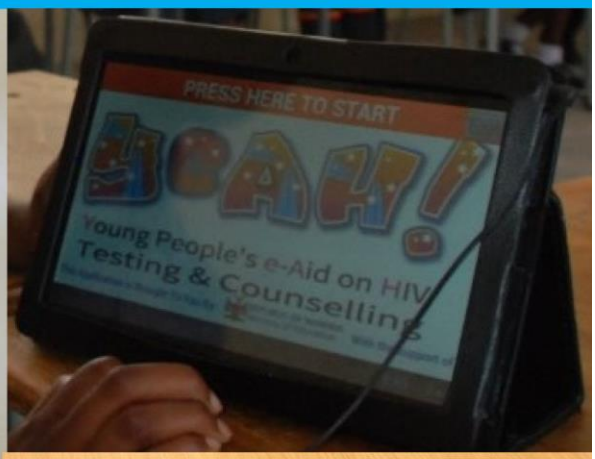
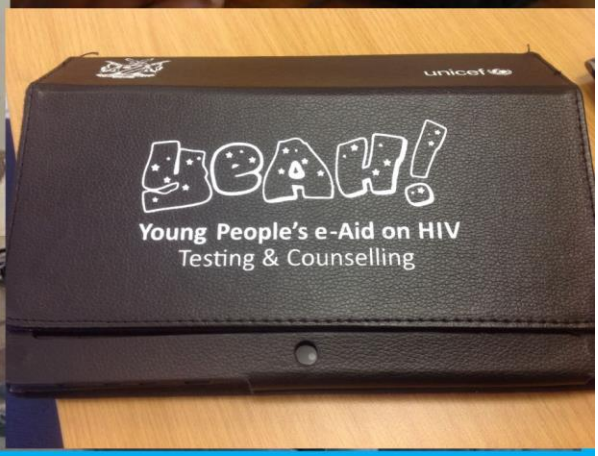
School-based HTC Pilot Programme

Namibia

Final Evaluation Report

December 2014





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Susan Amoaten, Mthobisi Sibandze

December 2014

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ACRONYMS

AFHS	Adolescent-Friendly Health Service
AIDS	Acquires Immune Deficiency Syndrome
AIDSTAR	AIDS Support and Technical Assistance Resources
ALWHIV	Adolescent Living with HIV
CSO	Civil Society Organisation
DAPP	Development Aid from People to People
DHS	Demographic and Health Survey
EMIS	Education Management Information System
FGD	Focus Group Discussion
HAMU	HIV/AIDS Management Unit
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
HRSA	Health Resources and Service Administration
KII	Key Informant Interview
MFMC	My Future My Choice
MHTC	Mobile HIV Testing and Counselling
M&E	Monitoring and Evaluation
MOE	Ministry of Education
MOHSS	Ministry of Health and Social Services
NIP	National Institute of Pathology
RACE	Regional AIDS Coordinator for Education
RFP	Request for Proposals
SC	Steering Committee
SPNS	Special Projects of National Significance
SRH	Sexual and Reproductive Health
SSA	Sub-Saharan Africa
TOR	Terms of Reference
UNAIDS	United Nations Joint Programme on HIV
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organisation

EXECUTIVE SUMMARY

This evaluation is designed to assess the pilot programme being implemented by Development Aid from People to People (DAPP), led by the Ministry of Education (MOE) in collaboration with the Ministry of Health and Social Services (MOHSS) funded by UNICEF. The two research questions to be explored are:

- **Is having HIV Testing and Counselling (HTC) in schools appropriate and able to increase the uptake of HIV testing and counselling among young people?**
- **Does utilisation of computer tablets for mobilisation motivate young people to take up HIV testing and counselling (services)?**

Background

The pilot School-Based HTC programme was designed to encourage at risk school-based adolescents to take a voluntary HIV test using an innovative computer-based application specifically designed for young people. For those who tested positive, they were immediately to be linked into comprehensive care and support services. The pilot programme ran from June to September 2014, considerably shorter than the original timeframe due to delays in start-up. Regional AIDS Coordinators for Education (RACE Coordinators), were seen as important stakeholders to increase local ownership and sustainability. Parents were involved through parental consent forms. Life Skills teachers were expected to link the HTC programme into the general curriculum through life skills classes.

Evaluation Methodology

The evaluation used a mix of quantitative and qualitative methods, with data collected in September 2014 over a two and half week period in Omusati and Oshana Regions. A mix of stakeholders were included in this phase: MOE, MOHSS, DAPP, Field Officers, RACE Coordinators, Principals, Life Skills Teachers, Clinic staff, other CSOs, and learners at 8 schools (4 in Omusati and 4 in Oshana region). A one page questionnaire was administered with learners at the start of each school visit.

Qualitative data was synthesised from 31 KIIs, 9 FGDs and 295 questionnaires and used to respond to the two core evaluation questions specifically looking at: relevance, effectiveness, efficiency, impact and sustainability. The consultants were asked to respond to the two core evaluation questions and to provide recommendations on how this pilot project could be scaled-up to a programme for consideration by the National SB HTC Steering Committee as per guidance from the National Steering Committee. The zero draft of the evaluation report was presented to the National Steering Committee for feedback, once feedback was provided, the report was presented to a broader group of stakeholders before holding a workshop jointly convened by the MOE and MOHSS in November. The final evaluation report includes feedback from the MOE workshop.

Quantitative data was available through DAPP's monitoring system which collected information on number of learners who used the YEAH! application, number of learners who took an HIV test within school, and the number referred to the local health centre for an HIV test. However, no data was collected at the start of the programme on HIV test uptake within schools and testing was not offered in schools without the use of YEAH! To mitigate these factors, the evaluators attempted to establish a baseline through Ministry of Health and Social Services monitoring system of uptake of HTC by 15-19 year olds in Omusati and Oshana Regions.

The pilot programme was plagued with delays which affected implementation. Initially scheduled to start work in schools in February, it did not start until June in Term 2 running into September in Term 3. Therefore the evaluation was being undertaken at the same time as the pilot in some instances, which conflicted with G9 and G11 learners' exam timetables.

Overall results of the pilot programme

		Total Number of leaners aged 16+yrs	# of Learners who used tablets			# HCT Services in Schools			# of learners referred to health centres for HTC	# of learner forms demonstrating HTC at health centre
OSHANA REGION			F	M	Total	F	M	Total		19
	Andimba Toivo ya Toivo	**841**	69	14	83	0	0	0	83	
	Mwadhina gwaNembenge	**520**	73	42	115	103	44	147	0	
	Nangolo S.S	**227**	37	26	63	0	0	0	63	
	Ekwafo S.S	**446**	57	34	91	57	33	90	0	
	Oshakati S.S	**556**	211	80	291	145	54	199	0	
	Evululuko S.S.	**567**	153	71	224	105	43	148	0	
OMUSATI REGION										**3**
	Shaanika Nashilongo S.S	**400**	100	82	182	0	0	0	182	
	Mwaala S.S	**300**	96	11	107	73	7	80	0	
	Etalaleko S.S	**400**	139	50	189	0	0	0	189	
	Shikongo Iipinge S.S	**350**	111	39	150	86	23	109	0	
	David Sheehama S.S	**319**	131	89	220	78	37	115	0	
	Onesi S.S	**557**	142	116	258	137	63	200	0	

The SB HTC pilot programme exceeded its target of providing 1,000 learners in 14 schools in Omusati and Oshana Regions with HIV testing information in 100% and HTC in 50% of schools, 8 of whom were found to be HIV positive, and did so within it budget of N$1,600,000. Table 5 clearly shows that providing HTC within schools was significantly more likely to result in learners undertaking an HIV test, with similar results in both regions.

There was strong support for the SB HTC programme from all stakeholders who maintained that the YEAH! app. encouraged learners to take an HIV test, and that providing HTC in schools with fully trained and knowledgeable Field Officers was successful and important, though there was not universal support for HTC in schools being provided by non-health care workers.
Existing data shows a positive correlation between use of technology and HTC uptake in each school. However, it is not possible to conclude whether HTC uptake was due to availability and accessibility or more influenced by the excitement of novel technology because of the lack of clearly defined variables during design stage (controlled variables, independent variables, dependent variables). Furthermore the YEAH! app. Is seen as providing a highly ethical way of increasing demand for testing in that it is entirely voluntary, addresses one of the key challenges to demand i.e. fear of the process, and is in line with government policy that it is the right of every Namibian to know their HIV status and access relevant services according to the result.

PEPFAR undertook an analysis of the cost of HTC per person being incurred in the country under PEPFAR programmes. Costs varied from USD10 to USD75 per person depending on the geographical location of the intervention and the approach used to encourage people to come forward for an HIV test[1]. Assessing the costs of the SB HTC pilot programme would suggest that the cost per test would be between USD76.50 and USD17.40. These figures demonstrate that the cost per test are within

[1] Source: UNICEF November 2014

the normal range, and would need to be considered against the intended outcome of encouraging adolescent males and females to know their status.

Recommendations

This evaluation has demonstrated that providing HTC in schools can increase uptake of testing amongst adolescents and youth and that a computer tablet is an excellent tool to motivate adolescents and youth to take up the test.

Programmatic

- The National Steering Committee (NSC) must take a stronger monitoring and advocacy role within the programme.
- The RACE Coordinator at regional level is essential to ensure good buy-in from schools and establish links with the Health Sector and other key stakeholders, they should be encouraged to be fully engaged from the beginning and report on progress regularly to the NSC.
- The Life Skills teacher within the school is a key stakeholder to encourage more vulnerable learners such as youth to come forward for YEAH! and testing and to ensure the programme is properly linked with other aspects of the Life Skills curriculum i.e. sex education
- No school should participate in the SB HTC without firstly going through the YEAH! app in order to be better informed about its content
- If HTC is to be made available within schools, the timeframe should be developed in line with the number of learners aged 16 or over to ensure all learners have an opportunity to use YEAH! and access HTC

Technical

- The content of YEAH! should be broadened to include more information about HIV prevention including VMMC and correct condom use as well as issues around sex and sexuality and SRH.

Unresolved issues warranting further investigation

Stigma was a major concern amongst learners, particularly youths. Whilst this was greater in some schools than others, particularly schools without a strong commitment to Life Skills or without a Counsellor, boys felt very vulnerable to ridicule and discrimination which hampered them using the YEAH! app. or going for HIV testing. Further investigation would be needed to identify how to address stigma within a school environment which encourages positive peer support around HIV and SRH in general, for both girls and youths.

Support within schools for learners who are HIV positive was discussed but without any clear recommendations. In some schools there exist dedicated Life Skills teachers who have been trained in MFMC and who are backed by the school Principal to play a strongly supportive role within the school. But this was by no means universal and remains a real challenge for any HIV positive learner who maybe without support nearby. One issue to investigate is what training support may be relevant for school counsellors. At the end of the field research phase, agreement was reached that psycho-social support training could be rolled out with Life Skills teachers working in the pilot areas; it would need investigation to determine the relevance and effectiveness of this training.

The finding from this evaluation is that boys are extremely vulnerable around HIV and SRH due to their own fears. There is an unmet need with boys which needs further investigation to resolve.

A voluntary scheme such as the SB HTC pilot programme may not reach learners who are more vulnerable such as learners in sexual relationships with older men. Staff in most schools expressed

their concerns about female learners with older boyfriends as they see high levels of teenage pregnancy in this group. More research needs to be undertaken to determine how to best encourage this sub-group of learners to come for an HIV test.

If HTC is to be introduced into schools, it needs to be clearer about what it expects to achieve and how it fits into the custodial role of the school. HIV awareness clubs in schools, understanding sexual behaviour of adolescents, how to address stigma, knowing how to address issues of adolescents born with HIV could all be included in the YEAH! app to broaden its potential.

Conclusion

This evaluation has clearly demonstrated that having HIV Testing and Counselling (HTC) in schools is appropriate to the wants and needs of adolescent learners, and is able to increase the uptake of HIV testing and counselling. However, there are areas that need to be improved in order to ensure all learners will participate including male learners who are more fearful of HTC and female learners in relationships with older men who feel powerless to influence safer sex with their boyfriends.

The utilisation of computer tablets has also proven to be very popular and successful at motivating learners to take up HIV testing and counselling services, particularly if those services are brought within the school premises. The popularity of the computer tablet could be broadened to include other information relevant to adolescents and youth in the areas of HIV prevention, care and support as well as broader SRH. The confidential nature of the computer tablets, as well as the fact they can be used individually at the pace of the user was particularly successful at reaching out to male learners.

1. Introduction

This evaluation is designed to assess the pilot programme being implemented by Development Aid from People to People (DAPP), led by the Ministry of Education (MOE) in collaboration with the Ministry of Health and Social Services (MOHSS) funded by UNICEF. The two research questions to be explored are:

- Is having HIV Testing and Counselling (HTC) in schools appropriate and able to increase the uptake of HIV testing and counselling among young people?
- Does utilisation of computer tablets for mobilisation motivate young people to take up HIV testing and counselling (services)?

In accordance with the Terms of Reference ("TOR"), the evaluation included an assessment of relevance, effectiveness, efficiency, impact, and sustainability. In addition, the report makes recommendations on how the pilot programme can be scaled up to increase uptake of HTC by adolescents aged 16 and over in secondary schools.

1.1 International and Regional literature on HTC for adolescents and youth

In 2010 the UNAIDS Outcome Framework: Business Case 2009-2011 was published as a means to reach 'zero new HIV infections, zero discrimination and zero AIDS-related deaths'[2]. It identified young people as accounting for 40% of all new global HIV infections and half of all other STI infections. It highlighted adolescents' and youths' vulnerability as being dependent on age, sex and other contextual factors, stressing that young women were more vulnerable and more likely to contract HIV than young men due to biological, economic, cultural as well as social reasons. The Business Case put forward a proposed plan of action:

- Provision of comprehensive HIV and SRH education, skills and services in safe and supportive settings
- Redoubling efforts and actions toward prevention and effectively reaching adolescents and youth
- Introducing context-specific HIV programming for vulnerable subgroups within adolescents and youth
- Promoting provision of combination programmes that are audience-specific

There is a scarcity of evidence on how best to strengthen HTC services for adolescents and youth, however some literature does exist on how to expand uptake of HTC.

