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Swiss Agency for Development and Cooperation SDC

"Together We Can Grow Up Happy, Healthy and Safe (HHS)"

Pilot Phase Evaluation Report

June 2010

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ABBREVIATIONS AND ACRONYMS

ABC	Abstinence, Being faithful to one faithful sexual partner, Condom (consistent correct) usage
AIDS	Acquired Immune Deficiency Syndrome
AZ	Alliance for Community Action on HIV and AIDS in Zambia (Alliance Zambia)
CSE	Comprehensive sexuality education
CSO	Civil Society Organisation(s) / Community Support Organisation(s)
DHMT	District Health Management Team
DHS	Demographic and Health Survey
FHI	Family Health International
FLAS	Family Life Association of Swaziland
Happy	Young Happy Healthy and Safe
HBC	Home based care
HC	Health centre
HHS	Happy healthy and safe (an acronym for the "Together we can grow up happy healthy and safe" programme)
HIV	Human Immunodeficiency Virus
IEC	Information education communication
IHAA	International HIV/AIDS Alliance
IP	Implementing Partner
IPPF	International Planned Parenthood Federation
IPPFAR	International Planned Parenthood Federation Africa Region
MA	Member Associations (of IPPF)
M&E	Monitoring and Evaluation
MCH	Maternal and child health
MCP	Multiple concurrent sexual partners
MOE	Ministry of Education (Zambia)
MOET	Ministry of Education and Training (Swaziland)
MOH	Ministry of Health
MOU	Memorandum of Understanding
NAC	National HIV/AIDS/STI/TB Council (Zambia)
NCCU	National Children Coordination Unit (Swaziland)
NERCHA	National Emergency Response Council on HIV/AIDS (Swaziland)

NGO	Non Governmental Organisation
NSF	National HIV/AIDS Strategic Framework
NZP+	Network of Zambian People Living with HIV/AIDS
PLWHA	People/Person(s) living with HIV and AIDS
PPAZ	Planned Parenthood Association of Zambia
PMTCT	Prevention of Mother To Child Transmission
REMSHACC	Regional Multisectoral HIV and AIDS Coordination Committee (Swaziland)
RFSU	The Swedish Association for Sexuality Education
SADC	Southern Africa Development Community
SDC	Swiss Agency for Development and Cooperation
SNDP	Sixth National Development Plan (Zambia)
SRH	Sexual and reproductive health
SRH&R	Sexual and reproductive health and rights
STI	Sexual transmitted infections
SWANEPA	Swaziland Network of People Living with HIV/AIDS
TOT	Training of trainers
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USD	United States Dollar(s)
VCT	Voluntary Counselling and Testing
YAM	Youth Action Movement
YFS	Youth friendly service(s)
YHHS	Young, Happy, Healthy and Safe (Happy)
YMEP	Young Men as Equal Partners

1.0 EXECUTIVE SUMMARY

"Together we can grow up happy, healthy and safe" (HHS) programme is an SRH and HIV programme providing interventions that target young people aged 10 – 20 years, in Swaziland and Zambia. The programme was initiated by the International HIV/AIDS Alliance through *Alliance Zambia* - its Zambia Country Organisation. In Swaziland, HHS is implemented by the Family Life Association of Swaziland (FLAS) a member association (MA) of the International Planned Parenthood Federation (IPPF). Young, Happy, Healthy and Safe (abbreviated as YHHS or *Happy*), a Zambian Non Governmental Organisation, implements the programme in Chipata district of the Eastern Province of Zambia.

The overall goal of the programme is *to contribute to improving the sexual, reproductive and psychosocial health of young people aged 10–20 living in Zambia and Swaziland by December 2010.*
The programme has 3 main objectives:

1. To *increase the* number and quality of youth interventions implemented in Zambia and Swaziland which improve the sexual and reproductive health of young people aged 10-20 years.

2. To *strengthen the capacity* of community systems, CSO, health services and education institutions in Zambia and Swaziland to respond to SRH with young people.

3. To *document best practices,* processes and outcomes of the innovative programmes and disseminate lessons learned through the Alliance and IPPF.

In order to achieve the above goal and objectives, HHS programme in Swaziland and Zambia carries out a number of activities including providing/facilitating access to information, comprehensive SRH services, counselling, sexuality and life skills education, as well as access to treatment and psychosocial support. The HHS programme strategically places schools at the centre of its activities, while engaging various key community-based and government stakeholders that have influence on young people's SRH. These stakeholders include teachers, school committees, parents, health centres, community leaders (chiefs, village head persons and religious leaders) and civic leaders, among others. This model/approach forms the philosophy and name of the project: "*Together we can grow up happy, healthy and safe*". It encourages and helps young people to develop positive behaviours, attitudes, paradigms and practices that enable them to protect themselves, express their sexuality safely and enjoy happy, safe and healthy lives.

The *Swiss Agency for Development and Cooperation (SDC)* has been supporting the HHS programme since March 2009. The programme has been implemented as a pilot project during the period of March 2009 to August 2010, with a view to scale-up during the next phase.

An external evaluation was conducted in June 2010, to inform development and scale-up of the next phase of the programme. Preceded by document review, this evaluation used participatory appraisal approaches, involving interviews/consultations with beneficiaries, stakeholders, volunteers, staff and management of implementing organisations and Alliance Zambia, as well as participating CSOs and community groups in Swaziland and Zambia. Relevant donor, NGO and government agencies at various levels were also interviewed.

The report has 3 main sections.

1. The **Introduction** provides background, context and rationale of the HHS programme. It also introduces and describes the process of the evaluation.

2. **Findings of the Evaluation** documents, analyses and comments on the progress of the programme informed by findings from field interviews and document review.

   Several "teething" problems were encountered at the beginning of the programme. These challenges included late receipt of grant disbursement, and delayed activity implementation while time was still being invested on relationship building between implementing partners and governmental stakeholders. Nevertheless, in terms of outputs and results during the period under review, the programme recorded substantial achievements including the following:

   - The programme *achieved or exceeded targets for 10 out of the 19 indicators* of the programme's 3 objectives, during the period under review. This translates that HHS programme achieved or exceeded target in *53%* of the its main targets

   - At country/IP level, *Happy* in Chipata, Zambia achieved *12 targets (63%)* out of the 19; while *FLAS* in Swaziland achieved *8 targets (42%).*
   - Achieved a total of *28,950 young people in supported communities attending sexuality and life skills sessions. This is almost 150% r*each of the 20,000 target.
   - A total of *13 schools and school communities* served by the programme in Swaziland and Zambia. In addition*, 4 rural health centres and their surrounding communities* served by the project in Chipata, Zambia. The 13 schools and 4 health centres have had their capacity to respond to SRH issues with young people improved through support from the HHS programme.
   - *9 effective capacity building events (training) for community systems, organisational and institutional development* were conducted, out of a target of 6 such events
   - *Government and community leadership support to the programme*. The HHS programme enjoys government support and collaboration at national, provincial/regional and local levels in Swaziland. In Chipata, Zambia, the programme has a lot of such support and collaboration at district and community levels.
   - A number of outcomes have already started to show. As a result of insights from the programme, some traditional leaders in Chipata district and Hhohho region in Zambia and Swaziland respectively are facilitating positive change in their communities, by banning harmful traditional practices that promote structural drivers of sexual reproductive ill-health and HIV infections.

   The programme fell short of targets in a number of areas – overall 47% of its output indicators for its 3 objectives noted above were not achieved. Significant among these are

   - *Young people in project areas using the health facilities*. Poor reach and record system were noted in this area - very much reflective of the programme's monitoring and evaluation system (by FLAS and Happy) which is still under-developed. The evaluation could not therefore quantitatively or qualitatively measure the level of achievement in this area. In Swaziland, the programme had not yet started working with health centres/facilities. In Zambia, data collection tools and data management systems had not been fully developed and neither had they been shared with health centres. Further the evaluation deduced that much of the shortfall in this area has been due to inadequate usage of the programme's M&E Logical Framework Matrix as a planning and management tool.
   - *Lessons learned case studies documented through video for wider dissemination*. No real achievement in this area was noted. The lack of achievement is largely due to the fact that the pilot phase was rather too short to facilitate real lessons learning, documentation and sharing. The time was barely enough to get the programme established on the ground. To the less extent however, the lack of achievement is

attributed to the programme's not having developed a plan or strategy for documenting and sharing best practices.

- *Stakeholder meetings held with a positive outcome (learning and/or action*).
- *Youth and adult advocates for SRHR trained and active.* On average the programme attained 30% achievement in this area. This is a very dynamic target. The programme does not, and will not, have guarantee that young people and adults it trained as SRH advocates will remain in the respective communities or catchment areas of the programme.

The evaluation further asserted that the programme was still at its nascent stage, and did not yet have in place mechanisms to facilitate strengthened learning and sharing, sustainability and Regionality. It was also noted that the programme still needs to strengthen its gender focus, as interventions were still largely gender neutral.

The paramount aspect noted from the findings was that although the project was still in its nascent stage and did not meet some of its output and result indicators, evidence on the ground is that much positive change and value have already started to surface. The evaluation met a number of girls and boys "whose lives have been rehabilitated" as a result of the information and training from the programme.

3. **Recommendations** section distils salient findings and makes recommendations for consideration aimed at improving the programme's performance during the next phase. Key among these include:
   - Age group for the programme target to be expanded to the range of 7 – 24 years in order to include the "window of hope" age group (7 – 14 years) and the most vulnerable group of 18 – 24 years.
   - Improving the programme design and planning at joint-country (or later, regional level) to ensure that country and site-specifics are well catered for and provide for challenges noted in (2) above, and in line with the programme's M&E Framework matrix
   - The programme becomes increasingly gender sensitive and responsive. It should include interventions that address particular vulnerabilities of girls as well as of boys.
   - The programme puts in place innovative interventions with relevant government agencies to increase access of young people to SRH services; for example outreach/mobile VCT and STI screening and treatment services, resources permitting
   - Improvement of the monitoring, evaluation and reporting system to enhance performance based programme management.

The report also includes a conclusion and appendices.

The evaluation noted that the HHS programme is a very strategic programme that has been well managed and supported in participatory and accountable manner. It deserves increased support both in form of funding and technical support.

2.0 INTRODUCTION

The *Swiss Agency for Development and Cooperation (SDC)* has been supporting **"Together we can grow up happy, healthy and safe" (HHS)** programme since March 2009. **HHS** is an SRH and HIV programme providing interventions that target young people aged 10 – 20 years, in Swaziland and Zambia. The programme was initiated by the International HIV/AIDS Alliance through its Zambia Country Office now called *Alliance for Community Action on HIV and AIDS in Zambia* – abbreviated as *Alliance Zambia.* In Swaziland, the programme is implemented by the Family Life Association of Swaziland (FLAS) a member association (MA) of the International Planned Parenthood Federation (IPPF). Young, Happy, Healthy and Safe (YHHS or *Happy* in short), a Zambian Non Governmental Organisation, implements the programme in Zambia, specifically in Chipata district, Eastern Province.

HHS programme seeks to link SRH with HIV and AIDS interventions, bridging and addressing a disconnect that has been inadequately addressed over the more than 2 decades of the HIV and AIDS pandemic.

In response to a project proposal[1] by the International HIV/AIDS Alliance, the *SDC* provided funding through Alliance Zambia, to support HHS programme during its pilot phase - March 2009 to end of August 2010. A funding budget of USD313 719 was approved and allocated for this purpose, of which USD184 638 was for granting to FLAS and YHHS as direct implementation funding support. The support agreement provided for an evaluation of the programme before the end of the pilot phase, so as to guide the scaling up, focus and approaches of the programme in the subsequent phase. An evaluation of the programme was therefore conducted in June 2010. This report documents findings and recommendations of the said evaluation.

2.1 Background and Rationale of the HHS Programme[2]

2.1.1 Background

Link between SRH and HIV: The link between SRH and HIV/AIDS in the Southern Africa region is very strong and direct. In the region, over 75% of HIV infections are transmitted sexually. HIV transmission through mother to child (during pregnancy, at birth and through breast-feeding) account for more than 20% of the infections. STIs are known to facilitate routes for HIV infections. Additionally, sexual and reproductive ill-health and HIV/AIDS have common root-causes and factors such as unprotected sexual intercourse/low condom usage, multiple concurrent sexual partnerships (MCP), poverty and income inequality, social marginalisation and social dynamics, gender-based inequalities and vulnerabilities, among other factors.

HIV/AIDS is a global crisis, and constitutes one of the most formidable challenges to development and social progress. Countries in Southern Africa have the highest prevalence of HIV infection in the world. At the end of 2007, about 14 million adults and children in the SADC region were living with HIV, amounting to 51% of all PLWHA in Africa. In Southern African countries, the more than 75% of HIV infections noted above, is through heterosexual intercourse. Most of these infections are

[1] "Together we can grow up happy, healthy and safe" (HHS). A youth programme in Zambia and Swaziland. A proposal submitted to the Swiss Government by the International HIV/AIDS Alliance. Version: 03 November 2008.

[2] Based mainly on information from Terms of Reference (TORs) for Evaluation of "Together We Can Grow up Happy, Healthy and Safe" programme. Swiss Agency for Development and Cooperation, April 2010.

among young people (aged between 15 and 29 years). More than two decades into the pandemic, the majority of young people still have limited understanding about HIV (how it is transmitted and how to protect themselves).

A SADC think tank meeting held in Maseru, in 2006, identified multiple concurrent sexual partnerships by men and women, low levels of male circumcision, low levels of and inconsistent condom use, intergenerational sex between older men and younger women as the key drivers of the HIV/AIDS epidemic in Southern Africa.

It is therefore important to take cognisance of the link between SRH and HIV/AIDS; and even more so, to design and implement interventions that address both issues.

SRH and HIV/AIDS Situation in the Programme Countries: Swaziland and Zambia are among countries that have the heaviest burden of HIV and AIDS. According to latest surveys[3], HIV prevalence among people aged between 15 and 49 years is estimated to be 14.3% and 25.9% for Zambia and Swaziland respectively. In terms of HIV prevalence, Swaziland has the highest rate in the world! In both countries women and girls are more vulnerable than are males. In Zambia, out of the total 14.3%, prevalence rate among females (aged between 15 and 49 years) is 16.1% compared to 12.3% for males. The situation is similar in Swaziland where rates are 31% for females and 20% for males. Due to social and economic factors, young women aged 15-24 years are particularly more vulnerable to becoming infected with HIV than are their male counterparts in the same age group. They face risks of early and unprotected sex, resulting in un-planned (and in many cases unwanted) pregnancies, STIs, HIV and the effects of abuse. Gender inequality is evident in gender-based violence. Zambia has witnessed a recent increase in levels of child defilement, particularly of girl children. Likewise, women and girls are highly marginalised in Swaziland. The status of women was only recently legally amended from that of minors in Swaziland's national constitution (2006) and, in practice women remain marginalized in domestic and social relationships. Gender perspectives should therefore be given increased focus in addressing SRH-HIV/AIDS issues in both countries.

Although a lot of work has been done in and by both countries to respond to the situation, a number of gaps, in as far as SRH and HIV/AIDS interventions for young people are concerned, still exist. These gaps include:

- *Barriers disabling young people* from accessing information, life skills and services they need to protect themselves from HIV/AIDS and to avoid sexual and reproductive ill-health. Taboos and certain traditional socialisation practices promote some harmful norms related to gender and sexuality.

- *Inadequate access to SRH services, especially in rural areas*, due to logistical, financial, and social barriers including lack of confidentiality/privacy, distance to service centres, peer pressure, stigma, gender and social norms. MCH clinics are the only facilities serving women, while men rely on private STI clinics and services provided by traditional healers.

- *Limited comprehensive knowledge about HIV/AIDS and SRH*. Although awareness is high (above 97% in both countries), comprehensive knowledge is as low as 53%; and translation of such knowledge into positive action is even more limited.

[3] Republic of Zambia, Central Statistical Office: 2007 DHS; Zambia National HIV/AIDS/STI/TB Council: *Zambia HIV Prevention Response and Modes of Transmission Analysis,* June 2009. The Kingdom of Swaziland: T*he National Multisectorial Strategic Framework for HIV and AIDS, 2009-2014.* Central Statistical Office of Swaziland: 2007 DHS.

- *Limitations in the existing health systems and legal frameworks* thus presenting barriers to SRH of young people. In both countries health care services are already over-burdened with the HIV/AIDS epidemic. The facilities face challenges in providing comprehensive services; and in many cases fail to deal with the complexity of RSH issues of young people. These facilities usually do not have youth-focused service providers for prevention, treatment and care services.

