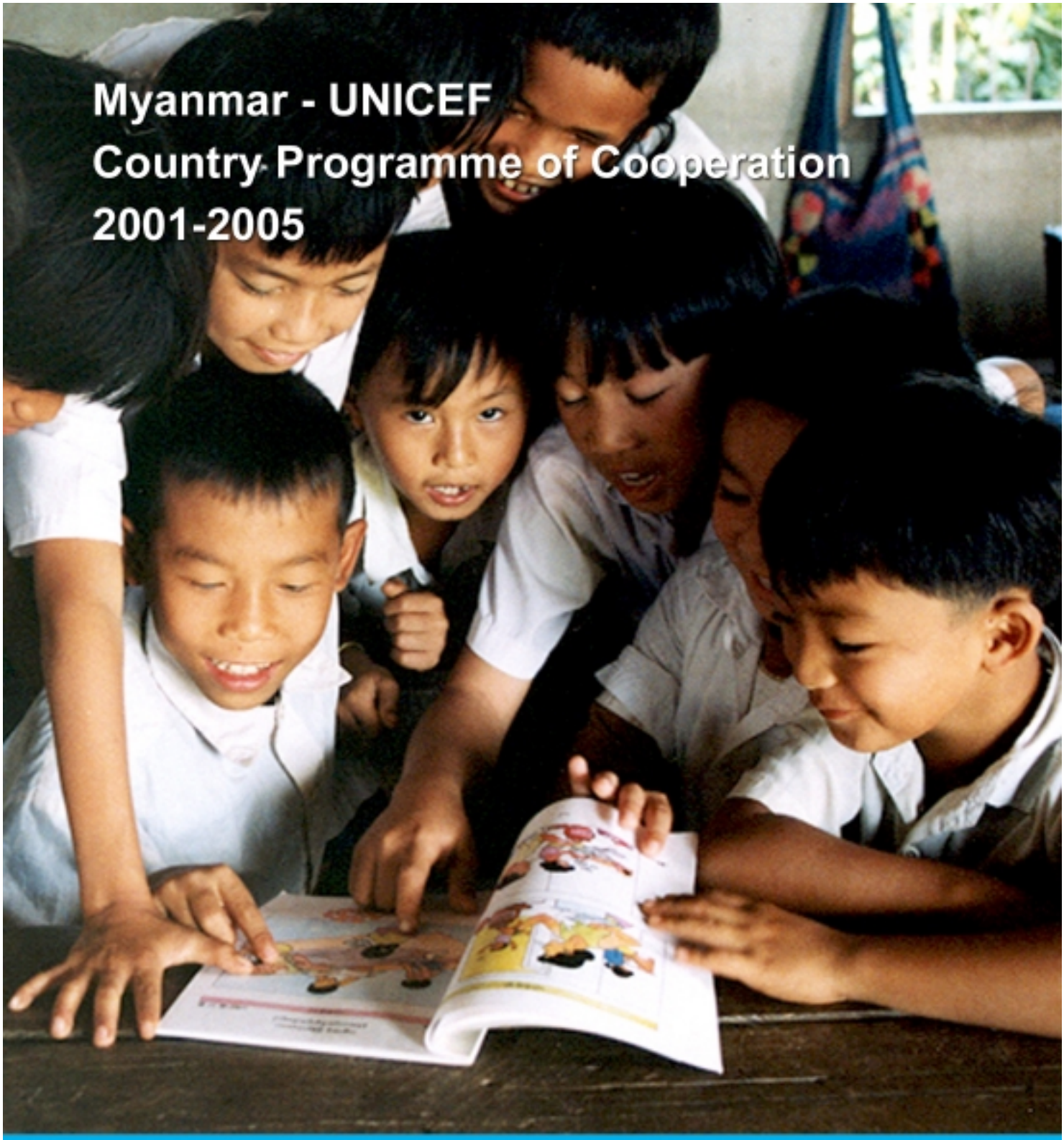

Myanmar - UNICEF
Country Programme of Cooperation
2001-2005

Assessment of SHAPE

MID-TERM REVIEW REPORT

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY

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May 2003

Myanmar-UNICEF Country Programme of Cooperation 2001-2005
Mid-Term Review Documents

I. Cross-cutting Themes

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2. Addressing Protein Energy Malnutrition and Further Developing IECD
3. Programme Communication including Organizational Implications
4. Area-Focused Township Approach
5. Partnerships and the building of Civil Society

II. Management Issues

1. Assessment of Field Officers (Operational)
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UNICEF Myanmar

ASSESSMENT OF THE HIV/AIDS COMPONENT OF "SHAPE"
(SCHOOL-BASED HEALTHY LIVING AND HIV/AIDS PREVENTION EDUCATION)

Yangon, Myanmar
12 December 2002

CONTENTS

ACRONYMS

ACIS	All Children in School
AIDS	Acquired Immune Deficiency Syndrome
ASEAN	Association of Southeast Asian Nations
BCG	Tuberculosis Vaccine
BDCC	Behavior Development and Change Communication
BFHI	Baby Friendly Hospital Initiative
BSS	Behavior Surveillance System
CAPS	Continuous Assessment and Progression System
CHEB	Central Health Education Bureau
CRC	Convention on the Rights of the Child
CSO	Central Statistical Organization
DBE	Department of Basic education
DEPT	Department of Education Planning and Training
DSW	Department of Social Welfare
ECCD	Early Childhood Care and Development
ECD	Early Childhood Development
EFA	Education for All
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, TB and Malaria
HIV	Human Immuno-deficiency Virus
IEC	Information, Education and Communication
IDU	Intravenous Drug User
INGO	International Non-governmental Organization
MCH	Maternal Child Health
MICS	Multiple Indicator Cluster Survey
MMA	Myanmar Medical Association
MMCWA	Myanmar maternal and Child Welfare Association
MMR	Maternal Mortality Rate
MNCWA	Myanmar National Committee on Women's Affairs
MOH	Ministry of Health
MPO	Master Plan of Operations
MRCS	Myanmar Red Cross Society
MTCT	Mother to Child Transmission
MTR	Mid-term Review
NCRC	National Committee on the Rights of the Child
NGO	Non-governmental Organization
NNGO	National Non-governmental Organization
PHC	Primary Health Care
PLWA	People Living with HIV/AIDS
PMCT	Prevention of Mother and Child Transmission
PTA	Parent Teacher Association
SCF	Save the Children Fund
SHAPE	School-Based Healthy Living and HIV/AIDS Prevention Education
SPDC	State Peace and Development Council
STI	Sexually Transmitted Illness
TPDC	Township Peace and Development Committee
UN	United Nations
UNAIDS	United Nations AIDS Programme

UNDP	United Nations Development Programme
UNESCO	United Nations Education, Culture and Science Organization
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
VCCT	Voluntary Confidential Counseling and testing
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

EXECUTIVE SUMMARY

School-Based Healthy Living and HIV/AIDS Prevention Education (SHAPE) was initiated jointly by the Ministry of Education of the Government of Myanmar and UNICEF in 1997. SHAPE is a life skills project with a emphasis on prevention of HIV/AIDS and its related problems of STI and drug abuse. SHAPE project objectives were initially undefined[1], but can be interpreted to be: 1) provision of necessary life skills to children and youth in schools including ways to stay healthy and avoid disease, reproductive health, good nutrition and sanitation practices, problem solving, decision making and social skills; 2) contribute to the prevention of HIV/AIDS and its related problems of STI and drug abuse by providing knowledge and raising awareness of their dangers; and 3) sensitize children and youth in support of compassion, care and support for those who have HIV/AIDS.

SHAPE implementation began in 30 townships during the 1998/99 school year and was expanded to 30 more townships in the two years that followed. Now SHAPE is being implemented in 104 townships. This assessment focused only upon the initial townships where results would be more apparent. Nine of the initial 60 townships were selected to represent a cross-section of areas and conditions in Myanmar. They were visited by the national and international consultants and field workers from the Department of Planning and Training (DEPT) between 30 October and 22 November 2002. The townships visited were North Okkalapa in Yangon, Taungoo in Bago, Chanayethazan in Mandalay, Monywa in Sagaing, Hsibaw in Northern Shan, and Pathein in Ayeyawaddy. The DEPT field workers visited Myitkyina Township in Kachin, Dawei Township in Taninthayi, and Kengtong Township in Eastern Shan. A total of nine state primary schools, eight state middle schools, and six state high schools were visited.

In each of the nine townships visited, the TEO or ATEO was interviewed. At each school the headmaster/headmistress, a community leader, and one to five PTA members were interviewed. A discussion was held with a group of teachers, of students, and of parents (three to eight). A short test of student knowledge of HIV/AIDS related information was conducted in several schools with 4th or 5th graders The number of respondents participating in the assessment were as follows:

5 - TEO
4 - ATEO
21 - Community Leaders
22 - School Heads
59 - PTA Members
95 - Teachers
117 - Students
92 - Parents

Nearly all of the data used for the assessment is narrative, collected through interviews and group discussions. Compilation and analysis of the data was accomplished using a series of matrices summarizing responses for each main

[1] SHAPE evolved as a response to opportunities that arose to introduce life skills training and especially HIV/AIDS prevention education into the schools. As such, it initially was not a formal project with clearly defined objectives and activities.

issue. Thirty-five issues in three categories were assessed. The three categories were status of implementation, results, and future development.

Future development is an especially relevant category for the preparation of SHAPE – Plus. In July 2002, UNICEF proposed a "strategic shift" mid-way into its country programme for 2001 to 2005. The purpose was to provide expanded and more effective support to the National HIV/AIDS Response and UN Joint Plan of Action. A number of priorities were identified for the strategic shift. One of these priorities is SHAPE-Plus. SHAPE-Plus involves improvement of the program in school and its expansion to reach out-of-school youth and adults.

The most important general conclusions are that from the evidence gathered in the assessment, the SHAPE project is well liked and appreciated by those involved. SHAPE has contributed to knowledge gain, and positive change in both attitudes and behaviors with regard to prevention of HIV/AIDS, STI, smoking and drug abuse both among students and in the community. Improvement also has been observed by the respondents in nutrition, health and hygiene, decision making and social skills among students. To some extent it has contributed to change in sanitation, health and nutrition practices in communities.

Respondents familiar with SHAPE – school heads, teachers, students, their parents – in general believe the SHAPE curriculum and materials to be of good quality. They like the teaching methods used, and feel the current training programs are effective. Yet, a number of weaknesses remain. These include: imbalance and inefficiency in the allocation of resources, mostly training and materials; improper understanding and use by teachers of the full range of child-centered teaching methods; insufficient teacher training and follow-up contributing to the improper use of teaching methods; and poor monitoring, evaluation and supervision.

Respondents approve highly the basic concept of SHAPE and believe it supports important development objectives of the township. They express nearly unanimous support for extension of SHAPE activities out of school. In general, they like the SHAPE in school programs as they are designed now, but several improvements in school were proposed for future development of SHAPE-Plus:

- More lessons should be provided on HIV/AIDS especially at 5th grade level where there are none. More detail and examples should be provided to make the threat of HIV/AIDS "real";
- More lessons on drug abuse and smoking should be provided. The use of amphetamines is on the increase and information on the threat must be included in the curriculum. Chewing of betel nut should also be addressed;
- The student books and teachers' guides are good already, but more student books should be provided and children encouraged to take them home. More teaching aids are required such as charts, illustrations, flash cards, videos, and paper and crayons for drawing;
- The grade 3 and 4 curriculum should be revised because it was too much alike. Moving some of the topics from grade 5 and 6 (e.g. brothers and sisters) was suggested;
- The redesigned initial training programs for teachers are now good, but it is important that sufficient time be provided for every trainee to actively participate. Refresher training covering all teachers, especially primary teachers, is required;

- Selection of participants in training by the townships should be reviewed. Some teachers are not serious about teaching SHAPE and some townships have an oversupply of SHAPE trained teachers;
- A regular SHAPE training program for newly recruited teachers is necessary, as is management training for new school heads;
- Teachers require more detailed training on HIV/AIDS and STI;
- The teaching methods are good, but not all teachers are using them. Children like poems, stories and role plays and more should be added;
- A guide should be developed on child-centered teaching in difficult conditions to help teachers adopt SHAPE teaching methods in constrained teaching environments;
- More time should be allocated for SHAPE teaching through provision of additional periods;
- Monitoring and supervision of SHAPE in school activities should be strengthened. This is widely acknowledged by those familiar with SHAPE. *"Need more monitoring. Should have cluster based meetings and reviews often, and spot checks in schools of SHAPE activities. Cluster heads should be delegated for monitoring. Difficulties are hard to reach schools and communication problems, especially during rainy season. It would help if SHAPE became a regular curriculum subject."*

There was near unanimous agreement that the SHAPE program should be expanded to reach persons out-of-school. There was some variation regarding target groups. Some suggested out-of-school children as young as ten be targeted, others that adults as old as 40 be included. In general, respondents agreed that out-of-school youth and adults 14/15 to 20 or 25 years of age from both sexes were the most important to reach. They gave the reason as being this group is more exposed to the threats of HIV/AIDS, STI and drug abuse. Most all agreed that these were the most important messages to convey. Others suggested that messages on health, nutrition, hygiene, smoking and alcohol were also important.

Respondents were asked what linkages might be made at the local level to strengthen implementation of SHAPE-Plus especially future out-of-school programs. The most common responses were to explore links with the Health Department, school health teams, MMCWA, MCH and Myanmar Red Cross. Other suggestions were to call upon assistance from local authorities to help organize out-of-school programs and encourage young people to attend. An important area of linkage to be established would be with the AIDS/STI Control Teams and sentinel surveillance operations for implementation of behavior sentinel surveillance in the AFT.

Working together at local level would require sanction from the central level. At the central level efforts should be made to explore a mechanism, such as a SHAPE-Plus working group, to bring together agencies interested in prevention of HIV/AIDS, STI and drug abuse. The Ministries of Health and Education, UNAIDS, WHO, UNFPA, UNICEF and the larger NGOs such as Myanmar Red Cross, World Vision and Save (UK) should be included. Ideally, this group would act to encourage policy and gain approvals at the national level to help ensure and strengthen cooperation at the local level.

I. Background and Status

A. Introduction

School-Based Healthy Living and HIV/AIDS Prevention Education (SHAPE) is a sub-project under the Child Friendly Schools Project of UNICEF Myanmar's Education Programme. SHAPE responds to three priorities of UNICEF and the Government of Myanmar. The first two are among the six Education for All (EFA) goals specified in the Dakar Framework for action*: "(iii) ensuring that the learning needs of young people and adults are met through equitable access to appropriate learning and life skills programmes", and "(vi) improving all aspects of the quality of education and ensuring excellence of all so that recognized and measurable learning outcomes are achieved by all, especially in literacy, numeracy and essential life skills"*. Although, in essence, a life skills project, SHAPE responds to an important objective of the Government of Myanmar/UNICEF Country Programme *"to reduce the transmission of HIV/AIDS and its impact on children, women and young people".* (UNICEF, 2000a, p.9)

HIV/AIDS is now recognized as a serious threat to the well being of the population by both the Government of Myanmar and international agencies. UNAIDS/WHO uses 1 percent HIV/AIDS prevalence among pregnant women as the benchmark for a generalized epidemic. The 29 sentinel surveillance sites throughout Myanmar indicated 2.2 percent of pregnant women were infected (UNAIDS, 2002, p.5).

The response to the threat has been broad and varied. The Government of Myanmar has initiated widespread HIV/AIDS awareness campaigns using various media. Sexually transmitted illness is the sixth highest priority in the National Health Plan. AIDS/STD control teams have been established in 27 townships. Behavior sentinel surveillance (BSS) is being conducted in 29 townships. Health workers and peer educators are being trained. Donated blood is being tested. Over 1.5 million free condoms are distributed each year, and a 100 percent condom use programme in four townships in 2000/01 (Ministry of Health, 2002, pps.5-10). United Nations organizations[2] are responding with a United Nations Joint Plan of Action involving seven priority programme areas.[3] They are:

- Targeted condom use and reproductive health;
- Behavioral development and change communication;
- Compassion care and support for people living with AIDS (PLWA);
- Reducing the harmful consequences of injecting drug use;
- Expansion of blood supply programs to cover remote areas and rural communities;
- Improved multi-sectoral coordination and enhancement of national NGO capacity;
- Surveillance and research.

UNICEF Myanmar has made HIV/AIDS prevention and control one of its five priority areas in its 2001-2005 programme cycle. In July 2002, a "strategic shift" was made in

[2] The organizations are: UNAIDS, UNDP, UNDCP, UNFPA, UNICEF and WHO.
[3] A number of international NGOs also are providing support. They include: the International Federation of the Red Cross, World Vision, CARE, Save the Children (UK), Population Service international, Medecins du Monde, Medecins sans Frontieres, Marie Stopes International, World Concern, and the Population Council.

the UNICEF response to HIV/AIDS. The strategic shift involves three main elements – prevention, care and support, and partnership building – in order to:

- *"Reduce HIV transmission among young people;*
- *Prevent mother to child transmission; and*
- *Reduce the impact of HIV/AIDS on people infected and affected, with special priority accorded to children, young people and mothers."* (UNICEF,15 July 2002,p.1)

SHAPE is a key component among UNICEF prevention activities. This assessment of SHAPE and especially its HIV/AIDS component has two primary objectives. It is designed to examine, after two to four years, the results of SHAPE in nine of the 60 townships where the program was first implemented. It also is designed to contribute to the planning of "SHAPE - Plus" to improve and expand SHAPE during the second half of the programme cycle. As such this assessment report is divided into three main section: status of implementation, results, and future development.

