Impact Evaluation of the Teen Club Programme for Adolescents Living with HIV in Eswatini

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unicef
for every child

Baylor College of Medicine Children's Foundation Swaziland

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List of Acronmys

AGYW	Adolescent Girls and Young Women
ALHIV	Adolescents Living with HIV
ART	Anti Retroviral Therapy
CoE	Centre of Excellence
CPD	Country Programme Document
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FGD	Focus Group Discussion
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus List of Appendices
HMIS	Health Management Information Systems
HRBA	Human Rights Based Approach
HTC	HIV Testing and Counselling
ICAP	International Centre for AIDS and Treatment Programme
ICT	Information Communication Technology
KAP	Knowledge, Attitude and Practice
LFTU	Lost to Follow Up
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NGO	Non-Governmental Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
SPSS	Statistical Package for Social Sciences
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
UNDAF	United Nations Development Assistance Framework
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund

VLS	Viral Load Suppression
WHO	World Health Organization

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Acknowledgements

The Teen Club programme is an initiative by Baylor College of Medicine Swaziland in collaboration with the Ministry of Health. Established in 2006 with support from UNICEF Eswatini, support groups known as Teen Clubs were put in place to help adolescents living with HIV (ALHIV) to build positive relationships, improve their self-esteem and acquire life skills through peer mentorship, ultimately leading to improved clinical and mental health outcomes and a healthy transition into adulthood.

Baylor College of Medicine has been coordinating the clubs over the years, and there was need to determine the relevance, effectiveness, impact, efficiency and sustainability of the Teen Club initiative in addressing the needs of ALHIV in Eswatini. The findings of the evaluation will go a long way in providing ways on how to scale up the initiative and make relevant adjustments in the programme to achieve greater impact.

The report is the product of collaborative effort of Ministry of Health and UNICEF Eswatini. Baylor College of Medicine highly appreciates the Technical Committee for the guidance and oversight provided. The group comprising of Zandile Nhleko, Sebentile Myeni, Sibonangaye Sithole, Mduduzi Mbingo and Nobuhle Mtetwa, played a key role in providing inputs and comments throughout the evaluation process.

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Executive Summary

Young people aged 10–24 years are among the most vulnerable, yet overlooked, populations affected by the human immunodeficiency virus (HIV) epidemic. Worldwide, an estimated 1,800,000 [1,100,000– 2,600,000] people aged 10–19 years were living with HIV in 2017, more than 80 per cent of whom were residing in Sub-Saharan Africa. With the high numbers of estimated new infections among older adolescents (15–19 year olds) and many of the 920,000 children globally receiving antiretroviral therapy (ART) surviving into adolescence, adolescents have become a critical age group to focus on in terms of their vulnerability.

Eswatini has the highest HIV prevalence rate in the world, with 27.4 per cent of adults living with HIV.[1] In 2017, 850 [600–1,200] children 0-14 years were newly infected with HIV and AIDS. [2] However, this figure does not include the 15–19 year olds, who are also the target group for the Teen Clubs. (There is no specific data set that captures the 10–19 years age group.) In 2017, 15 to 24-year-old women were 5.5 times more likely to be living with HIV than their male counterparts (16.7 per cent vs.3. per cent prevalence).[3]

Stigma associated with HIV and AIDS in Eswatini prevents many people from being tested for HIV or declaring their HIV status. HIV is perceived to be linked with sexual promiscuity, and often causes people living with HIV to be excluded from family activities.[4] Underlying risk factors for increased vulnerability and susceptibility to HIV infection among Adolescent Girls and Young Women (AGYWs) include economic disenfranchisement, early sex debut, intergenerational sex and sub-optimal knowledge about HIV risk prevention[5].

Despite growing awareness about effective interventions to prevent HIV transmission among young people, they still make up 45 per cent of new transmissions worldwide. Whether infected during the neonatal period or during adolescence, adolescents living with HIV (ALHIV) have unique and pressing psychosocial needs on top of the daily challenges of being adolescents.[6] Adherence to medication, disclosure of HIV status, issues relating to sex and sexuality and lack of support networks are problems faced by all ALHIV.[7]

It is against this background that in 2006 Baylor College of Medicine Swaziland (here-after refered to as Baylor), with support from UNICEF Eswatini, established support groups,

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[1] UNAIDS 'AIDS info'
[2] UNAIDS Data 2018 www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf (accessed 28/12/18)
[3] UNAIDS (2016) 'Country Factsheet: Eswatini'
[4] IRIN News (2012, 12 November) 'Eswatini: HIV stigma still a barrier'
[5] Extended National Multi-sectoral HIV and AIDS Framework (eNSF) (2014-2018)

known as Teen Clubs, to help ALHIV to build positive relationships, improve their self-esteem and acquire life skills through peer mentorship, adult role-modelling and structured activities — ultimately leading to improved clinical and mental health outcomes and a healthy transition into adulthood.

Purpose of the evaluation

The purpose of the evaluation was to determine the relevance, effectiveness, impact, efficiency and sustainability of the Teen Club initiative in addressing the needs of ALHIV in Eswatini. The evaluation assessed the extent to which, and under what circumstances, the Teen Clubs for ALHIV achieved their intended objective over the last five years and provides recommendations on how to scale up the initiative and make relevant adjustments in the programme to achieve greater impact.

Methodology

The methodology for the evaluation involved extensive literature review as well as field work. Documents reviewed included Baylor programme documents, as well as progress and activity reports. An extensive literature search was carried out on adolescents and HIV in Eswatini and globally. The consultant also reviewed clinic records from Baylor clinics. Field work involved key informant interviews with UNICEF and Baylor programme staff, as well as with key partners in the Ministry of Health. Focus group discussions (FGDs) were conducted with ALHIV: those still in the Teen Clubs and those who have graduated. FGDs were also conducted with Teen Club leaders and with parents/caregivers of members. Qualitative data was analysed using content analysis while SPSS was used to analyse quantitative data.

Findings

While the evaluation focused on the three UNICEF-supported Teen Clubs run by Baylor in Mbabane, Manzini and Hlatikhulu, there are 81 other Teen Clubs at health facilities across the country that cater for 3,742 ALHIV. This however still leaves out the majority, about 9,000, of the over 13,000 ALHIV in the country.

The evaluation established that the Teen Clubs Programme is relevant as it addresses some of the most critical challenges facing ALHIV, including Lost to Follow Up (LTFU) resulting in defaulting on treatment, poor adherence, self-stigmatization and stigma in communities. The programme is relevant as it is in line with international and national guidelines and strategies for ALHIV. It is also contributing to the achievement of Goal 3.3 and 3.7 of the Sustainable Development Goals (SDGs) on HIV and AIDS which state:.

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

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

The Programme was effective in supporting disclosure – the first step in accepting one's HIV status. Full disclosure is a condition for joining the Teen Clubs and all members have to know their status. The Programme improved treatment adherence among ALHIV, which in turn resulted in viral load suppression among most of the members. Viral load suppression among Teen Club members stands at 88.7 per cent compared to national averages of 44.2 per cent among the 15 to 24 year olds.[8]

The number and percentage of ALHIV on Anti-Retroviral Therapy (ART) for 6 months or more with undetectable viral load among the Teen Club members at the three Baylor clinics rose from 403/429 representing 87 per cent to 341/390 representing 89.9 per cent between August 2017 and July 2018[9]. Viral load suppression was also higher among Teen Club members compared to non-members with Teen Club members achieving 90.3 per cent against 88.60 per cent for non-members. At the same time, LTFU reduced from 10 per cent at the start of the In-Reach programme in 2011 to 0.2 per cent in 2018[10].

The Teen Club programme empowerered adolescents by building their self-confidence, self-esteem and self-efficacy. These are critical attributes that enabled them to live positively and which contributed to positive health outcomes. Because they are empowered, the ALHIV are better able to deal with self-stigma and to fight stigma in the wider society.

The evaluation noted that the Teen Club programme was efficient and cost effective and is a good investment. Making an investment case for the Programme would clearly show the gains derived from the Programme outweigh the costs. Using the counterfactual analysis would show that if the intervention had not been implemented, the adolescents would be much worse off in terms of their health status as Teen Club members are mostly recruited from those who would have defaulted, have low viral load suppression and who have low self-esteem.

While it might be difficult to sustain the programme without external support there are elements of sustainability within the programme, which include the programme's heavy reliance on volunteers at little or no cost to Baylor; the political will within government to sustain the programme (the government is paying 90 per cent of Teen Club costs, mostly in the form of staff salaries). As part of the sustainability strategy, development partners currently supporting the Teen clubs, should come up with an exit strategy with timelines which would clearly map out how they will be transitioned from the Teen Clubs. Such an

[8] Government of Eswatini (2017) Eswatini HIV Incidence Survey 2: A Population-based HIV Impact Assessment
[9] Balyor Clinic Records
[10] Baylor Clinic Records

exit strategy should however not be abrupt to ensure that there are no disruptions to the Programme.

The Teen Clubs is a promising initiative which has achieved its intermediate outcomes – increased adherence and retention and viral load suppression. The Programme has also achieved impact by empowering adolescents and building their self-confidence and self esteem. The empowered adolescents have been able to overcome self-stigma and to fight stigma against them in the community. While the adolescents in the club live positively they are however not so confident of life beyond the clubs. Of critical note is that the transition to adulthood has not been smooth as many of them feel that they were transitioned from when they were not yet ready. There was a general feeling among the adolescents, which was also shared by Baylor, that there is a need to design a strategy to ensure a smooth transition. Such a strategy would entail the creation of support groups for young adults and supporting unemployed young adults to gain skills to make a living. This is particularly critical given Eswatini's high youth unemployment levels (47 percent among 15-35 year olds).

Recommendations

1. Ensuring a smooth transition into adulthood

Both Baylor and the young adults admit that the transition/graduation from the Teen Clubs membership has not been smooth and has been too abrupt leaving them feeling abandoned. **Baylor should design a comprehensive programme to facilitate the smooth transition of the adolescents into adulthood. Such a programme should address their bio-medical as well as their psychosocial needs.**

2. Addressing the social determinants of adherence

Several factors can affect adherence among adolescents, including the home environment, stigma and discrimination and gender based violence (GBV), among others. **There is need for a more holistic approach to adherence, which takes cognizance and tries to address factors in the external environment that can impact on adherence. Such an approach should strengthen the coping mechanisms of ALHIV and also seek ways to mitigate the effects of the external environment on the adolescents.**

3. Need for more intense anti-stigma programmes

The fear expressed by the young adults to engage in relationships is a reflection of the high stigma levels and low levels of knowledge about HIV prevailing in Eswatini. It is only by addressing these issues within communities that people living with HIV (PLHIV) will be accepted and be able to live normal lives. **The Ministry of Health, working with development partners, should design and implement comprehensive anti-stigma programmes to be rolled out across the country as a long term strategy to address the high levels of stigma in the Eswatini society.**

4. Strengthening mental health services

Baylor provides mental health services to adolescents. But because of the limited number of social workers, the services are only provided to those experiencing adherence problems, leaving out many more adolescents who require the services. Mental health services are not available to parents of ALHIV although many need them. **Baylor should strengthen its mental health services to enable it to screen and provide services to more adolescents and parents/guardians who need the services.**

5. Coming up with an exit strategy

Since the formation of the Teen Clubs, their activities have been largely funded by development partners, including UNICEF and The President's Emergency Plan for AIDS Relief (PEPFAR) through International Center for AIDS Care and treatment Programme ICAP. The efficacy of the concept has been proved, hence the opening of 81 other clubs outside Baylor. This may be an opportune time for the government to take over the programme, considering that it is already paying the bulk of the costs in salaries. **Partners should advocate for the government to take over funding of all the Teen clubs and for their roll out to the remaining health facilities in the country that offer HIV services, so that more ALHIV can access the services**.

6. Ensuring more even coverage of content in the Teen Club ***Manual***

The Teen Club manual is comprehensive and addresses the information and knowledge needs of ALHIV. However responses from FGDs and the KAP study show that adherence is the major topic that the trainings focus on, while the rest of the topics in the manual receive scant attention. **The Teen Club trainings should be broader to cover other issues in the manual that impact on adherence, such as gender-based violence (GBV), self-assertiveness, leadership, decision making, etc. A narrow focus on adherence may fail to broaden the knowledge base of the adolescents sufficiently to enable them to navigate through their adult lives with confidence**

7. Improving the home environment for the adolescents

For successful treatment adherence, ALHIV need psychosocial and treatment adherence support. However this is often lacking in their homes, with the result that the adolescents continue to default on treatment. **There is a need for Baylor to form support groups for parents that will (a) strengthen their capacity to provide psychosocial support to their children; (b) address their information needs; (c) create a platform where the parents can also receive psychosocial support; and, (d) address their mental health problems.**

8. Broadening the range of services available to adolescents

The effectiveness of Teen Clubs has been enhanced by supporting interventions such as the In-Reach and the Mental Health programmes as well as Challenge Clinic, which together constitute a comprehensive package to address the diverse needs of ALHIV. **In rolling out the Teen Clubs Programme across the country, it will be necessary to incorporate the In-Reach and the Mental Health Programme as well as the Challenge**

Clinic to ensure the provision of a comprehensive package of services for adolescents.

9. Providing adherence support in boarding schools

From the literature review and from the FGDs it emerged that some adolescents in boarding schools default from treatment because the environment is not conducive for them to take their medication and they lack adherence support. ***Schools should complement Teen Club efforts to improve adherence by providing discreet adherence support and creating conditions that enable ALHIV to take their medication in private. Parents/guardians should be encouraged to disclose the status of their children to school heads on registration so that they can be provided adherence support and counselling if they need it.***

10. Strengthening social safety nets for indigent ALHIV

High poverty levels in Eswatini, especially among children, contributes to poor adherence among ALHIV from poor households. **Baylor, working with national case management teams, should identify and refer vulnerable adolescents for social protection services to reduce barriers to treatment and improve adherence. At the same time, a strong advocacy campaign should be carried out to influence the government to strengthen social safety nets that cater for vulnerable ALHIV.**

11. Resuming Holiday Teen Clubs for Adolescents with poor adherence

According to Baylor, Teen Clubs for adolescents with a high viral load were effective in improving adherence and viral load suppression. However, they were discontinued because of lack of funding. ***Baylor should fundraise for resources to resume the special Teen Clubs as they proved critical to improving health outcomes for adolescents who had poor adherence and high viral load.***

12. ***Strengthening the U Report***

Social media is the communication mode of choice for most adolescents. The U Report is an attempt to provide adolescents with useful information using the SMS platform. However the platform has not taken off as well as it should have because of initial operational challenges experienced. ***UNICEF and Baylor should iron out the technical glitches still being experienced by users by (a) ensuring that questions asked are responded to on time and (b) that issues discussed are relevant to the adolescents***.

Introduction

1.1 Background and Context

Young people aged 10–24 years make up one of the most vulnerable, yet overlooked, populations affected by the human immunodeficiency virus (HIV) epidemic. Worldwide, an estimated 2,100,000 [1,400,000– 2,700,000] people aged 10–19 years were living with HIV in 2016, 80 per cent of whom were residing in Sub-Saharan Africa.[11] With high numbers of estimated new infections among older adolescents (15–19 year olds) and many of the 920,000 children receiving antiretroviral therapy (ART) surviving into adolescence,[12] adolescents have become a critical age group to focus on in terms of their vulnerability. Nonetheless, adolescents continue to be underserved by current interventions across the HIV cascade. Adolescents have significantly inferior access to and coverage of ART, higher rates of lost to follow-up (LTFU) poor adherence and increased need for psychosocial support and sexual reproductive health (SRH) services[13] [14].

Despite growing awareness about effective interventions to prevent HIV transmission among young people, they still make up 45 per cent of new transmissions worldwide. Whether infected during the neonatal period or during adolescence, adolescents living with HIV (ALHIV) have unique and pressing psychosocial needs on top of the daily challenges of being adolescent.[15] Adherence to medication; disclosure of HIV status; issues relating to sex and lack of support networks are problems faced by all ALHIV[16].[17]

Between 2000 and 2015, annual AIDS-related deaths declined for all age groups except adolescents (aged 10–19 years), where mortality more than doubled from 18,000 to

[11] UNAIDS. 2017 Estimates. Geneva, Switzerland: UNAIDS; 2017
[12] Mahy M. Latest Estimates for Pediatric and Adolescent HIV Prevalence and Coverage. Presented at: 9th International Workshop on HIV Pediatrics; July 21-22, 2017; Paris.
[13] Hudelson C, Cluver L. Factors associated with adherence to antiretroviral therapy among adolescents living with HIV/AIDS in low- and middle income countries: a systematic review. AIDS Care. 2015;27:805–816.
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[15] Murray KR, Dulli LS, Ridgeway K, Dal Santo L, Darrow de Mora D, Olsen P, et al. (2017) Improving retention in HIV care among adolescents and adults in low- and middle-income countries: A systematic review of the literature. PLoS ONE 12(9): e0184879. https://doi.org/
[16] Murray KR, Dulli LS, Ridgeway K, Dal Santo L, Darrow de Mora D, Olsen P, et al. (2017) Improving retention in HIV care among adolescents and adults in low- and middle-income countries: A systematic review of the literature. PLoS ONE 12(9): e0184879. https://doi.org

41,000,[18] due to the increasing number of adolescents with vertically acquired infection who remain unidentified or unsupported, even when on treatment.

Access to treatment and care for ALHIV remains inadequate. Following HIV Testing and Counselling (HTC), there are poor linkages to and retention in care for most populations and Anti-Retroviral Therapy (ART) coverage rates for adolescents are lower than for other age groups. Interventions and support for sustained treatment adherence and retention in care are challenges in many settings, the inability to address these issues has led to treatment failure and the high levels of HIV-related morbidity and mortality increasingly being recognized in this group.[19]

1.1.1 Low retention in care for adolescents

Retention in HIV care is substantially lower for adolescents than for other age groups[20] [21]. A recent systematic review of 154 adult HIV patient cohorts in low- and middle-income countries (LMIC) found that, on average, 83 percent of patients had been retained in HIV treatment services after 12 months on ART, but the proportion declined to only 60% after 60 months on ART[22]. Comparable data on long-term retention in care are not available for adolescents or youth. Data from four LMIC, however, show that youth (15-24 years) had 59 percent higher attrition than adults (25-54 years) one year after initiating ART.

Adolescents also have suboptimal adherence and lower rates of viral suppression compared to other ages[23] [24]. Retention in HIV health care services is a critical precursor to ART adherence and viral suppression. Clinical visits for patients on ART are essential to initiate ART, ensure continuous access to medication, monitor medication side effects, diagnose treatment failure, and, when necessary, switch to second- or third-line ART regimens.[25] Retaining patients in care helps them maintain high medication adherence, thereby achieving viral load suppression, improving health outcomes and reducing the risk of horizontal transmission[26] [27].

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[18] UNAIDS/UNICEF/WHO Global AIDS Response Progress Reporting and UNAIDS 2016 estimates.
[19] WHO (2013) HIV and Adolescents: Guidance for HIV Testing and Counselling and Care for Adolescents Living with HIV
[20] Lamb MR, Fayorsey R, Nuwagaba-Biribonwoha H, Viola V, Mutabazi V, Alwar T, et al. High attrition before and after ART initiation among youth (15–24 years of age) enrolled in HIV care. AIDS. 2014; 28 (4):559–68. https://doi.org/10.1097/QAD.0000000000000054 PMID: 24076661
[21] Brown LB, Havlir DV, Ayieko J, Mwangwa F, Owaraganise A, Kwarisiima D, et al. High levels of retention in care with streamlined care and universal test and treat in East Africa. AIDS. 2016; 30(18):2855– 64. https://doi.org/10.1097/QAD.0000000000001250 PMID: 27603290
[22] Fox MP, Rosen S. Retention of Adult Patients on Antiretroviral Therapy in Low- and Middle-Income Countries: Systematic Review and Meta-analysis 2008±2013. J Acquir Immune Defic Syndr. 2015; 69 (1):98±108. https://doi.org/10.1097/QAI.0000000000000553 PMID: 25942461
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PLHIV who are not retained in care stop or interrupt ART, increasing their risk of drug resistance and mortality. Data on long-term retention in care from four low and middle income countries, show that youth (15–24 years) had higher attrition rates than adults (25–54 years) one year after initiating ART underscoring the need to develop and test interventions to improve retention that specifically target youth[28]. Low retention of HIV-positive adolescents in care is a major problem across HIV programmes. For instance, at Katooke Health Center, Mid-Western Uganda, approximately 70 per cent of adolescents were non-retained in care.[29]

Early entry and retention in HIV medical care increases the success of the Test and Treat Strategy, a policy guideline where all persons who test HIV positive are started on ART irrespective of their age, immune and clinical status[30] [31]. Retention is thus a critical requirement for achieving favourable long-term clinical outcomes of HIV treatment[32].

1.1.2 Knowledge levels about HIV and AIDS among adolescents

A UN General Assembly report recently concluded that young people's accurate and comprehensive knowledge about HIV has stagnated.[33] In sub-Saharan Africa, just 26 per cent of adolescent girls and 33 per cent of adolescent boys aged 15–19 years have comprehensive HIV knowledge. Levels of condom use also remain very low, with only 32 per cent of sub-Saharan adolescent girls (69.6 per cent in Eswatini) with multiple partners reporting condom use at last sex.[34]

1.1.3 Interventions targeting adolescents living with HIV and AIDS

Once adolescents living with HIV are identified and enrolled in care and treatment, they have specific support needs, including psychosocial and community-based support that extends beyond clinical services. According to UNAIDS, several small programmes are good examples of how to provide such support, including the Baylor International Pediatric AIDS Initiative Teen Club programme in Botswana, Malawi, Eswatini and Uganda, which empowers adolescents through peer-to-peer support and trainings on HIV and AIDS and on life skills; Africaid's Zvandiri programme in Zimbabwe – a child-centred and child-led programme for ALHIV that offers peer counseling and support through trained Community Adolescent Treatment Supporters (CATS), that are linked to health facilities to provide a

[28] Lamb MR, Fayorsey R, Nuwagaba-Biribonwoha H, Viola V, Mutabazi V, Alwar T, et al. High attrition before and after ART initiation among youth (15–24 years of age) enrolled in HIV care. AIDS. 2014; 28 (4):559–68. https://doi.org/10.1097/QAD.0000000000000054 PMID: 24076661

[29] Izudi J et al (2018) Retention of HIV-Positive Adolescents in Care: A Quality Improvement Intervention in Mid-Western Uganda

[30] TheRepublic of Uganda, "Consolidated guidelines for HIV prevention and treatment in Uganda," in *The Republic of Uganda*, pp. 121-122, Ministry of Health, Kampala, Uganda, 2016.

[31] G. Marks, L. I. Gardner, J. Craw, and N. Crepaz, "Entry and retention in medical care among HIV-diagnosed persons: ametaanalysis," *AIDS*, vol. 24, no. 17, pp. 2665–2678, 2010.

[32] M.-C. Kempf, J. McLeod, A. K. Boehme et al., "A qualitative study of the barriers and facilitators to retention-in-care among HIV-positive women in the rural southeastern united states: Implications for targeted interventions," *AIDS Patient Care and STDs*, vol. 24, no. 8, pp. 515–520, 2010.

[33] United Nations, 'On the Fast Track to Ending the AIDS Epidemic: Report of the Secretary-General, A/70/811', United Nations, New York, 1 April 2016

[34] UNICEF analysis of DHS, MICS and other national household surveys, 2005–2015.

comprehensive and adolescent-friendly referral chain; the Mildmay Centre in Uganda, which uses a family-centred approach to address prevention, care and treatment. Mildmay Uganda uses a holistic, multi-disciplinary approach to prevention, care and treatment, which focuses on the physical, social, spiritual and emotional well-being of a client through trained health centre personnel and counsellors.[35]

1.1.3 HIV and AIDS among adolescents in Eswatini

Eswatini has the highest HIV prevalence rates in the world, with 27.4 per cent of adults living with HIV.[36] Adolescent girls and young women (AGYW) are particularly affected by HIV. In 2016, 15-24 year old women were 4.5 times more likely to be living with HIV than their male counterparts (17.6 per cent versus 3.8 per cent prevalence).[37] Underlying risk factors for increased vulnerability and susceptibility to HIV infection among AGYW include economic disenfranchisement, early sexual debut, intergenerational sex and sub-optimal knowledge about HIV risk prevention[38].

Stigma associated with HIV and AIDS in Eswatini prevents many people from being tested for HIV or declaring their HIV status. HIV is perceived to be linked with sexual promiscuity, and often causes HIV-positive people to be excluded from family activities.[39]

Sexual debut among adolescents in Eswatini is 16 years for girls and 18 years for boys.[40] Data shows that 10 per cent of women's first sexual act was with a man 10 or more years older[41] and 15 per cent of 15-24 year olds who had had sex in the last 12 months, was with a partner 10 or more years older[42]. The high rate of age mixing exposes many adolescents to the risk of contracting HIV. As a result of the age mixing and other risky behaviour, HIV prevalence among girls increases sharply between the age groups 15-19 years and 20-24 years, from 7.2 per cent to 20.9 per cent respectively while for boys aged 15-19 years, the prevalence is 3.9 per cent and this increases marginally to 4.2 per cent for those aged 20-24 years.[43]

Further, knowledge levels about HIV and AIDS among children 10-14 years is estimated at 34.6 per cent with a slight difference between males (33.8 per cent) and females (35.6 per cent)[44]. Only 66.1 per cent of ALHIV under 15 years are aware of their HIV status[45].

Adolescents also suffer from low treatment rates. Using programme data (HMIS) to assess the treatment cascade for children 0-14 years shows significant gaps throughout

[35] UNAIDS (2010) Children and AIDS – Fifth Stocktaking Report 2010
[36] UNAIDS 'AIDS info'
[37] UNAIDS (2016) 'Country Factsheet: Eswatini'
[38] Extended National Multi-sectoral HIV and AIDS Framework (eNSF) (2014-2018)
[39] IRIN News (2012, 12 November) 'Eswatini: HIV stigma still a barrier'
40 Ministry of Health (2012) Eswatini HIV Incidence Measurement Survey.
39 Ministry of Health (2012) Eswatini HIV Incidence Measurement Survey Ministry of Health, Mbabane.

42 Ministry of Health (2012) Eswatini HIV Incidence Measurement Survey. Ministry of Health, Mbabane
[43] The Kingdom of Eswatini National Multisectoral HIV and AIDS Strategic Framework 2018 – 2022
[44] SHIMS 2016/17
[45] The Kingdom of Eswatini National Multisectoral HIV and AIDS Strategic Framework 2018 – 2022

the cascade. The data shows that of the 73 per cent children LHIV who have been diagnosed, only 66 per cent are on ART and a mere 16 per cent had access to viral load testing[46] Prevalence of viral load suppression (VLS) among HIV-positive people in Eswatini is highest among older adults: 87.3 per cent among HIV-positive females and 89.3 per cent, among HIV-positive males ages 55-64 years. In contrast, prevalence of VLS is lowest among younger adults: 55.5 per cent among HIV-positive females and 32.9 per cent among HIV-positive males ages 15 to 24 years.[47]

Early enrolment and improved retention of ALHIV on ART has reduced average morbidity rates in Eswatini. Between 2009 and 2015, LTFU cases among adolescents dropped from 9 per cent to 4 per cent while the death rate among adolescents also declined from 4 per cent to 2 per cent over the same period.[48] Among ALHIV, self-stigma and fear partly account for late initiation on ART especially among males and hinders status disclosure and adherence to treatment. ALHIV also indicated external stigma and discrimination in the community and among service providers[49]. In addition, ALHIV face challenges in accessing treatment and/or taking medication in a school setting as they do not wish to disclose their HIV status.[50]

1.2 Teen Clubs

It was against this background that in 2006 Baylor Eswatini in collaboration with Ministry of Health established adolescent support groups, known as Teen Clubs. The purpose of the Teen Clubs is to empower HIV-positive adolescents to build positive relationships, improve their self-esteem and acquire life skills through peer mentorship, adult role-modelling and structured activities—ultimately leading to improved clinical and mental health outcomes and a healthy transition into adulthood. [51]

UNICEF Eswatini has been supporting Baylor Teen Clubs since their establishment. UNICEF's involvement was largely influenced by its childrens' mandate and the realization that there were no interventions targeting ALHIV in Eswatini. The Programme was in line with UNICEF's Strategic Plan, 2018-2021, making it an appropriate intervention. According to UNICEF's Health Specialist, "The Teen Clubs presented an opportunity to make a difference in the lives of young people. Not many young people were eager to be tested. It was also important for ALHIV to appreciate the importance of taking their medication as well as to deal with issues of stigma and discrimination. Through the programme we were able to access ALHIV to provide them information and a platform where they could meet and share information".

[46] The Kingdom of Eswatini National Multisectoral HIV and AIDS Strategic Framework 2018 – 2022
[47] Government of Eswatini (2017) Eswatini HIV Incidence Survey 2: A Population-based HIV Impact Assessment
[48] The Kingdom of Eswatini National Multisectoral HIV and AIDS Strategic Framework 2018 – 2022
[49] Focus Group Discussions held during the end term evaluation of the Extended Multisectoral HIV and AIDS Strategic Framework 2014-2018
[50] The Kingdom of Eswatini National Multisectoral HIV and AIDS Strategic Framework 2018 – 2022
[51] GOS (2017) Eswatini Integrated Teen Club Curriculum

Teen Clubs provide fun educational activities focusing on life skills, healthy relationships and building confidence. These forums allow teenagers to learn to constructively express themselves and discuss issues regarding their health without fear of stigmatization[52]. The 2010 UNAIDS report "Children and AIDS"[53], recognized the Teen Clubs as a global model of excellence for the provision of care and support to HIV-positive adolescents. According to the UNAIDS Report,[54] the Teen Club Programme provides an opportunity to assist HIV-positive adolescents as they approach adulthood and begin to engage in relationships, initiate sexual activity, consider marriage and perhaps start a family.

Currently 554 ALHIV are registered in Teen Clubs at three Baylor sites in Eswatini – the Baylor Centre of Excellence (CoE) in Mbabane, Nazarene Raleigh Fitkin Memorial (RFM) Hospital CoE, and Hlatikhulu CoE. However, attendance to the clubs is not consistent and tends to fluctuate.

Teen Clubs are largely led by the adolescents themselves and use innovative approaches to deliver services, such as the In-Reach and the Mental Health Programme as well as the Challenge Clinic and the Teen Clubs themselves that are designed to provide a supportive and non-threatening environment for ALHIV, enabling them to learn about HIV and also to thrive in a stigma-free environment.

Teen Clubs meet once a month on Saturday mornings and the activities intersperse games with lessons extracted from the Teen Club Manual. Other activities include the teen health days, which are held twice weekly. These have created a platform where adolescents can discuss urgent issues affecting their health without having to wait for the Teen Club day, which comes only once a month.

1.2.1 Challenge Clinic

Baylor also organizes the Challenge Clinic to improve adherence among the adolescents. The Challenge Clinic is a multi-disciplinary approach for adolescents with chronic poor adherence. A patient is enrolled on the programme in the presence of a doctor, a social worker and the caregiver who all sit down with the patient to find out how support can be provided to improve adherence. The Challenge Clinic is run every Tuesday and Thursday at Baylor Clinic in Mbabane. With support from Elizabeth Glazer Peadiatric AIDS Foundation (EGPAF, Baylor has taken the Challenge Clinic to high volume clinics (mostly government facilities) and plans to extend the programme to five additional non-Baylor sites.

1.2.2 Providing individualised care

Teen Clubs meet in large groups of up to 150 adolescents. This does not provide an ideal environment to give the adolescents individual attention. To address the problem, Baylor created a Teen Club for adolescents with a high viral load which met for three days during

[52] https://bipai.org/Eswatini
[53]Children and AIDS. Fifth Stock taking Report 2010. UNAIDS
[54] Ibid

the school holidays. The meetings were used to conduct group counselling sessions and discuss with the adolescents the issues they were facing as well as to go deeper into why their viral load was not suppressed. The intervention contributed substantially to improved adherence and decreased viral load among the adolescents. However due to lack of funding, the programme was stopped.

Once a year, Baylor with technical and financial support from SeriousFun Children's Network, based in the United States of America, organizes a week-long camp during the school holidays where they also bring together adolescents with high viral load to give them more focused attention. In some cases they have found that adherence among the adolescents is affected by the anger they harbour against their parents, in particular their mothers, for giving them the virus or by a non-supportive home environment. The annual camp provides the adolescents the opportunity to discuss these issues and to provide group counselling.

1.2.3 The In-Reach Programme

Baylor CoE started the In-Reach Programme in 2011 to address the high rate of LTFU among ALHIV. Altghough not directly linked to the Teen Clubs, the Programme dovetails well with the Teen Clubs objectives, making the two highly complementary. In-Reach targets adolescents with poor adherence; those who have defaulted on treatment; those with high viral load and those experiencing treatment failure. Social workers also conduct in-reach visits for pre-ART initiation for newly diagnosed pediatric patients to assess social support available for the patient, which also includes the identifiction of a primary and secondary treament supporter. The programme also assists adolescents facing social problems e.g. lack of food and bus fare to come to the clinic, that makes them default.

Advantages of the In-Reach Programme

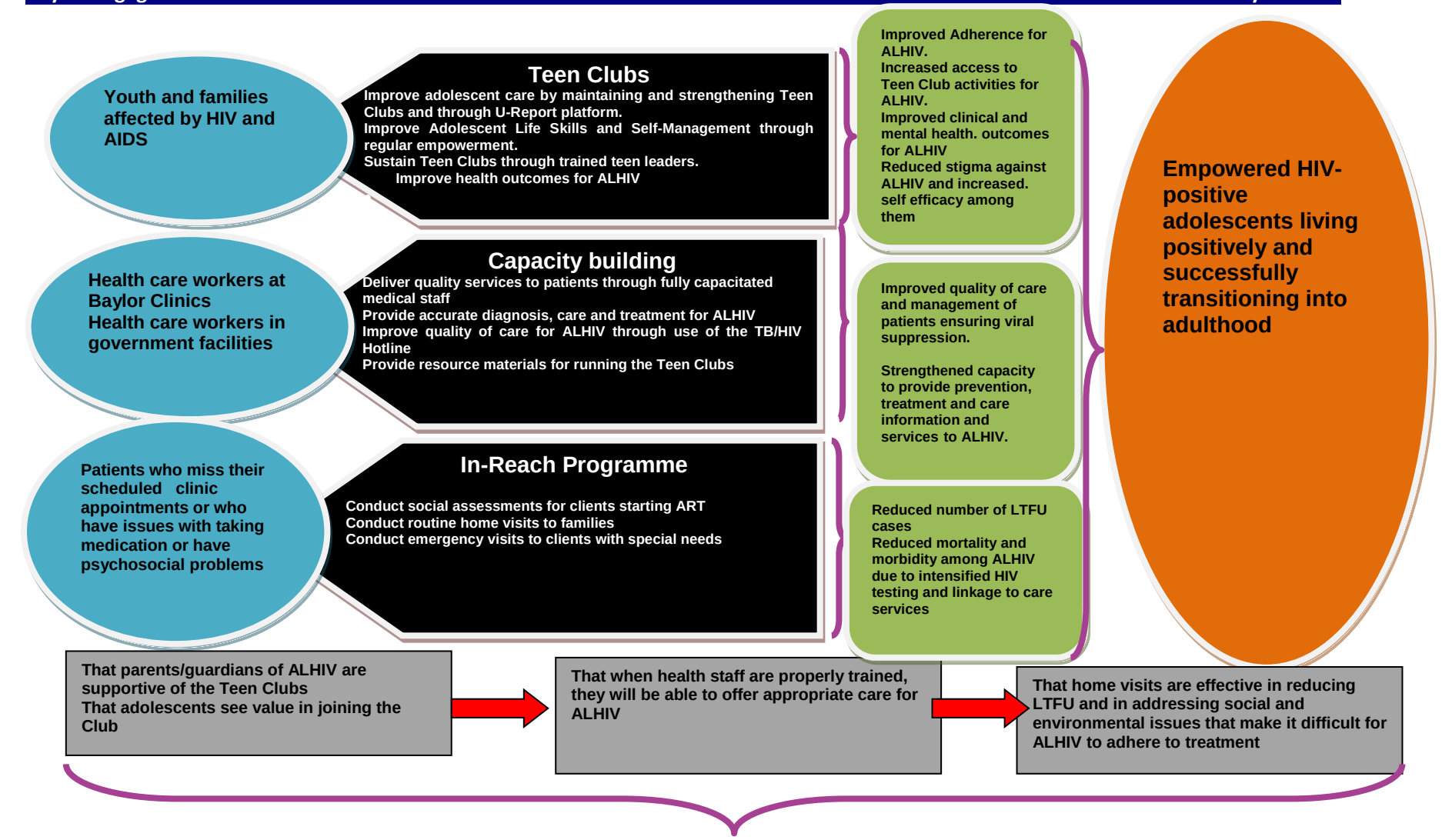
- Patients' problems are discussed in a comfortable home environment unlike the clinic which might feel threatening;
- During in-reach visits, Baylor staff (social workers) are able to assess the social support that is available but which a patient might not be aware of;
- It makes it possible to reach caregivers who cannot attend clinic visits due to disability or age or who might not be sure of their role in caring for the patient;
- It helps to trace patients who have defaulted on treatment or are lost to follow up and bring them back to care;
- It allows for family counselling as it is difficult for everyone to attend clinic visits, yet during home visit everyone at home can attend the session.

1.3 Theory of Change

The Teen Clubs Programme did not have a theory of change, but was developed (Diagram 1) by the consultant based on his understanding of what informed the design of the programme. The diagram below shows an abridged version of the theory of change: the blue highlights the key stakeholders – youth and families affected by HIV and AIDS;

healthcare workers at Baylor and at government facilities and patients who miss regular appointments. The Black highlights the activities, which include the Teen Club meetings etc., capacity building and the inreach programmes. The green highlights the outcomes of the programme, while the brown highlights the ultimate goal of the programme. The grey highlights the underlying assumptions of the programme. Although the theory of change was designed just prior to the start of the evaluation, it proved relatively accurate when assessed against the situation prevailing on the ground.