- *Limited number and quality of youth initiated and led interventions for SRH-HIV/AIDS*. In many cases youth programmes in both countries are designed and implemented by adults

- *Inadequate legislation and law enforcement to protect girls and women from vulnerabilities and gender-based inequalities and violations.*

2.1.2 Rationale of the programme

In response to the situation and gaps noted in 2.1.1 above, Alliance Zambia supported by their international secretariat - the International HIV/AIDS Alliance, initiated a comprehensive SRH-HIV programme that seeks to address the common root-causes of SRH-HIV problems; hence providing a meaningful entry point for young people and communities to intervene. The programme uses an integrated approach for comprehensive SRH programming, addressing the need to create environments where young people are able to protect themselves, enjoy happy and healthy relationships, and express their sexuality safely. It is based on the premise that actively engaging young people in situational assessment, project design, implementation and evaluation ensures that activities are relevant to their needs, with continuous feedback on progress for continuous improvement. It further recognises that if adequately supported, young people will lead local activities, participate in local, national and regional advocacy as well as lessons learning and sharing.[4]

Two organisations, FLAS and Happy (or YHHS) with good track record of SRH programming, were selected as implementing partners in Swaziland and Zambia respectively. As a member association (MA) of the IPPF, FLAS has been providing family planning, SRH and YFS services in Swaziland since 1979. In Chipata, Zambia, Happy was founded on the backbone of SRH-HIV programming, as its core service delivery area. Happy has been proving comprehensive SRH services and related documentation in Chipata since its inception in 2005. In fact the formation or establishment of Happy was motivated by the need to continue SRH work of a PPAZ project in Chipata that was winding-up at that time. PPAZ is an MA of IPPF in Zambia. The HHS programme builds on existing programmes by 'Young, Happy, Healthy and Safe' (Happy) in Zambia and Family Life Association of Swaziland (FLAS). The approach includes providing/facilitating access to information, comprehensive SRH services, counselling, sexuality and life skills education, as well as access to treatment and psychosocial support.

The **overall goal** of the programme is *to contribute to improving the sexual, reproductive and psychosocial health of young people aged 10–20 living in Zambia and Swaziland by December 2010.*

The programme has 3 main **objectives**:

[4] "Together we can grow up happy, healthy and safe" (HHS). A youth programme in Zambia and Swaziland. A proposal submitted to the Swiss Government by the International HIV/AIDS Alliance. Version: 03 November 2008.

4. To *increase the* number and quality of youth interventions implemented in Zambia and Swaziland which improve the sexual and reproductive health of young people aged 10-20 years.

5. To *strengthen the capacity* of community systems, CSO, health services and education institutions in Zambia and Swaziland to respond to SRH with young people.

6. To *document best practices,* processes and outcomes of the innovative programmes and disseminate lessons learned through the Alliance and IPPF.

The programme set itself deliverables for each of the above objectives. These deliverables are at 3 levels: (a) Community level (b) Country level and (3) Joint country level.

HHS programme's conceptual framework is guided by a change hypothesis, which links interventions to desired effects on behaviour and ultimately desired contribution to impact.

Table 1: The Change Hypothesis relating to Objective 1[5]

INTERVENTION →	EFFECT ON BEHAVIOUR →	IMPACT
Mobilise Communities	Increased participation of young people and other relevant stakeholders in design and implementation	Trust and supportive working between groups and networks of young and adult males is built
	Young people and adults are able to talk about sexuality, gender and culture in helpful ways	Young people are empowered to make healthy decisions and influence their environment through group activities and advocacy
	Young people and key stakeholders collectively take action to address the causes of young people's vulnerability at behavioural, social normative and structural levels	There is more respect and communication between young people and adults
		Harmful cultural practices are reduced; gender equality is increased and young people's rights are respected
Participatory Learning Activities	Young people and adults increase their knowledge, self esteem, positive attitudes, skills and social capital	Young people enabled to adopt protective behaviour and reduce risks to their SRH
		Adults enabled to support young people in SRH as they grow up

[5] "Together we can grow up happy, healthy and safe" (HHS). A youth programme in Zambia and Swaziland. A proposal submitted to the Swiss Government by the International HIV/AIDS Alliance. Version: 03 November 2008.

		Young people and adults enabled to take collective action to strengthen norms and practices which support SRH and change those that hinder it
		Young people adopt protective behaviour and reduce risk to their SRH
Provide accessible comprehensive SRH services for young people	Young people have the knowledge and skills to make informed choices and the means to adopt safer sexual behaviour. They know their HIV status and have access to products to prevent re-infection, infection of others and MTCT and treatment	Young people who know they have HIV take steps to avoid re-infection and infecting others and to keep healthy Young people take steps to avoid MTCT
		STI incidence decreases together with risk of HIV
	STIs are treated promptly and correctly	
		There is a reduction in unwanted pregnancy
	Able to avoid pregnancy	

Of the above 3 objectives, objective 1 (To *increase the number and quality of youth interventions implemented in Zambia and Swaziland which improve the sexual and reproductive health of young people aged 10-20 years*) speaks directly to achievement of the overall goal. It directly contributes to desired change at beneficiary/community level. Objectives 2 and 3 facilitate the first objective. Accordingly, the above tabulation illustrates the change hypothesis behind interventions of community mobilisation, participatory learning activities and provision of accessible comprehensive SRH-HIV services for young people, under Objective 1. Interventions under objective 2 seek to enable the change to happen; while objective 3 is meant to encourage stronger and more effective models in both programmes (Swaziland and Zambia).

2.2 The Evaluation

During the period of March 2009 to August 2010, HHS has been implemented as a pilot project, with a view to scale-up (i.e. increasing coverage in terms of people, institutions, communities and possibly countries) during the next phase. An external evaluation was therefore required to facilitate thorough understanding of what the programme has achieved, its strengths, weaknesses, the possible value add to the work of HIV/AIDS Alliance on HIV prevention as well as to the desired regional HIV programme. In addition, it was expected that the evaluation suggested how the programme could be further developed in the possibility of a future cooperation.

In fulfilment of the above requirement, this evaluation was conducted in June 2010 by a team of 3 external consultants. The consultants visited programme sites and consulted with stakeholders in Zambia and Swaziland. Ignatius Kayawe was the lead-consultant responsible for the overall evaluation and prepared this report. Patricia M M Ndhlovu was assistant consultant with special focus and responsibility for gender aspects of the evaluation in Zambia, while Sizakele T Hlatshwayo was similarly the assistant consultant in Swaziland.

2.2.1 Focus of the Evaluation

The main focus of the evaluation was *assessment of the overall results of the programme (in terms of outputs and outcomes), comparing original plans with actual implementation* taking into consideration the time span of the project.

The following issues were to be addressed by the evaluation, answering a number of questions to these issues:

- *Relevance:* To evaluate the relevance of the chosen project approach and methodology in achieving the intended objectives including the choice of partners.

- *Effectiveness:* To review strategies and ascertain extent to which the programme has addressed the structural drivers of sexual and reproductive ill-health and HIV/AIDS the epidemic among youth to reduce youth vulnerability to HIV infection, among other aspects. To review the strategies adopted to address the key drivers of SRH problems and HIV/AIDS.

- *Efficiency:* To what degree can the cost of inputs (expenditure) be justified by results achieved (outputs and outcomes)? Were there any alternatives that would have achieved the same results at lower cost? Or, could higher level of achievement be expected at the same cost?

- *Sustainability:* To what extent has the programme succeeded in soliciting additional funding? What are sustainability factors of the programme? Etc

- *Policy dialogue and Regionality:* What is the potential of the programme to influence national level policies/strategies for youth HIV prevention? What partnerships have been established with which governments and what are the results? What initiatives and potential exist for making the programme truly regional?

- *Gender:* To assess the extent to which gender has been factored and mainstreamed into the project. Do the project design and implementation have gender sensitive/responsive objectives, results, outcomes and indicators?

- *Model of best practice:* What is the potential of this strategy to develop and inform a youth focussed model on SRH/HIV prevention?

- *Monitoring:* To review monitoring and evaluation systems the project has in place; assessing their relevance, adequacy and extent of application.

- Knowledge management: To note how the project takes stock of best practices in order to facilitate AIDS Alliance, YHHS, FLAS and others to improve knowledge management, level of

understanding and ensure a result based approach within regional partnership. What is the potential of this strategy to develop and inform a youth focussed model on SRH/HIV?

2.2.2 Approach/process of the Evaluation

A participatory appraisal approach, involving beneficiaries, stakeholders, volunteers, staff and management of implementing organisations - Happy and FLAS – Alliance Zambia, as well as participating CSOs and groups, was used. Relevant donor and government agencies at various levels were interviewed. In order to facilitate this approach and process, an evaluation instrument (an evaluation framework with interview guiding questions) was jointly developed and shared with SDC, Alliance Zambia, FLAS and Happy prior to field work. The evaluation instrument catered for the need to collect data relating to relevance, effectiveness, efficiency, sustainability, being-in-line, policy aspects, gender, Regionality, model of best practice, knowledge management and monitoring as stipulated in the terms of reference. The evaluation instrument catered for input from (1) youth interventions and youths (2) CSOs (3) education institutions (4) health services (5) donor agencies (6) government agencies (7) community systems (8) SDC (9) Alliance Zambia and (10) FLAS and Happy. Feedback relating to gender issues still remained cross-cutting. See appendix 2.

The approach included: (1) Document *Review* carried out at the onset of the evaluation exercise *(2) Briefing Meetings* with SDC, IHAA, Alliance Zambia (AZ), Happy and FLAS prior to commencement of field work (3) *Individual consultations/Interviews* with beneficiaries and other stakeholders in both countries (4) *Focused Group Discussions* with youth beneficiaries and adult collaborators (5) Actual physical observation of programme activities and (6) *Debriefing Meetings* with Happy, FLAS and AZ upon completion of field work.

2.2.3 Strengths, Constraints and Challenges of the Evaluation

The participatory approach was the major **strength** of the evaluation. All the 3 partners, informed by their respective stakeholders, including target beneficiaries, had input in the planning and actual assessments of the programme. The approach encouraged transparency and objectivity. The combination of approaches such as group discussions and individual interviews during field work provided for on-the-spot verifications of perspectives, while ensuring that sensitive issues such as sexual, gender related, and even relational/partnership aspects could still be safely discussed and compared to documented and group discussed perspectives, hence ensuring further verification.

Constraints and challenges mainly related to limited time for field interviews in both countries. In Zambia, challenges also did exist in terms of appointments with stakeholders at MOE and MOH headquarters – evidencing limitations to the extent to which the project had so far built relationship with stakeholders at these higher levels. This was positively different in Swaziland. Due to the fact that programme's M&E system was still in its nascent stage as indicated in the findings below, the evaluation did have challenges relating to capturing reliable data upon which to base concrete assessments and deductions. However, rigorous scrutiny of available data and information (primary, secondary and anecdotal) was made by the evaluation. The evaluation is therefore very confident about the assessments and recommendations arrived at.

3.0 FINDINGS OF THE EVALUATION

3.1 Programme Design, Planning and Implementation

3.1.1 Programme Design

As already noted in section 2.0 above, the programme was initiated by the International HIV/AIDS Alliance (IHAA) through *Alliance Zambia.* The IHAA, based in Brighton, prepared the project proposal, and shared it with AZ, FLAS and Happy. The relevance and appropriateness of the AZ and the 2 implementing partners – FLAS and Happy – have already been noted in section 2.1.2 above. In itself, the project proposal was a comprehensive design of the programme, which was well in touch with the realities on the ground for each of the 2 countries. Nevertheless, the project proposal still indicated that programme site-specific details and requirements were to be determined by the local implementing partners, in collaboration with AZ. This is understood by the evaluation, as implying the need for programme design by each country programme.

Programme sites: In Zambia, a total of 9 sites (5 schools and 4 rural health centres) in Chipata district, the provincial headquarters of the country's Eastern province, were selected for the programme. The selection was based on a criteria developed and agreed upon with district health and education authorities.

Figure 1: Map of Zambia showing provinces

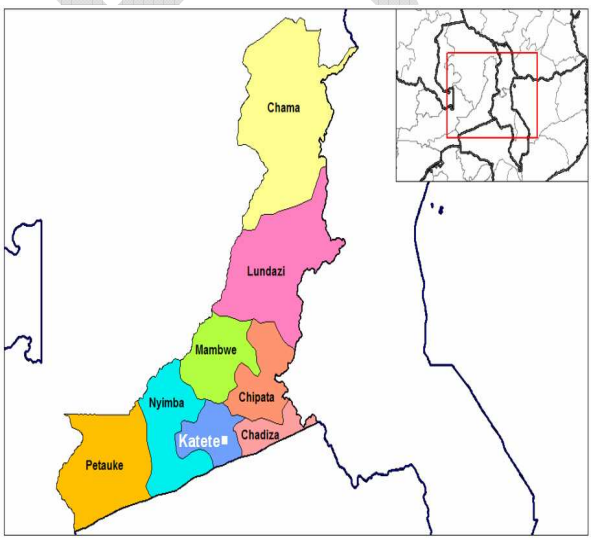

Figure 2: Eastern province, showing location of Chipata and other districts

The evaluation noted that the decision to choose Chipata district and not to spread the programme across the country or even across Eastern province was objective and appropriate, considering the geographic areas and populations to be covered as well as resources available for the programme through Happy. Zambia spreads across a total surface area of 752,612 square kilometres, with population estimated at 12, 525,791 for mid 2008. Eastern province spreads across 69,106 square kilometres with 2008 mid-year population estimated at 1,684,910[6]. Due to several major reasons including limited resources such as human capital and transport, as well as the need to learn lessons prior to scaling up, it would not have been practical for the programme/Happy to cover all the 8

[6] Central Statistical Office – Census of Population and Housing in Zambia, 2000; Central Statistical Office – *The Monthly*, Volume 67, October 2008.

districts of Eastern province during the pilot phase under review. It was therefore decided that the programme be operated in the 9 sites (5 school sites and 4 rural health centres) of Chipata district only.

In Swaziland representatives of national authorities such as MOET and NERCHA, advised that the project be implemented in all the 4 regions (Hhohho, Manzini, Lubombo and Shiselweni) of the country. Swaziland is relatively smaller in both geographic area (17,364 square kilometres) and population (1,018,449)[7] than Eastern province of Zambia; therefore spreading the programme across all the 4 regions of Swaziland was practical and feasible. The critical aspect was which sites in the regions were to be selected. The selection criteria agreed upon with the authorities included level of need, vulnerability, and value addition in terms of selected sites being able to facilitate learning, sharing and possible cascading to other sites. Eight (8) sites, all being schools were selected in the 4 regions of Swaziland. In each region, 2 schools were selected. In all, 5 schools out of the total 8 are located in the rural areas where service delivery has been very limited (directly responding to one of the key gaps noted in 2.1.1 above).

Figure 1: Map of Swaziland showing the 4 regions and main towns

The September 2009 FLAS quarterly report indicates that, "...The selection of the sites was undertaken in collaboration with the Ministry of Education and Training in Swaziland, the Guidance Department. The Regional Guidance Officers were consulted and using the Ministry's criteria, the schools were selected. School Characteristics: Four of the selected schools are high schools and four are primary schools. Out of the total, four are Mission schools whilst the other four are Government schools. By Geographical location, five schools are located in a rural area, whilst two are in an urban area and one being in a semi-urban community." Similarly, in Chipata, Zambia, the MOH, through

[7] 2007 Population and Housing Census, Swaziland

the District Health Management Teams (DHMT) and the MOE through the DEBS office guided Happy in selecting sites for the programme.

The tabulation below shows the sites in which the programme has been implemented during the period under review:

Table 2: Programme Sites

No.	Site Name	Type/Sector	Region/District
Swaziland			
1	Nyamane High School	School/Education	Shiselweni
2	Nhlangano Primary schools	School/Education	Shiselweni
3	Mliba Nazarene Primary School	School/Education	Manzini
4	Manzini Nazarene High schools	School/Education	Manzini
5	Malandzela Primary School	School/Education	Hhohho
6	Mater Dolorosa High School	School/Education	Hhohho
7	Lubuli High School	School/Education	Lubombo
8	Lubuli Primary School	School/Education	Lubombo
Zambia			
1	Vizenge Rural HC	Rural HC/Health centre	Eastern Prov/Chipata
2	Chiparamba Rural HC	Rural HC/Health centre	Eastern Prov/Chipata
3	Mnukwa Rural HC	Rural HC/Health centre	Eastern Prov/Chipata
4	Madzimoyo Rural HC	Rural HC/Health centre	Eastern Prov/Chipata
5	Chipangali Basic School	School/Education	Eastern Prov/Chipata
6	Chankhanga High School	School/Education	Eastern Prov/Chipata
7	Kasenga Basic school	School/Education	Eastern Prov/Chipata
8	Hillside Basic school	Urban School/Education	Eastern Prov/Chipata
9	Chipramba High School	School/Education	Eastern Prov/Chipata

Note: The evaluation team visited 7 out of the total 17 programme sites. Vizenge RHC, Mnukwa RHC, Chankhanga Basic School and Hillside Basic School were visited in Zambia; while in Swaziland the team visited Manzini Nazarene High School, Malandzela Primary School and Lubuli High School.

