Tanzania

Program Summary

AMREF, LSHTM, and NIMR: MEMA Kwa Vijana Program

The African Medical and Research Foundation (AMREF), in collaboration with the London School of Hygiene and Tropical Medicine (LSHTM) and the (Tanzanian) National Institute for Medical Research (NIMR), initiated a program in 62 primary schools and 18 health facilities in Mwanza region of Tanzania in January 1999.

Its main objective was to improve reproductive health knowledge among 12- to 19-year-olds and decrease the rate of sexually transmitted infections (STIs) and HIV infection as well as the number of unwanted pregnancies. To do this, teacher-led peer educators use informal and participatory techniques to teach young people about reproductive health. Health workers are also trained to make health services more youth friendly, and the community is mobilized to participate in Youth Health Weeks, which are held once a year.

The program reaches approximately 2,850 new adolescent participants a year, at an estimated cost of US$1.37 per child per year. Of the 16 UNAIDS benchmarks for effective programs, the program was found to have successfully met 13 and partially met 2, and 1 was not applicable.

AMREF, LSHTM, and NIMR: MEMA Kwa Vijana Program

PART A: DESCRIPTION OF THE PROGRAM

Program Rationale and History

Between 1994 and 1998, several baseline studies were conducted in the Mwanza region and neighboring Mara region in Tanzania to look into the status of HIV infection in primary schools. They found that youth in their early 20s were most at risk of becoming infected.

To tackle this problem, the MEMA kwa Vijana program was set up in 62 primary schools in four (of the seven) districts in the Mwanza region in 1999 to target 12- to 19-year–olds, the age just before which they are most likely to become infected. The idea was to equip youth with information about adolescent sexual and reproductive health (ASRH) and get them to think about the consequences of their sexual behaviors. The program title reflects its rationale: *MEMA kwa Vijana* means "Good Things (MEMA) for Young People."

> Setting up an intervention for youth who are at high risk will assist in equipping them with correct information about sex before they start sexual relationships. It also means they will be more likely to practice safer sex. Otherwise, many youth learn from their peers, who also lack the correct information.
>
> ***Program coordinator***

The program is a collaboration between three organizations: the African Medical and Research Foundation (AMREF), the London School of Hygiene and Tropical Medicine (LSHTM), and the National Institute for Medical Research (NIMR) of Tanzania. AMREF designed the program and is responsible for its implementation in collaboration with the Tanzanian Ministry of Health (MoH) and Ministry of Education and Culture (MoEC). NIMR is responsible for designing and implementing the evaluation, looking at both the impact and the cost-effectiveness of the intervention. LSHTM provides technical assistance to both AMREF and NIMR, as well as providing the majority of the funding for the program.

The program involves teacher-led and peer-assisted, participatory, in-class teaching and informal ASRH peer education in clubs and through one-to-one contact. The program also involves youth-friendly SRH services and community mobilization. The program has been set up using an

experimental design: The intervention is being conducted in 62 primary schools and 18 health facilities, with the same number of schools and health facilities acting as a control group (see Evaluation below). This design allows scientific measurement of the impact of the intervention program.

So far, the program has reached approximately 17,000 students. The program's future will be determined by the results of the evaluation currently under way (2002) and the availability of funds.

Program Overview

Aim

The main aim of the program is to improve ASRH knowledge and decrease the rate of sexually transmitted infection (STI) and HIV infection and unwanted pregnancies among 12- to 19-year-old youth in Mwanza region.

Year	Events
1995	• Preliminary design • Soliciting for funds
1997	• Approval of program given by MoEC, MoH, and regional and district authorities
1998	• Design and intervention details developed and pretested (July–December) • Cohort recruitment survey (September–December) • Initial needs assessment survey (November 1997–May 1998) • Development and pretesting of teachers' guides (November 1997–May 1998)
1999	• Program begins in 62 primary schools and 18 health clinics • Health and Lifestyle Research (HALIRA) program begins • Evaluation conducted by Dr. W. Lugoe (Canada)., G. Akingabe (The University of Dar es Salaam [UDSM], Tanzania), and Dr. J. Ferguson (World Health Organization [WHO]) to assess progress • Evaluation conducted by Mary Plummer to assess community and class peer educator training
2000	• Focus group discussion and in-depth interviews with young people in Mwanza • Evaluation of peer education conducted by Ak'ingabe Guyon (Canada), Dr. Lugoe (UDSM, Tanzania) and Dr. Ferguson (WHO)
2001	• Interim (midterm) survey (February–June) • Simulated patients exercise used to compare the ASRH services provided in intervention and control communities (October–December) • Evaluation of teacher training and curriculum
2002	• Final (endline/impact) survey (October 2001–April 2002) • Evaluation report of the impact on health and behavior

