STRENGTHENING HIV PREVENTION AND PSYCHO-SOCIAL SUPPORT FOR ADOLESCENTS IN SECONDARY SCHOOLS IN KABAROLE DISTRICT, UGANDA

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DECLARATION

I Jane Namuddu do hereby declare that this programmatic activity report entitled Strengthening HIV Prevention and Psychosocial Support for students in secondary schools in Kabarole district has been prepared and submitted in fulfillment of the requirements of the MakSPH-CDC HIV/AIDS Fellowship Program and has not been submitted for any other academic qualifications.

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DEDICATION

This programmatic activity report is dedicated to my lovely parents Margaret and Mathias Kibira for bringing me up as a God fearing and hard working child. It is the two that have enabled me ride through this rough and bumpy fellowship road to success.
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ABSTRACT

Background: Worldwide, more than 10 million adolescents are living with HIV and many lack access to HIV prevention and support programs. In Uganda 150,000 children (0-14) are living with HIV with many growing into adolescence. Seventy percent of Uganda’s positive young people are in school, creating an opportunity for interventions targeting schools. Baylor Uganda implemented an intervention to strengthen HIV prevention and psychosocial services for secondary school adolescents in Kabarole district.

Objectives: The overall objective of this intervention was to contribute to the reduction of new HIV infections amongst adolescents in Uganda. Specifically, the intervention set out to: i) increase knowledge on HIV prevention strategies among adolescents in selected schools, ii) build capacity of teachers to offer HIV prevention information to adolescents in the four selected schools in Kabarole, and iii) initiate psychosocial support services in 4 intervention secondary schools.

Intervention description: This intervention was implemented in 4 schools. The project is part of the larger Baylor- Uganda HIV prevention programs in the Rwenzori region. Project implementation was done in collaboration with Baylor Uganda’s training and psychosocial support departments. Project inception meetings were held with Ministry of Education officials, district officials and schools where the intervention was implemented. As part of the intervention, 82 peer educators and 14 education service providers including teachers, nurses and matrons were trained in sex and sexuality, HIV prevention strategies, peer pressure, life skills, child and adolescent counseling, psychosocial support, stigma and discrimination from only one trained teacher prior to the intervention. The trained peer educators and service providers delivered HIV prevention messages to students in the four schools. Information, Education and Communication materials including brochures, fliers, story books, message books, posters, newspaper prints and films were distributed.
Evaluation

After two months of project implementation, a process evaluation was conducted among 164 students, 40 peer educators, 4 teachers and 2 nurses from the 4 schools to assess the extent to which the program was being implemented in the four intervention schools. Specific objectives for the evaluation were to; i) assess progress in implementing HIV prevention and psychosocial support related activities in the four intervention schools, ii) assess the extent to which HIV prevention messages were offered to students and how often they were conducted by both education service providers and peer educators in the four secondary schools in Kabarole district. The evaluation employed both quantitative and qualitative methodology.

Results

- Knowledge of HIV prevention services increased from 32% to 88% after intervention. This increase was higher in boarding (80%) and both day and boarding (75%) compared to 45% in day schools.

- A total of 14 teachers, school nurses and matrons trained. A large percentage (80%) of the trained service providers offers HIV prevention education to students in their schools.

- Teachers reported increased knowledge of HIV prevention services.

- Psychosocial support activities have increased with all the four intervention schools providing the services compared to none before the intervention.

- Increase in service delivery after the intervention compared to the baseline with counseling reported at 88% from 32%, drama at 77% from 12%, health talks, 73% from 36%. Information, education and communication (I.E.C) materials were reported by 92% of students compared to 63% at baseline. This increase was higher in boarding (80%) and both day and boarding (75%) compared to 45% in day schools.

- Psychosocial support activities have increased with all the four intervention schools providing the services compared to none before the intervention.

Lessons learned:
• Training more education service providers in HIV/AIDS can increase the number of service providers and thus coverage in schools. The zeal and commitment of the coordinating teachers and trained education service providers has a major contribution to the success or failure of the intervention.

• HIV prevention messages can become boring to students especially if creativity and innovativeness are not employed by peers, teachers, nurses and guest speakers to attract their attention and avoid routine activities that may create boredom.

• Incorporation of the intervention activities in the school programs can lead to more acceptance of the program together with a more involvement of both students and education service providers.

• Implementation of the intervention was easier in boarding & mixed day & boarding schools where students have more free time at school compared to day schools where students have minimal and restricted time at school. School based programs can work best when implemented in school terms one and two of the school calendar since this is less busy with minimal interruption compared to term three which has internal and external exams.

Recommendations:

• Refresher training courses are important for both education and school health service providers and peer educators to equip them with more skills of handling the challenges of the intervention and to enable them continue offering HIV prevention services in their schools.

• Motivation of education service providers is necessary since many times they offer services during their free time given the busy school schedules. Student’s motivation in form of small items that continue to communicate HIV prevention messages such as T shirts, wrist bands and cups is good for encouraging peer educators.

• Incorporation of the program activities in other school programs is important and necessary for program acceptability and increased student and education service provider involvement.

• We recommend continued monitoring and support from the administration for the success of the intervention.
CHAPTER ONE: INTRODUCTION AND BACKGROUND

This chapter presents the introduction to the intervention as well as giving a background to the programmatic activity.

1.1 Introduction
School-based programs can be effective in improving young people’s knowledge of HIV/AIDS and reducing risky sexual behavior, thus leading to a change in behavior among adolescents[1]. As adolescents gain more accurate knowledge about sex and HIV/AIDS, they develop more rational reasoning for engaging in sexual activities and are more likely to abstain from sexual intercourse[2]. Findings from an adolescent intervention on HIV/AIDS prevention through peer support implemented in secondary schools in South Africa indicated that peer education can contribute to a delayed onset of sexual activity and can therefore contribute to the prevention of HIV/AIDS among adolescents[3]. A similar project to empower youth in schools to fight against HIV/AIDS in Uganda indicated a change in sexual behavior among pupils and this was noted to be primarily a consequence of information, education and communication activities aimed at increasing their knowledge about HIV/AIDS[4]. Evaluation of this project indicated a reduction in self-reported sexual activity of pupils due to fear of disease and pregnancy. The proportion of boys who viewed abstinence as good increased from 62% in 1994 to 89% in 2001 while that of girls increased from 65% in 1994 to 91% in 2001.

