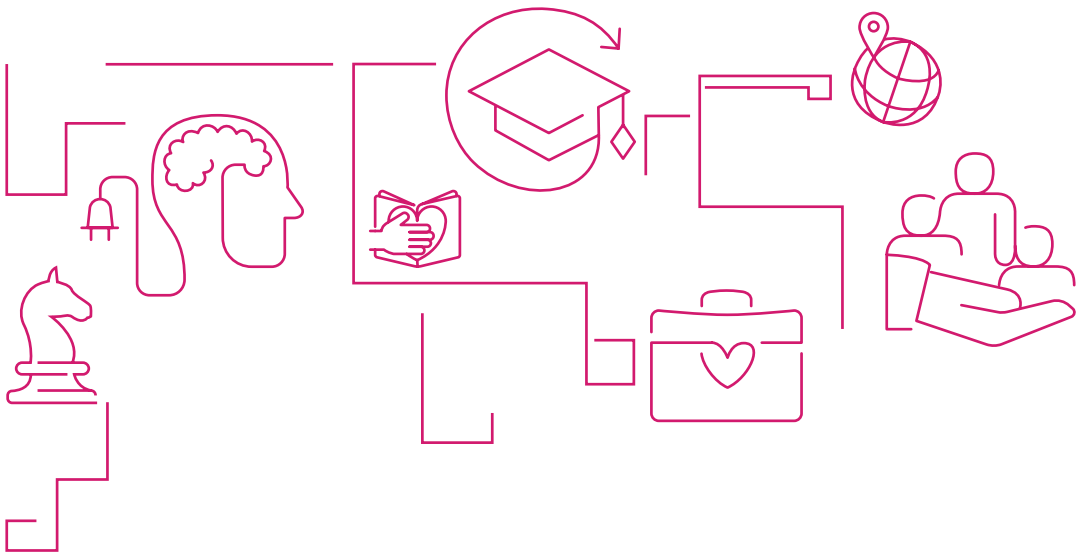

Final Evaluation of the Netherlands' Regional HIV/AIDS and SRHR Programme in Southern Africa

Annexes to Final Report

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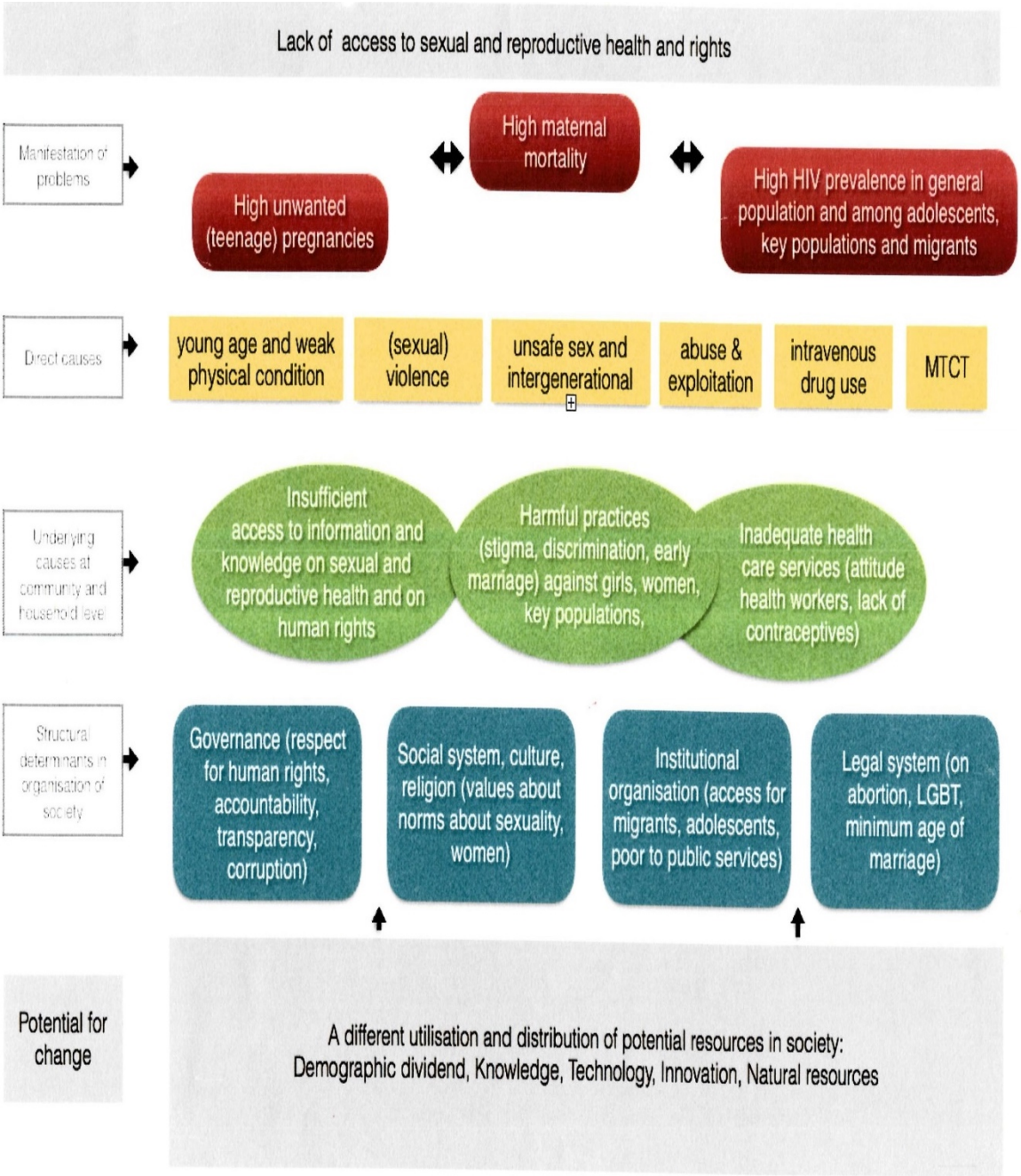
CONTENTS

Annex 1 Theory of Change Regional Programme



Annex 2 Country Case Study Mozambique

1. Country Context (HIV/SRH)

Mozambique has a population of almost 28 million people. HIV prevalence in 2015 was 13.2% (for adults aged 15-49), among which 17% in urban areas and 11% in rural areas. In the first semester of 2018, ART coverage for PLHIV was 56% (1,216,427), with 53% of ART HIV-positive children (89,394) and 57% of ART HIV-positive adults (1,127,033). The National Strategic Plan to Fight HIV and AIDS and National Guide for KP approach (Ministry of Health) have defined four groups of key populations namely (i) female sex workers (FSW) and their clients, (ii) men who have sex with men (MSM), people who inject drugs (PID) and prisoners. PLHIV, adolescent girls and young women, and mobile and migrant workers are among five defined groups of vulnerable populations. The response is coordinated by the National AIDS Council and guided by the current National Strategic Plan to Fight HIV and AIDS (2015-2019) in Mozambique. This Strategic Plan aims at reducing the incidence of HIV infections among young people, particularly girls aged 15-24, and improving the human rights of people living with HIV and AIDS.

National legislation has some protections in place such as Law n. º 19/2014, Lei de Protecção da Pessoa, Candidato e Trabalhador Vivendo com HIV e SIDA [Law for the Protection of Persons, Candidates and Workers Living with HIV and AIDS]. The National Strategy to Prevent and Fight against Underage Marriage (2016-2019) is among examples of the creation of a better legal environment to protect PLHIV and promote SRHR of young key populations. However, as noted in the Legal Environment Assessment (LEA) of the LPP programme and the baseline study on young key populations, there are gaps in the legislation. For instance, sex work and same-sex relations are neither criminalized nor legal which leaves space for stigma, discrimination and violence against these groups of key populations.

2. Introduction to the country programme

Four projects are implemented in Mozambique as part of the Netherlands' Regional HIV/SRHR programme: READY +; the IOM SRHR/HIV Knows No Borders project, the UNDP Linking Policy and Programming (LPP) project and the Hands Off! project.

REPPSI/READY+[1] is a four-year project (2016 – 2020), led by Frontline AIDS, aimed at working with and for adolescents and young people living and affected by HIV (A&YPLHIV) in Mozambique, eSwatini, Tanzania and Zimbabwe. The main aim of the project is to increase care and comprehensive support for A&YPLHIV by promoting rights in sexual and reproductive health and mental health. With this aim, the project will foster resilience[2].

In Mozambique, the project is being implemented by the Regional Psychosocial Support Initiative (REPSSI) in Maputo city, Maputo and Beira. REPSSI has three implementing partners in Maputo namely ADECC, Associação Hixikanwe and OASIS. The implementing partners work with trained Community Adolescent Treatment Supporters (CATS) to provide sustained support to their peers - A&YPLHIV and adolescent and young people in general - both at community level and at the health facilities. The Knows no Borders project is

1 International HIV/AIDS Alliance & READY (2019) Terms of Reference Mid Term Review of the READY+ Project.
2 Digital & Health (n.d.) Mapa Interactivo de Serviços de Saúde Sexual e Reprodutiva para Adolescentes e Jovens. Maputo.

coordinated by IOM, and it aims at improving the sexual reproductive health rights of migrants, adolescent & young people and sex workers in six countries in the SADC region: South Africa, Mozambique, eSwatini, Malawi, Lesotho and Zambia.

In Mozambique, the project is being implemented by the Associação Pfuka Lixile in Ressano Garcia in Maputo Province and by Save the Children in Chifunde district in Tete Province. In Chifunde, the project focuses on the Mwaladzi administrative post, in five communities. These are Mugomo, Khamande, Bolimo, Nkantha and Mualadzi. Change agents have the role of supporting the communities in sexual reproductive health and rights and HIV by for instance, providing counselling, referring patients to health centres, helping in scheduling appointments at health facilities and doing home visits.

The Linking Policy to Programming project implementation is coordinated by UNDP and aims to strengthen sexual reproductive health and rights (SRHR) of young key populations in five countries in the region: Angola, Madagascar, Mozambique, Zambia and Zimbabwe. In Mozambique, UNDP facilitates Legal Environment Assessment (LEA) processes in which government officials, lawyers and representatives of key populations jointly assess current legislation and the need for legal reforms. UNDP has also facilitated a baseline study[3] on young key populations and sexual and reproductive health and rights. The study highlighted that there was insufficient understanding of the heterogeneity within MSM and FSW populations, and that there was a need for more precise knowledge on the types of support and services that young key people needed to mitigate SRH risk and exercise their rights in Mozambique[4].

The Hands Off! sex workers project is a project coordinated by Aidsfonds (NL) and aims to reduce the violence against sex workers in Botswana, Mozambique, Namibia, South Africa, and Zimbabwe. The project is committed to strengthening civil society and sex workers in their response to violence against sex workers. Research on violence against sex workers is undertaken by the sex workers themselves to map the violence, calls for attention to the violence and formulate recommendations to curb the violence.

In Mozambique, the project is jointly coordinated by Pathfinder International and Tiyane Vavassate. In two focal point areas - Maputo city and Matola-peer educators have worked with Pathfinder International and Tiyane Vavassate, Gabinete de Atendimento à Família e Menor Vítima de Violencia (GAFMVM) at the Mozambique Republic Police (MRP) and health facilities to protect the sexual reproductive health and rights of sex workers, as well as denounce and refer cases of violence against sex workers.

3. Methodology

The regional evaluation assessed the extent to which the programmes contributed to observed change in a selected number of results. A contribution analysis was conducted to assess the changes. The regional evaluation consisted of various meetings, review visits, interviews and focus groups discussions. The evaluation was carefully planned in close coordination with the country focal points/coordinators of the four programmes. The

3 The study was conducted by Medical School of Eduardo Mondlane in partnership with Health Economics and HIV AIDS Research Division (HEARD), University of KwaZulu-Natal.
4 HEARD, MOZAMBIQUE: Baseline report on young key populations and sexual and reproductive health and rights, 2018.

coordinators assisted the evaluation team in drafting a detailed work plan, preparing visits, providing documents and made suggestions of key informants.

In terms of data collecting, 12 days of field research were carried out in Mozambique. The field research included semi-structured interviews and focus group discussions with the coordinators of the four programmes, implementing partners, two governmental officials, health facilities´ workers, representatives of advocacy targets, beneficiaries and parents and care givers in Maputo, Moamba, Ressano Garcia and Beira. Purposive and convenience sampling methods were used to select stakeholders and participants. In total, 7 key-informant interviews, 8 FGDs, 2 group interviews and 1 interview with a care giver were carried out for the REPPSI/READY+ project; 6 key-informant interviews, 3 FGDs, 1 group interview, and 1 interview with a beneficiary and a change agent for the IOM project; 7 key-informants interviews for the UNDP project and; 7 key-informant interviews, 3 FGDs and 1 group interview with two focal points for sex workers and 1 with two Tiyane Board members. All evaluation participants were informed about the purpose and aims of the evaluation and the use of data provided before the commencement of the interviews, FGDS and group interviews. Informed and voluntary consent was sought and obtained specifically from participants under 18 years (READY + programme).

The contribution analysis question for REPSSI/READY+ was: *To what extent and how have the READY+ community dialogue sessions/workshops contributed to changing social norms around sexuality and health in communities?*

The main impact statement is: A&YPLHIV are resilient, empowered and knowledgeable and have the freedom to make healthier choices and access services and commodities related to their sexual and reproductive health and rights. In the READY+ programme, the following three plausible change pathways could be identified from the information available:

- Pathway 1: Community Access Treatment Supporters (CATS) are trained, active and successful in outreach to target group which leads to an increase in numbers of A&YPLHIV participating in group safe spaces where they learn about issues relating to SRHR and HIV. This, in turn, leads to a better access to accurate, relevant and comprehensive information for A&YPLHIV, which results to a better understanding of the issues and a higher self-reported adherence rate to ART.
- Pathway 2: Parents/caregivers participate in community dialogue sessions/trainings that provide platforms for debating social norms around sexuality and health. These community dialogue sessions and the acceptance of CATS in the communities contribute to parents and caregivers engaging in open dialogue with their children about HIV and SRHR. This, in turn, leads to safe and secure communities that promote the rights, health and wellbeing of A&YPLHIV and support their access to SRHR information, services and commodities. This pathway is reportedly plausible in Mozambique, but not in Zimbabwe and eSwatini due to delays in technical assistance to conduct the training.
- Pathway 3: A&YPLHIV are aware and know their preferences with regards to the quality of services (demand side). Health care workers have developed an improved understanding and relationship with CATS along with the A&YPLHIV they serve (supply-side). This leads to having dedicated youth-friendly services, which contributes to an improved referral system and better cooperation between smaller health facilities

and larger health centres, which, in turn, leads to improved uptake of and utilization of services by A&YPLHIV.

The contribution analysis question for SRHR Knows no Borders programme was: *How have the programme´s training/sensitization sessions delivered to change agents (health care workers, gatekeepers such as traditional and religious leaders, local NGOs) contributed to better access to and use of SRH-HIV services by target beneficiaries?*

The Impact statement is: Improved SRHR and HIV outcomes among target populations in migration affected communities in the SADC region. The SRHR Knows no Borders programme is explained in the following three plausible pathways of change, focused on the demand side of services, supply and accessibility of services, and creating an enabling environment:

Pathway 1: Demand-creation - Training and sensitization of change agents recruited from the community to provide SRHR-HIV health education to the target beneficiaries (migrants, AYP and SWs) leads to improved knowledge among beneficiaries, which, in turn, leads to a greater freedom of choice for the target populations regarding their sexuality. This results in an increase in demand for accessible and quality SRHR-HIV services and ultimately this leads to better sexual health outcomes for the target beneficiaries.

Pathway 2: Supply & accessibility of responsive SRHR/HIV services - Training and sensitization of change agents (health care workers, gatekeepers such as traditional and religious leaders, local NGOs) to do outreach to target beneficiaries (migrants, AYP and SWs) leads to an increase of access to and use of SRH-HIV services by target beneficiaries which contributes to better sexual health outcomes for the target beneficiaries. Key assumption here is an existence of functional referral systems (improved linkages between service providers) and an improved and functioning SRH/HIV commodities supply chain.

Pathway 3: Enabling environment – Sensitization of national and regional level policymakers and gatekeepers about SRHR-HIV needs for migrants, AYP and SWs leads to a greater willingness to cooperate on the issues. This results In to the establishment of national and regional technical consultations to discuss gaps and challenges. This, in turn, leads to the development of advocacy action plans to address identified gaps and challenges related to SRHR and HIV among migrants, sex workers and young people and in the establishment of national and cross border coordination mechanisms which results in the creation of an enabling environment to address the SRHR-HIV information and service needs of the target populations.

The contribution analysis question Linking Policy to Programming (UNDP) was: *How have community-based groups contributed to regional and national CSOs claiming rights/advocating for strengthened national HIV/SRH-related legal, policy and strategy environments and improved HIV/SRH service provision for YKPs?* The programme's main impact statement is: To improve SRH outcomes for YKP in SADC countries. The Linking Policy to Programming project is explained by the following five plausible pathways of change, identified from the documentation:

- Pathway 1: Development of research, reviews and tools on HIV/AIDS & SRHR for YKP groups. This pathway is most concerned with delivering tools such as: (1) Legal Environment Assessment (LEA) produced; (2) National Steering Committee (NSC)

established; (3) Civil Society Engagement Scan (CSES) produced; (4) Regional training for NSC members (40) on the implementation of LEA; (5) Advocacy Guide for YKPs produced, (6) KP scorecard produced and; (7) Scorecard country reports produced. It could not be determined from the evidence If the other steps In the pathway are plausible. The programme has delivered outputs so far.

- Pathway 2: Strengthening the capacity of national governments could lead to governments putting in place HIV/SRH related legal, policy and strategy documents that respect the rights of YKP.
- Pathway 3: Strengthening the capacity of regional and national CSOs including community groups to claim rights and advocate for strengthened national HIV/SRH related legal, policy and strategy environments and improved HIV/SRH service provision for YKPs. Here too, focus is on delivering outputs such as having YKP Advocacy Group established (to participate in, contribute to and learn from regional and multi-country activities and events).
- Pathway 4: Strengthen capacity and leadership of SADC to facilitate member states put in place legal, policy and strategy environments that respect the right of YKPs and promote regional learning

The contribution analysis question for the Hands Off! programme was: *To what extent and how have sex workers´ individual and organizational capacity trainings on legal and constitutional rights contributed to establishment of collaborative community-led response systems to decrease violence against sex workers?* The project's impact statement is: reducing violence and HIV transmission caused through violence and supporting violence victims amongst sex workers in the Southern African region. The Hands Off! project can be illustrated by the following pathways of change:

- Pathway 1: Individual and organizational capacity training of sex workers, especially on legal and constitutional rights, leads to increased empowerment on an individual and community level. This, in turn, leads to a greater ability to access necessary legal services which leads to sex workers claiming rights (with or without assistance) AND less client violence.
- Pathway 2: Sex worker's empowerment and increased knowledge on their rights leads to increased collaboration with and sensitization of potential allies (police, NGOs, health care organisations. media, lawyers), which consequently results in an increase in (collaborative) services and protections, including a community-led response system to violence, contributing to a decrease in violence.
- Pathway 3: Sex worker's empowerment and increased knowledge on their rights leads to an increased capacity for requesting legal support and provide case documentation which leads to sex workers being better equipped to access their rights and contribute to decision making processes for the development of national policies and guidelines.

4. Contribution Analysis

4.1 Contribution Analysis to READY +

Table 1 Community dialogue sessions and changes in social norms around sexuality and health in communities

Contributing FACTORS	TYPE	EVIDENCE Signs/facts	SIGNIF.

A. Solid technical assistance to CATS	Primary	CATS have benefited from training in matters of SRHR and HIV. CATS are also A&YPLHIV. This has been fundamental to assist their peers in communities and health facilities.	Strong
B. Regular community dialogues involving caregivers and parents	Primary	CATS organize and facilitate community dialogues in which SRHR related to adolescent and young population are discussed. Care givers and parents have supported CATS in assisting A&YPLHIV to maintain themselves in anti-retroviral treatment.	Strong
C. Proper consultation to identify intervention communities	Primary	The project was presented in health services at central and provincial levels. The three implementing partners (ADECC and Hixikanwe in Maputo, and OASIS in Beira) have worked with health facilities in which there is a significant number of adolescents and young people seeking for services. The health facilities have helped to recruit and guide CATS	Strong
D. Dedicated youth-friendly services in health facilities	Primary	CATS provide counselling, referrals and guidance in scheduling appointments at health facilities, monitoring antiretroviral treatment and home visits. Health facilities have *Serviços de Atendimento ao Adolescentes e Jovens* (SAAJ) which are specifically for adolescents and young population. A&YPLHIV that visit Health facilities participating in the project have access to a scorecard that can be used to assess their satisfaction with the services. This has contributed to more youth-friendly services in health facilities.	Medium
E. Previous experience of working with migrants	Contributing	The three implementing partners have experience in working with A&YPLHIV. For instance, Hixikanwe is a community- based organisation of people living with HIV. This experience combined with the project focus on A&YPLHIV has provided support for CATS and their work with their peers in communities and health facilities.	Medium
F. Highly mobility of health care workers	Contra	The project requires strong and constant involvement of health care workers not only in health care provision but also in community dialogues and training and mentoring change agents. Health professionals with whom beneficiaries (A&YPLHIV), communities, and CATS have worked are subject to transfers to other health facilities. Whenever this occurs, it is necessary to train the new health care workers.	Strong
G. Challenges to retain CATS	Contra	CATS are also A&YPLHIV. Their work has helped them to keep on their treatment regime. Many of them started going to school. To do home visits they have to travel far, sometimes	Strong

		by foot. This has been a challenge to the implementing partners and CATS.	

The change observed:
Community dialogue sessions/workshops have contributed to changing social norms around sexuality and health in communities. CATS from each of the three implementing partners (ADECC, Hixikanwe and OASIS) have organized and facilitated dialogue sessions in communities and health facilities. CATS work in and with communities, do home visits to A&YPLHIV, support them with counselling and taking ART medication and do active search for those A&YPLHIV who stopped treatment. They are also based in health centres to help A&YPLHIV booking appointments with health care workers, and support YPLHIV in receiving ARTs. Parents and caregivers have been key actors in discussing SRHR and HIV in families and communities as well as support A&YPLHIV.

Contribution Claim:
Based on the analysis of contributing factors (Table 1), it can be concluded that the community dialogue sessions and workshops have made the primary contribution to changing social norms around sexuality and health in communities. Discussing SRHR in communities was not easy. It has been difficult to discuss with care givers, parents and adolescents and A&YPLHIV. The programme implementing partners, the CATS, health care workers and community leaders have cooperated strongly together to make community dialogues possible. Community dialogues are complemented by home visits and dialogues sessions at health care facilities.

The programme made significant progress to enable this by providing solid technical assistance to CATS, do proper consultations to identify the best intervention communities and have regular community dialogues involving caregivers and parents. This enabled youth-friendly services in health facilities. One external factor has also contributed to this achievement: the previous experience of implementing partners in working with A&YPLHIV helped a lot to make a swift start with the programme. Two external factors are endangering the progress in READY+. These are the high mobility of health care workers and the working conditions such as remuneration and subsidies for transport to keep CATS motivated and engaged. Sometimes, they have to walk long distances to do home visits, reach beneficiaries and organize community dialogues and without some form of remuneration this is hard. Whenever a health care work is transferred to a different health care facility, the implementing partners have to train the new health care workers about the programme and the work with CATS. This takes time and CATS had spent some time without a proper supervision and support from health care workers. A peer-support training within the facilities would increase the sustainability of the system.

Conclusions and recommendations to READY +
The programme has contributed to changes in social norms around sexuality and health in communities. CATS, health care workers and community leaders have made community dialogues possible to discuss SRHR issues related to A&YPLHIV in communities and families. Community members and care givers have helped and supported CATS in assisting A&YPLHIV. CATS have assisted and supported A&YPLHIV, families, communities and health facilities by organizing dialogues, making home visits, providing counselling and orientating them to the health facilities. The high mobility of the health care workers and

challenges to retain CATS are among factors that the programme needs to address to be able to achieve in the end the impact envisaged. Thus, it can be recommended the following:

- Use the available forum and coordination meetings with CNCS and health facilities to identify strategies to reduce the impact of the high mobility of the health care workers.
- Communities' dialogues can be challenging both to organize and coordinate. Provide CATS with more means both in terms of remuneration, training, information and tools for daily work with A&YPLHIV, communities and health facilities. CATS had to travel long distances by foot to do home visits to A&YPLHIV. Transport arrangements and an increase in the financial support are needed to reduce exhaustion and prevent them from leaving the programme.
- CATS are A&YPLHIV themselves. As such, they also need support and assistance. Implementing partners and health care workers need to be more sensitive and attentive in assisting CATS and monitoring their work.
- Adolescents and young people, communities and health facilities still need the project. One way for the project to become sustainable is for the health facilities themselves and the community to take ownership by adopting the model and including adolescents and young people as key actors to work with their peer in SRHR and A&YPLHIV.

4.2. Contribution Analysis for IOM´s HIV and SRHR Knows no Borders

Table 2 Better access to and use of SRH-HIV services by target beneficiaries

Contributing FACTORS	TYPE	EVIDENCE Signs/facts	SIGNIF.
H. Inclusive process of selecting and training change agents	Primary	Community leaders participated actively in the process of selecting and recruiting change agents. The selection criteria used were (1) to be from community/migrant; (2) know how to read and write; (2) speak the local language; (4) have no criminal record. The involvement of community leaders extends to monitoring the activities of change agents in communities.	Strong
I. Supply and accessibility of responsive SRHR/HIV services	Primary	The change agents support counselling, testing, referrals and guidance in scheduling appointments at health facilities, monitoring antiretroviral treatment and home visits. As for SRHR in general, CAs participate in counselling migrants, sex workers, and other community members as well as do condom distribution and attend health fairs. Change agents also assist sex workers and their clients during evenings by providing counselling and condoms. In schools, change agents offer advice to students in places called the *cantinho do jovem (*youth corner).	Strong
J. Proper consultation to identify intervention communities	Primary	The project was presented at central levels (Ministry of Health and National AIDS Council) and at provincial (Maputo and Tete) and district levels (Ressano Garcia and Chifumde). Ressano Garcia borders South Africa and is Mozambique's busiest border. Chifumde is a district that connects with Zambia and Malawi. The	Strong

		intervention in five communities of the Mualadzi Administrative Post was suggested by the reference group coordinated by the state prosecutor's office.	
K. Regular participation in national and regional dialogues	Primary	Community members, implementing partners, and change agents participate in coordination forums in communities, localities, districts, provinces, and in national dialogues. They also participate in discussions with cross-border reference groups and coordination mechanisms with countries such as Malawi and South Africa.	Medium
L. Previous experience of working with migrants	Contributing	IOM and the Pfuka Lixile Association had experience of working with migrants and SRHR prior to the start of the project. Save the Children also has a lot of experience in SRHR issues. This experience combined with participation in community, national, cross-border dialogues and coordination with health facilities has led to more migrants and community members having access to health services and more information about SRHR.	Medium
M. High mobility of health care workers	Contra	The project requires strong and constant involvement of health care workers not only in health care provision but also in community dialogues and training and mentoring change agents. Health professionals with whom beneficiaries, communities, and change agents have worked are subject to transfers to other health facilities. Whenever this occurs, it is necessary to train the new health care workers transferred to the communities where the project is being implemented. And that takes time and resources.	Strong
N. Persistence of cultural barriers to address SRHR	Contra	The project has mobilized community leaders and their support has been critical for change agents to work in communities. There are some cultural barriers that pose challenges in the discussion of SHRH. For instance, in Chifunde it is has not been easy to discuss abortion. Community dialogues, school youth corners, and community leadership training in SHRH and on project objectives and the role of leadership have contributed to greater openness in the discussion of SHRH issues including on contraceptive methods. The growing influx of communities at health fairs is an example of this.	Strong

The change observed:
The project has contributed that migrants, AYP and SW have improved knowledge on SRHR and HIV and have access to appropriate and friendly services. Results show an increased use of SRHR/HIV services. The intervention communities in Ressano Garcia and Chifunde have provided training in SRHR for change agents and, community leaders and created a strong liaison with health centres and schools. Tents for testing and counselling, youth corners in

schools and home visits made by change agents have contributed significantly to the increase in knowledge of, accessibility to and increased use of SRHR/HIV services.

Contribution Claim:

Based on the analysis of contributing factors (Table 2) it can be concluded that the HIV and SRHR Knows no Borders programme has made the primary contribution to improved knowledge, accessibility and increased use of SRHR/HIV services by migrants, AYP and SW in the communities where the programme is active. The programme made four significant choices to enable that, among which are: proper consultation with government (at national, provincial and district levels) and community leaders to identify the intervention communities, an inclusive process of selecting and training change agents, support to ensure supply and accessibility of responsive SRHR/HIV services and regular participation in national and regional dialogues.

One important external factor has contributed to this result. That is the previous experience and expertise of the implementing partners in working with migrants, AYP, SW and SRHR/HIV services. Two external factors are endangering the progress made by change agents and the project. These are the high mobility of health care workers and the persistence of cultural barriers to address SRHR issues, particularly in Chifunde. Health care workers from intervention communities had been transferred to other health care facilities. Whenever that happened, the implementing partners had to train the new health care workers about the programme and the work with change agents. Cultural barriers had prevented the discussion of sensitive issues such as abortion.

Conclusions and recommendations to IOM HIV and SRHR Knows no Borders
The project contributed to the creation of new SRHR and HIV knowledge and service platforms such as five community dialogue forums, two sex worker associations and teenage and youth counselling corners. Communities are using the health facilities and the tents where change agents do HIV testing and provide counselling. In Chifunde, a site with a low literacy rate, the community radio has helped raising awareness on SRHR and HIV issues. Some of the change agents are from mobile populations themselves. The high mobility of health care workers and persistence of cultural barriers to address SRHR are among factors that the programme needs to address to deliver the envisaged impact. Thus, it can be recommended the following:

- Use the available forums, platforms and meetings to discuss strategies to handle the high mobility of health care workers, including the possibility for a peer training mechanism within the group of trained health care workers.
- Equip change agents with more means both in terms of (financial) resources, training, information and tools for daily work. Beneficiaries in ART treatment and change agents asked for support for food. It had been hard to stay in treatment when there are economic issues and difficulties to establish a livelihood.
- Many manuals for change agents are in English. It takes time to translate them into Portuguese so that they can get input from the Ministry of Health and other key actors. Due to language barriers, the implementing partners translate the manuals and working documents before sharing them with government institutions (Ministry of Health), stakeholders, change agents and beneficiaries. As a Portuguese speaking country, working in Mozambique requires time to do translations of working documents and materials related to the programme. This also comes with a cost. Thus, additional budget is needed to cover translation costs.

- Chifunde and Ressano Garcia are two different sites. As such they need specific outcomes. Even though the programme had increased access to SRHR knowledge and services including on conceptive methods, Chifunde is a rural setting where cultural barriers had posed challenges to the programme.
- There are other key migration corridors such as Goba, Namaacha and Machipanda. The programme coordinators, government and stakeholders could consider discussing how to address SRHR of young key population in these corridors based on successes and lessons learned at the current programme sites.

4.3. Contribution Analysis to UNDP Linking Policy to Programming

Table 3 Development of research, reviews and tools on HIV/AIDS & SRHR for YKP groups

Contributing FACTORS	TYPE	EVIDENCE Signs/facts	SIGNIF.
A. Conduction of research on HIV/AIDS & SRHR for YKP	Primary	Two studies on HIV/AIDS & SRHR for YKP have been carried out. These are the Legal Environment Assessment (LEA) and Baseline study on young key populations and sexual and reproductive health and rights. LEA is in process of validation and dissemination. A civil society engagement scan (CSES) was also produced.	Strong
B. Creation of Advocacy Group for YKP	Primary	The Advocacy Group became particularly active in 2019 with a change of the implementing partners coordinating it –LAMBDA. Organisations working with YKP were involved and meetings are held on a regular basis. In September this year there was a training of the key populations on conducting advocacy to improve policies on sexual and reproductive health and rights. LAMBDA has participated in regional and international meetings on SRHR.	Medium
C. Existence of National Steering Committee (NSC)	Contributing	The National Steering Committee (NSC) was established before the commencement of the project. It is coordinated by the National Directorate of Juridical and Constitutional Affairs at the Ministry of Justice, Religious and Constitutional Affairs[5]. The NSC has members from government, civil society and international agencies such as UNDP. NSC has been one of the channels through which the LEA, baseline study and CSES are presented, discussed and validated.	Strong
D. Encouraging legal environment on HIV/AIDS & SRHR for some YKP	Contributing	Events such as decriminalization of abortion and the inclusion of men who have sex with men, people who inject drugs and prisoners as key populations in the National Strategic Plan to Fight HIV and AIDS and National Guide for KP have contributed to a creation of an environment for discussing and addressing SRHR and HIV issues faced by YKP. It is within this environment that the programme seeks to contribute to the	Medium

5 The steering committee also includes CNCS, representatives of the four key civil society populations, UNDP, UNAIDS and ILO.

		revision of legislation and produce advocacy tools on HIV/AIDS & SRHR for YKP groups to work on the harmonization of existing legislation and hopefully on the enactment/implementation of new protective ones.	
E. Persistence of gaps in the legislation	Contra	LEA has identified gaps and even contradictions in the current legislation and tools related to HIV/AIDS & SRHR for YKP groups. For instance, within LGBTI, transgender people are almost invisible in the legal framework. Sex workers operate in a grey zone, it is neither a crime nor legal. Still, it is not recognised as work.	Strong

The change observed:
The programme has developed important pieces of research and reviews on HIV/AIDS & SRHR for YKP groups. The Legal Environment Assessment (LEA), the baseline study on young key populations and their sexual and reproductive health and rights as well as the civil society engagement scan (CSES) are important output products that will form the foundation for policy advocacy. These studies have provided knowledge on the legal environment and social norms on HIV/AIDS & SRHR for YKPs that wasn´t available before. These studies are currently being disseminated, so the change on an outcome level is not quite clear yet, although the potential is there. The programme has also created an advocacy group to coordinate activities on HIV/AIDS & SRHR for YKPs. The advocacy group includes members from organisations representing the four key population defined on the National Strategic Plan to Fight HIV and AIDS such as female sex workers (FSW) and their clients, men who have sex with men (MSM), people who inject drugs and prisoners. Since the advocacy group was still planning strategies for intervention, it might help to discuss and address the specific needs on SRHR of each of these young key populations.

Contribution Claim:
Based on the analysis of contributing factors (Table 3), it can be concluded that the programme contributed to the production of knowledge on the legal environment and social norms on HIV/AIDS & SRHR for YKP. The steering committee has been discussing the way forward and eventually will come up with a policy advocacy action or activity plan on the issues that the studies highlight. Some of LEA's key findings were (ii) there was a weakness in the implementation of health-related human rights; (ii) there are limited legal services and support systems related to health and domestic violence as a means of improving the human rights environment of PLHIV and (iii) the need to expand Serviços de Atendimento ao Adolescentes e Jovens (SAAJ) to more health facilities . The programme made the choice to focus on collecting more data to make the evidence-based claim with policy makers and the government to do more for YKPs.