Comments on programme design and site selection

(a) Programme design: The evaluation noted that start-up meetings (AZ, FLAS and Happy joint-country level meetings, as well as country-level meetings between each implementing partner and AZ) were held in which substantial issues of the programme were explored. *However, the evaluation deduced that there was insufficient un-packing and localisation of the project proposal. The evaluation further noted that issues relating to programme coordination and management were the main focus of these start-up meetings by the tri-partite partners (AZ, FLAS and Happy). This is evidenced by the lack of programme design document for either country programme. The inadequate focus on localisation of the programme design prior to project start-up resulted in certain aspects (few though they may be) such as common understanding among implementing partners of what is meant by community systems, measurement criteria and approaches, not being fully grasped, owned and shared. This gap also translated into limitation or inadequacy in the programme management, i.e. lack of country specific document to be used as tool for managing the programme. Point (b) below illustrates an example of result of this gap.*

(b) Site selection: *Selection of sites in Swaziland did not include any health facilities/centres. The evaluation established from FLAS that omission of health facilities as programme sites did weaken the programme's potential to achieve the intended results.* Similar reflection was also given by AZ. Section 3.3.1 below of this report makes related comments on this issue. It is noteworthy to highlight that if a country specific programme design document was developed and shared prior to project start-up, AZ as the partner responsible for overall management and coordination of the programme would have been in position to identity this gap and could have pro-actively facilitated support for corrective action. Other issues include:

- *Predominance of rural sites in the case of Chipata,* Zambia. Only Hillside Basic School is an 'urban' based (within town) centre. The need to have positive bias in favour of rural areas is well appreciated, but it is also important to consider a proportional balance between rural and urban areas, as seems to be the case for Swaziland.

- The *apparent predominance of one denomination for the selected mission* schools in Swaziland. Out of the 4 mission schools selected as programme sites, 3 are from one denomination.

- Notwithstanding the fact that gender aspects are cross-cutting, from gender perspective, *the design is rather gender-neutral in both countries.* There is need for gender-specific interventions aimed at addressing the gender-related imbalances, vulnerabilities and perspectives articulated in the situational analysis. The evaluation noted that the M&E log-frames especially indicators are equally gender neutral.

Overall, the evaluation noted a number of very positive aspects in the design of the programme, both in Swaziland and Zambia. These include strong involvement of relevant government and traditional authorities, consultation with and involvement of young people (boys and girls), adults (women and men), religious leadership, etc from the selected sites. The design has a strong conceptual framework, aimed at validating the approaches, in addressing the felt needs, based on concrete evidence.

3.1.2 Programme Planning, Implementation and reporting

The evaluation established that the HHS programme, in line with the project proposal, held regular planning meetings - coordinated and facilitated by AZ. A start-up planning meeting of the 3 partners was held in March 2009 prior to commencement of programme implementation. During this start-up planning meeting, country programme specific M&E frameworks and work plans were developed, shared and harmonised among AZ, Happy and FLAS.

During implementation, efforts were made to adhere to quarterly work plans. Quarterly and semi-annual reports were produced and submitted to AZ by FLAS and Happy. In turn, AZ collated and submitted reports to SDC and IHAA. The IHAA monitoring and reporting systems (MRS) provided guidance to the work. From review of programme quarterly reports evidence of high adherence to and achievement of plans/planned activities was exhibited by both FLAS and Happy throughout the period under review.

All partners (SDC, AZ, Happy and FLAS) interviewed by this evaluation expressed satisfaction with the way programme planning, implementation and reporting have been handled during the pilot phase of the project under review. The resource provider (SDC), the technical support provider (AZ/IHAA)

and implementers (FLAS and Happy) felt that the reporting met information needs of the intended audiences. The evaluation acknowledges the excellent quality of the reports especially by AZ.

Nevertheless, communication challenges in terms of slow (or at times no) response on the part of AZ were expressed by the other partners.

The lack of country specific programme design document, inadequate planning beyond activity focus, not adequately using the Monitoring and Evaluation Logical Framework Matrix (provided in the proposal) as a tool for programme planning, implementation, monitoring and reporting by Happy and FLAS were among the major weaknesses in the HHS programme management during the pilot phase under review.

In other words, the planning, monitoring and reporting did not sufficiently ensure programme adequacy nor did it have "the finger on the pulse" to gauge progress against plan during implementation of the pilot phase.

The evaluation noted several areas of inadequacies, in which the planning, implementation and reporting need improvement:

(a) *The Planning (for overall pilot phase, annual and quarterly work plans) by both FLAS and Happy did not adequately reflect the "Monitoring and Evaluation Logical Framework Matrix* of the programme as stipulated in the project proposal. The evaluation asserts that much of the planning at start-up and quarterly, monthly, etc, was activity-focused, with little bearing on objectives/targets in terms of outputs, results and outcomes. In some cases during this evaluation, partners (AZ, Happy and FLAS) exhibited lack of certainty on what components of the joint country targets were allocated to FLAS or Happy. Issues of inadequacy of planning and lack of country specific programme document apply. Both of these issues are attributable to the adequacy and focus of start-up process and planning meeting. Further, it is reasonable to deduce that the programme's low level of target achievement (see section 3.2 below) partly to the inadequate planning. The *Monitoring and Evaluation Logical Framework Matrix* provided in the proposal was not adequately used as a tool for programme planning, implementation, monitoring and reporting. This factor, coupled with the lack of country programme design document, implied that the programme's mechanism for ensuring effective management was disabled.

(b) As was the case for planning*, the quarterly and semi annual reporting has not been in line with the Monitoring and Evaluation Logical Framework Matrix.* While the MRS was followed, the programme reporting mainly reported on activities but provided insufficient pertinent data and information necessary to give an indication of the programme's progress status, i.e. comparing actual against planned not only for activities but also outputs and where possible results. In other words, the monitoring and reporting did not adequately have *the finger on the pulse* in as far as gauging progress against plan. Except for financial reporting, none of the narrative reports made attempts to assess and analyse actual performance against planned. This could have been accommodated within the IHAA reporting template.

3.2 Progress on Outputs against Targets

The programme had 19 main indicators, hence 19 main targets in all for its 3 objectives for the pilot phase. Table 3 below reflects progress towards targets for the period under review.

Table 3: HHS Progress against Targets for the Period 1 March 2009 – 31 May 2010

Intervention	Objectively Verifiable Indicators	Targets Vs Actual					
		Total		Swaziland (FLAS)		Zambia (Happy)	
		Target	Actual	Target	Actual	Target	Actual
Goal: Contribute to improving the sexual, reproductive and psychosocial health of young people aged 10 – 20 years living in Zambia and Swaziland by December 2010							
Expected Results: • Increased use of health services in project area by young people by the end of the project • Improved confidence and capacity of young people aged 10 – 20 years in supported communities to practice safer sex by the end of the project	• # of young people in project areas using the health facilities	16,000	6'200	8,000	676	8,000	???
	• # of young people in supported communities attending sexuality and life skills sessions	20,000	**28,950**	10,000	**10,823**	10,000	**18,127** (M=9,434 & F=8,693)
	• Perceived improvement in the capacity of young people to practice safer sex	Qualitative	Qualitative feedback indicate that this has been achieved	Qualitative	Qualitative feedback indicate that this has been achieved	Qualitative	Qualitative feedback indicate that this has been achieved
Objective 1: *To increase the number and quality of youth interventions* implemented in Zambia and Swaziland which improve the sexual and reproductive health of young people aged 10 – 20 years	• # of schools implementing high quality SRH activities for young people	9	**13**	4	8	5	5
	• # of schools organising community SRH events	9	13	4	8	5	5
	• # of quality outreach activities implemented	2,500	1,842	1,250	184	1,250	1,658
	• # of SRH interventions accessible to young people	6	**6**	6	5	6	6
	• # of stakeholder meetings held with a positive outcome (learning and/or action)	150	66	75	42	75	24
	• # of different stakeholders per community actively involved in SRH for young people	7	**8**	7	7	7	8
	• # of youth	100	32	0	0	50	32

	advocates for SRHR trained and active						
	• # of active adult advocates for SRHR trained and active	100	28	0	0	50	28
Objective 2: *To strengthen the capacity* of community systems, CSO, health services and education institutions in Zambia and Swaziland to respond to SRH with young people	• # of effective technical support visits on youth sexual and reproductive health provided to the partner civil society organisations in Zambia and Swaziland	6	**15**	3	3	3	12 (2 by AZ and 10 by Happy)
	• # of effective capacity building events (training) for community systems, organisational and institutional development	6	**9**	3	3	6	6
	• # of networks of Multisectoral organisations created and active	10	**15**	5	7	10	8
	• # of CBOs effectively supported to respond to SRH with young people	18	6	9	0	9	6
	• # of health services effectively supported to respond to SRH with young people	9	9	0	0	9	9
Objective 3: *To document best practices, procedures and outcomes* of the innovative programmes and disseminate lessons learned through Alliance and IPPF	• # of strengthened models of sexual and reproductive health programming for young people developed and disseminated	1	1	1	1	1	1
	• # of young people trained in documentation and lesson sharing, including participatory video, via 3 training sessions – community-based, national and international	20	17	10	5	10	12
	• # of learning and	12	9	6	4	6	5

	knowledge sharing events, including (# for cross country learning/sharing events: - Introductory /experience sharing / work plan developme nt workshop - # in-the-field sharing experience - Lesson-learning review)	(4 1 4 1)	2 4 2	1 4 1	1 2 1	1 1 2 1	1 1 2 1
	• # of national sharing events with SRH/HIV stakeholders (CS and Govt) in Zambia and Swaziland	6	5	3	0	3	5
	• Adaptation and /or combination of existing IHAA SRH/HIV learning materials/guides/t oolkits/films/radio	Qualitative	Qualitative feedback indicate that this has been achieved	Qualitative	Qualitative feedback indicate that this has been achieved	Qualitative	Qualitative feedback indicate that this has been achieved
	• # of lessons learned case studies documented through video for wider dissemination (with accompanying articles and photos)	6	0	3	0	3	0

Highlights:

1. At joint country level, the programme achieved or exceeded targets for 10 out of the 19 indicators during the period under review. In percentage terms, this achievement could be translated as HHS programme having achieved or exceeded target in **53%** of the 19 main targets of the programme's 3 objectives.

2. At country/IP level, Happy in Chipata, Zambia achieved 12 targets (63%) out of the 19; while FLAS in Swaziland achieved 8 targets (42%). Achievement levels could have been higher in both countries, and there is need to explore factors behind current low levels of achievement. Besides teething problems at the beginning of the programme, limited focus on targets-based planning (in line with the programme's M&E Logical Framework Matrix outlined in the proposal contributed to the slippage. The programme's planning was more activity-based, with little focus on deliverables (outputs). As a matter of fact, the evaluation

noted that there was poor tracking and recording of deliverables outlined under section 3.2 of the proposal[8] in both Swaziland and Zambia.

3. In terms of objectives; it is noted that targets for objective 3 (*To document best practices, procedures and outcomes of the innovative programmes and disseminate lessons learned through Alliance and IPPF*) were the least achieved. Only 2 out of 7 main targets for this objective were achieved. This is understandable. Logically, best practices and lessons can be documented and shared realistically after considerably period of time of the programme. However, it is important to note that the HHS programme had not developed a plan or strategy for documenting and sharing best practices; and this gap does contribute negatively to achievement of the set targets. See section 3.3.1 (c) below. Targets relating to Objective 2 (*To strengthen the capacity of community systems, CSO, health services and education institutions in Zambia and Swaziland to respond to SRH with young people*) were the most achieved; while targets for objective 1 (*To increase the number and quality of youth interventions implemented in Zambia and Swaziland which improve the sexual and reproductive health of young people aged 10 – 20 years*) could be said to have been **achieved at 50% level**.

3.3 Results and Outcomes

The evaluation noted the variations in which the terms *'activities', 'inputs', 'results', 'outputs', 'objectives', 'goal', 'outcomes' and 'impacts',* were understood by different members of the implementers of the project – both as individuals and organisation. In order to facilitate understanding of the assessments and observations made by this evaluation, the tabulations of working definitions are provided as appendix 5. The definitions have been framed with considerations of those contained in SRH policy documents and the M&E Plan/Framework of both Zambia and Swaziland respectively[9].

The HHS programme had 2 key result areas and 3 key indicators/targets towards the **Goal** (*To contribute to improving the sexual, reproductive and psychosocial health of young people aged 10 – 20 years living in Zambia and Swaziland by December 2010*)

Expected Results:

- Increased use of health services in project area by young people by the end of the project
- Improved confidence and capacity of young people aged 10 – 20 years in supported communities to practice safer sex by the end of the project

Indicators/(targets):

- Number of young people in project areas using the health facilities (16,000)

[8] See pages 12 to 15 of the proposal - "Together we can grow up happy, healthy and safe" (HHS). A youth programme in Zambia and Swaziland. A proposal submitted to the Swiss Government by the International HIV/AIDS Alliance. Version: 03 November 2008.

[9] The Kingdom of Swaziland: *National Multisectorial HIV and AIDS Monitoring and Evaluation Framework, 2009 – 2014,* National Emergency Response Council on HIV and AIDS; *Integrated Sexual and Reproductive Health Strategic Plan, 2008 – 2015*, Ministry of Health. Government of the Republic of Zambia: *National HIV/AIDS/STI/TB Monitoring & Evaluation Plan, 2006 – 2010*, National HIV/AIDS/STI/TB Council; *Empowered Engaged Encouraged, National Standards for SRH, HIV and AIDS Peer Education Programmes*, Ministry of Sport, Youth and Child Development, March 2010.

- Number of young people in supported communities attending sexuality and life skills sessions (20,000)
- Perceived improvement in the capacity of young people to practice safer sex (qualitative; secondary and anecdotal data)

In order to assess the programme's level of attainment of results and outcomes the evaluation considered: *(1) primary data, (2) secondary data and (3) anecdotal data.*

Primary data was that which was directly captured by the programme through its service delivery, while secondary data was that which was obtained from other stakeholders, outside the programme's control. Anecdotal data was gathered from beneficiaries/stakeholders' personal and institutional reflections and experiences in relation with/about the programme.

In both countries, the programme's M&E systems were still under-developed and did not have consistent mechanisms and practice for capturing secondary/illustrative data. For example, number of girls who fell pregnant and dropped-out from school; number of boys/young men and girls/young women aged between 10 and 20 years who accessed VCT and; trends of STIs among boys/young men and girls/young women in the HHS catchment areas. Such data is monitored and kept by the district/regional education and health authorities as well as the respective schools and health facilities respectively. It is unfortunate that the HHS programme did not have mechanism for collecting and utilising such data. This evaluation was therefore not availed such data as more time would have been needed by the authorities to prepare and make the data available.

Table 4 below represents performance of the programme based on data available from Happy, FLAS and AZ. Unfortunately the data for the first indicator for the first result was incomplete, underscoring the concern about the programme's inadequate data management system.

Table 4: HHS Results - Progress against Targets (1 March 2009 – 31 May 2010)

Intervention	Objectively Verifiable Indicators	Targets Vs Actual					
		Total		Swaziland (FLAS)		Zambia (Happy)	
		Target	Actual	Target	Actual	Target	Actual
Goal: Contribute to improving the sexual, reproductive and psychosocial health of young people aged 10 – 20 years living in Zambia and Swaziland by December 2010							
Expected Results: • Increased use of health services in project area by young people by the end of the project • Improved confidence and capacity of young people aged 10 – 20 years in supported communities to practice safer sex by the end of the project	• # of young people in project areas using the health facilities	16,000	676 + ??	8,000	676	8,000	???
	• # of young people in supported communities attending sexuality and life skills sessions	20,000	**28,950**	10,000	**10,823**	10,000	**18,127** (M=9,434 & F=8,693)
	• Perceived improvement in the capacity of young people to practice safer sex	Qualitative	Qualitative feedback indicate that this has been achieved	Qualitative	Qualitative feedback indicate that this has been achieved	Qualitative	Qualitative feedback indicate that this has been achieved

Highlights:

1. Notwithstanding the low reach in terms of young people in the project areas using health facilities, feedback from respondents in the all the visited sites, without exception, overwhelmingly indicated that the project was bearing good and desired results. Many people reported to have been accessing health services and that there was positive behaviour change relating to SRH among young people and adults.

