REPORT NO 2/2014

HIV AND AIDS RESPONSE 2010-2013

A REVIEW OF SAVE THE CHILDREN'S HIV AND AIDS GLOBAL PROGRAMMES

PORTFOLIO REVIEW

Save the Children
Norway

WE ARE the world's leading independent organisation for children.

OUR VISION is a world in which every child attains the right to survival, protection, development and participation.

OUR MISSION is to inspire breakthroughs in the way the world treats children, and to achieve immediate and lasting change in their lives.

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FOREWORD

We are now at a tipping point. Ending AIDS is within reach. The results have been remarkable. New infections are declining, aids-related deaths averted and 14 million people - close to half of the number of people living with HIV - are now on treatment. At the same time there is a real chance that we can lose the gains made. Some think that the battle is over. Others want to move on and shift to something new. Funding opportunities are changing. This also affects organizations like Save the Children. Fresh initiatives are more attractive than staying on course for a long haul.

This evaluation report argues that we need to do both – staying on course and taking fresh, new initiatives to do better. We cannot risk a return to a world where AIDS is out of control. We cannot afford to lose the investment made in children and adolescents, capacity, relationships and insights.

The work of partners on the ground, such as Save the Children, is critical for AIDS, whether the main focus is on health, education, child protection, nutrition or other child development challenges. At the same time "staying on" with AIDS offers strategic opportunities with important potential for Save the Children that can be captured going forward, also if AIDS is not defined as a special initiative.

A growing insight is the need to respond better to the diversity of the AIDS epidemic with more contextual, tailored and integrated ("ecological") responses. Rather than being unique to AIDS, these challenges are also central to the broader debate on equity, social justice and sustainable development, where the case is made for better linkages and connections between the different selective agendas for health, education, rights, livelihoods and environment. In this, the concrete experience with AIDS clearly has the potential to serve as a path-finder, and this opportunity should be captured.

Save the Children as a partner in the AIDS response can here make a real difference. In the same way as for AIDS, the rights based child development and protection agenda calls for tailoring, integration and rooting with local community systems. It takes voice and agency from partners on the ground to overcome fragmentation and institutional rigidity in governmental systems and bureaucracies. Both for AIDS and for children there is a need for actors on the ground that is able to understand the complex interaction of factors that cause vulnerability.

The evaluation report should be read and discussed with these dual purposes in mind; to optimize AIDS programming based on "staying in for a long haul", and to capture the opportunity of using AIDS as a pathfinder for better differentiated and integrated programming across sectors and themes, where being a partner on the ground gives the organization unique opportunity.

Sigrun Møgedal

Former Norwegian AIDS Ambassador
Vice President of Board of Save the Children Norway

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We would like to thank Save the Children Norway for the opportunity to learn about its work addressing HIV and AIDS.

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The Review could not have been carried out without the country to visit to Zimbabwe. We thank Save the Children Zimbabwe for making us feel welcome before and during our stay and for providing comments on various drafts of the review reports. We especially thank **Linile Malunga** for her extraordinary efforts arranging interviews and meetings during the country and Mberengwe visits on very short notice.

Our thanks also go to **Robert Shumba** for providing us with many opportunities to talk to community groups during our visit to Mberengwe. We are grateful that our driver to Mberengwe, **Basil Chigwerewe**, safely got us to remote areas where roads were sometimes difficult due to rains. **Vudzaishe Maidza**´s assistance when talking with the child protection committees and young people was very much appreciated and essential our understanding of community views in Mberengwe.

We enjoyed and appreciated the opportunity to learn more about Zimbabwe. Thank you!

The Review Team

ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ANC	Anti-natal care
ARSH	Adolescent reproductive and sexual health
ART	Anti-retroviral therapy
CABA	Children affected by AIDS
CABA	Children affected by AIDS
CAP	Country annual plan
CAR	Country annual reports
CAR	Country annual report
CLWHA	Children living with HIV and AIDS
CPC	Child protection committees
CSO	Civil society organisations
DHS	Demographic and Health Surveys
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
HAPCO	Federal HIV/AIDS Prevention and Control Office (Ethiopia)
HIV	Human immunodeficiency virus
M & E	Monitoring and evaluation
MARG	Most at-risk groups
MFA	(Norwegian) Ministry of Foreign Affairs
MOESAC	Ministry of Education, Sport, Arts and Culture
MOHCW	Ministry of Health and Child Welfare (Zimbabwe)
MPSLSW	Ministry of Public Service, Labour and Social Welfare (Zimbabwe)
MTCT	Mother-to-child transmission
MTR	Mid-term review
NAP	National Action Plan for orphans and vulnerable children
NCPI	National Commitments and Policies Instrument
NGO	Non-governmental organisation
OVC	Orphans and vulnerable children
PLWH	People living with HIV
PMTCT	Prevention of mother-to-child-transmission
PSS	Psychosocial support
RH	Reproductive health
SCI	Save the Children International
SCN	Save the Children Norway
SCNE	Save the Children Norway in Ethiopia
SCZ	Save the Children Zimbabwe
SoVAA	Social volunteers against AIDS