In Uganda, such programs have largely been implemented in primary schools with very little documented about similar programs in secondary schools. Baylor-Uganda therefore implemented a school-based HIV prevention program in selected secondary schools in Kabarole district aimed at contributing to the reduction of new HIV infections and HIV/AIDS associated morbidity and mortality amongst adolescents in Uganda.

1.2 Background
In many regions of the world, new HIV infections are heavily concentrated among young people (15-24 years of age)[5]. Worldwide, more than 10 million adolescents are currently living with HIV and many lack access to prevention and support programmes [6]. In Eastern and Southern
Africa (ESA) around 2.7 million people aged 15-24 years live with HIV, more than half of all positive young people globally[7]. In the hyper endemic countries of Botswana, Lesotho and Swaziland, more than 1 in 10 young people are infected[8].

In Uganda 30,000 infants are born with the HIV virus each year, increasing the population of children and adolescents with perinatally acquired HIV[8]. With improved treatment for HIV, many of these infants have grown into adolescence and may have the desire to experiment with sex and have children[9]. According to a 2009 Population Council Report, 70% of Uganda’s HIV positive young people are in school and only 14% of school children know their HIV status[6]. Many of these are now exploring their sexuality, posing a health risk to other teenagers through unsafe sex.

By nature, adolescents are more vulnerable to the adverse consequences of unsafe sexual relations including unintended pregnancy and sexually transmitted infections including HIV/AIDS compared to any other age group[10]. They are risk-takers, especially with respect to sexual intercourse. They are more likely to engage in high risk sex and even less likely to use condoms. Evidence from research indicates that fewer than half of all sexually active youth report using condoms even where HIV prevalence is high[1].

The situation is even worse in schools where students engage in sex at any opportunity, including behind classrooms, in washrooms and backstage, among others, with no opportunity and even time to use condoms[11]. This prevails in an environment where there are both HIV positive and negative students with limited disclosure and sometimes knowledge of their HIV status. A study assessing special needs of in-school HIV positive young people in Uganda indicated that more than half of the HIV positive adolescents had not disclosed their HIV status to their teachers and four in five had not disclosed to the school nurse[6]. Findings from the same study indicated that among the HIV positive adolescents and young adults aged 11-21 years, majority of those interviewed preferred partners who are HIV negative for fear of re-infection[6].

In some schools, risky sexual behavior is happening in an environment with limited or no psychosocial support, information, or HIV prevention messages. In addition, schools tend to
have inadequate mechanisms for the provision of quality health care resulting in frequent illnesses, absenteeism, poor diets and adherence challenges among adolescents living with HIV[12]. Teachers and care givers of adolescents in schools, including nurses and matrons, lack appropriate training in HIV and adolescent care and support. Whilst 81% of students in school turn to teachers and adults around them for information about health and disease,[13] they are unable to offer adequate HIV prevention messages and Psycho-social support for students in school. Given such a background, there is a need to protect the health of young people and encourage promotion of safer sexual behavior in order to curb the spread of HIV/AIDS and related adverse reproductive health outcomes.
CHAPTER TWO: LITERATURE REVIEW

This chapter presents the background literature to the intervention. It includes among others, the factors blamed for inadequate HIV prevention in secondary schools, strategies that have been implemented to increase HIV prevention in secondary schools, HIV prevention programs in secondary schools. It also includes the problem statement, justification and conceptual framework together with the goal and objectives of the intervention as illustrated in the sections following.

2.1 Factors leading to inadequate HIV prevention and psychosocial support in secondary schools

2.1.1 Adolescent Sexual Behavior in schools
A study conducted among secondary school adolescents in South Africa indicated that many young people are still at risk because of high risk sexual behavior despite sound knowledge about sexual health risks[14]. A survey on youth’s sexuality and behavior revealed that over 80% of male and 25% of female secondary school students in Tanzania were predisposed to STDs including HIV/AIDS due to having unprotected sex[15]. Similar findings reveal that although today’s youth are much more informed about HIV/AIDS than any proceeding even in countries with generalized pandemic, more than 80% of young people still do not have sufficient understanding of how to avoid HIV[16]. The level of perceived vulnerability in this group was found to be low and unprotected sex was common[14]. The real challenge however consists in changing risky behaviors, even among those who know that condoms prevent HIV, few actually use them. Research findings further reveal that by nature young people are more vulnerable to adverse consequences of unsafe sexual relations including unintended pregnancies and sexually transmitted infections[17].

The situation is not any different in Ugandan secondary schools where anecdotal data shows that the rate of STD infection including HIV/AIDS in secondary schools is high due to the high rate
of sexual involvement among secondary school adolescents. Findings from a baseline survey on Strengthening HIV Prevention and psychosocial care and support in secondary schools carried out by Baylor- Uganda in May 2011 indicate that adolescents in school practice unsafe sex[18]. Five (5) of the eight (8) schools reported dismissing 3-5 girls found pregnant every beginning and end of term[18]. Reasons put forward for this behavior included youth being sexually active because they want to have sex out of curiosity, adolescent raging hormones, peer pressure, limited or lack of parental guidance, examples set by parents and siblings, mass media and lack of cash and employment opportunities to support their desired expensive life style[19].

2.1.2 Psychosocial issues

Stigma, discrimination and physical abuse were reported among the major psychosocial problems affecting adolescents living with HIV[16]. Adolescents living with HIV in schools reported experiencing feelings of negative attitudes to going to school, worry, sadness/stress and pressure or anger that affect their concentration in class. Findings from a study about the needs of HIV positive adolescents revealed that 17% of those who participated in the study had negative attitudes about going to school while 30% of them were worried or sad all the time and 32% were stressed. Sources of worry were noted to include; lack of scholastic requirements, their poor and deteriorating health, death or illness of family member, knowing about their own HIV status and the treatment from teachers and fellow students at school.

