



Evaluation of MTV Shuga in Botswana (2020-2022)

Final Inception Report

12 May 2023

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2 Acronyms

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

1 Introduction

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

The inception report provides details of the team's understanding of the project, scope of the evaluation as well envisaged methodology for evidence gathering and analysis. It also presents the work plan for the completing the evaluation. The inception report has been informed by inception meetings with UNICEF, NAHPA and Makgabaneng. It also draws from review of secondary literature (project documents and monitoring reports, etc.), and feedback through a review meeting with the Evaluation Reference Group (ERG). The report underwent review by stakeholders. Their comments and suggestions have informed the final inception report.

2 Background

2.1 Context

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

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

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

Against this background and in alignment with the Third National Strategic Framework (NSF) for HIV and AIDS in Botswana (2019-2023), UNICEF and the National AIDS and Health Promotion Agency (NAHPA) worked together from 2018 in Partnership with MTV Staying Alive Foundation to adapt the MTV Shuga Programme as a behaviour change communication strategy to help adolescents and young people adopt safe sexual behaviour by targeting key drivers of new infections and non-adherence to ARV treatment. The programme directly responded to the need to address barriers to reduction of HIV prevalence among adolescents and young people and especially girls and young women as recognised in the NSF for HIV and AIDS (2019-2023).

2.2 Description of the project

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

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

The programme under evaluation is a catalytic initiative linked to the UNICEF's Country Programme Outcome 2 which seeks to ensure that by 2026, adolescents and young people (10–24 years), particularly the most vulnerable, will be more empowered and engaged to access quality and gender-responsive HIV, health, nutrition, education, and child protection services. The program also addresses sustainable development goal 3 (SDG 3), on ending HIV and AIDS epidemic by 2030. The programme has therefore been adapted and implemented as a behaviour change communication strategy to help adolescents and young people adopt safe sexual behaviour by targeting key drivers of new infections and non-adherence to ARV treatment. The following were the key programme objectives:

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

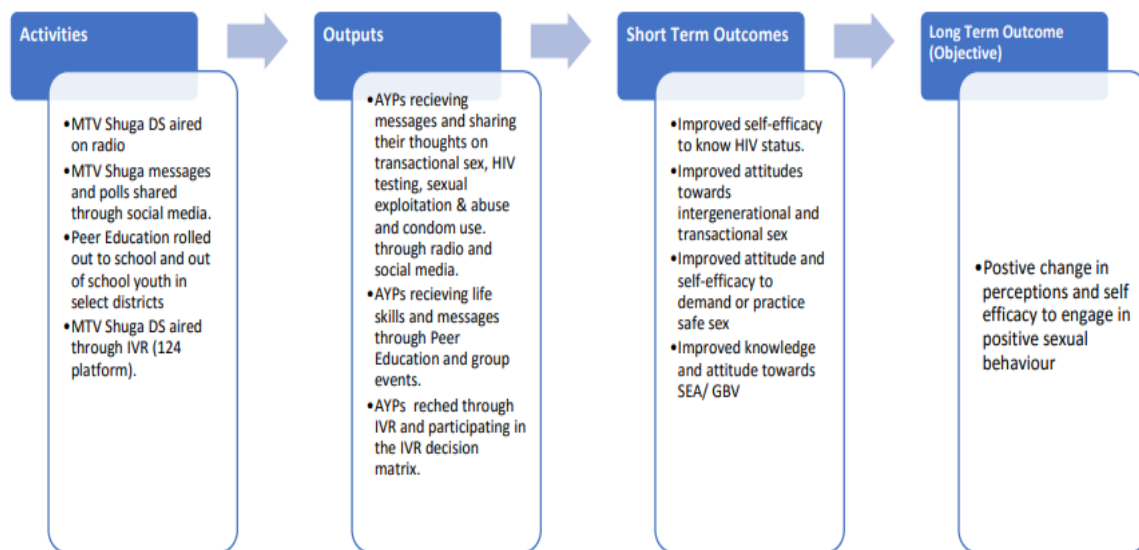
The programme's theory of change posits that:

If MTV Shuga messaging and support is delivered through multiple channels: radio, peer educators, and Interactive Voice Response (IVR) targeting both in- and out-of-school adolescents and youth, more adolescents and young people will receive knowledge and skills

to avoid transactional sex, undertake HIV testing, avoid or report sexual exploitation and abuse (SEA) and gender-based violence (GBV) and use condoms which will then lead to: 1) improved self-efficacy to know HIV status; 2) improved attitudes towards intergenerational and transactional sex; 3) improved attitude and self-efficacy to demand or practice safe sex; and 4) improved knowledge and attitudes towards SEA/GBV. These will ultimately lead adolescents and young people practicing safe sexual behaviour.

Figure 1 provides a summary of this theory of change. The TOC will be detailed further during the course of the evaluation and will be the premise for analysing changes influenced by the interventions.

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



The programme had a set of key results and indicators presented in Annex 3. Some additional results not reflected in the key programme objectives are presented below:

- i. Improved behaviour changes to adopt safe sexual behaviour.
- ii. Improved gender equitable attitudes.
- iii. Increased demand for health services.
- iv. Improved uptake of HIV Testing.

Programme components

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

- i. **Radio:** The Drama series are an adaptation of MTV Shuga Down South with episodes of about 7-10 minutes, followed by in studio discussions by young people for some of the episodes so that the messages portrayed can be buttressed and to spark issues of discussion by audience. The programme airs on Radio Botswana 2 (RB2) FM and

Yarona FM which are the 2 leading youth radio station and have a wider geographic coverage, especially RB2 fm.

- ii. **Interpersonal communication:** Peer education component specifically aimed to promote and support the adoption of positive behaviours, mitigate the impact of and prevent HIV, sexual exploitation, and abuse (SEA) and gender-based violence (GBV) among adolescents and young people (AYP) from within and around Selibe-Phikwe, Boteti, Ghanzi and Okavango (Shakawe and Gumare) districts. The model uses the MTV Shuga Peer Facilitation Guide which contains 7 sessions which were increased to 9 sessions that each group of participants have to complete to be classified as being fully exposed to the MTV Shuga Peer education Programme. Pre-assessments are run by the Educators from the beginning and post assessment done at the end of the 9 sessions for each group. This component is done by an implementing partner, Makgabaneng, with the support of both UNICEF and National AIDS and Health Promotion Agency (NAHPA) as technical and funding partners. Twenty-four (20 Peer educators and 4 Peer coordinators) volunteers were locally recruited, trained, and worked in close collaboration with district authorities to implement the MTV-Shuga peer education programme for in and out of school youth in the four districts.

The programme intended to train four peer coordinators (one per district) and twenty peer educators for face-to-face interaction and support across the four districts, whilst mentoring and coaching them to strengthen their agency, leadership, and communication skills, for meaningful engagement and participation in decision making processes. The peer educators were also designed to

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

utilise the revised peer education manual (now with additional sessions on peer face to face interaction and engagement with parents and teachers). The other components which were covered during the trainings or refreshers were on social media literacy, sexual exploitation, abuse, and COVID-19.

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

Out of school sessions: The out of school sessions comprised of youth within the districts. These included football clubs, traditional dance groups, drama groups, choirs just to mention a few. The groups met at their agreed convenient time and location with the peer educator.

The groups in the four districts were young stars (Selibe- Phikwe), Banyana Banyana football club (Letlhakane) and in Okavango and Ghanzi, a mix of local youth formed part of the sessions. In Gumare, the youth convened at 6 BOCAIP, in Seronga they convened at Okavango Community Trust and in Ghanzi they convened at Rollen Academy.