Conclusion and recommendations to UNDP Linking Policy to Programming
LEA and the baseline study on young key populations and sexual and reproductive health and rights provided knowledge of the legal environment and social norms on HIV/AIDS & SRHR for YKP. One of the next steps after LEA and the baseline study will be the establishment of a national follow-up mechanism[6] composed of the Ministries of Justice and Religious Affairs, Health, Interior, Youth and Sport and Education. The mechanism will have technical experts

6 The steering committee has not decided how it will advocate to policy makers and the government to do more for YKP.

and its role is to advise the Conselho Nacional de Combate ao SIDA (CNCS) to ensure that the recommendations made by the studies (LEA and the baseline) are applied. In addition, the YKP advocacy group has started working/meeting on a regular basis and has engaged with at least six organisations working with young key populations. To implement the research recommendations, provide support to the advocacy group, and deliver the outcomes and impact as per programme design, the programme needs to:

- Disseminate the key findings of LEA and the baseline study in a less technical language in all provinces of Mozambique. The LEA reviewed and analysed legislation that applies to young key populations in Mozambique, and as such, the results are relevant to all provinces.
- Strengthen the role of the steering committee as advocates for the revision of the gaps on legislation. The steering committee has members from government institutions and civil society organisations. It can engage with more organisations representing the young key populations and discuss mechanisms to monitor the work of the YKP advocacy group.
- Clarify its intervention, strategies and ways in which the project will be engaging with each of the four young key populations in Mozambique taking into account the LEA and baseline, as all groups have specific needs and issues around HIV and SRHR.

4.4. Contribution Analysis to Hands Off!

Table 4 Community-led response systems to decrease violence against sex workers

Contributing FACTORS	TYPE	EVIDENCE Signs/facts	SIGNIF.
A. Solid technical assistance to sex worker-led initiatives	Primary	Tiyane Vavassate has benefited from training in matters of governance, human rights, development, implementation of programmes and monitoring and evaluation. There was also training for data collection in the study on violence against workers if sex. It is based on this training that sex workers have systematically collected information about violence, contributed to the reporting and referral of cases of violence. There was also selection, recruitment and training of two focal points (for the cities of Maputo and Matola) and 27 peer educators.	Strong
B. Creation of sex workers platforms and forums	Primary	In 2017 a National Platform for Sex Workers Rights was created. Apart from Tiyane Vavassate, two other sex worker-led networks had been influential in the process – Ungagodoli and ABEVAMO. There are also monthly meetings at the Gabinete de Atendimento à Família e Menor Vítima de Violência (GAFMVV) [Cabinet for Support to Family and Children Victims of Domestic Violence] in Maputo city. Sex workers participate in these meetings and address their concerns, ask questions, denounce cases of violence and seek follow-up.	Strong
C. Inclusion of sex workers in	Contributing	The National Strategic Plan to Fight HIV and AIDS and National Guide for KP approaches (Ministry of	Strong

the national plan and initiatives		Health) has included sex workers as key populations. However, the national strategy and the plan has a focus on female sex workers only. By working with other implementing partner such as LAMBDA, the project has attempted to include transgender sex workers.	
D. Legal status of sex work	Contributing	Sex work is not a crime in Mozambique, but it is also not legalized. Trainings, work of focal points, supervisors and peer educators have enabled sex workers to denounce cases of violence against them. Sex workers use this to protect their dignity, defend themselves against violence and get access to health care services and SRHR.	Medium
E. Training Police officers to work with key population	Contributing	There is a manual to help police officers to work with key populations (including sex workers). The first edition has been published in 2019. The manual is used in the police academy and stations to guide police officers in their daily work with four key populations – (i) female sex workers and their clients; (ii) Men who have sex with men; (iii) people who inject drugs and (iv) prisoners.	Medium
F. Highly mobility of allies (police officers and health care workers)	Contra	The project requires a permanent collaboration and involvement of the Gabinete de Atendimento à Família e Menor Vítima de Violência (GAFMVV) [Cabinet for Support to Family and Children Victims of Domestic Violence] to denounce cases and violence and advocate for access to health care services. Police officers, police office commander, coordinators of the GAFMVV and health professionals with whom focal points and sex workers have worked are subject to transfers. Whenever this occurs, it is necessary to socialize/sensitize the new coordinators, police office commanders and health care workers transferred to where the project is being implemented.	Strong
G. Persistence of violence against sex workers	Contra	Although sex work is not a crime, sex workers experience violence from clients, police and community members. Hot spots are sometimes considered as indecent places. This sometimes results in the dismantling of the hot spot especially when it is not a pension or hotel. Whenever this happen, sex workers find other hot spots to continue their activities. However, is not easy for the focal points and peer educators to identify every new hot spot and provide counselling and assistance for the sex workers working there.	Strong

The change observed:

The sex workers´ individual and organisational capacity trainings on legal and constitutional rights contributed to the establishment of collaborative sex workers community-led response systems to decrease violence against sex workers. Maputo city has at least three sex workers-

led networks – Tiyane Vavassate, Ungagodoli and ABEVAMO. The project has provided training in SRHR and HIV and human rights for sex workers network board members, focal points, supervisors and peer educators. Focal points, peer educators and supervisors have worked with sex workers in hotspots, bars, streets and health centres. They also guide sex workers to use helplines and denounce cases of violence. Sex workers have increasingly counted on them as a support mechanism.

Contribution Claim:
Based on the analysis of contributing factors (Table 4), it can be concluded that the Hands Off! project has made the primary contribution to the establishment of collaborative sex workers and community-led response systems to decrease violence against sex workers. The programme made two significant choices to enable that, among which are: solid technical assistance to sex worker-led initiatives, and the creation of sex workers platforms and forums (movement building and community mobilization). Two external factors have contributed to this achievement such as the inclusion of sex workers in the national plan and National Guidelines (2016) for the implementation of HIV Counselling and Testing (HCT) initiatives and the training of police officers to work with key populations including sex workers.

Two external factors are endangering the progress made by sex works networks and the project. These are the high mobility of allies (police officers and health care workers) and the persistence of violence and discrimination against sex workers particularly in communities, based on social and religious values and norms. Sex workers shared cases of violence and discrimination in communities, and the role of community leaders to address these cases at community level or assist them in denouncing the cases. The cases were particularly persistent to sex worker living with HIV. Clients and Police officers were reported as some of the perpetrators of violence against sex workers.

Conclusions and commendations to Hands Off!
The programme has contributed to strengthening the collaborative sex workers-led responses through movement building and community mobilization to advocate and work towards a decrease in violence against sex workers, train sex workers in issues such as SRHR, HIV and human rights, and provide better access to health facilities. There is a high expectation on the part of the sex workers that the programme will continue because it has contributed to their training on SRHR and enabled them to denounce and report cases of violence. One of the next steps will be to include sex workers networks from other provinces. The programme is owned by the sex workers, which increases the changes of sustainability. A data collection instrument was created to give input to advocacy initiatives. They use that instrument to collect cases of violence and do the follow-up of the cases reported to the police stations. In addition, sex worker peer educators interact with the Conselho Nacional de Combate ao SIDA (CNCS) and receive condoms to be distributed to other sex workers in hot spots and health facilities.

The high mobility of key actors and allies such as police officers and health care workers and the persistence of violence against sex workers are among factors that the programme needs to deal with in order to reach the stated objectives and goals. Thus, the following can be recommended:

- Use the available forums such as the platform and meeting at GAFMVV to discuss strategies to deal with the high mobility of key actors including sex workers themselves.

- Monitor the training of police officers to work with sex workers. There is a manual[7], and its use can be scaled up. Police officers can no longer claim that there is no information and manual available to assist their work with all four key populations.
- Maputo city and Maputo have each one focal point for sex workers and some peer educators. Sex worker networks need resources to either increase the number of their staff or complement their activities in a way that supervisors, focal points and peer educators can respond to more than one organisation and provide support to any sex worker in need. This requires more inclusion of different groups of sex workers and comprehensive training to enable them to work on different issues and with different groups of sex workers.
- Maputo-city is the intervention area. The project can either extend to other areas of intervention or use the platform and the GAFMVV to share information and train sex workers from other provinces as a scaling up and replication strategy.

5. Other significant findings

5.1. Effectiveness

The 4 programmes have specific implementation strategies and partners in Mozambique. Training to each implementation partner to understand the nature of each programme, their regional dimension and expected results and impact on issues related to SRHR and HIV has been key to effectiveness. Even though the 4 programmes share some target groups such as young key population, A&YPLHIV, sex workers and LGBTI, the coordination and sharing mechanism between the 4 programmes is missing. This has affected the overall effectiveness of the regional programme on a country level.

5.2. Relevance

All the 4 programmes are relevant to the SRHR and HIV specific needs of the four key populations listed in the National Strategic Plan for HIV and AIDS (2014-2019). Those are female sex workers (FSW) and their clients, men who have sex with men (MSM), people who inject drugs (PWID) and prisoners. In addition, the programmes have also included needs and priorities of groups not fully accommodated on the National Strategic Plan for HIV and AIDS such as adolescents, young adults, A&YPLHIV and the LGBTI community. The interventions have mainly taken place in communities, health centres and schools as centres of change.

5.3. Sustainability

All the 4 programmes have implementing partners and mechanisms of coordination (regional and national). The READY+, HIV/SRHR Knows No Borders and Hands Off! programmes have engaged stakeholders, provided trainings for peer educators, health workers and police officers and reached successfully a significant number of beneficiaries. UNDP LPP has coordinated the LEA and baseline study on young key populations and sexual and reproductive health and rights and supported steering committee. However, it would be a risk assuming that the sustainability of the programmes is assured momentarily. Firstly, all the 4 programmes need to continuously train and maintain staff for implementing partners, activists and peer educators (CATS, change agents, sex workers and members of the advocacy group). For instance, CATS and change agents have asked for better conditions such subsidies and transportation funds for their daily work. It creates a continuous cycle of training and

7 Comando Geral da Polícia, Manual do Formador Atendimento à População-Chave, 1ª Edição, 2019. The manual was funded by Bridging the Gap.

capacity building and need for resources. Secondly, implementing partners such as Tiyane Vavassate (Hands Off!) and Associação Pfuka Lixile (IOM HIV/SRHR Knows No Borders) do not have their own offices. Associação Pfuka Lixile has used installations of the Scalabrianas sisters for more than 6 years. Tiyane Vavassate has used a room at Pathfinder's headquarters in Maputo city. Finally, UNDP LPP was still planning for next steps following LEA recommendations, so not much can be said on its sustainability in Mozambique.

6. Conclusions on a country level

The regional SRHR and HIV programme is relevant to Mozambique's national response to HIV AIDS and initiatives to promote SHHR for key populations such as female sex workers (FSW) and their clients and young key population such as A&YPLHIV. The programme's theory of change framework has provided guidance and focus for the interventions in the country. The programmes have addressed causes that prevent young key population to access to SRHR such as (i) insufficient access to information and knowledge on SRHR; (ii) harmful practices against girls, women and key population, and (iii) inadequate health care services. The 4 individual programmes have contributed to access to information and knowledge on SRHR and the establishment of more friendly health services to young key population at health centres. More coordination between the 4 individual programmes at country level is needed to make the interventions more effective and hopefully sustainable. The high mobility of key actors and allies such as police officers and health care workers and the persistence of violence against sex workers are among factors that the programmes have to deal with in order to reach the stated objectives and goals. Thus, the following can be recommended:

- Use the available forums such as the national platform and the national steering committee to discuss strategies to link the 4 programmes and create synergies between them.
- Equip CATS, change agents and sex workers with more means in terms of resources, training, information and tools for daily work to keep them motivated and active in the programme structures. Beneficiaries in ART treatment, CATS and change agents asked for support for food. It had been hard to stay in treatment when there are economic issues and difficulties to establish a livelihood.
- Include more people who inject drugs (PWID), prisoners and underage sex workers in interventions to promote access to information and knowledge on SRHR and health care services.
- English is the language of communication of the regional programme. Portuguese is the official language in Mozambique. Translating working documents and materials from English into Portuguese and vice versa takes a lot of time and resources which are not always covered in the programme budgets. This is a must.

Annex 3 Country Case Study South Africa

1. Country Context

South Africa has the largest HIV epidemic in the world, with 7.1 million people living with HIV. HIV prevalence is high among the general population at 20.4%. South Africa's National Strategic Plan 2017-2022 identifies a number of groups who are particularly at risk of HIV transmission. Men who have sex with men, transgender women, sex workers and people who inject drugs experience even higher HIV prevalence rates.

Nationally, HIV prevalence among sex workers is estimated at 57.7%. Certain factors increase HIV risk for South African sex workers, including poverty, the number of dependents they have and lack of alternative career opportunities. Injecting drug use is also common among sex workers exacerbating their vulnerability to HIV infection. Studies have also found that understanding of HIV risk is often low among female sex workers. Sex workers in South Africa face high levels of stigma and discrimination and are restricted by the laws under which they work, as sex work is criminalised in S.A and there is on-going police harassment.

HIV prevalence among men who have sex with men in South Africa is now estimated at 26.8%. Despite a constitution that protects the rights of LGBT communities, many men who have sex with men face high levels of social stigma and homophobic violence as a result of traditional and conservative attitudes within the general population. Transgender women in Sub-Saharan Africa are twice as likely to have HIV as men who have sex with men. To address the high HIV prevalence in this group they have developed peer-led interventions, in which members of the transgender community will identify other at risk individuals and help to provide them with psycho-social support as well as better targeted information and services. Stigma is another major barrier to transgender individuals receiving care.

In 2017, an estimated 280,000 children (aged 0 to 14) were living with HIV in South Africa, with only 58% of them on treatment. New infections have declined among South African children, from 25,000 in 2010 to 13,000 in 2017. This is mainly due to the success of prevention of mother-to-child transmission (PMTCT) programmes. Children are also affected by HIV through the loss of family members. In South Africa more than 2 million children have been orphaned by HIV and AIDS. Orphans are particularly vulnerable to HIV because of economic and social insecurities; they are often at risk of being forced into sex, have sex in exchange for support, and typically become sexually active earlier than other children.

HIV prevalence among young women in South Africa is nearly four times greater than that of men their age. Young women between the ages of 15 and 24 made up 37% of new infections in South Africa in 2016. Poverty, the low status of women and gender-based violence (GBV) are all been cited as reasons for the disparity in HIV prevalence between genders. Intergenerational relationships, between older men and younger women, are understood to be driving a cycle of infections[8].

According to the International Organization for Migration South Africa faces "being the host of migration"-related challenges, including: increased prevalence of irregular migration in

8 Avert. 2019. Global information and education on HIV and AIDS

particular with respect to women and unaccompanied minors; inadequate migration management policies and border management processes; rising xenophobic sentiments that in some cases turn into actual violence against migrants as well as high prevalence of communicable diseases such as HIV and AIDS and tuberculosis. In 2013 the Southern African region recorded over 4 million migrants, excluding irregular migrants, of which 44% were female and 20% were under 19 years of age. By far the largest number of migrants is found in South Africa (2.4 million, including some 1.5 million from Zimbabwe).

In South Africa, the high prevalence of sexual and gender-based violence and other harmful gender norms result in the increased vulnerability of young women and a high prevalence of teenage pregnancy, sexually transmitted infections (STIs) and HIV. According to the South African Department of Health report 9 poverty impacts advisedly on the ability of people to access health services including those related to their sexual and reproductive health (as they do not have money for transport to reach clinics). Many clinics also continue to discriminate in terms of age and sexuality. In addition, poverty can force people into situations where they have sexual relationships in exchange for resources. This in turn further increases people's vulnerability. In 2017, 10.9% of recorded births were to mothers aged 10 to 19. In the same year, 9.5% of maternal deaths during childbirth were of mothers aged under 20.

There are also substantial inequities across the country both with respect to the availability and the quality of services. Providing quality services is also undermined by the poor implementation of SRHR programmes and the failure to meet agreed (international) standards, non-use information for planning, monitoring and improving service delivery; the lack of service integration and effective referral systems between levels of care. Sexual and reproductive health and rights services tend to focus on women and are not oriented to meet the diverse needs of other populations.

2. Introduction to the country programme

The evaluation will be looking at the South African context where two programmes were implemented under the regional HIV/AIDS and SRHR programme, namely Hands Off! and SRHR and HIV Knows No Borders.

The **Hands Off!** sex workers programme aims to reduce the violence against sex workers through empowering sex workers in order for them to enjoy safer working conditions and to reduce their vulnerability. Also it addresses stakeholders (like police officers, health workers and surrounding communities) to ensure a supportive environment without stigma and discrimination. The project focuses on the following result areas: reduction of violence against sex workers; ensuring sex workers' human rights, facilitate access for sex workers to needed health services and to sensitize healthcare providers in the provision of sex worker-friendly and stigma free services, address stigmatising and discriminatory attitudes by law enforcement towards sex workers[10]. The following organisations have played a significant role in implementing the Hands Off! programme in South Africa: Sex Workers Education and Advocacy Taskforce (SWEAT), Sisonke, North Star Alliance, COC Nederland and the Women's

9Republic of South Africa Department of Health, South Africa,2011. Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011–2021 and beyond
10 Inception Report EKN Evaluation 2019

Legal Centre (WLC). In 2018 the involvement of the WLC ended and SWEAT was able to launch its own Legal Defence Centre (LDC).

SRHR and HIV Knows no Borders aims at improving the sexual and reproductive health of migrants (including adolescent & young people and sex workers) as well as non-migrants and others living in migration-affected communities. The project has the following result areas: demand creation for SRHR-HIV services through door to door health education, Comprehensive sexual education and community dialogues; facilitating supply of and accessibility to responsive sexual and reproductive health and HIV services through referral systems; and creating an enabling environment through engaging gatekeepers at regional and local levels. The programme seeks to achieve these results through providing enhanced knowledge of SRHR and creating better access to SRH, health and HIV services[11]. The programme is implemented in the Ekurhuleni district municipality in Etwatwa and in the Ehlanzeni district municipality in the Nkomazi area in South Africa. Nkomazi serves as a link between Mozambique and South Africa at the Lebombo border. Both targeted locations are affected by migration, high unemployment, poverty as well as high HIV prevalence. Because Nkomazi is located near the Mozambique and eSwatini borders, it is a gateway for migrants from neighbouring countries. Ekurhuleni is the industrial hub of Gauteng making it the preferred destination for migrants seeking better livelihoods and economic opportunities[12]. The project is implemented by IOM, Save the Children Netherlands (SC) and Witwatersrand School of Public Health.

3. Methodology

Key informant interviews were conducted with the implementing partners for Hands Off!-programme as well as implementing partners for the SRHR and HIV Knows no Borders-programme. Focus group discussions were conducted with beneficiaries and change agents from both programmes in the Durban and Johannesburg areas where the programmes were implemented. More specifically this included:

Hands Off!: 6 key informant interviews were conducted with implementing partners SWEAT, Sisonke, North Star Alliance and COC Nederland. A focus group discussion was held with 9 female sex workers and 1 transgender sex worker in Durban.

SRHR and HIV Knows No Borders: Three Key informant interviews were conducted with implementing partners: the International Organization for Migration, Save the Children Netherlands. A focus group discussion was conducted with 11 change agents in Ekurhuleni.
The major limitation of the study was the non-responsiveness of government officials for interviews and/or non-availability of some of the key stakeholders for interviews. Attempts were made to set up interviews, but the issue raised by these key role players was that they had been interviewed recently for the programme (likely for the mid-term review) and didn't feel they had anything to add at this point. This complicated the process of validating certain findings in this review though previous evaluation reports to mediate this challenge.

A contribution analysis was applied to determine the contribution of each of the programmes to the overall theory of change of the regional programme and its envisaged outcomes on

11 Inception Report EKN Evaluation 2019
12 IOM Proposal 2016 :SRHR-HIV Knows No Borders

access to information, access to services and the enabling environment. To conduct the contribution analysis, the following questions were used to guide data collection:

Hands Off!
Question 1: *To what extent have community-led response systems been effective in decreasing violence against sex workers?*
Question 2: *How have sex worker and civil society capacity trainings on legal and constitutional rights contributed to increased access to information and services to enable sex workers to enjoy safe working conditions and to make their own choices about their health and welfare?*

HIV and SRHR Knows no Borders
Question 1: *How did the sensitization of national and regional level policymakers and gatekeepers about SRHR-HIV needs for migrants, AYP and SWs lead to a greater willingness to cooperate on the issues at national and regional level?*
Question 2: *Which national and cross border coordination mechanisms have been established and how have they created an enabling environment to address the SRHR-HIV information and service needs of the target populations (migrants, AYPS, sex workers)?*

4. Contribution analysis

4.1 The contribution of the individual programmes to the regional objectives

Available evidence from interviews conducted, confirmed that, individually and collectively, implementing partners in both programmes, conducted a range of activities in order to meet the expected outcomes of their respective programmes. Implementing partners explained that they worked with a variety of stakeholders (government, NGOs, community leaders) to meet these outcomes. Reports confirm that relationships were developed and that there was buy-in from key stakeholders into the programme.

There is also an indication that there was a willingness to cooperate at local, provincial, national and regional levels. Evidence from key informant interviews and beneficiaries, in both programmes, shows that there were capacity building and sensitization interventions for both beneficiaries and stakeholders and that these interventions accounted for the changes that have been observed.. According to one respondent (an implementing partner), the consultations and interactions between target beneficiaries (key populations) and police officers, health workers and surrounding communities laid a foundation whereby there was better understanding of each other and an opportunity to start meaningful relationships.

In order to do this analysis we have focused on the outcomes within the overall Theory of Change of the regional programme and considered the contribution that each of the two programmes that were implemented in South Africa, made to the realisation of these outcome goals:

Outcome 1: Better information and greater freedom of choice for young people about their sexuality
The evidence that was collected through this evaluation demonstrates that individuals from the target key populations have gained access to and received more/better information on SRHR and HIV. Project reports explain that in order to challenge negative cultural and religious norms, harmful cultural practices as well as to remove institutional barriers to full enjoyment of freedoms related to one's sexuality, the Knows No Borders project sensitised

2,347 gatekeepers at the national and local (district) levels in 2017[13]. As a result of the engagements, local support as well as involvement of the communities in the project has been created. Both programmes indicated that there were no specific indicators of improved freedom of choice for young people about their sexuality beyond addressing issues of better information and choice. This issue was addressed with respect to sex workers although it was not an area where we found evidence of significant change (made more difficult by gate keepers as will be discussed in this report).

Hands Off! has contributed to this outcome through its active engagement with sex workers on issues that affect them and particularly through the implementation of educational workshops for sex workers as well as other role players such as health workers and police. These workshops focus on a range of SRHR and HIV related issues and were located within a human rights framework. The programme also used a peer educator and peer led model across all implementing sites, whereby trained sex workers / peer educators played a critical role in providing information and advice on sexual and reproductive health to fellow sex workers.

SWEAT and Sisonke mobilised and coordinated trainings of sex workers related to sexual health, human rights education, leadership and financial training. Sisonke and sex workers (including North Starts Peer educators) participated in the regional Health, Rights and Safety Training of Trainers (ToT) in Johannesburg in 2017. Following the ToT, health, rights and safety modules of the training were rolled out in SA, Botswana and Zimbabwe and 19 peer educators were trained as trainers and these peer educators have trained 499 peers across the 3 countries'

There has also been additional training provided through the collective effort of partners, which in itself seems an important achievement of the programme. SWEAT facilitated part of North Star's training for peer educators and Community Response Team (CRT) members on sex worker's rights. Through the North Star Alliance sex workers received training on HIV prevention, health seeking behaviour, counselling and testing, as well as sexual and reproductive health education. Through this process, 40 sex workers in South Africa received training on topics such as sexual and reproductive health, sex worker rights and self defence[14]

In addition, as part of the Hands Off! programme an integrated SAPS training manual was developed. A context analysis on the South African Police Service's systems, knowledge, attitude and practices of the police was carried out by COC. A manual development meeting was held with regional partners to share all materials and experiences, and decisions were made on the manual outline. A group of writers consisting of academics and representatives from CSOs, including SWEAT and Sisonke, and SAPS was established to draft the modules for the manuals for trainers and learners with input from local experts on sexuality, gender, human rights, criminal justice lawyers and key populations.

This manual was then used for the training of trainers, which was attended by the SAPS' Employee Health and Wellness (EHW) police officers, allies from civil society and SW, LGBTI and PWUD organisations' staff members. In addition, the Botswana Police Service, The Botswana National Coordinating Agency, the Zimbabwe Republic Police and the Zimbabwe National Aids Council also participated in the five-day Train-the Trainer workshop. This

13 2017 Annual Report THE SRHR-HIV KNOWS NO BORDERS PROJECT
14 Hands Off! Final Narrative and financial report 2017

training was important as it sought to ensure that there was a shared understanding of the manual for easier adaption and customisation in their respective countries.

The manuals for trainers and learners were then tested in Johannesburg, Pretoria, Cape Town and Durban with operational police officers, EHW functionary police officers, and trainers and facilitators from the SAPS training colleges. Revisions were then made, and there is now a conversation with the South African National Aids Council (SANAC) to include the roll-out of this training as part of the 2019-2024 South African Global Fund programming[15]. In addition, respondents indicate that a Memorandum of Understanding has been signed between the SAPS and COC to formalise the partnership and the SAPS Human Resource Development Department has indicated an openness to register the manuals within SAPS and to standardise the usage of these manuals for in-service training.

With respect to the **SRHR-HIV knows No Borders** project, this evaluation found that the project trained change agents (CAs-AYPs, sex workers, migrants, non-migrants). According to IOM, the training covered: Sexual and Reproductive Health rights, HIV/AIDS, roles and responsibilities of CAs, facilitation skills, counselling, migration and health, Comprehensive Sexuality Education (CSE) as well as Monitoring and Evaluation (M&E) to enhance their data collection and reporting skills. The Save the Children and IOM Regional offices based in Pretoria, South Africa provided continued support to the country teams through the production of additional behaviour change communication (BCC) materials to reinforce health education messages as well as the coordination of best practices, sharing sessions to enhance cross-learning and identify promising practices[16].

The project annual reports indicated that in 2017 a total of 954 Change agents were identified, trained and commissioned to work in six countries[17]. By December 2018 a total of 2634 change agents had been trained and as of December 2018, a total of 886 change agents were still actively engaged in the project activities. In South Africa between 2017-2018 a total of 144 change agents were trained and in December 2018 there were 91 CAs still actively engaged in the project[18]. Change Agents (CAs) received refresher training, which focused on community capacity enhancement skills and mentorships. This reportedly assisted the CAs to increase their health promotion activities[19].

These trained CAs were able to use mixed strategies, which allowed the project to disseminate SRH-HIV information through methods such as peer-to-peer and door-to-door education, community dialogues, the provision of Comprehensive Sexual Education (CSE) at schools and referrals of clients to treatment and care for SRH-HIV problems. Through these mixed methods, used by the CAs, the project was able to reach key populations with SRHR and HIV information that is relevant to these communities. The 2017 SRHR Knows No Borders Annual report suggests that the door-to-door method emerged as the preferred strategy for reaching

15 SOUTH AFRICAN POLICE SERVICES & COC NETHERLANDS Lessons Learned The South African Police Service's Dignity, Diversity And Policing Project: The Promotion And Protection Of Human Rights, Dignity And Safety For All. Publication ISBN: 978-90-6753-043-9

16 2018 Annual Report THE SRHR-HIV KNOWS NO BORDERS PROJECT

17 2017 Annual Report THE SRHR-HIV KNOWS NO BORDERS PROJECT

18 The reasons that the CAs left the programme was explained by the following: a view that the monthly stipend was too low, some trained change agents were able to access better remunerated employment using the skills gained from the project (this mobility is seen as positive as achieving increased levels of mobility is seen as integral to enhancing the lives of the sex workers and migrants). The project reports that in order to replace change agents that dropped out or migrated out of the project implementing sites they provided additional training.

19 2018 Annual Report The SRHR-HIV Knows No Borders Project

beneficiaries as it created a safe space in which beneficiaries feel secure and could be spoken with in a confidential manner.

The extent of this success, with respect to reach, is evidenced by 2017 and 2018 SRHR-HIV Knows No Borders Annual reports. In South Africa specifically the numbers are as follows[20]:

- 57,781 key population members were reached with SRHR and HIV education by April 2018.
- With respect to the school programme, in South Africa the reports indicate that 20 schools were reached in April 2018.
- 20,155 AYPs beneficiaries were reached with SRHR-HIV information/education by April 2019
- 14,861 migrant beneficiaries with information reached by April 2019
- 1,656 sex workers with information by April 2019

Over and above the increased reach, evidence from previous evaluations also shows that there is improved coordination at local, national and regional levels where there is now an exchange of information and best practices and development of country plans through regional events. These regional events involved key ministries from the countries (Lesotho, Kingdom of Eswatini, Malawi, Mozambique, South Africa and Zambia). The first of these was held in November 2017 when there was a stakeholder Regional Technical Consultation on SRHR and HIV for migrants, SWs and AYP in eSwatini. The project held its second Regional Technical Consultation in South Africa in 2018.

Through these processes, the project established and strengthened three cross-border coordination mechanisms. These include Malawi-Mozambique, Malawi-Mozambique-Zambia and Mozambique-South Africa- Eswatini. In an overview:

CONTRIBUTING FACTOR	TYPE	EVIDENCE Signs/Facts	Likely IMPORTANCE
a. Availability of quality resource materials: COC, in collaboration with SWEAT and Sisonke developed a training manual.	Contributing	The SAPS training manual was used in capacity building interventions, which were conducted by COC. These workshops included the police and sex workers as well as LGBTI persons and drug users. The manual focused on addressing stigmatising and discriminatory attitudes by law enforcement officers. IOM and SC provided continuous training and produced additional behaviour change communication (BCC) materials to reinforce health education messages	Strong - Hands Off! and SRHR-HIV KNB

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b. Collaboration between implementing partners	Contributing	SWEAT and Sisonke mobilised and coordinated training of Sex workers related to sexual health, human rights education, leadership and financial training. Implementing partners from SWEAT, Sisonke, North Star Alliance ensured that their specific beneficiaries/ SW peer educators attended the coordinated trainings including the SAPS training The SRHR_HIV KNB project worked with SWEAT in recruiting SW change agents	Strong - Hands Off! and SRHR-HIV KNB
c. The role of peer educators in improving knowledge, attitude and skills related to sexual and reproductive health.	Contributing	Through North Star Alliance over 500 sex workers received training on HIV prevention, health seeking behaviour, counselling and testing, as well as sexual and reproductive health education. 19 Sex workers in South Africa, Botswana and Zimbabwe were trained to become peer educators. They were trained on human rights, health rights and safety, basic skills and legal literacy training. 19 peer educators cascaded training to 499 of their peers 2634 Change Agents were trained to disseminate SRHR and HIV information and to become peer educators in Sexual and Reproductive Health rights, HIV/AIDS, roles and responsibilities of CAs, facilitation skills, counselling, migration and health, Comprehensive Sexuality Education(CSE) as well as Monitoring and Evaluation (M&E) 886 are still actively involved in the project.	Strong - Hands Off! and SRHR-HIV KNB
d. Difficulty with language	Contradicting	Beneficiaries struggled with the language in which the human rights training was conducted and more specifically with understanding some of the legal terms used by facilitators. This was particularly the case for beneficiaries who have limited education.	Weak-Hands Off!
e. Relationship established with Social development, Department of health, Department of education enabled collaboration in the recruitment of change agents and training of teachers	Primary	Change agents (including SWs, AYPs and migrants) were recruited and trained to conduct door to door health education on SRHR and HIV related issues. Teachers were trained to provide Sexual Education with a focus on sexuality rights, pregnancy prevention and HIV prevention. This was supported by the involvement of all government departments in the selection and recruitment of CAs. These departments also offered spaces for training to be conducted. During the training representatives from DoH were present to engage with CAs. Through the Hands Off! programme North Star Alliance facilitated training for public	Strong- SRHR-HIV KNB and Hands Off!

		health care service providers/ local clinics in providing sex worker friendly and stigma free services	
f. Relationships established with the community and key role players and this contributed to an enabling environment for the project	Primary	Community dialogues were held with the community and the Department of Health, Department of Social Development, SAPS, Department of Home Affairs, Department of Basic Education and Local government. These dialogues explored ways to address barriers to migrants, AYP and SWs accessing their SRHR. Through North Star Alliance the involvement of community religious leaders was established	Strong- SRHR-HIV KNB and Hands Off!
g. Attrition rate of Change agents	Contradicting	A drop-out of CAs was recorded in countries in South Africa, Lesotho and Eswatini due to inadequate provision of monthly stipends.	Weak- SRHR-HIV KNB

Outcome 2: Improved access to and use of sexual and reproductive health commodities and quality health care

Evidence indicates that there is improved access to and use of SRH commodities and healthcare amongst the target groups of both programmes. Both the training and sensitization of change agents and stakeholders (including health care workers, gate keepers, local NGOs, SAPS) led to an increase of, access to and use of SRH-HIV services by target beneficiaries. Sex workers interviewed stated that this was particularly true with respect to the mobile health facilities. They observed that the programmes added value in enabling them to access health services through mobile health facilities/clinics where they did not face stigma and discrimination.

The Results Matrix (2018 HIV-SRHR Knows No Borders) states that in South Africa 173 individuals from service provider organisations (from health sector and non-health sector-education, immigration, social services and the police) received training on Migration and Health to focus on the needs and rights of key populations (AYPs, SWs and migrants).

Further, in an effort to strengthen access to SRH and HIV services the project used its community referral systems, including referrals to police, social services and legal support. By December 2017, the project reported that the referral completion rate was at 91%. This percentage is calculated in terms of the number of clients who were referred and who then received the service at the referral destination point. In 2018, 18 930 people (97% of all people referred) were reached with SRH and HIV services. Of those referred, 11 952 were tested for HIV (7006 were tested at the health facilities while 4 946 were tested directly at community level by the implementing partner); 1124 received ART, 447 received antenatal care, 3677 received family planning services and 852 of those referred received sexual and gender-based violence (SGBV) services[21].

The Results Matrix (2018 HIV-SRHR Knows No Borders) report also indicates that in April

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2018 in South Africa there were 1974 referrals and of these, 1194 migrants, AYP and SWs were referred and received services at the referral destination points.

Beneficiaries are positive about the services supported through the project. They contrasted this with other public healthcare facilities that are not participating in the project. During the FGDs in Durban and Ekurhuleni, sex workers indicated that since health care workers in public clinics were provided with training to be responsive to their needs, they have been going to the public clinics more than before. They also indicate that they have received better treatment than they had received before the training but suggested that the quality in general of the public health care services is still unsatisfactory.

This view, about the persistent challenges with respect to public health services, was echoed by the change agents from Knows no Borders. Respondents observed that there are still challenges with discrimination including unfair treatment and continued ridicule. As a result some sex workers do not fetch their ARV treatment due to the fear of mistreatment. A sex worker stated that, ''there needs to be more training of public health workers as at the end of the Hands Off! programme we may not have continued access to mobile clinics and would have to go back to the same unchanged public health system''. Change agents from the Knows No Borders project in Ekurhuleni agreed that the stigma at the local clinic is still existing, stating that both migrants and sex workers are still faced with discrimination when seeking health services.

The other reported challenge relates to the lack of availability of SRH and HIV commodities at referral facilities within the project sites. Some SRHR-HIV service points reported having experienced stock outs of essential SRH supplies such as condoms. Based on the Results Matrix (2018 HIV-SRHR Knows No Borders Reports), 8 service points experienced stock outs of essential SRH and HIV commodities by April 2018 in South Africa..