2. Evidence of outcomes and potential to contribute to impact had started to emerge. Many people interviewed both in Zambia and Swaziland gave feedback to that effect. The remarks below were typical of what were received from many:

> *"As a result of this programme, we have now started to see some change. Adults, including teachers and school managers are beginning to be supportive of SRH rights of young people. In our schools, teachers are no longer shy to name body parts – the private parts – freely; and helping pupils to address their sexual and reproductive health issues. Also, issues of sexual abuse of girls is more openly discussed. The project is inculcating assertiveness among young people, including girls. Although I do not have statistics at hand with me now, I can tell you that rate of pregnancy in schools is reducing,"* observed Mr. John Hlophe – Director Career Guidance, MOET, Swaziland.

3.3.1 Comments on Results in relation to each Objective

(a) Objective 1: To *increase the* number and quality of youth interventions implemented in Zambia and Swaziland which improve the sexual and reproductive health of young people aged 10-20 years

Overall, the programme had made available avenues through which young people accessed SRH services in Chipata. Through the programme, youth in Chipata and Swaziland had 9 and 8 centres respectively through which they can access SRH services. These centres (4 RHC and 13 schools) facilitate comprehensive SRH services. The training and materials provided by the programme had greatly increased the quality of services offered. However, beyond centres run by the programme, it was difficult to quantify and qualify the extent to which the programme had resulted in increasing the number and quality of youth interventions.

The programme could do well to help some of the vibrant community youth groups turn into community based youth CBOs, in order to scale-up youth interventions in both countries. The challenges relating to this suggestion should be obvious, and need to be considered and provided for thoroughly in the process.

The target group of 10 – 20 years was considered to be exclusive of other vulnerable age groups of young people. All respondents in both countries (Swaziland and Zambia) suggested that the target age group be expanded. In Zambia, it was argued that the age group of 5 – 14 years was considered the "window of hope" in which HIV prevalence was relatively low and targeting strong SRH-HIV behavioural formation interventions in that age group would be very strategic for sustainable prevention. In both countries it was observed that sexual curiosity and learning start at much earlier age than at the age of 10 years. The official school-going age in Swaziland and Zambia starts at 7 years. It was therefore felt that 7 years would be the best age at which to start inculcating sexuality education and behavioural formation into young people. Further, it was noted that young people become most vulnerable to SRH-HIV behavioural challenges during the age group of 18 – 24 years. The age group of 7 – 24 years was therefore overwhelmingly recommended to be the target group for the HHS programme.

In terms of the 3 expected results as outlined on the plan Vs progress – table 2 above, the major area in which the programme had performed dismally is that of "*increased use of health services in project area by young people by the end of the project*".

In Swaziland, FLAS had made a lot of effort in relationship building with the MOH at regional and national levels. However, the programme had not yet started working with health centres or health facilities.

In Chipata, Zambia, Happy worked with 4 rural health centres. The programme had introduced youth friendly corners, through which young people accessed comprehensive SRH services. To this extent, a structure was constructed at Mnukwa RHC and fully dedicated to YFS through the programme. Unfortunately, the programme was still weak in data collection and management. Its referral system was still not fully functional and had not been well shared with the health centres. To try and get a sense of the extent to which the programme had achieved in facilitating young people to access health facilities, the evaluation endeavoured to go through Mnukwa and Vizenge RHC records. While an increase in young people accessing VCT and STI screening between 2008 and 2010 was noted, the numbers were dismally small. There was no indication in the RHC records as well as in Happy records reflecting young people who accessed these services through referral from the programme. At both Mnukwa and Vizenge RHCs, it was noted that commodity stock-outs was common. Both male and female condoms often ran out of stock. This was the case for HIV test kits – determine and unigold used for screening and confirmatory testing were noted to be in very short supply. Young people often get discouraged to access SRH services like VCT if they get turned back due to non availability of necessary kits or materials. The programme could support the local system by supplementing RHC supplies.

Results in Relation to the Change Hypothesis: The evaluation noted that most of the aspects categorized as impacts would be more appropriately considered as outcomes - Please see appendix 5. Table 5 below makes comments on the change hypothesis relating to objective 1.

Table 5: Progress Update on the Change Hypothesis relating to Objective 1

INTERVENTION	EFFECT ON BEHAVIOUR	COMMENTS ON PROGRESS AND TOWARDS CONTRIBUTION TO IMPACT
Mobilise Communities	Effect as per proposal: Increased participation of young people and other relevant stakeholders in design and implementation Comment: Involvement of young people and relevant stakeholders in design of interventions was still very minimum, almost none – mostly they were told what to do. When it comes to implementation, almost all the work is actually carried out by young people and adult community volunteers.	Impact Indicator as per proposal: *Trust and supportive working between groups and networks of young and adult males is built* Comment: Viewed against the working definitions provided in appendix 5, this is an outcome indicator. Feedback from all the 7 sites visited by the evaluation reflects that there is some emerging trust and supportive working relationship between youths and adults in general. No strong gender related feedback was received.
	Effect as per proposal: Young people and	Impact Indicator as per proposal:

	adults are able to talk about sexuality, gender and culture in helpful ways Comment: Very evident in all sites visited.	*Young people are empowered to make healthy decisions and influence their environment through group activities and advocacy* Comment: This more of a result indicator The evaluation has not been able to ascertain the extent of young people's influence and advocacy work. There is need for the programme to have in place advocacy strategies
	Effect as per proposal: Young people and key stakeholders collectively take action to address the causes of young people's vulnerability at behavioural, social normative and structural levels Comment: Good progress was noted in all the 7b sites visited.	Impact Indicator as per proposal: *There is more respect and communication between young people and adults* Comment: Result/outcome indicator. Feedback from all 7 sites visited suggest that this is being realised
		Impact Indicator as per proposal: *Harmful cultural practices are reduced; gender equality is increased and young people's rights are respected* Comment: Combination of outcome indicators. There is evidence that harmful cultural practices are being eliminated in both countries. This is also the case for gender equality and equity, but there is still a lot to be done
Participatory Learning Activities	Effect as per proposal: Young people and adults increase their knowledge, self esteem, positive attitudes, skills and social capital Comment: 'very evident. Good progress has been noted	Impact Indicator as per proposal: *Young people enabled to adopt protective behaviour and reduce risks to their SRH* Comment: Outcome indicator. Feedback suggests that this is happening. It is recommended that that the programme includes operations research to verify extent to which this aspect is happening.

		Impact Indicator as per proposal: *Adults enabled to support young people in SRH as they grow up* Comment: Outcome indicator. Very evident in both countries.
		Impact Indicator as per proposal: *Young people and adults enabled to take collective action to strengthen norms and practices which support SRH and change those that hinder it* Comment: More work still to be done, especially in Zambia. Involvement of traditional leaders is very necessary.
Provide accessible comprehensive SRH services for young people	Effect as per proposal: Young people have the knowledge and skills to make informed choices and the means to adopt safer sexual behaviour. They know their HIV status and have access to products to prevent re-infection, infection of others and MTCT and treatment Comment: Knowledge and skills are increasing among young people in the programme sites. Observations from the field suggest that girls are less forward-looking and involved than their male counterparts. It is necessary that gender-responsive interventions are scaled up in the programme.	Impact Indicator as per proposal: *Young people adopt protective behaviour and reduce risk to their SRH* Comment: Outcome indicator. Progress was suggested.
		Impact Indicator as per proposal: *Young people who know they have HIV take steps to avoid re-infection and infecting others and to keep healthy* Comment: Outcome indicator. The evaluation was not able to ascertain this as the programme does not have specific interventions for "Prevention with the Positive"
		Impact Indicator as per proposal: *Young people take steps to avoid MTCT* Comment: Outcome indicator. No

		evidence was provided.
	Effect as per proposal: STIs are treated promptly and correctly Comment: No evidence received. Monitoring data sharing between programme and HCs is still under-developed.	Impact Indicator as per proposal: *STI incidence decreases together with risk of HIV* Comment: IMPACT indicator. Could not be ascertained by this evaluation.
	Effect as per proposal: Able to avoid pregnancy Comment: Need for study in programme sites, with control sites.	Impact Indicator as per proposal: *There is a reduction in unwanted pregnancy* Comment: Could be both outcome and impact indicator. Feedback was given to the affirmative, but no data to substantiate.

b) Objective 2: To *strengthen the capacity* of community systems, CSO, health services and education institutions in Zambia and Swaziland to respond to SRH with young people.

Community systems, collaborating civil society organisations, health facilities and educations institutions have received capacity in a number of ways. In Zambia, through HHS programme, all the 4 rural health centres (Vizenge, Mnukwa, Madzimoyo and Chiparamba) now have a cadre of youth volunteers that are dedicated to providing SRH services to young people. Each of the total of 13 schools in Swaziland and Zambia, have a number of teachers in each school trained in sexuality education by the HHS programme. These schools now have teachers that are trained in and providing sexuality education. The 13 schools in Swaziland and Zambia, and the 4 rural health centres, serve as resource centres in which community volunteers and members access SRH-HIV/AIDS training, information, and other services. Chiefdoms and other traditional leadership establishments have had their members trained, and therefore capable of providing informed advice to the chiefdoms regarding issues of SRH-HIV/AIDS especially for young people. In Zambia, traditional initiators in all the 9 sites have been trained in SRH-HIV/AIDS; and have started to review their own/communities' traditional values and practices with the aim of changing those that put young people at risk.

However, there are a number of gaps, which if addressed would strengthen the programme performance to achieve this objective:

1. Site level baseline, follow-up and end-line surveys: No baseline surveys were conducted at project site level. The evaluation asserted that the baseline surveys conducted by the programme (by AZ M&E Specialist) at national levels in Swaziland and Zambia are too broad to provide basis for effective monitoring and evaluating facility and community level interventions. Lack of site-level (facility and community)

baseline surveys and no provision for follow-up and end-line surveys means that interventions at site/community level are really not well guided. See (2) below.

2. Specific priority areas for strengthening of community systems, CSO, health services and education systems were not explicitly identified for each facility or community. There was lack of systematic approach for doing so. The evaluation noted the need to make provisions for baselines, follow-up and end-line surveys as suggested in (1) above. It is also important to have MOUs between the programme/implementing organisations and CSOs, Health Centres, schools, etc in order to formalize and spell out their mutual commitments to the collaboration.

3. There was lack of a well articulated strategy for strengthening the capacity of community systems, CSO, health services and education institutions in Zambia and Swaziland to respond to SRH with young people. The evaluation noted that the programme's approach was ad-hoc in the 2 countries during the period under review. This observation is directly connected to points (1) and (2) above, but does not seek to dissuade local innovation and uniqueness. It rather seeks to encourage well articulated documented approaches, within which local variations and diversity could be accommodated. At the time of the evaluation, the programme had no clear documented strategy for facilitating capacity building and strengthening of community systems, CSO, health services and education institutions. A well designed and documented system inclusive of provisions for site-level baselines, well designed capacity development support approaches such as structured training and exchange visits among project sites and countries, inter-country workshops (which would become regional as the programme expands) is vital. This would also facilitate development of regionality strategy and approach.

c) Objective 3: To *document best practices,* processes and outcomes of the innovative programmes and disseminate lessons learned through the Alliance and IPPF

As already noted in 3.2 (highlight 3) above, this objective was the least achieved. Only 2 out of 7 main targets for this objective were achieved. This is because best practices and lessons can only be documented and shared realistically after considerably period of time of programme implementation. The 1 year 3 months of the pilot phase had not been sufficient.

However, it is also important to note that the HHS programme had not developed a plan or strategy for documenting and sharing best practices; and this gap does contribute negatively to achievement of the set targets under this objective. The following gaps would limit the success of the programme in this objective both at country and joint-country/regional levels, if not addressed:

- Lack of systems for identifying and prioritising areas for documentation, lessons learning and sharing. At the time of this evaluation, the programme had no system in terms of standard criteria, tools and guidelines for determining and documenting best practices in the 2 programme countries.

- No Operations Research (OR) and documentation plan in place. A number of issues such as prevalence of certain SRH-HIV challenges in certain communities and regions relative to others need further exploration and insights. Operations research and related documentation could play a useful part in such cases. Although the programme does

conduct photo-exhibitions, etc as a way of bringing out such issues, the evaluation asserts that this is just a start of the process. The programme needs a well articulated OR and documentation strategy.

- Inadequate Regionality Strategy and approach. The programme is setting out to become regional, i.e. not only operating in 3 or more countries, but also facilitating synergies, exploiting comparative advantages and facilitating inter-country policy influence. It is important that the programme develops a "product brand" that could facilitate adaptations, cascading and promoting synergic collaborations among programme countries. It is also important that the programme considers lessons from other programmes already implemented by MAs of the IPPF in the programme countries and the IPPFARO. For example, the IPPFARO has been implementing YMEP programme in Zambia, Tanzania, Uganda and Kenya since 2006. Some of the work by FLAS in areas of male circumcision involving youth, safe abortion initiative, etc could also provide insight to the HHS programme.

3.3.2 Funding and Financial Matters

Funding: During the period under review, the programme had only 1 source of funding – the SDC – whose total budget stood at US$313,719.00. While intensions and efforts to seek funding for the programme from other resource providers were on the agenda, especially on the part of AZ; there had not yet been any funding realised from

Financials: The evaluation was not availed a financial report as at May 31, 2010. It was therefore unable to carry out an analysis relating to the project's funding status, closer to the date of this evaluation than end of the second bi-annual reporting period. This section therefore only makes observations and assessments based on the programme's financial report for the period ended 28 February 2010, contained in the second half annual report dated March 2010. Brief feedback on the programme's financial reporting was also obtained from SDC via email.

According to the programme's Bi-Annual Report for the period of 1 September 2009 – 28 February 2010, the programme gained a total of US$ 40,641.00 due to foreign exchange currency fluctuations during the first 12 months of its pilot project phase. This exchange gain brought the total funds available to the programme to US$354,360.00. As at February 28, 2010, the programme had spent a total of US$257,461.80 translating into 72.66% absorption of the total funds committed to the project. The US$ 96,898.20 unspent balance was contributed to by mainly 3 budget lines: (1) FLAS, (2) Happy and (3) the exchange gain which had US$21,943.21; US$22,337.59 and US$30,325.93 unspent balances respectively. The programme spent a total of US$10,315.07 from the exchange gain funds, on office equipment (US$617.21) and technical support to partners (US$9,697.86) as at 28 February 2010. If the exchange gain and expenditure from it were not realised, the programme would have spend a total of US$247,146.73 as at 28 February 2010. This would have translated into 78.78% of the US$313,719.00 SDC grant budget, i.e. leaving a balance of 22.12% for remainder of the programme's 6 months period of 1 March to 31 August, 2010. Section 3.4.3 below considers this expenditure rate against programming performance to comment on efficiency of the programme.

3.4 Assessment of the programme in Terms of the Key Evaluation Issues

3.4.1 Relevance and Being In-Line

As noted in the introduction, HHS is a comprehensive SRH-HIV programme that seeks to address the common root-causes of SRH-HIV problems; hence providing a meaningful entry point for young people and communities to intervene. HHS uses an integrated approach for comprehensive SRH programming, addressing the need to create environments where young people are able to protect themselves, enjoy happy and healthy relationships, and express their sexuality safely. The approach includes providing/facilitating access to information, comprehensive SRH services, counselling, sexuality and life skills education, as well as access to treatment and psychosocial support. The programme works with youth themselves, community support organisations, civil society organisations, health and education institutions, government and traditional authorities and other opinion leaders that influence sexual and reproductive health of girls/young women and boys/young men in their respective communities.

The evaluation explored the relevance of the approach and methodology from a number of perspectives. Feedback from all stakeholders and analyses reflect that the programme approaches and methodology were very relevant to needs of beneficiaries. In both countries, the programme was well in line with government priorities at all levels – national, regional/provincial, district and community. The gaps that still exist in the SRH and HIV/AIDS interventions for young people (see section 2.1.1) are better addressed through the combination and inclusive approaches that the programme has chosen.