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

- iii. **Interactive voice response (IVR):** Episodes of the MTV Shuga drama series are uploaded to the interactive voice response (IVR) platform known as 124, for audience to listen to at their own time in case they missed the radio show. Also, a ‘choose-your-adventure’ game has been introduced to the platform for improved interaction with audience, the game allows young people to choose characters they like and personify the character’s decision making process and listen to how their story ends. This approach magnifies the significance of decision making by young people, elevating them to be more conscious in their decision making about key themes of the drama series.
- iv. **Social Media:** With the advent of COVID-19, the programme adopted virtual peer education approaches to ensure and sustain service demand generation and uptake by adolescents and young people. The 2020 lockdowns that came due to COVID-19 stopped the implementation of the face-to-face sessions in the four districts. The use of social media platforms such as WhatsApp and Facebook became key in implementation and for the continuation of the programme. As such, online meetings were held with peer educators using WhatsApp to engage and monitor progress on the online tasks given. These included holding bi-weekly meetings with Peer Coordinators, COVID-19 sensitisation campaigns through Facebook and WhatsApp, Peer Education sessions using WhatsApp and sharing Youth Motivational videos on Facebook and WhatsApp platforms. Virtual peer education through the use of Facebook also helped in disseminating and engaging young people about the programme.

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

Peer education summary reach				
Year	Face to Face Education	Peer	Virtual Peer Education	
2020	5272		-	
2021	4363		21 297	
2022	8250		56 682	
Total	17, 885		77, 979	

institutions, within the districts. Makgabaneng programme reports show that in 2021, 21 297 AYP were reached through virtual peer education whilst 4363 AYP (52.3% females) were reached through face-to-face peer education across the four districts. Majority (56.4%) of the participants reached through face to face were aged 15-19 years, followed by those aged 10-14 years with 39.6%. By end of 2021 and August 2022, 7000 and 8250 (82.5% of the target) adolescents and young people (AYP) had been reached, respectively through the face-to face

peer education component whilst over 10000 AYP had been reached through the social media platforms across the four districts. By the end of 2022, 56 682 had been reached through virtual peer education. The peer education component has been rolled out to more districts such as Chobe, Goodhope/Lobatse, Kweneng, Gaborone and Francistown with support from UNICEF, NAHPA and Makgabaneng, through a social contracting partnership arrangement.

Programme stakeholders

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

Table 1: Partnership arrangements and roles

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

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

2.3 Evaluation purpose

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

2.4 Evaluation objectives and scope

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

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

It will also determine the relevance and effectiveness of delivery models and communication channels utilised.

Scope: The evaluation will cover the period 1 January 2020 to 31 December 2022. While the evaluation of outcomes will cover all four districts, fieldwork will only be undertaken in two districts. In accordance with the ToR, the evaluation scope is guided by the evaluation questions developed for five criteria: Relevance, Efficiency, Effectiveness, Gender and Equity, and Sustainability. The evaluation criteria are discussed further under Section 2.6: Evaluation framework. Measurement of outcomes will rely on secondary data from the programme's monitoring system and from the health information system (baseline, pre- and post-exposure assessments) as no primary quantitative data will be collected. The evaluation will also consider the effect of gender and geographical location on the intended outcomes of the programme.

2.5 Evaluability assessment

An evaluability assessment was undertaken during the inception phase. Its main concern was to determine the feasibility of using available monitoring data drawn from the baseline study, pre and post assessment data to measure the outcomes of MTV Shuga programme. The measurement of outcomes in the programme is undertaken by a comparison of pre-exposure surveys and post-exposure surveys. The post exposure survey is undertaken immediately after the last session of the MTV Shuga programme. Using data from the post-exposure survey to measure behavioural or indeed attitudinal questions could have limitations in that the two behavioural transformations take time with continued support than is available between completion of the last session and the survey. Thus, the monitoring data is likely to understate any behavioural indicators or sustained attitudinal changes. This fact was already known as the weakness of the monitoring system and is well documented in the MTV Shuga Programme brief as the system is intended to measure intermediate and not sustained changes (pp. 4). A review of the programme's indicators (See Annex 3) shows that majority of them are knowledge and attitude based and include self-reported capacity to undertake various actions. These are likely to provide sufficient estimates of the programme's performance at the time of completing the sessions. However, it is unlikely to provide an accurate performance on for example, *"Percentage of AYPs who have tested for HIV and know their status"*.

To support the evaluation’s ability to measure this indicator we propose to use health facility data for facilities within the locality of the intervention to ascertain uptake of not only HIV testing but health services as well. The limitation with this approach is that data will be for the entire geographical area including adolescents and young people not on the programme. In an environment where the MTV Shuga is the main programme, it could be plausible to attach a contribution analysis to any changes in uptake of services to the programme. This is more difficult in areas where several interventions are implemented such as in Selebi Phikwe. An environmental analysis will be undertaken during the data collection to determine the feasibility of a contribution analysis. This will be completed by time series analysis to determine influence/contribution of the MTV Shuga intervention. Further feasibility assessments will be undertaken during phase 2 of the evaluation as more time is needed than was available during the inception phase. In addition to the data from government health facilities, the evaluation will collect data from NGOs offering HIV testing services over the period of the project. These will include BOCAIP and Tebelopele and others as identified during primary data collection. We will apply the same data analysis approach to identify trends in service utilisation as markers of the project’s performance on this behaviour.

To support measurement of sustained change, the evaluation will rely on the primary qualitative data to be collected during the second phase. The qualitative data – collected through Focus Group Discussions and Case studies – with the cross section of stakeholders at district and community levels will explore sustained change including behavioural changes noted among AYP that participated in the MTV Shuga sessions. This data will not be able to ascertain fully the breadth of change (how many have sustained change) but rather the depth of change common among participants and areas where change is limited.

Lastly, programme was adapted during implementation from seven (2020- 2021) to 10 sessions in 2022. The differences in session exposure could also have a bearing on programme performance. Our analysis of post exposure data will therefore consider the two phases separately.

2.6 Evaluation framework

The evaluation will be undertaken according to the criteria of Relevance, Effectiveness, Efficiency, Gender and Equity, and Sustainability. Questions and issues to be addressed during the evaluation for each criterion are detailed below. An evaluation framework was developed and is presented in Annex 2. Answers to questions in the evaluation framework will take on a gender, disability, and location lenses.

2.6.1 Relevance

Relevance will answer the following questions:

<i>To what extent was the intervention adequate to address behaviour change among adolescents and young people?</i>	To what extent were the beneficiaries satisfied with the behaviour change intervention?
	To what extent were the programme strategies, approaches, and methods relevant and responsive to the local settings, population, circumstances, and challenges?

The evaluation will assess perceptions of stakeholders on programme’s ability to address the main drivers of new HIV infections, and non-adherence to ART among adolescents and young

people. It will identify the problems being addressed and those that are still outstanding that may be contributing to new HIV infections among adolescents and young people. Alignment of the content to the daily lives of adolescents and young people to enhance its effectiveness in behaviour transformation will be assessed.

Delivery mechanisms will also be assessed for their appropriateness in context and including gender and disability. Specifically, the evaluation will review the satisfaction of beneficiaries with the quality of support from peer educators, the strength of linkages between peer educators with district and community level cadres to facilitate behaviour change and perceptions on the adequacy of interventions to transform the targeted behaviour.

2.6.2 Effectiveness

In this criterion the evaluation will answer the following questions:

<p><i>How well did the MTV Shuga programme achieve its results?</i></p>	<p>To what extent did adolescents and young people adopt safe sexual behaviours as a result of the programme? Was there an improvement in self-efficacy? Did AYP access SRHR and other related services?</p>
	<p>To what extent did attitudes towards the following improve:</p> <ul style="list-style-type: none"> • intergenerational and transaction sex • gender norms related to prevention of HIV and unwanted pregnancy?
	<p>What were the key factors influencing the achievement or non- achievement of results?</p>

This criterion will measure performance of the MTV Shuga programme on outcomes. The analysis will be guided by indicators in Annex 3. As noted under Section 2.5: Evaluability assessment, this will be buttressed by qualitative data that determines sustained behaviour changes among participants of the MTV Shuga programme.

In determining the key factors influencing achievement or non-achievement of results the will assess the role played by the following:

- 1) capacity of peer educators (including motivation);
- 2) linkages to district and village structures;
- 3) quality of content and support;
- 4) other contributory factors e.g., access to services, motivation of stakeholders; and
- 5) COVID-19 restrictions and aftermath.

Furthermore, the evaluation will also determine the influence of management and coordination on performance of the programme including: 1) supportive supervision to peer educators; 2) coordination between implementing partner (IP), DAC, District Health Team (DHMT), and peer educators; and 3) other existing support in communities.