The study further revealed that some of the students who had disclosed their status to friends or teachers had been teased and insulted because of their sero status. Students further felt that rumors were spreading around the school about their status. This was affirmed during the baseline where 60% of students reported rumors as the major source of information about HIV positive students. Although the baseline was conducted among all students in targeted schools irrespective of their HIV status, findings indicate that stigma and discrimination are still prevalent in the schools with 68% of the students who participated in the baseline survey citing discrimination as one of the problems faced by adolescents living with HIV in schools.
A study to understand the special needs of HIV positive adolescents in Uganda expressed the need for support groups and clubs for students in school but only 16% of the students who participated in the study had them in their schools[6]. Findings from the baseline survey conducted in Kabarole indicated that students in only three of the eight schools received support from the schools. It was reported that even where programs on HIV prevention exist, psychosocial support to students was minimal hence the need to strengthen psychosocial support in selected schools of project implementation.

2.1.3 Policy factors

The Government of Uganda developed a national policy on HIV/AIDS with roles and responsibilities of implementing it spread out to heads of institutions, teachers, educators, community leaders and students. The policy focuses on health particularly Sexual and Reproductive Health (SRH) and HIV/AIDS, gender and education[20]. Implementation of the policy is however limited as the education system is silent about the issue of HIV in-school positives and how they can be supported within the school system. It is plausible that they assume their needs are handled within the health HIV and AIDS care structure and hence focusing on them within schools might be stigmatizing.

2.1.4 Social factors

Adolescence in itself was perceived as a time of sexual experimenting and having to deal with peer influence. Peer pressure was reported to be one of the main barriers to protection as young people wanted to get involved in sexual relationships just like their friends who had been earlier involved in relationships[21].Baseline survey findings indicate that this is similar among students in Kabarole schools where some students were reported to engage in sex in exchange for money and other benefits. Findings further revealed that majority of the students found pregnant during medical checkups are peers an indication that peer pressure has a role to play in contributing to adolescent risky sexual behavior calling for awareness creation programs among adolescents.
2.2 Strategies where HIV Prevention Programs for adolescents have shown improvement

Sixteen out of 22 scientifically evaluated school based interventions in developing countries were successful in reducing the incidence of risky sexual behavior among youths[16]. Training peers to be positive role models can positively influence young people’s behaviors; facilitating access to and creating trust among young people. The peer promotion program in Peru, the Nigerian project with youth serving organization and the Peer education program in Cameroon all have evidence of increasing awareness and in improving some behavioral indicators such as condom use at last sex[22].

Key elements of a successful school based intervention should be that teachers must be sufficiently trained and encouraged to use interactive teaching methods and that they do not hesitate to address sexual matters explicitly[23]. Research has found that teacher training can positively affect teacher attitudes towards sexuality education and participatory techniques. In Thailand 35 teachers received training that emphasized a better understanding of young people and their environment, teachers own attitudes and values towards HIV/AIDS and sexuality and toward people living with HIV/AIDS. Pre and post test interviews indicated that following the training, teachers had more knowledge and understanding of HIV/AIDS, more positive attitudes towards young people’s sexuality and toward people living with HIV/AIDS and increased willingness and commitment towards teaching about sexuality and HIV/AIDS[24].

Evidence from research indicates that HIV related interventions in schools are increasing HIV knowledge among adolescents in schools and resultanty influencing behavior change. A review by UNESCO assessing sex and HIV education programs in developing and developed countries found that to have maximum impact, school-based sexuality education must be taught by trained teachers[25]. National efforts to decrease or delay sexual activity, increase condom use and reduce the number of sexual partners may be effective in preventing HIV nationwide.
2.3 HIV Prevention Programs in Secondary schools in Uganda

In order to address the problem of increasing HIV infection in secondary schools, various interventions have been implemented in schools. The main purpose for most of these programs is to increase HIV/AIDS awareness among students and education service providers and reduce infection in schools. HIV/AIDS education has been taught in secondary schools through a variety of extracurricular means including media, youth groups, talks, drama and music among others[26]. Below is a summary of some of the programs implemented in secondary schools together with an analysis of their gaps.

2.3.1 Presidential Initiative on AIDS Strategy Communication to Youth (PIASCY)

PIASCY is a national holistic programme designed to provide all school going children and teachers with information on HIV/AIDS both to cope with the disease for those infected and affected and to prevent further infections[27]. It was initiated in 2002 and currently in Uganda, school programs on HIV prevention are largely undertaken under the umbrella of the PIASCY initiative where health education including HIV/AIDS education and prevention is part of the primary school curriculum in primary schools[28]. The focus however, has been more at the primary than secondary schools. In secondary schools, a three days training was provided to two teachers per school (inclusive of the head teacher) prior to the start of the intervention. The trained teachers are expected to pass on the knowledge and skills to other teachers who are in turn expected to deliver HIV prevention messages to students after each lesson irrespective of the lesson being taught. This is also supposed to be reflected in the work plans of teachers.

The intervention was reported to have succeeded in primary schools where teachers embraced the program enabling students to get messages on HIV prevention[26]. The situation is however different in secondary schools with some of the teachers not keen to deliver HIV prevention messages. Preliminary findings from the baseline study conducted to Strengthen HIV Prevention and Psychosocial Support in secondary schools in Kabarole district reveal that the few teachers who share HIV prevention messages after every lesson do not include this in their work plan as required. This makes it hard for program implementers to prove the activity was conducted but
also to know the themes/ topics covered making program evaluation hard. The two teachers trained per school may not be in a position to effectively pass on the skills to other teachers especially given the academic oriented environment in which they operate together with the limited or no facilitation for the additional work.

2.3.2 Straight Talk

Straight Talk (ST) intervention started in 1993 and targets secondary school students (15-19) and young adults in institutions of higher learning. It advocates for safer sex, including abstinence, non-penetrative sex and condom use[29]. It is adolescent driven; values based and also promote life skills. The popularity of Straight Talk has led to its expansion into clubs that are now venues for open discussion about adolescent issues and has greatly increased knowledge about HIV/AIDS and exposure on reproductive health issues among secondary school students enabling them submit their questions and reproductive health problems and getting them responded to.