STI	Sexually transmitted infections
ToR	Terms of reference
UN	United Nations
UNAIDS	Joint United Nationals Programme on HIV/AIDS
UNICEF	United Nations Children Fund
VCT	Voluntary counselling and testing
ZAPP	Zimbabwe AIDS Prevention Project

EXECUTIVE SUMMARY

This report is a Review of Save the Children Norway's (SCN) HIV and AIDS portfolio. SCN set out priorities for its work in its 2010 – 2013 Strategy. One of its thematic priorities is to fulfill the rights of children to protection against the impact of HIV and AIDS. Prioritised planned objectives for this thematic area are:

- Strengthened capacity within the community to protect children against the impact of HIV and AIDS i.e. care and support
- More adolescents protect themselves and others against HIV infection i.e. HIV prevention
- Newborn children are protected from mother-to-child transmission of HIV i.e. PMTCT

The purpose of this Review is to document results achieved as a result of the investments made by SCN, Norad, and the Norwegian Ministry of Foreign Affairs in HIV and AIDS during the period 2010 – 2013. The Review should also help SCN in documenting key successes, challenges and make feasible recommendations for SCN and country offices in how to ensure that the rights of children within the field of HIV and AIDS are taken care of or get enough consideration in future programming. Countries covered in the Review are Nepal, Nicaragua, Ethiopia, Uganda, and Zimbabwe.

The Review is largely a desk study. The main documents used are SC country office documents, international reports, national strategies and plans, SCN documents, and Save the Children International (SCI) OneNet archive. The document review was supplemented by a field trip to Zimbabwe 8 – 15 April, 2014. Further information was also gained through Skype interviews with key informants and/or implementing partners in the four countries that were not visited.

Conclusions and recommendations

Conclusion 1: HIV and AIDS continue to significantly impact on the lives of children in medium and high HIV prevalence countries. SCN´s programming in the five Review countries were relevant to their country context in terms of their HIV prevalence, pattern of infection, and national responses. In Zimbabwe, where a coordinated response was needed for orphans and vulnerable children, working in at district level with national coordination was highly relevant and effective in 2003. In Uganda and Ethiopia with mature national responses, underserved geographical areas were selected for activities. In Nepal and Nicaragua, gaps existed in the national responses, which SCN interventions filled.

Recommendation 1: SCN should continue with HIV and AIDS investments in countries and situations significantly affected by HIV and AIDS. SCN should continue to be selective about where and how it can most effectively work given the national context. SCN should bring together country offices in those countries with high HIV prevalence to discuss how to take HIV work forward.

Conclusion 2: The reasons for SCN´s projects successes are:

a) **Care and support interventions have been well anchored in communities** which have identified the children in need, identified their problems, and found solutions to assisting. The rights-based perspective has enabled child protection committees and village

communities in Zimbabwe see their responsibilities as duty holders for vulnerable children in their midst.

b) **Strategic choice of partners.** All the programmes work closely with authorities ranging from the national to local levels. In Ethiopia, there is close collaboration with HAPCO, the federal HIV prevention and control office, and with the University of Gondar. Not only has this provided a different type of expertise, it has also widened SC´s network.

c) It has worked from **platforms that provide a range of central actors.** SC country offices have shown that they can work effectively with national authorities and UN agencies as well as with local communities. SCZ´s collaboration spanned from national to district level authorities. At district level, it works across sectors relevant to the care and support of OVCs. SC Nepal´s SOVAA project works closely with district and village AIDS and development committees. SC Nepal has been a GFATM principal recipient since 2010. It has recently been selected by the Government of Nepal to carry out its cash transfer programme for children affected by AIDS in a pilot project.

Recommendation 2: Country programming should continue its strategic choice of partners and where appropriate, anchoring programming in local communities. For new initiatives where there is a fragmented national response, SC should seek or establish a platform that includes a range of actors representing different sectors (e.g. health, social services, education, justice, police, labour and livelihoods), levels of government, types of NGOs, UN organisations, and the donor community.

Conclusion 3 Available documents give an insufficient picture of breadth and depth of SC´s HIV and AIDS work.