Figure 1. Time Line of Major Program Events

Objectives

According to the program coordinator, the program objectives are to

- improve young people's knowledge and skills to avoid sexual and reproductive health risks,
- decrease the prevalence of HIV infection and other STIs among youth,
- decrease the number of unintended pregnancies,
- improve young people's access to youth-friendly SRH services,
- improve adults' attitudes toward ASRH needs, and
- improve adults' skills to respond to ASRH needs.

> We appreciate the program because it exposes us to issues which we didn't used to know about. It also allows us to talk freely about things we weren't allowed to before, like mentioning the male and female reproductive organs.
>
> ***Youth participant***

Target Groups

Primary Target Group

The target group are students in 62 primary schools aged 12 to 19 years (grades 5, 6, and 7) in Mwanza region.

Secondary Target Group

The secondary target group are

- students in grades 1 to 4 and out-of-school youth reached during the annual interschools Youth Health Week festivals;
- teachers in the schools where the program is running;
- health workers in the health clinics where the program is running;
- approximately 2,000 out-of-school youth who participate in drama, role plays, and songs, and who are involved in the promotion and distribution of condoms, which they buy and sell at a profit; and
- community members who are exposed to the program.

Site

The program was started and is mainly based in primary schools in the region. It also works in health centers, where it has trained health workers to deliver youth-friendly SRH services.

Program Length

The program has lasted for three years so far.

Program Goals

The list in figure 2 shows how the program coordinator ranked the program goals. The idea is that if young people receive correct information and are taught behavioral and life skills before they engage in sex, they will be more likely to practice safer sex (e.g., using condoms, choosing safe partners, limiting the number of partners, seeking SRH services, etc.) once they become sexually active.

Approaches

Figure 3 shows the program's approaches, ranked in order by the program coordinator.

HIV/AIDS testing and counseling were conducted in 1999 on 10,000 in-school and out-of-school youth (both males and females) who make up the intervention group. They were counseled and tested again in 2002.

Figure 2. Program Goals Ranked in Increasing Importance by Program Coordinator

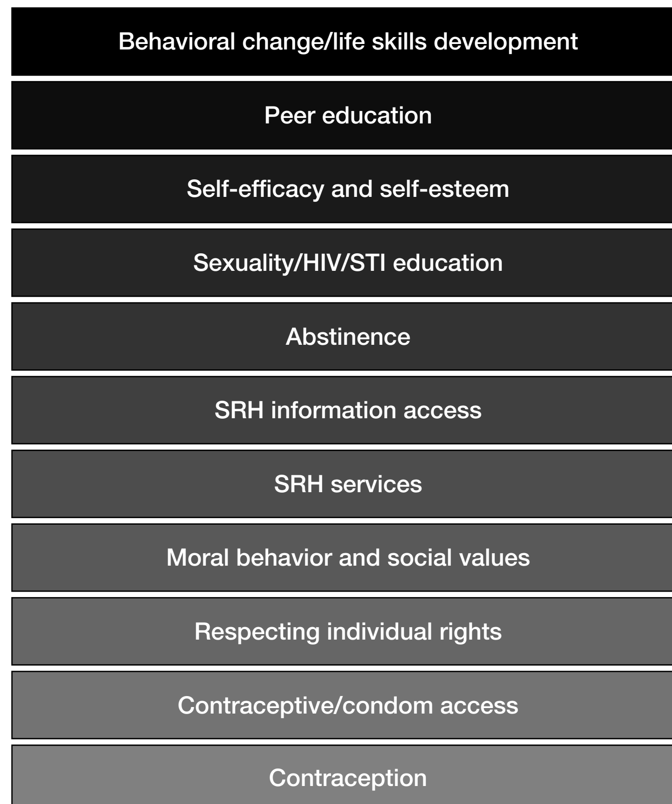

Figure 3. Program Approaches Ranked in Increasing Importance

Activities

The students enjoy drama and role plays most because they can get involved and are given an opportunity to show off their skills. Condom distribution occurs less frequently, because it is done by out-of-school youth on a voluntary basis.