Lastly, it will explore positive and negative unintended results of the programme.

2.6.3 Efficiency

Under efficiency the evaluation will respond to the following questions:

<p>Do the programme</p>	<p>To what extent were the implementing strategies appropriate for achieving results?</p>
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results justify the investments (financial and human resources) made?	Which components of the intervention and its communication channels are less resource intensive but critical for the program results?
	To what extent did the programme generate solid evidence from monitoring and evaluation in order to inform policy/advocacy and improved programming?

In answering these questions, the evaluation will explore perceptions of stakeholders on the management approach for UNICEF, and Makgabaneng and effectiveness of stakeholder oversight by NAPHA. The quality of peer educators (exploring their ability to deliver the content effectively, to support their peers and to engage with stakeholders at different levels). The evaluation will also determine the quality of training provided including its adequacy to meet the demands of targeted adolescents and young people (including those with disabilities, male and female and in rural and urban settings).

Efficiency will also be concerned with the effectiveness of monitoring systems used for the project. In this regard, the evaluation will determine the M&E systems used for the project using the SMART¹ criteria. This will also include alignment of data requirements with the project's theory change whose conceptual framework is premised on the Health Belief model which suggests that successful adoption of healthy behaviour starts with an individual's perception of their risk relative to their personal profile and linking it with their perception of the threat/ risk, barriers, opportunities and self-efficacy for adopting new healthy behaviour. The objective will be to determine whether the set of indicators used for programme monitoring provided sufficient evidence to understand alignment of the programme's performance to this model. Quality of the monitoring system in terms timeliness in data availability, quality of data, and comprehensiveness of data and accessibility will be other dimensions to be used to assess the monitoring system.

Monitoring is not the end. Utilisation of data for programme improvements is the goal of any monitoring system (in addition to the accountability function). The evaluation will therefore determine whether data from the system was used for decision making, what type of decisions were made and their effectiveness. Further, the evaluation will explore the extent to which monitoring data was used for advocacy.

2.6.4 Gender and equity

The following questions will be answered under this criterion:

To what extent did the implementation of the intervention address child rights and Leave No-one Behind (gender and other excluded and marginalized groups).	How well did the programme integrate gender and equity considerations into its design and implementation?
	Was sufficient information collected during the implementation period on specific result indicators to measure progress on gender and equity?
	To what extent was the programme disability inclusive?

¹ Specific, Measurable, Achievable, Realistic, and Timebound

The evaluation will explore the measures put in place by the programme to integrate: (1) gender; (2) disability; and (3) equity in the programme including the successes, challenges and lessons learned in doing so. Specifically, the evaluation will assess measures to ensure disability inclusiveness including their adequacy in accordance with the UNICEF Essential actions on disability inclusive health².

Any intervention to integrate gender, disability and equity requires sufficient data and of the right quality to provide for evidence informed decisions. The evaluation assesses the data collected to measure project’s impact on gender and equity to identify the strengths and weaknesses including data gaps that existed and exploring additional data that could have been collected.

2.6.5 Sustainability

Sustainability will answer the following questions:

<p>Has the programme systematically promoted national ownership, capacity-building, and skills transfer to counterparts (government, civil society, AYP) in order for them to be able to sustain the programme?</p>	<p>To what extent has the programme been able to leverage other partners’, including Government resources, to contribute to sustainability of the programme?</p> <p>What is required to take the package of interventions to scale?</p>
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The evaluation will assess the effectiveness of measures put in place by the programme to sustain the programme results/benefits (including learning systems, peer support and service uptake by AYP) without external funding. This will also include measures put in place by the programme to support continuation or scale up of the programme within the four districts and nationally. Specifically, the evaluation will explore government ownership and commitment to the programme, including their contribution and plans (including any secured funding) for taking over the programme.

2.7 Evaluation audience and users

The primary user of the evidence generated from the evaluation will be the **Government of Botswana through NAHPA** as the evaluation will inform the current scale up of the programme to other districts. NAHPA will ensure that lessons learned are documented and built into the current programme for better implementation.

UNICEF will use the evidence to continue advocacy efforts towards ensuring adolescent and young people programmes for safe sexual behaviours are developed and implemented. This evaluation will also provide adolescent and young people programming sector invaluable evidence on how to implement a social and behavioural change for adolescent and young people in Botswana that is both relevant and sustainable.

Development partners and other non-governmental organisations stand to benefit from the results of the evaluation as well on the use of peer approaches to behaviour change and in alignment with other programs targeting AYP such as DREAMS and Sky Girls.

² <https://www.unicef.org/media/124146/file/Essential%20actions%20on%20disability-inclusive%20humanitarian%20action.pdf> Accessed 12 April 2023

3 Methodology

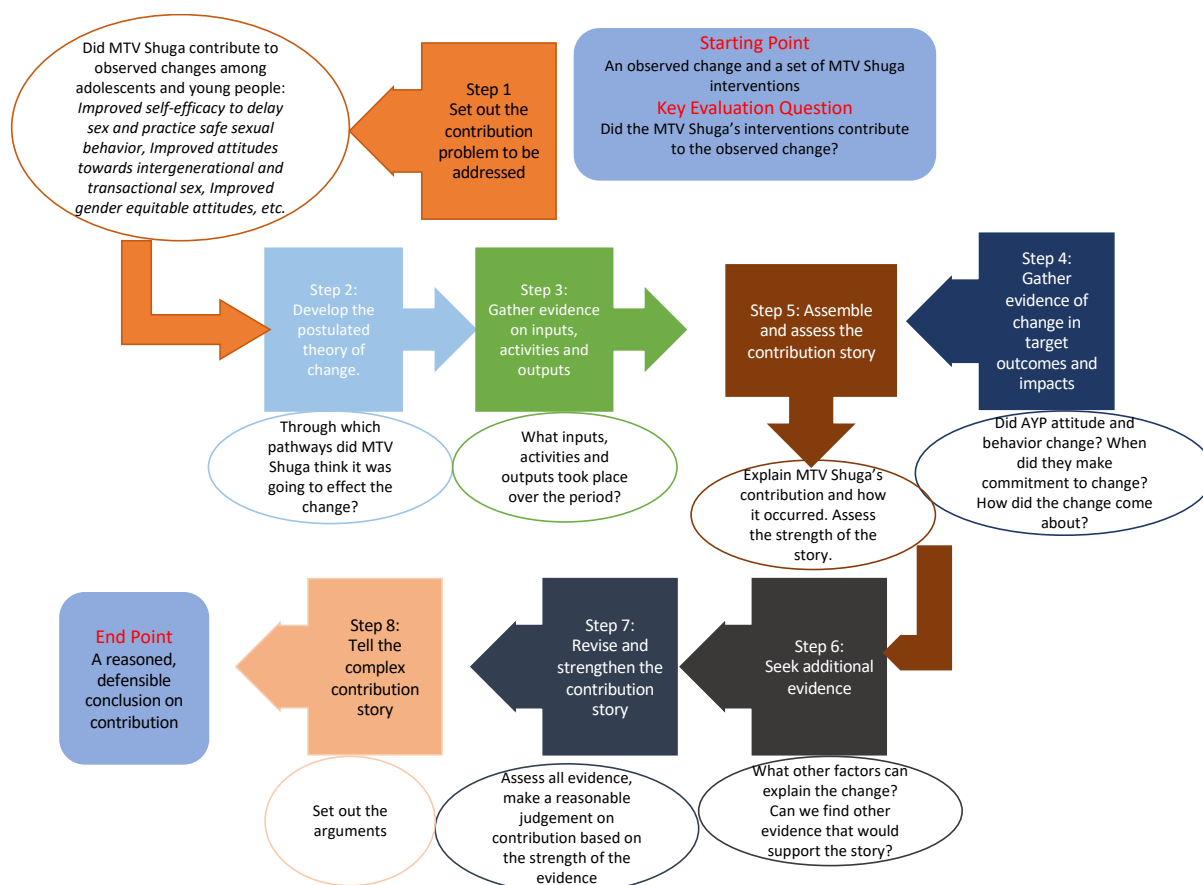
This section presents the evaluation methodology. It includes two broad sections on: 1) **evaluation approach** which provides key guidance for the evaluation and its overall framing and design; and 2) **evaluation methodology** which provides the specific details for data collection and analysis.