B. The Assessment

1. Purpose

An assessment of the SHAPE project emphasizing its HIV/AIDS component was to be conducted and a report made available by the end of December 2002. The evaluation was to contribute to the mid-term review of SHAPE and to planning HIV/AIDS related activities in school and out of school under the UNICEF strategic shift in HIV/AIDS programming. In accordance with the terms of reference for the consultancy, the assessment was to examine:

- *" whether and how SHAPE-induced practices, messages and overall trends meet the project's goals and objectives;*
- *the content and outreach of the life skills curriculum;*
- *the contents and methodology of teacher training packages and training processes;*
- *how messages are delivered by teachers, assimilated, accepted and put into practice by students, PTAs, teachers; analysis of pedagogical and motivational processes;*
- *appraisal and analysis of extra-curricular outputs and activities (e.g. reading and play materials);*
- *appraisal of linkages between students, parents, PTAs and other actors with regard to the sharing of preventative messages and experiences in and out of the classroom and onto communities."*

SHAPE is a life skills project rather than an HIV/AIDS education project. However, it represents an important response by UNICEF to combat HIV/AIDS. Because of this a special emphasis was placed in the assessment on the HIV/AIDS component of SHAPE. However, many of SHAPE's other life skills lessons are related to and supportive of the HIV/AIDS component. They too were to be included in the evaluation.

Very little quantitative data was available for the assessment on prevalence of HIV/AIDS, STI or drug abuse other than that from the sentinel surveillance surveys from 1999 onwards. Basic quantitative data on the schools implementing SHAPE also is limited. What is available on the 60 townships implementing SHAPE between

1998 and 2001 can be found as Attachment 1. Because of limitations of time, triangulation using a variety of data types (e.g. household or school surveys, questionnaires) was not possible. Instead the evaluation relied primarily on qualitative data from semi-structured interviews and group discussions. This allowed triangulation of respondents to be used in examination of key issues by asking similar questions of TEO/ATEO, community leaders, school heads, PTA members, teachers, students and parents.

2. Methodology

SHAPE was initiated in 1997. Implementation began in 30 townships during the 1998/99 school year and was expanded to 30 more townships in the two years that followed. Now SHAPE is being implemented in 104 townships. This assessment, however, is focused only upon the initial townships where results may be more apparent. Nine of the initial 60 townships were selected to represent a cross-section of areas and conditions in Myanmar. They were visited by the national and international consultants and field workers from the Department of Planning and Training (DEPT) between 30 October and 22 November 2002. The national and international consultants visited six townships: North Okkalapa in Yangon, Taungoo in Bago, Chanaye Thazan in Mandalay, Monywa in Sagaing, Hsibaw in Northern Shan, and Pathein in Ayeyawaddy. The DEPT field workers visited Myitkyinar Township in Kachin, Dawei Township in Taninthayi, and Kengtong Township in Eastern Shan. A total of nine state primary schools, eight state middle schools, and six state high schools were visited.

In each township one to four schools were visited based upon the time available. In general, one school could be completed in a day. The schools included primary, middle and high schools considered by township education officials as good, fair or poor in their implementation of SHAPE. The schools selected also had to be accessible. As a result, remote schools were not included in the assessment, but a number of rural schools in poorer agricultural areas were visited. Attachment 2 presents background data on the 20 of the 23 schools visited.

Upon arrival in a township the TEO or ATEO was interviewed. At each school the headmaster/headmistress, a community leader, and one to five PTA members were interviewed. A discussion was held with a group of teachers, of students, and of parents (three to eight). A short test of student knowledge of HIV/AIDS related information was conducted in several schools with 4th or 5th graders The number of respondents participating in the assessment were as follows:

5 - TEO
4 - ATEO
21 - Community Leaders
22 - School Heads
59 - PTA Members
95 - Teachers
117 - Students
92 - Parents

A number of assessment questions were generated addressing implementation of SHAPE, its results and future development (Attachment 3). They provided a basis for a set of draft evaluation instruments which were tried out on 30 and 31 October 2002. Four interview formats (TEO/ATEO, village head, headmaster/mistress, PTA head) and three group discussion guides (teachers, students and parents) were used to

collect qualitative data (Annex 1). A test developed by CARE was used to assess the knowledge of fifth graders concerning HIV/AIDS.

Previous studies, reviews, reports and manuals were examined (see references). Very useful but not comprehensive data came from the report of the baseline study conducted for UNICEF by ENVIPRO (Myanmar) Co. Ltd. in November 2001. The study was conducted in 23 AFT townships, six of which are among the original 60 SHAPE townships. Two evaluations of SHAPE training, a review of the SHAPE curriculum, and a participatory evaluation of the life skills training program were also useful.

3. Analysis

Nearly all of the data used for the assessment was narrative, collected through interviews and group discussions. This data was compiled during the last week of November 2002 and analyzed by the consultants during the first two weeks of December 2002. Compilation and analysis of the data was accomplished using a series of matrices summarizing responses for each main issue (Annex 2). Table 1 presents the issues by category and the respondents questioned regarding the issue. As mentioned although triangulation by types of data was not possible, the use of the matrices allowed triangulation by type of respondent to look at each issue from a number of perspectives.

Table 1. Issues and Respondents for the Assessment

Category	Issue	Respondent						
		TEO/ ATEO	Comm. Leader	School Head	PTA Member	Teacher	Student	Parent
Implemen-tation: **Inputs**	Materials, Distribution	X		X		X	X	
	Curriculum/ Materials Quality			X		X	X	X
	Training	X		X		X		
Implemen-Tation: **Context**	Social and Cultural Views – Life Skills	X	X		X	X	X	X
	Social and Cultural Views – HIV/AIDS	X	X	X	X	X	X	X
	Social and Cultural Views – STI	X	X	X	X	X	X	X
	Social and Cultural Views – Drug Abuse	X	X	X	X	X	X	X
	Community Perception of SHAPE		X		X	X	X	X

Category	Issue	Respondent						
		TEO/ ATEO	Comm. Leader	School Head	PTA Member	Teacher	Student	Parent
Implemen-tation:	Teaching Methods			X		X	X	X
Processes	Hours of Teaching					X	X	X
	Monitoring/ Supervision	X		X	X	X		
	SHAPE Committee	X						
	PTA Role			X	X	X		
	Advocacy			X	X	X		X
Results/ Outcomes	General Benefits	X	X	X	X	X	X	X
	Knowledge Gain			X	X	X	X	X
	Attitude Change		X	X	X	X	X	X
	Behavior Change		X	X	X	X	X	X
	Decision Making, Problem Solving			X		X	X	X
	Teaching Methods, Other			X		X	X	
	Students' Health and Nutrition		X	X	X	X	X	X
	Community Health, Nutrition, Sanitation		X	X	X	X	X	X
	Negative Outcomes	X	X	X	X	X	X	X
Future Develop-ment:	Concept, Assumption	X	X		X	X	X	
	Curriculum, materials	X	X	X	X	X	X	X
In-School	Training	X	X	X	X	X	X	
	Teaching Methods			X	X	X	X	X
	Monitoring, Supervis., Managmnt.	X		X	X	X	X	
Future Develop-ment:	Target Groups	X	X	X	X	X	X	X
	Delivery Systems	X	X	X	X	X	X	X
Out of School	Content of Training	X	X	X	X	X	X	X
	Changes in Methods/Materials	X	X	X	X	X	X	X
	Linkages	X	X	X	X	X	X	X
	Other	X	X	X	X	X	X	X

C. Current Status of the SHAPE Implementation

This sections examines implementation of SHAPE in the 23 schools and nine townships included in the assessment. The intent of SHAPE program planners and the actual situation reported in the schools is presented. Some responses from interviews and discussions that express a general view are quoted.

1. Objectives and Scope of SHAPE

SHAPE is a life skills project with an emphasis on prevention of HIV/AIDS and its related problems of STI and drug abuse. SHAPE project objectives have been left undefined[4], but can be interpreted to be: 1) provision of necessary life skills to children and youth in schools including ways to stay healthy and avoid disease, reproductive health, good nutrition and sanitation practices, problem solving, decision making and social skills; 2) contribute to the prevention of HIV/AIDS and its related problems of STI and drug abuse by providing knowledge and raising awareness of their dangers; and 3) sensitize children and youth in support of compassion, care and support for those who have HIV/AIDS.

In the 2000/01 school year, SHAPE reached primary, middle and high school students in grades 2 to 9 in 60 townships. This means approximately 1.3 million of the 7 million students in Myanmar and 50,000 of 193,000 teachers should have been exposed to SHAPE. The project design calls for every primary, middle and high school in a township to implement SHAPE. In this case, approximately 8,600 schools should have been implementing SHAPE in the 60 townships involved. The criteria used in selection of the 60 original townships for implementation of SHAPE were:

1. *"Priority townships as identified by the National AIDS programme;*
2. *Townships where UNICEF HIV/AIDS related health projects had already started especially with the involvement of local NGOs;*
3. *Areas where HIV/AIDS was prevalent; and*
4. *Townships where the mobility of the population was significant."* (UNICEF, 2000, p.3)

In 2001, only five of the 60 SHAPE townships were area-focused townships (AFT). Now SHAPE is a sub-project of the Child Friendly Schools (CFS) Project. The CFS Project is to be implemented in 44 more AFT between 2001 and 2003. This will mean a total of 104 SHAPE townships by the end of 2003 (of 324 townships now in Myanmar).

4 Curriculum, Materials and Methods

The SHAPE curriculum was designed on the basis of four principles: *"1) knowledge of ones' own body as a basic element for healthy living; 2) healthy habits, positive and responsible attitudes and socially desirable values need to be developed in order to prevent different kinds of illnesses; 3) social skills are essential ingredients of healthy living; and 4) acquisition of necessary health knowledge and development of healthy habits, responsible attitudes and social skills will become permanent and sustainable when provided with opportunities to solve daily life health problems and*

[4] SHAPE evolved as a response to opportunities that arose to introduce life skills training and especially HIV/AIDS prevention education into the schools. As such, it initially was not a formal project with clearly defined objectives and activities.

consequently this will result in a sound mind in a sound body". (Aung, March 1997, p.5) The curriculum consists of 14 main topics in four areas for students in grades 2 to 9. Table 2 identifies these topics, areas and grade levels at which they are taught

Table 2. SHAPE Topics by Grade Level

AREA	TOPIC	GRADE LEVEL							
		2	3	4	5	6	7	8	9
1. Healthy Living and Understanding Your Body	1.1.Personal Hygiene	X	X	X	X				
	1.2.Physical Growth and Development			X	X	X			
	1.3.Emotional Growth				X	X	X	X	
	1.4.Parental Love							X	
	1.5.Birth Spacing								X
	1.6.Baby Care								X
2.Health and Diseases	2.1.Diseases	X	X	X	X	X	X	X	
	2.2.Drugs		X	X	X	X	X	X	
	2.3.HIV/AIDS		X	X		X	X	X	X
3.Social Skills for Healthy Living	3.1.Decision Making Skills	X	X	X	X	X	X	X	X
	3.2.Communication Skills	X	X	X	X	X	X	X	X
	3.3.Coping with Emotion			X	X	X	X	X	X
	3.4.Counseling			X	X	X	X	X	X
4. A Sound Mind in a Sound Body				X	X	X	X	X	

SHAPE is a co-curricular subject which means students are not tested and graded as in regular subjects. Guidelines call for SHAPE being taught for three periods (30 minutes) per week at lower primary level (grade 2), two periods (35 minutes) per week at upper primary level (grades 3,4), and one period (45 minutes) per week at middle and high school level (5 to 9).

Teachers' guides have been prepared for primary level teachers and for middle/high school teachers. Every teacher is to have a teachers' guide. Recently a draft revised version of the middle/high school teachers guide has been prepared. It is now being tried out. Student books are distributed to every school in the selected townships. Distribution is the responsibility of the SHAPE Committee in the township. The ratio for allocation to schools is one book for three students in primary, middle and high school level. In addition, art paper/newsprint, crayons, scissors, pencils and exercise books have been distributed for students.

Teaching methods are to be active and child-centered. Methods include buzz groups, brainstorming , lecture-discussion, problem solving, demonstration, cooperative learning, story telling, laboratory technique, dramatization, role play, simulation, simulation and game, inquiry learning approach, student presentations, debate, panel discussion and guest speakers. Specific methods with instructions for teachers are presented for each lesson in the teachers' guides.

The Situation

Curriculum and Materials: Township officers and school heads report that they have received the intended teachers' guides and student books. Delivery of the materials was the responsibility of the SHAPE Committee, and seems to have been accomplished. (The assessment team was unable to visit very remote schools where the situation may be different.) However, teachers and students must themselves provide any funds necessary for the delivery of the SHAPE materials as no allocation is made from township level. Teachers often consider the books their own and take them if they are reassigned. Variation from the norm is reported in the numbers of student books supplied and in some cases in the number of teachers' guides. The intended ratio for distribution is one book per three students and one teachers' guide per teacher. In some cases four students share a book and in others there is nearly one book for each student. Distribution of teachers' guides also varies but less radically. Most teachers report sufficient teachers' guides. Most teachers said that one student book for two or three students is sufficient. A number of teachers expressed a need for more teaching aids. Some said they would make their own if provided the materials.

"We need more teaching aids. If the materials were provided we could make our own aids. Initially UNICEF provided material. When it ran out we had to buy in the market. We now collect a fund from students to pay for these materials."

'*Two to three students share one book. Had some little fights between the students because they wanted to read them. We do not let students take the books home, afraid we will lose them and cannot replace. We need more teaching aids, but otherwise we are OK*."

In the majority of schools examined, students are not allowed to take the books home. Teachers fear that the books will be lost or damaged. In those instances where students are allowed to take the books home, they show them to parents and (out-of-school) friends and talk with the about the stories and pictures – a clear benefit. Consideration should be given to directing school heads to allow the books to be taken home. Books seem to be very sturdy. Those received in 1998/99 are still in good shape and it is estimated they will last three to five years more; well in excess of a normal textbook.

There is nearly unanimous agreement among school heads, teachers and students that the materials are good or very good. Parents who have seen the materials like them as well. There seems to be little objection to either the topics or content, with a few exceptions. Several teachers felt that fourth grade children were too young to learn about sexual matters. However, most suggested that fifth grade would be appropriate. A few of the younger girls (primarily in the rural schools) reported being uncomfortable with some of the topics and pictures in the books but they were a minority. Boys had no problems with either the topics or pictures. The large majority of teachers said they were not embarrassed to teach the topics, but a few suffered some initial embarrassment.

Many teachers and students said they would like more information on HIV/AIDS. A majority of students reported that HIV/AIDS was their favorite SHAPE topic. Few parents to object to the curriculum including HIV/AIDS, STI and drug abuse, most saying it is appropriate to teach the children these things. In several instances, however, it was reported that parents (especially rural parents) really did not know what was going on in the school. They were simply too busy working to pay attention.

"I like the way it is organized. Subjects are very relevant to age and standard. It is a good course. I also like the student books, they are easy for children to follow and relevant. All lessons are appropriate. HIV/AIDS is appropriate. There are some words and usage that are not appropriate for children, but SHAPE has used an acceptable form or reference and makes it humorous. Children understand the terms. Additional information should be added on HIV/AIDS. Cannot pinpoint a real case of HIIV, but would like to make reference to real cases, real without becoming socially unacceptable."

Methods: Most teachers and students say they like the more active and child-centered learning methods. However, the methods used by teachers are generally limited to group discussion, question and answer (Q&A)[5], and to a less extent role play, brainstorming and demonstration. Group discussion is by far the favorite methodology with both students and teachers. It and Q&A are sometimes used in schools in teaching regular curriculum subjects, but this is not the norm. Many teachers complain they are unable to use the new methods (even in teaching SHAPE) due to constraints of large class size or multi-grade classes, limited facilities (rooms too small to move furniture around), and time (periods too short). While it is true child-centered teaching becomes more difficult in such conditions, it is not impossible. It may be useful to develop a guide to help teachers adopt teaching methods appropriate to such conditions.

Teachers and students complain that the time for teaching SHAPE is too short, both in number of minutes per period and number of periods per week. The number of minutes per period varies from 30 in primary level to 45 minutes in secondary level. (Primary teachers report periods ranging from 30 to 45 minutes.) Teachers state that many of the child-centered teaching methods cannot be used because 30 or 35 minutes is insufficient for the method to be used, especially if SHAPE is taught only once a week. At primary level two or three periods per week is the guideline, but some schools are allocating one period or less for SHAPE. The variation in periods can be seen in Attachment 3. Anywhere from two periods per month to five periods per week for SHAPE is reported by school heads.

"[We have] one period per week of 35 minutes for SHAPE, but also have training on Monday at group assembly. Thirty-five minutes is not enough for most lessons, but we sometimes adjust the time if more is needed. Activities like role play take more time. Would like to have more time teaching SHAPE – three periods per week. The methodology requires more time."

"We would like to learn more, at least two or three times a week. Want to learn more so can teach friends about it, especially out-of-school friends. [We] like the idea of having SHAPE as a regular curriculum subject."

3. Training

The Intent

SHAPE curriculum training is provided to teachers with assistant lectures from TTC, school heads and ATEO acting as teacher trainers. SHAPE management training is provided to primary, middle and high school heads with members of the SHAPE Committee acting as trainers. Training is also provided to selected members of the school PTA with ATEO and cluster heads acting as trainers. Through the end of the

[5] In one school Q&A consists of the teacher writing a question on the board, then writing its answer and having the children copy both in their exercise books.