Recommendation 3 Reporting should focus more on documentation for learning rather than on documentation for accountability with a reliance on quantitative indicators. The links between interventions and expected changes should be more clearly spelled out. When they occur, evidence for them and why they occur should be presented. Analysis of why they do not occur as planned should also be presented with alternative ways to achieving an objective.

Future country programming should include detailed information about how activities relate to outputs, outputs to outcomes, and outcomes to achieving the stated objective. When changes are made in annual programming, reasons for the adjustments should be documented. Greater use should be made of diagrams to show the relationships among the outputs, outcomes, objectives, central actors, and structural institutions affecting these. Case studies could be used to show outcome results along the pathways to change. These would supplement the currently used case stories of individual people.

Conclusion 4: Although HIV and AIDS is no longer a global initiative for SCI, there is a need to sharpen or keep a focus on HIV- related issues in the non-HIV programme areas.

Recommendation 4: SCN should have an HIV focal person in the other thematic areas who will ensure opportunities for HIV and AIDS programming are not lost. The focal person should help identify the HIV-related interventions, ensure that these are adequately funded, and ensure that these are kept on the radar by clearly identifying the results to be achieved, reporting, and follow - up.

Conclusion 5: Although HIV and AIDS is no longer a global initiative for SCI, there are many HIV and AIDS issues that can be addressed in other programme areas.

Recommendation 5: SCN and country offices should examine programme areas for HIV relevant links. For example, in:

- Education
    - Targeting orphans and vulnerable children for school enrolment and completion
    - Meeting the emotional and psychological needs of children and young people living with HIV
    - Addressing the HIV stigma and discrimination in learning settings, among children, teachers, parents, and school authorities, and in learning materials
    - Including HIV prevention skills and competency based learning in child-centred learning
- Health and nutrition
    - Adolescent sexual and reproductive health and rights (ASRH) opens for a wide range of prevention, treatment, and care activities. Advocating, establishing guidelines and standards, and developing monitoring and evaluation systems for good quality youth friendly services should include the needs of young people living with HIV
    - All four PMTCT "prongs" should be included in programming aimed at reducing vertical transmission of HIV. The "prongs" are: prevention of HIV, prevention of unwanted pregnancy, prevention of HIV transmission from mother-to-child, and provision of care and support to mothers, children, and their families.
- Child protection
    - Ensuring that children affected by HIV and AIDS receive adequate care and support
    - Include interventions to address the HIV-related prevention, care, and treatment needs among victims of abuse, young migrants, and children in emergency situations
- Child rights governance
    - Promoting the voices of children and young people living with HIV in establishing appropriate, acceptable, affordable, and technically high quality youth friendly health services
    - Ensuring that the rights of children living with HIV and affected by HIV are fulfilled

Conclusion 6: SCN´s three HIV and AIDS objectives were broad enough to allow country offices to place their HIV and AIDS activities under one or more of them. Adjustments were made in the annual log frame planning over the strategy period. This probably enables more effective responses adapted to local circumstances but led to confusing reporting

Recommendation 6: Annual programme planning should continue to be flexible but better document the reasons for changes in focus.

Conclusion 7: The use of the comprehensive knowledge indicator and the care and support OVC indicator do not give a good picture of the work carried out under SCN´s three HIV and AIDS objectives. Knowledge about HIV needs to be supplemented with knowledge about HIV and health services, services for voluntary counselling and testing, and how to obtain affordable condoms. The attention given to the comprehensive knowledge indicator may

have over-shadowed other prevention results such as Nepal´s efforts to increase access to attending HIV services. Moreover, prevention should be accompanied by skills competency for autonomous decision-making and behaviour change for use of services and safe sexual behaviour.

Recommendation 7: HIV prevention is a complex area that cannot be reduced to knowledge acquired. SCN should find other ways to report on HIV prevention. This may be by not using a quantitative indicator but through more qualitative reporting that includes output results that impact on more than one outcome – but all leading to prevention of the spread of HIV.

Conclusion 8: SCI´s OVC indicator does not provide information about "Strengthened capacity within the community to protect children against the impact of HIV and AIDS". A definition of "community capacity" was not found in the documents reviewed. It was measured in one outcome: "percentage of OVCs receiving care and support".

Recommendation 8: Strengthened community capacity should be defined. Suggested dimensions on which it could be assessed are participation, social networks, involvement in policy-making, problem solving, formal linkages, delivering services, and/or increased trust among individuals and groups.