3.1 Evaluation approach

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

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

Figure 2: Contribution analysis



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

3.1.1 Evaluation guidance and principles

The evaluation will be guided by the following UNICEF and UN guidance:

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

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

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

Independence, impartiality, and conflict of interest: As independent evaluators, the evaluation team has no interest in the outcome of the evaluation. The team has not been involved in programme implementation and neither will benefit from the outcome of the evaluation. Thus, the evaluation team's conclusions will not be influenced by future gain or past involvement with the programme and its implementers.

Credibility: the evaluation team will ensure that evaluation results are of high-quality based on a sound and tested methodology, which is comprehensive, evidence based, uses a mix of qualitative and quantitative methods appropriate to this assignment, and includes participation of key stakeholders and beneficiaries. The strength of the analysis and assessment is based on asking the right questions and in a language familiar with study participants, speaking to relevant stakeholders, and collecting the required information, as well as extensive experience by evaluation team members, to reach sound and justifiable conclusions and recommendations to meet the needs of the evaluation's target audience. The structure and content of the report will be strongly influenced by UNEG Norms and Standards for Evaluation and UNICEF adapted evaluation report standards and GEROS.

Accountability: All evaluation outputs will be validated with stakeholders of the programme providing them an opportunity to agree, disagree or seek clarifications on the findings and recommendations. Whenever there are disagreements in the findings, the evaluators will seek additional evidence to retract the finding or strengthening their argument. In this way the evaluators are held to account for their findings and that the evaluation conclusions remain evidence based.

3.2 Evaluation methodology

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

3.2.1 *Secondary literature review*

A variety of secondary literature of the programme was made available to the evaluation team during the inception phase. This included programme documents on MTV Shuga programme from UNICEF and Makgabaneng, quarterly and annual programme reports from Makgabaneng, and various activity reports. This literature was used to inform the design of the evaluation, methods, and data collection tools. In the second phase of the evaluation secondary literature will be used to contribute analysis of the evaluation criteria as directed by the evaluation framework. The list of documents to be reviewed is presented in Annex 5. The information collected from secondary literature will be verified with primary data from field visits, interviews, and workshops. The review will also take stock of other related programs and interventions to examine collaborations and complementarity with the MTV Shuga programme.

3.2.2 *Quantitative evaluation*

The quantitative evaluation will rely on secondary from the programme's monitoring system (baseline survey, pre- and post-exposure surveys, and monitoring reports). The quantitative evaluation will focus on ascertaining achievement of the programme's outcomes. The main data sources will be:

- 1) Baseline, pre- and post-exposure survey data; and
- 2) Health facility health management information systems (HMIS) data.

The secondary data source will be for the following indicators for adolescent sexual and reproductive health:

- 1) Number of adolescents and young people seeking HIV testing;
- 2) Number of adolescents and young people seeking condoms and other contraceptives; and
- 3) Number of adolescents seeking sexual and reproductive health services.

Data for these indicators will be collected from facilities in programme areas in the four districts. This will be extracted from the HMIS with the assistance of Makgabaneng (health facilities in programme areas) and NAHPA (access to HMIS).

The evaluation also understands that sexual exploitation and abuse was one of the key issues of the project with focus on encouraging reporting of SEA cases. The evaluation will therefore include analysis of data on reporting of SEA cases at school, social workers, and police. A second indicator: "*Number of adolescents reporting sexual exploitation and abuse cases*" will be added. Data from police will require special clearance. The evaluation will require support from UNICEF and NAPHA in accessing such data.

3.2.3 *Qualitative evaluation*

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

Key informant interviews: Key informants will be drawn from institutional stakeholders. These will be purposively selected with those with the most knowledge of the programme being selected. A list of key informants is presented in Annex 4. Key informants from national level will include UNICEF, Makgabaneng, NAHPA, MTV Shuga, BIHL, MTV-SAF, MESD. At the district level the following will be consulted: Peer educators, DAC, Chief Education Officer, DHMT lead, G&C teachers, community leaders etc. See Annex 6 for the data collection tools.

Focus Group Discussions (FGDs): FGD discussants will primarily be adolescents and young people that went through the MTV Shuga sessions in- and out of school. Separate groups of males and females will be interviewed with each group having a maximum of 10 and a minimum of 8 participants. FGD participants will be divided into two age groups 15-18 and 19-24.

Case study interviews: these in-depth discussions will be held with selected participants of the MTV Shuga programme that demonstrate changes in the outcome domains of the programme. Case study interviews will seek to ascertain how the MTV Shuga contributed to the change in knowledge, attitudes and behaviour observed in the individual. A balance between male and female will be maintained. Disability will also be considered. However, such disability should allow the evaluation team to be able to fully interact with the respondent.

Sampling and sample sizes

Only two districts will be visited for primary data collection. After conducting initial discussions with NAHPA and Makgabaneng, two districts – Selebi Phikwe and Okavango were selected. The selection was based on the need to have two districts that can provide a representative context of the project implementation. The two districts provide urban area programming (Selebi Phikwe), rural and remote area (Okavango). Selebi Phikwe provides additional performance context – where there is a high concentration of actors aiming to reduce HIV incidence among adolescents and youth – providing the evaluation additional analysis on programme contribution to outcomes such contexts. Okavango, in addition to providing remoteness, it is also viewed as a successful district. This will provide the evaluation an opportunity to explore what success means for MTV Shuga programme and what makes it successful. Within Okavango, Gumare and Etsha 6 were selected as the locations for the evaluation in addition to Selebi Phikwe. Selection of the locations was undertaken in collaboration with Makgabaneng to ensure urban, rural, and remote dimensions were included. Therefore, four wards within the two selected districts will be visited.

In each selected area, a school targeted by the programme will be randomly selected for FGDs. Past participants from this school will be included in the sampling frame with the actual respondents being randomly selected from participants' lists. We are cognisant that some past participants may have completed their high schooling, this will not exclude them from being selected as long they still reside with the locale of the school. Out of school participants living in the around the school will be included in the sampling frame for participants with 8-10 past participants (that have gone through all the sessions) being selected for each of boys' and girls' groups. They will be randomly selected from the list of participants.

Participants for case studies will be purposively selected with the help of peer educators. These will be individuals that will have participated in all sessions, and demonstrate changes as observed by the educators or as feedback to educators.

The peer educator for the selected area will be automatically selected for interviews while the Peer Coordinators from each of the four districts will be included in the survey. Those in the two targeted districts will be interviewed physically while those from the other two districts not selected for field visits will be interviewed virtually.

Sample sizes for the qualitative interviews are presented in Table 2.

Table 2: Sample sizes for the qualitative evaluation

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

Data collection

Qualitative data collection will be led by the team leader and will involve all team members. The international team members will be accompanied by interpreters during data collection at the community level. Such interpreters will be trained on the tool and the data the evaluation seeks to obtain. This will ensure no data is lost between translations. Data will be collected over a period of 10 days allowing the team at least two days per locality.

3.2.4 Data analysis

Quantitative data analysis: Primary data from pre- and post-exposure surveys will be analysed in accordance with the indicators being measured. Differences between the baseline and post-exposure survey will be compared to ascertain the differences. Time series analysis will be applied to HMIS data to determine changes in uptake of key sexual and reproductive health services. However, sustained safe sexual behaviour cannot be measured with the data available.

Qualitative data analysis: The data collected in each district will be systematically analysed, triangulated, and synthesised by the evaluation team. The Evaluation Framework, Annex 2, will provide an analysis framework for gathering and synthesising data against the key

evaluation questions. The analysis will explore gendered differences in responses to specific questions of the evaluation and understand, where differences exist, the possible reasons for such differences. The use of the TOC will help the evaluation to ascertain the contribution of MTV Shuga to observed outcomes. The TOC will be the bedrock of a more detailed contribution analysis.

All qualitative data will be coded and analysed using qualitative coding software, NVivo. The transcripts will be analysed to identify key themes in the data. These themes will be analysed to respond to the evaluation questions. Using the software, the evaluation team will conduct first-level coding to analyse the qualitative data in terms of geography, respondent type, and gender. The evaluation team will then conduct a second level analysis, by using inductive coding, to better identify emerging themes and explanations.