For Hands Off! the Legal Defence Centre (LDC) enabled SWEAT to work towards a more efficient and effective model of direct legal service provision and human rights defence for sex workers in need of legal advice and court support, including representation of sex workers in court. Through the LDC, the project supports a 24-hour legal helpline. The 24 hour Helpline has also been effective in recording and referring beneficiaries to needed services and information[22]. The establishment of Crisis Response teams has also been critical in referring beneficiaries to needed services and information.

The contribution analysis in table form:

CONTRIBUTING FACTOR	TYPE	EVIDENCE Signs/Facts	Likely IMPORTANCE
a. Information and education about available SRH services and commodities and where and how to access them	Contributing	There is reportedly a greater awareness of services and this is evidenced by the increased number of clinic visits to access services such as primary healthcare, HIV/STI testing and treatment, pre-exposure prophylaxis , as well as cervical cancer screening.	Strong - Hands Off! and SRHR-HIV KNB

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b. The opportunity to get health advice and available local health services and referral services from informed change agents and peer educators c. Opportunity to get health and legal services through referral systems	Contributing	Based on the project data as of Dec 2018 the CAs have reached 74 540 beneficiaries with SRH and HIV services in SA. During house visits information about health services that can be accessed was also given, additionally there is a referral system where CAs refer people especially migrants to local health providers to get health services including HIV testing, STI screening and medical care for common diseases identified during the visit. 90% referral completion has been achieved	Strong - SRHR-HIV KNB and Hands Off!
d. Availability of convenient services	Contributing	During the dialogues and house and brothel visits, participants are provided with services such as HIV testing and condoms. Sex workers reported to have increased access to HIV and SRH services though programme mobile health facilities such as Blue Box Clinics and Wits School of Health.	Strong - Hands Off! and SRHR-HIV KNB
e. Health care workers unable /unwilling to provide sex worker friendly and non - discriminatory services	Contradicting	During the focus group discussions sex workers who are part of both programmes indicated that they have not observed significant changes in the way they are treated at public healthcare facilities stating that stigma and discrimination is still evident.	Strong - Hands Off! and SRHR-HIV KNB

Outcome 3: Respect for the sexual and reproductive rights of groups who are currently denied these rights

Sex work is still criminalized in South Africa and this inhibits SWs' ability to claim their human rights. There is evidence that sex workers continue to be denied their human rights by law enforcement agencies such as the police.

There have though been activities undertaken to address this outcome and the results of this will need to be monitored over time. This includes workshops facilitated by SWEAT and Sisonke that focused on sexual health and human rights and the support offered by the Women's Legal Centre and the earlier discussed Legal Defence Centre (LDC) whereby sex workers were able to get referred to paralegals that provided legal advice and assisted sex workers to report cases. Further, Sisonke was able to engage SWs in the Asijiki coalition whereby sex workers, activists, advocates and human rights defenders advocate for law reform: the decriminalization of sex work in South Africa. The evaluation did not find any specific advocacy work on legal reform by the Knows no Borders-programme, but strong evidence on work trying to shift social norms and values through the trainings and sensitization of local, national and regional level policy makers and gatekeepers. The contribution analysis:

CONTRIBUTING FACTOR	TYPE	EVIDENCE Signs/Facts	Likely IMPORTANCE
a. Legal support is provided as part of this programme and is seen as integral to training on human rights	Contributing	SWEAT and Sisonke worked with The Legal Defence Centre where sex workers are referred to paralegals to be supported with legal advice and reporting cases. SWEAT and Sisonke also provide court support to SW that have been violated and reported cases. Sex workers in Durban stated that they have received court support and counselling with different court cases of rape and attempted murder. Currently they are engaging with Sisonke to follow up on a case where the perpetrator raped and shot their fellow SW and the perpetrator was given 3 years suspended sentence	Strong – Hands Off!
b. Advocacy work conducted to ensure SRHR and HIV needs of key populations are institutionalized through policy and collaboration mechanisms	Primary	A total of 1818 local, national and regional level policy makers and gatekeepers have been sensitized about SRHR-HIV needs for migrants, AYP and SWs. As a result there has been set up of committee structures and consultation at a regional level to review regional SRHR-HIV issues, exchange lessons learned and best practices, and develop country plans to deal with emerging identified barriers Sisonke engaged SW in the Asijiki coalition to advocate for sex workers rights and decriminalization	Strong - SRHR-HIV KNB and Hands Off!
c. Establishing community (sex worker) -led responses towards reduction of violence	Contributing	Throughout the Crisis Response Teams (CRT) pilot a total of 93 cases of sexual and gender-based violence were documented. 73 cases were acted on. Upon follow up with the clients, 1 was placed in a shelter, 1 was moved to a place of safety by the police, 90 reported that they went back to where they live or work, and 8 were in hospital at the time of contact.89 cases had followed up. 63 cases were resolved, 44 cases had no resolution and 4 cases did not have data about follow.	Weak-Hands Off!
d. Sex Work managers/ pimps	Contradicting	There is still a real challenge when engaging sex workers that their "pimps" do not allow sex workers to access information or make choices. This is confounded by the role of drugs in this space and the pressure that is placed on sex workers to be involved in drugs.	Weak-Hands Off! and SRHR-HIV KNB

e. Levels of violence in SA society	Contradicting	The levels of overall violence in SA society, and specifically gender based violence, makes this outcome particularly hard to achieve. This requires these efforts to be part of a wider transformation of society.	Weak -Hands Off!

4.2 The contribution claims

Evaluation of each programme's contribution to the EKN programme was guided by specific contribution analysis questions. The following questions were used:

Hands Off!

Question 1: To what extent community-led response systems been effective in decreasing violence against sex workers?

Question 2: How have sex worker and civil society capacity trainings on legal and constitutional rights contributed to increased access to information and services to enable sex workers to enjoy safe working conditions and to make their own choices about their health and welfare?

According to North Star Alliance Programme manager the CRT pilot offered a comprehensive and integrated approach, bringing together sex workers, NGO staff, police, law enforcement and service providers. When an incident is reported to a CRT, the peer educator and CRT leader are responsible for documenting it on a standard 'Violence Against Sex Workers' form, which captures information on the type of violence, category of the perpetrator, as well as the immediate and follow-up actions required or already taken. The CRT in Durban consists of 2 police officers, 1 clinician from North Star Alliance, SWEAT and Sisonke as well as a pastor and sex workers.

The pastor was recruited by the sex workers to join their CRT team. He was identified by sex workers because his church was in close proximity to the sex workers working site, According to the sex workers he was very reluctant to become involved at the beginning but after attending their meetings and through continued interactions to understand their backgrounds, challenges and needs he made himself available to provide spiritual counselling and support to the sex workers including availing himself to assist with funeral arrangements and leading ceremonies where required (this had previously been a challenge as religious leaders are reluctant to support this community). In addition to this direct support from the pastor, this CRT has created a WhatsApp group where they communicate with each other so that it is possible to ask questions where there is a need for information or determine where services might be available. In addition, the SWs also have all the numbers of the people in the CRT team on speed dial in case of emergency, including when they are in danger.

Sex workers state that the establishment of CRTs has been valuable as they are able to get counselling, are linked to services such as hospitals and police stations and receive advice on safety measures. There has also been an increase in the documentation of violence which forms the basis for engagement and advocacy. However, there is no certainty about whether, through this intervention, violence against sex workers has decreased permanently and, according to sex workers because there is insufficient presence of the SAPS in the CRTs, they are still reporting violence and face police brutality when they are arrested. This suggests

that to achieve the intended goal of the programme there is still a need to sustain this work and ensure that the community-led CRT is strengthened further.

The training that has been provided (with reference to question 2) has made some progress in this space. The dialogues, which relate to the other component of this work, between the police and sex workers, have been held and are having a positive effect on the way in which the police handles cases brought forward by sex workers. COC Nederland coordinated an intervention that worked with South African CSOs and the South African Police Service (SAPS) at the national level to develop a sensitisation manual and to train SAPS officers with regard to sex workers (SW), people who use drugs (PWUD), and lesbian, gay, bisexual, transgender and intersex (LGBTI) people.

The training addressed police attitudes towards embracing dignity and diversity when they deal with SW, PWUD and LGBTI people. The SAPS trainings included pre- and post-evaluation questionnaires that checked the level of knowledge both before and after the training. Participants viewed the training as having improved their knowledge of legislation impacting sex workers and having fewer stigmatising views of sex workers, LGBTI people and PWUD after the training. Based on these responses, a general assumption is that a certain percentage of the SAPS members are most likely to improve on their delivery of services and possibly change their personal attitude to SW, PWUD and LGBTI people.

This view was shared by implementing partners. According to one informant ''during the training between SAPS and SWs, the police engaged with sex workers to understand sex work. Through this process an increased understanding was created, and these interactions have led both sides to better understand their realities and develop positive relationships. If nurtured further, those could become lasting relationships that could improve service delivery to sex workers and ultimately reduce to some extent the human rights violations and abuses perpetrated by police".

However, despite this progress, the experiences from this programme suggest that to achieve the goal there is a need to expand to address more actively the judicial environment, which still appears to be a significant challenge. As an illustration of the extent of the challenge, during an FGD a participant shared the following experience: "XX was raped and shot in 2017, she was in the hospital for months before the case was reported. She encountered the Hands Off! programme through North Star Alliance, SWEAT and Sisonke. Her case was reported to North Star Alliance through the CRT in her area. When she was in hospital the project paid for her food and transport costs as well as rent costs through the emergency fund. She received court support and legal advice through SWEAT and was able to report a case and went to court. Her peers and Sisonke provided court support for her for the following year. The perpetrator was given a 3 year suspended sentence, and as a result the perpetrator is walking freely and victimizing the SW further. As a result she lives in different places hiding due to fear". This case highlights the extent of the important support both needed and provided by the programme. It also emphasises the challenges linked to the judicial environment.

SRHR and HIV Knows no Borders

Question 1: How did the Sensitization of national and regional level policymakers and gatekeepers about SRHR-HIV needs for migrants, AYP and SWs lead to a greater willingness to cooperate on the issues at national and regional level?

Question 2: Which national and cross border coordination mechanisms have been established and how have they created an enabling environment to address the SRHR-HIV information and service needs of the target populations (migrants, AYPS, sex workers)?

Implementing partners explained that in order to create an enabling environment, so that migrants, AYP and SWs' SRH-HIV rights and needs can be institutionalized, the project sensitized national and regional level policy makers and gatekeepers about SRHR-HIV rights and needs through community dialogue platforms, intersectoral collaborations and regional consultations. In South Africa specifically the project provided technical support in the development of the Ekurhuleni Municipality HIV and STI strategic plan in which issues of migrants, AYP and sex workers as key and vulnerable populations were integrated.

The project held its second Regional Technical Consultation in South Africa in 2018 with 82 delegates These included representatives from National AIDS councils, national departments of health, social development, education, home affairs, transport, United Nations agencies, private sector and civil society organisations to discuss and identify key priority intervention areas and develop strategies for enhancing cross-border collaboration, coordination and integration of SRH and HIV services for migrants, adolescents, young people and sex workers into national plans of the various sectors[23]. These regional events involved key ministries from the six countries (Lesotho, Kingdom of Eswatini, Malawi, Mozambique, South Africa and Zambia) to review regional SRHR-HIV issues, exchange lessons learned and best practices, and develop country plans to deal with emerging identified barriers to achieving SRHR sensitive service provision and access by migrants, AYP and SWs.

Further, in **South Africa** a total of 146 policy makers, gatekeepers and influencers were sensitized about the SRHR-HIV needs of migrants, AYP and SWs in 2018. In addition, to create an enabling environment for the realisation of SRHR and migration responsive systems, dialogues were conducted with gatekeepers and other stakeholders. In South Africa the project reports that it has established 9 inter-sectorial collaborations with local municipalities, police, Home Affairs, Health, Education, Social Development, traditional and religious leaders. The aim of the intersectoral collaboration is to improve social cohesion and enhance peaceful co-existence of the migrant population and reduce stigmatization and xenophobic tendencies when conducting the SRH activities. Further, in South Africa during 2018, 17 community dialogues and forums where migrants, AYP and SWs advocate their SRHR-HIV needs were held to support improved community involvement in addressing barriers to SRH-HIV rights and needs[24]. The project also established cross-border coordination mechanisms. In particular, a tripartite cross border health committee with Health departments from South Africa, Eswatini and Mozambique was formed.

IOM also established a process for providing joint reviews on key national documents. In 2018, IOM provided technical support to Global Fund concept notes for Mozambique, Eswatini and South Africa (MOSASWA). This process, built from lessons learnt through the

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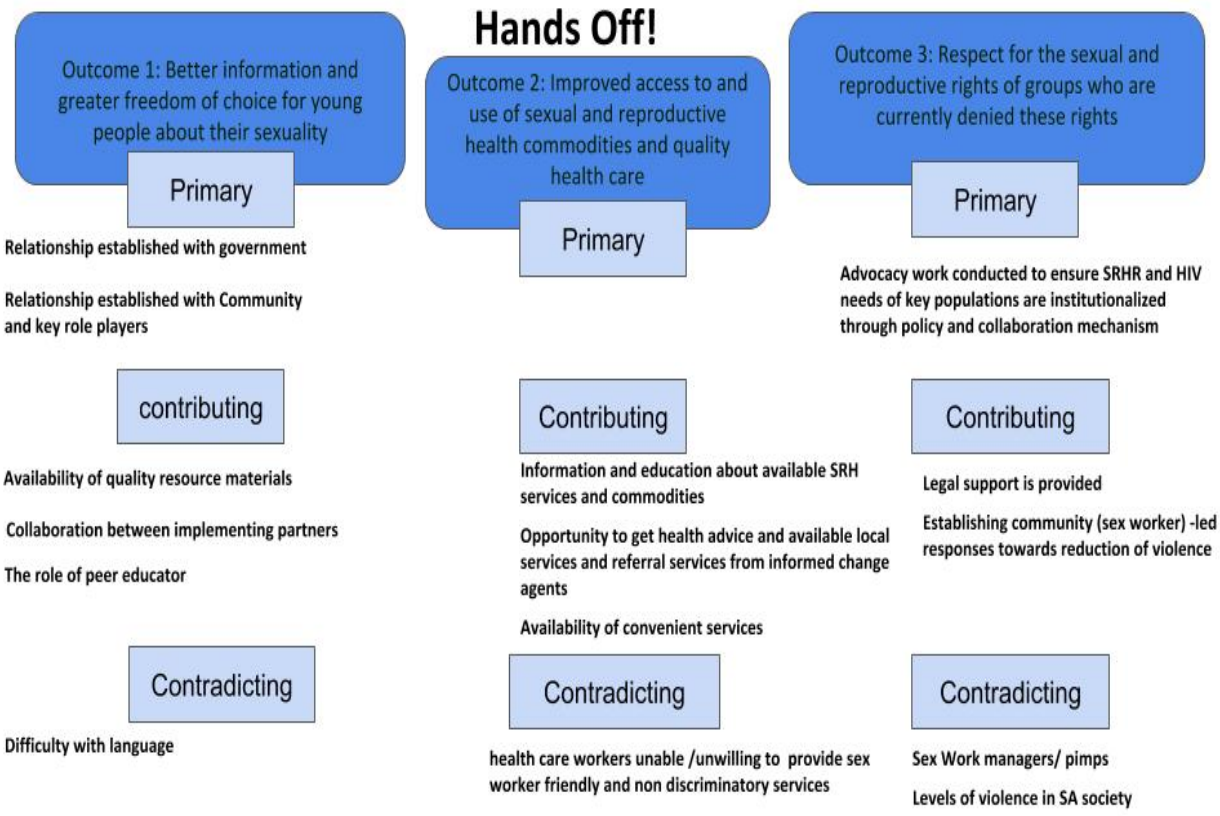
implementation of this project, aimed to ensure that wider health interventions benefit migrants, AYP and sex workers. Some of the SRHR interventions and cross-border coordination mechanisms were included in the SADC Malaria Control Plan for 2018 and Regional AIDS Team for East and Southern Africa (RATESA) 2018 work plan to enhance intersectoral cross-border coordination and collaboration with other programmes and UN agencies.

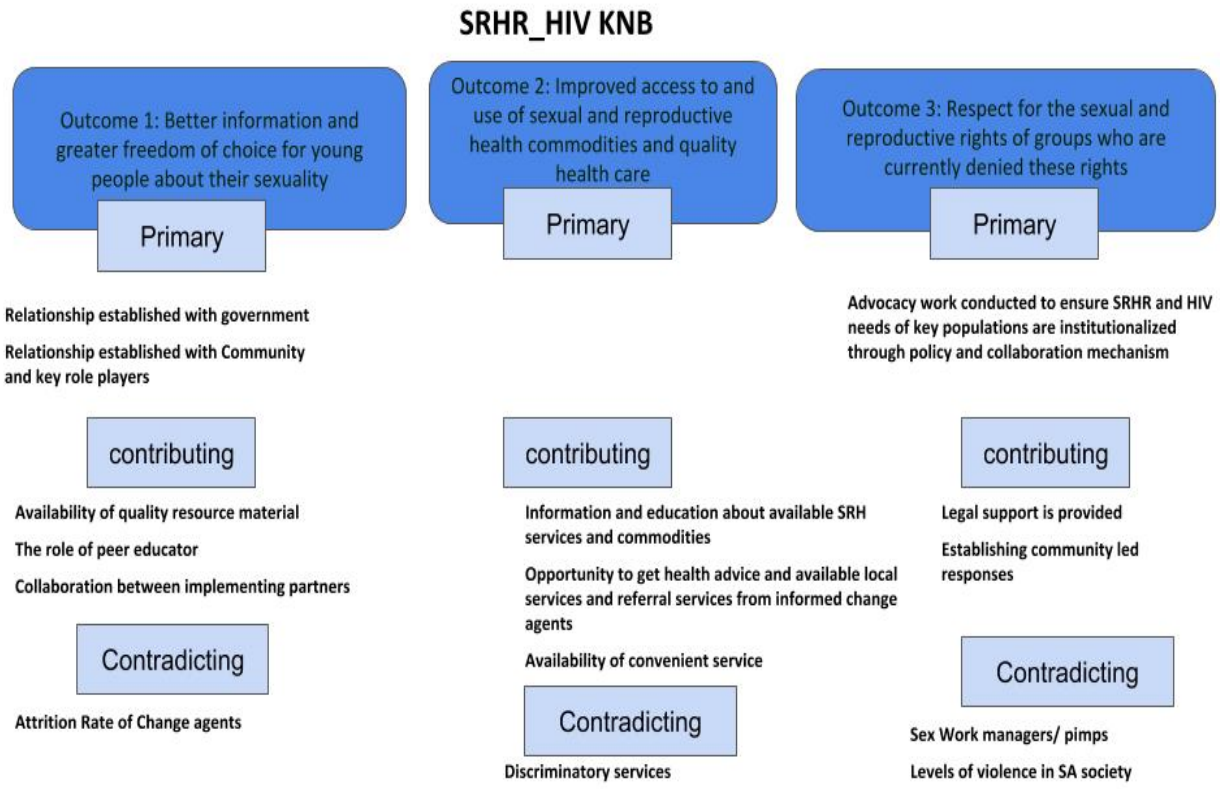
During the Migration Dialogue for Southern Africa (MIDSA) meeting held in 2018 in Pretoria migration health/HIV issues were discussed and formed part of the content of the zero draft of the SADC Regional Migration Policy Framework. Some of the recommendations made at the MIDSA meeting included: strengthening public health preparedness and responses, particularly at cross-border communities; preventing and eliminating major communicable diseases, enhancing HIV integration into SRHR, TB programming in the mining sector and the need to expand collaborative and strategic partnerships among Ministries of Health, Immigration and Foreign Affairs, looking at migration health as a cross cutting issue.

This consultation was organized by IOM in partnership with the Government of South Africa with over 50 delegates in attendance, consisting mainly of directors with migration policy related functions and responsibilities from the Ministries of Home Affairs, Labour and Foreign Affairs from within the SADC region, regional bodies (SADC), the African Union Commission (AUC) as well as UN agencies, and other relevant partners.

The above is an indication of the level of partnership and collaboration that exist at regional and country levels and the Annual report in 2018 (SRHR-HIV knows No Borders) suggests that through these efforts a greater willingness to cooperate on the issues at national and regional level was demonstrated.

4.3 Visuals of the contribution claims





5. Other significant findings

5.1 Efficiency

Implementing partners indicate that the funding allowed them to implement the project activities. Aidsfonds was flexible, which allowed them to adopt and review activities as long as this was within the budget. Overall, the projects have sought to demonstrate efficiencies and the projects were implemented by skilled and competent teams at regional and country levels. Further, the North Star Alliance was able to hire a consultant for the CRT brief through Aidsfonds's financial support.

With the support of the Hands Off! funds, Sisonke was able to register as an independent, not-for-profit organisation in May 2017. This makes it the largest, independent, registered sex worker movement organisation on the continent. In order to ensure the efficient functioning of the programme, SWEAT continued to host Sisonke until they could fully function autonomously. With the support of the Hands Off! programme, SWEAT launched the Legal Defence Centre (LDC), which enabled SWEAT to offer comprehensive day-to-day legal services to sex workers[25] .

There are though some capacity considerations that affect efficiency. Within the SRHR and HIV knows no Borders the project implementers have identified that there is a shortage of condoms and/or family planning resources in the local clinics but were unable to assist because of their procurement rules. Other challenges with respect to efficiency is evidence by the findings, that in 2017, the Hands Off! budget was underspent by 35% in South Africa and it was indicated that this was a result of capacity constraints. Changes within the organisation at both SWEAT and Sisonke resulted in many activities not being rolled out or only partially being rolled out.

Hands Off! implementing partners COC Nederland as well as North Star Alliance suggest that there should be one organisation based in the region to coordinate the programme. This would allow for local- led ownership and would also reduce management complexities and potentially costs for Aidsfonds as they would be able to liaise with one partner instead of twelve.

For the Knows No Borders at country level, some of the project officers were engaged in more than one project and respondents suggest that this could impact their overall performance on the SRHR project. Further, respondents suggest that the budget did not allow them to reach certain areas/provinces in the country as well as some target populations (specifically sex workers under 18 years of age). Ways to utilise the budget more efficiently so as to expand this reach will need to be considered.

5.2 Effectiveness

This review has found that the programmes effectively strengthen key population's individual and collective capacities (SRHR knowledge and skills), attitudes, actions and access to SRH services and information. The training of beneficiaries, change agents and peer educators led to improved knowledge on SRHR and HIV as well as improved access to services. With respect to the Hands Off! this quote was given by sex workers involved in the programme:

…''when I joined the Hands off! programme I did not know my HIV status as well as my health status related to cervical cancer. after joining the programme I was able to access health services through mobile clinics I did not know existed, being part of this programme, I have been able to

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gain knowledge on health interventions as well as safety measures while at work such as to work in groups in our operating sites''.

"…I learned about alternative mobile health services through the CRT team, and I am grateful because I get to attend training that empowers me with knowledge to secure my welfare as far as safety seeking behaviour and health services available.."

The programme also appears to have effectively documented violations, which is seen as critical to creating greater levels of awareness. The programme supported the introduction, in December 2017, of an improved documentation system that supports the documentation of human rights violations through a case management approach. SWEAT and Sisonke staff members were trained to use this system, called Case Box. And within the first weeks of December 188 cases were already registered. The majority of the cases registered were fines issued to sex workers.

Other cases documented were labour disputes and human rights violations against sex workers by their clients and/or law enforcement agencies. Through the system, criminal complaints that were received included rape and assault. This system is supported by the CRTs: when an incident is reported to a Crisis Response Team , the peer educator and CRT leader are responsible for documenting it on a standard 'Violence Against Sex Workers' form, which captures information on the type of violence, category of the perpetrator, as well as the immediate and follow-up actions required or already taken. Prior to the pilot, North Star had limited data on sexual and gender-based violence against sex workers. This has improved and through the CRT pilot a total of 93 cases of sexual and gender-based violence were documented. This is considered an important start to making changes as there is now a greater level of awareness about the problem, documented evidence and a mechanism for taking up violations.

However, whilst the programme appears to have effectively empowered sex workers and provided access to services, more work is still required to transform public health facilities. As observed by one sex worker who said .." *I am afraid to go to the clinic because we are insulted by the health caregivers, if we come with an infection regularly they eventually find out we are sex workers and make comments like what are we expecting with our line of work all we will get is STIs and HIV".*

Further, as mentioned previously, the programme does not appear to have been able to involve a sufficient number of police in these processes. Thus whilst police are involved in training this does not yet appear to have effectively translated into a commitment from police to playing an active role in addressing challenges in the community. This is an area that will still require considerable focus.
"..*we are still violated by the Police, when they arrest us they rape us and detain us and we stay in cells for a day or two and we are required to clean the holding cells in order to be released"*

This challenge was recognised by partners who state that it is evident that sharing information with the police and health workers will not effectively transform the stigmatising and discriminatory nature of the provision of services. A respondent from one of the implementing partners commented that*, ''the intended long-term results will depend on whether the training is rolled out to everyone in SAPS".* SAPS has acknowledged that training alone will not bring about the intended results as per the Hands Off! Programme Theory of

Change. There needs to be a way to ensure that the officers will commit to the envisioned change (reduction in violence especially perpetrated by Police)''.

The other issues that undermined the effectiveness of the programme relates to the role of gate keepers ('pimps') who would not allow peer educators or change agents to talk to the sex workers. The other factor that makes change difficult is that sex workers are also faced with the pressure from clients to take drugs, and, as a result some sex workers end up being drug users making choices even more complex.

In terms of the Knows No Border programme we found that it has been effective in reaching beneficiaries with SRHR and HIV information through door to door health education, community dialogues and schools comprehensive sexuality education. The project fostered significant partnerships and collaborations at country level and regional level, which has been particularly important in the migrant community (the focus of the Knows No Borders project) as the evidence suggests that otherwise this community is reluctant to come forward and seek affordable services because of fear and the level of discrimination that they experience.

''I have been able to help a migrant during door to door visits that was sick and afraid to go to the clinic because he did not have the papers to be in the country I referred him to the clinic as a change agent and because there was sensitization at the clinic they were able to help him''- Change agent.

''In 2014 when Thandi a migrant from Eswatini moved to South Africa in Nkomazi to join her partner Thando*. Upon arrival she told him that she was pregnant, Thando her partner became violent. While on his daily health promotion work as a Change Agent, Vusi knocked on Thandi's door and it just so happened that on that day, she had been severely beaten by Thando. Due to her irregular migrant status, Thandi did not even think of reporting the abuse to the police. She feared that she would be deported. Vusi shared with Thandi about her rights regardless of her irregular migration status and gave her a referral letter to go to a hospital. With support from the doctor and Vusi Thandi eventually reported a case and her partner was promptly arrested. Thandi was assisted, removed from an abusive environment and got a second chance at life. Today, Thandi is back in eSwatini''*[26].

This report has highlighted the effectiveness of the capacity building, and training interventions that have been undertaken. In particular it has begun to point to the value of the peer to peer led models that have been utilised in this programme. It can also be argued that the programme has been effective in increasing the use and access to services at country level through referral systems and information about available services.

5.3 Relevance

This review has found that both programmes are considered relevant to the SRHR and HIV specific needs and priorities of adolescents, young adults, sex workers and migrants in South Africa. Both programmes seek to address human rights and improve access to health services by the target population.

The review has also found that the approaches used by these programmes, including capacity building, supporting improved knowledge, amongst the target groups, about their sexual and reproductive health rights as well as human rights through door to door work. Further the

26 Stories of Change - SRHR-HIV project - April 2019

programme has responded to the levels of discrimination through the establishment of the CRT model (and involvement of SAPS), the documentation of abuses, as well as, facilitating access to SRHR and HIV services through mobile clinics and improving referral systems are very relevant to the target groups. The need for cross border solutions has also been a focus of this work and this is evidenced by the increased levels of cooperation that has been established through these programmes. We found that both programmes were guided by needs assessments to determine the interventions that the programmes would implement. This supported the relevance of these programmes.

In 2015 by Aidsfonds together with sex worker groups from five Southern African countries (Botswana, Mozambique, Namibia, South Africa and Zimbabwe) conducted a needs assessment. This process found that in South Africa sex workers are faced with an increased risk of violence, police abuse and a lack of access to health care and the justice system. It stated that the fact that "prostitution is criminalized" makes sex workers even more vulnerable. According to the report 82% of sex workers face discrimination, 61% economic violence, 65% physical violence and 52% sexual violence, perpetrators are the clients, police, community and health workers[27]. Police-perpetrated violence and human rights violations against sex workers were identified as being a huge challenge and one of the reasons why the region had such high HIV prevalence and incidence rates. The research found that police officers were using condoms found on sex workers as evidence of their soliciting for sex in the streets; some were demanding unprotected sex in exchange for the release of sex workers without charge; and the number of arrests made was being used as a performance indicator for police officers[28]. This report has highlighted the ways in which the programme's design responds to the imperatives outlined.

Similarly, the SRHR/HIV Knows No Borders also conducted a needs assessment and developed a baseline report. This provided contextual information to ensure that project interventions are tailored to the needs of the target groups. The baseline survey sought to create a basis against which changes that took place during the project period could be evaluated. The needs assessment demonstrated that AYP, sex workers and migrants experience challenges regarding access and use of SRHR-HIV services at service delivery points, with most of them having to either access these services from private health facilities or from other available alternatives.

A crosscutting need that was identified amongst all target groups is the need for sustainable SRHR-HIV programmes and services. The needs assessment also established that SRHR-HIV interventions in project sites are often not sustainable and are only implemented for short periods of time. It was also revealed that there is interrupted supply of SRH commodities especially condoms at border posts and that there is a need for decriminalization of sex work in order to ensure access to health services. Key findings from the baseline survey demonstrated low levels of service availability for AYP, migrants and SWs in surveyed service delivery points, and equally low levels of SRH service uptake regarding family planning. In addition comprehensive and accurate knowledge on SRH among the target populations was low. These findings highlight the relevance of the strategic SRHR-HIV interventions for AYP, migrants and sex workers that has been adopted by the programme[29].

27 South African Needs Assessment fact sheet 2017
28 South African Police Service and COC Netherlands Lessons Learned Report
29 SRHR/HIV Knows No Borders Needs Assessment and Baseline Report

5.4 Sustainability

The training and sensitization of key populations and allies appears to have laid the groundwork for continued activities and it is therefore anticipated that this will have a longer term impact. Examples of initiatives that appear likely to support the sustainability of the changes introduced by the Hands Off! programme includes: the agreements reached with SAPS and the possibilities associated with other discussions with SANAC, which bode well for the sustainability of the programme. Further, the sustainability of the achievements has been enhanced through linkages with existing government structures and service providers to enhance integrated SRH-HIV service delivery in the project sites, community involvement of gatekeepers and community change agents has increased provision of SRH-HIV services in a less discriminatory manner in some project sites.

The peer model creates an on-going mechanism for sustainability and continued support, There are concerns about the implications of the challenges that the Knows no Borders change agents have highlighted related to remuneration. Unless these are resolved it is likely that additional CAs will leave the programme. This is perhaps appropriate, and their ability to access other related employment is seen as positive for the system, but it suggests there is a need for a sustainability plan to ensure the on-going recruitment and training of CAs. Further, change agents from the SRHR programme indicated that they still would need resources to continue their work specifically for door to door visits and community dialogues. In addition the change agents indicated the need for further training and support with materials such as pamphlets and visual demonstrations while doing peer to peer and door to door visits.

During the key informant interviews with IOM, they commented that they had realised that the programme did not have a sustainable livelihoods and economic empowerment component. As a result they have tried to address this challenge through engagement with agencies such as the NYDA and Phakamani foundation with the intention of attracting other resources to ensure that income opportunities are put in place for change agents at the end of the programme. Such engagements are at infancy stage as there is no real commitment in place yet. However work has begun, and these organisations have done presentations with key populations.

Finally, implementing partners such as SWEAT and Sisonke explained that they will continue with programme activities as that is their mandate even in the absence of this programme. Other implementing partners such as COC indicated that they will seek to source alternative grants to continue programme activities in order to meet the intended outcomes. This commitment expressed by implementing partners suggests that a strong sense of ownership of these initiatives has been established. Given the credibility of these parties this is also a positive sign with respect to the potential sustainability of these initiatives, although it is our view that some of the activities begun through this programme need to be consolidated if they are to really become sustainable.

5.5 Impacts especially those that are linked to the regionality of the programme

A regional Crisis Response team model for the Hands Off! programme fostered the translation of lessons and promising practices across countries and also enabled the implementing partners to reach a balance between delivering a standardised intervention and customising to local needs, realities and contexts. According to the North Star Alliance programme

manager the multi-sectorial design of the CRTs allowed for replication in different country contexts. The make-up of CRTs is customised to the context surrounding each North Star Blue Box clinic. A regional approach was important for understanding how replicable the programme was in terms of expansion and growth. The CRT model was applied across Botswana, South Africa and Zimbabwe.

A Hands Off! partners meeting was held with the support of Aidsfonds in 2018. This meeting, as well as others that were held, is seen as helpful and there was consensus, amongst partners about the importance of collaboration across countries. These meetings also assisted to ensure that information was shared. A key success in terms of the regionality of the programme is that Sisonke has been able to strengthen its efforts to create a sex worker coalition that will work across the region. This is seen as important as it will support the alignment of advocacy efforts to address access to SRHR, HIV and legal services by Sex workers. This would also create further opportunities to share lessons and best practices between countries.

As indicated earlier the Knows no Borders project was able to secure local and regional collaborations. According to one informant *" If this was not a regional programme it would have been difficult for us to bring in ministries of health from other countries to collaborate and discuss SRHR issues and mobilized participation. This development is perceived as critical as migration cannot be tackled by a single country, "when migrants that come into different countries and have already been sensitized about SRH-HIV issues from their home countries it makes our work easier."*

6. Conclusions and recommendations

During the evaluation beneficiaries have reported increased access to health and legal services. Project data also indicates that between 2016 and 2018 there has been an increase of access to services by key populations and that this has been supported by both programmes either through referral systems or through the direct delivery of services.

The review has indicated that the interventions appear to have been effective. In particular the review has highlighted the value of the training and sensitization interventions and has pointed to the role that this has played in ensuring that the target group has access to accurate and relevant information. The target groups of both programmes suggest that through the Hands Off! programme as well as the SRHR-HIV Knows No Borders programmes they have been empowered with information regarding sexual health and other health related issues. This has been achieved through capacity building interventions, peer led trainings, door to door work as well as implementation of referral systems.

This review has also talked to the importance of both supporting direct access to services and critically, for the longer-term sustainability of the programme, the value of the referral systems which is realising success in improving access and use of services amongst the target populations. In addition, the establishment of platforms – at different levels - that include the target groups as well as other stakeholders and policy makers is seen as really valuable at a local level with the CRT through to the regional level such as the cross country mechanisms supported by the HIV/AIDS knows no borders project.

Both programmes were found to be relevant in addressing the SRHR needs of the target population. The value of designing interventions that are informed by research (including the needs assessments that were undertaken) is evident from this review. This ensured that the interventions are based on an understanding of the context and situation of the target populations.

It is difficult to measure the sustainability of the programmes. However, there are positive indications and the extent of the local ownership and the level of knowledge building that has been established by the programmes bodes well for sustainability. This was affirmed by respondents during this review process and it is evident that the credibility of the implementing partners has been vital for the establishment of relationships with key stakeholders.