2001 a total of 47,246 teachers, 8,570 school heads, and 38,130 PTA members have been trained. An additional 12,166 teachers, 1,934 school heads, and 12,945 PTA members have been trained in 2002. Table 3 on the following page summarizes the training programs.

In the 1997/98 school year curriculum training was provided in a three-tier fashion. Trainers of trainers were trained at central level in Yangon. They in turn trained teacher trainers at zonal level who then trained the teachers in the townships. In the 1999/2000 school year, curriculum training was changed to a two-tier system with central training of trainers in Yangon and teacher training in the townships. Length of teacher training also was increased from three in 1998 to four days in 2000 and six days in 2002. Training of trainers also increased from six to seven days.

The Situation

Teacher Training: Most, but not all, SHAPE teachers have been trained. Those untrained include newly assigned teachers or teachers unable to participate when training was offered. In addition, there are some secondary teachers who have received SHAPE training but are not teaching SHAPE. Primary and secondary teachers in the first 30 SHAPE townships received only three days of training in 1998. Primary (75%) and secondary teachers in the second batch of 20 townships received four days of training in1999, as did the teachers in the third batch of 10 townships in 2000. Many primary teachers received no additional training, but in some instances (for example, Monywa Township) new primary teachers have received training in a township organized program. Secondary teachers from the first 30 townships received a three-day refresher training program in 1999. Six days of training was provided to secondary teachers in 2002.

Teachers involved in the earlier short training programs complained that three or four days was too little training, the classes were too large (up to 600), and the program contained little opportunity to practice the new methods. As a result the training programs have evolved and improved. SHAPE training programs are now longer with more emphasis on practice. Classes are smaller and trainers are encouraged to follow-up with teachers after training. Teachers involved in the more recent training programs like them very much and believe them effective. Length of time (six days) and the practical workshop format are the reasons.

Most primary teachers have not yet received this longer more practical training and many feel they had too little training. As a result they have had difficulty in implementing the new teaching methods. Many school heads and teachers stated a need for refresher courses and additional information of HIV/AIDS, STI and drug abuse.

"Initial teacher training in 1999 was not very effective. Only primary teachers were in the 1999 training. Their only reinforcement is trainers sharing information at monthly meetings. Recent training was much better. Two persons were selected for central training of seven days. The training was very effective. We conducted multiplier training in the township of six days. ATEO, middle and high school heads and teachers, SAT physical education/sport teachers were trainers and resource persons. They have been effective. Suggest have trainers for primary level. Now we only have for middle and high level. Used to have primary trainers but now don't. We need to cover all teachers, many have no training.".

Management Training: In 1999 and 2000, management training was provided for 8,570 heads of primary, middle and high schools in the initial 60 townships. The

training lasted for three days and was generally felt to be useful, but insufficient. The school heads who have attended the teacher training workshops seem to regard them as more useful and interesting.

PTA Training: By the end of 2001 38,130 PTA members had been trained in SHAPE. The two to three-day training program was designed to teach parents how they could assist in implementation of the SHAPE project. In some instances there has been increased assistance to the school after the training, usually in the form of better sanitation and latrines. However, most PTA must be asked for help by the school head. They do not do it on their own initiative. The general view seems to be that the training has not resulted in change with regard to support for SHAPE, but other positive things have happened.

"Fifteen members in PTA. In 2000 they got three days training on SHAPE from teachers. PTA arranged for safe drinking water. They pay more attention to personal hygiene. Even poor parents bought sweaters for their children when before they did not. Also home sanitation is improved."

"PTA provides no substantial support as an organization. Parents and PTA are not too cooperative. They support the (SHAPE) program but they have no time. Most are farmers. No regular meeting with PTA. Only an annual meeting."

SUMMARY OF SHAPE TRAINING PROGRAMS 1997 TO 2002

Table 3. Summary of SHAPE Training, 1997 to 2002

	Type of Training	Participants	Quantity		Duration		
			Numbers	Townships	(days)	Time	Place
1	Central level training workshop	AL, JAT	70		6	Nov-97	Ygn
2	Training of trainers workshop	Teachers	1,081	30	6	Jan-98	Zone
3	Orientation workshop	AIS, TEO	106		2	Aug-98	Ygn
4	Township level training workshop	Pri.,Sec. teachers	21,375	30	3/4	May/Sep-98	Twsp
5	Orientation workshop	ATEO, school heads	97	20	3	Apr-99	Ygn
6	Reorientation workshop	AL, Curr.member	40		3	May-99	Ygn
7	Zonal training for trainers	Pri,mid,high teachers	526		6	May-99	Ygn, Mdy
8	Township level training workshop	Pri.Teachers (75%)	15,771	20	4	Jun-99	Twsp
9	Refresher course for trainers	Mid,high sch.trainers	400	30	3	Aug-99	
10	Refresher course for teachers	Mid,high sch.teachers	10,100	30	3	Aug-99	Twsp
11	Review/manegement workshop	SHAPE committee	200	30	3	Aug-99	
12	TOT for management trainers	SHAPE committee	153	20	3	Sep-99	Ygn
13	Management training workshop	School heads	3,061	20	3	Sep-99	Twsp
14	Management training workshop	School heads	4,003	30	3	Sep-99	Twsp
15	Review workshop	SHAPE committee	160	30	3	Sep-99	Ygn
16	Orientation wksp for new twsp	ATEO, HM,cluster head	54	10	3	Apr-00	Ygn
17	Training of trainers	SAT,JAT,PH	220	10	6	May-00	Ygn
18	Teacherr training	SAT,JAT,PH	4,834	10	4	May/June-00	Twsp
19	Training of trainers	HH,MH,PH,ATEO	62	10	3	Jun-00	Ygn
20	Training of school heads	HH,MH,PH	1,506	10	3	June	Twsp
21	Wksp to develop PTA training	DEPT	35			Jul/Aug-00	Ygn
22	Training of PTA trainers	ATEO, cluster heads	30	10	5	Aug-00	Ygn
23	Training of trainers	DEPT and AL	36		4	Aug/Sep-00	Ygn
24	Training of school heads	HH,MH	850	50	4	Sep-00	Twsp
25	Training of cluster PTA trainers	Cluster heads	390	10	3	Sep-00	Twsp
26	Training of school PTA members	PTA members	6,640	10	2	Sep-00	Twsp
27	Review meeting	SHAPE committee	50	10	3	Oct/Nov-00	Ygn
28	Review meeting	SHAPE committee	50	10	3	Dec-00	Ygn
29	Review workshop	SHAPE committee	150	50	3	Dec-00	Ygn
30	Training of PTA trainers - central	ATEO, cluster heads	54	10	5	Dec-00	Ygn
31	Training of PTA trainers - cluster	Cluster heads	473	10	3	Jan-01	Twsp
32	Training of PTA members	PTA members	6,965	10	2	Jan-01	Twsp
33	Training of PTA trainers - central	ATEO, cluster heads	52	10	4	Feb-01	Ygn
34	Training of PTA trainers - cluster	Cluster heads	444	10	3	Mar-01	Twsp
35	Training of PTA members	PTA members	8,935	10	2	Mar/Apr-01	Twsp
36	Orientation workshop	TEO	30	10	3	May-01	Twsp
37	Training of PTA trainers - central	ATEO, cluster heads	49	10	5	Jun-01	Ygn
38	Training of PTA trainers - cluster	Cluster heads	426	10	3	Jun-01	Twsp
39	Training of PTA members	PTA members	7,010	10	2	Jun-01	Twsp
40	Training of PTA trainers - central	ATEO, cluster heads	54	10	5	Sep-01	Ygn
41	Training of PTA trainers - cluster	Cluster heads	476	10	3	Sep-01	Twsp
42	Training of PTA members	PTA members	8,580	10	2	Oct-01	Twsp
43	Training of PTA trainers - central	ATEO, cluster heads	40	10	5	Dec-01	Ygn
44	Training of PTA trainers - cluster	Cluster heads	270	10	3	Jan-02	Twsp
45	Training of PTA members	PTA members	4,955	10	2	Jan-02	Twsp
46	Training of trainers	ATEO, School heads	126	19 AFT	7	May-02	Ygn
47	Training of teachers	Mid.,high sch.teachers	1,792	19 AFT	5	May-02	Twsp
48	TOT for non-AFTs	Secondary teachers	101	15 nonAFT	7	May-02	Ygn
49	Training of teachers	Mid.,high sch.teachers	1,624	15 nonAFT	6	Jul-02	Twsp
50	TOT for management trainers	ATEO, school heads	142	19 AFT	5	Aug-02	Ygn
51	Management training	School heads	1,934	19 AFT	4	Aug-02	Twsp
52	TOT for refresher training	ATEO, school heads,tch	600	49	7	Oct-02	Twsp
53	Refresher training	Mid.,high sch.teachers	8,750	49	6	Oct-02	Twsp
54	Training of PTA trainers - central	ATEO, cluster heads	41	14 AFT	5	Nov-02	Ygn
55	Training of PTA trainers - cluster	Cluster heads	406	14 AFT	3	Dec-02	Twsp
56	Training of PTA members	PTA members	7,990	14 AFT	2	Dec-02	Twsp

Key:
AL - Assistant lecturer
AIS - Assistant Inspector of Schools
ATEO - Assistant Township Education Officer
HH,MH,PH - high school head, middle school head, primary school head
JAT - Junior Assistant Teacher
PTA - Parent/Teachers Association
SAT - Senior Assistant Teacher

4 Management and Supervision

The Intent

SHAPE is to be implemented by the Department of Planning and Training (DEPT) and the Department of Basic Education (DBE) of the Ministry of Education. DEPT is responsible for curriculum development and training activities at the central level and DBE for implementation at the township level. A SHAPE manager is assigned by the Ministry of Education to assist with SHAPE activities.

Each SHAPE township is to have a SHAPE Committee responsible for coordination of SHAPE activities. Among the more important of these activities are distribution of materials, organization of training, monitoring and supervision of SHAPE. SHAPE Committees are to be composed of 10 to 18 members as follows:

Patrons: Chairperson of the Township Peace and Development Committee (TPDC)
Township Medical Officer

Members: TEO (Chairperson)
Head of SHS who participated in coordination meeting (Co-chairperson)
ATEO (Secretary)
ATEO "
ATEO "
ATEO "
Heads of SPS and SMS and teachers who participated in coordination meeting (5 to 10 persons)

The roles and functions of the SHAPE Committee are to be:

1. *"To select participants to attend training at central and township level;*
2. *Effective implementation in conducting training at township level and multiplier training;*
3. *Close monitoring and supervision for effectiveness of implementation with the emphasis on monthly syllabus (where necessary, cooperate with school family/cluster heads);*
4. *To provide follow-up support and monitor SHAPE in-action activities for children to develop safe and responsible behavior and healthy practices;*
5. *To promote community participation through the necessary support and mobilization;*
6. *To liaise with Government and NGOs and other departments for the support of SHAPE in action.*
7. *To monitor and supervise for timely liquidation, collection and supply of material and distribution to end user and to monitor the proper use of materials;*
8. *Report to the central office at least twice a year by half yearly basis."* (Circular issued by DEPT on 12 July 1999)

Below township level the school cluster or family is to provide support and assistance. Each cluster is to have a SHAPE resource person responsible for supervision, reporting and advice to SHAPE teachers. These cluster resource persons also act as SHAPE trainers and attended the central level training of trainers.

The Situation

With some exceptions, the general view seems to be that the SHAPE Committees are not very effective. In the townships with effective SHAPE Committees the TEO is supportive of the SHAPE project and the SHAPE Committee Secretary is motivated and active. Most school heads monitor SHAPE as with other subjects. Techniques used are lesson planning with teachers, checking teacher diaries and lesson reports, observation of teaching, meetings, personal hygiene inspections, and monitoring children washing hands after using the latrine. With perhaps two exceptions, outside monitoring and supervision of SHAPE is nonexistent in nearly all the townships that were visited. Routine monitoring and supervision of schools by the township does take place, but for regular curriculum subjects, not SHAPE. This lack of supervision and support is a key factor contributing to inadequacies in SHAPE teaching.

"SHAPE activities are not fully supported by the committee. Monitoring and supervision is the weakest."

"Township level monitoring and supervision is not specific to SHAPE activity, just routine inspection. School level the headmaster himself visits classrooms and assesses learner performance. He checks the diary and gives comments on teaching/learning activities."

A contributing factor to the lack of outside supervision is SHAPE's status as a co-curricular subject. As such, it is not reported upon or discussed at monthly township meetings of school heads with TEO and ATEO, nor in regular cluster meetings (if any). This has led a few school heads (and teachers) to consider SHAPE to be less important than other regular curriculum subjects. Most all teachers and a majority of school heads felt that more monitoring and supervision was required both inside the school and from the township and/or central level.

"Most teachers do not teach effectively after training because it is co-curriculum and teachers believe it is not that important. If it became curriculum they would be more motivated."

In the few townships with outside monitoring and supervision, the school clusters system provides a supportive structure. The cluster (four or five local schools) has a SHAPE specialist who has been trained as a teacher trainer or resource person for SHAPE. This person informally provides support and assistance to SHAPE teachers in the cluster and monitors SHAPE activities in the schools. In one township, the SHAPE Committee Secretary has designed a special format to be used by cluster SHAPE specialists to monitor SHAPE activities. As mentioned above, this is the ideal. Initially motorcycles and bicycles were provided to facilitate monitoring and supervision. In most instances this has not happened. The problem has been noted and provision of motorcycles and bicycles discontinued by the UNICEF SHAPE manager.

5 Financing

SHAPE development activities began in 1997 but full implementation did not begin until 1998. In the !997 and 1998 fiscal years (January to December) a total of UD$ 344,604 was expended for SHAPE activities. This included US$ 97,616 for SHAPE teachers guides and student books (supply). In 1999, a total of US$ 401,903 was expended. This amount included US$ 134,123 for printing teachers' guides and

student books, US$ 129,814 for orientations and training, and US$ 137,966 for supplies (typewriters, stencil machine accessories, duplicating paper, newsprint and bicycles). (UNICEF, 2000b, p.4)

In the year 2000, total expenditures were 97 percent of the allocation. Of the US$210,083, slightly more than half went for supplies. Expenditure rate dropped to 77 percent in 2001. Total expenditures amounted to US$ 163,334 including US$ 123,396 for training and US$ 39,939 for materials. Through the end of October 2002, expenditures for SHAPE have been US$ 77,528 for supply and US$ 308,542 for cash. A further expenditure of US$ 69,282 for cash and US$ 100,000 for supply is planned. If this were accomplished, the expenditure rate would be 78 percent or almost the same as that of 2001. Table 4 summarizes the allotments and expenditure for SHAPE between 1997 and November 2002.

Table 4. SHAPE Allotments and Expenditure by Year, 1997/98 to 2002 (US$)

Year	Allotment	Total Expenditure	Expenditure		% Expended
			Cash	Supply	
1997, 1998		344,604			
1999		401,903	129,814	272,089	
2000	216,595	210,083	101,832	108,251	97%
2001	213,073	163,334	123,396	39,939	77%
2002*	713,073	386,070	308,542	77,528	54%
Total					

* As of 1 November 2002

In a recent evaluation of training programs, Seymour (23 November 2001, p.12) calculated unit costs during the years 1998, 1999 and 2000 for training and materials. SHAPE training in 1998 cost an average of Ks. 500 for four days training (or about US$ 0.42 per day) which is the same as CAPS training of 20 days and ACIS training of two days at township level In 1998, 1999 and 2000, the primary teachers' manual cost US$ 0.63 per copy and the middle/high school teachers' manual cost US$ 0.99 per copy. Other data indicates a unit cost for teacher training in 1999 was US$ 0.96 to 0.99 per day, and may be US$ 2.00 to 2.40 per day in 2002.

Training and materials are the primary categories of expenditure for the SHAPE project. A questionnaire on basic school information and SHAPE was completed by 21 of the 23 school heads contacted during the field visits to schools. Of the 21 school heads, 18 had received SHAPE training. The total number of teachers in the 21 schools was 623. Of this total 445 had been trained by SHAPE, but only 253 were actually teaching SHAPE. SHAPE guidelines call for a ratio of one book for three students. However, reports from school heads indicate distribution of teachers' guides ranges from five teachers' guides for each SHAPE teacher to one teachers' guide for seven teachers. Distribution of student books ranges from 51 books for 63 students to 30 student books for 2,109 students.

Clearly questions could be raised as to the cost efficiency of training and materials distribution. The limited number of schools included in this assessment makes it impossible to determine the extent of such inefficiencies, but the issue requires examination. To do so, a much more extensive basic school data collection effort should take place.

II. Results and Issues

A. Outcomes

In this section, outcomes will be examined primarily with regard to changes in knowledge, attitudes or behaviors related to HIV/AIDS, STI, and drug abuse. To a lesser extent the results of SHAPE in changing health, nutrition, and sanitation practices, decision making, problem solving and social skills also will be examined. It should be remembered that the data used for the analysis is qualitative consisting personal views, perceptions and beliefs which may or may not be accurate. To help minimize the problem of inaccurate perceptions, in most instances the respondents were asked to provide examples. In most cases they did. Some of these examples, those representing a general finding, are reported below.

Ideally, quantitative data on changes over time would be available to help validate these views, perceptions and beliefs. This data, however, is minimal. What is available includes sentinel surveillance data from UNAIDS in 29 townships (2002). Four of the 29 townships in the sentinel survey are among those in the sample for this assessment. They are Dawai, Monywa, Myitkyina, and Pathein. The following data is available for the years 1992 to 2001.