In Uganda ST activities is associated with greater knowledge about sexual and reproductive health, more balanced attitudes toward condoms, and more communication with parents about sexual and reproductive health issues[25]. The results also show that for girls, exposure to ST materials is associated with greater self-assuredness, greater sense of gender equity, and the likelihood of having a boyfriend but not having a sexual relationship. Among males, ST exposure is associated with lower likelihood of sexual activity, greater likelihood of resuming abstinence, and a greater likelihood of taking relationships with girls seriously. Adolescents exposed to ST were more likely to have been tested for HIV than those never exposed[25].

Straight Talk is however not in all secondary schools in Kabarole district. Three of the eight schools that participated in the Baseline survey were not accessing straight talk. This implies that some adolescents miss out on the program. While in some schools the Straight Talk newspaper is put in the library or other places where students can access it any time, in other schools the newspaper is only distributed to students who take it home and use it the way they wish. Although this allows more reading time for adolescents who receive it, access is limited to a few.
Students who reported benefiting a lot from straight talk reported discussing letters and problems with the guidance of teachers or peer educators and looking out for personal experiences related to the raised questions and problems. This they noted enabled them to put personal experiences into perspective and knowing how best to deal with them. Such a method was acknowledged by both students and teachers but it was noted to exist in three of the eight that participated in the baseline survey.

2.3.3 Peer to Peer club

In this program, students are trained as peer educators and are expected to offer peer support to fellow students. It is assumed that where students may fear to share their experiences with teachers for fear of disciplinary actions, they can share with trained peers who can advise them accordingly and if need be they share or seek guidance from teachers without necessarily disclosing the affected students. Findings from the baseline survey however indicate that peer educators were trained only once and since then, some of them have left the schools because they were in candidate classes. In the five schools where the club exists, some of the peer educators had attended a one day training workshop while others had not. Adolescents that had not been trained reported using own HIV/AIDS knowledge and experience to advise and educate others on reproductive health and HIV related issues. This poses a danger on the accuracy of information they are passing on to their peers. It further indicates that information passed on in form of guidance and awareness creation is not uniform thus posing a risk to further confuse the recipients of the information. Lack of Information, Education and Communication materials to guide and enable peer educators to get more accurate knowledge about HIV/AIDS was commonly reported among all schools that participated in the baseline survey.

2.3.4 Teen Star

Teen star program is about sexuality teaching in the context of adult responsibility. It targets senior three students (young women) for a period of 1 year. Teachers were selected from participating schools, received training in Kampala and provided with a syllabus that they are
expected to follow when teaching the students. In the participating schools, students meet once a week and cover a given topic as illustrated in the curriculum. The program was being implemented in one of the eight schools that participated in the baseline. In addition, it only targets S 3 students yet all adolescents in secondary schools are vulnerable to HIV infection and therefore all need to be targeted.

2.3.5 Kabarole Youth Alliance

This is a program aimed at creating awareness on HIV/AIDS among youths in Kabarole district. In this effort, awareness creation is done in secondary schools. In addition to awareness creation is conducting HIV testing in secondary schools.

2.4 Problem statement, justification and conceptual Framework

2.4.1 Statement of the problem

Worldwide, more than 10 million adolescents are currently living with HIV and many lack access to prevention and support programs[6]. In Uganda 30,000 infants are born with HIV each year increasing the population of children and adolescents with perinatally acquired HIV[30]. With improved treatment for HIV, many of these infants have grown into adolescence, and may have the desire to experiment their sexuality and have children[9]. According to Population Council (2009) Report, 70% of Uganda’s positive young people are in school providing an opportunity for interventions targeting schools. Research findings further indicate that only 14% of school children have their status known[6]. Many of these adolescents are now exploring their sexuality, posing a health risk to other teenagers through unsafe sex. High risky sexual behavior is common among school going adolescents and is happening in an environment characterized by adolescents living with HIV/AIDS, non-disclosure and limited or no condom use thus exposing them to infection and re-infection. In addition, little is being done by education service providers in form of providing HIV prevention information and psycho-social support to adolescents in school. Although some programs have been implemented to educate adolescents
more about Reproductive health issues, most of these have been in primary schools and few programmes address secondary school adolescents thus leaving a gap. It is against this background that Baylor- Uganda designed and implemented a pilot model for a school-based HIV prevention program to strengthen HIV prevention and psycho-social support services in selected schools in Kabarole district.

2.4.2 Justification/Rationale

Findings from research indicate that most Ugandans begin their sexual activity during their adolescence hence the need for programs on HIV prevention to start early thereby increasing chances of reducing HIV infection. Although some interventions on Sexual and reproductive health have been implemented in some schools in Uganda, most of them are in primary and not secondary schools and little has been documented about such programs in secondary schools. This intervention contributed to what is known about adolescent’s sexual behavior and what can be done in terms of HIV prevention and Psycho-social support to adolescents in secondary schools and ultimately increase HIV prevention and psychosocial support and care in secondary schools. It demonstrated what the multi-faceted approach (use of Information, Education and Communication (IEC), peer education and support from education service providers) can do to influence adolescent behavior. Findings from the intervention may inform policy and practice, increase HIV prevention and Psycho-social support for adolescents in secondary schools and equip education service providers in schools with skills to provide HIV prevention messages and support to both HIV positive and negative adolescents in school. This pilot intervention could provide a model for scale-up of HIV Prevention interventions in secondary schools in Uganda.

2.4.3 Conceptual framework

Inadequate HIV Prevention and Psychosocial support in secondary schools as a problem is caused by a number of factors grouped under themes; knowledge factors, social factors and
policy factors as illustrated in the conceptual framework below. If not addressed, these result into risk sexual behavior, increased HIV infection, increased school dropout, poor adherence, stigma and discrimination among others. The suggested intervention to address the problem was to increase knowledge of HIV prevention strategies and increasing access to psycho-social support among adolescents in secondary school using peer educators, education service providers and IEC materials. This was through; training of education service providers and peer educators to enable them impart knowledge on HIV/AIDS as well as encouraging them to pass on the messages and offer psycho-social support to students in selected secondary schools.