There are though areas that require further work. While the project focused on training health care workers in public clinics, sex workers indicated that there are still challenges related to stigma. Sex workers also stated that in terms of reduction of violence they observe that there are still violations by police and clients, and they feel that legal support could be improved. The need to continue with the roll out of the training throughout SAPS and to focus more on training within the justice system is evident by the challenges highlighted during this review.

Further, sex workers have highlighted that there are still gaps in their knowledge about human rights and explain that this was due to complexity of this area and the language barriers as the workshops are run in English. This makes it difficult for participants to understand and contribute or ask questions. The peer educators that have been part of various training interventions stated that they do not fully understand the content of the training

due to the language and this in turn makes it difficult for them to share this component of the learning with fellow sex workers. This challenge has been recognised and SWEAT organised translators during subsequent training sessions, Sex workers noted that this made a difference, although they recommended that ideally facilitators should use a language that they understand as otherwise it is intimidating and to an extent embarrassing to be the only people that need translations in the room.

Finally, whilst this review has highlighted the progress that has been made in terms of cross border engagements and mechanisms, there is still a need to understand the extent to which the health service is able to seamlessly offer services where people are mobile. This is an area that was flagged as requiring further work.

Based on the findings the following recommendations are proposed:

- The programmes should invest further in a knowledge generation through supporting implementers to generate evidence to inform practice, policy and learning. Ways to translate this learning into different contexts should be explored within this context.
- Related to this, there is a need for improved documentation of success (with clear evidence) as this will support the replication of strategies, which could make scaling up easier in a regional context
- The sex workers programme needs to include a focus on young girls, who are sexually exploited, and are under 18 years of age as this group is an excluded and marginalised group that is in need of SRH services.
- There is a need to address the language of training as this otherwise becomes a real barrier to the on-going sharing of learning.
- Sex workers have identified the need for exit strategies when they retire from sex work and stated that the programme should focus more on skills training that would enable them to find alternative employment, such skills could be basic hand skills like sewing or hair dressing
- The programme has highlighted the value of ensuring that services supporting improved SRHR are available through a range of different mechanisms including door to door, mobile clinics and the public health system. It has however highlighted that whilst there is now increased utilisation of the public health services there are still challenges in this regard. Ways to link in with public health facilities that have been sensitised through this, and other initiatives, is considered critical for the sustainability of the programme. This should be complimented by further efforts to work with the public health system to both ensure that staff are more sensitive and to encourage more outreach work to meet the needs of the diverse target groups.
- Robust partnerships with government and community-based organisations are essential to ensure the programme's benefits can be sustained over time. These have been established through this programme and need to be consolidated such that these relationships can be sustained.
- Further, there is a need to increase the level of involvement of certain key players (such as police) in key forums and create greater levels of awareness amongst magistrates (perhaps linking in with existing training programmes for magistrates that address issues of gender).
- At a regional level there is a need for an increased focus on police-to-police interactions to support a shared approach to human rights and gender within the region.

- To influence policy change within Southern Africa there needs to be more coordination and participation on a regional level. This requires of project implementing partners, that they identify the policy implications of the work that they are doing and determine how these feed into relevant forums. Partners that are already working in these spaces create these linkages. This requires further work as it is not evident that this level of coordination within this overall programme is taking place. The challenges that this programme seeks to tackle can only be addressed through coordinated efforts and advocacy plans to influence policy.

Annex 4 Country Case Study Zambia

1. Country Context

Zambia is a large but sparsely populated country of 15 million people. HIV prevalence in 2018 was 11.3% (for adults aged 15-49), which remains one of the highest in the world.[30] New infections occur mainly in adolescents and young people (AYP), mobile groups and key populations (KP), such as sex workers, People Who Inject Drugs (PWID), People in Prison (PIP), Men Who have Sex with Men (MSM) and Lesbians, Gay, Bi-sexual, Transgender and Intersex (LGBTI) persons.

Behavioural factors that contribute to the high HIV infection rates of AYP are unsafe sexual practices, intergenerational sex, Gender-Based Violence (GBV) and gender inequalities. Underlying causes are related to a lack of knowledge, harmful traditional practices, as well as attitudes and discrimination.[31] Child marriage remains a huge issue in Zambia, with AYG entering marriage due to pressure from poverty, unintended pregnancies, a desire for increased social status, the vulnerability of orphans and stepchildren and/or a lack of realistic future options.[32]

Stigma, discrimination, criminalization of same-sex relationships, drug use and sex work[33], police harassment and other human rights violations contribute to high HIV prevalence amongst key populations. Of the different groups of KPs, LGBTI persons are one of the most vulnerable groups in Zambia. Zambia is a religious conservative country with one of the toughest anti-gay laws in Africa. Policy makers and political leaders have largely ignored the need for a legal framework protecting LGBTI persons, who are seen as undesirable, deviant and/or sinners, and have openly called for continued criminalization and abuse of their rights.[34]

2. Introduction to the Country Programme

Two projects were implemented in Zambia as part of the Netherlands' Regional HIV/SRHR programme: the Linking Policy and Programming (LPP) project, coordinated by UNDP and the SRHR/HIV Knows No Borders project, coordinated by IOM.

2.1. Introduction of Linking Policy to Programming (UNDP)

The long-term outcome of the UNDP Linking Policy and Programming (LPP) project is to strengthen HIV/SRH related rights of Young Key Populations (YKP) in law, policy and strategy.[35] The project is implemented by UNDP, AMSHeR and HEARD. Implementation of LPP project activities in Zambia started in September 2017.

30 https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/zambia
31 Process appraisal document (BEMO) for calls for proposals, p.4-5
32https://www.unicef.org/zambia/reports/national-advocacy-and-communication-strategy-ending-child-marriage-zambia-2018-2021
33 Sex work is partially criminalized in Zambia and same sex intercourse is illegal, punishable with up to 14 years in prison.
34 https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/zambia;
http://www.panos.org.zm/wp-content/uploads/2017/04/Panos-The-Right-to-Equality.pdf
35 For the LPP project's Theory of Change refer to Annex 1.

UNDP's focus has been on pathway 1 (Development of Research) and 2 (Strengthening the Capacity of National Government). Key activities coordinated by UNDP were the development of the Legal Environmental Assessment (LEA)[36] and the Civil Society Engagement Scan (CS scan).[37]

UNDP holds the secretariat function of the National Steering Committee (NSC), consisting of members representing CSOs, YKPs, academia and national government. The NSC oversees the implementation of the KP activities by the LPP project and its members advocate for policy change, health services and addressing human rights violations through round table dialogues. The National Aids Council (NAC) is the chairperson of the NSC.[38] Based on the LEA, the NSC developed a National Action Plan (NAP).

AMSHeR focused on pathway 3 (Strengthening the Capacity of CSOs to claim rights). It worked with a group of 25 YKPs from Lusaka, Livingstone, Kitwe and Chipata. The YKPs participated in 2 annual trainings; the validation workshop of the LEA, the SC Engagement Scan and the HEARD research. Some YKPs are members of the NSC as well as the YKP Advocacy Working Group (AWG). The AWG was created by AMSHeR and consists of 7 CSO members (initially 12) and 2 YKP. It had its first meeting in January 2018. Some YKPs have been provided sponsorship by the project to attend regional and international level meetings.[39] In addition to working with the YKPs, AMSHeR coordinated the Capacity Development of TransBantu Association Zambia (TBZ).

HEARD is the research partner of the LPP project and produced a formative study on YKP in Zambia and a study on Mental Health of MSM in 5 Zambian districts.[40]

2.2. Introduction of SRHR/HIV Knows No Borders (IOM)

The SRHR/HIV Knows No Borders project is implemented by IOM, Save the Children (SC), Wits School of Public Health and 2 local implementing partners in 3 districts in the Eastern Province. The long-term outcome of the project is that migrants, AYP and sex workers (SW) in migration-affected communities have greater freedom of choice about their sexuality. This, the project believes, will ultimately contribute to positive impact in terms of improved SRHR/HIV outcomes for the target group population.[41] The main challenges the project aims to address, as well as key strategies to address these challenges are:

- **Pathway 1: Demand Creation –** The project trained Change Agents (CA), who work on a voluntary basis and are the foot soldiers of the project. They are peers and direct influencers who sensitize people on where to access services, assist with referrals and provide SRH commodities. The project created Radio Listening Groups and Reflect Circles, facilitated by CAs, where AYP discuss SRH issues and support one another in addressing these issues.

36 UNDP & NAC (2019) Zambia: Legal Environment Assessment for HIV, TB, Sexual and Reproductive Rights. The LEA identifies and examines laws, regulations, policies, practices and issues affecting people living with HIV, TB, vulnerable and KPs, including YKP and develops recommendations for action for law review and reform.
37 This is a scan of health laws and policies that provides info on opportunities for engaging in law and policy review and reform.
38 The National Aids Council is a quasi-governmental organisation that coordinates and monitors HIV Aids activities in the country.
39 Such as the Satellite Meeting on YKPs at the SADC Parliamentary Forum for Minimum Standards for the Protection of KPs Access to HIV Services, ICASA Cote d'Ivoire and AIDS2018 (Netherlands).
40 At the time of writing, this study was undergoing a last round of internal reviews at HEARD.
41 For the SRHR/HIV Knows No Borders project's Theory of Change (ToC) refer to Annex 2.

- **Pathway 2: Supply & accessibility of SRH/HIV services –** The project trains Health Care and other service providers, so that they can deliver improved SRH/HIV and other services. The project strengthened Youth Friendly Corners at Health Clinics and opened up Information Hubs, in order to bring SRH services closer to the target group. Gatekeepers (traditional and religious leaders) are targeted so that they have increased understanding of the importance of accurate SRH/HIV information and support SRH/HIV initiatives.
- **Pathway 3: Enabling environment –** To holistically address the diverse needs of migrants, SW and AYP, the provincial and district AIDS task forces are strengthened. The Tri-Partite Cross-Border mechanism (Zambia, Malawi and Mozambique) is strengthened, with the aim to improve referral systems cross-country. Sex workers are organized in forums and the youth through sports.
- **Pathway 4: Economic empowerment**[42] **–** To address issues of transactional sex amongst AYP, and as a strategy to retain Change Agents, the project trained CAs to facilitate Savings Groups (March 2019). Currently, 15 Saving Groups are operating. In order to reduce vulnerability and promote economic independence, a group of sex workers received training in Economic Empowerment and were supported with a loan.

3. Methodology

The regional evaluation assessed the relevance, effectiveness, efficiency, impact and sustainability of the programme. A Contribution Analysis was conducted to assess whether the regional programme made a noticeable contribution to a selected number of observed results and in what way. UNDP and IOM in Zambia were presented with 2 Contribution Analysis questions and invited to select the question they felt was most relevant to be included in the evaluation. In addition to desktop review, 7 days of field research were carried out in Zambia in October 2019, to collect additional data and evidence. 3 days were dedicated to the UNDP project, with fieldwork taking place in Lusaka. 4 days were dedicated to IOM, with 1 day of interviews in Lusaka and 3 days of field work in the Eastern Province.

A locally based interpreter, well versed in the SRH/HIV field, assisted the consultant in the Eastern Province, as most respondents were more comfortable conversing in the local Chewa language. Purposive and convenience sampling methods were used to select stakeholders and participants. In total, 9 key-informant interviews and 3 FGDs were carried out for the UNDP project and 6 key-informant interviews and 11 FGDs for the IOM project. Annex 7 provides a comprehensive list of all evaluation participants. Evaluation participants were informed about the purpose and aims of the evaluation and the use of data provided. Informed and voluntary consent was sought and obtained from each participant. Consortium partners were invited to comment on the draft version of the Zambia country report and their feedback was taken into consideration in drafting the final version.

4. Contribution Analysis

The Contribution Analysis question that will be analysed reads as follows: *To what extent and how did the strengthened capacity of regional and national CSOs including community groups lead to increased success in claiming rights?*

42 This is an additional pathway that was not part of the project's original TOC.

TransBantu Association Zambia (TBZ) received capacity development from the LPP project in the areas of M&E, project management and internal policy development.[43] It is not immediately clear how increased capacities in these areas would lead to an increased capacity to claim rights. Beyond the support to TBZ, the LPP project did not strengthen the capacity of other CSOs or community groups. However, the project capacitated 25 YKPs and the Contribution Analysis will focus on this.

The change observed: Firstly, a shift has been observed from older KPs speaking for YKPs to YKPs taking the lead and occupying spaces where their voices can be heard, such as the National Steering Committee and the Advocacy Working Group. The facilitation team of TBZ's National Policy Dialogue (2019), attended by over 60 stakeholders from government and civil society, for the first time included YKPs. Some YKPs have become actively involved in the National KP Technical Working Group and others are entering mainstream spaces, where they are representing YKP issues. In a relatively short 2-year intervention, some of the YKPs have moved from being a volunteer to becoming employed in leadership positions in KP organisations. Young intersex people formed a national association, which among other things, aims to promote their equitable access to health.

To what extent the newfound confidence of YKPs and their increased skills and exposure has contributed to an actual increase in success in claiming rights seems too early to tell. In 2018 five YKPs from different SADC countries were supported by the project to participate in the SADC regional meeting. According to UNDP, participation of the YKPs in this event was significant, as Member States had begun to recognize and accept them as part of their delegations and included them in their deliberations and discussions. It created an opportunity for YKPs to establish relationships and familiarize themselves with the regional perspective and opportunities.[44]

YKPs shared instances where they are claiming rights in their personal lives. In terms of advocating for improved policies and laws, YKPs mentioned that they now know whom to approach and target. They decided that in the near future they would look into the issue of decriminalization of same sex relationships, an issue that older KPs have so far not dared to touch. The general consensus was that the project has succeeded in building the leadership of YKPs and that the potential of YKPs to start claiming their rights is there.

Contribution claim

It can be concluded that the LPP project made the primary contribution to building the skills, confidence and know-how of 25 YKPs, by exposing them to the following opportunities:

- Advocacy spaces where YKPs could actively participate, share their ideas and make their voices heard, such as the National Steering Committee (NSC) and the Advocacy Working Group (AWG).
- Exposure to local, regional and international conferences where they were able to engage with YKPs from the region and learn from those with more experience in advocacy and claiming rights.

43 TBZ carried out a self-assessment and based on the needs identified, received support for developing an organisational M&E framework (pending); skills training in M&E for 3 staff members (2 week course), project management for 3 staff members and in data collection for 1 staff member and support with internal policy development, e.g. Anti-Bribery & Fraud Policy.
44 UNDP Narrative report 2018

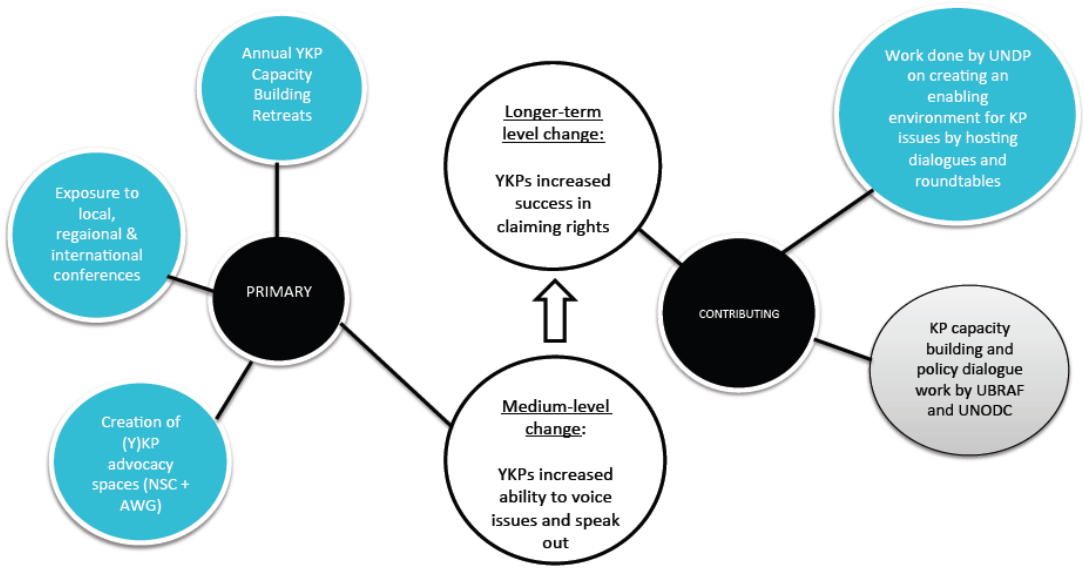
- Two capacity building retreats, where advocacy and related skills were imparted.

There is consensus amongst the different stakeholders that the changes described above would not have happened without the LPP project. The project reduced hostility from government towards KP activities, creating some degree of safety for YKP activities to operate unimpeded. The project created momentum and provided a platform for YKPs to start speaking out about their issues.

LPP efforts on creating an enabling environment synergizes with KP capacity building and policy dialogue work done under the Unified Budget, Results and Accountability Framework (a UNAIDS instrument that aims to maximize coherence, coordination and impact of the UN response to HIV/Aids) and the United Nations Office on Drugs and Crime (UNODC).

Whilst the formation of the young intersex association is not the direct effect of the LPP project, some of the young people involved in the process participated in the trainings provided by AMSHeR and the meetings organized by UNDP and NAC.[45]

Figure 1 Visual of LPP Contribution Claim



4.2. Contribution Analysis SRHR/HIV Knows No Borders (IOM)

The Contribution Analysis question that will be analysed reads as follows: *To what extent and how have the project's training/sensitization sessions delivered to Change Agents, Health Care workers and gatekeepers (traditional and religious leaders) contributed to better access to and use of SRH-HIV services by target groups?*

The change observed: 265 active Change Agents reached 127,790 people with information on SRH/HIV. The referral system set up by the project shows that 15,880 people (host community 49%; migrants 35% and sex workers 16%) were referred for health care services. 59% of people referred by the project consisted of children and youth in the age bracket of

45 UNDP Narrative report 2018

10-24 years. 75% of those who were referred received services. 25% did not reach the referral destination or did not receive the service of their choice.

According to the Change Agents who participated in the evaluation, adolescents and young people can more easily access family planning and preventive measures now. Previously this was not the case, as they would be considered too young by health clinic staff. Even if young people still fear going to the clinic, they can access information and commodities at the Information Hubs in their community. The clinic staff that participated in the evaluation observed an increased openness of AYP who are better able to ask for and receive treatment according to their problems. As a result of the project, one of the clinics has started an initiative whereby they give first priority to AYP who don't have to queue, as a way of promoting the project and to increase access to AYP.

Sex workers confirmed that Health Care providers have "understood the issue of human rights" and they no longer struggle to access services. Sex workers reported that community members are no longer shy to visit the Information Hubs to access condoms, even married women visit regularly. The sex workers themselves also benefit from the hubs. Where previous to the project there were often shortages of condoms, now the can access condoms 24/7.

Clinic staff mentioned they are now aware of the importance of accommodating migrants where previously they were not sure if they were supposed to treat them without asking for papers.

It should be mentioned that, although access and quality of services received at health clinics has improved, there are also contradicting stories of health workers who still "swim in the old mind-set". At least one story was shared of a young person who was denied STI treatment at a public clinic until he would come back with his partner (which in this case was impossible as it concerned a case of casual sex in a night club).

Analysis of primary contributing factors: The SRHR/HIV Knows No Borders project contributed to increased access to SRHR/HIV services for AYP, sex workers and migrants through:

1. The increased understanding of SRH/HIV issues by the different target groups as a result of the work done by 265 Change Agents in terms of sensitizing and information sharing. This led to an increased understanding of SRH/HIV issues by the target groups. The following structures, set up by the project, were also helpful in increasing understanding and sparking people to action (taking up health care services):
    - Establishing 53 Information Hubs and 26 Village Health Corners, where people have access to non-judgemental service provision (information, commodities and referrals). 53 Information Hubs were established against 30 planned, due to demand from beneficiaries, government institutions and community members.
    - Facilitation of 15 Radio Listening Groups and 28 Reflect Groups.
    - Opening 18 Youth Friendly Corners where Change Agents are stationed who form the link between target groups and nurses, which increases the likelihood that the young person will receive non-judgmental service.

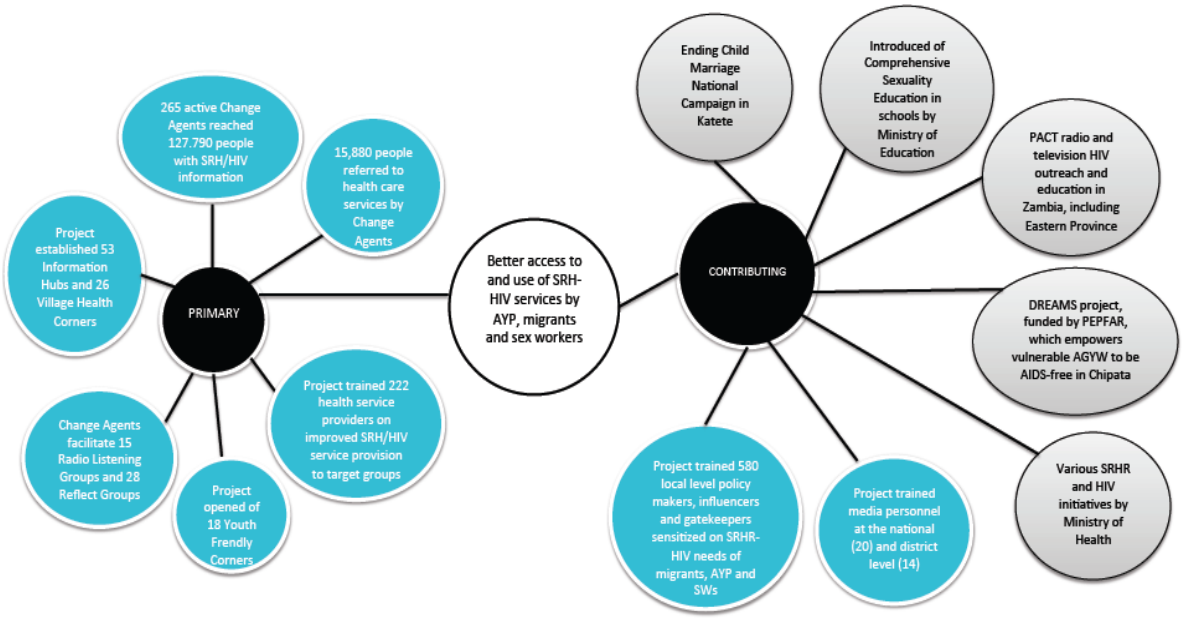
2. In total 222 health care providers were trained by the project, which led to an increased ability/willingness to provide SRH/HIV services to the target groups. Clinics are also benefitting from the project's Change Agents who refer/accompany AYP and other clients.

Other contributing factors:

- Training by the project of media personnel at the national level (20) and district level (14) in order to increase the frequency and balanced nature of reporting on SRH/HIV issues.
- 580 local level policy makers, influencers and gatekeepers were sensitized on SRHR-HIV needs of migrants, AYP and SWs by the project. As a result, the project was able to leverage the active support from Traditional leaders and counsellors to SRH/HIV initiatives.
- The Ministry of Education, which has introduced Comprehensive Sexuality Education (CSE) in schools. The SRH/HIV Knows No Borders project provided support to 40 schools in the target districts, reaching 12,220 school pupils with CSE sessions.
- PACT is using radio, television and other kinds of outreach and education to boost HIV awareness, change risky behaviour and increase the use of HIV services by high-risk groups in Zambia (including the Eastern Province).
- The DREAMS project, funded by PEPFAR, empowers vulnerable AGYW in Zambia to be AIDS-free (including Chipata).
- The Ministry of Health, which implements various SRHR and HIV initiatives.
- The Ending Child Marriage National Campaign, which covers the Katete district.
- The linkages and networking of key stakeholders.

Contribution claim: Based on the analysis of contributing factors, it can be concluded that the project made a strong contribution to increasing access and use of SHR/HIV services for target groups. This increase might not have happened without the active sensitization and information sharing by Change Agents, the increased availability of services and commodities at Information Hubs and Village Health Corners, as well as the community groups that were created, such as the Radio Listening Groups and the Reflect Circles. The referral system set up by the project shows that 15,880 referrals where the direct result of project efforts.

Figure 2 Visual of SRH/HIV Knows No Borders Contribution Claim



5. Evaluation Findings Linking Policy to Programming (UNDP)

5.1. Relevance

5.1.1. Extent to which regional Theory of Change is guiding project delivery

The LPP project contributes to 1 of the 3 objectives as identified by the regional Theory of Change, (respect for the sexual and reproductive rights of groups who are currently denied these rights). It further speaks to 3 of the 4 structural barriers (viz. governance, institutional organisation and legal system) as well as to 1 of the underlying causes (inadequate health care services). It does not focus on any of the direct causes identified in the regional ToC. The regional ToC does not seem to guide the LPP project beyond the fact that it was used in the assessment phase of proposals for the regional programme. The project team has not been asked to report on its contribution to the regional ToC. As far as the consultant is aware, the regional ToC has never been adapted and is not actively guiding the project.

5.1.2. Relevance of project design

The LPP project is the first project in Zambia that specifically focuses on mobilizing and engaging YKPs. This group had never been meaningfully engaged in Zambia before. The project's ToC, with mutually reinforcing linkages between the development of research documents, the strengthening of advocacy capacity of YKPs and the creation of an enabling environment in terms of government's willingness to engage on KP issues makes logical sense.

5.1.3. Relevance of partnerships

UNDP is well positioned to convene government stakeholders and AMSHeR is well renowned in the region, with a wealth of experience on Sexual Orientation and Gender Identity (SOGI) issues. Due to the volatile and hostile country context, stakeholders felt it was necessary to have UNDP coordinating the project. However, the AMSHeR coordinator questioned the selection of his organisation (which is sometimes mistaken for a donor) over a national

organisation that could potentially have led the YKP capacity building component of the project.

5.1.4. Regional character of the programme

Some regional components can be distinguished in the project. The LPP project supports the SADC secretariat to integrate KP issues in the regional strategic frameworks and to promote investment in HIV prevention and reduction of new HIV infections among KPs in the region (pathway 4). This is however carried out by UNDP Headquarters and not by country staff, who could not comment on these activities or to what extent this contributed to member states putting in place legal, policy and strategy environments that respect the rights of YKPs. In terms of regional learning and exchange, the LPP implementing partners participated in annual regional learning events in South Africa. HEARD was involved in a regional exchange with research teams from 5 SADC countries. The NSC or AWG members have not been invited to learning exchanges with NSC/AWG in other countries. Contact, coordination, collaboration or learning exchanges with other partners of the SRHR/HIV regional programme was non-existent in Zambia. None of the LPP implementing partners were aware of the existence of the IOM SRHR/HIV Knows No Borders project.

5.2. Effectiveness

5.2.1. Reach of target groups and geographical areas

Not all planned target groups have been successfully reached by the LPP project. There was a serious challenge with reaching YIP. There were also challenges with reaching YPUD, as they are not organized as a constituency in Zambia. Harm Reduction organisations were sometimes reluctant to engage with the project and not all of them are advocates for YPUD. Organisations of sex workers are still nascent and fragmented and were struggling with leadership issues at the time of project implementation.

5.2.2. Development of Research + Strengthening Capacity of National Governments

UNDP feels that the LPP project made an important contribution to creating an enabling environment for KP issues in Zambia. The project reduced hostility from government towards KP activities, creating some degree of safety for YKPs activities to operate unimpeded. The LPP project and the presence of UNDP in the space demystified and authenticated the plight of the KP/LGBTI community. Where previously the LGBTI population was considered through the binary orientation of homosexual vs. heterosexual, UNDP brought another angle to the discussion, which includes other binaries. Previously to the project, there was no coordination between different KP organisations and activities took place mainly underground. The LPP project created more synergies and solidarity amongst different KP organisations. Organisations that never worked together have started to collaborate on projects outside of the LPP project.[46]

One stakeholder (the director of a KP organisation) felt that UNDP made no unique contribution but rather complemented existing work with e.g. the LEA publication. Others were more generous in their feedback and felt that as a result of the project's engagement with government officials, the mind-set of technocrats is slowly changing. YKP issues were not on the agenda 3 years ago, but now institutions like NAC and HRC (who are both NSC members) are actively promoting YKP rights.

46 Other stakeholders corroborated this. Two specific examples were mentioned, namely, Friends of Rainka collaborating with PWID and TransBantu actively engaging the Human Rights Commission.

"The project made an important contribution to KPs in Zambia. Previously there was zero space to discuss this; if you raised the issue, people would think you are promoting something illegal. The project provided some space where we could talk about these issues, to the extent where we can now say it is not just a health but also a human rights issue. In this, the project was catalytic." (National Steering Committee member)

The development of the LEA and the Civil Society Engagement Scan can be seen as a success in itself; especially since the development of these documents was highly consultative, with the NSC and AWG being involved in planning, review and validation workshops. Even though the LEA has not been shared as widely and proactively as possible yet, it has started to have an impact: *"Prior to our engagement with UNDP, in terms of KP programming, we had zero. In a way because of the LEA and the capacity building that took place, as well as the development of an action plan by the NSC, it gave us a different perspective. Our mandate is so important for this work to move forward, but previously we just brushed it aside. Now we are trying to see how we can align KP issues and mainstream it. Without UNDP we would not have realized that importance."* (Human Rights Commission).

UNDP and AMSHeR feel the changes described above would not have happened in the absence of the project. The strengths that contributed to these change are analysed under section 5.2.5.

5.2.3. Strengthening Capacity of CSOs to claim rights

One of the key activities under pathway 3 (Strengthening Capacity of CSOs to claim rights) was the creation of an YKP Advocacy Working Group (AWG). The LEA helped the AWG select their 2 advocacy priorities: the revision of the Health Care Providers curriculum to include YKP issues and an anti-bullying campaign in schools.[47] However, no advocacy activities have been carried out by the AWG yet. A HEARD consultant is currently reviewing the curriculum and the Anti-bullying activity is planned for 2020. Changes achieved in terms of increased capacity of YKPs to claim their rights have been covered in the Contribution Analysis section of this report. In addition to that, at the level of individual YKP members, the project was successful in achieving the following results:

- *Safe space & solidarity* – Being part of the YKP group helped build self-confidence and kept YKPs from engaging in negative coping skills. Where previously each group had their prejudices against other KP groups, now they are spending time together outside of the project activities and provide each other with moral and practical support.
- *Skills development* - YKP members gained a number of new skills, such as advocacy, communication, leadership, facilitation and counselling skills. They also mentioned being more aware of diversity issues and the importance of inclusion.
- *Professional growth* – The University of Zambia School of Public Health now consistently engages YKPs to transcribe/collect data.

5.2.4. Research component

The HEARD research on Mental Health of MSM is in its final round of internal review. It was the first study on MSM ever to be approved by the National Research Ethics Committee,

47 Acting on advice received from the Ministry of Health (MoH), the reform of the Health Care curriculum focuses on the University of Zambia and the University of Chreso before aiming at national level reform, as the latter would involve multi-stakeholder processes led by MoH, with faith-based organisations and the Ministry of Religion and National Guidance, which the project fears will pose serious barriers to a successful outcome at this point in time.

setting an important precedent. Previously, research on gay men and MSM was either not permitted in Zambia, or the Ministry of Health would not permit the results of the research to be formally shared. The fact that HEARD worked closely with NAC was an important contributing factor to this success, as well as UNDP's engagement with the National Research Ethics Committee.

5.2.5. SWOT analysis

Strengths

1) **UNDP convening role** – UNDP's strength lies in convening government stakeholders. None of the other stakeholders would have been able to achieve this. Stakeholders also appreciate the safety that working under the jurisdiction of a UN body brings.
2) **HEARD research -** Partners were free to decide what the research would focus, which is an opportunity rarely granted by funders. It allowed for flexibility in terms of topic selection and allowed HEARD to use a powerful peer-to-peer approach, capacitating YKPs with research skills in the process.
3) **Strategies used by the LPP project to create an enabling environment, such as:**
    - In a volatile and homophobic-prone setting, the project was able to prevent creating an even more hostile space by not being confrontational with government and by riding on windows and opportunities that arose, such as the recognition and inclusion of KPs in the National Aids Strategic Framework (NASF 2017-2021), which was spear-headed by UNDP.
    - Unlike in the past where the focus of advocacy initiatives has been on recognition of KPs and especially gay men (which is still unacceptable for large sectors of the Zambian society), the LPP project focused on KPs human right to services without discrimination (whilst supporting efforts aimed at recognition).
    - The project facilitated open and honest round-table discussions with different constituencies. Stigma towards KPs and LGBTI people mainly stems from a knowledge gap and misinformation spread by politicians and religious leaders (who label LGBTI people as sick, sinners and/or demon possessed). Through these conversations different stakeholders, including some religious leaders, have started to soften their stance.
    - The NSC has a mixture of leaders coming from diverse backgrounds who took the lead in establishing this form of dialogue. The diverse group composition with members from different sectors makes the NSC a good resource that can be capitalized on.
    - The LEA also contributed significantly to shifting the narrative, as it paints a facts-based picture of the KP human rights situation in Zambia and it was often the first time government officials would encounter this kind of evidence-based information.
4) **YKP participation as central guiding principle -** YKP participation has been a central guiding principle in implementing the activities by the consortium partners. The AMSHeR country coordinator, who was pivotal in mobilizing and coordinating the YKPs, identifies as a member of YKPs. YKPs have been able to determine the priority activities for the NSC and AWG and an YKP person occupies the position of Vice Chairperson in the NSC as well as the AWG. The HEARD research team on Mental Health of MSM, was made up only of YKP data collectors (MSM, queer and transgender) and transcribes (lesbian women).

Weaknesses (challenges/gaps)

1) **Politics and coordination issues of National Steering Committee –** Coordination of the NSC has been an on-going challenge for UNDP. This could just be because NSC members are all busy people who volunteer their time but some degree of politics also seems to be involved.
2) **Limited ownership of National Action Plan** – The NAP developed by the NSC is an ambitious work-plan, outlining a considerable number of activities. Even though NSC members developed the National Action Plan in a participatory way, there is currently little ownership of the NAP by some of the essential NSC members, such as NAC, who feel that without budgetary support for the actual implementation of the plan, their hands are tied. Besides some initial work with regards to the review of the Law Enforcement curriculum, no progress has been made on the implementation of the other activities. Since no deadlines were allocated to the different activities, it is not possible to assess whether the implementation of the work-plan is on schedule or not.
3) **Overlap between NSC and AWG –** There is overlap in membership between the NSC and AWG, which has caused a certain fatigue. There is limited communication between both bodies. Even though in theory the NSC focuses at national level advocacy and the AWG is more community based, in practice this difference is not so clear, with both groups currently working on reviewing the Law Enforcement and Health Care Providers curriculum respectively. Anti-bullying policies for schools is on the agenda of both the AWG and NSC. By working with 2 groups aiming at very similar objectives, there is a risk of diluting the effectiveness of the work.
4) **Attendance challenges NSC and AWG** – AWG meetings have been infrequent and attendance numbers have consistently declined from 12 to 7 members. Communication with the constituency has not been strong. The NSC struggled with inconsistent attendance by government members, such as the Ministry of Health and Ministry of Home Affairs.
5) **Not all YKP groups equally involved in project –** Some groups had stronger representation in the project than others. The project struggled to interact and involve YPUD and YIP and to a lesser degree sex workers. The project hasn't been able to reach young people below 20 years of age due to age of consent issues.
6) **No clear link between Capacity Development of CSOs and advocacy** – The capacity development support TBZ received form the project did not have an advocacy focus or a link with an increased ability to claim rights. There were not clear goals or milestones that had to be achieved as a result of the CD. It seems this component was not very well thought through by the project at regional level.