In Malawi, an article which appeared in the Malawi Medical Journal reportedthat HTC service provision and uptake for adolescents and youth was poor even though there had been a significant increase in adolescent incidence of HIV and early pregnancies (2007)[3]. The paper explored issues involved in HTC uptake by adolescents who had the highest prevalence rates yet did not know their sero-status. It argued the importance of understanding barriers to existing services. These barriers were grouped under the headings of 'availability', 'accessibility' and 'acceptability.

Availability: lack of infrastructure; inadequate financial resources; and poor service capacity due to lack of technically skilled staff or trained counsellors. The reality was that there was a far greater

[2] UNAIDS. 2009. UNAIDS Outcome Framework: Business Case 2009–2011. Geneva.

[3] Daire J. 2007. Advocating for the improvement of adolescent VCT services in Malawi. Malawi Medical Journal [Internet]; 19(3): 118-122. Available at: http://dx.doi.org/10.4314/mmj.v19i3.10935

demand for VCT services than the supply could provide, where rural areas in particular lacked VCT centers, and support was inconsistent.

Accessibility: lack of knowledge of VCT; privacy, confidentiality and comfortableness were compromised; and service locations and operational hours were inconvenient for adolescents.

Acceptability: lack of youth friendliness despite the creation of Youth-Friendly Health Services. Adolescents felt unwelcomed and not respected, and so relied on informal sources for information outside the health system.

Råssjö et al. focused their attention on factors which reduced youth uptake of HTC in Kampala, Uganda (2007)[4]. While the study found that youth had a generally positive attitude towards HTC, there were several obstacles: cost of HIV testing; long waiting times; time constraints (operational hours coinciding with school/work hours); distrust of quality of testing; fear of pain during blood collection; fear of stigmatisation; and fear of being unable to cope with a positive result.

1.1.1 Factors which can improve uptake of HTC by adolescents and youth

In Malawi, Daire (2007) made several suggestions on how to improve uptake of HTC looking at availability, accessibility and acceptability. He advocated resources should be mobilised towards expanding youth-friendly HTC through improved staff training as well as increasing the number of outlets for services. This should be complemented by an increase in HTC campaigns to raise awareness and to increase availability of services and mobile facilities should be used to make services more accessible in rural areas.

In Uganda, the researchers suggested access to HTC by adolescents could be improved by: making changes in health centres: removing barriers of cost; changing the hours of health centres and improving the quality of testing and counselling; introducing school-based HTC sites; and advocacy at youth venues such as youth clubs.

MacPhail et al[5] found a new model of HTC service delivery was necessary which would be appropriate specifically for adolescents and youth, based on their research in South Africa. This model contains four critical practices:

1) Community mobilisation to raise awareness and normalise HTC for adolescents
2) Counselling to address stigma, and 'incorporate risk reduction within present … sexual relationships'
3) Support after testing for both youth and carers
4) Linkages between HTC service providers and a network of youth friendly organisations to which they can be referred for further specialised support.

Despite studies advocating the importance of developing testing facilities specifically aimed as adolescents with recommendations of how to do so, there are few published examples of how this was put into practice. In 2014, Idele et al[6] attempted to map out the

[4] Råssjö E, Darj E, Konde-Lule J & Olsson P. 2007 Responses to VCT for HIV among young people in Kampala, Uganda, African Journal of AIDS Research [Internet]. 6(3): 215-222. DOI: 10.2989/16085900709490417

[5] MacPhail CL, Pettifor A, Coates T & Rees H. 2008. ''**You must do the test to know your status": Attitudes to HIV voluntary counseling and testing for adolescents among South African youth and parents.** Health Education & Behavior [Internet]. 35(87): 87-104. DOI: 10.1177/1090198106286442

[6] Idele, P., Gillespie, A., Porth, T., Suzuki, C., Mahy, M., Kasedde, S., & Luo, C. 2014. Epidemiology of HIV and AIDS Among Adolescents: Current Status, Inequities, and Data Gaps. JAIDS Journal of Acquired Immune Deficiency Syndromes [Internet]. 66: S144-S153.

situation of the HIV epidemic related to adolescents. The article argued that despite world leaders signing various declarations since 2000, accountability to adolescents remained a challenge.

In 2012, there were 35.3 million PLWHIV of which 2.1 million were adolescents. The majority, 56%, were female living in sub-Saharan Africa (SSA). Most adolescents, it reported, are not aware of their status. An average of less than 1 in 3 adolescent girls reported ever having had an HIV test in SSA. Globally between 2009 and 2012 there has only been a 36% reduction in adolescent HIV incidence compared to 52% in children. Between 2005 and 2012 there is a reported 50% increase in HIV-related deaths among adolescents.

The article concludes that even with data gaps, current evidence shows that adolescents are more vulnerable than any other age group and that some effective actions are known, therefore there is a need to effect sound strategies – of which HTC is a crucial part.

The World Health Organisation (WHO) developed guidelines on providing HTC for adolescents in 2013[7]. The WHO report stated that in SSA only 10% and 15% of young men and women respectively knew their HIV sero-status which is, in part, a result of poor prioritization of adolescent health policies. The document lists the following guiding principles:

- Services must be flexible and able to adapt to different adolescent sub-group's needs
- Adolescents, especially ALWHIV, should be involved in programming
- HTC must follow the five Cs: "Consent, Confidentiality, Counselling, Correct test results and Connections to treatment, care and prevention services"
- Services must be embedded within a human rights framework
- Legal and policy support is critical to effective service provision

The key recommendations were similar to those expounded a decade earlier:

1. HTC be made available and accessible with linkages to other prevention, treatment and care services for all adolescents, whether in generalized, low or concentrated epidemic settings
2. Adolescents must receive guidance about the context of disclosure of their sero-status
3. Utilising community-based approaches and training health care staff in delivering youth-friendly services may prove effective in service delivery and ensuring that adolescents remain in treatment and care for the right amount of time
4. Staff should be trained in youth-friendly delivery service

In December 2013, USAID's AIDS Support and Technical Assistance Resources (AIDSTAR-One) published a report based on findings from 10 Sub-Saharan African countries[8] which explored HIV services and policies for adolescents. It indicated that despite a trend demonstrating an increase in adolescent prevalence rates dating back to the early 2000s, the availability and accessibility of specific services addressing adolescent HIV testing and treatment remain limited. Overall country findings indicated that:

- Countries are aware of the need to create youth friendly HTC and treatment programmes
- Most countries have small-scale programmes aimed at adolescents that are largely uncoordinated.
- Adolescent services are mainly limited to school-based initiatives, especially through SRH and HIV prevention education. However, three main problems inhibit the effectiveness of these initiatives:

[7] WHO 2013. HIV and Adolescents: Guidance for HIV Testing and Counselling and Care for Adolescents Living with HIV [Internet] ISBN 978 92 4 150616 8. available at: http://www.refworld.org/docid/52b2dd9d4.html

[8] Pitorak, Heather, Heather Bergmann, Andrew Fullem, and Malia H. Duffy. 2013. Mapping HIV Services and Policies for Adolescents: A Survey of 10 Countries in Sub-Saharan Africa. [Internet]. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

attendance and retention rates of adolescents limit the number of adolescents reached; curricula content can be inconsistent; and there are poor linkages between school-based programmes and other interventions.

- Data collection for adolescents is inadequate and unreliable owing to inconsistent definitions of the age range of 'adolescence'.
- Few staff are trained to provide youth friendly service.

Some overall recommendations to increase services catered to adolescents were:

1. Clarify and make consistent the age of consent for HTC, treatment, VMMC and other services and the definition of adolescence.
2. Adolescents, especially ALWHIV, should be involved in design and implementation of evidence-based progammes.
3. Programming should focus on key adolescent populations.
4. HIV prevention and treatment services should be comprehensive, integrated, and linked to relevant prevention and care services.
5. Increase effectiveness of interventions by involving caregivers and communities.
6. Ensure accessibility to interventions that are evidence-based and have been shown to be effective such as VMMC and PMTCT.
7. Increase creative collaborations to provide HIV services beyond just health and education sectors.

1.2 Namibia context – problem analysis

With an adult HIV prevalence rate of 13.1%, and 54% of all new infections occurring amongst 15-24 year olds three quarters of whom are female (MOHSS estimates and projections report 2012), reducing new infections amongst adolescents and youth is a national priority.

41.7% of young women and 24.6% of young men aged 15-19 had been tested and received their results (draft DHS 2013)

There are 183,449 learners aged 15-19 and 19,559 learners aged 20-24 (EMIS 2011)

The HIV prevalence rate among young pregnant women aged 15-19 is 6.6 % among those aged 15 to 19 (HMIS2011)

The draft DHS report of 2013 reported that 51.1% males, 61.6% females, and a total of 56.3% young people (all 15-24) had the correct and comprehensive knowledge of HIV/AIDS. HIV testing and counselling (HTC) remains a key HIV intervention in Namibia as an entry point to accessing services to remain HIV negative (including voluntary medical male circumcision VMMC) or to live positively with the virus. HTC service uptake among adolescents and youths has been low in Namibia. Whilst 93.2% females and 86.9% males aged 15-19 knew where to get an HIV test while only 41.7% females and 24.6% males of the same age group had ever been tested and received their results; while only 28.5% females and 13.9% males aged 15-19 had been tested in the last 12 months (draft DHS 2013). Young women are more likely to get tested than young men, partially because they will be routinely tested at antenatal services (17.5% of pregnancies occur amongst women aged 15-19) and adolescents and youth over 19 are more likely to go for testing than the 15-19 year old age group (UNICEF 2012). Data from the records in Oshana and Omusati Regions demonstrate an even lower percentage of 15-19 year olds are testing compared to older age groups.

Table 1: Data on HTC uptake

OSHANA	Jun			Jul			Aug			Sep		
	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total
15-19	506	150	656	359	110	469	227	46	273	167	21	188
TOTAL	**4848**	**1994**	**6842**	**2663**	**988**	**3651**	**2375**	**837**	**3212**	**1784**	**592**	**2376**
15-19 as % of total	10%	8%	10%	13%	11%	13%	10%	5%	8%	9%	4%	8%
OMUSATI	Jun			Jul			Aug			Sep		
	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total
15-19	385	34	419	123	40	163	175	17	192	205	38	243
TOTAL	**3466**	**1038**	**4504**	**1132**	**441**	**1573**	**1778**	**575**	**2353**	**1831**	**575**	**2406**
15-19 as % of total	11%	3%	9%	11%	9%	10%	10%	3%	8%	11%	7%	10%

Source: HMIS 2014

Between June and September 2013 15-19 year-olds accounted for an average of 9.8% of all tests in Oshana and 9.3% in Omusati. When looking at the difference in uptake of testing by gender, female adolescents average 10.5% in Oshana while males only average 7.0%. In Omusati, females 15-19 account for 10.8% of tests taken and males account for 5.5%. More females are testing in general for all age groups. On average, 13 adolescents were tested per day over the four month period.

Government strategies to increase testing have included: increasing the number of HTC sites nationally; door-to-door testing; and national testing days all of which have been successful at reaching older age groups but have not yet had a significant impact on adolescents and youth. Obstacles to adolescent HTC include: low risk perception; fear of testing as well as fear of discrimination if HIV+; distance from health centres as well as lack of confidentiality and attitude of health centre staff towards adolescents and youth (UNICEF 2012).

The school-based HIV Testing and Counselling Pilot Programme was specifically developed to increase access to and uptake of HTC amongst school based learners over the age of 16 in line with government policy to ensure universal access to testing[9].

Table 2: Programme Summary June 2014

Name of programme: Location	**School-based HIV Testing and Counselling Pilot Programme** Omusati and Oshana Regions, Namibia
Start-End Dates:	1 November 2013 – 31 January 2015 (including preparations and end reporting)
Budget:	N$ 1,600,000
Location:	The pilot programme is being implemented in two regions, Omusati and Oshana and in 14 schools (8 schools in Oshana region and 6 schools in Omusati region).
Expected result:	Through this programme a total of 1,000 learners 16 years and older in the Oshana and Omusati regions will receive counselling and testing services within their school environment. More learners will receive the information package in the Aps and be referred to HCT services at health facilities.

[9] Without documentation on the development of the pilot programme, this evaluation relied on KIIs with MoH, MoE and the National Steering Committee for details of the history of the programme.

1.2 Description of the Pilot SB HTC Programme

The pilot School-Based HTC programme emerged over a number of discussions at national levels within the newly formed National SBHTC Steering Committee jointly led by the Ministry of Education and the Ministry of Health[10]. Both Ministries were interested to explore innovative ways of increasing the number of adolescents' testing for HIV, in line with the Revised National Strategic Framework for HIV and AIDS 2010/11 – 2016/17 (draft), the Combination Prevention Strategy (CPS) for HIV in Namibia (June 2014), and the National Strategy and Action Plan for HIV Counselling and Testing (2014). The pilot programme was designed to encourage at risk school-based adolescents to take a voluntary HIV test using an innovative computer-based application specifically designed for young people. For those who tested positive, they were immediately to be linked into comprehensive care and support services, and those who expressed interest in services related to HIV prevention (VMMC, access to condoms, SRH services), were to be linked to relevant services.

The National SBHTC Steering Committee was developed to include stakeholders from different sectors and consisted of the MoE and MOHSS, civil society organisations involved in HTC, UNICEF, CDC and other development partners. The Steering Committee identified Development Aid from People to People (DAPP) as the preferred implementing partner due to its experience working in community based HTC through a Global Fund and PEPFAR grant. It identified Oshana and Omusati Regions as the sites for the pilot programme due to their high population density and relatively high HIV prevalence rates.