Figure 1


Baylor engages with
in order to
so that there is
ALHIV ultimately become
Youth and families affected by HIV and AIDS
Teen Clubs
Improve adolescent care by maintaining and strengthening Teen Clubs and through U-Report platform.
Improve Adolescent Life Skills and Self-Management through regular empowerment.
Sustain Teen Clubs through trained teen leaders.
Improve health outcomes for ALHIV
Health care workers at Baylor Clinics
Health care workers in government facilities
Capacity building
Deliver quality services to patients through fully capacitated medical staff
Provide accurate diagnosis, care and treatment for ALHIV
Improve quality of care for ALHIV through use of the TB/HIV Hotline
Provide resource materials for running the Teen Clubs
Patients who miss their scheduled clinic appointments or who have issues with taking medication or have psychosocial problems
In-Reach Programme
Conduct social assessments for clients starting ART
Conduct routine home visits to families
Conduct emergency visits to clients with special needs
Improved Adherence for ALHIV.
Increased access to Teen Club activities for ALHIV.
Improved clinical and mental health. outcomes for ALHIV
Reduced stigma against ALHIV and increased. self efficacy among them
Improved quality of care and management of patients ensuring viral suppression.
Strengthened capacity to provide prevention, treatment and care information and services to ALHIV.
Reduced number of LTFU cases
Reduced mortality and morbidity among ALHIV due to intensified HIV testing and linkage to care services
Empowered HIV-positive adolescents living positively and successfully transitioning into adulthood
That parents/guardians of ALHIV are supportive of the Teen Clubs
That adolescents see value in joining the Club
That when health staff are properly trained, they will be able to offer appropriate care for ALHIV
That home visits are effective in reducing LTFU and in addressing social and environmental issues that make it difficult for ALHIV to adhere to treatment

2.0 Purpose of the evaluation

The purpose of the evaluation was to determine the relevance, effectiveness, impact, efficiency and sustainability of the Teen Club initiative in addressing the needs of ALHIV in Eswatini. The evaluation also assessed the extent to which, and under what circumstances, the Teen Clubs for ALHIV achieved their intended objective over the last five years, the period covering the evaluation, and to provide recommendations on how to scale up the initiative and make relevant adjustments in the programme to achieve greater impact.

2.1 Use of the evaluation

The main users of the evaluation include Baylor, Ministry of Health, UNICEF Eswatini and other UN agencies, contributing and other interested donors, NGOs, other stakeholders and partners interested in implementing the Teen Clubs approach. The evaluation is especially important in supporting accountability and learning in relation to the UNICEF Eswatini and Government of the Kingdom of Eswatini Country Programme.

2.2 Specific Objectives

The specific objectives of the evaluation were:

- To provide current status of the functioning of the Teen Clubs, membership (age and sex), type of activities conducted, trained teen leaders (including sex disaggregation) at each site and the management and mentoring aspects.
- To assess the quality of outputs, outcomes and results of the project related to knowledge, attitude and practices among active and former Teen Club members in the four facilities, on issues related to their health and well-being.
- To determine the effectiveness of the Teen Club model in providing support to adolescents in disclosing their status, transitioning between pediatric and adult care and treatment services, acquiring quality HIV information and education, adhering to treatment and adopting safe sexual behaviours.
- To identify key and unique needs of adolescent boys and girls, the differentiated needs of rural and urban based adolescents and whether these were met by the programme interventions.
- To identify key good practices and key lessons learnt, identify gaps, what strategies and interventions to continue and/or discontinue, and to what extent and make recommendations for future improvement based on evaluation findings.
- To determine the extent to which the programme took a rights based approach both in its design and implementation.
- To determine the extent to which the programme factored in gender and equity issues in its design and implementation.

2.3 Key Evaluation Questions

The evaluation used the Organisation for Economic Co-operation and DevelopmentDevelopment Assistance Cooperation (OECD-DAC), UN Evaluation Group and UNICEF evaluation criteria, looking at relevance, effectiveness, impact, efficiency and sustainability. Below are the key evaluations questions that were used. The detailed Evaluation Design Matrix is included under Appendix 10.

a) Relevance assessed the extent to which the objectives of the Teen Clubs programme are consistent with beneficiaries' and country needs, global priorities and are aligned with UNICEF country programme priorities. Evaluation questions under relevance were:

- What is the value of the Teen Clubs in relation to primary stakeholders' needs, national priorities, and national and UNICEF strategies and country programme; international frameworks, including the SDGs, the Eswatini National Development Plan, Natonal HIV/AIDS plan/strategies and the UN Development Assistance Framework (UNDAF).
- What is the relevance of the programme in relation to the UNICEF Strategic Plan, 2018-2021s, Regional Priorities and UNICEF/Government of Kingdom of Eswatini Country Programme 2016-2020?
- Are the activities and outputs of the Teen Clubs programme consistent with the overall goal and the attainment of its objectives and with the intended impacts and effects?

b) Effectiveness

Effectiveness assessed the extent to which the Teen Clubs programme objectives were achieved, or are expected to be achieved, taking into account their relative importance. Evaluation questions relevant to this criterion are:

- Is the Teen Clubs programme achieving satisfactory results in relation to stated objectives?
- What are the major factors influencing the achievement or non-achievement of the objectives?

c) Efficiency

Efficiency looked at the extent to which the outputs of the Teen Clubs Programme have been achieved or are likely to be achieved with the appropriate amount of resources/inputs (funds, expertise, time, equipment, administrative costs etc.) Evaluation questions relevant to this criterion are:

- To what extent were the resources available adequate to achieve the expected outputs?
- To what extent have programme benchmarks and achievements been monitored? To what extent has the programme supported and strengthened the M&E system of Baylor?
- Did the programme use the resources in the most economical manner to achieve its objectives? Were activities cost-efficient?

- To what extent did the the programme take advantage of existing opportunities for synergies?
- Was the programme or project implemented in the most efficient way compared to alternatives?

d) Impact

Impact focused on the positive and negative, primary and secondary long-term effects produced by the programme intervention, directly or indirectly, intended or unintended. Evaluation questions relevant to this criterion are:

- What has happened as a result of the Teen Clubs programme ? What are the results of the programme – intended and unintended, positive and negative – including the social, economic, environmental effects?
- How do the results affect the rights and responsibilities of individuals, communities and institutions, especially the most disadvantaged ones?
- To what extent has the Teen Clubs intervention led to a reduction of inequities?
- What real difference has the activity made to beneficiaries?

e) Sustainability

Sustainability reviewed the extent to which the benefits of the Teen Clubs programme are likely to continue after major development assistance has been completed. It also looked at the probability of continued long-term benefits and whether the interventions were financially sustainable. Evaluation questions relevant to this criterion are:

- What were the major factors which influenced the achievement or non-achievement of sustainability of the Teen Clubs programme?
- Are the activities and their impact likely to continue when external support is withdrawn?
- To what extent do the strategies used by the Teen Clubs programme lend themselves to wider scalability and programme expansion, overall and in specific contexts? Will the strategy be more widely replicated or adapted? Is it likely to go to scale?
- To what extent has UNICEF been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?
- To what extent have interventions supported by UNICEF contributed to (or are likely to contribute to) a sustainably in particular for Adolescents Living with HIV?

a) Equity, Gender Equality and Human Rights Based Approach (HRBA)

In addition to the above OECD criteria, the evaluation determined the extent to which the design and implementation of the Teen Club programme, the assessment of results and the evaluation process incorporate equity, gender equality and a human rights-based perspective. Evaluation questions relevant to this criterion were:

- How well were equity, HRBA and gender equality goals and processes incorporated into the planning documents of the Teen Clubs programme being evaluated?
- To what extent is the Teen Club programme aligned with, and contributes to, national policies and strategies on gender equality?
- How well did the Teen Clubs programme succeed in involving girls and boys, and rights-holders as well as duty-bearers, especially the worst-off?
- To what extent did the most disadvantaged ALHIV benefit in different ways from the programme?

2.4 Evaluation Scope

The evaluation covered the implementation and the results of the Teen Club programme for ALHIV during the period 2012-2017. The evaluation included both rural and urban communities and health facility dimensions of ALHIV Teen Clubs in the three sites of implementation and a fourth site – Siphofaneni, which used to be a Baylor site; management including financing of the programme, gender dimensions of the programme and partnerships leveraged across different stakeholders.

3.0 Methodology

The evaluation used a non-experimental design which tracked outcomes and impact for the target beneficiaries only. The design enabled changes within the ALHIV to be measured. The design was also useful for obtaining information relating to service delivery, extent of reach of the intervention and progress towards objectives. To enhance the design, the evaluation used a variety of quantitative and qualitative data collection methods and sources of information. Highlights of the methodological approaches are outlined below:

3.1.1 Briefing Meeting

At the start of the evaluation, the consultant held a briefing meeting with key stakeholders including UNICEF and Baylor. The meeting provided a broad overview of the programme and helped the consultant to chart a road map for conducting the evaluation.

3.1.2 Literature review

The consultant reviewed
and analyzed pertinent programme documents
and other relevant literature relating to the programme that were provided by UNICEF and Baylor, including Baylor progress and activity reports and Baylor clinic records. Other documents reviewed included national strategy documents for Eswatini, such as the National HIV and AIDS Strategy, National Youth Policy and UN strategy documents such as the UNDAF, the UNICEF
Country Programme Document as well as the Teen Club Manual and other in-house Baylor documents. The consultant also carried out an extensive literature search on the internet focusing on interventions for ALHIV across the world as well as World Health Organisation Guidelines on evidence-based interventions for ALHIV. Literature review was ongoing throughout the evaluation as new documents came to the attention of the consultant. A total of 52 documents were reviewed for the evaluation (see Appendix 9 for List of References). The literature review provided insights into the programme as well as background data that informed the design of the data collection tools and also fed into the key findings. Literature review also provided critical programme data over the evaluation period, enabling the consultant to track positive changes that have happened as a result of the programme.

3.1.3 Key Informant Interviews

Key informant interviews were conducted with stakeholders from UNICEF, Baylor and Ministry of Health. Other key stakeholders interviewed included clinic staff (doctors, nurses, counsellors and social workers) as well as volunteers. Working with a team of eight research assistants, key informant interviews and focus group discussions were conducted at the three sites run by Baylor as well as Siphofaneni, a site that used to be run by Baylor, but is now run by Cabrini, a Catholic development agency.

3.1.4 Focus Group Discussions

FGDs were conducted with adolescents participating in the programme and those who have graduated. FGD participants were divided into two groups by age (10–14 years and 15–19 years) to make it easier to discuss age-specific issues. One FGD was conducted for each of the sub-groups at each of the four sites. FGDs were also conducted with young adults who have graduated from the programme. The purpose of these was to get their perspectives on life after the Teen Clubs and their views on the transitioning process. FGDs were also conducted with parents and guardians of ALHIV to get their perspectives on the changes that have happened to their children which they can attribute to the Programme (see Table 1 for details of FGDs and KAP respondents). FGDs were conducted in Siswati using interview guides and translated into Siswati (see English and Siswati Interview guides for different groups, Appendixes 6A and B through to Appendixes 9A&B).

3.1.5 Knowledge Attitude, Practice and Behaviour (KAPB) survey

A KAPB survey was administered to determine the level of knowledge and to assess the attitude and practice of adolescents in the programme, as required in the Terms of Reference. The KAP was administered to adolescents participating in the programme as well as those who have graduated. Most of the respondents were between the ages of 14–19 years, with 17 year olds making the bulk of the respondents (20.8 per cent)[55] Respondents were selected randomly, but ensuring gender parity.

A total of 106 KAP questionnaires were administered to adolescents in the different age groups as well as to young adults (see Table 1 for detailed breakdown of KAPB participants by age, site and gender). Issues covered in the KAP (which had a total of 69 questioins) included on HIV and AIDS; their participation in the Teen Clubs; SRH; life skills, including communication, leadership and goal setting. The research assistants administered the KAP questionnaires in Siswati. More than 50 per cent of the respondents in the KAPB had been participating in the programme for 4 years and above (51 per cent) while 11.3 per cent have been club members for 1 year and below. Respondents distribution by sex was 37.7 per cent males and 62.3 per cent female. The highest level of education attained by the respondents was secondary level (56.6 per cent), while only 2.8 per cent had tertiary education.[56]

Table 1: Breakdown of FGD and KAP Participants by site, gender and age **r distribution**

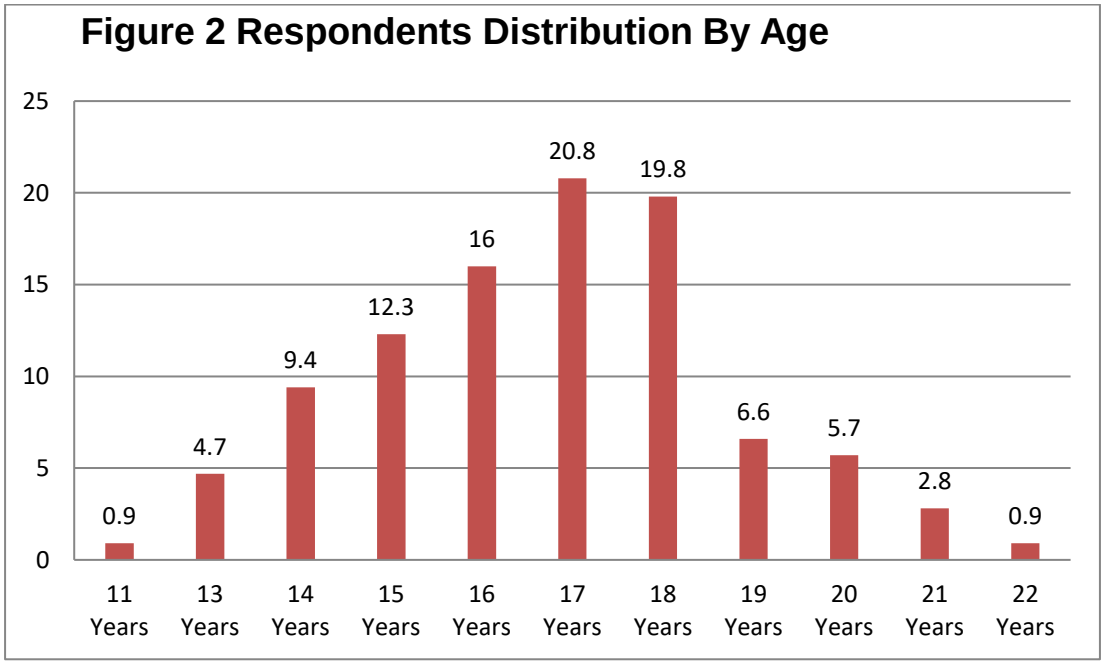
				Male	Female
Mbabane Baylor CEO	ALHIV 10 – 14 years	1	10	5	5
	ALHIV 15 – 19 years	1	10	5	5
	Teen Club Leaders	1	13	7	6
	Young adults 20 – 30 years	1	10	4	6
	Parents/ Guardians	1	10	3	7
	KAP Questionnaire		25	12	13
Manzini Baylor CEO	ALHIV 10 – 14 years	1	10	5	5
	ALHIV 15 – 19 years	1	10	5	5
	Teen Club Leaders	1	6	2	4
	Young adults 20 – 30 years	1	8	3	5
	Parents/ Guardians	1	10	3	7
	KAP Questionnaire		48	12	36
Hlathikulu COE	ALHIV 10 – 14 years	1	12	6	6
	ALHIV 15 – 19 years	1	12	6	6
	Teen Club Leaders	1	8	5	3
	Young adults 20 – 30 years	1	10	4	6
	Parents/ Guardians	1	7	3	5
	KAP Questionnaire		24	13	12
Siphofaneni	ALHIV 10 – 14 years	1	12	6	6
	ALHIV 15 – 19 years	1	12	6	6
	Teen Club Leadeers	1	6	3	3
	Young adults 20 – 30 years	1	8	3	5
	Parents/ Guardians	1	16	6	10
	KAP Questionnaire		9	3	6

[55] KAP Survey Demographic data Appendix 1
[56] KAP Survey Results

Total FGD Participants	**20**	**232**	**107**	**125**
Total KAP Participants		**106**	**40**	**66**

3.1.6 Data collation, Analysis and Report Writing

The consultant collated data from the content reviews, key informant interviews, FGDs and the KAP survey. Data analysis was guided by the key outcome areas, which included analysis to inform: relevance, effectiveness, efficiency, sustainability, replicability, impact, lessons learned and recommendations.



3.1.7 Evaluation Sampling for KAP

Individual KAP questionnaires were administered to current Teen Club members (10-19 years old) and former Teen Club members (20-30 years old). The survey sample was calculated using a margin of error of 5 per cent; confidence interval of 7.01 and response distribution of 50 per cent. This yielded a minimum sample size of 110 individuals which was representative enough for the targeted sites. This sample size was shared among the implementation sites using Probability Proportionate to Size (PPS) sampling.

3.1.8 Training of research assistants

Training of the eight research assistants was conducted to familiarize them with the KAP tool and FGD interview guides. Because the study involved minors, the training emphasised UNICEF's Ethical Guidelines on Research Involving Children. The training also covered issues of quality data collection and, as much as possible, ensuring equal gender participation in all the discussion platforms, including FGDs and the KAP survey.

3.1.9 Ethical considerations

Information pertaining to the study was given to all potential participants. Informed consent was sought. Written informed consent was obtained from each research participant. For young people aged 10-17 years consent was obtained from the parents/guardians prior to the interview dates. Participants were informed about their right to withdraw from the discussions at any stage without penalty, and reassured that refusal to participate or withdrawal during the course of the discussion would not affect their care and access to services, or their work, in the case of service providers. Codes were used to protect the identity and privacy of participants. The consultant prepared a research protocol and used it to apply for ethical clearance from the Eswatini Health Research Review Board and was granted a Research Protocol Clearance Certificate (see Certificte separate attachment).

3.1.10 Quality Assurance

For quality assurance, the evaluation was guided by the United Nations Evaluation Group (UNEG) Ethical Guidelines for Evaluation which specify the need for independence, impartiality, credibity, no conflict of interest, honesty and integrity and accountability.

3.1.11 Data validation mechanisms

Data collected was triangulated with other available data, such as that from Baylor progress reports and UNICEF programme documents and reports. Besides a systematic triangulation of data sources and data collection methods and tools, validation of data was achieved through regular exchanges with both UNICEF and Baylor. The evaluation data was disaggregated by sex, and by age.

3.1.12 Analysis of data or information

Quantitative and qualitative data collected from the key informant interviews, questionnaire and focus group discussion was analysed. Quantitative data, including data from the KAP survey, was analysed using SPSS, while content analysis was used to analyse FGDs and key informant interviews.

3.1.13 Limitations of the evaluation

Although this was an impact evaluation, some fundamental elements were missing that would have made it more comprehensive: no baseline study was carried out at the beginning of the programme, which limited the usefulness of the KAP survey and also made it difficult to compare the before and the after. The programme did not have a theory of change which the consultant would have used to analyse the results chain. Instead the consultant was requested to design a theory of change at the start of the assignment and to use this to guide the analysis.

There was no control group, which is a requirement in an impact evaluation. Although initially it was thought that Siphofaneni Clinic could act as a control, on closer analysis it was found that it had been a Baylor site until 2016, which meant that there would not be much difference in the data considering that the evaluation was going back only to 2012. Although the consultant used the counterfactual, it was only possible to hypothesize what could have been the situation without the intervention given the absence of a control group, to get any evidence for an argument.

4.0 Findings

4.1 Status of the Teen Clubs

Baylor College of Medicine Children's Foundation working with the Ministry of Health, initiated the Teen Club model in 2006. The Teen Clubs operate from three sites – Mbabane Baylor CoE, Manzini Baylor CoE and Hlathikulu COE. Currently the total number of Teen Club members is 462 comprising of 257 female and 205 male adolescents ranging in age from 10 to 19 years among the general membership while Teen volunteers (usually adults who have graduated from the club) can be as old as 28 years. Teen Clubs provide adherence support and learning on HIV, SRH and lifeskils covering a brad range of issues. The clubs are based in communities where the teens reside.

Table 2: Number of Teen Club Members at the three Baylor COE

	Male	Female
Mbabane	60	90
Manzini	81	108
Hlathikulu	64	59
Sub total	205	257
Total		**462**
Source: Baylor COE		

Athough this evaluation focuses on Teen Clubs at the three Baylor sites, there are 81 other Teen Clubs situated at health facilities across the country's four regions that are run along the Baylor model but are supported by other partners, including PEPFAR. Out of the country's 242 health facilities, 201 provide HIV services (including HTC).This means that Teen Clubs coverage is only 40 per cent of the facilities that provide HIV services. According to the Eswatini Ministry of Health 2017 Annual HIV Report, a total of 3742 adolescents are enrolled in health facility Teen Clubs out of the 13000 adolescents estimated to be living with HIV and AIDS countrywide[57]. The Baylor Teen Clubs are run by coordinators working with Teen Club leaders and volunteers (usually Teen Club members who have graduated from the clubs as well as experts who are invited to give a talk on specific topics).

4.2 Relevance

Relevance looked at the extent to which the Teen Club Programme is in line with Eswatini's priorities and policies regarding interventions for ALHIV as well as the needs and priorities of the adolescents and of UNICEF. It was important to assess whether the interventions, which were crafted when the Teen Clubs were first established in 2006, are still relevant given the changing face of the epidemic.

The evaluation established that the Teen Club Programme is still relevant as it addresses the health and psychosocial needs of the ALHIV through various interventions that are designed to improve their adherence to treatment, achieve viral load suppression, address their mental health problems and help them to live a positive life.

[57] Joint United Nations Programme on HIV and AIDS 2015 Data[57]

The Programme is in line with national strategies, including the Eswatini National Youth Policy, which calls for improved access to HIV/AIDS treatment for youth, the integration of Life Skills Education curricula in all institutions, the promotion of school and community-based health clubs and the scale-up of SRH services targeting all youth, to reduce STI prevalence and unplanned pregnancies.[58]

Teen Club activities are also aligned to interventions for adolescents that are advocated for in the National Multisectoral HIV and AIDS Framework for Eswatini, that include the following:

- Actively educate caregivers (including males) on the benefits of ART for children and establish systems to facilitate the linkage of HIV positive children to early initiate on ART.
- Linkage of HIV positive children to early initiate on ART.
- Strengthen adolescent-responsive HIV care and treatment services including a "one stop shop" that offers a range of services from testing to treatment to routine viral load monitoring.[59]

The Teen Club Programme is also relevant as it is in line with World Health Organisation (WHO) guidelines on interventions for ALHIV[60] which address issues of:

- **Disclosure –** this is a precondition for adolescents to join the Teen Clubs
- **Adherence to treatment and retention in care –** this is an outcome of the Teen Clubs
- **Successful transition to adult services –** this is the goal of the Teen Clubs
- **Community-based interventions for ALHIV to support adherence –** these include the In-Reach Programme, which targets defaulting adolescents and their families in their home environment and the family-centred approach, which is premised on the need to involve all members of the family for positive health outcomes for the adolescents.
- **Peer-supported interventions –** the Teen Clubs are peer-led

The Teen Clubs contribute to the achievement of the Sustainable Development Goal Three – "Ensure healthy lives and promote well-being for all at all ages". Particularly relevant to Baylor's mandate for ALHIV and for women of reproductive age, including adolescents, are Targets 3.3 and 3.7 respectively:

- By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
  By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

The Programme also resonates with the Eswatini United Nations Development Assistance Framework (UNDAF) 2016-2020 **Outcome 2.3 – Youths' risky sexual behaviors reduced and citizens' uptake of HIV services increased by 2020.** Under this outcome, the UN system will support treatment, care and support services to combat HIV and AIDS and will also support

[58] National Youth Policy, 2009
[59] The Kingdom of Eswatini National Multisectoral HIV and AIDS Strategic Framework 2018 – 2022

[60] HIV and Adolescents: Guidance for HIV Testing and Counselling and Care for Adolescents Living with HIV

the strengthening of the health sector's capacity to deliver quality HIV treatment, care and support services. The UN will also offer targeted support focusing on three aspects: prevention of new infections, delivery of treatments and support services; and the coordination of the HIV response.[61]

The All- In Agenda recognizes the importance of a holistic, multi-sectoral approach towards addressing risk and vulnerability in adolescents. The All- In strategic framework directs countries to focus on those adolescent populations most at risk of HIV infection or AIDS-related death including: ALHIV, i.e., adolescents with vertically-acquired HIV and those who acquire HIV during adolescence (diagnosed and undiagnosed).[62] By focusing on ALHIV, most of whom acquired AIDS through vertical transmission, the Teen Club Programme meets one of the strategic objectives of the All In Initiative and is therefore relevant. The All- In is anchored on four pillars, two of which are aligned to Baylor's work with ALHIV. These include the following:

- Engage, mobilise and support adolescents as leaders and agents of social change
- Foster innovation in approaches that improve the reach of services for adolescents and increase the impact of prevention, treatment, and care programmes

The fact that the Teen Clubs interventions preceded the All- In Agenda shows the extent to which the Programme has kept to date and even anticipated strategies that are only being adopted globally now.

The Teen Club Programme is also relevant as it is in line with the Eswatini-UNICEF Country Programme which among other things focuses on "adolescent protection, learning and development". In the Country Programme Document (CPD), UNICEF states that "HIV programming will be at the heart of the country programme, as will ensuring an equity focus across all interventions, so that all children have access to quality and inclusive services". This resonates well with the Baylor Programme, where the focus has been on HIV and AIDS care and support for ALHIV as well as on the provision of quality and inclusive services.

The Eswatini Ministry of Health (MOH) has adopted the Teen Clubs approach, using the Baylor model, as a promising practice to enhance adherence to ART among adolescents living with HIV and led the development of Teen Club Guidelines/Manual for use by programme implementers, a clear sign that the Ministry sees a role for the clubs in the country's HIV response.

5.1 Impact

5.1.1 Extent to which the Teen Clubs activities are consistent with the Programme goal

To assess the impact of the programme, it was necessary to separate the outcomes from the impact. For the purpose of the evaluation, outcomes were defined as the time bound and measurable changes that happened to the adolescents. On this basis, the reach of the

[61] Swaziland United Nations Development Assistance Framework 2016-2020
[62] UNICEF (2015) Strengthening the Adolescent component of National HIV Programmes through Country Assessments

outcomes was pre-defined and the scope was similarly limited.[63] Thus for the Teen Club Programme, the outcomes include improved adherence and retention, reduced lost to follow up; reduced viral load to undetectable levels, increased knowledge (about HIV and AIDS, SRH and other lifeskills).

On the other hand, impact was conceptualised as the longer term effect of the outcomes[64]. For example, the impact of improved adherence, viral load suppression and increased knowledge manifests in increased self-confidence and self-esteem; no self-stigmatisation and in the empowerment of the adolescents. Compared to outcomes that tend to be pre-defined and can be measured objectively, the personal experiences and inherently personal nature of impact is intuitively subjective[65].

In the case of the Teen Clubs, the impact of the programme matches its goal, which was "to empower adolescents living with HIV to live positively to successfully transition into adulthood". To a large extent, the Programme succeeded in empowering the adolescents to live positively, although, as will be seen in the report, it was less successful in transitioning them into adulthood.

Text Box 1: How ALHIV have been empowered

- **I have gained confidence and courage to disclose my status** – *ALHIV, 18, female, Mbabane*
- **Joining the Teen Club has made it easy for me to accept my status** – *ALHIV, 16 years, male, Manzini*
- **My self esteem has been boosted and I now feel empowered –** *ALHIV, 18 years, male, Mbabane*
- **I can express myself and talk to other people freely about my status**—*ALHIV, 20 years, female, Manzini*
- **The Teen Club has made me comfortable with the person that I am regardless of the fact that I am living with HIV**, *ALHIV, 17 years, female,*

5.1.2 Empowering adolescents to live positively

From FGDs with the adolescents, it was clear that the Programme has empowered them (see Text Box 1). Through the programme, the adolescents gained self-confidence and self-esteem, which gave some of them the courage to disclose their status. Improved self-confidence also manifested itself in better ability to relate to other people, which was lacking before they joined the clubs. Responses from the KAP Survey mirrored those from the FGDs, where 58.5 per cent of the ALHIV saw the main purpose of the Teen Clubs as being to

[63] Harding A (2018) What is the difference between an impact and an outcome? Impact is the longer term effect of an outcome. http://blogs.lse.ac.uk/impactofsocialsciences/2014/10/27/impact-vs-outcome-harding/(accessed 3rd Jan 2019)

[64] Harding A (2018) What is the difference between an impact and an outcome? Impact is the longer term effect of an outcome. http://blogs.lse.ac.uk/impactofsocialsciences/2014/10/27/impact-vs-outcome-harding/(accessed 3rd Jan 2019)

[65] Harding A (2018) What is the difference between an impact and an outcome? Impact is the longer term effect of an outcome. http://blogs.lse.ac.uk/impactofsocialsciences/2014/10/27/impact-vs-outcome-harding/(accessed 3rd Jan 2019)

empwer them to build positive relationships, followed closely by 38.7 per cent who said it was to improve their self esteem.

5.1.3 Combating Stigma and Discrimination

With the world's highest antenatal HIV prevalence rate (39.2 per cent), Eswatini has also been described as among the most stigmatizing countries in the world.[66] Stigma prevents many people from being tested for HIV or declaring their HIV status. HIV is perceived to be linked with sexual promiscuity and often causes HIV-positive people to be excluded from family activities.[67] A 2014 Micro Indicator Cluster Survey by the Central Statistical Office found 37 per cent of women and 36 per cent of men displaying discriminatory attitudes towards people living with HIV.[68] The 2011 Stigma and Discrimination Index found that self-stigma among people living with HIV remains high.[69] But since joining the Teen Clubs, the adolescents are no longer self-stigmatizing while many of them are also fighting stigma in their communities as the quotes below illustrate:

> "Before I joined the Teen Club, I could not openly talk about my feelings, now I can talk even about my status."—*ALHIV, 19 years, Female, Mbabane*
>
> "I am now able to teach those who discriminate against us that we are still human beings like them even though we have the virus." – *ALHIV, 15 years, Male, Manzini*

The reduced self-stigma, improved self-confidence, acceptance of their status and the positive outlook on life that they gain from the club improves their adherence, reduces their viral load resulting in positive health outcomes. Viral suppression among Teen Club members across all age groups is higher than among non-members, which shows the positive benefits derived from belonging to the Teen Clubs. To this extent therefore, programme impact is closely correlated with the positive outcomes.

Speaking openly about their condition is a powerful tool to fight stigma in the community. As a parent of one of the adolescents in the Teen Clubs aptly said: "People living with HIV and AIDS should be given platforms in their communities to talk openly about the disease. This is a powerful way of modelling positive behaviour as it makes people more receptive to information because the people are known to them and they identify with them. It is also easy for people to reach out to those who openly disclose their status and get more information in informal settings".[70]

[66] Situating Experiences of HIV related Stigma in Swaziland
[67] IRIN News (2012, 12 November) 'Eswatini: HIV stigma still a barrier'
[68] Central Statistical Office (2015) 'Eswatini Multiple Indicator Cluster Survey 2014'
[69] Eswatini Ministry of Health (2014) 'Eswatini Global AIDS Response Progress Report'[pdf]
[70] Parent/Guardian FGD, Mbabane 13/11/18

5.2 Unintended positive impact

5.2.1 Improved school performance

With improved adherence and retention in care better health outcomes and improved self-confidence and self-efficacy. For some adolescents this has translated into better performance at school. While evidence of the better performance was not obtained from the schools, several parents in FGDs indicated positive changes among their children as the quotes below show:

> **"She has been more diligent in taking her pills and has improved in the way she applies herself at school and as a result she has performed extremely well at school."** – parent*, female, Mbabane*.

> **"My child has improved her grades at school and he is now physically stronger."** *– parent, female, Hlathikulu*

School performance was also one of the major concerns among the adolescents themselves and according to the KAP survey, 67.9 per cent of them listed it as an issue they worry about. That school performance ranks above issues such as whether "your friends like you", which was important for only 33 per cent of the adolescents, shows the extent to which the programme is helping them to gain self-worth.

5.2.2 Teaching others about HIV and AIDS

As a result of the self-confidence and self-esteem that the adolescents have gained, some of them have become vocal advocates in the fight against stigma and discrimination in their communities and schools and in raising awareness about the disease. Some also use the knowldge they gain from the Teen Clubs to (a) encourage others to go for HTC; (b) provide correct information on HIV and AIDS and dispel myths about the disease; and, (c) encourage adherence among other ALHIV.

The quotes below show how Teen Club members have been empowered not only to accept themselves and their status but to reach out to others:

- **"They mentored me to disclose my status. I am now empowered and can stand my ground and teach others about HIV'** *– ALHIV, 17 years, male, Manzini*
- **"At school, most people do not understand about HIV, so we teach them and disclose our status freely"** *– ALHIV, 15 years, female, Mbabane*
- **"I'm able to help those who default on treatment to take their medication consistently" –** *Young adult LHIV, 22 years, male,* Hlatikhulu
- **My child is a peer leader, she spoke to her teachers about her condition and has now been nominated to speak at the school once a month about the condition. She educates other children** *– parent, female, Mbabane***.**

Two Teen Club leaders in Manzini explained how they have been visiting schools talking about their condition and explaining about HIV and AIDS. They recently approached the national

broadcaster to give them a slot on radio where they can talk about HIV and AIDS. As people living with HIV, the young adults are effective advocates against stigma and discrimination as they are prepared to speak openly about their status: **"We want to make the lives of the next generation of HIV positive adolescents easier than ours. We want to promote youth to youth education,"** one of the young adults said.

Some of the adolescents are involved in national events, including the National AIDS Day, where they organised a walk to raise awareness:
"As Teen Club members we are more active in the Teen Club activities and can organize such activities. For example, last year we organized a walk to raise awareness on HIV and AIDS." – *19 year old young adult, Manzini.*

5.3 Unintended Negative Impact

5.3.1 Disclosure exposes ALHIV to stigma and discrimination

Because of the high levels of stigma and discrimination prevailing in Eswatini, in some cases the benefits of disclosure can be outweighed by the negative repercussions. In FGDs, both adolescents and some parents expressed their disquiet at the level of stigma and discrimination targeting the adolescents, which discourages disclosure. The quotes below show the dilemma faced by adolescents who have disclosed:

- **"Family members are very discriminatory and at times they make sarcastic remarks about her constantly taking of medication"** – *parent of ALHIV, Manzini.*
- **"If you disclose you sometimes find yourself with no friends, they discriminate against you" –** *ALHIV, 12 years, male, Hlatikhulu*
- **"Some people do not want even to touch you or share anything like clothes with you. They think they will get HIV"** – *ALHIV, 14 years, female, Manzini*

6.0 Effectiveness

Effectiveness looked at the extent to which the Teen Club Programme achieved its objectives. Because effective interventions led to positive health outcomes, the evaluation linked effectiveness with programme outcomes. Among the successes of the Teen Clubs were the following :

- Teen Clubs contributed to higher retention in care and consequently to an increase in Teen Club members with undetectable viral load who have been on ART for six months or more (see Table 3).

The clubs provide a platform for adolescents to discuss SRH issues that they cannot talk about at home such as teenage pregnancy, sexually transmitted infections (STIs) and contraception.

Table 3: Number and Per centage of ALHIV on ART for 6 months or more with undetectable viral load disaggregated by gender					
Reporting period	**Target**	**Male**	**%**	**Female**	**%**
March 16th to Aug 2017	**90 %**	**362/422**	**86 %**	**403/449**	**87 %**
March 16 to 31st Jan 2018	**90 %**	**383/446**	**86 %**	**378/429**	**88 %**
1st July –31 July 2018	**90 %**	**407/461**	**88.3 %**	**341/390**	**89.8 %**
Source: Baylor Clinic records					

6.1.1 Disclosure an entry ticket into Teen Clubs

Within the Teen Clubs, disclosure is encouraged and is a requirement for joining the Teen Clubs, the reason being that only those who know their status can benefit from the Teen Clubs. HIV disclosure works at two levels – full disclosure by the parent/guardian to the adolescent and disclosure by the adolescent to those they choose to disclose. Adolescents who participated in the KAP survey appreciated the importance of disclosure with 72.6 per cent indicating that if you disclose to someone they will remind you to take your medication, while 27.4 per cent indicated that once you disclose you will be able to talk freely about your condition to the person you would have disclosed to. The importance of disclosure was also highlighted in FGDs with adolescents at all three sites as the quotes below show:

- **"They mentored me to disclose my status and I am empowered to stand my ground and teach others about HIV",***ALHIV, 15 years, female, Mbabane*
- **"At school, most people do not understand about HIV, so we have managed to teach them and disclose our status freely",** *ALHIV, 14 years, male, Hlatikulu*
- **"We are empowered about how to disclose our HIV status to our friends and to others"***, ALHIV, 16 years, female, Manzini*

6.1.2 Adherence to ART

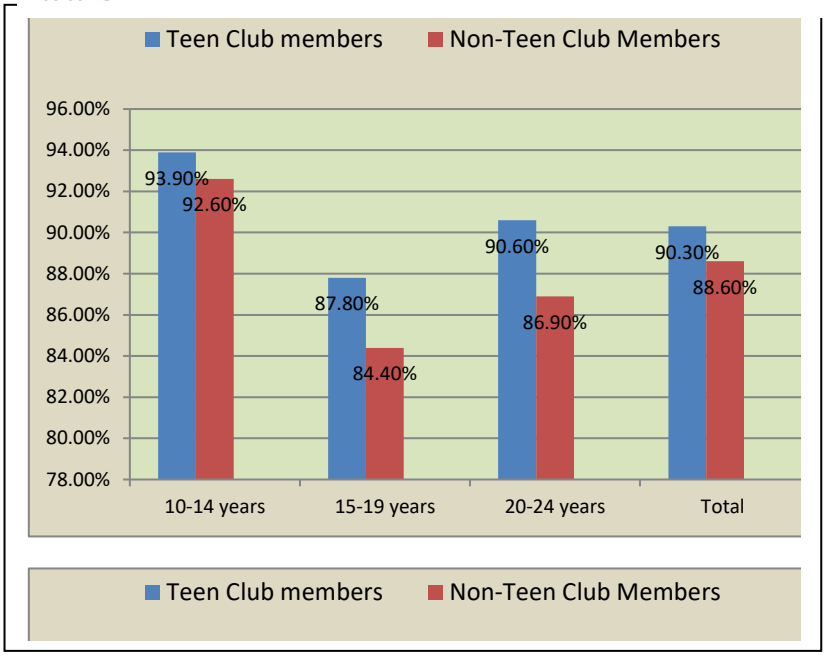
Adolescents interviewed at all the three Baylor sites said their adherence had improved markedly since they joined the Teen Clubs. Asked what was the biggest benefit they had derived from joining the Teen Clubs, almost all adolescents across the different age groups said the clubs had helped them achieve better adherence. The responses below, from FGDs with ALHIV in Mbabane, were repeated in FGDs at all sites with only slight variations:

- ***"We learn many things about the treatment and good adherence"*** *– ALHIV, 12 years, Male, Mbabane*
- ***"I learnt about the importance of taking the pills and what they are for****" – ALHIV, 13 years, female, Mbabane*

Over time, the Project has contributed to an increase in the number of adolescents with undetectable viral load as Table 5 shows. The positive change has been particularly marked among the females with the per centage of those with undetectable viral load rising from 87 per cent in 2017 to 89.8 per cent in July 2018, just 0.2 per cent[71] short of the 90 per cent target.