<u>Opportunities</u>

1) **Use and uptake of research –** There is a sense that UNDP is not taking sufficient advantage of existing platforms and structures to give visibility to the project/LEA. Frustration remains about the lack of clarity/communication about the way forward, with several NSC members questioning how the LEA and the Mental Health of MSM research would be used. With the National Aids Strategic Framework coming to an end in 2021, there is an important opportunity to use the different research documents produced by the project to advocate for KP rights.
2) **Capacity Development of KP organisations –** A few KP organisations were established in Lusaka in the past 2 years. These are small and nascent organisations, without any formal structures or procedures in place. There is an opportunity for the project to focus on the capacity development of these CSOs and community organisations, in addition to capacitating individual YKP staff members of these

organisations. organize YKP into organized entities/structures and build their capacity to run these organizations

3) **Existence of a multi-stakeholder KP platform (NSC) –** The significance of the creation of the NSC as an enabler towards reducing barriers for KPs is high. This could not have happened two years ago as government officials would have been arrested or fired for attending/participating. This is a milestone which the KPs movement in Zambia should take advantage of.

Threats

1) **Continued homophobia at the highest political level** – The Zambian President remains outspokenly anti-gay, labelling gay peoples and MSM as "sick" people who need help and dismissing support for LGBTI people as a Western agenda. He recently declined US aid support if it is tied to respect for LGBTI rights.[48]

5.3. Efficiency

The total budget allocated to the LPP project in Zambia comes to USD 747,382 for 4 years, which is similar to the amount allocated to the other 4 SADC countries where the project is being implemented. The regional components of the project add another USD 3,487,079 to the project, which has an overall budget (for 5 SADC countries) of USD 7,453,606 (excluding 8% GMS). The LPP project in Zambia (as in other countries) is consultant-heavy, with 11% of the country budget (USD 80,994) spent on numerous different research consultancies (this is in addition to the research undertaken by HEARD).

Table 3 shows the total direct programme costs by intervention in USD. As can be observed, 6 out of 10 components are regional (roughly 50% of the total budget). Furthermore, Table 3 shows how the yearly budget is allocated (Sep 2016-Dec 2020). In Zambia implementation only started in year 2 (September 2017). It is not clear how this has affected expenditure and whether the project is currently sitting with a budget surplus (in terms of personnel and other budget line items) and/or if there is a need for a non-cost extension after December 2020 to complete the work as planned.

Component 7 refers to the development and roll out of KP scorecards and makes up a significant 44% of the 4 components that are country-based (components 1, 2, 6 and 7). AMSHeR finalized a key population scorecard with technical support from Accountability International in 2018. However, due to increasing pressure by the authorities in Zambia on key populations, particularly MSM, the scorecard could not be rolled out in 2018.[49] This activity was not implemented in 2019 either and is now scheduled for 2020.

Table 3 Total direct programme costs by intervention in USD

	Year 1	Year 2	Year 3	Year 4	Total
Component 1 **LEA and National Action Plan**	248,655	236,207	112,427	112,427	**709,716**
Component 2 **Civil Society Engagement Scan**	237,167	136,574	217,427	112,427	**703,596**

48 Some examples of recent anti-gay statements by the Zambian President: https://www.pinknews.co.uk/2019/12/16/zambia-us-ambassador-daniel-foote-president-edgar-lungu/; https://www.youtube.com/watch?v=DyNQGrwt7Ig&feature=youtu.be

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Component 3 REGIONAL **Stakeholder Capacity Strengthening**	173,867	177,015	173,867	173,867	**698,616**
Component 4 REGIONAL **Training tools for Capacity Development of Judges**	46,652	65,800	46,652	37,052	**196,156**
Component 5 REGIONAL **SADC regional frameworks addressing needs of YKPs**	87,022	90,170	87,022	87,022	**351,235**
Component 6 **Capacity strengthening for YKPs**	281,572	347,312	331,572	281,572	**1,242,028**
Component 7 **Mechanisms for community input into policy and service provision**	500,201	531,139	500,201	512,251	**2,043,793**
Component 8 REGIONAL **Baseline study & mid-term review (HEARD)**	102,677	105,825	102,677	102,677	**413,856**
Component 9 REGIONAL **Operational research on barriers to SRHR for YKPs**	196,237	132,965	129,817	129,817	**588,836**
Component 10 REGIONAL **Cross country comparative analysis of change processes**	125,657	128,805	125,657	125,657	**505,776**
Total by intervention	**1,999,707**	**1,951,812**	**1,827,319**	**1,674,769**	**7,453,606**

Consortium partners in Zambia felt that in general, the budget allocated to the project was sufficient. AMSHeR expected a bit more financial support towards AWG activities and the capacity development of TBZ. UNDP disburses the funds in Zambia, but other consortium partners felt there was little transparency as to how much budget was available and how certain budget lines were allocated.

5.4. Sustainability

In case of a potential withdrawal of support from the project after 2020, some stakeholders felt that the NSC would continue to meet, as it is based on voluntary participation and does not rely on funding. However, the coordination challenges and insufficient ownership of and sense of responsibility for implementing the NAP by some NSC members, raises doubts as to how functional a future NSC will be without an organisational holding. With regards to the AWG, the same applies. Without support, this work will not continue. It requires resources and coordination – an organisational holding. The capacity of AWG members is limited in terms of engaging stakeholders like the MoH and professional bodies and this would require continued technical assistance from UNDP or other key stakeholders for the next few years. The increased capacity and self-confidence of YKPs will endure and they will continue to use this in whatever personal and professional environment they find themselves. However, for the advocacy work to continue and be successful, the technical capacities of some of the YKP would need to be strengthened and focus on growing their knowledge of country commitments on SRH and HIV, legal provisions, policies, etc.

6. Evaluation Findings SRHR/HIV Knows No Borders (IOM)

6.1. Relevance

6.1.1. Extent to which regional Theory of Change (ToC) is guiding project delivery

The project contributes to 3 of the 4 structural determinants identified by the regional ToC (governance, social system, culture and religion and institutional organisation), all of the underlying causes (insufficient access, harmful practices and inadequate health care services) and all of the direct causes, except for mother-to-child-transmission. The 3 pathways of the project's ToC[50] are closely aligned with the 3 result areas as identified in the regional ToC. The regional ToC does not seem to guide the project beyond the fact that it was used in the assessment phase of proposals for the regional programme.

6.1.2. Relevance of project design

The project's ToC is of sufficient quality. There is a plausible connection between the 3 pathways and their contribution to the longer-term outcome of increased sexual freedom for the target groups. As project implementation progressed, the project team in Zambia added a fourth additional pathway on economic empowerment, realizing its importance for realizing SRH rights of its target groups. The project contributes to Zambia's National AIDS Strategic Framework 2017-2021 and project indicators feed the National AIDS Council Management Information System.

6.1.3. Relevance of partnerships

Stakeholders perceive the implementing partners as influential and capable. Implementing partners all had previous experience working on SRH/HIV. There is a shared common vision for the project and an efficient division of labour between consortium partners.

6.1.4. Regional character of the programme

A few regional components can be distinguished in the project. The project specifically selected its geographical target area based on where synergies could be established across countries. The Eastern Province is part of a migration corridor between Zambia, Malawi and Mozambique. Project partners, government officials and civil society organisations of these 3 countries are part of the Tri-partite Cross-Border Mechanism. The local implementing partners have been invited to 2 regional meetings where lessons were exchanged. Finally, the project created linkages between Change Agents in Zambia and Malawi, to facilitate health-care referrals of mobile populations. Contact, coordination, collaboration or learning exchanges with other partners of the SRH/HIV regional programme was non-existent in Zambia.

6.2. Effectiveness

6.2.1. Reach of target groups and geographical areas

The easiest group to reach were the AYP. It was challenging to identify migrants and sex workers. The project used Change Agents to assist with identification of sex workers. Migrants are primarily targeted with information and assistance as they are crossing the border. Mobile populations and sex workers are also targeted during annual weeks-long ceremonies that take place in the Eastern Province, which unite the Chewa population from Zambia, Malawi and Mozambique. While the projects endeavours to reach all migrants, it has not been able to identify potential CAs from certain countries. CAs mentioned they face

50 For the SRH/HIV Knows No Borders project ToC refer to Annex 2.

language barriers with approximately 10% of migrants (from e.g. Mozambique, Angola, Tanzania and DRC Congo). There are also deaf people in the communities that they struggled to communicate with, as they do not master sign language. The 3 districts have not been reached uniformly. The project received funding to focus on Chipata and Katete districts, but IOM received an overwhelming request from the provincial government to add the neighbouring Chadiza district, which it could not decline. The focus has been along the migration spaces of vulnerability in the districts. Chipata has received more focus than the other districts.

6.2.2. Leadership & personal development of Change Agents

Change Agents reported increased knowledge with regards to SRHR and increased self-confidence as a result of their participation in the project. They received increased respect and recognition from community members. They have bonded with each other (friendships) and function as a peer-support system. Some of them used to engage in negative behaviour but have changed since they became a Change Agent. They have become leaders in their own communities and in some instances use their counselling skills and influence to assist not just with regards to SRH/HIV issues but also on issues such as drug and alcohol abuse and domestic violence.

In addition to contributing to increased knowledge of SRH/HIV rights (see Contribution Analysis) the project also focused on increasing knowledge of other rights, such as the right of stay of migrants and the rights on equal pay for equal work. As a result of this, evaluation participants shared some stories of change. However, due to the limited scope of this evaluation, it is not possible to gauge the extent of the project's contribution to increased respect and enforcement to rights other than SRH/HIV.

6.2.3. Behaviour change & change of harmful traditional practices

Different stakeholders observed the following changes in terms of behaviour as a result of the SRH/HIV information shared by the project:

- Sex workers self-report that they have started to use condoms consistently and correctly although there are instances where they will agree to unprotected sex if it means they can charge more. If this happens, they will visit the Information Hub in the morning, to get a referral to the clinic.
- Sex workers self-reported that they all know their status, take their ARV medication and have their viral loads tested every 3 months.
- Sex workers and AYP Change Agents reported that before the project, it was very difficult for people to openly live positively. Now stigma has reduced and people are increasingly open about their status. There is also an increase in referrals from the Information Hubs by people who want to go for VCT. An increase in people who adhere to their ART and test their CT4 count was also reported.
- Reports of GBV received by the Victim Support Unit have increased, which seems to be an indication that there is increased knowledge of this issue and willingness by victims to speak out.

Traditional leaders shared that they have started to advocate for migrants' rights and examples were shared of cases where they have ensured that ill migrants were attended at the Health Clinic without discrimination. At the level of the health clinics, traditional leaders observed the following changes:

- After delivering, mothers are now given further counselling by health care providers.
- Information shared on family planning has helped women to space their children. As a result, mothers and babies are healthier.
- Previously men were not allowed to escort their wives or partners to get a first antenatal, now they are requested to do so.
- Women are no longer allowed to deliver from home.

It is difficult to gauge the contribution of the project to the above-mentioned changes, given that there are other on-going interventions, such as the Ministry of Health programmes and the He-for-She Campaign. However, one of the local implementing partners felt that the referrals the project facilitated for antenatal services, the Radio Listening groups, the Reflect Circles and the training of Alangizi (female initiation counsellors) contributed to these changes by creating demand for (improved) maternal and child health services.

The project made rare inroads in terms of engaging 15 Traditional Leaders and male and female initiation counsellors (referred to as Alumbwe and Alangizi respectively) in the Kawaza chiefdom.[51] Initially, there was heavy resistance as to work and/or interact with especially the male initiators used to be an absolutely no-go area. Prior to the project, the Alumbwes used to operate like an informal army, rounding up boys between 10-24 years of age, unannounced, to take them to the bush for initiation, for a period of 30 days. The initiation rites used to be brutal, with physical violence sometimes resulting in fatal injuries. Once released, the boys felt entitled to have unprotected (and unsolicited) sex, contributing to GBV, the spread of HIV/Aids and teenage pregnancies. Because of the project's contribution, the following traditional practices have changed in the Kawaza chiefdom:

- Young men are only initiated when they reach 25 years of age, so they can first finish their education.
- The curriculum for male initiation has changed and is more in line with respect for human rights. There is no more physical punishment.
- Only when girls/young women are ready for marriage will they receive information pertaining to it. The family has to inform that they are intending to send the girl for initiation. Younger girls are still initiated but they only receive information that is pertinent for their age, such as female hygiene, as this prevents girls from staying out of school when they are menstruating.
- Initiation rites for both genders no longer take place during school terms, thereby increasing school attendance and progression.
- The traditional ceremony to celebrate the completion of male and female initiation rites, called the "Big Dance" used to go on late into the night, leading to youngsters engaging in (unprotected) sex. The Big Dance is now conducted during the day.

The work with the Traditional Leaders and counsellors has been remarkable, but changes achieved were not solely the result of the project's influence. The Kawaza chiefdom has its own Local Development Strategic Plan. Eliminating childhood marriages is the main objective of this plan, but there is also a focus on combatting child labour such as cattle herding by young boys, as well as a strong focus on education for both genders.

51 The Kawaza chiefdom administers a large area of 800 villages, spreading into Malawi and Mozambique. The project covers approximately a quarter of the chiefdom.

6.2.4. Sex Workers Forum + economic empowerment

Sex workers were organised by the project in hubs (25-30 members) and at the district level in a Sex Worker Forum (1 in Katete and 1 in Chipata with 30 members each). The Sex Worker Forums consist of influential individuals and hub leaders, who help the project identify sex workers' issues and needs, which the project then advocates for with stakeholders, on the sex workers' behalf. The sex workers that participated in the FGD did not know about the Sex Workers Forum and hence could not comment on its relevance or effectiveness.

At the lower level of the hubs, sex workers have become more organised. If there are issues of GBV, they assist one another with reporting cases to the Victim Support Unit and if a client does not pay, the sex workers will mobilize and "force" the client to pay, which did not use to happen before. The fact that sex workers are more united and coordinated is significant as the sex workers are far from being a homogenous group; there are differences in social class, age and how much individuals (can) charge, which at first created distrust and made certain sex workers feel intimidated by others. According to implementing partners, the hubs and forums have increased the solidarity between Zambian and migrant sex workers but this was not confirmed in the FGD, where sex workers complained that migrant sex workers have distorted the labour market, are "not very friendly people" and "could even grab your shoes or the shoes of a client".

Sex workers reported that because of their increased visibility and activity in the Information Hubs, community members have a better understanding of their work and stigma against them has "finished completely". Their self-stigma has also reduced. They are aware now that they have human rights and the right to access services.

"Those of us who benefitted from the loan, we have no time for sex work. There is a big difference! When you work at the market you have money all the time, you can eat when you want. I have been able to take my children to school and I even bought a big fridge. With sex work I never could buy a fridge!" (Female sex worker)

Through collaboration with different ministries, facilitated by the project, 60 sex workers were trained in entrepreneurial skills (June 2018), funded by the project. Fifteen of them subsequently qualified for an interest free loan (May 2019). The group was able to pay back 100% of the loan, without defaulting. The informal businesses started by the sex workers are still going and they have been able to reduce the hours spent on sex work, although some of them still have irregular clients. The project has found that those sex workers who have been economically empowered remain connected to the sex work trade and are now able to provide support to their peers, e.g. when a sex worker falls ill or pregnant or is beaten up by a client. The improved coordination of sex workers in hubs and forums contributed to this increased solidarity.

6.2.5. Tri-Partite Cross-Border Forum

The absence of standardization and referral forms and systems between neighbouring countries is hindering SRH/HIV service provision. IOM addresses this through providing technical and financial support to the Tri-Partite Cross-Border Forum between Zambia, Malawi and Mozambique. The cross-border forums that previously used to exist had a security outlook. The first meeting was attended by 86 NGO and governmental delegates. As a result of this meeting, the Terms of Reference and Standard Operating Procedures for the Cross-Border Forum were revised to include health and HIV components. The cross border forums

are instrumental in monitoring issues of service provision and access for migrants across the 3 countries and providing feedback to counterparts as needed.

While it is still at early stages, they have been useful in bringing topical issues to the attention of various stakeholders.[52] Even though the Cross-Border Mechanism was not created by the project, according to PACA the project played a significant role in enhancing the collaboration. Without the project the tripartite meetings would not have happened, as these require substantial resources. IOM also played a significant role in mobilizing the different stakeholders in all 3 countries to attend the meetings. IOM however admits that the Cross-Border Mechanism has not yet been as successful as it would want it to be in terms of achieving greater autonomy from the project and greater recognition of the forums in national structures (e.g. by including them as part of the mandated coordination bodies with attendant measures of performance, as well as national and sub-national level commitment towards ensuring the continuity of these bodies by allocating state resources towards convening them).

6.2.6. Multi-sectorial approach

As issues affecting migrants, SWs and AYPs transcend several departments, the project promoted a multi-sectorial approach, bringing together different governmental service providers (at provincial and district level). The project support towards this consisted of trainings in the human rights-based approach to service delivery and support for meetings and transport. IOM reports that the multi-sectorial approach allowed for joint planning and action and the referral of clients across the various sectors.[53] The Provincial AIDS Coordination Advisor, confirms this and shared that because of the multi-sectorial coordination mechanism, different stakeholders have discovered the value of working in integration.

"Because of this project the individual has become the centre of the service provision rather than institutional agendas. The police cannot just pick an individual who is suspected to be a migrant and throw him in the cell. Now they have been educated on the rights-based approach to services. If this individual requires technical help in terms of migration they will call someone from immigration. This is trickling down to the policeman on the street." (PACA)

However, FGD participants felt that forum meetings (at both provincial and district level) have not been consistent enough to allow the multi-sectorial approach to take root and for participants to have a sense of working towards a common goal.

6.2.7. SWOT analysis

<u>Strengths</u>

52 For instance, Zambia delegates raised concern about the issue of maltreatment of their nationals along the border with Mozambique by border patrol guards. The forum discussed and proposed to escalate this issue to the National Attorney general in Maputo to engage his Defence counterpart. The forum is waiting for feedback on this.

53 One of the challenges the project identified was that a number of SWs were using short-term methods of Family Planning (FP), which had a lower success rate and led to unplanned and unwanted pregnancies with clients, many then resorted to illegal abortions and some reportedly died from this. The project engaged the MoH through the multi-sectorial structures to prioritise the SWs for FP and give them information and access to more reliable methods. Through this initiative, a number of SWs were referred for long-term methods (implants), which serves a dual purpose of preventing unwanted pregnancies as well as unsafe abortions.

1. **Capacity to galvanize government** – IOM has a strong capacity to galvanize government stakeholders at the national and provincial level.
2. **Use of established and qualified local implementing partners** – Instead of bringing in new actors, the implementing partners worked with local qualified organisations with experienced and committed members of staff.
3. **Focus on existing community structures** – Apart from the Change Agents, the project worked mainly through existing community structures, such as Traditional Leaders and counsellors and Queen Mothers (an informal leadership position amongst sex workers).
4. **Change Agents** – The Change Agents are qualified, motivated and inspired to make a difference.

"We are giving information to adolescent girls but no matter how much you tell them, the following moment she is pregnant. (…) After giving birth, she goes back to school, you teach her again and she falls pregnant again. Not only do we refer them to services even myself I provide condoms, even here I have condoms in my bag but they really don't want. My worry is what am I going to do with such girls, I really want to save them, what methodology do I use?" (Young female Change Agent)

<u>Weaknesses (areas for improvement)</u>

1. **Socio-economic determinants of health –** Some of the CAs aired their frustration that after providing people with information there is nothing else they can offer community members. Without more emphasis on economic empowerment and livelihoods they feel the project has limited impact on preventing AYG from entering the sex trade and/or addressing cases of domestic violence and GBV.
2. **Intergenerational gap -** The communities in the Eastern Province are facing massive societal changes, as a result of the influence of improved education, migration and the recent modernization of initiation rites. This has laid bare an intergenerational gap, where youth and parents/elders no longer seem to understand or respect each other. The project has not taken this challenge sufficiently into account.
3. **Working conditions of Change Agents –** According to IOM and SC, there is an agreement with local IPs that Change Agents will work 2 days a week for a maximum of 3 hours. In practice, no tabs are kept on this. In addition to mobilizing communities and sharing information, some of the CAs facilitate between 1-4 saving groups (and/or youth groups). They also need to report on their work and meet to reflect and plan the work. Change Agents that work at the border use mainly one-on-one contact or work with small groups of people, which affect their targets so they felt obliged to put in extra hours. The community demands more and more time from CAs who are not always able to keep boundaries as they live in the same communities. Similarly, the Information Hubs are manned 24/7 by volunteer sex workers. Change Agents complained they have not received a certificate for the trainings they have successfully completed, and were not given a T-shirt that would identify them as a project Change Agent or a project ID, which would make them more visible and approachable in the communities and would facilitate access to the clinics they serve.

Opportunities

Increased appreciation for importance of migration issues – Through the project, the Eastern Province government realized that migration is not just an international but an internal phenomenon and how to contribute and facilitate it. This is an opportunity the project could use to increase governmental support for migration-related issues.

Threats (challenges)

1. **Teenage pregnancies and under-age sex workers remain a huge challenge - T**he project does not work with sex workers under 18 years of age, as their engagement in the trade is considered "defilement" (rape). However, the majority of sex workers in the Eastern Province is very young, if prevention efforts don't target this age bracket the problem is likely to get worse. Teenage pregnancies are also a continuous challenge.[54]
2. **Commodity stock outs -** Throughout the project, there have been challenges with SRH/HIV commodities not reaching the rural areas of the Eastern Province (even though at national level there are no shortages). The project has no provision for procuring commodities as there are other organisations already supporting supply-chain issues with much larger investments. Still, the project occasionally supported NAC with the distribution of condoms in the project area. As a result, the availability of condoms is currently not a challenge, however, HIV test kits, STI test kits, pregnancy test kits and treatment for STIs haven't been available in some places for the past 6 months. This is posing a serious barrier to the effectiveness of the project.
3. **Staff attrition in the health sector** – A new trend over the past few years has been high attrition at all levels (national, provincial and clinic) in the health sector, leading to high turn-over of officials in offices strategic to the project.
4. **Lack of consistent and reliable data collection at provincial level –** Inconsistent data collection methods used by different ministries makes it challenging for the project to gauge its contribution to improving SRH outcomes (impact level).

6.3. Efficiency

The budget allocation for the project met the needs and expectations of the implementing partners for what the project initially planned to do. However, the government's request to add a 3rd district to the intervention area meant the budget became stretched and partners had to re-engineer it. Partners feel that the budget has been adequately used. Human resources allocated to the project consisted of 2 IOM staff, 2 Save the Children staff, 4 Chisomo and 5 YHHS staff members. Human Resources were sufficient in terms of quantity and quality. All staff members are capable, appropriately trained and dedicated to the work. IOM staff generally spent 10-20% more time on the project than allocated because of IOM's coordinating role in the consortium.

The total budget in Zambia consisted of USD 1,395,078. 61% of this was earmarked for operations, with the remainder earmarked for staff, office, travel and vehicles. To date, the 265 active Change Agents reached 127,790 people with information on SRH/HIV. This is 15% of the 835,112 total population of the 3 districts where the project operates, which is a positive result, as the project only operates in specific sites in each district and did not set

54 One young female CA shared how out of 34 group members that she regularly engages with, at least 6 AYG fell pregnant in the past 2 years. A young male CH shared how 2 active AYG members of his group fell pregnant. According to them, the problem is biggest at boarding schools, which sometimes have an arrangement where girls are accommodated in the village, with a lack of supervision.

out to cover the entire population.[55] The referral system set up by the project shows that 15,880 people were referred for health care services. This is 12% of those reached with information and 2% of the total population. Considering that the project worked with 265 active Change Agents, who reached 127,790 people; on average each Change Agent reached 482 people over a period of almost 3 years (this averages to 160 per year/13 per month). On average, each Change Agent referred 60 people over a period of 3 years (20 per year).

6.4. Impact

The contribution of the project to the short, medium and long-term outcomes has been assessed in the chapter on effectiveness. The results achieved seem to confirm the current ToC, especially the important link between pathway 1 (demand creation) and pathway 2 (supply and accessibility of SRH/HIV services). With regards to the impact level of the project (improved SRH/HIV outcomes for the target groups), stakeholders who participated in the evaluation shared the following self-reported changes:

- Sex workers self-reported a decrease in the number of (illegal) abortions.
- Sex workers self-report that they are increasingly practicing child spacing.
- 67 child marriages have been intercepted by Traditional Leaders in the Kawaza chiefdom.
- In 2018, over 100 child mothers resumed their primary school education after delivery.[56]
- Traditional Leaders reported that HIV related deaths of migrants have reduced, as they no longer hide when ill but know they have a right to access health services such as ART.

The information on changes at impact level mentioned above is ad-hoc and relies primarily on self-reports. Unfortunately, the project was not able to share cumulative data collected on some of the higher-level outcomes of the project.[57] As a result no comparison could be made with regards to the situation as reported in the baseline study. The full roll out of the mobile data collection, storage and analysis software DHIS2, which is currently being piloted at 2 health sites, should improve this situation and provide the project with more sophisticated monitoring data at outcome and impact level.

6.5. Sustainability

A number of sustainability measures can be identified in the project. The project is strengthening its engagement with existing government structures as well as aligning to existing coordination mechanisms to ensure that it doesn't create parallel systems. At community level, the project is working through structures that were already in place (Queen Mothers, Alangizi and Alumbwe). In addition to working through existing structures, the project tapped into existing plans in the communities, such as the Strategic Plan of the Kawaza Chiefdom. In 2019, the project started to incorporate and train as Change Agents the newly recruited Community Health workers under the MOH. This will help reduce the rate of turn-over, as they are individuals who have been given pensionable jobs within the MoH

55 The projected population size for the 3 districts for 2019 based on Census Data from 2010 is: Katete 202,507; Chipata 554,230; Chadiza 78,375. This brings the total population for 3 districts to 835,112. (https://citypopulation.de/en/zambia/admin/03_eastern/)

56 IOM Zambia Annual Report 2018

57 E.g. % increase of service delivery points providing one or more HIV service and one or more SRH services which are sensitive and responsive to migrant and non-migrant AYP and SWs needs and rights; % of migrant women, young women and female SWs reporting access to modern contraceptive methods; % individuals in migration affected communities who are satisfied with the way service provider institutions handle SGBV case management; % of service delivery points that experienced stock out of SRH-HIV commodities.

structures. Change Agents that had not been linked to health facilities have been linked to Information Hubs or Health Clinics. The project took into consideration factors that have a major influence on sustainability, such as economic, social and cultural aspects. The project has no formal exit strategy but part of this could be assisting government to come up with a sustainability plan for the intervention, as requested by PACA.

7. Conclusion of the Netherlands Regional HIV/AIDS and SRHR Programme in Zambia
Available evidence from secondary data and focus group and interview respondents confirm that interventions of the 2 projects implemented in Zambia as part of the regional programme were varied and contributed independently and in isolation to the outcomes the regional programme set out to achieve. None of the implementing partners of the 2 consortia in Zambia (UNDP and IOM) were aware of the fact that the other projects were either being implemented in the country and/or contributing to a regional Theory of Change. The Dutch Ministry of Foreign Affairs/EKN In Maputo created no opportunities for synergies between the projects in Zambia. Effectiveness is evident in these individual country projects but not as a collective contribution to the regional programme. The sustainability of the regional programme cannot be assured under the current arrangements in Zambia as there is in fact no regional programme to speak of. Despite the lack of synergies between the 2 projects, the Theory of Change of the regional programme is still relevant in the Zambian context.

8. Conclusion & recommendations Linking Policy to Practice (UNDP)
After 2 years of implementation (Sep 2017-Oct 2019), the LPP project is still in its infancy. Advocacy results, such as changes at national policy level, amendments of laws and the implementation thereof, take time. However, the partnership between UNDP, AMSHeR and HEARD delivered some initial results in Zambia. The LEA, the Civil Society Engagement Scan and the research on Mental Health of MSM are important and useful documents that should give future guidance to the advocacy efforts of the project and will be beneficial to other initiatives that focus on improving SRH and human rights of KPs. The project contributed to the creation of an enabling environment for KPs in the context of addressing barriers to access to services through the creation of a National Steering Committee. A sizeable group of 25 YKPs were empowered and are able to speak about their issues at national and regional forums. A safe space for YKPs to get together and share about challenges was created, which in itself could be considered a success. There is greater solidarity between KP organisations. The NSC and AWG both have potential as YKP advocacy groups, but require a continued organisational holding and in the case of the AWG, technical support, in the years to come. The approval of HEARD's research on MSM by the National Research Ethics Committee is an important precedent and steppingstone for future research focussing on LGBTI/KP issues and populations in Zambia.

The main activities of the LPP project consisted of producing advocacy/research documents, coordination of the NSC and AWG and the capacity building of YKPs and TBZ. Actual advocacy efforts in-country have not properly taken off yet, beyond some initial conversations with the Zambian Police Forces on the Law Enforcement curriculum review and the production of a draft review of the Health Service Provider curriculum by HEARD. There is limited reporting on and limited knowledge of country staff with regards to what has been achieved by UNDP HQ at the regional level, and how this relates to the work being implemented at country level, which risks diluting the regional aspect of the project.

With regards to the partnership consortium, the choice of 1 multi-lateral and 2 regional partners made sense, as the topic of YKPs is very controversial in the Zambian context. However, it might have increased the effectiveness and sustainability of the project if a national organisation with the proper human and financial resources had been part of the consortium.

The evaluation identified the following recommendations:

1. **Improve coordination and communication between HQ and country level –** Teams should improve their communication and understanding of how activities at the regional level link to and strengthen the work at country-level and vice versa. The responsibility for in-country follow-up on regional events should be clearly established and monitored.
2. **UNDP to redefine its role –** UNDP needs to either exert a more active leadership role and be more hands-on with regards to technical and practical implementation of the National Action Plan or identify another organisation to do this. A strategically positioned local organisation (with the right support) might be in a better position to assume responsibility for the coordination and implementation of the plan. If future implementation remains in the hands of a regional/multi-lateral organisation, a local organisation such as NAC and/or the HRC should be added to the consortium to increase local ownership and sustainability.
3. **Disseminate the LEA + related policy briefs –** The LEA needs to be launched officially at the national level in a way that gives visibility to the document as well as the LPP project. The NSC should start breaking down the LEA and the mental health research of MSM into thematic policy briefs, using bolder (less legalistic) language and actionable recommendations.
4. **Create an Advocacy Roadmap –** The NSC should consider taking the National Action Plan back to the drawing board, select a few key priorities and create a roadmap in terms of specific advocacy strategy, timelines and budgets, thinking also of ways in which the recommendations of the MSM mental health study can be used to inform advocacy. This consolidated and updated version of the NAP can be used to mobilize financial resources for its implementation.
5. **Continue strengthening advocacy capacity of YKPs** – The work with YKPs should continue, so that a cadre of advocates is formed. There is a need to grow YKPs practical knowledge of country commitments on SRH/HIV, legal provisions, policies, etc. The project should continue to encourage the YKPs to come with their own advocacy ideas even if these do not directly speak to HIV/SRHR.
6. **Work more closely with KP organisations –** Going forward, the project should involve the different KP organisations more actively, especially the smaller, emerging ones. The capacity of KP organisations varies across groups, with sex worker communities, intersex and YPUD at an early stage of establishing themselves in Zambia. It would make sense for the project in going forward, to broaden the scope of OD to include these KP organisations.
7. **Improve communication and ownership of AWG –** The AWG should follow up with members who have stopped attending, replacing them with new representatives where needed. The AWG could meet more frequently or at least keep members and its constituency updated through regular communication, through e.g. a WhatsApp group.
8. **Safeguard equal participation of different YKP groups –** The project should make sure that those YKP groups that have stronger representation and are better organised

don't dominate, but pay equal attention to the needs of minority YKP groups. The project should explore innovative ways of involving more PWUD and YIP.

9. **Create more synergy between NSC & AWG –** The project should consider a merger between the NSC or create more synergies in the form of occasionally hosting joint meetings and updating each other on work plans.
10. **Involve under-18 YKPs in feedback sessions** – Even though the project is not able to directly target YKPs younger than 18, both the NSC and AWG could engage the wider YKP networks with more frequency, to inform them about the work and ask for feedback.
11. **Start targeting opponents –** The project should start to engage with those stakeholders most hostile to YKP issues, such as religious leaders, parliamentarians and politicians of both the ruling party and opposition. The project has so far targeted the easy entry-points, but instead of targeting e.g. the Health Secretariat of the Zambian Police Forces, it should also start engaging with the Criminal Investigation Department.
12. **Work with (social) media –** The project should start working with (social) media in order to increase visibility of the project and contribute to changing the narrative around YKP issues.
13. **Develop a safety mechanism** - UNDP has provided a safe environment for the YKPs and other stakeholders it works with through its bilateral relationship with government. However, there is no clear and deliberate safety mechanism available for YKPs or KPs that are involved. The project should develop a practical mechanism, including legal assistance that will protect those who speak out from being fired/arrested or otherwise threatened as a result of participating in the project.
14. **Increase coordination within UN system –** The UN could look into mainstreaming KP issues internally, so that e.g. UNICEF does not promote comprehensive sex education using a narrow binary perspective.

9. Conclusion & recommendations SRHR/HIV Knows No Borders (IOM)

The SRHR/HIV Knows No Borders project in Zambia made an important contribution to increasing the SRHR/HIV knowledge of 127,790 AYP, migrants and sex workers, thanks to the efforts of 265 active Change Agents. This, together with efforts to change the attitudes and practices of essential stakeholders such as health care providers and traditional leaders, as well as the creation or strengthening of Information Hubs, Village Health Corners and Youth Friendly Corners, contributed to increased access to SRHR/HIV commodities and services. As a result of the project, some examples of positive behaviour change were reported. Child marriages, teenage pregnancies and the high level of under-age sex workers remain a challenge and would require concerted efforts by multiple stakeholders over the years to come. Some AYG actually want to get married early, most likely to escape their dire economic circumstances.

Evaluation participants largely agreed that clinic staff have improved attitudes, which made it easier for migrants, AYP and sex workers to receive the appropriate SRH/HIV services and commodities. Some changes in terms of ante and postnatal care were reported, but it is difficult to gauge the contribution of the project to these changes, although there is some likelihood that the referrals the project facilitated for antenatal services, the Radio Listening groups, the Reflect Circles and the training of female initiation counsellors may have contributed to these changes by creating demand for (improved) maternal and child health services.

With regards to tackling social norms and stigma, the traditional leadership of the Kawaza chiefdom has been a great asset to the project. Remarkable results were achieved in terms of modernizing the initiation practices of both female and male initiation counsellors. The SRH/HIV Knows No Borders was the first project to gain entry to the male counsellors in the Kawaza chiefdom, which is unprecedented and testimony to the foresight, creativity, patience and respect of the implementing partners as well as the leadership of the local Chieftainess. The fundamental changes in how initiation rites are conducted are expected to contribute to a reduction in teenage pregnancies, child marriages and GBV in the medium term and will also improve school attendance and progression of both young boys and girls.