The process of developing the pilot programme followed a 'learning by doing' approach, as no examples of SBHTC were identified from other countries. This trial and error approach did mean the timeline of the programme was extended, resulting in an increase in costs. UNICEF provided a grant of USD1.5 million towards the pilot programme which was to be supplemented by USD800,000 by another development partner.

UNICEF supported the development of the computer-based application through external technical assistance as well as in-house IT support. The eventual application, YEAH!, is an interactive touch screen application developed with learners in and around Windhoek which takes the user through a series of screens to help them determine their risk of being HIV positive. Using two female caricatures, one white and one black, it uses Namibian voices and graphics specific to Namibia in language familiar to adolescents and youths. The programme goes into detail about the HIV testing process itself and into less detail about what happens if testing HIV positive. Its primary objective was to encourage learners to assess their personal risk of HIV and encourage them to take an HIV test. Additionally, YEAH! informs learners about the testing process and gives some information of what happens if the test is positive. The app was designed to store data on every user including: age, gender, sexually active, risk taking behaviours. This data was then expected to be downloaded into a spreadsheet to identify the profile of YEAH! users as part of the monitoring process. Unfortunately the finalisation of this process was not completed until September 2014, towards the end of the pilot phase, as this involved a significant amount of trial and error to perfect and the National Committee took the decision to start the pilot phase without it.

The pilot programme was expected to start in January 2015 running for 14 months[11] with a strong monitoring element to be implemented by another partner concurrently. DAPP

[10] There is an absence of documentation on the process of developing the pilot programme, therefore this section has been developed through KIIs with the relevant stakeholders as well as the original pilot proposal submitted by DAPP.
[11] Annex 1 original programme proposal approved by the National SBHTC Steering Committee

were contracted from November 2014 and immediately recruited staff and trained them. However, the actual start of the programme was delayed until June 2014, 5 months later than planned. There were a number of reasons for the delay:

- Harmonisation of protocols and guidelines of the MOHSS and MoE took longer than anticipated, particularly the age of learners eligible for this pilot programme. In January 2015, the age of consent was agreed to be 18 years, this later changed to 16 years in line with the government legal age of consent.
- The YEAH! app needed to be tested with learners before finalisation, then the model adapted in line with findings of the test and uploaded onto computer tablets. This process had not been considered in the original design of the pilot programme.
- Monitoring was considered an essential element of the pilot, to be undertaken by a development partner with significant experience in providing high quality quantitative data. However, delays in agreeing the exact parameters of the role eventually led to the dropping of the partnership leaving the monitoring role of the pilot programme hanging.

In June 2015 the National SBHTC Steering Committee took the decision to begin the pilot programme as there was a sense of urgency to access its results. The missing monitoring role was considered, and it was decided to use the monitoring forms of the MOHSS with basic data on numbers of participants in the programme without forming a baseline. The National Steering Committee was aware that starting so late in the year was likely to have some challenges, particularly the pressure schools are under to prepare G10 and G12 learners for their final exams, and that this may have an effect on uptake of YEAH! and HTC in schools.

DAPP submitted its programme document to the National SBHTC Steering Committee in which it described the focus of the pilot programme:

> *(1) To assess whether HIV counselling & testing service operated in schools is having an impact or not on the uptake of HCT amongst young people, and;*
> *(2) To assess whether technology for development plays a role in the uptake of HCT amongst young people as well as contribute to put them at ease*

The methodology of the pilot programme was designed to encourage long term sustainability and local ownership by working closely with the Regional AIDS Coordinators for Education (RACE Coordinators), and through a specially established Regional SBHTC steering committee to oversee the school-based HTC pilot programme, based on guidance from the National SB HTC steering committee. This methodology, whilst initially expensive to establish as it involves training, mentoring and back-up support, was considered more sustainable in the longer term as it could be absorbed into the functions of RACE Coordinators. The RACE Coordinators were expected to convene steering committee meetings, select schools for the pilot based on rural/urban location and distance from health centre; and monitor the pilot programme in their region. Their role was described in Terms of Reference provided to the RACE Coordinators by the National SBHTC Steering Committee. DAPP's role was as implementing partner, training Field Workers to undertake HTC based on MOHSS guidelines, working directly with the schools, and working directly with learners in schools as an extension of the role of health care professional. This approach, successfully implemented by DAPP in its TCE programme, was viewed as a possible way to reduce pressure on overstretched health care professionals in health centres. Parents were engaged in the programme in two ways: through signed parental consent forms; and through the School Board.

All learners were provided parental consent forms to take home for discussion and signature by their parent/carer in order to participate in the pilot programmes. Once

learners proved they had their parents' consent, DAPP entered the school to begin mobilisation for the pilot programme. DAPP begins work in the school, introducing the programme to learners in a general meeting and distributing booklets on HTC. Health clinics were contacted to engage in the pilot programme by providing rapid HIV tests, providing MOHSS monitoring data forms and clarifying which if any SRH/HIV prevention services it provided. NOTE: CD4 tests and ART initiation are both only available from the hospital, meaning anyone found to be HIV positive would be referred to the regional health facility using a standardised form. Learners were then provided the opportunity to go through a voluntary 10-15 minute application (YEAH!) which allowed them to assess their risk of exposure to HIV and took them through the testing process. Any learners interested in undertaking an HIV test, based on their assessment of risk, were able to do so either within the school premises the following week or received a referral letter to take to the local health facility able to provide such a service. Schools for the pilot were selected for their geographical proximity to a health facility.

HTC is offered in 50% of the pilot schools, testing is available to the rest of the schools through their local health centre. DAPP provides HTC within the school premises (in a classroom identified by school staff to provide confidentiality and privacy) every afternoon for two weeks at the end of each school day. Each DAPP Field Officer aims to undertake up to 8 tests (each takes approximately 35-50 minutes) per day – the maximum number of tests any one tester may undertake in one day as described by the MOHSS. Testing strictly follows MOHSS guidelines on HTC including all government policies on ensuring accurate results. The Field Officer uses the MOHSS referral form for any learner in need of other services such as VMMC.

Any learner who tests HIV positive is provided extensive, personal followed up by testing field officer and supported through the process of going for a CD4 count and also disclosing their status to their family. All DAPP Field Officers undergo 4 weeks training in MOHSS HTC, and work with National Institute of Pathology (NIP) to ensure they maintain strict quality control, in addition they are trained by DAPP in working with adolescents. Weekly meetings between field officers and DAPP coordinators provide an opportunity for monitoring and debriefing.

Whilst the National SBHTC Steering Committee met regularly during the design phase, they did not hold any meetings during the implementation phase. One monitoring visit was made to the Omusati and Oshana region to participate in the establishment of the Regional SBHTC Steering Committees and review implementation of the programme.

1.3 Scope of the evaluation

The evaluation team was appointed in August 2014 consisting of Susan Amoaten as team leader and responsible for the field research, and Mthobisi Sibandze responsible for the international literature review and data analysis. The field work was undertaken during September 2014. Key findings are outlined in section four and analysed in depth against the two core objectives of the evaluation. Section five provides a number of recommendations for the National Steering Committee to consider if it is to scale-up the school-based HTC programme.

2. Methodology

This evaluation was conducted in a number of inter-connected stages:

2.1 Preparation

The evaluation team was provided with background documentation on the pilot programme which it supplemented with relevant policy-related documents from Namibia. There is a significant lack of documentation on the process of developing the pilot programme and the many changes made to the pilot. This shortage of written material was taken into

account in the evaluation design, and led to an increased reliance on information gathering from qualitative sources such as KIIs and FGDs. From this base it developed the research framework and tools which were presented in an inception report to the National Steering Committee. Once the final inception report was endorsed, the team prepared for field work with support from DAPP and RACE coordinators in Omusati and Oshana.

2.2 School sampling

Eight schools were selected for in-depth inclusion in the evaluation out of the 14 pilot schools (8 in Oshana region, 6 in Omusati region). The selection of schools considered three variables: package of services provided to the school through the pilot project, (use of android application with or without in-school HTC services); type of school (boarding/combined schools); and geographical location (urban/rural). In addition, the MOHSS had requested the evaluation to consider schools near health-facility HTC and schools far from health-facility HTC. This methodology was adapted for practical reasons as the pilot programme was on-going, therefore only 12 of the schools had been covered. In addition, all the schools in Oshana Region included in the evaluation were close to health-facility HTC services.

Table 3: Selected Schools in each region

School Name	Activity		Location		Type		Part of sample
	App	HTC	Rural	Urban	Boarding	Combined	
Oshana Region							
Andimba Toivo ya Toivo Secondary	**Yes**	**No**		✓	✓		✓
Nangolo Secondary	**Yes**	**No**		✓		✓	✓
Eheke Secondary	**Yes**	**Sept**	✓		✓		
Ekwafo SS	Yes	Sept		✓		✓	
Mwadhina gwaNembenge SS	**Yes**	**Yes**		✓		✓	
Onamutai SS	Yes	Sept	✓		✓		
Oshakati SS	**Yes**	**Yes**		✓		✓	✓
Evululuko SS	**Yes**	**Yes**		✓		✓	✓
Omusati Region							
Shaanika Nashilongo SS	**Yes**	**No**		✓		✓	✓
Etalaleko SS	**Yes**	**No**		✓		✓	✓
Mwaala SS	**Yes**	**Yes**	✓			✓	✓
Shikongo Lipinge SS	Sept	Sept	✓			✓	
David Sheehama SS	**Yes**	**Yes**		✓		✓	
Onessi SS	**Yes**	**Sept** [12]	✓			✓	✓

2.3 Data collection

Data was collected in September 2014 over a two and half week period in Omusati and Oshana Regions as well as Windhoek (3 – 19 September 2014) as described below. A mix of stakeholders were included in this phase: MOE, MOHSS, DAPP, Field Officers, RACE Coordinators, Principals, Life Skills Teachers, School Board members, Clinic staff, other CSOs, and learners at 8 schools (4 in Omusati and 4 in Oshana region). A one page questionnaire was administered with learners (annex 1) at the start of each school visit. This was then followed up by FGDs with someone to translate into local languages when needed, wherever possible separate male and female FGDs were held.

There were some challenges with primary data collection which the consultants attempted to mitigate:

[12] At the time of the evaluation, Onessi SS had been introduced the YEAH! programme but not HTC.

- FGDs were a critical part of the evaluation methodology providing an opportunity for learners to feed their views into the research. Each school was asked to identify a group of learners who had been involved in the pilot programme to complete a questionnaire and from this group, the researchers had intended to invite a maximum of 15 female and 15 male learners to undertake FGDs (one group of females and another of males). This approach was intended to allow an equal number of participants to contribute from each school which would perhaps allow the opportunity of comparison on the YEAH! and HTC. However, each school interpreted the instructions differently leading to a more self-selecting approach to FGDs. This lack of a consistent approach to the FGDs makes comparisons problematic, however the views of approximately 120 female learners and 60 male learners were solicited and have greatly contributed to the research.
- The FGD at Evululuko SS had to be cancelled when over 80 learners arrived, some of whom were expected to be awaiting their G12 final oral examinations. Efforts to reduce the number created some conflict, therefore the evaluator only administered the questionnaires and no FGD was held.
- September is the start of the exam period for G12, and a key revision period for G10. As soon as the evaluator was made aware of this, the methodology was adjusted to only include G11 learners in the evaluation FGD which means that responses from Oshana and Omusati regions differ in terms of inputs.

Table 4: Data collection: KIIs, FGDs and questionnaires

Targeted Respondent Groups per Selected District	KII UNICEF/ DAPP	KII MoE/ MOHSS	National/ regional Steering Committee	KII teachers/ Principals	FGD learners	Other/ health clinic staff	Question-naires
Windhoek	2	2	1			2	
Oshana Region							**175**
Oshakati	2	1	1			2	
Oshakati SS				2	2		51
Nangolo SS				3	1		43
Evululuko SS				2	-		40
Andimba Toivo ya Toivo				1	1		41
Omusati Region							**120**
Outapi	1		1			1	
Onesi SS				2	2		40
Mwaala SS				3	1		11[13]
Shaanika Nashilongo SS					1		39
Etalaleko SS				2	1		30

A data collection matrix ensured that each of the research questions were answered from the perspective of different stakeholders to provide a broader input into the evaluation (Annex 3).

2.3 Data analysis and presentation

Data analysis was expected to rely on information from four different sources: background documents, monitoring data, qualitative data and learner questionnaires. Each different source of information was to provide different perspectives on the pilot programme yielding statistics as well as personal experience of the pilot. However, it became quickly apparent that the lack of a monitoring element to the pilot programme was going to have a negative impact on

[13] Mwaala only informed G12 of the pilot programme therefore when we asked to meet with G11 learners for the evaluation, most had not participated. Mwaala did not inform us of this before arriving at the school.

providing statistics to back up information collected from the other three sources. The pilot programme mainly collected statistics relevant to the MOH HMIS system as well as information on the uptake of the YEAH! app. Unfortunately, it did not include information on who used the testing services (to identify whether it was reaching those most at risk), or link whether using the YEAH! app directly led to uptake of HTC, or whether simply providing HTC in schools without motivation would also increase uptake of testing. As a result, this evaluation has had to rely on data from the three alternative sources: background documents, qualitative data and learner questionnaires. Whenever possible the consultants have attempted to use what monitoring information exists and compare this to regional statistics.

Qualitative data was synthesised from 31 KIIs, 9 FGDs and 295 questionnaires and used to respond to the two core evaluation questions specifically looking at: relevance, effectiveness, efficiency, impact and sustainability. The consultants were asked to respond to the two core evaluation questions and to provide recommendations on how this pilot project could be scaled-up to a programme for consideration by the National SB HTC Steering Committee as per guidance from the National Steering Committee. The zero draft of the evaluation report was presented to the National Steering Committee for feedback, once feedback was provided, the report was presented to a broader group of stakeholders before holding a workshop jointly convened by the MOE and MOHSS in November. The final evaluation report includes feedback from the MOE workshop.