Table 5. Changes in HIV Prevalence Among Pregnant Women and STI in Dawai, Monywa, Myitkyina, and Pathein, 1992 to 2001 (in % of population)

Township	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Dawai										
- HIV prevalence among pregnant women		2.5	0.5	1.0	1.0	2.0		1.8	5.3	4.0
- STI patients	4.0	6.5	9.0	0.5	2.5	4.0		2.0	5.0	2.0
Monywa										
- HIV prevalence among pregnant women		0.5	0.8	0.8	0.0	2.2		1.7	0.5	4.6
- STI patients	4.4	12.8	3.0	7.0	11.5	6.5		7.0	0.0	1.0
Myitkyina										
- HIV prevalence among pregnant women	0.5	1.0	2.3	1.0	0.8	1.5	2.3	3.5	3.0	2.5
- STI patients	8.7	2.6	8.3	9.3	5.5	12.1		12.5	19.2	28.6
Pathein										
- HIV prevalence among pregnant women								0.5	1.0	1.0
- STI patients (males only)		0.0	2.0	0.6	1.1	0.5	0.6	1.5	2.0	0.0

Source: UNAIDS, 2002, p.13.

Nationwide the average prevalence of HIV among pregnant women in townships outside of major urban areas in 2001 was 2.05. The rate had grown yearly since 1992 peaking at 2.3 percent in 1999. STI prevalence showed the same trend since 1992 peaking at 6.75 in 1999 and dropping to 4.0 in 2001. Generally the same trends

hold for the four sentinel survey townships included in the SHAPE assessment. The exception is Pathein where STI patients among the general population have continued to increase to well above the national average.

1. General Benefits for Students and the Community

Before being questioned about specific benefits, respondents were asked an open question about the general benefits that may have come to students or the community as a result of SHAPE. Nearly all responded that there have been benefits to both students and the community. The examples were numerous, ranging from children being more active and motivated to learn, to cleaner and healthier, to SHAPE educating the community as a whole to the dangers of HIV/AIDS. These comments are too numerous to list and can be found as Attachment 4.

Respondents were also asked about the negative outcomes of SHAPE. Nearly all said there were no negative outcomes. There were a few exceptions. The exceptions were all from primary schools. In one an older student (5^{th} grade) was chewing betel nut and was asked to stop by teachers as it was addictive. He said he would not and quit school instead. Another primary school head said his teachers worried about what the consequences might be from teaching the children about sexual matters when before they knew nothing. The girls ask about love making and all want to know what is a condom. (The teachers try to answer in a polite way and show students what a condom is.) In the third instance primary teachers heard secondhand from middle school teachers that there were problems in middle school such as more drugs and sex due to SHAPE. However, these three comments were a very small minority and most school heads and teachers felt that SHAPE had reduced the frequency of sexual behavior at a young age, as well as the use of drugs in their school and community.

2. Knowledge Gain

HIV/AIDS and STI

With the exception of those in the larger towns, most respondents said the prevalence of HIV/AIDS and STI was low in their areas. They also stated that awareness of the danger of HIV/AIDS was widespread among children, their parents and the community. However, detailed knowledge of HIV/AIDS and STI was not common in the community. In part the awareness of HIV/AIDS and STI was due to government media campaigns. Many respondents said the detailed knowledge of HIV/AIDS among parents and community was only coming from the children and was a result of what they were learning in SHAPE.

"Children know better than their parents. Parents get the health message from children."

"Through their children the parents learn about these things and this will help reduce the prevalence."

"All have heard about HIV on TV, but learn much more about it in school."

"SHAPE is helpful and effective and can reach outside the schools which will reduce the problem."

"Five HIV/AIDS patients died in the past few years. We didn't know how to prevent it. The children explain the causes of HIV infection."

Nearly all parents are supportive of teaching their children about HIV/AIDS and STI. They feel it is appropriate even at primary school level. Most children talk to their parents about what they have learned and value the HIV/AIDS lessons as the most important thing they are learning in SHAPE. A number of 4th and 5th grade students were tested on what they remembered about the ways that HIV/AIDS is transmitted.[6] They did well in differentiating the most dangerous behaviors and the ways in which HIV is not transmitted. They had problems in identifying the less dangerous, but possible, modes of transmission.

Smoking and Drug Abuse

Smoking is cited as a common practice, but drug abuse is low in most areas. The children learn the (potential) sequence of smoking leading to drug abuse and pass the information on to their parents, siblings, and friends. Some incorrect information is being passed as well, such as smoking causes TB and hepatitis B comes from dirty water. This information, however, is in other school material and not the SHAPE material. A number of school heads, teachers and parents asked that the problem of betel nut chewing be included as a SHAPE lesson. Several head mistresses see this as a special problem because addictive and unhealthy substances are being mixed in with the betel.

"Smoking is a bad habit as well as chewing betel."
"Active participation of parents is necessary for success."
"Kids have retold a lot, but we remember only a few subjects."
"Children are well aware of the bad sequence of drug abuse."

Other

Better knowledge of diseases like how to avoid malaria, the importance of staying clean, good nutrition and hygiene practices are cited by most respondents. This knowledge has led to a number of changes in attitudes and behaviors presented in the next section.

3. Attitude and Behavior Change

HIV/AIDS and STI

In a few instances, no attitude or behavior change was noted by respondents, but a third (about 40 of 120 opportunities for response) agreed that attitude changes had occurred, and cited specific examples. Some of the attitude change was considered the result of exposure to media, but nearly all respondents stated it was the result of SHAPE in part if not all. It is interesting to note that in some instances the SHAPE information has resulted in differing attitude changes. It seems that among younger children in primary level, the SHAPE information on HIV/AIDS has made them more afraid of it, but older children at middle and high school level are less afraid of it because they know how to avoid it.

[6] The test was provided by CARE Myanmar and developed by Ms.Skjoukje Zjilstra, a consultant for World Vision. We extend our thanks to her and these agencies.

"All in the village are afraid now if it [HIV/AIDS]. Can be attributed to SHAPE."

"In the past aware HIV is very dangerous, but now think it is not dangerous because it can be avoided. Can be attributed to SHAPE because children talk to their parents about what they have learned."

"I am very afraid because it is so serious."
"I am afraid that I will be infected."

"I now think that HIV/AIDS is less serious than I thought before, because I know how to get it."

Behavior change with regard to HIV/AIDS or STI was noted by approximately one fourth of the respondents (about 32 of 120 instances). Most of the behavior change related to asking for unused razor blades when getting a haircut, avoiding blood transfusions and tattooing, asking for new syringes when getting injections at clinics. More of these behavior changes are noted among middle and high school students, while attitude change is more common among primary students.

"My own child (10th grade boy) has become very conscious about having blood transfusions or not using sterile syringes. Community members also seem to avoid unnecessary transfusions and look for disposable needles. No commercial sex in the village, but sometimes if village men go out of town and get girls they will use condoms."

"My son in 6th grade after learning about HIV now asks to have haircuts at home. Grandparents do it because I do not know how."

"Request new needle at the private clinic. Special request by customers when they get their hair cut."

"I noticed premarital sexuality cases decreased."

"HIV/AIDS problem high. Use more disposable syringe and as for hair cutting use fresh blades. Sex pleasure seekers become less."

The SHAPE curriculum encourages upper level students to have a compassionate attitude toward HIV/AIDS sufferers. With a few exceptions like that quoted below, there is little evidence that this is happening. Most children remain afraid of HIV/AIDS and want to stay away from anyone who may have it.

"Students accept HIV infected person at school. Teachers know that person (a teacher community appointed) and work together with her."

"Teachers raised questions on how you respond to an HIV positive person in the village. Children's attitude to it was very constructive."

Smoking, Alcohol and Drug Abuse

Changes in attitudes regarding smoking are mentioned by about one third of the respondents (40 of 120 opportunities). There are fewer cases of change in attitude and behavior regarding drug abuse. This is likely because of strong government

campaigns against it and its low prevalence in the areas visited. Changes in attitudes toward drinking alcohol are also cited.

"Children have been exposed to this in the media as well as school. Children don't like smoking and won't light cigarettes for their parents now. This can be attributes to SHAPE."

"Children are telling parents and others to stop smoking, bad for health. Yes, can be attributed to SHAPE."

'Yes, there has been attitude change toward smoking and have noticed that children in this village smoke less when they get older than children in other villages. Can be attributed to SHAPE."

"People are avoiding drug addicts now. Addict becomes isolated. Can be attributed to SHAPE."

"Smoking and drinking are not good. One neighbor is drunk and the family broke up just like in the lesson."

Behavior change resulting from SHAPE is noted among students and community members with regard to smoking and drinking in about 39 of120 instances. In a few instances drug abuse in the area seems to have decreased and may in part be the result of SHAPE.

"I now smoke less than ever because my son told me not to smoke."

"Yes. Significant change regarding smoking. Smokers are less and less. Shopkeepers also say they are selling fewer cheroots. Can be attributed to SHAPE but health department also gives talks."

"In the last three months, my 14 year old son had been smoking and had friends who smoked (out-of-school friends). Now he has stopped smoking and only goes out with school friends who do not smoke."

"Had instance of visible change. Children tell parents things. Child had a friend whose father drank alcohol. I think that the student encouraged the father to stop drinking."

"In the past in this compound there were drug problems, but now they have learned about this and they seem to be controlling themselves. Now hardly ever encounter the problem. Think the children now understand and accept this problem. My personal experience in the past, had drug abusers actually falling down in the compound and had to drag them out. Now no cases."

Other

Nearly half of the school heads, teachers, PTA members, parents and students cite examples of attitude and behavior change among students regarding health and nutrition in 57 of 120 opportunities. Among the most commonly cited changes for students are: more brushing of teeth, combing hair, cutting nails, washing hands before eating and after going to the lavatory, taking baths, and dressing in clean clothes. These changes are noted more among primary students, but they also occur among middle and high school students. Regarding nutrition, new practices include drinking more boiled water, protecting food from flies, asking mothers to cook food properly and make more nutritious foods (vegetables, meat and fish) and varying diet. These changes are attributed to SHAPE.

"Notice that in the middle of the year children are becoming more healthy and thinking skills are improved. I think better nutrition and hygiene are reasons for improved health."

"Kids changed their behavior. They spend more time on personal hygiene, for example brushing teeth before going to bed, cleaning nails and dressing up in clean clothes."

"Now parents do not have to remind children to take baths or cut nails."

"My daughter is asking now for more vegetables at home."

"Malaria incidence is high and I like including this in the curriculum. At home when I tell the children to stay away from mosquitoes they did not listen. But when school taught about dengue fever and malaria, they got scared and now they do it."

"Here is an assumption with some risk: when children grow up they will create a healthy living environment and hand down these good experiences to a new generation."

In some communities as a result of SHAPE activities, mosquito nets are being used more frequently to protect from malaria, awareness of environmental sanitation and use of sanitary latrines has increased, shopkeepers protect food from flies, there is better disposal of garbage, and/or safe drinking water has been arranged (34 instances cited of 120 opportunities).

"Yes, attitude and behavior change. Now keep food covered and try to avoid eating fly touched food. Also know how to avoid foods that cause diarrhea. But children have not asked parents to cook more nutritious foods."

"Now using sanitary latrines more in the community. Maybe attributable to SHAPE but health department has been giving talks over the last three years,. In the past we ate only corn and wheat. Now have more balanced diet. Have started eating rice, vegetables and meat. Can be attributed to SHAPE."

"They adopt proper wastage disposal practices, burn down the garbage, use toilet and wash hands after toilet, and eat nutritious foods."

"As a result of the SHAPE program the PTA tried to build fly-proof latrines in the school. People from the village noticed that environmental sanitation improved, but believed the village needs more water use for a sustainable impact. The PTA is aware of it and dug a tube well and installed a hand pump machine. Now it serves the purpose."

In 34 of 100 opportunities to respond school heads, teachers and parents have noted changes in the students with regard to decision making, problem solving and social skills. Two major changes were noted in several instances. Children were said to be refusing friends offers to go to the video parlor to watch videos when they had homework to do, and the general climate of the classroom seemed to be getting more friendly and helpful. It was also noted a number of times that boys and girls were being nicer to each other. The topic brothers and sisters was said to be especially helpful by secondary school students.

"I take notice of changes in behavior. They tend to respect each other. They look more united and appreciate collective effort. [They] help each other when someone gets into trouble. Teachers let them clean the school campus and watch how they get started. Some students take a leading role and get consensus through collective decisions. The students divide the groups and start their work."

"Before children were rude, but now they are more helpful and friendly to each other. Less rough. Also in this rural setting children enroll when they are older. In grade 4 and 5, they have changed attitude toward sexual morality. Now less 'I love you' at age of puberty. Have observed that in the past when were given homework they did not do it. Now they seem to understand that it is important to do it. Also when playing football, they stop if people come by. Before they did not. So they seem to be more polite."

"Students become more friendly. In the past 6th grade boys started to tend to keep girl friends. Now boys and girls treat each other like brothers and sisters. Girl students could make right decision such as whether to have sex or not when boys force them to do so."

"Decision making and problem solving have helped. For example, I do not go to watch TV with friends when I should be doing homework."

"Children have become more polite and civilized. Relate religion to topics as well, like not too many partners and HIV. Children now think missing class is not good. They want to be punctual. Children also volunteer to go out and find out why their friend may not be attending school and encourage them to do so."

The quote above is one of the several instances were SHAPE was said to have an effect on attendance, or teaching methods in other courses. Only three of 22 school heads, and four of 19 teacher groups said SHAPE methods had an effect on teaching in other subjects. Only two teachers noted an effect on attendance.

B. Constraints and Lessons Learned

Problems and difficulties in implementation of SHAPE since 1998 were explored with all respondents. Constraints examined can be placed in four main categories: contextual factors, curriculum, materials and methods, training, monitoring and evaluation. In some instances the constraints were identified early, lessons were learned, and actions taken. In other instances the constraints remain.

1. Contextual Factors

Potential social and/or cultural constraints for SHAPE were discussed with all respondents. An emphasis was placed on the views of the community on teaching about HIV/AIDS, STI and drug abuse. Support of the community is high for the teaching of life skills in the schools. Forty-four of 56 respondents said support among the community was high or very high for the teaching of life skills in school. Among the 71 respondents asked to rank community support for teaching HIV/AIDS, 60 ranked support as high or very high. The other three respondents said support was medium. A similar result was found with regard to teaching about STI in schools. Forty-nine of 57 respondents said community support was high or very high, but there was a lower proportion saying the support was very high. Response was nearly unanimous for teaching about drug abuse in school. Fifty-nine of respondents said support was high or very high with half saying it was very high. A large portion of this support can likely be attributed to the government campaigns against HIV/AIDS, STI

and drug abuse. In many cases SHAPE is seen as an effective means to address these dangers.

"The community likes the program very much. They expect their children to become polite, clever and informed citizens when they grow up. Because of this [SHAPE] people out-of-school learn informally through their children."

"The SHAPE program generated the idea about community health education and it rekindled the interest of the community."

"We like HIV/AIDS education, drug abuse and lessons on environmental sanitation and clean water. We dislike that it [SHAPE] does not cover the whole area. It should reach all people. It is still weak in organizing others in the community, especially teenagers."

"Community in general does not know what is going on in school. A few do but they do not like teaching reproductive health topics. Teachers asked the children to talk to their parents about it. Parents support teaching about HIV/AIDS, STI and drug abuse. There are campaigns about this and they know. No other problem topics but there are strange situations with reproductive health."

The SHAPE project is not constrained by resistance from the community. A large majority of community members agree their children should be taught life skills and especially about HIV/AIDS, STI and drug abuse which also are a focus for government prevention programs. In a number of instances respondents asked that more information be provided to students on these topics. A few sensitive topics still exist, but the consensus seems to be that the SHAPE materials handle them well.

2. Curriculum, Materials and Methods

No major constraints exist with regard to curriculum. It is generally liked as it is. Some additional information is requested on topics of interest especially HIV/AIDS. There are three major constraints with regard to SHAPE materials.

There are shortages of SHAPE student books and teachers' guides. There is also oversupply in a number of instances. Materials are not being resupplied or redistributed from areas of excess to areas of need. One reason is that a system to do so has not been established. A second reason is that the problem is not understood due to a lack of data.

A second (and related) constraint with regard to materials is that fact that most students are not allowed to take their books home. An opportunity is being missed. Children are clearly interested in SHAPE topics and frequently talk to their parents and friends (including out-of-school friends) about various topics and especially HIV/AIDS, STI and drug abuse. Being able to show and discuss pictures and stories from their books with family and friends would serve to help disseminate the information in the community.

The third constraint is a lack of learning support materials. Some exist and are appreciated and used (posters primarily), but teachers request more and offer to make their own if the resources are provided.

Effectiveness of SHAPE teaching (and the establishment of child-friendly schools) is being constrained by lack of use by SHAPE teachers of the suggested teaching methods. Some are being used, especially group discussion and Q&A. Some are being misused, like Q&A. Some are never used because the teachers feel they are

constrained by time, class size, and/or facilities. Some of these constraints are real and some are excuses. Time constraints are real. It takes time to accomplish demonstrations, role plays, presentations and other techniques. Teachers have made several suggestions – lengthen the periods, add more periods per week, and make them sequential so that a block of time is available. All these options should be explored.

Large class-sizes, multi-grade classes and inadequate facilities are a reality. This, however, while making it more difficult, does not preclude the use of at least some active learning techniques. Teachers need to be shown some of these methods can work even in less desirable conditions. A manual could be prepared on teaching using certain active, child-centered methods in a variety of constrained conditions. This information should also be included in training programs for teachers facing these conditions.