The work with regards to the Tri-partite Cross-Border Mechanisms and multi-sectorial collaboration produced some promising initial results but requires a longer-term approach in order to guarantee sustainability. As a result of the project, provincial authorities are more aware of the importance of SRH/HIV services for migrant and mobile populations. This is important, since the relevance of interventions targeting these populations will only increase in the near future due to climate-change and the Southern African region's food-security crisis, which will continue to affect the most vulnerable through gender-based violence and intensified risk of HIV transmission.

The evaluation identified the following recommendations:

1. **Strengthen the economic empowerment of target groups –** Continued interventions on economic empowerment are an essential component for a follow up phase. The project could scale up the interventions implemented with the assistance of partners with the relevant experience in economic empowerment and micro-credit.
2. **Focus on prevention (in addition to behaviour change) -** There may be a link between a decrease in child marriages and an increase in under-age sex workers, which the project may need to investigate further. A stronger focus on prevention and linkages to other programmes that focus on education could help reduce the number of young girls who enter the sex trade.
3. **Continued mentoring and follow up with Traditional Leaders –** It would be important for the project to continue to provide some sort of mentoring and follow-up assistance to those traditional leaders trained by the project in order to anchor the changes achieved. The 15 Traditional Leaders trained by the project represent only a small percentage of the total chiefdom. Working with a Training of Trainers modality to reach out to larger sections of the chiefdom would be important.
4. **Create Horizontal Learning exchanges for sex workers –** In order to empower the sex workers who are members of the 2 forums so they will gradually become their own spokespersons (as opposed to the project advocating on their behalf), the project could invest in creating horizontal learning exchanges between them and more established groups (e.g. the Zambia Sex Workers Alliance, based in Lusaka).
5. **Be more innovative in addressing stock-out issues –** The effectiveness and sustainability of the project (and any other effort to improve SRH/HIV outcomes) relies heavily on the availability of SRH/HIV commodities. The project should prioritize looking into innovative opportunities of addressing "last mile" stock-out issues. There might be ways in which this can be linked to the economic empowerment of Change Agents.
6. **Start targeting parents and focus on intergenerational work –** The project should start looking at how the different generations can be brought together to improve

social cohesion and reduce stigma and discrimination of young people who engage in sexual activities. Likewise, parents should be more specifically targeted by the project.

7. **Strengthen the Multi-sectorial forums** – This could be done by meeting more frequently, holding people accountable for joint plans and by providing financial resources so that ToT can reach more government officials.
8. **Support government with sustainability plan –** The project might want to consider supporting the provincial government with drafting a sustainability plan that shows how elements of the project can become part of government's responsibility.
9. **Working conditions of Change Agents –** The project should ensure that issuing Change Agents with a certificate T-shirt and an ID becomes standard practice. Support with transport becomes necessary to reach the outskirts of towns and to escort referrals. A bar of soap and/or gumboots for the rainy season would go a long way to show appreciation. Change Agents mentioned the need for more frequent information updates and follow-up training so they can stay abreast of new developments in SRH/HIV.

Annex 5 Country Case Study Zimbabwe

1. Country Context

Zimbabweans have never enjoyed real and lasting peace since independence in 1980. A culture of fear and violence expressed through arbitrary arrests, abduction, physical abuse, torture and hate speech that usually peak during election periods has continued to compromise individual fundamental rights and freedoms. The rights of KPs and the LGBTIQ community in particular, have therefore remained under constant threat through intimidation and harassment of members. The LGBTIQ community is neither recognised nor acknowledged in current legislative and policy frameworks, least of all in the Constitution which increases their vulnerability through acts of commission and/or omission by key duty bearers across the board. The ruling party has not been consistent nor clear about its tolerance of the human rights of this community whilst the rights of key populations i.e. sex workers, MSM, trans people and those that inject drugs have largely remained invisible[58].

It is against this backdrop that sexual reproductive health and rights also continue to be a cultural taboo for many, especially the KPs and LGBTIQ community. Adolescents and youths in Zimbabwe have high levels of HIV prevalence (and account for new sources of infection) which can be attributed to poor access to prevention, treatment and care services which is even worse for young KPs and LGBTIQ sub-groups. They have weak capacity to advocate and/or negotiate for family planning or safe sex even among and within their own networks, let alone advocate for access to quality, friendly and affordable services from duty bearers.

The traditional structures have collapsed due to the macro-level socio economic status of the country that has decimated families in search of better livelihoods. Therefore, aunties and uncles who used to educate and nurture adolescents and youths about their SRHR are none-existent anymore; others rely on their parents who are still steeped in traditional stereotypes about sex, sexuality and hardly conversant about 'human rights' which doesn't help the situation either as long as they cannot speak directly to the specific SRHR issues presented; communities in turn do not appreciate the need to discuss and tackle SRHR issues for the same target group which has had a devastating effect at personal, family and community levels.

This is despite the fact that they are going through a period of experimentation, physical and emotional change that need consistent guidance and support. For example, there is evidence of increased teen age pregnancies, abortions, child marriages, STIs on the rise and high levels of school drop-out also due to peer pressure. There are no more family and social safety nets to guide and nurture the adolescents and youths for safe passage to adulthood whilst social media is just making the situation worse as they use it to get advice and solutions to their specific SRHR issues. The general socio-economic downturn has created multiple levels of vulnerabilities that are fuelling inter-generational sexual relationships and the challenges it presents including in the context of HIV. Young people cannot even access basic health services which is their right e.g. sanitary ware thus increasing their vulnerability especially in

58 Zimbabwe: A Country Context Analysis on the Human Rights and Health Situation of LBGT; COC Netherlands and Southern Africa Partners of COC in Bridging the Gaps Programme (June 2016)

tertiary institutions that are meant to provide them meals, accommodation and other basic services but are failing. The big effect of this current reality is yet to be seen.

Attitudes of the police and health workers especially in key public institutions have further compromised the SRHR of this target group, at times reversing the gains made in the HIV national response especially around prevention. Another complexity is the need for parental or guardianship consent when engaging with these adolescents and young adults which at times is difficult due to gender dynamics, traditional and cultural beliefs.

Sex workers continue to be discriminated by law enforcement agents on charges of soliciting clients and/or loitering although it is not a crime to sell sex officially. It is also illegal to live on the earnings of sex work and to facilitate and procure sex work. Criminalization e.g. of wilful transmission of HIV still remains a barrier to the SRHR of sex workers, for example. Criminalisation is enforced through different sections of The Criminal Codification and Reform Act. The President's Emergency Plan for AIDS Relief (PEPFAR) Zimbabwe estimated 85,949 sex workers in Zimbabwe.[59] HIV prevalence among sex workers is estimated between 38-70%, of which only 61% know their HIV status (PEPFAR), thus making Zimbabwe one of the countries with the highest prevalence among sex workers compared to the general population.

Incestuous relationships as LGBTIQ sub-groups fight for partners has fuelled stigma and discrimination by society who end up identifying them as sexual perverts; whilst harassment and violence continue to push KPs and LGBTIQ to the margins of society and deny them access to basic health and social services[60]. Gender marginalization and discrimination with regards to access to resources and opportunities (e.g. for education and livelihoods) have further increased vulnerability and insecurity of KPs and LGBTIQ members. Most sub-groups of LGBTIQ work underground as a result of fear from heightened political backlash, thus making targeting difficult. Gender dynamics in KP groups and the LGBTIQ community are also affected by patriarchy that requires a change of mind-set because it makes women more challenged in coming out and engage in available public spaces. This in turn entails that policies do not integrate their needs effectively e.g. for family planning yet it is their legitimate right.

1.1. Introduction to the programmes in Zimbabwe

Zimbabwe's contribution to the regional programme was through 3 specific programmes. These were:

1.2.1 READY+

The overall aim of READY+ is to reach 30 000 adolescents and young people aged 10-24 years in rural and urban areas and living with HIV (A&YPLHIV) with better information; greater freedom of choice about their sexuality and improved access to and use of sexual and reproductive health commodities; and, quality health care. The programme is implemented through 6 health facilities (also known as Paediatric AIDS Treatment for Africa - PATA sites) at hospitals in Beatrice, Chitungwiza, Masvingo, Bulawayo and Harare.

59 Hands Off! Needs Assessment Report
60 UNAIDS press release 16 July 2019

The programme distinguishes between early, middle and late adolescents for implementation to ensure age-appropriate content and strategies are applied. Beneficiaries are supported by community case care workers and village health workers for effective programme roll out. The overall approach and strategy has been to build on AfricAid/Zvandiri CATS model (Community Adolescent Treatment Supporters)[61] which is the backbone of the project and has been a good practice model in HIV programming for adolescents' SRHR in Zimbabwe and the region. The CATS provide peer to peer information, counselling and support. AfricAid is therefore the key technical partner responsible for rolling out the model in other READY+ countries whilst upscaling it in Zimbabwe.

REPSSI is the lead of the consortium implementing the programme. They lead and coordinate PATA sites in Masvingo in collaboration with (BASO - Batanai HIV AIDS Service Organisation) in Bulawayo at Mpilo Hospital (in partnership with MMPZ - Million Memory Project Trust Zimbabwe) and at Chitungwiza General Hospital. Besides being a technical advisor to the programme, AfricAid/Zvandiri programme leads and coordinates PATA sites in Harare as well as United Bulawayo Hospital (UBH) in Bulawayo. ALN leads the development of country reports and has been responsible for design and administration of research tools, methods, participatory community research, data analysis and documentation as well as mapping SRHR and PSS services that are used for referrals and evidence generation. Community research also feeds into development of advocacy and accountability interventions. Another partner, M&C Saatchi has been strategic in relation to media and communication needs of the programme.

An in-country Steering Committee led by REPSSI and involving all consortium and implementing partners meets quarterly. At times, key stakeholders such as Ministry of Health are invited as all the programme activities are integrated in the national HIV response and has to contribute to the score card reporting system that is led by Y+.

Zimbabwe's contribution to the EKN SRHR and HIV Regional programme outcomes was to be assured through 210 CATS through which 10 thousand A&YPLHIV beneficiaries would be reached; train health care providers in PSS through REPSSI as well as convene community dialogues, care giver meetings and home visits especially with active involvement of CATS.

1.2.2 UNDP Linking Policy and Programming (LPP) to HIV

This strategic programme seeks to link policy and programming which, until now, had not been effectively nor sufficiently integrated. A conducive environment to tackle SRHR and HIV especially among A&PLHIV is critical in a country where new sources of infection are adolescents and youths aged 13 – 24 most of whom were born with the virus. It therefore seeks to tackle structural challenges and their effect on service delivery through a conducive environment. The programme was signed off in March 2015 by UNDP for all the implementing countries including Zimbabwe before the countries could verify and agree on implementation modalities. This was to present later, implementation and accountability challenges.

UNDP is the lead agency for the programme and responsible for 8 out of 10 objectives. A national Steering Committee with the KP organisations provides strategic guidance to the

61 These are youths aged 18-22 and selected on the following criteria: they must know their HIV status, do well on ART, must not be pregnant nor breastfeeding at the time of recruitment, can read and write and are willing to disclose their status for peer-to-peer support. In Zimbabwe unlike other countries, the CATS receive basic PSS training for effective programme scale up

programme. A Technical Working Group of 6 members is responsible for taking forward the legal environmental assessment processes with support of 2 consultants for technical assistance. AMSHeR is one of the partners who is responsible for capacity building and mobilisation of KPs. HEARD is another strategic partner responsible for research and documentation of SRHR issues and experiences of the adolescents and the young people. HEARD does not have physical presence in Zimbabwe and works through FACT, a local aids service organisation that has extensive experience in HIV programming. The Advocacy Working Group co-chaired by NAC and GALZ/TIRZ is strategic to the lobby and advocacy interventions of the programme that seek to implement recommendations of the legal environment assessment that should ultimately benefit the adolescents and young KPs comprehensively.

The core activities of the programme are:

- Legal environmental assessments (led by UNDP)
- Development of national plans in order to improve the legislative environment for key populations (UNDP)
- Community dialogues as the key strategy for mobilizing KP groups for advocacy (led by AMSHeR and drawing on their experience)
- Extensive research on HIV, SRHR and young KPs which was led by HEARD/ FACT

1.2.3 Hands Off!

The Hands Off! Programme seeks to reduce violence against sex workers through prevention, care and support. Violence increases their vulnerability to HIV/AIDS because of inconsistent condom use and prevents them from accessing valuable legal and health care[62]. The programme therefore works with sex worker-led groups, law enforcement, health and support services, legal centres and NGOs working on human rights. The programme rooted its design and implementation in the priorities and needs expressed by sex workers themselves and based on a strong participatory approach that ensured meaningful participation at every level. Capacity building of sex workers and sex worker-led organisations in the region was at the centre of the programme. The main target group of the programme are female, male and transgender sex workers; sex worker organisations, or organisations supporting sex workers; law enforcement officers, healthcare workers, community and religious leaders; as well as, government representatives.

In Zimbabwe, the programme is coordinated by Aidsfonds (NL), and implemented through a consortium that is led by Sexual Rights Centre (SRC) and which has ZIMSA and PowWow as the key implementing partners. SRC is responsible for overall local coordination whilst the Zimbabwe Sex Workers Alliance (ZIMSWA) and PowWow mobilise their respective community members to implement planned interventions including follow up and home visits.

2. Methodologies Used

For the Zimbabwe case study, a mixed methods approach was applied. Purposive sampling that was informed by evidence from literature review of secondary data was used for all the three programmes. Literature review of secondary data was done using 'snowballing' where

62 Paraphrased from Hands Off! Needs assessment report

key informants were asked to avail additional literature for evidence as the evaluation process evolved. The following additional details suffice:

READY+: a) Focus group discussions were conducted with representatives of CATS aged 18-22; care givers; CRFs and actual beneficiaries aged 13 – 26 years; b) key informant interviews with implementing partners i.e. REPSSI (consortium lead), BASO in Masvingo and MMPZ; c) relevant programme staff in AfricaAid and the Country Director

UNDP Linking Policy to Programming: a) key informant interviews with consortium lead partner UNDP and other consortium members i.e. AMSHeR and HEAD/FACT; b) key informant interviews with other important stakeholders i.e. NAC, UNAIDS, GALZ, TIRZ, Global Fund Focal Point and Liaison at NAC; c) key informant interview with Member of Parliament as a key beneficiary; and, focus group discussion with members of key populations who constitute the Advocacy Working Group, a key beneficiary of the programme

Hands Off!: The a) key informant interviews with programme lead SRC and implementing partners PowWow and ZIMSWA; b) focus group discussion with direct beneficiaries of the programme i.e. female, male and transgender sex workers.

A contribution analysis was applied to determine the contribution of each of the programmes to the **overall theory of change** of the regional programme and the following **three outcomes**:

- Better information and greater freedom of choice for young people about their sexuality;
- Improved access to and use of sexual and reproductive health commodities and quality health care;
- Respect for the sexual and reproductive rights of groups who are currently denied these rights.

To enhance analysis of the contribution for each programme, the following questions were used to guide data collection:

a. READY+:

- Question 1: How have CATS contributed to an increase (a) youth and (b) adolescents self-reporting ART?
- Question 2: How have the READY+ community dialogue sessions/workshops contributed to changing social norms around sexuality and health in communities?

b. UNDP Linking Policy to Programming:

- How have the (robust) research methodology and data on YKP groups contributed to YKP participation in high level forums and engagements in the development of a government-led national action plan in support of necessary reforms and strengthening of accountability mechanisms for YKP?

c. Hands Off!:

- Question 1: How have sex workers´ individual and organisational capacity trainings on legal and constitutional rights contributed to establishment of collaborative community-led response systems to decrease violence against sex workers?
- Question 2: How has information on sex workers' rights contributed to the provision of case documentation?

The major limitation of the study was the non-responsiveness of government officials for interviews and/or feedback to the interview questions and non-availability of some of the key stakeholders for interviews. This implies a gap in the validation of the data collected but feedback from NAC and Global Fund Liaison persons was used as a proxy in the validation of the data[63].

3. Findings

The Regional SRHR and HIV Regional programme sought to achieve the following outcomes:

- Better information and greater freedom of choice for young people about their sexuality;
- Improved access to and use of sexual and reproductive health commodities and quality health care;
- Respect for the sexual and reproductive rights of groups who are currently denied these rights.

Available evidence from secondary data and anecdotal evidence from focus group and interview respondents confirm that interventions of the three programmes were varied and contributed independently or in isolation to these outcomes. Almost all of the key informants were not aware of the fact that the other programme(s) were either being implemented in the country and/or contributing to a regional theory of change of the EKN SRHR and HIV regional programme. This entails that potential strengths and opportunities for synergies between the programmes were lost.

The following factors also confirm the extent to which the Zimbabwean programmes contributed (or not) to these outcomes and the overall theory of change of the Regional programme:

Outcome 1: Better information and greater freedom of choice for young people about their sexuality

There are varied levels of success discerned from available information generated and made available through each of the 3 programmes and how they influenced improved freedom of choice for young people about their sexuality. READY+ has made the most contribution to this outcome through its tried and tested CATS model with support from care givers and CRFs that assured A&PLHIV youths take charge of the initiatives to engage their peers and disseminate SRHR and HIV information to help them make informed choices. The LEA report is difficult to understand which limits its use by the Advocacy Working Group. Decisions about sexuality are still a challenge given high levels of (self-) stigma and discrimination including within the families and society at large, especially about their PLHIV status and/or

63 This made sense in a context where NAC is also a quasi-government institution whose activities are guided by government's HIV and Aids/SRHR frameworks and is the custodian of the HIV national response

sexual orientation. They fear further ostracizing by 'outing' about their sexual preferences especially as LGBTIQ.

Sex workers in turn have benefitted immensely from SRHR and legal information that they have used to assert their rights more especially in the face of violence from police. On-going national and regional initiatives by AMSHeR using its own resources e.g. networking and knowledge sharing conventions have enabled its young KPs to improve access to SRH and HIV information through the LPP as an extra mile.

CONTRIBUTING FACTOR	TYPE	EVIDENCE Signs/Facts	Likely IMPORTANCE
(a) Needs assessments done by/with meaningful involvement of beneficiaries KPs, A&PLHIV and youths	Primary	Both Hands Off! And READY+ based their interventions on sound evidence collected through needs assessment of their beneficiary target groups. The needs assessment of Hands Off! Was actually done by the sex workers themselves	Strong - READY+ and Hands Off!
(b) Capacity building and peer support among target beneficiaries (all programmes)	Primary	Trained CATS of READY+ provide relevant, accurate, comprehensive and up to date information to their peers including through safe spaces they create to discuss SRH and HIV issues openly. They also conduct home visits and follow ups to check on other PLHIV beneficiaries and facilitate referrals. This accounts for a high-rate of self-reporting by programme beneficiaries and has improved adherence Peer educators of Hands Off! conduct education and awareness raising sessions with members; follow up their peers, support them to assert their SRH rights with service providers (police and health providers) and at times provide counselling to peers Working group members of LPP create spaces and platforms to engage on SRH issues and recommendations raised through LEA to inform action	Strong
(c) Use of age appropriate language, tools and strategies that facilitate access to SRHR specific issues	Primary	READY+ uses IEC materials that are customised to uptake needs of different age-groups targeted. Training, education and awareness sessions are done separately for each age group and for parents, guardians and service providers	Strong
(d) Difficulty with legal language of LEA documents	Contradiction	The Advocacy Working Group of LPP is challenged by understanding and conceptualising appropriate actions informed by LEA documentation	Weak

(e) Knowledge generation and sharing lived experiences of young KPs at national and regional levels by AMSHeR to facilitate advocacy for mechanisms, regional and international opportunities	Contribution	AMSHeR has used its own additional budgets beyond allocation of the LPP to document and facilitate exchange between young KPs in order to facilitate advocacy for SRH and HIV information and services with the Advocacy Working Group	Strong
(f) AMSHeR has developed and advocacy guide with clear process steps to support young KPs and the Advocacy Working Group implement LEA recommendations in addition to other SRH and HIV issues	Primary	Young KPs and members of the Advocacy Working Group participated in the LEA process and production of the Advocacy Guide with technical assistance from AMSHeR	Strong
(g) Sustained engagement by consortium partners guided by clear work plans and results frameworks	Primary	Results framework and work plans are used to guide activities and follow up action very effectively by READY+; Hand Off! is guided by work plans but internal dynamics with sex-worker groups at times compromise effective follow through with planned activities. For example some of the groups do not want to engage in the safe spaces at SRC due to dysfunctional dynamics with SRC. Limited resources by sub-groups have compromised their capacity to conduct their activities independent of SRC; the LPP Advocacy Working Group of LGBTIQ has only engaged with the LEA process but has not yet followed through with the planned activities. The Programme is behind with other planned activities	Strong – READY+ Medium – Hans Off! Weak - LPP
(h) Focused interest by target group	Contribution	Beneficiaries of all programmes appreciate the potential of life change	Strong – READY+

	beneficiaries and the potential of the interventions to change their lives or address their pressing issues		through the interventions. READY+ CATS are real change agents that are excited about their role and have visible presence and tangible results especially at the health facilities. For LPP the LEA process has ONLY gone as far as stimulating interest in advocacy by trans people but sustained action is yet to be realised.	Weak - LPP
(i)	Improved confidence as KPs and A&PLHIV in asserting their rights at family and community levels as well as in targeted spaces such as health care facilities and police stations (all programmes)	Contribution for READY+ and Hands Off!	CATS work effectively with most stakeholders (at home, community and health facility) and are able to demand respect of their rights and services with service providers. Peer educators of Hands Off! are limited with inadequate technical information e.g. about the implications of various drugs administered simultaneously on their members and cannot demand SRHR when engaging with health providers at health facilities. However, they are more assertive with police.	Strong – READY+ Medium – Hands Off!

Outcome 2: Improved access to and use of sexual and reproductive health commodities and quality health care

Cheap quality free condoms are readily available at health facilities and within the organisations of KPs, young adolescents and youths besides ART that is accessed through health facilities. Family planning and hormonal therapy commodities are available in 'limited' quantities at health centres as it is not always clear which methods to adopt given the complexities involved (e.g. as a PLHIV on ART and trans person who is also working as a sex worker). Information and education about available options in such instances is therefore limited. Health workers do not always give sound advice as they too seem to be limited in capacity to articulate the implications of different drug regime on such (and other) clients.

Access and use of commodities are therefore limited for such persons who then tend to rely on information and experience from their peers which can also be dangerous to their health and life. Negative attitudes of health professionals towards KPs and LGBTIQ persons have compromised access to quality health care. Some of them discriminate these beneficiaries especially when they present STIs and cannot afford to follow through its treatment because it is not free. Cancer screening for target groups in Bulawayo is limited by inadequate equipment hence congestion at health facilities discourages access and opportunities for quality health care. Treatment for cancer is also too expensive and not readily accessible.

CATS, development facilitators of MMPZ and peer educators of Hands Off! have been instrumental in facilitating access and use of sexual and reproductive health commodities as well as access to quality health services through IEC information, education and sensitization spaces as well as referrals.

Lack of livelihood options for ALL target group beneficiaries across the 3 programmes is compromising their own capacity to access comprehensive, holistic and quality SRH services

that are not provided free e.g. STI and cancer treatment. This implies that quality health services might be available but access is limited by capacity including financial resources.

CONTRIBUTING FACTOR	TYPE	EVIDENCE Signs/Facts	Likely IMPORTANCE
(a) Training, information and education about available SRH services and commodities; where and how to access them (all programmes)	Primary	All programmes have used different mechanisms guided by their work plans and results frameworks to enhance access and to some extent, use of SRH and HIV services and commodities. Customised IEC materials have enhanced access to information that has informed decisions by target beneficiaries	Strong
(b) Correct SRH information about available options for trans people	Contribution	Some health providers do not provide comprehensive and quality information about drugs and hormonal therapy they administer to beneficiaries who are trans people	Weak
(c) Negative attitudes of health service providers (all programmes)	Contribution	Stigmatising and discriminatory tendencies by health workers has severely compromised access to accurate, reliable and comprehensive information in response to specific needs of target group beneficiaries of all the 3 programmes	Strong
(d) Limited equipment at health facilities e.g. for viral load testing, cancer screening, lab services (all programmes)	Contribution	Access to quality health care has been compromised by unavailability and/or obsolete equipment at public health facilities	Strong
(e) Lack of livelihood options for target group beneficiaries	Contribution	All programmes do not provide options for improved livelihoods for their target group beneficiaries. This has limited their capacity to access (pay) services and commodities (e.g. flavoured and ribbed condoms that are more preferable to young KPs and youths). Viral load suppression and adherence have ultimately been compromised thereby affecting targets for 90:90:90	Strong

Outcome 3: Respect for the sexual and reproductive rights of groups who are currently denied these rights

Attitudes, behaviours and practices towards A&YPLHIV and KPs by care givers, parents and guardians reached by the READY+ programme have been impacted positively. This is evidenced by the fact that the adolescents and youths under their care demonstrate better results compared to their counter parts without similar support. Except for a few individuals, many respondents and beneficiaries of all the programmes feel that respect of SRHR among adolescents and youths is still a pie in the sky so long appropriate support systems and mechanisms starting from family level do not exist. They felt that it might actually take a whole generation to impact meaningfully on some of the social norms, values and myths around SRHR and HIV to assure respect for such rights for marginalised groups who are not yet accessing these rights.

CONTRIBUTING FACTOR	TYPE	EVIDENCE Signs/Facts	Likely IMPORTANCE
(a) Engagement and training of service providers i.e. health workers and police (READY+ and Hands Off!)	Primary	Planned engagements and training sessions with health workers have facilitated positive attitudes by some health workers at public health institutions	Strong
(b) Community dialogues and sensitisation sessions	Primary	These have been conducted including with influential stakeholders such as traditional religious leaders besides parents, caregivers and a community cadre of health workers. It is a fact that attitude and behaviour change takes time. Such change is therefore yet to be realised through these programmes. The research that is supposed to inform these interventions have not been conducted effectively yet, due to unclear commitments and ways of operating between HEARD and FACT. This has affected trust and commitment in this partner by other consortium members	Weak
(c) Claiming spaces by young KPs and engaging policy makers (LPP)	Primary	The Advocacy Working Group has deliberately sought out and engaged Members of Parliament (MPs), religious and traditional on their SRHR and HIV issues who are central to influencing attitude and behaviour change in society and through policies	Strong
(d) Transfer and relocation of trained cadre of service providers	Contradiction	Trained health workers that are seasoned with SRHR awareness and information have been transferred/relocated to other public health facilities thus creating a vacuum in service	

		provision at times. The same applies to police – those that have worked very well with Hands Off! suffered the same fate when they were transferred. Some trained Members of Parliament who have been working as change agents for the LPP lost their seats in the last harmonised elections of July 2018. This has entailed that the programmes have to 'start afresh' in such instances.	
(e) Delays in disbursements	Primary	For LPP, planned community actions have not yet taken off as the programme is behind schedule partly due to delays in disbursements. Consortium partners have only accessed activity based budget allocations without full knowledge of the total package they are entitled to. In other instances, budgets submitted to UNDP have been cut thereby compromising effectiveness of the planned and approved research by FACT/HEARD. This is affecting their commitment to the programme	Weak
(f) Lack of country presence by HEARD	Contradiction	Given current dynamics and implementation arrangements in the LPP consortium, HEARD's physical presence (except through FACT which is a proxy) is compromising commitment and transparency in rolling out the programme. FACT is not necessarily privy to the details of the contract between HEARD and UNDP in order to assert its contribution to the programme more effectively. The other partners, AMSHeR and UNDP are equally frustrated by the quality of contributions from HEARD/FACT	Weak
(g) Budget cuts have caused human resources constraints for FACT	Primary	FACT has had serious human resources constraints i.e. from a budget of us$102k they submitted to HEARD/UNDP, only us$56k was approved resulting in cutting back on a lot of the necessary human resources required for the research. This has caused delays in their	Strong (this is a very significant weakness with strong implications and significance in the programme)

		commitments and targets to the programme	

4. Contribution claims

The evaluation of each programme's contribution to the EKN programme was guided by specific contribution analysis questions.

4.1 READY + Contribution Analysis

The following questions were used: *How have CATS contributed to an increase (a) youth and (b) adolescents self-reporting ART?*

AfricAid/Zvandiri programme has reached 12 thousand A&YPLHIV beneficiaries aged 10-19 years and trained 190 CATS so far as a contribution to this programme. The CATS are also adolescents and young people living with HIV hence they are also beneficiaries. Peer support through the CATS is therefore the greatest strength of the programme. Peers understand and confide in each other. They give time to other beneficiaries at the health facility and follow up through home visits where they further discuss, guide and counsel their colleagues. Home visits and follow ups have improved self-reporting on ART hence the programme is on track in achieving its 90:90:90 targets. CATS are a support group that also uses a Support Group Screening Tool to determine vulnerability of beneficiaries they support from which they identify issues for referral. A service tracker is then used by AfricAid with other implementing partners as a robust referral system and helps manage the beneficiaries and reduce loss to follow up.

At regional level, the programme used lessons learnt from Zimbabwean experience to make adaptations to the model since there is no physical presence of AfricAid in other participating countries. Systems were further strengthened and more innovations introduced. For example, mentorship tools have been adapted to facilitate cross-pollination between beneficiaries thus deepening impact including in Zimbabwe. PSS has improved adherence and client empowerment that has helped reduce viral load and increased retention at sites and facilities.

The Change Observed:

Respondents during the evaluation confirmed that through the support of CATS, adolescents and young PLHIV feel empowered by increased knowledge, skills and confidence to assert their rights as they access SRH information and health service at public institutions. With peer support led by the CATS, they challenge and support each other to achieve viral load targets through monthly reporting mechanisms in the programme. Quality of services provided at PATA sites has greatly improved as trained health workers support beneficiaries e.g. through the youth friendly corner and mentorship that has helped address specific SRHR challenges besides HIV treatment, care and support.

Contribution Claim:

It is evident from documents reviewed, interviews and discussions with evaluation respondents that the successes of self-reporting have been greatly facilitated by the CATS and peer educators (development facilitators of MMPZ). Beneficiaries participating on the READY+ have consistently demonstrated treatment success and are significantly contributing to the achievement of the last 90: targets. This has been enhanced through an effective referral system and collaboration between consortium partners, trained health care workers and community support structure of trained care givers

How have the READY+ community dialogue sessions/workshops contributed to changing social norms around sexuality and health in communities?

Community dialogues and sessions have been facilitated by REPSSI and its implementing partners (BASO in Masvingo and MMPZ in Bulawayo). This is in addition to such sessions being held by AfricAid at their PATA sites as well. These sessions provided spaces for parents and guardians as care givers and CRFs to discuss openly (at times with the A&PLHIV target beneficiaries) social norms around sexuality and health. These conversations continued with the CATS as their children at home and within the communities. This has resulted in fairly safe and secure communities in specific wards[64] where READY+ is operating that promote the rights, health and wellbeing of adolescents and young people living with HIV and support their access to SRHR information, services and commodities. Stigma and discrimination is still a significant challenge at household and community levels partly because the dialogues and workshops have not yet been conducted at the expected level to improve knowledge, attitude and behaviour change. This is still a weak link in the programme.

Change observed:
Parents, guardians and other the general community still find it difficult to talk about SRHR issues of adolescents and young adults because of traditional and religious taboos. To some extent, those that were interviewed during the evaluation and are participating in the READY+ demonstrate improved knowledge, attitude and behaviour and confirmed that they discuss SRHR issues more openly within their families, at social gatherings e.g. church, funerals and provide dedicated support to the A&YPLHIV who are READY+ beneficiaries e.g. for adherence and reporting at the health facility.

Contribution Claim:
Care givers in the READY+ programme have engaged effectively with beneficiaries and continue to provide relevant treatment and care support. Changing social norms around sexuality and health in communities requires more dedicated and sustained support involving whole communities beyond the number of those targeted and engaged by the programme so far.

4.2 UNDP LPP Contribution Analysis

The following question was used: *How have the (robust) research methodology and data on YKP groups contributed to YKP participation in high level forums and engagements in the development of a government-led national action plan in support of necessary reforms and strengthening of accountability mechanisms for YKP?*

HEARD/FACT is the partner in the consortium responsible for the provision of robust research through which evidence that can be used by the KPs, young adults and members of the LGBTI community for targeted advocacy is available. A conducive environment to tackle SRHR and HIV especially among A&Y is critical in a country where new sources of infection are the A&Y aged 13 – 24 most of whom were born with the virus. FACT has conducted SRHR and HIV specific research that HEARD has not integrated in its contribution to the LPP.

The funded research that it prefers as a contribution has not met quality standards that are favourable to the rest of the partners in the consortium to the extent that it has limited the

64 Such as Ward 23 in Masvingo from were respondents for the FGDs were drawn from

capacity of YKPs' participation in high level forums and engagements in the development of a government-led national action plan in support of necessary reforms and strengthening of accountability mechanisms for YKP. So far, the LEA document is the only available 'research' to the LPP that is being worked on to develop the necessary advocacy action plans through the Advocacy Working Group.

Most of the Members of Parliament trained under the programme did not make it back to the House in the current Parliament – only one is still involved with the programme. This means the programme has lost a critical mass of change agents to support engagements of YKP who can champion and support the development of a national action plan and enhance strengthening of accountability mechanism for YKPs.

The change observed:
The key research output so far is the LEA report that is generally regarded as a legalistic document that is not yet accessible to YKPs due to its language. Other outputs include recommendations made that have been tabled before Parliament e.g. issue of criminalisation of sex workers, KPs and legal age of majority as it relates to SRHR. Conversations informed by the LEA report have also started at national level e.g. to build the capacity of MPs so that they can raise issues relating to HIV and health. Currently, ZNASP 3 is about to be reviewed and the LEA report will be used as a key data source for this.

Contribution Claim:
Engagement of Parliament and government by YKPs through the LEA report is critical to ensure that their SRHR needs and specific issues are integrated effectively in government led national action plans and accountability mechanisms. This has not yet happened at a level to effect expected change.

4.3 Hands Off! Contribution Analysis
The contribution analysis question used was: *How have sex workers´ individual and organisational capacity trainings on legal and constitutional rights contributed to establishment of collaborative community-led response systems to decrease violence against sex workers?*

So far, SRC has been working with sex-worker led organisations (PowWow and ZIMSWA) to train sex workers and strengthen their capacity to assert their legal and constitutional rights albeit in their individual and/or organisational capacities. Hands Off! is in the process of mobilizing and supporting specific sex-worker groups e.g. TREAT whose members are not comfortable accessing services and commodities through SRC.

A collaborative community-led response to decrease violence against sex workers is yet to be realised as long as dysfunctional relationships exist between specific sex-worker groups and SRC for example. ZIMSWA on the other hand wants to be independent of SRC and position itself as 'THE' national body for various sex-worker groups. As long as these institutional development issues are not addressed head on, collaborative community-led response systems cannot be used effectively to fight violence and GBV against sex workers.

The change observed:
SRC, ZIMSWA and PowWow are collaborating towards a community-led rapid response, protection and prevention systems for sex workers. Training and capacity development of individual and sex-worker groups/organisations in SRHR has improved their ability to assert

their rights with police and clients either individually and/or with support of peers and their organisations thereby reducing violence meted on them.