2.4 Ethical considerations

Steps were taken to ensure the field research took place in an ethical manner that respected the programmes of participating schools and the rights of learners. The evaluation dates coincided with the start of final exams for G12, and revision for final exams for G10. Therefore, the FGD in schools adapted to only include learners from G11 so as not disturb their education. Male learners were less comfortable to come forward than female learners, whilst measures were taken to improve their participation by specifically reaching out to them, holding male only FGDs and speaking to male learners informally, they are less evident in this study which needs to respect their wishes.

3. Constraints and limitations of the evaluation

The main constraint of this evaluation was the lack of a strong monitoring component to the pilot programme as already mentioned. Other limitations worth mentioning include:

- **The pilot programme worked with 14 schools in two districts over three months.** This is a small sample upon which to base findings relevant to national scale up over an extremely short timeframe[14]. Therefore the results of the evaluation should be viewed with some caution with regards to national scale-up.
- **Delays in starting the pilot programme also delayed the evaluation**. The pilot programme was due to be implemented in Term 1&2 of the school year but did not start until June in Term 2. Whilst every effort was made to ensure both the YEAH! programme and HTC were implemented as originally envisaged, schools requested DAPP to delay HTC until Term 3 (September) in four schools. This limited the number of schools available for the evaluation, and meant the evaluation had to adapt to work mainly with G11 learners to not conflict with schools' exam timetable.

[14] This problem was discussed by the National Steering Committee but it was decided to proceed as there was a perceived sense of urgency to get going on the pilot.

- **Programme implementation was not consistent across the schools or across the two regions partially as a result of delays in start-up of the pilot programme**. Differences in implementation both provide opportunities and constraints from an evaluation perspective; the different models and methodologies provide an opportunity for comparison, but the inconsistencies in different environments also make it difficult to make any decisive judgements.
- **Focus Group Discussions with learners in schools were entirely voluntary and may not have attracted those most at risk of HIV**. The YEAH! app was designed to collect statistics on learners' perception of their risk of exposure to HIV, but as already mentioned it was not possible to extract this data during the pilot phase. The questionnaires too, give little indication of level of risk.
- **Male learner involvement in the pilot and in the evaluation was noticeably less evident both in numbers of male participating and with regards their input.** When asked why, it was clear that boys feel far more constrained by fear of negative peer pressure with regards to sexual behaviour in general and HIV related issues in particular.

Whenever possible, the consultants have tried to mitigate these constraints, and have taken them into consideration in the following analysis.

4. Overall results of the pilot programme

This section starts by describing findings from the programme as a whole before focussing on the two specific objectives of the evaluation.

Table 5: Summary of SB HTC pilot programme data

		Total Number of leaners aged 16+yrs	# of Learners who used tablets			# HCT Services in Schools			# of learners referred to health centres for HTC	# of learner forms demonstrating HTC at health centre
OSHANA REGION			F	M	Total	F	M	Total		19
	Andimba Toivo ya Toivo	**841**	69	14	83	0	0	0	83	
	Mwadhina gwaNembenge	**520**	73	42	115	103	44	147	0	
	Nangolo S.S	**227**	37	26	63	0	0	0	63	
	Ekwafo S.S	**446**	57	34	91	57	33	90	0	
	Oshakati S.S	**556**	211	80	291	145	54	199	0	
	Evululuko S.S.	**567**	153	71	224	105	43	148	0	
OMUSATI REGION										**3**
	Shaanika Nashilongo S.S	**400**	100	82	182	0	0	0	182	
	Mwaala S.S	**300**	96	11	107	73	7	80	0	
	Etalaleko S.S	**400**	139	50	189	0	0	0	189	
	Shikongo Iipinge S.S	**350**	111	39	150	86	23	109	0	
	David Sheehama S.S	**319**	131	89	220	78	37	115	0	
	Onesi S.S	**557**	142	116	258	137	63	200	0	

Source: DAPP Nov 2014

The SB HTC pilot programme exceeded its target of providing 1,000 learners in 14 schools in Omusati and Oshana Regions with HIV testing information in 100% and HTC in 50%

of schools, 8 of whom were found to be HIV positive, and did so within it budget of N$1,600,000. Table 5 clearly shows that providing HTC within schools was significantly more likely to result in learners undertaking an HIV test, with similar results in both regions.

4.1 General findings of the SB HTC programme

There was strong support for the SB HTC programme from all stakeholders who maintained that the YEAH! app. encouraged learners to take an HIV test, and that providing HTC in schools with fully trained and knowledgeable Field Officers was successful and important, though there was not universal support for HTC in schools being provided by non-health care workers.

RACE Coordinators, school staff, learners, health workers and MOE and MOHSS all believed that the parental consent forms were a useful way of ensuring parents were involved in HTC for adolescents and would be particularly important if the learner tested HIV positive. A total of 1339 and 1082 parental consent forms were submitted in Oshana and Omusati respectively. No school staff or learners had experienced any resistance to the pilot programme in terms of the ethics of introducing HTC to learners, though some did express concerns with the timing of the pilot in late Term 2 and early Term 3. The only concern expressed about the overall SB HTC programme was by the Omusati Regional Steering Committee which had not met since the initial meeting when the National Steering Committee had visited to introduce the pilot. The Omusati Regional Steering Committee's main concern was that they saw HTC as a health issue and therefore not something for the MOE to engage in. Interestingly, this issue was raised by a life skills teacher whose school had not been part of the pilot, and those who had participated were more positive about building linkages between schools and health centres. Unfortunately the Omusati Regional Steering Committee does not have health care workers as members to discuss this within the Committee.

This pilot programme demonstrated a strong functional collaboration between the MOE and MOHSS, particularly in Oshana Region. At national level there was engagement from both Ministries through the National Steering Committee as well as at the Regional Steering Committee in Oshana Region. In Omusati Region the relationship between DAPP as implementers of the pilot programme and health facilities, including the regional hospital, were good making the intervention itself proceed smoothly, but their engagement at regional level was not evident as they were not a part of the regional steering committee.

The pilot programme used a referral system previously developed by DAPP within its Total Control of the Epidemic programme, working in cooperation with MOHSS. Schools where the YEAH! programme helped identify learners' self-evaluated risk of exposure to HIV without provision of HTC within schools were referred for HTC at the nearest facility. For those schools where HTC services were provided, the tool was used to refer positives to the nearest health facility for further treatment and care services. When a learner reached the health facility, they were expected to put their form into a referral box within the health facility placed by DAPP. This way DAPP was able to identify which leaners had been given forms against the number who had gone for testing or follow-up services. Field Officers were NOT tasked to follow up with learners who chose not to go to the Health Facilities.

Table 6: HTC pilot programme referrals

	HTC SERVICES REFERRALS		# of Referrals Reached the HTC Facilities	
	Females	**Males**	**Females**	**Males**
Oshana	216	84	19	0
Omusati	73	16	3	0
Total	**289**	**100**	**22**	**0**

Source: DAPP monitoring data

These forms demonstrate that few learners when referred to HTC provided from health facilities actually undertook tests. This could have been for a number of reasons: learners too busy; opening hours of health centres; fear of stigma and discrimination by health facility staff; refusal to undertake HTC by health facility staff; fear to ask permission to go to the health facility by learners; etc. During FGDs with both learners and health facility staff, the main reason for not being able to take the test was twofold: learners feared discrimination by going to the health facility, this was particularly true for males; and being turned away by health facility staff and return with a parent. Both reasons suggest there is still a long way to go to make health facilities more adolescent friendly.

4.2 Assess whether using technology in the form of computer tablets to conduct a 'test for test' would motivate young people to take up an HIV test.

The main objective of the YEAH! app is to increase uptake of HTC amongst school-based adolescents through the incentive of using a touch screen computer tablet. Called a 'test for a test', the YEAH! app starts with a 'test' to determine an individuals' personal risk, before encouraging all learners to go for an HIV test.

The original purpose of YEAH!:

- To support users to check whether they need an HIV test or not
- To take users through the steps of HTC through a short video
- To clarify the implications of being HIV positive or HIV negative and
- To provide information on sexual and reproductive health.

The process of learning about HTC through the application was universally applauded by school-based staff. Principals and Life Skills teachers were impressed at how motivated the learners were to participate in the voluntary pilot programme. Whilst staff believed a significant motivation was the use of touchscreen tablets, they also had had feedback that the learners enjoyed this method of learning. However, in most schools the relationship between the pilot programme and core school activities was minimal, and staff did not use the opportunity to link the pilot programme to life skills classes. There were two exceptions to this, one where the Life Skills teacher undertook a workshop on sexual and reproductive health (SRH) during the week of the pilot and another where the Life Skills teacher linked the pilot to his lesson plans and connected the pilot to existing school clubs around SRHs. Only two Life Skills teachers out of the eight schools visited had actually gone through the YEAH! app, limiting comments on the application itself.

'The application is fun and yet educational and complements the Life Skills classes in school'
'Learners seemed to be impressed and encouraged by YEAH!'
'the app is encouraging learners to do this on their own'
'at first we thought learners may not be interested, but demand has been very high'
KIIs - Principal and Life Skills teachers

Learners were universally positive about YEAH! The response to the application was remarkably uniform across different schools, and did not differ by either age or gender. Learners liked the fact that YEAH! was aimed specifically at their age group and demystified the process of taking an HIV test which they learned was quick, painless and free. They also liked that the app was something they did individually which meant they could learn at their own pace and be completely honest about their HIV related behaviour without fear of judgement. This freedom meant they could assess their risk for themselves. By far the most important positive feature of YEAH! was that it was confidential and trustworthy. During FGDs learners said that they did not always trust information provided to them about HIV prevention or care and support, but that they did trust the information in the YEAH! app because it was 'official'. Both the questionnaires and FGDs demonstrated a strong belief that the application encouraged them to go for an HIV test, and helped them to realise the importance of knowing their HIV status.

> 'Learning through YEAH! is not so embarrassing'
> 'Living with HIV isn't as scary as I thought it would be'
> 'I didn't realise testing is something we should do when we are young'
> 'If I know about my status, then I can plan for my future'
> *FGDs and questionnaires - learners*

Table 7: Use of tablet and uptake of HTC - Oshana region

Name of School	# of Learners that used tablets	# HTC Services in Schools
Andimba Toivo ya Toivo	83	0
Mwadhina gwaNembenge	115	147
Nangolo S.S	63	0
Ekwafo S.S	91	90
Oshakati S.S	291	199
Evululuko S.S.	224	148

Source: DAPP monitoring data

Table 8: Use of tablet and uptake of HTC - Omusati region

Name of School	# of Learners that used tablets	# HCT Services in Schools
Shaanika Nashilongo S.S	182	0
Mwaala S.S	107	80
Etalaleko S.S	189	0
Shikongo Iipinge S.S	150	109
David Sheehama S.S	200	115
Onesi S.S	258	200

Source: DAPP monitoring data

The tables demonstrate a positive correlation between use of technology and HTC uptake in each school. However, it is not possible to conclude whether HTC uptake was due to availability and accessibility or more influenced by the excitement of novel technology because of the lack of clearly defined variables during design stage (controlled variables, independent variables, dependent variables).

When considering *how* the YEAH! app motivated learners to take an HIV test, some key points emerged:

- Learners found the process of learning from an interactive application informative and said that even though it was not necessarily new information, it reinforced what they had learned from Life Skills classes in a non-judgemental manner.
- YEAH! was motivational because it was specifically aimed at people of their age and circumstance.
- The learner was able to dictate the speed at which they learned the information which helped them to personalise the information.

4.2.1 Has the app improved uptake of testing?

Findings from the questionnaires, FGDs, KIIs and monitoring data all demonstrate clearly that the YEAH! app motivates learners to go for an HIV test. However, whilst it does motivate learners, particularly girls, to undertake an HIV test, health care staff, school staff and some learners expressed some continued fears and reservations:

a) **Stigma and discrimination was often cited as a significant problem in schools, particularly by the male learners.** Fear of teasing stopped some male learners from even using the YEAH! app and the statistics show that less males went for HIV testing after using the app than females. An observation of the evaluator is that schools with stronger commitment to life skills appeared to demonstrate less fear of stigma and discrimination.

b) **Knowledge levels about comprehensive HIV information were mixed, and knowledge about critical elements of SRH were significantly deficient.** This meant that some learners, mainly younger girls, were not clear about the implications of an HIV test or how to protect themselves from exposure to HIV. For instance, a significant minority of learners (male and female) said they did not know how to use a condom and some girls in one school privately asked the evaluator what 'sexual intercourse' actually consisted of.

c) **Disclosure of HIV status to parents and carers was a deep concern for learners** both male and female were concerned their families may be disappointed in them or angry if they were HIV+, though felt their support would be essential.

d) **A weakness of YEAH! is that it does not specifically address the widespread phenomenon of female learners with older boyfriends from outside school.** Whilst many girls see older boyfriends as an indispensable coping strategy to provide necessities[15], they recognised the challenges of negotiating safer sex (condom use) with older men, or alcohol use etc. and teenage pregnancy rates in seven of the eight schools were considered high (between 8 and 15 known pregnancies in each school in 2014 to date) by both learners and staff.

4.2.2 Is YEAH! relevant to national HTC related priorities and policies[16]?

The national HTC strategy specifically includes adolescents as a priority area:

"To increase youth-friendly and age-appropriate HTC services and uptake among adolescents and adolescents and youth ages 10-24 with an outcome result by 2016/17 of 75% of adolescents and adolescents and youth aged 10-24 counselled, tested and receiving results. Further, the strategy includes the promotion of school based HTC within its operational plan (4.1.2 main activities)."

[15] KIIs with school staff described how rural girls were sent to school without sufficient funds particularly if they had to find accommodation. Girls in the FGDs mentioned that they needed boyfriends to buy them both necessities as well as luxuries and that the men would give them more if they would have sex without condoms. Teachers believed the most vulnerable girls were those from poorer families or families without any guidance from home such as OVC.

[16] Relevance - The extent to which the activity is suited to the priorities and policies of the government (OECD definition).