The team will also develop an iterative coding framework using relevant research questions as well as questions from the interview guides. The coding framework allows for a deductive coding process that is standardised across a team of qualitative analysts, ensuring consistency and replicability, as well as comparability. The framework is iteratively refined throughout the coding process to better reflect themes and issues emerging from the data.

3.2.5 Reporting and validation

All findings will be validated by stakeholders through two processes. The first will be a preliminary findings presentation that will seek to validate initial findings of the evaluation team with UNICEF, Makgabaneng and NAHPA. This will be followed by a presentation to a broader that can include district level stakeholders where possible.

The evaluation report will follow guidance from the UNICEF-Adapted UNEG Evaluation Reports Standards³.

3.3 Ethical Considerations

Necessary safeguarding and ethical research safeguards will be put in place. The evaluation will undergo ethical approval with the HRDC. The evaluation will adhere to principles of confidentiality and informed consent for all respondents to the evaluation. All data from health facilities or HMIS will be anonymised before transmission to the MDS team. Consolidated data will be used depending on what is available to limit exposure of individual clients. The evaluation will involve interviewing children and therefore will draw guidance from UNICEF Ethical Guidelines and standards for research and evaluation and Ethical Research Involving Children. Interviewing children is necessary to understand the outcomes of the MTV Shuga and receive feedback on the quality and adequacy of the programme. While no significant harm is foreseen in the conduct of the evaluation to child participants, the following will guide all conduct of the evaluators:

- **All children will assent to being interviewed and parental consent** sought through the help of the school (for in-school participants) and peer educators (for out of school participants). IF seeking consent for an interview from parents or caregivers can put the child in harm's way, then such children will not participate in the evaluation. the evaluation will depend on the experience of peer educators with the cohorts of

³ <https://www.unicef.org/evaluation/media/816/file/UNICEF-Adapted-UNEG-Evaluation-Report-Standards.pdf>

participants they worked with during the programme period. All consent or assenting must be fully informed about the evaluation therefore the evaluation will ensure:

- children have an understanding of the evaluation and their participation within it;
 - consent is an explicit agreement between the children and their parents/caregivers;
 - children's consent is given voluntarily (and without coercion); and
 - consent is renegotiable, so that children can withdraw at any stage of the evaluation process.
- **Respecting the privacy and confidentiality of children and young people participating in research.** This involves close consideration of several aspects: (1) Privacy with regard to how much information the child wants to reveal or share, and with whom; (2) How to discuss research confidentiality with children, including mention of the limits to this (e.g., safety concerns such as harm, neglect or abuse), in a way that does not introduce new, potentially worrisome, ideas; (3) Privacy in the processes of information gathering/ data collection and storage that allows the exchange of information to be confidential to those involved; and (4) Children's anonymity and / or recognition in the publication and dissemination of evaluation findings and associated activities.
 - **Children who participated will be given feedback** on the results of the evaluation through NAHPA and the implementing partner (Makgabaneng).

If during the evaluation the evaluators come across a safeguarding issue including a child being abused, a referral pathway will be discussed with the UNICEF and NAHPA that will be used to ensure the child receives the necessary assistance. The evaluation will have an obligation to report the incident to ensure safety of the child.

Box 1: Ethical considerations

Risks: The evaluation protocol is noninvasive and involves minimal risk to participants. The probability and magnitude of harm or discomfort anticipated in the evaluation are not greater than those encountered in daily life or during the performance of routine physical or psychological examinations.

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

Compensation: Participants will not be compensated for participation in the survey.

Adverse events and protocol deviations: All protocol non-adherent events, defined as "any breach of the protocol that occurs during the survey" will be documented by the survey staff and reported to the investigators. Investigators will review each event and decide if it meets the standard for reporting to an IRB. Events that do not meet the standard for reporting to an IRB will be documented in a note to file. Timelines and other reporting requirements of individual IRBs will be followed when informing them of reportable events.

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

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

Box 1: Ethical considerations

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

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

Potential risks for children and their mitigation measures are presented in Table 3.

Table 3: Potential risks for children in the evaluation and mitigation measures

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

3.4 Limitations of the evaluation

The main limitation of the evaluation is the ability of the available secondary data to fully explore the programme's conceptual underpinning of the Health Belief model. This is because available data is unable to provide sufficient evidence of sustained change at intermediate (attitudes and intentions to practice) and outcome level (actual behaviour/practice). This limitation is fully discussed under Section 2.5: Evaluability assessment. Complementing the quantitative data with qualitative data will enhance the analysis of outcomes but will still be insufficient to ascertain the scale of such changes.

The other limitation concerns the visiting of two out of the four districts. While this may undermine full picture of the programme, the selection of four wards that represent fully the context of the programme including selecting some successful localities, provides the evaluation with sufficient variation to fully explore the programme's performance.

4 Evaluation Work Plan

The evaluation will be undertaken in accordance with the Gantt chart below.

		Month	Apr-23	May-23					Jun-23			Jul-23				Aug-23			
		week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1	Inception Phase																		
IP1	Submission of inception report (25/04/2023)																		
IP2	Presentation of inception report (25/04/2023)																		
IP3	Review of inception report by the ERG (end 5/5/2023)																		
IP4	Incorporation of comments from ERG																		
IP5	Submission of Final Inception Report (12/05/2023)																		
2	Field Prep Phase																		
FP1	Receive ethical clearance for the evaluation																		
3	Field Mission Phase																		
FM1	National level interviews																		
FM2	District & Community level Consultations with stakeholders																		
4	Reporting Phase																		
RP1	Data Cleaning																		
RP2	Data Analysis																		
RP3	Presentation of preliminary results to stakeholders (16/06/2023)																		
RP4	Development of Draft Evaluation Report																		
RP5	Submission of Draft Evaluation Report (7/07/2023)																		
RP6	Review of Draft Evaluation report by the ERG (end 21/7/2023)																		
RP7	Incorporation of comments from ERG																		
RP8	Submission of Final Evaluation Report (4/08/2023)																		
RP9	Development of Policy Brief (12/08/2023)																		

4.1 Quality assurance and evaluation management

MDS will utilise Quality Assurance (QA) procedures which we instigate proportionate to our needs as a consultancy firm providing professional services. QA will be important for effectively overseeing the activities under this assignment and ensuring our standards of quality. In practice, the overall QA procedures we would apply include:

- i. Open, **communicative relationships** with **and timely reporting** to UNICEF, involving a combination of face-to-face meetings and virtually. UNICEF will also monitor and provide feedback on the quality of processes and deliverables through the Evaluation Reference Group. This will ensure and guarantee ownership and quality of all evaluation of processes and deliverables thereby enhancing utilisation of the evaluation lessons and results.
- ii. **Internal Quality Control checks** of products at each stage as well as deliverables before submission to UNICEF. This includes careful review of data sets produced; and a thorough proof –reading and review of all reports/recommendations by the Project Manager and peer review by other keys experts proposed for this assignment.
- iii. **Regular team meetings** led by the Project Manager and attended by the delivery team and finance/admin staff, as appropriate, with briefing, planning, joint analysis, and collaboration.

Several methods will be used to improve the quality of the collected data. The training and education of the enumerators will constitute an important stage in ensuring that data of high quality are gathered. At the end of each day, there will also be debriefing sessions with research assistants to review the day's findings. Because of this, it will be feasible to check for problems that are now being experienced and address them continuously. Using applications that collect data in real-time or real-time will ensure timely submissions of completed survey questionnaires electronically to the data analyst daily. This will also ensure that data is checked continuously and, if necessary, corrective measures are taken before leaving the field. In addition, using electronic applications makes it possible for quality assurance checks to be integrated as a module by utilizing skip patterns and omission rules. Mobilization and the construction of an appropriate field itinerary will ensure that respondents are aware, in advance, of the dates and times that they will be interviewed. Due to the predictability of the situation, we will be able to obtain the desired sample or one that is as close to it as feasible.

4.2 Roles and responsibilities of stakeholders

The institutions to support the evaluation will be:

UNICEF: shall be responsible for coordinating the evaluation and linking the evaluation team with the IP and NAHPA. UNICEF, working with the evaluation reference group (ERG) will approve all evaluation outputs.