3. Training

To a large extent the lessons have been learned from the problems arising in the initial SHAPE training programs. Training has been lengthened from three to six or seven days, class sizes have been reduced, and format has become more participatory and practical. The school heads and teachers who have attended these new training programs like them very much. However, several constraints remain.

With some limited exceptions, there is no effective system for in-service training of new teachers in SHAPE. This is especially the case with new primary teachers (and a few who may never have received training). SHAPE trainers and resource persons are in place for in-service training of new secondary teachers, but many of the primary teacher trainers are gone. Even if they remained they are not familiar with the new training formats.

This year life skills training, including HIV/AIDS prevention education, was introduced into the pre-service training programs for primary teachers. One period per week was provided for the first 16-week semester. It was not included in the second semester. SHAPE was not part of this program, but is to be included next year in the pre-service training for both primary and secondary teachers.

Follow-up or reinforcement training still is insufficient. Attempts are being made to improve follow-up, but the cluster system is not sufficiently organized and effective to fulfill its potential in providing this support. The lesson is clear from previous experience. Initial training is less effective if it is not reinforced. Teacher training is the key to success of SHAPE and it still needs to be improved through follow-up and reinforcement. School clusters can play a role in this reinforcement.

Life skills training programs of the Ministry of Education (MOE) are also improving but are now reaching a level similar to the earliest SHAPE training. More effort should be made by UNICEF to share experiences, convince MOE decision makers of needs, and provide assistance to improve their teacher training programs. There is also a need to explore with the MOE more effective ways to provide preservice teacher training in life skills and SHAPE.

4. Monitoring, Evaluation and Supervision

Monitoring, evaluation and supervision is a major area of weakness. No effective quantitative data collection system is in place to monitor or evaluate the status of implementation of SHAPE, resource needs, problems encountered, or progress being made. With SHAPE – Plus an opportunity exists to counteract this weakness. Some suggestions on how to do so are presented in the final section.

Outside supervision of SHAPE by township, division or central levels is nearly nonexistent. This leads to inefficient implementation of SHAPE in the schools. In some cases too few periods of SHAPE are being provided, teachers are teaching the content but not using the suggested methods, and/or using the methods incorrectly. Improved supervision can help solve these problems. However, several constraints remain.

Divisional Offices of Education have responsibility for secondary schools and most have only one or two Assistant Inspectors of Schools (AIS). A number of AIS insufficient to reach all secondary schools in an effective manner. Secondly, SHAPE is not a regular curriculum subject and has lower priority. The cluster system should be strengthened for supervision and support to primary schools. SHAPE also should become a regular curriculum subject. Secondary school heads would then be required to monitor and report on the status of SHAPE in monthly meetings, contributing to, at least, some minimal supervision.

5. Other

A lack of cooperation between health and education offices at the local and central levels still exists and acts as a constraint to mutually beneficial activities. UNICEF should use its, not inconsiderable, influence to explore and encourage cooperative efforts especially in prevention education and monitoring of HIV/AIDS, STI and drug abuse. This should include a redefinition of responsibility for implementation of IEC, in-school and out-of-school activities.

III. Conclusions and Recommendations

The most important general conclusions are that from the evidence gathered in the assessment, the SHAPE project is well liked and appreciated by those involved. SHAPE has contributed to knowledge gain, and positive change in both attitudes and behaviors with regard to prevention of HIV/AIDS, STI, smoking and drug abuse both among students and in the community. Improvement also has been observed by the respondents in nutrition, health and hygiene, decision making and social skills among students. To some extent it has contributed to change in sanitation, health and nutrition practices in communities.

Respondents familiar with SHAPE – school heads, teachers, students, their parents – in general believe the SHAPE curriculum and materials to be of good quality. They like the teaching methods used, and feel the current training programs are effective. Yet, a number of weaknesses remain. These include: imbalance and inefficiency in the allocation of resources, mostly training and materials; improper understanding and use by teachers of the full range of child-centered teaching methods; insufficient teacher training and follow-up contributing to the improper use of teaching methods; and poor monitoring, evaluation and supervision.

A. SHAPE-Plus

In July 2002, UNICEF proposed a "strategic shift" mid-way into its country programme for 2001 to 2005. The purpose was to provide expanded and more effective support to the National HIV/AIDS Response and UN Joint Plan of Action. A number of priorities were identified for the strategic shift. They were interactive education, SHAPE – Plus, supportive environment (coordination and support at township level), information and communication about prevention of HIV transmission, compassion and understanding, home based care and community involvement, partnership, and advocacy. In this section, recommendations are provided with regard to the second of these priorities, SHAPE – Plus.

SHAPE is a life skills program. Its purpose is to help ensure students lead healthy and successful lives. HIV/AIDS and related problems of STI and drug abuse have become a threat to their lives. To better counteract this threat, several actions have been proposed under SHAPE – Plus: 1) revision or adjustment of school based activities, 2) development of activities out of school including development and dissemination of a new SHAPE curriculum with an overarching HIV/AIDS component, 3) support activities for out-of-school marginalized young people, and 4) design and development of social marketing.

Participants in the assessment were asked how SHAPE activities should be improved in school, and what could be done to better serve populations out of school. Their responses are reflected below.

1. In School

Respondents approve highly the basic concept of SHAPE and believe it supports important development objectives of the township. They express nearly unanimous support for extension of SHAPE activities out of school. In general, they like the SHAPE in school programs as they are designed now, but several improvements are proposed:

- More lessons should be provided on HIV/AIDS especially at 5th grade level where there are none. More detail and examples should be provided to make the threat of HIV/AIDS "real";

- More lessons on drug abuse and smoking should be provided. The use of amphetamines is on the increase and information on the threat must be included in the curriculum. Chewing of betel nut should also be addressed;

- The student books and teachers' guides are good already, but more student books should be provided and children encouraged to take them home. Funds for the delivery of books should be made available to the townships. More teaching aids are required such as charts, illustrations, flash cards, videos, and paper and crayons for drawing. But teachers must be encouraged to use them properly. (For example, children's art was not being displayed in most of the schools visited.);

- The grade 3 and 4 curriculum should be revised because it was too much alike. Moving some of the topics from grade 5 and 6 (e.g. empathy for others) was suggested;

- The redesigned initial training programs for teachers are now good, but it is important that sufficient time be provided for every trainee to actively participate. Refresher training covering all teacher is required. Training of primary teachers is the highest priority;

- Selection of participants in training by the townships should be reviewed. Some teachers are not serious about teaching SHAPE and some townships have an oversupply of SHAPE trained teachers;

- A regular SHAPE training program for newly recruited teachers is necessary, as is management training for new school heads;

- Teachers require more detailed training on HIV/AIDS and STI;

- The teaching methods are good, but not all teachers are using them. Children like poems, stories and role plays and more should be added;

- A guide should be developed on child-centered teaching in difficult conditions to help teachers adopt SHAPE teaching methods in constrained teaching environments;

- More time should be allocated for SHAPE teaching through provision of additional periods;

- Monitoring and supervision of SHAPE in school activities should be strengthened. This is widely acknowledged by those familiar with SHAPE. *"Need more monitoring. Should have cluster based meetings and reviews often, and spot checks in schools of SHAPE activities. Cluster heads should be delegated for monitoring. Difficulties are hard to reach schools and communication problems, especially during rainy season. It would help if SHAPE became a regular curriculum subject."*

A number of respondents suggested that SHAPE become a regular curriculum subject to raise its status and support better monitoring and supervision. In the past, SHAPE planners were reluctant to do so because they felt that "teaching to the test" common among teachers would hinder the effectiveness of SHAPE. This should be reconsidered within the context of a child-friendly school environment where continuous assessment is to be the norm.

Before SHAPE is disseminated more widely either in school or out of school, consideration should be given to what is the basic "package" of interventions necessary to ensure SHAPE runs effectively. Past experiences have pointed to a danger in adopting a major change in the education system without the necessary training, materials, and or support services.

2. Out of School

There was near unanimous agreement that the SHAPE program should be expanded to reach persons out-of-school. There was some variation regarding target groups. Some suggested out-of-school children as young as ten be targeted, others that adults as old as 40 be included. In general, respondents agreed that out-of-school youth and adults 14/15 to 20 or 25 years of age from both sexes were the most important to reach. They gave the reason as being this group is more exposed to the

threats of HIV/AIDS, STI and drug abuse. Most all agreed that these were the most important messages to convey. Others suggested that messages on health, nutrition, hygiene, smoking and alcohol were also important.

Although some said the SHAPE in-school curriculum and materials were fine as is, others felt that modifications of the SHAPE curriculum and materials were required to reach this somewhat different target group. Many felt that informal talks and presentations, would be more appropriate than the child-centered leaning methods used in school. Only group discussion and Q&A were felt to be appropriate. Multi-media materials, for example videos, posters, handouts be prepared rather than books requiring a lot of reading. However, one respondent suggested a separate, more detailed book on HIV/AIDS be prepared and another proposed an open library. Peer education also was suggested.

Most felt that the school during the days it was not in use (weekends, holidays) was the best venue for out-of-school programs. Some suggested the monastery as an option, but others felt monks should not be involved with subjects such as HIV/AIDS or STI. It was felt that the village basic health staff, and local authorities could help organize training and encourage people to come. Some suggested a single program of seven to ten days during the summer, while others felt that 1.5 hours per week for several months would be appropriate designs for delivery of training.

Such variation in proposals indicates that it would be appropriate to pilot test a number of approaches for SHAPE-Plus out of school, before widespread dissemination is planned.

B. Linkages

Respondents were asked what linkages might be made at the local level to strengthen implementation of SHAPE-Plus especially future out-of-school programs. The most common responses were to explore links with the Health Department, school health teams, MMCWA, MCH and Myanmar Red Cross. They are already implementing activities such as talks, presentations, and media for awareness and prevention of HIV/AIDS, STI and drug abuse. In a few instances none of these agencies were said to be active in the village. Other suggestions were to call upon assistance from the local authorities to help organize out-of-school programs and encourage young people to attend. Some respondents said the religious community might help if they were asked. The Buddhist community might help with activities related to health, nutrition and sanitation, but not HIV/AIDS, STI or sexually related topics. It was felt the Christian community might be willing to assist with activities related to any of these topics.

An important area of linkage to be established would be with the AIDS/STI Control Teams and sentinel surveillance operations for implementation of behavior sentinel surveillance in the AFT.

Working together at local level would require sanction from the central level. At the central level efforts should be made to explore a mechanism, such as a SHAPE-Plus working group, to bring together agencies interested in prevention of HIV/AIDS, STI and drug abuse. The Ministries of Health and Education, UNAIDS, WHO, UNFPA, UNICEF and the larger NGOs such as Myanmar Red Cross, World Vision and Save (UK) should be included. Ideally, this group would act to encourage policy and gain approvals at the national level to help ensure and strengthen cooperation at the local level.

C. Other Recommendations

Improvement of monitoring, evaluation and supervision is a priority. Design of SHAPE – Plus provides the opportunity to remedy past inadequacies in this area. The focus of effort should be twofold. First, further discussions should be held with central, division, township and school managers and teachers from selected townships (those with more effective and less effective monitoring and supervision) to examine the feasibility of various approaches to improving SHAPE monitoring and supervision. These would include school based, cluster based, and policy related approaches (e.g. increasing hours and making SHAPE regular curriculum). MOE provision of funding for transport of monitors/supervisors might also be reconsidered (a constraint in the past). The approach(es) decided upon should be carefully pilot tested.

The second area for improvement is data collection for monitoring national SHAPE implementation and evaluating its outcomes. Because the SHAPE program "evolved" rather than being comprehensively planned as though it were a project, the necessary monitoring and evaluation mechanisms were not put in place in 1998. This should now be accomplished as follows:

1. Comprehensive basic data collection on SHAPE implementation in school should be conducted. The two-page format used in this assessment (Attachment 6) can be used with some slight modifications (i.e. data added on female teachers and students and the teacher "type" section modified). A MOE/UNICEF representative (DBE the best option) should bring the necessary formats to each township, advise the TEO how they are to be distributed to all schools and collected after a period of one month, and when the representative would return to review and collect the formats. A computerized database should be prepared and used for planning (training, materials distribution) and as a baseline for evaluation and for routine monitoring of implementation;

2. A SHAPE – Plus evaluation strategy should be designed. This should include pre- and post-tests for children, youth and adults in school and out-of-school for examining knowledge gains, the HIV/AIDS/STD behavioral assessment survey (Attachment 5) for evaluating attitudes and behaviors among in-school youth, and some of the techniques already used in schools, such as monitoring hand washing after using the latrine and hygiene/cleanliness checks. The UNAIDS guide for monitoring and evaluation of national AIDS programs[7] can provide further ideas for improvement in this area. It identifies and details indictors that can be used for measuring progress.

SHAPE advocacy efforts to date have not attained desired results. The large scale PTA training programs have not yet proven effective and should be reexamined and possibly redesigned. (The problem may not lie in the design but in external factors that are hard to control.) As part of SHAPE – Plus out-of-school, an extensive IEC campaign should be implemented in cooperation with the agencies mentioned above under linkages. This is needed to motivate township officials (especially those in education and health) as well as community members to support SHAPE – Plus.

[7] UNAIDS. *National AIDS Programmes: A Guide to Monitoring and Evaluation.* June 2000.

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OTHERS:

30. Learning materials for students (in Myanmar)
31. Brochure issued by DEPT/ UNICEF Yangon in Myanmar
32. Untitled booklet: with information and some success stories inside

ATTACHMENT 1. SUMMARY DATA ON SHAPE TOWNSHIPS, 1998 AND 2000

		PRIMARY						LOWER SECONDARY						UPPER SECONDARY					
		Schools		Teachers		Students		Schools		Teachers		Students		Schools		Teachers		Students	
State/Division	Township	1998/99	2000/01	1998/99	2000/01	1998/99	2000/01	1998/99	2000/01	1998/99	2000/01	1998/99	2000/01	1998/99	2000/01	1998/99	2000/01	1998/99	2000/01
1998/99																			
Kachin	Myitkyina	134	135	707	633	28300	28386	14	14	450	641	16977	17996	9	9	176	181	7312	7836
	Bhamo	71	73	221	210	14038	13302	8	8	169	176	5798	6165	4	4	54	59	2317	2407
Kayah	Loikaw	96	96	278	493	13032	12405	16	16	137	202	6603	6510	5	5	94	91	3738	3889
Kayin	Pa-an	383	382	1169	785	46338	47616	28	29	763	817	12972	13605	9	9	140	153	4288	4713
	Myawaddy	28	28	78	59	4761	5663	2	2	64	84	1487	2040	2	2	17	16	432	542
Chin	Hakha	75	77	259	266	8904	7447	9	9	115	94	2989	3617	3	3	43	44	1287	1143
Mon	Mawlamyaing	100	114	614	721	25895	26461	14	14	873	1000	16384	15979	13	15	2333	266	7232	8062
Shan (S)	Taunggyi	208	208	1219	1122	40184	40142	24	24	586	591	18200	19184	10	10	189	204	7351	7364
Shan (N)	Lashio	120	118	610	637	24207	24243	10	10	318	281	9780	10335	6	6	95	92	3010	3233
	Muse	57	57	243	169	10762	11127	5	5	62	32	3071	3516	2	2	12	10	458	498
Shan (E)	Kengtone	153	154	478	503	15017	14875	9	9	144	147	5181	5214	5	5	47	55	1426	1720
	Tachileik	68	68	226	127	7198	8964	4	4	50	71	2014	2657	2	2	16	15	297	489
Rakhine	Sittwe	93	93	909	877	18267	18063	12	12	336	350	8751	9266	7	7	134	130	3556	3950
Mandalay	Aung Myay Thaz	45	40	600	821	20188	20364	8	7	765	1020	15555	14668	11	11	216	205	8472	7040
	Myinchan	178	178	1133	841	24402	21646	10	11	358	424	10020	7274	3	3	86	78	3712	2953
	Meikhtila	236	237	1164	1359	23318	44656	11	11	525	545	15808	12473	6	6	152	147	6662	6967
Bago	Bago	182	183	1177	1047	45467	42241	16	16	719	690	19032	17795	8	8	208	217	7525	8472
	Pyay	161	163	683	834	20251	21011	9	9	444	493	11053	1112	6	7	111	136	4486	5854
Sagaing	Kalay	141	141	786	923	37927	33787	9	9	325	361	13621	8328	3	3	70	79	5913	2824
	Shwebo	151	151	582	438	28466	27688	8	8	980	965	8628	7065	5	5	113	103	4504	3347
	Monywa	156	156	1014	1132	31751	31866	9	9	683	680	12579	13280	6	6	213	200	6768	7137
Magway	Magway	171	171	925	874	33154	31939	10	10	315	304	8039	7938	5	5	105	125	3639	3479
	Pakkoku	185	186	1064	898	15979	28545	10	10	417	306	13371	12597	8	8	154	147	3734	5920
Yangon	Pazundaung	9	9	103	101	2218	2110	3	3	112	42	2114	1904	4	4	48	48	1053	1076
	Dawbon	12	12	157	142	7165	6821	4	4	129	116	3747	3728	1	1	26	27	1308	1406
	Kyimyindaing	15	15	245	186	6069	6073	3	3	187	186	3702	3370	5	5	82	79	1792	1457
	Hlaingthayar	44	44	530	487	23472	23950	5	5	194	55	10964	3682	3	3	72	59	2878	3963
Taninthayi	Dawei	105	104	428	358	17761	19707	7	8	234	220	6627	7204	5	5	89	90	2769	2640
	Myeik	122	122	611	538	28802	28726	7	7	279	357	12044	12418	6	6	105	112	5061	4793
	Kawthaung	54	54	168	186	10987	13314	3	3	66	90	2606	4022	2	2	18	24	816	1258
	Sub-Total	3553	3569	18381	17767	634280	663138	287	289	10799	11340	279717	254942	164	167	5218	3192	113796	116432
1999/00																			
Kachin	Phakat	52	54	126	158	13723	15550	5	5	55	63	3883	4984	2	2	14	13	409	760
Kayin	Kawkareik	179	178	696	421	23975	22736	13	13	232	328	8044	8178	4	5	47	64	1865	2282
Chin	Falam	158	158	306	397	8911	8255	14	14	163	103	3873	3429	4	4	39	51	1403	1378
Mon	Thaton	152	152	788	834	26488	27009	9	9	258	339	74666	7450	5	5	77	82	2404	2286
	Thanphyuzayat	107	108	502	469	19640	16267	2	2	196	238	6190	6786	7	7	61	78	2054	2304
Shan (S)	Kalaw	152	152	499	431	18540	17225	9	9	154	164	5210	5248	4	4	44	51	1761	2032
Rakhine	Mrauk-oo	175	175	689	653	4855	19713	8	8	115	126	4246	3981	2	2	27	32	1046	1406
	Thandwe	175	175	606	601	10484	10145	9	9	203	202	3845	3884	5	5	67	67	1261	1708
Mandalay	Chanayethazan	45	45	628	804	17430	17563	5	5	562	670	12231	12041	10	10	115	105	7255	6342
	Thazi	174	175	718	856	23523	21733	8	8	235	236	7027	7642	4	4	61	62	2072	2735
	Pyinmana	196	196	848	850	31501	29172	11	11	402	174	125	12565	5	5	93	98	4516	4536
Bago	Nyaung Lay Bin	141	141	666	694	26048	25436	10	10	287	328	8377	9143	5	5	84	98	3285	3793
	Taungoo	154	154	947	812	24435	22571	9	9	413	439	10354	9760	7	7	113	123	4959	4949