Some of the trained health care workers demonstrate sensitivity to female sex workers but male and trans sex workers still suffer stigma and discrimination whilst in their care. Trained police are also sensitive to the rights of sex workers and have influenced some observable attitude and behaviour change among police in their individual capacities because most of them are afraid of their superiors who continue to stigmatise sex workers because they feel sex work is illegal.

Request for sexual favours from police have also reduced in some of the police stations although young and street kids who are sex workers continue to be targeted for sexual favours. They are at times arrested on allegations of 'blocking the pavement' because they don't know and cannot assert their SRHR rights as they are not members of any of the sex worker organisations. Hands Off! successfully mobilised sex workers to lobby against that were criminalizing them for soliciting.

Contribution Claim:
Trained sex workers are now empowered to stand up for their rights with duty bearers especially police and health care providers. Some have successfully challenged arrests at court through effective representation organised by SRC. With improved knowledge and capacity to assert their rights, most of the trained sex workers can now access health care through PSI and CeSSHIRE for free, instead of relying on traditional healers. Sex workers are generating own evidence through documentation of human rights violations (stories that are collected by SRC) which is now used to design informed interventions and lobbying for a conducive environment for sex workers to enjoy their SRHR as equal citizens e.g. decriminalisation of sex work.

5. Other significant findings

Efficiency
This is evident in individual country programmes but not as a collective contribution to the Regional Programme. As noted already, delays in disbursements of resources to LPP has caused delays; budget cuts for approved research by FACT has compromised its contribution to the LPP whose key research deliverable so far is the LEA done by external consultants. READY+ CATS model is acknowledged as a good practice model that provides value for money evidenced from the quality of its deliverables and results.

Effectiveness
The 3 programmes have different implementation arrangements in Zimbabwe. Each one has its own oversight body e.g. a Steering Committee whose coordination capacity is varied across the programmes. In the LPP, coordination is weak as accountability mechanisms are not as transparent to enable programme effectiveness. In Hands Off!, structural institutional development challenges are compromising the ability of partners to coalesce on a common agenda and create a critical mass at a higher level (national advocacy) to make it more effective. Suffice to say that capacity training in legal and constitutional rights for individual sex workers and their organisations has enabled them to assert such rights especially with the police as well as their clients thus, reducing violence on sex workers to some extent.

In contrast, the design and in-country implementation mechanisms of READY+ has enabled it to stand out as an effective model to achieve 90:90:90 targets with effective engagement of A&PLHIV who drive the process. Overall, the effectiveness of the Regional Programme is therefore derived from the diverse implementation mechanisms of each of the 3 programmes which is isolated at country level. Sadly, opportunities to improve effectiveness between the programmes as their contribution to the regional programme have been missed.

Relevance
All the 3 programmes are relevant to the SRHR and HIV specific needs and priorities of adolescents, young adults, PLHIV, KPs and the LGBTIQ community in Zimbabwe albeit in their individual capacities. The LPP is very strategic to the requirements of the national HIV response especially the link between policy and programming which, until now, had not been effectively nor sufficiently integrated. A conducive environment to tackle SRHR and HIV especially among A&Y is critical in a country where new sources of infection are the A&Y aged 13 – 24 most of whom were born with the virus. Achievement of 90:90:90 targets by also targeting SRHR needs of A&YPLHIV, KPs and LGBTIQ community has been strategic to enhance the quality of HIV national response which can be integrated into the Regional SRHR and HIV Programme.

Sustainability
From the fore-going assessment of each of the programmes, it is a fact that the sustainability of the regional programme cannot be assured under the current arrangements in Zimbabwe.

Impact, especially those that are linked to the regionality of the programme
The impact of the programme is discerned from the individual contributions of each of the three programmes in relation to each outcome. Despite the 'silo' implementation arrangements within and between the programmes, it is evident that:

Outcome 1: Better information and greater freedom of choice for young people about their sexuality

- Education and awareness raising interventions using age appropriate language, tools and strategies have been effective in facilitating access to SRHR specific issues to the extent that beneficiaries openly talk about 'social taboos' including in public spaces confidently and with ease
- Peer support has enabled beneficiaries to make informed choices about SRHR decisions such as proper family planning methods (especially for the females) although they lament lack of female condoms. For trans sex workers, they are still not sure about the health implications of taking hormonal therapy combined with family planning and ART.
- With peer support, some of the CATS and beneficiaries have managed to disclose their HIV status with ease to their partners, as part of the 'condition' for becoming and/or remaining a CAT since they are expected to be role models
- Beneficiaries of all the programmes can now assert their SRHR albeit to varying levels and in different contexts e.g. for sex workers with police, for young KPs at health facilities
- Information is NOT always readily available in the vernacular languages thus limiting access by minority languages. LEA recommendations are not yet enforceable because of the legal language that the KPs

Outcome 2: Improved access to and use of sexual and reproductive health commodities and quality health care

- Attitudes, stigma and discrimination from family through to facility and community levels have compromised opportunities to access SR and health commodities by target beneficiaries of all the programmes
- The ONLY commodity besides ART that is readily available are cheap quality free condoms and some family planning options for females e.g. contraceptives
- Other livelihood services that are critical for adherence e.g. sustainable meals have not been integrated in the programmes and need **URGENT** attention
- Quality health care has been comprised by negative attitudes of health professionals some of whom still discriminate the beneficiaries especially when they present STIs and cannot afford to follow through treatment because it is not free. This has compromised viral load in some of the clients/beneficiaries
- Holistic and quality health care requires health commodities (e.g. lab reagents) and equipment (e.g. VL and lab machines) that work at the health facilities. Given the economic meltdown, health facilities are suffering distress that has negated realisation of these health rights for target beneficiaries of all the programmes to differing degrees

Outcome 3: Respect for the sexual and reproductive health rights of groups who are currently denied these rights

- It is evident that the care givers including guardians and parents that have been reached by the programmes are now in a different space and place as regards their attitudes, behaviours and practices towards A&YPLHIV to the extent that the adolescents and youths under their care demonstrate better results compared to their counter parts without similar support
- Many beneficiaries feel that respect of their SR rights is still a pie in the sky as it might actually take a generation to impact meaningfully on some of the social and religious norms, values and myths around SRHR and HIV among adolescents, youths, KPs and the LGBTIQ community
- Interventions to impact on this result have not yet been effectively integrated beyond awareness and education and need URGENT attention and scale up if the 90:90:90 targets will be met. There are still a lot of adolescent, young adults, KPs and the LGBTIQ community who have been missed by interventions of the 3 programmes yet they are equally denied sexual and reproductive health rights. These include those in rural and mining areas; those in prison; the disabled (be it physical or cognitive such as stunting, hearing and speech delayed); and, those suffering from mental health conditions.

6. Conclusions

The Regional SRHR and HIV Programme is relevant to Zimbabwe's national response especially given the focus of each of the 3 individual programmes and the current gaps. These include lack of a conducive environment that promotes and protects SRHR of A&YPLHIV, KPs, LGBTIQ groups; none (and/or ineffective) integration of hard to reach adolescents, young adults, KPs, LGBTIQ groups, the disabled and those in prison in the national HIV response e.g. those in rural and mining areas; no inclusion of street kids some of whom provide unprotected sex to MSM; challenges of social stigma, discrimination and criminalisation; negative attitudes of duty bearers such as health workers, police and policy

makers; and, lack of livelihood opportunities that empower these target groups economically so that they can access quality health care and services holistically, especially those that need payment.

Despite the lack of synergies between the 3 programmes, the EKN Regional Programme is still relevant as evidenced by the Programme's theory of change. Attempting to institutionalise SRHR when tackling high HIV prevalence among A&YPLHIV, KPs and members of the LGBTIQ who have contributed to new sources of HIV infection is strategic. The fact that sex workers exhibit a very high prevalence is therefore cause for concern, for example as this reverses the previous gains in reducing prevalence including among the general population some of whom are their clients.

It is true for Zimbabwe that insufficient access to information and knowledge of SRHR among target group and the general population, combined with stigma and discrimination against KPs, members of the LGBTIQ community, women and girls is still a fact. In addition, the spike in STI incidence confirms general failure of HIV prevention and treatment. Negative attitudes of health care workers also continue to compromise access to relevant, reliable and up to date SRHR information and quality comprehensive health care and services. Their limited capacity and knowledge of LGBTIQ SRHR issues for example, is comprising quality advise and health care e.g. to trans people who may also be sex workers, PLHIV and taking hormonal therapy.

Effectiveness, relevance and sustainable gains of Zimbabwe's HIV response therefore requires consistent and sustained efforts in tackling SRHR specific issues of adolescents and young people; KPs, LGBTIQ. This counts especially for those that are HIV positive but still don't know their status and those that are already on ART but still have limited access to relevant HIV information, commodities and quality health care as a result of poor national governance. National governance Is characterized by ignorance of duty bearers of the specific SRHR issues and denial about the existence of the LGBTIQ community coupled with public health facilities that are under distress; social and religious norms and values. That all still make conversations about sexuality and SRHR of these groups a taboo. Additionally we can mention the Institutional challenges that prevent access to public health services; and, legal systems that limit engagement with SRHR for some of these target groups e.g. parental consent before engaging adolescents, ignorance of the rights of LGBTIQ in the Constitution and critical policies etc.

7. Recommendations

The future of the EKN Regional SRHR and HIV programme needs to consider the following recommendations in order that it remains strategic and relevant to the needs of adolescents, young adults, KPs, LGBTIQ groups as well as those living in hard to reach areas who are yet to be targeted:

- Create synergies between the different programmes and their implementation processes as they all feed into the national HIV response. The synergies must take into consideration and leverage the strengths and comparative advantage of each programme e.g. READY+ CATS; enforcement of LEA recommendations and use of the KP Advocacy Handbook for the LPP; and, sex worker initiatives of Hands Off!. The synergies also need to prioritise clearly the target groups to be reached in order that the programme remains strategic. Synergies should catalyse and integrate bottom up…and

top down approaches and make them effective using multi-sectorial approaches for effectiveness and long term sustainability

- It is prudent to also invest in areas that are difficult to access funding through Global Fund especially barriers to accessing services by KPs (especially young KPs) and LGBTIQ vis-à-vis the general population
- Programme leads need to identify strategic and priority areas for investment through consultation and meaningful, effective involvement of adolescents, young adults, young KPs, LGBTI groups and those living with disabilities
- The current spike of STIs nationally especially among youths[65] require the programme to go back to the drawing board and empower all target groups about HIV education in addition to SRHR
- The programme must invest in consistent and sustained efforts in tackling SRHR specific issues of adolescents and young people; KPs, LGBTIQ especially those that are HIV positive but still don't know their status; those that are already on ART but still have limited access to relevant HIV information, commodities and quality health care as a result of poor national governance (ignorance of duty bearers of the specific SRHR issues and denial about the existence of the LGBTIQ community coupled with public health facilities that are under distress); social and religious norms and values that still make conversations about sexuality and SRHR of these groups a taboo; institutional challenges that prevent access to public health services; and, legal systems that limit engagement with SRHR for some of these target groups e.g. parental consent before engaging adolescents, ignorance of the rights of LGBTIQ in the Constitution and critical policies
- Draw on good practices outside the programme to inform better strategies that influence knowledge, attitude and behaviour change to fight stigma and discrimination targeting parents and guardians (as care givers); duty bearers that are at the coal face of engaging with the target groups such as police, traditional and religious leaders, health workers as well as policy makers. Relevant Section 12 Commissions in the Zimbabwe Constitution (i.e. Human Rights Commission, Gender Commission, National Peace and Reconciliation Commission) must be deliberately targeted[66] to support national level advocacy efforts of the programme, in addition to other national, regional and international bodies ceased with the same issues of SRHR and/or HIV for adolescents, young adults, youths, KPs and LGBTIQ groups
- To the extent possible, provide innovative livelihood options to improve access to quality, affordable and relevant health services by target group beneficiaries. This might entail setting up a revolving fund through which they can access seed capital for livelihood initiatives of their choice based on sound business proposals. In addition, introduce a referral system with service providers that can provide the necessary technical and business knowhow[67] to support the livelihood initiatives. Such

65 Interview respondents noted that this is a generation that is lost and have failed to understand messages about HIV because prevention is still NOT taken seriously enough.

66 For example, educate them about the rights of adolescents, young adults, different KP and LGBTIQ groups drawing on the LEA recommendations (about access to justice, provision of legal support and legal aid) in order to support them to assert the rights in collaboration with relevant CSOs whilst empowering the rest of the Zimbabwean society with SRHR education and information

67 For example, with business development organisations; micro-finance institutions; business training providers; relevant government departments providing humanitarian / national entrepreneurship opportunities…and other NGOs providing livelihood projects

partnership arrangements must be guided by signed MoUs that clarify commitments and accountability measures.

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Annex 7 List of Interviewees

NAME	ORGANISATION	FUNCTION
Aantjes, Carolien	HEARD	HEARD Project Manager
Aly, Fatima	MFA	Policy officer SRHR and HIV EKN Maputo
Van Beekum, Ingeborg	Aidsfonds	Hands Off! Coordinator
Beurskens, Dorien	Young Africa	CEO/ Co-founder
Bhayani, Lubna	Frontline AIDS	Senior Advisor: Funding, Influence
Caswell, Georgina	Frontline AIDS	Lead Programmes
Davies, Harry	MFA	Policy officer press and public diplomacy
Davis, Joannah	Frontline AIDS	Lead Institutional Funding and Partnerships
Deug, Febe	Aidsfonds	Manager Programmes
Diedericks, Linda	MFA	Senior Policy Officer Political Affairs
Dziwa, Chengetai	Frontline AIDS	Senior Advisor M&E
Euverman, Yvonne	MFA	DSO-Policy Officer Health and HIV
Getahun, Mesfin	UNDP	HIV and AIDS Policy Specialist
Hildebrand, Mikaela	SIDA/Gov Sweden	First secretary – Senior Policy Advisor
Huesken, Jan	MFA	Deputy Head of Mission SA
Huijsman, Sanne	MFA	Department SRHR and HIV EKN Maputo
Kamphuis, Monique	MFA	First Secretary-Health and HIV/AIDS
Keppy, Dewi	Save the Children NL	Programme Manager
Klinkert, Els	MFA	Coordinator
Labode, Dr. Ruth	SADC/MP Zimbabwe	MP Zimbabwe
Leung, Kit	IOM	Regional Migration Health Specialist IOM
Matheson, Kate	Save the Children NL	Technical Expert
Middelhoff, Monique		
Mulekya. Francis	IOM	Regional Program Manager, MH/SRHR
Mutie, Rogers	IOM	M&E
Ngocbo, Nonkululeko	IOM	M&E SRHR programme
Ntshangase, Senelisiwe	UNDP	Programme Coordinator HIV & Law project
Rijnart, Janneke	MFA	Senior Policy Officer
Saha, Amitrajit	UNDP	Team Leader Africa, HIV, Health and Development
Tuinstra, Siemon	MFA	Deputy Director MINBUZA
van Beekum, Ingeborg	Aidsfonds	Hands Off! Coordinator
Van Dunem, Carina	MFA	Policy Officer
Verstraeten, Rogier	MFA	Regional Energy Coordinator
Vrolings, Eliane	Aidsfonds	Senior Advisor Children Affected by HIV

Werlich, Lynn	Aidsfonds	Head of International Sex Worker programme
Weve, Martine	Aidsfonds	Team Manager and Acting Programme Manager
eSWATINI		
Khudzie Mlambo, Charmaine	Clinton Health Access Initiative/MaxART	MaxART Senior Research Manager
Khumalo, Gavin	SWANNEPHA	Regional Coordinator
Ndlela-Simelane, Sibongile	Eswatini Ministry of Health	Former Minister of Health 2013-2018
Okello, Dr Velephi	Eswatini Ministry of Health	Deputy Director Clinical Services, Ministry of Health
Reis, Ria	University of Amsterdam	Professor of Medical Anthropology
Zwane-Machakata, Mandisa	SAfAIDS	Country Representative Eswatini
MOZAMBIQUE		
Aantjes, Carolien	HEARD	Project Manager
Alexandre, Fátima	OASIS	OASIS Coordinator
Amaral, Ivan	Save the Children	Project Coordinator
Banco, Leopoldina	OASIS	READY + Focal point
Chichava, Armando	Associação Pfuka Lixile	Project Coordinator
Chichava, Josina	GAFMVV	Responsible of care for victims of violence
Chirindza, Sara	ADECC	READY+ Programme coordinator
Cuinhane, Jorge Manuel	National AIDS Council (NAC)	
Dr Adelina	Executive Committee of HIV and AIDS – Maputo city	Head of Unit
Kerchan, Benjamin	IOM	Country Coordinator
Langa, Ana Maria	GAFMVV - Police of Republic of Mozambique	Head of Unit
Macassar, Albachir	Ministry of Justice, Religious and Constitutional Affairs	National Director of Juridical and Constitutional Affairs
Malumbe, Esperança	ABEVAMO	Coordinator
Merique, Salmina	UNDP	Project Officer
Miambo, Dr Alberto	Moamba District Health Services	Director
Muchanga, Egídio	ABEVAMO	Gender Focal Point

Muchanga, Vasco	Medical School – Eduardo Mondlane University	Researcher Consultant
Munguambe, Khátia	Medical School – Eduardo Mondlane University	Researcher Consultant
Nhantumbo, Sabino G.	LAMBDA/ AMSHER	Member of National Steering Committee
Pepetsa	LAMBDA	Focal Point Hands Off!
Pililão, Dr Florinda Joyce	Provincial Directorate of Health (Maputo)	
Sega, Dr. Abdul	Ressano Garcia Health Centre	Director
Siguice, Avelina	ADECC	M & E officer
Silveira, Carla	Pathfinder	International Project Director
Suande, Virgilio	REPSSI	Programme Officer
Tomm-Bonde, Laura	IOM	Country Coordinator
Uamba, Amélia	Hixikanwe	READY + Focal point
SOUTH AFRICA		
Annott, Jayne	SWEAT	Programme Manager
Becker, Michael	North Star Alliance	Programme Manager
Chakuvinga, Pamela	Sisonke	Assistant National Coordinator
Gititu, Wambui	IOM	National Migration and Health officer
Katumba, Munya	COC Nederland	Programme Manager
Mogale, Maud	North Star Alliance	Programme Officer
Oss, Maserame	Save the Children	Health Project Manager
Rapatsa, Teenage	IOM	Migration Health Project Assistant
Sohal, Raman	North Star Alliance	Senior Strategy Advisor
ZAMBIA		
Banda, Emmanuel	UNDP	Project Officer
Cham, Nathasha	Young Key Population representative	Vice-Chairperson of National Steering Committee
Chama, Emmanuel Daniel	Government of Zambia	Provincial AIDS Coordination Advisor (PACA)
Chieftainness Kawaza		Traditional Leader
Dr. Kabalo	Ministry of Health	Director of Health Promotion
Hamuyube, Foster	National Human Rights Commission	Member of National Steering Committee
Kabwe, McLean	Advocacy Working Group	Chairperson and Member of National Steering Committee
Menon, Anitha	University of Zambia	Associate Prof of Health Psychology
Musaba, Gladys	Save the Children	Programme Coordinator Children Without Proper Care
Musonda, Jo	Save the Children	Country Director Zambia

Muwanga, Ellen	National AIDS Council	Public & Private Sector Coordinator
Ncube, Nomagugu	IOM	Programme Officer Migrant Health
Nsonge, Elijah	Save the Children	Project Officer Migration
Phiri, George	Zambia Police Forces	Director Medical Services
Reggee, Sean	TransBantu Association	Executive Director
Sinkala, Emmanuel	IOM	Migration Health and Gender Assistant
Tembo, Taonga Thomas	AMSHeR	Project Officer
Zulu, Dr Joseph	HEARD	Research Consultant
ZIMBABWE		
Chimoko, Stanley	Africaid	M&E Officer
Chirongoma, Farai	AMSHeR	Programme Officer
David	REPPSI	
Dr. Sibanda	Mpilo Hospital, Bulawayo	Medical Director
Dube, Charmaine	POWPOW	
Hwenga, Linda	UNAIDS	Advocacy and Communications officer
Kalweo, Jane	UNAIDS/PEPFAR/Global Fund	Liaison and Advisor
Kata, Gregory	ZIMSWA	Coordinator
Labode, Dr Ruth	Government of Zimbabwe	Member of Parliament
Maposa, Charlene	UBH, Bulawayo	Focal Point Programme
Maziwa, Regina	Morgenster Hospital, Masvingo	District Officer
Mhaka, Tendai	NAC	KP Focal Point Person and co-chair AWG
Moekele, Mojalifa	SRC	Programme Officer
Mr Chieza	UBH, Bulawayo	Nurse
Mtetwa, Courage	Bhaso, Masvingo	Programme Officer
Munyoro, Sheperd	UBH, Bulawayo	Programme Officer
Musungwa, Sarah	UNDP	Programme Specialist
Naipai, Tanvaradzwa	Africaid	Head of M&E Officer
Ngubo, Felistas	Africaid	Programme Manager
Sande, Tinashe	TIRZ	Director and co-chair AWG
Sister Mathe	UBH, Bulawayo	Sister for Youth Services
Sylvester	GALZ	Programme officer and co-chair AWG
Wills, Nicola	Africaid	Country Director
Yekeye, Raymond	National AIDS Council (NAC)	Director
Zambezi, Pemberai	HEARD/FACT	Programme Manager

Annex 8 Term of Reference Evaluation

Terms of Reference
Evaluation of the
Netherlands' Regional HIV/AIDS and SRHR Programme in Southern Africa

Commissioned by:	The Embassy of the Kingdom of the Netherlands in Maputo
Time period:	15 August 2019 – 22 January 2020
Expertise required:	1 international and 4 local consultants

1. Background

The Netherlands international development policy has recognised the threat of the HIV/AIDS epidemic since the 1980's. And from the beginning of the 21st century it became clear that the epicentre of the epidemic was in southern Africa. Early 2000, the (Southern Africa) Regional Dutch Ambassadors Conference called for a regional HIV/AIDS approach to prevent the further spreading of HIV-infections and to mitigate the impact of the epidemic. In 2001, the Netherlands launched the regional HIV/AIDS programme for Southern Africa ("the regional programme").

The regional programme has evolved through different phases adapting to a changing political environment in the region, scientific findings and policy shifts in the international development policy of the Netherlands. The 'region' refers to all member countries of the Southern African Development Community (SADC) except the Seychelles, Mauritius and DRC[68]. The focus of the programme broadened from a specific emphasis on HIV/AIDS to enhancing sexual and reproductive health and rights of women, young people and other vulnerable groups like migrants, sex workers and men having sex with men (MSM).

Over the last years major progress has been reported in the region. Deaths from AIDS-related illness have been averted (there were 42% fewer in 2017 than in 2010) and new infections have been prevented (30% fewer in 2017 than in 2010). The scale of the region's HIV epidemic, however, remains massive. An estimated 800 000 people in eastern and southern Africa acquired HIV in 2017, and an estimated 380 000 people died of AIDS-related illness. Eastern and southern Africa remains the region most affected by the HIV epidemic, accounting for 45% of the world's HIV infections and 53% of people living with HIV globally.

Gender inequalities and gender-based violence, combined with physiological factors, place women and girls at huge risk of HIV infection. In 10 countries in the region, laws and policies that require parental consent to access sexual and reproductive health services discourage adolescent girls from accessing the services they need to stay healthy. In addition insufficient attention is given to key populations in the region despite extremely high HIV prevalence among them. Population size estimates suggest there are nearly 1 million sex workers in need of services.[69]

68 The Seychelles and Mauritius are middle-income countries. In DRC, SRHR/HIV/AIDS activities are covered by the Regional Great Lakes programme (BEMO for calls for proposals page 2, 2016)
69 UNAIDS Data 2018| UNAIDS reference document page 22-23

In line with the rules and regulations of the Ministry of Foreign Affairs an evaluation of the regional SRHR and HIV/AIDS programme 2016 – 2020 needs to be undertaken at the end of 2019. The Ministry intends to continue a regional SRHR and HIV/AIDS-programme after 2020.

1.1 Developments in the regional programme

The regional programme evolved and objectives and criteria for support shifted over the last ten years. In a nutshell, in the period 2008-2011, the overall objective was formulated as follows: "to accelerate the response to the AIDS pandemic, through regional cross-border approaches, which complement and/or strengthen country-level efforts, leading to more efficient and effective country-level prevention and mitigation efforts."

Based on the outcomes of the Review of the Regional HIV/AIDS/SRHR Programme in Southern Africa (2009)[70]the next phase of the programme 2012 – 2015 focused on three intervention areas:

a) Migration and mobile populations
b) Human Rights issues which are too sensitive to tackle on a bilateral level, such as LGBTI rights
c) Innovative HIV-prevention measures, which could be scaled-up to the region.

All themes are selected based on their regional (SADC) added value: issues which can better be tackled at regional level, rather than at national level. Demand-driven and the active involvement of regional partners-such as SADC- become even more important criteria for support. The regional programme complies with the Dutch policy on Sexual and Reproductive Health & Rights (SRHR) and HIV/AIDS as explained in the letter of the Minister for European Affairs and International Cooperation (7 May 2012) to Parliament[71].

In 2014 the mid-term review (MTR)[72]concluded that the regional programme has been successful in selecting intervention areas that are highly relevant to the region to address key gaps in the southern Africa regional HIV, AIDS and TB response. The reviewers concluded that the regional programme is '*doing the right things'*, has selected good implementing partners, and has the potential to have high added value in their objectives and expected outcomes. The complexity of the multi-country and multi-level projects and dependency on the capacities and performance of other actors and systems make it difficult to measure the effectiveness and efficiency of the projects. However, the report mentions that three of the seven implementing partners are in need of improved effectiveness and four of improved efficiency. Due to the persistence of the challenges related to SRHR and HIV faced by the target groups, the MTR recommends continuing the regional programme in southern Africa. The report of the mid-term review was well-received by the implementing partners and involved embassies and discussed by the Regional Advisory Group.

70 Royal Netherlands Embassy of South Africa (2009). Review of the Regional HIV/AIDS/SRHR programme in Southern Africa: Final Report. Pretoria, South Africa.
71 Netherlands Ministry of Foreign Affairs (2012). Letter of 7th May 2012 from the Minister for European Affairs and International Cooperation to the House of Representatives on policy on sexual and reproductive health and rights, including HIV/AIDS. The Hague, The Netherlands.
72 Mid-Term Review of the Netherlands Regional HIV/AIDS/SRHR programme in Southern Africa 2012-2015: Final Report (February 2014).

In 2016 EKN Maputo launched a call for proposals to design the next phase of the regional programme. In line with the recommendations of the MTR, a Theory of Change guided the development of this new phase. The call solicited innovative ideas and modalities in the continued effort to address problems that cause and perpetuate the HIV/AIDS epidemic, high (unwanted) teenage pregnancies and maternal mortality in the southern Africa region.

1.2 Current regional programme 2016 – 2020

In 2015 the Sustainable Development Goals (SDGs) were adopted by the General Assembly of the United Nations and these SDGs became the backbone of Dutch international cooperation. For the regional programme it implied that activities should contribute to the results of the health SDGs 3, 4 and 5 including the targets of UNAIDS Strategy 2016–2021: 90 – 90 - 90 [73]. The SDGs build on the principle of "leaving no one behind" and emphasize a holistic approach to achieving sustainable development for all.

In the period 2016 – 2020 the regional programme counted five activities. Two projects, MaxART and Hands Off, started already in 2014 and 2015 respectively. MaxART was completed in 2018 and Hands Off will be finalized in 2019. These two activities were selected based on the criteria for Human Rights and Innovative HIV-prevention established by EKN Pretoria.[74]

The three other activities were chosen through the call for proposals organized by EKN Maputo in 2016, taking into account the two running projects:

1. READY+ - led by the International HIV/AIDS Alliance
2. HIV/SRHR Knows no Borders – led by IOM
3. HIV and the Law – led by UNDP

All three proposals included a results framework in compliance with the Dutch policy document 'A World to Gain- A New Agenda for Aid, Trade and Investment' and were based on the Theory of Change developed by the Department of Social Development (DSO) at the Ministry of Foreign Affairs in The Hague. This implied that all three consortia were expected to achieve results in the following areas:

- Better information and greater freedom of choice for young people about their sexuality
- Improved access to and use of sexual and reproductive health commodities and quality health care
- Respect for the sexual and reproductive rights of groups who are currently denied these rights

Every project focusses on different aspects of enhancing SRHR and of the international AIDS response. They aim at different target groups and cooperate with different implementing partners at local, national and regional levels:

1. **READY+** aims at reaching 30 000 adolescents and young people living with HIV (A&YPLHIV) in Mozambique, eSwatini, Tanzania, and Zimbabwe. The multi-layered project works to provide better information and greater freedom of choice for A&YPLHIV about their

73 Target UNAIDS: By 2020, 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression.
74 2012 – 2015 Plan of Action for the Regional Programme

sexuality and improved access to and use of sexual and reproductive health commodities and quality health care. A key part of the programme are the CATS (Community Adolescent Treatment Supporters) who provide peer to peer information, counselling and support.

2. **HIV and SRHR Knows no Borders** aims at improving the sexual and reproductive health of migrants, adolescent & young people and sex workers in six countries in the SADC region: South Africa, Mozambique, Swaziland, Malawi, Lesotho and Zambia. Migrants, adolescents and young people and sex workers, in migration affected communities will have enhanced their knowledge of SRHR and have better access to SRH, health and HIV services. Local, national and regional authorities are more aware of the importance of SRHR for migrant and mobile populations.

3. **HIV and the Law programme** aims to strengthen sexual and reproductive health and rights of young key populations in five countries in the region: Angola, Madagascar, Mozambique, Zambia and Zimbabwe. UNDP facilitates Legal Environment Assessment (LEA) processes in which government officials, lawyers and representatives of key populations jointly assess legislation and the need for legal reforms.

The two programmes mentioned above that were already on-going in 2016 are:

- The **Hands Off** sex workers programme, coordinated by the Aids Fonds (NL), aiming to reduce the violence against sex workers in Botswana, Mozambique, Namibia, South Africa and Zimbabwe. Research was undertaken by the sex workers themselves to map the violence, call for attention to the violence and draw recommendations. Country fact sheets were produced and sex workers communities have been empowered.
- In Swaziland **MaxART** entailed a study to better understand the acceptability, feasibility, clinical outcomes, affordability and scalability of Treatment as Prevention (TasP), later named Early Access to ART to All (EAAA), providing people living with HIV immediate access to treatment (ART). The results could speed up the AIDS response in the region, by lowering the number of new HIV-infections and mortality.

All individual projects (2016 - 2020) are undertaking a Mid-Term Review (MTR) this year with the exception of MaxART and Hands Off. The MTR reports will become available in July 2019. MaxART conducted their MTR in 2016 and Hands Off is being evaluated in the first half of 2019.

1.3 Financial and institutional set-up

From the launch of the regional programme onwards many activities have been funded in southern Africa. EKN Pretoria managed the programme, but due to the closure of its development cooperation programme in 2014, the management of the activities was handed over to EKN Maputo. Both embassies have been guided by the Regional Advisory Group. This group consists of representatives of embassies in the region and a policy advisor from the Ministry of Foreign Affairs in The Hague. The Advisory Group conducts annual meetings, functions as a steering committee and ensures regional embedding.

The total budget for 2016 – 2020 of the 5 programmes is around EUR 34 million. Annual expenditure for the regional programme is budgeted around EUR 8 million. The budgets of the projects are:

- MaxART EUR 1,438 mln (1 June 2014 – 31 Dec 2018)
- Hands Off! EUR 4,407 mln (01 Dec 2014 – 31 July 2019)
- UNDP USD 8,049 mln (01 Oct 2016 – 01 Dec 2020)
- IOM EUR 11,057 mln (01 Oct 2016 – 01 Dec 2020)
- READY+- IHAA Alliance EUR 9,536 mln (01 Oct 2016 – 01 Dec 2020)

2. Objective of the evaluation

The Embassy would like to receive an answer on the following question: To what extent did the regional programme achieve its objectives?

- Better information and greater freedom of choice for young people about their sexuality;
- Improved access to and use of sexual and reproductive health commodities and quality health care;
- Respect for the sexual and reproductive rights of groups who are currently denied these rights.

Taking into account the three target groups of the regional programme: mobile groups, key populations and adolescents.
This also implies that the Netherlands Government would like to have an insight into the relevance, added value, effectiveness, efficiency, impact and sustainability of the regional programme and receive recommendations, including suggestions for the future for the next phase of the regional programme.

2.1 How will the evaluation be used?

The Embassy will use the evaluation to

- Design the next phase of the regional programme.
- Report to the Ministry of Foreign Affairs on the progress towards the outcomes and lessons learned
- Share and discuss the findings with the implementing consortia

3. Scope of the work

The evaluation will look into the projects selected in 2016 (READY+, IOM SRHR/HIV Knows no Borders and UNDP HIV and the Law) and MaxART and Hands Off, which started in 2014 and 2015 respectively. The MaxART programme had an MTR in 2016 and Hands Off is being evaluated in the first half of 2019. The evaluation of the regional programme will build on the findings of the MTRs and the evaluation report (Hands Off).

The evaluator(s) should keep in mind that the selection of MaxART and Hands Off was based on different criteria than the three projects selected through the call for proposals in 2016. This will require some adjustments of the proposed questions below.

The outcome of the evaluation will be a report answering the key question and outlining lessons learnt, key challenges and opportunities, as well as recommendations to inform and give strategic direction to the regional programme.

3.1 Evaluation questions

Relevance	• To what extent is the regional programme's Theory of Change (ToC)', objectives, assumptions, outputs and result areas valid? Is the ToC aligned to the needs and priorities of adolescents and young people, mobile groups and key populations[75]? (not only on paper but also in practice) • Did the regional programme do the right things? Did the programme address gaps in the regional and national HIV/AIDS and SRHR response, by focusing on key populations (sex workers, young people living with HIV, LGBT-groups and Injecting Drug Users (IDUs), migrants, adolescents) and advocating for better access to information, services, rights and legal change? • In view of the programme and country responses, to what extent was the allocation of funds to the different countries reasonable? • To what extent has the programme been working with the right (influential and capable) organisations/consortia? • Are the interventions aligned with SADC policies? Is there coherence or even complementarity with SADC regional policies? • To what extent is there coherence or complementarity with other donors' for example with, Swedish regional assistance? • What is the added value of a regional approach vis-à-vis country programmes? Do the individual projects have regional components, or are we implementing the same project in multiple countries?
Effectiveness	• To what extent is the programme on-track to meet its objectives and to achieve its expected results? Are the target groups and planned geographic areas being successfully reached? • What are the projects' comparative strengths, weaknesses/gaps and opportunities and how are these perceived by the stakeholders, including the beneficiaries for the future of the programme? • Are there any successful, innovative approaches and lessons learnt to date that can be scaled up within the programme and externally, including effectiveness and appropriateness of implementation approaches?
Efficiency	• To what extent are the costs and benefits of the development interventions in a reasonable proportion to each other from a business and economic point of view? • Are financial and human resources adequately allocated and efficiently used?
Impact	• What evidence is emerging that the programme is on-track to achieve, by the time it closes, its outcome and impact level results? • What happened in the programme and to what extent can the changes be attributed to the projects? What would have happened in the absence of the projects?