The improved adherence among Teen Club members in turn resulted in better health outcomes. There is a significant difference in viral load suppression among adolescents receiving care at the three Baylor sites between those who are members of the Teen Clubs and those who are not, with Teen Club members outperforming non-Teen Club members across all age groups (see Figure 3). To that extent therefore, the programme has been a major success and has made a difference in one of its key outcome areas – adherence leading to viral suppression.

Figure3: Viral Load Suppression among Adolescents Receiving Care at Baylor COE, Mbabane



In a country with the highest HIV and AIDS burden in the world, the Teen Clubs are an island of hope as they are contributing to the achievement of the 90-90-90 targets which specify that:

- 90 per cent of all people living with HIV should know their status
- 90 per cent of all those who are diagnosed HIV positive to be on sustained antiretroviral treatment (ART).
- 90 per cent of those on ART having an undetectable viral load.

As a condition for enrolling in the Teen Clubs, adolescents must know their HIV status and it should have been disclosed to them; all Teen Club members are on treatment and they are close to attaining the 90 per cent viral load suppression[72].

6.1.3 Increasing knowledge among ALHIV

One of the achievements of the Teen Clubs is the extent to which they have increased knowledge levels among ALHIV on HIV and AIDS. The Teen Club Manual, the main tool used in the trainings, focuses on issues such as disclosure, adhrence, stigma and discrimination and also touches on SRH. The manual also deals with issues of leadership, team building and child

[71] Baylor Mbabane Clinic Records
[72] Baylor College of Medicine Children's Foundation Swaziland (Aug. 2018) Activity Report: Support for Adolescents Living with HIV

rights among other topics. Equipping the ALHIV with knowledge enables them to understand and appreciate their condition and also to develop other skills that helps them to cope with the different situations they face. In both FGDs and in the KAP, adolescents showed how their increased knowledge put them at an advantage over others. As the quotes below from FGDs with adolescents show:

- **"I am not scared about life, we are empowered through the lessons we learn from the club"** *– ALHIV, 14 years, Female, Manzini*
- **"We are taught to follow our dreams and set goals in life"—***ALHIV, 12 years, female, Hlathikulu*

The increased knowledge about HIV and AIDS results in positive health-seeking behaviour. For instance, asked if they would stop taking ARVs when they feel completely well 97.1 per cent of the adolescents in the KAP Survey said they would not stop. Equally 92.5 per cent of the adolescents were aware that ART must be taken for life.[73]

6.1.4 Reducing LTFU – through the In-Reach Programme

The In-Reach programme works with a social worker to identify adolescents who would have defaulted from treatment and brings them back to care. When the programme started in 2011, LFTU at Baylor clinics stood at 10 per cent but it has now gone down to about 0.2 per cent[74]. The In-Reach programme is effective as it also exposes issues that health staff would otherwise not be aware of. For instance, in some households the In-Reach team found that there was a drug or alcohol abuse problem with the caregiver, which made them unsuitable as primary caregivers for the child. The programme has helped Baylor staff to understand the environment in which their patients live and in that way, how to help them. The In-Reach is one of Baylor's success stories, as it has reduced lost to follow up and recruited adolescents to the Teen Clubs. According to Baylor, retention care for ALHIV currently stands at 96 per cent,[75] which is high by any standards and speaks to the efficacy of the programme.

6.1.5 Improved access to health and to SRH services

Being a member of the Teen Clubs has impacted positively on the rights of the adolescents to health as all Teen Club members are enrolled on treatment. Teen Club members also have access to SRH, including family planning, condoms, STI treatment and cervical cancer screening. The increased SRH knowledge among the ALHIV was reflected in the KAP Survey where 86.8% respondents agreed (47.2-strongly agree; 39.6-agree) that they were positive to able to handle the changes that their bodies go through as they grow up.

To facilitate adherence, Baylor provides money for transport to adolescents who would otherwise not be able to access health services because they do not the have money. This

[73] KAP Survey Results Appendix One
[74] Baylor Progress Report July 2018
[75] Clinic records Baylor (covering all three sites)

ensures that they can enjoy their right to health while at the same time it contributes to a reduction in inequity.

6.1.6 Improved mental health of ALHIV

Mental health is a critical and neglected global health challenge for adolescents living with HIV, which is largely misunderstood and not addressed. Mental health disorders including depression and anxiety are more common among perinatally HIV-infected adolescents vs those who are not infected.[76] Adolescents living with HIV have a greater risk of psychiatric hospitalization compared to those not living with HIV.[77] A similar situation confronts adolescents under the care of the three Baylor COE who are experiencing a relatively high rate of mental health problems. Mental health problems can lead to depression, which in turn can result in the adolescents defaulting on treatment. In severe cases it can lead to suicide or to suicide ideation.

According to one of the Medical Doctors at Baylor Clinic Mbabane, at least 15 per cent of the adolescents at their three facilities are experiencing "mild to severe levels of depression".[78] To address the problem, the Programme has introduced the mental health tool – PHQ9 a screening tool to assess depression, which is the most common condition facing ALHIV. For the adolescents, the tool has been modified for pediatric care.

The mental health programme was introduced in 2017 and Baylor admits that it is not yet strong. One of the reasons is that mental health is a relatively new intervention for Baylor and coverage is still very limited as the tool has so far only been administered on adolescents experiencing adherence problems. This is despite the fact that many adolescents and young adults who might appear self-confident and secure could be experiencing mental health problems.[79] By December 2018, only 108 adolescents had been screened for mental health, which was still short of the targeted 300 adolescents targeted.[80]

Text Box 2: Suicide ideation

"Sometimes once people know my status it happens that I begin to have fears and begin to feel like death is the only solution. It helps a lot to talk to the Teen Club staff and colleagues because it brings hope and comfort." - ALHIV in FGD, Mbabane

Perinatally infected ALHIV often express anger against their mothers for infecting them with the virus. In many cases, they also turn the anger against themselves by refusing to take their medication or turning to drugs and alcohol. This results in them defaulting on treatment. The mental health programme can help to identify the source of this anger and help both the parents and the adolescdents to address it.

[76] Vreeman RC, McCoy BM, Lee S Mental health challenges among adolescents living with HIV. *J Into AIDS Soc.* 2017;20(Suppl 3):21497.
[77] Mellins CA, Brackis-Cott E, Leu C-S, et al. Rates and types of psychiatric disorders in perinatally human immunodeficiency virus-infected youth and seroreverters. *J Child Psychol Psychiatry.* 2009;50(9):1131-1138.
[78] Key informant interview with Dr Mafulu Mundende, RFM Manzini
[79] Key informant Interview with Dr Mafulu Mundende, RFM Manzini
[80] Baylor College of Medicine Children's Foundation, Swaziland: Activity Report March 28, 2018

6.1.7 Using ICT to communicate with ALHIV

Young people across the world now make extensive use of Information Communication Technology (ICT), through social media, so it is important to communicate with them using their preferred modes of communication. UNICEF, working with Baylor and other partners, has set up the U- Report, which is an SMS platform that enables adolescents to ask questions about their health. Currently 273 Teen Club members have joined the platform, which operates under a different code for Baylor Teen Clubs and other ALHIV in the country, where is it called *Simjojo*. Although the *Simjojo* platform has great potential to attract a huge following, it has been experiencing some teething problems which made it lose some of the initial followers. In FGDs, some adolecents pointed out that there had been late reponses or no responses to querries, while they did not think some of the issues discussed on the platform were relevant. However, despite the glitches, the platform has been effective and according to a social worker at Baylor, she was able to avert a suicide through the platform, when an adolescent girl sent distress messages across.[81]

6.1.8 Capacity building

A critical component of the Baylor initiative is capacity building on pediatric care, not only for Baylor staff but for health staff across the country. Baylor receives funding from EGPAF to provide technical support and capacity building for health staff. Currently Baylor doctors have 20 high-volume sites that they visit regularly to mentor the doctors and nurses on pediatric care. Capacity building also includes training of nurses who run Teen Clubs on youth friendly services. Nurses are also mentored on how to identify treatment failure as well as nurse-led initiation on ART.

6.1.9 Providing a Comprehensive package of care

The Teen Clubs should not be seen in isolation from the other supporting interventions, without which they would be less effective. These include the In-Reach Programme, which identifies adolescents lost to follow up and brings them back to treatment; the Challenge Clinic, which works with the families of adolescents experiencing adherence problems and the mental health programme, that addresses mental health problems faced by ALHIV, which impact on adherence. While these interventions are not directly linked to the Teen Clubs, they have a strong bearing on the performance of the clubs and without them, the effectivess of the Teen Clubs would be highly compromised.

Text Box 3: Addressing HIV and AIDS in communities with a gender lens

Community leaders need to focus more on male involvement, because most HIV cases are detected among women who are tested when they are pregnant. Men are generally afraid to address physical health issues. In community meetings the gender aspect of addressing HIV and AIDS should be considered. It should always be the first item on the Agenda to ensure that the targeted groups can be reached because if it is put at the end when important issues have been discussed people will leave. Many people are still very ignorant about HIV and AIDS, seeing the disease as something very far and not affecting them. We need come up with an aggressive way to address it. If it becomes important at community level the message will trickle down into the family set-up.

[81] Key informant interview with Baylor Social Worker Mbabane

7.0 Efficiency

In looking at eficiency, the outputs – qualitative and quantitative – were measured in relation to the inputs to assess whether the Teen Club Programme used the least costly resources to achieve the desired results. Alternative approaches to achieving similar outputs were also compared to see whether the most efficient process had been adopted. However this proved difficult as similar interventions targeting adolescents have different cost structures.

The Teen Clubs have been very successful in improving adherence, reducing viral load and achieving viral suppression. The majority of adolescents who join Teen Clubs are defaulters or adolescents with low viral load suppression but after joining the clubs, their adherence improves and they achieve viral load suppression. If one were to make an investment case for the Teen Clubs, one would look at what would be the cost of care for an adolescent who defaults on treatment and is LTFU compared to recruiting them to the Teen Clubs and putting them back on treatment. Investing in bringing defaulting adolescents back to treatment through the Teen Clubs is not only cost effective, but also saves lives. One can also take the counterfactual analysis on the cost of treatment if the ALHIV remained as a defaulter and had to be put on second or third line treatment.

The Baylor Teen Club model is a cost effective intervention that capitalizes on internal synergies to deliver a well integrated programme for ALHIV. Through the In Reach Programme and the Challenge Clinic, the Programme brings adolescents LTFU back on treatment. This is done through home visits by the social worker and by opening dialogue between the caregivers doctors, nurses and the social workers. While initially it was envisaged that the In Reach programme would also include a doctor, nurse and social worker, this has proved not viable and as a result only the social worker carries out home visits. This has reduced costs, while still maintaining the quality of the intervention.

Apart from salaries that are met by Government, one of the big expense items of the programme is the provision of food and transport reimbursements to adolescents on the Saturday that they meet once a month. To reduce food costs, Baylor has secured food from well wishers – from a hotel, for the adolescents in Mbabane and from Community Care Point in Manzini who provide a snack in the morning before the teen club meetings. These strategic partnerships have reduced the costs of hosting the Teen Club meetings, making them more cost effective.

The Programme relies heavily on volunteers, some of whom help with logistical arrangements, while others are resource people who come to give talks on particular topics to the adolescents ~~for free~~. The Teen Club leaders are also not paid, although they are responsible for most of the peer to peer learning in the clubs. These are all cost saving measures that also enhance national ownership of the programme.

In terms of cost sharing, Government is the largest contributor to the Teen Clubs, contributing 90 per cent of costs, which are mainly in salaries for staff, including for Teen Club Coordinators.

UNICEF's contribution is focused on strategic interventions, including the In-Reach Programme, capacity building of health personnel, equipment for the Teen Clubs as well as for the mental health component. UNICEF also provides the equipment that the adolescents use for games.

8.1 Sustainability

Sustainability can be defined as the ability to maintain the positive impact of a programme, once that programme has achieved its objectives. Looking at the Teen Club Programme, the question to ask is what is the programme's positive impact? One can say that it is ensuring continued adherence among ALHIV and maintaining viral load suppression among those who are still in the programme and those who have graduated out of the programme. In interviews with young adults who graduated, all of them said they remained virally suppressed, so to this extent the programme's key objective has been met, making it sustainable.

Another measure of sustainability is the extent to which the programme has been institutionalized. The Ministry of Health has adopted the Teen Clubs approach using the Baylor model as a promising practice to enhance adherence to ART among adolescents and led the development of Teen Club Guidelines for use by programme implementers. Although the staff running the Clubs at governmnent facilities are government employees, there is no specific budget line in the national budget for Teen Club activities. But considering that the annual unit cost of the programe is US$ 78.9 (Emalangeni 1,093.00) and government pays 90 per cent of Teen Club costs through staff salaries, the remaining ten per cent is a cost that the government could be able to cover.. Outside the Baylor Teen Clubs there are 81 other Teen Clubs all supported by donors, including PEPFAR. But like the Baylor Clubs, Government is also paying salaries for the staff running the clubs, which accounts for the bulk of the costs. There is therefore need to advocate with Government to take over the remaining costs so that the programme becomes wholly nationally funded.

The fact that the Baylor Teen Club model has been scaled up across the country where 81 other clubs have been set up is a clear sign that the model has been seen to have positive benefits on ALHIV in particular in enhancing adherence and viral suppression, contributing to the overall sustainability of the Programme.

A pull factor for the Baylor Clubs is the food and refreshments as well as transport reimbursements provided to adolescents who attend Teen Club meetings. On the other hand, the Teen Club in Siphofaneni, which used to be run by Baylor but is now managed by Cabrini, with funding from PEPFAR no longer provides food or transport reimbursements. Many adolescents say they will no longer come if there is no food or transport money[82]. Subsequently a key question should be asked whether the Baylor Clubs model can be sustained if the food component and transport reimbursement components are removed.

Teen Clubs rely substantially on volunteers to run their activities. The volunteers include young adults who have graduated from the programme and subject matter experts who come to give talks on different topics. There is a very low rate of attrition among the volunteers, most of whom

[82] FGD with Adolescents Manzini 12/11/18

are motivated by their love for children (among those who come in as resource persons) and by their desire to remain connected to the clubs (among those who have graduated from the programme). Volunteers reduce the costs of running Teen Clubs by doing some of the work that would otherwise be done by fulltime staff. The concept of volunteers enhances the scope for the project's sustainability going into the future.

8.1.1 Replicability

The Teen Club Programme has shown itself to be replicable as 81 other Teen Clubs, serving a total of 3,742 adolescents have been established across the country all following the Baylor model. The establishment of these Teen Clubs is a clear sign that (a) there is political will to support the programme; (b) the model has been seen to be effective; (c) it is a cost effective intervention; and, (d) there is sufficient skilled personnel for operationalization. The political will on the part of Government to support the Programme is a critical component to its long-term success and sustainability. Although international partners such as UNICEF, PEPFAR and ICAP are funding Teen Club activities, Gvernment pays staff salaries who run the programme, which is the biggest cost that also makes the programme replicable. Based on this assessment, one can conclude that the programme is replicable in its current form.

9.1 Gaps and challenges

9.1.1 Over emphasis on adherence

While adherence is of critical importance to the ALHIV as it is the main rationale for the formation of Teen Clubs, the evaluation noted that an over-emphasis on this component, at the expense of other equally important topics in the manual, could affect adherence by ignoring other topics that can empower the adolescents and strengthen their coping strategies.

9.1.2 Empowering parents through support groups

Since the Teen Clubs were formed, there has been recognition of the importance of family support for ALHIV and realization that while Teen Clubs are important, they could only play the role of surrogate family to ALHIV and that for better adherence, there was need for a more supportive home environment. To create a supportive home environment, there is need for the parents/caregivers themselves to be empowered through knowledge and psychosocial support.

In FGDs, parents suggested that the Programme should set up support groups that would equip them with knowledge so that they are on the same level with their children and are also better equipped to support their children. The support groups would also provide mental health services to parents, some of whom cannot handle the stress of taking care of their sick children. Currently UNICEF supports the Baby Club, a support group for parents of children aged 0-2 years old who have HIV. This could be expanded to also cover parents of the adolescents. Baylor recognizes the need for setting up support groups for parents.

9.1.3 Addressing social determinants of adherence

Poor adherence is often blamed on the adolescents alone, but in Siphofaneni, a largely rural community, adolescents face other problems that are poverty-related, such as shortage of food, which makes it difficult for them to take their medication. They also don't have money for transport to come for refills: "The difference here is that the children are already marginalised ... whether they are single or double orphans and in child-headed household.," says the nurse in charge of the Siphofaneni clinic, Sister Dumisile Gwebu.

In Eswatini, the relevance of both social protection and child protection are heightened by the high poverty prevalence, including among children. Despite its classification as a lower-middle income nation, 58.9 per cent of Eswatini's population still lives below the poverty line. The Eswatini poverty rate is attributed to multiple factors, including stalled economic growth, severe drought, unequal distribution of wealth, high unemployment and a high rate of HIV/AIDS[83],[84]. Poverty disproportionately affects children with a total of 69 per cent of children classified as poor, while 71 per cent are orphaned or vulnerable[85]. Although Eswatini spends about 1.6 per cent of its GDP on social safety nets – close to the global average of 1.5 per cent [86] - this is insufficient to cater for vulnerable children and poverty continues to stalk ALHIV, especially in the rural areas.

Text Box 4: Doing things differently

"Older adolescents want something that speaks to their age. They want to understand the stage in life they are at. They want to be treated as adults. They don't want to be mixed with the children.... Being 19 and above you start worrying about money, employment... Baylor should help them with life skills... handicraft etc. Find out from them what kind of skills they have and support them in those skills. They don't want to be singing and dancing all the time. The skills programme can incorporate issues of adherence etc*. (FGD participant, Mbabane*)

Partly because of the poverty, the clinic recently reported a spike in the number of adolescents whose viral load had gone up. Betwen July and November 2018, the clinic recorded 16 cases of adolescents whose viral load had gone up out of the 72 registered at the clinic[87]. According to the sister in charge, many of those with the high viral load are also defaulting.

To address this problem, there is need for a more integrated approach to addressing adherence among ALHIV that takes into consideration the socio-economic environment in their homes that make them default such poverty and the resultant lack of food, lack of money for transport for ART refills. Such an approach would aim to strengthen the social safety nets for the indigent.

9.1.4 Transitioning into adulthood

[83] The Norgen Project (2017) AUG 2017 The Swaziland Poverty Rate

[84] The Borgen Project (2017) Poverty in Swaziland
[85] UNICEF (2017) Social Protection Budget Swaziland 2017/2018
[86] World Bank Group (2018) The State of Social Safety Nets 2018
[87] Siphofaneni Clinic Records

While the Teen Club Programme has been successful in helping ALHIV to live positive lives, it has been less successful in helping them to transition into adulthood because there is no specific intervention that prepares them for skills development, employability and coping without the structured psychosocial support provided in teen clubs. In FGDs, young adults felt that the programme was not equipping them with the requisite skills to enable them to transition smoothly into adulthood. Baylor's Programme Manager admits to the weakness of their intervention and says "the programme has not done anything" to prepare young people for adulthood: "The transition was neglected. Baylor management are cognizant that this is a gap, and have begun discussions on the development of a programme to prepare young people for transition out of the programme into adulthood. The best would be to come up with a programme that caters for young adults". There are several reasons why the young adults are not happy with the transition process. They feel that:

- The Teen Clubs do not prepare them sufficiently for life outside the sheltered environment that the Club provides:
  "**I am not happy about the weaning process because we are not given information and empowerment for the life outside"** – *young adult, 23 years, male, Mbabane*
- **"Please empower us how to handle mental and emotional issues that we are likely to experience as HIV positive young adults" –** *young adult, 22 years, female, Manzini*

- They feel that the transition is too abrupt:
  - **"Weaning should be a process not a sudden termination without preparation for life after the Teen Club"** – *young adult, male, 24 years,* Hlatikhulu*.*
- They need other supporting structures to lean on when they graduate from the Teen Clubs:
  - **"We must exit from one club to another rather than to be left alone out there"** – *young adult, 22 years, female, Mbabane*
  - **"Baylor should help us form a support group for graduating teens".**
- The Teen Clubs are not just a place for the young people to meet, but have become more central to their lives:
  - **"The Teen Club is like a family to us. Imagine if all of a sudden you are expected to leave your family and never come back. It hurts"** – *young adult, 20 years, female, Mbabane*

The lessons they are taught are too narrowly focused on HIV and AIDS:

- **"The only thing we know is adherence, disclosure and prevention of HIV spread"** – *young adult, male, 25 years, Manzini*
- **"Please empower us on general life on the outside world instead of just focusing on health-related issues"** – *young adult, female, 22 years, Manzini*
- **"We need skills like using computers, typing etc. rather than always repeating the same information on adherence and living with HIV"** – *young adult, female, 20 years* Hlatikhulu,

The over-emphasis of the Teen Club meetings on HIV education, disclosure and adherence was confirmed in the KAP survey where they were mentioned by 92.5 per cent of the

respondents as the most discussed topics, followed by sexual reproductive health, which was mentioned by 25.5 per cent of the respondent.

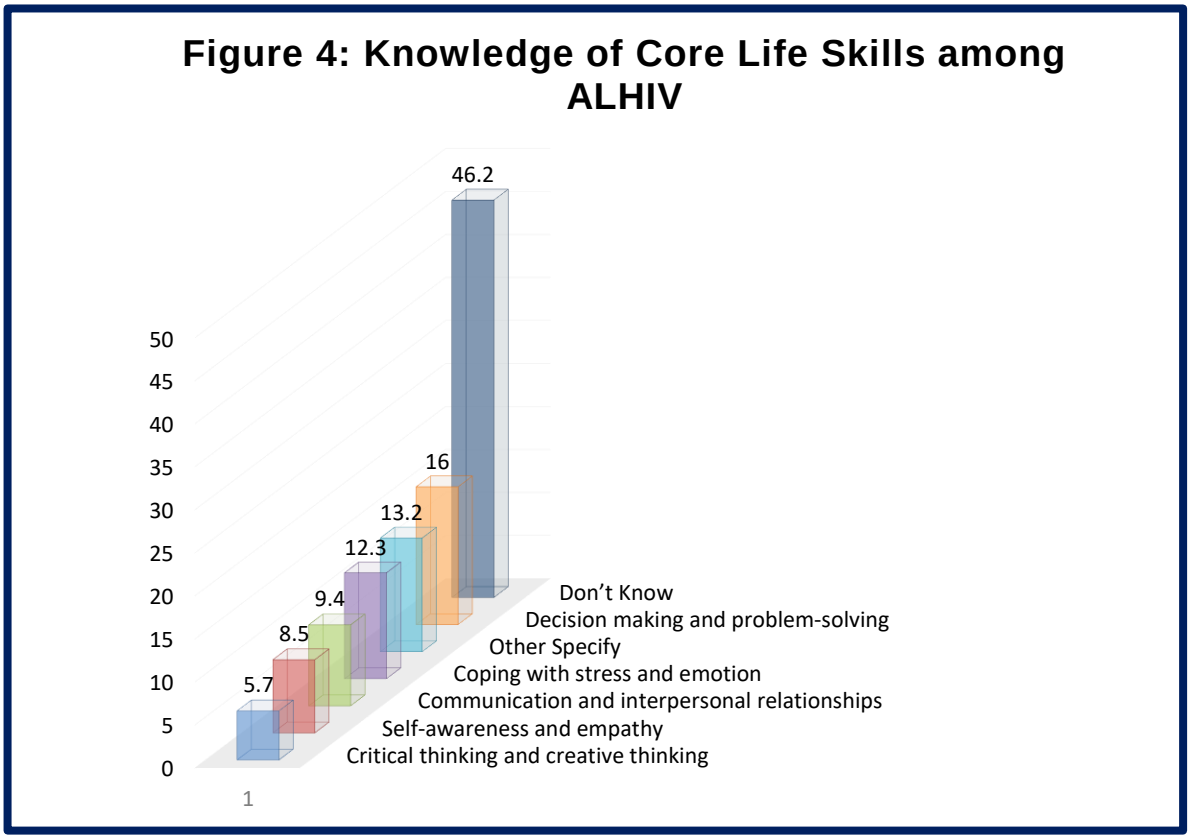


Figure 4 from the KAP Survey confirms the skewed nature of the trainings, with almost half the adolescents 46.2 per cent, saying they are not aware of any core life skills. The core life skill most mentioned by respondents were decision making and problem solving (16 per cent) while critical thinking and creative thinking were mentioned by only 5.7 per cent of the respondents.

9.1.5 Additional support for young adults

The Baylor doctor in charge of the Manzini Programme, says most adolescent deaths across the three sites occur between the ages of 19-22 years as some of them can go for up to six months without taking medication and these are the same young adults who would have graduated from the Teen Club Programme. He thinks that setting up young adults support groups is important to reduce mortality: "When they are under 18, their adherence is good, but once they are over that age, they are a problem. When they leave the Teen Club, they are considered adults and nobody follows them up. It might be better to keep them in the young adults club until they are 22 to 23 years of age. The transition will be smoother. In the past the transition has been too abrupt," he says.

Given this perspective, it becomes clear that young adults need additional support to transition successfully into adulthood. At the same time, there is also need to consider other factors that

make it difficult for the adolescents to transition successfully into adulthood that are beyond the scope of the Programme. For instance, according to both the young adults themselves and Baylor, young adults who go into tertiary education from the Teen Clubs do not experience the same sense of alienation and estrangement when they leave. This is because they have something that fills their lives.

On the other hand, young adults who have dropped out of school and are unemployed experience a sense of isolation and loss when they leave the Teen Clubs (from their own testimony). In 2017 youth unemployment in Eswatini stood at 54.78 per cent,[88] - and is probably higher among ALHIV – which means that the majority of young adults, including HIV negative ones, could be experiencing similar frustrations. Many ALHIV are either single or double orphans while others live with a step parent and do not have a supportive home environment. When they are transitioned from the club, they therefore feel abandoned because it had become like the family they never had.

In addressing transitioning therefore, it will be necessary to take these factors into consideration to ensure that an appropriate response is designed that addresses their needs. For instance, there might be need to link up the young unemployed adults with organizations that provide income-generating skills to ensure that they are productive and can earn a living. According to a Teen Club Coordinator at Baylor, there is also a need to add a module on transition to adulthood onto the Teen Club curriculum as some of the "Teen Club" members are over 30 years old and need to be equipped to stand on their own.

9.2 Extent to which the clubs assist young adults to engage in relationships, initiate sexual activity, consider marriage and starting a family

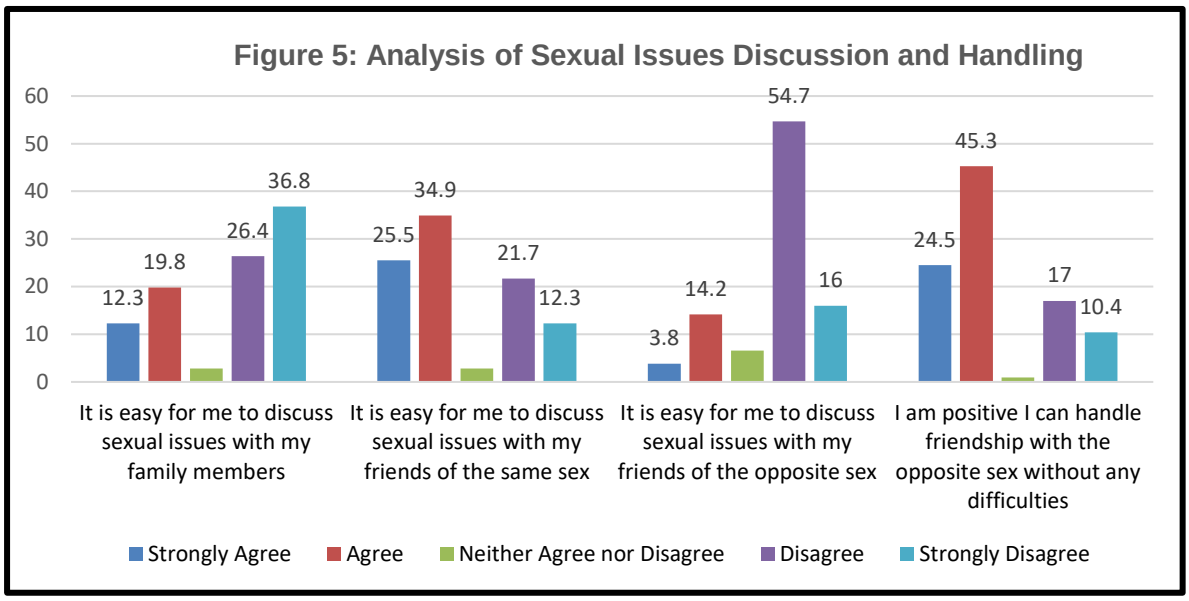
As young adults, transitioning involves engaging in relationships and starting a family. From the FGDs with young adults however, it would appear that this is another area where they are poorly equipped. The majority of young adults interviewed were not comfortable getting into relationships where they would disclose their status to their partners out of fear of rejection. Several of them spoke from their own experience of how they had been rejected after they disclosed their status as the following quotes show:

- **"I have a lot of fears when I think about the possibility of starting a family because people cannot be trusted. I may get hurt in the process".** – *Young male adult, 24 years, female, Mbabane*
- **"I think of having my own family one day but I once disclosed and I was dumped by my boyfriend"***—young female adult, 22 years, Mbabane.*
- **"Marrying an HIV negative person may come back to haunt you because the HIV negative partner may feel he is doing you a** *favour" – young female adult, 21 years, Mbabane.*

The responses above are from an FGD with young adult participants. With only one exception out of a group of 10, the rest were not positive about starting a family. This shows the deep seated fear among young adults – most of whom were members of Teen Clubs for between

[88] The World Bank

seven to ten years – of being rejected because of their status. The responses show that being members of Teen Clubs for that many years was not enough to dispel or allay their fear of getting hurt in relationships. The apprehension is real as three of those in the group who disclosed their status to their boyfriends who ended the relationship.



The views from FGDs were reinforced by the responses from the the KAP Survey Figure 5, where a large proportion of the adolescents (70 per cent) said they find it difficult to discuss sexual issues with friends of the opposite sex.

Baylor is coming up with several initiatives to address the gaps in the transitioning process. These include setting up support groups for young adults and supporting the unemployed to get basic skills to enable them to make a living. Baylor assisted a group of young adults to set up a cleaning company and is now assisting them to market their services. Baylor tried to interest the young adults to join a micro-finance scheme that was set up for caregivers, where they make fabric softener for sale, but the young adults were not interested saying this was for old people. It is evident adolescents are motivated by different elements; jobs and entrepreneurship – this should guide how the programme comes up with a strategy on skilling young people, for the market. Despite their low education levels, many of them aspire for the more attractive jobs for young people such as in computers. But currently Baylor does not have sufficient financial resources to run support groups for young adults or to equip them with practical skills but is fundraising for the interventions.

10.1 Monitoring and evaluation

Baylor uses the Electronic Medical Records system to capture general patient data. When the ALHIV attend general clinic, the system captures their data. The system is able to monitor programme impact by linking the attendance of adolescents to Teen Clubs to their clinical outcomes. However, currently the system is not capturing all the relevant data to enable Baylor

to assess the reasons why an adolescent may not be achieving viral load suppression as some of the causes may be due to the home environment.

As a partner, UNICEF sees the need for critical improvemnets to be made in monitoring, for example having a clear results matrix.

Baylor's Activity Reports do not capture critical data like the number of adolescents who have gone through the mental health tests and what were the results. In many cases the data does not differentiate between Teen Club members and non-members, making it difficult to measure the changes that can be attributed to the programme. Baylor also faces challenges in capturing qualitative outcomes. Currently the M&E system only captures attendance to Teen Clubs, but does not link this to clinical outcomes. This is an area that needs to be strengthened in the new M&E framework that is being designed. However, these problems were expected to be addressed when a new M&E system was to be launched at the end of 2018.

To measure the impact of their work, Baylor has come up with a concept note to carry out a study to determine if there is a significant difference in the clinical outcomes between those who do and those who do not attend Teen Clubs[89].

11.1 Cross-cutting issues

11.1.1 Equity, Gender Equality and Human Rights Based Approach (HRBA)

Taking a HRBA has been very critical to the way Baylor works with ALHIV, whose rights are often infringed in various ways, including through stigmatization. To take a HRBA to programming, Baylor has relied heavily on the Eswatini Children's Protection and Welfare Act (2012) which outlines the rights of children. The Act also addresses issues of GBV, which is often a cause of defaulting among adolescent girls. The Act enables Baylor to provide services to adolescents which in the past they could not access, such as contraceptives to girls above the age of 12 years, where parental consent is no longer required.

The Act also allows children above 12 years to get tested for HIV without parental consent. What has enhanced the HRBA is that the Children's Protection and Welfare Act has penalties for those who violate the Act. For instance, in cases where parents refuse blood transfusion for their child on religious grounds, Baylor now has the power, through the Act, to provide blood transfusion without parental consent. The Act also enables Baylor to motivate and advocate for services for adolescents.

Baylor is also guided by the Swaziland National Gender Policy, which reinforces the Sexual and Reproductive Health and Rights (SRHR) of adolescents and "will take measures that promote, improve, and protect the sexual and reproductive health rights as well as the health status of men, women, boys and girls throughout their life cycle".[90] Eswatini remains a very patriarchal

[89] Key informant interview, M&E Officer Baylor Clinic Mbabane
[90] The Kingdom of Swaziland (2010) The National Gender Policy 2010

society and promoting the SRH rights of women is key to their empowerment, especially those living with HIV and AIDS.

Baylor has designed strategies that are gender-specific to address the challenges faced by girls in Teen Clubs, including pregnancies. Although the programme provides family planning services to adolescents, the uptake is very low as “the girls have been fed with the wrong information that that if you take contraceptives you will not have children. The end result is that the girls are falling pregnant”, says Baylor’s Senior Doctor. As part of the SRH services, Baylor nurses give talks on family planning to the adolescent girls at each of their visits to the clinic and if they are sexually active and if they agree, they are put on a contraception method that suits them. However despite this, some girls are still falling pregnant.

11.1.2 Partnership and collaboration

As a CoE Baylor plays a critical role in piloting new interventions, such as the Teen Clubs. Working with partners, the organisation has assisted the Ministry of Health to set up Teen Clubs across the country. Baylor also collaborates with the Ministry of Health in the provision of psychosocial support to the Teen Clubs. Social workers from Baylor are helping EGPAF in training Teen Club coordinators. “We are a referral for the Ministry of Health and we have been providing them with technical backstopping,” Baylor’s Programme Manager says. EGPAF’s support to Baylor includes establishing challenge clinics in the EGPAF supported sites, training of social workers and other health care workers as well as providing mentorship for the management of paediatric HIV/TB in 20 facilities in Hhohho and Shiselweni and also supporting national level training for health care workers.

Baylor collaborates with the International Centre for AIDS and Treatment Programme (ICAP), which supports the Manzini Teen Club with refreshments and transport reimbursement for the Teen Club meetings, while a local hotel provides lunches for the adolescents in Mbabane. Baylor collaborates closely with the National AIDS Programme, where it works with the National Pediatric HIV advisor, who participates as a resource person in the Teen Club leadership trainings.

11.1.3 South-South Cooperation

Baylor is a U.S-based organization that has set up programmes for ALHIV in Botswana, Eswatini, Tanzania and Uganda. There is scope for cross fertilization of ideas among the Baylor institutions in the African region, which they are doing through South-South learning . Baylor also learns from other organizations involved in adolescent HIV care and recently one of its nurses spent 20 days working with the Africaid’s Zvandiri Programme in Zimbabwe, which runs a successful programme for adolescents similar to the Teen Clubs. South-South cooperation should be encouraged as it provides opportunities for cross learning between organizations operating in similar cultural and geographical settings. In FGDs, ALHIV said they were keen to participate in exchange visits to learn from similar programmes in the region. This is an idea that Baylor could explore to enrich the experiences of the Teen Club members. The use of technology, which as social media that can link groups or Communities of Practices to link both country groups could be explored.

12.1 Lessons learnt

The lessons learnt from the Teen Clubs Programme include:

- Teen Clubs are effective as forums for ALHIV to meet share experiences and provide each other with mutual support to improve adherence, gain self-confidence and address self-stigma and fight stigmatisation against them in the wider community.