Through institutions of learning, the programme is well-facilitated to provide increased and comprehensive information, life skills and service delivery to young people. Similarly, the case is true for working through health institutions in order to facilitate increased access to SRH services for young people. Community leadership and systems ensure positive reinforcement of the interventions and desired change on the ground. Having government authority on board facilitates the necessary authorisation to introduce and implement interventions broadly; facilitates and accommodates lessons sharing, adoption of best practices as well as necessary policy reviews, formulation and improvements. In both countries government representatives as well as other stakeholders appreciated the relevance of the programme's approaches:

> *"...As government here in Chipata district, we a very happy with the way Happy is doing this work on SRH and HIV/AIDS programme, because you are working with us and our officers at the various levels in the community. My office always follows up; and I see that your work is very inclusive, relevant and useful. ...We have given our commitment to this work; please continue and do more",* said Mr. Moses D C Nyirenda - District Commissioner, Chipata, Zambia.

The relevance and strategic positions of FLAS and Happy as chosen implementing partners have already been noted in section 2.1.2 of this report. The 2 organisations have good track record of SRH programming, and already had SRH-HIV interventions running.

3.4.2 Effectiveness

In order to address key drivers of sexual and reproductive ill-health and HIV/AIDS among youth the programme has used a combination of approaches. These approaches included promotion of 'ABC'; awareness campaigns through drama, photo exhibitions, community discussions ("indabas")

involving youth, adults, education authorities, and others; integrated sexuality education for young people in schools; counselling, among others.

Although there has been no study to ascertain effectiveness of these interventions in the SRH-HIV programme, the evaluation noted a number of good results/outcomes of the programme. For example, following a series of community consultations and campaigns by the programme in Malandzela area, Hhohho region of Swaziland, the Umphakatsi (area chief) Mncina made a declaration against early marriages in his chiefdom. Similarly, in Vizenge area of Chipata district, Zambia, Chief Chanje made a declaration against early marriages. Chief Chanje further declared that traditional initiations of young boys and young girls in his chiefdom shall only be conducted during school holidays, so that young people's schooling is not affected. Chief Chanje also directed that initiators should provide age and situational sensitive messages and training to their initiates. Chief Chanje further banned initiating in performances related to sexual intercourse. In both chiefdoms, the traditional leaders are supporting youth SRH debate that include, among other aspects, reviewing with intent to increase the legal age of sexual consent.

Boys and girls interviewed in all the 6 schools (both countries combined) felt that the sexuality education and life skills offered to them were imparting them with knowledge, self-esteem and assertiveness to take recourse against, reject or avoid situations or actions that put them at risk of sexual and reproductive ill-health as well as HIV/AIDS. Most of the interviewed boys and girls said they were practicing abstinence. Those who are sexually active indicated that the programme had reinforced their motivation to adhere to safer sex such as consistent correct usage of condoms. Even more interestingly, a total of 7 boys (2 at Lubuli Nazarene High School and 3 at Manzini Nazarene High School in Swaziland; and 2 at Chankhanga Basic School in Chipata, Zambia) indicated that they stopped having multiple concurrent sexual partners as a result of one-on-one peer education through the programme. Another youth, 18 year old form 5 girl at Lubuli Nazarene High School, said that her life changed for the better after having been trained by her friend who received peer education and SRH training from FLAS in Manzini.

Community systems, collaborating civil society organisations, health facilities and educations institutions have received capacity in a number of ways. In Zambia, through HHS programme, all the 4 rural health centres (Vizenge, Mnukwa, Madzimoyo and Chiparamba) now have a cadre of youth volunteers that are dedicated to providing SRH services to young people. Each of the total of 13 schools in Swaziland and Zambia, had a number of teachers trained in sexuality education by the HHS programme. These schools now have teachers that are trained in and providing sexuality education. The 13 schools in Swaziland and Zambia, and the 4 rural health centres, serve as resource centres in which community volunteers and members access SRH-HIV/AIDS training, information, and other services. Chiefdoms and other traditional leadership establishments have had their members trained, and therefore capable of providing informed advice to the chiefdoms regarding issues of SRH-HIV/AIDS especially for young people. In Zambia, traditional initiators in all the 9 sites have been trained in SRH-HIV/AIDS; and have started to review their own/communities' traditional values and practices with the aim of changing those that put young people at risk.

A number of challenges, issues and gaps were noted by the evaluation and key among them include:

1. *Integrated approach for sexuality education and life skills in schools is inadequate.* Integrated approach means integrating SRH-HIV issues such as sexuality education, life skills training, assertiveness training, in the regular school periods for classroom subjects such as mathematics, geography, history, biology, vernacular languages. In both countries all teachers, community representatives, education officials and pupils interviewed by this evaluation asserted that the integrated approach does <u>not</u>

provide enough time to allow SRH-HIV issues to be thoroughly explored. They therefore recommend that separate periods for SRH-HIV/AIDS educations and life skills be allocated stand alone periods. Others even suggest that SRH and sexuality education become examinable subjects. These aspects need broad-based advocacy, backed by concrete evidence for benefits of stand-alone SRH and sexuality education periods in schools.

2. *Insufficient interventions addressing gender inequalities and gender-related differences and needs.* The evaluation observed that the programme activities are largely gender neutral.

3. *The MOE and MOET policies in both Zambia and Swaziland respectively, do not permit condom distribution in schools.* According to respondents to this evaluation, reality on the ground is that although most of the sexual intercourse by young people does not take place in schools, schools are the most youth-friendly places where young people could conveniently access condoms (as they would for other services like counselling and life skills training). The NAC and NERCHA in Zambia and Swaziland respectively indicated the need to explore strategies for facilitating increased safer sex options for in-school youth. The HHS programme has potential to facilitate or contribute to such efforts.

4. *The programme has recorded very low achievement in facilitating young people (boys and girls/young men and young women) to access SRH services such as VCT, STI screening and male circumcision.* There is need to strengthen planning, implementation of interventions that facilitate young people access SR health services. The efforts in this regard should include improving monitoring and data management of the programme.

3.4.3 Efficiency

As already noted in 3.3.2 above, the evaluation was unable to conduct exhaustive financial scrutiny because AZ were still updating their financial reports during the time of the evaluation. To determine degree to which the cost of inputs (expenditure) can be justified by achieved outputs, results and outcomes, the evaluation consideration of the programme's performance – see sections 3.2 and 3.3 – and its financial report. As at 28 February 2010, the programme spent a total of US$257,461.80 out of the US$354,360.00 (inclusive of currency exchange gains) committed to the programme. This translates to into 72.66% absorption of the total funds committed to the project. Disregarding the exchange gains and expenditure related to it, the level of spending reflects a slightly higher level at 78.78% of the US$313,719.00 SDC grant budget.

In terms of achievement of targets, the HHS programme achieved or exceeded target in **53%** of the 19 main targets of the programme's 3 objectives, as at May 31, 2010. In this sense, even though the relationship between expenditure and targets is not linear, it can be safely said that the programme had operated a bit below desired efficiency levels during the period under review. The evaluation felt it was very likely that the programme would have exhausted funds committed to it by end of pilot phase (August 31, 2010), but doubted whether the programme would have achieved all its set targets by then.

Considering start-up challenges and learning curve, the expenditure and service delivery achievement levels are justifiable. Feedback from field interviews reflects high levels of indications

of outcomes relative to output numbers. The value on the ground seems higher than expected for the reach in terms of numbers. This is a much better scenario than the other way round.

This evaluation is of the opinion that the programme would have achieved better outputs, results and even outcomes at the same or lower costs if it had been more target-focused in terms of outputs, results and outcomes as suggested in section 3.1.2 (a) and (b) above.

Notwithstanding, it is worthy to note that Happy and FLAS provided economies of scale to the HHS programme through their other projects that are supported by other resource providers.

3.4.4 Sustainability

During the period under review, no resource mobilisation was yet carried out for the programme. This was because all efforts were being expended on ensuring that the programme was well established on the ground during this pilot phase. It is realistic to expect reasonable resource mobilisation during the next phase of the programme.

The evaluation assessed sustainability of the programme from several considerations. It considered the capacity of the implementing organisations to ensure sustainability of the programme's service delivery through:

- *Own resources:* Both Happy and more so FLAS do have potential and capacity to realise the potential of sustaining reasonable components of the programme through their own resources. The starting point would be to have HHS programme/approaches feature in the implementing organisation's overall strategy. At the time of this evaluation, neither organisation had HHS included in their strategic plans. In fact Happy did not have a strategic plan. AZ on the other hand did not include Eastern province (where Happy is implemented in Zambia) as being among the geographic target areas for AZ work in Zambia. The same applies for Swaziland in terms of IHAA, but Swaziland fits IHAA criteria for expansion. It is important that AZ, FLAS and Happy make strategic provisions for sustaining the programme.

- *External resources such as from funders and programme country governments:* Also having HHS programme/approaches feature in the implementing organisation's overall strategy is the starting point here. Currently this is not the case as indicated above. AZ, Happy and FLAS, as well as other IP that would come on board, will have to scale-up resource mobilisation for the programme during the next phase. The regional approach of shared and pooled synergies would become increasingly vital.

- *Other stakeholders and implementers buying into the HHS approaches and implementing using resources provided or sourced by them:* In as far as this SRH-HIV programme is concerned governments in programme countries are the key most stakeholders to target the buy-in. National and community level NGOs and CBOs respectively are also critical. The lessons learning, documentation and sharing would be cardinal strategy through which this buy-in could be achieved. At community level, the implementing partners (FLAS and Happy) would do well to strengthen community groups and CBOs to have capacity to independently solicit for resources and implement the programme.

Besides global economic and donor factors, there were no obvious negative influences (social, cultural, political, etc) noted that potentially threaten sustainability of the project. The evaluation felt that the programme had more opportunities than threats.

3.4.5 Policy dialogue and Regionality

Section 3.4.2 above has already alluded to the potential of the programme to contribute to the national and regional policy and strategy for youth HIV-SRH. The success of this contribution would largely depend not only on the quality and scale of programme service delivery, but also its capacity for evidence-based programming (monitoring, evaluation, documentation, advocacy as well as lessons learning and sharing) and partnerships with regional bodies like SADC and COMESA as well as governments in programme countries.

Although the programme has not yet formalized partnerships with any government, good collaborative relationships have been achieved in both countries, resulting in good recognition of the programme by the governments. This is an opportunity to be exploited by the programme to formalise partnership with government. The programme could further seek partnerships with SADC and/or COMESA.

The Alliance Zambia, as the programme's main technical support provider, has demonstrated high level capacity in monitoring and evaluation and documentation. Backed with support from the IHAA, Alliance Zambia could coordinate a well articulated policy dialogue initiative within a regional programming approach. Two (2) main aspects should be addressed:

(a) Regionality based programme approach: AZ and implementing partners will have to develop and practice systems that support Regionality. The starting point would be the project proposal for the next phase of the HHS programme to reflect Regionality aspects. SADC has provision to support regional initiatives in HIV and AIDS which include SRH issues. At the time of this evaluation the Secretary and Chairperson of the SADC Regional Coordinating Mechanism of the GFATM were resident in Swaziland and Zambia respectively – so the programme could have in-country direct link with the regional grouping.

(b) Implementing partners' commitment to having in place well developed and functional monitoring, data management and evaluation systems: This is cardinal for evidence-based programming. At the time of this evaluation, significant gaps were noted in this area. Section 3.4.8 below provides more information.

3.4.6 Gender

The evaluation noted that the project proposal had substantial gender analysis. A number of gender factors, upon which structural drivers of SRH-HIV issues for young people are founded were outlined. Unfortunately, most of the factors and issues outlined in the project proposal's analysis had not been catered for in terms of gender-specific and sensitive interventions within the programme.

The programme is largely gender neutral. For example, it does not have specific interventions that address patriarchal traditional and structural norms, targeting young males; nor does it have interventions addressing the socialisation norms which make girls feel subservient to their male counterparts.

It was noted that the HHS programme's Monitoring and Evaluation Logical Framework Matrix (i.e. the objectives, results, outcomes and indicators), provided in the proposal is itself very gender neutral.

3.4.7 Model of best practice

The programme does have potential to develop and inform youth focussed SRH-HIV prevention programme as a model of best practice especially in involving traditional leadership. It also has strong potential in demonstrating the youth-adult collaboration.

Realisation of the potential as model of best practice will depend on various aspects relating to evidence based programming as already noted in many parts of this report. The HHS programme will require to strengthen its programme design; monitoring; data collection and management; as well as documentation, lessons learning and sharing.

3.4.8 Monitoring

This is one critical area of the programme which requires very significant and urgent attention to fill the gaps in the system. Inputs and activities are well tracked and documented. The monitoring of outputs and related collection of related data had been very inconsistent and inadequate. Mechanisms to ascertain results and outcomes have been inadequate, in some cases non-existent.

The under-developed status of the M&E and reporting system has been mentioned in many parts of this report. While the inadequate usage of the programme's Monitoring and Evaluation Logical Framework Matrix as a planning, monitoring, management and reporting tool has frequently been highlighted as a key gap, the major factor really is the capacity and commitment of the two implementing partners – FLAS and Happy – to finalise development of, and then implement the desired adequate M&E system. The evaluation noted that AZ M&E specialist had provided training in M&E to both FLAS and Happy. The training was backed up by technical assistance in M&E system development. The system (guidelines, procedures and tools) so developed had remained in draft form for more than 6 months till the time of this evaluation. The evaluation therefore asserted that monitoring and evaluation system in both programmes was still incomplete and not to standard due to 2 major factors:

1. *Lack of M&E function or staff position at Happy*. Currently the 2 programme officers are also responsible for M&E; yet they are over-stretched even for their regular service delivery programming work. They still require increased support in M&E.

2. *Limited commitment to M&E by implementing partners:* FLAS on the other hand has an established monitoring, evaluation and research unit, led by a manager. It is reasonable to suggest that the status of M&E system in such a case may be due to commitment.

This evaluation suggests that management of both implementing partners take steps to prioritise improvement of M&E for the project as well as their organisations within which the project is accommodated. Firstly, there is need to ensure effective planning.

3.4.9 Knowledge management

The evaluation sought to note how the HHS programme takes stock of best practices in order to facilitate AIDS Alliance, YHHS, FLAS and others to improve knowledge management, level of understanding and ensure a result based approach within regional partnership. It also sought to ascertain the potential of this strategy to develop and inform a youth focussed model on SRH/HIV.

Good efforts had been made by the programme. Firstly, the programme collected a number literature from various stakeholders – IHAA, AZ, FLAS, among others – and shared these with

implementing partners, who in turn distributed them to programme sites. As a result, CSO and community systems have had good basis upon which to build their capacity. The implementing partners in turn try and enhance library services by stocking them with literature on youth SRH which can be accessed by young people. FLAS has a good library facility for young people at its centres in Manzini and Mbabane.

Taking stock of best practices as part of good knowledge management depends on good planning, monitoring, documentation, evaluation, learning and sharing. While good efforts have been made in these areas, the programme still had a number of gaps as pointed out in the earlier parts of this report.

4 RECOMMENDATIONS

Throughout Section 3 – Findings of the Evaluation - this report has attempted to include suggestions and recommendations. This section crystallizes them and provides key recommendations for consideration by the project during the next phase. It is further advised that all other suggestions and recommendations made by this report be considered.

4.1 Target Age Group of the programme

During the pilot phase, the programme focused on age group of 10 – 20 years, but this is felt to have excluded strategic age group of 7 – 10 in which sexuality education and behavioural formation interventions would result in stronger foundation for prevention of SR ill-health and HIV infection among young people. The age group of 18 – 24 years is extremely predisposed to SRH-HIV vulnerabilities

- *It is therefore recommended that the programme considers adjusting age group of its focus to be 7 – 24 years, both in-school and out-of-school youth.*

4.2 Programme Design, Planning and Reporting

(a) *The Planning (for overall pilot phase, annual and quarterly work plans) by both FLAS and Happy did not adequately reflect the "Monitoring and Evaluation Logical Framework Matrix* of the programme The *Monitoring and Evaluation Logical Framework Matrix* provided in the proposal was not adequately used as a tool for programme planning, implementation, monitoring and reporting. This factor, coupled with the lack of country programme design document, implied that the programme's mechanism for ensuring effective management was disabled.

- *The evaluation recommends that the programmes enhances its programme design, first by ensuring that each country programme prepares a programme document, which translates the generic proposal into country specific programme. This process be guided by the Monitoring and Evaluation Logical Framework Matrix of the programme outlined in the proposal. Further the Monitoring and Evaluation Logical Framework Matrix be used during the joint or individual planning sessions by AZ, FLAS and Happy.*

(b) While the MRS was followed, the programme reporting mainly reported on activities but provided insufficient pertinent data and information necessary to give an indication of the programme's progress status, i.e. outputs, results and even indication towards outcomes where possible. This gap did not facilitate on-going assessment of actual performance against planned.

