



## Evaluation of MTV Shuga in Botswana (2020-2022)



Final Report

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**Cover photo credit:** an MTV Shuga session in progress for out of school youth. Picture taken by Ngonidzashe Marimo

# Table of Contents

<b>ACKNOWLEDGEMENTS .....</b>	<b>I</b>
<b>TABLE OF CONTENTS .....</b>	<b>II</b>
LIST OF FIGURES .....	III
LIST OF TABLES .....	III
<b>ACRONYMS.....</b>	<b>IV</b>
<b>EXECUTIVE SUMMARY.....</b>	<b>V</b>
RECOMMENDATIONS.....	XII
<b>1 INTRODUCTION .....</b>	<b>1</b>
<b>2 BACKGROUND .....</b>	<b>1</b>
2.1 CONTEXT .....	1
2.2 DESCRIPTION OF THE PROJECT .....	2
2.3 EVALUATION PURPOSE .....	8
2.4 EVALUATION OBJECTIVES AND SCOPE .....	8
2.5 EVALUATION FRAMEWORK.....	8
2.6 EVALUATION AUDIENCE AND USERS .....	8
<b>3 METHODOLOGY.....</b>	<b>10</b>
3.1 EVALUATION APPROACH.....	10
3.1.1 <i>Evaluation guidance and principles</i> .....	11
3.2 EVALUATION METHODOLOGY .....	11
3.2.1 <i>Secondary literature review</i> .....	11
3.2.2 <i>Quantitative evaluation</i> .....	11
3.2.3 <i>Qualitative evaluation</i> .....	13
3.2.4 <i>Reporting, validation and participation of rights holders</i> .....	16
3.3 ETHICAL CONSIDERATIONS.....	16
3.4 LIMITATIONS OF THE EVALUATION.....	19
<b>4 FINDINGS.....</b>	<b>20</b>
4.1 RELEVANCE .....	20
4.1.1 <i>To what extent were the beneficiaries satisfied with the behaviour change intervention?</i> .....	20
4.1.2 <i>To what extent were the programme strategies, approaches, and methods relevant and responsive to the local settings, population, circumstances, and challenges?</i> .....	22
4.2 GENDER AND EQUITY .....	24
4.2.1 <i>How well did the programme integrate gender and equity considerations into its design and implementation?</i> .....	24
4.2.2 <i>Was sufficient information collected during the implementation period on specific result indicators to measure progress on gender and equity?</i> .....	25
4.2.3 <i>To what extent was the programme disability inclusive?</i> .....	25
4.3 EFFECTIVENESS .....	26
4.3.1 <i>To what extent did adolescents and young people adopt safe sexual behaviours as a result of the programme? Was there an improvement in self-efficacy? To what extent did attitudes towards the following improve: intergenerational and transaction sex; gender norms related to prevention of HIV and unwanted pregnancy?</i> .....	26
4.3.2 <i>Achievement of project targets.....</i>	31
4.3.3 <i>What were the key factors influencing the achievement or non-achievement of results?</i> .....	31
4.4 EFFICIENCY.....	35
4.4.1 <i>To what extent were the implementing strategies appropriate for achieving results?</i> .....	35
4.4.2 <i>Which components of the intervention and its communication channels are less resource intensive but critical for the programme results?</i> .....	37

4.4.3 To what extent did the programme generate solid evidence from monitoring and evaluation in order to inform policy/advocacy and improved programming? .....	38
4.5 SUSTAINABILITY.....	39
4.5.1 How well has the programme been linked to and is synchronised with other programmes on reproductive health? .....	39
4.5.2 To what extent have advocacy efforts been successfully used to contribute to national ownership? .....	40
<b>5 CONCLUSION, LESSONS LEARNED AND RECOMMENDATIONS .....</b>	<b>42</b>
5.1 CONCLUSION .....	42
5.2 LESSONS LEARNED .....	44
5.3 RECOMMENDATIONS.....	45
<b>ANNEXES .....</b>	<b>49</b>
ANNEX 1: TERMS OF REFERENCE .....	49
ANNEX 2: EVALUATION FRAMEWORK .....	74
ANNEX 3: LIST OF PEOPLE MET .....	80
ANNEX 4: MTV SHUGA BOTSWANA RESULTS FRAMEWORK .....	81
ANNEX 5: LIST OF DOCUMENTS REVIEWED .....	85
ANNEX 6: ETHICAL APPROVAL LETTER.....	87
ANNEX 7: CONSENT FORMS .....	88
ANNEX 8: DATA COLLECTION TOOLS.....	91

## List of Figures

Figure 1: Summarised theory of change of the MTV Shuga programme .....	3
Figure 2: Contribution analysis .....	10
Figure 3: Key drivers of new HIV infections for male and female AYP .....	21
Figure 4: Project achievements by outcome (pre- and post-exposure measurements) .....	27
Figure 5: Increase from baseline by sex of AYP.....	27
Figure 6: AYP reached by MTV Shuga communication channels .....	33

## List of Tables

Table 1: Partnership arrangements and roles .....	5
Table 2: Sample sizes for the qualitative evaluation .....	15
Table 3: Indicator analyses definitions and rationale .....	12
Table 4: Potential risks for children in the evaluation and mitigation measures.....	18
Table 5: Overall performance of the MTV Shuga programme .....	29

## Acronyms

AYP	Adolescents and Young People
BIHL	Botswana Insurance Holdings Limited
DAC	District AIDS Coordinator
DCs	District Commissioners
DEO	District Education Officer
DHMT	District Health Management Team
DMSACs	District Multi Sectoral AIDS Committees
ERG	Evaluation Reference Group
FGDs	Focus Group Discussions
G&C	Guidance and Counselling
GBV	Gender-based violence
HMIS	Health Management Information System
IP	Implementing Partner
IVR	Interactive voice response
KIIs	Key Informant Interviews
MESD	Ministry of Education and Skills Development
MSC	Most Significant Change
NAHPA	National AIDS and Health Promotion Agency
QA	Quality Assurance
RB 2	Radio Botswana 2
MTV-SAF	MTV Staying Alive Foundation
SEA	Sexual exploitation and abuse
STI	Sexually Transmitted Infection
TOC	Theory of Change
ToR	Terms of Reference
UNEG	United Nations Evaluation Group

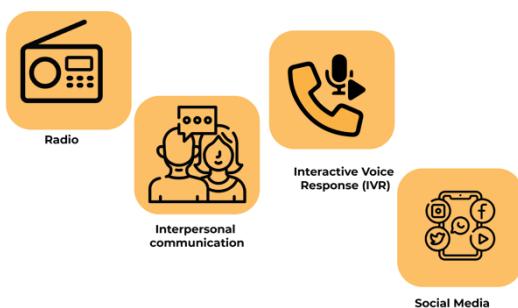
# Executive Summary

## Project description

The MTV Shuga programme is an award-winning TV programme in Africa and Asia, that uses edutainment as a model to showcase challenges of young people in different contexts with the aim to provide behaviour change content to adolescents and young people. Aligned with the Third National Strategic Framework for HIV and AIDS in Botswana, the programme was initially introduced by National AIDS and Health Promotion Agency (NAHPA) through the national Botswana television in 2011 and later reintroduced on radio with the support of UNICEF in 2018 with the goal of reaching adolescents and young people with behaviour change content focusing on safe sexual behaviour (delayed sex debut, prevention of transactional and intergenerational sexual relationships) and uptake of HIV services. As such, it was implemented through a collaboration mainly between UNICEF and the National AIDS and Health Promotion Agency (NAHPA), in partnership with MTV Staying Alive Foundation (MTV SAF), with a budget of budget was US\$1,724,696.00. The programme under evaluation was a catalytic initiative linked to the UNICEF's Country Programme Outcome 2 which seeks to ensure that by 2026, adolescents and young people (10–24 years), particularly the most vulnerable, will be more empowered and engaged to access quality and gender-responsive HIV, health, nutrition, education, and child protection services. The programme also addressed sustainable development goal 3 (SDG 3), on ending HIV and AIDS epidemic by 2030. The programme was therefore adapted and implemented as a behaviour change communication strategy to help adolescents and young people adopt safe sexual behaviour by targeting key drivers of new infections and non-adherence to ARV treatment. The following were the key programme objectives:

- i. To improve self-efficacy to know HIV status and access sexual and reproductive health services.
- ii. To improve attitudes towards intergenerational and transactional sex.
- iii. To improve attitude and self-efficacy to demand or practice safe sex.
- iv. To improve knowledge and attitude towards sexual exploitation and abuse (SEA) and gender-based violence (GBV).

The MTV-Shuga peer education programme, was piloted in two districts in 2019 and scaled up to four districts in 2020 (Selibe-Phikwe, Boteti, Ghanzi and Okavango (Shakawe and Gumare) districts). With the advent of COVID-19, virtual peer education (through social media platforms) programme was introduced in Botswana in 2020 to ensure continuous access to information and services among AYP during this period. Various adaptations to the MTV programme, to secure a comprehensive reach – especially to deepen impact of the radio programme and improve access in remote rural and peri-



urban areas were therefore made. The programme included: **Radio:** The Drama series were an adaptation of MTV Shuga Down South with episodes of about 7-10 minutes, followed by in studio discussions by young people for some of the episodes. **Interpersonal communication:** Peer education component (led by trained Peer Educators (PEs)) targeted in school and out of school adolescents and young people (AYP) in Selibe-Phikwe, Boteti, Ghanzi and Okavango (Shakawe and Gumare) districts. The model used the MTV Shuga Peer Facilitation Guide which contained 7 sessions

which were increased to 9 sessions (to incorporate parent to child engagement) that each group of participants have to complete to be classified as being fully exposed to the MTV Shuga Peer education Programme. **Interactive voice response (IVR):** Episodes of the MTV Shuga drama series were uploaded to the interactive voice response (IVR) platform known as 124, for audience to listen to at their own

time in case they missed the radio show. Also, a ‘choose-your-adventure’ game was introduced to the platform for improved interaction with audience. The game allowed young people to choose characters they like and personify the character’s decision making process and listen to how their story ends. **Social Media:** With the advent of COVID-19, the programme adopted virtual peer education approaches to ensure and sustain service demand generation and uptake by adolescents and young people.

### **Evaluation purpose, scope, objectives and intended audience**

The evaluation purpose was “to evaluate how well the MTV Shuga programme achieved its outcomes”. The evaluation intended to measure the outcomes of the MTV Shuga programme in all the four targeted districts. It also determined how effective the programme was in achieving its set targets. The evaluation results are intended to inform replication of the programme by the Government of Botswana in several districts of the country. The primary user of the evidence generated from the evaluation will be the Government of Botswana through NAHPA as the evaluation will inform the current scale up of the programme to other districts. UNICEF will use the evidence to continue advocacy efforts towards ensuring adolescent and young people programmes for safe sexual behaviours are developed and implemented. Development partners and other non-governmental organisations stand to benefit from the results of the evaluation as well on the use of peer approaches to behaviour change and in alignment with other programmes targeting Adolescents and Young People (AYP).

### **Methodology**

**Evaluation approach:** The evaluation used mixed methods approaches premised on qualitative and quantitative data. Quantitative data was used to determine MTV Shuga’s performance on envisaged outcomes while qualitative data was used to answer questions on relevance, efficiency, sustainability as well to validate and explore further outcomes of the programme. The evaluation was designed on the premise of a contribution analysis approach where the evaluation did not seek attribution but rather how the MTV Shuga sessions and other support are contributing to observed outcomes. The evaluation utilised the contribution analysis methodology to help track emerging programme impacts/outcomes and determine the programme’s contribution. Across all evaluation criteria the evaluation explored the extent to which the project design mainstreamed human rights, gender equality, disability, and equity. The United Nations Evaluation Group (UNEG) guidance on evaluation, human rights centred, and gender responsive evaluation were adopted in the tools and data collection approaches. The UNICEF Global Evaluation Reports Oversight System (GEROS) was the main guidance on evaluation quality standards. Evaluation principles of independence, credibility, integrity, and inclusiveness were integral to the evaluation approach.

**Data sources, collection, and analysis:** The evaluation team conducted an extensive literature review to inform the design of the evaluation, methods, and data collection tools as well as the findings. The quantitative evaluation component relied on secondary data from the programme’s monitoring system (baseline survey, pre- and post-exposure surveys, and monitoring reports). The qualitative evaluation component comprised Key Informant Interviews (KIIs), Focus Group Discussions (FGDs), Case Studies (using the Most Significant Change (MSC) approach). Key informants were drawn from programme stakeholders such UNICEF, Makgabaneng, NAHPA, BIHL, MTV-SAF, Peer Coordinators, DAC, Chief Education Officer, DHMTs, and teachers for Guidance and Counselling (G&C). FGD discussants were primarily adolescents and young people (AYP) that went through the MTV Shuga sessions in- and out of school, in separate groups of males and females. Case studies were held with selected participants of the MTV Shuga programme. Only two districts: Selibe Phikwe and Okavango were selected for the qualitative data collection. Primary quantitative data from pre- and post-exposure surveys was analysed in accordance with the indicator definitions provided by UNICEF. Differences between the

baseline and post-exposure survey was compared to ascertain the differences. Qualitative data collected was systematically analysed, triangulated, and synthesised by the evaluation team. The collected qualitative data complemented and clarified the quantitative findings by helping to identify common themes.

**Validation and dissemination:** The evaluation reference group reviewed the draft evaluation report to correct any factual errors. The results of the evaluation will be disseminated to all stakeholders by implementing partners.

**Limitations of the evaluation:** The following were the limitations of the evaluation exercise: 1) Only the in-person peer educator programme and the IVR platform had pre- and post-exposure data. This meant assessment of the performance of the programme was limited to these two channels. 2) Visit to only two of four districts had the potential to skew the perceptions on programme performance. The evaluation ensured the selection of four wards that represent fully the context of the programme including selecting some successful localities, provided the evaluation with sufficient variation to fully explore the programme's performance. 3) The study relied on secondary data (pre- and post-exposure survey data) due to unavailability of funding for primary quantitative data collection. Primary qualitative data on programme outcomes was collected instead. 4) There was potential to collect and use clinical data (especially utilisation of HIV services). While this could have provided trends in utilisation of services, the low performance of lower-level results meant such a contribution story would be very weak. Resultantly this data was not used for the analysis of outcomes. The programme had no focus on linkage to health services a requirement for enhancing utilisation of such services further weakening the contribution story. Instead, the evaluation relied on qualitative obtained through FGDs and case studies on the outcomes of MTV Shuga.

## **Findings**

### Relevance

1. The MTV Shuga programme was strongly aligned to the Government of Botswana's HIV response and prevention framework – the third Strategic Framework. Use of multiple channels of communication (Interactive Voice Response platforms (IVR), radio, social media (Facebook and WhatsApp) interpersonal communication (through peer educators) allowed for various categories of AYP with differing resourcing to access behaviour change messages.
2. Content delivered through these platforms was relatable for AYP and applicable in varying context although in some instances such as in Okavango some adaptations were necessary to address specific cultural context. Content for IVR and interpersonal sessions were modelled from extensive research on drivers of new HIV infection among AYP and understanding the motivations for risky sexual behaviours among the group undertaken in the pilot first phase of the programme. However, content for social media platforms was not standardised and driven by district level online peer educators. While such an approach can affect the quality and depth of behaviour change communication, the use of young people within districts to drive the online engagements made the content relatable for AYP in those contexts.
3. Young people, through peer educators, led delivery of the programme in particular interpersonal communication and social media platforms enhancing the effectiveness of communication.
4. While the programme targeted in school and out of school AYP, the design was more effective in retaining in school than out of school AYP in the programme. For out of school AYP, the lack of integration with livelihoods or economic empowerment initiatives removed motivation for their continued participation in the context of other competing needs. Also, when refreshments were provided for meetings, attendance by out of school AYP tended to increase. However, there was no budget for this in the programme. In Selibe Phikwe and Okavango peer educators made arrangements with local NGOs HPP and BOCHAIP respectively for venues for holding sessions with

out of school AYP. While this was commendable it was only for one locality in each district with space for holding sessions for out of school a challenge throughout the programme period across all districts. On targeting again, the programme could have been effective by adopting differentiated approaches, especially after delivery of the nine sessions, to support behaviour change for those most at risk AYP. This could have been supported by more effective risk profiling of participants.

5. IVR platform also struggled to keep listeners logged in for majority of sessions as the number of listeners for the last session decreased by 90% from the first session (approximately 32,000 to 2,000). However, majority of participants had received two sessions on the platform.
6. Peer educators were well trained and perceived to be effective by Guidance and Counselling (G&C) teachers and AYP (in-school and out of school) in delivering sessions. Because of their effectiveness peer educators were being allocated more time for sessions in schools including requests for them to address other issues not necessarily part of their focus e.g., bullying and drug abuse. However, in Boteti and Okavango districts, Peer Educators had challenges in reaching out to some hard-to-reach areas for the out of school AYP and their engagements with their caregivers/parents due to transport constraints.
7. Programme learned and adapted during implementation. One adaptation was the integration of parent to child communication to improve the enabling environment for AYP behaviour change which led to expansion of the sessions from seven to nine. Attendance of parents to these sessions was low due to a poor community mobilisation strategy that failed establish meaningful relationships with community leaders.

#### Gender and equity

8. The programme design document recognised the importance of gender but fell short of providing specific strategies to make the programme gender responsive beyond the session content. Despite this, during implementation, several initiatives were put in place to enhance gender responsiveness including recruitment of equal numbers of male and female peer educators, data collection included sex disaggregated data, and implementation of gender specific interventions such as targeting teen mothers or “boys’ and girls’ talks”. Majority of these initiatives were district specific and adhoc. Gender responsiveness of the programme could have been improved by the collection of session experiential data to address gender specific concerns in session delivery, and collection of additional demographic data for session participants such marital status, childbearing etc to support differentiated support.
9. Disability was not considered in the design and implementation of the programme. Peer educators had no capacity handle children with disabilities and therefore generally avoided them. In schools where there was some existing capacity or initiatives to support children with disabilities such as at Lebogang Junior Secondary School (JSS) some support was provided to PEs to handle such children.
10. Equity was considered in the selection of districts which ensured urban, rural and hard to reach areas were selected for the programme. While this was commendable resource allocation did not consider the additional costs incurred for reaching out to AYP in remote areas which compromised quality of delivery of the programme in such areas e.g., Shakawe in Okavango.

#### Effectiveness

11. The MTV Shuga programme improved the capacity of AYP to delay sex and practice safe sex (4.9%,  $p\text{-value}=0.000$ ) as well as gender equitable attitudes in relationships (13.1%,  $p\text{-value}=0.000$ ). It had a negligible effect on improving AYP’s attitudes towards intergenerational and transactional sex (0.6%,  $p\text{-value}=0.7975$ ). The main challenge for this was males whose views of intergenerational

and transactional sex did not change. For female AYP, an increase of 3.1% had improved attitudes on intergenerational sex compared to 1.8% for males. However, AYP's perceptions of transactional sex did not improve with a high proportion of over 80% of MTV Shuga participants still maintaining that it was reasonable for a partner to expect sex in exchange for money or gifts. Therefore, while negative attitudes towards risky sexual behaviour changed slightly, the programme had a greater effect in building capacities of AYP to practice safe sexual behaviours within those relationships (ability to negotiate safe sex, that both males and females should carry condoms etc.).

12. MTV Shuga in Botswana had a greater effect on females than males. This is important in the context of equity as new HIV infections were high among female AYP. Nonetheless the effect changes were marginal primarily as a result of limited engagement of session participants post completing the standard 9 sessions as discussed earlier. The initiative by PEs in Boteti to reinforce behaviour change through creating platforms for engaging those AYPs that demonstrated emerging behaviour change is an emerging practice that could be explored for other districts.
13. While there was a 4% change in the proportion of AYP "*intending to go for an HIV test in the next three months*" after the post session survey, the overall proportion of 29% of participants was still very low showing a lingering reluctance among AYPs.
14. The MTV Shuga programme failed to achieve the targets of any of the outcomes. However, output indicators were achieved for some outputs e.g., *Programme Output 2: Effective and efficient project management*. The best performing indicator was "*Percentage of adolescent boys who hold gender equitable attitudes*" which was 0.8% short of the target. This was followed by the indicator, "*Percentage of AYPs who demonstrate intention to demand safe sex under pressure*" which was 10% off the target. The programme was able to reach 8,250 AYP instead of the target of 10,000 primarily due to challenges with mobilising out of school AYP.
15. There were cases of young people that had changed their behaviour e.g., stopping transactional sex, intergenerational sex, drug, substance, and alcohol abuse. Mary's story (Case study 1) demonstrates the effect the MTV Shuga sessions can have on behavioural outcomes of adolescents and young people. The session delivery approach and its content can have a profound effect on changing risky sexual behaviour as observed in Mary's story. However, cases of such behaviour change, as noted by PEs were still few. This could be a result of limited follow of the MTV Shuga cohorts by PEs or the limited engagement of the same cohort post 9 sessions of MTV Shuga.
16. Several factors contributing to the programme's effectiveness including:
  - a. PEs' ability to deliver the programme sessions effectively.
  - b. Varying levels of support provided to PEs by District AIDS Coordinators (DACs) helped improve PEs' work through linkages to other important stakeholders and provision of office space etc.
  - c. PEs' relationships with schools ensured access to adolescents.
  - d. Availability of multiple virtual or online communication channels allowed the programme to adapt quickly to COVID-19 restrictions. Virtual PEs were able to reach 21,297 AYP with behaviour change messages, 92,983 AYP were reached through various IVR platforms, and 8,250 were reached through physical interaction with PEs.
17. Challenges undermining effectiveness included:
  - a. A PE to AYP ratio of 1:295 may have been too high for PE's effective interaction with AYP.
  - b. Nine (9) sessions were inadequate to facilitate behaviour change and needed to be supported with additional risk-based support to AYP.

- c. Out of school AYP were difficult to motivate to stay on the programme and therefore the MTV Shuga programme was not successful with this group.
- d. Module content was adaptable across districts but could have addressed some context specific issues and other areas to support behaviour change.

#### Efficiency

18. While the PEs created strong relationships with DACs linkages and coordination with other critical stakeholders were weak. For education, PEs had close working relationships with schools but less so with the district education office. This posed challenges when school access was denied as occurred in Ghanzi and in Shakawe, Okavango. Limited linkages with the youth ministry were a lost opportunity to create synergies with livelihoods or economic empowerment interventions of the ministry. While Makgabaneng tried to foster these relationships through engagement of all stakeholders at the onset of the programme in each district this was not followed through by PEs as there was a lack of a standard stakeholder engagement strategy they could follow.
19. Makgabaneng was responsible for programme implementation in the districts for the peer education programme and UNICEF for the IVR platforms through Viamo Inc and the radio programme. Quarterly meetings between UNICEF and Makgabaneng were held to support review and planning. These were informed by PE reports, quarterly monitoring and supportive visits undertaken by Makgabaneng and joint monitoring visits conducted with UNICEF and NAHPA. Refresher trainings were also used as points of reflection. However, coordination of the programme could have more systematically involved NAHPA through the structured quarterly meetings to ensure they kept abreast of the programme implementation. This would have added to the involvement of NAHPA in training of PEs.
20. Peer educator training was conducted through a Training of Trainers approach, with quality assurance being provided by MTV SAF. PEs generally appreciated the scope and content of the training they received but viewed the duration as too short.
21. Adaptation of the programme to incorporate virtual communication platforms increased reach even in the face of restrictions on physical interaction to contain the COVID-19 pandemic but required additional support to be effective. This included (1) provision of audio and visual content to support communication on Facebook and WhatsApp for the virtual PEs, (2) integration with social mobilisation using community leaders and influential people to increase access by AYP, and (3) unavailability of pre and post exposure questionnaires for participants made the work of virtual PEs unmeasurable.
22. While virtual platforms with their high reach are more likely to be cost efficient (e.g., 93,000 were reached with virtual platforms compared to 8,000 from the in-person peer education over the same period). Results from the IVR show similar or better performance on selected indicators when compared to in-person peer education. Season 1 of the IVR had impact on attitudes towards transactional sex, condom use and capacity to negotiate safe sex. Season 2 had an impact across all indicators including on HIV testing which lagged among participants in the physical peer education programme. Given that the numbers reached by the IVR platform are over ten times that of the physical peer education programme, the former is likely to result in shifts in attitudes and capacities among larger population of AYP. It is therefore likely to be more cost effective. However, all the channels are required. While the virtual communication channels may appear to be more cost effective, they may not be best to deliver equity as some AYP were unaware or did not have resources to access these platforms. A differentiated approach is necessary accompanied by risk profiling to address specific needs of AYP to achieve behaviour change. This is difficult to achieve with mass communication and would need to be supported by social mobilisation through the physical peer education programme.
23. The programme's data collection framework was aligned to its results framework with data being used to inform programme changes. Areas for improvement were performance feedback to PEs and local stakeholders, and collection of qualitative data on behaviour change.

## Sustainability

24. NAHPA has demonstrated readiness (willingness and capacity) to integrate the MTV Shuga programme scope into its roll out plans, without external support. The MTV Shuga programme (primarily the peer educator programme) was incorporated in the current round Global Funding cycle for Botswana under the HIV prevention pillar and within the behaviour change communication thematic area. The funding will enable scale up of the programme in all high-risk districts. Furthermore, NAPHA has included the MTV Shuga programme under its HIV response social contracting modality. Makgabaneng provides technical leadership working with CSOs in four additional districts implementing the full package of the MTV Shuga peer educator programme. The programme budget is BWP16 million.
25. Integration of the PEs sessions with G&C sessions served as a good entry point for comprehensive sexuality education. There was limited integration with health facilities. While PEs are well recognised as an important stakeholder, the MTV Shuga programme was not always included in the district evidence-based HIV annual plan e.g., in Okavango it was included while in Selibe Phikwe it was excluded.
26. DACs, G&C teachers, and PEs have demonstrated readiness to continue supporting the programme but require more orientation or sensitisation on additional programme components.
27. The adoption of MTV Shuga as part of the national HIV response is testament to the success of advocacy efforts by UNICEF for national ownership and effectiveness of the technical support from MTV SAF.

## **Conclusion**

MTV Shuga programme has provided a model design that is feasible, acceptable, and implementable without external funding through PEs, schools, and communities. It can be easily scaled as it is applicable in multiple contexts of Botswana. The multiple communication channels provide the programme the unique ability to reach a broad range of AYP with behaviour change messaging. The evaluation demonstrated that the programme in its current state can build capacities of AYP, especially females, to negotiate and practice safe sex and support more gender equal attitudes within sexual relationships. However, what remained in the programme is to ensure with this capacity AYP can overcome the barriers that undermine positive behaviour. This is where the programme needed to invest more through differentiated approaches that addressed the unique needs of the most at risk AYP. The current model has also failed to sustain engagement with out of school AYP and requires re-designing to integrate economic livelihoods and linkages with health facilities whilst strengthening differentiated PE approaches and parent-AYP engagement.

## **Lessons learned**

Below are the lessons have been learned from the implementation of the MTV Shuga programme in Botswana:

**Lesson 1: Out of school AYP require incentives or additional motivation to participate in MTV Shuga sessions.** The programme faced challenges in mobilising AYP as they found the opportunity cost high or just lacked interest to meet and talk about "*HIV and teenage pregnancies*". When refreshments were introduced during meeting sessions participation in the programme increased. The motivation must be a basket of interventions to support the diverse needs of AYP.

**Lesson 2: A programme targeting AYP must remain adaptable and agile to remain relevant.** The MTV Shuga programme in Botswana was implemented through a changing context at national and micro level. The advent of COVID-19 led to introduction virtual peer education programme which has continued post COVID-19. When visual TV episodes were not working due to vandalism of electrical

facilities in schools the programme had to quickly change to using radio sessions. The programme kept on adapting through its life cycle in this way it remained relevant to the needs of AYP.

**Lesson 3: Using multiple channels of communication increased the breadth of reach for the programme and its ability to influence change among targeted AYP.** However, they should not operate in isolation but complement each other. Over the course of the programme the various channels reached over 200,000 AYP of varying backgrounds and circumstances in Botswana. Use of multiple communication channels increases the chance of being successful in achieving outcomes. Exposure from social media had the potential to be reinforced through the in-person peer education programme. Referrals can occur from the virtual platform to the in-person interaction enhancing the effectiveness of both platforms.

**Lesson 4: It is not only important to ensure introduction of the programme at district level at the commencement of the programme is key but to complement this with a regular monitorable plan for engagement.** This will make implementation easy and make stakeholders to be part of the project. The programme was formally introduced at the districts in June 2020 whereas the PEs started in December 2019. Second even with the introductory meetings relationships between PEs and stakeholders were not fully established which affected implementation of the programme.

**Lesson 5: For in-school sessions use of G&C sessions were found to be ideal as they proved less disruptive of the school academic calendar.** In schools, the use of guidance and counselling lessons were explored. This was to enable the lessons to be utilised for the sessions. With the curricular affected by COVID- 19, more time was allocated to classes therefore the use of G&C classes was ideal less disruptive to the catch-up programme employed by schools. The worked collaboratively with the school to map a plan for sessions using the school planner. to slot the sessions in the G&C classes.

### **Recommendations**

Below is a summary of the proposed recommendations to enhance implementation of a future programme:

**Recommendation 1:** A future programme should revise the programme module to include ART adherence, Post Exposure Prophylaxis. It should also allow for provisions for adaptation after rapid situation assessments to ensure unique context specific drivers are considered including content and reach for certain AYP population groups with tailored messages e.g., the Basarwa in Okavango.

**Responsibility: NAHPA**

**Recommendation 2:** Enhance the parent and AYP engagement module by developing guidelines and support for social mobilisation to support community buy in of the programme as a pillar for effective parent involvement. This needs to be complemented by community-based Caregiver - AYP dialogues to facilitate common understanding and break silence for discussions at household/family levels.

**Responsibility: Makgabaneng**

**Recommendation 3:** There is need for the programme to advance beyond the 9 sessions. The components are already there e.g., motivational talks, meetings with AYP beginning to demonstrate behaviour change, differentiated targeting e.g., teen mothers etc. This needs to be harnessed and provided in a structured handbook and guidance for PCs and PEs to effectively use these instruments to achieve behaviour change. **Responsibility: Makgabaneng.**

**Recommendation 4:** There is need for the programme to have a stakeholder engagement strategy and guidelines that PEs follow to ensure all necessary stakeholders are engaged effectively. This should be

supported with mechanisms for monitoring and supporting engagement. **Responsibility: Makgabaneng.**

**Recommendation 5:** There is need consider the additional cost burden for onboarding remote areas onto the programme to ensure effectiveness in delivery. **Responsibility: NAHPA.**

**Recommendation 6:** The programme needs to develop a standard PE:AYP ratio that ensures efficiency and effectiveness in the delivery of support by PEs. This is especially so in the context of any additional load with differentiated support. **Responsibility: NAHPA.**

**Recommendation 7:** A future programme needs to put in place a local sustainability plan that involves building capacity of the education office and schools and DACs in the MTV Shuga programme content and delivery. This should be supported with mechanisms to influence incorporation of the MTV Shuga concept in the annual Evidence plans and the education office district plans as well. **Responsibility: Makgabaneng.**

**Recommendation 8:** A multi-pronged approach to incentivise participation needs to be employed by the programme, to include:

- a) facilitating linkages with opportunities for economic and livelihood opportunities through engagement with Ministry of Youth, and private sector
- b) support provision of certificates after completing the standard MTV Shuga sessions
- c) Consider provision of refreshments where feasible with adequate fiduciary risk management.
- d) facilitate the identification of venues to hold the sessions preferably with the visual than on radio to increase the appeal.

**Responsibility: Makgabaneng.**

**Recommendation 9:** the programme need to support the current monitoring system with mechanisms to support outcome monitoring:

- a) consider introducing annual outcome surveys that target the cross-section of recipients of the MTV Shuga support (virtual and in person participants)
- b) introduce qualitative data aimed at understanding the change the attitudinal and behavioural outcomes occurring and how the programme is contributing to them.

**Responsibility: NAHPA.**

**Recommendation 10:** There is need for structured feedback loops at district community and levels and from implementing CSO to PCs on performance. This will keep stakeholders engaged and motivated for the programme. **Responsibility: Makgabaneng.**

**Recommendation 11:** The programme needs to put in place the following to support improvement of session delivery and support of participants to facilitate behaviour change:

- a) collect participants experiential data with the aim of improving session delivery.
- b) collect risk profiling data for participants.
- c) include collection of disability inclusion data to support disability inclusion in the programme.

**Responsibility: Makgabaneng.**

## **1 Introduction**

This report presents findings for the Evaluation of MTV Shuga in Botswana covering the period 1 January 2020 to 31 December 2022. The evaluation was undertaken by Muthengo Development Solutions on behalf of UNICEF and National AIDS and Health Promotion Agency (NAHPA).

This report provides details of the scope of the evaluation, its methodological approach used to draw evidence for the evaluation's conclusions and recommendations. The findings of the evaluation process are presented according to the evaluation criteria of Relevance, Gender and equity, Effectiveness, Efficiency and Sustainability. Conclusions and recommendations for improving a similar programme in the future are also provided. The evaluation report is also a culmination of several validation processes held with stakeholders of the programme to validate and verify the findings as well as building acceptance of the recommendations.

## **2 Background**

### **2.1 Context**

National HIV estimates, and projections indicate that Botswana has the fourth highest level of HIV prevalence in the world. In 2022, according to Botswana HIV/ AIDS Impact Survey (BAIS V) prevalence of HIV of 2022 among adults in Botswana was 20.8%, which corresponds to approximately 329,000 adults living with HIV. While females in the general population carry the heavier HIV burden (26.2% among females and 15% among males), young women and adolescent girls are more affected. The HIV prevalence for adolescent girls of 15-19 years age was about double that of the boys (1.6% compared to 2.7%). The disparity is higher in the 20-24 age group with HIV prevalence of young women, at 6.7% being more than double that of young males at 2.7%. According to the Botswana HIV/ AIDS Impact Survey (BAIS V) prevalence of HIV of 2018, an estimated 8,510 new HIV infections occurred in 2018 being 33% among young people aged 15-24 years. This accounted for 3 in every 10 new infections that occurred during that year.

Sexual abuse and violence against children have been reported to be major issues among adolescents (Botswana Youth Risk Behavioural and Biological Surveillance Survey II, 2016). In this regard, almost 19% of sexually experienced students were forced to have sexual intercourse during 12 months prior to the survey. One-third of sexually experienced students had sexual intercourse for the first time before age 13 years, with 22% of them reporting being forced to have sexual intercourse. The report indicates that 13.4% of girls reported having been pregnant. Furthermore, according to the Violence Against Children's Study, 6 to 9% of young people ages 18 to 24 years have experienced sexual violence and 14% experienced emotional violence. Among adolescents 13 to 17 years of age, 4 to 10% have experienced sexual violence and 12% have experienced emotional violence.