YEAH! has demonstrated it increases 16+ adolescents in schools to take up HTC and therefore fits within the national strategy. However, in its current form it is unclear how it relates to the broader goal to reduce HIV incidence in Namibia through early detection of HIV infection and effective linkage to prevention, treatment, care and support services. In order to properly link HTC with comprehensive HIV services, YEAH! would need to broaden its programme to more clearly link to HIV prevention as well as care and treatment.

Learners provided some advice on issues which YEAH! could usefully include: risks of young girls having sex with older men; how to stay negative (HIV prevention including voluntary medical male circumcision); how to have a sex life as a learner living with HIV and sex between discordant couples; how to disclose HIV status to family or carers; the importance of early medical follow-up/ART; living positively through healthy nutrition; youth-friendly Support Groups for HIV positive adolescents and youth; and the importance of tackling stigma and discrimination to reduce fear and prejudice.

There was a strong demand from learners and Principals/ Life Skills teachers for YEAH! to include issues of sexual and reproductive health and contraception. Learners asserted that most pregnancies were unintended and had devastating impact on the lives of girls but they were not clear exactly how to avoid them. Principals and Life Skills teachers were very concerned about the high numbers of pregnancies in the school, particularly in G11 and said the performance of pregnant students nearly always dropped.

> The biggest problem is during the December holidays. Taxi drivers promise us presents for sex without condoms but do not give us them ….
> 'I fear older men, they give us alcohol even if we don't want it'
> 'how do I know if I have had sex?'

4.2.3 How effective has YEAH! been to help increase uptake of HTC[17]?

Because of problems with the overall monitoring of this pilot programme, and the lack of either a control school or schools which would receive HTC without YEAH! it is not possible to say with confidence how effective YEAH! has been at increasing uptake by comparing it to a control school, but the statistics do suggest that significant numbers of learners who first used the YEAH! app then went on to undertake an HIV test if it was provided in schools as demonstrated in tables 7 and 8 above.

With regards to the costs associated with the YEAH! app, this needs to be judged by whether the YEAH! app was able to encourage more learners to go for HTC than without the YEAH! app. Since the pilot programme did not include schools where HTC was offered without the motivation of the app, or provide control schools, this can best be looked at by comparing the uptake of HTC by adolescents in the Regions as demonstrated by HMIS data and comparing it to the uptake of HTC in the 8 pilot schools. However, this too is problematic.

[17] Effectiveness - A measure of the extent to which an aid activity attains its objectives (OECD definition)

Table 9: Number of 15-19 year olds undertaking HTC

Regions	Jun-Sep 2013			Jun-Sep 2014			**Jun-Sep 2014 DAPP**		
	female	male	both sexes	female	male	both sexes	**female**	**male**	**both sexes**
Omusati	888	129	1017	818	87	905	**374**	**130**	**504**
Oshana	1259	327	1586	1846	584	2430	**410**	**174**	**584**
Both Regions	2147	456	2603	2664	671	3335	**784**	**304**	**1088**

Source: HMIS November 2014

Data from the HMIS shows a decrease in the number of 15-19 year olds undertaking an HIV test in Omusati from 2013 to 2014, though an increase in Oshana Region. However, when this data is cross-referenced with monitoring data from the SB HTC programme a confused picture emerges whereby the total number of male learners in only 6 schools is the same number as *all* adolescent males 15-19 reached in the whole of Omusati region, and is higher than the number of males reached in 2014. This suggests there may be a problem with data from the HMIS on HTC.

The total cost of developing the YEAH! app was $99,069 (UNICEF financial data November 2014) which included the purchase of the computer tablets themselves. No judgement can be as to whether this is cost effective as in order to do so, the cost of implementing YEAH! would need to be compared to the use of another methodology which was not part of this pilot programme.

4.2.4 How efficient has YEAH! been at increasing HTC uptake, including demand for HTC and implementation, management and the decision-making process[18]?

The monitoring data shows an increase in demand for HTC by learners when it is introduced into schools, and learners own views expressed during the FGDs was that the YEAH! app greatly helped alleviate fears of the testing process. YEAH! was seen as an ethical way of increasing demand for testing in that it is entirely voluntary, addresses one of the key challenges to demand i.e. fear of the process, and is in line with government policy that it is the right of every Namibian to know their HIV status and access relevant services according to the result.

With regards to how far the YEAH! app has been efficiently implemented to increase uptake of HTC, there is some evidence that it was reasonably efficient. The National Steering Committee was set up as a multi-disciplinary body, jointly led by the MOE and MOHSS and as such provides an excellent example of collaboration between two line ministries. The Committee also included members from UNICEF, DAPP and other relevant stakeholders such as LL/CL, USAID, UNAIDS, NAPPA and Positive Vibes. It was crucial in setting up the pilot programme developing the strategies, approaches, protocols and operational guidelines for the pilot collaboratively. One of its greatest successes has been the harmonising of the custodial role of MOE towards adolescents and the objective service

[18] Efficiency measures the outputs - in relation to the inputs. It is an economic term which signifies that the aid uses the least costly resources possible in order to achieve the desired results (OECD definition).

provision role of the MOHSS. As a result, there has been the highest level buy-in to the pilot from both Ministries. The monitoring role of the national SC has been less successfully implemented, particularly looking at progress on a monthly basis and considering key factors such as whether the programme was reaching those most at risk.

The Regional Steering Committee role was also expected to be made up of a multi-disciplinary team responsible for oversight at regional level. In Oshana Region this went well and they met regularly to support implementation of the pilot and monitor its progress. The committee clearly felt a strong engagement in the pilot and were aware of its positive outcomes. The RACE Coordinator worked closely with DAPP, though she had not been with them to see the pilot being implemented in schools. The Omusati Steering Committee consisted of Principals and Life Skills teachers and had not met since its inception. They were convened once at the start of the pilot where they gave their consent for the pilot to proceed, but had not been involved after the initial meeting. The reasons for this are multi-various including: lack of availability of the RACE Coordinator to convene meetings; lack of clarity on the roles and responsibilities of the Steering Committee; distances of the pilot schools from Onesi. The RACE Coordinator had not seen the YEAH! app and accompanied the evaluators on two school visits to learn more about the programme but was less attached to the pilot.

The timing of school visits was programmed by DAPP in coordination with schools. However, delays in the start of the pilot, and the pressure this put DAPP under to advance implementation, did mean the timing of the pilot has been a problem. The pilot was introduced in some schools at such a time that learners were not able to go home to access parental approval and conflicted with other school activities, particularly mock exams for G10 and G12. Furthermore, the flow of information about key issues such as age of consent for testing learners to participate did not appear to reach some schools in a timely manner, thus limiting the outreach of the pilot. These challenges appeared to particularly affect participation in Omusati Region, where engagement of the RACE Coordinator was more limited. The evaluation demonstrated that the timing of the pilot definitely affected its uptake and that either end of Term 1 or beginning Term 2 would be a more appropriate time for its implementation, when new learners joining the school in G11 would have had a chance to get to know one another and settle into the school, and the Life Skills teacher would have already introduced My Future My Choice (MFMC).

The parental consent form was expected to be a condition of use of YEAH! but this was inconsistent. Not all learners received their forms in time to ask for parental consent, and some schools said learners 'faked' signatures on the forms to access the app. Most school staff and learners thought it a good thing to get parental consent to keep parents/carers informed of activities within the school and to potentially provide support to the learner should they test positive for HIV. Very few learners thought the parental consent form a barrier to accessing the programme as few parents would object to such a programme

4.3 Assess whether provision of HTC services within school premises is appropriate and would increase uptake of the services by adolescents and youth.

In order to assess whether HTC within schools is appropriate and would increase uptake of testing, this evaluation looked at data from different sources including monitoring data of actual numbers of learners who utilised HTC within schools, number of learners who went to Health Centres after undertaking the YEAH! programme and responses of learners to the questionnaires.

This information was supplemented with the opinions of other key stakeholders including School Principals and Life Skills teachers, Regional Steering Committees and Health Centre staff.

Table 10: SB HTC Pilot Summary Report Omusati and Oshana Regions

Ministry of Health and Social Service HTC summary report (24 June - 8 September 2014)	Female	Male	Total
Total number of Clients registered and received results	784	304	1088
Total number of first time testers	641	261	902
Total number of repeat testers	144	42	186
Total HIV Negative Results	778	302	1080
15-19	636	206	842
20-24	142	96	238
Total HIV Positive Results	6	2	8
15-19	5	1	6
20-24	1	1	2

Source: DAPP monitoring data 2014

Overall the provision of HTC within schools was seen as positive. Uptake of HTC significantly increased amongst the 16-24 age group when testing was provided in school premises. There was also an increase in demand for testing by learners from health centres, though FGDs demonstrated that very often learners would be turned away from HCs and therefore were not able to be tested.

> 'the field officers were patient and kind'
> 'testing at school I am surrounded by many people and if I feel suicidal I won't easily do it'
> 'testing at school is convenient and we are supported by our friends'
> 'being at school we can just do it'
> *FGDs & questionnaires - learners*

Learners said the reason for being turned away from health centres could be because they were considered too young (16 or 17 year olds), they did not have their parents present and therefore could not test, or that there were simply too many of them to undertake a test that day. As a result of testing, 8 adolescents were found to be HIV+, including one learner who was actually on ART but had not been aware the medication they were taking was for HIV. Whilst these statistics demonstrate the national trend of more females than male adolescents being HIV+, this should be read with caution as more than 50% of those who tested were female. These statistics are roughly in line with national HIV incidence trends within Namibia (Spectrum 2013). In each case the adolescent was referred to the health centre for follow-up and treatment and were counselled through the process of disclosure.

Life Skills teachers in about half the schools thought HTC within schools was a natural add-on to their existing work. Linkages with the MFMC sex education programmes, existing outreach work with local health centres and social services, were all raised as directly relevant to the pilot programme. This viewpoint was reinforced by School Principals who were mandated to have a school counsellor whose role was to provide psycho-social support, recognising that a number of learners in each school would already be HIV+. As a result of the availability of trained Life Skills teachers and Counsellors some believed that schools had the potential to be a more supportive

environment for HTC for learners, though most believed more training would be needed. However, not all Life Skills teachers were of this opinion, and some recognised they neither had the appropriate training or time to devote to the specific counselling and support needs of vulnerable learners discovering their HIV status for the first time.

It was not clear if the provision of HTC in schools was viewed positively in response to negative perceptions of HTC at health centres. Learners, school staff and health centre staff all discussed barriers faced by learners when going for HTC at health centres. Firstly, learners would need to ask permission of their school to go to a health centre which many felt embarrassed to do, and the hours of health centres clash with school hours. Secondly, learners would have to sit in the waiting room with general members of the community, often for many hours, to be tested which risked them being identified by family members. Thirdly, learners often complained of being turned away from health centres even though they were over 16. These challenges of access to HTC were a major factor in low use of HTC through health centres. Conversely, HTC provided on school premises was quick, efficient and easy, and learners found the DAPP field officers helpful, sympathetic and enjoyed the fact they were close to their own age.

> 'the nurse asked me questions with my parents in the room, it was embarrassing'
> 'even though I had the form from my parents and DAPP, the health centre would not test me' (17 year old girl)
> 'my father took the whole family to the health centre to be tested, they were very nice to us'
> 'I don't know if we can trust health centres, will they tell others what we tell them?'
> *FGDs & questionnaires - learners*

Health Centre staff were concerned that HTC undertaken in schools without parental supervision may result in adolescents and youth feeling isolated and potentially suicidal, but this concern was not expressed by the learners themselves, or backed up by findings from qualitative data. They were concerned that adolescents and youth of 16-18 may not be mentally ready to know their sero-status (unless they were pregnant or had already had a child). Whilst they did note that this was a fear not backed up by experience as in their personal experience very few adolescents did test positive, and those who had tested positive had reacted calmly to their serostatus, there was clearly a great concern about how best to work with adolescents who they saw as 'different' from adults. Interestingly, health centre staff did not have these fears with pregnant adolescents, even as young as 16. Learners expressed concerns that health centre staff did not provide counselling along with testing and therefore they were more supported through HTC at schools than in health centres.

Confidentiality once again was the major preoccupation of learners with regards to HTC, and there was not any consensus on whether school or health centres would be more private. On one hand, health centres were seen as more anonymous than school as school friends would not be aware that you had gone for a test and therefore would not ask you the result. However, other learners believed health centres were too public and that any member of the community may know you or your family and 'gossip'. Furthermore, learners worried that some health centre staff may share their private information with others. In essence, the results suggested that the geographical location of the test was less relevant than the way the test was undertaken and the respect for privacy of results for every learner.

School staff were equally concerned with issues of confidentiality. Whilst they did believe that school could be a less intimidating place for learners to be tested, they were also acutely aware that testing learners in classrooms was problematic as they would need to walk past their peers after

testing which may be difficult for those who tested positive. Teachers at one school suggested that a mobile clinic just outside the school may be a better solution, providing learners with the confidentiality they craved but making HTC immediately accessible.

All stakeholders discussed the importance of quality counselling that was specifically geared towards adolescents. Teachers were acutely aware that adolescents can be particularly vulnerable and that HTC may raise concerns that would need careful handling by the person undertaking the test. Health Centre staff too were aware that adolescents needed a different type of counselling which they responded to as best they could, though current HTC training is not necessarily geared towards this age group. A further concern with HTC in schools was to whom any HIV+ learner would be referred within the school. Current policy is for any HIV+ person to designate a support person and be helped to disclose their status to this person. For adolescents this person is usually a family member, but this may be harder in a boarding school where the learner lives far away from their home. It is not clear whether anyone within schools has the capacity to perform such a role.

The terms of reference for this evaluation had asked to look at the cost effectiveness of this pilot. In its simplest form, cost effectiveness looks at the achievement of outcomes in relation to the underlying associated costs. However, it is only when this data is compared to another methodology to achieve the same results that the figures become meaningful. Without such data, this evaluation can only give a crude figure of the cost of each test per learner, but further analysis would be essential to look at other factors such as: cost per test and value of reaching this priority age group; or cost per test and equity of access where existing MOHSS data clearly demonstrates the problems of including adolescents and young people in HTC programmes.