Lessons learned

1. HIV and AIDS is not simply a health issue or a child protection problem. An ecological framework for HIV and AIDS takes into account an individual´s resources, capabilities, behaviour, and socioeconomic position within family and community settings where there are many social and cultural factors. All these are affected by structural factors such as legal structures, policy environment, structural violence and discrimination, presence or absence of armed conflict, and demographic change factors. [1]

Applying a theory of change approach to HIV and AIDS programming in the future could provide a better basis for reviewing country results. Starting with information about the context, it would take into account political, social, and cultural factors as well as the policy environment in which the programming is situated. HIV and AIDS programming planning would show the expected processes or sequences of changes, assumptions about how these changes might happen, and a summary of outcomes. It should provide information about the different actors and their roles. HIV and AIDS present a dynamic situation and are situated in an every changing context. Annual reporting on results (or lack of such) within an overall picture of pathways to change would help document reasons for shifts in annual planning. The development of the output tracker could assist with this provided it includes HIV-related outputs.

The social epidemiology approach provides a framework for mapping outcome pathways that is highly compatible with SC´s theory of change with its focus on voice, innovation, results at scale, and partnerships. It requires inputs that include children´s voices, advocacy, capacity building, and most importantly, linkages with non-heath sectors.

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[1] See Poundstone *et al,* 2004, "The Social Epidemiology of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome" in *Epidemiologic Reviews, Vol. 26, 2004.*

2. Children´s participation and their self-articulated perspectives are not clearly featured in reporting. When planning HIV and AIDS programming, specific space should be given to the active participation of children in identifying needs, finding different potential solutions, and assessing results. This is especially true for issues relevant to children living with HIV and for developing interventions addressing stigma and discrimination.

3. Concern with adolescents most often focuses on programming that focuses on the prevention of HIV transmission. With the growing numbers of children and young people who are living with HIV, there is a need to systematically meet their wider needs. Programming that is adapted to children´s evolving capacities will be different depending on whether efforts are directed to young children, young teens, and/or young adults. Their needs cover a wide range such as *health issues* e.g. access to ART, drug compliance, youth friendly services; *psychosocial support* e.g. disclosure of HIV status, bereavement, meeting stigma and discrimination, loneliness; and *transitioning to the adult world* e.g. adolescent sexuality, forming their own families, barriers to formal education and jobs. Especially for adolescent programming, young people can make important contributions and it is essential that they participate actively. SCN´s earlier work with around key quality elements in programmes noted that participation is essential to the quality of a programme. It is also a route to self-esteem, taking control over one´s own life and has a strong resilience strengthening effect.[2]

4. A number of SC country programmes appear to be working in these areas but we did not find any systematic documentation of SC work with these issues. As the MTR of the SCN programmes funded by Norway in Zimbabwe noted, there is a lack of documentation and publishing of good practice. SC is well placed to document how HIV and AIDS affects children. With a large number of country offices including HIV and AIDS programming, SC can also provide evidence of good programming and practices. This is an area where sharing of SC´s work would benefit others.

5. Adolescent sexual and reproductive health provides many concrete opportunities for HIV and AIDS programming. The four "prongs" of PMTCT can be included in adolescent health care settings. Developing youth friendly services that are relevant, accessible, acceptable, and affordable requires active inputs from young people themselves.

6. Document review does not give an adequate picture of the scope and depth of SCN´s HIV and AIDS investments in country programming. One reason for this is that the reporting format does not provide sufficient detail to show the links between activities and outputs which led to outcomes related to the programme objectives. Country strategic plans lack output statements and information showing the links between these and expected outcomes. Subsequent annual reporting reflected this weakness and made it difficult to follow annual progression especially since countries were undergoing substantial organisational changes which also contributed to inconsistencies in reporting.

7. Another reason for an incomplete and often fragmented picture emerging from SCN documents is that more documents are available at country offices than at SCN. The Zimbabwe country visit provided additional documents about its HIV and AIDS work. Skype interviews with the other countries indicated that this was the case those countries as well. SCI´s OneNet system is difficult to navigate through for the inexperienced user. Annual

[2] Personal communication with Elisabeth Jareg

reporting earlier than 2013 is not easy to find. Annexes referred to in CAR are not consistently accessible. Moreover, documents in SCN´s archives are not always dated and can be difficult to find when there is rapid staff turnover.

Report structure
Chapter 1 of this Report provides the context in which the HIV and AIDS investments were made. Chapter 2 explains the scope and purpose of the Review. Chapter 3 gives the methodology used. This is supplemented by information in Annexes 4 and 5. Chapter 4 presents the county programming before presenting Findings in Ch. 5. Chapter 5 is presented in two parts with Findings from the Zimbabwe Country Case study before a discussion of findings from the other four countries which are supplemented by information found in Annexes 1, 2, and 3. An assessment of indicators is presented in Chapter 6. Conclusions and recommendations follow in Chapter 7 and Lessons learned in Chapter 8.