The Intervention led to; Strengthened capacity of teachers to offer HIV prevention to adolescents in selected secondary schools, increased knowledge of HIV prevention strategies among adolescents in the selected secondary schools; strengthened capacity of education service providers to offer adolescent counseling to students in the selected schools and increased psycho-social care and support in the four selected secondary schools.
Figure 1: Conceptual Framework for Inadequate HIV Prevention and Psycho-social support in Secondary schools

**Knowledge factors**
- Knowledge of HIV care and support among education service providers
- Inadequate training in HIV/AIDS care and support
- Lack of knowledge on HIV sero status

**Social factors**
- Peer influence
- Adolescent’s sexual exploration
- Risky sexual behavior among adolescents in school
- Self stigma
- Stigma from education service providers
- Non disclosure of parents and students to school authorities
- Fear of stigma and discrimination from fellow students
- Non adherence among HIV positive adolescents in school
- Biological sexual changes
- Adolescents sexual exploration

**Policy factors**
- Policy gaps
- Gaps in education service provision
- Gaps in health service provision

**Inadequate HIV Prevention and Psychosocial support in secondary schools**

**Intervention**
Increasing knowledge of HIV prevention strategies and increasing access to psychosocial support among adolescents in secondary school using peer educators, education service providers and IEC materials.

**Outcomes**
- Increased knowledge of HIV prevention strategies among adolescents in the selected secondary schools
- Strengthened capacity of teachers to offer HIV prevention to adolescents in selected secondary schools
- Strengthened capacity of education service providers to offer adolescent counseling to students in the selected schools
- Increased psycho-social care and support in the four selected secondary schools
2.5: Goal and Objectives of the Intervention

2.5.1: Goal or Aim Of the intervention

To contribute to the reduction of new HIV infections amongst adolescents in Uganda

2.5.2 General Objective

To improve HIV/AIDS prevention among adolescents in secondary schools in Kabarole district

2.5.3: Specific Objectives

This project was intended to:
1. Increase knowledge on HIV/AIDS prevention strategies among adolescents in selected schools in Kabarole district within the four months.
2. Build capacity of teachers to offer HIV prevention information to adolescents in selected schools in Kabarole
3. Initiate psychosocial support services in 4 secondary schools in Kabarole district
CHAPTER THREE: METHODOLOGY

This chapter presents the methodology used to implement the intervention as well as the process evaluation. It illustrates the site where the intervention was implemented, target population as well as giving a clear description of the intervention.

3.1: Intervention site/area

The project was implemented in 4 out of 31 secondary schools in Kabarole district. The district is located in the western part of Uganda, some 320 km south-west of Kampala. Kabarole has a total area of 1,844.25 sq km of which 137,802 hectares is covered by forests. Kabarole borders the districts of Bundibugyo in the West and North, Kasese and Kamwenge in the South and Kyenjojo in the East. By March 2010, the district had an estimated population size of 403,100 people. The district was targeted because it is the most urbanized in the region with the highest HIV prevalence of 11.3%. In addition, the district has an estimated 163,998 Persons Living with HIV/AIDS (PLHAs) and only 25,637 (16%) of them in care.

3.2: Target population

The project primarily targeted all adolescents in selected secondary schools because they are all exposed to risky sexual behavior. Peer educators were targeted based on the assumption that behavior is socially influenced and that behavioral norms are developed through interaction. Peer education and support can be effective among adolescents because friends are their main sources of information about sexual practices and peer influence often motivates behavior. Teachers, school nurses and matrons were targeted for their daily interaction with adolescents at both group and individual levels.

Findings from the baseline survey on strengthening HIV Prevention and Psycho-social support in secondary schools conducted by Baylor- Uganda indicated that in some of the schools where HIV positive students have disclosed their HIV status, their medication was kept by the nurse
who also ensured they adhere. In some schools, guardians and care takers disclosed to the school nurses and matrons who they trusted to be closer to their children outside the classroom setting. Findings further revealed that adolescents easily confided in school nurses and matrons compared to teachers who were sometimes seen as disciplinarians and not easily approached on sexually related issues.

3.3: Intervention Description

The project design was a cross sectional before and after assessment implemented in four secondary schools. All the 4 schools participated in the baseline survey conducted by Baylor-Uganda which also informed the design of the project. The schools received a full package of the planned intervention activities including training of education service providers and peer educators, distribution of a range of Information Education and Communication materials. Project monitoring visits were made every month and interviews conducted with coordinating teachers, peer educators, school nurses and matrons where they existed. After two months of project implementation, a process evaluation was conducted to assess progress in implementing the program in the four schools. The evaluation was both quantitative and qualitative. Self-administered questionnaires were completed by students in the four schools. Key Informant interviews were conducted with education service providers specifically teachers and school nurses while focus group discussions were held with peer educators in the 4 schools.

3.4: Development of training manuals

Training manuals were developed with support and supervision from the Baylor- Uganda training department, a training consultant and a team of counselors, home health workers, training coordinator, and an adolescent trainer.
CHAPTER FOUR: PROJECT IMPLEMENTATION

This chapter presents the process of implementing the intervention. It details the training of both education service providers and peer educators, delivery of Information, education and communication materials, monitoring and support supervision as well as giving the outputs and outcomes of the intervention.

4.1: Training of education service providers and peer educators

Project implementation was commenced with project inception meetings held to; update the Baylor- Uganda regional office on progress of the intervention, to introduce the intervention to the district officials including the Residence District Commissioner (RDC), Deputy Chief Administrative Officer (DCAO), District Health Officer (DHO), Probation Officer (PO) and District Education Officer (DEO) as well as introducing the intervention to the schools. All inception meetings discussed issues of the nature of the intervention. In schools, meetings were held with head teachers in all the 4 schools. Clarity was given on the components of the intervention and specific activities to be implemented. All head teachers were happy that their schools were going to benefit from the intervention. Inception meetings were held to explain how the intervention was to be implemented and the expected roles of schools, head teachers, teachers, nurses, matrons and peer educators. Each school nominated a teacher who was to coordinate the project within the school. A detailed work plan was shared with all the schools and dates for training agreed upon with the school head teachers and coordinating teachers.