Components

The program consists of four main components:

1. teacher-led and peer-assisted, participatory SRH education and informal peer education,
2. training of health workers to deliver youth-friendly SRH services,
3. condom distribution, and
4. community mobilization.

School Component

Classroom teaching. Each school has approximately three MEMA teachers who have been trained to deliver participatory SRH education. Students in the last three years of primary school are taught about ASRH for one hour per week by these teacher-guardians, who are

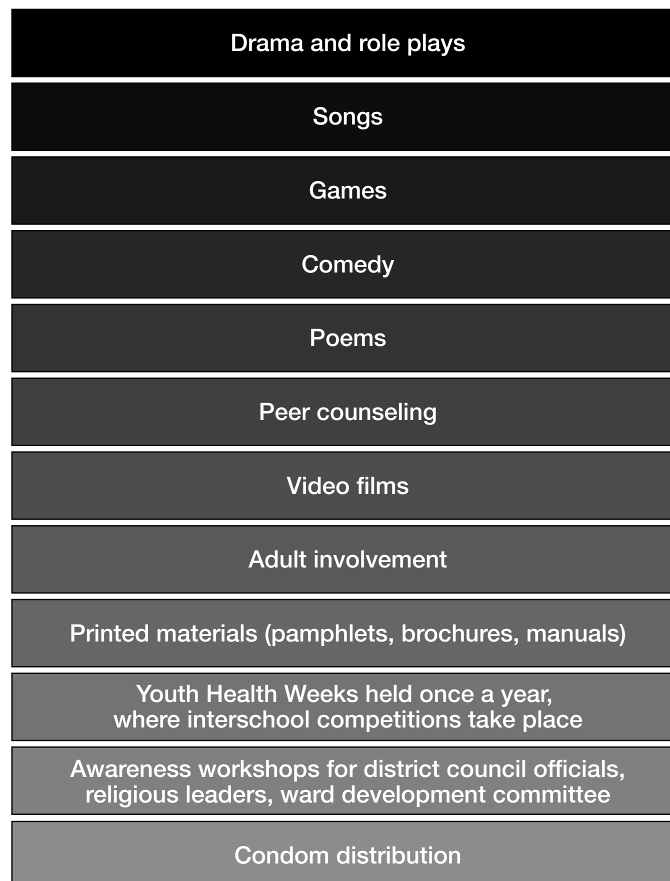

Figure 4. Program Activities Ranked in Increasing Frequency of Use by Youth

assisted by peer educators. The in-class sessions have been developed in partnership with the regional education authorities and aim to enhance adolescents' knowledge and attitudes concerning SRH. They also include a substantial skills-training component designed to assist adolescents in translating attitudes and intentions into behavior.

> Prior to MEMA kwa Vijana program, we never attended to any pupil. I think they had no confidence in our confidentiality — also, they felt ashamed and feared their parents.
>
> ***Public health nurse***

After school hours, these lessons are followed by drama, songs, role plays, and poems prepared (with help from teachers) by the students. Debate clubs are held twice a month in each school. Younger pupils and out-of-school youth are invited to attend these.

There is a 15-member school committee: two teachers, the ward education coordinator, the village or ward executive officer, a health care worker, and other male and female community members. The committee guides the school by discussing the views, needs, progress, and recommendations reported from all stakeholders (students, teachers, and community members).

Teachers also attend yearly workshops, where they meet with teachers from other schools to monitor and evaluate program progress and exchange ideas and new findings.

The ward education coordinator visits each school three times a month to make sure that the academic subjects and ASRH topics are taught as arranged. They also discuss program progress with the peer educators and teachers. Any problems raised are discussed first by the school committee, and if no resolution can be found, the district education inspector and MEMA kwa Vijana are informed.

Case Study of a Class Session

The session opens with the teacher asking a pupil to sing a song to "break the ice." The teacher then reviews the previous session through questions — for example, "Who can tell us what we talked about in the last class?" Then the teacher posts the topic of the current session on the board. The pupils are asked to read it and guess what they think will be discussed that day. The topic is then introduced through a short drama enacted by peer educators. Students then form small groups to answer questions in a quiz competition the teacher has posed to them. The students are then given an opportunity to ask questions and review what they have learned that day. Homework questions are given, and the students are asked to discuss them and the lessons in general with others not reached by this session (out-of-school peers, siblings, parents).