- The importance of carrying out a baseline survey and designing a theory of change at the beginning of an intervention to set clear benchmarks and indicators against which programme performance will be measured. This will also make it easier to assess the programme's contribution to change using a control group.

- The importance of making SRH services available to adolescents, including condoms, family planning services and treatment for STIs. By creating safe spaces for adolescents within their health facilities, uptake of the services has improved as well as the health seeking behavior of the adolescents.

- The importance of Baylor coming up with a more comprehensive transition programme for young adults that will adequately prepare them for life outside the clubs. Such a programme should also be linked to interventions to address the pervasive stigma and discrimination now prevailinig in Eswatini to create an environment that is more accepting of PLHIV.

- The need for a more integrated approach to addressing adherence among adolescents that takes into consideration socio-economic factors in the adolescents' home environment that make them default such as lack of food, lack of money for transport for ART refills. Such an approach would aim to strengthen the government social welfare system to ensure that poor and marginalised children do not fall through the cracks.

- The need for Baylor to design an M&E framework with indicators that capture the key result areas of the Teen Clubs to facilitate better monitoring of the project.

13.1 Conclusion

The evaluation of the Teen Club shows that the Programme is relevant as it addresses some of the most critical challenges faced by ALHIV, including LTFU resulting in defaulting on treatment, poor adherence, self-stigmatisation and stigma in communities against the adolescents. The programme is also relevant as the interventions are in line with international and national guidelines and strategies for ALHIV and is contributing to the achievenement of Goal 3.3 and 3.7 of the SDGs.

The Programme has been highly effective in supporting full disclosure among Teen Club members, which is the first step in accepting one's status. The programme has brought positive changes in the lives of the adolescents through improved adherence, which in turn has resulted

in viral load suppression among most of the Teen Club members. The value of the Teen Clubs also just lies in the forum they provide for adolescents in a similar situation to meet and share experience. This reduces their sense of isolation and helps them to accept their status.

Through the trainings, the programme empowers adolescents and builds their self-confidence, self-esteem and self-efficacy. These are critical attributes that enable them to live positively and which also have positive health outcomes in achieving viral load suppression. Because they are empowered, the ALHIV are able to deal with self-stigma and to fight stigma in society. Evidence from programme monitoring showed that viral suppression was higher among Teen Club members than among non-members. This was a clear sign of the efficacy of the programme and that it was achieving its objectives.

But the effectiveness of the Teen Clubs should not be seen in isolation from the other supporting interventions, that include the In-Reach and the Mental Health Programmes as well as the Challenge Clinic. While these interventions are not directly linked to the Teen Clubs, they have a strong bearing on the performance of the clubs and without them, the effectivess of the Teen Clubs would be highly compromised.

The evaluation noted that Teen Club Programme is eficient and cost effective and is good value for money. Making an investment case for the Programme would clearly show the gains that have been derived from implementing it clearly outweigh the costs. Using the counterfactual analysis would also show that if the intervention had not been implemented, the adolescents would be in a much worse state than they are in terms of their health status as Teen Club members are recruited from among those who would have defaulted, have low viral load suppression and who have low self-esteem.

In terms of sustainability, while it might be difficult to sustain the programme without external financial resouces, there were elements of sustainability built in within the programme, which include the programme's heavy reliance on volunteers to run the programme at little or no cost to Baylor; the low unit cost per adolescent which would make it easier to find alternative resources should external funding end; the political will within the government to sustain the programme evaluation (the government is paying 90 per cent of Baylor's costs, mostly in the form of salaries). The programme concluded that as part of the sustainability strategy, there is need for an exit strategy with timelines which would clearly map out how the Teen Clubs will be weaned off. The exit strategy should however not be abrupt to ensure that there are no disruptions to the Programme.

The evaluation concluded that the Teen Club is a promising initiative which has achieved most of its intermediate outcomes – increased adherence, high viral load suppression and empowered adolescents who have overcome self-stigma and can fight stigma against them in the community. The evaluation however noted that while the adolescents were living positively they were not so confident of themselves once they left the club.

Of critical note was that transition to adulthood was not smooth as many of them felt that they had been transitioned out fo the programme at a time when they were not yet ready. There was a general feeling among the adolescents, which was also shared by Baylor, of the need for a

more well thought out strategy to ensure a smoother transition. Such a strategy would enatil the creation of support groups for young adults, and where possible linking up unemployed young adults with livelihood interventions. This was particularly critical given Eswatini's high youth unemployment levels.

14.1 Developing the Recommendations

The recommendations were developed through a consultative process with key informants who each offered recommendations on different aspects of the Teen Clubs and how they felt these could be improved to produce better results. In the FGDs, the adolescents themselves made recommendations on how they wanted the programme to be run as well as what they considered should be key priority areas for the trainings to focus on. The recommendations were also developed from a deep analysis of the findings of the evaluation as well as from the literature review.

14.2 Recommendations

14.2.1 Ensuring a smooth transition into adulthood

Both Baylor and young adults admit that thegraduation from Teen Clubs has not been smooth and has been too abrupt leaving them feeling abandoned. **Baylor should design a comprehensive programme to facilitate the smooth transition of the adolescents into adulthood. Such a programme should address their bio-medical as well as their psychosocial and employment skills development needs.**

14.2.2 Addressing the social determinants of adherence

Several factors can affect adherence among adolescents, including the home environment, stigma and discrimination and GBV among others. **There is need for a more holistic approach to adherence, which takes cognizance and tries to address factors in the external environment that can impact on adherence. Such an approach should strengthen the coping mechanisms of the adolescents and also seek ways to mitigate the effects of the external environment on the adolescents.**

14.2.3 Need for more intense anti-stigma programmes

The fear expressed by young adults to engage in relationships is a reflection of the high stigma levels and low levels of knowledge about HIV prevailing in Eswatini. It is only by addressing these issues within communities that PLHIV will be accepted and be able to live normal lives. **The Ministry of Health, working with development partners, should design and implement comprehensive anti-stigma programmes to be rolled out across the country as a long term strategy to address the high levels of stigma in the Eswatini society.**

14.2.4 Strengthening mental health services

Baylor provides mental health services to adolescents. But because of the limited number of social workers, the services are only provided to those experiencing adherence problems, leaving out many more adolescents who require the services. Mental health services are not available parents of ALHIV although many need them. **Baylor should strengthen its mental**

health services to enable it to screen and provide services to more adolescents and parents/guardians who need the services.

14.2.5 Designing an exit strategy

Since the formation of Teen Clubs, their operational activities have been largely funded by development partners, including UNICEF, PEPFAR and EGPAF. The efficacy of the concept has been proved, hence the establishment of 81 additional clubs through the Ministry of Health. This may be an opportune time for the government to take over the programme, considering that it is already paying the bulk of the costs in salaries. **Partners should advocate for the government to take over funding of all the Teen Clubs and for their roll out to the remaining health facilities in the country that offer HIV services, so that more ALHIV can access the services**.

14.2.6 Ensuring more even coverage of the Manual

The Teen Club manual is comprehensive and addresses the information and knowledge needs of ALHIV. However responses from FGDs and the KAP study show that adherence is the major topic that the trainings focus on, while the rest of the topics in the manual receive scant attention. **The Teen Club trainings should be broader to cover other issues in the manual that impact on adherence, such as GBV, self-assertiveness, leadership, decision making etc. A narrow focus on adherence may fail to broaden the knowledge base of the adolescents sufficiently to enable them to navigate through their adult lives with confidence**

14.2.7 Improving the home environment for the adolescents

For successful adherence, ALHIV need psychosocial and treatment adherence support. However this is often lacking in their homes, with the result that the adolescents continue to default on treatment. **There is a need for Baylor to form support groups for parents that will (a) strengthen ther capacity to provide psychosocial support to their children; (b) address their information needs; (c) create a platform where the parents can also receive psychosocial support; and, (d) address their mental health problems.**

15.2.8 Broadening the range of services available to adolescents

The effectiveness of the Teen Clubs has been enhanced by supporting interventions such as the In-Reach and the Mental Health Programmes as well as Challenge Clinic, which together constitute a comprehensive package to address the diverse needs of ALHIV. **In rolling out the Ten Clubs Programme across the country, it will be necessary to incorporate the In-Reach and the Mental Health Programme as well as the Challenge Clinic to ensure the provision of a comprehensive package of services for adolescents.**

14.2.9 Providing adherence support in boarding schools

From the literature review and the FGDs it emerged that some adolescents in boarding school default from treatment because the environment is not conducive for them to take their medication and they lack adherence support. ***Schools should provide sensitive and discreet adherence support and create conditions that enable adolescents to take their***

medication in private. Parents should be encouraged to disclose the status of their children to school heads on registration so that they can be provided adherence support and counselling if they need it.

14.2.10 Strengthening social safety nets for indigent ALHIV

High poverty levels in Eswatini, especially among children, contribute to poor adherence among ALHIV from poor households. ***Baylor, working with national case management teams, should identify and refer vulnerable adolescents for social protection services to reduce barriers to treatment and improve adherence. At the same time, a strong advocacy campaign should be carried out to influence the government to strengthen social safety nets that cater for vulnerable ALHIV.***

14.2.11 Resuming Holiday Teen Clubs for Adolescents with poor adherence

According to Baylor, Teen Clubs for adolescents with a high viral load were effective in improving adherence and viral load suppression. However, they were discontinued because of lack of funding. ***Baylor should fundraise for resources to resume the special Teen Clubs as they proved critical to improving health outcomes for adolescents with poor adherence and high viral load.***

14.2.12 Strengthening the U Report

Social media is the communication mode of choice for most adolescents. The U Report is an attempt to provide adolescents with useful information using the SMS platform. However the platform has not taken off as well as it should have because of initial operational challenges experienced. ***UNICEF and Baylor should iron out the technical glitches still being experienced by users by (a) ensuring that questions asked are responded to on time (b) that issues discussed are relevant to the adolescents***.

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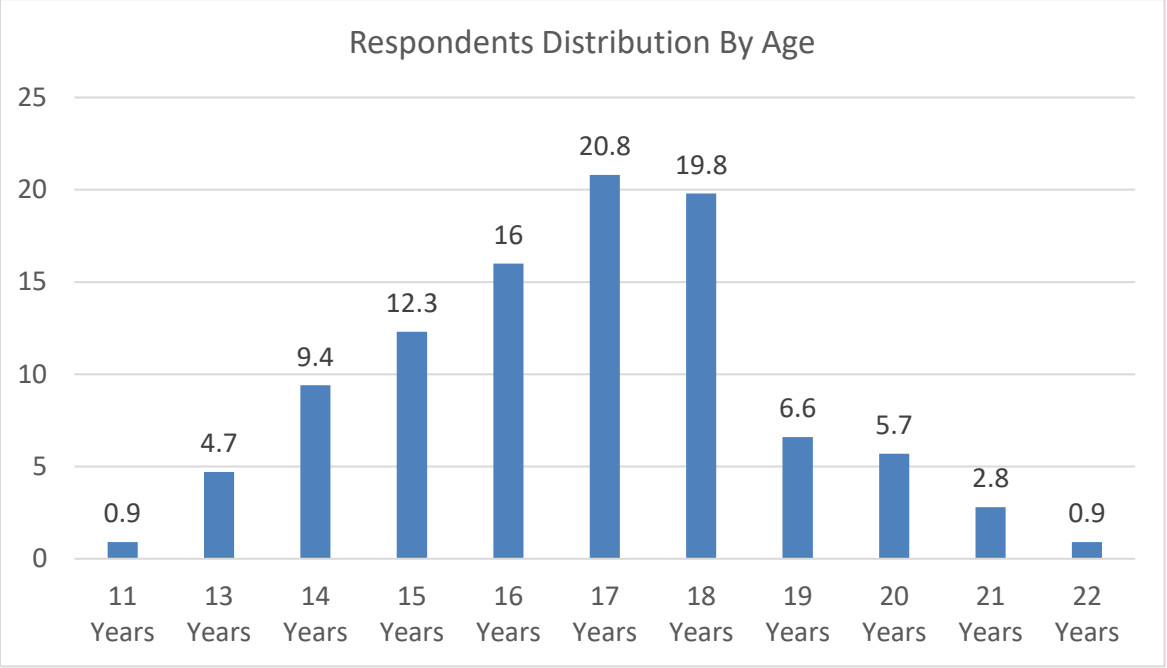
Appendix 1: KAP Survey Results

A total of 106 young people were interviewed through the individual questionnaire that was administered in four sites. The distribution according to numbers is shown in the figure below:

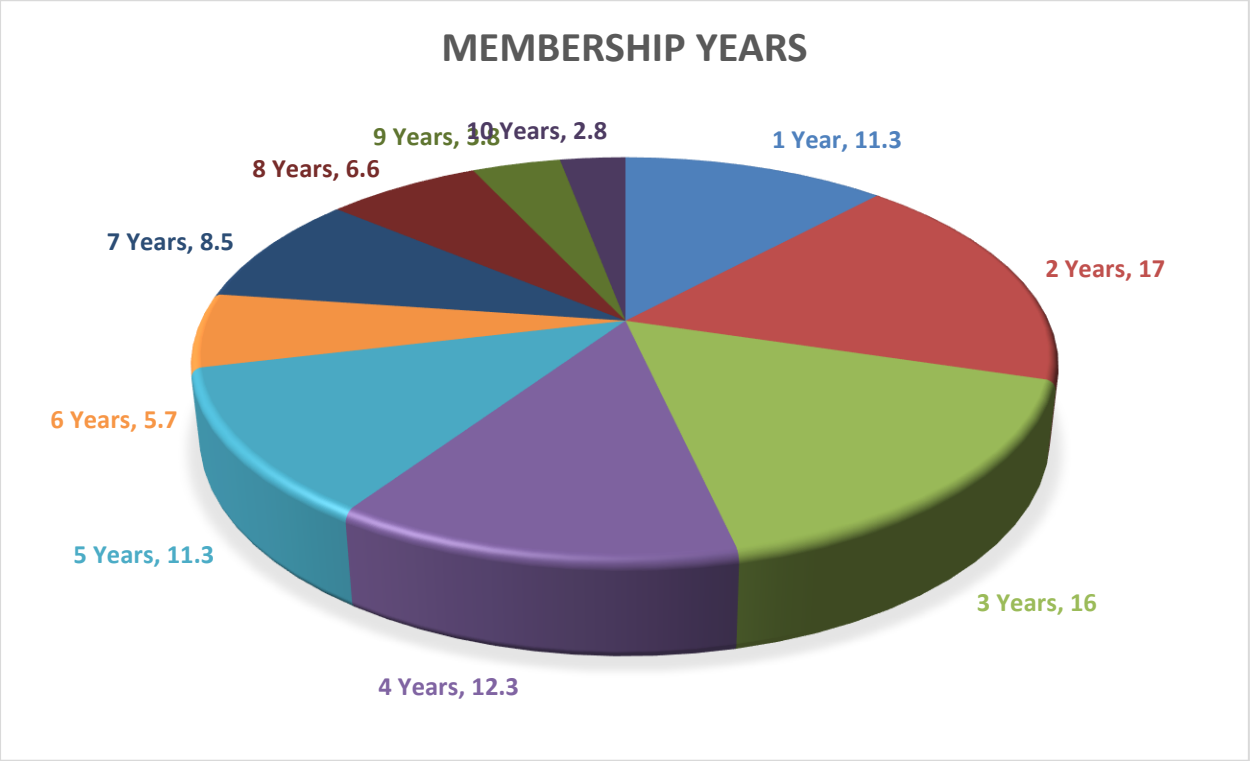
Site	Frequency	%
Baylor Mbabane	25	23.6
Hlatlukhulu	24	22.6
Siphofaneni	9	8.5
Baylor RFM	48	45.3

Respondents Distribution By Age



Most of the respondents were between the ages of 14 and 19, with 17 year olds making the bulk of the respondents (20.8%)

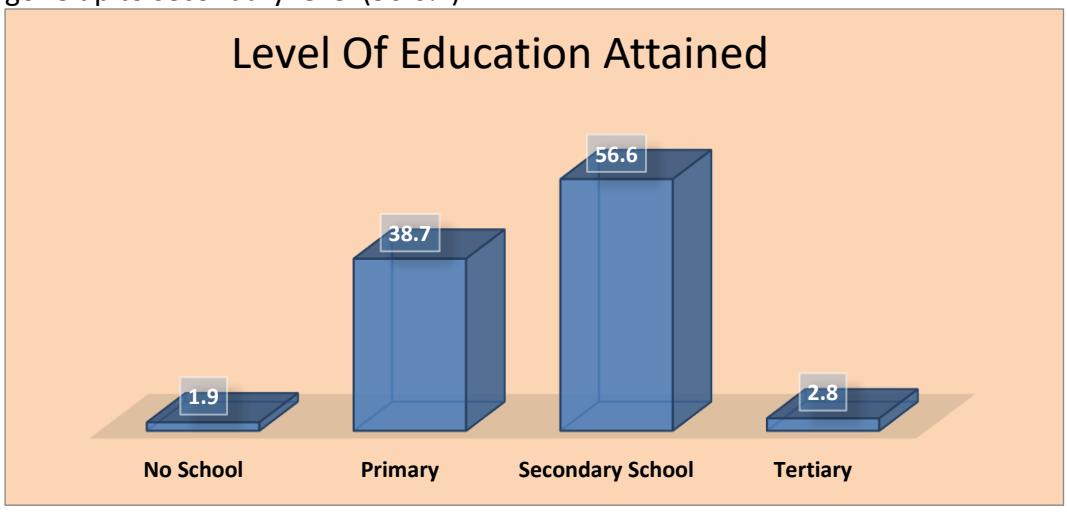
Respondents were asked for how long they have been a member of the Teen Club and the following results were obtained:



More than 50% of the respondents have been part of the programme for 4 years and above (51%) while 11.3% have been part of the clubs for 1 year and below.

Respondents Distribution by Sex; 37.7 were males while 62.3% were female.

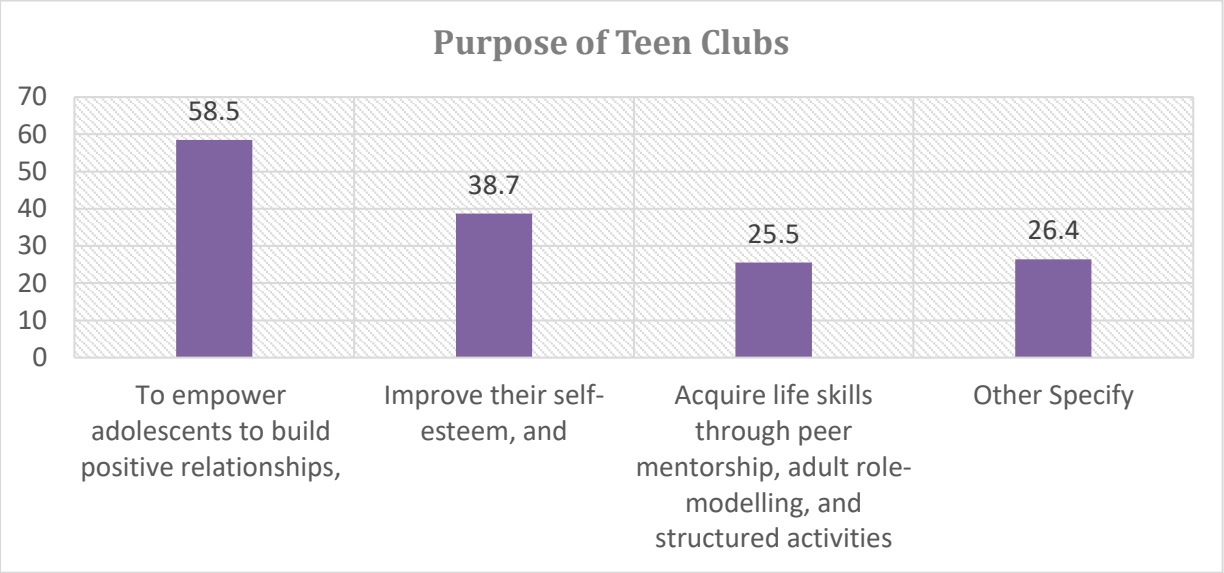
When asked on the highest level of education they have attained, most of the respondents had gone up to secondary level (56.6%)



When asked what they did for a living, 88.7% of the respondents indicated that they were still in school, 8.5% unemployed while only 1.9% indicated that they were self-employed.

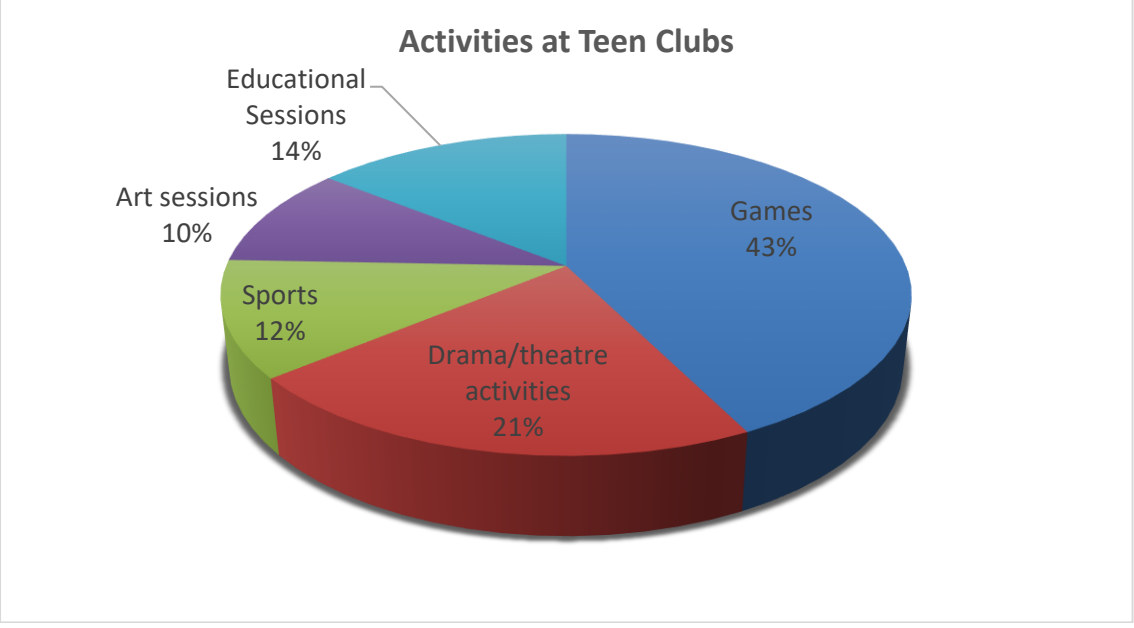
GENERAL QUESTIONS ABOUT TEEN CLUBS

Respondents were asked what they understood as the purpose of Teen Clubs.

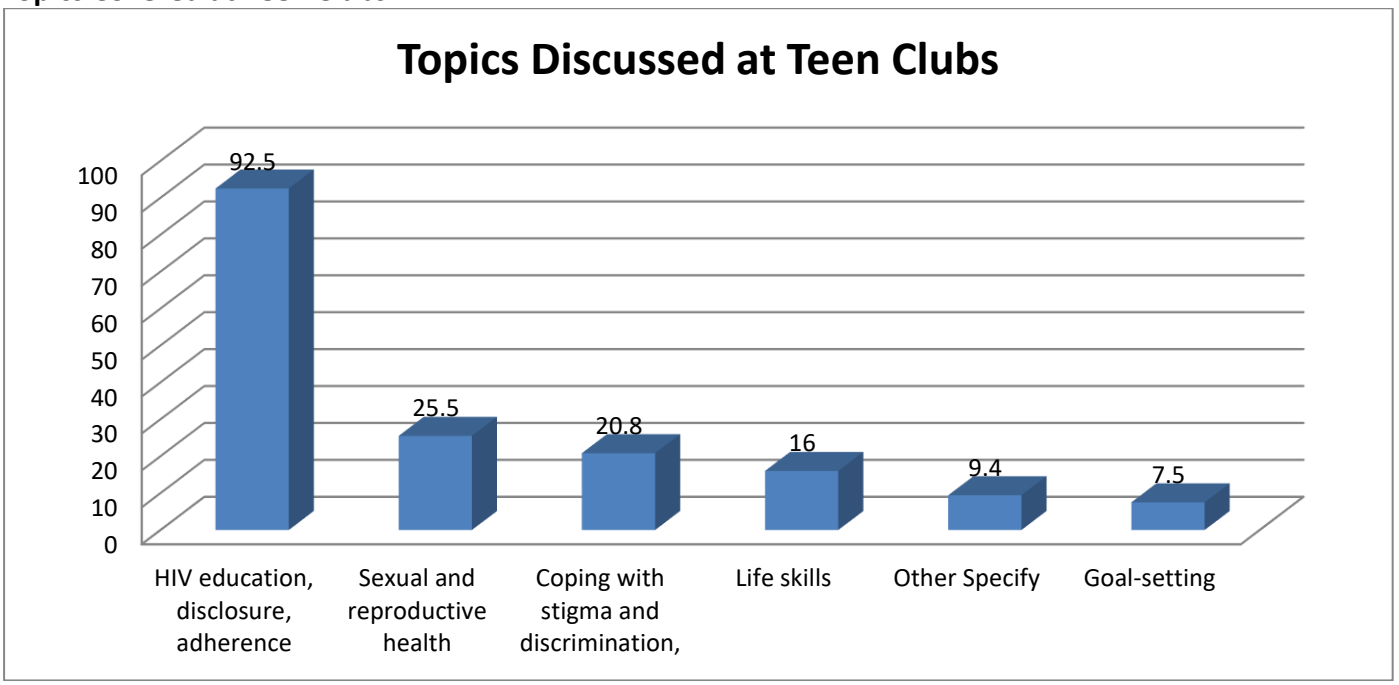


Most of the respondents (58.5%) mentioned Teen Clubs as meant to empower adolescents to build positive relationships followed by 38.7% who mentioned improved self-esteem. The other frequently mentioned purpose for Teen Clubs was to support each other on treatment adherence (23.6%)

Activities Conducted at the Teen Clubs

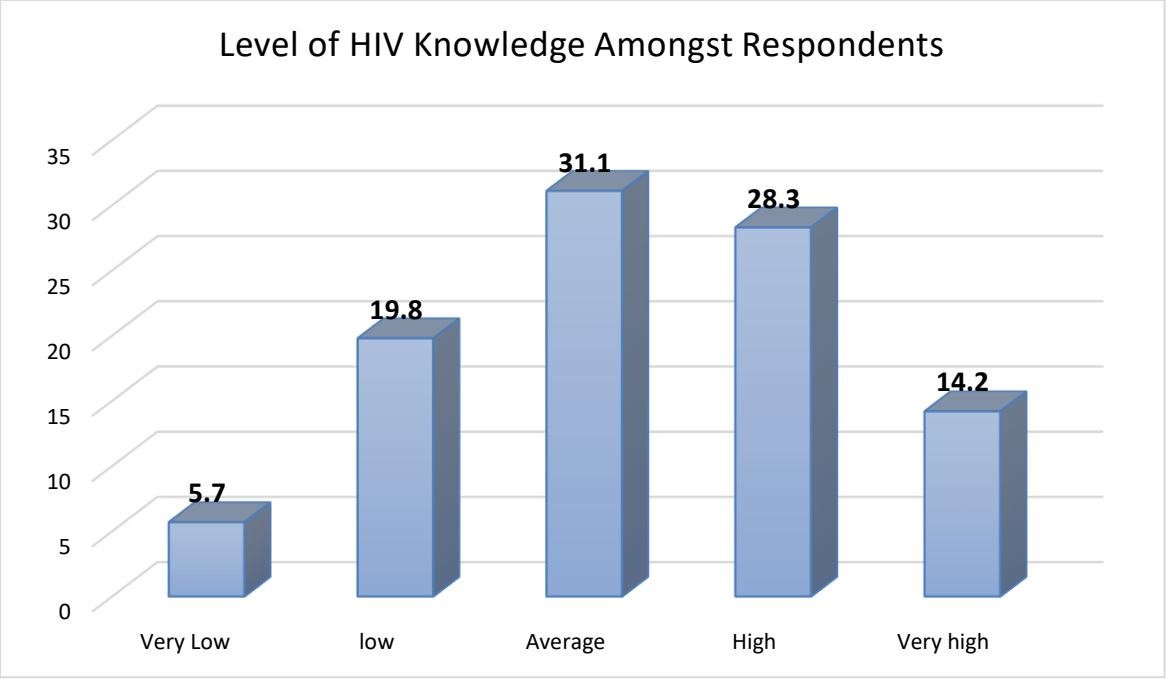


Topics Covered at Teen Clubs



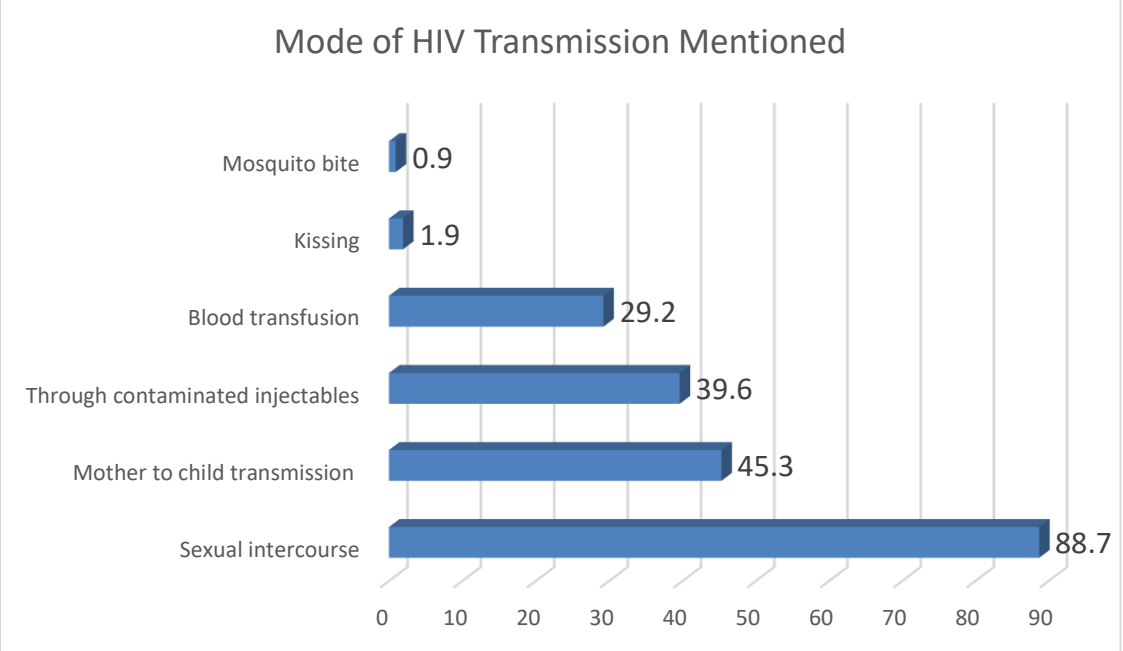
Other topics mentioned include moral issues, peer pressure; personal hygiene; human rights among others.

Asked how they would rate their level of knowledge about HIV, 31.1% of the respondents indicated that it was average while 14.2% reported that it was very high.

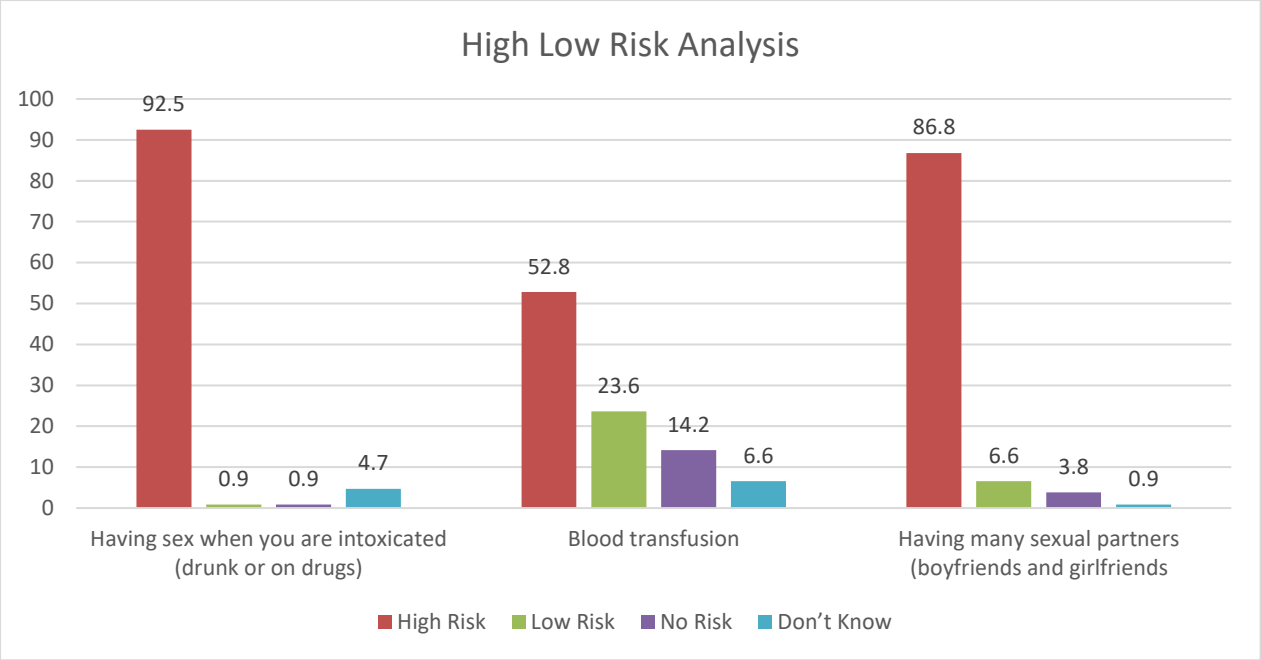


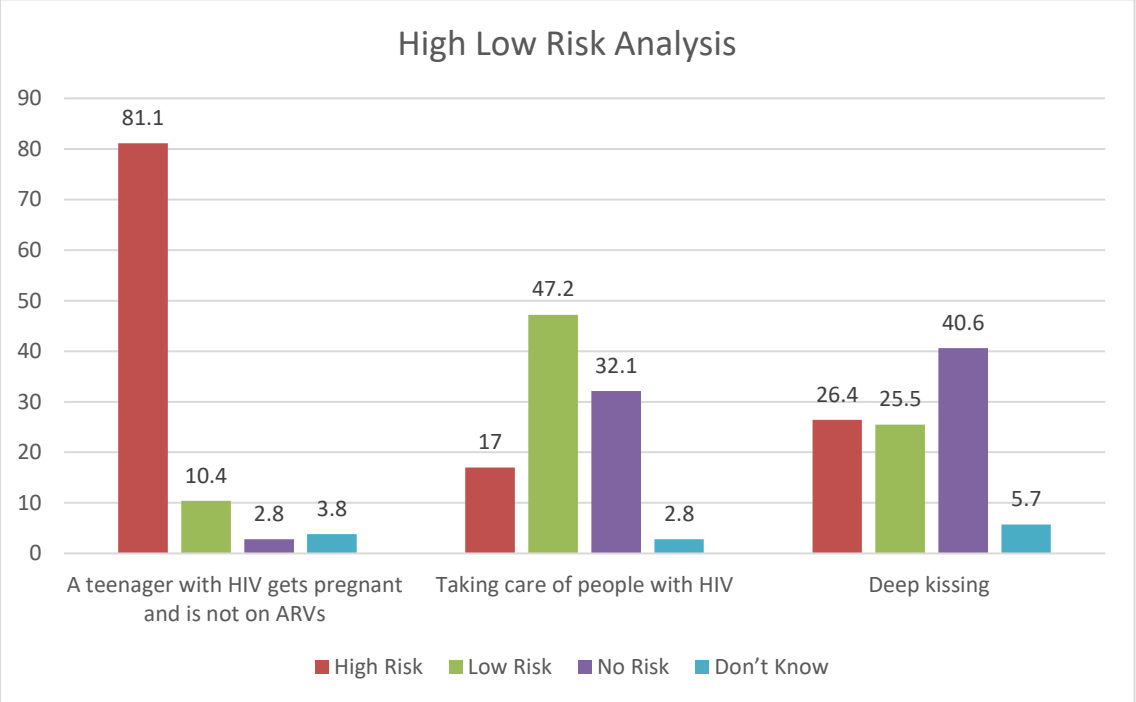
Knowledge on HIV Transmission

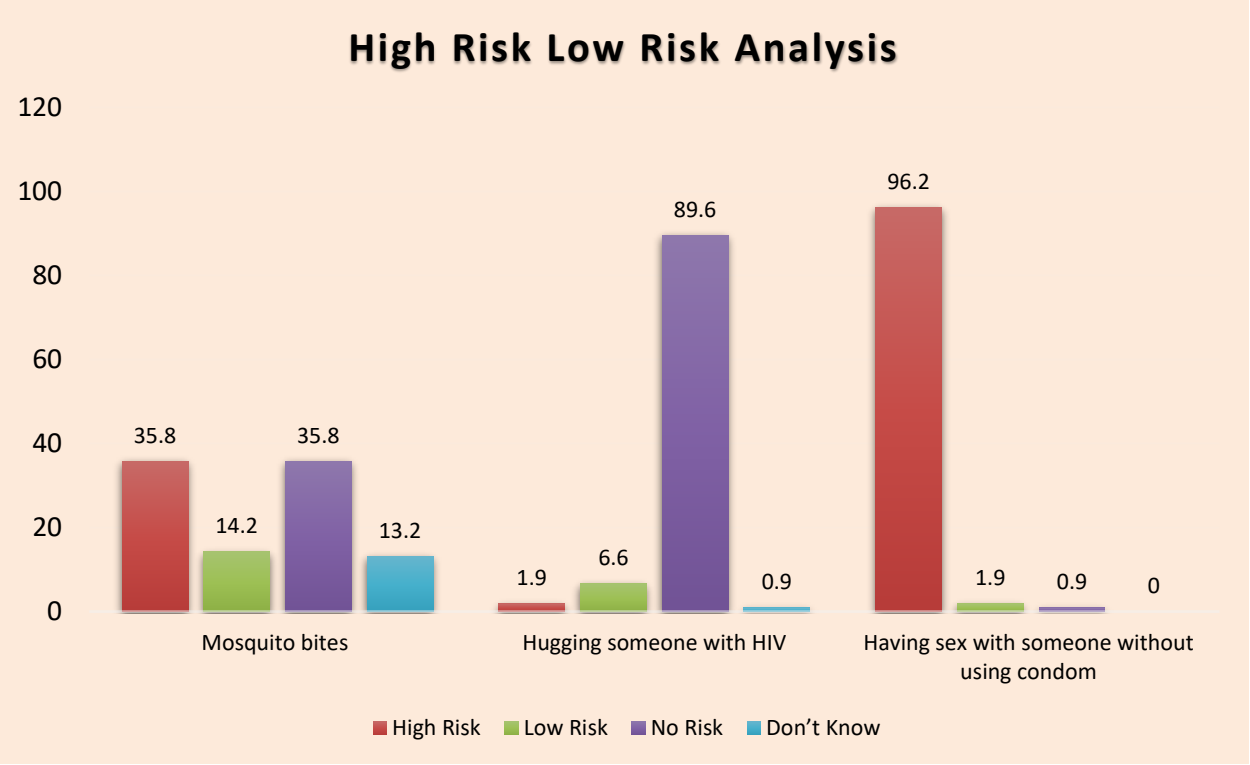
Sexual intercourse was mentioned highly as a mode of HIV transmission by 88.7% of the respondents while 2.8% still think that HIV can be transmitted through kissing and mosquito bites.

