lako ni kukubali je unaweza kueleza kwa nini unafikiria ni lazima watu walioathirika na VVU waambie wenzao hali zao?
(majibu mengi unayoona ni sahihi)

Ili jumuia iwasaidie watu walioathirika na VVU	
Ili watu walioathirika na VVU wasiwaambulize wengine	
ili watu walioathirika na VVU wapate huduma ya kitabibu	
ili familia zao zijiandae kwa kifo cha muathirika huyo	
sababu nyingine (tafadhali eleza)	

29. Je watoto walioathirika na VVU waruhusiwe kwenda shuleni na watoto wengine?
(Jibu moja)

Ndiyo	
Hapana	

30. Je unamjua mtu yoyote aliyekufa kwa UKIMWI katika jamii au familia yako?
(Jibu moja)

Ndiyo	
Hapana	

31. Je unamjua mtu yeyote aliyekufa kwa UKIMWI kutoka katika shule yako – mwalimu, mwanafunzi au mfanyakazi.
(jibu moja)

Ndiyo	
Hapana	

32. Kama mwalimu ana VVU lakini hajisikii kuumwa au haonekani mgonjwa je aruhusiwe kuendelea kufundisha shuleni?
(jibu moja)

Ndiyo	
Hapana	

33. Kama mwanafunzi wako mmoja akionekana na wasiwasi kuwa huenda ameathirika na VVU utafanyaje?
(majibu mengine unayoona sahihi)

mshauri mwanafunzi kutafuta suluhisho zuri	1	
mwambie mwanafunzi asali na asijali	2	
mwambie kila mtu ili wengine wasiambukizwe na mwanafunzi	3	
mwambie mwanafunzi aende kupima virusi kwa hiari	4	
Mengineyo (tafadhali eleza)	5	

34. kama mwanafunzi wa kike atakuambia kuwa mwalimu wa kiume anajaribu kuwa na uhusiano wa kimapenzi/mahusiano na yeye utafanya nini?
(Majibu mengine unayoona ni sahihi)

Nitazungumza na mkuu wa shule kuhusu tatizo hili	1	
mwambie msichana aache kusema uongo	2	
zungumza na mwalimu aliyetajwa	3	
zungumza na wazazi wa msichana na washauri wa mwondoe katika shule hiyo	4	
mshauri msichana kuwa makini na shupavu ili asikubali mahusiano hayo pia aache tabia ya kubaki peke yake na mwalimu huyo.	5	
jadiliana na mwanafunzi ana uamuzi gani na mwache aamue mwenyewe	6	
Siwezi kufanya chochote kwa sababu siwezi kumbadilisha	7	
sababu nyingine, (tafadhali eleza)	8	

35. mwanafunzi wa kike anakuambia kisa kifuatacho:

.jana nilikuwa peke yangu nyumbani. Jirani yetu alikuja na aliniomba maji ya kunywa. Alianza kuniambia ni kwa jinsi gani ananipenda. Halafu alianza kunishikashika mwili wangu. Sikupenda kitendo hicho na nilisimama. Alinifuata na aliendelea kunishikashika. Nilijaribu nitoke nje lakini hakuniruhusu nifanye hivyo. Niliogopa kupiga kelele kwa sababu sikujua kitu gani kingetokea. Alinisukumiza katika chumba kimojawapo na kuanguka sakafuni alinivua nguo na alifanya ngono na mimi. Nilijisikia vibaya. Alipomaliza alinionya kutomwambia mtu yeyote kwa sababu yeye ni mtu anayejulikana sana katika jumuia yetu. Wazazi wangu waliporudi nyumbani nilikuwa ninalia lakini sikuweza kumwambia yeyote kwa nini ninalia. Ninaogopa na sijui la kufanya.

35.a. Unajisikiaje kuhusu tabia ya jirani huyu? Jibu moja au zaidi

hivi ndivyo wanaume walivyo	1	
jirani amembaka msichana, tabia hii haiwezi kukubalika	2	
Mahusiano mazuri na jirani ni muhimu, kwahiyo nina uhakika alikuwa na sababu nzuri kwa tabia hiyo.	3	
wanaume kama hawa wafungwe	4	
Mengineyo, (tafadhali eleza)	5	

35.b. Utafanyaje, (jibu moja au zaidi)

zungumza na mkuu wa shule kuhusu tatizo hili	1	
mwambie msichana aache kusema uongo	2	
hivi ndivyo mambo yalivyo katika jumuia. Nitamwambia msichana asijali kuhusu jirani na aepuke siku zijazo	3	
nitamshauri msichana na kumsaidia kutafuta anachofikiri ni suluhisho bora	4	
kutoa taarifa polisi	5	
Sitafanya chochote kwa sababu haikutokea shuleni	6	
Sitafanya chochote kwa sababu hawezi kufanya kitu	7	
mengineyo (tafadhali eleza)	8	

36. Yapi kati yafuatayo unafikiri ni majukumu ya washauri wa shule (Jibu moja au zaidi)

kusaidia wanafunzi kutafuta suluhisho la matatizo waliyonayo (kwa mfano; mahusiano baina ya wazazi na walimu, afya ya uzazi na magonjwa)	1	
kutoa masomo ya ziada kwa wanafunzi wanaofanya vibaya kitaaluma	2	
kuwa adabisha wanafunzi wanaopotoka kinidhamu	3	
kutoa taarifa kuhusu kujamiana na VVU/UKIMWI	4	
Sina uhakika	5	
Mengineyo, (tafadhali eleza)	6	

ASANTE SANA

Annex V

Timetable for PASHA Counselling Training Workshop

	Day 2	Day 2	Day 3	Day 4	Day 5
Session 1	Introductions Expectations & Objectives Norms Elections Programme Overview	Sex, Sexuality & Gender Reproductive System	Risk Behaviour Decision Making	HIV/AIDS	Guidance, Counselling, Teaching & Advising
Break					
Session 2	Circulars No 3 & 11 MoEC HIV/AIDS guidelines	Biological & Psychological Changes	STI's	Cultural Factors & HIV/AIDS VCT	The Counselling Relationship Steps of the Counselling Process
Break					
Session 3	Needs & Rights of Adolescents Consequences of depriving needs HIV/AIDS in Tanzania	Fertilization, Pregnancy, Abortion, FGM	Family Planning Methods	Stigma & Discrimination Care & Support for PLWHA's	Communication Skills: Active Listening Feedback
Evaluation of the Day					

	Day 6	Day 7	Day 8	Day 9	Day 10
Session 1	Communication Skills: Active Listening Feedback	Counselling Process Steps 3-5	Practicing the whole counselling process	Stigma, Discrimination & the Counsellor's role	Use of Resources Resource Network
Break					
Session 2	Communication Skills: Attending Behaviour Questioning Skills	Characteristics of a good counsellor	Practicing the whole counselling process	Crisis Counselling	Action Plans Question Box
Break					
Session 3	Communication Skills: Questioning Skills	Practicing the whole counselling process	Different Types of Counselling: Group versus Individual Counselling	Grief Counselling	Record Keeping
Evaluation of the Day					

Annex VI

Abbreviations

ASRH	Adolescent sexual reproductive health
KA	Knowledge and attitude
KAP	Knowledge, attitude and practice
MoEVT	Ministry of Education and Vocational Training
PASHA	Prevention and Awareness in Schools about HIV/AIDS project
SRH	Sexual reproductive health