Comprehensive knowledge of HIV among adolescents and young people aged between 15 and 24 years is generally low, estimated at 47.9% (Botswana AIDS Impact Survey, 2013). Progress in reducing new HIV infections among adolescents and young people is further constrained by intergenerational & transactional sex, peer pressure, stigma & discrimination, and gender-based violence. Barriers include entrenched harmful gender norms, gaps between policies and their implementation and inadequate resource allocation for prevention programmes. These factors call for strategic, relevant, and appropriate interventions for adolescents and young people to reverse and mitigate the impact of HIV and AIDS.

Against this background and in alignment with the Third National Strategic Framework (NSF) for HIV and AIDS in Botswana (2019-2023), UNICEF and the National AIDS and Health Promotion Agency (NAHPA) worked together from 2018 in Partnership with MTV Staying Alive Foundation to adapt the MTV Shuga Programme as a behaviour change communication strategy to help adolescents and young

people adopt safe sexual behaviour by targeting key drivers of new infections and non-adherence to ARV treatment. The programme directly responded to the need to address barriers to reduction of HIV prevalence among adolescents and young people and especially girls and young women as recognised in the NSF for HIV and AIDS (2019-2023).

## 2.2 Description of the project

The MTV Shuga programme is an award-winning TV programme in Africa and Asia, that uses edutainment as a model to showcase challenges of young people in different contexts with the aim to provide behaviour change content to adolescents and young people. Aligned with the Third National Strategic Framework for HIV and AIDS in Botswana, the programme was initially introduced by National AIDS and Health Promotion Agency (NAHPA) through the national Botswana television in 2011 and later reintroduced on radio with the support of UNICEF in 2018 with the goal of reaching adolescents and young people with behaviour change content focusing on safe sexual behaviour (delayed sex debut, prevention of transactional and intergenerational sexual relationships) and uptake of HIV services. As such, it was implemented through a collaboration mainly between UNICEF and the NAHPA, in partnership with MTV Staying Alive Foundation.

The programme budget was US\$1,724,696.00.

The MTV Shuga programme was a catalytic initiative linked to UNICEF's Country Programme Outcome 2 which seeks to ensure that by 2026, adolescents and young people (10–24 years), particularly the most vulnerable, will be more empowered and engaged to access quality and gender-responsive HIV, health, nutrition, education, and child protection services. The programme also addressed sustainable development goal 3 (SDG 3), on ending HIV and AIDS epidemic by 2030.

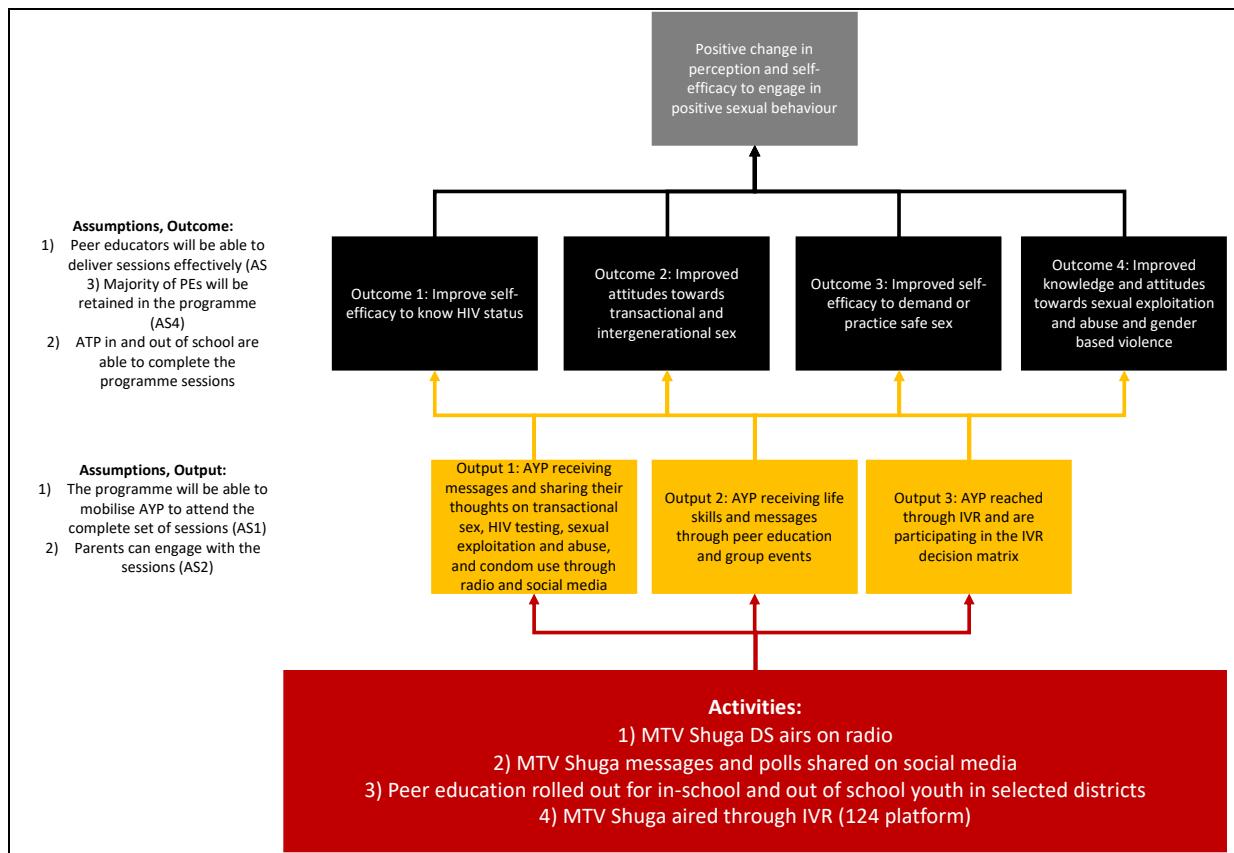
The programme was adapted and implemented as a behaviour change communication strategy to help adolescents and young people adopt safe sexual behaviour by targeting key drivers of new infections and non-adherence to ARV treatment. Objectives of the programme were to improve:

- i. self-efficacy to know HIV status and access sexual and reproductive health services;
- ii. attitudes towards intergenerational and transactional sex;
- iii. attitude and self-efficacy to demand or practice safe sex; and
- iv. knowledge and attitude towards sexual exploitation and abuse (SEA) and gender-based violence (GBV).

The programme's theory of change posits that:

*if MTV Shuga messaging and support is delivered through multiple channels: radio, peer educators, and Interactive Voice Response (IVR) targeting both in- and out-of-school adolescents and youth, more adolescents and young people will receive knowledge and skills to avoid transactional sex, undertake HIV testing, avoid or report sexual exploitation and abuse (SEA) and gender-based violence (GBV) and use condoms which will then lead to: 1) improved self-efficacy to know HIV status; 2) improved attitudes towards intergenerational and transactional sex; 3) improved attitude and self-efficacy to demand or practice safe sex; and 4) improved knowledge and attitudes towards SEA/GBV. These will ultimately lead adolescents and young people practicing safe sexual behaviour.*

**Figure 1: Summarised theory of change of the MTV Shuga programme**



### Programme components

The MTV-Shuga peer education programme, was piloted in two districts in 2019 and scaled up to four districts in 2020 (Seliibe-Phikwe, Boteti, Ghanzi and Okavango (Shakawe and Gumare) districts). With the advent of COVID-19, virtual peer education (through social media platforms) programme was introduced in Botswana in 2020 to ensure continuous access to information and services among AYP during this period. As such, below are the various adaptations to the MTV programme, to secure a comprehensive reach – especially to deepen impact of the radio programme and improve access in remote rural and peri-urban areas:

- i. **Radio:** The Drama series were an adaptation of MTV Shuga Down South with episodes of about 7-10 minutes, followed by in studio discussions by young people for some of the episodes so that the messages portrayed can be buttressed and to spark issues of discussion by audience. The programme aired on Radio Botswana 2 (RB2) FM and Yarona FM which are the 2 leading youth radio station and have a wider geographic coverage, especially RB2 fm.
- ii. **Interpersonal communication:** Peer education component specifically aimed to promote and support the adoption of positive behaviours, mitigate the impact of and prevent HIV, sexual exploitation, and abuse (SEA) and gender-based violence (GBV) among adolescents and young people (AYP) from within and around Seliibe-Phikwe, Boteti, Ghanzi and Okavango (Shakawe and Gumare) districts. The model used the MTV Shuga Peer Facilitation Guide which contained 7 sessions which were increased to 9 sessions that each group of participants have to complete to be classified as being fully exposed to the MTV Shuga Peer education Programme. Pre-assessments were run by the facilitators from the beginning and post assessment done at the end of the 9 sessions for each group. This component was done by an implementing partner, Makgabaneng, with the support of both UNICEF and National AIDS and Health Promotion Agency (NAHPA) as technical and funding partners. Twenty-four (20 Peer educators and 4 Peer coordinators) volunteers were locally recruited, trained, and worked in close collaboration

with district authorities to implement the MTV-Shuga peer education programme for in and out of school youth in the four districts.

The programme intended to train four peer coordinators (one per district) and twenty peer educators for face-to-face interaction and support across the four districts, whilst mentoring and coaching them to strengthen their agency, leadership, and communication skills, for meaningful engagement and participation in decision making processes. The peer educators were also designed to utilise the revised peer education manual (now with additional sessions on peer face to face interaction and engagement with parents and teachers). The other components which were covered during the trainings or refreshers were on social media literacy, sexual exploitation, abuse, and COVID-19.

*In-school sessions:* In Ghanzi, Itekeng JSS, Ghanzi SSS and Ghanzi Brigade were the targeted schools. In Okavango, the targeted schools were the following: Okavango JSS, Shakawe JSS, Shakawe SSS, Ngambao JSS, Popagano JSS, Okavango Brigade and Ngethu Brigade. In Boteti the schools of scope were Ditsweletse Junior Secondary school Motsumi Junior Secondary School and Orapa Junior Secondary School and Letlhakane Senior Secondary school. The target schools in Selibe Phikwe district were: Boikhutso Junior Secondary School, Lebogang Junior Secondary School, Makhubu Junior Secondary School, Meepong Junior Secondary School, Mojamarago Junior Secondary School, Phatsimo Junior Secondary School and Selibe- Phikwe Senior Secondary school.

*Out of school sessions:* The out of school sessions comprised of youth within the districts. These included football clubs, traditional dance groups, drama groups, choirs just to mention a few. The groups met at their agreed convenient time and location with the peer educator. The groups in the four districts were young stars (Selibe- Phikwe), Banyana Banyana football club (Letlhakane)and in Okavango and Ghanzi, a mix of local youth formed part of the sessions. In Gumare, the youth convened at 6 BOCAIP, in Seronga they convened at Okavango Community Trust and in Ghanzi they convened at Rollen Academy.

Peer educators also conducted district level advocacy campaigns on issues affecting AYP. They also implemented community outreach activities such as motivational talks, one on one session with girls, house to house campaigns, addressing of primary school students, born fire, Youth Dialogues, GBV cycling campaigns, Arts workshops, and cultural festivals.

iii. **Interactive voice response (IVR):** Episodes of the MTV Shuga drama series were uploaded to the interactive voice response (IVR) platform known as 124, for audience to listen to at their own time in case they missed the radio show. Also, a ‘choose-your-adventure’ game was introduced to the platform for improved interaction with audience. The game allowed young people to choose characters they like and personify the character’s decision making process and listen to how their story ends. This approach magnified the significance of decision making by young people, elevating them to be more conscious in their decision making about key themes of the drama series.

District	Villages/ Town	No. of peer educators
Selebi Phikwe	Selebi Phikwe	6
Boteti	Lethakane	3
	Orapa	1
	Rakops	1
Ghanzi	Ghanzi	1
	D'kar	1
	Grootlartle	1
Okavango	Shakawe	2
	Gumare	2
	Etsha 6	1
	Seronga	1
<b>TOTAL</b>		<b>20</b>

iv. **Social Media:** With the advent of COVID-19, the programme adopted virtual peer education approaches to ensure and sustain service demand generation and uptake by adolescents and young people. The 2020 lockdowns that came due to COVID-19 stopped the implementation of the face-to-face sessions in the four districts. The use of social media platforms such as WhatsApp and Facebook became key in implementation and for the continuation of the programme. As such, online meetings were held with peer educators using WhatsApp to engage and monitor progress on the online tasks given. These included holding bi-weekly meetings with Peer Coordinators, COVID-19 sensitisation campaigns through Facebook and WhatsApp, Peer Education sessions using WhatsApp and sharing Youth Motivational videos on Facebook and WhatsApp platforms. Virtual peer education using Facebook also helped in disseminating and engaging young people about the programme.

In 2020, the implementation coverages were as follows: 1) In Selibe-Phikwe, the project solely focused on the town, six junior schools and one senior secondary school; 2) In Boteti, implementation was focussed on Letlhakane and Orapa areas; 3) In Okavango, Gumare, Shakawe, Sepopa and Seronga and 4) In Ghanzi the focus of implementation was only on the town. However, by the end of 2022, the programme had been expanded to more remote and underserved areas/villages, as well as new schools and tertiary education institutions, within the districts. Makgabaneng programme reports show that in 2021, 21 297 AYP

were reached through virtual

peer education whilst 4363 AYP (52.3% females) were reached through face-to-face peer education across the four districts. Majority (56.4%) of the participants reached through face to face were aged 15-19 years, followed by those aged 10-14 years with 39.6%. By end of 2021 and August 2022, 7000 and 8250 (82.5% of the target) adolescents and young people (AYP) had been reached, respectively through the face-to-face peer education component whilst over 10000 AYP had been reached through the social media platforms across the four districts. By the end of 2022, 56 682 had been reached through virtual peer education. The peer education component was rolled out to more districts such as Chobe, Goodhope/Lobatse, Kweneng, Gaborone and Francistown with support from UNICEF, NAHPA and Makgabaneng, through a social contracting partnership arrangement from NAHPA.

#### **Programme stakeholders**

The MTV Shuga programme had diverse stakeholders at national and district level as presented in Table 1. These included: UNICEF, NAHPA, MTV Staying Alive Foundation (SAF), Makgabaneng, Botswana Insurance Holdings Limited (BIHL), and Ministry of Education and Skills Development among others.

**Table 1: Partnership arrangements and roles**

Stakeholder	Role
<b>UNICEF</b>	<ul style="list-style-type: none"> <li>• Provides technical guidance on behaviour change strategies for the programme and coordinates all partners to ensure alignment and impact.</li> <li>• Coordination of Shuga Peer education partners i.e., NAHPA, BIHL, MTV-SAF and Makgabaneng on integrating programme into government system scale up and sustainability.</li> <li>• Project technical oversight and management.</li> <li>• Co- lead consultative meetings in the districts.</li> </ul>

Stakeholder	Role
	<ul style="list-style-type: none"> <li>• Support the recruitment, training, and branding of both virtual and district-based peer educators.</li> <li>• Support and undertake joint quarterly monitoring and support visits with NAHPA and Makgabaneng.</li> <li>• Project communication and documentation (photography, videography, documentary, story/ blogs).</li> <li>• Provide guidance and branding requirements.</li> <li>• Pre- approve all materials prior to execution in partnership with NAHPA.</li> </ul>
<b>NAHPA</b>	<ul style="list-style-type: none"> <li>• Custodian of the programme and provide national leadership of the programme.</li> <li>• Support engagement with districts and other government stakeholders involved in the programme including support to Makgabaneng to integrate the programme in the districts of implementation.</li> <li>• Pre- approve all materials prior to execution.</li> <li>• Support the recruitment of peer educators.</li> <li>• Support and undertake joint quarterly monitoring and support visit with UNICEF.</li> </ul>
<b>MTV- Staying Alive Foundation (MTV – SAF)</b>	<ul style="list-style-type: none"> <li>• Provides radio production services in collaboration with local production houses and develops the adapted peer education content for implementation including peer educator training.</li> <li>• MTV-SAF also provides M&amp;E tools design and implementation; a platform for data repository, analysis and a dashboard which can be accessed by partners for monitoring through the ODK app.</li> </ul>
<b>Makgabaneng</b>	<ul style="list-style-type: none"> <li>• The implementing partner that manages the day to day running of the Peer Education programme.</li> <li>• Recruits and contracts peer educators and manages their performance and programme delivery.</li> <li>• Leads documentation and publicity services for the Peer education programme.</li> <li>• Provides office space for the peer educators through partnerships and the network of already existing stakeholders and relationships, as an entry point for community mobilisation.</li> <li>• Facilitates integration of peer educators with various stakeholders that include Regional Education Officers responsible for the targeted schools, the District Commissioners (DCs), District AIDS Coordinators (DAC), District Multi Sectoral AIDS Committees (DMSACs), District Health Management Teams (DHMTs), Baylor Botswana, Sentebale, Tebelopele, other Non-Governmental Organisations and stakeholders in the targeted districts.</li> <li>• Organisation of district engagement and consultative meetings with key stakeholders.</li> <li>• Supervises the capturing of data on the monitoring tools and capturing of data on the ODK app.</li> </ul>
<b>BIHL</b>	<ul style="list-style-type: none"> <li>• Provided financial support particularly for the expanding Peer Education to remote and underserved communities.</li> </ul>

Stakeholder	Role
<b>Botswana Insurance Holding Limited</b>	<ul style="list-style-type: none"> <li>Supported AYP competition and awards ceremony.</li> </ul>
<b>Ministry of Education and Skills Development (MESD)</b>	<ul style="list-style-type: none"> <li>Provides guidance for the school-based intervention.</li> <li>Facilitate engagement and consultations with Regional Education officers.</li> <li>Participate in planning, district consultations, project implementation and oversight of activities.</li> </ul>
<b>Positive action</b>	<p><b>Programme project: supported by MTV SAF</b></p> <p>The programme was implemented in four months September- December 2022).</p> <ul style="list-style-type: none"> <li>The goal was to augment the implementation of the SHUGA peer education programme in the face-to-face sessions and Virtual sessions</li> <li>In addition to the monthly stipends for the Peer Facilitators, the project added a provision for merchandise for the Peer Facilitators, Tablets for data capturing and documentation of the programme and snacks for the out of school sessions.</li> <li>The project provided technical and financial support for the duration of four months (September to December 2022)</li> </ul>
<b>Peer Facilitators</b>	<ul style="list-style-type: none"> <li>Deliver MTV Shuga sessions and facilitate dialogue and support for in and out of school target.</li> <li>Report on the implemented sessions.</li> <li>Participate in the local district activities.</li> <li>Participate in TAC meetings.</li> </ul>
<b>G&amp;C teachers</b>	<p>The MTV Shuga sessions (for the in-school target) utilises the Guidance and Counselling classes.</p> <p>The Guidance and Counselling teacher's role includes:</p> <ul style="list-style-type: none"> <li>Support peer facilitators deliver sessions in school.</li> <li>Plan for sessions with the peer facilitators based on the school calendar.</li> <li>Technical support for peer facilitators</li> </ul>
<b>Traditional and other community leaders</b>	<ul style="list-style-type: none"> <li>Support peer facilitators in engagement with morafe/ community</li> </ul>
<b>Chief Education officer</b>	<ul style="list-style-type: none"> <li>Support with school entry for in school sessions.</li> <li>Engage with the schools (support letters for the Peer Facilitators to engage with students for the sessions.</li> </ul>
<b>District Health Team</b>	<ul style="list-style-type: none"> <li>Provide services and aids in referrals such as HIV testing, STI screening etc.,)</li> <li>Expert information provision in some sessions (where need be in sessions where the Peer Facilitator needs expert opinion for the session and explanation to the participants.)</li> </ul>
<b>District AIDS Coordinator</b>	<ul style="list-style-type: none"> <li>District engagement for the project implementation.</li> <li>Liaise with the peer facilitators and the stakeholders in implementation.</li> <li>Support for the peer facilitators in implementation</li> <li>Engages the peer facilitators in DMSACs.</li> </ul>

Stakeholder	Role
NGOs offering HIV testing e.g., BOCAIP and Tebelopele	<ul style="list-style-type: none"> <li>• Involve the peer facilitators in TAC meetings.</li> <li>• Provide HIV testing services to adolescents and young people in project's operational areas.</li> </ul>

## 2.3 Evaluation purpose

The evaluation purpose was stated in the Terms of Reference (ToR) as, “*to evaluate how well the MTV Shuga programme achieved its outcomes*”. The evaluation measured the outcomes of the MTV Shuga programme in all the four targeted districts. It also determined how effective the programme was in achieving its set targets. The evaluation results are intended to inform replication of the programme by the Government of Botswana in several districts of the country.

## 2.4 Evaluation objectives and scope

**Objectives:** The main objective of the evaluation was to undertake an outcome evaluation of the MTV Shuga programme. In particular, the evaluation intended to measure whether the programme resulted in:

- a) Improved behaviour changes to adopt safe sexual behaviour;
- b) Improved self-efficacy to practice safe sexual behaviour;
- c) Improved attitudes towards intergenerational and transactional sex;
- d) Improved gender equitable attitudes;
- e) Increased demand for health services; and
- f) Improved uptake of HIV Testing.

It determined the relevance and effectiveness of delivery models and communication channels utilised.

**Scope:** The evaluation covered the period 1 January 2020 to 31 December 2022. While the evaluation of outcomes covered all four districts, fieldwork was only undertaken in two districts. In accordance with the ToR, the evaluation scope was guided by the evaluation questions developed for five criteria: Relevance, Efficiency, Effectiveness, Gender and Equity, and Sustainability. Measurement of outcomes relied on secondary data from the programme's monitoring system (baseline, pre- and post-exposure assessments). No primary quantitative data was collected due to budgetary constraints. The evaluation also considered the effect of gender and geographical location on the intended outcomes of the programme.

## 2.5 Evaluation framework

An evaluation framework was developed to guide the evaluation presented in Annex 2.

## 2.6 Evaluation audience and users

The primary user of the evidence generated from the evaluation will be the **Government of Botswana through NAHPA** as the evaluation will inform the current scale up of the programme to other districts. NAHPA will ensure that lessons learned are documented and built into the current programme for better implementation. **UNICEF** will use the evidence to continue advocacy efforts towards ensuring adolescent and young people programmes for safe sexual behaviours are developed and implemented. This evaluation will also provide adolescent and young people programming sector invaluable evidence on how to implement a social and behavioural change for adolescent and young people in Botswana that is both relevant and sustainable. **Development partners** and other non-governmental organisations stand to benefit from the results of the evaluation as well on the use of peer approaches

to behaviour change and in alignment with other programmes targeting AYP such as DREAMS and Sky Girls.

### 3 Methodology

This section presents the evaluation methodology. It includes two broad sections on: 1) **evaluation approach** which provides key guidance for the evaluation and its overall framing and design; and 2) **evaluation methodology** which provides the specific details for data collection and analysis.

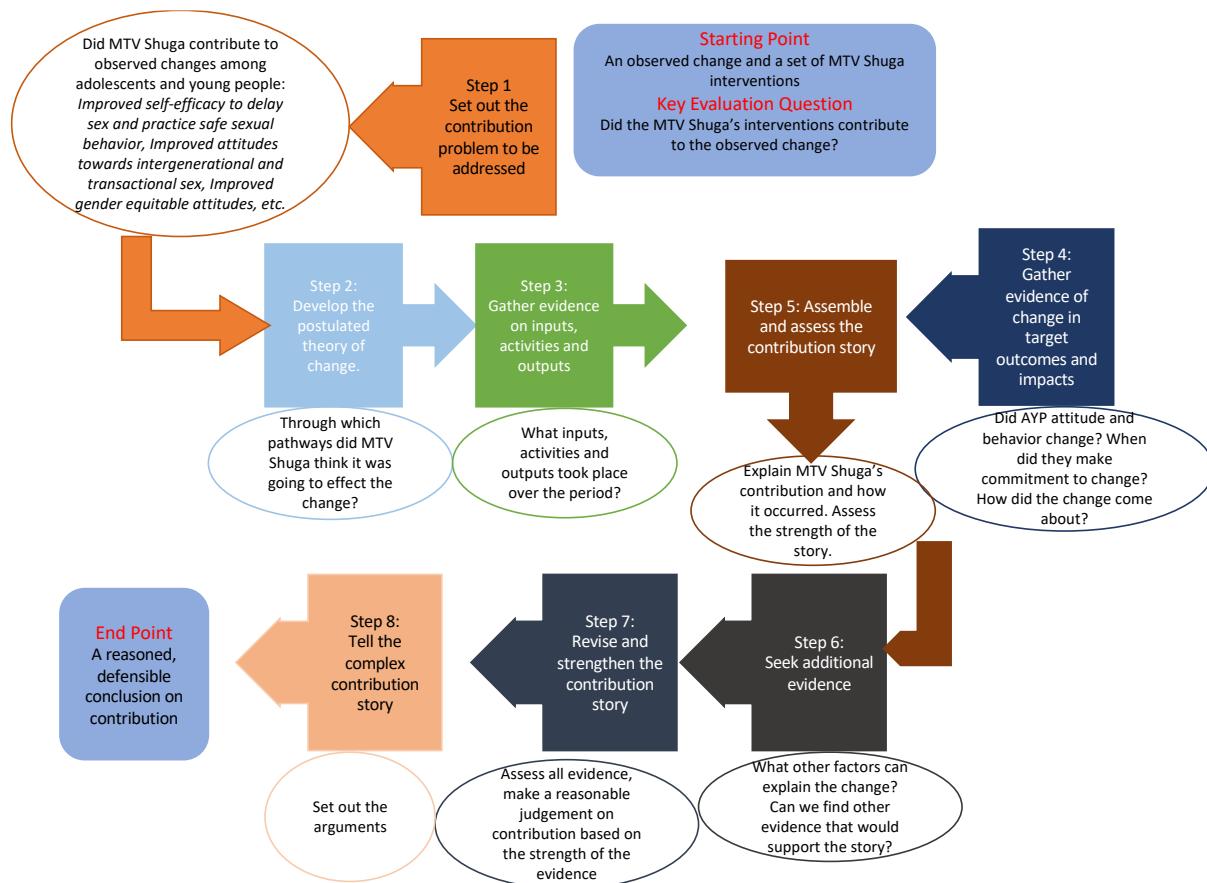
#### 3.1 Evaluation approach

The evaluation used mixed methods approaches premised on qualitative and quantitative data. Quantitative data was used to determine MTV Shuga's performance on envisaged outcomes while qualitative data was used to answer questions on relevance, efficiency, sustainability as well to validate and explore further outcomes of the programme.

The evaluation was designed on the premise of a contribution analysis approach where the evaluation did not seek attribution but rather how the MTV Shuga sessions and other support are contributing to observed outcomes. The evaluation utilised the contribution analysis methodology to help track emerging programme impacts/outcomes and determine the programme's contribution. Figure 2 provides a summary of the process for determining the contribution story for MTV Shuga.

This was the most relevant approach given that there was no impact design (control and treatment) provided at the onset of the programme and that the behavioural outcomes have multiple

**Figure 2: Contribution analysis**



Across all evaluation criteria the evaluation explored the extent to which the project design mainstreamed human rights, gender equality, disability, and equity.

### *3.1.1 Evaluation guidance and principles*

In general, the evaluation was guided by the following UNICEF and UNEG evaluation and research guidelines:

- United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation in the UN System 20161 (including impartiality, independence, quality, transparency, consultative process).
- Ethical Guidelines for UN Evaluations;
- UNICEF Ethical Guidelines and standards for research and evaluation and Ethical Research Involving Children;
- UNEG guidance on integrating human rights and gender equality and UN System-Wide Action Plan (UN-SWAP) on gender equality;
- UNICEF Guidance on Gender Integration in Evaluation;
- UNICEF adapted evaluation report standards and GEROS;
- UNICEF Guidance Note on Adolescent participation in UNICEF monitoring and evaluation; and
- Disability-Inclusive Evaluations in UNICEF: Guideline for Achieving UNDIS Standards

Principles of independence, impartiality, credibility, conflicts of interest, and accountability guided the evaluation.

**Independence, impartiality, and conflict of interest:** As independent evaluators, the evaluation team had no interest in the outcome of the evaluation and was not involved in the programme's implementation. The evaluation team's conclusions were not influenced by future gain or past involvement with the programme and its implementers.

**Credibility:** the evaluation ensured data collection followed the agreed scope of work at inception. The structure and content of the report was strongly influenced by UNEG Norms and Standards for Evaluation and UNICEF adapted evaluation report standards and GEROS.

**Accountability:** All evaluation outputs were validated with stakeholders of the programme providing them an opportunity to agree, disagree or seek clarifications on the findings and recommendations. Whenever there were disagreements in the findings, the evaluators sought additional evidence to retract the finding or strengthening their argument.

## 3.2 Evaluation methodology

The evaluation methodology was divided into quantitative and qualitative methodology. Overarching was literature review.

### *3.2.1 Secondary literature review*

A variety of secondary literature of the programme was made available to the evaluation team during the inception phase. This included programme documents on MTV Shuga from UNICEF and Makgabaneng, quarterly and annual programme reports from Makgabaneng, and various activity reports. This literature was used to inform the design of the evaluation, methods and data collection tools as well as the findings. The list of documents reviewed is presented in Annex 5. The information collected from secondary literature was verified with primary data from field visits, interviews, and workshops.

### *3.2.2 Quantitative evaluation*

The quantitative evaluation relied on secondary data from the programme's monitoring system (mainly pre- and post-exposure surveys, and monitoring reports). The quantitative evaluation focused on ascertaining achievement of the programme's outcomes. The main data source was the pre- and post-

exposure survey data. While there was potential to use clinical data on SRH service utilisation, for example, the contribution story for outcomes was weak and lower-level results were not fully achieved (See Section 3.4, Limitations of the evaluation).

### Data analysis

Secondary data from pre- and post-exposure surveys was analysed in accordance with the indicator definitions provided by UNICEF. Differences between the baseline and post-exposure survey was compared to ascertain the differences. The following **Indicator Analyses Definitions and Rationale** were used in coming up with the analysis logic.

There were seven (7) indicators that were analysed. Outcome 1 had 4 indicators, Outcome 2 had 2 indicators and Outcome 3 had 1 indicator. For each indicator, an adolescent was assigned “1” if he or she gave a response that matched the ones defined in the third column (**Analysis Definition and Rationale**) and a “0” if other response was given.

**Table 2: Indicator analyses definitions and rationale**

Outcome	Indicator	Analysis Definition and Rationale
<b>Outcome 1: Improved self-efficacy to delay sex and practice safe sexual behaviour</b>	Percentage of AYPs who report ability to demand safe sex under pressure.	AYPs responding to options <b>‘say nothing, refuse sex’</b> and <b>‘try to persuade, refuse sex’</b> are showing self-efficacy to demand safe sex, the latter being a high level of self-efficacy.
	Percentage of AGYW who feel at ease to report sexual abuse cases through formal structures, Child Helpline, Schools and etc.	AGYWs who chose the option <b>‘I disagree’</b> are considered to be finding it easier to report sexual abuse cases because to them the act of reporting would not create more problems for them.
	Percentage of AYPs with intention to go for HIV testing in the next 3 months.	AYPs who chose the option <b>‘Yes’</b> are the ones considered to be having intentions to go for HIV testing.
	Percentage of AYPs who have tested for HIV and know their status.	AYPs who chose option <b>‘Yes’</b> are considered to have accessed HIV testing services.
<b>Outcome 2: Improved attitudes towards intergenerational and transactional sex</b>	Percentage of AYPs who think it is not okay to date a partner that is 10 years older.	AYPs who chose option <b>‘I disagree’</b> are considered to be having correct attitude towards intergenerational relationships.  <b>NB:</b> please note that the question on the system says 5 years not 10 years, which may be the reason why most young people did not consider this to be qualifying as intergenerational or having high power dynamics for them
	Percentage of AYPs who do not think it is reasonable for a partner to expect sex in exchange for money or gifts.	AYPs who chose the option <b>‘I Disagree’</b> are considered to be having the correct attitude towards transactional sex/relationships.

Outcome	Indicator	Analysis Definition and Rationale
<b>Outcome 3:</b> Improved gender equitable attitudes	Percentage AGYW who think it is both boys' and girls' responsibility to carry condoms.	<p>AGYW who chose option '<b>Both</b>' are considered to be having gender equitable norms/ attitudes.</p> <p><b>NB:</b> <i>we had decided in the last 2 years that this the question that best measures the gender equitable norm as compared to others, but feel free to include others if needed.</i></p>

A cluster of indicators with correct responses ("1") were used to assess whether one will have achieved that outcome or not. The following reason or logic was used:

1. For Outcome 1, an adolescent was considered having "self-efficacy to delay sex and practice safe sexual behavior" if one had scored "1"s for the first 2 indicators and a "1" for the last two. For the last two indicators, it is either one has the intention to get tested or was tested and not all. The total score was 3. The proportion of those who scored 3 was therefore calculated and compared for the pre- and post-exposure data sets and this enabled us to come up the proportion of those with "Improved self-efficacy to delay sex and practice safe sexual behavior".
2. For Indicator 2, one was considered having "positive attitudes towards intergenerational and transactional sex" when he/she scored "1"s for all the two indicators. The total score was 2. The proportion of those who scored 2 was therefore calculated and compared for the pre- and post-exposure data sets and this enabled us to come up the proportion of those with "Improved attitudes towards intergenerational and transactional sex".
3. For Indicator 3, a score of a "1" for the indicators sufficed for one to be considered "Improved gender equitable attitudes". The total score was 1. The proportion of those who scored 1 was therefore calculated and compared for the pre- and post-exposure data sets and this enabled us to come up the proportion of those with "Improved gender equitable attitudes".

An adolescent was also considered to have achieved all the three indicators if he/she scored 7.

In all the three cases, calculation of the *p*-value using the *protest*<sup>1</sup> in STATA was used to find out whether there was a statistically significant difference between the pre- and post-exposure percentages. A *p*-value less than 0.05 indicates that the difference was statistically significant and worth considering as an effect of the programme whereas that greater than 0.05 would suggest that there was no major difference between the two compared pre- and post-exposure proportions.

### 3.2.3 Qualitative evaluation

The qualitative evaluation comprised Key Informant Interviews (KIIs), Focus Group Discussions (FGDs), Case Studies (using the Most Significant Change (MSC) approach).