- *It is recommended that, within the IHAA MRS template, the programme ensures that reporting is well in line with the Monitoring and Evaluation Logical Framework Matrix provided in the proposal, and as per approved funding contract.*

4.3 Effectiveness

(a) The Integrated approach - integrating SRH-HIV issues such as sexuality education, life skills training, assertiveness training, in the regular school periods for classroom subjects - does not provide enough time to allow SRH-HIV issues to be thoroughly explored.

- *It is recommended that separate periods for SRH-HIV/AIDS educations and life skills be allocated as stand- alone periods. It is further recommended that the programme supports debate making SRH and sexuality education become examinable subjects. The programme will need to facilitate broad-based advocacy, backed by concrete evidence for benefits of stand-alone SRH and sexuality education periods in schools.*

(b) The programme recorded very low achievement in facilitating young people (boys and girls/young men and young women) to access SRH services such as VCT, STI screening and male circumcision.

- *The evaluation recommends that the programme scales up resource mobilisation, strengthens planning; and includes interventions such as joint ventures with MOH/MOET to provide mobile VCT and STI treatment outreach services that enable young people to increasingly access SR health services. These efforts should include improving monitoring and data management of the programme.*

4.4 **Efficiency**

Although Happy and FLAS provided economies of scale to the HHS programme through their other projects that are supported by other resource providers, the programme's expenditure levels could be more justifiable if outputs were higher.

- *It is recommended that the programme's budgeting and expenditure system become increasingly tied to outputs and results for related interventions/activities. Increased usage of the Monitoring and Evaluation Logical Framework Matrix in the monitoring of the programme be considered as vital*

4.5 **Sustainabilit**y

During the period under review, no resource mobilisation was yet carried out for the programme, as all efforts were being expended on ensuring that the programme was well established on the ground during this pilot phase. Sustainability of the programme will have to be ensured through (a) own resources by AZ, FLAS, Happy and any future partners; (b) external resources from external funders and (c) government and other stakeholder buying into the programme and implementing the same using own resources.

- *It therefore recommended that resource mobilisation be scaled up during the next phase of the programme and that:*

    - *For sustainability through own resources, it is critical that AZ, FLAS, Happy and any future partner develop self-sustainability strategies within their overall strategic plans, and that such strategies include provisions for sustaining the HHS programme.*

    - *In order attract external resources such as from funders and programme country governments, AZ, Happy, FLAS and any future partners will need to ensure that the HHHS programme/approaches feature is managed as a best practice model*

programme and that the HHS programme is provided within the implementing organisation's overall strategies (i.e. strategic plans).

- *Governments in programme countries, other key stakeholders and implementers be strategically targeted and involved for buy-into the HHS approaches so that they feel the need to implement the HHS interventions and approaches using resources provided or sourced by them. It is further recommended that FLAS, Happy and any new partners strategically supports national NGOs and community groups and CBOs to have capacity in SRH in order to independently solicit for resources and implement the programme.*

4.6 Policy dialogue and Regionality

The programme has great potential to contribute to the national and regional policy and strategy for youth HIV-SRH. The success of this contribution would largely depend not only on the quality and scale of programme service delivery, but also its capacity for evidence-based programming, and partnerships with regional bodies like SADC and COMESA as well as governments in programme countries.

- *It is recommended that the programme addresses two (2) main aspects should be addressed:*

  a) *Regionality based programme approach: AZ and implementing partners develop and practice systems that support Regionality. The starting point would be the project proposal for the next phase of the HHS programme to reflect Regionality aspects.*

  b) *Implementing partners' commitment to having in place well developed and functional monitoring, data management and evaluation systems: This is cardinal for evidence-based programming.*

4.7 Gender

The evaluation observed that the programme activities are largely gender neutral and had insufficient interventions addressing gender inequalities and gender-related differences and needs.

- *It is recommended that the programme interventions become more gender sensitive and the programme ensures that gender related issues articulated in the project proposal are provided for in the programme interventions. In some cases, this may require to have specific interventions addressing needs and vulnerabilities of girls or boys.*

4.8 Monitoring

The monitoring of outputs and related collection of related data had been very inconsistent and inadequate. Mechanisms to ascertain results and outcomes have been inadequate, in some cases non-existent. The programme's M&E system (guidelines, procedures and tools) at FLAS and Happy is still in draft form and under-developed, despite the fact that the AZ M&E Specialist provided extensive technical support in M&E and related system development to both FLAS and Happy.

- *It is recommended that the programme addresses the 2 major factors:*

1. *Lack of M&E function or staff position at Happy. A position for M&E officer be supported at Happy. In order to avoid lengthy learning curve, the longer serving of Happy's 2 programme officers could be offered the proposed position as M&E officer. A new person could then be recruited as replacement - programme officer.*

   Both Happy and FLAS require at least one additional programme officer each. Both organisations will still require increased support in M&E.

2. *Limited commitment to M&E by implementing partners: FLAS on the other hand has an established monitoring, evaluation and research unit, led by a manager. It is reasonable to suggest that the status of M&E system in such a case may be due to commitment.*

- *It is further recommended that management of both implementing partners take steps to prioritise improvement of M&E for the project as well as for their organisations within which the project is accommodated.*

3. CONCLUSION

The **"Together we can grow up happy, healthy and safe" (HHS)** is a very strategic programme that links combines together HIV and SRH interventions. The programme further facilitates effective collaboration between youth and adults, working together, in seeking SRH-HIV/AIDS interventions. From the just one and half years of the programme so far, indications do exists that the programme does provide spin-offs that have potential to contribute broadly to country level and regional HIV and AIDS interventions.

The programme needs increased funding and technical support in order to scale-up and scale out.

4. APPENDICES

6.1 Appendix 1: Evaluation Terms of Reference

Terms of Reference (ToR)
of
International HIV/AIDS Alliance –Zambia Country Office
"Together we can grow up happy, healthy and safe" programme

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1. Introduction

The Swiss Agency for Development and Cooperation (SDC) is supporting the International HIV/AIDS Alliance Zambia Country Office on an HIV and AIDS prevention programme **"Together we can grow up happy, healthy and safe".** The programme is implemented in two countries, Zambia and Swaziland from March 2009 until August 2010. The overall goal is to contribute to improving the sexual, reproductive and psychosocial health of young people aged 10–20 living in Zambia and Swaziland by December 2010. An external evaluation is therefore required to get a thorough understanding of what the programme has achieved, its strengths, weaknesses, the possible value add to the work of HIV Alliance on HIV prevention as well as to the SDC's regional HIV programme. In addition, it is expected that the evaluation will suggest how the programme could be further developed in the possibility of a future cooperation.

2. Background

The HIV/AIDS is now a global crisis, and constitutes one of the most formidable challenges to development and social progress. Countries in Southern Africa have the highest prevalence of HIV infection in the world: between 10% and 33% of the population is infected. At the end of 2007, about 14 million adults and children in the SADC region were living with HIV which amounts to 51% of all infections in Africa. The majority of these infections are among young people, more than two decades into the pandemic, the majority of young people still have a limited understanding of how HIV is transmitted and how to protect themselves. A SADC think tank meeting held in Maseru, in 2006, identified the following as the key drivers of the epidemic in Southern Africa: multiple concurrent partnerships by men and women and low levels of male circumcision.

Young women aged 15-24 years are particularly vulnerable to becoming infected, due to social and economic factors, including the risks of early and unprotected sex, resulting in unwanted pregnancy, STI, HIV and the effects of abuse. Gender inequality is evident in gender-based violence, and Zambia has witnessed a recent increase in levels of child defilement, particularly of girl children. Likewise, women and girls are highly marginalised in Swaziland. The status of women was only recently legally amended from that of minors in the national constitution (2006) and, in practice, women remain marginalized in domestic and social relationships.

In response to these challenges the International HIV Alliance Zambia Country Office is implementing a comprehensive Sexual and Reproductive Health(SRH) programme that seeks to address the common roots causes of SRH problems and provides a meaningful entry point for young people and communities. The programme is building on existing programmes being delivered by our implementing partners, 'Young, Happy, Healthy and Safe' (Happy) in Zambia and Family Life Association of Swaziland (FLAS).

The programme is using an integrated approach, addressing the need to create environments where young people are able to protect themselves, enjoy happy and healthy and relationships and express

their sexuality safely. This includes having access to comprehensive SRH services, counselling, life skills education, access to treatment and psychosocial support.

The programme has 3 main objectives

1. To *increase the* number and quality of youth interventions implemented in Zambia and Swaziland which improve the sexual and reproductive health of young people aged 10-20 years
2. To *strengthen the capacity* of community systems, CSO, health services and education institutions in Zambia and Swaziland to respond to SRH with young people.
3. To *document best practices,* processes and outcomes of the innovative programmes and disseminate lessons learned through the Alliance and IPPF

3. Scope of work

The International HIV/AIDS Alliance is a new partner of SDC, and as well as implementing a new strategic focus for SDC, it was decided for an initial phase with a timeframe of 18 months (March 2009 until August 2010).

The evaluation shall assess the overall results of the project (in terms of output, outcomes), comparing original plans with actual implementation taking into consideration the time span of the project.

Importantly the evaluation results shall provide an input into a lesson learning and forward planning workshop for a potential next phase of the programme. The evaluation will be conducted in selected areas in Swaziland and Zambia. It should as well advise how the programme could be scaled into a regional programme, advice on the specific elements that should be considered in the follow-on phase.

The following issues shall be addressed by the evaluation:

Relevance

Evaluate the **relevance** of the chosen project approach and methodology in achieving the intended objectives including the choice of partners.

Effectiveness

5. To what extent has the programme addressed the structural drivers of the epidemic among youth to reduce youth vulnerability to HIV infection.
6. To review the strategies adopted to address the key drivers such as multiple concurrent partnerships by men and women, low inconsistent condom use, male attitudes and behaviours, intergenerational sex, gender and sexual violence and stigma have been addressed. To what extent are these strategies effective and what is their potential in reducing the incident of HIV?
7. To what extent have the capacity of community systems, CSO, health services and education institutions in Zambia and Swaziland been built to respond to Sexual and Reproductive Health (SRH) with young people. How is this evident.
8. How has the programme addressed gender equality issues and what are the results thus far?
9. To what extent has the programme succeeded in addressing young people's vulnerability to SRH problems, in particular in reducing the vulnerability of girls and young women to HIV?

10. What capacities do young people have to lead prevention activities among their communities and how is this capacity evident?
11. What are the hindering/contributing factors for effectiveness?

Efficiency

12. To what degree can the cost of inputs (expenditure) be justified by results achieved (outputs and outcomes)? Were there any alternatives that would have achieved the same results at lower cost? Or, could higher level of achievement be expected at the same cost?
13. What factors inhibit or contribute to the efficiency of the implementation process?

Were inputs delivered in an appropriate timeframe?

Sustainability

14. To what extent has the programme succeeded in soliciting additional funding?
15. What are sustainability factors of the programme.
16. What factors inhibit or contribute to the appearance of sustainable effects?
17. Does the project have the capacity to carry out activities (placement of staff, adequacy of budget, appropriate decision making process, etc)
18. Are there negative influences that potentially threaten sustainability of the project (social, cultural, economic, and political, etc)?

Policy dialogue

19. What is the potential of the programme to influence national level policies/strategies for youth HIV prevention?
20. What partnerships have been established with which governments and what are the results?

Model of best practice

- What is the potential of this strategy to develop and inform a youth focussed model on SRH/HIV prevention?

Knowledge management

In order to improve knowledge management and ensure a result based approach within our regional partnership, SDC would like to take stock of best practices in its partnerships and identify the level of understanding, use and implication of outcome monitoring and knowledge management. SDC's intention is to integrate these two concerns in all its project reviews in 2010. This will help produce valuable information to build SDC long term strategy in the region beyond 2010.

The evaluation team is therefore requested to address the following additional questions:

Monitoring

- What level is monitored (output, outcome and impact) and how is it done (inclusive quality control of collected data)?
- Is it done for all projects/programmes or for part of them only?
- Is the monitoring requirement different from donor to donor (if yes, what are the differences and what does it imply for HIV Alliance?
- What is the use of the monitoring in HIV Alliance (management purposes, reporting purposes,…)?
- Does the project incorporate outcome monitoring to demonstrate effects of the project on its target groups?

5. Outputs

The evaluation team is requested to present its findings and conclusions on which results have been achieved and provide SDC and Alliance Zambia with recommendations on how the programme can increase the relevance, effectiveness, efficiency, sustainability and development impact. A report of maximum 25 pages (excluding appendices but including executive summary of maximum 2 pages) by 27 May 2010. A draft report (appendices will not be required at this stage) shall be delivered by 7 June 2010.

The methodology will mainly be descriptive and include:

- A review of all relevant Alliance Zambia documents, project reports and evaluations
- Interviews with a Board member and the programme manager
- Visits to project sites and interviews with project partners
- Information collection and consultation with other donors, select governments, international agencies (e.g. UN), SADC, Regional NGOs.
- Presentation of findings and facilitating analytical input from partners at workshop (see point 7, below)

7. Learning and forward planning Workshop

It proposed that, using the information gathered and reviewed, the consultant will facilitate 1-day of a 2.5 day workshop in partnership with the Alliance for Community Action on Health in Zambia. Facilitation objectives will involve:

a) Share evaluation findings in the form of a presentation

b) To facilitate and document partner input with respect to these findings

c) To elaborate outcomes/ indicators as they emerge from the evaluation and workshop discussions.

Expertise and Availability Required

- Be familiar with issues of HIV/ AIDS development in Southern Africa region, including national HIV/AIDS priorities and strategies
- Knowledge of SRHR and youth issues as they relate to HIV/AIDS.
- Have experience in strategy evaluation and organisational analysis.
- Have experience of monitoring and evaluating development projects,
- Have experience of programme development.
- Be available to commence assignment 10 May.

6.2 Appendix 2: Evaluation Framework

CRITERIA	INFORMATION NEEDS	DATA SOURCES	METHOD TO BE USED	COMMENTS/STAKEHOLDERS TARGETED FOR CONSULTATION
1.Relevance (and being in line)	1. To ascertain how relevant to needs of beneficiaries, and being in line with, community, district, provincial, national and regional priorities and strategies the project approach and methodology are in achieving the intended objectives 2. To review relevance of	• Project documents including progress reports • Project beneficiaries • Other Stakeholders, including community leaders and government agencies • Happy, FLAS and	• Document review • Individual and group interviews with direct beneficiaries and implementers, government agencies, AZ and CSO using interview guide • Observation of	• In-school youth at 4 schools in Chipata and another 4 schools in Swaziland • Peer educators in Chipata and Swaziland • Alangizi in Chipata, and similar groups in Swaziland

	project partners (Happy/FLAS);and criteria used in selecting/choosing them	Alliance Zambia (AZ) Board, management and staff	activities in the field during site visits at selected project sites	• AZ, Happy and FLAS personnel (Board rep, Directors and project staff) • NAC, MOH, 2 hospitals, 3 Health Centres, MOE, DHMT, DATF, Provincial Health Director (Chipata)
2.Effectiveness	• To find out extent the programme has addressed the structural drivers of the epidemic among youth to reduce youth vulnerability to HIV infection?	• Project reports • Beneficiaries and other stakeholders	• Document review • Individual and group interviews with beneficiaries and implementers, local clinics, health centres, schools, stakeholders, government agencies, AZ and CSO using interview guide	• In-school youth at 4 schools in Chipata and another 4 schools in Swaziland • Peer educators in Chipata and Swaziland • Alangizi in Chipata, and similar groups in Swaziland • AZ, Happy and FLAS personnel (Board rep, Directors and project staff) • NAC, MOH, 2 hospitals, 3 Health Centres, MOE, DHMT, DATF, Provincial Health Director (Chipata)
	• To review the strategies adopted to address the key drivers such as multiple concurrent partnerships by men and women, low inconsistent condom use, male attitudes and behaviours, intergenerational sex, gender and sexual violence and stigma have been addressed. To what extent are these strategies effective and what is their potential in reducing the incident of HIV?	• Project documents including progress reports • Project beneficiaries • Other Stakeholders, including community leaders and government agencies • Happy, FLAS and Alliance Zambia (AZ) Board, management and staff	• Document review • Individual and group interviews with direct beneficiaries and implementers, government agencies, AZ and CSO using interview guide • Observation of activities and later engaging the audience in a discussion during site visits at selected project sites	• In-school youth at 4 schools in Chipata and another 4 schools in Swaziland • Peer educators in Chipata and Swaziland • Alangizi in Chipata, and similar groups in Swaziland • AZ, Happy and FLAS personnel (Board rep, Directors and project staff) • NAC, MOH, 2 hospitals, 3 Health Centres, MOE,