Project implementation commenced two weeks after the project inception meetings. This started with a six days training of 14 education and health service providers(teachers, school nurses and matrons) from the four intervention schools of Kibiito S.S.S, St Leo’s College Kyegobe, Fort Portal S.S.S and Rusekere S.S.S. a total of 82 peer educators from the same schools were also trained. Two trainings run in parallel sessions. During the first three days, education service providers were trained and in a parallel session; 22 peer educators from Kibiito S.S.S were trained. The following three days comprised of students from the three schools of St Leo’s College Kyegobe, Fort Portal S.S.S and Rusekere S.S.S. These were divided up into two groups of 30 each by age (12-15) and (16-18).
Both education service providers and peer educators trainings covered the following topics; sex and sexuality, peer pressure and behavioral choices, overview of HIV/AIDS, HIV Prevention, life skills, child and adolescent counseling, confidentiality, coping with trauma, communication in counseling, psychosocial support, stigma and discrimination and peer psychosocial support services for adolescents. Details in content and discussions were however tailored to the age of the trainees. Trainers included Baylor- Uganda staff (3 counselors, one adolescent trainer and the MakSPH CDC fellow). All trainings were opened and closed by the district education officials.

Training methods included presentations, discussions, skits, role plays, watching films on counseling, STDs and living with slim. On completion of the training, a post test was given and certificates of attendance were given to participants who attended the full training.
Certificates that were issued to participants showing content at both the front and back.

4.2: Delivery of Information Education and Communication (IEC) materials

Various IEC materials on HIV prevention, peer education, abstinence, drug abuse, early pregnancies, facts about HIV/AIDS in Uganda, teens talk about HIV, sexual abuse among others were distributed to all the schools in the intervention. Books given out included; Peer to Peer User guide, Drug and Alcohol to Peer Prevention Program, Abstinence will give you 100% Freedom, ROCK POINT: Booze Trouble in Rock Point vol 7 ROCK POINT: Good Deal Gone Bad vol 8, LUKIA’s story, Make a Positive Start Game and User Guide, HIV.... to Protect yourself Learn the facts book, TEENS TALK about HIV book, FACTS For MEN on HIV/AIDS (TRUE MANHOOD), Quick facts about Children and HIV/AIDS in Uganda. Posters on Drug and substance abuse, domestic violence, sexual abuse and alcohol DVD/ Films distributed to students include; Karate kids, the school canteen Yellow Card, Scenario’s of the Sahel, More Time and Karate Kids.
4.3: Monitoring the project activities

Three monitoring activities were conducted throughout the project implementation period. These involved assessing the extent to which HIV prevention messages and psychosocial support were being offered by both education service providers and peer educators in the four schools. Technical support supervision to education service providers and peer educators was also given during the monitoring visits and strategies for improving program implementation were discussed during meetings with peer educators and education service providers at every visit. Support supervision and monitoring visits were also used to illustrate HIV related debates and quizzes as some of the possible activities peer educators and education service providers could lead for the students in schools.

Monitoring tools that were completed by education service providers and peer educators every time they conducted an activity were collected during monitoring visits. These were used to track the number of students accessing services as well as the range of issues discussed during the meetings or interaction of peer educators.

Findings from the monitoring activities indicated that the intervention was well received and appreciated in all the 4 intervention schools. The schools were more excited about the trainings
for education service providers (teachers, school nurse and matron) and peer educators together with the IEC materials.

4.4: Outputs and outcomes of the Project

- A total of 82 peer educators were trained in HIV Prevention and psychosocial support and were eager to go and share the messages with their colleagues at individual and group levels.

- Education service providers (14) including teachers, school matrons and nurses were trained in HIV Prevention and psychosocial support. A large percentage (80%) of the trained service providers offer HIV prevention education to students in their schools.

- Ministry of education, Kabarole district local government and the district education and all the four school head teachers welcomed the intervention in the schools.

- A range of IEC materials were collected and distributed to the schools.

- Teachers reported increased knowledge of HIV prevention services as illustrated “I have learnt a lot of things not for the students alone but for myself, my children, and my husband. There is a lot I did not know as a senior woman teacher and I had never got an opportunity of being trained in HIV issues and life skills. I am now going to train fellow teachers as well as students” senior woman teacher in one of the schools.
CHAPTER FIVE: PROCESS EVALUATION

This chapter details the process evaluation. It mainly presents the evaluation process, characteristics of the respondents, the HIV prevention services in the intervention schools, provision of services after the intervention, availability and utilization of IEC materials. The chapter further presents the intervention implementation challenges as well as the lessons learnt.

5.1: Process evaluation

After two months of project implementation, a process evaluation was conducted to assess the extent to which the program was being implemented in the four intervention schools. We mainly assessed progress in implementing HIV prevention and psychosocial support related activities in the four intervention schools, assessed the extent to which HIV prevention messages were offered to students and how often they were conducted and assessed by both education service providers and peer educators in the four secondary schools in Kabarole district.

Both quantitative and qualitative methods were used in the process evaluation with self-administered questionnaires completed by 164 randomly selected students from the four intervention schools. Eight Focus Group Discussions where held with peer educators and Key Informant Interviews were held with a selected teacher, school nurse and matron in each of the four schools.
Results

5.2: Characteristics of respondents

A total of 164 students from the four intervention schools responded to the self-administered questionnaire. Of all respondents, 64% of respondents were from day schools while 36% were boarding scholars. Details of the quantitative respondent’s characteristics are in table 1 below. Eight focus group discussions were held with peer educators in the four schools. Focus group discussions were disaggregated by sex in mixed schools while in the single sex schools they were disaggregated by age. A total of 4 teachers 2 school nurses and one matron participated in the key informant interviews.