**Key informant interviews:** Key informants were drawn from institutional stakeholders. These were purposively selected with those with the most knowledge of the programme being selected. A list of

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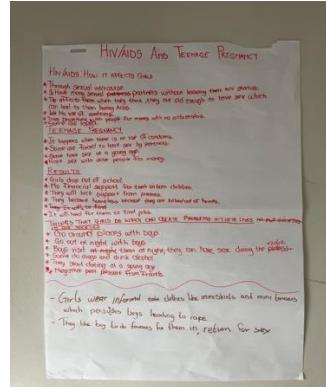
<sup>11</sup>*prtest* performs tests on the equality of proportions using large-sample statistics. The test can be performed for one sample against a hypothesized population value or for no difference in population proportions estimated from two samples.

key informants met during the evaluation is presented in Annex 3. Key informants from national level included UNICEF, Makgabaneng, NAHPA, BIHL, MTV-SAF. At the district level the following were consulted: Peer educators, DAC, Chief Education Officer, DHMT lead, G&C teachers, etc. See Annex 3 for list of people met and Annex 8 for the data collection tools.

**Focus Group Discussions (FGDs):** FGD discussants were primarily adolescents and young people (AYP) that went through the MTV Shuga sessions in- and out of school. Separate groups of males and females were interviewed with each group having a maximum of 10 and a minimum of 8 participants. FGD participants were divided into two age groups 15-18 and 19-24. The 19-24 were primarily out of school youths. Adaptations were made to the tools to ensure the tool could be completed in a reduced time. The tool was more participatory by including programme posters and problem analysis, other child friendly methods to gain deeper feedback in a shorter period. The FGDs included separate groups of male and female which were later joined together to discuss programme impact through project posters. Picture collage in Box 1 provides a sample of the process. These analyses became the entry points to discuss the evaluation questions in the AYP tool.

#### Box 1: Child sensitive data collection methods

##### Girls doing HIV infection problem analysis      Complete HIV infection problem analysis for girls



##### Mixed group doing a programme poster



##### Complete programme poster



**Case study interviews:** these in-depth discussions were held with selected participants of the MTV Shuga programme that demonstrate changes in the outcome domains of the programme. Case study interviews sought to ascertain how the MTV Shuga contributed to the change in knowledge, attitudes and behaviour observed in the individual. A balance between male and female was maintained. While disability was considered, the programme did not include persons with disability.

#### Sampling and sample sizes

Only two districts were visited for primary data collection. After conducting initial discussions with NAHPA and Makgabaneng, two districts – Selibe Phikwe and Okavango were selected. The selection was based on the need to have two districts that can provide a representative context of the project

implementation. The two districts provided urban area programming (Selibe Phikwe), rural and remote area (Okavango). Selibe Phikwe provided additional performance context – where there is a high concentration of actors aiming to reduce HIV incidence among adolescents and youth – providing the evaluation additional analysis on programme contribution to outcomes in such contexts. Okavango, in addition to providing remoteness, it was also viewed as a successful district. This provided the evaluation an opportunity to explore what success meant for MTV Shuga and what made it successful. Within Okavango, Gumare and Etsha 6 were selected as the locations for the evaluation in addition to Lebogang and Meepong in Selibe Phikwe. Selection of the locations was undertaken in collaboration with Makgabaneng to ensure urban, rural, and remote dimensions were included. Therefore, four wards within the two selected districts were visited.

In each selected area, a school targeted by the programme was randomly selected for FGDs. Past participants from the selected school were included in the sampling frame with the actual respondents being randomly selected from participants' lists. Due to their busy schedule, out of school participants were difficult to meet as a group. the evaluation team resorted to meeting them individually.

Participants for case studies were purposively selected with the help of peer facilitators. These were individuals that had participated in all sessions, and demonstrated changes as observed by the facilitators or as feedback to facilitators.

The peer educator for the selected area was automatically selected for interviews while the Peer Coordinators from the selected districts were included in the survey.

Sample sizes achieved for the evaluation are presented in Table 3.

**Table 3: Sample sizes for the qualitative evaluation**

Stakeholder	Type of interview	No. of Interviews					
		National/ Regional		Selibe Phikwe		Okavango	
		Planned	Actual	Planned	Actual	Planned	Actual
UNICEF	KII	2	1				
Makgabaneng	KII	3	3				
NAHPA	KII	1	1				
MESD	KII	1	0				
BIHL	KII	1	1				
MTV-SAF	KII	1	2				
Viamo	KII	1	0				
DAC	KII			1	1	1	1
Chief Education officer	KII			1	0	1	1
DHMT	KII			1	1	1	0
Community leaders	KII			2	0	2	0
G&C Teachers	KII			4	2	4	2
Health facility nurse	KII			2	1	2	0
Peer educators	KII			2	5	2	3
Peer coordinators				1	2	1	1
Adolescents and young people (past participants in and out of school)	FGD			4	4	4	4
Case Studies	IDI			2	1	2	0
<b>Total</b>		<b>10</b>	<b>10</b>	<b>20</b>	<b>17</b>	<b>20</b>	<b>12</b>

#### Data collection

Qualitative data collection was led by the team leader and involved all team members. The international team members were accompanied by interpreters during data collection at the community level. Interpreters were trained on the tool and the data the evaluation sought to obtain. This ensured no data was lost between translations. Data was collected over a period of 10 days allowing the team at least two days per locality.

### **Data analysis**

The data collected through qualitative methods in each district was systematically analysed, triangulated, and synthesised by the evaluation team. The collected qualitative data complemented and clarified the quantitative findings by helping to identify common themes. The Evaluation Framework, Annex 2, provided an analysis framework for gathering and synthesising data against the key evaluation questions. The analysis explored gendered differences in responses to specific questions of the evaluation and understand, where differences exist, the possible reasons for such differences.

#### ***3.2.4 Reporting, validation and participation of rights holders***

All findings were validated by stakeholders through two processes. The first was a preliminary findings presentation that sought to validate initial findings of the evaluation team with UNICEF, Makgabaneng and NAHPA. This was followed by a presentation to the Evaluation Reference Group.

**Participation of duty bearers:** UNICEF, NAHPA, Makgabaneng, MTV SAF, BIHL and local governments all participated in the evaluation as sources of information as well as validating the findings. Participation included other stakeholders from outside Botswana including from the UNICEF regional office for Eastern and Southern Africa, and regional office for MTV Shuga. The Evaluation Reference Group, facilitated by the Evaluation Manager at UNICEF Botswana, and comprising a cross-section of stakeholders for the programme was the primary platform through which these stakeholders contributed to reviewing and validating the evaluation findings and recommendations.

**Participation of rights holders:** participation of rights holders, in this case adolescents and young people, was achieved through ensuring their full participation in the data collection. In Selebi Phikwe the evaluation recruited a young person to be involved in the data collection with AYP. We also employed methods of data collection that facilitated their full participation in the evaluation. However, they were not involved in the validation processes of the evaluation.

### **3.3 Ethical Considerations**

Necessary safeguarding and ethical research safeguards were put in place. The evaluation underwent ethical approval with the HRDC. The evaluation adhered to principles of confidentiality and informed consent for all respondents to the evaluation.

The evaluation will involve interviewing children and therefore drew guidance from UNICEF Ethical Guidelines and standards for research and evaluation and Ethical Research Involving Children. Interviewing children was necessary to understand the outcomes of the MTV Shuga and receive feedback on the quality and adequacy of the programme. While no significant harm is foreseen in the conduct of the evaluation to child participants, the following guided all conduct of the evaluators:

- **All children assented to being interviewed and parental consent** sought through the help of the school (for in-school participants) and peer educators (for out of school participants). If seeking consent for an interview from parents or caregivers would put the child in harm's way, then such children would participate in the evaluation. The evaluation depended on the experience of peer educators with the cohorts of participants they worked with during the programme period. All consent or assenting were fully informed about the evaluation therefore the evaluation ensured:

**1**

children understood the evaluation and their participation

**2**

consent is an explicit agreement between the children and their parents/caregivers;

**3**

children's consent is given voluntarily (and without coercion);  
and

**4**

consent is renegotiable, so that children could withdraw  
at any stage of the evaluation process.

- **Respecting the privacy and confidentiality of children and young people participating in research.** This involved close consideration of several aspects: (1) Privacy with regard to how much information the child wanted to reveal or share, and with whom; (2) How to discuss research confidentiality with children, including mention of the limits to this (e.g., safety concerns such as harm, neglect or abuse), in a way that did not introduce new, potentially worrisome, ideas; (3) Privacy in the processes of information gathering/ data collection and storage that allows the exchange of information to be confidential to those involved; and (4) Children's anonymity and / or recognition in the publication and dissemination of evaluation findings and associated activities.

1



Privacy with regard to how much information the child wanted to reveal or share, and with whom.

2



How to discuss research confidentiality with children, including mention of the limits to this (e.g., safety concerns such as harm, neglect or abuse), in a way that did not introduce new, potentially worrisome, ideas.

3



Privacy in the processes of information gathering/ data collection and storage that allows the exchange of information to be confidential to those involved.

4



Children's anonymity and / or recognition in the publication and dissemination of evaluation findings and associated activities.

- **Children who participated will be given feedback** on the results of the evaluation through NAHPA and the implementing partner (Makgabaneng).

The evaluation did not come across any safeguarding issue and therefore the safeguarding protocol was not employed.

#### Box 1: Ethical considerations

**Risks:** The evaluation protocol was noninvasive and involved minimal risk to participants. The probability and magnitude of harm or discomfort anticipated in the evaluation were not greater

**Box 1: Ethical considerations**

than those encountered in daily life or during the performance of routine physical or psychological examinations.

**Voluntary participation:** As part of the informed consent procedure, all potential participants were instructed that they can choose not to participate in the survey if they do not want to. They were also instructed that if they decide to participate, they do not have to disclose personal information that they were uncomfortable sharing and that they could withdraw from the survey at any time.

**Compensation:** Participants were not compensated for participation in the survey.

**Adverse events and protocol deviations:** There were no adverse events and protocol deviations.

**Inclusion Criteria:** Outline of criteria for selection of subjects, gender, ethnic group, and performance sites (provide justification for single gender or group).

- For those aged 10 to 64 years, able and willing to provide verbal (oral) informed consent in English or Setswana;
- For emancipated minors (aged 10 to 17), able and willing to provide verbal informed consent in English or Setswana.

**Exclusion Criteria:** Outline criteria for exclusion of subjects, gender, ethnic group, and performance sites (provide justification for single gender or group).

- Unable or unwilling to provide consent or assent.
- Persons who are unable to give consent or assent due to cognitive impairment or intellectual disability will not be eligible to participate.
- Cognitive ability will be assessed by providing information on participation and asking the participant to summarize their understanding of the purpose of the evaluation and what is requested from them if they choose to participate.
- Individuals who are unwilling to participate will also be excluded from the evaluation.

Potential risks for children and their mitigation measures are presented in Table 4.

**Table 4: Potential risks for children in the evaluation and mitigation measures**

Risk	Mitigation
Children can face harm on their way back home	We ensured that all interviews with children happened in the morning
Children face abuse from parents because of participating in the research either due to misunderstanding of its objectives or not having consented	We ensured that all parents with children participating in the project receive a project brief that explains the purpose of the evaluation.  Only children whose parents consented were interviewed
Children might miss some school lessons because of the survey	We ensured interviews of in-school children are conducted during breaks (morning or lunch break)
Discussions on SGBV (although presented in general manner in the evaluation research tools) may arouse emotions among children who are survivors of SGV.	Our researchers were trained to identify respondents in distress during the group and individual discussions and apply the research protocol or excusing the individual from the group and provide personal comfort.

Annexes 6 and 7 provide the Ethical approval letter from the Human Research and Development Council (HRDC) and the consent form respectively.

### 3.4 Limitations of the evaluation

The following were the limitations of the evaluation:

1. Visit to only two of four districts had the potential to skew the perceptions on programme performance. The evaluation ensured the selection of four wards that represent fully the context of the programme including selecting some successful localities, provided the evaluation with sufficient variation to fully explore the programme's performance.
2. Analysis of the programme's performance on outcomes was dependent on pre- and post-exposure surveys as there were budget constraints to undertake a KAP survey of AYP that were exposed to various elements of MTV Shuga in Botswana. The pre-exposure surveys were conducted for each group of AYP prior to participating in the MTV Shuga sessions. This was followed by post exposure surveys undertaken after completion of sessions. Only the in-person peer educator programme and the IVR platform had pre- and post-exposure data. This meant assessment of the performance of the programme was limited to these two channels.
3. There was potential to collect and use clinical data (especially utilisation of HIV services). While this could have provided trends in utilisation of services and shown how the programme was, through improved knowledge and attitudes, contributing to behavioural outcomes (utilisation of HIV services), the low performance of lower-level results (especially improvement in attitudes) (See Section 4.3.1, Effectiveness) meant such a contribution story would be very weak or near impossible to establish. Additionally, the programme had no focus on linkage to health services a requirement for enhancing utilisation of such services further weakening the contribution story (See Finding 6 under Section 4.1). Resultantly clinical data was not used for the analysis of outcomes. Instead, the evaluation relied on qualitative data obtained through FGDs and case studies on the outcomes of MTV Shuga.
4. The evaluation was undertaken during school term. Majority of AYP participants, who were in school, were given the G&C session, of 45 minutes, to participate in the evaluation. The AYP tool had to be adapted to ensure FGDs with AYP could be completed within this time. Time constraints were also experienced with out of school AYP who preferred to have meetings in the evening. This cut short the time for interviews from one and a half hours to an hour at most.

## 4 Findings

This section presents findings of the evaluation in accordance with the evaluation criteria of Relevance, Gender and equity, Effectiveness, Efficiency and Sustainability. In each criterion the evaluation answers questions posed in the evaluation framework, Annex 2.

### 4.1 Relevance

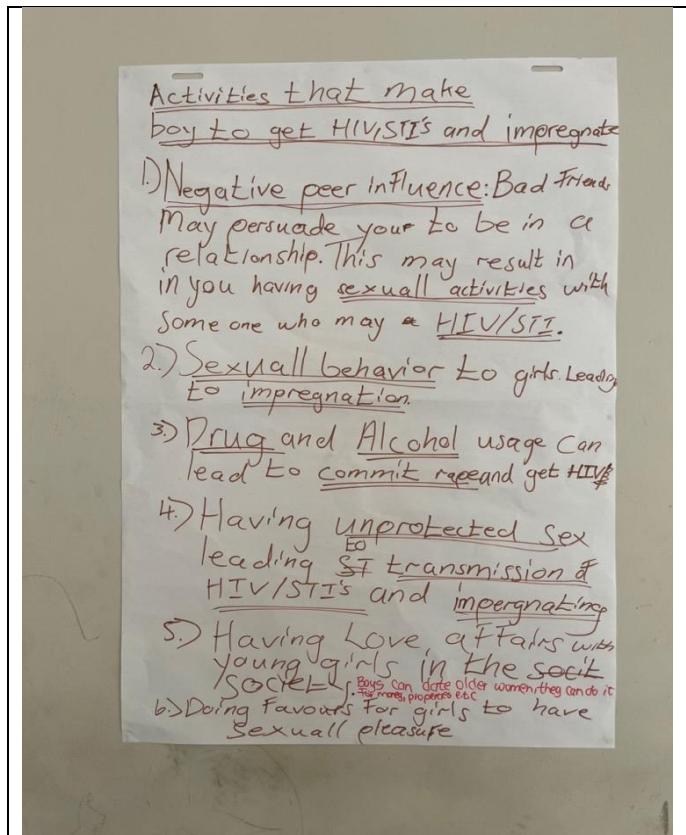
#### 4.1.1 *To what extent were the beneficiaries satisfied with the behaviour change intervention?*

**Finding 1: The MTV Shuga programme used multiple channels of communication (both online and offline) to address negative attitudes and behaviours that lead to new HIV infections and teenage pregnancies. However, weak parent- AYP engagement and integration of economic empowerment (for out of school) undermined design effectiveness.**

The programme had a very strong integrated peer education and community-based approach to increasing knowledge and developing positive attitudes towards HIV prevention, teenage pregnancy, Gender Based Violence, and other issues affecting adolescents and young people in Botswana.

Integration of advocacy and community outreach activities to the peer education programme component, were perceived by stakeholders to provide a holistic approach towards increasing knowledge whilst influencing attitudes towards HIV prevention. The complementarity of the radio drama series, the interactive voice response (IVR) 124 platform and the choose-your-adventure' game provided an opportunity for AYP to interact on radio, IVR and choose characters they like and personify the character's decision making process, thereby influencing their attitudes and practices.

Other additions such as the inclusion of social media platforms (Facebook and WhatsApp), identification of advocacy issues and integration of community outreaches through motivational talks, one on one session with girls, house to house campaigns, addressing of primary school students, youth Dialogues, GBV cycling campaign, arts workshops, and cultural festivals provided multiple communication platforms for the programme to address negative attitudes around drivers of new HIV infections among adolescents. These multiple channels were able to increase knowledge of risky sexual behaviours as demonstrated by boys in an FGD at Lebogang JSS (see picture above).



Parent to child engagement was introduced in the third year of the programme as part of addressing some of the barriers towards positive decision making by AYP on HIV prevention practices.

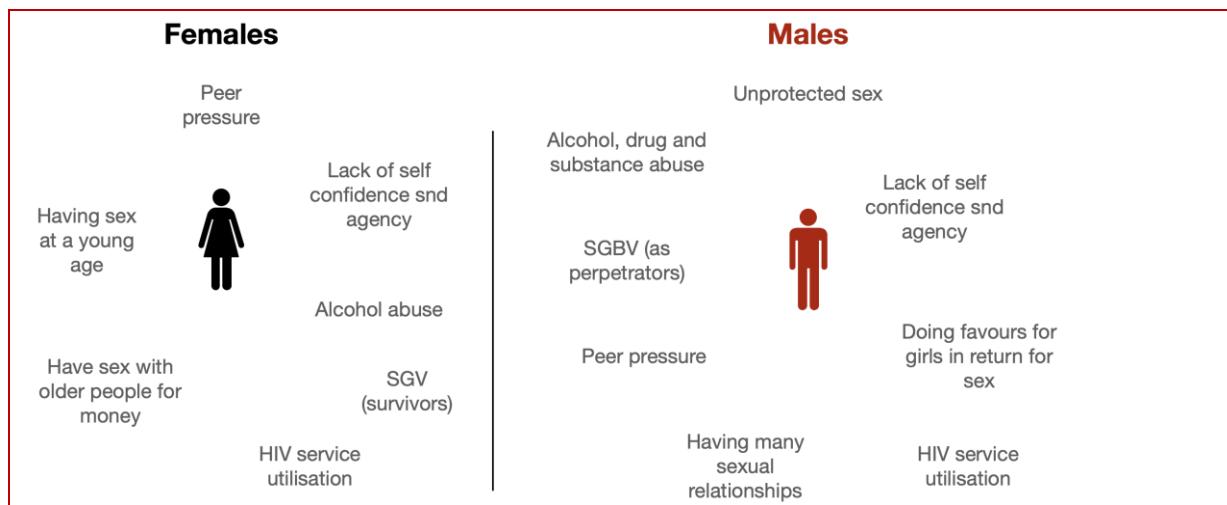
**Parent/Caregiver – AYP engagement** was recommended and implemented as a response to the lessons learnt and voice of AYP towards creation of an enabling environment for decision making among AYP. However, PEs faced challenges in mobilising caregivers to attend these sessions primarily due to a fault in the design of the engagement approach. It did not include a social mobilisation component to ensure there was buy in from caregivers on the intentions of the programme. It could have been, for example, strengthened by household follow ups and mentoring to facilitate meaningful conversations and household support for AYP decision making, including support for HIV testing, protection from GBV, and uptake of related HIV and pregnancy prevention services. In addition to the cultural festivals, the parent-AYP engagement sessions could have been complemented by community dialogues with traditional and religious leaders, to create a more enabling environment for protection of AYP from GBV, drug and substance abuse and sexual exploitation.

The programme faced challenges in mobilising and retaining out of school AYP because of there was no incentive or motivation for them to take time out of their schedules to attend a talk about “HIV and pregnancies”. This challenge is reflected in all annual reports. However, in instances where refreshments were provided higher attendance by out of school was experienced. In general, out of school AYP and PEs were of the opinion that if the meetings were to be integrated with economic empowerment or livelihood activities the former would find the motivation to join and continue in the group until all sessions are completed. Another challenge was the limited availability of appropriate space to conduct sessions for the group.

**Finding 2: The scope and design of the programme rightfully addressed the key drivers of new HIV infections among adolescents in the targeted districts. During implementation the programme also integrated drug and substance abuse prevention and management a key driver of risky sexual behaviour.**

AYP during FGDs were asked to list the behaviours they see every day in their community that are likely to lead to HIV infection or teenage pregnancies. The identified drivers are presented in Figure 3. Intergenerational and transactional sex, peer pressure, lack of confidence and agency, and SGBV were common drivers for both male and female AYP. Alcohol abuse was mentioned for both girls and boys however, substance and drug abuse was mentioned primarily by boys. Early sexual debut was mentioned as another driver for girls.

**Figure 3: Key drivers of new HIV infections for male and female AYP**



*Source: FGDs with in-school male and female AYP*

The aim of MTV Shuga was to improve adoption of safe sexual behaviour by targeting drivers of new HIV infections among adolescents and young people such as transactional sex and gender inequality,

also to improve uptake of HIV and health services such as HIV testing. It also aimed to support AYP to delay sexual debut as well as understand the social complexities of negotiating safe sex. Therefore, in its design, the programme was addressing a majority of the drivers of new HIV infections among AYP. The programme design document for MTV Shuga did not address alcohol, drug and substance abuse as a key driver of new HIV infections. Lessons learnt during engagements with parents, caregivers, school authorities and police, through peer education, advocacy efforts and community outreach activities established an increase in substance and drug abuse among both in and out of school AYP. As such, inclusion of drug and, alcohol and substance abuse in the programme albeit outside the standard MTV Shuga sessions (such as motivational talks, community outreach etc.) demonstrated the programme's adaptability to new realities (discussed more under Effectiveness and Efficiency).

**Finding 3: The programme approaches were designed largely along the urban – rural, the in- out of school and male-female divides. It did not implement differentiated approaches for engaging and reaching out to the diverse groups of AYP beyond the three classifications.**

Though the programme scope was adapted to both rural and urban settings, it largely used the schooling status in profiling approaches for reaching out and engaging with AYP. The project focussed more on male and female gender differentials, with a special focus on adolescent girls and young women, with no deliberate efforts for engaging and reaching out to other genders. Therefore, the programme lacked differentiated efforts or initiatives for engaging or reaching out to diverse groups of adolescents and young people, to address the different vulnerabilities and most appropriate approaches for reaching out and engaging AYP in their diversity. PEs could have been trained and empowered to engage and work with different groups (both in and out of school) such as adolescents living with HIV (including ART adherence as part of combination HIV prevention), teen mothers/fathers, AYP selling sex, those with disabilities, and special tribes such as the Basarwa in Okavango. As such, household vulnerability assessments could have helped the programme in identifying the most vulnerable AYP for post peer education support and enrolment in differentiated parent/caregiver – AYP sessions.

Though the project intended to increase self-efficacy for uptake of HIV testing, and practice sex through PrEP, condoms and family planning services, the linkages between demand generation/peer education, advocacy, community outreach and health service systems improvement towards these outcomes was weak.

**Finding 4: Peer educators were perceived to be effective in delivering sessions with AYP in both in and out of school AYP.**

Programme beneficiaries expressed satisfaction with skills and approach of peer educators across all districts and settings (both rural and urban). No variations were noted on competency between male and female peer educators. In schools, peer educators gained the confidence of both the G&C teachers and the learners, to the extent learners were more confident in sharing and discussing sensitive sexuality matters on HIV, teenage pregnancy, GBV and sexual exploitation with peer educators than the G&C teachers, in both settings (rural and urban) (See more in Finding 14). However, in Boteti and Okavango districts, Peer Educators had challenges in reaching out to some hard-to-reach areas for the out of school AYP and their engagements with their caregivers/parents due to transport constraints.

**4.1.2 To what extent were the programme strategies, approaches, and methods relevant and responsive to the local settings, population, circumstances, and challenges?**

**Finding 5: Content of MTV Shuga sessions was generally aligned to the daily lives of AYP, with in-person delivery approaches appropriate for meaningful engagements with AYP.**

The content of the MTV Shuga sessions was adaptable to the lives and contexts of the AYP, both rural and urban. However, due to the diversity of AYP, beyond the rural-urban and schooling differentials,

the IVR sessions could have been contextualised to the diverse categories of AYP (including those from child headed households), so as to address the different vulnerabilities of AYP, in terms of HIV and pregnancy prevention, GBV and sexual exploitation.

The delivery of in-person sessions by PEs and G&C teachers was perceived by AYP and stakeholders as more appropriate as they provided for learning and engagement through various edutaining and practical demonstrations (including through drama and songs). Similarly, the delivery of peer led sessions for the out of school AYP through football clubs, traditional dance groups, drama groups, among others at agreed convenient time and locations was very acceptable and appropriate for AYP, for being more interactive, participatory and edutaining than virtual platforms such as Facebook and WhatsApp. Establishment of district level Facebook pages and WhatsApp groups was also widely accepted for contextualising discussions and issues to the respective localities.

**Finding 6: While assumptions underpinning the programme theory of change were valid, there was insufficient attention to manage the risks they posed.**

The evaluation identified five key assumptions underpinning the effectiveness of the programme. Each of these assumptions is detailed below and the programme's approach to manage them.



**Assumption 1 – MTV Shuga can deliver drivers of the health belief model:** The programme is underpinned by the health belief model which posits that, “*successful adoption of healthy behaviour starts with an individual’s perception of their risk relative to their personal profile and linking it with their perception of the threat/risk, barriers and opportunities for adopting new healthy behaviour. The model suggests that addressing perceived susceptibility, severity and amplifying benefits could go a long way in building motivation to adopt new behaviour, which if augmented well with linkages to solutions or services and promoting self-confidence to change, behaviour changes is highly likely to occur*<sup>2</sup>”*. The MTV Shuga programme can realise the model as shown by Mary’s case (see Finding 15). The programme sessions do well in improving risk awareness and improving capacity to address the barriers for adopting new behaviours. However, there were weaknesses that undermine the achievement of the model. First, and shall be detailed under Section 4.3, the nine sessions were inadequate to support behaviour change. Risk profiling and supporting differentiated approaches post the general MTV Shuga sessions were missing elements to enhance the effectiveness of the standard nine sessions. Also, continuum of support was needed including at the critical transition point of Form 3 and senior secondary school as most teenage pregnancies were reported to occur at this point. Second, the programme had weak referral to services (See Finding 18).*



**Assumption 2 – The programme will be able to mobilise AYP to attend the complete set of sessions:** This assumption largely held for in-school AYP but less so for those out of school for reasons already discussed under Finding 1. Therefore, the programme needed to support further mobilisation of out of school AYP with linkages to economic empowerment and livelihood opportunities or incentives for attending sessions such as refreshments or certificates. The IVR platform also faced similar challenges with session participants dropping by 90% on the last episode compared to those that participated in the first (See Finding 17).



**Assumption 3 – Peer educators will be able to deliver sessions effectively:** PEs were deemed to be effective as demonstrated by their relationship with AYP and G&C teachers (See Findings 4 and 14).

<sup>2</sup> MTV SAF (2021) MTV Shuga Programme Brief 2021/22 Botswana.

**Assumption 4 – Parents can engage with the sessions:** In general, there was poor attendance by parents to the parent and AYP engagement meetings owing to weak community mobilisation strategy (See Finding 1).



**Assumption 5 – Majority of PEs will be retained in the programme:**

AYP are a highly mobile group and hence this assumption was more a risk. However, the programme did plan for it with recruiting and training of trainers stationed in the districts to offer training to new PEs. MTV SAF, Makgabaneng and UNICEF ran refresher trainings for PEs which enabled new PEs to get up to speed with their work.

**Finding 7: Challenges undermining responsiveness of in-person interventions included infrastructure, PEs' mobility for out of school AYP sessions and retention of out of school AYP.**

In-person interventions also encountered various challenges, that relate to infrastructure, peer educators' mobility and retention of out of school AYP in the programme. Due to poor linkages of the programme with economic livelihoods, the programme had challenges in motivating and retaining out of school AYP in all the 9 sessions as they were committed to other more economically productive or promising activities. As compared to in-school programming, where schools could provide conducive spaces for individual one on one sessions for AYP, there were limited spaces for such services for the out of school AYP. Additionally, peer educators and peer coordinators had challenges of transport in reaching out to hard to reach and more vulnerable communities, especially in Boteti and Okavango districts. In some rural areas, peer educators also encountered challenges in accessing electricity for projecting out of school sessions.

## 4.2 Gender and equity

### 4.2.1 *How well did the programme integrate gender and equity considerations into its design and implementation?*

**Finding 8: Integration of gender was integrated from the recruitment of male and female PEs and subsumed in the MTV Shuga sessions, which had a special focus on adolescent girls and young women. Equity was also integrated through selection of urban, rural, and hard to reach areas.**

Gender integration was recognised in the programme document of the MTV Shuga programme as addressed through content of sessions which was inclined towards addressing challenges faced by adolescent girls and young women as the group affected the most. However, the design document fell short of providing specific strategies to enhance gender inclusion beyond the content.

In practice, however, several initiatives were put in place by project implementers and PEs in the districts. First, the programme deliberately recruited male and female PEs in same localities to address gender specific issues among AYP participants. Nonetheless, the programme still faced challenges in recruiting an adequate number of male PEs resulting in some locations having majority female PEs. This was noted to cause some challenges in facilitating boys' or girls, to open up to the PEs about their struggles and get referral assistance. Secondly, PEs, on their own initiative, introduced various measures in their localities to address gender specific issues. At Ethsa 6 Junior Secondary School (JSS) in Okavango district, PEs had a separate session with boys to address bullying, and at Lebogang JSS separate boys' session were held to address drug, and alcohol and substance abuse which was common among them. PEs also reported having some separate dialogues with boys and girls on specific issues including teenage pregnancies.

Equity was addressed through the selection of urban, rural and remote districts. In each of the districts except for Selibe Phikwe (predominantly urban) there was a focus on proximity and remoteness in the

selection of districts. In Okavango for example, the programme was in Gumare (the urban centre), in Estha 6 (rural ward) and in Shakawe.

For remote areas, such as Shakawe in Okavango, where population was dispersed, PEs faced the additional burden of walking long distances to reach AYP on the programme. To oversee such PEs the PC had to incur additional costs of lodging as it took a whole day of travel to reach the PEs. These additional costs to support effectiveness of PEs and PCs in such areas were not considered in the programme's cost allocation.

**Finding 9: The absence of gender inclusion strategies in programme documents of MTV Shuga intervention undermined ability of implementers to effectively address needs of varying categories of adolescents.**

As noted above, PEs faced with different challenges or circumstances differentiated their target groups for specific issues. At Estha 6 a session was held with teenage mothers to help address their specific needs and drivers of HIV infection. Across all four districts boys' and girls' talks were held. In Boteti FGDs were held in 2022 for children who were exhibiting behavioural change to reinforce the change. Such initiatives were adhoc and unplanned and dependent on the PEs' own initiative. Because this gendered approach was not always implemented by PEs it undermined the ability of the programme to fully address circumstances of adolescent and young people groupings.

*4.2.2 Was sufficient information collected during the implementation period on specific result indicators to measure progress on gender and equity?*

**Finding 10: Data was being collected to measure project's impact on gender and equity but was not sufficient to address the data needs for implementing a gender responsive programme.**

The programme's monitoring system comprising session registers, and pre and post sessions exposure surveys all collected sex disaggregated data. Furthermore, all indicators were sex disaggregated. Through these provisions the programme was able to ascertain the impact on males and females. While this was important to learn on the programmes gendered effect, process level data such as experiences of males and females with the sessions was missing and important to determine gendered approaches to session delivery by the PEs or timing and delivery approach for the IVR platform. Apart from the standard nine sessions in the peer educator MTV Shuga guidelines, PEs did undertake, as noted earlier, additional dialogues with programme participants. Data from such dialogues was important to understand the extent to which different districts were putting in place measures to address gender specific issues.

The session registers while providing sex disaggregated data, they were also inadequate for profiling of session participants including marital status, teen mothers/ fathers, disability etc to facilitate a gender differentiated approach to session delivery and content.

*4.2.3 To what extent was the programme disability inclusive?*

**Finding 11: In general, the MTV Shuga programme was not disability inclusive.**

Disability inclusion was not considered in the programme design nor during implementation. PEs and G&C teachers generally reported limited capacity to handle children with disabilities undermining actions to fully incorporate children with disabilities in the programme sessions. However, where the school had some provisions to support persons with disability e.g., in Lebogang JSS, children with disability were participating in the MTV Shuga programme but this was limited to visual and physical impairments. Data collection forms did not reflect disability.

## 4.3 Effectiveness

**4.3.1 To what extent did adolescents and young people adopt safe sexual behaviours as a result of the programme? Was there an improvement in self-efficacy? To what extent did attitudes towards the following improve: intergenerational and transaction sex; gender norms related to prevention of HIV and unwanted pregnancy?**

**Finding 12: The MTV Shuga programme improved capacity of AYP to practice safe sex and gender equitable attitudes. Adoption of safe sexual behaviours was less observed.**

The project aimed to achieve three outcomes:



Improved self-efficacy to delay sex and practice safe sexual behaviour



Improved attitudes towards intergenerational and transactional sex

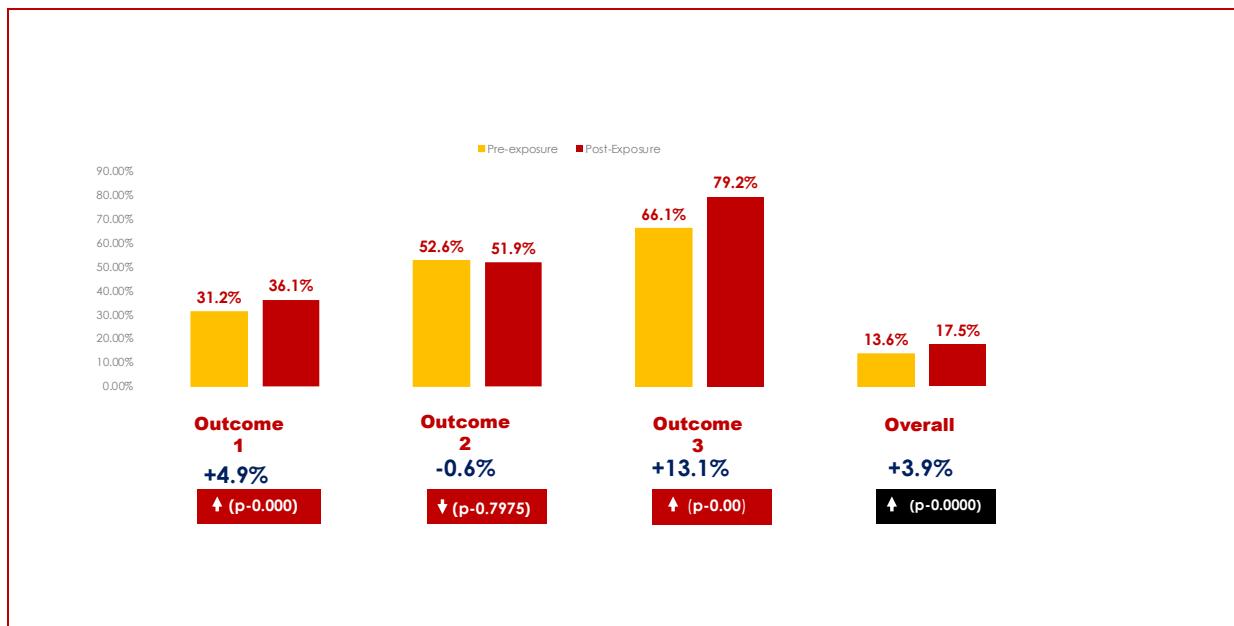


Improved gender equitable attitudes

To determine the programme's performance on these three outcomes the evaluation compared pre- and post-assessment data of MTV Shuga session participants covering indicators of the three outcomes.