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1 BACKGROUND AND CONTEXT

This report is a review of Save the Children Norway's (SCN) HIV and AIDS portfolio. The thematic priorities for SCN's work are set out in "Save the Children Norway's strategy 2010 – 2013" approved by the SCN National Congress in September 2009. In the 2010-2013 Strategy. SCN's main thematic priorities are child rights governance and children's right to basic education. The strategy also intends that SCN will increase its capacity to prevent and respond to humanitarian crises. During the period, protecting children against violence and abuse and against the impact of HIV and AIDS are also thematic areas for work.

In order to fulfil the right of children to protection against the impact of HIV and AIDS, SCN invested nearly NOK 30 million during the period in eight countries in Africa, Asia, and Latin America.[3] The planned objectives for the HIV AND AIDS thematic area were:

- Strengthened capacity within the community to protect children against the impact of HIV and AIDS
- More young people protect themselves and others against HIV infection
- Newborn children are protected from mother to child transmission of HIV

In short, one can view SCN's HIV and AIDS portfolio as comprising three components: a) care and support for OVCs, 2) prevention of the spread of HIV, and 3) reduction of vertical transmission of HIV. It was expected that each country programme would "prioritise the thematic objectives differently depending on the local situation".

This Review of SCN's HIV and AIDS portfolio assesses investments made at a time of considerable change for Save the Children (SC) member and country offices. The effort and ramifications of the changes were substantial and required considerable time in some countries. The following changes took place:

- Country offices were unified into one organisation sometimes unifying up to seven different offices e.g. Ethiopia.

- After unification, country offices became part Save the Children International (SCI) as a single organisation at country level. Countries underwent these changes at different times. In Nicaragua, unification was completed before this strategic period began while in Nepal, it was completed in 2011. SC Zimbabwe (SCZ), among the last countries to affiliate with SCI, joined in January 2014.

- SCI, itself was undergoing organisational changes and shifts in focus and SCN's development reflected these changes. According to the ToR, HIV and AIDS was a global initiative for SCI's programme and member countries in 2010 but later ceased to be "a separate thematic area" and the last reporting from it as a SCI Global Initiative was in 2012. It is intended that the HIV and AIDS investments will be part of the Health & Nutrition and Child Protection global initiatives and a thematic area within Child Rights Governance at country programme level.

[3] See Terms of Reference for the Review

- In 2010 SCN and country programme strategies start with the three above objectives for their HIV and AIDS work. Planning for them includes stated objectives, expected results and outcomes, and baseline values reflecting a logframe approach. Changes during the Review period show an increased use of a theory of change approach which has resulted in a different types of results reporting among countries each year.

According to the Review´s ToR, SCN's total HIV and AIDS expenditures declined during the Review period from 3.7% of SCN´s total budget in 2010 to 0.9% in 2013.[4] Similarly, according to the Review's ToR, the overall HIV and AIDS funding in 2013 was 43% the amount in 2010. For the five selected countries covered in this Review, the amounts of the 2013 grants were 61% of the amounts granted in 2010 declining from NOK 7 845 162 in 2010 to NOK 4 759 965 in 2013.

Globally, within the field of HIV and AIDS, other developments were taking place. Global HIV and AIDS funding levelled off. Starting in 2009, total global funding for HIV ceased to grow so that by 2011, there was 30 per cent gap between the target of what was needed and the USD 16.8 billion that was spent. [5]

At the same time, the push for universal access to treatment gained new momentum. Countries themselves decided whether and when to follow these new eligibility guidelines for anti-retroviral treatment (ART) that changed both in 2010 and 2013 thus increasing the numbers of people who would benefit from accessing ART.

In 2011, 22 countries adopted the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. [6] Global targets are to reduce the number of new HIV infections among children by 90% and reduce AIDS-related maternal deaths by 50%. Ethiopia, Uganda, and Zimbabwe are among the countries that agreed to achieve these targets.

Finally, young people aged 15 – 24, as a group gained increasing attention. Statistics are now often given for the age group 15 – 19 years of age separate from those aged 20 – 24 years. The growing group of people living with HIV (PLWH) includes larger numbers of children living with HIV who are transitioning into adolescence and are facing challenges as they become sexual beings and parents themselves.

2 SCOPE AND PURPOSE OF THE REVIEW

All of the above changes led to a complex background against which SCN's HIV and AIDS investments have been carried out, with the circumstances in each country changing at different times.