Sagaing	Tamu	70	71	316	321	11255	11183	3	3	152	124	4289	4115	3	3	51	30	1511	1482
Magway	Minbu	129	130	620	578	19917	18489	8	7	199	186	5947	5567	2	3	49	60	2488	2675
Yangon	North Okkalapa	47	47	820	805	25433	25512	10	10	694	668	18860	17788	6	6	186	185	8876	7974
	Thakata	46	46	699	649	21700	20191	8	8	524	491	15247	14040	4	4	148	135	7151	6496
Ayeyawaddy	Pathein	207	233	1019	1093	28304	32290	14	15	731	517	13267	13283	10	11	184	219	7726	7961
	Hinzeda	318	318	1152	1052	38273	37993	18	18	514	428	11283	13421	7	7	121	150	3901	5209
	Kyankhin	107	107	347	347	10815	9484	8	8	224	135	4229	3142	2	2	33	40	1847	1929
	Sub-Total	2784	2815	12992	12825	405250	408517	181	181	6313	5959	221193	166447	98	101	1614	1743	67790	70237
2000/01																			
Kayah	Dimawsoe	102	104	253	357	10170	8425	12	12	72	68	3822	4070	1	1	15	15	626	602
Kayin	Hlaingbwe	176	180	613	487	23167	24388	14	14	128	237	4260	4990	1	3	23	37	896	939
	Thandaung	183	183	403	193	9306	9951	10	10	119	134	2766	3017	3	3	22	31	651	788
Mon	Kyaikmaraw	121	121	512	471	23901	21024	7	7	119	164	4531	4666	3	3	28	29	927	863
Shan (S)	Sisang	138	144	377	361	13780	14219	7	7	68	68	2498	2885	3	3	23	24	471	844
	Hopone	141	144	357	302	10698	10379	4	4	47	53	1981	1734	2	2	15	18	356	403
Shan (N)	Thibaw	140	140	387	341	11977	111730	5	5	80	78	2713	2848	3	3	25	37	925	892
Magway	Chauk	168	168	800	807	24256	22031	10	10	287	273	8529	8150	4	4	93	95	3816	3640
Taninthayi	Launglone	106	106	361	350	18270	17621	6	6	65	88	3643	4257	2	2	17	19	530	831
	Thayetchaung	110	109	370	349	17801	16894	5	5	73	90	4225	4748	1	3	24	34	963	1372
	Sub-Total	1385	1399	4433	4018	163326	256662	80	80	1058	1253	38968	41365	23	27	285	339	10161	11174
	TOTAL	7722	7783	35806	34610	1202856	1328317	548	550	18170	18552	539878	462754	285	295	7117	5274	191747	197843

ATTACHMENT 2. BACKGROUND DATA ON SCHOOLS INCLUDED IN THE ASSESSMENT

TOWNSHIP/	TYPE SCHOOL			LOCATION					ANY ADULTS WHO?			ANY CHILDREN WHO?		
SCHOOL	SPS	SMS	SHS	Sm.Village	Lg.Village	Town	Peri-Urban	Urban	HIV	AIDS	Use Drugs	HIV	AIDS	Use Drugs
North Okkapala														
SPS 27	1					1								
SHS 2			1			1				1		1		
Taungoo														
SPS Le Bu	1			1										
SMS 1		1					1				1			
SHS Kay Tu Myothit			1		1									
Chanayetharzan														
SMS 4		1				1								
SHS 12			1			1			1	1	1	1	1	1
Monywa														
SPS Za Loke	1				1									
SMS 2		1				1			1	1	1	1	1	1
SHS Ka Tet Kan						1								
Hsipaw														
SPS 1 Ton Sint	1					1								
Pathein														
SPS Nyaung Kone	1			1										
SMS Thalat Kwa		1			1									
Myit Kyi Nar														
SPS 3	1					1			1	1	1	1	1	1
SMS Shwesat		1			1				1	1	1	1	1	1
SMS 7		1					1							
SHS 2			1			1			1		1	1	1	1
										1				
Dawai														
SPS Shan Malei Zwe	1					1			1	1	1	1	1	1
SMS 1		1				1			1	1	1	1	1	1
SHS 3			1			1			1	1	1	1	1	1
Kyaing Tun														
SPS Wan Lwin	1				1									
SMS Yanlaw		1			1				1	1	1	1	1	1
SHS 1			1				1		1	1	1	1	1	1
TOTAL	8	8	6	2	6	12	3	0	10	11	11	11	10	10

SUMMARY DATA ON TEACHERS INCLUDED IN THE ASSESSMENT

TOWNSHIP/ SCHOOL	SCHOOL HEAD							TEACHERS		
	Female	Male	Age	Yrs. HM	Assn.Sch.	Trained	SHP Comm.	Total	ained SH	Teach SHP
North Okkapala										
SPS 27		1	46	12	6	1	2	38	38	37
SHS 2	1		57	6	2			73	66	10
Taungoo										
SPS Le Bu	1		55	25	20	1	1	5	5	4
SMS 1	1		50	7	2	1	1	27	22	22
SHS Kay Tu Myothit										
Chanayet+A33harzan										
SPS 4	1		52	15	11	1		17	17	8
SHS 12	1		61	9	7	1	3	112	42	42
Monywa										
SPS Za Loke	1		49	15	11	1		11	5	11
SMS 2	1		46	11	1.3			45	37	37
SHS Ka Tet Kan		1	47	4	0.75	1	3	15	5	5
Hsipaw										
SPS 1 Ton Sint										
Pathein										
SPS Nyaung Kone		1	41	11	9	1		3	3	3
SMS Thalat Kwa	1		40	4	4	1		14	14	3
Myit Kyi Nar										
SPS 3	1		48	23	11	1	1	8	5	4
SMS Shwesat	1		42	4	4	1		13	13	8
SMS 7		1	46	3	0.2			17	6	4
SHS 2		1		55	4	1	2	66	38	16
Dawai										
SPS Shan Malei Zwe	1		55	21	17	1		11	10	3
SMS 1		1	49	11	1.4	1		31	28	7
SHS 3	1		53	2.4	0.9	1		68	65	18
Kyaing Tun										
SPS Wan Lwin	1		29	2	0.6	1		7	3	7
SMS Yanlaw	1		50	5	5	1		13	4	4
SHS 1	1		54	8	8	1		29	19	
TOTAL	15	6	46.19	12.07	6.01	18		623	445	253

SUMMARY DATA ON STUDENTS AND NUMBER OF SHAPE SESSIONS PER MONTH

TOWNSHIP/ SCHOOL	KG		GRADE 1		GRADE 2		GRADE 3		GRADE 4		GRADE 5		GRADE 6		GRADE 7		GRADE 8		GRADE 9		GRADE 10		GRAND TOTAL	
	Total	Sessions	Total	Sessions	Total	Sessions	Total	Sessions	Total	Sessions	Total	Sessions	Total	Sessions	Total	Sessions	Total	Sessions	Total	Sessions	Total	Sessions	All	Sessions
North Okkapala																								
SPS 27	189		220		239	2	223	2	213	2													1084	
SHS 2											379	4	351	4	278	4	348	4	663	4	816		2835	
Taungoo																								
SPS Le Bu	38		26		40	1	24	1	25	1	24	1											177	
SMS 1	107		94		97	4	85	4	64	4	105	4	91	4	87	4	85	4					815	
SHS Kay Tu Myothit																								
Chanayetharzan																								
SPS 4	280		307		151	4	146	4	119	4													1003	
SHS 12	115		96		66	8	61	8	77	8	422	4	371	4	355	4	335	4	459	2	258		2615	
Monywa																								
SPS Za Loke	75		64		64	4	62	4	49	5	44	6											358	
SMS 2	48		65		68		49		46		137		121		91		66						691	
SHS Ka Tet Kan	52		43		56	4	36	4	44	4	95	4-6	83	4-6	98	4-6	65	4-6	63	4-6			635	
Hsipaw																								
SPS 1 Ton Sint																								
Pathein																								
SPS Nyaung Kone	33		40		31	3	23	2	25	2													152	
SMS Thalat Kwa	60		67		70	4	61	4	62	4	100	4	98	4	98	4	66	4	60	4	56		798	
Myit Kyi Nar																								
SPS 3	63		65		57	2	78	2	53	2													316	
SMS Shwesat	66		58		84	5	82	5	72	6	164	4	150	4	151	4	115	4					942	
SMS 7	70		59		46		67		54		107	1	112	1	110	1	106	1					731	
SHS 2	73		55		74	4	110	8	71	8	365	4	323	4	320	4	318	4	508	1	454		2671	
Dawai																								
SPS Shan Malei Zwe	54		52		42	12	56	8	62	8													266	
SMS 1	57		63		49	12	29	8	73	8	193	4	171	4	131	4	110	4					876	
SHS 3	70		69		63	20	64	8	74	8	252	4	195	4	211	4	217	2	381	2	390		1986	
Kyaing Tun																								
SPS Wan Lwin	51		26		49		41		30		23	4											220	
SMS Yanlaw	33		37		32	8	34	8	33	8	62	4	39	4	32	4	35	4					337	
SHS 1	69		61		79	4	70	4	71	4	98	4	91	4	115	4	93	4	144	4	130		1021	
TOTAL	1603		1567		1457		1401		1317		2570		2196		2077		1959		2278		2104		20529	

SUMMARY DATA ON SHAPE BOOK DISTRIBUTION

TOWNSHIP/ SCHOOL	GRADE 2		GRADE 3		GRADE 4		GRADE 5		GRADE 6		GRADE 7		GRADE 8		GRADE 9		SHAPE TEACHERS		COMMENTS			Impact
	Students	Books	Students	Books	Students	Books	Students	Books	Students	Books	Students	Books	Students	Books	Students	Books	Teachers	Books	SB Qual.	TB Qual.	Other	on Twsp.
North Okkapala																						
SPS 27	239	90	223	90	213	100											37	43	G	VG	Relevant	Y
SHS 2							379	100	351	100	278	100	348		663	350	10	50	G	G	Relevant	Y
Taungoo																						
SPS Le Bu	40	12	24	12	25	14	24										4	5	VG	VG	Relevant	Y
SMS 1	97	49	85	49	64	20	105	44	91	39	87	25	85	34			22	54	G	G	Relevant	Y
SHS Kay Tu Myothit																						
Chanayetharzan																						
SPS 4	151	40	146	55	119	30											8	14	G	G	Relevant	Y
SHS 12	66		61		77		422		371		355		335		459		42	NR	NR	NR		Y
Monywa																						
SPS Za Loke	64		62		49		44										11	5	VG	VG	33 SB Tot	Y
SMS 2	68	20	49	20	46	10	137	7	121	7	91	7	66	20			37	33	G	G		Y
SHS Ka Tet Kan	56	15	36		44		95	7	83	5	98	3	65	7	63		5	NR	G	G	Relevant	Y
Hsipaw																						
SPS 1 Ton Sint																						
Pathein																						
SPS Nyaung Kone	31	15	23	11	25	12											3	4	G	G	Relevant	Y
SMS Thalat Kwa	70	27	61	27	62	17	100	17	98	27	98	32	66	25	60	45	3	15	VG	VG	Relevant	Y
Myit Kyi Nar																						
SPS 3	57		78		53												4	4	VG	VG	38 SB Tot	Y
SMS Shwesat	84		82		72		164		150		151		115				8	NR	G	G	Relevant	Y
SMS 7	46		67		54		107		112		110		106				4	NR	G	G	Relevant	Y
SHS 2	74		110		71		365		323		320		318		508		16	4	G	G	30 SB Tot	Y
Dawai																						
SPS Shan Malei Zwe	42	17	56	17	62	20											3	6	VG	VG	Relevant	Y
SMS 1	49	5	29		73	20	193	5	171	60	131	44	110	44			7	13	NR	NR	Relevant	Y
SHS 3	63	51	64	51	74	49	252	85	195	83	211	84	217	49	381	3	18	29	G	G	Relevant	Y
Kyaing Tun																						
SPS Wan Lwin	49		41		30		23										7	1	G	G		Y
SMS Yanlaw	32		34		33		62		39		32		35				4	NR	G	G	34 SB Tot	Y
SHS 1	79		70		71	31	98	35	91	44	115	26	93	39	144		NR	47	G	G	Teaching sex difficult	Y
TOTAL	1457		1401		1317		2570		2196		2077		1959		2278		253					

ATTACHMENT 3. GENERAL QUESTIONS ADDRESSED IN THE ASSESSMENT

	Possible Questions (priority)	H-master	Teacher	Students	Parents	TEO/ATEO	PTA	Vill. Leader	UNICEF
	IMPLEMENTATION	HM	T	S	P			VL	
Inputs									
1	number/type of supplies and equipment needed and received (L)	1							
2	numer/type of learning materials needed and received (H)	2							
3	quality and appropriateness of learning materials (M)	3	3	3	3				
4	quality and appropriateness of training (M)	4	4						
5	type and adequacy of transport facilities (L)					5			
Context									
6	what social or cultural factors suport/constrain the tecahing of life skills esp. HIV/AIDS (H)	6	6			6			
7	level of community support for the teaching of life skills esp. HIV/AIDS (H)	7	7			7	7		
8	perceptions of community concerning life skills training in gerneral and SHAPE in particular (M)	8	8		8	8	8		
Process									
9	number of hours of TOT and teacher training recieved and the appropriatenesss of training (M)	9	9						
10	number of hours of management/PTA training received and the appropriateness of training (M)	10				10	10		
11	number of hours of student teaching received and its appropriateness (M)	11	11	11	11				
12	appropriateness of teaching methods in various settings (e.g. rural villages, crowded classrooms) (M)	12	12						
13	effectiveness of SHAPE-related role and activities of the PTA (M)	13	13				13		
14	activities and effectiveness of township SHAPE committee (M)	14				14			
15	monitoring and supervision activities and their effectiveness (M)	15	15			15			
16	effectiveness of advocacy campaigns esp. HIV/AIDS (M)	16	16			16	16		
17	effectiveness of implementing agencies (M)	17	17			17			
18	effectiveness of extra-curricular outputs and activities (L)	18	18	18	18				
Outputs									
19	number/type of students receiving training (H)					19			
20	number/type of resource persons receiving training (M)					20			
21	effect on attendance rates (L)	21	21						
22	number/type of PTA and community support activities (M)	22	22				22		
23	knowledge gained esp. HIV/AIDS (M)		23	23	23				
24	awareness gained esp. HIV/AIDS (M)		24	24	24				
25	social services used (M)	25	25	25	25				
26	is SHAPE cost-effective (L)								
	RESULTS								
Outcomes									
27	changes in attitudes toward smoking, drug use, nutritution, hygiene, sanitiation (H)		27	27	27		27	27	
28	change in attitudes toward the sick, infirm, those with AIDS and their families (H)		28	28	28		28	28	
29	change in smoking, drug, nutrition, hygiene and sanitiation bahaviours of individuals and families (H)		29	29	29		29	29	
30	improvements in problem solving and decision making skills of students (H)		30	30	30		30	30	
31	changes in teaching methods used in schools for other subjects (M)	31	31						
Impact									
32	has SHAPE training improved the health of students, their families and communities (H)		32	32	32		32	32	
33	has SHAPE training improved the environmental conditions for sutdents, their families and communities (M)		33	33	33		33	33	
34	has SHAPE training improved the income levels of students, their families and communities (L)		34	34	34		34	34	
35	have rates of HIV/AIDS, STI decreased/increased (H)						35	35	
36	have rates of various diseases in AFTs decreased/increased (M)						36	36	
	FUTURE DEVELOPMENT (SHAPE-PLUS)								
In-school									
37	is the mission/concept of UNICEF SHAPE activities appropriate (M)					37			37
38	are the basic assumptions of SHAPE appropriate (M)					38			38
39	how should UNICEF SHAPE activities support GoM objectives (M)					39			39
40	what aspects of the curriculum lshould be changed esp. HIV/AIDS (H)	40	40	40			40		
41	what teaching methods should be changed (M)	41	41	41			41		
42	what additional training will be needed (M)	42	42				42		
43	what monitoring, evaluation, EMIS systems are required (M)	43	43			43	43		
44	what new management systems are required	44				44	44		44
45	current and potential linkages with HIV/AIDS activities of other agencies (M)	45				45	45	45	45
Out-of school									
46	type and location of target beneficiaries for out of school SHAPE-Plus program (H)	46				46	46	46	
47	what are the most viable delivery mechanisms for out of school SHAPE-Plus programs (H)	47				47	47	47	
48	what is most appropriate role for INGOs and NNGOs (M)	48				48		48	
49	what is the developmental process for out of school SHAPE-Plus programs and who should be involved (M)					49	49		49
50	what aspects of the curriculum should be changed (H) esp. HIV/AIDS	50	50			50	50	50	
51	what teaching methods should be changed esp. HIV/AIDS(H)	51	51			51	51	51	
52	what training programs are required (H)	52	52						
53	what monitoring, evaluation, EMIS systems are required (H)	53	53			53		53	
54	current and potential linkages with HIV/AIDS activities of other agencies (H)					54	54	54	54