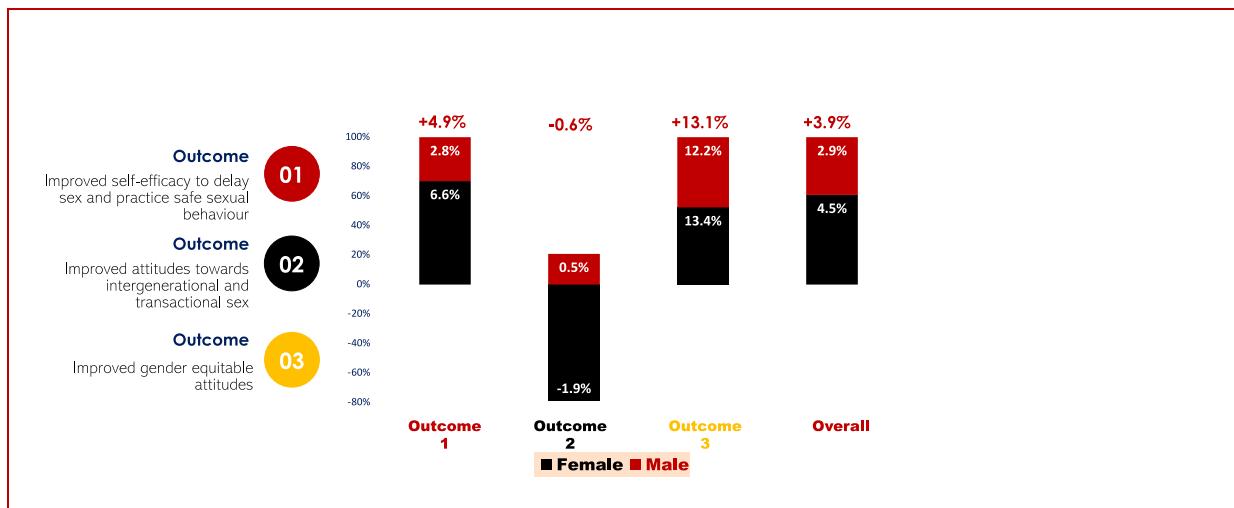
There was a 3.9% ( $p$ -value = 0.000) increase in the proportion of AYP who achieved all three outcomes between pre- and post-exposure (See Figure 4). The greatest change was in Outcome 3 with a 13.1% ( $p$ -value = 0.0000) increase in the proportion of AYP with improved gender equitable attitudes between pre- and post-exposure assessments. The proportion of AYP with the capacity to delay sex and practice sexual behaviour increased by 4.9% ( $p$ -value = 0.000). However, there was a marginal increase of 0.6% ( $p$ -value = 0.7975) in the proportion of AYP with improved attitudes towards intergenerational and transactional sex. This was not statistically significant – meaning there was no change between pre- and post-exposure assessment and that AYP perceptions on intergenerational or transaction sex did not change between before and after exposure to the MTV sessions. **Therefore, while negative attitudes towards risky sexual behaviour changed slightly, the programme had a greater effect in building capacities of AYP to practice safe sexual behaviours within those relationships (ability to negotiate safe sex, that both males and females should carry condoms etc.).**

**Figure 4: Project achievements by outcome (pre- and post-exposure measurements)**



When gender is considered, in general more females than males achieved all the three outcomes (See Figure 5). Females (6.6%) were about 2.4 times more likely to have improved self-efficacy to delay sex and practice safe sexual behaviour compared to their male counterpart (2.8%). Exposure to the intervention had no significant change in males' attitudes towards intergenerational and transactional sex. For females, participation in the sessions led to a marginal increase of 1.9% of females with improved attitudes towards intergenerational and transactional sex. The highest proportion of MTV Shuga session participants achieved Outcome 3, gender equitable attitudes (12.2% for males and 13.4% for females) with slightly more females achieving this outcome. **Thus, it can be concluded the programme had a greater effect on females than males. This is important in the context of equity as new HIV infections were high among female AYP. Nonetheless the effect changes were marginal primarily as a result of limited engagement of session participants post completing the standard 9 sessions as discussed earlier.**

**Figure 5: Increase from baseline by sex of AYP**



Additional analysis was undertaken to understand the performance of indicators contributing to each of the three outcomes. The results are presented in Table 5. Under Outcome 1, while all indicators were above 5% change in the proportion of AYP demonstrating positive attitudes towards negotiating safe sex and reporting sexual abuse, there was still a reluctance to undergo HIV testing and counselling. Part of the challenge with this indicator could be the majority of the age group included in the MTV Shuga sessions which were early adolescence group or Form 1 in Junior Secondary School. During the evaluation when asked about whether they found questions for the pre- and post-exposure survey easy to respond to, participants from Lebogang JSS in Selibe Phikwe had this to say:



*"Sometimes the questions were hard for us to answer. For some of us it is too early to be talking about HIV testing."* FGD participants, Lebogang JSS, Selibe Phikwe

This finding is consistent with other evaluations of MTV Shuga elsewhere e.g., in South Africa. Birdthistle *et al* (2022)<sup>3</sup> found older AYP, 19-24 years exposed to the MTV Shuga intervention were more likely to know their HIV status than younger adolescents (15-19). They were also more interested in using an HIV self-test kit than younger adolescents.

While there was not much shift in attitudes towards intergenerational relationships and transactional sex, the largest change of 2.6% was on attitudes related to intergenerational relationships with a higher proportion of females (3.1%) compared to males (1.8%) saying *"it was not okay to date a partner that is 10 years older"*. However, this change was not statistically significant (*p*-value = 0.9995). AYP's perceptions of transactional sex had a very marginal change of 1.1% with males (1.6%) have the higher proportion of those with a positive change in perception. A high proportion of over 80% of MTV Shuga participants still maintained that it was reasonable for a partner to expect sex in exchange for money or gifts.

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<sup>3</sup> Birdthistle I, Mulwa S, Sarrassat S, Baker V, Khanyile D, O'Donnell D, Cawood C, Cousens S. Effects of a multimedia campaign on HIV self-testing and PrEP outcomes among young people in South Africa: a mixed-methods impact evaluation of 'MTV Shuga Down South'. BMJ Glob Health. 2022 Apr;7(4): e007641. doi: 10.1136/bmigh-2021-007641. PMID: 35365480; PMCID: PMC8977807.  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8977807/#SP2>

**Table 5: Overall performance of the MTV Shuga programme**

	Pre-exposure			Post-exposure			+/- Increase			<i>p</i> -value
	Female (n=3,662)	Male (n=3,495)	Overall (n=7,157)	Female (n=5,127)	Male (n=4,305)	Overall (n=9,432)	Female	Male	Overall	
<b>Outcome 1: Improved self-efficacy to delay sex and practice safe sexual behaviour</b>	32.3%	30.0%	31.2%	38.9%	32.8%	36.1%	6.6%	2.8%	4.9%	0.0000
1.1 Percentage of AYPs who report ability to demand safe sex under pressure.	79.2%	70.2%	74.80%	90.4%	78.4%	84.90%	11.2%	8.2%	10.1%	0.0000
1.2 Percentage of AGYWs that feel at ease to report sexual abuse cases through formal structures, Child Helpline, Schools etc.	55.6%	51.4%	53.5%	63.0%	58.3%	60.9%	7.4%	6.9%	7.3%	0.0000
1.3 Percentage of AYPs who have tested for HIV and know their status.	35.2%	43.1%	39.1%	34.6%	42.0%	38.0%	-0.6%	-1.1%	-1.1%	0.9173
1.4 Percentage of AYPs with intention to go for HIV testing in the next 3 months.	27.1%	23.3%	25.2%	31.5%	26.5%	29.2%	4.4%	3.2%	4.0%	0.0000
<b>Outcome 2: Improved attitudes towards intergenerational and transactional sex</b>	<b>54.6%</b>	<b>50.4%</b>	<b>52.6%</b>	<b>52.7%</b>	<b>50.9%</b>	<b>51.9%</b>	<b>-1.9%</b>	<b>0.5%</b>	<b>-0.6%</b>	<b>0.7975</b>
2.1 Percentage of AYPs who think it is okay to date a partner that is 10 years older.	58.8%	60.7%	59.7%	55.7%	59.0%	57.2%	-3.1%	-1.8%	-2.6%	0.9995
2.2 Percentage of AYPs who think it's reasonable for a partner to expect sex in exchange for money or gifts.	88.1%	77.2%	82.8%	88.2%	78.7%	83.9%	0.1%	1.6%	1.1%	0.0307
<b>Outcome 3: Improved gender equitable attitudes</b>	<b>69.4%</b>	<b>62.8%</b>	<b>66.1%</b>	<b>82.8%</b>	<b>75.0%</b>	<b>79.2%</b>	<b>13.4%</b>	<b>12.2%</b>	<b>13.1%</b>	<b>0.0000</b>
3.1 Percentage AGYWs who think it is both boys' and girls' responsibility to carry condoms.	69.4%	62.8%	66.1%	82.8%	75.0%	79.2%	13%	12%	13.1%	0.0000
<b>Achieved all the three outcomes</b>	<b>14.6%</b>	<b>12.7%</b>	<b>13.6%</b>	<b>19.1%</b>	<b>15.6%</b>	<b>17.5%</b>	<b>4.5%</b>	<b>2.9%</b>	<b>3.9%</b>	<b>0.0000</b>

There were cases of young people that had changed their behaviour e.g., stopping transactional sex, intergenerational sex, drug, substance, and alcohol abuse. Mary's story (Case study 1) demonstrates the effect the MTV Shuga sessions can have on behavioural outcomes of adolescents and young people. The session delivery approach and its content can have a profound effect on changing risky sexual behaviour as observed in Mary's story. However, cases of such behaviour change, as noted by PEs were still few. This could be a result of limited follow up of the MTV Shuga cohorts by PEs or the limited engagement of the same cohort post 9 sessions of MTV Shuga. As noted earlier, the initiative by PEs in Boteti to reinforce behaviour change through creating platforms for engaging those AYPs that demonstrated emerging behaviour change is an emerging practice that could be explored for other districts.

#### Case study 1: MTV Shuga can lead to safe sexual behaviours

Mary (not real name) is a 25-year-old young woman, who was born, raised and schooled in Selibe Phikwe. She was raised very well by her humble family and was viewed by her classmates as a clean and responsible student. Her problems started when she entered senior secondary school at Selibe Phikwe Senior Secondary School. She experienced peer pressure from other students who had started drinking alcohol, smoking and frequently engaging in binge drinking over the weekend with older men. Oftentimes, over the weekend they would visit bars and night clubs drinking with older men who were buying them alcohol. She said she used to sleep with multiple men every weekend. She did not concentrate on her schoolwork. She said drinking and smoking was glamourized by her peers as something cool. Mary said that she was part of a community of students who were studying very hard at school but due to peer pressure from bad friends she ended up practising bad behaviour that predispose her to HIV infection, STIs and teenage pregnancy.

Mary stated that due to her bad behaviour she ended failing Form 5 dismally and had to now face the realities of life with her parents at home and community. As she was coming from a low-income family, her initial plans when she got to the secondary school were to pass and proceed to the university and then get a well-paying job that would help her get her family out of poverty.

Now that she failed her form 5, Mary became an added burden to her family which was already struggling. She sadly said that her problem started to worsen as she now started drinking with multiple men and ended getting impregnated by a man who later dumped her. She also indicated that the child added another burden to her already struggling family because the child needed to be cared for. Realizing that she had added a huge burden to her family, she then got employed by Ipelegeng Government Programme. She then got some small money to support her child. ***"At Ipelegeng life became better than not working at all".***

It is at Ipelegeng where Mary got to know about MTV Shuga Programme, after Shuga peer educators visited them during one of their daily works at the site. She enrolled into the programme and received sessions which she found very intriguing and helped to change her behaviour. During the time she was participating in the sessions, she started realizing how she had lost direction in life and her future was in ruins. She realized that if Shuga had reached while in primary school she would not experience peer pressure at secondary school. She said they learned about HIV prevention, self-confidence, HIV testing and to avoid drug and alcohol abuse, engaging in multiple sexual relations as well intergenerational sex.

Mary indicated that since joining the MTV Shuga programme she has since stopped drinking alcohol and rarely visit bars and has also stopped dating older men. This she said is because of the competency of peer educators who served as mentors to her and the fact that the sessions are very stimulating and interesting. She said she is now confident and able to negotiate safer sex, resist peer pressure, always uses condoms, and regularly goes for HIV testing. ***"I have now realized that***

Case study 1: MTV Shuga can lead to safe sexual behaviours

**accepting gifts does not mean agreeing to sex and that engaging in relationships with older men can be exploitative**". Mary advised the government to start implementing MTV Shuga programme at primary schools as doing so will impact young people's behaviours as they learn to be resilient when there are still young. She quoted a Setswana saying, "*Lore lo oojwa le sale metsi*".

#### 4.3.2 Achievement of project targets

##### **Finding 13: The programme did not achieve any of its outcome targets.**

Annex 4 provides details of the achievement of programme outcomes. It shows that the programme failed to achieve the targets of any of the outcomes. However, output indicators were achieved for some outputs e.g., *Programme Output 2: Effective and efficient project management*. The best performing indicator was "*Percentage of adolescent boys who hold gender equitable attitudes*" which was 0.8% short of the target. This was followed by the indicator, "*Percentage of AYPs who demonstrate intention to demand safe sex under pressure*" which was 10% off the target.

The programme was able to reach 8,250 AYP instead of the target of 10,000 primarily due to challenges with mobilising out of school AYP.

#### 4.3.3 What were the key factors influencing the achievement or non-achievement of results?

##### **Finding 14: PEs' ability to deliver the programme sessions contributed to programme effectiveness. However, training duration was viewed as inadequate by some PEs.**

PEs were recruited through a competitive and participatory process spearheaded by the DACs in all four districts. The effectiveness of PEs to undertake the sessions was appreciated by all key stakeholders: G&C teachers, AYP and DACs. AYP were particularly happy with the approach taken during the sessions that was participatory and with session delivery appropriate for various age groups as group in school (Estha 6 JSS) said: "[we like the PEs] as they viewed us as students [they delivered in a way we understood]". This capacity is reflected in several ways. AYP noted how through the sessions they were to increase their knowledge on various topics including improving their self-confidence and risk awareness (which helps them in decision making). G&C teachers reported that students were more comfortable speaking to PEs about their personal struggles which are then referred to the G&C by PEs for further handling. Not only were the student trusting the PEs, the G&C teachers themselves (Estha 6 JSS and Lebogang JSS) were giving PEs more G&C teaching sessions than were required by the programme and the task of addressing other problematic issues in the schools e.g., bullying at Estha 6 JSS. Key attributes noted by stakeholders for PEs was their enhanced emotional management and ability to use various methods to engage the AYP.

PEs were also highly motivated and had passion for the work which helped them continue with their work even under difficult circumstances such as long distances in Okavango or with inadequate money for transport (Selibe Phikwe).



*"Yes, the money for transport is not enough and I walk long distances to schools [because of it]. I have never stopped going to schools because I like what I do and the change I make with these children."* Interview with PE, Selibe Phikwe

The training undertaken by UNICEF, Makgabaneng and MTV SAF contributed to capacity of PEs. This training was complemented with the recruitment of volunteer Training of Trainers in each district and some refresher trainings undertaken by UNICEF and Makgabaneng within districts. While these trainings were generally well appreciated by PEs for their ability to equip them with skills and knowledge necessary for their work, there was general consensus among them that they were more satisfied with the training in 2019/20 than the 2021 training. The latter training was noted as too short and focused mainly on emotional management, handling children disclosing abuse etc. It did not adequately equip new PEs at that point.

Despite the presence of TOT volunteers in each district there were still PEs who were still to be trained in Okavango for example.

**Finding 15: DACs provided varied levels of support for PEs, which helped improve PEs' work. Their relationships with schools ensured access to adolescents.**

The DACs across all districts provided varying support to PEs improving their effectiveness. Where support was the strongest, such as in Okavango, PEs were provided office space, were supported with linkages to other important stakeholders and guidance in implementing their work. Because of the strong relationship between PEs and the DAC in Okavango, the DAC was able to put in place mechanisms to continue supporting PEs with allowances over three months in 2022 when there was a short break in support to ensure they continued to provide services. The DAC also supported the PEs develop a relationship with a local NGO, BOCHAIP, to secure space for conducting MTV Shuga sessions for out of school youth. In the districts where the relationship between PEs and DACs was weak, such as Selibe Phikwe, the DACs were still able to provide support for linking the PEs to other stakeholders such as the DHMT. Due to such linkages PEs participated in health promotion activities especially those targeting AYP in all the four districts. Such approaches helped broaden the reach of AYP.

Their importance to the DACs was beyond conducting MTV Shuga sessions, to include mobilising AYP for various HIV behaviour change activities in the districts. The usefulness of PEs in mobilising AYP strengthened their relationship with DACs.

However, there were instances where the relationship between the DAC and PEs was weak. In one such district the PEs complained about the support from the DAC while the DAC also did the same about the working relationship with the PEs. Despite the PEs being used to mobilise for AYP and being called to provide talks at community health promotion events the weak relationship with the DAC led to limited support for the PEs in their work that included availing of office space, supporting access to venues for MTV Shuga sessions for AYP out of school and support with the DHMT. It may seem in this district the entry meeting alone and having DACs recruit the PEs was inadequate to establish a strong working relationship and a structured approach to relationship building facilitated by Makgabaneng would have been appropriate.

In addition to their engagement with DACs, the PEs established strong relationships with schools which provided them access to students. As discussed under Finding 14, such relationships led to PEs receiving more time with students providing increased platforms for adolescent engagement.

**Finding 16: Weak relationships with other stakeholders undermined availability of necessary support to enhance the programme interventions.**

Across all districts there were weak linkages with other stakeholders outside the DACs. Such relationships could have enhanced the work of PEs in the districts. For example, challenges with space for meetings with out of school AYP could have been potentially addressed through linkages with village development committees (VDCs) and traditional leaders. Such a relationship could have opened up "community halls" or "Dikgotla" that are owned by VDCs and traditional leaders. PEs also faced

challenges in mobilising caregivers for the parent child engagement sessions. Closer engagement with community leaders from the onset would have helped to gain community buy in and leadership of the programme.

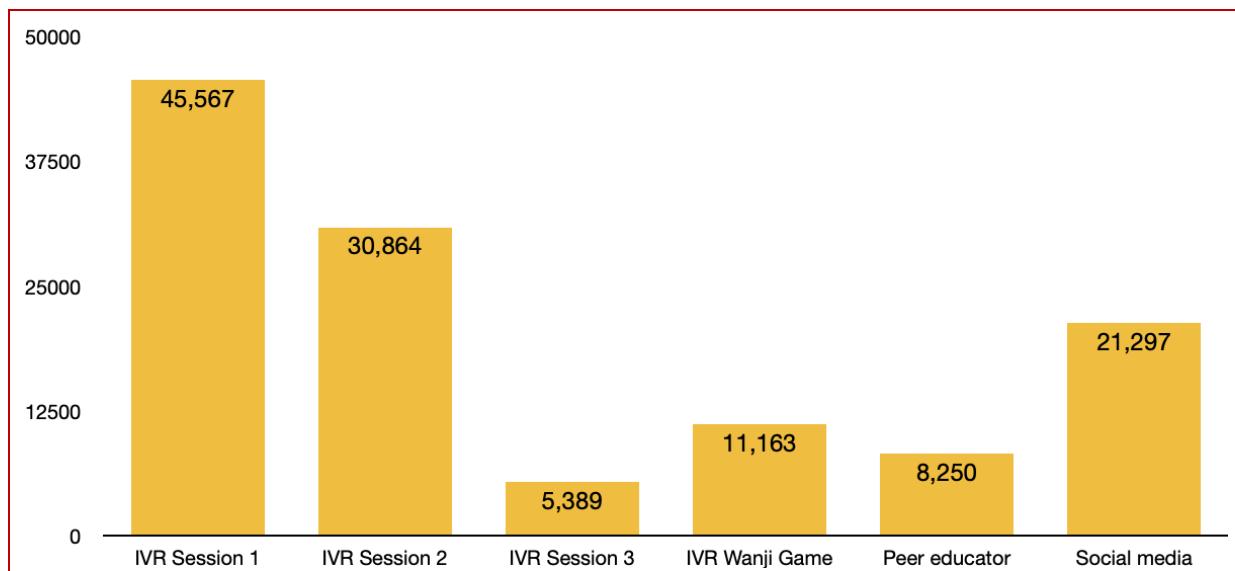
While the MYC was listed by the project as a key stakeholder they were seldom engaged in its implementation beyond the project entry meeting. They could have provided potential opportunities for accessing economic empowerment or other livelihoods activities that would have enhanced mobilisation and retention of out of school AYP in the programme. Across all districts PEs had no relationship with the chief education officers which could have been helpful and helping PEs access schools at the end of COVID-19 in districts such as in Shakawe Okavango and throughout the programme in Ghanzi.

*"On the 2nd of November the coordinator met Kabakae Primary [in Ghanzi] school head teacher to requests for slots. The school requested for a letter from Ministry of Basic Education before they could give a go ahead." Extract from October to December 2022 quarterly report*

**Finding 17: Availability of multiple virtual or online communication channels allowed the programme to adapt quickly to COVID-19 restrictions. The restrictions affected continuity and depth of support for AYP supported through the in-person peer education programme.**

The advent of COVID-19 and the restrictions on movement halted all forms of physical interaction with beneficiaries of the programme. The adoption, from the onset of the programme, of multiple channels of communication that included, the adaptation of the radio programme through the 124 IVR programme (titled Wanji game), the MTV Shuga sessions adapted for IVR, the radio programme, and physical interaction through peer educators provided the programme the ability to reach a wide range of adolescents. With the advent of COVID-19 the programme was able to continue with virtual platforms thus limiting disruptions due to lack of physical interaction. The numbers reached by the programme by December 2021 are presented in Figure 6. The large reach of the IVR platform continued even during COVID-19. Virtual platforms were able to reach 92,983 AYP as shown in Figure 6.

**Figure 6: AYP reached by MTV Shuga communication channels**



*Source: Progress report August to December 2022; Shuga Radio Drama & Shuga Wanji Game January to December 2021; MTV Shuga Report Quarter 2, October to December 2021*

While the programme was able to continue with behaviour change messages using online platforms there were numerous issues that reduced effectiveness. For social media it was frequently reported

that, for AYP, finding the phone and mobile data to use to engage with the content was challenging. Thus, while the virtual peer educators had large followings the engagement of targeted AYP with the content was less than 10% of the followers. On the IVR platforms participants rarely received full exposure to all episodes thus limiting the ability of the exposure to influence behaviour change. For example, 39,306 unique listeners called in for the first episode of Season 1. By Season 12 only 2,042 unique listeners were recorded. The same trend was observed for all three Seasons of MTV Shuga on the IVR platform.

**Finding 18: There were several challenges faced in the implementation of the programme that undermined achievement of outcomes.**

**Peer educator to AYP ratio may be too high:** the project was able to reach 8,250 participants through the peer educator programme. This gave a PE to AYP ratio of 1:295. This may have overloaded PEs limiting their ability to do more with the targeted beneficiaries including providing additional sessions above the standard nine MTV Shuga sessions. Additionally, this happened in a project environment where there was no set/defined PE:AYP ratio.

**Nine (9) sessions were inadequate to facilitate behaviour change:** Exposure within just the nine sessions was insufficient to achieve the large shifts in behaviour change within the timeframe and is one of the reasons why improvements in attitudes and behaviour may not have been widespread in the programme. While there were instances of PE initiatives to address specific issues of groups of AYP (boys, girls, teen mothers etc), this was not always structured and therefore ad hoc at best. As noted earlier the absence of risk profiling and provision of specific support to AYP at risk of taking on risky behaviours was a limitation in the programme. Some PEs such as those in Boteti did put in mechanisms to reach out to AYP such as the additional sessions with participants demonstrating emerging behaviour change.

In all four districts, AYP included community outreach as part of a larger health promotion effort of the DHMT or through HIV behaviour change activities of the DAC and other CSOs in the districts. Additionally, PEs organised dramas (e.g., in Ghanzi) and motivational talks in all districts. These different interventions offered a variety of communication channels and opportunities to introduce additional emerging topics such as drugs, alcohol and substance abuse, and teen pregnancies. However, because these were not adequately planned for in the programme document including ensuring sufficient overlap between those exposed to the MTV Shuga sessions and then the additional support meant there was no consistent messaging to influence attitudes change and ultimately behaviour as demonstrated by pre- and post-exposure data.

**Out of school AYP were difficult to motivate to stay on the programme and therefore the MTV Shuga programme was not successful with this group:** The difficulty in accessing venues for holding the out of school AYP MTV Shuga sessions, the absence of incentives for participation – refreshments, economic or livelihood support all combined to limit retention of AYP in the sessions. Resultantly, of the 8,250 AYP reached with the peer educator programme less than 10% were out of school. While it can be argued that a larger proportion of out of school was covered by virtual sessions, the decrease in numbers exposed to various episodes militates against effectiveness of exposure (See Finding 20).

*"There has been a better turn out with regard to out of school participants since the introduction of snacks"*  
**Interview with Estha 6, Okavango**

**Module content was adaptable across districts but could have addressed some context specific issues and other areas to support behaviour change:** As noted earlier the MTV Shuga session content was adaptable and relatable to the context in which AYP lived. However, it could have address

additional specific context issues that drive new HIV infections and teen pregnancies such early child marriages and bride offerings<sup>4</sup> in Okavango. As one stakeholder put it:

*"While the content of MTV Shuga is good, there was need for Makgabaneng to do a rapid situation analysis to understand the context and adapt their content accordingly to ensure it addressed the main challenges we face here in Okavango."* KII with stakeholder, Gumare Okavango district.

There were some specific modifications that could also have been made to the MTV Shuga module including the following:

- 
- 1**  
Module 6 which could have addressed modern contraceptives was limited to condom use and abstinence undermining effectiveness on teenage pregnancies.
  - 2**  
On HIV prevention the module focused on PreP, ART and condom use while missing other HIV prevention methods e.g., VMMC, and Post exposure Prophylaxis;
  - 3**  
Module 3 which could have adopted a life skills approach was limited to self-awareness in the context of HIV testing;
  - 4**  
The module did not unpack the diverse adolescent population groups and how they relate to each session; and
  - 5**  
Referral and linkages of AYP to HIV/SRH services was an important part of the work of PEs. However, discussions with PE showed referral is mainly to the G&C teacher who has limited to no links with health workers in the community. Furthermore, PEs did not have the tools to help track referrals.

## 4.4 Efficiency

### 4.4.1 To what extent were the implementing strategies appropriate for achieving results?

**Finding 19:** The MTV Shuga programme management and coordination mechanisms were decentralised and integrated into district levels, with interventions reviewed annually to align it to lessons and new realities.

The MTV Shuga programme, informed by lessons from Makgabaneng's previous experiences in Selibe Phikwe and Boteti districts was designed as a multi-stakeholder intervention overseen at district level by the DACs. To strengthen this multi-stakeholder approach Makgabaneng included multi-stakeholder meetings as launchpads of the programme in each district that included key government departments such as education, youth, and local government to ensure buy in and support for project activities. However, these engagements were not followed through in implementation as PEs failed to build on this momentum. Working relationships were established with the DACs and less so with other stakeholders with others being non-existent e.g., youth, local government, education, health, private sector, and traditional leadership. For education the relationships were established by PEs at school

<sup>4</sup> Families agree to offer their girl child to boy. The grows knowing which girl they will marry as arranged by the families. this leads to early sex and in cases teenage pregnancies.

levels which strengthened implementation at this level but also introduced new challenges when entry into schools was denied such as in Ghanzi and Shakawe in Okavango (see Findings 18 and 19 above). The strength of relationships between PEs and other stakeholders also varied across districts depending on the motivation of the DAC to support the programme.

The collaboration with NAHPA provided opportunities for integrating the programme in the HIV response and scaling the programme into more districts. At the onset NAHPA was able to support the four programme districts to develop priority actions for AYP to be included in the overall district comprehensive plans, thereby facilitating alignment of responses to the overall HIV responses and priorities for the districts. While the collaboration was commendable, more could have been done to ensure NAHPA was an integral part of the programme. For example, while NAHPA was included in trainings of PEs, and some joint monitoring visits it was not always included in the quarterly meetings between Makgabaneng and UNICEF. Any such meetings when held were adhoc and not part of a structured process for incorporating NAHPA in planning and reporting. This would have been useful to ensure NAHPA was fully abreast of the programme implementation.

Refresher trainings of PEs were also used as moments of reflection and learning from PEs on progress in implementation, challenges being faced and emerging issues. UNICEF and Makgabaneng used this feedback and results from monitoring visits and reports to inform programme steering. Therefore, the programme took an adaptive management approach that used these lessons to make annual changes to programme implementation. These changes included adding the two additional sessions to support parent to child engagement, changing from use visuals to radio in response to vandalism of electricity supply to classrooms, support for PE local advocacy initiatives, and supporting PE initiatives for community outreach that included use of alternative communication approaches such as dramas, motivational talks etc.

The use of multiple communication channels (as noted under Finding 20): interpersonal communication, mass media and community mobilization approaches to reach the target audiences with information and services, enabled the programme to rapidly adjust to the negative effects of COVID-19 on programme implementation. The introduction of virtual peer education programme that used WhatsApp and Facebook, and the continued use of IVR and radio platforms allowed the programme to continue AYP engagement. Having the social media platforms administered locally was appropriate as it ensured the content and discussions were locally relevant.

**Finding 20: Peer educator training was conducted through a Training of Trainers approach, with quality assurance being provided by MTV SAF. PEs generally appreciated the scope and content of the training they received but viewed the duration as too short.**

MTV SAF provided the training materials and content through a Training of Trainers approach for Makgabaneng, for the rolling out of the initial training of peer educators and coordinators. The programme utilised the MTV Shuga Down South Peer Facilitation Manual and tools, which had adolescent friendly content focused on the key themes of the MTV Shuga Series including HIV prevention, testing, PrEP, HIV treatment, sexual exploitation, and abuse (SEA) and direct access of services. PEs and PCs perceived the training to have had comprehensive content, delivered by experienced, motivated, and competent trainers though the duration was seen to be short. Apart from addressing content issues, the trainings also managed to clarify the roles and responsibilities as well as monitoring and supervision mechanisms for peer educators, through the DACs.

The MTV Shuga programme was also efficient in facilitating PE replacement in times of attrition whilst trainings of new PEs recruits was not limited to residential in-person workshops but included on-the-job-trainings by Peer Coordinators and specifically recruited Training of Trainers volunteers as well.

Such recruitment to replace departed PEs was undertaken by DACs in consultation with Makgabaneng and PCs. This ensured efficiency in implementation of activities.

Supportive IEC materials such as graphic novels were also produced to reinforce the educational sessions.

**Finding 21: Adaptation of the programme to incorporate virtual programming increased reach but required additional support to be effective.**

The COVID-19 pandemic disrupted and altered the implementation of the MTV Shuga programme through adoption and implementation of virtual approaches to peer education, trainings, and stakeholder engagements. These changes were well reflected in programme agreements/programme documents between UNICEF and Makgabaneng. The programme due to COVID-19 restrictions on movement and safety precautions, stopped the implementation of the face-to-face sessions and adopted use of social media platforms such as WhatsApp and Facebook managed and facilitated by virtual PEs. Four virtual PEs (one for each of the four districts) were trained and dedicated to facilitating district level social media activities through the use of Facebook, WhatsApp, and SMSs. For example, in Okavango, on the Facebook page, discussions we held on: HIV testing, prevention and care; Transactional sex; Sexual exploitation; Condom use and Disclosure, among others. In addition to training, virtual PEs received internet modems/routers to support virtual engagements.

However, virtual peer education was undermined by unavailability of audio-visual messages compatible to WhatsApp and Facebook to facilitate engagement of participants. Furthermore, reach of these platforms to AYP in target areas could have been improved with integrating it with social mobilisation using community leaders, influential members of the community and PEs (responsible for the interpersonal communication). AYP frequently reported limited access to phones and data which could have been addressed with more effective engagement of the wider community. In spite of the wider reach AYP in remote areas remained disadvantaged as they did not have access to the resources necessary to access these platforms. For example, AYP spoken to in Okavango were not aware of such platforms in the district. Lastly, it was difficult to measure the effectiveness of virtual PEs due to unavailability of pre and post exposure questionnaires for participants.

*4.4.2 Which components of the intervention and its communication channels are less resource intensive but critical for the programme results?*

**Finding 22: The delivery of peer education sessions through social media platforms was well received and cost effective. However, network challenges and lack of social media skills affected quality delivery of the sessions.**

Use of virtual approaches do lead to lower costs of implementation given the likely high reach with much lower investment than physical interaction. While other studies have shown that they can also lead to attitudinal and behaviour change<sup>5</sup>, in the context of this evaluation this was not possible to evaluate<sup>6</sup>. However, given the context of the programme there were several challenges that could have undermined effectiveness. Lower skills among PEs in promoting their Facebook and WhatsApp led them to yield low results as noted in Peer educators' monthly reports. Poor internet connectivity made it difficult for the teams to participate in online trainings and other online implementation forums.