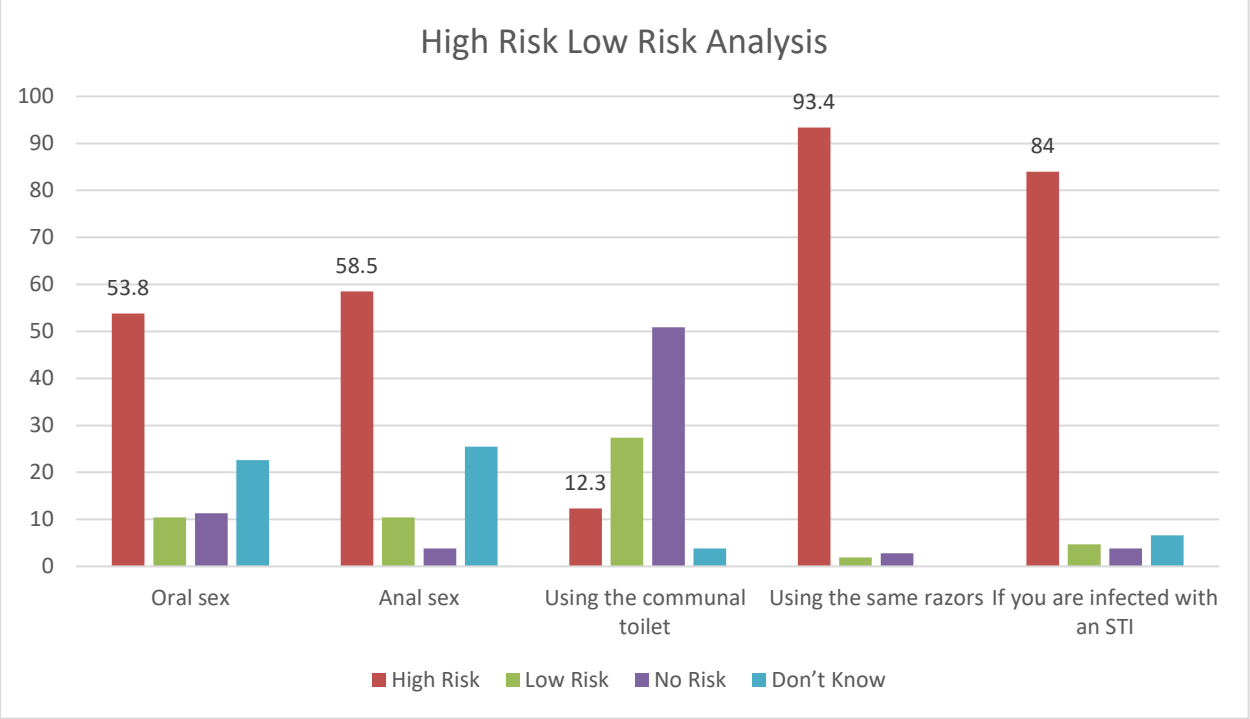


Respondents were asked to indicate whether each of the following behaviors is HIGH, LOW, or NO RISK in terms of HIV infection


High Low Risk Analysis
100
90
80
70
60
50
40
30
20
10
0
92.5
0.9
0.9
4.7
52.8
23.6
14.2
6.6
86.8
6.6
3.8
0.9
Having sex when you are intoxicated (drunk or on drugs)
Blood transfusion
Having many sexual partners (boyfriends and girlfriends
High Risk
Low Risk
No Risk
Don't Know


High Low Risk Analysis
90
80
70
60
50
40
30
20
10
0
81.1
10.4
2.8
3.8
17
47.2
32.1
2.8
26.4
25.5
40.6
5.7
A teenager with HIV gets pregnant and is not on ARVs
Taking care of people with HIV
Deep kissing
High Risk
Low Risk
No Risk
Don't Know



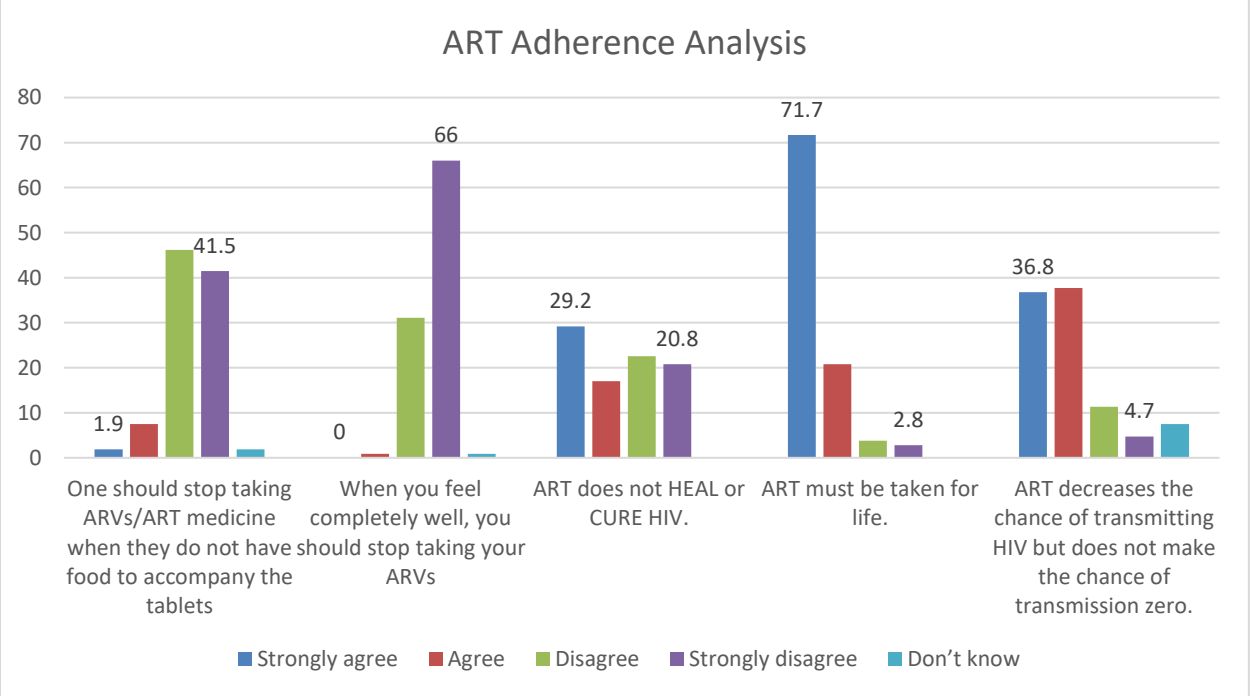


Asked whether they would not want to keep the HIV+ status of a family member a secret, 42.5% agreed to that (21.7% strongly agreed, 20.8% agreed) while 53.8% indicated that they would want to keep it as a secret. Asked whether an individual living with HIV could go to

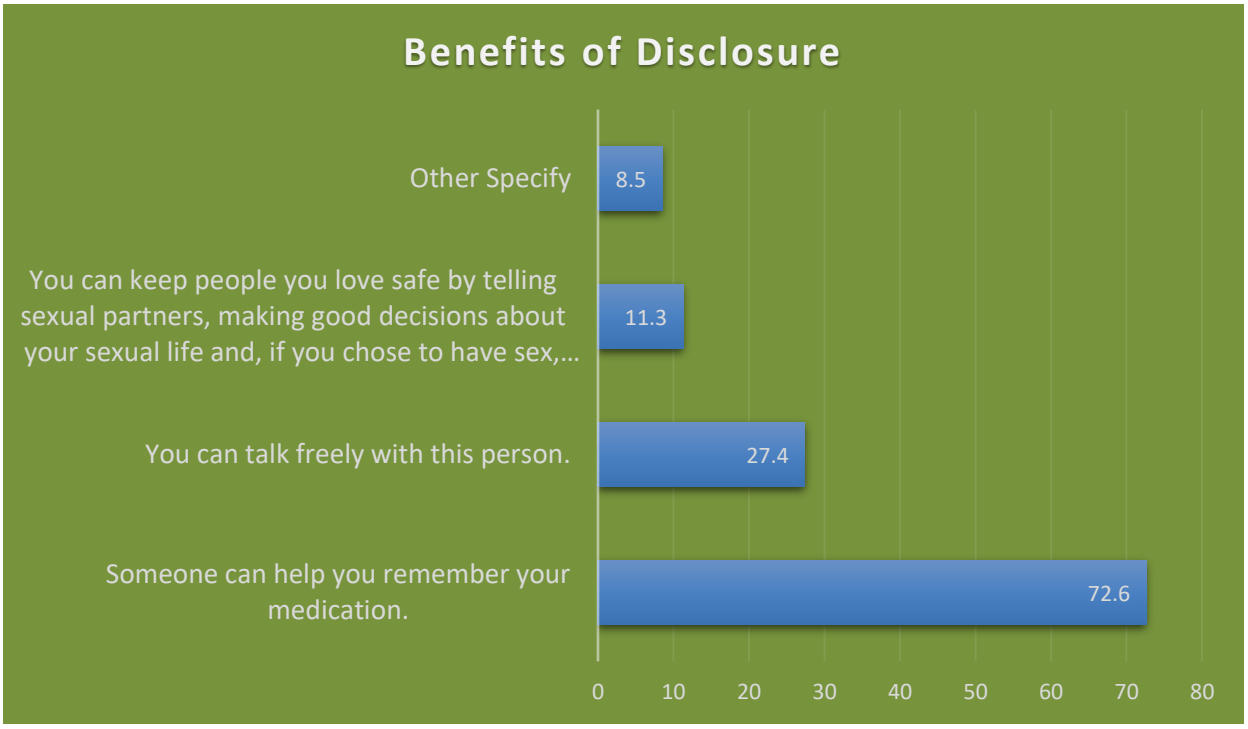
school and earn a degree, 90.6% indicated that this would be possible while a low of 3.8% said this would not be possible.

Indicate the level of your agreement on the following statements regarding ART Adherence

	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
One should stop taking ARVs/ART medicine when they do not have food to accompany the tablets	1.9	7.5	46.2	41.5	1.9
When you feel completely well, you should stop taking your ARVs	0	0.9	31.1	66.0	.9
ART does not HEAL or CURE HIV.	29.2	17.0	22.6	20.8	0
ART must be taken for life.	71.7	20.8	3.8	2.8	0
ART decreases the chance of transmitting HIV but does not make the chance of transmission zero.	36.8	37.7	11.3	4.7	7.5

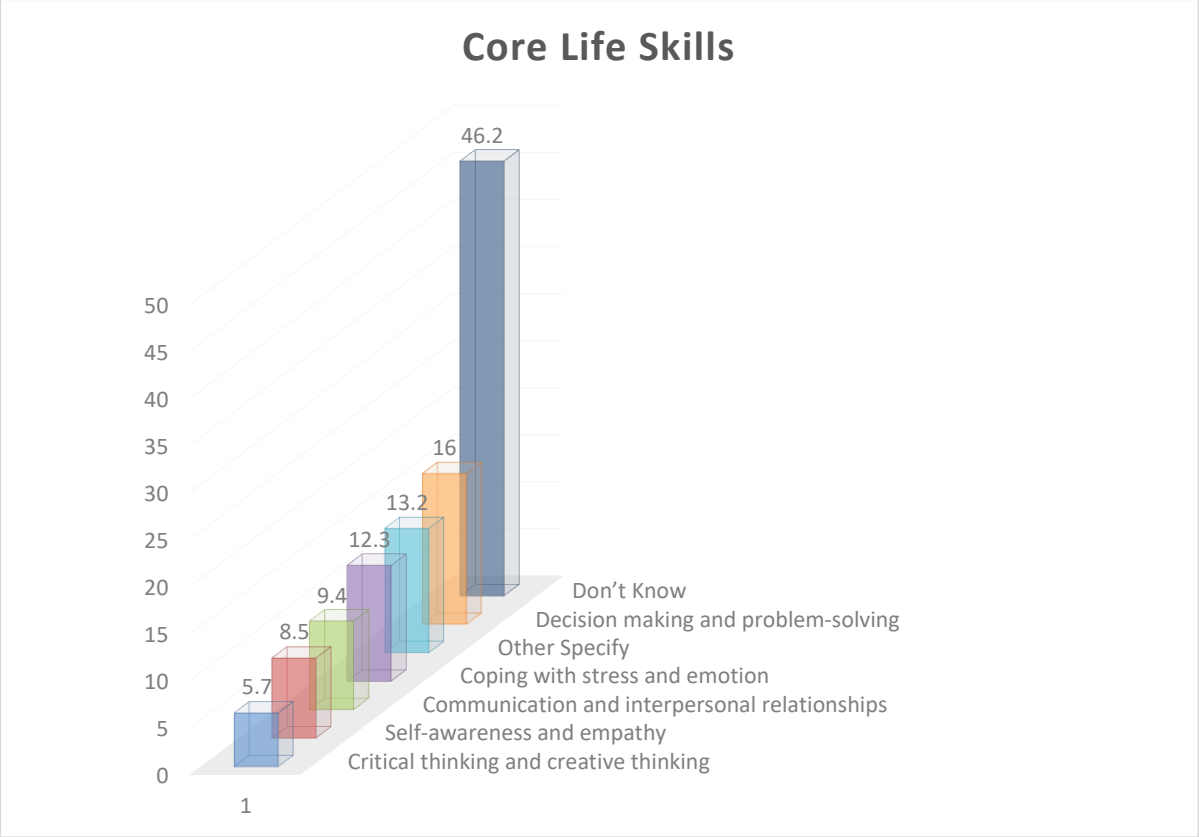


On the benefits of HIV disclosure to other people, 72.6% respondents reported that someone can help you remember your medication, while 27.4% indicated that you can talk freely with this person once you have disclosed to them



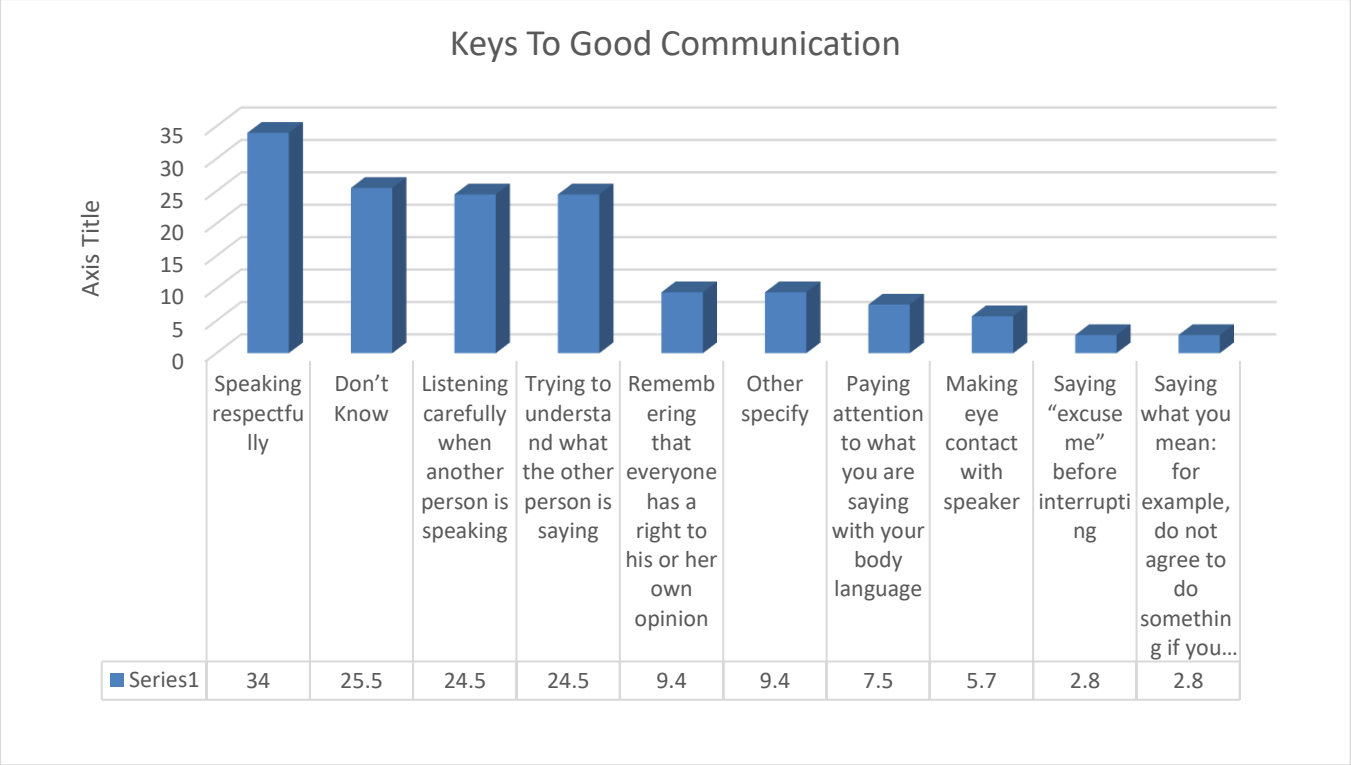
For good personal hygiene, 88.7% of the respondents reported that they have to take care of their body, while 50.9% mentioned their clothes. A considerable number of respondents (13.2) highlighted that it was important for them to take care of their external environment to enhance their personal hygiene. Responding on the types of food groups that are there, 84.9% mentioned body building foods, 80.2% mentioning protective foods while 74.5% mentioned energy-giving foods.

Core Life Skills

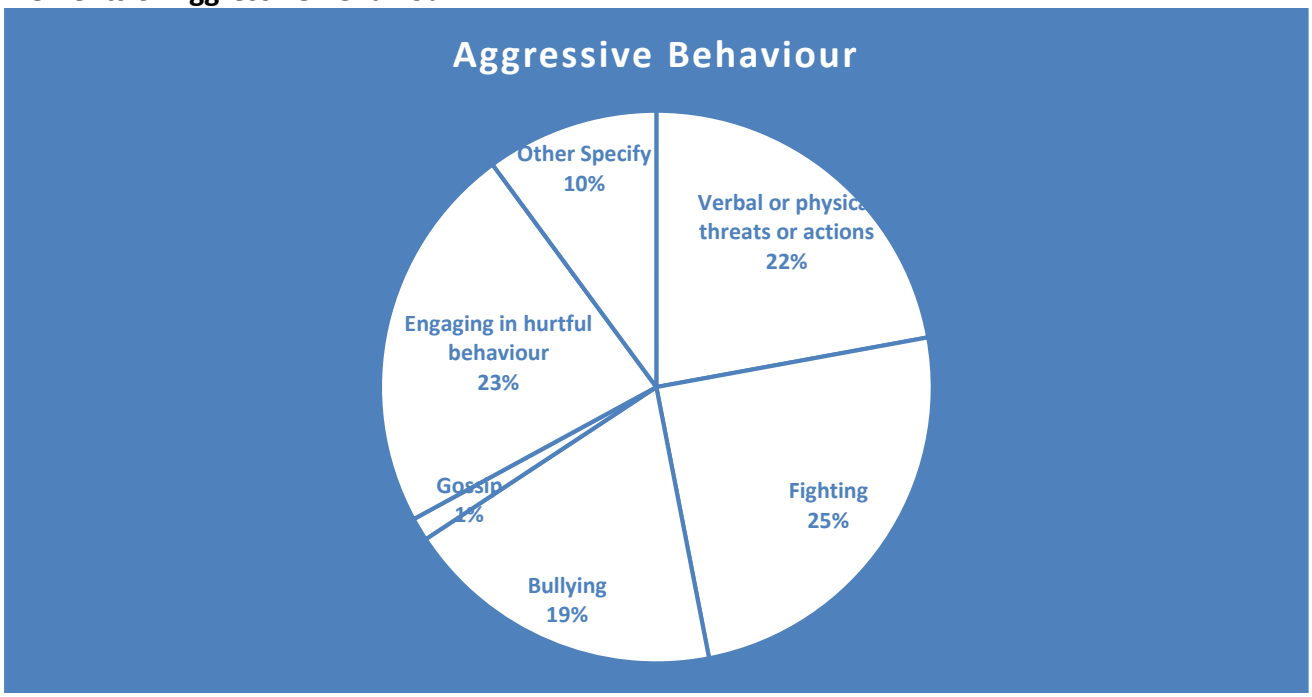


The core life skill most mentioned by respondents was decision making and problem solving (16%). Most of the respondents (46.2%) indicated that they were not aware of any core life skills. Critical thinking and creative thinking were lowly mentioned as a core life skill by only 5.7% respondents. This is one part of the Teens Clubs implementation curricula that is lacking in the day to day implementation.

Keys to Good Communication



Elements of Aggressive Behaviour

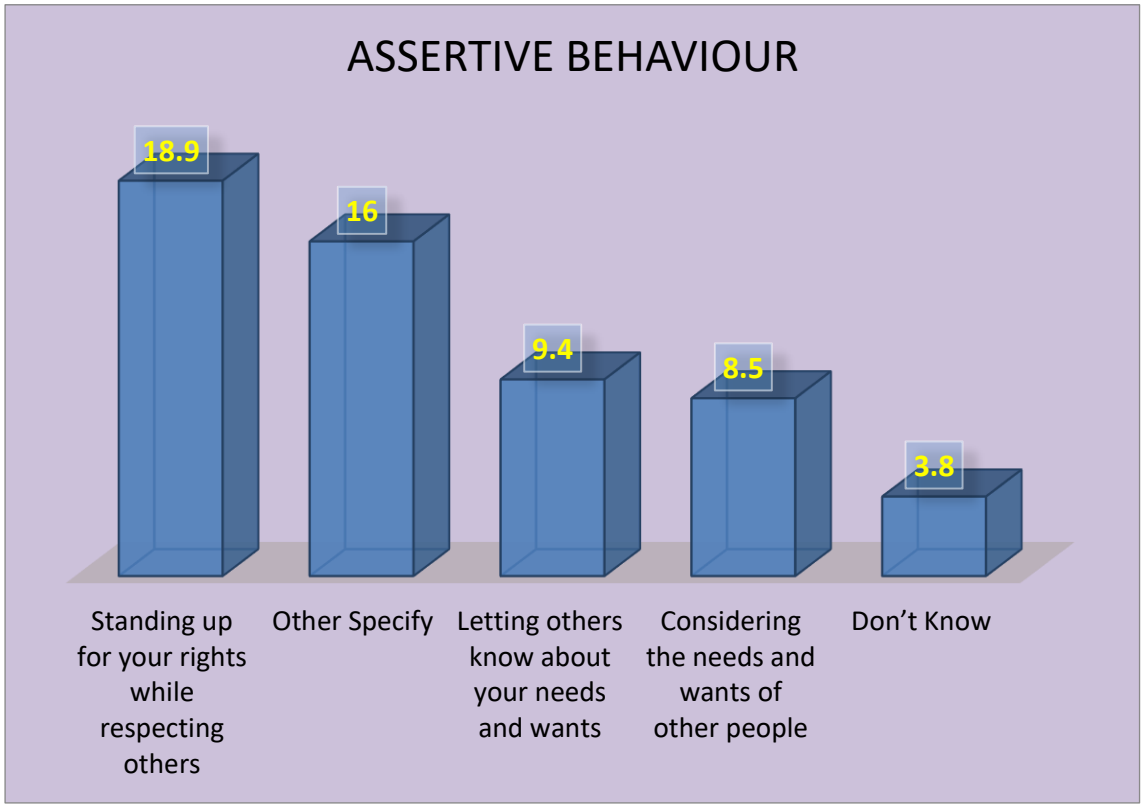


Other elements of aggressive behavior mentioned include being angry, isolating oneself, disrespectful; selfishness, and also killing.

Passive Behaviour

Elements of passive behavior were not well known amongst the respondents with 53.8% indicating that they don't know about it. Ignoring (17%) was the second common response on passive behavior followed closely by letting the other person get what he/she wants (16%). 11.3% mentioned "not saying anything" as another element of passive behavior.

What Assertive Behaviour Involves
"Standing up for your rights while respecting others" was highly mentioned as an element of assertive behavior while other elements included self-confidence, being open and smart amongst others.

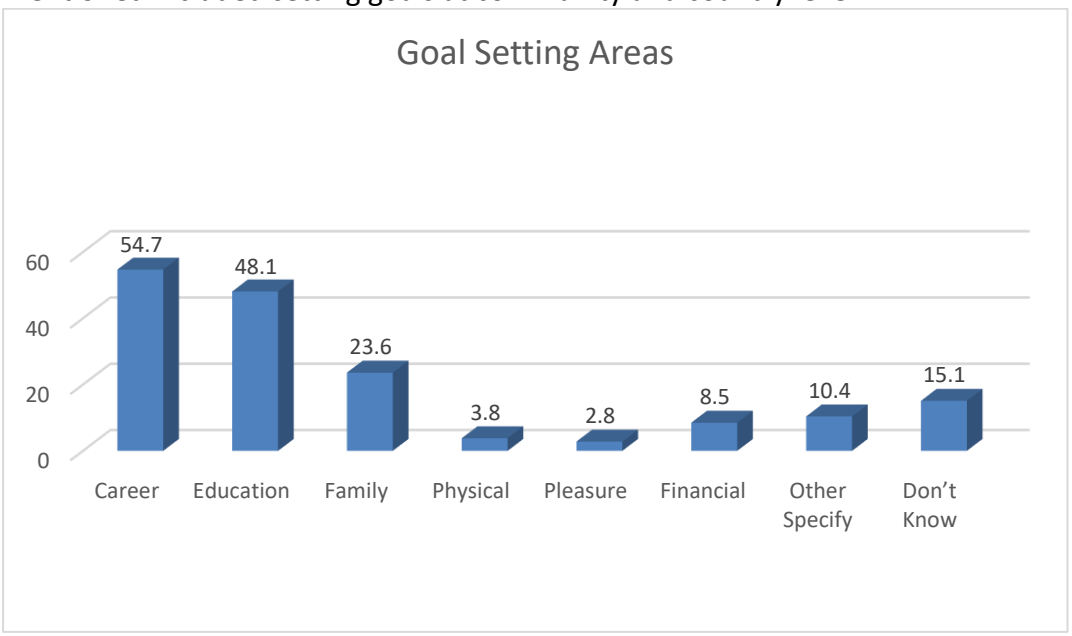


When asked what sort of traits an active listener is seen by, 30.2% mentioned understanding, 18.9% mentioning reflective while other traits were mentioned by 30.2%. Other traits included answering questions clearly, seeking clarity, showing commitment to discussion, amongst others.

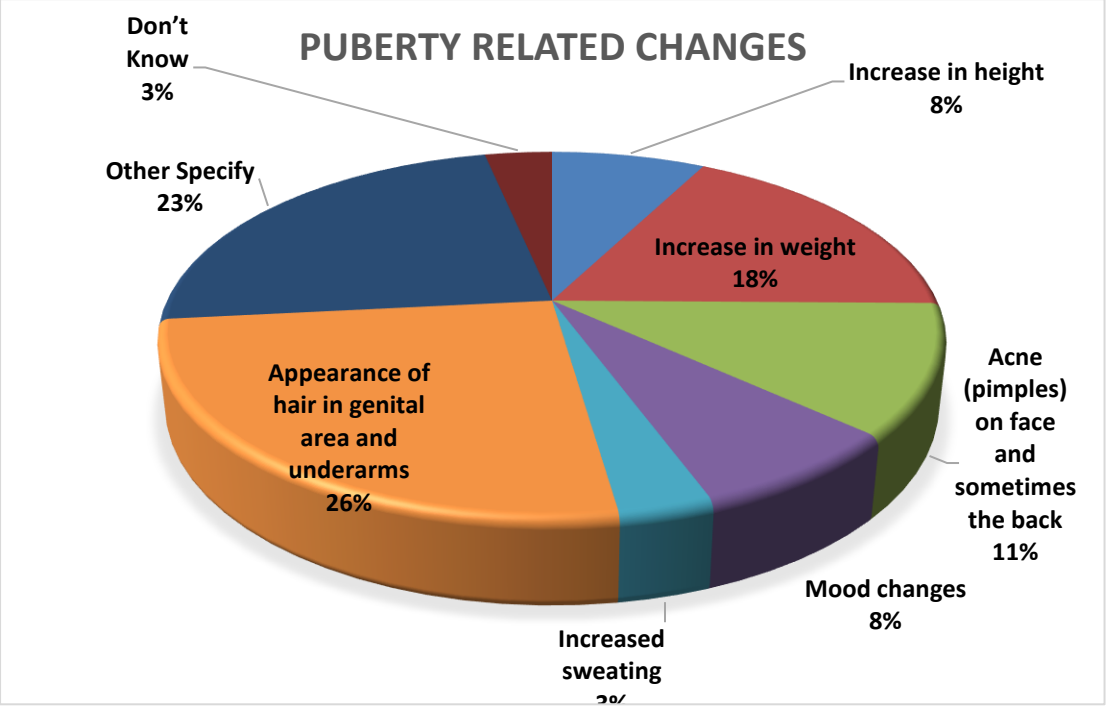
When asked what type of leadership styles they were aware of, only 13.2% mentioned democratic leadership, 5.7%mentioning autocratic and laissez-Faire, with most of the respondents indicating that they don't know any (76.4%).
When asked about some good leadership qualities that teen leaders should exhibit, the following results were obtained:

Other qualities mentioned included caring, friendly, good behavior, humble, loving, patient, polite, sociable, transparent and trustworthy

When asked in which areas within their life young teens should set goals in, 54.7% of the respondents pointed to career goals, closely followed by education goals (48.1%). Other areas mentioned included setting goals at community and country level.



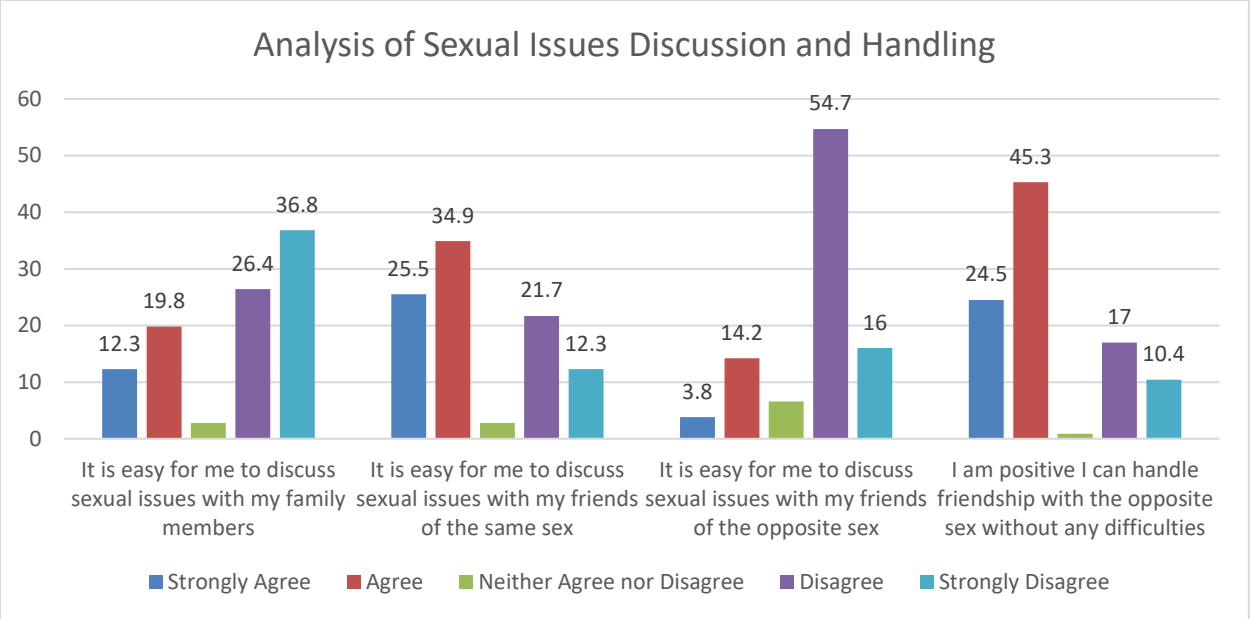
Changes That Happen During Puberty Stage



Breasts enlargement, broad shoulders, hips development, deep voice in boys, menstruation, wet dreams were mentioned as other changes that happen in young people during puberty stage.

86.8% respondents agreed (47.2-strongly agree; 39.6-agree) that they were positive to able to handle the changes that their body is going through as they grow up

An analysis of different issues regarding sex and sexuality is given below, with a high per centage of young people indicating that it is not easy to discuss sexual issues with friends of the opposite sex, this mainly coming from young girls as compared to young boys.

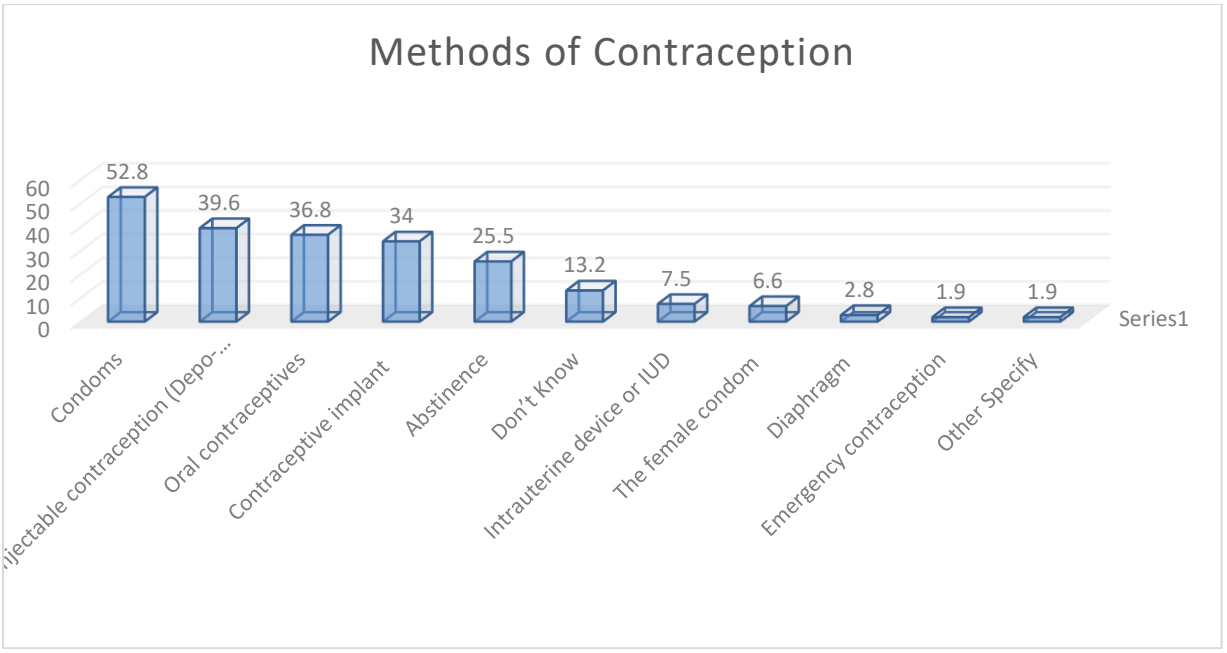


50.9% (11.3-Strongly Agree; 39.6-Agree) of the respondents indicated that they feel that the interference from their parents/guardians is just too much such that they interfere with their things. 50% respondents strongly agreed while 31.1 agreed that they are able to decide to wait until marriage or until they feel more ready for the responsibilities that come with sex, while 8.5% responded otherwise.