Table 1: Demographic characteristics of respondents

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=164</td>
</tr>
<tr>
<td>Sex</td>
<td>n= Percentage</td>
</tr>
<tr>
<td>Male</td>
<td>86</td>
</tr>
<tr>
<td>Females</td>
<td>78</td>
</tr>
<tr>
<td>Age</td>
<td>Frequency</td>
</tr>
<tr>
<td></td>
<td>N=164</td>
</tr>
<tr>
<td>12-15</td>
<td>20</td>
</tr>
<tr>
<td>16-19</td>
<td>127</td>
</tr>
<tr>
<td>20-24</td>
<td>17</td>
</tr>
<tr>
<td>Class</td>
<td>Frequency</td>
</tr>
<tr>
<td></td>
<td>N=164</td>
</tr>
<tr>
<td>S2</td>
<td>48</td>
</tr>
<tr>
<td>S3</td>
<td>39</td>
</tr>
<tr>
<td>S4</td>
<td>47</td>
</tr>
<tr>
<td>S6</td>
<td>30</td>
</tr>
<tr>
<td>Status of respondent</td>
<td>Frequency</td>
</tr>
<tr>
<td></td>
<td>N=164</td>
</tr>
<tr>
<td>Day</td>
<td>105</td>
</tr>
<tr>
<td>Boarding</td>
<td>59</td>
</tr>
</tbody>
</table>
5.3: HIV Prevention Services in schools

In all the four intervention schools, more students reported knowledge of HIV prevention services compared to services reported at baseline. An increase in service delivery was reported after the intervention compared to the baseline findings with counseling 88% compared to 32% at baseline, drama 77% from 12%, health talks; 73% from 36%, brochures with HIV prevention messages were reported by 51.8% from 14%. It was also reported that services including, skits with various messages, quiz with students, psychosocial support, HIV related films and debates with HIV related topics that were not reported in these schools at baseline had started after the intervention as evident in figure 2 below.

Figure 2: Services offered during the time of the baseline survey and during the implementation of the intervention

5.4: Service provision
During discussions with the teachers, it was reported that HIV prevention services were offered by teachers, school nurses, matrons and peer educators. Process evaluation findings indicated that peer educators were shared HIV prevention messages with fellow peers in various ways including one on one talks, group talks, through debates, and drama. Findings from the student’s interviews however indicated that the service providers differed depending on service as illustrated in table 2 below.

<table>
<thead>
<tr>
<th>Services</th>
<th>Teachers</th>
<th>Nurses</th>
<th>Matrons</th>
<th>Peer educators</th>
<th>Guest speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>37.7</td>
<td>11.5</td>
<td>6.3</td>
<td>38.2</td>
<td>6.3</td>
</tr>
<tr>
<td>Debates</td>
<td>51.5</td>
<td>0</td>
<td>0</td>
<td>40.3</td>
<td>6.7</td>
</tr>
<tr>
<td>Drama</td>
<td>25.4</td>
<td>2.2</td>
<td>5.2</td>
<td>66.4</td>
<td>0</td>
</tr>
<tr>
<td>Films</td>
<td>41.2</td>
<td>1.5</td>
<td>9.2</td>
<td>38.9</td>
<td>9.2</td>
</tr>
<tr>
<td>Health talks</td>
<td>35.2</td>
<td>28.1</td>
<td>9.4</td>
<td>19.5</td>
<td>7.8</td>
</tr>
<tr>
<td>Brochures</td>
<td>37.4</td>
<td>14</td>
<td>4.7</td>
<td>25.2</td>
<td>18.7</td>
</tr>
<tr>
<td>Skits</td>
<td>19.5</td>
<td>0</td>
<td>0</td>
<td>80.5</td>
<td>0</td>
</tr>
</tbody>
</table>

As evident in table 2 above, teachers and peer educators provide most of the services or facilitate the provision of most services compared to school nurses, guest speakers and matrons. Training teachers and peer educators can therefore lead to increased service delivery in secondary schools.

5.5: Availability, access and utilization of HIV reading materials

All the 4 intervention schools reported availability of Information Education and Communication (IEC) materials in their schools as noted by one of the teachers during a KII

“with this intervention, we have been able to get a variety of materials. In the past we mainly used to get straight talk and rock point only”.
This was affirmed by students with 92% of those who participated in the process evaluation reporting availability of IEC materials in their schools compared to 63% of the students who reported receiving the same materials during the baseline survey. There was increased utilization of materials with 50.3% of students reading once a week compared to 47.6% at baseline, 11.9% reading once a fortnight compared to 6.5% reported at baseline, 5.3% reading them once a term compared to 3.5% at baseline. Increased utilization can be partly attributed to changes in storage of the materials whereby the intervention saw changes in storage with IEC materials stored in different places compared to storage at baseline as in figure below.

Figure 3: Storage of IEC materials in the different schools as reported by students

![Graph showing places for IEC materials storage in the intervention schools]

5.6: Project implementation challenges

Timing for project implementation: Implementing the project during term three was the biggest challenge given the fact that it is the busiest period in the school calendar. Students were
engaged in revision for external and internal exams leaving little time for engagement in extra-curricular activities. Teachers too were busy in internal and external examination supervision and marking beginning of term, midterm and end of term exams not forgetting the extra classes to enable teachers and the school completes all uncompleted syllabuses. Peer educators were also busy with a preference to spend any extra time in revision as opposed to supporting their peers. All this made implementation of the intervention in the first two months hard. Despite this, two of the intervention schools proved more actively involved in implementation compared to their counterparts.

**Status of the school:** Implementation of the program was more challenging in day schools than boarding schools. This can be attributed to the limited time day scholars have at school compared to that of boarding scholars who have evenings and weekends at their disposal. One of the intervention schools was for example changed to shift study system where students of S1-S3 study in the morning and others study in the afternoon. This reduces their time of stay at school further limiting time for engagement with teachers and peers.