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<sup>5</sup> Tulane University School of Public Health and Tropical Medicine (2011) External Evaluation of the Southern African Regional Social and Behaviour Change Communication Programme.

<https://www.oecd.org/derec/unitedkingdom/Southern-African-Regional-Social-Behaviour-Change-Communication-Programme.pdf>

<sup>6</sup> There was no pre- and post-exposure data collected for social media participants. However pre- and post-exposure data was collected for those participating on the IVR platform, but the evaluators could not verify this data.

Similarly, the data packages bought from the monthly airtime, provided social network bundles though it was perceived to be insufficient. This was also coupled with limited skills among PEs and PCs to mobilise using social media and to create demand for online platforms postings. In some cases, the phones were not compatible with the applications.

The IVR platform used two modes the radio programme and the Wanji Game. As noted earlier the programme was able to reach about 93,000 listeners across the three radio Seasons and the Wanji Game (See Figure 6). Season 1 of the IVR had impact on attitudes towards transactional sex, condom use and capacity to negotiate safe sex. Season 2 had an impact across all indicators include on HIV testing which lagged among participants in the physical peer education programme (see Findings 15). Given that the numbers reached by the IVR platform are over ten times that of the physical peer education programme, the former is likely to result in shifts in attitudes and capacities among larger population of AYP. It is therefore likely to be more cost effective.

However, each mode is important for achieving results in different contexts. Given the challenges expressed by AYP in school about access to a phone, regular access to the IVR platform can be a challenge which could have contributed to the drop in listenership with each episode across all three seasons. AYP in remote areas can be particularly disadvantaged due to their limited or lack of access to phones and therefore need the physical approach. However, to achieve behaviour change, the channels are complementary. As noted earlier (see Finding 21) a differentiated approach is necessary accompanied by risk profiling to address specific needs of AYP to achieve behaviour change. This is difficult to achieve with mass communication and would need to be supported by social mobilisation through the physical peer education programme.

#### *4.4.3 To what extent did the programme generate solid evidence from monitoring and evaluation in order to inform policy/advocacy and improved programmeming?*

**Finding 23:** The programme's data collection framework was aligned to its results framework with data being used to inform programme changes. Areas for improvement were performance feedback to PEs and local stakeholders, and collection of qualitative data on behaviour change.

The MTV Shuga programme had clear monitoring systems in place aligned to the results framework. This included a set of indicators for each outcome with baselines and targets supported with tools that collected required data for such indicators before and after exposure to the intervention. The tools used an online application, ODK®, in which PEs entered data from paper base questionnaires completed by MTV Shuga participants before and after sessions. A corresponding dashboard was developed for all indicators.

*There were notable delays in transitioning from paper-based data collection tools to the ODK application due to various challenges such as, initially not being able to segregate data according to sex, age, location, in school and out of school. Additionally, the application could not allow further analyses to be done for some of the performance indicators, especially those that are gender specific and outcome level results (behavioural tracking), so as to inform the programme's first objective. Only performance indicators that are not gender specific were therefore analysed.*

The radio programme, on the IVR platform, also included questions that collected data on programme performance indicators ensuring its performance and contribution to programme outcomes could be measured. The Waji game on the other hand did not have pre- and post-questions to understand its effects on programme indicators. Also, there was no mechanism for determining effectiveness of the virtual peer education programme.

Pre- and post-exposure surveys were supported by programme review meetings and joint monitoring visits for stakeholders to have a first-hand experience of programme implementation. In addition to

joint monitoring visits, Makgabaneng conducted quarterly monitoring **and** supportive visits to all districts to understand programme implementation and offer technical support to the PEs and PCs.

As noted above, findings and learning generated from the monitoring system were used to make improvements to the intervention on an annual basis demonstrating the utility of the monitoring system to the programme. Evidence from the programme was used to influence uptake by NAHPA and youth led development under the social development pillar of the National Development Strategy (See Finding 29).

Despite these measures, there were several issues that needed to be addressed in the monitoring system:



- **Feedback loops were not working:** There was no feedback from Makgabaneng to PCs and PEs on their performance based on data from the pre- and post-exposure assessments. This feedback was important to keep PCs and PEs motivated or determine areas they needed to improve. Because PCs had no feedback on performance, there was also no feedback on performance to the G&C teachers and schools in general on the performance of the programme. This is important to cultivate ownership and motivation for continued support of the intervention by schools. Even DACs raised concerns about not receiving information on the performance of the programme although they do get updates on progress in implementation from the PCs.
- **There was over reliance on outcome data and less attention on process data (session experience information):** The programme collected session experience data from the perspective of PEs. While this was a good practice, it would have benefited more with direct experiential feedback from AYP themselves to ensure sessions were delivered in a way that addressed their needs.
- **The was no collection of qualitative outcome data:** The assessment of performance relied on quantitative outcome data collected through the monitoring system. To effectively assess its impact on behaviour change there was need to include in its monitoring system, qualitative data on stories of change from session participants. Such data would demonstrate the validity of the theory of change premised on the health belief model.

## 4.5 Sustainability

### 4.5.1 *How well has the programme been linked to and is synchronised with other programmes on reproductive health?*

**Finding 24: NAHPA has demonstrated readiness (willingness and capacity) to integrate the MTV Shuga programme scope into its roll out plans, without external support. Integration of the PEs sessions with G&C sessions served as a good entry point for comprehensive sexuality education. There was limited integration with health facilities.**

The MTV Shuga programme (primarily the peer educator programme) was incorporated in the current round Global Funding cycle for Botswana under the HIV prevention pillar and within the behaviour change communication thematic area. The funding will enable scale up of the programme in all high-risk districts. Furthermore, NAPHA has included the MTV Shuga programme under its HIV response social contracting modality. Makgabaneng, the contracted national NGO, provides technical leadership working with CSOs in four additional districts implementing the full package of the MTV Shuga peer educator programme. The programme budget is BWP16 million. Thus, the MTV Shuga is well integrated in the HIV response programme in Botswana. At the time of the evaluation NAPHA had plans to further scale up the project in more districts using the 2023/24 fiscus funding using the social contracting modality. NAPHA was also ready to finance continuation of the IVR platform and the radio programme which had been discontinued. NAPHA was waiting for handover from UNICEF at the time of the evaluation.

At district levels PEs were invited to various health promotion platforms to reach out to AYPs with messages on HIV and SRH (see Finding 18). Okavango PEs participated in a condom campaign by Women Against Rape, and in Ghanzi PEs worked with the Botswana GBV support group to address GBV. The importance of PEs in mobilising AYP was recognised in the districts as demonstrated by their enrolment in various district level health promotion initiatives.

While PEs are well recognised as an important stakeholder, the MTV Shuga programme was not always included in the district evidence-based HIV annual plan. While in Okavango, the MTV Shuga peer educator programme included in the plan this was not the case in Selibe Phikwe.

**Finding 25: DACs, G&C teachers and PEs have demonstrated readiness to continue supporting the programme but require more orientation or sensitisation on additional programme components.**

G&C teachers in all schools expressed readiness to continue working with the PEs even when the programme stops. The only challenge was allowances for PEs which the schools could not provide. DACs in Selibe Phikwe and in Okavango have demonstrated that they could fill the gap in funding for PEs through their participation in HIV prevention activities of the DAC where they are provided allowances for participation. G&C teachers also needed orientation on the programme to support the PEs and reinforce their messages to adolescents' post meetings/sessions. There is readiness among G&C teachers to integrate some of the peer education approaches for the G&C sessions – however this requires the necessary training.

Several other initiatives are required to support readiness of stakeholders to continue supporting the programme and possibly taking over at the local level:

- PEs have sufficient capacity but there is need for local CSOs to have capacity for retraining when attrition of PEs occurs. Through the NAHPA social contracting modality Makgabaneng was training and supporting local CSOs to implement the MTV Shuga peer education programme. Further support is needed to ensure that these CSOs can continue regenerating the same capacity among PEs. This could include mentorship support from Makgabaneng.
- The DACs in all districts require training on the programme and in order to: 1) support implementation; 2) to reinforce the message by the PEs; and 3) support retraining of PEs when needed in collaboration with CSOs.

#### *4.5.2 To what extent have advocacy efforts been successfully used to contribute to national ownership?*

**Finding 26: The adoption of MTV Shuga as part of the national HIV response is testament to the success of advocacy efforts by UNICEF for national ownership.**

UNICEF was deliberate in setting a path for national ownership of the programme from the onset. This included ensuring NAHPA was an integral part of programme implementation through their participation in all aspects of the programme and that a national CSO (Makgabaneng) had the capacity to support its implementation. This approach also included working with NAHPA on a clear road map for scale up of the programme that includes fiscus funding and as well as through the global fund.

UNICEF also used data and lessons from the MTV Shuga programme to influence development of the National Development Plan under the social development pillar with a particular focus on youth led development processes.

## 5 Conclusion, Lessons Learned and Recommendations

### 5.1 Conclusion

**Overall:** MTV Shuga programme has provided a model design that is feasible, acceptable, and implementable without external funding through PEs, schools, and communities. It can be easily scaled as it is applicable in multiple contexts of Botswana. The multiple communication channels provide the programme the unique ability to reach a broad range of AYP with behaviour change messaging. The evaluation demonstrated that the programme in its current state can build capacities of AYP, especially females, to negotiate and practice safe sex and support more gender equal attitudes within sexual relationships. However, what remained in the programme is to ensure with this capacity AYP can overcome the barriers that undermine positive behaviour. This is where the programme needed to invest more through differentiated approaches that addressed the unique needs of the most at risk AYP. The current model has also failed to sustain engagement with out of school AYP and requires re-designing to integrate economic livelihoods and linkages with health facilities whilst strengthening differentiated PE approaches and parent-AYP engagement.



**Relevance:** The programme was well aligned with the Third Botswana Strategic Framework for HIV and AIDS 2019 – 2023. The challenges it addressed were aligned with those experience by AYP in the target districts. Its content reflected well the lived circumstances of AYP in the four districts. Appropriate channels were used for reaching AYP comprising the radio, IVR platform, in person and virtual peer to peer interaction. It put AYP at the centre of driving the initiatives, whilst challenging caregivers/parents and communities to create a supportive and enabling environment. The programme content and delivery approaches were also flexible and adaptable to the COVID-19 environment, through adoption of responsive approaches and was innovative to develop livelihoods skills as part of promoting the

employability and business skills of AYP, thereby addressing poverty as one of the underlying vulnerability causes for risky sexual practices by AYP in Botswana. However, this was not a significant feature of the programme. The programme was also well integrated with other already existing relevant programmes for AYP, such as NAHPA's social contracting modality on peer education component. Nonetheless, the programme had inadequate tools, and time for meaningful engagements at family level whilst differentiated approaches for engaging and reaching out to the diverse groups of AYP, and weak referral linkages with health facilities and economic empowerment opportunities were notable gaps in the design of the programme.

**Gender and equity:** Gender was a key consideration of the programme given female AYP were disproportionately affected, with new HIV infections more than double among females than males. Significant proportion of the content was inclined towards female AYP. Data collection systems ensured sex disaggregated data to determine the effect of programme interventions on males and females. Gender responsiveness of the programme could have been enhanced by collecting sex disaggregated experiential data of the MTV Shuga sessions. Disability was not considered in the design and implementation of the programme. However, equity was considered in the selection of districts, but the programme fell short on financing the additional cost burden faced by PEs and PCs operating in remote areas.

**Effectiveness:** While negative attitudes towards risky sexual behaviour changed slightly, the programme had a greater effect in building capacities of AYP to practice safe sexual behaviours within intergenerational and transactional relationships (ability to negotiate safe sex, that both males and females should carry condoms etc.). The results of both the IVR platform (radio programme) and the in-person peer education programme show that female AYP exposed to the programme interventions performed better than their male counterparts which can have a significant long-term influence in reducing new HIV infections among AYP. Utilisation of HIV services such as HIV Testing and Counselling was low with no significant change when before and after the intervention are compared. Despite positive changes in two of the three outcomes, the programme failed to meet its targets. At the same time, while capacities were built and gender equitable attitudes developing, behaviour change was not widely observed.

**Efficiency:** The MTV Shuga programme's efficiency lied heavily on the radio and peer education approaches as appropriate and accessible to reach out to both in and out of school AYP. The radio programme, which was also complimented by the IVR platform and in person peer educator led sessions provided an opportunity for AYP to be reached through mutually reinforcing approaches. Implementation of the MTV Shuga programme, through Makgabaneng, which already had a good working relationship with Government of Botswana at the national and district levels, through various and decentralised structures (including District Multi-Sectoral AIDS Committees, DACs, DHMTs, Regional Education Officers, Department of Youth & Culture and Youth Groups) facilitated smooth programme entry, implementation (including delivery of trainings), monitoring and reporting. The programme therefore benefited from Makgabaneng's experiences from similar programme in Selibe-Phikwe and Boteti districts, hence was already familiar with the respective communities and UNICEF's planning and procurement processes. The programme resources (e.g., time and financial) were utilized as planned, including the re-programming that was introduced during COVID-19, through the introduction of virtual approaches such as Facebook and WhatsApp. The use of PEs and PCs provided a good entry point for checking feasibility and acceptability of the programme approaches, through their participation at district level coordination and management structures. However, the programme had limited engagements with other stakeholders such as the health, private sector, and traditional leadership as well as limited feedback mechanisms between Makgabaneng, G&C teachers and PEs.

**Sustainability:** Because of the ease of scale up that does not require significant technical input, NAHPA had already scaled up the project into additional four districts with more districts planned to be added in the 2023/24 fiscal year. MTV Shuga concept was incorporated in the current funding round of the Global Fund funding mechanism for Botswana providing additional resources for scale up of the programme. All this demonstrates that the programme concept has taken root in Botswana. At local levels gaps in training of G&C teachers and DACs may hamper continuation of the programme in existing localities. This is more so given majority of the current funding under the social contracting modality is not multi-year but annual cycles. This heightens the need to put in place sustainability mechanisms at local level.

## 5.2 Lessons learned

Several lessons have been gleaned from the implementation of the MTV Shuga programme in Botswana as follows:

**Lesson 1: Out of school AYP require incentives or additional motivation to participate in MTV Shuga sessions.** The programme faced challenges in mobilising AYP as they found the opportunity cost high or just lacked interest to meet and talk about "*HIV and teenage pregnancies*". When refreshments were introduced during meeting sessions participation in the programme increased. The motivation must be a basket of interventions to support the diverse needs of AYP.

**Lesson 2: A programme targeting AYP must remain adaptable and agile to remain relevant.** The MTV Shuga programme in Botswana was implemented through a changing context at national and micro level. The advent of COVID-19 led to introduction virtual peer education programme which has continued post COVID-19. When visual TV episodes were not working due to vandalism of electrical facilities in schools the programme had to quickly change to using radio sessions. The programme kept on adapting through its life cycle in this way it remained relevant to the needs of AYP.

**Lesson 3: Using multiple channels of communication increased the breadth of reach for the programme and its ability to influence change among targeted AYP.** However, they should not operate in isolation but complement each other. Over the course of the programme the various channels reached over 200,000 AYP of varying backgrounds and circumstances in Botswana. Use of multiple communication channels increases the chance of being successful in achieving outcomes. Exposure from social media had the potential to be reinforced through the in-person peer education programme. Referrals can occur from the virtual platform to the in-person interaction enhancing the effectiveness of both platforms.

**Lesson 4: It is not only important to ensure introduction of the programme at district level at the commencement of the programme is key but to complement this with a regular monitorable plan for engagement.** This will make implementation easy and make stakeholders to be part of the project. The programme was formally introduced at the districts in June 2020 whereas the PEs started in December 2019. Second even with the introductory meetings relationships between PEs and stakeholders were not fully established which affected implementation of the programme.

**Lesson 5: For in-school sessions use of G&C sessions were found to be ideal as they proved less disruptive of the school academic calendar.** In schools, the use of guidance and counselling lessons were explored. This was to enable the lessons to be utilised for the sessions. With the curricular affected by COVID- 19, more time was allocated to classes therefore the use of G&C classes was ideal less disruptive to the catch-up programme employed by schools. The worked collaboratively with the school to map a plan for sessions using the school planner. to slot the sessions in the G&C classes.

### 5.3 Recommendations

The following recommendations are proposed to enhance implementation of a future programme. They are organised according to three categories of Programme Content, Programme Delivery, and Monitoring and Evaluation. The recommendations were developed through stakeholder consultations and validated through two processes: a meeting with implementers and meetings with broader stakeholders of the programme. The recommendations were formulated in the context of programme scale up by NAHPA into other districts and considerations for other organisations intending to use the concept in contexts similar to Botswana. The recommendations have also been formulated with the intention to enhance effectiveness of the model by addressing challenges with the programme content, implementation and monitoring and evaluation.

#### Programme content

Finding	Recommendation	Responsibility	Time Frame
<b>Ref: Finding 1, Finding 5, and Finding 18</b> There were gaps in module content to address specific context drivers, adding missing elements such as adherence to ART, adopt a life skills approach and support a differentiated support.	<b>Recommendation 1:</b> A future programme should revise the programme module to include ART adherence, Post Exposure Prophylaxis.  It should also allow for provisions for adaptation after rapid situation assessments to ensure unique context specific drivers are considered including content and reach for certain AYP population groups with tailored messages e.g., the Basarwa in Okavango.	<b>Primary:</b> NAHPA  <b>Secondary:</b> Makgabaneng, MTV SAF and UNICEF	Medium term 1-2 years
<b>Ref: Finding 1 and Finding 6</b> While the programme included a parent to AYP engagement module, the content failed to support social mobilisation to enhance parents' buy in into the programme and hence their poor participation	<b>Recommendation 2:</b> Enhance the parent and AYP engagement module by developing guidelines and support for social mobilisation to support community buy in of the programme as a pillar for effective parent involvement. This needs to be complemented by community-based Caregiver - AYP dialogues to facilitate common understanding and break silence for discussions at household/family levels.	<b>Primary:</b> Makgabaneng  <b>Secondary:</b> UNICEF, NAHPA, MTV SAF	Medium term 1-2 years
<b>Ref: Finding 6 and Finding 18</b> The nine sessions were inadequate to facilitate behaviour change.	<b>Recommendation 3:</b> There is need for the programme to advance beyond the 9 sessions. The components are already there e.g., motivational talks, meetings with AYP beginning to demonstrate behaviour change, differentiated targeting e.g., teen mothers etc. This needs to be harnessed and provided in a structured handbook and guidance for PCs and PEs to effectively use these instruments to achieve behaviour change.	<b>Primary:</b> Makgabaneng  <b>Secondary:</b> UNICEF, NAHPA, MTV SAF	Medium term 1-2 years

## Programme delivery

Finding	Recommendation	Responsibility	Time Frame
<b>Ref: Finding 16</b> The district entry meetings were inadequate to establish strong working relationships between PEs and all stakeholders. Such relationship could have helped to advance the programme objectives in various ways.	<b>Recommendation 4:</b> There is need for the programme to have a stakeholder engagement strategy and guidelines that PEs follow to ensure all necessary stakeholders are engaged effectively. This should be supported with mechanisms for monitoring and supporting engagement.	<b>Primary:</b> Makgabaneng  <b>Secondary:</b> UNICEF, NAHPA, MTV SAF	Medium term 1-2 years
<b>Ref: Finding 8</b> While the programme addressed equity in geographical selection it did not provide resources to address the additional burden faced by those in remote areas such higher costs due to longer distances.	<b>Recommendation 5:</b> There is need consider the additional cost burden for onboarding remote areas onto the programme to ensure effectiveness in delivery.	<b>Primary:</b> NAHPA  <b>Secondary:</b> Makgabaneng,	Short term < 1 year
<b>Ref: Finding 18</b> PEs had concerns of being overwhelmed as they had to cover large areas. The absence of a standard PE:AYP ratio for the in-person peer education programme undermines planning.	<b>Recommendation 6:</b> The programme needs to develop a standard PE:AYP ratio that ensures efficiency and effectiveness in the delivery of support by PEs. This is especially so in the context of any additional load with differentiated support.	<b>Primary:</b> NAHPA  <b>Secondary:</b> Makgabaneng, MTV SAF and UNICEF	Medium term 1-2 years
<b>Ref: Finding 25</b> The programme paid sufficient attention to national level sustainability – mainly funding and capacity but had limited focus on local level sustainability. Yet the schools were eager to continue, and DACs expressed willingness to support PEs in varying ways but were hamstrung by limited knowledge of the programme delivery.	<b>Recommendation 7:</b> A future programme needs to put in place a local sustainability plan that involves building capacity of the education office and schools and DACs in the MTV Shuga programme content and delivery. This should be supported with mechanisms to influence incorporation of the MTV Shuga concept in the annual Evidence plans and the education office district plans as well.	<b>Primary:</b> Makgabaneng  <b>Secondary:</b> NAHPA	Medium term 1-2 years
<b>Ref: Finding 1 and Finding 18</b> There were challenges with mobilising and retaining out of school AYP in the programme. This affected programme effectiveness. the main challenges were	<b>Recommendation 8:</b> A multi-pronged approach to incentivise participation needs to be employed by the programme which includes: e) facilitating linkages with opportunities for economic and livelihood opportunities through engagement with	<b>Primary:</b> Makgabaneng  <b>Secondary:</b> NAHPA	Immediate

Finding	Recommendation	Responsibility	Time Frame
the lack of incentives for their participation	<p>Ministry of Youth, and private sector</p> <p>f) support provision of certificates after completing the standard MTV Shuga sessions</p> <p>g) Consider provision of refreshments where feasible with adequate fiduciary risk management.</p> <p>h) facilitate the identification of venues to hold the sessions preferably with the visual than on radio to increase the appeal.</p>		

### Monitoring and evaluation

Finding	Recommendation	Responsibility	Time Frame
<b>Ref: Finding 23</b> The programme primarily relied on pre- and post-exposure assessments for measure performance. However, the post exposure assessment does not give sufficient time to measure attitudinal changes and behavioural outcomes hence could be one of the reasons for poor performance of the programme on these dimensions.	<p><b>Recommendation 9:</b> the programme need to support the current monitoring system with mechanisms to support outcome monitoring:</p> <ul style="list-style-type: none"> <li>c) consider introducing annual outcome surveys that target the cross-section of recipients of the MTV Shuga support (virtual and in person participants)</li> <li>d) introduce qualitative data aimed at understanding the change the attitudinal and behavioural outcomes occurring and how the programme is contributing to them.</li> </ul>	<b>Primary:</b> NAHPA <b>Secondary:</b> Makgabaneng, MTV SAF and UNICEF	Medium term 1-2 years
<b>Ref: Finding 23</b> The feedback loop was not working in the programme undermining continued motivation and engagement by various stakeholders.	<p><b>Recommendation 10:</b> There is need for structured feedback loops at district community and levels and from implementing CSO to PCs on performance. This will keep stakeholders engaged and motivated for the programme.</p>	<b>Primary:</b> Makgabaneng <b>Secondary:</b> NAHPA	Immediate
<b>Ref: Finding 23</b> The monitoring system had deficiencies in collecting process and participants profiling to facilitate differentiated programmeming.	<p><b>Recommendation 11:</b> The programme needs to put in place the following to support improvement of session delivery and support of participants to facilitate behaviour change:</p> <ul style="list-style-type: none"> <li>d) collect participants experiential data with the aim of improving session delivery.</li> </ul>	<b>Primary:</b> Makgabaneng <b>Secondary:</b> UNICEF, NAHPA, MTV SAF	Medium term 1-2 years

Finding	Recommendation	Responsibility	Time Frame
	<p>e) collect risk profiling data for participants.</p> <p>f) include collection of disability inclusion data to support disability inclusion in the programme.</p>		

## Annexes

### Annex 1: Terms of Reference

#### **UNICEF BOTSWANA TERMS OF REFERENCE FOR INSTITUTIONAL CONTRACT**

Title of assignment:	Evaluation of MTV Shuga in Botswana
Section:	Programme (Adolescent &HIV)
Location:	Gaborone, Botswana
Duration:	7 Months
Estimated start date:	1 November 2022
Estimated end date:	31 May 2023

#### **1. Background**

National HIV estimates, and projections indicate that Botswana has the fourth highest level of HIV prevalence in the world. In 2018, the HIV prevalence among adults 15-49 years was 20.3 per cent with women having a higher prevalence than men (25% and 16% respectively). Overall, a total of 29,000 people aged 10-24 years were living with HIV of whom 64 % (18,847) were females and 36 per cent (10,644) were males. An estimated 8,510 new HIV infections occurred in 2018 being 33 per cent among young people aged 15-24 years. This accounted for 3 in every 10 new infections that occurred during that year.

Sexual abuse and violence against children have been reported to be major issues among adolescents (Botswana Youth Risk Behavioural and Biological Surveillance Survey II, 2016). In this regard, almost 19 % of sexually experienced students were forced to have sexual intercourse during 12 months prior to the survey. One-third of sexually experienced students had sexual intercourse for the first time before age 13 years, with 22 % of them reporting being forced to have sexual intercourse. The report indicates that 13.4 % of girls reported having been pregnant. Furthermore, according to the Violence Against Children's Study, 6-9 % of young people ages 8-24 years have experienced sexual violence and 14 % experienced emotional violence. Among adolescents 13-17 years of age, 4-10 % have experienced sexual violence and 12 % have experienced emotional violence.

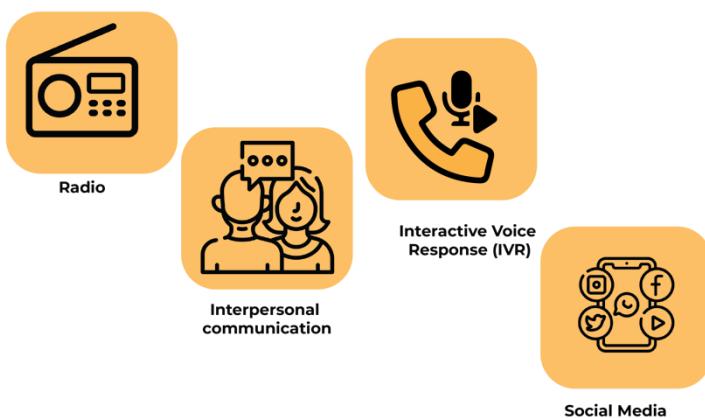
Comprehensive knowledge of HIV among adolescents and young people aged between 15 and 24 years is generally low, estimated at 47.9 per cent (Botswana AIDS Impact Survey, 2013). Progress in reducing new HIV infections among adolescents and young people is further constrained by intergenerational & transactional sex, peer pressure, stigma & discrimination, and gender-based violence. Barriers include entrenched harmful gender norms, gaps between policies and their implementation and inadequate resource allocation for prevention programmes. These factors call for strategic, relevant, and appropriate interventions for adolescents and young people in order to reverse and mitigate the impact of HIV and AIDS.

Against this background and in alignment with the Third National Strategic Framework for HIV and AIDS in Botswana, UNICEF and the National AIDS and Health Promotion Agency (NAHPA) worked together from 2018 in Partnership with MTV Staying Alive Foundation to adapt the MTV Shuga Programme as a behaviour change communication strategy to help adolescents and young people adopt safe sexual behaviour by targeting key drivers of new infections and non-adherence to ARV treatment.

### The MTV Shuga Programme

The MTV Shuga programme is an award-winning TV programme in Africa and Asia, that uses edutainment as a model to showcase challenges of young people in different contexts with the aim to provide behaviour change content to adolescents and young people. The programme extends to radio, social media, and several other platforms to have a 360 degree reach of young people. In Botswana, the programme was introduced by NAHPA on the national TV in 2011 and later reintroduced on radio with the support of UNICEF in 2018 with the goal of reaching adolescents and young people with behaviour change content focusing safe sexual behaviour (delayed sex debut, prevention of transactional and intergenerational sexual relationships) and uptake of HIV services. The radio programme has so far aired 3 seasons with the support of UNICEF and extended the radio seasons to the interactive voice response (IVR) platform and face to face peer education in 4 districts with persistent HIV incidence and HIV prevalence, of Selibe Phikwe, Boteti, Ghanzi and Okavango.

### Adaptation of the MTV Shuga programme



The adaptations which were introduced to the MTV Shuga programme through the NAHPA, UNICEF collaboration was centred on leveraging other communication channels to secure a comprehensive reach of the programme i.e., utilising:

- **Radio:** The Drama series are an adaptation of MTV Shuga Down South with episodes of about 7-10 minutes, followed by in studio discussions by young people for some of the episodes so that the messages portrayed can be buttressed and to spark issues of discussion by audience.

The programme airs on Radio Botswana 2 (RB2) fm and Yarona fm which are the 2 leading youth radio station and have a wider geographic coverage, especially RB2 fm. UNICEF supported production of 3 seasons of radio series since 2018.

- **Interpersonal communication:** Peer education model uses the MTV Shuga Peer Facilitation Guide which contains 7 sessions that each group of participants have to complete to be classified as being fully exposed to the MTV Shuga Peer education Programme. Pre-assessments are run by the facilitators from the beginning and post assessment done at the end of the 7 sessions for each group. This component is done by an implementing partner, Makgabaneng, with the support of both UNICEF and NAHPA as technical and funding partners.
- **Interactive voice response (IVR):** Episodes of the MTV Shuga drama series are uploaded to the interactive voice response (IVR) platform known as 124 for audience to listen to at their own time in case they missed the radio show. Also, a 'choose-your-adventure' game has been introduced to the platform for improved interaction with audience, the game allows young people to choose characters they like and personify the character's decision making process and listen to how their story ends. This approach magnifies the significance of decision making by young people, elevating them to be more conscious in their decision making about key themes of the drama series.
- **Social Media:** Using MTV Shuga social media pages/ dedicated page to broaden the reach of the show, and use polls to monitor impact etc.

## **Programme Stakeholders**

**UNICEF:** The programme is a catalytic programme linked to UNICEF's Country Programme Outcome 2; By 2026, adolescents and young people (10–24 years), particularly the most vulnerable, are more empowered and engaged to access quality and gender-responsive HIV, health, nutrition, education, and child protection services. The programme also addresses sustainable development goal 3 (SDG 3), ending HIV and AIDS epidemic by 2030. To this end, UNICEF provided initial funding for the programme including inception of Peer Education in 4 districts. Furthermore, UNICEF provides technical guidance on behaviour change strategies for the programme and coordinates all partners to ensure alignment and impact.

### **National AIDS and Health Promotion Agency (NAHPA)**

NAHPA provide national leadership of the programme as custodian for the programme from Government side and supports engagement with districts and other government stakeholders involved in the programme. NAHPA is currently leading scale up of the programme in ten (10) other districts.

### **MTV Staying Alive Foundation (SAF)**

The partner provides radio production services in collaboration with local production houses and develops adapted Peer education content for implementation. MTV-SAF also provide a platform for data repository, analysis and dashboard which can be accessed by partners for monitoring.

### **Makgabaneng**

Makgabaneng is the implementing partner that manages the day to day running of the Peer Education programme, they recruit and contracts Peer Facilitators and manages their performance and programme delivery. IP also provide documentation and publicity services for the Peer education programme.

### **Botswana Insurance Holdings Limited (BIHL)**

BIHL recently became a partner to the programme as a funder particularly for the expanding Peer Education to remote and underserved communities.

UNICEF, in support of the Government of Botswana, is seeking to contract the services of an institution to conduct the evaluation of the MTV Shuga programme in Botswana. The evaluation will be conducted through a contract with a third-party service provider which will assess the outcome of the intervention package on improving adolescent and young people behaviour. A researcher and/or research organization will be recruited to carry out the evaluation. Lessons learned and products generated from the programme will be widely disseminated and government supported for any replication or scale up efforts.

## **2. Evaluation Purpose, Objectives and Scope**

The main purpose of the evaluation is to evaluate how well the MTV Shuga programme achieved its outcomes. The evaluation will measure behaviour change results due to the MTV Shuga programme among adolescents and young people exposed to the interventions in 4 districts in Botswana (Selibe Phikwe, Boteti, Ghanzi and Okavango) during the time of implementation from 2020 to 2022. The evaluation to be carried out in 2 out of the 4 districts.

An outcome evaluation will be conducted to determine how effective the MTV Shuga programme was in achieving its intended results with more focus on outputs and how well it was implemented.

The evaluation will coincide with the end of UNICEF support and the start of replication of the programme by the government in several districts.

The evaluation will also consider the effect of gender and geographical location on the intended outcomes of the programme. In particular, the evaluation intends to measure whether the programme resulted in:

- a) Improved behaviour changes to adopt safe sexual behaviour
- b) Improved self-efficacy to practice safe sexual behaviour.
- c) Improved attitudes towards intergenerational and transactional sex
- d) Improved gender equitable attitudes.
- e) Increased demand for health services
- f) Improved uptake of HIV Testing
- g) And to determine the relevance and effectiveness of delivery models and communication channels utilized.

Evaluators will be expected to utilise as much as possible existing baseline and monitoring data to analyse the results outlined above.

### **3. Evaluation Framework**

The following evaluation questions and sub-questions will form the evaluation framework:

<b>Criteria</b>	<b>Evaluation Questions</b>	<b>Sub-questions</b>
Effectiveness	How well did the MTV Shuga programme achieve its results?	To what extent did adolescents and young people adopt safe sexual behaviours as a result of the programme? Was there an improvement in self-efficacy?  To what extent did attitudes towards the following improve: <ul style="list-style-type: none"><li>• intergenerational and transaction sex</li><li>• gender norms related to prevention of HIV and unwanted pregnancy?</li></ul>
		What were the key factors influencing the achievement or non-achievement of results?
Relevance	To what extent was the intervention adequate to address behaviour change among adolescents and young people?	To what extent were the beneficiaries satisfied with the behaviour change intervention?
		To what extent were the programme strategies, approaches, and methods relevant and responsive to the local settings, population, circumstances, and challenges?
Sustainability	Has the programme systematically promoted	How well has the programme been linked to and is

	<p>national ownership, capacity-building and skills transfer to counterparts (government, civil society, AYP) in order for them to be able to sustain the programme?</p>	<p>synchronised with other programmes on reproductive health?</p> <p>To what extent have advocacy efforts been successfully used to contribute to national ownership?</p>
Efficiency	<p>Do the programme results justify the investments (financial and human resources) made?</p>	<p>To what extent were the implementing strategies appropriate for achieving results?</p> <p>Which components of the intervention and its communication channels are less resource intensive but critical for the programme results?</p> <p>To what extent did the programme generate solid evidence from monitoring and evaluation in order to inform policy/advocacy and improved programming?</p>
Gender and Equity	<p>To what extent did the implementation of the intervention address child rights and Leave No-one Behind (gender and other excluded and marginalized groups).</p>	<p>How well did the programme integrate gender and equity considerations into its design and implementation?</p> <p>Was sufficient information collected during the implementation period on specific result indicators to measure progress on gender and equity?</p> <p>To what extent was the programme disability inclusive?</p>

#### 4. Evaluability and Methodology

**Evaluation design:** It is expected that the evaluation will utilise a mixed-method design that is gender sensitive and socially inclusive, incorporating quantitative and qualitative methods. To establish the evidence, the evaluation team should assess and suggest the most appropriate design in their proposal for review.