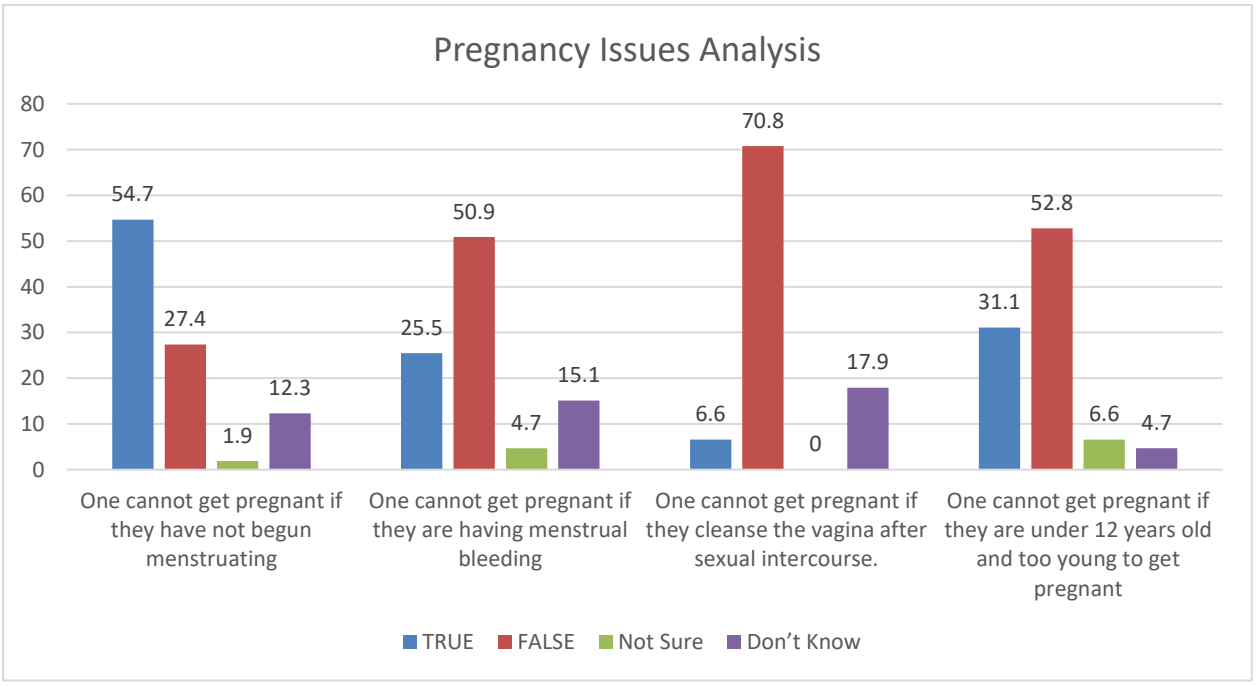
	Sexual activity does NOT always need to be part of a romantic relationship with the opposite sex.	In my relationship, if my partner is not ready for sex, I am able to respect their decision.	I am able to delay sexual intercourse until I am comfortable enough to disclose my HIV status to my partner.
Strongly Agree	22.6	52.8	41.5
Agree	30.2	34.9	39.6
Neither Agree nor Disagree	3.8	.9	.9
Disagree	22.6	4.7	7.5
Strongly Disagree	13.2	0	3.8

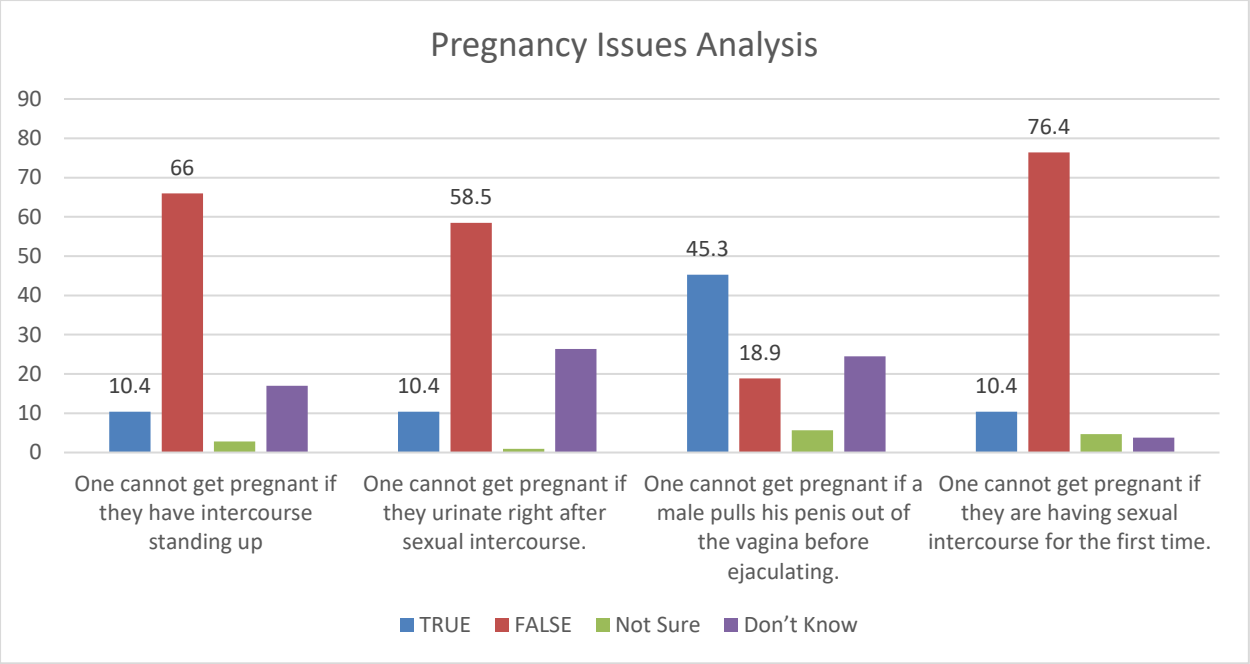
When asked if they thought they have received enough training or mentorship to handle sex and sexual issues as a teenager, 50.9% said yes while 42.5% indicated No. 4.7% were not sure.

The most common method of contraception mentioned was use of condoms (52.8%) followed by injectable contraception (39.6%). Other methods mentioned are indicated in the figure below.



When asked if condoms can be washed and reused, 90.6% did not agree with that while 1.9% agreed with that. 55.7% did not believe that contraceptives will make you sterile and never able to have children, while 22.6% believed it. 67.9% did not agree with the statement that if you use condoms you don't need to use other forms of family planning while 15.1% agreed to that. 79.2% respondents indicated that it is possible for a woman with HIV to have a baby without HIV





As a teenager do you worry about the following?

	Answered yes
If the changes in your body are normal?	22.6
If your friends like you?	33.0
Whether you should start having a boyfriend/girlfriend?	43.4
How you can perform better in school?	67.9
If your guardians love you regardless of your mistakes?	59.4

Appendix 2A: KAP Survey Questionnaire (English)

The interview will take about 30 minutes to ask the questions. Would you be willing to participate?"

A. If "Yes" Proceed and If "No" thank them and move to the next potential respondent.

	IDENTIFICATION
ID01	Questionnaire No. _____
ID02	Locality Name _____

	Question	**Responses**		**Skip Instructions**
1.	How old are you?	Age_____		
2.	For how long have you been a member of the Teen Club			
3.	Sex of Respondent	Male Female	1 2	
4.	What is the highest level of education you have attained?	No School Primary Secondary school Tertiary	1 2 3 4	
5.	What do you do to earn a living?	Still in school Employed Self employed Unemployed No response	1 2 3 4 99	
	GENERAL QUESTIONS ABOUT TEEN CLUBS			
6.	What do you understand as the purpose of Teen Clubs?	To empower adolescents to build positive relationships, Improve their self-esteem, and Acquire life skills through peer mentorship, adult role-modelling, and structured activities Other Specify	1 2 3 4	
7.	What sort of activities do you do at the Teen Clubs?	Games, Drama/theatre activities, Sports, and Art sessions Other Specify	1 2 3 4 5	
8.	What topics do you cover when you meet as Teen Clubs?	HIV education, disclosure, adherence, Goal-setting Sexual and reproductive health, Coping with stigma and discrimination,	1 2 3 4	

		Life skills Other Specify_____	5 6	
	HIV and AIDS			
9.	How would you rate your level of knowledge about HIV?	Very Low low Average High Very high No Response	1 2 3 4 5 99	
10.	How is HIV transmitted?	Mosquito bite Kissing Sexual intercourse Blood transfusion Mother to child transmission Through contaminated injectables	1 2 3 4 5 6	
	Indicate whether each of the following behaviours is HIGH, LOW, or NO RISK in terms of HIV infection			
11.	Having sex when you are intoxicated (drunk or on drugs)	High Risk Low Risk No Risk Don't Know No Response	1 2 3 98 99	
12.	Blood transfusion	High Risk Low Risk No Risk Don't Know No Response	1 2 3 98 99	
13.	Having many sexual partners (boyfriends and girlfriends	High Risk Low Risk No Risk Don't Know No Response	1 2 3 98 99	
14.	A teenager with HIV gets pregnant and is not on ARVs	High Risk Low Risk No Risk Don't Know No Response	1 2 3 98 99	
15.	Taking care of people with HIV	High Risk Low Risk No Risk Don't Know No Response	1 2 3 98 99	

16.	Deep kissing	High Risk Low Risk No Risk Don't Know No Response	1 2 3 98 99	
17.	Mosquito bites	High Risk Low Risk No Risk Don't Know No Response	1 2 3 98 99	
18.	Hugging someone with HIV	High Risk Low Risk No Risk Don't Know No Response	1 2 3 98 99	
19.	Having sex with someone without using condom	High Risk Low Risk No Risk Don't Know No Response	1 2 3 98 99	
20.	Oral sex	High Risk Low Risk No Risk Don't Know No Response	1 2 3 98 99	
21.	Anal sex	High Risk Low Risk No Risk Don't Know No Response	1 2 3 98 99	
22.	Using the communal toilet	High Risk Low Risk No Risk Don't Know No Response	1 2 3 98 99	
23.	Using the same razors	High Risk Low Risk No Risk Don't Know No Response	1 2 3 98 99	
24.	If you are infected with an STI	High Risk Low Risk No Risk Don't Know No Response	1 2 3 98 99	
	Indicate your degree of agreeing or disagreeing with the following statements:			
25.	I would not want to keep the	Strongly agree	1	

	HIV+ status of a family member a secret	Agree Disagree Strongly disagree Don't know No Response	2 3 4 98 99	
26.	An individual living with HIV cannot go to school and earn a degree	Strongly agree Agree Disagree Strongly disagree Don't know No Response	1 2 3 4 98 99	
	Indicate the level of your agreement on the following statements regarding ART Adherence			
27.	One should stop taking ARVs/ART medicine when they do not have food to accompany the tablets	Strongly agree Agree Disagree Strongly disagree Don't know No Response	1 2 3 4 98 99	
28.	When you feel completely well, you should stop taking your ARVs	Strongly agree Agree Disagree Strongly disagree Don't know No Response	1 2 3 4 98 99	
29.	ART does not HEAL or CURE HIV.	Strongly agree Agree Disagree Strongly disagree Don't know No Response	1 2 3 4 98 99	
30.	ART must be taken for life.	Strongly agree Agree Disagree Strongly disagree Don't know No Response	1 2 3 4 98 99	
31.	ART decreases the chance of transmitting HIV but does not make the chance of transmission zero.	Strongly agree Agree Disagree Strongly disagree Don't know No Response	1 2 3 4 98 99	
32.	What are the benefits of HIV disclosure?	Someone can help you remember your medication. You can talk freely with this person. You can keep people you love safe by telling	1 2	

		sexual partners, making good decisions about your sexual life and, if you chose to have sex, always using condoms. Other Specify Don't Know No Response	 4 5 98 99	
	PHYSICAL AND SOCIAL WELLBEING			
33.	For good personal hygiene I should take care of	My body My teeth My clothes My hair Other Specify Don't Know No Response	1 2 3 4 5 98 99	
34.	What are the types of food groups that we have?	Body-building foods Energy-giving foods. Protective foods Other Specify Don't Know No response	1 2 3 4 98 99	
35.	What are the core life skills that you know?	Decision making and problem-solving Critical thinking and creative thinking Communication and interpersonal relationships Self-awareness and empathy Coping with stress and emotion Other Specify Don't Know No response	1 2 3 4 5 6 98 99	
	COMMUNICATION/LEADERSHIP/GOAL SETTING			
36.	What are some of the keys to good communication?	Listening carefully when another person is speaking Trying to understand what the other person is saying Saying "excuse me" before interrupting Making eye contact with speaker Paying attention to what you are saying with your body language Saying what you mean: for example, do not agree to do something if you know that you cannot do it or will not do it Speaking respectfully Remembering that everyone has a right to his or	1 2 3 4 5 6 7	

		her own opinion Other specify Don't Know No Response	8 9 98 99	
37.	What does aggressive behaviour involve?	Verbal or physical threats or actions Fighting Bullying Gossip Engaging in hurtful behaviour Other Specify Don't Know No Response	1 2 3 4 5 6 98 99	
38.	What does passive behaviour involve?	Ignoring Not saying anything Letting the other person get what he/she wants Other Specify Don't Know No Response	1 2 3 4 98 99	
39.	What does assertive behaviour involve?	Letting others know about your needs and wants Considering the needs and wants of other people Standing up for your rights while respecting others Other Specify Don't Know No Response	1 2 3 4 98 99	
40.	An active listener is seen by what sort of traits?	Encouraging Reflective Understanding Other Specify Don't Know No Response	1 2 3 4 98 99	
41.	What type of leadership styles are you aware of?	Autocratic Democratic Laissez-Faire Other Specify Don't Know No Response	1 2 3 4 98 99	
42.	What are some of the good leadership qualities that teen leaders should exhibit?	Good listener Active and involved Confident with humility Good self-esteem Motivated Leads by example Punctual Positive attitude Empowers others Creative Respectful	1 2 3 4 5 6 7 8 9 10	

		Other Specify Don't Know No Response	11 98 99	
43.	Young teens should set goals in which areas within their life?	Career Education Family Artistic/talent Physical Pleasure Financial Other Specify Don't Know No Response	1 2 3 4 5 6 7 8 98 99	
	SEXUAL AND REPRODUCTIVE HEALTH ISSUES			
44.	What changes happen in both girls and boys during puberty stage?	Increase in height Increase in weight Acne (pimples) on face and sometimes the back Mood changes Increased sweating Appearance of hair in genital area and underarms Other Specify Don't Know No Response	1 2 3 4 5 6 7 98 99	
45.	I am positive I am able to handle the changes that my body is going through as I grow up	Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree No Response	1 2 3 4 5 99	
46.	It is easy for me to discuss sexual issues with my family members	Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree No Response	1 2 3 4 5 99	
47.	It is easy for me to discuss sexual issues with my friends of the same sex	Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree No Response	1 2 3 4 5 99	
48.	It is easy for me to discuss sexual issues with my friends of the opposite sex	Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree	1 2 3 4 5	

		No Response	99	
49.	I am positive I can handle friendship with the opposite sex without any difficulties	Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree No Response	1 2 3 4 5 99	
50.	I feel that the interference from my parents/guardians is just too much such that they interfere with my things	Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree No Response	1 2 3 4 5 99	
51.	I am able to decide to wait until marriage or until I feel more ready for the responsibilities that come with sex.	Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree No Response	1 2 3 4 5 99	
52.	Sexual activity does NOT always need to be part of a romantic relationship with the opposite sex.	Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree No Response	1 2 3 4 5 99	
53.	In my relationship, if my partner is not ready for sex, I am able to respect their decision.	Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree No Response	1 2 3 4 5 99	
54.	I am able to delay sexual intercourse until I am comfortable enough to disclose my HIV status to my partner.	Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree No Response	1 2 3 4 5 99	
55.	Do you think you have received enough training or mentorship to handle sex and sexual issues as a teenager?	Yes No Don't Know No Response	1 2 98 99	
56.	What methods of contraception do you know?	Abstinence Condoms The female condom Oral contraceptives Diaphragm Emergency contraception	1 2 3 4 5 6	

		Intrauterine device or IUD Contraceptive implant Injectable contraception (Depo-Provera) Other Specify Don't Know No Response	7 8 9 2 98 99	
57.	Condoms can be washed and reused.	True False Not Sure Don't Know No Response	1 2 3 98 99	
58.	Contraceptives will make you sterile and never able to have children.	True False Not Sure Don't Know No Response	1 2 3 98 99	
59.	If you use condoms you don't need to use other forms of family planning	True False Not Sure Don't Know No Response	1 2 3 98 99	
60.	It is possible for a woman with HIV to have a baby without HIV	True False Not Sure Don't Know No Response	1 2 3 98 99	
61.	One cannot get pregnant if… they have not begun menstruating	True False Not Sure Don't Know No Response	1 2 3 98 99	
62.	One cannot get pregnant if… they are having menstrual bleeding.	True False Not Sure Don't Know No Response	1 2 3 98 99	
63.	One cannot get pregnant if… they have intercourse standing up	True False Not Sure Don't Know No Response	1 2 3 98 99	
64.	One cannot get pregnant if… they urinate right after sexual intercourse.	True False Not Sure Don't Know No Response	1 2 3 98 99	
65.	One cannot get pregnant if…	True	1	

	they cleanse the vagina after sexual intercourse.	False Not Sure Don't Know No Response	2 3 98 99	
66.	One cannot get pregnant if… they are under 12 years old and too young to get pregnant	True False Not Sure Don't Know No Response	1 2 3 98 99	
67.	One cannot get pregnant if… a male pulls his penis out of the vagina before ejaculating.	True False Not Sure Don't Know No Response	1 2 3 98 99	
68.	One cannot get pregnant if… they are having sexual intercourse for the first time.	True False Not Sure Don't Know No Response	1 2 3 98 99	
69.	As a teenager do you worry about the following? (Read all responses out)	If the changes in your body are normal? If your friends like you? Whether you should start having a boyfriend/girlfriend? How you can perform better in school? If your guardians love you regardless of your mistakes?	1 2 3 4 5	

Appendix 2B: KAP Questionnaire (Siswati)

Loku kutawutsatsa imizuzu lengu 30 wesikhatsi sakho . Uyavuma yini kutsi sengingacala ngikubute?

B. Uma atsi “yebo” chubeka kani uma atsi “cha” bonga bese uchubekela kulomunye

	IDENTIFICATION
ID01	Questionnaire No. _____
ID02	Locality Name _____

#	Question	Responses		Skip Instructions
70.	mingakhi iminyaka yakho/uneminyaka lemingakhi?	Umnyaka_____		
71.	Sonesikhatsi lesingakanani ulilunga lale teanclub			
72.	Bulili balophendvulako	Wesilisa/wesifazane	1 2	
73.	Ufundze wagcina kuliphi libanga?	Angifundzanga ePrimary eSecondary ekolishi	1 2 3 4	
74.	Wentani kwekutiphilisa/yini lokwentako kwekutiphilisa?	ngisesesikolweni Ngicashiwe Ngiyatisebenta Angisebent Akaphendvuli	1 2 3 4 99	
	GENERAL QUESTIONS ABOUT TEEN CLUBS			
75.	Ngekucondza noma ngekubona kwakho utsi ngabe yini umgomo/inhloso yesigungu sebantfu labasha(Teen Clubs?	kuhlomisa bantfu labasha kutsi bakhe budlelwano lobuphilako Kukhulisa kutetsemba kwabo Kutfola emakhono emphilo ngekwakha budlelwano nabontsanga yabo,labadzala labasibonelo lesihle kubo netinhlelo letakhiwe kahle takhelwa bona lokunye(chaza)	1 2 3 4	
76.	Nenta tintfo tini kulesigungu sebantfu labasha?	imidlalo tikeshi imidlalo kudweba Nalokunye (chaza)	1 2 3 4 5	

77.	Ngutiphi tihloko lenikhuluma ngato nanihlangene kuleTeenclub?	Tifundvo ngeHIV,kusho simo sakho sengati,kunatsa imitsi yakho ngendlela lefanele Kutincumela ngalokufunako emphilweni Tindzaba tekulala nekutalana Kukhona kuphilanesici nekubandlululeka kutfola emakhono ekuphila Lokunye(chaza)_____	1 2 3 4 5 6	
	HIV and AIDS			
78.	Ungatikala utsi lunganani lwati lwakho nge HIV?	Low /luphansi Luphansi kakhulu Lungalokusemkhatsini Lusetulu Lusetulu kakhulu Kubete imphendvulo	1 2 3 4 5 99	
79.	Itsatselwana kanjani iHIV?	Ngekusutelwa yimbuzulwane Ngekwangana Ngekulalana Ngekufakelwa ingati emtimbeni Uma ukhulelwe/ngesikhatsi ukhulelwe Uma ubeleka/ngesikhatsi ubeleka Ngesikhatsi umunyisa Ngekusebentisa inyalitsi lengcolile noma lese ike yasebenta	1 2 3 4 5 6 7 8	
	Indicate whether each of the following behaviours is HIGH, LOW, or NO RISK in terms of HIV infection			
80.	Kulala nemuntfu nawusebentise tidzakamiva	Kukufaka engotini lenkhulu Bungoti bakhona buncane kakhulu Akunangoti / kute bungoti Angati Kubebete imphendvulo	1 2 3 98 99	
81.	Ngekufakwa ingati emtimbeni wakho	Kukufaka engotini lenkhulu Bungoti bakhona buncane kakhulu Akunangoti / kute bungoti Angati Kubebete imphendvulo	1 2 3 98 99	
82.	Ngekulala nebantfu labaningi labehlukene(tingani tebafana noma nemantfombatana	Kukufaka engotini lenkhulu Bungoti bakhona buncane kakhulu Akunangoti / kute bungoti Angati Kubebete imphendvulo	1 2 3 98 99	
83.	Umuntfu lomusha lokhulelwe kani akekho kuma ARVs	Kukufaka engotini lenkhulu Bungoti bakhona buncane kakhulu Akunangoti / kute bungoti Angati Kubebete imphendvulo	1 2 3 98 99	
84.	Ngekunakekela bantfu labane HIV	Kukufaka engotini lenkhulu Bungoti bakhona buncane kakhulu	1 2	

		Akunangoti / kute bungoti Angati Kubebete imphendvulo	3 98 99	
85.	Ngekwangana kakhulu ngendlela lejulile,	Kukufaka engotini lenkhulu Bungoti bakhona buncane kakhulu Akunangoti / kute bungoti Angati Kubebete imphendvulo	1 2 3 98 99	
86.	Ngekusutelwa yimbuzulwane	Kukufaka engotini lenkhulu Bungoti bakhona buncane kakhulu Akunangoti / kute bungoti Angati Kubebete imphendvulo	1 2 3 98 99	
87.	Ngekugodla umuntfu lone HIV?	Kukufaka engotini lenkhulu Bungoti bakhona buncane kakhulu Akunangoti / kute bungoti Angati Kubebete imphendvulo	1 2 3 98 99	
88.	Ngekulala nemuntfu ungasebentisi ikhondomu	Kukufaka engotini lenkhulu Bungoti bakhona buncane kakhulu Akunangoti / kute bungoti Angati Kubebete imphendvulo	1 2 3 98 99	
89.	Ngekulalana nisebentisa umlomo	Kukufaka engotini lenkhulu Bungoti bakhona buncane kakhulu Akunangoti / kute bungoti Angati Kubebete imphendvulo	1 2 3 98 99	
90.	Ngekulalana ngemuva	Kukufaka engotini lenkhulu Bungoti bakhona buncane kakhulu Akunangoti / kute bungoti Angati Kubebete imphendvulo	1 2 3 98 99	
91.	Ngekusebentisa umthoyi wesive	Kukufaka engotini lenkhulu Bungoti bakhona buncane kakhulu Akunangoti / kute bungoti Angati Kubebete imphendvulo	1 2 3 98 99	
92.	Ngekusebentisa ilezana yinye	Kukufaka engotini lenkhulu Bungoti bakhona buncane kakhulu Akunangoti / kute bungoti Angati Kubebete imphendvulo	1 2 3 98 99	
93.	Ngekugula ngetifo letitfolakala ngelicansi	Kukufaka engotini lenkhulu Bungoti bakhona buncane kakhulu Akunangoti / kute bungoti Angati	1 2 3 98	

		Kubebete imphendvulo	99	
	Indicate your degree of agreeing or disagreeing with the following statements:			
94.	Ngingete ngasigcina siyimfihlo simo sengati selilunga lemndeni	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu Angati Kubebete imphendvulo	1 2 3 4 98 99	
95.	Loyo lophila neligciwane leHIV angete akhona kufundza aze atfole ticu			
	Indicate the level of your agreement on the following statements regarding ART Adherence Khombisa lizinga lekuvuma kwakho kuletitatimende letilandzelako mayelana neART nekulandzela indlela lefanele yekunatsa imitsi noma emaphilisi			
96.	Kumele kutsi umuntfu ayekele kutsatsa imitsi/emaphilisi yema ARVs\ART nangabe kute kudla lokutawuphekeletela lamaphilisi/lemitsi	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu Angati Kubebete imphendvulo	1 2 3 4 98 99	
97.	Nangabe utiva shengatsi sewuphile ungumcemane,kumele uyekele kutsatsa ema ARV's	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu Angati Kubebete imphendvulo	1 2 3 4 98 99	
98.	ART akelaphe iHIV	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu Angati Kubebete imphendvulo	1 2 3 4 98 99	
99.	ART kumele uyitsatse imphilo yakho yonkhe	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu Angati Kubebete imphendvulo vulo	1 2 3 4 98 99	
100.	ART unciphisa ematfuba ekutsi wendlulisele iHIV kulabanye kepha ayiwenti lamatfuba ekulengcisela embili leligciwane abe ngekho sanhlobo	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu Angati Kubebete imphendvulo	1 2 3 4 98 99	
101.	Yini lokungaba tinzuzo tekutsi udalule/usho simo sakho ngeHIV?	Ukhona longakusita kukukhumbuta kutsi unatse umutsi/emaphilisi akho Ungakhuluma nomayini nalomuntfu	1 2	

		ngekukhululeka Ungenta kutsi bantfu lobatsandzako bavikeleke ngekutsi ubatise labo lotsandzana nabo ngesimo Ungenta tincumo letikahle ngemphilo yakho yekulala,uma ukhetsa kutsi ufuna kulala,ungasebentisa ikhondomu ngaso sonkhe sikhatsi Lokunye(chaza) Angati Kubebete imphendvulo	 4 5 98 99	
	PHYSICAL AND SOCIAL WELLBEING			
102.	kuze umtimba wami uhlale uhlobile kumele ngiwunakekele ngekutsi nginake;	Umtimba wami Ematinyo ami Kokwembatsa kwami Tinwele tami Lokunye(chaza) Angati Kubebete imphendulo	1 2 3 4 5 98 99	
103.	Ngabe ngutiphi tinhlobo tekudla lesinato ngebucembu bato?	Kudla lokwakha umtimba Energy-giving foods./kudla lokunika emandla Kudla lokuvikelako Other Specify/lokunye(chaza) Angati No response/kubebete imphendvulo	1 2 3 4 98 99	
104.	Ngutiphi tindlela tekutiphilisa letimcoka kakhulu lotatiko?	Kwenta tincumo nekuchacha tinkinga Kucabangisisa kahle nalokwakhako Tekuchumana nekwakha buhlobo nalabanye bantfu Kutati kutsi ungubani nekutifaka eticatfulweni talabanye Kukhona kubamba kukhatsateka nekuba phansi kwemoya Lokunye(chaza) Angati Kubebete imphendvulo	1 2 3 4 5 6 98 99	
	COMMUNICATION/LEADERSHIP/GOAL SETTING			
105.	Ngutiphi tindlela letimcoka ekukhulumisaneni kahle?	Kulalela kahle nangabe lomunye akhuluma Kuzama kucondza kutsi lomunye utsini Kutsi"ngiyacokisa"ungakaphazamisi Kumbuka emehlweni loyo lokhulumako Kunaka loko lokushoko ngemtimba wakho Kusho loko lokushoko: njengekutsi nje ungavumi kutsi utakwenta intfo ube wati kutsi ngeke uyente	1 2 3 4 5 6	

		Kukhuluma ngenhlonipho Kukhumbula kutsi nguloyo naloyo unelilungelo lekutsi abe nembono wakhe Lokunye(chaza) Angati Kubebete imphendvulo	7 8 9 98 99	
106.	Ngabe similo sebudlova sifakani?	Kwenta tifungo netinsongo ngemlomo noma ngekubambana ngema washini Kulwa Kuhlukubeta Kuhleba Kuvisa buhlungu labanye Lokunye(chaza) Angati Kubebete imphendvulo	1 2 3 4 5 6 98 99	
107.	Similo sekutsi umuntfu anganaki tintfo sifakani	Kunganaki Kungasho lutfo Kuyekela lomunye atfole loko lakufunako Lokunye(chaza) Angati Kubebete imphendvulo	1 2 3 4 98 99	
108.	Umuntfu lonesimilo sekutitsatsela etulu tintfo ubonakala ngani?	Kwenta labanye bati ngetidzingo takho nalokufunako Kucabangela labanye ngetidzingo tabo nalabakufunako Kumela loko lokungemalungelo akho usahlonipha nalabanye Llokunye(chaza) Angati Kubebete imphendvulo	1 2 3 4 98 99	
109.	Umuntfu lonesiphiwo sekulalela kahle labanye, ubonakala ngatiphi timphawu?	Kukhutsata Kubuka emuva Kucondzisisa kahle Kunye(chaza) Angati Kubebete imphendvulo	1 2 3 4 98 99	
110.	Nguluphi luphawu lwebuholi lolwatiko?	Sandla lesicinile Intsandvo yeliningi Isijubo sakhe lesiba kahle kubo bonkhe bantfu Lokunye(chaza) Angati Kubebete imphendvulo	1 2 3 4 98 99	
111.	Ngutiphi timphawu tebuholi letibhekeke lulabahola insha?	Lolalelako Lokhutsele nalotifakako etintfweni Lotetsembako kepha abe aphansi Longenakutikhobosa lokukahle Lokhutsatekile	1 2 3 4 5	

		Losibonelo lesihle Logcina sikhatsi Lonesimilo lesikahle Lobakhutsatako labanye Lonemasu lamahle phindze abe nenhlonipho Lokunye(chaza) Angati(chaza) Kubebete imphendvulo	6 7 8 9 10 11 98 99	
112.	Bantfu labasha kumele batentele imigomo kutiphi tinhlangotsi temphilo yabo?	Ekutitfutfukiseni Emfundvweni Emndenini Emakhonweni nasekudwebeni Lokuphatsekako Kukwekutijabulisa/noma kwekucitsa sikhatsi Ngetimali Lokunye(chaza) Angati Kubebete imphendvulo	1 2 3 4 5 6 7 8 98 99	
	SEXUAL AND REPRODUCTIVE HEALTH ISSUES			
113.	Kwenteka mehluko muni emfaneni nasentfombataneni nabefika esigabeni sekutfomba?	Kukhula ngebudze Kukhula ngesisindvo Kuba nemajiji ebusweni ngalesinye sikhatsi ngemuva kwemtimba Kuba phansi kwemoya wakho Kukhula kwemfomo Kuba neboya etindzaweni tangasese nangaphansi kwemakhwapha Lokunye(chaza) Angati Kubebete imphendvulo	1 2 3 4 5 6 7 98 99	
114.	Nginesiciniseko sekutsi ngiyakhona kumelana netingucuko letenteka emtimbeni wami Kanye naleto umtimba wami lohlangabetana nato ngisakhula.	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu Angati Kubebete imphendvulo	1 2 3 4 5 99	
115.	Kulula kimi kutsi ngikhulume tindzaba tekulalana nemalunga emndeni wami	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu Angati Kubebete imphendvulo	1 2 3 4 5 99	
116.	Kulula kimi kutsi ngikhulume tindzaba tekulalana nebangani bami lesibulili bunye nabo.	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu	1 2 3 4	

		Angati Kubebete imphendvulo	5 99	
117.	Kulula kimi kutsi ngikhulume tindzaba tekulalana nebangani lesinebulili lobungafanani.	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu Angati Kubebete imphendvulo	1 2 3 4 5 99	
118.	Nginesiciniseko sekutsi ngingakhona kububamba bungani bami nemuntfu lonebulili lobungafani nebami ngaphandle kwenkinga.	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu Angati Kubebete imphendvulo	1 2 3 4 5 99	
119.	Ngiva shengatsi lokugaceka noma kungena ekhatsi etindzabeni tami kwebatali bami noma labo labanelilungelo lokungikhulisa, ngiva ungatsi kungetulu kwemandla lokungena ekhatsi ngalokuphatselane nami	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu Angati Kubebete imphendvulo	1 2 3 4 5 99	
120.	Ngiyakhona kutsi ngincume kutsi ngime ngize ngishade nomake ngize ngive kutsi sengilungele kumelana nato tonkhe tintfo letihambelana nekulala	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu Angati Kubebete imphendvulo	1 2 3 4 5 99	
121.	Kulalana AKUSHO kutsi njalo nje kungaba yincenye yebudlelwano lobumnandzi nalabo bebulili lobehlukene.	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu Angati Kubebete imphendvulo	1 2 3 4 5 99	
122.	Ekutsandzaneni kwami,uma atsi loyo lengitsandzana naye akalungeli kulala, ngiyakhona kuhlonipha leso sincumo sabo.	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu Angati Kubebete imphendvulo	1 2 3 4 5 99	
123.	Ngiyakhona kuphuta kucala kulala kuze kufike sikhatsi lapho ngitativa sengikhululekile kutsisengingasisho simo sami seHIV kuloyo lengitsandzana naye	Ngivumelana nako kakhulu Ngiyavuma Angivumi Angivumelani nako kakhulu Angati Kubebete imphendvulo	1 2 3 4 5 99	
124.	Ingabe ucabanga kutsi sewutfol	Yebo	1	

	kucecesheka lokwanele yini noma kukhuliseka kahle yini kutsi sewungakhona konkhe lokutindzaba letiphatselene nekulala usengumuntfu lomusha?	Cha Angati Kubebete imphendvulo	2 98 99	
125.	Ngutiphi tindlela tekuhlela umndeni lotatiko?	Kutila ungalal Ikhondomu Ikhondomu yebesifazane Emaphilisi Sivimbo sekuvala umlomo wesibeletho Liphilisi lelisetjenyiswa esimeni lesiphutfumako Iluphu Kwekuvikela lokufakwa emkhonweni Umjovo Kuvala kwebesifazane Kuvala kwebesilisa Lokunye(chaza) Angati kubebete imphendvulo	1 2 3 4 5 6 7 8 9 10 11 12 98 99	
126.	Kuliciniso noma kungemanga/Awati kahle kutsi; ikhondomu ingawashwa noma isetjentiswe futsi	Liciniso Akusilo liciniso Anginasiciniseko Angati Kubebete imphendvulo	1 2 3 98 99	
127.	Kuhlela umndeni kukwenta kutsi ungakhoni kutfola bantfwana	Liciniso Akusilo liciniso Anginasiciniseko Angati Kubebete imphendvulo	1 2 3 98 99	
128.	Uma usebentisa ikhondomu asikho sidzingo sekutsi usebentise letinye tindlela tekuhlela umndeni	Liciniso Akusilo liciniso Anginasiciniseko Angati Kubebete imphendvulo	1 2 3 98 99	
129.	Kungenteka yini kutsi make loneHIV atale umntwana longenayo leHIV?	Liciniso Akusilo liciniso Anginasiciniseko Angati Kubebete imphendvulo	1 2 3 98 99	
130.	Ungeke ukhulelwe uma …..ungakacali kuya emfuleni	Liciniso Akusilo liciniso Anginasiciniseko Angati Kubebete imphendvulo	1 2 3 98 99	
131.	Ungeke ukhulelwe uma ….. uya emfuleni	Liciniso Akusilo liciniso	1 2	

		Anginasiciniseko Angati Kubebete imphendvulo	3 98 99	
132.	Ungeke ukhulelwe uma ….. ulala nemuntfu umile	Liciniso Akusilo liciniso Anginasiciniseko Angati Kubebete imphendvulo	1 2 3 98 99	
133.	Ungeke ukhulelwe uma ….ubese uyochama masinyane nje ucedza kulala	Liciniso Akusilo liciniso Anginasiciniseko Angati Kubebete imphendvulo	1 2 3 98 99	
134.	Ngeke ukhulelwe uma ……usheshe wageza intfombi masinyane nje nawucedza kulala	Liciniso Akusilo liciniso Anginasiciniseko Angati Kubebete imphendvulo	1 2 3 98 99	
135.	Ungeke ukhulelwe uma …..ungaphansi kweminyaka lengu 12	Liciniso Akusilo liciniso Anginasiciniseko Angati Kubebete imphendvulo	1 2 3 98 99	
136.	Ungeke ukhulelwe nangabe …… ucencuka	Liciniso Akusilo liciniso Anginasiciniseko Angati Kubebete imphendvulo	1 2 3 98 99	
137.	Ungeke ukhulelwe nangabe…….ucala ngca nje kulala	Liciniso Akusilo liciniso Anginasiciniseko Angati Kubebete imphendvulo	1 2 3 98 99	
138.	Ngabe loku lokulandzelako kuyakukhatsata yini njengemuntfu lomusha? Tifundze tonkhe timphendvulo	Kutsi lushintjo lolusemtimbeni wami lukhombisa imphilo lekahle yini Kutsi bangani bakho bayakutsandza yini? Kutsi sewungacala yini kuba nesingani? Kutsi ungentani kute wente ncono esikolweni? Kutsi labakunakekelako bayakutsandza yini noma wenta emaphutsa?	1 2 3 4 5	

Appendix 3: Interview Guide for Baylor Staff

1. What would you say has been the biggest success in the Teen Clubs Programme? What do you attribute the success to?
2. The issue of adolescents who default on treatment (LTFU) is a big concern, to what extent has the programme been able to deal with this and with what success?
3. It would appear that many of the adolescents who are referred to your programme from the clinics are defaulters or have poor adherence. How does this affect the way you structure your programmes in terms of prioritizing issues for discussion in the groups?
4. You mention that a drive has been launched to encourage full disclosure, what were the key elements of that drive and how successful has been the drive (need for figures to back up claims)?
5. From your reports, it would appear that there are challenges with users of the U Platform, relating to issues such as responses to questions etc. how have you addressed these challenges and how effective is the platform now?
6. What synergies, if any, has your programme struck with other HIV and AIDS interventions targeting adolescents and young women such as the PEPFAR DREAMS Project? How have the synergies helped you in your work? What other partnerships and synergies are you involved in or are you pursuing?
7. One of the goals of the Teen Clubs is to empower ALHIV, to what extent do you think this has been achieved and what is the evidence of this among the youths?
8. What is the level of collaboration and partnership that you have with schools and how do school AIDS programmes complement what you are doing?
9. An important consideration in UN supported interventions is South –South Cooperation. To what extent has your programme benefited from South- South and what have you incorporated into your programme from collaborating with?
10. The issue of mental health is becoming increasingly important in relation to ALHIV. In your reports you mention that not enough is being done about screening adolescents for this. What steps are you taking to improve on this important aspect? What interventions do you have in place to address issues of mental health, apart from the setting up of an additional social work office? What capacity does Baylor have to deal with some of the social problems within the lives and families of adolescents that impact on their wellbeing and participation in the clubs e.g. cause depression; contribute to defaulting?
11. What is the unit cost of providing services to one adolescent going through your programme? How does the cost compare to that of similar interventions in the region? What constitutes the biggest unit cost? What strategies have you adopted to reduce the unit costs? How are the costs shared between your partners? Have you experienced financial gaps in your programming? How have you covered for such gaps and with what success?
12. Baylor uses teen club leaders to facilitate the trainings. It also has at any one time volunteers from universities in the US and UK as well as Peace Corps? What is the specific value-added of the overseas volunteers? To what extent do they contribute or detract from the local ownership of the programme, which is so key to its long-term sustainability?