			• Focus Group Discussions (FGDs)	DHMT, DATF, Provincial Health Director (Chipata)
	• To that extent has the project enabled young people to adopt protective behaviour and to reduce risks to their SRH?	As in 2. above	As in 2. above	As in 2. above
	• To what extent have the skills and knowledge to make informed choices and means to adopt safer sexual behaviour?	As in 2. above	As in 2. above	As in 2. above
	• To what extent have the capacity of community systems, CSO, health services in Zambia and Swaziland been built to respond to Sexual and Reproductive Health (SRH) with young people. How is this capacity evident?	As in 2. above	As in 2. above	As in 2. above
	• How has the programme addressed gender equality issues and what are the results thus far?	As in 2. above	As in 2. above	As in 2. above
	• To what extent has the programme worked to address young people's vulnerability to SRH problems, in particular in reducing the vulnerability of girls and young women to HIV?	As in 2. above	As in 2. above	As in 2. above
	• What capacities do young people have to lead HIV prevention activities among their communities and how is this capacity evident?	As in 2. above	As in 2. above	As in 2. above
3.Efficiency	1. Were inputs delivered in an appropriate timeframe 2. **Cost Vs results:** To what degree can the cost of inputs (expenditure) be justified by results achieved (outputs and outcomes)? Were there any alternatives that would have achieved the same results at lower cost? Or, could higher level of achievement be expected at the same cost? **3. Economy of scale:** How do other programmes of the implementers (Happy, FLAS and collaborating CSO) enhance efficiency of the project? 4. **Factors:** What factors inhibit or contribute to the efficiency of the	• Project progress reports • Project co-implementers and beneficiaries • Other Stakeholders, including community leaders and government agencies • Happy, FLAS and Alliance Zambia (AZ) Board, management and staff	• Document review including of financial reports together with narrative progress reports • Individual and group interviews with Happy, FLAS and Alliance Zambia (AZ) management and staff as well as CSO using interview guide • Focus Group Discussions (FGDs with project partners co-implementers like)	• Happy, FLAS and Alliance Zambia (AZ) • Peer educators in Chipata and Swaziland • Alangizi in Chipata, and similar groups in Swaziland • School and health centres' managers • CSO

	implementation process?			
4.Outcomes	1. To ascertain the outcomes (intermediate i.e. less than 3 years - effects, changes, benefits, trends, etc at community, societal and population-wide level) of the project over the 15 months period since March 2009: - Is there evidence that interventions of the project are bringing about changes, effects, benefits, etc that have potential to contribute to impact in future? How do these compare with plan as per the project's *Change Hypothesis Diagram*? - What needs to be strengthened, changed or adjusted?	• Project proposal and progress report documents • Project co-implementers and beneficiaries • Other Stakeholders, including community leaders and government agencies • Happy, FLAS and Alliance Zambia (AZ) Board, management and staff	• Document review • Individual and group interviews with direct beneficiaries and implementers, government agencies, AZ and CSO using interview guide • Focus Group Discussions (FGDs)	• In-school youth at 4 schools in Chipata and another 4 schools in Swaziland • Peer educators in Chipata and Swaziland • Alangizi in Chipata, and similar groups in Swaziland • AZ, Happy and FLAS personnel (Board rep, Directors and project staff) • DATF/DACA, DHMT, Provincial Health Director in Chipata, MOHSW, NERCHA, MOE in Swaziland
5.Sustainability	• To what extent has the program succeeded in soliciting additional funding? • What are sustainability factors of the programme? • What factors inhibit or	• Project proposal and progress report documents • Project co-implementers and	• Document review • Individual and group interviews with direct beneficiaries and implementers,	• In-school youth at 4 schools in Chipata and another 4 schools in Swaziland • Peer educators in Chipata and

	contribute to the appearance of sustainable effects? • Does the project have the capacity to carry out activities (placement of staff, adequacy of budget, appropriate decision making process, etc) • Are there negative influences that potentially threaten sustainability of the project (social, cultural, economic, and political, etc)?	beneficiaries • Other Stakeholders, including community leaders and government agencies • Happy, FLAS and Alliance Zambia (AZ) Board, management and staff	government agencies, AZ and CSO using interview guide • Focus Group Discussions (FGDs)	Swaziland • Alangizi in Chipata, and similar groups in Swaziland • AZ, Happy and FLAS personnel (Board rep, Directors and project staff) • DATF/DACA, DHMT, Provincial Health Director in Chipata, MOHSW, NERCHA, MOE in Swaziland • Cooperating partners (donors) and government agencies
6.Policy dialogue	• What is the potential of the programme to influence national level policies/strategies for youth HIV prevention? • What partnerships have been established and with government and what are the results thus far?	• Happy, FLAS and Alliance Zambia (AZ) board, management and staff • Programme document and Progress reports • Communications, MOUs, etc between AZ and national, multi-country and regional organisations/ institutions • National institutions multi-lateral institutions running similar project	• Review of programme and progress report documents • Review of available MOUs, communication on intent to collaborate, etc • Interviews with national, multi-country and regional institutions using interview guide	• AZ, Happy and FLAS personnel (Board rep, Directors and project staff) • DATF/DACA, DHMT, Provincial Health Director in Chipata, MOHSW, NERCHA, MOE in Swaziland • Cooperating partners (donors)
7.Knowledge Management and Model of Best Practice	1. What is the potential of this strategy to develop and inform a youth focussed model on SRH/HIV 2. To note how the project takes stock of best practices in order to facilitate SDC and partners (AIDS Alliance, YHHS, FLAS and many others) to improve knowledge management, level of understanding and	• Project documents including progress reports • Happy, FLAS and Alliance Zambia (AZ) board, management and staff • Project beneficiaries (to find how the project compares with other which they may have experience with)	• Review of proposal, baseline and progress report documents • Interviews with Happy, FLAS & Alliance Zambia (AZ) Board, management and staff using interview guide • Interviews with Stakeholders,	• AZ (especially M&E officer and Learning & Documentation Officer) , Happy and FLAS personnel (including project staff) • FLAS and YHSS management and project staff

	ensure a result based approach within regional partnership	• Stakeholders, including community leaders and government agencies • SDC	including community leaders and government agencies using interview guide • Teleconference interview with SDC using interview guide	
8.Gender	1. To assess the extent to which gender has been factored and mainstreamed into the project. Do the project design and implementation have gender sensitive/responsive objectives, results, outcomes and indicators?	• Progress documents and reports • Happy, FLAS and Alliance Zambia (AZ) Board, management and staff • Peer educators, beneficiaries and co-implementing stakeholders	• Review of proposal, baseline and progress report documents • Interviews with Happy, FLAS & Alliance Zambia (AZ) Board, management and staff using interview guide	• Happy, FLAS & Alliance (AZ) personnel • In-school youth at 4 schools in Chipata and another 4 schools in Swaziland • Peer educators in Chipata and Swaziland • Alangizi in Chipata, and similar groups in Swaziland
	2. To establish the extent the project provided for and ensured needs, roles, participation and responsibilities of girls and boys relative to each other and how it has "impacted" on them. Are girls and boys participating and benefiting equally from the activities and services being provided under the project? Are results of the project disaggregated by sex to gauge the differential impacts on the boys and girls?	• Progress reports and beneficiary lists • Project beneficiaries both girls and boys • Service providers • Happy, FLAS and Alliance Zambia (AZ) Board, management and staff	• Review of progress reports • Interviews with girls and boys in the catchment areas and service providers • Review of project beneficiary lists. • Review of services offered	• In-school youth at 2 schools in Chipata and • another 2 schools in Swaziland • Out of school youth in 1 community each in • Chipata and Swaziland • Peer educators in Chipata and Swaziland • Happy and FLAS personnel 2 hospitals, 2 health centres
	3. To review how the project has addressed gender blind and insensitive social norms and structures that predispose young people especially young women/girls to HIV/AIDS. Have strategic issues of girls and boys been addressed by the project?	• Progress and training reports • Project beneficiaries • Happy, FLAS and Alliance Zambia (AZ) Board, management and staff • Service co-providers (teachers, alangizi, etc)	• Review of progress and trained reports • Interviews with people trained using interview guide • Interviews with girls and boys who benefit from or are involved with, the project	• Trained Alangizi and Peer educators in Zambia and similar groups in Swaziland • Boys and girls in 2 schools and out of school in 1 community in both Zambia and Swaziland • 2 hospitals and 2 health centres in Zambia and

			using interview guide • Interviews with service co-providers using interview guide	Swaziland
9.Regionality (and National Potential)	1. What strategies and actions has the project put in place in order to influence regional bodies/level policies, strategies and practices for youth HIV prevention? 2. What regional level partnerships and synergic initiatives have been established or planned for? What are the results thus far? 3. To ascertain extent to which the project is building on similar work already being done or supported by other institutions such as IPPF, gates Foundation, Irish Aid, UNICEF, UNFPA, Global Fund, Stephen Lewis Foundation, Gates Foundation, so as to develop/strengthen national level and Regionality of interventions as stated in section 3.5 of proposal document.	• Programme document • Progress reports • Communications, MOUs, etc between AZ and national, multi-country and regional organisations/ institutions • Happy, FLAS and Alliance Zambia (AZ) Board, management and staff • National institutions multi-lateral institutions running similar projects • Similar projects supported by the noted national, bilateral and multi-lateral institutions	• Review of programme and progress report documents • Review of available MOUs, communication on intent to collaborate, etc • Interviews with national, multi-country and regional institutions using interview guide	• Cooperating agencies such Irish Aid, UNFPA, UNICEF, Global Fund, IPPF, Gates Foundation, Irish Aid, UNICEF, UNFPA, Global Fund, Stephen Lewis Foundation, Gates Foundation in each country where applicable
10.Monitoring	1. To understand what level is monitored (output, result, as well as progress towards outcome and impact) and how is it done (inclusive of quality control of collected data)? - Is it done for all projects/programmes or for part of them only? - Is the monitoring requirement different from donor to donor (if yes, what are the differences and what does it imply for HIV Alliance? - What is the use of the monitoring in HIV Alliance (management purposes, reporting purposes, etc)? - Does the project incorporate assessment of progress towards outcomes and	• Project documents including progress reports • Happy, FLAS and Alliance Zambia (AZ) board, management and staff • Project beneficiaries (to find out ways through which they give feedback into the project) • Other Stakeholders, including community leaders and government agencies (to find out ways through which they give feedback into the	• Document review • Individual and group interviews with direct beneficiaries and implementers, government agencies, AZ and CSO using interview guide • On-site document sighting and verification – including evidence of utilisation of the	• In-school youth at 4 schools in Chipata and another 4 schools in Swaziland • Peer educators in Chipata and Swaziland • Alangizi in Chipata, and similar groups in Swaziland • AZ (especially M&E officer and Learning & Documentation Officer) , Happy and FLAS personnel (including project staff) • School managers,

	contribution to impact to demonstrate effects of the project on its target groups?	project)	project's monitoring and evaluation framework matrix.	Health Centres, MOE, DHMT, DATF, Provincial Health Director (Chipata), and MOHSW, MOE, NERCHA in Swaziland.

6.3 Appendix 3: Programme of the Evaluation Exercise

Day No.	Dates and Time Frames	Activity	Comments
		Evaluation mission	
1.	Mon May 10 08:00 – 17:00	Briefing by SDC and HIV Alliance Zambia – Inception.	Documents (such as programme /proposal document; strategic plan, progress reports – both narrative and financial - etc) from Alliance Zambia to be provided to consultant during or after the briefing meeting. Discuss evaluation proposed programme
2	Tues May 11 08:00 – 17:00	Documentation review; development of evaluation framework and instrument; programming of evaluation mission	Evaluation instrument and framework to be emailed to SDC by 17:00 hrs
3	Wed May 12 08:00 – 13:00 14:00 – 17:00	Documentation review continued; Receive feedback from SDC on evaluation framework and instrument as well as programme of evaluation mission Amend and finalise evaluation instrument, incorporating feedback from SDC	SDC expected to confirm project sites and stakeholders to be visited by the evaluation
4	Thu May 13 08:00 – 13:00 14:00 – 17:00	Data collection and Field Visit in Lusaka. Interviews with: Alliance Zambia; 1 national youth NGO 2 Regional NGOs (14:00 – 17:00)	Identification or communication of Orgs to be visited expected on 10/05/2010
5	Fri May 14 08:00 – 13:00 14:00 – 17:00	2 donor agencies and 1 national CSO network 2 government agencies (MOH/NAC and MOE)	Identification or communication of Orgs to be visited expected on 10/05/2010
	Sat May 15		
	Sun May 16		
6	Mon May 17	Travel to Project Sites (Chipata?) - Zambia	
7	Tues May 18	Field work in Zambia	Details of schedule to be worked out after document review and 1st briefing meeting with SDC. Field visits & interviews to include (1) youth interventions and youths (2) CSOs (3) community
8	Wed May 19	Field work in Zambia	
9	Thu May 20	Field work in Zambia	

			representatives/leaders (4) education institutions and (5) health services
10	Fri May 21	Return to Lusaka	
	Sat May 22		
	Sun May 23 06:00 – 14:00	Travel to Swaziland	SDC to facilitate logistics including flights and accommodation bookings, etc.
11	Mon May 24 08:00 – 10:00 10:00 – 17:00	Briefing Meeting with FLAS; reconfirm schedule and logistics Interviews with government and donor agencies in Swaziland	Details of schedule to be worked out after document review and 1st briefing meeting with SDC. Field visits & interviews to include (1) youth interventions and youths (2) CSOs (3) community representatives/leaders (4) education institutions and (5) health services
	Tue May 25	Field work in Swaziland	
12	Wed May 26	Field work in Swaziland	
13 a	Thu May 27	Return to Zambia; Drafting report (5 pages) and send to SDC	
13 b	Fri May 28	Briefing SDC	
	Sat May 29		
	Sun May 30		
	Post-mission		
14	Mon May 31	Attend forward planning workshop with (presentation of report)	To be Advised (TBA)
15	Tue June 1	Attend forward planning workshop with (presentation of report)	TBA
16	Wed June 2	Drafting of Final Report (with inputs from SDC, partners)	
17	Thu June 3	Drafting of Final Report (with inputs from SDC, partners)	
18	Fri June 4	Drafting of Final Report (with inputs from SDC, partners)	
19	Mon June 7	Completion and Submission of final report; Acceptance of Final Report by SDC and AZ	

6.4 Appendix 4: List of People Consulted

No.	Name of Persons Consulted	Sex	Institution/organisation (Region)	Position/Role
Swaziland				
1	Dudu Simelani	F	FLAS	Executive Director
2	Thobile Mngadi	F	FLAS - Ayihlome Ihlasele project	Coordinator
3	Lungelo Bhembe	M	FLAS	HHS Proj. Coord
4	Thoko Ngubeni-Simelane	F	MOH – Shiselweni Region	Regional Health Administrator
5	Rev Senzo Hlatshwayo	M	SADC Regional Coordinating Mechanism	Secretary
			CCM - Swaziland	Vice Chairperson
			World Vision - Swaziland	HIV/AIDS Prog. Manager