From the evaluation questions, the evaluators will propose an evaluation matrix which will include for each question, appropriate data collection methods and tools and analyses required.

Based on UNICEF's data quality standards, all data collection and analysis will be disaggregated by key demographic characteristics (age, sex, location) and if possible, by vulnerability, including disability.

**Data collection tools:** Currently the intervention utilises the Pre and Post survey tool to capture indicator information before and after exposure to the various channels of delivery. For Peer Education the Peer Facilitator also use Session Tracking form which captures what and how the Peer Facilitator conducted the session, and it is completed by the Peer Facilitator after each session. Evaluators are expected to design tools or data capture instruments that will allow for collection of secondary data and possibly primary data as needed. Tools should collect both quantitative and qualitative data.

**Evaluation scope:** The evaluation should include 2 out of the 4 targeted districts and among adolescents and young people ages XX – XX.

**Flexibility of approach:** UNICEF is cognizant that methodology and approach may be affected by prevailing conditions (e.g., COVID-19 pandemic) and budgetary constraints and therefore expects the successful evaluators to be flexible and creative in responding to changing situations.

A clear articulation of how the fieldwork will be undertaken and any contingency measures that will be in place to deal with COVID-19 should be detailed by the applicants. This should include alternative data collection methods if needed and safety precautions for participants and staff are accounted for. Partnership with a local research firm/institution is highly recommended.



The evaluation will be based on the United Nations Evaluation Group (UNEG) criteria for evaluating development programmes, namely relevance, effectiveness, efficiency, impact and sustainability with a focus on the impact criteria.<sup>7</sup> Quality of the evaluation will be assessed against UNICEF's Global Evaluation Report Quality Standards (see link below). At least a 'Satisfactory' rating for the draft inception as well as final reports will be expected as per definitions therein. The evaluation team should refer to these in the development of the inception and final evaluation reports.

<https://www.unicef.org/evaluation/media/816/file/UNICEF-Adapted-UNEG-Evaluation-Report-Standards.pdf>

## 5. Primary users and intended use of the Evaluation

The primary user of the evidence generated from the evaluation will be the Government of Botswana through NAHPA as the evaluation will inform the current scale up of the programme to the other districts and ensure that lessons learned are documented and built into the current programme for better implementation. UNICEF will use the evidence to continue advocacy efforts towards ensuring adolescent and young people programmes for safe sexual behaviours are developed and implemented. This evaluation will also provide adolescent and young people programming sector

<sup>7</sup> Further details on the UNEG criteria can be obtained from: <http://www.unevaluation.org/document/detail/22>.

invaluable evidence on how to implement a social and behavioural change for adolescent and young people in Botswana that is both relevant and sustainable. Development partners and other non-governmental organisations stand to benefit from the results of the evaluation as well on the use of peer approaches to behaviour change.

## **6. Work Plan, Relationships and Reporting**

The selected institution will work closely with UNICEF team, the National AIDS and Health Promotion Agency in the form of a Steering Committee, to conduct the evaluation and the cost analysis for the intervention package. The focal point to facilitate and coordinate this interaction will be the UNICEF Botswana Evaluation Focal Point.

The consultancy will be for the duration of 7 months over the period 1 November 2022 to 31 May 2023. The consultancy will follow the schedule in line with the expected deliverables and timelines will only be negotiated if the delay is due to conditions beyond the control of the incumbent.

A *phased approach* will be adopted to ensure the successful implementation of the evaluation. It is foreseen that the assignment would entail the following broad stages:

- 1) *Inception Report and Endorsement*: Develop an Inception Report that (i) articulates the theory of change; (ii) recommends an evaluation design detailing the sampling approach, data collection tools and instruments; and (iv) proposes a detailed timeline and stakeholder consultations.
- 2) *Design and Implementation of Evaluation*: Data collection, analysis, report writing and stakeholder engagement by using proposed and approved methodology to investigate the effectiveness of the MTV Shuga programme as per scope of the TOR.
- 3) *Participate in one or more validation workshops of evaluation design and evaluation findings and recommendations with the steering committee and other stakeholders*
- 4) *Produce a final evaluation report in line with UNICEF GEROS requirements*
- 5) *Evaluation advocacy brief*: For dissemination of evaluation findings.

#	Deliverables	Duration	Instalments
1.	The Inception Report (desk review, adapt methodological approach, tools development, stakeholder validation meetings, relevant ethical clearance as appropriate)	November 2022 – December 2022	20%
2.	The Evaluation Research (sampling of research tools, data collection, data analysis, presentation of preliminary results to stakeholders, draft report)	January 2023 - March 2023	50%
3.	Final evaluation report and advocacy brief	April 2023 - May 2023	30%

The draft and final evaluation report should be between 40-60 pages, excluding the executive summary and annexes. The report should indicatively be structured as follows:

- a. Executive summary
- b. Introduction
- c. Description of the project, including the Theory of Change

- d. Overview of the evaluation approach, the design and methods used, including limitations and challenges
- e. Findings
- f. Conclusions and lessons
- g. Recommendations
- h. Annexes

UNICEF's Evaluation Quality Standard and Evaluation Report Standards can be found here:  
<https://www.unicef.org/evaluation/media/816/file/UNICEF-Adapted-UNEG-Evaluation-Report-Standards.pdf>

**All reports should be submitted in electronic form and in English.** As annexes to this TOR, please find all relevant **UNICEF-GEROS Quality Assessment System and Checklists** for your review and understanding of our expectations.

## **6. Payment Schedule**

Payment will be upon satisfactory completion of deliverables as outlined in the table above. UNICEF's policy is to pay for the performance of contractual services rendered or to effect payment upon the achievement of specific milestones described in the contract. UNICEF's policy is not to grant advance payments except in unusual situations where the potential contractor, whether an individual consultant, private firm, NGO or a government or other entity, specifies in the bid that there are special circumstances warranting an advance payment.

Payments will be made upon delivery and approval of deliverables by UNICEF. UNICEF reserves the right to withhold all or a portion of payment if performance is unsatisfactory, if outputs are incomplete, not delivered or for failure to meet deadlines.

## **7. Management and Oversight**

The evaluation management team, comprising members from UNICEF and UNICEF ESARO will provide technical and management support. A Reference Group composed of members from the Ministry of Health and NAHPA and relevant stakeholders will provide feedback at critical stages in the evaluation process, including inception and report writing stages.

## **8. Qualification Requirements**

UNICEF and the Government seek an institution with team members that have the following qualifications:

- Demonstrable experience in designing and conducting evaluations including cost analysis studies;
- Ability to analyse and synthesize information from a broad range of sources;
- Experience in conducting evaluating HIV and adolescents' programmes will be an added advantage;
- Familiar with adolescents' and young people's issues;
- Able to work in a multicultural environment;
- Excellent spoken and written fluency in English required; the team must also include an expert able to communicate in Setswana; knowledge of other local languages in the area desired;
- Excellent analytical, research and report writing skills;
- Effective communication and relationship-building skills

- Evaluation design: the team should consist of members with demonstrated skills and expertise required to design, plan and conduct **mixed-method evaluations**, potentially using **quasi-experimental techniques that are gender-sensitive and socially inclusive**;
- Skills in **quantitative and qualitative** data collection and analysis, drawing findings from multiple sources and handling potential contradictions between datasets.
- Relevant subject matter knowledge and experience: knowledge and experience required in **conducting evaluation against the OECD DAC Criteria, research about children, gender, equity, and child rights** to ensure that the evaluation design and research methods are as relevant and meaningful as possible given the aims and objectives of the project and the context in which it is being delivered;
- Evaluation management: the team has experience managing complex evaluation (impact and process) and research process from end to end.
- Primary research: **gender-sensitive** design, management, and implementation of primary quantitative and qualitative research in potentially challenging project environments, such as during the COVID-19 pandemic
- Country experience: it is particularly important that the team has the appropriate country knowledge /experience and **language proficiency** (Sesotho and English) required to conduct the research
- Team composition: a gender-balanced and culturally diverse team that makes use of national/regional evaluation expertise is an asset
- Information management: design and manage sex- and equity-disaggregated data and information systems capable of handling large datasets
- Statistical analysis: the team should have capacity for **statistical modelling and analysis** of impact data; highly proficient user of SPSS or STATA; and **qualitative data analysis** techniques, including the use of software e.g., ATLAS.ti, NVivo or equivalent where needed;
- Safety considerations: ensuring the whole evaluation process adhere to best practice for research, including the implementation of **safeguarding policy and procedures to ensure safety and protection of participants**. Note that all bidders are expected to be able to show that they have a safeguarding policy in place during the research activities.
- Experience working with/in the UN or other international development organizations in the social sector is an asset

The selected institution must provide UNICEF with a Certificate of Incorporation and other documentation that this is a registered company or institution. The institution must possess at least 5 years' experience in evaluation of programmes in health, nutrition, food security, social research with an emphasis on mixed method data collection and analysis.

The institution should come with sufficient human resources to complete the evaluation within the desired timeframe. At a minimum, the evaluation team should include expertise in the areas of social and behaviour change, adolescent and young people programming, adolescent sexual behaviour, evaluation of ICT platforms and HIV/AIDS prevention and response. Up-to-date CVs/resumes of proposed team members should be included in the submission of a technical proposal.

The lead researcher/team leader must have:

- An advanced University degree (master's or PhD) in Public Health, Epidemiology, Statistics or other relevant social science with strong experience in evaluation design;
- At least 10 years of relevant experience and proven expertise in conducting evaluations, reviews and/or assessments;
- Experience working with the United Nations, particularly UNICEF, including a strong understanding of UNICEF's policies and programming is an asset;

- Proven skills in research analysis, including quantitative and qualitative data collection and analysis techniques;
- Excellent report writing skills, analytical skills, as well as good computer skills;
- Experience leading teams and team processes;
- Excellent command in written and spoken English.

## 9. Content of Proposal

The interested institutions are expected to develop the above into a proposal. All proposals should include an introductory note, summary of understanding of the terms of reference, clear outline of evaluation design and methodology with a detailed breakdown of inception phase proposed scope, data collection methodology and data analysis report writing dissemination plan and timeline including stakeholder consultation and engagement. A draft timeline for completion of assignment, a company profile and CVs of key individuals proposed for assignment should be included in the proposal. The proposal should be in two parts: Part A – Technical; Part B – Financial, of not more than 10 pages. Please note Annexes can be included.

Financial proposals should clearly outline proposed phases of the study. Each phase must be budgeted as progression to each phase will be dependent on available budget. Cost breakdown of consultancy fees, DSA operational costs for field work, air fare and related cost that will be incurred for the assignment.

## 10. Technical Evaluation Criteria and Relative Points

Item	Technical Evaluation Criteria	Max. Points Obtainable
1	<b>Overall Response</b> ( <i>e.g. the understanding of the assignment and the alignment of the proposal to the TOR</i> )	<b>10</b>
1.1	Completeness of response	5
1.2	Overall concord between RFP requirements and proposal	5
2	<b>Company and Key Personnel</b>	<b>30</b>
2.1	Range and depth of Institutional experience and capacity ( <i>operational partner/third party agreements, client references, previous results. Clarity on services that are to be obtained from a third party and related cost (if any).</i>	20
2.2	Experience with projects of similar scope and complexity	5
2.3	Key personnel: relevant experience and qualifications of the proposed team for the assignment	5
3	<b>Proposed Methodology and Approach</b> ( <i>e.g., Work plan showing detail sampling methods, project implementation plan in line with the project</i> )	<b>30</b>
3.1	Proposed robust plan ( <i>such as timelines, steps to set-up, criteria/methodology in management, quality assurance, monitoring tools.) Rationale/methodology is provided.</i>	20
3.2	Technologies used: compatibility with UNICEF ( <i>Security/IT systems</i> )	5
3.3	Innovative approach	5
	<b>TOTAL TECHNICAL SCORES</b>	<b>70</b>

*Note: Minimum technical required score – 50 points. Technical proposal weight is 70%, while financial proposal's weight equals 30%.*

## **11. Risks**

Some activities may be delayed if feedback and inputs from key stakeholders are delayed. The selected institution will work closely with the Government and UNICEF Teams for the respective follow-up.

## **12. Terms and Conditions**

The institution will use their own vehicles equipment, including computers. UNICEF will be under no operational obligation to pay operational costs related to this consultancy, all costs required to operationalise this consultancy shall be borne by the hired institutional firm and should be included into the proposed financial proposal.

## **13. How to Apply**

- A cover letter expressing interest in the work. The cover letter should indicate relevant experience, availability and daily rate;
- Previous work samples that are relevant to this assignment;
- A technical and financial proposal as per TOR;
- Professional curriculum vitae for all team members;
- Three professional references (for the team/company);
- Company/Team profile (as applicable).

Proposals should be submitted no later 23:59hrs 28th October 2022 Botswana Time to  
[BTW\\_procurement@unicef.org](mailto:BTW_procurement@unicef.org) with a cc to [ritumeleng@unicef.org](mailto:ritumeleng@unicef.org)

**Prepared by:**

Gape Machao  
Planning, Monitoring & Evaluation  
Officer

Date:

**Reviewed by:**

Tryphinah Lungah  
Operations Manager

Date:

**Approved by:**

Alexandra Illmer  
Deputy Representative

Date:



## **Annexes**

### **ANNEX I. Inception report outline**

#### **CONTENTS**

##### **1. INTRODUCTION\***

- 1.1. Objective of the evaluation
- 1.2. Background and context
- 1.3. Scope of the evaluation

##### **2. METHODOLOGY**

- 2.1. Evaluation criteria and questions
- 2.2. Conceptual framework
- 2.3. Evaluability
- 2.4. Data collection methods
- 2.5. Analytical approaches
- 2.6. Risks and potential shortcomings

##### **3. PROGRAMME OF WORK**

- 3.1. Phases of work
- 3.2. Team composition and responsibilities
- 3.3. Management and logistic support
- 3.4. Calendar of work

#### **ANNEXES**

- I. Terms of reference of the evaluation
- II. Evaluation matrix
- III. Stakeholder map
- IV. Tentative outline of the main report
- V. Interview checklists/protocols
- VI. Theory of change / outcome model
- VII. Detailed responsibilities of evaluation team members
- VIII. Reference documents
- IX. Document map
- X. Project list
- XI. Project mapping
- XII. Detailed work plan

\*The structure of inception reports may be adjusted depending on the scope of the evaluation.



Individual Rating Criteria Guide	Rating	Explanation
	Yes	Criterion is addressed.
	Partially	Criterion is only partially addressed, one or more important elements are missing or incorrect.
	No	Criterion is not addressed or is inadequately addressed, all important elements are missing or incorrect.
Not rated		Criterion could not be rated, reasons are provided.

#### RATING SCALES

Section Rating Criteria Guide	Rating	Explanation
	Highly Satisfactory (87.5% - 100%)	Exceeds UNICEF/UNEG standards for evaluation inception reports.
	Satisfactory (62.5% - 87.49%)	Meets UNICEF/UNEG standards for evaluation inception reports.
	Fair (35% - 62.49%)	Meets UNICEF/UNEG standards for evaluation inception reports in some regards, but not all.
	Unsatisfactory (0% - 34.99%)	Does not sufficiently meet UNICEF/UNEG standards for evaluation inception reports.

## INCEPTION REPORT REVIEW

### SECTION A: OPENING PAGES AND INTRODUCTION (weight 5%)

<b>Question 1.</b>	<b>Do the opening pages and introduction of the Inception Report contain all the relevant information?</b>
1.1	The introduction contains a short description of the purpose <b>and content</b> of the IR, the key activities undertaken for its preparation and its place in the evaluation process.
1.2	The introduction highlights any emerging issues that have arisen during the inception phase (if applicable).
1.3	Basic elements in the opening pages are presented ( <b>evaluation title, country, years covered by the evaluation, name(s) and/or organization(s) of the evaluator(s), and commissioning organization on cover page, list of acronyms, table of contents, including list of tables and figures</b> ).
<b>Feedback on Section A - The rater will briefly (3-5 sentences) assess top line issues for this section and provide suggestions for improvements.</b>	

### SECTION B. CONTEXT AND DESCRIPTION OF THE OBJECT OF THE EVALUATION (weight 10%)

<b>Question 2.</b>	<b>Are the context and description of the object of the evaluation clearly presented?</b>
2.1	<b>Clear and relevant description of the context of the object of the evaluation (i.e. relevant policy, socio-economic, political, cultural, power/privilege, institutional, international factors) and how context relates to the implementation of the object of the evaluation.</b>
2.2	<b>Linkages are drawn to the SDGs and relevant targets and indicators for the area being evaluated.</b>
2.3	<b>The object of the evaluation is briefly and clearly explained (<b>its objectives, stakeholders involved and their roles, contributions, and stakes, right holders/beneficiaries and their status and needs, time period, budget, geographic scope, phase of implementation</b>).</b>
2.4	<b>The description of the object of the evaluation makes adequate references to human rights, gender, and equity/inclusion.</b>
2.5	<b>The logic model or the theory of change (ToC) of the object being evaluated is described to some extent, with the assumption that it will be further refined or finalized in the Evaluation Report.</b>
<b>Feedback on Section B - The rater will briefly (3-5 sentences) assess top line issues for this section and provide suggestions for improvements.</b>	

### SECTION C: PURPOSE, OBJECTIVES, AND SCOPE OF THE EVALUATION (weight 10%)

<b>Question 3.</b>	<b>Are the purpose, objectives and scope of the evaluation clearly presented?</b>
3.1	<b>The evaluation purpose is clearly presented, including the rationale behind the evaluation, its intended use and what this use is expected to achieve, its primary intended users and how they stand to gain or lose from the results of the evaluation.</b>
3.2	<b>The evaluation objectives are clearly presented with reference to any changes made to the</b>

#### SECTION D: EVALUATION FRAMEWORK (weight 20%)

<b>Question 4.</b> <b>Are the evaluation criteria and questions clearly presented?</b>	
4.1	All of the evaluation criteria and questions <b>are listed</b> as per ToR. If criteria/questions differ from ToR, the Inception Report justifies the changes, e.g., efforts to prioritize questions and reduce number of questions to address should be noted in the report.
<b>Question 5.</b> <b>Are evaluation findings derived from the conscientious, explicit and judicious use of the best available, objective, reliable and valid data and by accurate quantitative and qualitative analysis of evidence.</b>	
5.1	The Inception Report links the evaluation criteria and questions to the chosen methodology through an evaluation matrix <b>that includes indicators, benchmarks, assumptions and/or other processes from which the analysis can be based and conclusions drawn, referring to the Convention on the Rights of the Child (CRC), Leave No one Behind (LNOB), and disability inclusion as appropriate.</b>
5.2	<b>Indicators, data sources, and data collection and methods are identified for each question.</b>
5.3	The indicators chosen are specific, easily measurable, and relevant to the corresponding evaluation questions and ToC
5.4	The evaluation questions and indicators include reference to human rights, gender, and equity dimensions.
	<b>Feedback on Section D - The rater will briefly (3-5 sentences) assess top line issues for this section and provide suggestions for improvements.</b>

#### SECTION E: METHODOLOGY (weight 30%)

<b>Question 6.</b> <b>Is the methodology clearly presented, technically sound, logically feasible, and appropriate considering the evaluation framework?</b>	
6.1	<b>Clear and complete description of a relevant and robust methodological design and set of methods that are suitable for the evaluation's purpose, objectives, and scope. Any adaptations to the methods proposed in the ToR are explained and justified.</b>
6.2	If the evaluation asks attribution questions (outcome or impact level), an appropriate evaluation design (qualitative or quantitative) to reliably measure attribution <b>is proposed.</b>

6.8	Questions in interview protocols, discussion guides and questionnaires are robust, focused, linked to the evaluation matrix and avoid leading questions.
6.9	The Inception Report describes relevant methodological limitations to the evaluation.
6.10	<b>Clear and complete description of evaluation limitations, potential biases and constraints faced by the evaluation team, and mitigation strategies to be used.</b>
6.11	The Inception Report specifies that the evaluation will follow the UNEG Norms and Standards as well as the UNEG Ethical Guidelines for Evaluation. weblinks: <a href="http://www.uneval.org/normsandstandards/index.jsp">http://www.uneval.org/normsandstandards/index.jsp</a> <a href="http://www.unevaluation.org/ethicalguidelines">http://www.unevaluation.org/ethicalguidelines</a>
6.12	<b>Explicit and contextualized reference to the obligations of evaluators (independence, impartiality, credibility, conflicts of interest, accountability) in accordance with UNEG ethical standards.</b>
6.13	<b>Description of ethical safeguards for participants appropriate for the issues described</b>

#### SECTION F: EVALUATION WORKPLAN (weight 20%)

Question 7.	<b>Is the workplan complete and containing relevant information?</b>
7.1	The evaluation phases are clearly described, including a timeline with associated activities, number of days for each team member, locations and deliverables.
7.2	The roles and responsibilities of each member of the evaluation team are <b>clearly</b> described.
7.3	If the evaluation requires official ethical approval, <b>the process to be followed is clearly described.</b>
7.4	The Inception Report describes the evaluation quality assurance process.
7.5	The logistics of carrying out the evaluation are discussed (e.g. assistance required from UNICEF for interview arrangements, field visits, etc.) and the expected roles and responsibilities from the commissioning organization(s) or oversight committee are adequately explained.
	<b>Feedback on Section F - The rater will briefly (3-5 sentences) assess top line issues for this section and provide suggestions for improvements.</b>

## SECTION G: INCEPTION REPORT STRUCTURE/PRESENTATION (weight 5%)

<b>Question 8.</b>	<b>Do the annexes contain all the relevant elements?</b>
8.1	The evaluation ToR are included in the annexes.
8.2	The following elements are annexed to the Inception Report: logic model/ToC, evaluation matrix, bibliography, data collection tools (draft interview protocols, survey, case study formats), list(s) of people to be interviewed, if applicable and available ethical review board approval form and/or informed consent form.
<b>Question 9.</b>	<b>Is the Inception Report coherent and logical?</b>
9.1	Structure is easy to identify and navigate (for instance, with numbered sections, clear titles and sub-titles, well formatted).
9.2	Inception Report is easy to understand (written in an accessible way for intended audiences and generally free from grammar, spelling and punctuation errors), and conveys key information through the use of visual aids (such as infographics, maps, tables, figures, photos) which are clearly presented, labeled, and referenced in text.
	<b>Feedback on Section G - The rater will briefly (3-5 sentences) assess top line issues for this section and provide suggestions for improvements.</b>

**The title page and opening pages provide key basic information**

1. Name of the evaluation object
2. Timeframe of the evaluation and date of the report
3. Locations (country, region, etc.) of the evaluation object
4. Names and/or organizations of evaluators
5. Name of the organization commissioning the evaluation
6. Table of contents which also lists Tables, Graphs, Figures and Annexes
7. List of acronyms

**Executive Summary** is a stand-alone section of 2-3 pages that includes:

1. Overview of the evaluation object
2. Evaluation objectives and intended audience
3. Evaluation methodology
4. Most important findings and conclusions
5. Main recommendations

**Annexes increase the credibility of the evaluation report. They may include, inter alia:**

1. ToRs
2. List of persons interviewed, and sites visited
3. List of documents consulted
4. More details on methodology, such as data collection instruments, including details of their reliability and validity
5. Evaluators biodata and/or justification of team composition
6. Evaluation matrix
7. Results framework

**Object of Evaluation**

**The report presents a clear and full description of the ‘object’ of the evaluation**

1. The logical model and/or the expected results chain (inputs, outputs, and outcomes) of the object is clearly described

2. The **context of key social, political, economic, demographic, and institutional factors** that have a direct bearing on the object is described. For example, the partner government's strategies and priorities, international, regional, or country development goals, strategies and frameworks, the concerned agency's corporate goals and priorities, as appropriate.

Scale and complexity of the object of the evaluation are clearly described, for example:

3. **The number of components**, if more than one, and the size of the population each component is intended to serve, either directly or indirectly

- **The geographic context and boundaries** (such as the region, country, and/or landscape and challenges where relevant).

#### **- The purpose and goal, and organization/management of the object**

- The **total resources** from all sources, including human resources and budget (s) (e.g., concerned agency, partner).

4. The **key stakeholders involved** in the object implementation, including the implementing agency (s) and partners, other key stakeholders and their roles

5. The report identifies **the implementation status of the object**, including its phase of implementation and any significant changes (e.g., plans, strategies, logical frameworks) that have occurred over time and explains the implications of those changes for the evaluation

#### **Evaluation Purpose, Objective(s) and Scope**

##### **The evaluation's purpose, objectives and scope are fully explained**

1. The purpose of the evaluation is clearly defined, including why the evaluation was needed at that point in time, who needed the information, what information is needed, how the information will be used by different intended audiences.
2. The report should provide a clear explanation of the evaluation objectives and scope including main evaluation questions and describes and justifies what the evaluation did and did not cover
3. The report describes and provides an explanation of the chosen evaluation criteria, performance standards, or other criteria used by the evaluators
- 4 As appropriate, evaluation objectives and scope include questions that address issues of gender and human rights

#### **Evaluation Methodology**

##### **The report presents transparent description of the methodology applied to the evaluation that clearly explains how the evaluation was specifically designed to address the evaluation criteria, yield answers to the evaluation questions and achieve evaluation purposes.**

1. The report describes the data collection methods and analysis, the rationale for selecting them, and their limitations. Reference indicators and benchmarks are included where relevant.
2. The report describes the data sources, the rationale for their selection, and their limitations. The report includes discussion of how the mix of data sources was used to obtain a diversity of perspectives, ensure data accuracy, and overcome data limits.
3. The report describes the sampling frame – area and population to be represented, rationale for selection, mechanics of selection, numbers selected out of potential subjects, and limitations of the sample
4. The evaluation report gives me complete description of stakeholder's consultation process in the evaluation including the rationale for selecting the particular level and activities of consultation
5. The methods employed are appropriate for the evaluation and to answer its questions.
6. The methods employed are appropriate for analysing gender and human rights issues including child rights issues identified in the evaluation scope.

7. The report presents evidence that adequate measures were taken to ensure data quality, including evidence supporting the reliability and validity of data collection tools (e.g. interview protocols, observation tools etc.)

8. The evaluation design was ethical and included ethical safeguards where appropriate, including protection of confidentiality, dignity, rights, and welfare of human subjects particularly children, and respect of the values of the beneficiary community.

## **5. Findings**

**Findings respond directly to the evaluation criteria and questions detailed in the scope and objectives section of the report are based on evidence derived from data collection and analysis methods described in the methodology section of the report**

1. Reported findings reflect systematic and appropriate analysis and interpretation of the data
2. Reported findings address the evaluation criteria (such as efficiency, effectiveness, sustainability, impact, and relevance) and questions defined in the evaluation scope
3. Findings are objectively reported on the evidence
4. Gaps and limitations in the data and/or unanticipated findings are reported and discussed
5. Reasons for accomplishments and failures, especially continuing constraints, were identified as much as possible
6. Overall findings are presented with clarity, logic, and coherence

## **6. Conclusions and Lessons Learned**

**Conclusions present reasonable judgements based on findings and substantiated by evidence and provide insights pertinent to the object and purpose of the evaluation**

1. The conclusions reflect reasonable evaluative judgements relating to key evaluation questions
2. Conclusions are well substantiated by the evidence presented and are logically connected to evaluation findings
3. Stated conclusions provide insights into the identification and/or solutions of important problems issues pertinent to the prospective decisions and actions of evaluation users
4. Conclusions present strengths and weaknesses of the object (policy, programmes, projects or other intervention) being evaluated, based on the evidence presented in taking due account of the views of a diverse cross-section of stakeholders
5. Lessons learned, when presented, were generalized beyond the immediate intervention being evaluated to indicate what wider relevance there might be.

## **7. Recommendations**

**Recommendations are relevant to the object and purpose of the evaluation, are supported by evidence and conclusions, and were developed with involvement of relevant stakeholders**

1. The report describes the process followed in developing the recommendation including consultation with stakeholders
2. Recommendations are firmly based on evidence and conclusions
3. Recommendations are relevant to the object and purpose of the evaluation

## **ANNEX IV. UNICEF Quality Assurance Checklist for the Evaluation Report**



RATING SCALES

Individual Rating Criteria Guide	Rating	Explanation
Yes		Criterion is addressed.
Partially		Criterion is only partially addressed, one or more important elements are missing or incorrect.
No		Criterion is not addressed or is inadequately addressed, all important elements are missing or incorrect.
Not rated		Criterion could not be rated, reasons are provided.

RATING SCALES

Section Rating Criteria Guide	Rating	Explanation
	Highly Satisfactory (87.5% - 100%)	Exceeds UNICEF/UNEG standards for evaluation reports and decision makers may use the evaluation with a high degree of confidence.
	Satisfactory (62.5% - 87.49%)	Meets UNICEF/UNEG standards for evaluation reports and decision makers may use the evaluation with confidence.
	Fair (35% - 62.49%)	Meets UNICEF/UNEG standards for evaluation reports in some regards, but not all. Decision makers may continue to use the evaluation with caution, but substantive improvements are possible.
	Unsatisfactory (0% - 34.99%)	Does not sufficiently meet the UNICEF/UNEG standards for evaluation reports; and thus decision makers cannot rely on the evaluation.

## DRAFT EVALUATION REPORT REVIEW

### SECTION A: BACKGROUND (weight 5%)

Question 1.	Is the object of the evaluation clearly described?
1.1	Clear and relevant description of the intervention, including: location(s), timelines, cost/budget, and implementation status.
1.2	Clear and relevant description of intended rights holders (beneficiaries) and duty bearers (state and non-state actors with responsibilities regarding the object of the evaluation) by type (i.e., institutions/organizations; communities; individuals...), by geographic location(s) (i.e., urban, rural, particular neighborhoods, town/cities, sub-regions...) and in terms of numbers reached with disaggregation by gender, age, disability . . .(as appropriate to the purpose of the evaluation).
Question 2.	Is the context of the intervention clearly described?
2.1	Clear and relevant description of the context of the object of the evaluation (i.e. relevant policy, socio-economic, political, cultural, power/privilege, institutional, international factors) and how context relates to the implementation of the object of the evaluation.
2.2	Linkages are drawn to the SDGs and relevant targets and indicators for the area being evaluated.
2.3	Clear and relevant description (where appropriate) of the status and needs of the right holders/beneficiaries of the intervention.
Question 3.	Are key stakeholders, their relationships and contributions clearly identified?
3.1	Identification of implementing agency(ies), development partners, right holders, and additional duty bearers and other stakeholders; and of linkages between them (e.g., stakeholder map) (if relevant).
3.2	Identification of the specific contributions and roles of key stakeholders (financial or otherwise), including UNICEF.
	Feedback on Section A - The rater will briefly (3-5 sentences) assess top line issues for this section and provide suggestions for improvements.

## SECTION B: EVALUATION PURPOSE, OBJECTIVES AND SCOPE (weight 5%)

<b>Question 4.</b>	<b>Is the purpose of the evaluation clearly described?</b>
4.1	Specific identification of how the evaluation is intended to be used and what this use is expected to achieve.
4.2	Identification of appropriate primary intended users of the evaluation.
<b>Question 5.</b>	<b>Are the objectives and scope of the evaluation clear and realistic?</b>
5.1	Clear and complete description of what the evaluation seeks to achieve by the end of the process with reference to any changes made to the objectives included in the ToR and/or in the inception report.
5.2	Clear and relevant description of the scope of the evaluation: what will and will not be covered (thematically, chronologically, geographically with key terms defined), as well as the reasons for this scope (e.g., specifications by the ToR and/or inception report, lack of access to particular geographic areas for political or safety reasons at the time of the evaluation, lack of data/evidence on particular elements of the intervention).
<b>Question 6.</b>	<b>Is the theory of change, results chain or logic well articulated?</b>
6.1	Clear and complete description of the intervention's intended results or of the parts of the results chain that are applicable to, or are being tested by, the evaluation.
6.2	Causal relationship between outputs and outcomes is presented in narrative and graphic form (e.g., results chain, logic model, theory of change, evaluation matrix).
6.3	For theory-based evaluations, the theory of change or results framework is assessed, and if requested in the ToR, it is reformulated/improved by the evaluators.
	<b>Feedback on Section B - The rater will briefly (3-5 sentences) assess top line issues for this section and provide suggestions for improvements.</b>

## SECTION C: EVALUATION METHODOLOGY (weight 20%)

<b>Question 7.</b>	<b>Does the evaluation use questions and the relevant list of evaluation criteria that are explicitly justified as appropriate for the purpose of the evaluation?</b> UNICEF evaluation standards refer to the OECD/DAC criteria. Not all OECD/DAC criteria are relevant to all evaluation objectives and scopes. Standard OECD DAC Criteria include: Relevance; Effectiveness; Efficiency; Sustainability; Impact. Evaluations should also consider equity, gender and human rights (these can be mainstreamed into other criteria). Humanitarian evaluations should consider Coverage; Connectedness; Coordination; Protection; Security.
7.1	Evaluation questions and sub-questions are appropriate for meeting the objectives and purpose of the evaluation and are aligned with the evaluation criteria.
7.2	In addition to the questions and sub-questions, the evaluation matrix includes indicators, benchmarks, assumptions and/or other processes from which the analysis can be based and conclusions drawn.