The analysis of cost per HIV test for this pilot is complicated by the delays in start-up of the pilot which moved the start date from February 2014 to June 2014, but only after field staff had been recruited. This meant that the pilot was incurring costs but unable to implement its activities. The pilot then reduced its targets downwards from the original figure of 2,780 learners to 1,000 in four months from June to September. However, many of its costs could not be reduced as staff had been recruited and capital outlay (training and supplies) had already been spent.

PEPFAR undertook an analysis of the cost of HTC per person being incurred in the country under PEPFAR programmes. Costs varied from USD10 to USD75 per person depending on the geographical location of the intervention and the approach used to encourage people to come forward for an HIV test[19]. It is not known how PEPFAR reached its cost per person, but the below table provides a number of different methods of developing a cost per person figure.

[19] Source: UNICEF November 2014

Table 11: Cost of HIV test per person from SB HTC pilot[21]

Actual costs reaching 1088 learners over four months	Cost per HIV test in schools[20]	
Staff cost 16 Field Officers + backroom staff (Coordinator, 4 Group Leaders, P-T Accounts, data clerk, M&E)	N$489.31	**USD44.48**
Staff + transport to and from schools (includes backroom staff monitoring and coordination travel)	N$606.09	**USD56.00**
Staff + transport + coordination + organisation overhead	N$841.60	**USD76.50**
Projected costs if the programme had run for the intended 8 months reaching and intended 2780 learners		
Staff cost 16 Field Officers + backroom staff (Coordinator, 4 Group Leaders, P-T Accounts, data clerk, M&E)	N$191.50	**USD17.40**
Staff + transport to and from schools (includes backroom staff monitoring and coordination travel)	N$241.12	**USD21.92**
Staff + transport + coordination + organisation overhead	N$329.37	**USD29.94**

Source: DAPP finance data October 2014

These statistics demonstrate that the highest calculated cost per test would be USD76.50 and the lowest USD17.40. These figures would suggest that the cost per test using this methodology are within the normal range, and would need to be considered against the intended outcome of encouraging adolescent males and females to know their status.

5. Recommendations

This evaluation has demonstrated that providing HTC in schools can increase uptake of testing amongst adolescents and youth and that a computer tablet is an excellent tool to motivate adolescents and youth to take up the test. The cost of undertaking each test is likely to be USD30 per person.

There are a number of specific comments and recommendations which may improve the programme if it were to be scaled-up as per the evaluation TORs:

5.1 Programmatic Recommendations

- The National Steering Committee must take a stronger monitoring and advocacy role within the programme. This should include looking at issues such as confidentiality, under presented groups such as male learners or female learners with older boyfriends, or the skill level of Life Skills teachers to provide ongoing counselling support for HIV positive learners.
- The RACE Coordinator at regional level is essential to ensure good buy-in from schools and establish links with the Health Sector and other key stakeholders, they should be encouraged to be fully engaged from the beginning and report on a monthly basis to their national level line manager on progress with the programme
- The Life Skills teacher within the school is a key stakeholder to encourage more vulnerable learners such as youth to come forward for YEAH! and testing and to ensure the programme is properly linked with other aspects of the Life Skills curriculum i.e. sex education
- No school should participate in the SB HTC without firstly going through the YEAH! app in order to be better informed about its content

[20] Exchange Rate USD1 = N$11

[21] See Annex * for overview of programme costs

- If HTC is to be made available within schools, the timeframe should be developed in line with the number of learners aged 16 or over to ensure all learners have an opportunity to use YEAH! and access HTC
- Principals, teachers and learners all asked that access to condoms for learners over 16 be re-introduced to schools both as an HIV preventative measure and to reduce the risk of teenage pregnancies which is a major concern. They mentioned that up until about two years ago, condoms had been made available but that funding (from a Global Fund grant) had apparently run out and now access to condoms for adolescents is extremely limited

5.2 Technical Recommendation

The content of YEAH! should be broadened to include more information about HIV prevention including VMMC and correct condom use as well as issues around sex and sexuality and SRH.

5.3 Unresolved issues warranting further investigation

Stigma was a major concern amongst learners, particularly youths. Whilst this was greater in some schools than others, particularly schools without a strong commitment to Life Skills or without a Counsellor, boys felt very vulnerable to ridicule and discrimination which hampered them using the YEAH! app. or going for HIV testing. Further investigation would be needed to identify how to address stigma within a school environment which encourages positive peer support around HIV and SRH in general, for both girls and youths.

Support within schools for learners who are HIV positive was discussed but without any clear recommendations. In some schools there exist dedicated Life Skills teachers who have been trained in MFMC and who are backed by the school Principal to play a strongly supportive role within the school. But this was by no means universal and remains a real challenge for any HIV positive learner who maybe without support nearby. One issue to investigate is what training support may be relevant for school counsellors. At the end of the field research phase, agreement was reached that psycho-social support training could be rolled out with Life Skills teachers working in the pilot areas; it would need investigation to determine the relevance and effectiveness of this training.

Whilst statistically more girls tested HIV positive than boys in this pilot, this could potentially be because more girls went for testing than boys. The finding from this evaluation is that boys are extremely vulnerable around HIV and SRH due to their own fears. During FGDs they declared their health-seeking behaviour in general was poor, but they also demonstrated enormous interest in knowing more about HIV prevention and care and support as well as SRH, particularly family planning. There is an unmet need with boys which needs further investigation to resolve.

A voluntary scheme such as the SB HTC pilot programme may not reach learners who are more vulnerable such as learners in sexual relationships with older men. Staff in most schools expressed their concerns about female learners with older boyfriends as they see high levels of teenage pregnancy in this group. The learners also were concerned as they said it was harder for girls to negotiate safer sex with older men. More research is needed to see how to encourage this sub-group of learners to undertake an HIV test.

If HTC is to be introduced into schools, it needs to be clearer about what it expects to achieve and how it fits into the custodial role of the school. HIV awareness clubs in schools, understanding sexual behaviour of adolescents, how to address stigma, knowing how to address issues of adolescents born with HIV could all be included in the YEAH! app to broaden its potential.

6. Conclusion

This evaluation has clearly demonstrated that having HIV Testing and Counselling (HTC) in schools is appropriate to the wants and needs of adolescent learners, and is able to increase the uptake of HIV testing and counselling. However, there are areas that need to be improved in order to ensure all learners will participate including male learners who are more fearful of HTC and female learners in relationships with older men who feel powerless to influence safer sex with their boyfriends.

The utilisation of computer tablets has also proven to be very popular and successful at motivating learners to take up HIV testing and counselling services, particularly if those services are brought within the school premises. The popularity of the computer tablet could be broadened to include other information relevant to adolescents and youth in the areas of HIV prevention, care and support as well as broader SRH. The confidential nature of the computer tablets, as well as the fact they can be used individually at the pace of the user was particularly successful at reaching out to male learners.

Annexes

Annex 1: Pilot Programme document

PILOTING
SCHOOL-BASED HIV COUNSELING & TESTING
IN THE REGIONS OF OSHANA & OMUSATI

SUBMITTED BY DEVELOPMENT AID FROM PEOPLE TO PEOPLE (DAPP)
TO
THE UNITED NATIONS CHILDREN'S FUND (UNICEF) NAMIBIA

1st November 2013 to 15 January 2015

DAPP Namibia
Development Aid from People to People

1. COVER PAGE

Programme	HIV Counselling & Testing
Project Title	School-based HIV Counselling and Testing of Learners 18 Years and Older
Duration of the Agreement	14.5 months
Aim	• To pilot **HCT services operated in schools** which will have an impact on the uptake of HCT among learners aged 18 year olds and above • To experiment with the use of **technology for development (android app)** supporting counselling services • To document **programmatic challenges** that can inform the potential future roll out of expanded school-based HCT services
Geographical Focus	2 Regions; o Omusati (8 schools) o Oshana (8 schools)
Expected Results	**Expected Results:** Through this program a total of 6,405 learners 18 years of age and older in the Oshana and Omusati regions will receive counselling and testing services within their school environment. • Regional Directors, RACE Coordinators, Regional School Counsellors, Inspectors, Schools principals, Representatives of Schools Unions, Representatives of Schools Boards in the two regions understand and accept the pilot intervention • 16 combined and or secondary schools participate in the pilot program in the regions of Oshana and Omusati (see list below) • HIV counselling and testing promoted in all participating schools totalling a target audience of 5,710 learners in grades 11 and 12 • HIV counselling and testing promoted without in-school HCT service delivery to 8 schools totalling a target audience of 2,930 learners in grades 11 and 12 • **HIV counselling and testing offered within the school premises of 8 of the participating schools totalling a target audience of 2,780 learners** • Technology for Development (android app) operated in tactile tablets piloted in 12 schools
Total Cost of the Project	2,304,952 N$
Sources of Funding	**UNICEF:** 1,500,000 N$ **DAPP:** 804,952 N$

2. EXECUTIVE SUMMARY

the cooperation as outlined in this document contributes directly to intermediate result number 6 in the UNICEF namibia 2013 work plan; “hiv prevention approaches and interventions for girls and most at risk adolescents are evidence informed.” looking ahead to UNICEF’s new country programme 2014-2018, this cooperation contributes to realization of the rights of all children and adolescents across health outcomes of the cpd 2014 - 2018. In addition, innovation is very much a focus with the use of technology for development, materialising as an android app supporting counseling services and operated on tactile tablets.

The school system represents a promising ground to enhance the implementation of hiv counselling and testing services to young adults.

The objectives of the pilot are two folds:

(1) to asses whether hiv counselling & testing service operated in schools is having an impact or not on the uptake of hct amongst young people, and;

(2) to assess whether technology for development plays a role in the uptake of hct amongst young people as well as contribute to put them at ease.

The pilot will target learners aged 18 year olds and above in grade 11 and 12 and be implemented in a total of 16 combined and secondary schools of the oshana and omusati regions. The intervention will take place during the 2 first school terms from january to september 2014. A pre-test will be carried out in 2 schools before the end of the current school year 2013.

Both the ministry of education and ministry of health will be leading the intervention. While development aid from people to people (dapp) has been identified as the service provider, the united children’s fund (UNICEF) will fund the pilot phase. The center for disease control and prevention (cdc) will provide technical assistance for the m&e component. Quality control will be ensured by the namibian institute of pathology (nip).

The school-based hiv counselling and testing programme will make a significant contribution to the operational plan of the ministry of health and social services (mohss) which was drafted during the swakopmund stakeholder meeting in april 2013. The implementation of the pilot will take into account approaches, standard operating procedures and lessons learned of home based door-to-door hct.

3. SITUATIONAL ANALYSIS

In Namibia the uptake of HCT among young people is low; There are 31.3 % of girls and 12.9 % of men aged 15-24 that were tested and received their results (MOHSS 2008). In addition very few adolescents under the age of 19 are being tested. Indeed, the majority of adolescents know about HCT and where to get the service but use of HCT facilities is low due to limited access, fears, and low perceived risk resulting in a low level of HIV testing.

There are large cohorts of adolescents who are sexually active in the school system; Schools represent a significant opportunity in targeting the large cohort of adolescents who are already sexually active. According to the 2011 data from the Educational Management Information System (EMIS), there are 183,449 learners aged 15-19 and 19,559 learners aged 20-24. If extrapolation using the Demographic Health Survey (DHS) 2006 is done there are 100,839 learners who have already had sexual intercourse. Among those sexually active approximately 44,055 learners did not use a condom for their first sexual experience. In addition, below is data providing evidence-based information about sexuality, HIV prevalence and teenage pregnancy within this cohort:

- *Young people are sexually active*: 8% of girls aged 15-16 and 23% of girls aged 17-19 reported being sexually active (DHS 2006) and the most determinant behaviour that put young people at risk is inconsistent condom use.

- *The HIV prevalence among young pregnant women is high:* 6.6 % among those aged 15 to 19 is in 2010. HIV prevalence among 15-19 year old pregnant girls increased from 5.1% to 6.6% in 2008 against the national average of 15.4 % (MoHSS/UNAIDS HIV projection survey 2010)

- *16 % of new infection occurs amongst 15-19 year olds:* 73% of those new infections were amongst girls (MoHSS/UNAIDS HIV Projection Survey 2010)

- *Teenage pregnancy is alarming* and results in school dropout: 15% of 15-19 year olds have started childbearing. About 17.5% of pregnancies are in 15-19 year olds (DHS 2006)

The school infrastructure provides a ground for operating and promoting HCT services; The school system also offers infrastructure were HCT can be operated and promoted. There are 1,703 schools in Namibia (including 476 combined and 196 secondary) and 350 school hostels (hosting 8 % of the learner population).

The curricula in place are conducive of an enabling environment for operating and promoting HCT services; The school curricula is well equipped with leaning outcomes on HIV and AIDS, which provide a conducive environment for the roll out and promotion of HCT. The My Future is My Choice Programme (MFMC) has been made compulsory for all grade 8 learners. In addition the life skill syllabus is inclusive of learning outcomes in relation to HCT (also in grade 8) and support of people living with HIV.

Human resources, organisation and policies of the Ministry of Education; Besides the fact that the MoE has a School Health Policy in place (a result of consultations between the MoE and the Ministry of Health and Social Services) and a Policy and Prevention on the Management of Learner pregnancy, HIV interventions are coordinated by the HIV/AIDS Management Unit (HAMU). The Regional AIDS Coordinators for Education (RACE) are the relay of HAMU in the 14 regions of Namibia. The MoE has also recruited more than 450 Life-Skills teachers, who will be responsible for the teaching of MFMC in grade 8. MCA-N, through Project Hope and in coordination with UNICEF is currently working to develop the capacity development plan for both life skills teachers and RACE Coordinators.

It is against this backdrop that the pilot programme was developed, particularly looking at how to address barriers that young people faces toward HCT as well as taking in consideration existing structures in place to be used as leverage for action.