The ultimate purpose of this Review is to document results achieved as a result of the investments made (by SCN, Norad and MFA) to fulfil the right of children to protection

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[4] personal communication April 1, 2014

[5] http://www.avert.org/funding-hiv-and-aids.htm downloaded 8May 2014

[6] UNAIDS, *Countdown to Zero, Global Plan Towards the elimination of new HIV Infections Among Children by 2015 and Keeping Their Mothers Alive 2011 - 2015*

against the impact of HIV and AIDS during the period of 2010 - 2013. In addition, the review should help SCN document key successes, challenges and make feasible recommendations for SCN and country offices in how to ensure that the rights of children within the field of HIV and AIDS are taken care of or get enough consideration in future programming. (See Annex 6 for ToR)

Ten issues are highlighted in the Review's ToR to focus the review of the portfolio. Six are refinements to the ultimate purpose of the review:

- Assess SCN's HIV and AIDS investment in terms of relevance and effectiveness
- Assess if considerable results have been documented with measuring against SCN's key HIV and AIDS indicators
- Analyze data from the SC's monitoring and evaluation systems within HIV and AIDS and assess the type of results, number of children and youth benefiting from holistic HIV and AIDS programmes
- Assess if the investment in HIV and AIDS has contributed to any policy formulation, changes and response in the respective countries
- Assess the role and engagement of civil society and partnership among stakeholders towards HIV and AIDS intervention
- Assess to which extent HIV and AIDS is integrated into other thematic sectors like education, health, protection, and child rights governance and the potential benefits or disadvantages with this approach

Two refer specifically to Zimbabwe:

- The extent to which HIV and AIDS programmes financed by SCN covered specific niches that were not covered by other partner/donors involved in HIV and AIDS
- Assess the existing capacity at country office levels and identify capacity needs for better HIV and AIDS intervention in the future

Two refer to the conclusions, recommendations, and lessons learned:

- Document lessons learned and challenges encountered during the intervention period
- Advise how to ensure the rights of children are taken care in future programming

Country Offices with programmes supported by SCN have reported annually on the overall SCN support in their country annual reports (CAR). Reporting on HIV and AIDS is not gathered in a single document but can be found in each country´s country annual plan (CAP), CAR, and annual reporting to SCN each year. This Review focuses on HIV and AIDS programming and not on overall country programme progress.

3 METHODOLOGY

The Review is largely based on the review of documents. The main documents examined are:

- SCN documents: the Periodic Results Reports from March 2014, strategies, internal documents
- Country Office documents: Country Strategies for 2010 – 2013/2014, CAP, CAR, country annual reporting to SCN
- Documents from the SCI OneNet archive

- Reports from UN organisations and agencies, national reporting to UNAIDS, Demographic and Health Survey (DHS) reports
- National strategies and plans
- When available, country level reviews and evaluations

From April 8 – 15, 2014, the document review was supplemented by a field trip to Zimbabwe to explore how the HIV and AIDS interventions are carried out within a country programme and to gain insight into SC as an organisation. On very short notice, SCZimbabwe (SCZ) arranged for the Review team to meet people in Harare and at the local level, especially to see its community-based efforts supporting orphans and vulnerable children (OVC) in rural communities. Focus group discussions were conducted with ten community groups. Informant interviews were carried out with 17 key informants representing ten organisations**.** A list of people met for the Review including during the country visit is provided in Annex 4; this includes information about participants in the group discussions. Data collection tools were prepared before the Zimbabwe visit and reviewed by SCN. They are available upon request.

Additional information was gained through 5 key informant interviews (4 women, 1 man) at SCN both before and after the Zimbabwe field trip. Skype interviews were also carried out with 9 country office informants and/or implementing partners (3 women, 6 men) in the four countries that were not visited: Uganda, Nepal, Nicaragua, and Ethiopia.

The Skype interview informants had different roles in each country so the data sets for the countries vary. For example, in Uganda and Nepal, the Skype interviews were with implementing partners and not with the country office staff.

SCN commented on the Inception Report prepared before the Zimbabwe field visit. Findings from the country visit were discussed with SCZ before departing Harare. A Preliminary Findings Report was sent to SCN after the Zimbabwe visit was completed.

An international consultant led the Review with support from a Zimbabwean consultant especially during the country visit. An international consultant provided quality assurance.

Limitations of the review process
SCN's HIV and AIDS support to Cambodia ended in 2010 and in 2011 to Mozambique and Zambia. Therefore these three countries are not covered by this Review. During the four year Review period, they received 16% of the SCN´s total HIV and AIDS funding. [7] Thus the Review covers 5 countries: Nepal, Nicaragua, Ethiopia, Uganda and Zimbabwe.