<b>Question 8.</b>	<b>Does the report specify methods for data collection, analysis, and sampling?</b>
8.1	Clear and complete description of a relevant and robust methodological design and set of data collection methods that are suitable for the evaluation's purpose, objectives, and scope.
8.2	Data sources are appropriate, normally including qualitative and quantitative sources (unless otherwise specified in the ToR), and are all clearly described.
8.3	Sampling strategy is provided, describing how diverse perspectives were captured (or if not, providing reasons for this).
8.4	Clear and complete description of data analysis methods.
8.5	Methodology allows for drawing causal connections between outputs and expected outcomes.
8.6	Clear and complete description of evaluation limitations, biases and constraints faced by the evaluation team and mitigation strategies used.
<b>Question 9.</b>	<b>Are ethical issues and considerations described?</b> The evaluation should be guided by the UNEG ethical standards for evaluation and to 2015 UNICEF Procedure on Ethics to conduct Research, Studies, Evaluation. As such, the evaluation report should include:
9.1	Explicit and contextualized reference to the obligations of evaluators (independence, impartiality, credibility, conflicts of interest, accountability) in accordance with UNEG ethical standards.
9.2	Description of ethical safeguards for participants appropriate for the issues described (respect for dignity and diversity, right to self-determination, fair representation, compliance with codes for vulnerable groups (i.e. adherence to ethical principles and procedure, do no harm, confidentiality and data collection). For those cases where the evaluation involved interviewing children, explicit reference is made to the UNICEF procedures for Ethical Research Involving Children.
9.3	If the Evaluation Report required an official ethical approval and informed consent, both forms are included as an annex in the draft final evaluation report.
	<b>Feedback on Section C - The rater will briefly (3-5 sentences) assess top line issues for this section and provide suggestions for improvements.</b>

<b>SECTION D: EVALUATION FINDINGS (weight 25%)</b>	
<b>Question 10.</b>	<b>Do the findings clearly address all evaluation objectives and scope?</b>
10.1	Findings contain sufficient levels of evidence to systematically address all of the evaluation's criteria and questions. Gaps in evidence that was generated and mitigation of bias are highlighted if relevant.
10.2	If feasible and relevant to the purpose, cost analysis is clearly presented (how costs compare to similar interventions or standards, most efficient way to get expected results)-if not feasible, an explanation is provided.
10.3	Explicit use of the intervention's results framework/ToC in the formulation of the findings.

<b>Question 11.</b>	<b>Are evaluation findings derived from the conscientious, explicit and judicious use of the best available, objective, reliable and valid data and by accurate quantitative and qualitative analysis of evidence.</b>
11.1	Evaluation uses credible forms of qualitative and quantitative data, presenting both output and outcome-level data as relevant to the evaluation framework. Triangulation is evident through the use of multiple data sources.
11.2	Findings are clearly supported by, and respond to, the evidence presented, including both positive and negative. Findings are based on clear performance indicators, standards, benchmarks, or other means of comparison as relevant for each question.
11.3	Unexpected effects (positive and negative) are identified and analyzed.
11.4	The causal factors (contextual, organizational, managerial, etc.) leading to achievement or non-achievement of results are clearly identified. For theory-based evaluations, findings analyze the logical chain (progression -or not- from implementation to results).
<b>Question 12.</b>	<b>Does the evaluation assess and use the intervention's Results Based Management elements?</b>
12.1	Clear and comprehensive assessment of the intervention's monitoring system (including completeness and appropriateness of results/performance framework -including vertical and horizontal logic; M&E tools and their usage) to support decision-making.
	<b>Feedback on Section D - The rater will briefly (3-5 sentences) assess top line issues for this section and provide suggestions for improvements.</b>

<b>SECTION E: EVALUATION CONCLUSIONS &amp; LESSONS LEARNED (weight 10%)</b>	
<b>Question 13.</b>	<b>Do the conclusions present an objective overall assessment of the intervention?</b>
13.1	Conclusions are clearly formulated and reflect the purpose and objectives of the evaluation. They are sufficiently forward looking (if a formative evaluation or if the implementation is expected to continue or have additional phase).
13.2	Conclusions are derived appropriately from findings, and present a picture of the strengths and limitations of the intervention that adds insight and analysis beyond the findings.
<b>Question 14.</b>	<b>Are logical and informative lessons learned identified? [N/A if lessons are not presented and not requested in ToR]</b>
14.1	Identified lessons stem logically from the findings, have wider applicability and relevance beyond the object of the evaluation.
14.2	Lessons are clearly and concisely presented, yet have sufficient detail to be useful for intended audience.
	<b>Feedback on Section E - The rater will briefly (3-5 sentences) assess top line issues for this section and provide suggestions for improvements.</b>

## SECTION F: RECOMMENDATIONS (weight 15%)

<b>Question 15.</b>	<b>Are recommendations well grounded in the evaluation?</b>
15.1	Recommendations align with the evaluation purpose, are clearly formulated and logically derived from the findings and/or conclusions.
15.2	Recommendations are useful and actionable for primary intended users and uses (relevant to the intervention); guidance is given for implementation, as appropriate.
15.3	Process for developing the recommendations is described, and includes the involvement of duty-bearers, as well as rights holders when feasible (or explanation given for why they were not involved).
<b>Question 16.</b>	<b>Are recommendations clearly presented?</b>
16.1	Clear identification of groups or duty-bearers responsible for action for each recommendation (or clearly clustered group of recommendations). Clear prioritization and/or classification of recommendations to support use.
	<b>Feedback on Section F - The rater will briefly (3-5 sentences) assess top line issues for this section and provide suggestions for improvements.</b>

## SECTION G: EVALUATION STRUCTURE/PRESENTATION (weight 5%)

<b>Question 17.</b>	<b>Does the evaluation report include all relevant information?</b>
17.1	Opening pages include: Name of evaluated object, timeframe of the object evaluated, date of report, location of evaluated object, name(s) and/or organization(s) of the evaluator(s), name of organization commissioning the evaluation, table of contents -including, as relevant, tables, graphs, figures, annexes; list of acronyms/abbreviations, page numbers.
17.2	Annexes include: terms of reference, evaluation matrix, list of interviewees, results chain/ToC/logical framework (unless included in report body), list of site visits, data collection instruments (such as survey or interview questionnaires), list of documentary evidence. Other appropriate annexes could include: additional details on methodology, information about the evaluator(s).
<b>Question 18.</b>	<b>Is the report logically structured?</b>
18.1	Structure is easy to identify and navigate (for instance, with numbered sections, clear titles and sub-titles, well formatted).
18.2	Structure follows UNICEF guidelines for evaluation reports: context, purpose, objectives and methodology would normally precede findings, which would normally be followed by conclusions, lessons learned and recommendations.
18.3	Report is easy to understand (written in accessible way for intended audience) and generally free from grammar, spelling and punctuation errors.
18.4	Frequent use of visual aids (such as infographics, maps, tables, figures, photos) to convey key information. These are clearly presented, labeled, and referenced in text.
18.5	Report is of reasonable length; it does not exceed number of pages that may be specified in ToR.
	<b>Feedback on Section G - The rater will briefly (3-5 sentences) assess top line issues for this section and provide suggestions for improvements.</b>

## SECTION H: EVALUATION PRINCIPLES (weight 10%)

<b>Question 19.</b>	<b>Did the evaluation design and style consider incorporation of the UN and UNICEF's commitment to a human rights-based approach to programming, to gender equality, and to equity?</b>
19.1	Reference and use of rights-based framework, and/or CRC, and/or CCC, and/or CEDAW and/or other rights related benchmarks in the design of the evaluation.
19.2	Clear description of the level of participation of key rights holders and duty bearers in the conduct of the evaluation, including in the development of recommendations, (for example, a reference group is established, stakeholders are involved as informants or in data gathering).
19.3	Stylistic evidence of the inclusion of these considerations can include: using human-rights language; gender-sensitive and child-sensitive writing; disaggregating data by gender, age and disability groups; disaggregating data by socially excluded groups.
<b>Question 20.</b>	<b>Does the evaluation assess the extent to which the implementation of the intervention addressed equity?</b>
20.1	Evaluation assesses the extent to which the implementation of the intervention addresses child rights and Leave No-one Behind (gender and other excluded and marginalized groups). It is disability inclusive, i.e. it is aligned with the UN Disability Inclusion Strategy as appropriate.
<b>Question 21.</b>	<b>Does the evaluation meet UN SWAP evaluation performance indicators?</b>
<b>Note: this question will be rated according to UN SWAP standards</b>	
21.1	GEEW is integrated in the Evaluation Scope of analysis, and evaluation criteria and questions are designed in a way that ensures GEEW-related data will be collected.
21.2	A gender-responsive Evaluation Methodology, Methods and tools, and Data Analysis Techniques are selected.
21.3	The evaluation Findings, Conclusions and Recommendations reflect a gender analysis.

## SECTION I: EXECUTIVE SUMMARY (weight 5%)

<b>Question 22.</b>	<b>Can the executive summary inform decision-making?</b>
22.1	An executive summary is included that is of relevant conciseness and depth for key users. (Maximum of 5 pages unless otherwise specified in ToR).
22.2	Includes all necessary elements (overview of the object of the evaluation, evaluation purpose, objectives and intended audience, evaluation methodology, key conclusions on findings, lessons learned if requested, and key recommendations) as per ToR.
22.3	Includes all significant information to understand the object of the evaluation and the evaluation itself AND does not introduce new from what is presented in the rest of the
	<b>Feedback on Section I - The rater will briefly (3-5 sentences) assess top line issues for this section and provide suggestions for improvements.</b>

## Annex 2: Evaluation framework

Evaluation Criteria	Key Evaluation Questions	Specific Evaluation Questions	Indicators	Methods	Data source
Relevance	To what extent was the intervention adequate to address behaviour change among adolescents and young people?	To what extent were the beneficiaries satisfied with the behaviour change intervention?	<p>Perception on whether MTV Shuga intervention addressed negative attitudes around condom use (drivers of new HIV infections among adolescents, non-adherence to ART etc) - <b>(consider for gender and different locations – rural, urban and remote)</b></p> <p>Problems being addressed by the intervention as identified by AYP and stakeholders</p> <p>Problems that are still outstanding/not addressed driving HIV infections and non-adherence to ART by AYP – <b>(consider for gender and different locations – rural, urban and remote)</b></p> <p>Satisfaction of beneficiaries with the quality of support from peer educators (also in different settings – in and out of school) - <b>(consider for gender and different locations – rural, urban and remote)</b></p>	Key Informant Interviews (KIs)  Focus Group Discussions (FGDs)  Document review	DHMT (Health Education), DAC, G&C teachers, UNICEF, Makgabaneng, NAPHA  AYP (boys and girls), community leaders, caregivers, peer educators  MTV Shuga (2019-2022) Programme Document Pre-test reports MTV sugar Quarterly reports from Makgabaneng Annual Project Reports
	To what extent were the programme strategies, approaches and methods relevant and responsive to the local settings, population, circumstances and challenges?		Alignment of sessions' content to daily lives of AYP  Perceptions of AYP and other stakeholders on appropriateness of delivery (working through peer educators for out school and with peer educators and G&C teachers in school) <b>consider for gender and different locations – rural, urban and remote</b>	Key Informant Interviews (KIs)  Focus Group Discussions (FGDs)  Document review	DHMT (Health Education), DAC, G&C teachers, UNICEF, Makgabaneng, NAPHA  AYP (boys and girls), community leaders, caregivers, peer educators  MTV Shuga (2019-2022) Programme Document Pre-test reports MTV sugar

Evaluation Criteria	Key Evaluation Questions	Specific Evaluation Questions	Indicators	Methods	Data source
			<p>Strength of linkages between peer educators and community cadres, schools, and district level to facilitate behaviour change</p> <p>Validity of the assumptions underpinning the envisage change from interventions</p> <p>Perceptions of stakeholders and AYP on adequacy of interventions</p> <p>Challenges faced undermining responsiveness of interventions</p>		Quarterly reports from Makgabaneng Annual Project Reports
Effectiveness	How well did the MTV Shuga programme achieve its results?	To what extent did adolescents and young people adopt safe sexual behaviours as a result of the programme? Was there an improvement in self-efficacy? Did AYP access SRHR and other related services?	<p>Percentage of AYPs who report ability to demand safe sex under pressure.</p> <p>Percentage of AGYW that feel at ease to report sexual abuse cases through formal structures, Child Helpline, Schools and etc</p> <p>Percentage of AYPs with intention to go for HIV testing in the next 3 months.</p> <p>Percentage of AYPs who have tested for HIV and know their status.</p> <p>Percent difference in AYP receiving SRHR services (ANC, Cervical cancer screening, VMC, contraceptives etc) in local health facilities</p>	Secondary data analysis	<p>Pre- and post-assessment surveys</p> <p>Health facility records from the towns and villages under the project in the four districts</p>
		To what extent did attitudes towards the following improve: <ul style="list-style-type: none"> <li>• intergenerational and transaction sex</li> <li>• gender norms related to prevention of HIV</li> </ul>	<p>Percentage of AYPs who think it is okay to date a partner that is 10 years older.</p> <p>Percentage of AYPs who think it's reasonable for a partner to expect sex in exchange for money or gifts.</p>	Secondary data analysis	Pre- and post-assessment surveys

Evaluation Criteria	Key Evaluation Questions	Specific Evaluation Questions	Indicators	Methods	Data source
Efficiency		and unwanted pregnancy?	Percentage AGYW <sup>s</sup> who think it is both boys and girls' responsibility to carry condoms.  Percentage of AYP <sup>s</sup> who think it's a girl/ woman's responsibility to ensure she doesn't fall pregnant.		
		What were the key factors influencing the achievement or non-achievement of results?	<b>Role played by</b> 1) capacity of peer educators (including motivation); 2) linkages to district and village structures; 3) quality of content and support; 4) other contributory factors e.g. access to services, motivation of stakeholders; and 5) COVID-19 restrictions and aftermath.  <b>Role played by management and coordination:</b> 1) supportive supervision to peer educators; 2) coordination between IP, DAC, DHMT, and peer educators; 3) other existing support in communities.	Key Informant Interviews (KII <sup>s</sup> )  Focus Group Discussions (FGD <sup>s</sup> )  Document review  Case studies	DHMT (Health Education), DAC, G&C teachers, UNICEF, Makgabaneng, NAPHA  AYP (boys and girls), community leaders, peer educators  Quarterly reports from Makgabaneng  Annual Project Reports  Steering Committee minutes  AYP former participants in MTV sugar sessions
	Do the programme results justify the investments (financial and human resources) made?	To what extent were the implementing strategies appropriate for achieving results?	Perceptions of stakeholders on the management approach for UNICEF, Makgabaneng  Perceptions on effectiveness of stakeholders oversight arrangements with NAPHA  Perceptions of quality (ability to deliver the content and support peers) of peer educators  Satisfaction of peer educators with quality of training (adequacy of content, time available, and after training support)	Key Informant Interviews (KII <sup>s</sup> )  Focus Group Discussions (FGD <sup>s</sup> )  Document review  Case studies	DHMT (Health Education), DAC, G&C teachers, UNICEF, Makgabaneng, NAPHA  AYP (boys and girls), community leaders, peer educators  Quarterly reports from Makgabaneng  Annual Project Reports  Steering Committee minutes  Peer educators

Evaluation Criteria	Key Evaluation Questions	Specific Evaluation Questions	Indicators	Methods	Data source
			Alternative strategies that could have been used to achieve same or better results		
		Which components of the intervention and its communication channels are less resource intensive but critical for the programme results?	Cost of interventions Cost of communication channels	Secondary data analysis	Financial and programme monitoring reports
		To what extent did the programme generate solid evidence from monitoring and evaluation in order to inform policy/advocacy and improved programming?	Monitoring systems are in place for the project  Alignment of data with the project's theory of change  Examples of use of monitoring data in project planning and implementation  Examples of use of monitoring data for advocacy  Quality of the monitoring system (timeliness in data availability, quality of data, comprehensiveness of data and accessibility)  Perceptions of stakeholders on the quality of the monitoring system	Key Informant Interviews (KIs)  Focus Group Discussions (FGDs)  Document review  Case studies	DAC, G&C teachers, UNICEF, Makgabaneng, NAPHA  AYP (boys and girls), peer educators  Quarterly reports from Makgabaneng Annual Project Reports Steering Committee minutes  Peer educators
Gender and Equity	To what extent did the implementation of the intervention address child rights and Leave No-one Behind (gender and other excluded and marginalized groups).	How well did the programme integrate gender and equity considerations into its design and implementation?	Measures to integrate: (1) gender; (2) disability; and (3) equity in the programme  Successes in integrating (1) gender; (2) disability; and (3) equity in the programme  Challenges in integrating (1) gender; (2) disability; and (3) equity in the programme	Key Informant Interviews (KIs)  Focus Group Discussions (FGDs)  Document review	DHMT (Health Education), DAC, G&C teachers, UNICEF, Makgabaneng, NAPHA  AYP (boys and girls), community leaders, peer educators  Quarterly reports from Makgabaneng

Evaluation Criteria	Key Evaluation Questions	Specific Evaluation Questions	Indicators	Methods	Data source
Sustainability			Lessons learned in integrating (1) gender; (2) disability; and (3) equity in the programme	Case studies	Annual Project Reports Steering Committee minutes  AYP with disabilities and those that are females
			Was sufficient information collected during the implementation period on specific result indicators to measure progress on gender and equity?	Data collected to measure project's impact on gender and equity  Data gaps that existed  Additional data that could have been collected	Key Informant Interviews (KII)  Focus Group Discussions (FGDs)  Document review
			To what extent was the programme disability inclusive?	Measures to ensure disability inclusiveness  Adequacy of measures for disability inclusive implementation (in accordance with the UNICEF Essential actions on disability inclusive health <sup>8</sup> )  Challenges in ensuring disability inclusive actions	Key Informant Interviews (KII)  Focus Group Discussions (FGDs)  Document review
					Quarterly reports from Makgabaneng Annual Project Reports Steering Committee minutes  Peer educators  Quarterly reports from Makgabaneng Annual Project Reports Steering Committee minutes MTV Shuga (2019-2022) Programme Document
			Has the programme systematically promoted national ownership, capacity-building and skills	Measures put in place by the programme to sustain the programme results/benefits (including learning systems, peer support and service	Case studies  AYP with disabilities

<sup>8</sup> <https://www.unicef.org/media/124146/file/Essential%20actions%20on%20disability-inclusive%20humanitarian%20action.pdf> Accessed 12 April 2023

Evaluation Criteria	Key Evaluation Questions	Specific Evaluation Questions	Indicators	Methods	Data source
transfer to counterparts (government, civil society, AYP) in order for them to be able to sustain the programme?	sustainability of the programme?		uptake by AYP) without external funding Measures put in place by the programme to support continuation or scale up of the programme  Contributions by government and other partners to the programme  Plans in place by government and other partners to continue with or scale up the programme  Perceptions of stakeholders on their capacity to continue with the programme	Document review	Quarterly reports from Makgabaneng Annual Project Reports Steering Committee minutes MTV Shuga (2019-2022) Programme Document
	What is required to take the package of interventions to scale?		Support needed to ensure programme continues or is scaled up	Key Informant Interviews (KIs)  Focus Group Discussions (FGDs)  Document review	DAC, G&C teachers, UNICEF, Makgabaneng, NAPHA  Peer educators  Quarterly reports from Makgabaneng Annual Project Reports Steering Committee minutes MTV Shuga (2019-2022) Programme Document

Annex 3: List of people met

Name	Position	Organisation
Lesedi Tshikare	M&E Officer	Makgabaneng
Matlhogonolo Motshegwa	MTV Shuga Programme Manager	Makgabaneng
Tony Buru	Executive Director	Makgabaneng
Joseph Segodi	SBC SPecialist	UNICEF
Gofhamodimo Sechele	BIHL Trust Assistant	BIHL
Kriyen Ponnan	Programme Manager, MTV Shuga	Positive action
Sheila Lesotlho	Principal Information Education Communication for AYP Officer	NAHPA
Yvonne Diogo	Country Director	MTV Staying Alive Foundation
Kabo Moatlhodi	Selibe-Phikwe Peer Coordinator	Makgabaneng
Kempho Kaelo	Okavango District Peer Coordinator	Makgabaneng
Mr Patrick Kopano	Selibe-Phikwe Assistant District AIDS Coordinator	NAHPA
Mr Sam Kenaape	Okavango District AIDS Coordinator	NAHPA
Mrs Lempadi	Okavango, Chief Education Officer	MESD
ibid	Selibe-Phikwe, Peer Trainer of Trainer	Makgabaneng
ibid	G&C teacher	Meepong Junior Secondary School
ibid	G&C teacher	Lebogang Junior Secondary School
ibid	G&C teacher	Gumare Junior Secondary School

Annex 4: MTV Shuga Botswana results framework

Result statement	Performance indicator/s	Location	Baseline	Target	Achieved	Means of Verification <sup>9</sup>
Corresponding output from Country programme/ Humanitarian Response Plan <sup>10</sup>	- Corresponding RAM indicator Output 2.1.1: Adolescents 10-19 who were tested for HIV and received their results in the past 12 months.  Output 2.1.2: Number of districts supported to develop/incorporate priority adolescent HIV interventions in operational plans  Output 2.1.3: Adolescents behavior change communication platform targeting adolescents and using T4D developed.	Ghanzi Okavango Selibe-Phikwe Boteti	63%  4	70%  4	38%  Shuga Radio programme and U-Report scaled up (Shuga IVR 124 platform and SRH/HIV polls conducted)	BAIS V  Programme Reports  Programme Reports
<b>Programme Output 1: Quality Peer Education</b>	Number of in and out of school AYPs reached through Peer Education	Ghanzi Okavango Selibe-Phikwe	5,272	10,000	8,250	Programme Reports

<sup>9</sup> The specific sources from which the status of each of the performance indicators can be ascertained. If any data source is a survey or a study which the implementing partner is planning to conduct for this programme, this should be planned and budgeted for in section 3 below (programme work plan and budget).

<sup>10</sup> The most relevant output level result from the Country Programme (CP)/ Humanitarian Response Plan should be identified here, with the corresponding performance indicator(s), directly drawn from CP official documents. If the programme contributes to more than one CP/Humanitarian Response Plan output, each should be identified in a separate line, with programme outputs listed below each corresponding CP output. Identification of the most relevant output level result and corresponding performance indicator(s) is done in consultation with UNICEF Office during the finalization of the programme document.

Result statement	Performance indicator/s	Location	Baseline	Target	Achieved	Means of Verification <sup>9</sup>
<b>provided for in and out of school youth:</b>  By December 2021 AYP have increased knowledge, skills and self-efficacy to adopt safe sexual behaviours and uptake HIV, Protection and SRH services.	<b>Disaggregation:</b> Sex, age, location, in-school and out of school.	Boteti		(8,000 in-school, 2,000 – out of school)		
	Percentage of AYPs with intention to go for HIV testing in the next 3 months. <b>Disaggregation</b> Sex, age, location, in-school and out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	25.2%	75%	29.2%	Post assessment report.
	Percentage of AYPs who have tested for HIV and know their status. <b>Disaggregation</b> Sex, age, location, in-school and out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	39.1%	50.0%	38.0%	Post assessment report.
	Percentage of AYPs who think it is “okay” to date a partner that is 10 years older. <b>Disaggregation</b> Sex, age, location, in-school and out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	59.7%	8%	57.2%	Post assessment report.
	Percentage of AYPs who think it's reasonable for a partner to expect sex in exchange for gifts. <b>Disaggregation</b> Sex, age, location, in-school and out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	82.8%	5%	83.9%	Post- assessment report.
	Percentage of AYPs who demonstrate intention to	Ghanzi Okavango	74.8%	95%	84.90%	Post- assessment report.

Result statement	Performance indicator/s	Location	Baseline	Target	Achieved	Means of Verification <sup>9</sup>
	demand safe sex under pressure. <b>Disaggregation</b> Sex, age, location, in-school and out of school.	Selibe-Phikwe Boteti				
	Percentage AGYWs who think it is boys/men's responsibility to carry condoms. <b>Disaggregation</b> Sex, age, location, in-school and out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	33.9%	10%	20.8%	Post- assessment report.
	Percentage of Adolescent Girls that feel they can report abuse cases through official and un-official mechanisms. <b>Disaggregation</b> Sex, age, location, in-school and out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	53.5%	90%	60.9%	Post- assessment report.
	Percentage of adolescent boys who hold gender equitable attitudes <b>Disaggregation</b> Sex, age, location, in-school, out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	66.1%	80%	79.2%	Post-assessment report.
	Percentage of sexual abuse cases referred to services using the district referral tool. <b>Disaggregation.</b> Sex, age, location, in-school, out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	0	<i>All identified cases.</i>	No cases referred	Quarterly progress reports

Result statement	Performance indicator/s	Location	Baseline	Target	Achieved	Means of Verification <sup>9</sup>
By 2021 AYPs are actively engaged in addressing their challenges and have increased knowledge on financial literacy.	Number of AYPs participating in the Peer Education National Competition to identify solutions to their challenges.		0	5000	78	Quarterly progress reports
	Number of Out of School youth who participate in the App for Change.		0	1000	No data	Quarterly progress reports
<b>Programme Output 2:</b> <b>Effective and efficient project management.</b>  Quarterly monitoring and supportive supervision visits carried out for improved quality of service and effective engagement of stakeholders, capacity development of Peer Educators and project documentation (quarterly and end of project).	Number of monitoring and supportive supervision visits conducted and reports produced.  <b>Disaggregation</b> By location	Ghanzi Okavango Selibe-Phikwe Boteti	2	2	2	2 field monitoring and supervision reports
	Number of project reports	Ghanzi Okavango Selibe-Phikwe Boteti	2	3	3	2 quarterly reports and 1 end of project report.
	Percentage of session tracking forms uploaded on ODK App		0	80%	97%	Quarterly Progress reports

## Annex 5: List of documents reviewed

1. MTV-SAF (ibid) **MTV Shuga Indicator-Question Matrix**
2. UNICEF (ibid) **MTV Shuga Programme Log Frame**

### **2018**

3. Young love (2018) **Radio show concept and design**
4. UNICEF and Young Love (2018) **WhatsApp Baseline Survey**
5. UNICEF and Young Love (2018) **MTV Shuga Radio Endline Survey**

### **2019**

6. UNICEF and Makgabaneng (2019) **MTV Shuga Radio Peer Education and Community Mobilisation Programme**
7. NAPHA (2019) The National Strategic Framework for HIV and AIDS 2019-2023

### **2020**

8. Makgabaneng (2020) **Quarterly Report for the period January to March 2020**
9. Viamo (2020) **Shuga Season 2 Radio Drama Content Report from The 124 Service: Final reach and engagement report Quarter 1.**
10. Viamo (2020) **Shuga Season 2 Radio Drama Content Report from The 124 Service: Quarter 2 report**
11. Viamo (2020) **Shuga Radio Drama & Shuga Wanji Game Content Report for UNICEF Botswana, September 2020**
12. Makgabaneng (2020) **End of Project Report MTV Shuga Peer Education and Community Mobilisation**
13. Makgabaneng (2020) **End of Year Review Visit Report**
14. Makgabaneng (2020) **MTV-SAF Shuga Down South Mid-Year Review Report 2020**

### **2021**

15. UNICEF (2021) **MTV Shuga Botswana Programme Brief**
16. Viamo (2021) **Shuga Radio Drama & Shuga Wanji Game Content Report for UNICEF Botswana, Annual report January to December 2021**
17. Makgabaneng (2021) **MTV Shuga Quarter 1 report July 2021 – September 2021**
18. Makgabaneng (2021) **MTV Shuga Quarter 2 report October 2021 to December 2021**
19. Makgabaneng (2022) **MTV Shuga Radio Peer Education and Community Mobilisation Programme Quarter 2 Report for the period April to June 2022**
20. TeacherShip International South Africa (2021) **UNICEF Botswana Training Report for Peer Facilitators, 10 – 12 August 2021**

### **2022**

21. UNICEF, Makgabaneng, NAPHA (2022) **Shuga Peer Education Training Report (19-22 April 2022), Francis Town**
22. Makgabaneng (2022) **MTV Shuga Radio Peer Education and Community Mobilisation Programme Annual Report for the period August to December 2022**
23. Makgabaneng (2022) **MTV Shuga Radio Peer Education and Community Mobilisation Programme Annual Report for the period February to December 2020**
24. Makgabaneng (2022) **MTV Shuga Radio Peer Education and Community Mobilisation Programme, Monthly Report, April – June 2022**
25. Makgabaneng (2022) **MTV Shuga Radio Peer Education and Community Mobilisation Programme, Monthly Report, January – March 2022**

26. Makgabaneng (2022) **MTV Shuga Radio Peer Education and Community Mobilisation Programme, Monthly Report, July – September 2022**
27. Makgabaneng (2022) **Monitoring Visit and Training Report**
28. Makgabaneng (2022) **MTV Shuga Radio Peer Education and Community Mobilisation Programme, Quarter 2 Report (Oct to Dec 2022)**
29. Viamo (2022) **Botswana Teen Clubs Digital Training: Supporting the Continuity of the Provisioning of Essential Services to Adolescents Living with HIV (ALHIV) – During and Post COVID-19**
30. **Peer Educators Monthly Report for March 2022 for Selibe Phikwe, Okavango, Boteti and Ghanzi**

#### **2023**

31. Makgabaneng (2023) **Peer Education Competition Report**
32. Social dialogue Organisation (ibid) **Shuga MA2000BW, ICT Platform and Promotions Promotions Proposal**

Annex 6: Ethical approval letter

TELEPHONE: 363 2500  
FAX: 317 0155  
TELEGRAMS: RABONGAKA  
TELEX: 2818 CARE BD



MINISTRY OF HEALTH  
PRIVATE BAG 0038  
GABORONE

**REFERENCE NO: HPRD: 6/14/1**

**16<sup>th</sup> June 2023**

**Health Research and Development Division**

Notification of IRB Review: **Exemption**

Emmanuel Mafoko  
Plot 6010, Ranfurwa  
Tlokweng  
Gaborone  
Botswana

**Dear Emmanuel Mafoko,**

**RE: EVALUATION OF MTV SHUGA IN BOTSWANA PROGRAMME  
(ADOLESCENT AND HIV) VERSION 1.0 MAY 2023**

We refer to your letter dated 19 May 2023.

According to HRDC Standard Operating Procedures (SOP) 4.7 (ii), this is a non-research activity, not meant to contribute to "generalizable" knowledge and therefore is exempted from review. Furthermore, annual continuing review is not required for this non research activity. However, investigators are required to report modifications that may change the eligibility of the protocol for exempt status.

**Permission is therefore granted to conduct the above-mentioned exercise.**  
This exemption does not however grant you authority to collect data from the selected organization without prior approval from their management. Consent from identifiable individuals should be obtained.

If you have any questions please do not hesitate to contact Mr Abia Sebaka at, [asebaka@gov.bw](mailto:asebaka@gov.bw), Tel +267-3632754 and Mr Kgomotso Motlhanka at, [kgmmotlhanka@gov.bw](mailto:kgmmotlhanka@gov.bw), Tel +267-3632751.

Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours Sincerely

A handwritten signature of Mr Abia Sebaka.  
Mr Abia Sebaka  
**for/HRDC CHAIRPERSON**



Vision: *A Healthy Nation by 2036.*

Values: *Botho, Equity Timeliness, Customer Focus, Teamwork, Accountability*



## Annex 7: Consent forms

### **INDIVIDUAL CONSENT FORM FOR PARTICIPATION IN THE EVALUATION OF MTV SHUGA IN BOTSWANA**

**What language do you prefer for our discussion today?**

English

Setswana

**Title of Study:** This study is called the Evaluation of MTV Shuga in Botswana

#### **1.0 Interviewer reads:**

Hello. My name is \_\_\_\_\_. I would like to invite you to take part in **Evaluation of MTV Shuga in Botswana**. The National AIDS and Health Promotion Agency (NAHPA) and United Nations Children Emergency Fund (UNICEF) are conducting this evaluation in two districts, namely Selibe Phikwe and Okavango district. The Project was implemented by Mkgebaneng, an NGO based in Gaborone through peer educators in the two districts.

#### **2.0 Purpose of study**

The main purpose of the evaluation is to evaluate how well the MTV Shuga programme achieved its outcomes. The evaluation will measure behaviour change results due to the MTV Shuga programme among adolescents and young people exposed to the interventions in 4 districts in Botswana (Selibe Phikwe, Boteti, Ghanzi and Okavango) during the time of implementation from 2020 to 2022. Though covering the 4 districts, field work for the evaluation to be carried out in 2 out of the 4 districts.

#### **3.0 Study Procedures**

The outcome evaluation of the MTV Shuga programme in Botswana will be conducted through a gender sensitive and socially inclusive method mix approach to collect both quantitative and qualitative data. Data will be collected from beneficiaries and other key stakeholders using the FGDs, In-depth Interviews and Key Informants Interviews (KII).

#### **4.0 Alternatives to taking part**

You can decide not to take part in this study. If you decide not to take part, it will not affect your healthcare in any way. If you choose to take part in the study, you may change your mind at any time and stop taking part. If you decide to leave the study, no more information will be collected from you; however, you will not be able to take back the information that has already been collected and shared.

#### **5.0 Costs for being in the study**

**There is no cost to you for being in the study, apart from your time.**

#### **6.0 Benefits**

The main benefit for you to be in the study is the chance to contribute to make a contribution to a study that will directly help improve support provided to adolescent and young people to

reduce their exposure to HIV and that they receive the support they need to live healthy lives. Your taking part in this study could help us learn more about MTV Shuga in Botswana. It can help us learn about how MTV Shuga programme is working in the country and how we can improve and scale it up to other districts.

## **7.0 Risks**

The risks involved with taking part in the study are small. You may feel uncomfortable about some of the questions we will ask. You can refuse to answer any question. As with all studies, there is a chance that someone could find out you participated in the study. We are doing everything possible to ensure confidentiality and minimize this risk.

## **8.0 Confidentiality and access to your health information**

We will do everything we can to keep your answers confidential. The information we collect from you will be identified by a number and not by your name. Your name will not appear when we share study findings and study data. The data from this study will be released to the public without any identifiers, and this will not require another consent from you. Your name and contact information will not be released outside of the study groups listed unless there is an issue of safety.

## **9.0 Ethical Approval**

*[Interviewer: read from here]*

This study has received approval from the Human Research and Development Committee (HRDC) of the Ministry of Health in Botswana.

## **10. Who should you contact if you have questions?**

If you would like to have more information about the study, you may contact:

*[Interviewer: indicate the following information to the participant - do not read aloud]*

Sheila Lesotlho- National Health Promotion and AIDS Agency (NAHPA)

Landline: +267 367 1336; Mobile: +267 71973340

Email: [slesotlho@gov.bw](mailto:slesotlho@gov.bw)

*[Interviewer: read from here]*

For issues related to injuries or other harms, or for questions about the process of agreeing to take part in this study or for more information about your rights as someone taking part in this study, you may contact:

*[Interviewer: indicate the following information to the participant - do not read aloud]*

Abia Sebaka, Health Research and Development Committee

Landline: +267 363 2018/+267 363 2500

Email: [asebaka@gov.bw](mailto:asebaka@gov.bw)

## **11. Do you want to ask me anything about the study?**

## **12. Consent Statement**

By answering the questions below, you confirm that any questions have been answered satisfactorily and you have been offered a copy of this consent form.