4. STRATEGIES

Background/Context; The need to provide counselling and testing services to young women and men 18 years and older and the subsequent development of the School-based HIV Counselling and Testing Program is aligned with the *UNICEF Programme Component Result (PCR 11): 80% of adolescents have correct information and relevant skills and have access to services to reduce their risk and vulnerability to HIV.*

Lessons learned; DAPP Namibia has experience in implementing several different community development and HIV counselling and testing programmes including the TCE (Total Control of the Epidemic) program with support from the United States Centre for Disease Control and Prevention (CDC) and the Global Fund (GF) along with the Child Aid program with support from UNICEF and the European Union. Through both of these programmes the need to increase access to HIV counselling and testing services for young women and men in the Oshana and Omusati regions has been well established.

- The process, at school level, will especially involve life skills teachers who will give general health and HIV specific education.
- The pace of testing is estimated at 4 counselling and testing sessions per day per Field Officer and takes place over a period of 4 days per week. Therefore 16 counselling and testing sessions per week can be conducted in a school by each Field Officer (taking into account that it can happen only after normal school hours).

Field Officers	Number of Counseling & Tests Conducted	During 6 months / 10 weeks (holidays subtracted) with 4 days of testing per week
1 Field Officer	4 tests per day with testing conducted 4 days per week equals 16 test per week per Field Officer	160 learners counseled and tested
9 Field Officers In Oshana		Can counsel and test 1,440 learners
9 Field Officers in Omusati		Can counsel and test 1,320 learners

- The programme will take place in schools simultaneously
- Follow-ups, Referrals and ART adherence as well as prevention and commitment to safe sex will take place with individuals who were counselled and tested according to needs on specific days in a co-operation between the TCE program and the life skills teacher.
- Only learners aged 18+ will be offered HCT
- The HCT services should be rolled out after school hours for a period of 4 hours, from 1.00 to 5.00 PM and on Saturdays when agreed upon by local schools
- The HCT service should take place within the school or school hostel premises
- The HCT service should be rolled out during the 2 first terms of the school year in order not to disturb examination periods.

Sustainability of Results; As a pilot project the results gathered from the implementation of this program will inform the direction of future program implementation and rollout. While the MoE is taking the lead, the MoHSS and the National Institute of Pathology will also have a critical role in the intervention.

Proposed Strategies;

- ***Use of Technology for Development to facilitate the process of HCT***
  A software application supporting HCT services and operated on tactile tablets will be piloted. This application will have the objective of (1) Assessing whether user are at risk or not (the test for the test); (2) Explaining the steps of HCT (a short video), (3) Stating the implications of being positive and negative and (4) providing additional information about sexuality / reproductive health (this last part will mostly uses content of MFMC, WoH and also information from campaigns like Break The Chain).

- ***Mobile HCT services to learners***
  Considering the barriers faced by young people to access HCT and the fact that secondary schools represents a ground with a captive audience of learners aged 18 and above, mobile HCT services appears to represent a promising strategy to reach out young people

- ***Referral to psychosocial and treatment services***

The pilot is going beyond HCT and is critically looking at follow up in groups and individually. The follow up will link to referral systems for both the psychological and physical well-being of the young people.

Proposed Collaboration; The program will involve the following collaborative organizations:

- ***The Ministry of Education (MOE);*** The HIV/AIDS Management Unit (HAMU) at central level, the Regional Directors of Education, The Regional AIDS Coordinators for Education (RACE) at sub-national level and the School Principals and Life Skills Teachers at school level will be critical in the implementation of the programme. In addition School Boards will also play a role in smoothly implementing the programme.

- ***The Ministry of Health and Social Services (MoHSS);*** The Ministry of Health and Social Services will play the role providing support to the HCT in schools, especially in the areas of supply and training, technical guidance and support.

- ***The National Institute of Pathology (NIP);*** The NIP will provide quality assurance of rapid testing and training.

- ***The United Nations Children's Fund (UNICEF);*** UNICEF will facilitate discussion between the MoE, the MoHSS at both central and sub-national levels. UNICEF will contract DAPP and fund the pilot phase. UNICEF will also provide technical and financial support to the programme.

5. RESULTS FRAMEWORK

Level	Narrative Summary	Indicators	Baseline	Target
GOAL	Support Government Efforts in reaching young people targets of the National Strategic Framework (NSF) on HIV Counselling & Testing	• % of women aged 15-49 by FY 2015-16 • % of men aged 15-49 by FY 2015-16	• NA	• 90 % of women • 75 % of men
PURPOSE	1) Assess whether HIV Counselling & Testing operated in schools is having an impact or not on the uptake of HCT amongst young people 2) Assess whether technology for development play a role in the uptake of HCT amongst young people as well as contribute to put them at ease	• Number of learners grade 11 and 12 who accessed HCT within their schools • Number of learners grade 11 and 12 who accessed HCT in clinics	• NA	• To be defined in consultation with CDC
OUTPUTS	A pilot intervention taking place in selected secondary school in the regions of Oshana and Omusati Region	• Number of Secondary schools involved	• NA	• 16 schools
		• Number of learners grade 11 and 12 and aged 18 and above exposed to HCT messages	• NA	• 5,710 learners
		• Number of learners grade 11 and 12 and aged 18 and above offered HCT within school premises	• NA	• 2,780 learners
		• Number of learners grade 11 and 12 and aged 18 and above using the app / tablets	• NA	• 2,780 learners
INPUTS	DAPP certified counsellors deployed in selected schools using SOP of MoHSS and NIP Use of application working on tablets,	• Number of counsellors deployed	• NA	• 20 counsellors

6. MANAGEMENT AND COORDINATION ARRANGEMENTS

DAPP Namibia; will undertake and be responsible for the following programme implementation processes:

- Recruitment of staff required to implement the pilot project
- Procurement of supplies required to implement the pilot project
- Implementation of pilot project activities
- Coordination of stakeholder meetings
- Reporting of pilot project programmatic and financial progress and results in-line with project reporting conditions established by UNICEF

The following Human Resources will be attached to the intervention:

- Country Director (part time)
- An overall Coordinator (full time)
- 4 group leaders (full time)
- 16 field officers (full time)
- 1 data clerk (full time)
- 1 finance & administration (part time)
- 1 M&E Staff (part time)

7. FUND MANAGEMENT ARRANGEMENTS

Disbursement of funds will be made by UNICEF to DAPP Namibia in support of programme implementation on a quarterly basis in-line with the agreed upon budget. In order to provide financial oversight to on-going programme expenditures DAPP will also provide UNICEF with financial reports on a quarterly basis which will detail the programme expenditures against disbursements for the previous quarter.

For the following items there will be cost sharing with the existing DAPP TCE programme: office rent and overheads, the salaries of key staff, and the use of vehicles to implement the pilot project.

MoHSS will provide rapid test kits and trainers, and that the NIP will provide quality assurance services free of charge in support of project implementation.

8. MONITORING, EVALUATION, AND REPORTING

Monitoring; In order to ensure effective monitoring of programme implementation field visits will be conducted by DAPP management on a quarterly basis to ensure high quality programme implementation and to observe implementation challenges and opportunities to optimize existing programme implementation and to inform improvement to future programme implementation methods.

Annual/Regular Reports; Detailed annual programmatic and financial reports will be submitted by DAPP to UNICEF which will provide detailed accounting of programmatic results inclusive of variance analysis and recommendations along with financial accounting records for the expenditure of funds in support of programme implementation.

Evaluation; DAPP management will in concert with UNICEF undertake a programme evaluation exercise in order to gauge the on-going effectiveness of programme implementation activities in concert with planned financial expenditure in support of programme activities in April, August, and December, 2014.

9. WORKPLAN (14.5 Months)

Results, Activities & Timeline		2013		2014												2015	Budget
		Quarter 1				Quarter 2				Quarter 3				Quarter 4			
		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Pre-planning achieved	Finish agreement on the proposal with main stakeholders	X															
	Define the guidelines and M&E tools	X															
	Agreements with schools confirmed	X															**150,791**
Pre-test of HCT and use of tablet carried out in 2 schools	Rehearsal including in 2 schools (one in Oshana and one in Omusati region)	X															
Procurement & training achieved	Preparation of materials for mobilisation	X	X														
	Information for recruitment made public	X	X														**387,300**
	Procurement of supplies	X	X	X	X												**284,685**
	Staff training		X	X													**360,815**
	Meetings with relevant stakeholders such as principals, school boards, parents	X	X	X	X												
Implementation in 16 schools accomplished	Programme implementation at schools				X	X	X	X	X	X	X	X					**969,211**
M&E carried out	Program result tracking				X	X	X	X	X	X	X	X					
	M & E on site visits by DAPP leadership					X		X		X		X					
	Internal assessment of progress to be shared with UNICEF							X			X						
	Assessment of pilot program implementation											X	X	X			**152,150**
	Quarterly reporting			X			X			X			X				
	MOHSS-NIP-HAMU-UNICEF-DAPP-CDC coordination as needed	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
	Preparation and implementation of the evaluation with CDC	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
Final report drafted	Submission of final report – closure of the intervention															X	
TOTAL																	2,304,952

10. BUDGET (please see Excel sheets for details)

PILOT SCHOOL BASED HCT INTERVENTION IN OSHANA & OMUSATI						
From 1-Nov-2013 to 15-Jan-2015 (14,5 months)						
Budget lines		**Unit cost**	**Months or unit**	**Number**	**Sub-total in N$**	**Total N$**
1	**HUMAN RESOURCES**					
	Coordinator	13,250	14.5	1	192,125	
	Group Leaders	4,028	9	4	145,008	
	Field Officers	3,180	9	16	457,920	
	Data Clerk	3,922	12	1	47,064	
	Finance & Administration staff partly	4,028	14.5	1	58,406	
	Allowance for interviewers in assessment for 10 days	254.40	10	8	20,352	
	M&E staff partly	4,028	12	1	48,336	**969,11**
2	**SUPPLIES**					
	Office supplies	1,200	14.5	3	52,200	
	Printing of household registers adapted to schools	253	1	24	6,072	
	Printing of Training manuals	120	1	24	2,880	
	HCT registers	370	1	24	8,880	
	Client result register	370	1	24	8,880	
	Attendance register	20	1	24	480	
	Printing of reporting tools	276	1	24	6,624	
	Printing of referral forms	370	1	24	8,880	
	T-shirts & Caps uniforms for Field Officers	450	1	24	10,800	
	Lap top incl. programmes	9,000	1	1	9,000	
	Stationary computer incl. printer	10,000	1	2	20,000	
	Digital cameras	2,000	1	5	10,000	
	Folding tables	350	1	16	5,600	
	Back packs	600	1	16	9,600	
	Cooler boxes	200	1	16	3,200	
	Ice packs	30	1	32	960	
	Spray bottles	25	1	16	400	
	Scissors	24	1	16	384	
	Timer	250	1	16	4,000	
	Thermometer	345	1	16	5,520	
	Torch	100	1	16	1,600	
	Sharps disposable containers	280	1	100	28,000	
	Consumables for HCT	12	1	3750	43,725	
	Camping Materials (mattress, sleeping bags)	450	1	20	9,000	
	Camping Tents	3,500	1	8	28,000	**284,685**
3	**TRAVEL**					
	Director travel & accommodation for monitoring	6,000	1	4	24,000	
	Transport coordinator	3,000	14.5	1	43,500	
	Transport Field Officers and Special Forces for training	300	2	20	12,000	
	Transport Field Officers to schools 20 FO and SF x 16 schools x 3 times	200	32	20	128,000	
	Transport to and from the Heath facilities/clinic	200	96	4	76,800	

	Transport Field Officers monthly meetings	200	9	20	36,000	
	Transport for interviewers during assessment 10 days	200	10	8	16,000	
	NIP Quality Assurance Officer transport	3,000	8	1	24,000	
	Transport group leaders for biweekly meetings	200	18	4	14,400	
	Transport for facilitators for the MoHSS approved training	4,200	1	3	12,600	**387,300**

4	**OTHER**					
	Monthly meetings for the field groups (accom. and refreshm.	250	9	20	45,000	
	Office communication cost sharing	1,000	14.5	3	43,500	
	Communication Coordinator	1,000	14.5	1	14,500	
	Communication Field Officer groups	100	9	4	3,600	
	Group leaders biweekly meetings refreshments	60	18	5	5,400	
	Courier & postage	100	14.5	1	1,450	
	Bank charges	600	14.5	1	8,700	
	Audit fees	20,000	1.5	1	30,000	**152,150**
5	**TRAINING**					
	4 weeks of training in counseling and testing (Acc, food, venue)	250	28	23	161,000	
	Facilitators from MoHSS - SNT rates	709	15	2	21,270	
	Facilitator from NIP - SNT rates	709	5	1	3,545	
	Per Diem for staff while they are in the field/schools	50	175	20	175,000	**360,815**
	Sub total 1					***2,154,161***
6	**MANAGEMENT AND COORDINATION FEE**				-	
	7% of the overall expenses				150,791	**150,791**
	OVERALL TOTAL IN N$					**2,304,952**

Annex 2: Evaluation TORs

Consultancy to Conduct an Evaluation of the School-Based HIV Testing & Counselling Pilot Project in Namibia: LRPS-lma-2014-9111933

1. Understanding of the terms of reference and scope of work

Susan Amoaten (lead) and Mthobisi Sibandze (research assistant) are pleased to submit this technical proposal. As instructed, our financial proposal is included under separate cover.

This evaluation is designed to assess the pilot programme being implemented by DAPP. The two research questions to be explored are: (i) Is having HIV Testing and Counselling in schools appropriate and able to increase the uptake of HIV testing and counselling among young people? (ii) Does utilisation of computer tablets for mobilisation motivate young people to take up HIV testing and counselling (services)? In accordance with the Terms of Reference ("TOR") the evaluation will include an assessment of relevance, effectiveness, efficiency, impact, sustainability, scalability/reliability, coherence, and coordination. The evaluation will follow the scope of work that is outlined in detail in the RFP and further discussed below. The assignment will result in an inception report, an evaluation draft report, and, ultimately, a final bound report accompanied by 3 CDs and soft copies.