13. Teen Clubs are open to adolescents from the age of 10 to 19 years. Among some of the topics that the Manual deals with are SRH issues including STIs, as well as reproductive health. In your trainings, how do you decide which topics are suitable for which age group and at what point are the adolescents separated?
14. Can you please explain how the family-centred, caregiver support services you offer operate and what have been the improved outcomes from this intervention?
15. What are the major challenges that you face in the in-Reach programme? What have been the programme's successes?
16. Viral Load suppression is one of the key indicators of success in interventions targeting ALHIV. What has been the success rate of the programme on this indicator compared to children not enrolled on the Programme?
17. What per centage of the Teen Club members is not HIV+? Are the HIV negative adolescents able to fit well into the programme?
18. What relationships have been fostered between the programme and the national HIV and AIDS programme?
19. What capacities have been built within the programme? How effective has the capacity building programme been?
20. What capacities were built to ensure that the programme runs smoothly?
21. How sustainable is the system of volunteers? What is the attrition rate of volunteers? What are the reasons given by volunteers for leaving the programme?
22. What keeps the volunteers in the programme motivated?

Appendix 4: Interview Guide for Clinic Staff

1. What are the challenges that you come across in dealing with ALHIV that you do not encounter with adults?
2. The issue of adolescents who default on treatment (LTFU) is a big concern, in what way and with what success have the Teen Clubs have contributed to the reduction in adolescents who default on treatment?
3. The transition from pediatric care to care for adolescents has been seen as a period when many of them default on treatment. What measures have you put in place to ensure the smooth transition and reduce LTFU?
4. What are the criteria that you use to recommend ALHIV to join the Teen Clubs?
5. What differences have you observed between adolescents who are members of the Club and those who are not in terms of (a) adherence (b) viral suppression (c) mental health

Interview Guide, Ministry of Health

1. The Ministry of Health has adopted the teen clubs approach as a promising practice to enhance adherence to ART among adolescents. What support does the Ministry provide to the clubs – financial and technical?
2. Outside the 4 Baylor Sites, Teen Clubs are being run at 77 other sites across the country. Are there any major differences in the way the programmes are being run? What is the government doing to ensure the sustainability of the clubs? Who is funding the activities in the 77 other project sites? What are the comparative unit costs between the 77 clubs and the Baylor-ran clubs? What is the biggest cost factor in the running of the clubs?
3. What are the policy gaps that the Ministry feels should be addressed to make the Teen Clubs more effective?
4. To what extent are the Teen Clubs in line with government priorities for HIV and AIDS as articulated in Swaziland's National Multisectoral HIV and AIDS Framework for 2014 – 2018?

Appendix 5: Interview guide for UNICEF

1. Apart from financial assistance, what technical support is UNICEF providing to the Teen Clubs?
2. What do you see as some of the sustainability factors working in favour of the Teen Clubs? And against their sustainability?
3. What attracted UNICEF to provide support to the Teen Clubs? How do the Teen Clubs compare with similar interventions for ALHIV in the region e.g. Zvandiri in Zimbabwe?

4. How has the Teens Club Programme benefitted from South-South cooperation? What aspects have been incorporated to enrich the programme from other countries in the South?
5. To what extent is the Teen Clubs Programme aligned to Global and Regional practices for interventions for ALHIV?
6. Apart from the Baylor sites, there are 77 other sites across the country running Teen Clubs. Which of the two interventions would you say is more cost effective and why? What support, if any, is UNICEF providing to the other sites? What lessons have been learnt from the Baylor sites that would inform the way the programmes are structured and run outside these sites?
7. What collaboration exists between UNICEF and the other partners supporting the Teen Clubs i.e. EGPAF, ICAP and URC. Do you have an established platform for coordinating your activities?
8. As one of the organisations providing support to the Teen Clubs, what are the programmatic and policy gaps that you have noticed in relation to the Clubs?
9. What capacities have been built within the programme? How effective has the capacity building programme been
10. How effective are the Teen Clubs' Programme's M&E systems?
11. What is the relevance of the Teen Clubs in relation to the UNICEF Strategic Plan (SP), Regional Priorities and UNICEF/ Government of Kingdom of Swaziland Country Programme 2016-2020?

Appendix 6A: Interview Guide for Parents/Guardians of ALHIV (English)

1. For how long has your child been participating in the Teen Club Programme?
2. What motivated him/her to join?
3. What benefit has he/she derived from participating in the club? Have you noticed any positive changes that have come about as a result of his participation in the Teen Clubs? What are these changes?
4. How has the child handled disclosure of his/her status? What were the support structures within the family to help him/her to cope with disclosure?
5. What costs has the family had to bear in relation to the child's participation in the Club?
6. What is the level of parental involvement in the Club activities? Do you think these are adequate or they should be increased?
7. ALHIV need psychosocial support. What form does that support take within your family/household?
8. As a family, how have you been able to deal with the issue of stigma associated with HIV and AIDS?
9. What do you think should be done to make families and communities more accepting of children living with HIV and AIDS? Who do you think would be most effective in raising awareness on the issue?

Appendix 6B: Interview Guide for Parents/Guardians of ALHIV (Siswati)

1. Sekusikhatsi lesinganani umntfwana wakho abe yincenye yaloluhlelo lwe Teen Club?
2. Yini lokwamgcugcutela kutsi alungenele loluhlelo?
3. Yini lokube yinzuzo lakutfolile ngekungenela loluhlelo.Kukhona yini lokuphatsekako lokuhle lokube yingucuko longakukhomba kutsi kwenteke ngenca yaloluhlelo lwe Teen Clubs.Ngutiphi tona leto tingucuko?
4. Kukhona yini lokubonile lokuhle lokwehlukile lokungumuphumela walokutsi wangenela lama Teen Clubs?Kwaba yini lomehluko/kwaba namehluko muni?
5. Ukhone njani umntfwana kubhekana netindzaba tekutsi adalule simo sengati yakhe.Kuba yini lokwentiwe ngumndeni kumesekela kutsi akhone kumelana netintfo letingavela kulandzela lokudalula simo sengati yakhe.
6. Tibe nganani tindleko umndeni lotikhiphile ngekutsi umntfwana bekalilunga leTeen Club? Kube ngakanani kutimbandzakanya kwebatali nale Club?Ucabanga kutsi lokutimbandzakanya kwabo nale club kwenele noma kusadzinga kukhuliswa?
7. ALHIV idzinga kwesekeleka kutencondvo nenhlalakahle.Wesekeleka kanganani umntfwana kuloku emndenini noma kulelo dladla lahlala kulo?

8. Njengemndeni,nikhone njani kubhekana netindzaba tekubandlululeka/tekubandlululwa ngekutsi umuntfu une HIV noma iAIDS?
9. Ucabanga kutsi yini lengentiwa kutsi imindeni nemango ukhone kubemukela bantfwana labaphila ne HIV noma AIDS?Ucabanga kutsi ngubani longaletsa lolwati lufike lube nesisindvo kulabo labatsintsekako?

Appendix 7A: Interview Guide for Teen Club Leaders (English)

1. What inspired/motivated you to become a Teen Club Leader?
2. What do you enjoy about being a Teen Club Leader?
3. What have been your greatest challenges as a Ten Club Member?
4. What support do you get from Baylor staff to make you a more effective leader?
5. Have you gone through a leadership training course? How did it help you in the way you deal with others? Have you found the leadership skills you gained useful outside the Teen Clubs and if so in what way?
6. What factors do you think support the Teen Clubs as a youth-driven initiative? What factors militate against leadership of the initiative by the youth?
7. As a teen leader what are the challenges you face in relation to (a) providing leadership to ALHIV, particularly those who may just have joined (b) building self-confidence in the ALHIV (c) encouraging disclosure among the youths (d) providing adolescence with adherence support?
8. What concepts do you find difficult to facilitate (teach) in the manual and what do you think should be done to make them more understandable?

Appendix 7B: Interview Guide for Teen Club Leaders (Siswati)

1. Yini leyakugcugcutela kutsi ube ngumholi kule Teen Club?
2. Yini lokutsandzako ngekuba ngumholi we Teen Club?
3. Yini lokube tinkinga letinkhulu ekubeni lilunga leTeen Club?
4. Ngukuphi kwesekeleka lokutfola etisebentini taka Baylor lokukwenta ube ngumholi lokahle?
5. Uke wakutfola yini kucecesheka ngebuholi? kukusite kanganani ebudlelwaneni bakho nalabanye bantfu?Lamakhono lowatfolile ebuholi akusitile yini nangaphandle kwale Teen Clubs, uma kunjalo kukusite kanjani?
6. Yini locabanga kutsi kwesekela leTeen Clubs isebente njengentfo yebantfu labasha lokumele ichutjwe ngabo?
7. Njengemholi walabasha tinkinga tini lobhekene nato ekutseni(a)Kunika buholi lobucotfo kubantfu laba ALHIV ikakhulu laba labasandza kujoyina (b)Kwakha kutetsemba kuALHIV (c) Kukhutsata kutsi bantfu labasha basisho simo sabo sengati (d) kusita bantfu labasha kutsi balandzele konkhe lokushiwoko ngekutsatsa imitsi noma emaphilisi abo.
8. Ngukuphi lokhandza kulukhuni kukhuluma ngako kulobhukwana wekufundzisa (manual) futsi ucabanga kutsi yini lekungentiwa kutsi kuvakale.

Appendix 8A: Interview Guide for FGD with Teen Club members (English)

1. What do you see as the greatest benefit that you have derived from being a member of the Teen Club?
2. What has changed in your life and in the way you feel about your condition since you joined the Teen Clubs?
3. What skills, information, have you learnt from the Teen Clubs that you think you could not have learnt from any other source?
4. What do you enjoy as a member of the Teen Club? What do you find to be not so pleasant about how the Club is run?
5. How has the Teen Club helped you with (a) adherence (b) gaining self confidence (C) dealing with stigma both self stigma and stigma from the community around you (d) accept your condition. How has this been done?
6. What challenges do you face outside the Teen Club environment because of your status? How are you managing to deal with them?
7. What concepts do you find difficult to understand in the manual and what do you think should be done to make them more understandable?

Appendix 8B: Interview Guide for FGD with Teen Club members (Siswati)

1. Yini lokubona kube yinzuzo kuwe ngekuba lilunga leTeen Club?
2. Yini lokuletse ingucuko emphilweni yakho ngendlela lotiva ngayo kulesimo sakho solo wajoyina le Teen Club?
3. Yini emakhono, lwati lokufundzile ku Teen Clubs locabanga kutsi bewungeke ukufundze encenye ngaphandle kwale Teen Club?
4. Yini lokukuchazako ngekuba lilunga laleTeen Club? Yini lokungakuchazi ngendlela leclub lephetfwe ngayo?
5. Ingabe ikusite njani leTeen Club etindzabeni letiphatselene (a) nekulandzela indlela umutsi noma emaphilisi lokumele atsatfwe ngayo (b) kwengeta kutetsemba (c) kubhekana netindzaba tekubandlululeka ngekutsi utibandlulule wena noma ubandlululwe ngumango lophila kuwo (d) kwemukela simo sakho.Ukwente njani loku?
6. Ngutiphi tinkinga lobhekana nato ngaphandle kwale Teen Club ngenca yesimo sakho? Utichacha njani?
7. Ngutiphi tintfo lotikhandza tilukhuni kutiva kulobhukwana (manual)Ucabanga kutsi yini lengentiwa kutsi tivakale kancono kunalendlela lokubekeke ngayo nyalo?

Appendix 9A: Interview guide for young adults who have graduated from the Teen Clubs

1. For how long were you a member of the Teen Clubs?
2. What spurred you to join the teen clubs?
3. In what ways do you think the Teen Clubs equipped you to deal with life as a young adult? Please explain?
4. Are you aware of other young people like you who did not join the Teen Clubs and what problems they continue to face?
5. As a young adult, how did the Teen Club equip you to handle relationships with boyfriend/girlfriend? Do you feel confident to start a family? Have you achieved viral suppression? Do you still have adherence problems or you have overcome them?
6. Do you think the process of weaning you off the Teen Clubs was done sufficiently well to enable you to integrate smoothly into life? What do you think should be done differently?
7. What skills do you think you need as a young adult that you feel the Club did not focus sufficiently on or at all?
8. What recommendations would you make for the Teen Clubs that would assist young adults to transition into the world more smoothly?
9. Currently the Clubs are supported by various donors. What do you think could be done to make the Clubs more self-sustaining?

Appendix 9B: FGD guide for young adults who have graduated from the Teen Clubs (Siswati)

1. Sewunesikhatsi lesinganani ulilunga lale Teen Clubs?
2. Yini lokwakwenta kutsi ujoyine le teen clubs?
3. Ngekucabanga kwakho, ikusite njani I teen clubs kukuhlomisa kutsi ubhekane nemphilo usengumuntfu lomusha?Please explain?Chaza?
4. Kukhona yini labanye bantfu labasha lobatiko labangazange bajoyine iteen clubs labachubekako nekuba netinkinga?
5. Njengemuntfu losakhula/lomusha, ikuhlomise ngani I teen clubs kutsi ukhone kutsi budlelwano bakho nesingani sakho ukhone kububamba kahle?Utiva unaso yini sibindzi sekucala wakho umndeni?Ukhonile yini kutsi emasotja akho akhule?Usenato yini tinkinga tekungalandzeli kahle kutsatfwa kwemitsi yakho noma emaphilisi?Noma sewute leyo nkinga?
6. Ucabanga kutsi lokulunyulwa kwakho ku teen clubs yenteka kahle yini kutsi sewungakhona kubhekana nemphilo ngaphandle kwenkinga? Ucabanga kutsi yini lengentiwa leyehlukile?
7. Yini emakhono locabanga kutsi uyawadzinga njengemuntfu lomusha kani iclub ayikakhoni kukunika wona noma-ke abe mancane angeneli/angakwenetisi?
8. Yini tincomo longatenta ku Teen Club letingasita insha kutsi iluhambe kahle loluhambo lwayo lwekuya ebudzaleni?

9. Kwamanje le Clubs isekelwa tinini tenkhosi letehlukene.Yini locabanga kutsi ingentiwa kuze ikhone kutimela inganciki kakhulu elusitweni loluchamuka ngaphandle?

Appendix 10 A: Parental/Guardian Consent form (English)

Parental Permission for Participation of your Child in the Evaluation of Teen Clubs Programme for Adolescents Living with HIV in Eswatini

Description of the research and your child's participation

We are inviting your child to participate in the evaluation of the Teen Clubs Programme for Adolescents Living with HIV being conducted by Leonard Maveneka, who is the Principal Investigator. The purpose of the evaluation is assess the extent to which the Teen Clubs for ALHIV have achieved what they were set up to achieve and to make recommendations that will assist to make the programme achieve greater impact.

Your child's participation will involve participating in group discussions where he, along with other children will be asked questions about what they think about the programme and how they have benefitted from it and what needs to be done to improve the programme.

Your child will be required to participate for a maximum of two hours. Transport costs to and from the venue (Baylor Clinic) will be reimbursed and your child will be provided with refreshments after the interviews and discussions.

Risks and discomforts

There are no known risks associated with the evaluation.

Potential benefits

There are no known direct benefits to the child that would result from his/her participation in the evaluation but the children will all benefit from the improvements that will come in the way the programme is run after t evaluation.

Protection of confidentiality

We will do everything we can to protect your child's privacy. Your child's identity will not be revealed in any publication resulting from the evaluation and information collected from your child will not carry his name and no photographs of your child will be taken during the evaluation.

Voluntary participation

Participation in this evaluation is voluntary. You may refuse to allow your child to participate or withdraw your child from the evaluation at any time. Your child will not be penalized in any way should you decide not to allow or to withdraw your child from the evaluation.

Contact information

If you have any questions or concerns about this study or if any problems arise, please contact **Leonard Maveneka** at UNICEF Eswatini phone: +**268 24096710** If you have any questions or concerns about your child's rights as a research participant, please contact **Mr Leonard Kamugisha, who is the Chief, Adolescents & Youth Development Officer at UNICEF Eswatini.**

Consent

I have read this parental permission form and have been given the opportunity to ask questions. I give my permission for my child to participate in this study.

Participant's signature_____ Date:_____

Child's Name:_____

A copy of this parental permission form should be given to you.

Appendix 10B: Parental/Guardian Consent form (Siswati)

Parental Permission for Participation of your Child in the Evaluation of Teen Clubs Programme for Adolescents Living with HIV in Eswatini

Description of the research and your child's participation

Siyacela kutsi umntfwanakho angenele nangu umsebenti welucwaningo loluhlose kubuka kutsi loluhlelo lwemaTeen Clubs lolucondzene nebantfu labaphila neHIV loluholwa ngu Leonard Maveneka,loyiPrincipal Investigator. Inhloso yalomsebenti kubuka kabanti kutsi lamaTeen Clubs ema ALHIV akhonile yini kufeza loko lasungulelwa kutsi akwente futsi bese kwentiwa tincomo letitawusita kutsi loluhlelo lusebente kahle futsi nemsebenti walo ubonakale.

Ngekungenela lomsebenti umntfwanakho kubhekeke kutsi angenele inkhulumo ncociswano (group discussions) lapho yena nalabanye batawubutwa imibuto ngalabakucabangako ngaloluhlelo nekutsi bona loluhlelo lubasite kanjani,phindze futsi basho kutsi ngekubona kwabo kungentiwa njani kuze kutsi loluhlelo lusebente ncono.

Umntfwanakho kubhekekile kutsi abe yincenye yaletinkhulumo ncocishwano letitawutsatsa lokungenani ema awa lamabili.Tindleko tekuhamba nekubuya (Baylor clinic) titawukhokhwa kantsi futsi umntfwana utawunikwa latakudla emvakwaletinkhulumo ncociswano./nasekuphele letinkhulumo ncociswano.

Risks and discomforts

. Kute lokutincabekelwano noma lokubungoti lokwatiwako lokuhambelana nalomsebenti.

Potential benefits

Kute futsi nenzuzo leyatiwako lebese icondzana ngco nalomntfwana ngekutsi ungenele lolucwaningo, kepha bantfwana batawuzuza ekubeni sekwentiwe ncono indlela loluhlelo lolutawu bese lusebenta ngayo emveni kwawo wonkhe lomsebenti.

Protection of confidentiality

Sitakwenta konkhe lokusemandleni etfu kutsi umntfwana avikeleke.Kute ligama lemntfwana lelitawuvetwa kunoma ngiyiphi imibiko yetfu letawakhiwa kulolucwaningo kantsi nemininingwane lesitayitsatsa kumntfwana ngeke ilifake ligama lakhe futsi kute netitfombe takhe letitawutsatfwa kusentiwa lolucwaningo.

Voluntary participation

Kute umntfwana lophocelelekile kutsi angenele lolucwaningo.Uvumelekile kutsi nawungeke ukhone, unalo lilungelo lekutsi ungavumi kutsi umntfwanako alungenele lolucwaningo kani noma asalungenele,ungamuyekelisa noma nini.Kute umntfwanakho latakutfola kube sijeziso uma ngabe wala kutsi angenele lolucwaningo,kantsi noma asalungenele wase umuyekelisa ekhatsi nekhatsi nalomsebenti, nakhona kutabete sijeziso.

Contact information

Uma kukhona imibuto noma longakuva kahle ngalolucwaningo nomake nakuba khona tinkinga letivelako:Tsintsa **Leonard Maveneka** at UNICEF Eswatini phone: +**268 24096710** Uma unemibuto noma kubekhona longakuva kahle ngemalungelo emntfwanakho, nakhona ungatsintsa **Mr Leonard Kamugisha, who is the Chief, Adolescents & Youth Development Officer at UNICEF Eswatini.**

Consent

Ngilifundzile lelifomu lebatali lekunika imvume ngaphindze nganikwa nelitfuba lekutsi ngingabuta nemibuto.Ngiyavuma kutsi umntfwanami alungenele lolucwaningo

Umtali:_____ Lusuku_____

Umntfwana:_____

Kumele unikwe nawe lelifomu.

Appendix 11A: Child Assent Form (English)

My name is……. I am carrying out an Evaluation for UNICEF the Teen Clubs Programme for Adolescents Living with HIV in Eswatini. The Evaluation will help UNICEF, Baylor College of Medicine and the Ministry of Health to provide and to support better services for adolescents participating in Teen Clubs. The evaluation will also help them to understand how the programme can be improved. The Evaluation will involve interviews with children and adolescents who are participating in the programme, Part of this will be through focus group discussions, where the consultant will bring about 8 – 10 of you to get your views on the programme. Part will also involve you answering a questionnaire to test your knowledge, attitude and practice in relation to HIV and AIDS.

Your participation in the evaluation will not pose any risk to yourself or any discomfort to you. The researcher will take all the necessary steps to protect your identity as well as your privacy by not releasing your name in the report, or photograph.

There will be no direct benefits that will come to you as a result of you participating in the evaluation. The only benefit will come through the Teen Club which may provide better service to you as a result of the recommendations coming out of the evaluation.

You assent to participate in the evaluation will be entirely voluntary and you do not have to participate if you do not want to. Even after you have agreed to participate, you will be free to withdraw from the study anytime that you want to and you will not be penalized for it.

You should discuss your participation in the evaluation with your parents or your guardians before you sign the assent form. We will also ask your parent(s)/guardian(s) to sign the consent form on your behalf.

Do you have any questions that you may want to ask me too?

Sign this form only if you:

- have understood what you will be doing for this study,
- have had all your questions answered,
- agree to take part in this research

Name of Parent(s) or Legal Guardian(s)

_____

Researcher explaining study

Signature Printed Name Date

Appendix 10B: Child Assent Form (Siswati)

Libito lami ngingu Leonard Maveneka. Ngenta lucwaningo nge Teen club ngekusebentisana na UNICEF Kanye na Baylor. Lolucwaningo lutosita Baylor, UNICEF Kanye ne Litiko letemphilo kwenta loluhlelo lwe Teen club kutsi luletse tinhlelo letilusito luphindze lubencono.

Lolucwaningo lutococisana nebantfwana labakule Teen club ngekubuta imibuto lephatselana nekusebenta kwaloluhlelo. Lenye yetindlela tekubuta kutsi ngicocisane ne group yebatfwana labangengci kulabalishumi, ngalokwenteka kuTeen club. Lolucwaningo lutophindze lubute umntfwana imibuto lecondzane nelwati nge HIV/AIDS.

Uma ungenela lolucwaningo kute lokuyingoti lokucokwenteka kuwe, kantsi futsi libito lakho kanye nayo yonkhe imininingwane ngawe angeke iniketwe labanye bantfu nome ibhalwe kulombiko.

Kute lotakuzuza lokuyimbhadalo ngalokungenela lolucwaningo, kepha timphendvulo takho titosita kutfutfukisa loluhlelo lweTeen club.

Awukaphoceleleki kungenela lolucwaningo, futsi noma sewulungenele, unga yekela kuphendvula imibuto noma ngusiphi sikhatsi. Kute lotakuphocelela.

Uma ufuna kulungenela lolucwaningo, ngicela ukhulume nemtali/Batali bakho utfole imvumo kubo ngekutsi basayine leliphepha.

Kukhona yini imibuto lonayo lofuna kungibuta yona?

Sayina leli fomu uma:

- uvisise kahle kutsi utokwentani kulolucwaningo,
- yonkhe imibuto yakho iphendvulekile,
- sewutfole imvumo kumtali/nomakubatali bakho ngalolucwaningo,
- uvuma kubayincenye yalolucwaningo.

_____

Sayina Ligama ne Sibongo Date

_____

Libito lemtali

_____

Libito lalobuta imibuto

Signature Printed Name Date

Appendix 10: Recommendations

Issue	Recommendation	Priority	Target audience
Coming up with an exit strategy Since their formation, aspects of the Teen Clubs have been funded by development partners, including UNICEF, PEPFAR and EGPAF. The efficacy of the concept has been proved, hence the opening of 81 other clubs outside Baylor. This may an opportune time for the programme to be taken over by the government.	**Partners should advocate for the government to take over funding of all the Teen clubs and for the roll out of the programme to the remaining health facilities in the country that offer HIV services so that more ALHIV can access the services**.	Medium	Baylor & funding partners (UNICEF, EGPAF, PEPFAR)
Broadening the range of services available to adolescents The effectiveness of the Teen Clubs has been enhanced by supporting interventions such as the In-Reach and the Mental Health programmes as well as the Challenge Clinic, which together constitute a comprehensive package of interventions to address the diverse needs of ALHIV.	**In rolling out the Ten Clubs Programme across the country, it will be necessary to incorporate the In-Reach and the Mental Health Programmes as well as the Challenge Clinic to ensure the provision of a comprehensive package of services for adolescents.**	Medium	Baylor/ UNICEF
Coming up with an exit strategy Since the formation of the Teen CLubs, their activities have been largely funded by development partners, including UNICEF, PEPFAR and EGPAF. The efficacy of the concept has been proved, hence the	**Partners should advocate for the government to take over funding of all the Teen clubs and for their roll out to the remaining health facilities in the country that offer HIV services, so that more ALHIV can access the services**.	Medium	Baylor, UNICEF, EGPAF, PEPFAR

Issue	Recommendation	Priority	Target audience
opening of 81 other clubs outside Baylor. This may be an opportune time for the programme to be taken over by the government.			
Ensuring a smooth transition into adulthood Both Baylor and the young adults admit that the transition from the Teen Clubs has not been smooth and has been too abrupt leaving them feeling abandoned.	**Baylor should design a comprehensive programme to facilitate the smooth transition of the adolescents into adulthood. Such a programme should address their bio-medical as well as their psychosocial needs.**	High	UNICEF
Strengthening mental health services Baylor provides mental health services to adolescents. But because of the limited number of social workers, the services are only provided to those experiencing adherence problems, leaving out many more adolescents who require the services. Mental health services should also be available to parents of ALHIV.	**Baylor should strengthen its mental health services unit to enable it to screen and provide services to more adolescents and parents/guardians who need the services.**	High	Baylor, UNICEF
Improving the home environment for the adolescents For successful adherence, ALHIV need psychosocial and treatment adherence support. However this is often lacking in their homes, with the result that the adolescents may continue to default on treatment.	**There is a need to form support groups for parents that will (a) strengthen their capacity to provide psychosocial support to their children (b) address their information needs (c) create a platform where the parents can also receive psychosocial support (d) address their mental health problems**	High	Baylor, UNICEF

Issue	Recommendation	Priority	Target audience
Ensuring more even coverage of the Manual The Teen Club manual is comprehensive and addresses the information and knowledge needs of ALHIV. However responses from FGDs and the KAP show that adherence is the major topic that the trainings focus on, while other topics in the manual receive scant attention.	**The Teen Club trainings should pay more attention to other issues in the manual that impact on adherence, such as GBV, self-assertiveness, leadership, decision making etc. A narrow focus on adherence may fail to broaden the knowledge base of the adolescents sufficiently to enable them to navigate through their adult lives with confidence**	High	UNICEF, Baylor, Government of Eswatini
Strengthening mental health services Baylor provides mental health services to adolescents. But because of the limited number of social workers, the services are limited to only to those experiencing adherence problems, leaving out many more adolescents who require the services. Mental health services are not available parents of ALHIV although many need them.	**Baylor should strengthen its mental health services to enable it to screen and provide services to more adolescents as well as to parents/guardians who need the services.**	High	Baylor, UNICEF
Need for more intense anti-stigma programmes The fear expressed by the young adults to engage in relationships is a reflection of the high stigma levels and low levels of knowledge about HIV prevailing in Eswatini. It is only by addressing these issues within communities that PLHIV will be accepted and be able to live normal lives.	**The Ministry of Health, working with development partners, should design and implemement comprehensive anti-stigma programmes to be rolled out across the country as a long term strategy to address the high levels of stigma in the Eswatini society.**	High	Ministry of Health, UNAIDS, UNICEF, HIV&AIDS Service Organisations

Issue	Recommendation	Priority	Target audience
5.2.9 Providing adherence support in boarding schools From the literature review and the FGDs it emerged that some adolescents in boarding school default from treatment because the environment is not conducive for them to take their medication and they lack adherence support.	***Schools should provide sensitive and discreet adherence support and create conditions that enable adolescents to take their medication in private. Parents should be encouraged to disclose the status of their children to school heads on registration so that they can be provided adherence support and counselling if they need it.***	High	Baylor, Schools, Ministry of Health and Ministry of Education
5.2.10 Strengthening social safety nets for indigent ALHIV High poverty levels in Eswatini, especially among children, contribute to high default rates among ALHIV from poor households.	**Baylor, working with national case management teams, should identify and refer vulnerable adolescents for social protection services to improve their adherence to treatment. At the same time, a strong advocacy campaign should be launched to press the government to strengthen social safety nets to cater for vulnerable ALHIV.**		Baylor and other partners working with ALHIV; Ministry of Social Services; Ministry of Health; UNICEF; World Bank
Resuming Holiday Teen Clubs for Adolescents with poor adherence According to Baylor, Teen Clubs for adolescents with a high viral load were effective in improving adherence and viral load suppression. However, they were discontinued because of lack of funding.	***Baylor should fundraise for resources to resume the special Teen Clubs as they proved critical to improving health outcomes for adolescents who with poor adherence and high viral load***	M	Baylor

Appendix 11: Terms of Reference for the Evaluation of Teen Clubs Programme for Adolescents Living with HIV in Eswatini (swaziland)

Background and Justification

An estimated 205,000 people are living with HIV comprising 78,000 males and 127,000 females. 12,500 children are living with HIV while 183,000 are adults[91]. HIV prevalence among people 15 years and older was 27.2% in 2017 with women being more affected (32.5%) than man (21.3%). In the same year, prevalence among adolescents and young people was estimated at 9.6% (16.2% for females and 3.0% for males)[92].

According to Swaziland HIV Incidence Measurement Survey (SHIMS) 2016/17, prevalence increases with age for both sexes, reaching the peak earlier for women (35-39 years; 54.2%) than men (45-49 years; 48.8%). Disparity in prevalence by sex is most pronounced among adolescents and young people with 20-24 year old females having five times higher prevalence (20.9%) than males (4.2%). One in every five young women 20-24 years are HIV positive, increasing to one in every three for women 25-30 years[93]. HIV prevalence among adolescents and young people is indicative of new infections acquired rather than a survival effect of the treatment programme.

Incidence among people 15+ years decreased by 44% from 2.70% in 2010 to 1.14% in 2017. Incidence is higher among women (1.37%) than men (0.93%) aged 15 years and older. The variation in incidence by sex is most pronounced among Adolescents and Young People 15-24 years with females having an incidence of 1.96% compared to 0.27% among males[94]. The number of annual new infections was estimated at 6500 in 2017 broken down to 5700 infections among people 15 years and older and 800 among children 0-14 years[95].

Swaziland has made tremendous progress in care and treatment of the people living with HIV. 84.7% of the PLHIV know their HIV status, 87.4 % of those diagnosed with HIV are on ART and 91.9% of those that are on ART are virally suppressed[96]. Despite these achievements, there is

[91] Spectrum, 2018
[92] Spectrum, 2018
[93] SHIMS 2016/17
[94] Spectrum, 2018
[95] Spectrum, 2018
[96] SHIMS, 2017

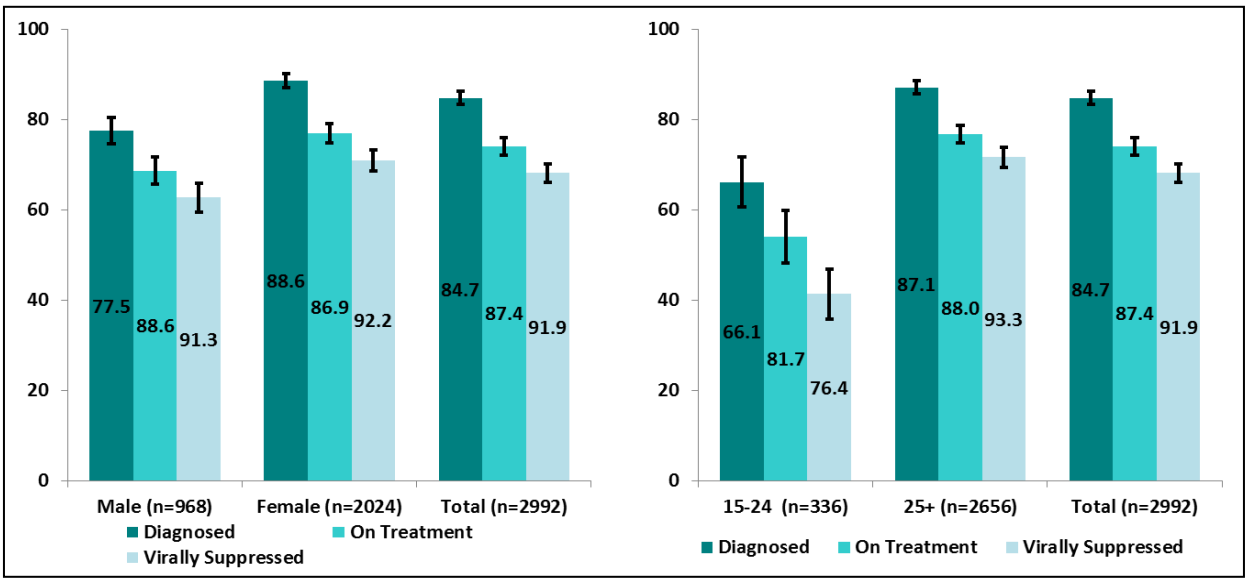
more work to be done. Evidence shows that the vulnerability factors and populations most affected by the epidemic are constantly evolving. There has been a shift from the generalised impact of the epidemic on women and men to micro-effects of the epidemic on adolescent girls and young women aged 15-24 years, adolescent boys and young men of the same age, adult men 25 years and older, adult women of the same age, single and coupled men and women, pregnant and lactating mothers, children 0-14 years, mobile populations and key populations among others. The epidemic has shifted from what was known traditionally as a generalised epidemic to micro-epidemics impacting on different groups in different ways.

Swaziland adopted the "Test and Start" strategy for provision of Antiretroviral Therapy (ART) and launched new treatment guidelines to guide implementation of this strategy in October 2016. "Test and Start" is defined as initiation on ART of all People Living with HIV (PLHIV) without consideration of their CD4 count or clinical status. "Test and Start" is recommended by WHO to accelerate progression towards viral suppression in order to reduce HIV transmission, and morbidity and mortality among PLHIV.

ART services are available countrywide. The services have been scaled up through decentralisation of ART initiation to the lowest level health facilities. In 2015, 70% of ART initiations took place at community clinics compared to 30% ART initiation in hospitals and health centres. Decentralisation has been facilitated by task shifting and capacity building for health care workers at lower level facilities.

The national ART coverage is at 84% (174,103 by March 2018). This figures shows that of the estimated 205,000 PLHIV (Spectrum 2018), at least 31,000 are not ART. There is low ART coverage among children, adolescents and young people and men 25 years and older. An assessment of the treatment cascade in Swaziland based on SHIMS 2016/17 found the same disparities in ART coverage. Overall, the survey found tremendous progress towards the 90-90-90 treatment targets, with 84.7% of PLHIV know their status; of these, 87.4% are on ART and of those on ART 91.9% are virally suppressed. However, adolescents and young people and men 25+ years had low coverage at all stages of the treatment continuum as shown in the graph below.

Figure: HIV treatment cascade by age and sex (SHIMS 2016/17)



As recognized by the 2010 UNAIDS report "Children and AIDS[97]," Teen Club have become a global model of excellence for the provision of care and support to HIV-positive adolescents. Per the UNAIDS Report [98], there is an opportunity to assist HIV-positive adolescents as they approach adulthood and begin to engage in relationships, initiate sexual activity, consider marriage and perhaps start a family. Whether these adolescents are the long-term survivors of mother-to-child transmission, now grown up, or were infected through sex or injecting drug use during adolescence, there is need to identify adolescents living with HIV and provide them with care, treatment and support before they progress to AIDS-associated illnesses. Such support include specific support needs, including psychosocial and community-based support that extends beyond clinical services.

Baylor College of Medicine Children's Foundation known as Baylor Swaziland initiated the teen club model in 2006 ahead of the UNAIDS report. This best practice is in fact cited in this report. Teen clubs are support groups for adolescents living with HIV established to empower Adolescents Living with HIV (ALHIV) to live positively and to successfully transition into adulthood. Adolescents value the opinion of their peers more than other age groups and in teen clubs empowered Teen Leaders deliver a positive, informed message to the peers. Teen Clubs provide fun educational

[97]Children and AIDS. Fifth Stock taking Report 2010. UNAIDS
[98] Ibid

activities focusing on life skills, healthy relationships and building confidence. These forums allow teenagers to learn to constructively express themselves and discuss issues regarding their health without fear of stigmatization. From 2011, , with financial and technical support from UNICEF, Teen Club sessions have been conducted to provide psychosocial support to male and female adolescents through teen club support services. During the period August 2011- April 2018, UNICEF has provided funding to the tune of USD258,162.59 Baylor Swaziland builds teen leadership capacity to support knowledge growth and leadership. This is done through semi-annual teen leadership training and encouraging peer leadership with in Teen Club activities.