75 Key populations have higher HIV prevalence rates than the general population and have only limited access to testing and treatment due to discrimination. They often consist of men having sex with men, sex workers and their clients, prisoners and injecting drug users. (source-BEMO Call for proposals)

Sustainability	• What evidence is emerging that the expected outcomes and outputs are likely to be sustained or remain in place once the programme has closed? • Have the projects formulated sustainability measures or an exit strategy? • What could be done to improve the sustainability of the outcomes?
Cross-cutting issues	• To what extent is the implementation of the programme embodying the principles of empowerment, participation, non-discrimination and accountability? (not only on paper but also in practice) • To what extent has the regional programme integrated gender and human rights-based approaches? • To what extent have the embassies in the region been involved in the design and implementation of the regional programme, including the choice of projects? • To what extent has the regional programme – the coordinating Embassy- communicated effectively with its implementing partners (in the opinion of the implementing partners)?

4. Methodology

A contribution analysis will be conducted to assess whether the regional programme made a noticeable contribution to an observed result and in what way. This methodology offers a step-by-step approach designed to help evaluators to arrive at conclusions about the contribution the program has made (or is currently making) to particular outcomes. The essential value of a contribution analysis is that it offers an approach designed to reduce uncertainty about the contribution the intervention is making to the observed results through an increased understanding of why the observed results have occurred (or not!) and the roles played by the intervention and other internal and external factors.

Contribution analysis helps to confirm or revise a theory of change; it is not intended to be used to surface or uncover and display a hitherto implicit or inexplicit theory of change. The report from a contribution analysis is no definitive proof but rather provides a line of reasoning from which we can draw a plausible conclusion that, within some level of confidence, the program has made an important contribution to the documented results.

In order to conduct a contribution analysis and come to conclusions:

- the evaluators will draw on the Mid-Term Reviews of: IOM project 'HIV & SRHR Knows no Borders', READY+, UNDP's project 'Linking policy and programming to reduce HIV for young key populations', MaxART and the evaluation report of Hands-Off (Aids Fonds).
- Field research will be done in at least four of the five countries: Mozambique, Zimbabwe, eSwatini, South Africa and Zambia. These countries have at least two regional project activities.
- Every project –except MaxART- should be visited at least once during the evaluation.

The evaluators will draw on relevant policy, programme and project documents, such as project proposals, base-line reports, annual progress reports and other communications (Web-sites/leaflets) of each project.

The quality of the base-line reports vary. Some Monitoring & Evaluation systems are more robust than others. This might have some influence on assessing the effectivity of the regional programme.

Interviews will be held with key informants including representatives of consortium partners, implementing partners and other relevant (local, national and regional) stakeholders. In addition it is of utmost importance to interview beneficiaries. Interviews can be done in person or via skype/phone/Whatsapp as is practical. Sampling of the interviewees will be done by the evaluators.

At least interviews will be held with the coordinators of each international lead agency. In addition, interviews will be conducted with representatives of at least two local implementing organisations per project. Preference is given to implementing organisations representing the interests of beneficiaries like Y+, AMSHeR and Tiyane Vavasate.

The implementing partners of the projects are the following:

- **READY+** (International HIV/AIDS Alliance): Y+, Africaid/Zvandiri, Coordinating Assembly of NGOs in eSwatini (CANGO), Global Network of People Living with HIV (GNP+), M&C Saatchi World Services, Paediatric AIDS Treatment for Africa (PATA), the Regional Psychosocial Support Initiative (REPSSI) and Tanzania Council for Social Development (TACOSODE).
- **HIV and SRHR Knows no Borders** (IOM)**:** International Organization for Migration (IOM), Save the Children Netherlands (SCNL) and Witwatersrand School of Public Health (WSPH).
- **HIV and the Law programme** (UNDP): UNDP, African Men for Sexual Health and Rights (AMSHeR), the Health Economics and AIDS Research Division (HEARD) of the University of Kwazulu-Natal.
- **MaxART** (Aids Fonds): Ministry of Health (Swaziland), National Emergency Response Council on HIV/AIDS Swaziland, Swaziland National Network of People Living with HIV (SWANNEPHA), GNP+, Clinton Health Access Initiative (CHAI), Southern Africa HIV and AIDS Information Dissemination Services (SAfAIDS), University of Amsterdam (UvA) – Centre of Social Studies and Global Health (SSGH), South Africa Centre for Epidemiological Modelling and Analysis (SACEMA), the 'Nationale Postcode Loterij' (NL), in collaboration with in-country implementation partners including Medecins Sans Frontieres (MSF), PEPFAR and UN-agencies.
- **Hands Off** (Aids Fonds): Aids Fonds, Tiyane Vavasate, Pathfinder International and the Vrije Universiteit Amsterdam

National partners of regional counterparts in Angola, Botswana, Lesotho, Malawi, Madagascar, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

Embassy staff in Angola, Mozambique, South Africa, Tanzania and Zimbabwe and staff in the Netherlands Ministry of Foreign Affairs (Department East and Southern Africa (DAF), Department of Social and Institutional Development (DSO), including the former Dutch Aids Ambassador Lambert Grijns. Monique Kamphuis who has been working with the regional programme at the Dutch Embassy in Maputo from 2014 – 2018 should also be consulted.
Swedish/Norwegian Regional Team in Lusaka

Secretariat of the Southern African Development Community (SADC).

The evaluation team will consist of one international team leader and 3 to 5 local experienced evaluators who will in cooperation with the international team leader conduct an assessment in their own country.

Deliverables

1. **Proposal and CVs:** A short inception proposal stating how the attribution/contribution of this regional programme can be determined. In other words, what will be the evaluation methodology, data collection tools to be used, selection criteria of interviewees and evaluation questions, work plan and stakeholder engagement. The proposal should also include a budget. The proposal will be complemented with the CVs of the proposed consultants.

2. **Summary report**: This summary should have a maximum of 6 pages. It should be easy to read and accessible and will be published on the website of the embassy.

3. **Full report**: It should include

- Executive summary of key findings and recommendations
- Short introduction, background and context of the regional programme
- Methods and data collection tools

Analysis of Relevance, Effectiveness, Efficiency, Impact, Sustainability and Cross-cutting issues

- Conclusions and lessons learned
- Recommendations

4. **Annexes** should include but are not limited to:

- Evaluation work plan
- TOR of the evaluation
- List of those interviewed
- Data collection tools
- Terms of acronyms
- Bibliography

5. **Presentation** of the findings, lessons learnt and recommendations.
The report of a maximum of 50 pages will include an analysis, findings, conclusions and recommendations. it will outline key challenges and emerging opportunities for the Netherlands' regional SRHR and HIV/AIDS programme and shall be structured in such a way that it clearly informs and gives direction to the future of the regional approach.

5. Management of the evaluation

The assignment will be managed by the Embassy of the Kingdom of the Netherlands in Maputo and guided by the International Research and Policy Evaluation team at the Ministry of Foreign Affairs in The Hague.

Fatima Aly (Fatima.aly@minbuza.nl) and Els Klinkert (Els.Klinkert@minbuza.nl) will act as the first points of contact for the consultants and will be responsible for overseeing the implementation of the evaluation. They will also provide access to the documents (proposals, progress reports, annual work plans and the Mid-Term Reviews of the individual projects). All correspondence and reporting will be conducted in the English language.

6. Timetable and number of days

Activity	**By when?**
Expression of interest submitted	
The Embassy invites shortlisted consultants to submit full proposal	
Submission of full proposals	15 July
Selection of consultant team	25 July
Evaluation work plan and methodology agreed	1 August
Desk study, interviews and field visits	15 August
Presentation and discussion at the meeting of the Regional Advisory Group in Maputo	29-30 October
Submission of draft report	9 December
Submission of final report and summary	22 January 2020

The review will commence on 15 August 2019. On 29 – 31 October the Regional Advisory Group will come together at the Embassy of the Kingdom of the Netherlands in Pretoria. The consultants will be invited to update this group on the findings so far and they will be able to pose questions to and consult the participants. Participants are representatives of the Dutch embassies involved in the regional programme, and all the lead contact persons of four projects. The MaxART-project will not be presented at this meeting.

The consultant(s) are advised to take into account the presidential elections in Mozambique. These elections will most likely take place around 15 of October. In view of this it is strongly advised to start the evaluation in Mozambique.

The submission of a first draft will be done by 9 December 2019. The Embassy in consultation with the Policy and Operations Evaluation Department (IOB - MoFA) will provide feedback on the report. The final report will be submitted no later than 22 January 2020.

The Netherlands Embassy in Maputo will contract a consultancy firm or consultants to implement the assignment. The selection of the consultant(s) will be based on the content of the inception proposal, proposed methodology, work planning, experience and the budget.
It is expected that the consultant(s), after having familiarized themselves with the relevant documentation (12 days), will conduct field research in the region in 4/5 countries (46 days). In each of the three countries, a local consultant will do the assessment in cooperation with

the team leader. The consultant(s) will have in-depth discussions with key informants as described under chapter 4.

Desk study	12
Field research	46
Presentation and discussion at the RAG meeting	2
Report writing and editing	10
Total number of days	70 days for the team leader 3-5 local evaluators x 15-20 days (desk review, field research and writing)

Consultancy fees will be paid at a daily rate. For field visits actual travel costs will be reimbursed and for costs for board and lodging the UN daily subsistence allowances for field visits will be paid.

7. Profile of consultancy team

The successful bidder will have one or more members who meet the following criteria:
Essential:

- The team leader has at least 10 years' experience in Monitoring and Evaluation in the areas of HIV/AIDS and SRHR, preferably in Sub-Saharan Africa. He/She is capable of conducting a contribution analysis, leading a team and encouraging cooperation and team building.
- All local consultants have a thorough understanding of HIV/AIDS and SRHR development challenges in Southern Africa
- Local consultants have substantial experience (3-5 years) in monitoring and evaluation of SRHR/health, HIV or human rights programmes
- Ability to think strategically and to analyse systematically
- Experience in presenting complex data and information to various stakeholders
- Experience with working in an international development context
- Excellent communication skills
- Excellent written and spoken English (for Mozambique, the local consultant needs to speak and read Portuguese and English)
- Ability and commitment to deliver the expected results within the agreed period of time.

We are looking for a consultant team comprising experts who are independent of the consortium partners and the Embassy of the Kingdom of the Netherlands in Maputo.

Annex 9 Evaluation Work Plan

The core evaluation team consists of one international team leader and four local experienced evaluators who will in cooperation with the international team leader conduct an assessment in their own country. The evaluation team presents all the necessary expertise for this assignment, including availability, knowledge of, experience with, and the skills for the evaluation of the Netherlands' Regional HIV/AIDS and SRHR Programme in Southern Africa. The evaluation's team composition:

Name	Role	Duty Station
Paul Jansen	Team Leader, Expert HIV/AIDS and SRHR interventions for key populations	Spain
Carmel Marock	Evaluator, responsible for case study South Africa	South Africa
Marianne Brittijn	Evaluator, responsible for case study Zambia	South Africa
Tsitsi Maradze	Evaluator, responsible for case study Zimbabwe	Zimbabwe
Domingos Jaime Langa	Evaluator, responsible for case study Mozambique	Mozambique
Irma Alpenidze	Quality assurance effect evaluations and evaluation methodologies	The Netherlands

Two team members are specifically responsible for overall quality assurance of the evaluation process, its outputs, and the dissemination of the evaluation results. This inception report describes the methodology to be used by the evaluation team. It explains how the evaluation is designed to achieve its purpose. It serves as a comprehensive research design and detailed work plan and as such supports the quality assurance. The findings of the evaluation report will reflect systematic analysis and be substantiated by evidence. The conclusions will be reasonable judgments, based on findings, and substantiated by evidence, and provide insights on the object and purpose of the evaluation.

The evaluation time frame, which was tentatively presented in the proposal for this evaluation, was adapted in the inception report to final dates.

Activity	By when?
Start evaluation	28 August
Draft inception report	4 October
Feedback on the draft inception report	10 October
Final inception report	14 October
Data collection Mozambique	21 October-6 November
Data collection South Africa	7-31 October
Data collection Zambia	29 October-6 November
Data collection Zimbabwe	14 October-15 November
Data analysis	4 October-25 November
Presentation and discussion at the meeting of the Regional Advisory Group in Maputo	29-30 October
Submission of the draft report	9 January 2020
Feedback on the draft report	16 January 2020
Submission of final report and summary	31 January 2020

Annex 10 Evaluation Matrix

Question	*Criteria*	*Sub-question / indicators / signs*	*Source of info*
1. To what extent is the regional programme's Theory of Change (ToC), objectives, assumptions, outputs and result areas valid? Is the ToC aligned to the needs and priorities of adolescents and young people, mobile groups and key populations[76] (not only on paper but also in practice)?	*Relevance*	*Sub-questions:* • *To what extent is the overall ToC is guiding programme delivery? What can be said about the quality and validity of ToC?* • *Are assumptions being monitored?* • *To what extent is the regional programme's ToC adapted and appropriately guiding projects?* • *How are project results linked back to the regional programme ToC? How are adjustments being made, if they are?* • *What ToC areas are more populated with the project results and what – less?* • *What does this say about priorities of adolescents and young people, mobile groups and key populations?*	*Desk study of programme and project documents and annual results reporting* *Data collected during case studies and interviews* *Interviews with key stakeholders*
2. Did the regional programme do the right things? Did the programme address gaps in the regional and national HIV/AIDS and SRHR response, by focusing on key populations (sex workers, young people living with HIV, LGBT-groups and Injecting Drug Users (IDUs), migrants, adolescents) and advocating for better access to information, services, rights and legal change?	*Relevance*	*Sub-questions:* • *To what extent was the design of the programme appropriate and relevant in view of the political, economic and social context in the country and the government's policy framework?* • *How were beneficiaries identified? Migrants, AYP and SWs?* • *Where there any other programmes or interventions, government or NGO-led that could have increased the provision of SRHR and HIV information and access to services of people from target groups?* • *What are the challenges and gaps that have been identified related to SRHR and HIV among migrants , sex workers and young people?* • *What is the SADC response to HIV/AIDS and SRHR in the region and what are the gaps? Also for each*	*Desk study of programme and project documents and annual results reporting* *Data collected during case studies and interviews* *Interviews with key stakeholders*

76 Key populations have higher HIV prevalence rates than the general population and have only limited access to testing and treatment due to discrimination. They often consist of MSM, sex workers and their clients, prisoners and injecting drug users (source-BEMO Call for proposals).

		case country, what is the national response and what are the gaps?	
3. In view of the programme and country responses, to what extent was the allocation of funds to the different countries reasonable?	*Relevance*	*Sub-questions:* • *What was the reasoning behind the budget allocation to the different countries and programmes looking at the populations targeted?*	*Desk study of programme and project documents and annual results reporting* *Interviews with key stakeholders*
4.To what extent has the programme been working with the right (influential and capable) organisations/consortia?	*Relevance*	*Sub-questions:* • *Are the implementing partners being seen as influential and capable? In what way?* • *What is their influence and contribution to change in the region on SRHR and HIV issues beyond the programme implementation?* • *To what extent does the mix multilateral and international implementing partners work and how do they influence each other's programmes, interventions outcomes and impact?* • *In the light of the principles (q 18) why were no local Southern African organisations chosen as lead partner as their influence on change could be much stronger?*	*Interviews with ministerial and embassy staff*
5. Are the interventions aligned with SADC policies? Is there coherence or even complementarity with SADC regional policies?	*Relevance*	*Sub-questions:* • *What are the current SADC regional policies?* • *Do stakeholders see coherence or complementarity between the SADC policies and the programme interventions. If so, which?* • *Have there been any changes in policies in the implementation period of the programme?* • *Were any changes influenced by the regional programme interventions?*	*Internet and document research on SADC policies regarding SRHR and HIV* *Interviews with SADC SRHR/HIV policy staff, lead implementing partners, regionally working partners such as AMSHeR and HEARD*

6.To what extent is there coherence or complementarity with other donors for example with, Swedish regional assistance?	*Relevance*	*Sub-questions:* • *What is the ToC of the Swedish regional programme and to which extent does it overlap/differ with the Dutch regional ToC?* • *Who are other donors working in the region on SRHR and HIV and what is their ToC?* • *What are the change/impact results that are influenced by the Swedish or other donor programmes?*	*Document research and data collected from other donors working on SRHR and HIV in Southern Africa* *Interviews with SIDA team and other donors.*
7.What is the added value of a regional approach vis-à-vis country programmes. Do the individual projects have regional components, or are we implementing the same project in multiple countries?	*Relevance*	*Sub-questions:* • *What is seen by stakeholders as the added value of a regional programme?* • *Can regional components be distinguished in the programmes and if so, what is their influence on the intended change?* • *What are concrete changes witnessed by the beneficiaries that directly relate to actions or interventions at a regional level? Can these be related to programme interventions?*	*Interviews with programme leads and national implementing partners* *Document research, mainly annual reports and MTR reports.*
8. Are the target groups and planned geographic areas being successfully reached?	*Effectiveness*	*Sub-questions:* • *Has there been an increase in numbers of people from the target groups reached with information on SRHR and HIV for target groups?* • *Has there been an increase in numbers of people from the target groups accessing SRHR and HIV services?* • *Did the different programmes reach the intended target groups? If not, what are factors that influenced the reach?* • *Has there been an increase in numbers of people from the target groups reached with information on SRHR and HIV for target groups?* • *Has there been an increase in numbers of people from the target groups accessing SRHR and HIV services?* • *Which target groups from the regional ToC were not reached?*	*Document research* *Interviews with EKN staff, lead partners and national implementing partners* *FDGs with beneficiary groups.*

9.What are the projects' comparative strengths, weaknesses/gaps and opportunities and how are these perceived by the stakeholders, including the beneficiaries for the future of the programme?	*Effectiveness*	*Sub-questions:* • *What do beneficiaries see as strengths, weaknesses, gaps and opportunities of the programmes?* • *Are there differences/overlaps in these between the different programmes?* • *How do these strengths, weaknesses, gaps and opportunities influence the changes intended at every level of the programme's ToC?*	*Interviews with implementing programme leads and key stake holders* *FGD and interviews with beneficiaries*
10.Are there any successful, innovative approaches and lessons learnt to date that can be scaled up within the programme and externally, including effectiveness and appropriateness of implementation approaches?	*Effectiveness*	*Sub-questions:* • *Which innovations within the programme implementation are identified by stakeholders?* • *Would these innovations be replicable in other contexts?* • *What effect do these innovations have on the cause-effect relationships the programme set out at programme design?*	*Programme documents, annual reports, MTR reports* *Interviews* *Case/best practice identification*
11.To what extent are the costs and benefits of the development interventions in a reasonable proportion to each other from a business and economic point of view?	*Efficiency*	*Sub-questions:* • *What can be said about costs effects and benefits of the changes on people's lives?* • *Has the intervention been cost-effective (compared to alternatives, maybe Swedish funded interventions)?*	*Document research/budget and financial documents* *Interviews with implementing partners*
12. Are financial and human resources adequately allocated and efficiently used	*Efficiency*	*Sub-questions:* • *How many staff is employed through the programme?* • *Did the project count with the right staff members, appropriately trained, capable to do the job, was the level of attrition acceptable and did it not affect the project adversely?* • *Was the proportion of the budget used on external consultants acceptable in terms of overall personnel budget? Did the project deliberately build capacity of local staff?* • *What are the % used for overheads and indirect costs?*	*Budget documents, annual reports and audits* *Interviews with lead implementing partners*

13.What evidence is emerging that the programme is on-track to achieve, by the time it closes, its outcome and impact level results?	*Impact*	*Sub-questions:* • *How do the planned programmatic cause-effect relationships contribute to the desired outcomes and impact?* • *Do the results reported/witnessed on outcome/impact indicators indicate an improvement in comparison with the baseline and/or national statistics for the programme's target populations?* • *Did the programme produce the intended results in the short, medium and long term? If so, for whom, to what extent and in what circumstances?* • *What unintended results – positive and negative – did the intervention produce? How did these occur?* • *What were the barriers and enablers that made the difference between successful and disappointing programme implementation and results?* • *To what extend do the achieved results confirm the current ToC? What causal links seem to work and which don´t?*	*MTR reports, annual reports* *Interviews with lead implementing partners and national/consortium partners*
14.What happened in the programme and to what extent can the changes be contributed to the projects? What would have happened in the absence of the projects?	*Impact*	*Sub-questions:* • *Are the programmes impacting positively on key target groups and issues that have been identified as important in the regional programme design and the ToC?* • *What are the most significant changes in the country/region/project sites that can be witnessed for the target groups? Are these influenced by the programmes?*	*Document research, data and statistics from national agencies.* *Interviews with key stakeholders* *FDGs with beneficiaries*
15.What evidence is emerging that the expected outcomes and outputs are likely to be sustained or remain in place once the programme has closed?	*Sustainability*	*Sub-questions:* • *How stable is the situation in the programme countries and the region regarding social justice for the programme´s target groups, economically and the political stability ?* • *What is needed to make these kind of programme outcomes and outputs sustained in the future?*	*Interviews with key informants in the region, lead implementing partners, embassy and ministerial policy and expert staff.* *Document research from MTRs*

		• *What risks and potentials are visible regarding the sustainability of the outputs and outcomes of the programmes and how likely is their occurrence?*	
16.Have the projects formulated sustainability measures or an exit strategy?	*Sustainability*	*Sub-questions:* • *Is there evidence that the initiatives are likely to grow – scaling up and out – beyond the programme life?* • *Do the different programmes have an exit strategy and if so, how does it envisage sustainability of the programme?* • *Can sustainability measures be identified in the programme? If so, what are these and in which phase of the programme are these implemented?*	*Document research: project proposals, annual reports, MTR*
17.What could be done to improve the sustainability of the outcomes?	*Sustainability*	*Sub-questions:* • *To what extent do the programmes reflect on and take into account factors which, by experience, have a major influence on sustainability like e.g. economic, social and cultural aspects?* • *How self-sustaining in particular are the local key stakeholders?* • *To what extent are the involved local/national organisations (financially, personnel-wise and in terms of organisation) capable and prepared to maintain the positive effects of the programmes?*	*Key informant interviews and/or FGD with local implementing partners, stakeholders and beneficiaries*
18.To what extent is the implementation of the programme embodying the principles of empowerment, participation, non-discrimination and accountability? (not only on paper but also in practice)	*Cross-cutting*	*Sub-questions:* • *What concrete evidence cases be found in the programme design and implementation on the application of the principles of empowerment, participation, non-discrimination and accountability?*	*Interviews with implementing partners, national partners and beneficiaries* *FGD with beneficiaries*
19.To what extent have the embassies in the region been involved in the design and implementation of the regional	*Cross-cutting*	*Sub-questions:* • *How was embassy staff from the regional embassies involved in the programme design and implementation process, if any?*	*Interviews with (former) embassy staff.*

programme, including the choice of projects?		• *Can staff mention activities and meetings in which they participated and where the programme design and implementation was discussed?* • *Was staff informed and involved through (e-)communication circles about the design and implementation of the programme?* • *Was staff involved in the assessment and selection of the projects? If so, how?*	
20.To what extent has the regional programme integrated gender and human rights-based approaches?	*Cross-cutting*	*Sub-questions:* • *Is there any evidence of an integrated gender and human rights- based approach in the programme?* • *If so, how does this integration look like and at what level in the programme does the integration take place (activity/output/outcome/impact)?*	*-Document research, MTR and activity reports.* *-Individual interviews with key staff of implementing agencies, national partners and informants from the Ministry*
21.To what extent has the regional programme – the coordinating Embassy- communicated effectively with its implementing partners (in the opinion of the implementing partners)?	*Cross-cutting*	*Sub-questions:* • *What evidence can be found on communications between the coordinating embassy and implementing partners?* • *What was the content of the communications?* • *How were the communications received and interpreted?* • *Where the communications useful in any aspect of the programme implementation?*	*-Document research* *-Individual interviews with staff from implementing partners*

Annex 11 Summary of important (regional) policy frameworks on SRHR and HIV

First of all the framework of **the 2030 Agenda for Sustainable Development** with the Sustainable Development Goals is important to mention. SDGs 3, Ensure healthy lives and promote well-being for all at all ages, and 5, Achieve gender equality and empower all women and girls, speak directly to the issues that need to be addressed, more specifically the targets:

SDG 3.1 By 2030 reduce the global maternal mortality ratio to less than 70 per 100,000 live births

SDG 3.2 By 2030, end preventable deaths of new borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

SDG 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

SDG 3.7 By 2030 ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs

SDG 5.1 End all forms of discrimination against women and girls everywhere

SDG 5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

SDG 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

SDG 5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences77.

Another framework worth mentioning is the revised **Maputo Plan of Action (MPoA): "Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa"**, adopted by the African Union in 2016. This plan follows on from the first Maputo Plan of Action 2007-2015 (2006) and is aligned with the strategic pillars of the African Union's Agenda 2063.

77 The review conferences for the ICPD and Beijing+25 were/are held in November 2019 (ICPD) in Nairobi, Kenya, and in 2019-2020 for the Beijing +25, ending with a global conference in July 2020 in Paris, France.

The MPoA mentions ten strategic action areas:

- Improving political commitment, leadership and good governance
- Instituting health legislation and policies for improved access to reproductive, maternal, newborn, adolescent and child health services (RMNACH)
- Increasing health financing and investments
- Ensuring gender equality, women and girl's empowerment and respect of human rights
- Improving SRHR information, education and communication
- Investing in SRHR needs of adolescents, youth and other vulnerable and marginalised populations
- Optimising the functioning of health systems and improving human resources by ensuring universal health coverage
- Improving partnerships and multi-sectorial collaborations for RMNACH
- Ensuring accountability and strengthening monitoring and evaluation, research and innovation.
- Increasing investments in health

The **SADC regional strategy on SRHR 2019-2030 (November 2018)** and corresponding score card is seen by many in the region as a ground-breaking document. It sets out the vision and targets for the region on SRHR. It presents a shift from the previous strategy from service focused to a rights-based approach. The document, which was adopted in 2018, present its vision as "Ensure that all people in the SADC region enjoy a healthy sexual and reproductive life, have sustainable access, coverage and quality SRHR services, information and education, and are fully able to realize and exercise their SRH rights, as an integral component of sustainable human development in the SADC region". The strategy in summary:

Outcomes:
"SADC Member States will be required to fast track progress towards achieving the following outcomes:

1. Maternal mortality ratio reduced to fewer than 70 deaths per 100,000 live births (SDG 3.1)
2. Newborn mortality ratio reduced to fewer than 12 deaths per 1,000 births (SDG 3.2)
3. HIV and AIDS ended as a public health threat by 2030 (SDG 3.3)
4. Sexual and gender-based violence and other harmful practices, especially against women and girls, eliminated (SDGs 5.1, 5.2 and 5.3)
5. Rates of unplanned pregnancies and unsafe abortion reduced
6. Rates of teenage pregnancies reduced
7. Universal access to integrated, comprehensive SRH services, particularly for young people, women, and key and other vulnerable 13 populations, including in humanitarian settings, ensured (SDGs 3.7 and 5.6)
8. Health systems, including community health systems, strengthened to respond to SRH needs; (SDG 5.6)
9. An enabling environment created for adolescents and young people to make healthy sexual and reproductive choices that enhance their lives and well-being (SDGs 4.7 and 5.6)

10. Barriers – including policy, cultural, social and economic – that serve as an impediment to the realization of SRHR in the region removed (SDGs 5.1 and 5c)".

The document mentions four core strategies on how to achieve the outcomes:

a) Innovative leadership that boldly accelerates the SRHR regional agenda. Member States should consider:

- Removing political, cultural, social and economic barriers so that all people, in particular women and girls, are able to make decisions about their bodies; including eliminating child marriage and gender-based violence, ensuring that people have access to SRHR information, education and access to quality integrated people-centred SRHR services (including contraceptives, and prevention and treatment of sexually transmitted infections (STIs), including HIV);
- Promoting gender equality by developing policies and strategies that also engage men and boys;
- Providing adequate financial and human resources to deliver quality people centred, integrated SRHR services;
- Domestication of this strategy, in the context of their respective legal and policy environments.

b) Alignment of Member States policy and legal frameworks with global and regional commitments, and international human rights standards. Member States should consider:

- Engaging with beneficiaries, and traditional faith-based and community leaders on the legal and policy SRHR gaps, and involve them meaningfully in the resulting revisions, as well as their implementation, and monitoring and evaluation;
- Defining and scaling up a national minimum package of social, behavioural, structural and biomedical interventions for adolescents and youth to reduce early and unintended adolescent pregnancies, unsafe abortion, STIs and HIV;
- Advancing the SRHR of adolescents and youth through ensuring access to quality, people-centred SRHR services and build the capacity of health-care workers to deliver these services;
- Protecting adolescents from child marriage through limiting the age of consent to marriage to 18 years, irrespective of gender;
- Reducing the criminalization of adolescents engaging in consensual sexual relations through conducting national consultations that consider the harmful legal and service delivery implications of the age of consent, and consider reducing the age of consent to 16 years, irrespective of gender, taking into consideration the rights of adolescents and youth to healthy consensual sexual relations based on their evolving capacity, and include close-in-age provisions (known as Romeo and Juliet Provisions);
- Defining and protecting the right of all people to protection from sexual and gender-based violence;

- Developing policies on the readmission and retention of pregnant girls in school so that they can reach their full potential;
- Promoting gender equality and develop policies, strategies and programmes that seek to engage men and boys as partners, and as persons with their own SRHR needs;
- Engaging on the need for safe abortion services as a human right for women, and explore ways in which the policy and legal environment can protect the health, lives, and rights of women and girls, while ensuring that policies facilitate the provision of comprehensive post-abortion care in all contexts.

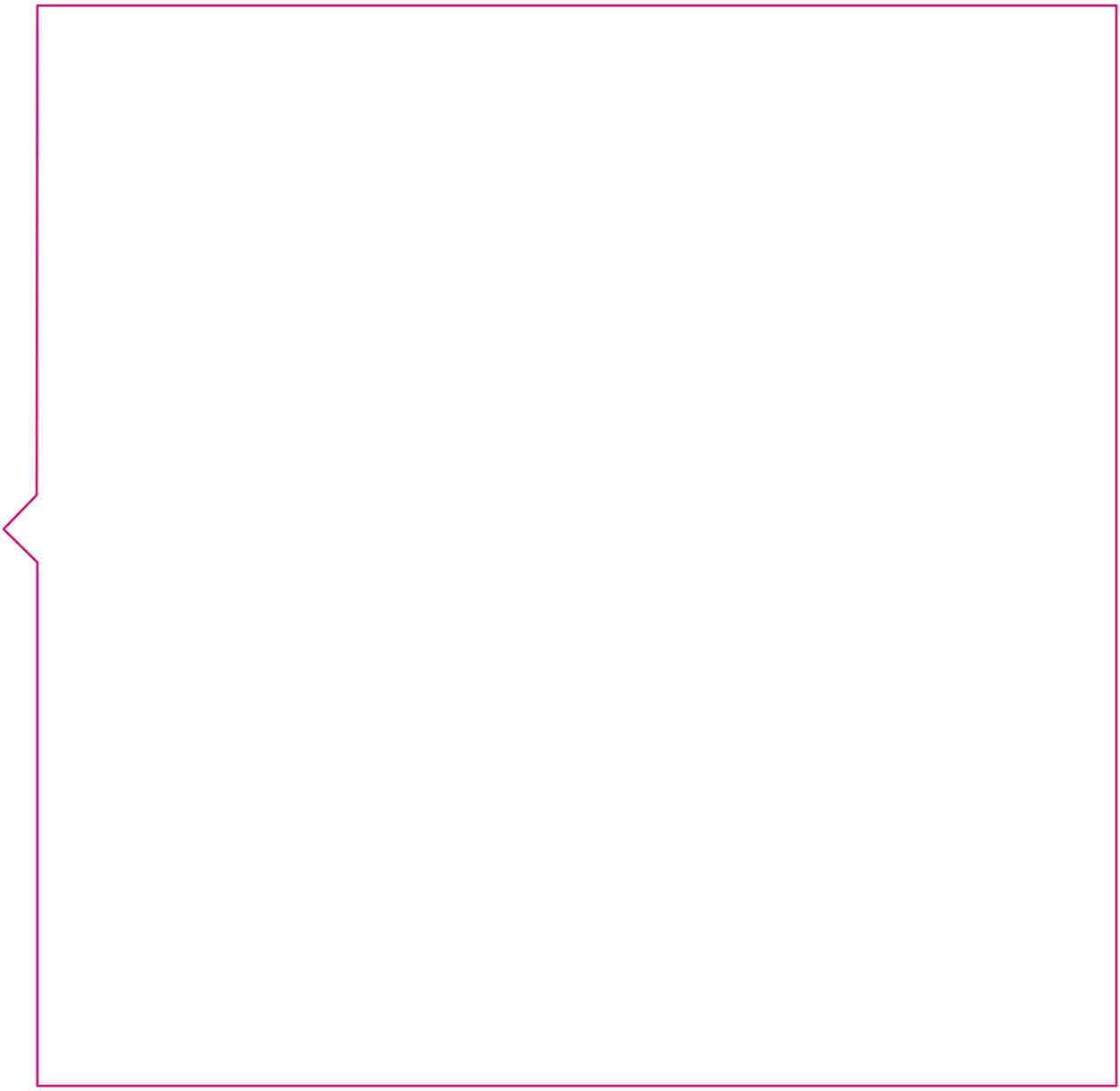
c) Universal health coverage and strengthened health systems in Member States to incorporate the essential SRHR package. Member States should consider:

- Addressing the range of social, economic, cultural and systemic challenges so that all people have universal access to quality healthcare services across their life cycle;
- Removing financial and other barriers to ensure equitable access to health-care services, including the full package of SRH interventions as defined by the ICPD;
- Removing barriers to education and creating economic opportunities, to break the cycle of inter-generational poverty and reap the benefits of the demographic dividend;
- Ensuring that services meet the specific SRHR needs of men and boys;
- Ensuring that adolescents and young people both in and out of school have access to good quality, comprehensive, age-appropriate, scientifically accurate life skills-based comprehensive sexuality education (CSE), with linkages to SRH services that are youth friendly;
- Building the capacity of educators, peer educators, and so on, to deliver quality life skills-based CSE services;
- Investing in health-care systems to deliver people-centred, quality integrated SRHR services, including to: increase the number and build the capacity of health-care workers, in particular midwives; institute programmes that encourage youth to enter the health workforce; improve the health infrastructure; ensure that health facilities have the necessary equipment, commodities and supplies; strengthen healthcare referral systems and establish linkages between health-care services and community structures.

d) Monitoring and evaluation for strengthened, evidence-based impact. Members States should consider:

- Prioritizing, fast tracking and reporting on progress through the annual scorecard, the M&E Plan and the evaluation of this strategy in 2021, 2025 and 2029;
- Establishing and/or strengthening national multi-sectorial monitoring, evaluation and reporting systems to track progress made, with data disaggregated by age, sex, population, socio-economic group and gender;
- Integrating various reporting tools, where possible, to reduce the burden of reporting on health-care workers;

- Investing in a national clearinghouse for all data to enable partners to come together, track progress, identify gaps and respond accordingly;
- Establishing a regional platform to strengthen data collection, analysis and reporting;
- Creating a regional knowledge-sharing network to (i) monitor trends,(ii) shape and accelerate responses to emerging issues, (iii) share good practices, and (iv) develop and inform a regionally responsive SRHR research agenda



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