ATTACHMENT 4. ANALYSIS MATRIX FOR THE HIV/AIDS COMPONENT OF SHAPE

CATEGORY: Results - Outcomes
ISSUE: Benefits General

TOWNSHIP SCHOOL	COMMENTS FROM INTERVIEWS WITH:			
	TEO/ATEO	COMMUNITY LEADER	SCHOOL HEAD	PTA MEMBER
North Okkalapa	-Preventative measures are taken because of understanding about diseases -Avoid going to video parlors where blue pictures are on screen -Prevalence could be under control			
		-yes -lessons will have very positive influence if followed	-children and parents have gained knowledge, more health conscious -students more assertive because have become more active in discussions -behavior change in personal hygiene -attitude change, more active now, interact more with each other	
Taungoo	-Yes. Found out some teenagers do not go to motels and guest houses anymore -In past teenagers were addicted to drugs but now less			
			-Children bear the valuable lessons beyond the classroom	-yes -it has had an effect, children leaving school are not smoking or chewing betel nut, also good for children's health
			-Notice that in middle of year children are becoming more healthy and thinking skills are improved. Think better nutrition and hygiene are reason for improved health. -When first arrived parents quarreled in compound, now do not. Also used to drink in open, now that happens less.	

			-Generally, SHAPE benefits all who get opportunity to get into it – students as well as teachers -How to live with other -How to live -Children changed their behavior – for example: they clean their teeth when they come to school -They cut nails, they dress up themselves clean shirts	
Chanaye Tharzan	Obviously, people support more and more because HIV/AIDS problem become considerably bigger and bigger. SHAPE is part of a whole which educate people in Myanmar			
		-Children share their knowledge with parents -Parents gain knowledge about nutrition, HIV/AIDS and drug	-Direct impact goes to parents from children -Parents are obliged to adjust themselves so that it will fit into the judgement given by children -Parents try to embrace their mistakes	-It is beneficial to new generation -Gain knowledge that required for healthy living -SHAPE program will have sustainable impact in near future
		-Children and youths show more polite manner -help themselves in personal hygiene	-Parents gain health knowledge form children -Health agency and education agency are complementary and supplementary to each other -children give critical outlooks in comparison with other schools and environment -Improve result of matriculation examination	

Monywa	-It is seen that there is a big gap in knowledge between AFT and non-AFT villages -Physically improved as a healthy school – clean, healthy and improved sanitation -Parents are happy to get access to improved knowledge through their children -"There are other townships that are still not aware of HIV/AIDS. But in this township, because of SHAPE, the people are more aware and know much more detail about HIV/AIDS."			
			-Now have a chance to learn about HIV/AIDS' danger and how to take care of patients – both for students and parents. Students tell parents about it. Children are also taking care of their own health.	-No clear outcomes. -Believe will have a positive effect because the children will learn things help themselves and their families. Will help the families gradually.
			-At least parents get access to learn something valuable from their children	-Family members enjoy their life more -Children become cleverer and so helpful to parents -House becomes clean -Environmental sanitation improved -Children do not eat food without fly proof -Children protect themselves from mosquitoes
		-Generally SHAPE program could prevent some cases related to local drinks and drugs through child to parent education	-Generally it really benefits the community by multiplying health and life skill knowledge	-Maybe
Hsipaw	-Adult students (8th and 9th grade) show more polite manner -less cases related to alcohol drink -Well-behave to their teachers			
		-Yes. -"When children learn they tell their parents. Children ask parents not to smoke. Parents also control themselves more in terms of smoking." (VPDC secretary) -Parents exposed	-PTA arranged for safe drinking water. Pay more attention to personal hygiene. Even poor parents have bought sweaters for their children when before they did not. Also home sanitation is	-Yes. -Think children have developed in health and social skills. (1) -Believe very helpful for children's future. (1) -Children avoid smoking and become better

		to media can help children.	improved. -Children as well as teachers are more socialized (more helpful and intimate), can protect from diseases better and adapt to the environment.	students, more disciplined. (1)
Pathein	-"In past had to action against drug abuse (mostly marihuana and amphetamines), but now not a problem. More the result of SHAPE activities than Government's programs."			
		-Definitely yes. -Benefit accrued	-Generally, strengthen the awareness of health and personal hygiene	-Yes, positive -After mass meeting, shop keepers said that fewer cigarettes were being sold. Children are saying that smoking is bad, will cause TB. Children telling smokers. -Also people now more aware of the need to use disposable syringes (from health dept. and private practitioners).
		-Yes positive results. -His own child (10^{th} grade boy) has become very conscious about having blood transfusions or not using sterile syringes. -Community members also seem to avoid unnecessary transfusions and look for disposable needles. -No commercial sex in the village, but sometimes if village men go out of town and get girls, they will use condoms.	-Children develop their decision making skills so that regular attendance is obviously improved -They make more friends in school -At least, parents learn form children informally -Improve access to learn primary health care through child to parents and parents to parents -School disciplines is improved, it is for sure. Stop smoking habit in school -Stop chewing betel quid in school	-We all observed that children change their bad habits more easily. -Some indicate by change of behaviors -Children take more time on personal hygiene -we all accept that this is because of SHAPE program in school

Myitkyina	-gain more knowledge -preventive measure taken in advance, e.g. personal hygiene, hand washing -children's response to environment can be used as an indicators, e.g asking for disposal syringes, using fresh blade for hair cutting			
		-has good effect -smokers and alcoholic become less -many betel shops some drugs put in it	-community benefited out of the program -know how to live healthy become eating more nutritiously -know danger of HIV	-has effect, children washed hands after eating, use soap
			-it has benefited to the community -received all the information from students -come to aware of personal hygiene, eating nutritious food -students follow what teachers has said -they themselves change behaviors, e.g. Hand washing after toilet -keep environment clean e.g. Collect every single garbage -SHAPE does not help children's decision making	Can't show the benefit
		-has good benefit -hand washing after toilet and before eating -washing fruits and vegetables before cooking	-benefit -gain knowledge about health	-hand washing after toilet and before eating -tell others not to smoke -bath regularly
			-cant show the significant changes -personal hygiene increase 40 - 50 % (e.g. Nail cutting) -have hand washing practice after toilet changes of 2/3 of the students attitude (not explain)	-eat more vegetables -personal hygiene improves -hair wash and nails cut -less use of drugs

Dawei	Have benefit. Less drug use and improve personal hygiene due to increase knowledge. Improving personal hygiene, less smoking, and adoption of HIV/AIDS avoidance behaviors can be used as indicators.			
		-have benefit -personal hygiene improve -less smoking -change of lifestyle can be used as indicators	-have benefit -children retold parents -children increase knowledge -avoid staying from contracting the diseases -children change behavior, they practice personal hygiene, do not chew betel and do not smoke	-have benefit -children attend school regularly -less smoking
			-have benefit -children improve personal hygiene -develop good behavior -dispose garbage properly -less smoking -school attendance more regular	-have benefit -improve personal hygiene -wash hands after toilet -use handkerchief when coughing -avoid crowd
		-have benefit -less smoking -personal hygiene improve -changes of behaviors are indicators	-have benefit -children relay messages to parents and then spread in the community -children gain health knowledge and about HIV/AIDS so their life become secured -children have changed behaviors, use disposable syringe, use fresh blade, personal hygiene improve, dispose garbage properly	-have benefit -less smoking, -less chewing betel -
Kengtong	-Community benefited out of it. -People working across border become less. Parents become aware of the problem and do not allow their children to go work across the border. -Number of households using latrines, and not working across the border can be used as indicators. It support township objectives.			
		-have benefit -come to know about the danger of drugs because it was learnt in school	-have benefit -messages spread within the community though adults when children told	-have benefit

		-eradication of addicts and becoming more healthy can be used as indicators	parents back -can make proper decision -knowledge gained and improved -children's attitude and behaviors have changed. E.g. Personal hygiene improved, decide not to eat fly rested foods	
		-have benefit -children from the village do not smoke and use drug -whatever children do good things can be used as indicators, e.g. Children not using drug	-have benefit -can differentiate right from wrong -changes occurred, previously boys and girls all mixed-up now such practice become less, primary level children pay attention to personal hygiene	-have benefit -dot need to remind children to brush teeth, practice personal hygiene, and to avoid drug
		-have benefit -children do not stroll around, stay at home and learn lessons -children not strolling around can be used as an indicator	-have benefit -messages reach to children from parents, then to the community, so it is good -before it is knowledge base only and now they learn more practical so it is very good -it helps them solve the real problem -children can differentiate right from wrong	-have benefit -brush teeth -does not need to remind to wash hands after toilet and before eating

TOWNSHIP SCHOOL	COMMENTS FROM DISCUSSIONS WITH:		
	TEACHERS	**STUDENTS**	**PARENTS**
North Okkalapa			
	-they will gain knowledge, know how to prevent diseases -can disseminate knowledge to friends even out-of-school friends -could improve mental health, social skills, decision making skills -personal hygiene, transmittable diseases esp. HIV, how to live a healthy life	-We (SHAPE learners), are not separated from those who do not learn SHAPE. We shared what we feel with close friends and relatives	
Taungoo			
	-From SHAPE lessons the children learn how to avoid difficult situations as they grow up. -SHAPE has had great effect on children in school but cannot estimate effect on children out-of-school		-Notice children gain more knowledge on health, practice personal hygiene (cut nails, keep body clean) have become aware of the nutritional value and know food groups. They know what vitamins are in food.
	-In school, rooms are clean and tidy -Children show respect to each other -They become duty consciousness		-Children come back with questions and they discuss. One says child asks every day others say 3-5 times a month. -Most important things learned are HIV, communicable diseases, how to eat properly, better hygiene habits.
		-Talk to family about what learned especially HIV/AIDS and drug abuse. Parents ask about what we are learning and seem to like it. -Also talk with friends and neighbors about what have learned. Talk informally when meet in street. No special place where they hang out. -Most important topics learned HIV, drugs and malaria. -Also talk to them about what food to eat and wrong concepts of malaria.	

Chanaye Tharzan			
	-children retold what they had learned at school to parents which made parents change attitudes on smoking and alcohol -adults learned from children -primary children could disseminate messages more quickly -HSAPE program has an effect on children and younger children gained more knowledge such as using fresh razor blades for haircutting -high school students become more assertive, cooperative, disciplined, friendly and developed3 self disciplined		-All parents said that they all thrust children because they are fully educated by SHAPE
Monywa			
		-Most important topics are personal hygiene and health, smoking, alcohol, betel chewing and not being bitten by mosquitoes.	-Parents are pleased with their children's skills development
	-"Program is good and can help save people's lives. -"Some topics unanticipated by students in grade 7,8 and program helps them be ready and avoid them. -"It helps learners adapt to their environment. -"Very effective in teaching dangers of drugs, tattooing and HIV/AIDS."		
	-When teach SHAPE got some unexpected good responses. For example, 9th standard boy said would leave girlfriend if they had some sexual practices. -Children's personal hygiene improving, pay more attention to nutrition. -People in village now using mosquito nets. -Attitude toward smoking has changed gradually.	-All feel more against smoking and drinking since they learned from SHAPE. -Have talked to parents about they have learned in SHAPE, inc. smoking, drinking, leprosy, HIV/AIDS, diarrhea, drugs. -Some say they have talked with friends about the material. Both girls and boys have out-of-school friends. They	-We find children become more polite and well behaved then they used to be.

	-Kids have reduced the amount of teasing about sex.	meet at video place and at homes.	
Hsipaw			
	-visible impact - seeing their behaviors change	-Most important topics are HIV/AIDS (4) and nose hygiene (1). Have learned about drugs and safe drinking water. -Now started drinking safe water, eat more body growth foods, look after nose and use handkerchief, wash hands more. -Have talked to parents about HIV, drugs, dengue fever, nose hygiene, and dangers of smoking and alcohol. -One girl has friends (D.O. grade 2) and talks to them about HIV and drugs.	-children become self-disciplined -Motivated to go to school regularly -children are more rationale thinking
Pathein			
	-Ask children to tell parents what they have learned in SHAPE. Children do it, parents report some of these requests, like fresh for haircutting.		-Think children are happier in school (Child friendly school) -We are motivated to learn something -Training is lively because it is different from what they know about the conventional training -They shared what they learnt with people at village. It is exciting.
	-children learn good lessons related to daily life experiences. -Teachers also have more self-awareness because these life skills lessons are applicable in daily life experiences, therefore we, teachers, also benefited from teaching -Personal hygiene and school sanitation is obvious. Students easily understand and observe to keep the environment clean -Not necessarily waiting to follow the teachers' instruction -Children look brighter with clean clothes	-Three of six students talk with parents about HIV. -One says talks to parents about drugs and sharing blades. -One told parents about mosquitoes and malaria. -One says parents about thinking before doing (e.g. going to video store before exam). -All have talked with out-of-school friends about what they learned – not to eat betel, smoking.	

	-We all notice that there is no bad smell in the crowded classes		
Myitkyina			
		-come to know more about disease, gain more knowledge -like birth spacing, gain knowledge about how to space birth when grown up	
Dawei			
			-know to use iodinated salt -know how to avoid HIV/AIDS -can differentiate right from wrong -can prevent for mosquito biting -adopt latrine using practices -eat more nutritious foods
	-teenagers become control themselves -avoid cigarette and cheroot -increase AIDS knowledge -attend school regularly -eat nutritious foods -personal hygiene improve -help each other -take responsibility	learned -HIV/AIDS -drug -malaria	
		-learned personal hygiene -sister and brother -school sanitation -AIDS -hand washing	-children improve personal hygiene -use disposable syringe fresh blade -improve social relationship -have more self confidence -develop right attitude towards HIV/AIDS
Kengtong			
	-there were many deaths due to HIV/AIDS in the past but now it become few -people become afraid of the disease -have seen the patients		
	-messages can reach to parents with present teaching methods -children can differentiate right from wrong		--messages reach to the community through parents -wants to start next program (out of school) as soon as possible

	-they can think logically now -before children cannot discuss, now they can discuss and can answers questions it is not included in the test so they do not pay attention. Teachers do not know if students understand the danger of smoking. But now, children say about the danger of smoking, they can differentiate bad and good friends		-the more you educate the more better -can educate through VPDC -children retold parents what they had learnt from school -though afraid of own father, they told them about the danger of smoking, its consequences

HIV/AIDS/STD BEHAVIORAL ASSESSMENT

FOR USE WITH UNMARRIED MALE AND FEMALE IN-SCHOOL YOUTH

TITLE OF SURVEY – COUNTRY - YEAR CONDUCTED

001 QUESTIONNAIRE IDENTIFICATION NUMBER |___|___|___|

002 TOWNSHIP_____ (provide locally appropriate categories)

003 DIVISION/STATE_____ (provide locally appropriate categories)

004 SCHOOL_____ (provide locally appropriate categories)

Introduction: "My name is… I'm working for… We're interviewing people here in [name of city, region or site] in order to find out about…[describe purpose of study]. Have you been interviewed in the past few weeks [or other appropriate time period] for this study? **IF THE RESPONDENT HAS BEEN INTERVIEWED BEFORE DURING THIS ROUND OF BSS, DO NOT INTERVIEW THIS PERSON AGAIN.** Tell them you cannot interview them a second time, thank them, and end the interview. If they have not been interviewed before, continue:

Confidentiality and consent: "I'm going to ask you some very personal questions that some people find difficult to answer. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand what people think, say and do about certain kinds of behaviors. We would greatly appreciate your help in responding to this survey. The survey will take about XX minutes to ask the questions. Would you be willing to participate?"

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

Interviewer visit

	Visit 1	Visit 2	Visit 3
Date			
Interviewer			
Result			

Result codes: Completed 1; Respondent not available 2; Refused 3; Partially completed 4; Other 5.