NAHPA: Shall link the evaluation team with DACs in the four districts of the programme. NAHPA will also support the application for ethical clearance for the evaluation. NAHPA will also assist with access to required HMIS data for identified facilities in the programme's location. They will review all outputs from the evaluation and provide feedback as part of the Evaluation Reference Group.

Makgabaneng: Will be responsible for providing all required secondary data from the monitoring system. Makgabaneng will also provide support to the evaluation team with mobilisation of respondents through the peer educators and DACs.

4.3 Roles and responsibilities of the team members

The roles and responsibilities for the team members is presented in Table 4.

Table 4: Roles and responsibilities of team members

Position	Country	Name and Qualifications	Role
Team Leader	Zimbabwe	Ngonidzashe Marimo MA Poverty and Development	Oversee overall implantation of the project and development of all technical deliverables Lead evaluation design, training of field teams and reporting Main point of contact with the client on technical deliverables (e.g., reports and presentations)
Technical Advisor	South Africa	Dr Jullian Moodley PhD, Public Health Policy, and Administration	Quality control all aspects of the evaluation Provide technical advice to the team leader and team on evaluation design. Support the project manager on all technical matters with the team
Adolescents Programming	Zimbabwe	Aveneni Mangombe Masters in Population Studies	Provide technical expertise in the field of adolescent programming. Support TL in development of all project deliverables
Social Behaviour Change Expert	Botswana	Emmanuel Mafoko Doctor of Philosophy (PhD) candidate Master of Public Health Bachelor of Science in Health Promotion Degree	Contribute to evaluation design. Training of field teams and undertake data collection. Contribute to drafting of the main report
Quantitative Data Manager and Analyst	Zimbabwe	Jack Jackson Bachelor of Science Degree in Statistics and Computer Science	Conduct training, monitor field work and data quality checks. Conduct data analysis and support development of all project related deliverables.
Qualitative Data Manager and Analyst	Zimbabwe	Tariro Mukupe Bachelor of Science (Biological Sciences/ Life Sciences)	Support development of data collection instruments Conduct training of qualitative field teams Supervise data collection and undertake qualitative data analysis
Project Manager	Zimbabwe	Nyasha Madzingira Bachelor of Arts International Supply Chain Management	Provide administrative and logistical support for the implementation of the project.

5 Annexes

5.1 Annex 1: Terms of Reference



ToR Evaluation MTV Shuga-revised_140223 (1).pdf

5.2 Annex 2: Evaluation framework

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

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

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

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

Evaluation Criteria	Key Evaluation Questions	Specific Evaluation Questions	Indicators	Methods	Data source
			Lessons learned in integrating (1) gender; (2) disability; and (3) equity in the programme	Case studies	Annual Project Reports Steering Committee minutes AYP with disabilities and those that are females
		Was sufficient information collected during the implementation period on specific result indicators to measure progress on gender and equity?	Data collected to measure project's impact on gender and equity Data gaps that existed Additional data that could have been collected	Key Informant Interviews (KIIs) Focus Group Discussions (FGDs) Document review	DAC, G&C teachers, UNICEF, Makgabaneng, NAPHA Peer educators Quarterly reports from Makgabaneng Annual Project Reports Steering Committee minutes
		To what extent was the programme disability inclusive?	Measures to ensure disability inclusiveness Adequacy of measures for disability inclusive implementation (in accordance with the UNICEF Essential actions on disability inclusive health ⁴) Challenges in ensuring disability inclusive actions	Key Informant Interviews (KIIs) Focus Group Discussions (FGDs) Document review Case studies	DAC, G&C teachers, UNICEF, Makgabaneng, NAPHA Peer educators Quarterly reports from Makgabaneng Annual Project Reports Steering Committee minutes MTV Shuga (2019-2022) Programme Document AYP with disabilities
Sustainability	Has the programme systematically promoted national ownership, capacity-building, and skills	To what extent has the programme been able to leverage other partners', including Government resources, to contribute to	Measures put in place by the programme to sustain the programme results/benefits (including learning systems, peer support and service	Key Informant Interviews (KIIs) Focus Group Discussions (FGDs)	DAC, G&C teachers, UNICEF, Makgabaneng, NAPHA Peer educators

⁴ <https://www.unicef.org/media/124146/file/Essential%20actions%20on%20disability-inclusive%20humanitarian%20action.pdf> Accessed 12 April 2023

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

5.3 Annex 3: MTV Shuga results framework

Result statement	Performance indicator/s	Location	Baseline	Target	Means of Verification ⁵
<p>Corresponding output from Country programme/ Humanitarian Response Plan⁶</p> <p>Output 2.1: Adolescents and young adults are engaged in positive behavior around HIV/AIDS.</p>	- Corresponding RAM indicator Output 2.1.1: Adolescents 10-19 who were tested for HIV and received their results in the past 12 months.	Ghanzi Okavango Selibe-Phikwe Boteti	63%	70%	BAIS V
	Output 2.1.2: Number of districts supported to develop/incorporate priority adolescent HIV interventions in operational plans		4	4	Programme Reports
	Output 2.1.3: Adolescents behavior change communication platform targeting adolescents and using T4D developed.		Shuga Radio programme and U-Report rolled out	Shuga Radio programme and U-Report scaled up (Shuga IVR 124 platform and SRH/HIV polls conducted and disseminated)	Programme Reports
<p>Programme Output 1: Quality Peer Education provided for in and out of school youth:</p> <p>By December 2021 AYP have increased knowledge, skills and self-efficacy to adopt safe sexual behaviours and uptake HIV, Protection and SRH services.</p>	Number of in and out of school AYPs reached through Peer Education Disaggregation: Sex, age, location, in-school and out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	5,272	10,000 <i>(8,000 in-school, 2,000 – out of school)</i>	Programme Reports
	Percentage of AYPs with intention to go for HIV testing in the next 3 months. Disaggregation Sex, age, location, in-school and out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	53.7%	75%	Post assessment report.
	Percentage of AYPs who have tested for HIV and know their status.	Ghanzi Okavango	35.2%	50%	Post assessment report.

⁵ The specific sources from which the status of each of the performance indicators can be ascertained. If any data source is a survey or a study which the implementing partner is planning to conduct for this programme, this should be planned and budgeted for in section 3 below (programme work plan and budget).

⁶ The most relevant output level result from the Country Programme (CP)/ Humanitarian Response Plan should be identified here, with the corresponding performance indicator(s), directly drawn from CP official documents. If the programme contributes to more than one CP/Humanitarian Response Plan output, each should be identified in a separate line, with programme outputs listed below each corresponding CP output. Identification of the most relevant output level result and corresponding performance indicator(s) is done in consultation with UNICEF Office during the finalization of the programme document.

Result statement	Performance indicator/s	Location	Baseline	Target	Means of Verification ⁵
	Disaggregation Sex, age, location, in-school and out of school.	Selibe-Phikwe Boteti			
	Percentage of AYPs who think it is "okay" to date a partner that is 10 years older. Disaggregation Sex, age, location, in-school and out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	20%	8%	Post assessment report.
	Percentage of AYPs who think it's reasonable for a partner to expect sex in exchange for gifts. Disaggregation Sex, age, location, in-school and out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	7%	5%	Post- assessment report.
	Percentage of AYPs who demonstrate intention to demand safe sex under pressure. Disaggregation Sex, age, location, in-school and out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	90%	95%	Post- assessment report.
	Percentage AGYWs who think it is boys/men's responsibility to carry condoms. Disaggregation Sex, age, location, in-school and out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	22% %	10%	Post- assessment report.
	Percentage of Adolescent Girls that feel they can report abuse cases through official and un-official mechanisms. Disaggregation Sex, age, location, in-school and out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	76%	90%	Post- assessment report.
	Percentage of adolescent boys who hold gender equitable attitudes Disaggregation Sex, age, location, in-school, out of school.	Ghanzi Okavango Selibe-Phikwe Boteti	67%	80%	Post-assessment report.
	Percentage of sexual abuse cases referred to services using the district referral tool.	Ghanzi Okavango Selibe-Phikwe	0	<i>All identified cases.</i>	Quarterly progress reports