6	John Hlophe	M	MOE	Director – career Guidance
7	Pinky masuka	F	MOE – Manzini Region	Guidance Officers
8	Babili Kunene	M	MOE – Manzini Region	Guidance Officers
9	Phumuzile Mabuze	F	MWCH - SRH Unit	Manager
10	Margaret Thusile Bhembe	F	UNFPA – SRH, HIV and AIDS Unit	National Programme Officer
11	Fanyana Mabundza	M	Nazarene High School (Manzini)	Principal
12	Samuel Nkambule	M	Nazarene High School (Manzini)	Deputy Principal
13	Bridget Maziya	F	Nazarene High School (Manzini)	Teacher
14	Jabulile Simelane	F	Malandzela Primary (Hhohho)	Teacher
15	Bongani M Bulunga	M	Malandzela Primary (Hhohho)	Teacher
16	Bonsile Tsabetie	F	Lubulin High (Lubombo)	Pupil
17	Bongiwe Mngometulu	F	Lubulin High (Lubombo)	Pupil
18	Nontobeko Mamba	F	Lubulin High (Lubombo)	Pupil
19	Thabile Dlamini	F	Lubulin High (Lubombo)	Pupil
20	Nothando Sambo	F	Lubulin High (Lubombo)	Pupil
21	Nokwanda Ndwandwe	F	Lubulin High (Lubombo)	Pupil
22	Thabile Gwebu	F	Lubulin High (Lubombo)	Pupil
23	Ntombiksyise Dlamini	F	Lubulin High (Lubombo)	Pupil
24	Lindelwa Vilane	F	Lubulin High (Lubombo)	Pupil
25	Ayanda Vilane	F	Lubulin High (Lubombo)	Pupil
26	Phitsiwe Shongwe	F	Lubulin High (Lubombo)	Pupil
27	Fikile Mngometulu	F	Lubulin High (Lubombo)	Pupil
28	Siyabonga Ngcamphalala	M	Lubulin High (Lubombo)	Pupil
29	Mcolisi Matsensengwa	M	Lubulin High (Lubombo)	Pupil
30	Sehliselo Mkhatfwa	M	Lubulin High (Lubombo)	Pupil
31	Mpilo Klane	M	Lubulin High (Lubombo)	Pupil
32	Ndumiso Mugometulu	M	Lubulin High (Lubombo)	Pupil
33	Mtembile Mamba	M	Lubulin High (Lubombo)	Pupil
34	Mafiso Sibandza	M	Lubulin High (Lubombo)	Pupil
35	Ayanda Mamba	M	Lubulin High (Lubombo)	Pupil
36	Sanele Mkhonta	M	Lubulin High (Lubombo)	Pupil
37	Sifiso Shongwe	M	Lubulin High (Lubombo)	Pupil
38	Mahlubi I. Hadebe	M	NERCHA	Prevention Coordinator
39	Bheka Mziyako	M	FLAS – Research & Evaluation	Manager
40	Zelda Nhlabatsi	F	FLAS	Programme Director
41	Laura Hastings	F	FLAS	Youth Affairs Manager
42	Musa Magongo	M	FLAS	Finance & Admin Manager
43	Gadlela Mcebo	M	Nazarene High School (Manzini)	Pupil
44	Dlamini Mcobo	M	Nazarene High School (Manzini)	Pupil
45	Nkambule Phuzukuvela	M	Nazarene High School (Manzini)	Pupil
46	Khumalo Bethu	M	Nazarene High School (Manzini)	Pupil
47	Sakhile Mabuza	M	Nazarene High School (Manzini)	Pupil
48	Jimo Jiyane	M	Nazarene High School (Manzini)	Pupil
49	Nkosivile Nkambule	M	Nazarene High School (Manzini)	Pupil
50	Lwazi Mahlalala	M	Nazarene High School (Manzini)	Pupil
51	Peter Matsenjwa	M	Nazarene High School (Manzini)	Pupil
52	Lindani Dlamini	M	Nazarene High School (Manzini)	Pupil
53	Mnakekeli Gwebu	M	Nazarene High School (Manzini)	Pupil
54	Michael Mahlalala	M	Nazarene High School (Manzini)	Pupil
55	Sindisiwe Dlamini	M	Lubulin High School (Lubombo)	Staff member

56	Khanyisil Gama	M	Lubulin Youth Centre (Lubombo)	Security Officer
57	Nhleko Khumbazile	M	Lubulin Youth Centre (Lubombo)	Coordinator
58	Hlandze Ganile	F	Inkuundla – Lubuli (Lubombo)	Secretary
59	Matsenjwa Dumsile	F	AME Church (Lubombo)	Finance Officer
60	Mngometutu Thabsile	F	Evangelical Church (Lubombo)	Member
61	Gamedce Bongwe	M	Lubuli community (Lubombo)	Youth member
62	Sister Mngonetulu	F	MEC Church (Lubombo)	Finance Officer
63	Anne Vilane	F	Methodist Church (Lubombo)	Pastor
64	Alice Gumbi	F	Umugeugeuteli (Lubombo)	Umugeugeuteli
65	Sibongile Gumbi		N.C.P. (Lubombo)	
66	Amos Mafulela	M	Evangelical Church (Lubombo)	Pastor
67	Mrs Gwebu	F	Lubulin High School	Teacher
68	Mr. Mabila	M	Lubulin High School	Teacher
69	Mrs Mhlanga	F	Lubulin High School	Teacher
70	Miss Vilakah	F	Lubulin High School	Teacher
71	Mr. T V Dlamini	M	Lubulin High School	Teacher
72	Mrs Ndwandwa	F	Lubulin High School	Teacher
73	Mfundisi Gumbi	M		Reverend
74	Zanele Mngomebulu	M	Lubuli community	Youth member
75	Jacob Mngomebulu	M	Lubuli community	Youth member
76	Nozipho nsibande	F	Lubuli community	Youth member
77	Gugu Thwala	F	Lubuli community	Youth member
78	Muzi Tembe	F	Lubuli community	FLAS Agent
79	Derrick Mamba	M	Lubuli community	Entrepreneur
80	Thandizile Gina	F	AME Church	Member
81	Shalusile mngometedu	M	Roman Catholic Church	Member
Zambia				
82	Ernest Kabulansando	M	Bridge of Hope Foundation	Chief Executive Officer
83	Martha Zulu	F	Breeze FM	Progammes Manager
84	Martin Mbewe	M	Ministry of Education	Actg District Resource Centre Coordinator
85	Naomi Mshanga	F	Youth Development Foundation	Administrative Assistant
86	Kennedy Tembo	M	Corridors of Hope	Behavioural Change Communication Coordinator
87	Lisbon Chamwe	M	Human Rights Commission	Investigation Officer
88	Stephen Alick Phiri	M	Young Happy Healthy and Safe	Programme Officer
89	Kennedy Zulu	M	NZP+	Programme Officer
90	Richard Lukonde	M	NZP+	Programme CDO
91	Zikhalo Phiri	M	Young Happy Healthy and Safe	Executive Director
92	Tuma Mufuzi	M	Chankhanga Basic School	School Manager
93	Lanjani Miti	M	Assemblies of God Church	Pastor (trained in SRH by YHHS)
94	Nelson Mwanza	M	Chankhanga community	PTA Chairperson/Pastor
95	Crispin Chimbalanga	M	Chankhanga community	PTA Vice Chairperson
96	William Ngoma	M	Chankhanga community	PTA Member
97	Davison Zulu	M	Chankhanga community	PTA Member
98	Njema Nkhoma	F	Chankhanga community	Grandparent
99	Tikonkenji Luwe	F	Chankhanga community	Grandparent
100	Elias Sakala	M	Chankhanga Basic School	Guidance & Counselling Teacher
101	Esther Njovu	F	Chankhanga Basic School	Teacher
102	Maureen Mwanza	F	Chankhanga Basic School	Teacher

103	Betty Nyirenda Mufuzi	F	Chankhanga Basic School	Teacher
104	Idah Phiri Ngoma	F	Chankhanga Basic School	Senior Teacher
105	Barbara Sakala	F	Chankhanga Basic School	Teacher
106	Ekless Sakala	F	Chankhanga community	Grandparent
107	Sitembile Sakala	F	Young Happy Healthy and Safe	Programme Officer
108	Gertrude Sakala	F	Young Happy Healthy and Safe	Finance & Admin Officer
109	Given Soko	M	Young Happy Healthy and Safe	Driver
110	Morgan Gondwe	M	Hillside Basic School	Teacher
111	Theresa Chayafya	F	Hillside Basic School	Teacher
112	Rachel Phiri Shawa	F	Hillside Basic School	Teacher
113	Loveness Chisenga Banda	F	Hillside Basic School	Teacher/IST Coordinator
114	Eunice Njovu	F	Hillside Basic School	Teacher
115	Masheke Sinkala	F	Hillside Basic School	Pupil/Trained Peer Educator
116	Blessing Kumwenda	M	Hillside Basic School	Pupil
117	Agnes Sitwaala	F	Hillside Basic School	Pupil/Trained Peer Educator
118	Rosalia Anthonio	F	Hillside Basic School	Pupil/Trained Peer Educator
119	Vitiwe Banda	F	Hillside Basic School	Pupil/Trained Peer Educator
120	Agnes Lungu	F	Hillside Basic School	Pupil
121	Abraham Banda	M	Hillside Basic School	Pupil/Trained Peer Educator
122	Mirriam Mwale	F	Hillside Basic School	Pupil
123	Douglas Musonda	M	Hillside Basic School	Pupil/Trained Peer Educator
124	Daliso Mumba	M	Hillside Basic School	Pupil/Trained Peer Educator
125	Glory Chilambo	F	Hillside Basic School	Pupil/Trained Peer Educator
126	Kezias K Lungu	M	Ministry of Education - Chipata	DEBS
127	Owen Zimba	M	District Health Office, Chipata	Health Promotion Officer
128	Patrick Mbewe	M	District Health Office, Chipata	Actg District Medical Officer
129	Yolani Banda	M	District Health Office, Chipata	Planner
130	Moses Daniel C. Nyirenda	M	District Administration - Chipata	District Commissioner
131	Vincent Mwale	M	Vizenge Community	Alangizi
132	Kennedy Mwale	M	Vizenge Community	Alangizi
133	Joseph Nyirongo	M	Vizenge Community	Alangizi
134	John Phiri	M	Vizenge Community	Alangizi
135	Francis Njovu	M	Visenge Community	Peer Educator
136	Martin Kumwenda	M	Vizenge Community	Alangizi
137	Stanley Malunga	M	Vizenge Community	Peer Educator
138	Gertrude Zulu	F	Vizenge Community	Alangizi
139	Maria Mtonga	F	Vizenge Community	Alangizi
140	Agnes Theo	F	Vizenge Community	Peer Educator
141	Lyness Banda	F	Vizenge Community	Alangizi
142	Margaret Banda	F	Vizenge Community	Alangizi
143	Lameck Njovu	M	Vizenge Community	Peer Educator
144	Thomas Banda	M	Vizenge Community	Peer Educator
145	Oscar Kamanga	M	Vizenge Community	Youth Member/beneficiary
146	Chaison Banda	M	Vizenge Community	Alangizi
147	Peter Zulu	M	Vizenge Community	Alangizi
148	Lottie Kumwenda	M	Vizenge Community	Peer Educator
149	Prisca Tembo	F	Vizenge Community	Peer Educator
150	Juliet Zulu	F	Vizenge Community	Youth Member/beneficiary
151	Simon Sakala	M	Vizenge Rural Health Centre	Clinical Officer-in-Charge
152	Dickson Mbewe	M	Mnukwa Community	Youth Member/Beneficiary

153	Leornard Nyirenda	M	Chambawa Basic School	Head Teacher
154	Danny Syambayi	M	Mnukwa basic School	Head Teacher
155	Joshua Harrison Zulu	M	Mnukwa Royal Establishment	Chief Mnukwa's representative
156	Nellow Daka	F	Mnukwa Community	Peer Educator
157	Christine Tembo	F	Mnukwa Community	Youth Member/Pupil
158	Christopher Jere	M	Mnukwa Community	Youth Member
159	Martin Moyo	M	Mnukwa Community	Peer Educator
160	James Banda	M	Mnukwa Community	Youth Member
161	Phillip Shawa	M	Mnukwa Community	Youth Member
162	Bernard Mazyopa	M	Mnukwa Community	Peer Educator
163	Joseph Banda	M	Mnukwa Community	Peer Educator
164	Francis Mazyopa	M	Mnukwa Community	Alangizi
165	Ashani Banda	M	Mnukwa Community	Alangizi/ Village Headman
166	Lyford Banda	M	Mnukwa Community	Alangizi
167	Wilson Lungu	M	Mnukwa Community	Alangizi
168	Baziliyo Zulu	M	Mnukwa Community	Alangizi
169	Yotam Kumwenda	M	Mnukwa Community	Peer educator
170	Moses Banda	M	Mnukwa Community	Youth Member
171	Michael Shawa	M	Mnukwa Community	Youth Member
172	Bridget Phiri	M	Mnukwa Community	Youth Member
173	Agnes Mbewe	F	Mnukwa Community	Alangizi
174	Royce Zulu	F	Mnukwa Community	Alangizi
175	Hilda Banda-Zulu	F	Mnukwa Community	Alangizi
176	Matildah Chokani	F	Mnukwa Community	Alangizi
177	Reselian Sinazongwe	M		
178	Esnart Ngulube	F	Mnukwa Community	Alangizi
179	Phylis Kawanga	F	Mnukwa Community	Alangizi
180	James Mazyopa	M	Mnukwa Community	Youth Member
181	Esther Mwale-Zulu	F	Mnukwa Rural Health Centre	Midwife/centre in-Charge
182	Agnes Lungu	F	Mnukwa Rural Health Centre	CDE
183	Jessy Chulu	F	Mnukwa Community	Youth member
184	Bernard Daka	M	Mnukwa Community	Youth Member
185	Jon Ngoma	M	Mnukwa Community	Alangizi
186	Beatrice Nyau	F	Chankhanga Basic School	Pupil
187	Taonga Mufuzi	F	Chankhanga Basic School	Pupil
188	Regina Lungu	F	Chankhanga Basic School	Pupil
189	Tinthani Banda	F	Chankhanga Basic School	Pupil
190	Nancy Moyo	F	Chankhanga Basic School	Pupil
191	Maureen Nkhuwa	F	Chankhanga Basic School	Pupil
192	Dolica Mwanza	F	Chankhanga Basic School	Pupil
193	Gertrude Phiri	F	Chankhanga Basic School	Pupil
194	Grandson Nyau	M	Chankhanga Basic School	Pupil
195	Matsauso Tembo	M	Chankhanga Basic School	Pupil
196	Geoffrey Ziwa	M	Chankhanga Basic School	Pupil
197	Gift Mbewe	F	Chankhanga Basic School	Pupil
198	Mercy Banda	F	Chankhanga Basic School	Pupil
199	Victor Banda	M	Chankhanga Basic School	Pupil
200	Fanwell Daka	M	Chankhanga Basic School	Pupil
201	Langson Nkhoma	M	Chankhanga Basic School	Pupil

202	Joseph Zulu	M	Chankhanga Basic School	Pupil
203	Reuben Banda	M	Chankhanga Basic School	Pupil
204	Tozana Jere	M	Chankhanga Basic School	Pupil
205	Zebron Daka	M	Chankhanga Basic School	Pupil
206	James Moyo	M	Chankhanga Basic School	Pupil
207	Yusuf Nkhoma	M	Chankhanga Basic School	Pupil
208	Abraham Mwanza	M	Chankhanga Basic School	Pupil
209	Barbara Mwale	F	Chankhanga Basic School	Pupil
210	Mphaso Chibanga	F	Chankhanga Basic School	Pupil
211	Jessica Jere	F	Chankhanga Basic School	Pupil
212	Fatima Ngoma	F	Chankhanga Basic School	Pupil
213	Rehema Mwale	F	Chankhanga Basic School	Pupil
214	Roxien Mumba	F	Chankhanga Basic School	Pupil
215	Hellen Kolala	F	Chankhanga Basic School	Pupil
216	Dr. Alex Simwanza	M	National AIDS Council	Director:

6.5 Appendix 5: Working Definitions of M&E Terms

NO.	TERM	WORKING DEFINITION
1	Input	A resource or commodity used or expended in a programme or intervention. For example money, personnel, energy, facilities, supplies and time. Inputs are required in order to carry out activities.
2	Activity	A set of tasks carried out in order to achieve a purpose; e.g. training, counselling and peer education. Activities are necessary to produce outputs and results.
3	Output	A direct product or deliverable of a programme activity, in form of commodities, entities, etc. For example, trained staff, people counselled and tested for HIV. Outputs are necessary to produce results.
4	Result	Value derived from activities and outputs; e.g. knowledge and skills, availability of VCT services. Results seek to fulfil objectives and goals.
5	Objective	Statement of specific purpose of what is to be achieved. It should be measurable, achievable, realistic and time-bound
6	Goal	Statement of broad purpose of what is to be achieved. It should be realistic, achievable, but not necessarily specific or measurable.
7	Outcome	Change, effect, trend, benefit, etc of an intervention on large (community-wide, nation-wide, societal) target audiences or populations, taking place at short or intermediate term (0.5 to 2 years). For example, behavioural change, knowledge and skills, increase in social support, and change in STI trends.
8	Impact	Change, effect, trend, benefit, etc of an intervention on large (community-wide, nation-wide, societal) target audiences or populations, taking place at longer term (3 or more years). For example, HIV trends, AIDS related mortality, social norms, coping capacity in community, and morbidity. These are rarely attributable to a single programme or stakeholder.