Advice. Empathic advice is given, either on demand and or when teachers identify the need, by the teacher-guardian or teachers who have had training in ASRH.

Youth Health Weeks. Youth Health Weeks are held once a year. Students from all participating schools in the district meet and display what they have learned during the year. Members of the community and leaders from the district or regional level are also invited. The aim here is to disseminate messages on HIV/AIDS/STI prevention and raise awareness of ASRH needs.

Health Clinic Component

A program of youth-friendly SRH services has been developed and is being implemented in 18 government-run primary health care facilities. Two health workers per clinic were trained to deliver youth-friendly SRH services with the aim of improving adolescents' access to effective sexually transmitted disease (STD) treatment and family-planning services. It focuses on adolescents' rights to comprehensive services, empathic treatment, respect, and confidentiality.

The trained health workers visit each school once a month to check on the general health of students and exchange news with teachers and the guardians.

Condom Distribution

The project has trained a total of 228 young people (peer condom promoters and distributors [CPDs]) who were elected by their peers to sell affordable condoms in the intervention villages. Condoms are supplied by the project to at least one central distributor in each project community, from whom the CPDs purchase their stock.

Community Mobilization

Community activities are scheduled throughout the year. They aim to raise community awareness of risks to ASRH and mobilize support for the other components of the intervention. These activities are overseen in each community by an advisory committee, which consists of 15 to 22 individuals who were elected by the community themselves at the end of a participatory community mobilization week in late 1998.

PART B: IMPLEMENTING THE PROGRAM

Needs Assessment

The needs assessment was not available. However, the program manager said that the main results revealed that most primary school students began sexual activity by the age of 13 or 14 years. It also found that 5 percent of girls and 1 percent of boys aged 19 years were HIV positive. Many young girls (particularly the poor) were enticed by small gifts into having unprotected sex with older, wealthier men. The men believe that the young and naïve girls are free from HIV infection.

Program Materials

MEMA kwa Vijana has developed its own materials for the teachers and students. The materials are in Kiswahili, and are being translated into English, with publication planned for early 2003. Other materials are adapted from other NGOs, such as Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), and programs such as Tanzania Netherlands Support for AIDS (TANESA), and so forth.

Target Group Materials

- Guide for peer educators (in Kiswahili) prepared by the Mo E and culture called KINGA;
- health and family life education materialsfor primary school classes 5, 6, and 7 (topics mainly on ASRH); and

- eight GTZ booklets giving answers to the questions adolescents ask most frequently about ASRH:
  - Volume 1 — *Growing Up,*
  - Volume 2 — *Male-Female Relationships,*
  - Volume 3 — *Sexual Relationships,*
  - Volume 4 — *Pregnancy,*
  - Volume 5 — *Healthy Relationships,*
  - Volume 6 — *HIV/AIDS and the New Generation,*
  - Volume 7 — *Drugs and Drug Abuse,* and
  - Volume 8 — *Alcohol and Cigarettes.*

The program is very useful because now the pregnancy rate, absenteeism, and drop out is low. For example, there has been no pregnant pupil for the past two years. Girls are also more assertive and confident. They can just say no to sexual advances, and there are good interpersonal relationships between boys and girls.

Teacher

Additional Materials

Other materials, such as a flip chart on female and male reproductive organs, and posters, booklets, and videos from the National AIDS Control Program and other NGOs, such as GTZ and TANESA, are also used.

Staff Training Materials

Three books, one for each class (grades 5, 6, and 7) have been developed for teachers to use as guides in the classroom:

- a questions and answers book for peer educators that cover common questions asked by young people,
- a teacher's guide used to deliver SRH education, and
- a teacher resource book with detailed information about HIV/AIDS/STI and family planning, including condom use.

Staff Selection and Training

- Initially, the program trained trainers of peers (TOPs) who participated in training their class peers, but these have been dropped in favor of using teachers.
- Senior posts were advertised in the media. Applicants were interviewed and successful candidates employed. Junior staff were recruited from the intervention region through internal and partner advertisement.
- Staff development is ensured through in-house mentoring and capacity-building, attending and presenting at national and international meetings, and access to up-to-date information via unlimited access to the Internet at the workplace.
- This year, the program coordinator has been sponsored to take a one-year course for a master's degree in public health (MPH) in London.