**Motivation for implementing education service providers:** Teachers school nurses and matrons implementing the intervention felt they were doing extra work yet not financially motivated to do it. Their complaints can be demonstrated in the following statements…..

“When organizations implement interventions in the districts or health centres, health service providers are given a top up allowance but when working with teachers, it is different with the expectation that we will work on our current meager salaries”. Teacher

“Talking to students and listening to their personal problems requires time, given the busy schedules, we end up doing most of this work outside our official working hours thus eating into on our personal time. We need to be motivated if we are to successfully implement the program” Teacher in one of the schools

“I already work extra hours since I have to see students any time of day or night, I feel talking to students about HIV plus the counseling involved is additional workload hence the need for a top up allowance if it is to be a success” School nurse
Student’s attitude about HIV: Discussions with peer educators and education service providers during monitoring visits and the process evaluation indicated that some students still have limited appreciation of HIV as a reality and still think it’s a myth. This was evident in the comments some students were making to peer educators as they tried to pass on HIV prevention messages. Such comments include questions like….. Did HIV come for trees? Will they cut timber out of us? Won’t we have children? ”

Such statements sometimes discourage peer educators from continuing to share messages on HIV prevention.

Bullying tendencies by male students: During a group discussion with female peer educators, it was reported that some students especially boys tend to shout at female peer educators trying to discourage them from sharing HIV prevention messages. It was reported that other male adolescents request for one on one counseling sessions but end up using the time to make requests for relationships instead of the risk reduction counseling requested for. Male students were also reported to frequently shout at colleagues telling them statements like…..

“You are already HIV positive and you are trying to share with us your problems and challenges”

“You are ugly and no boy is interested in you and now you are interfering in our relationships scaring off the beautiful girls we love”

Such statements were reported to sometimes demoralize and demotivate peer educators hindering them from actively sharing HIV prevention information with colleagues thus posing a challenge to program implementation.

Limited project funding: Education service providers and peer educators had various innovations that would add value to the program but most of them required financial support that the project could not afford to raise. This included monthly top up fees for education service providers, suggestion boxes for peer educators, T shirts for all peer educators in the schools, support in filming the skits that peer educators innovated after the training, support to enable the
peer educators have exchange visits with other schools so that they can share ideas. All these however required additional resources that the project budget could not afford

5.7: Lessons learnt

• Education service providers do not know much about HIV/AIDS as we often expect. This was evident in statements made during informal discussions with them after the training as noted “I have learnt a lot of things not for the students alone but for myself, my children, and my husband. There is a lot I did not know as a senior woman teacher and I had never got an opportunity of being trained in some areas including life skills. I am now going to train fellow teachers as well as students” senior woman teacher in one of the schools.

• District officials too need awareness creation in HIV/AIDS as evident in some statements made during the opening and closing functions during trainings where officials could make statements without imagining that some adolescents may have been prenatally infected thus stigmatizing them. Such statements include saying that Kabarole district will put special points for students who test HIV negative after S 6.

• Implementation of the intervention is easier in boarding and both day and boarding schools where students have more free time at school (after classes and weekends) compared to day schools where students have minimal and restricted time at school. More thought out interventions that also involve parents and care takers are required for day scholars.

• Implementation of school based interventions is best done in the first and second terms of the school calendar because this period is less busy and interrupted compared to term three which has internal and external exams.

• Continued support supervision, monitoring and support from the school administration can positively contribute to the success of the intervention. Similarly, the zeal and willingness of the coordinating teachers and trained education service providers has a major contribution to the success or failure of the intervention. Where they are well motivated, they are capable of being very active in implementation compared to schools where they are less motivated and therefore not going an extra mile in implementation of the program.
• Short exciting stories, films, skits, poems, drama and talks from guest speakers were considered more attractive and easier to contribute to learning among students.

• HIV prevention messages can become boring to students especially if creativity and innovativeness are not employed by peers, teachers, nurses and guest speakers to attract their attention and avoid routine activities that may create boredom.

• Students are more keen to listen to outsiders giving them talks than their usual teachers and peers whose voices and faces they can easily get used to.

• Incorporation of the intervention activities in the school programs can lead to more acceptance of the program together with a more involvement of both students and education service providers.

• The zeal and commitment of the coordinating teachers and trained education service providers has a major contribution to the success or failure of the intervention.
CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

This chapter stipulates the conclusions drawn from the intervention as well as the recommendations for strengthening interventions dealing with HIV prevention in secondary schools.

6.1: Conclusion

With training of education service providers including teachers, school nurses, matrons and peer educators, HIV prevention service availability increased in the four secondary schools that were targeted for the intervention. Ensuring continuity of the intervention however requires the support of the school administration through incorporation of the intervention activities in the rest of the school activities and curriculum, innovative ways of motivating and supporting the teachers and peer educators as well as resource allocation to enable innovativeness and creativity that can keep adolescents interested in the program. HIV prevention service availability is very limited in these schools.

6.2: Recommendations

- Bi annual or quarterly refresher training courses are important for both education service providers and peer educators to equip them with more skills of handling the challenges intervention as well as experience sharing and seeking advice from peers for better program implementation.
- Incorporation of the program activities in other school programs is important and necessary for program acceptability and increased student and education service provider involvement.
- There is need to work with parents/caretakers to design activities favorable for day scholars so that they do not totally miss out on the program.
• There is need to devise means of motivating teachers to enable them keep up the momentum and enable them provide adequate support to students even after classes and on weekends.

• There is need to design messages that students can continue to use during holidays to enable them sharpen their communication skills but also pass on the message to students in other schools.

• Peer educators need to be continuously encouraged to be assertive and school administration needs to put in place disciplinary measures for students who bully peer educators preventing them from sharing HIV prevention messages.

• For more conclusive results on impact of the intervention, we recommend an impact evaluation in both intervention and comparison schools after 3-5 months of intervention because this was conducted after one and a half months of interrupted implementation.

• Peer educators need to be continuously encouraged to be assertive and school administration needs to put in place disciplinary measures for students who bully peer educators preventing them from sharing HIV prevention messages.
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