The Teen Clubs are functioning across the 3 Baylor clinics- Centres of Excellence (CoEs), namely Mbabane CoE, Nazarene Raleigh Fitkin Memorial RFM Hospital CoE, and Hlatikhulu CoE and Siphofaneni. Teen Club meetings are generally held once a month (on Saturdays) at each site. To encourage participation, transportation reimbursement and refreshments are provided for the adolescents attending meetings. Approximately 800 teens are enrolled in the programme supported by UNICEF/Baylor and each month hundreds of teens participate in sessions at all four clinic locations.

In addition to the these sites, there are seventy-seven (77) other health facilities currently having teen clubs supported by other partners including the PEPFAR clinical partners in all the four regions. According to the MoH 2017 annual HIV report, 3742 adolescents are enrolled in health facility teen clubs.

The Ministry of Health (MoH) has adopted the teen clubs approach as a promising practice to enhance adherence to ART among adolescents and led the development of teen club guidelines for use by programme implementers. The ministry provides overall policy guidance and quality assurance.

It appears that teen clubs are effective in addressing the needs of adolescents who are on HIV treatment, however the effectiveness of these support groups have not been evaluated hence the decision to conduct an impact evaluation of the Teen Club project to provide benchmark estimates in terms of effectiveness, efficiency, sustainability of the project across the three Baylor clinics and Siphofaneni.

Justification.

The last evaluation of the intervention was undertaken in 2012. This evaluation made recommendations to improve the programme. Over the following years, new approaches to support Adolescent Living with HIV have emerging and these have influenced the way teen clubs are formed and function. Despite increasing interest by both government and non-governmental

entities, the impact and the scalability of the whole approach has not been asessed .The findings from the evaluation will provide information for improving programming of the Teen Club initiative; provide guidance for transition of youth living with HIV to adulthood; and inform strategies for scaling up Teen clubs for ALHIV in Swaziland.

The evaluation is in the UNICEF/Government work plan for 2018 and consultancy plan.

Scope of Work Evaluation purpose, Objectives and Scope

The **purpose** of the evaluation is to assess the extent to which, and under what circumstances, the Teen Clubs for ALHIV have achieved their intended objective over the last 5 years and provide recommendations on how to scale up the initiative or make relevant adjustments in the programme to achieve greater impact.

Objectives of the Evaluation

The overall objective is to determine the impact of the mixed sex teen club initiative in addressing needs of adolescents living with HIV.

The specific objectives of the evaluation are:

b) To provide current status of the functioning of the Teen Clubs, membership (age and sex), type of activities conducted, trained teen leaders (including sex disagregation) at each site, and the management and mentoring aspects.

c) To assess the quality of outputs, outcomes and results of the project related to **knowledge, attitude and practices** among active and former Teen Club members in the four facilities, on issues related to their health and well-being.

d) To determine the effectiveness of the teen club model in providing support to adolescents in disclosing their status, transitioning between pediatric and adult care and treatment services, acquiring a quality HIV information and education, adhering to treatment and adopting safe sexual behaviors.

e) To identify key and unique needs of adolescent boys and girls, the differentiated needs of rural and urban based adolescents and whether these were met by the programme interventions.

f) To identify key good practices and key lessons learnt, identify gaps, what strategies and interventions to continue and/or discontinue, and to what extent and make recommendations for future improvement based on evaluation findings?

Evaluation Scope

The evaluation will cover the implementation and the results of the Teen Club programme for ALHIV during the period 2012-2017

It will include both rural and urban community (parental involvement) and health facility dimensions of ALHIV teen clubs in the four areas/sites of implementation; management including financing of the programme, gender dimensions of the programme, and partnerships leveraged across different stakeholders. The evaluation will also involve select current and past male and female members of the teen clubs and cover all the three sites of teen club programme implementation.

Use of the evaluation

As the first comprehensive impact evaluation of the Teen Clubs for ALHIV in Swaziland its kind, the evaluation will generate important findings, lessons and recommendations that will be of use to a variety of stakeholders. The main users of the evaluation include Baylor College of Medicine, UNICEF other agencies in the UN system, Ministry of Health, contributing and interested donors, and NGOs, other stakeholders and partners interested in implementing the teen clubs approach.

This evaluation is especially important in supporting accountability and learning in relation to the UNICEF/ Government of the Kingdom of Swaziland country programme. The evaluation will also provide reliable evidence to inform decision-making within UNICEF

Inclusion and exclusion criteria

All current and former Teen Club members who have attended Teen Club activities at least three (3) times will be eligible to attend. All site volunteers working with Teen Clubs willing to participate will be eligible for inclusion. Current and former staff members at the 4 programme sites that have supported teen club activities will be eligible for inclusion. Any adolescents that have not participated in the teen clubs will be exluded.

Theory of change/ Logic Model: This does not exist and the evaluation team will reconstruct the Theory of Change retroactively. Using a theory-based approach to evaluations will allow the evaluation team to investigate in detail the expected pathways of change, including the assumptions that underpin the causal chains and linkages between elements of the results chain. For this purpose, the evaluation team will develop a theoretical model to validate the teen club programme's intervention logic and to provide an analytical framework to guide the evaluation. This reconstructed theory of change will be anchored in the joint programme's results frameworks. The evaluation team will review and take into account the following elements to develop the theory of change:a) results frameworks of the UNICEF country programmes; b) types of interventions strategies (types of activities) ; c) type and level of expected change (as articulated in the various Baylor/UNICEF programme proposals and results frameworks) and d) contextual or external factors.

The evaluation team will develop an initial reconstructed theory of change during the inception phase of the evaluation. During the mission incountry, the evaluation team will test and validate the assumptions and pathways of change as articulated in their model. The evaluation team will then propose an updated model to be used in the evaluation. During the evaluation process the evaluation team is expected to carefully assess whether the hypotheses hold true. Finally, based on the results of the evaluation, the evaluation team will present an ex-post theory of change in the final evaluation report in order to accurately reflect how change occurred in practice.

Evaluation criteria and Questions

The evaluation will use a set of guiding criteria used by OECD-DAC, UN Evaluation Group and UNICEF . The related sample evaluation questions are suggested; however, the final evaluation questions and the evaluation matrix will be finalized by the evaluation team in the design report.

a) Relevance: The extent to which the objectives of the teen clubs programme are consistent with beneficiaries' and country needs, global priorities and are aligned with UNICEF country programme priorities. Evaluation questions relevant to this criterion are:

What is the value of the teen clubs in relation to primary stakeholders' needs, national priorities, and national and UNICEF strategies and country programme; international frameworks , including the Sustainable Development Goals (SDGs), National Development Plan, Natonal HIV/AIDS plan/strategies, UN Development Assistance Framework (UNDAF)

What is the relevance in relation to the UNICEF Strategic Plan (SP), Regional Priorities and UNICEF/ Government of Kingdom of Swaziland Country Programme 2016-2020?

- Are the activities and outputs of the Teen Clubs programme consistent with the overall goal and the attainment of its objectives, and with the intended impacts and effects?

b) Effectiveness

The extent to which the Teen Clubs programme objectives were achieved, or are expected to be achieved, taking into account their relative importance.

Evaluation questions relevant to this criterion is:

- Is the Teen clubs programme achieving satisfactory results in relation to stated objectives?
- What are the major factors influencing the achievement or non-achievement of the objectives?

c) Efficiency

The extent to which the outputs of the Teen Clubs Programme have been achieved or are likley to be achieved witht he appropriate amout of resources/inputs(funds, expertise, time, equipment, administrative costs etc.) Evaluation questions relevant to this criterion are:

- To what extent were the resources available adequate to achieve the expected outputs?
- To what extent have programme benchmarks and achievements been monitored? To what extent has the programme supported and strengthened the M&E system of Baylor College of Medicine?
- Did the programme use the resources in the most economical manner to achieve its objectives? Were activities cost-efficient?
- To what extent did the the programme take advantage of existing opportunities for synergies?
- Was the programme or project implemented in the most efficient way compared to alternatives?

d) Impact

The Positive and negative, primary and secondary long-term effects produced by a development intervention, directly or indirectly, intended or unintended. This involves the main impacts and effects resulting from the teen clubs programme on the local social, economic, environmental and other development indicators. Evaluation questions relevant to this criterion are:

- What has happened as a result of the teen clubs programme ? What are the results of the programme – intended and unintended, positive and negative – including the social, economic, environmental effects?
- How do the results affect the rights and responsibilities of individuals, communities and institutions, especially the most disadvantaged ones?
- To what extent has the teen clubs intervention led to a reduction of inequities?
- What real difference has the activity made to beneficiaries?

e) Sustainability

The extent to which the benefits of the teen clubs programme are likely to continue after major development assistance has been completed. Sustainability looks to the probability of continued long-term benefits. Interventions need to be environmentally as well as financially sustainable. Evaluation questions relevant to this criterion are:

- What were the major factors which influenced the achievement or non-achievement of sustainability of the teen clubs programme?
- Are the activities and their impact likely to continue when external support is withdrawn?
- To what extent do the strategies used by the teen clubs programme lend themselves to wider scalability and programme expansion, overall and in specific contexts? Will the strategy be more widely replicated or adapted? Is it likely to go to scale?
- To what extent has UNICEF been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?
- To what extent have interventions supported by UNICEF contributed to (or are likely to contribute to) a sustainably in particular for Adolescents Living with HIV?

g) Equity, Gender Equality (GE) and Human Rights Based Approach (HRBA)

In addition to the above criteria from OECD, the evaluation will determine the extent to which the design and implementation of the Teen Club programme, the assessment of results and the evaluation process incorporates an equity, gender equality and a human rights-based perspective. Examples of evaluation questions relevant to this criterion are:

- How well were equity, HRBA and gender equality goals and processes incorporated into the planning documents of the Teen Clubs programme being evaluated?
- To what extent is the teen club programme aligned with, and contributes to, national policies and strategies on gender equality?
- How well did the teen clubs programme succeed in involving girls and boys, and rights-holders as well as duty-bearers, especially the worst-off?
- To what extent did the most disadvantaged adolescents living with HIV benefit in different ways from the programme?

Evaluation Methodology

Both qualitative and quantitative methods will be used. Quantitative data will be used to objectively assess if outcomes were achieved and to what degree whilst qualitative data will be obtained to assess Teen Club (TC) processes and to understand what the experiences of individual children were like in Teen Clubs.

Quantitative data will be collected using structured questionnaire among adolescents and young adults in the age group 10-24 years in the 3 Baylor clinics and Siphofaneni to establish clinical outcomes and social behaviors of former and current teen club members. In addition, a qualitative enquiry to understand the current status of the functioning of the Teen Clubs, type of activities conducted and the management aspects of the Teen Clubs by eliciting the perspective of various stakeholders will be conducted.

In addition, ***Document review*** which constitutes one of the most important data sources for the evaluation which includes strategic and planning documents, progress reports, monitoring data, financial data, reviews and evaluations, and other relevant reports

The evaluation targets adolescents 10-19 years who are active teen club members and young adults 20-24 years who have been part of teen club for five years and more and graduated from teen club. Hence, the target population are males and females in the age group 10-24 years where TCs have been established. In addition, the evaluation will target the parents, counsellors and the primary health care provider at the clinical sites. Further, in-depth interviews with key informants will be conducted to understand the current status of the functioning of the Teen Clubs, type of activities conducted and the management aspects of the TCs.

Evaluation design: . The evaluation team will propose an evaluation design which will be discussed and agreed as part of the inception report. Th evaluation will employ mixed methods for data collection which includes program documents and records reveiw, face to face interviews and focus group discussions with adolescents and health workers. Within the teen club population group, purposive sampling will be used because this evaluation is targeting specific populations who received the intervention.

Data validation mechanisms

The Evaluation Team will use a variety of methods to ensure the validity of the data collected. Data collected will be triangulated with other data avialable, such as that from national programme and UNICEF supported programme reports. Besides a systematic triangulation of data sources and data collection methods and tools, the validation of data will be sought through regular exchanges with both UNICEF and Baylor. Evaluation data will be disagregated by sex, age, rural/urban and disability status.

Stakeholders participation

The evaluation will adopt a human rights based including child rights based and geneder sensitive and inclusive approach, involving a broad range of key stakeholders for data collection and analysis. The evaluation team will perform a stakeholders mapping in order to identify both direct and indirect stakehoders that play a key role in the Teen Clubs Programme.

Limitations of the evaluation

The absence of a theory of change with a clear results matrix may impact on the ability of the evaluation team to assess the evaluation questions. However, it is anticipated the construction of the theory of change will facilitate the assessment.

The programme data management tools and systems used in implementation may pose challenges for secondary data collection as the robustness of the data may not be guaranteed.

Confidentiality and Ethical Considerations

The evaluation will follow the UNEG Norms and Standards for Evaluation in the UN system and abide by the UNEG Ethical Guidelines and Code of Conduct and other relevant ethical codes.

Ethical approval will be sought by developing and submitting a protocol to the Scientific and Ethics Committee in the Ministry appropriate board, as required.

Ethical considerations (of respondents and the evaluation team) will be of utmost priority in determining the most appropriate methods and their implementation and will be documented in the evaluation report. The evaluation will follow procedure for ethical standards in UNICEF research, evaluation, data collection and analysis involving children since children are likely to be intervewed. This can be accessed at :

https://icon.unicef.org/iconhome/ICON%20Document%20Library/PROCEDURE%20ON%20ETHICS%20IN%20EVIDENCE%20GENERATION.pdf

Written consent will be sought prior to starting the interview. Respondents will first receive an explanation of the purpose of the evaluation and that only participants who formally consented

and agreed to participate will take part in this evaluation. No reward will be given to participants to ensure reliability and to comply with ethical requirements. The evaluation team will be required to state potential ethical issues and approaches to deal with them in their proposal.

Rights to decide to participate

The decision to participate will solely rest with the respective participants. Their rights to terminate participation during the interview, will be communicated to all respondents before engagement. They will be allowed to decline answering some of the questions if they so wished. Respondents who are emotionally challenged i.e. cry during the interview will be referred for counselling on site.

Management arrangements

The evaluation will be conducted by a consultant who will be recruited by UNICEF Swaziland. The consultant will be supervised by the evaluation manager (Chief, Youth and Adolescent Development) supported by an Evaluation Reference Group (4-5 members) constituted from UNICEF, Bailor College of Medicine and Ministry of Health. These will be experts on the subject matter and evaluation.

The roles of the reference group are to:

a) Provide input to the ToR of the evaluation and to the selection of team of evaluators;
b) Contributes to the selection of evaluation questions;
c) Provide overall comments to the evaluation design report
d) Facilitate access of evaluation team to information sources (documents and interviewees) to support data collection;
e) Provide comments on the main deliverables of the evaluation, including the draft final report.

Reference to AWP areas covered:

This assignment supports the implementation of the 2018/2019 UNICEF-Government of Swaziland rolling work plan; activity 2.6.9: Support learning, knowledge sharing and national use of evidence for adolescent HIV programming

Key Tasks & deliverables

Following are the key tasks to be performed under the evaluation study:

- Undertake a literature review to inform an Inception report
- Develop an evaluation protocol (includes sample selection based on the agreed criteria, design and data collection tools) and present to for submission to NHRRB
- Develop a data collection plan including a selection of respondents in consultation with Baylor college of Medicine, Swaziland.
- Develop a data quality assurance plan
- preparation and sharing of field work plan: The consultant will prepare a detailed plan for field work and share the same in advance with UNICEF and Baylor college of Medicine, Swaziland.
- Undertake data collection as defined in the agreed methodology in the inception report
- Preparation of analysis plan: The consultant will prepare a detailed analysis plan that addressed the objectives of the evaluation. The analysis plan would be shared with the evaluation reference group before finalizing the same.
- Report writing: The consultant will undertake data analysis, prepare the draft report and share with UNICEF, evaluation reference group, and Baylor for comments and suggestions.
- The consultant will present the evaluation report at stakeholder validation meeting , for comments and inputs
- The consultant will incorporate the comments and submit the final report to UNICEF.

Evaluation time frame

It is proposed that the duration of the exercisebe 10 weeks from the date of signing the contract with the evaluation consultant.

INDICATIVE TIME SCHEDULE

	Deliverables	Dates
Design and desk review	Submission of draft inception report (first draft)	01 August 2018
	Submission of final inception report with Data collection tools (questionnaires, Interview Guides, etc)	05 August 2018
	Submission of an evaluation protocol for ethics approval	10 August 2018
	Seeking ethics approval	20 August
Data collection and field visit	Power Point presentation for the field phase debriefing	01 September 2018
Report writing	Submission of the draft evaluation report (first draft)	20 September 2018
	Comments from Evaluation Reference Group, ESARO and HQ on the draft final evaluation report (first draft)	25 September 2018
	Stakeholder validation meeting in-country	10 October 2018
	Submission of the draft final evaluation report (second draft); summary report and power point presentation	20 October 2018
Dissemination and	Management response	October , 2018

follow-up	Dissemination activities and stakeholder workshop	Dates to be confirmed

Deliverables

The evaluation deliverables are the following:

1. Inception report (including drafts as outlined above)
2. Evaluation protocol for ethics board
3. PowerPoint presentation for the field phase debriefing
4. Draft evaluation report
5. Power Point presentation for the stakeholder workshop
6. Final evaluation report that incorporates feedback from stakehoders

The outline of the final evaluation report

It is expected that the evaluation report will take the following format and size

Number of pages: 40-60 pages without the annexes

Table of contents

List of Acronyms

List of Tables (*)

List of Figures

Executive Summary: 7- 8 pages: objectives, short summary of the methodology and key conclusions and recommendations

1 Introduction:

Should include: purpose of the evaluation; mandate and strategy of UNFPA/UNICEF support elimination of FGM

2 Methodology

Should include: overview of the evaluation process; methods and tools used in evaluation design; analysis of results in the constructed theory of change; evaluation questions and assumptions to be assessed; methods and tools used for data collection; desk review; survey; limitations to data collection; methods and tools used for data analysis; methods of judgment; the approach to triangulation and validation

3 Main findings and analysis

Should include for each response to evaluation question: evaluation criteria covered; summary of the response; detailed response

4 Conclusions

Should include for each conclusion: summary; origin (which evaluation question(s) the conclusion is based on); detailed conclusion

5 Recommendations

Should include for each recommendation: summary; priority level (very high/high/medium); target (entity to which the recommendation is addressed); origin (which conclusion(s) the recommendation is based on); operational implications. Recommendations must be: linked to the conclusions; clustered, prioritized; accompanied by timing for implementation; useful and operational

Annexes shall be confined to a separate volume

Should include: evaluation matrix; ex-post theory of change; portfolio of interventions; methodological instruments used (survey questionnaire, focus groups, interviews etc.); bibliography/list of documents consulted; list of people interviewed; terms of reference.

(*) Tables, Graphs, diagrams, maps etc. presented in the final evaluation report must also be provided to UNICEF in their original version (in Excel, PowerPoint or word files, etc.).

The final version of the evaluation report shall be presented in a way that enables publication (professionally designed and copy edited) without need for any further editing (see section below). Please note that, for the final report, the evaluation team should share the files in Adobe Indesign CC software, with text presented in two columns with no hyphenation. Further details on design will be provided by UNICEF

Desired competencies, technical background and experience

The evaluation team is expect to have the following:

- Advanced degree (Masters or higher) in Bio-Statistics, Public Health, Epidemiology Social Science, or related field.
- Solid understanding of issues faced by adolescents and young people living with HIV, youth risk behaviors in Swaziland and/or Southern Africa.

- At least 10 years combined experience of conducting research in HIV and AIDS or related field (including research on sensitive issues among adolescents and youth).
- Proven experience in design and implementation of quantitative and qualitative evaluation tools and studies; preferably at least 5 years' experience in leading program evaluations, including KAP and baseline and completion studies.
- Experience with the deployment, oversight and management of research teams.
- Demonstrated experience in ethical research practices.
- Demonstrated expertise in undertaking gender responsive and equity focused evaluations

- Demonstrated excellence in oral and written English language skills, including a proven ability to prepare high quality reports in English in a clear, concise manner.
- Strong organizational skills, attention to detail, and ability to meet deadlines.
- Advanced computer and data analysis skills, including proficiency in use of Microsoft Office software and statistical software packages (SPSS, STATA, Epi-Info etc) and relevant qualitative analysis software.
- Knowledge of the country context is an added advantage.

Payment Schedule

Interim payments will be linked to deliverables as indicated in the table below. The final remuneration will be negotiated by HR.

Deliverables	Dates	Schedule of payment
Inception report with data collection tools (questionnaires, Interview Guides, etc)	20 July 2018	30%
Submission of the draft evaluation report (first draft)	12 September 2018	30%
Submission of the draft final evaluation report (second draft); summary report and power point presentation	30 September 2018	40%

Conditions

The evaluation team is expected to work with provision of his/her computer and administrative support.

UNICEF will provide office space during the time of in country presence if required

All travel is by most economical fare and reimbursement as per UNICEF policy,

As per UNICEF DFAM policy, payment is made against approved deliverables. No advance payment is allowed unless in exceptional circumstances against bank guarantee, subject to a maximum of 30 per cent of the total contract value in cases where advance purchases, for example for supplies or travel, may be necessary".

The candidate selected will be governed by and subject to UNICEF's General Terms and Conditions for individual contracts."

How to Apply

Interested applicants are requested to submit a technical and financial proposal (in English), electronically through the UNICEF Talent Management System (TMS)**.** The email should be titled **Evaluation of Teen Clubs programme .**

Technical proposal should explain how the applicant intends to carry out the work and should include the following:

- Updated Curriculum Vitae of the consultant(s) highlighting relevant qualifications and experience;
- Description of applicant's experience with assignments of a similar nature and details of 3 former clients who can be contacted for reference (name, position, contact details).A detailed approach and Methodology that the consultant suggests would be appropriate from their understanding of the TORs.including: a) Present the approach and methods for the evaluation; b) **Comment on any challenges or difficulties which might arise in structuring and conducting the evaluation, suggesting any solutions if applicable;** c) Quality assurance to be applied in performing the assignment.
- Detailed evaluation work plan for fulfilment of the assignment including aestimates of the time required for the different tasks of the assignment.

The financial proposal should detail the proposed budget for the evaluation. All logistical costs, including transportation, data collection and printing costs will be covered by the consultant and should be detailed and reasonably priced as part of the financial proposal.

Resources

- Evaluation results of the teen support programme (teen club). Baylor college of medicine children's foundation- Swaziland (2012)

- How to design and manage Equity-focused evaluations, UNICEF Evaluation Working Papers, Michael Bamberger and Marco Segone, (2011).
- OECD, Development Cooperation Directorate Website. Criteria for Evaluating Development Assistance. http://www.oecd.org/document/22/0,2340,en_2649_34435_2086550_1_1_1_1,00.html
- The "UNEG Handbook for Conducting Evaluations of Normative Work in the UN System", (2013)
- The UNEG Handbook "Integrating Human Rights and Gender Equality in Evaluation" (2011)
- UNEG Norms and Standards for Evaluations (2017). Available at https://www.unicef.org/evaluation/files/UNEG_NormsandStandards_for_EvaluationEnglish2017(1).pdf
- UNEG Code of Conduct for Evaluation (2007). Available at https://www.unicef.org/evaluation/files/Evaluation_Principles_UNEG_Code_of_Conduct.pdf
- UNICEF Evaluation Policy (2013) available at https://www.unicef.org/evaluation/files/2013-14-Revised_evaluation_policy-ODS-English.pdf
- United Nations Evaluation Group (UNEG), (2014), *UN SWAP Evaluation Performance Indicator Technical Note.* Retrieved from: http://www.unevaluation.org/papersandpubs/documentdetail.jsp?doc_id=1452

- UN Women. UN System Wide Action Plan on Gender Equality and the Empowerment of Women UN System Wide Action Plan on Gender Equality and the Empowerment of Women. April 2012. Available at http://www.unwomen.org/~/media/Headquarters/Attachments/Sections/How%20We%20Work/UNSystemCoordination/UN -SWAP-Framework-Dec-2012.pdf

- Procedure for ethical standards in UNICEF research, evaluation, data collection and analysis involving children, accessed at: https://icon.unicef.org/iconhome/ICON%20Document%20Library/PROCEDURE%20ON%20ETHICS%20IN%20EVIDENCE%20GENERATION.pdf

Appendix 12: List of Key informants Interviewed

Busi Mkhatshwa	Teen Club Coordinator, Baylor Mbabane
Dr Florence Anabwani-Ritcher	Baylor College of Medicine, Children's Foundation Swaziland
Dr Kanyamanda Katembo	Hlathikulu Baylor COE
Dr Mafulu Mundende	Manzini RFK, Baylor COE
Dumisile Gwebu	Sister in charge Charge Siphofaneni
Gcebile Dlamini	Expert Client, Baylor Clinic Mbabane
Leonard Kamugisha	Chief, Adolescents & Youth Development UNICEF Swaziland
Makhosazana Hlatshwayo	Executive Director Baylor College of Medicine, Children's
Makhosini Mamba	Health Specialist UNICEF Eswatini
Martha Matsenwa	Social worker, Manzini RFK, Baylor COE
Nelisiwe Dlamini	Monitoring and Evaluation Specialist, UNICEF Eswatini
Nobuhle Mtetwa	National Pediatric HIV Care and Treatment Coordinator
Sandile Dlamini	Monitoring and evaluation officer, Baylor College of Medicine, Children's Foundation Swaziland
Sankelisiwe Masilela	Nurse, Baylor clinic Mbabane
Sibongile Mumanga	Nurse Hlathikulu Baylor COE
Sisana Makhanya	Social Worker Baylor College of Medicine, Children's

Wandile Temba Mabaso	Teen Club Coordinator, Baylor Mbabane
Zandile Nhleko	Programme Manager Baylor College of Medicine, Children's
Abiy Assefa Korsa	Pharmacist, Baylor Clinic Mbabane

Appendix 13: Research Protocol Clearance Certificate

Research Protocol clearance certificate

Type of review	Expedited	X		Full Board		
Name of Organization	**BAYLOR/UNICEF**					
Title of study	**Evaluation of Teen Club Program for Adolescents Living with HIV at Baylor Clinic in Swaziland**					
Protocol version	**1.0**					
Nature of protocol	New	X		Amendment		Renewal
List of study sites	**Siphofaneni Clinic, RFM Hospital, Baylor Clinic, Mbabane Government Hospital, Hlatikulu Government Hospital**					
Name of Principal Investigator	**Leonard Maveneka**					
Names of Co- Investigators	**N/A**					
Names of steering committee members in the case of clinical trials	**N/A**					
Names of Data and Safety Committee members in the case of clinical trials	**N/A**					
Level of risk (Tick appropriate box)	Minimal			High		
	X					
Clearance status (Tick appropriate box)	Approved	X		Disapproved		
Clearance validity period	Start date	**30/10/2018**		End date	**30/10/2019**	
Signature of Chairperson						
Date of signing	**30/10/2018**					
Secretariat Contact Details	Name of contact officers		**Ms Babazile Shongwe**			
	Email address		babazileshongwe@gmail.com			
	Telephone no.		**(00268) 24040865/24044905**			

MINISTRY OF HEALTH
30 OCT 2018
HEALTH RESEARCH REVIEW BOARD
SWAZILAND

Appendix 14: Evaluation matrix

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
Relevance	Was the design of the Teen Clubs Programme the most appropriate and relevant strategy for addressing issues faced by ALHIV in accordance with the national development priorities as articulated in Swaziland's Extended National Multisectoral HIV and AIDS Framework 2014 – 2018?	What issues are faced by ALHIV in Swaziland? How appropriate and comprehensive was the project design? How relevant are the interventions to Swaziland's development challenges as articulated in the Framework for National Development Strategy	Project reports, Swaziland National Framework for National Development Strategy; Teen Club members; Key informants including; Baylor, UNICEF, Ministry of Health	Literature review, key informant Interviews, FGDs with beneficiaries	Evidence of improved adherence, greater self-confidence among ALHIV; higher levels of knowledge on the relevant lifeskills taught in the programme	Content analysis; Triangulation
	How has the Teen Clubs Programme adapted over time to reflect changes in Global, Regional and National programming	What are the National and Regional programming practices for ALHIV?	Project reports; international literature on similar interventions for	Literature review, web search, key informant	Adjustments in the programme to bring it in line with international best	Content analysis, quantitative analysis

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
	practices for ALHIV?	To what extent is the Teen Clubs Programme aligned to Global and Regional practices for interventions for ALHIV?	ALHIV	interviews	practices	
	How has the Teen Clubs Programme created change in services for ALHIV during the period of implementation? What is the value of the project in relation to the situation of ALHIV in Eswatini?	What services are available for ALHIV in Swaziland? How accessible are the services? What has been the role of the Teen Clubs programme in improving access to the services for ALHIV? What value do the ALHIV put on the programme?	Project reports, service providers	Literature review, key informant interviews	Evidence of improved services for ALHIV	Content analysis

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
	Was the partnership strategy appropriate and effective?	Who were the partners in the programme? What was the contribution of the individual partners to the achievement of the programme objectives?	Project reports; Baylor, UNICEF, Ministry of Health and other relevant partners	Literature review, key informant interviews	Evidence of effective partnerships with different players	Content analysis Triangulation
	How has the Teen Clubs programme addressed the problems experienced in programming for ALHIV and the strengthening partnerships?	What problems are experienced in programming for ALHIV? How did the Teen Clubs Programme address the problems and with what success? In what ways did the Teen Clubs Programme strengthen partnerships with other boundary	Programme documents, project partners	Literature review, key informant interviews, FGDs	Evidence of interventions to address problems in programming experienced by adolescent girls; evidence of strengthened partnerships between UNICEF and IP	Comparative analysis with interventions for girls in other developing countries

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
		partners? What needs to be done to improve partnerships? How responsive and sensitive was the programme to the specific needs of ALHIV?				
Effectiveness	Was the intervention supported by government, parents, community members, schools and other organisations? If so, how?	What support has the government provided to the Programme? What support have parents and community members given to the Programme? What support was provided by schools to the Programme? What form did that support	Baylor staff; Ministry of Health; community members and families of ALHIV. Resource allocation reports on the programme from the national budget	Literature review, key informant interviews	Evidence of support for the programme from the government, schools, community members and other organisations	

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
		take?				
	Have the Project objectives met on time and what services were provided by the programme? What is the quality of the services?	What were the programme objectives? Which objectives were met by the programme? Were the objectives met on time and if not, what were the limiting factors? What objectives did the programme not meet and what are the reasons for the failure to meet them? What was the quality of the services provided through the Programme?	Project progress reports, IPs, beneficiaries	Key informant interviews, FGDS, Project progress reports	Evidence of activities having been carried out	

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
	How inclusive and gender responsive were the activities of the Teen Clubs Programme?	To what extent has the programme created safe spaces for adolescent girls LHIV? To what extent has the programme addressed issues that impact on girls' participation in such activities (socio-cultural issues and Swaziland context)? To what extent does the programme deliberately address gender issues to improve gender equity? To what extent has gender been mainstreamed within the Programme?	Girls participating in the programme; IP	Key informant interviews, FGDs	Evidence of programme's gender responsiveness and inclusivity	Content analysis, triangulation
	How user friendly is the	To what extent are the	Teen Club Members;	FGDs, key	Evidence of	KAPB survey

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
	Swaziland Teen Club Curriculum in supporting programming for ALHIV? What is the quality of the manual? How has the manual impacted on the attitudes and practices of the beneficiaries?	team leaders able to translate the concepts in the manual into issues that ALHIV can identify with? To what extent has the tool influenced the behaviour of ALHIV and their approach to life? What concepts do the ALHIV find difficult to understand in the manual and what is being done to make them easier to understand? How age-appropriate is the material in the manual	volunteers; current and former staff; literature	informant interviews	behaviour change among the Teen Club members participating in the programme.	analysis; content analysis
Efficiency	What components in the	How cost effective were	Financial reports; value	Literature	Evidence of	

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
	Teen Clubs Programme were delivered with the best value for money and in what specific ways?	the interventions? What are the areas in which money could have been saved but was not? To what extent are these being addressed?	for money audit reports	review, key informant interviews, financial analysis	sound financial management in the project;	
	What have been the direct/indirect costs per beneficiary incurred through funding the Teen Clubs Programme? Could the same results have been achieved at a lower cost or could more or better results be achieved with the same cost by using different approaches?	What constitutes the programme's direct costs? The indirect costs? How are the costs being financed currently? Apart from UNICEF, what are the other possible sources of funding? What costs can be reduced without	Programme financial records; UNICEF and Baylor	Literature review, key informant interviews		

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
		compromising the programme quality? What are the unit costs per beneficiary? How do they compare with similar programmes elsewhere What alternative methods could have been used to deliver the same results? Were any of these tried and with what results?				
	To what extent did UNICEF support contribute to the achievement of the program results?	Was UNICEF support targeted to reach the beneficiaries identified? Was the financial support adequate and was it disbursed on	UNICEF and Baylor	Interviews, literature review,		

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
		time?				
	What factors contributed to or hindered achievement of the intended program results. How effective were the strategies and tools used in the implementation of the programme?	What were the programme's major achievements? What were the major constraints faced in project implementation? How effective was the programme M&E system and to what extent was it used to inform programme implementation?	Programme M&E framework; IP and UNICEF	Key informant interviews, FGDs		
Impact	What are the intended and unintended positive and negative outcomes of the Teen Clubs Programme?	What are the perceptions of the ALHIV themselves about the benefits of the programme?	UNICEF and IP; programme documents	Key informant interviews, literature review	Evidence of intended and unintended outcomes of the project	

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
	What led to the changes and why? What are the strategic results of the programme?	Has the programme resulted in positive outcomes in terms of improved adherence; improved health outcomes for ALHIV; reduced self stigma among beneficiaries? More empowered ALHIV?	Peer educators; beneficiaries; Baylor and UNICEF	Literature review; key informant interviews; FGDs	Evidence of number of ALHIV reached by the program; evidence of improved adherence and viral suppression Evidence of positive changes in the lives of the beneficiaries	
	How has the Teen Clubs Programme influenced or strengthened programming for ALHIV	What elements of the programme have made a significant difference in the way ALHIV approach and deal with issues affecting their lives?	Programme documents; Baylor and UNICEF.	Review of M&E reports and of registration forms, key informant interviews		Content analysis; statistical analysis of number of ALHIV participating in the programme in the area compared to those not participating
	How has the Teen Clubs Programme brought	Were there any parallel programmes run by	Baylor and project	Literature review; key		

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
	changes in the lives of beneficiaries, positive, negative, intended, unintended?	different organisations/donors? To what extent did the programmes collaborate in areas where duplication could exist?	documents	informant interviews		
Sustainability	Does the Teen Club Programme have the capacity to sustain its operations financially and programmatically after the end of donor funding	What are the key financial outlays that go into the programme set up and implementation? Are there components of the programme costs that can be removed without reducing the effectiveness of the programme? What is Baylor's financial contribution to the programme? Can	financial reports; Baylor staff	Qualitative data analysis, literature review and interviews	Evidence of Baylor's commitment to finance the programme; Evidence of the government's commitment to financing the programme	

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
		this be scaled up significantly? Were financial resources used efficiently?				
	How strong and sustainable are systems that were put in place? Can they continue delivering quality services to ALHIV after UNICEF support has ended?	What systems are in place to sustain the programme? What capacities were built to ensure that the programme runs smoothly? Is the system of volunteers the most sustainable? What is the attrition rate of volunteers? What are the reasons given by volunteers for leaving the	M&E frameworks; Baylor; past employees and volunteers	Document review and key informant interviews	Evidence of sustainable systems in place	Content analysis, triangulation

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
		programme?				
	What lessons related to sustainability can we draw from the execution of the programme?	What keeps the volunteers in the programme motivated? What is the level of programme ownership by the beneficiaries? How committed is Baylor to the programme?	Volunteers; Baylor staff and UNICEF	Key informant interviews and FGDs	Evidence of community ownership of the programme	Content analysis and
Capacity Building	Is national capacity being developed to administer the project?	What capacities have been built within the programme? How effective has the capacity building programme been?	Volunteers; peer educators; Baylor and UNICEF	Key informant interviews and FGDs	Evidence of enhanced capacity among trained volunteers other key staff	Content analysis and triangulation
Scalability	What components of the	What elements of the	Baylor and UNICEF.	Document	Evidence of	Content analysis

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
	Teen Club Programme show greater likelihood for scalability and why?	programme has the Ministry of Health shown most interest in and why?		review; key informant interviews; FGDS.	replicability of the programme	
	How likely is the Teen Club programme or its components to be scaled or replicated by other agencies and/or by the Ministry of Health? What are the key success factors which could be promoted to scale to ensure efficiency and effectiveness of the programme?	What other agencies are involved in interventions for ALHIV? What is the level of their collaboration with the Teen Club Programme? What interest has been shown by the Ministry of Health in the Teen Club Programme?	Ministry of Health; other relevant organisations working with ALHIV; Baylor and UNICEF	Key informant interviews	Evidence of interest in the key Ministry of Health other agencies working with ALHIV	Content analysis
Coordination	How have the activities in the Teen Club Programme been coordinated with	Who is responsible for coordinating the various components of	Baylor, UNICEF, volunteers	Key informant interviews, literature	Evidence of an integrated programme that	Content analysis

Relevant evaluation Criteria	Key Questions	Specific Sub-Questions	Data Sources	Data collection Methods / Tools	Indicators/ Success Standard	Methods of Data Analysis
	other related interventions/ approaches in the HIV/AIDS sector?	the programme? What relationships have been fostered between the programme and the national HIV and AIDS programme? And with other health programmes in the country? To what extent has the programme managed to integrate itself with other health programmes ASRH, HIV and AIDS and NCDs?		review	is well coordinated from the centre to the periphery	
Recommendations	What are the recommendations for similar support in future?	What are the recommendations for UNICEF? And for Baylor?	Collected data and information			Evidence of justification for the recommendations