1. Do you agree to take part in the individual interview? If you agree to take part in the individual interview, please state the following statement:

***"I agree to take part in the individual interview."***

Check this box if participant agrees to participate in the individual interview

If you refuse to take part in the individual interview, please state the following statement:

***"I do not wish to take part in the individual interview."***

Check this box if participant refuses to participate in the individual interview

(IF PARTICIPANT DOES NOT AGREE, THEN STOP)

2. Do you agree to be contacted for future research? If you agree to be contacted for future research, please state the following statement:

***"I agree to be contacted for future research."***

Check this box if participant agreed to be contacted for future research.

If you refuse agree to be contacted for future research, please state the following statement:

***"I do not wish to be contacted for future research."***

Check this box if participant refuses be contacted for future research.

Yes       No

Name of Participant (completed by interviewer): \_\_\_\_\_

PTID: \_\_\_\_\_

MTV SHUGA Interviewer signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

MTV SHUGA Interviewer name: \_\_\_\_\_

MTV SHUGA Interviewer ID number: \_\_\_\_\_

## Annex 8: Data collection tools

### UNICEF

Name	
Gender	
Sector:	
Place	
District:	
Official Title:	
Date:	

### Relevance

1. Did the intervention address the main drivers of new adolescent HIV infections and non-ART adherence for both girls and boys? Was this the same in all contexts of the four districts?
  - a. Which ones were addressed? **PROBE: Ask the problems for each of boys and girls.**
2. Were there problems addressed more than others? Which ones and why? **PROBE: For problems faced by boys and girls?**
3. Are there other challenges driving new HIV infections among adolescents and young people not addressed by the intervention?
  - a. Which ones? **(Consider for gender and different locations – rural, urban and remote)**
4. Were there any defined special groups of AYP which were targeted and addressed by the intervention?
5. How appropriate was delivery of interventions? **PROBE: delivery (working through peer educators for out school and with peer educators and G&C teachers in school) consider for gender and different locations – rural, urban and remote)**
6. Were there strong coordination linkages between peer educators and community cadres, schools, and district level to facilitate behaviour change?
  - a. What made this possible or undermined it?
  - b. What could be improved?
7. In your opinions were the interventions adequate to bring about the expected behaviour change among AYP (Improved self-efficacy to delay sex and practice safe sexual behavior, Improved attitudes towards intergenerational and transactional sex, Improved gender equitable attitudes). Why?
  - a. What else was missing or could have been added?
8. What challenges did you face in implementation that undermined the effectiveness of the interventions?
9. What assumptions underpinned the intervention?
  - a. Did this hold?

### Effectiveness

10. What were the main changes you have seen among AYP as a result of the intervention?
  - a. Are these same across gender and locations (four districts and within the four districts)?
11. How did the following contribute to the observed changes:

- a. capacity of peer educators (including motivation),
  - b. linkages to district and village structures,
  - c. quality of content and support,
  - d. other contributory factors e.g., access to services, motivation of stakeholders, and
  - e. COVID-19 restrictions and aftermath.
12. How did the management and coordination contribute to the changes in terms of the following:
- a. supportive supervision to peer educators,
  - b. coordination between IP, DAC, DHMT, and peer educators,
  - c. other existing support in communities.

### Efficiency

13. In your opinion were the management arrangements (staffing, support to peer educators, coordination) for the project adequate to deliver on the results? Why?
  - a. What could be improved?
14. What arrangements were there for oversight of the project?
  - a. Were these effective?- please provide examples. Why?
15. How were peer educators recruited (criteria for selection and procedure for identification)? Was this an effective way to obtain the quality of peer educators required? Why? **PROBE: overall opinion on quality of peer educators and why?**
16. What monitoring systems were in place for the project? D
17. Did these systems provide enough data to measure the achievement of the project across the result chain?
  - a. What was missing?
18. What was the quality of implementation of the monitoring system on a scale of 1-10 (**quality of data, data accessibility, timeliness of data availability, and comprehensiveness of the data**)?
  - a. Why do you say so?
19. How have outputs from the monitoring system been used for project decisions and advocacy? Please provide examples.

### Gender and Equity

20. What measures were put in place to integrate:
  - a. gender,
  - b. disability and
  - c. equity in the programme
21. Please provide examples of how these measures have been.
22. What challenges did you face in integrating gender, disability and equity in the project?
  - a. How were these overcome?
23. What lessons have you learned that can be used in a future project?
24. Was the data collected sufficient to support decisions on enhancing gender and equity in the project?

- a. What was missing and could have been added?
25. What measures were put in place to ensure the project was disability inclusive?
  - a. Were these measures adequate in your opinion? Why?
  - b. Were there any specific challenges you faced?

### **Sustainability**

26. What measures were put in place to support continuation or scale up of the programme? Please provide examples of how these plans have been successful.
27. What measures were put in place to sustain programme changes/benefits among AYP? Please provide examples of how these plans have been successful.
28. What contributions have been made by government and other partners towards the programme at national and district levels?
  - a. Will this continue beyond the project? Why?
29. What plans are in place by the government and other partners to continue with the programme?
30. What is required to take the package of interventions to scale?

## Makgabaneng

Name	
Gender:	
Name:	
Designation (Office):	
Area of Expertise:	

### Relevance

1. Did the intervention address the main drivers of new adolescent HIV infections and non-ART adherence for both girls and boys? Was this the same in all contexts of the four districts?
  - a. Which ones were addressed? **PROBE: Ask the problems for each of boys and girls.**
2. Were there problems addressed more than others? Which ones and why? **PROBE: For problems faced by boys and girls?**
3. Are there other challenges driving new HIV infections among adolescents and young people not addressed by the intervention?
  - a. Which ones? **(Consider for gender and different locations – rural, urban and remote)**
4. How appropriate was delivery of interventions? **PROBE: delivery (working through peer educators for out school and with peer educators and G&C teachers in school) consider for gender and different locations – rural, urban and remote)**
5. Were there strong coordination linkages between peer educators and community cadres, schools, and district level to facilitate behaviour change?
  - a. What made this possible or undermined it?
  - b. What could be improved?
6. In your opinions were the interventions adequate to bring about the expected behaviour change among AYP (Improved self-efficacy to delay sex and practice safe sexual behavior, Improved attitudes towards intergenerational and transactional sex, Improved gender equitable attitudes). Why?
  - a. What else was missing or could have been added?
7. What challenges did you face in implementation that undermined the effectiveness of the interventions?
8. What assumptions underpinned the intervention?
  - a. Did this hold?

### Effectiveness

9. What were the main changes you have seen among AYP as a result of the intervention?
  - a. Are these same across gender and locations (four districts and within the four districts)?
10. How did the following contribute to the observed changes:
  - b. capacity of peer educators (including motivation),
  - c. linkages to district and village structures,
  - d. quality of content and support,
  - e. other contributory factors e.g., access to services, motivation of stakeholders, and
  - f. COVID-19 restrictions and aftermath.

11. How did the management and coordination contribute to the changes in terms of the following:

- g. supportive supervision to peer educators,
- h. coordination between IP, DAC, DHMT, and peer educators,
- i. other existing support in communities.

### Efficiency

- 12. What arrangements were there for oversight of the project? Were these effective?- please provide examples.  
Why?
- 13. How were peer educators recruited (**criteria for selection and procedure for identification**)? Was this an effective way to obtain the quality of peer educators required? Why? **PROBE: overall opinion on quality of peer educators and why?**
- 14. What monitoring systems were in place for the project?
- 15. Did these systems provide enough data to measure the achievement of the project across the result chain?  
What was missing?
- 16. What was the quality of implementation of the monitoring system on a scale of 1-10 (**quality of data, data accessibility, timeliness of data availability, and comprehensiveness of the data**)? Why do you say so?

### Gender and Equity

- 17. What measures were put in place to integrate:
  - a. gender,
  - b. disability, and
  - c. equity in the programme
- 18. Please provide examples of how these measures have been.
- 19. What challenges did you face in integrating gender, disability and equity in the project?
  - a. How were these overcome?
- 20. What lessons have you learned that can be used in a future project?
- 21. Was the data collected sufficient to support decisions on enhancing gender and equity in the project?
  - a. What was missing and could have been added?
- 22. What measures were put in place to ensure the project was disability inclusive?
- 23. Were these measures adequate in your opinion? Why?
- 24. Were there any specific challenges you faced?

### Sustainability

- 25. What measures were put in place to support continuation or scale up of the programme? Please provide examples of how these plans have been successful.
- 26. What measures were put in place to sustain programme changes/benefits among AYP? Please provide examples of how these plans have been successful.
- 27. What contributions have been made government and other partners towards the programme at national and district levels?
  - a. Will this continue beyond the project? Why?
- 28. What plans are in place by the government and other partners to continue with the programme?
- 29. What is required to take the package of interventions to scale?

# NAPHA

Name	
Gender	
Name	
Position	

## Relevance

1. Did the intervention address the main drivers of new adolescent HIV infections and non-ART adherence for both girls and boys? Was this the same in all contexts of the four districts?
  - a. Which ones were addressed? **PROBE: Ask the problems for each of boys and girls.**
2. Were there problems addressed more than others?
  - a. Which ones and why? **PROBE: For problems faced by boys and girls?**
3. Are there other challenges driving new HIV infections among adolescents and young people not addressed by the intervention? Which ones? (**Consider for gender and different locations – rural, urban and remote**)
4. On a scale of 1-10 how satisfied were you with the intervention's ability to address the main drivers of new HIV infection among adolescent boys and girls?
  - a. Why do you say so?
5. Were there any defined special groups of AYP which were targeted and addressed by the intervention?
6. How appropriate was delivery of interventions? **PROBE: delivery (working through peer educators for out school and with peer educators and G&C teachers in school) consider for gender and different locations – rural, urban and remote)**
7. Were there strong coordination linkages between peer educators and community cadres, schools, and district level to facilitate behaviour change?
  - a. What made this possible or undermined it? What could be improved?
8. In your opinions were the interventions adequate to bring about he expected behaviour change among AYP (**Improved self-efficacy to delay sex and practice safe sexual behavior, Improved attitudes towards intergenerational and transactional sex, Improved gender equitable attitudes**). Why?
  - a. What else was missing or could have been added?
9. What challenges did you face in implementation that undermined the effectiveness of the interventions?
10. What assumptions underpinned the intervention? Did this hold?

## Effectiveness

11. What were the main changes you have seen among AYP as a result of the intervention? Are these same across gender and locations (four districts and within the four districts?)
12. How did the following contribute to the observed changes:
  - a. capacity of peer educators (including motivation),
  - b. linkages to district and village structures.
  - c. quality of content and support
  - d. other contributory factors e.g., access to services, motivation of stakeholders, and
  - e. COVID-19 restrictions and aftermath.
13. How did the management and coordination contribute to the changes: 1) supportive supervision to peer educators; 2) coordination between IP, DAC, DHMT, and peer educators; 3) other existing support in communities.

## Efficiency

14. In your opinion were the management arrangements (staffing, support to peer educators, coordination) for the project adequate to deliver on the results? Why? What could be improved?
15. What arrangements were there for oversight of the project?
  - a. Were these effective- please provide examples? Why?
16. How were peer educators recruited (criteria for selection and procedure for identification)?
  - a. Was this an effective way to obtain the quality of peer educators required? Why? **PROBE: overall opinion on quality of peer educators and why?**
17. What monitoring systems were in place for the project?

18. Did these systems provide enough data to measure the achievement of the project across the result chain? What was missing?
19. What was the quality of implementation of the monitoring system on a scale of 1-10 (quality of data, data accessibility, timeliness of data availability, and comprehensiveness of the data)? Why do you say so?
20. How have outputs from the monitoring system been used for project decisions and advocacy? Please provide examples.

### **Gender and Equity**

21. What measures were put in place to integrate:
  - a. gender,
  - b. disability, and
  - c. equity in the programme
22. Please provide examples of how these measures have been.
23. What challenges did you face in integrating gender, disability and equity in the project?
  - a. How were these overcome?
24. What lessons have you learned that can be used in a future project?
25. Was the data collected sufficient to support decisions on enhancing gender and equity in the project?
  - a. What was missing and could have been added?
26. What measures were put in place to ensure the project was disability inclusive?
27. Were these measures adequate in your opinion? Why?
28. Were there any specific challenges you faced?

### **Sustainability**

29. What measures were put in place to support continuation or scale up of the programme? Please provide examples of how these plans have been successful.
30. What measures were put in place to sustain programme changes/benefits among AYP? Please provide examples of how these plans have been successful.
31. What contributions have been made government and other partners towards the programme at national and district levels?
  - a. Will this continue beyond the project? Why?
32. What plans are in place by the government and other partners to continue with the programme?
33. In your opinion do you have sufficient capacity to continue with this programme on the same or wider scale?
  - a. What are the gaps and how can they be supported?
34. What is required to take the package of interventions to scale?

## DAC

Name	
Gender	
Name	
Name of district	
Designation (Office)	

### Relevance

1. Did the intervention address the main drivers of new adolescent HIV infections and non-ART adherence for both girls and boys?
  - a. Was this the same in all contexts of the four districts?
  - b. Which ones were addressed? **PROBE: Ask the problems for each of boys and girls.**
2. Were there problems addressed more than others?
  - a. Which ones and why? **PROBE: For problems faced by boys and girls?**
3. Are there other challenges driving new HIV infections among adolescents and young people not addressed by the intervention? Which ones? (**Consider for gender and different locations – rural, urban and remote**)
4. On a scale of 1-10 how satisfied were you with the intervention's ability to address the main drivers of new HIV infection among adolescent boys and girls? Why do you say so?
5. Any defined special groups of AYP which were targeted and addressed by the intervention
6. How appropriate was delivery of interventions? **PROBE: delivery (working through peer educators for out school and with peer educators and G&C teachers in school) consider for gender and different locations – rural, urban and remote)**
7. How well, on a scale of 1-10 (where 1 is very bad and 10 is excellent) did you work with peer educators? Why do you say so?
8. How well were peer educators working with other cadres: community leaders, schools and health facilities? What could have been improved? "
9. In your opinions were the interventions adequate to bring about he expected behaviour change among AYP (**Improved self-efficacy to delay sex and practice safe sexual behavior, Improved attitudes towards intergenerational and transactional sex, Improved gender equitable attitudes**). Why?
  - a. What else was missing or could have been added?
10. What challenges did you face in implementation that undermined the effectiveness of the interventions?

### Effectiveness

11. What were the main changes you have seen among AYP as a result of the intervention? Are these the same across gender and locations of the project in this district?
12. How did the following contribute to the observed changes:
  - a. capacity of peer educators (including motivation),
  - b. linkages to district and village structures,
  - c. quality of content and support,
  - d. other contributory factors e.g., access to services, motivation of stakeholders, and
  - e. COVID-19 restrictions and aftermath.
13. How did the management and coordination contribute to the changes,
  - a. supportive supervision to peer educators,
  - b. coordination between IP, DAC, DHMT, and peer educators, and
  - c. other existing support in communities.

### Efficiency

14. In your opinion were the management arrangements (staffing, support to peer educators, coordination) for the project adequate to deliver on the results? Why?
  - a. What could be improved?
15. What arrangements were there for oversight of the project in this district? Were these effective- please provide examples? Why?

16. How were peer educators recruited (criteria for selection and procedure for identification)? Was this an effective way to obtain the quality of peer educators required? Why? PROBE: overall opinion on quality of peer educators and why?
17. What monitoring systems were in place for the project?
18. Did these systems provide you with enough data to measure progress of the intervention?
  - a. What was missing? PROBE: if any monitoring data was shared with stakeholder and whether this was appropriate.
19. What was the quality of the monitoring system including:
  - a. sharing of monitoring results timely,
  - b. quality of the data provided to you,
  - c. comprehensiveness of the data (the data enabled you see all the achievements by the project you expected, timeliness of the data)
20. How have you used outputs from the monitoring system in your district? Please provide examples.

### **Gender and Equity**

21. What measures were put in place to integrate:
  - a. gender,
  - b. disability, and
  - c. equity in the programme.
22. Please provide examples of how these measures have been.
23. Was the data collected sufficient to support decisions on enhancing gender and equity in the project?
  - a. What was missing and could have been added?
24. What measures were put in place to ensure the project was disability inclusive?
25. Were these measures adequate in your opinion? Why?
26. Were there any specific challenges you faced?

### **Sustainability**

27. What measures were put in place to support continuation or scale up of the programme? Please provide examples of how these plans have been successful.
28. What measures were put in place to sustain programme changes/benefits? Please provide examples of how these plans have been successful.
29. What contributions have been made government and other partners towards the programme at district levels?
  - a. Will this continue beyond the project? Why?
30. What plans are in place in your district to continue with the programme?
31. In your opinion do you have sufficient capacity to continue with this programme on the same or higher scale in this district?
  - a. What are the gaps and how can they be supported?
32. What is required to take the package of interventions to scale?

## DEO

Name	
Gender	
Name	
Name of district	
Designation (Office)	

### Relevance

1. Did the intervention address the main drivers of new adolescent HIV infections and non-ART adherence for both girls and boys?
  - a. Was this the same in all contexts of the four districts?
  - b. Which ones were addressed? **PROBE: Ask the problems for each of boys and girls.**
2. Were there problems addressed more than others?
  - a. Which ones and why? **PROBE: For problems faced by boys and girls?**
3. Are there other challenges driving new HIV infections among adolescents and young people not addressed by the intervention? Which ones? (**Consider for gender and different locations – rural, urban and remote**)
4. On a scale of 1-10 how satisfied were you with the intervention's ability to address the main drivers of new HIV infection among adolescent boys and girls?
  - a. Why do you say so?
5. Any defined special groups of AYP which were targeted and addressed by the intervention
6. How appropriate was delivery of interventions? **PROBE: delivery (working through peer educators for out school and with peer educators and G&C teachers in school) consider for gender and different locations – rural, urban and remote)**
7. How well, on a scale of 1-10 (**where 1 is very bad and 10 is excellent**) did you work with peer educators?
  - a. Why do you say so?
8. How well were peer educators working with other cadres: community leaders, schools and health facilities?
  - a. What could have been improved? "
9. In your opinions were the interventions adequate to bring about the expected behaviour change among AYP (**Improved self-efficacy to delay sex and practice safe sexual behavior, Improved attitudes towards intergenerational and transactional sex, Improved gender equitable attitudes**). Why?
  - a. What else was missing or could have been added?
10. What challenges did you face in implementation that undermined the effectiveness of the interventions?

### Effectiveness

11. What were the main changes you have seen among AYP as a result of the intervention? Are these same across gender and locations of the project in this district?
12. How did the following contribute to the observed changes: 1) capacity of peer educators (including motivation); 2) linkages to district and village structures; 3) quality of content and support; 4) other contributory factors e.g., access to services, motivation of stakeholders; and 5) COVID-19 restrictions and aftermath.

13. How did the management and coordination contribute to the changes: 1) supportive supervision to peer educators; 2) coordination between IP, DAC, DHMT, and peer educators; 3) other existing support in communities.

### Efficiency

14. In your opinion were the management arrangements (staffing, support to peer educators, coordination) for the project adequate to deliver on the results? Why?

- a. What could be improved?

15. What arrangements were there for oversight of the project in this district? Were these effective?- please provide examples. Why?

16. On a scale of 1-10 (where 1 is not satisfied at all and 10 is extremely satisfied) how satisfied were you with the quality of peer educators?

- a. Why do you rate this way?

17. What monitoring systems were in place for the project?

18. Did these systems provide you with enough data to measure progress of the intervention? What was missing?  
**PROBE: if any monitoring data was shared with stakeholder and whether this was appropriate.**

19. What was the quality of the monitoring system including:

- a. sharing of monitoring results timely,
- b. quality of the data provided to you
- c. comprehensiveness of the data (the data enabled you see all the achievements by the project you expected, timeliness of the data)

20. How have you used outputs from the monitoring system in your district? Please provide examples.

21. Please provide examples of how these measures have been.

### Sustainability

22. What measures were put in place to sustain programme changes/benefits? Please provide examples of how these plans have been successful.

23. What contributions have you made towards the programme at district levels?

- a. Will this continue beyond the project? Why?

24. In your opinion do you have sufficient capacity to continue with this programme at the same or higher scale in this district?

- a. What are the gaps and how can they be supported?

25. What is required to take the package of interventions to scale?

## DHMT

Name	
Gender	
Name	
Name of district	
Designation (Office)	

### Effectiveness

1. Have you seen an increase in the updating of SRH and HIV services by adolescents and young people in this district?
  - a. Since when did you begin to see a change?
  - b. What can you attribute to this change?
  - c. **PROBE:** for contribution of the MTV Shuga intervention.
  
2. What measures are being put in place in your district to ensure adolescents and young people have access to SRH and HIV services in health facilities?
  - a. How have these measures been performed?
  - b. What factors make these measures successful?
  - c. What factors undermine the measures?

### Sustainability

3. What are you doing as a district to sustain access to SRH and HIV services by adolescents and young people? Please provide examples of how these plans have been successful.

## Community Leaders

Name	
Gender	
Name of Ward	
Name of district	
Position in community	

### Relevance

1. Did the intervention address the main drivers of new adolescent HIV infections and non-ART adherence for both girls and boys?
  - a. Was this the same in all contexts of the four districts?
  - b. Which ones were addressed? **PROBE: Ask the problems for each of boys and girls.**
2. Were there problems addressed more than others?
  - a. Which ones and why? **PROBE: For problems faced by boys and girls?**
3. Are there other challenges driving new HIV infections among adolescents and young people not addressed by the intervention? Which ones? (**Consider for gender and different locations – rural, urban and remote**)
4. On a scale of 1-10 how satisfied were you with the intervention's ability to address the main drivers of new HIV infection among adolescent boys and girls?
  - a. Why do you say so?
5. Was the content of the peer education and radio sessions aligned to the daily lives of adolescents and young people in this area?
  - a. Why do you say so?
6. How appropriate was delivery of interventions? **PROBE: delivery (working through peer educators for out school and with peer educators and G&C teachers in school) consider for gender and different locations – rural, urban and remote)**
7. How well, on a scale of 1-10 (where 1 is very bad and 10 is excellent) did you work with peer educators?
  - a. Why do you say so?
  - b. What can be improved?
8. In your opinions were the interventions adequate to bring about the expected behaviour change among AYP (**Improved self-efficacy to delay sex and practice safe sexual behavior, Improved attitudes towards intergenerational and transactional sex, Improved gender equitable attitudes**). Why?
  - a. What else was missing or could have been added?

### Effectiveness

9. What were the main changes you have seen among AYP as a result of the intervention? Are these the same for males and females in your community? **PROBE: self-efficacy for safe sex, and to delay sex, attitudes towards intergenerational and transactional sex, access and use of other SRH services.**
10. For the changes you mentioned, what support from the project made it be successful?

### Efficiency

11. On a scale of 1-10 (where 1 is not satisfied at all and 10 is extremely satisfied) how satisfied were you with the quality of peer educators?

a. Why do you rate this way?

### **Sustainability**

12. What measures were put in place to sustain programme changes/benefits among AYP?

a. How will your support and commitment be sustained? Please provide examples of how these plans have been successful.

## G&C Teachers

Name	
Gender	
Name of Ward	
Name of district	
Name of school	
Designation (Office)	

### Relevance

1. Did the intervention address the main drivers of new adolescent HIV infections and non-ART adherence for both girls and boys?
  - a. Was this the same in all contexts of the four districts?
  - b. Which ones were addressed? **PROBE: Ask the problems for each of boys and girls.**
2. Were there problems addressed more than others?
  - a. Which ones and why? **PROBE: For problems faced by boys and girls?**
3. Are there other challenges driving new HIV infections among adolescents and young people not addressed by the intervention?
  - a. Which ones? **(Consider for gender and different locations – rural, urban and remote)**
4. On a scale of 1-10 how satisfied were you with the intervention's ability to address the main drivers of new HIV infection among adolescent boys and girls? Why do you say so?
5. Was the content of the peer education and radio sessions aligned to the daily lives of adolescents and young people in this area? Why do you say so?
6. How appropriate was delivery of interventions? **PROBE: delivery (working through peer educators for out school and with peer educators and G&C teachers in school) consider for gender and different locations – rural, urban and remote)**
7. How well, on a scale of 1-10 (where 1 is very bad and 10 is excellent) did you work with peer educators?
  - a. Why do you say so?
  - b. What can be improved?
8. In your opinions were the interventions adequate to bring about the expected behaviour change among AYP (**Improved self-efficacy to delay sex and practice safe sexual behavior, Improved attitudes towards intergenerational and transactional sex, Improved gender equitable attitudes**). Why?
  - a. What else was missing or could have been added?
9. What challenges did you face in implementation that undermined the effectiveness of the interventions?

### Effectiveness

10. What were the main changes you have seen among AYP as a result of the intervention? Are these the same across gender and locations of the project in this district?
11. How did the following contribute to the observed changes:
  - a. capacity of peer educators (including motivation),
  - b. linkages to district and village structures,
  - c. quality of content and support,

- d. other contributory factors e.g., access to services, motivation of stakeholders,
  - e. COVID-19 restrictions and aftermath.
12. How did the management and coordination contribute to the changes:
- a. supportive supervision to peer educators,
  - b. coordination between IP, DAC, DHMT, and peer educators,
  - c. other existing support in communities.

### **Efficiency**

- 13. In your opinion were the management arrangements (staffing, support to peer educators, coordination) for the project adequate to deliver on the results? Why? What could be improved?
- 14. On a scale of 1-10 (where 1 is not satisfied at all and 10 is extremely satisfied) how satisfied were you with the quality of peer educators? Why do you rate this way?
- 15. Did these systems provide you with enough data to measure progress of the intervention? What was missing? PROBE: if any monitoring data was shared with stakeholder and whether this was appropriate.
- 16. What was the quality of the monitoring system including: 1) sharing of monitoring results timely, quality of the data provided to you, comprehensiveness of the data (the data enabled you see all the achievements by the project you expected, timeliness of the data)
- 17. How have you used outputs from the monitoring system in your school? Please provide examples.

### **Gender and Equity**

- 18. What measures were put in place to integrate:
  - a. gender
  - b. disability, and
  - c. equity in the programme
- 19. Please provide examples of how these measures have been.
- 20. What challenges did you face in integrating gender, disability and equity in the project?
  - a. How were these overcome?
- 21. What lessons have you learned that can be used in a future project?
- 22. Was the data collected sufficient to support decisions on enhancing gender and equity in the project?
  - a. What was missing and could have been added?
- 23. What measures were put in place to ensure the project was disability inclusive?
  - a. Were these measures adequate in your opinion? Why?
  - b. Were there any specific challenges you faced?

### **Sustainability**

- 24. What measures were put in place to sustain programme changes/benefits? Please provide examples of how these plans have been successful.
- 25. In your opinion do you have sufficient capacity to continue with this programme at the same or higher scale in this school? What are the gaps and how can they be supported?
- 26. What is required to take the package of interventions to scale?

## Peer Educators and Peer Coordinators

Name	
Gender	
Name of Ward	
Name of district	
Name of province	
Designation (Office)	

### Relevance

1. Did the intervention address the main drivers of new adolescent HIV infections and non-ART adherence for both girls and boys?
  - a. Was this the same in all contexts of the four districts?
  - b. Which ones were addressed? **PROBE: Ask the problems for each of boys and girls.**
2. Were there problems addressed more than others?
  - a. Which ones and why? **PROBE: For problems faced by boys and girls?**
3. Are there other challenges driving new HIV infections among adolescents and young people not addressed by the intervention?
  - a. Which ones? **(Consider for gender and different locations – rural, urban and remote)**
4. On a scale of 1-10 how satisfied were you with the intervention's ability to address the main drivers of new HIV infection among adolescent boys and girls? Why do you say so?
5. Was the content of the peer education and radio sessions aligned to the daily lives of adolescents and young people in this area?
  - a. Why do you say so?
6. How appropriate was delivery of interventions? **PROBE: delivery (working through peer educators for out school and with peer educators and G&C teachers in school) consider for gender and different locations – rural, urban and remote)**
7. How well, on a scale of 1-10 (**where 1 is very bad and 10 is excellent**) did you work with various stakeholders e.g., education, health, community leaders etc.? Why do you say so?
  - a. Were there relationships that were particularly challenging for you? Which ones and why?
8. In your opinions were the interventions adequate to bring about the expected behaviour change among AYP (**Improved self-efficacy to delay sex and practice safe sexual behavior, Improved attitudes towards intergenerational and transactional sex, Improved gender equitable attitudes**). Why?
  - a. What else was missing or could have been added?
9. What challenges did you face during implementation that hindered you from being effective- your ability to help AYP change their attitudes towards risky sexual behaviour and practice safe sex or delay sex?

### Effectiveness

10. What were the main changes you have seen among AYP as a result of the intervention?
  - a. Are these the same for males and females in your community? **PROBE: self-efficacy for safe sex, and to delay sex, attitudes towards intergenerational and transactional sex, access and use of other SRH services.**
11. How did the following contribute to the observed changes:

- a. capacity of peer educators (including motivation),
  - b. linkages to district and village structures,
  - c. quality of content and support,
  - d. other contributory factors e.g., access to services, motivation of stakeholders,
  - e. COVID-19 restrictions and aftermath.
12. How did the management and coordination contribute to the changes:
- a. supportive supervision to peer educators,
  - b. coordination between IP, DAC, DHMT, and peer educators
  - c. other existing support in communities.

### **Efficiency**

13. In your opinion were the management arrangements (**staffing, support to peer educators, coordination**) for the project adequate to deliver on the results? Why?
- a. What could be improved?
14. What arrangements were there for oversight of the project in this district?
- a. Were these effective?- please provide examples. Why?
15. As peer educators do you think you had sufficient capacity to carry out your responsibilities? Why do you say so?
16. On a scale of 1-10 how satisfied were you with the quality of training you received? **Consider the following: adequacy of content, time available for training, and after training support)**
17. What monitoring systems were in place for the project?
18. Did these systems provide you with enough data to measure progress of the intervention? What was missing?  
**PROBE: if any monitoring data was shared with stakeholder and whether this was appropriate.**
19. What was the quality of the monitoring system including:
- a. sharing of monitoring results timely,
  - b. quality of the data provided to you,
  - c. comprehensiveness of the data (the data enabled you see all the achievements by the project you expected, timeliness of the data)
20. How have you used outputs from the monitoring system in your work? Please provide examples.

### **Gender and Equity**

21. What measures did you put in place to ensure males and females received support relevant to them.
- a. What measures did you put in place to ensure those with disabilities were able to participate with others?
22. Please provide examples of how these measures have been.
23. What challenges did you face in integrating gender, disability and equity in the project?
- a. How were these overcome?

24. What lessons have you learned that can be used in a future project?
25. Was the data collected sufficient to support decisions on enhancing gender and equity in the project?
  - a. What was missing and could have been added?
26. What measures were put in place to ensure the project was disability inclusive?
27. Were these measures adequate in your opinion? Why?
28. Were there any specific challenges you faced?

### **Sustainability**

29. What measures were put in place to sustain programme changes/benefits among you as peer educators and your AYP/peers?
  - a. How will your support and commitment be sustained? Please provide examples of how these plans have been successful.
30. In your opinion do you have sufficient capacity to continue with this programme in the absence of support from Makgebeneng?
  - a. What are the gaps and how can they be supported?
31. What is required to take the package of interventions to scale?

## AYP in school and out of school

Name	
Gender	
Name of Ward	
Name of district	
Name of province	
Designation (Office)	
Area of Expertise	

### Relevance

1. Split the group into three. Have one group for male, one group for females and one that is mixed.
  - a. In the separate groups ask the following: Tell me what leads to adolescents and young people getting infected by HIV, STIs or getting pregnant. The boy's group should make boys get infected, while the girls should do what makes girls get infected or pregnant. **As you do so always ask what causes this and why?**
  - b. When you look back at the intervention- support from Peer educators including with the radio programmes- would you say it was addressing the main problems causing new adolescent HIV infection and for those on ART not to adhere to treatment that you have discussed? Why do you say so?
2. The mixed group is to come up with a project poster. In the poster they need to detail what they liked about the programme and what they disliked about it. For each like and dislike write on a separate sheet about why you like or dislike?
3. On a scale of 1-10 how satisfied were you it supports you received from peer educators? Why do you say so?
4. Was the content of the sessions aligned to your everyday lives in this area? Why do you say so?
5. Was the way the sessions were delivered to you the most appropriate? Why do you say so? What could have been changed and how?: PROBE: differences between males and females.
6. In your opinion was the support you received enough to help bring about the following changes in AYP behaviour in your community? (Improved self-efficacy to delay sex and practice safe sexual behavior, Improved attitudes towards intergenerational and transactional sex, Improved gender equitable attitudes). Why? What else was missing or could have been added?
7. Overall, what would you like to see added to the programme to make it effective – helping young people stop risky sexual behaviour?

### Effectiveness

8. Separate boys and girls. Ask each group to write about the benefits the project has brought into their lives. **PROBE: self-efficacy for safe sex, and to delay sex, attitudes towards intergenerational and transactional sex, access and use of other SRH services.**
  - a. Are these changes the same for males and females in your community?

9. When you consider all the support you received, what aspects of the intervention helped to bring the changes you mentioned? **Instruction:** Write each of the following on a flip chart and ask them to encircle them with the largest size being the biggest contributor and the smallest being the smallest contributor: 1) capacity of peer educators (including motivation); 2) linkages to district and village structures; 3) quality of content and support; 4) other contributory factors e.g., access to services, motivation of stakeholders; and 5) COVID-19 restrictions and aftermath.
10. How did the programme engage and support you to participate in the planning, management and coordination of the intervention at various levels?
- To what extent was the voice of peer educators and AYP recognized and effected in decision making

### Efficiency

11. On a scale of 1-10 (**where 1 is not satisfied at all and 10 is extremely satisfied**) how satisfied were you with the quality of peer educators?
- Why do you rate this way?
12. How easy was it to complete the pre- and post-session questionnaires?
- Could this have been done in a different way? How?

### Gender and Equity

13. For boys/girls, were able to participate effectively in the sessions.
- Were the sessions and other support relevant to the challenges you face as boys/girls? /persons with disabilities?
14. As boys/girls/persons with disability did you face specific challenges in:
- attending the sessions,
  - fully participating during the sessions, and
  - receiving and using additional support from peer educators, the school, the community?

### Sustainability

15. What measures were put in place to sustain the changes/benefits that you have accrued as AYP?
- What will keep you motivated to sustain the benefits/changes?