Result statement	Performance indicator/s	Location	Baseline	Target	Means of Verification ⁵
	Disaggregation. Sex, age, location, in-school, out of school.	Boteti			
By 2021 AYPs are actively engaged in addressing their challenges and have increased knowledge on financial literacy.	Number of AYPs participating in the Peer Education National Competition to identify solutions to their challenges.		0	5000	Quarterly progress reports
	Number of Out of School youth who participate in the App for Change.		0	1000	Quarterly progress reports
Programme Output 2: Effective and efficient project management. Quarterly monitoring and supportive supervision visits carried out for improved quality of service and effective engagement of stakeholders, capacity development of Peer Educators and project documentation (quarterly and end of project).	Number of monitoring and supportive supervision visits conducted and reports produced. Disaggregation By location	Ghanzi Okavango Selibe-Phikwe Boteti	2	2	2 field monitoring and supervision reports
	Number of project reports	Ghanzi Okavango Selibe-Phikwe Boteti	2	3	2 quarterly reports and 1 end of project report.
	Percentage of session tracking forms uploaded on ODK App		0	80%	Quarterly Progress reports
Gender, Equity and Sustainability	<p>Gender is a key consideration and fully integrated across all aspects of the project. The project will empower both boys and girls, young men and young women with information knowledge and skills. However, there will be a specific focus on adolescent girls and young women, as they are disproportionately affected by HIV, face more risks and are more vulnerable. With regards to equity, the project will target rural and underserved areas and will aim to reach young people in remote parts of the country.</p> <p>The project is aligned to national strategies and priorities including the Third National Strategic Framework (2019-2023) which has identified adolescents and young people 10-24 years as a priority population of focus given the high HIV incidence and prevalence rates among this population and is guided by the priority interventions reflected in the national AYP strategies, plans and guidelines. The project has been developed in collaboration with NAHPA with sustainability a key consideration from the planning stage. The project will be delivered in partnerships with the districts under the leadership of the District Commissioners and the oversight of the District AIDS Coordinators in collaboration with key government departments including education, health, youth, and local government to ensure buy-in and support for project activities.</p>				

5.4 Annex 4: List of evaluation respondents

Stakeholder	Role	Contact Details
Program Partners		
Makgabaneng	<p>Key implementing partner</p> <ul style="list-style-type: none"> -Provides regular and timely project implementation oversight -Integrates the program and Peer Educators - Embarks on quarterly monitoring support visits -Provide support with recruitment, training, management of peer Educators -Project communication and documentation - Quarterly reporting of the program -Organisation of district engagement and consultative meetings with key stakeholders - Project administration and financial support - Supervises the capturing of data on the monitoring tools and capturing of data the ODK app 	<p>Mr Tony Buru Executive Director</p> <p>Ms Matlhogonolo Motshegwa Program Coordinator</p> <p>Ms Lesedi Tshikare- M&E Coordinator</p>
NAHPA	<ul style="list-style-type: none"> -Support Makgabaneng to integrate the program in the districts of implementation -Support district engagement and consultations with UNICEF -Pre- approve all materials prior to execution - Support the recruitment - Support and undertake joint quarterly monitoring and support visit with UNICEF 	Sheila Lesotlho
UNICEF	<ul style="list-style-type: none"> -Coordination of Shuga Peer education partners i.e., NAHPA, BIHL, MTV-SAF and Makgabaneng on integrating programme into government system scale up and sustainability. -Project technical oversight and management -Co- lead consultative meetings in the districts -Support the recruitment, training, and branding of both virtual and district-based peer educators -Support and undertake joint quarterly monitoring and support visits with NAHPA and Makgabaneng -Project communication and documentation (photography, videography, documentary, story/ blogs) -Provide guidance and branding requirements -Pre- approve all materials prior to execution in partnership with NAHPA 	
MESD	<ul style="list-style-type: none"> -Provides guidance for the school-based intervention -Facilitate engagement and consultations with Regional Education officers -Participate in planning, district consultations, project implementation and oversight of activities 	
BIHL Botswana Insurance Holding Limited	<ul style="list-style-type: none"> -Provided technical and financial support -Supported AYP competition and awards ceremony 	
MTV- Staying Alive Foundation (MTV- SAF)	<ul style="list-style-type: none"> -Peer education training -Production of Peer education manual -Support the establishment of peer education sessions -Provide content for virtual peer education -Supply USB to peer education 	<p>Ms Yvonne Diogo Country Director MTV Staying Alive Foundation</p>

Stakeholder	Role	Contact Details
	-M&E tools design and implementation through the ODK app	
Positive action	<p>Program project: supported by MTV SAF The program was implemented in four months September- December 2022).</p> <p>-The goal was to augment the implementation of the SHUGA peer education program in the face to face sessions and Virtual sessions</p> <p>-In addition to the monthly stipends for the Peer Educators, the project added a provision for merchandise for the Peer Educators, Tablets for data capturing and documentation of the program and snacks for the out of school sessions.</p> <p>-The project provided technical and financial support for the duration of four months (September to December 2022)</p>	Mr Kriyen Ponnann Project Manager MTV Shuga
Program implementing staff& stakeholders		
Peer Educators	<ul style="list-style-type: none"> -Deliver MTV Shuga sessions and facilitate dialogue and support for in and out of school target -Report on the implemented sessions - Participate in the local district activities - Participate in TAC meetings 	Selibe-Phikwe Peer Coordinator Kabo Moatlhodi Okavango District Peer Coordinator Kemphe Kaelo
G&C teachers	The MTV Shuga sessions (for the in-school target) utilises the Guidance and Counselling classes. The Guidance and Counselling teacher's role includes: <ul style="list-style-type: none"> -Support peer Educators deliver sessions in school - Plan for sessions with the peer Educators based on the school calendar - Technical support for peer Educators 	The contact details of the Guidance and counselling teacher(s) will be provided by Peer Coordinators. This will be guided by the school which the team wants to visit
Traditional and other community leaders	-Support peer Educators in engagement with morafe/ community	Okavango Gumare Kgosi Molelwa
Chief Education officer	<ul style="list-style-type: none"> -Support with school entry for in school sessions -Engage with the schools (support letters for the Peer Educators to engage with students for the sessions. 	Okavango Mrs Lempadi
District Health Team	<ul style="list-style-type: none"> - Provide services and aids in referrals such as HIV testing, STI screening etc.) - Expert information provision in some sessions (where need be: in sessions where the Peer Facilitator needs expert opinion for the session and explanation to the participants.) 	Okavango DHMT Head Dr Moali
District AIDS Coordinator	<ul style="list-style-type: none"> -District engagement for the project implementation -Liaise with the peer Educators and the stakeholders in implementation - Support for the peer Educators in implementation -Engages the peer Educators in DMSACs - Involve the peer Educators in TAC meetings 	Selibe- Phikwe Mr Patrick Kopano Assistant District AIDS Coordinator Okavango Mr Sam Kenaape District AIDS Coordinator
District Partners		

Stakeholder	Role	Contact Details
BOCHAIP	<p>At district level in Okavango, the peer Educators in Gumare work with BOCHAIP with the following support provided.</p> <ul style="list-style-type: none"> -Session space for out of school sessions -Help with recruitment for out of school participants - participants -Help with referral of the participants 	Okavango Keneilwe Gaboipone
HPP	<p>At district level in Selibe-Phikwe, the peer Educators in Selibe-Phikwe work with HPP with the following support provided.</p> <p>Session space for out of school sessions</p> <ul style="list-style-type: none"> -Help with recruitment for out of school sessions -participants - Hall space for refresher trainings for the peer Educators 	Selibe- Phikwe Leburu Gaepongwe

5.5 Annex 5: List of documents to be reviewed

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

2018

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

2019

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

2020

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

2021

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

2022

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

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

2023

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

5.6 Annex 6: Data collection tools

UNICEF

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

Relevance

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

Effectiveness

10. What were the main changes you have seen among AYP as a result of the intervention?
 - a. Are these same across gender and locations (four districts and within the four districts)?