Setting Up the Program

No information was available on how to set up the program.

Program Resources

The program has a spacious office, where books, posters, charts, fliers, pamphlets, and other materials are stored. The office also has a number of computers and printers and a photocopy machine. The program also has four vehicles.

Advocacy

MEMA kwa Vijana involves government officials and community leaders who give their firm support to the program. The government's involvement includes providing policy guidelines for the program and participating in implementing the program (MOEC and MOH, regional and district leaders). Government health facility workers are involved in providing youth-friendly services.

Discussion with the regional education officer for Mwanza and the zonal education inspector showed that they were happy with the program and would appreciate expansion to cover all schools in the region.

Program Finances

Estimates of the cost per participant in the program:

- During the pilot phase (heavy development and monitoring), the cost per primary-target-group youth was US$17 per year.
- The second-year cost was US$ 7.63.
- Annual implementation cost at present is US$1.37 per participant per year.

PART C: ASSESSMENT AND LESSONS LEARNED

Challenges and Solutions

Program Coordinator

- Teacher-led, peer-assisted SRH education is now acceptable and feasible within the regular school curriculum. This was achieved through discussions with educational leaders who agreed to dedicate one hour per week per class for ASRH education. The same is true for youth-friendly health services.
- By targeting parents, ASRH messages can be further integrated into community life.
- ASRH programs need to tap into and build local capacity and infrastructure to promote and sustain peer education.
- Some resistance was noted from religious leaders, especially on condom knowledge and use. This could be overcome if religious leaders are involved right from the beginning of the program. Discussions and demonstrations of condom use in classrooms also remain a controversial issue. This needs to be overcome, especially because it is educationally necessary.
- Building ASRH programs into activities that adolescents identify with (drama, sports, entertainment, and income-generating activities) has broader appeal to young people's needs.

Furthermore, combining ASRH education activities with youth-friendly services and counseling is more likely to result in behavior change.
- The degree of SRH risk an adolescent faces is often indicative of, and is made worse by, important but unmet social and economic needs. Hence, these also need to be addressed.
- It is difficult to train 12- to 19-year-old youth in peer education. However, they can perform excellent drama productions and are good as discussion starters. Therefore, their role should not be to educate directly, but to facilitate better trained, older peer educators.
- Even though condom promotion and distribution has increased in the communities, the youth responsible for distribution used the money earned to invest in other things because they were not earning enough money to realize a decent income. This had the consequence that many CPDs left the program or became very mobile ("searching for life"). The increase in absenteeism and sales inertia made the whole component difficult to sustain. Equipping the CPDs with business skills would not solve the problem; what is needed is for the communities to be more willing to buy and use condoms.
- Regular process evaluations build strong programs by making them proactive and keeping them relevant to emerging needs.

Teachers

Teachers requested that they all be given training.

Peer Educators

- During the annual Youth Health Week, several schools should hold competitions, and the best performers could be rewarded. This would be an incentive for sustaining the status while they learn.
- Use of videos of their performances could be more enjoyable and easily understood by the community and other youth.

Evaluation

The impact of the intervention on the sexual behavior and reproductive health of adolescents will be evaluated by NIMR in early 2003. The final report is expected by October or December 2002. The two principal components are explained below.

Biomedical Impact

The primary outcomes of the trial will be a comparison of HIV, other STIs, and unintended pregnancies between
- a cohort of students in 62 primary schools in 10 communities that were randomly assigned to receive the intervention in phase 1 (January 1999 to December 2002), and
- an equal number of students in 10 comparable communities that were randomly assigned to receive the intervention from July 2003 onward (if the intervention is found to have been effective during phase 1).

The prevalence of HIV, other STIs, and unintended pregnancies was measured when the trial cohort was recruited between August and December 1998, immediately before the introduction of the intervention. An interim follow-up survey was conducted between February and June 2000 (i.e., approximately 18 months after the cohort recruitment survey, and between 13 and 18 months after the start of the intervention in half of the communities). The final follow-up survey will be conducted between October 2001 and April 2002 (i.e., approximately 3 years

after the recruitment survey, and between 33 and 40 months after the start of the intervention in half of the communities).