Background information on Nicaragua is not as comprehensive as the other countries. Much of the information on Nicaragua´s national context is only available in Spanish. The last Country Progress Report submitted to UNAIDS was in 2010 and a National Commitments and Policy Instruments (NCPI) report has not been submitted. The most recent DHS conducted in Nicaragua was in 2006. Since the Nicaraguan Skype interview was carried out with the assistance of a translator, opportunities for follow-up questions to pursue issues in-depth were limited.

[7] ToR for the Review

4 COUNTRY PROGRAMMING

Before moving to a presentation of findings, information on each country´s HIV and AIDS programme is presented here. This has been drawn from the March 2014 Periodic Results Reports. Table 1 provides an overall summary of the five countries programming for the three SCN HIV and AIDS components: Care and support, HIV prevention, and PMTCT. The Review has used these reports as the starting point for understanding each country´s programming because the reporting format lends itself to comparisons across the Review countries. The Periodic Results reports give information on "achieved results" in relation to the identified "expected results" in the individual country strategy plans so that the table serves as a brief introduction to the findings in Chapter 5. Table 1 is followed by basic facts about each country´s national HIV and AIDS situation together with a narrative summary of features of each country´s HIV and AIDS programming.

Table 1 Country programming from the March 2014 Periodic Results Reports

	Overall national context and HIV & AIDS programming features	**Strengthened capacity within the community to protect children against the impact of HIV & AIDS** Expected/ *achieved results*	**More young people protect themselves against the impact of HIV & AIDS** Expected/ *achieved results*	**Newborn children are protected from mother-to-child transmission of HIV** Expected/ *achieved results*
Ethiopia	Mature national response coordinated by HAPCO SC programme implemented in North Gondar (Amhara) and Addis Ababa	Sustainable & quality community-based support for OVC in place, reflected in terms of children getting comprehensive services *Met* Minimum stands developed with regards to a comprehensive ´package of services for OVCs. Organisations adhering to this standard *Met* An inventory of best practices in OVC care & support developed & disseminated to key national & international stakeholders resulting in a change in the current service provision *Inventory developed & disseminated* *Change in practice not measured* Doubling of the number of children havingaccess to education, healthn & PSS support through SCNE supported efforts *Met* An orphan fund established in Amhara	Target children & youth have been empowered w/knowledge & life skills to protect themselves from HIV & AIDS. Incl. nos of children & YP who demonstrate comprehensive knowledge of HIV *Partially met (2013 data being further analysed)* Significantly reduced rate in new HIV & AIDS infections in the target population in the period covered by the Strategy *Not measured*	Number of new cases of MTCT is significantly reduced compared to the baseline *Not measured* Total number, as well as relative ration of pregnant women who has access to VCT & PMTCT services significantly increased *Met* Best practices documentation & tool kit developed & disseminated for use in woreda health centres across the region-resulting in improved level of services in terms of prevention & care at the woreda level *Partial met*

		region & has started dispensing funds in support of OVCs *Not met*		
	Overall national context and HIV & AIDS programming features	**Strengthened capacity within the community to protect children against the impact of HIV & AIDS** Expected/ *achieved results*	**More young people protect themselves against the impact of HIV & AIDS** Expected/ *achieved results*	**Newborn children are protected from mother-to-child transmission of HIV** Expected/ *achieved results*
Uganda	Mature national response SC programme Implemented in Northern and Western Uganda	Empower community members including children and youths to handle the socio-economic impacts of HIV & AIDS *Partially met*	The proportion of young people who know ways of HIV can be avoided & able to reject major misconceptions about AIDS increased from 15.7% *Met*	Strength capacity of communities to reduce mother to child transmission of HIV *Met*
Zimbabwe	National response is health centered and somewhat fragemented SC programme carried out in 3 rural districts and 2 areas PMTCT carried out in 1 district	% of OVC assisted to access priority needs (food, fees, uniforms, etc) *Exceeded target* %of targeted OVC benefitting from community coping mechanisms *Exceeded target*	% increased among 15-24 year olds demonstrante comprehensive HIV knowledge *Partially met* % reduction in teenage pregnancies *Met* % reduction in teenage STI *Met*	% of HIV exposed babies born to positive mothers on treatment testing negative *Met* % of HIV positive babies initiated on ART *Met*
Nepal	Concentrated epidemic SCNepal selected as a GFATM principal recipient SC programme is	Increased number of children & youth mobilized as SOVAA in 4 districts (Achham, Doti, Jhapa & Morang) *Numbers reported, unable to see whether these represent an "increase"* At least 1 district level network of SOVAA is established & functional in	Increased numbers of children 12-18 who can state at least 3 ways to protect themselves from HIV transmission from 2009 baseline in programme areas *91% children & youth demonstrate comprehensive knowledge*	Not planned under HIV theme however integrated under health as part of saving newborn life program (SNL)