2. Context and Overview of HTC in schools

The purpose of this evaluation is to assess the relevance and effectiveness of HTC in schools as a method to reach out to young people as well as to look at the use of technology in encouraging more young people to take up testing and counselling. Understanding the context of HTC in HIV prevention and opportunities provided through technology for development will be important in determining this.

Namibia is considered an upper middle income country with a GNI per capita of US$ 5,670 (UNICEF 2012) and a population of 2.5 million people, 983,300 of whom are below the age of 18. With an adult HIV prevalence rate of 13.3%, and 16% of all new infections occurring amongst 15-19 year olds (MoHSS/UNAIDS HIV Projection Survey 2010), HIV prevention with young people is an essential strategy of the Namibian government.

HTC service uptake among YP has been unsatisfactory in Namibia with 31.3 % of girls and only 12.9 % of youth aged 15-24 tested and received their results (MoHSS 2008). Data indicates that young people under the age of 19 (most of whom are in secondary school) are even less likely to access HTC despite reasonable rates of comprehensive knowledge about testing at 61.9 % males and 64.9% females (UNICEF 2012). However, due to limited access, social barriers, fear and a distorted perception of HIV risk knowledge is not converting into testing.

According to the UNAIDS Investment Approach, HTC is a key strategy in both prevention and care and support. HCT can prevent new infections when people recognise their HIV status and are given the necessary knowledge to prevent transmissions. HTC could also be the beginning of reducing the risk of HIV exposure through changing people's health-seeking behaviour and social norms. It also identifies those in need of treatment and directs people to the relevant services.

An android software application supporting HCT services and operated on tactile tablets is being piloted. This app's task is to provide knowledge and information to YP about testing, counselling and sexual reproductive health. Its versatility both in terms of the information it can share and the number of devices that can support it potentially make it an excellent tool for working with young people.

3. Purpose and specific objectives of the study

The purpose of this study is to assess how the implementation of School Based HIV Testing and Counselling will lead to positive outcomes in the uptake of HIV Testing and Counselling services among young people. The TOR for this consultancy articulates two specific objectives:

(i) Assess whether provision of HIV Testing and Counselling services within school premises would increase uptake of the services by young people.

(ii) Assess whether using technology in the form of computer tablets to conduct a 'test for test' would motivate young people to take up an HIV test.

The evaluation is to be undertaken simultaneously with the implementation of the pilot programme[22].

4. Proposed tasks and methodology:

The study team will use a mix of qualitative and quantitative methods, exploring the core research questions from the perspectives of different stakeholders including: learners (male and female); parents; teachers and principals; Ministry of Education staff, Ministry of Health & Social Services staff; DAPP; and UNICEF. It will attempt to map in quantitative terms what the uptake of HTC has been in schools and the role of the computer tablets in increasing uptake. This quantitative data will be analysed by three key variables: gender, age and academic year group. This quantitative data will be strengthened with qualitative data soliciting views and perspectives of different stakeholders related to uptake and in particular to scalability.

A substantial part of the data collection will be undertaken through quantitative means. The pilot programme is being implemented in two regions, Omusati and Oshana and in 16 schools (8 schools in each region). According to the programme proposal, a total of 6,405 learners aged 18 years and older are expected to receive counselling and testing services within their school environment. Sampling provides statistical data on the uptake of HTC in participating schools taking into account the three variables. Identification of sampling of schools for in-depth inclusion will follow a participatory process, involving the Steering Committee and attempt to include at least 4 of the 8 schools.

Data collection tools will be used to design an overarching set of questions that will guide data collection and analysis. Firstly the eight key areas that are outlined in the TOR (relevance, effectiveness, efficiency (cost effectiveness), impact, sustainability, scalability/reliability, coherence and coordination) will be tested against the overall programme objective. Secondly, the evaluation will look at the implementation of the programme, including the use of tablets for information dissemination. The approach would:

- Undertake a desk review
- Develop a statistical data system
- Develop a questionnaire to be implemented with learners by Field Officers as part of the HCT service
- Meet and interview key informants as well beneficiaries to collect representative quality data;
- Undertake in-depth visits to 4 schools in Oshana and 4 schools in Omusati selected in consultation with the TWG to represent differences in delivery and uptake of services; and
- Involve on a frequent basis the TWG

4.1 Methodology according to key tasks

Task 1: Develop an inception report indicating the research methodology in detail; data collection tools; a matrix for the impact evaluation and the final timeline for deliverables outlined in the TOR.

We propose developing two key documents to help guide the study:

[22] The pilot programme is scheduled to start on 18 june, if this is the case, the evaluation will not be undertaken simultaneously and will need to refine its methodology accordingly.

- **A data collection matrix** to ensure research questions outlined in the TORs are all responded to. The matrix will help track progress of the data collection process'; and
- A **framework** that will be used to map progress of the programme against the core research questions.

Task 2. Conduct a desk review of relevant literature related to the programme.
A review of relevant literature will be used to inform the development of the research questions and to analyse the underlying assumptions of the programme.

Task 3. Conduct an in-depth analysis of the programme in terms of scope and coverage by undertaking field visits to 4 of the 8 schools.
The study team would propose to include 4 schools from each of the 2 regions for in-depth meetings. Selection criteria could include: number of learners over 18 enrolled in Y11 and Y12; age and gender of learners; academic performance of the schools; and geographical location.

Key informant interviews would include: learners and the parents/carers; teachers and principals; District Education Officers; District Health Officers; DAPP, UNICEF.

Task 4. Conduct stakeholder consultations, and in-depth interviews with key stakeholders.
Stakeholder consultations will allow first-hand perspectives to feed the evaluation. Different tools would be needed for different questions and used with different stakeholders:

- A one page **questionnaire** will be administered through Field Officers with learners. This process will provide statistics on the two research questions disaggregated by age, gender and school.
- Semi-structured **interview forms** would be able to guide Key Informants Interviews.

All collected information will be sorted in order to identify data to answer the questions outlined in the TORs. Data coming from different sources and relevant to answer a specific question will be grouped, analysed and structured around a coherent answer. Computer programmes such as SPSS or Atlas Ti may be used to help with data analysis. The first analysis of data will be presented and discussed with the TWG, which will act as a reference group.

4.3 Ethical Issues

Steps will be taken to ensure that the research takes place in an ethical manner and does not harm participants, including children, caregivers or schools. A draft protocol with both adults and children will cover the following issues: anonymity of participants; KIIs with adults and children will be held in places familiar to them; a simple description explaining the purpose and use of the research, and providing each participant with repeated opportunities to decide whether or not to take part; providing refreshments and carrying out the research at times that suited participants; and no interview will be recorded without the express consent of participants.

5. Work Plan and Milestones

Activity	*Milestone*	*Timing*	*Consultancy Days*	*Responsible*
Develop methodology and tools	Inception Report	July	15	Susan Amoaten
Data collection and analysis, desk review	Evaluation draft report	July/August	35	Susan Amoaten and Mthobisi Sibandze

Data finalisation – comments from core team	Final report	September	10	Susan Amoaten

6. Capability statement and competencies of core team

Requirement	Relevant Qualifications and Experience
Post-graduate degree in social sciences, research, evaluations or relevant areas	Susan Amoaten MA Development Studies, School of Oriental and African Studies, University of London
Extensive experience (5-10 years) in conducting programme evaluations, with evaluation experience in HIV, preferably on adolescents and young people.	Susan Amoaten has over 20 years' experience of HIV programmes and evaluations and for the past five years has focussed on adolescents and young people. Mthobisi Sibandze has undertaken three major reviews as research assistant on HIV and adolescents.
Strong quantitative and qualitative research skills	Team members have been trained in research techniques with vulnerable children and in PLA techniques as well as questionnaire development and implementation
Experience in advanced data analysis	Susan and Mthobisi both have experience with SPSS, STATA (quantitative) and Atlas Ti (qualitative) data analysis
Strong analytical and conceptual skills	Both team members have undertaken work for a range of partners including UNICEF, UNAIDS, USAID, national and international CSOs
Demonstrated ability to meet deadlines	As consultants, team members are used to working to tight deadlines
Excellent communication skills and fluency in English, written and verbal	Susan and Mthobisi are both native English speakers and Mthobisi is bi-lingual with SiSwati.
Expertise in gender equality and human rights, including child rights	Susan has worked on gender and human rights approaches. Mthobisi has experience in child rights and gender equality.

Annex 3: Evaluation Questions

The evaluation will therefore answer the following two research questions;

> Is having HIV Testing and Counselling in school appropriate and able to increase the uptake of HIV testing and counselling among young people?
>
> Does utilisation of computer tablets for mobilization motivate young people to take up HIV testing and counselling?

The evaluation will therefore seek to answer the following questions under the major areas of an evaluationexercise which include relevance, effectiveness, efficiency (cost effectiveness}, impact, sustainability, scalability/reliability, coherence and coordination:

1. Relevance

Was the design of the pilot project most appropriate and a relevant strategy for addressing the relatively low HTC uptake among learners in accordance with the national development priorities and policies?
How has the project created change in comprehensive services for learners during the implementation period?
How has the pilot project addressed the problems experienced in programming for interventions for learners and strengthening of partnerships?
How has the project supported evolution of an appropriate and effective mechanism for coordination of school based efforts and pooling of resources into response targeting learners?
Was the intervention supported by schools boards, parents and community members?

2. Effectiveness

Have the project's goals and purposes been achieved as originally envisaged and what gaps (if any) remain?
How integrated was the project with other related national strategies such as life skills programme, school health programme, other HTC models?
How inclusive and gender responsive were the services and promotional materials for the pilot?
How user friendly was the project and how effectively did it support programming of school based health interventions?

3. Efficiency (cost effectiveness)

What components in the pilot project have been achieved or delivered with the best value for money and in what specific ways?
What have been the direct/indirect costs per learner beneficiary incurred?
Could the same results be achieved at a lower cost or could more or better results be achieved with the same cost by using different instruments or approaches?

4. Impact

What are the intended and unintended positive and negative outcomes of the pilot project? What lead the change and why?
How has the project influenced or strengthened programming for learners in the two Regions? Are there variations from one region to the other?
What if unintended changes outside programming for learners as a result of the pilot?
What influences did the pilot have in service provisioning of mixed HTC models in the two Regions?
How has the project brought changes in the lives of the learners, teachers and parents, positive, negative, intended, unintended to influence community development and enjoying quality of life?

5. Sustainability

Does the programme have the capacity to sustain its operations in terms of financial and programmatic implementation?
How strong and sustainable are systems put in place through the project at pilot stage to continue delivering quality services to targeted communities?
What lessons related to sustainability can we draw?

6. Scalability/Reliability

What components of the project show greater likelihood for scalability and why?
How likely is the project or its components going to be scaled or replicated by government and other agencies?

7. Coherence

How has the HTC project influenced coherence between policies of key stakeholders? Is it complementary or contradictory and why?
What is the effect of the project on such complementarity or contradictions?

8. Coordination

How have the activities in the Pilot Project Schools been coordinated with other related sectoral interventions/approaches such as life skills and overall school health programme?

Annex 4: Learner Questionnaire

School-based HIV Counselling and Testing Programme Learners' Questionnaire

About you

Age

16-17 years old **18-19 years old** **20 years and older**

Gender/Sex

Male **Female**

1. **When is the last time you had an HIV test?**

1-12 months ago More than a year ago I've never had an HIV test

2. **If you have been tested, where did you have the HIV test?**

Health centre Mobile HTC facility Other

4. **If someone tests HIV+, do you know where to go for further support: ART, male circumcision, condoms etc?**

Yes No

5. **Did life skills or health education provided through the school link with the testing service?**

Yes No

6. **Do you think providing HTC within the school grounds is a good idea? Please explain**

Yes No Maybe

7. **Did you use the YeAH programme?**

Yes No

8. **Has YeAH motivated you to take an HIV test? Please explain**

Yes No

9. **Do you think YeAH is a good way of encouraging young people to take an HIV test? Please explain**

Oshana Region consolidated questionnaires[23]

			last HIV test			Is SB HTC a good idea?		
Sex	Age	No of responses	Never	1-12 months	12+ months	Yes	No	May be
Female	16-17	29	12	14	3	26	2	1
	18-19	78	5	62	11	77	1	
	20+	16	2	12	2	15		1
Male	16-17	2		2		2		
	18-19	31	6	17	8	25	6	
	20+	15	4	9	2	11		4

Test Site		
	1-12 mths	12+ mths
School	76	
Health Centre	36	23
Mobile HTC	4	3

Omusati Region Consolidated

			last HIV test			Is SB HTC a good idea?		
Sex	Age	No of responses	Never	1-12 months	12+ months	Yes	No	May be
Female	16-17	34	11	15	8	30	4	0
	18-19	44	13	27	5	36	7	1
	20+	11	3	7	1	9	2	0
Male	16-17	3	1	2	0	3	0	0
	18-19	21	10	8	3	16	4	1
	20+	9	4	5	0	7	2	0

Test Site		
	1-12 mths	12+ mths
School	39	
HC	35	
MHTC	7	

[23] 4 questionnaires were not properly completed and therefore had to be discarded

Annex 5: Background literature

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Annex 6: SB HTC pilot programme expenditure (actual and projected)[24]

Item Description	Budget Approved N$	Budget Expended (projected) N$
Human Resources	767,175.00	532,378.00
Supplies	247,685.00	257,163.13
Travel	343,700.00	137,937.30
Coordination and Communication	152,150.00	94,557.67
Staff Training	251,071.00	331,661.50
Management & Coordination Fees	150,791.00	150,791.00
Grand total	**1,912,572.00**	**1,504,488.60**

Source: DAPP financial department Oct 2014

[24] Note: the pilot programme does not end until 31st January 2015. The data provided was accurate up to October 2014 with projections of future expenditure.