An initial survey (November 1997–May 1998) looking at HIV and STI prevalence was performed in the project communities. (Survey subjects were approximately 9,500 15- to 19-year-olds.) to ensure that the communities were sufficiently similar to be compared, and thus increase the power of the study.

Behavioral Impact

The project is also measuring the effect of the intervention on the SRH knowledge, attitudes, and behavior of adolescents in the same cohort. This is being done using a variety of quantitative and qualitative methods:

- participatory, qualitative study by research assistants who lived in households for seven weeks to study sexual behavior, beliefs, attitudes, and so forth;
- in-depth interviews with program members;
- focus group discussions in villages; and
- evaluation of health clinics by young "simulated patients." (This showed that health workers who had received training as part of the program were significantly less judgmental and more youth friendly.)

Evaluations of other aspects of the program (e.g., teacher/peer educator training, curriculum, etc.) are mentioned in the time line. For further information on these, please contact the program manger directly. (Contact information is given in Part d.)

UNAIDS Benchmarks

	Benchmark	Attainment	Comments
1	Recognizes the child/youth as a learner who already knows, feels, and can do in relation to healthy development and HIV/AIDS-related prevention.	Partially fulfilled	Youth are allowed to express their views freely, and these views are respected. They prepare and conduct drama, role plays, etc. They select their teacher-guardians. However, evidence of their involvement during the design and preparatory stages is not documented.
2	Focuses on risks that are most common to the learning group and that responses are appropriate and targeted to the age group.	✓	Teachers address issues related to the risks in their day-to-day teaching. Stories and drama are built around the risk issues and discussed.
3	Includes not only knowledge but also attitudes and skills needed for prevention.	✓	Skills and attitudes are reinforced. A good number of youth (and especially girls) seem to have the courage to say no to sex when approached. Sexuality is an issue they can now discuss with their peers and teacher-guardian more freely and openly.

	Benchmark	Attainment	Comments
4	Understands the impact of relationships on behavior change and reinforces positive social values.	✓	Positive social values are reinforced. For example, respect for elders, abstinence until marriage, how girls can cope with menstruation when it begins, and giving assistance to the elderly and the sick within the community.
5	Is based on analysis of learners' needs and a broader situation assessment.	✓	MEMA kwa Vijana conducted a needs assessment to determine the needs of the youth. Views were collected and used in the development of training guides.
6	Has training and continuous support of teachers and other service providers.	✓	Schoolteachers, guardians, and the service providers were trained before the program began, and they have an annual workshop to exchange experiences.
7	Uses multiple and participatory learning activities and strategies.	✓	The program fully involves schoolchildren through peer education, drama, role plays, poems, etc.
8	Involves the wider community.	✓	The community is very involved. They are represented at school committees, attend the youth festival week activities, etc. This has tended to improve ASRH communication among students, parents, and community. However, the community should be informed about the actual contents of the program in detail so as to iron out differences — e.g., condom demonstration in class.
9	Ensures sequence, progression, and continuity of messages.	✓	The program builds from simple messages in grade 5, increasing in complexity through grades 6 and 7.
10	Is placed in an appropriate context in the school curriculum.	✓	The program is part of the school curriculum. ASRH subjects are taught during school hours in biology or civic subjects. The MoEC has endorsed the program.
11	Lasts a sufficient time to meet program goals and objectives.	Partially fulfilled	Awaiting results of evaluation.

	Benchmark	Attainment	Comments
12	Is coordinated with a wider school health promotion program.	Not applicable	There is no systematic school health program in Mwanza region.
13	Contains factually correct and consistent messages.	✓	The materials were developed by health experts and are factually correct.
14	Has established political support through intense advocacy to overcome barriers and go to scale.	✓	The regional commissioner, ward counselor, and regional education officer requested scale-up to all schools in the region.
15	Portrays human sexuality as a healthy and normal part of life, and is not derogatory against gender, race, ethnicity, or sexual orientation.	✓	MEMA addresses these culturally sensitive issues. The teachers, peer educators, and guardians faced problems during the first year of the program (in grade 5) because sexuality was not traditionally discussed openly, especially with young people. Youth tend to be more comfortable from the second year onward.
16	Includes monitoring and evaluation.	✓	A large-scale, scientifically designed evaluation has been conducted.