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

Efficiency

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

Gender and Equity

20. What measures were put in place to integrate:
 - a. gender,
 - b. disability and
 - c. equity in the programme
21. Please provide examples of how these measures have been.
22. What challenges did you face in integrating gender, disability, and equity in the project?
 - a. How were these overcome?

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

Sustainability

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

Makgabaneng

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

Relevance

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

Effectiveness

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

- f. COVID-19 restrictions and aftermath.
11. How did the management and coordination contribute to the changes in terms of the following:
- g. supportive supervision to peer educators,
 - h. coordination between IP, DAC, DHMT, and peer educators,
 - i. other existing support in communities.

Efficiency

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

Gender and Equity

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

Sustainability

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

NAPHA

Name	
Gender	
Name	
Position	

Relevance

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

Effectiveness

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

Efficiency

14. In your opinion were the management arrangements (staffing, support to peer educators, coordination) for the project adequate to deliver on the results? Why? What could be improved?
15. What arrangements were there for oversight of the project?
 - a. Were these effective- please provide examples? Why?
16. How were peer educators recruited (criteria for selection and procedure for identification)?

- a. Was this an effective way to obtain the quality of peer educators required? Why? **PROBE: overall opinion on quality of peer educators and why?**
17. What monitoring systems were in place for the project?
 18. Did these systems provide enough data to measure the achievement of the project across the result chain? What was missing?
 19. What was the quality of implementation of the monitoring system on a scale of 1-10 (quality of data, data accessibility, timeliness of data availability, and comprehensiveness of the data)? Why do you say so?
 20. How have outputs from the monitoring system been used for project decisions and advocacy? Please provide examples.

Gender and Equity

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

Sustainability

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

DAC

Name	
Gender	
Name	
Name of district	
Designation (Office)	

Relevance

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

Effectiveness

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

Efficiency

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

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

Gender and Equity

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

Sustainability

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

DEO

Name	
Gender	
Name	
Name of district	
Designation (Office)	

Relevance

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

Effectiveness

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

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

Efficiency

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

Sustainability

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

DHMT

Name	
Gender	
Name	
Name of district	
Designation (Office)	

Effectiveness

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

Sustainability

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

Community Leaders

Name	
Gender	
Name of Ward	
Name of district	
Position in community	

Relevance

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

Effectiveness

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

Efficiency

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

Sustainability

12. What measures were put in place to sustain programme changes/benefits among AYP?
- a. How will your support and commitment have sustained? Please provide examples of how these plans have been successful.

G&C Teachers

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

Relevance

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

Effectiveness

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

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

Efficiency

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

Gender and Equity

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

Sustainability

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

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

Peer Educators and Peer Coordinators

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

Relevance

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

Effectiveness

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

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

Efficiency

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

Gender and Equity

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

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

Sustainability

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

AYP in school and out of school

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

Relevance

1. When you lookback at the intervention- support from Peer educators including with the radio programmes- would you say it was addressing the main problems causing new adolescent HIV infection and for those on ART not to adhere to treatment? Why do you say so?
2. On a scale of 1-10 how satisfied were you it supports you received from peer educators? Why do you say so?
3. Was the content of the sessions aligned to your everyday lives in this area? Why do you say so?
4. Was the way the sessions were delivered to you the most appropriate? Why do you say so? What could have been changed and how?: PROBE: differences between males and females.
5. In your opinions was the support you received enough to help bring about the following changes in AYP behaviour in your community? (Improved self-efficacy to delay sex and practice safe sexual behavior, Improved attitudes towards intergenerational and transactional sex, Improved gender equitable attitudes). Why? What else was missing or could have been added?

Effectiveness

6. What were the main changes you have seen among AYP as a result of the intervention? Are these the same for males and females in your community? **PROBE: self-efficacy for safe sex, and to delay sex, attitudes towards intergenerational and transactional sex, access, and use of other SRH services.**
7. When you consider all the support you received what aspects of the intervention helped to bring the changes you mentioned? **PROBE: 1) capacity of peer educators (including motivation); 2) linkages to district and village structures; 3) quality of content and support; 4) other contributory factors e.g., access to services, motivation of stakeholders; and 5) COVID-19 restrictions and aftermath.**
8. How did the programme engage and support you to participate in the planning, management, and coordination of the intervention at various levels?
 - a. To what extent was the voice of peer educators and AYP recognized and effected in decision making

Efficiency

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

Gender and Equity

11. For boys/girls, were able to participate effectively in the sessions.

- a. Were the sessions and other support relevant to the challenges you face as boys/girls? /persons with disabilities?

12. As boys/girls/persons with disability did you face specific challenges in:

- a. attending the sessions,
- b. fully participating during the sessions, and
- c. receiving and using additional support from peer educators, the school, the community?

Sustainability

13. What measures were put in place to sustain the changes/benefits that you have accrued as AYP?

- a. What will keep you motivated to sustain the benefits/changes?

AYP Case study for in and out of school

Name	
Gender	
Age	
Highest of Education	
Year of Completion of the Highest level of Education	
Type of house-hold head (Parent, Sibling, Relative, Self, Other)	
Employment Status	
Religion	
Name of Ward	
Name of district	
Name of province	
Designation (Office)	

Relevance

1. What did the project address in your life?
 - a. In your opinion was this the intention of the project?
2. How did the intervention address the problems being faced by other AYP within your particular group you represent?
 - a. Any special considerations?
3. How satisfied are you with the quality and composition of the peer educators?
 - a. What is the extent to which you identified with them?
4. Any defined special groups of AYP which were targeted and addressed by the intervention
5. How inclusive were the identified peer educators to serve any AYP within the group that you represent?
6. Was the support you received enough to improve your ability to negotiate or confidence to delay sex or have safe sex with your partner?
 - a. What about changing your attitudes towards intergenerational and transactional sex?

Effectiveness

7. What changes has the project brought in your life? **PROBE:** self-efficacy for safe sex, and to delay sex, attitudes towards intergenerational and transactional sex, access, and use of other SRH services.
8. When you consider all the support you received what aspects of the intervention helped to bring the changes you mentioned? **PROBE:** 1) capacity and adequacy of peer educators (including motivation); 2) linkages to district and village structures; 3) quality of content and support; 4) other contributory factors e.g., access to services, motivation of stakeholders; and 5) COVID-19 restrictions and aftermath.

Gender and Equity

9. For boys/girls, were able to participate effectively in the sessions. Were the sessions and other support relevant to the challenges you face as boys/girls/person with disabilities?
10. Did you face specific challenges in: attending the sessions, fully participating during the sessions, and receiving and using additional support from peer educators, the school, the community?

Sustainability

11. What has the programme done to sustain the changes/benefits that you have accrued as an AYP or keep you motivated? How will your motivation be sustained?

5.7 Annex 7: Individual consent Form

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

What language do you prefer for our discussion today?

English

Setswana

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

1.0 Interviewer reads:

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

2.0 Purpose of study

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

3.0 Study Procedures

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

4.0 Alternatives to taking part

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

5.0 Costs for being in the study

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

6.0 Benefits

The main benefit for you to be in the study is the chance to contribute to make a contribution to a study that will directly help improve support provided to adolescent and young people to reduce their exposure to HIV and that they receive the support they need to live health lives. Your taking part in this study could help us learn more about MTV Shuga in Botswana. It can help us learn about how MTV Shuga program is working in the country and how we can improve and scale it up to other districts.

7.0 Risks

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

8.0 Confidentiality and access to your health information

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

9.0 Ethical Approval

[Interviewer: read from here]

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

10. Who should you contact if you have questions?

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

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

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

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

Email: slesotlho@gov.bw

[Interviewer: read from here]

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

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

Abia Sebaka, Health Research and Development Committee

Landline: +267 363 2018/+267 363 2500

Email: asebaka@gov.bw

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

12. Consent Statement

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

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

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

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

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

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

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

(IF PARTICIPANT DOES NOT AGREE, THEN STOP)

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

"I agree to be contacted for future research."

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

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

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

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

_____ Yes

_____ No

Name of Participant (completed by interviewer):

PTID: _____

MTV SHUGA Interviewer signature: _____ Date: ___/___/___

MTV SHUGA Interviewer name: _____

MTV SHUGA Interviewer ID number: _____