005 INTERVIEWER: Code [____|____] Name_____

006 DATE INTERVIEW: __\ ____ \ _____

CHECKED BY SUPERVISOR: Signature _____ Date _____

SAMPLE HIV/AIDS/STD BEHAVIORAL ASSESSMENT SURVEY FOR STUDENTS

Section 1: Background characteristics

THIS SURVEY ONLY INTERVIEWS YOUTH AGED ** - ** WHO HAVE NEVER BEEN MARRIED OR LIVED WITH A SEXUAL PARTNER FOR 12 MONTHS OR LONGER. IF THE RESPONDENT IS YOUNGER THAN ** OR OLDER THAN **, OR HAS EVER BEEN MARRIED, OR LIVED WITH A SEXUAL PARTNER, DO NOT INTERVIEW THIS PERSON.			
No.	**Questions and filters**	**Coding categories**	**Skip to**
Q101	RECORD SEX OF THE RESPONDENT	MALE 1 FEMALE 2	
Q102	What is your present grade level in school?	MONTH [__|__] DON'T KNOW 98 NO RESPONSE 99	
Q103	How old were you at your last birthday? **(Compare and correct Q102 if needed)**	AGE IN COMPLETED YEARS [__|__] MUST BE BETWEEN 15 AND 19 YRS OLD DON'T KNOW 98 NO RESPONSE 99 **ESTIMATE BEST ANSWER**	
Q107	Who pays your school fees?	MOTHER 1 FATHER 2 RELATIVES 3 SEX PARTNER 4 GOVT/SCHOLARSHIP 5 "I PAY THEM MYSELF" 6 OTHER_____7 DON'T KNOW 8 NO RESPONSE 9	
No.	**Questions and filters**	**Coding categories**	**Skip to**
Q108	How often, if at all, have you missed school because you did not have enough money for school fees, lunch money or bus fare? Would you say… **READ RESPONSES**	VERY OFTEN 1 OFTEN 2 SOMETIMES 3 NEVER 4 DON'T KNOW 8 NO RESPONSE 9	
Q109	Do you work to earn money for yourself?	YES 1 NO 2 NO RESPONSE 9	**→Q112**
Q111	What do you do with this money? Do you keep most for yourself, give it to your family or what?	KEEP FOR SELF 1 FAMILY 2 OTHER_____3 DON'T KNOW 8 NO RESPONSE 9	
Q112	How long have you lived here in (NAME OF COMMUNITY/ TOWN NEIGHBORHOOD/ VILLAGE)?	NUMBER OF YEARS [__|__] RECORD 00 IF LESS THAN 1 YEAR DON'T KNOW 88 NO RESPONSE 99	

SAMPLE HIV/AIDS/STD BEHAVIORAL ASSESSMENT SURVEY FOR STUDENTS

Section 1: Background characteristics (continued)

No.	Questions and filters	Coding categories	Skip to
Q116	During the last 4 weeks how often have you had drinks containing alcohol? Would you say .....**READ OUT CIRCLE ONE**	Every day 1 At least once a week 2 Less than once a week or never 3 DON'T KNOW 8 NO RESPONSE 9	
Q117	Some people have tried a range of different types of drugs. Which of the following, if any, have you tried? **READ LIST**	(List locally appropriate categories) YES NO DK NR 1 2 8 9 1 2 8 9 1 2 8 9 1 2 8 9	

Section 2: Sexual history: numbers and types of partners

Now I am going to ask you some personal questions about sex. Remember we are asking these questions to learn more about how young people like yourself feel, in order to help you make your life safer. We know that *some* young people have had sexual intercourse and some have sexual intercourse with more than one person. Please answer the following questions honestly. Remember, your name is not written on this questionnaire.

No.	Questions and filters	Coding categories	Skip to
Q201	Have you ever had sexual intercourse? [For the purposes of this survey, "sexual intercourse," is defined as vaginal or anal penetrative sexual intercourse.]	YES 1 NO 2 NO RESPONSE 9	→Q503
Q202	At what age did you first have sexual intercourse?	AGE IN YEARS [__|__] DON'T KNOW 88 NO RESPONSE 99	
Q202A	Was a condom used during this first time you had sexual intercourse?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
Q203	What was the age of the person with whom you first had sexual intercourse?	AGE IN YEARS [__|__] DON'T KNOW 88 NO RESPONSE 99	
Q204	How much older or younger was the person with whom you had your first sexual experience? **READ OUT ANSWERS:**	MORE THAN 10 YRS OLDER 1 5-10 YRS OLDER 2 LESS THAN 5 YRS OLDER 3 YOUNGER 4 DON'T KNOW 8 NO RESPONSE 9	
Q205	Have you had sexual intercourse in the last 12 months?	YES 1 NO 2 NO RESPONSE 9	→Q503

SAMPLE HIV/AIDS/STD BEHAVIORAL ASSESSMENT SURVEY FOR STUDENTS

Section 4: Non-commercial partners

No.	Questions and Filters	Coding categories		Skip to
Q403	The last time you had sex with a partner, did you and your partner use a condom?	YES NO DON'T KNOW NO RESPONSE	1 2 8 9	 **→Q405** **→Q406**
Q404	Who suggested condom use that time? **CIRCLE ONE**	Myself My partner Joint decision DON'T KNOW NO RESPONSE	1 2 3 8 9	**→Q406** **→Q406** **→Q406** **→Q406**
Q405	Why didn't you and your partner use a condom that time? **ADD OTHER LOCALLY APPROPRIATE CATEGORIES AFTER PRE-TESTING** **CIRCLE ALL ANSWERS MENTIONED**		Y N Not available 1 2 Too expensive 1 2 Partner objected 1 2 Don't like them 1 2 Used other contraceptive 1 2 Didn't think it was necessary 1 2 Didn't think of it 1 2 Other_____ 1 2 DON'T KNOW 1 2 NO RESPONSE 1 2	
Q406	With what *frequency* did you and all of your partner(s) use a condom over the last 12 months?	EVERY TIME ALMOST EVERY TIME SOMETIMES NEVER DON'T KNOW NO RESPONSE	1 2 3 4 8 9	

Section 5: Male condoms

No.	Questions and Filters	Coding categories		Skip to
Q503	Have you ever *heard of* a male condom? **(Show picture or sample of one.)** (I mean a rubber object that a man puts on his penis before sex.)	YES NO DON'T KNOW NO RESPONSE	1 2 8 9	 **→Q601** **→Q601**
Q504	Do you know of any place or person from which you can obtain male condoms?	YES NO NO RESPONSE	1 2 9	 **→Q507**

Q505	Which places or persons do you know where you can obtain male condoms? **PROBE AND RECORD *ALL* ANSWERS** Any others?	Yes No Shop 1 2 Pharmacy 1 2 Market 1 2 Clinic 1 2 Hospital 1 2 Family planning center 1 2 Bar/guest house/hotel 1 2 Peer educator 1 2 Friend 1 2 OTHER_____ 1 2 NO RESPONSE 1 2	
No.	**Questions and Filters**	**Coding categories**	**Skip to**
Q507	*FOR SEXUALLY ACTIVE RESPONDENTS ONLY:* During the past 12 months, did you ever have sexual intercourse *without* using a condom with any commercial sexual partner or any other sexual partner who you have never lived with and are not married to?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	

Section 4: STDs

No.	Questions and filters	Coding categories	Skip to
Q601	Have you ever heard of diseases that can be transmitted through sexual intercourse?	YES 1 NO 2 NO RESPONSE 9	**→Q604**
Q602	Can you describe any symptoms of STDs in women? ….. Any others? **DO *NOT* READ OUT THE SYMPTOMS** **CIRCLE 1 FOR ALL MENTIONED.** **CIRCLE 2 FOR ALL *NOT* MENTIONED.** **MORE THAN ONE ANSWER IS POSSIBLE.**	Yes No ABDOMINAL PAIN 1 2 GENITAL DISCHARGE 1 2 FOUL SMELLING DISCHARGE 1 2 BURNING PAIN ON URINATION 1 2 GENITAL ULCERS/SORES 1 2 SWELLINGS IN GROIN AREA 1 2 ITCHING 1 2 OTHER _____ 1 2 NO RESPONSE 1 2	

Q603	Can you describe any symptoms of STDs in men? ….. Any others? **DO *NOT* READ OUT THE SYMPTOMS** **CIRCLE 1 FOR ALL MENTIONED.** **CIRCLE 2 FOR ALL *NOT* MENTIONED.** **MORE THAN ONE ANSWER IS POSSIBLE.**	Yes No GENITAL DISCHARGE 1 2 BURNING PAIN ON URINATION 1 2 GENITAL ULCERS/SORES 1 2 SWELLINGS IN GROIN AREA 1 2 OTHER _____1 2 NO RESPONSE 1 2	
Q604	Have you had a genital discharge during the past 12 months?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
Q605	Have you had a genital ulcer/sore during the past 12 months?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	

Section 7: Knowledge, opinions, and attitudes

No.	Questions and filters	Coding categories	Skip to
Q701	Have you ever heard of HIV or the disease called AIDS?	YES 1 NO 2 NO RESPONSE 9	**→Q801**
Q702a	Do you know anyone who is infected with HIV or who has died of AIDS?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	**→Q703** **→Q703**
Q703	Can people protect themselves from HIV, the virus that causes AIDS by using a condom correctly every time they have sex?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
Q704	Can a person get the HIV virus from mosquito bites?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
Q705	Can people protect themselves from HIV by having one uninfected faithful sex partner?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	

Q706	Can people protect themselves from HIV by abstaining from sexual intercourse?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
Q707	Can a person get HIV by sharing a meal with someone who is infected?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
Q708	Can a person get HIV by getting injections with a needle that was already used by someone else?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
Q709	Do you think that a healthy-looking person can be infected with HIV, the virus that causes AIDS?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
Q710	Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	 **→Q712** **→Q712**
Q711	What can a pregnant woman do to reduce the risk of transmission of HIV to her unborn child? **DO NOT READ LIST** **CIRCLE ALL THAT ARE MENTIONED.**	TAKE MEDICATION (Antiretrovirals) Yes 1 No 2 OTHER _____ 1 2 DON'T KNOW 1 2 NO RESPONSE 1 2	
Q712	Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
Q713	Is it possible in your community for someone to get a confidential test to find out if they are infected with HIV? By confidential, I mean that no one will know the result if you don't want them to know it.	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
Q714	I don't want to know the result, but have *you* ever had an HIV test?	YES 1 NO 2 NO RESPONSE 9	 **→Q801**

STD Treatment seeking behaviors

No.	Questions and filters	Coding categories				Skip to
	FILTER: CHECK Q* AND Q*** HAD GENITAL DISCHARGE AND/OR GENITAL ULCER……[___] IN LAST 12 MONTHS ↓ NO DISCHARGE OR ULCER IN LAST 12 MONTHS [__]→**					→
	Did you do any of the following the last time you had a genital ulcer/sore or genital discharge: **READ OUT. MORE THAN ONE ANSWER IS POSSIBLE.**	Yes	No	DK	NR	
	a. Seek advice/medicine from a government clinic or hospital?	1	2	8	9	
	b. Seek advice/medicine from a workplace clinic or hospital?	1	2	8	9	
	c. Seek advice/medicine from a church or charity-run clinic or hospital?	1	2	8	9	
	d. Seek advice/medicine from a private clinic or hospital?	1	2	8	9	
	e. Seek advice/medicine from a private pharmacy?	1	2	8	9	
	f. Seek advice/medicine from a traditional healer?	1	2	8	9	
	g. Took medicine you had at home?	1	2	8	9	
	h. Tell your sexual partner about the discharge/ STD?	1	2	8	9	
	i. Stop having sex when you had the symptoms?	1	2	8	9	
	j. Use a condom when having sex during the time you had the symptoms?	1	2	8	9	

No.	Questions and filters	Coding categories	Skip to
	Which of these things did you do FIRST? **ONLY ONE ANSWER IS POSSIBLE.** ADD OTHER LOCALLY APPROPRIATE CATEGORIES IF NECESSARY.)	a. Seek advice/medicine from a government clinic or hospital? 1 b. Seek advice/medicine from a workplace clinic or hospital? 2 c. Seek advice/medicine from a church or charity-run clinic or hospital? 3 d. Seek advice/medicine from a private clinic or hospital? 4 e. Seek advice/medicine from a private pharmacy? 5 f. Seek advice/medicine from a traditional healer? 6 g. Took medicine you had at home? 7 h. Other_____ 8 DON'T REMEMBER 88 NO RESPONSE 99	
	If you took medicine for the last episode of symptoms, from where did you obtain the medicine? **CIRCLE ALL THAT APPLY.**	Yes No Health worker in clinic/hospital 1 2 Pharmacy 1 2 Traditional healer 1 2 Friend or relative 1 2 "Took medicine I had at home" 1 2 Did not take any medicine 1 2 DON'T REMEMBER 1 2 NO RESPONSE 1 2	
	If you received medicine from a doctor, did you take all of the medicine prescribed?	Yes 1 No 2 DON'T KNOW 8 NO RESPONSE 9	
	If not, why did you not take all of the medicine prescribed? **CIRCLE ALL THAT APPLY.**	(List locally appropriate categories) Yes 1 No 2 DON'T REMEMBER 1 2 NO RESPONSE 1 2	

Stigma and Discrimination

No.	Questions and filters	Coding categories	Skip to
	Would you be willing to share a meal with a person you knew had HIV or AIDS?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
	If a male relative of yours became ill With HIV, the virus that causes AIDS, would you be willing to care for him in your household?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
	If a student has HIV but is not sick, should he or she be allowed to continue attending school?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
	If a female relative of yours became ill With HIV, the virus that causes AIDS, would you be willing to care for him in your household?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
	If a teacher has HIV but is not sick, should he or she be allowed to continue teaching in school?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
	If you knew a shopkeeper or food seller had the HIV virus, would you buy food from them?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	
	If a member of your family became ill with HIV, the virus that causes AIDS, would you want it to remain secret?	YES 1 NO 2 DON'T KNOW 8 NO RESPONSE 9	

Attachment 6.

SHAPE ACTIVITIES QUESTIONNAIRE FOR HEADMASTERS/HEADMISTRESSES

UNICEF is in the process of assessing the HIV/AIDS component of the School-Based Healthy Living and HIV/AIDS Prevention Education (SHAPE) program. As part of this assessment basic information on SHAPE activities in schools is being collected. To assist in this effort, we would appreciate your answering the following questions and returning the completed questionnaire to the Township Education Office so that it arrives by …… November 2002. (Please give your answer or a "tick" mark in the space where you agree.) Thank you.

1. SCHOOL INFORMATION

1.1. School Name _____
1.2. Township _____
1.3. Village Tract _____
1.4. Village/Town _____

1.5. Please indicate whether the school is in a: ____ small village
____ larger village
____ town
____ peri-urban area
____ urban area

1.6. Please indicate whether the school is a: ____ primary school
____ middle school
____ high school

2. PERSONAL INFORMATION

2.1. Your name _____
2.2. Your gender ____ Female ____ Male
2.3. Your age: _____ years
2.4. Number of years as a headmaster(ess): _____ years
2.5. Number of years assigned to this school: _____ years
2.6. Have you ever participated in training concerning SHAPE? ____ Yes ____ No
2.7. Have you attended a Township SHAPE Committee meeting in the last three months? ____ Yes ____ No

3. TEACHER INFORMATION

3.1. Number of teachers in the school: _____ Number female _____
3.2. Number of teachers who have received SHAPE training: _____ Number female _____

	Number	**Normal Subject Responsibility**
3.3. Number and type of teachers currently teaching SHAPE:	____	_____
	____	_____
	____	_____
	____	_____

4. STUDENT INFORMATION

4.1. Number of students by grade level: ____ KG, ____ Gr.1, ____ Gr.2, ____ Gr.3, ____ Gr.4 ____ Gr.5, ____ Gr.6, ____ Gr.7, ____ Gr.8, ____ Gr.9, ____ Gr.10.

4.2.Number of **female** students by grade level: ____ KG, ____ Gr.1, ____ Gr.2, ____ Gr.3, ____ Gr.4 ____ Gr.5, ____ Gr.6, ____ Gr.7, ____ Gr.8, ____ Gr.9, ____ Gr.10.

4.3. Actual number of SHAPE training sessions per month by grade level: ____ Gr.2, ____ Gr.3, ____ Gr.4 ____ Gr.6, ____ Gr.7, ____ Gr.8, ____ Gr.9,

5. SHAPE MATERIALS

5.1. Number of SHAPE teacher's manuals received by the school: _____

5.2. Number of SHAPE student books received by the school: ____ Gr.2, ____ Gr.3, ____ Gr.4 ____ Gr.6, ____ Gr.7, ____ Gr.8, ____ Gr.9,

	Very Good	Good	Average	Poor
5.3. Condition of teachers guides (check one):	____	____	____	____

	Very Good	Good	Average	Poor
5.4. Condition of student books (check one):	____	____	____	____

5.5. Please identify any SHAPE lessons that you feel are not suitable (appropriate) for the students. Identify the lesson and the grade level. (Use additional page if required.)

_____
_____

6. OTHER INFORMATION

6.1. Has the teaching of SHAPE in the school had any impact on the community in general? ____ Yes ____ No

6.2. If yes, please provide a specific example of what the impact has been.

_____

		Yes	No
6.3. Are there any **adults** in the local area that:	have HIV?	____	____
	have AIDS?	____	____
	use drugs?	____	____
6.4. Are there any **children** (<16) in the local area that:	have HIV?	____	____
	have AIDS?	____	____
	have STIs	____	____
	use drugs?	____	____
	smoking cigarettes?	____	____