PART D: ADDITIONAL INFORMATION

Organizations and Contacts

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Available Materials

For information on how to obtain these materials, please see color insert in this report.

Year 2 Training protocols: Final field versions
(order number: MEMA 01)

Final head teachers' training protocol, February 2002
(order number: MEMA 02)

Protocol for the training of health workers in the provision of youth friendly reproductive health services
(order number: MEMA 03)

Refresher protocol for YFS training for health workers
(order number: MEMA 04)

Chanzo cha Habari 2000
(order number: MEMA 05)

Kinga: Mwongozo wa malezi na ushauri nasaha shule za msingi
(order number: MEMA 06)

Kinga: Elimu ya Afya ya Kujikinga na Magonjwa ya Zinaa na UNIMWI. Kiongozi cha Mwelimishaji Rika. Wizara ya Elimu na Utamaduni
(order number: MEMA 07)

Elimu ya Afya ya Uzazi kwa shule za Msingi: Michezo ya Kuigiza kwa Waelimishaji Rika wa Darasa la 5–7
(order number: MEMA 08)

Elimu ya Afya ya Uzazi Kiongozi cha Mwalimu-Darasa la 7
(order number: MEMA 09)

Elimu ya Afya ya Uzazi Kiongozi cha Mwalimu-Darasa la 6
(order number: MEMA 10)

Elimu ya Afya ya Uzazi Kiongozi cha Mwalimu-Darasa la 5
(order number: MEMA 11)

MEMA kwa Vijana Cohort Recruitment: Self completion questionnaire MALE
(order number: MEMA 12)

MEMA kwa Vijana Cohort Recruitment: Self completion questionnaire FEMALE
(order number: MEMA 13)

1998 cohort recruitment self-completion questionnaire results report
(order number: MEMA 14)

Fourth annual report (Oct 2000- Sept 2001)
(order number: MEMA 15)

Report on a focus group discussion and in-depth interview series with young people in rural Mwanza, Tanzania, December 2000
(order number: MEMA 16)

Participant observation reports: Jan–Feb 2001
(order number: MEMA 17)

Process evaluation report: Community and class peer educator trainings, Feb 1999
(order number: MEMA 18)

Evaluation report of HIV/AIDS peer education in MEMA kwa Vijana project, Nov 2000
(order number: MEMA 19)

Evaluation of the teachers' training sessions for the MEMA kwa Vijana teacher-led component, Jan 2001
(order number: MEMA 20)

The MEMA kwa Vijana Curriculum: A review, May 2001
(order number: MEMA 21)

Sexual behaviour among young people in Bunda District, Mara Region, Tanzania; June 2000
(order number: MEMA 22)

Sexual and reproductive health among primary and secondary school pupils in Mwanza, Tanzania: need for intervention; 1998
(order number: MEMA 23)

MEMA kwa Vijana–Tutawaelimishaje?
(order number: MEMA 24)

National Policy on HIV/AIDS, Nov 2001. Prime Minister's Office
(order number: MEMA 25)

SADC HIV/AIDS strategic framework and programme of action: 2000–2004
(order number: MEMA 26)

APPENDIX 1. STAFF DATA

The number of staff currently working on the program is shown in table A.1.

Until recently, 22 community peer educators worked as volunteers. Until 2001, when payment was discontinued, peer educators receives Tsh5,000 (approximately US$5)per month. Their gender ratio varied over the first three years of the project from 60 percent male and 40 percent female to 75 percent male and 25 percent female. The declining number of female peer educators was due to much higher losses to the program among the females (for example, they moved away to get married, their husbands refused to allow them to continue to volunteer, or they had other domestic commitments).

Table A.1. Mema Kwa Vijana Program

Type	Number	Position	Gender
Full-time, paid	8	Coordinator	F
		Deputy coordinator	M
		Youth facilitators	M & F
		Secretary	F
		Driver (3)	M
Part-time, paid	2	Team leader (education	M
		Team leader (health)	M
Volunteers (peer educators not receiving allowances/incentives)	1,124	Class peer educators	M & F
Volunteers, part-time	62	Head teachers	M & F
	186	Teachers	M & F
Health facility workers	46	Health workers	M & F
Trainers of peers	22	Youth in the community (18–24 years)	M & F