	implemented in 4 districts	the HIV programme area *Exceeded target* Increased social acceptance & community response *Met* CABA has increased access to education & other basic needs *97% CABA continue their education*	Increased access of PLHIV/CABA to HIV & AIDS related services in the program districts *97% PLHIV/CABA received necessary services as per their needs*	
Nicaragua	Not an HIV priority country for SCI SC HIV programme implemented in 5 geographical areas of high risk	90% of children & adolescents who are orphans & vulnerable to impact of HIV receive comprehensive attention in the intervention areas *Plans not implemented*	Increase by 50% the baseline of 9% of adolescents who know at least 3 ways of preventing HIV transmission *Exceeded target*	5% annual increase from in pregnant mothers picked undergoing rapid HIV testing in intervention areas *Exceeded*

Zimbabwe

Facts about Zimbabwe
Population: 13 million *Human development index rank:* 172 *Pattern of HIV spread:* generalised *Adult HIV prevalence*: 13.1% § *HIV prevalence among young people 15 – 24:* females: 6.6%; males: 3.4% § *Number of people living with HIV*: 1,159,000 § *Children < 15 living with HIV:* 138, 642 § *Number of orphans and vulnerable children:* 1,600,000 * *Anti-retroviral coverage for those eligible:* 80% § *Total SCN funding*: NOK 11, 159 969; 40% of SCN's HIV and AIDS investments

§ Global AIDS Response Programme Report, 2012
* National Action Plan Phase II for Orphans and Vulnerable children

Country programme response to HIV andAIDS
The main focus of Zimbabwe's HIV and AIDS programming was a continuation of their care and support programme for OVC that started in 2003. Prior to SCZ´s work, Zimbabwe´s response to OVC was reported to be uncoordinated and fragmented. Recognising this fragmentation, together with UNICEF and the Ministry of Public Service, Labour, and Social Welfare, SCZ developed a community-based programme that served as a model for the country's National Action Plan I for Orphans and Vulnerable Children 2005 -2009 (NAPI). Working at the local level with one district council in each of the eight provinces, a multi-sectoral approach was developed drawing upon the relevant government sectors: the district AIDS Action Council, education, health, the police, social services, community mobilisers, and vital statistic registry. This was the model that was adopted nationally for the response in all 67 districts. During the Review period, the project was carried out in 14 project sites in 2010 but reduced to 4 sites by 2014

NAP I was followed by NAPII for 2011 – 2015 which is being implemented with a shift in model for child protection. Within SCZ, this has meant that NAP II is no longer followed by the HIV & AIDS and Health advisor but comes under the work of child protection.

SCZ's 2010 - 2014 Country Strategy notes that HIV and AIDS work in this period will add prevention and awareness components. Implementing this work was constained by lack of funding.

SCZ work around PMTCT is is carried out with one partner, the Zimbabwe AIDS Prevention Project (ZAPP) and their work in Chitungwiza.

Uganda

Facts about Uganda
Population: 34.5 million *Human development index rank:* 161 *Pattern of HIV spread:* generalised § *Adult HIV prevalence*: 7.3 § *HIV prevalence among young people 15 – 24:* females – 4.9%, males – 2.1% § *Number of people living with HIV*: 1,200,000 * *Children < 15 living with HIV:* 156,000 * *Number of orphans and vulnerable children:* 2,400,000 # *Anti-retroviral coverage:* 58%% * *Total SCN funding*: NOK 5,779,053; 20% of SCN's HIV and AIDS investments

§ Uganda AIDS Indicator 2011 Report
* Global AIDS Response Progress Report 2012
# National Strategic Programme Plan for of Interventions for Orphans and other Vulnerable Children 2011/12 – 2015/16

Country programme response to HIV and AIDS

Uganda's Country Strategy Plan clearly states that HIV and AIDS and child rights governance will function as crosscutting as well as standalone thematic areas. Some HIV and AIDS topics are identified as issues that can be addressed in SC Uganda´s education efforts, for example, "Increased access to quality primary education for out of school children, especially girls and children living with HIV and AIDS (CLWHA)". HIV and AIDS - relevant issues are also identified in messaging, attitudes, and behaviour interventions that can be addressed in a learning environment. PMTCT is included in health and nutrition. There is a recognition that young people represent 20% of Uganda's population and that they have a greater need for health services than is available. Integrating HIV and AIDS work into Adolescent Reproductive and Sexual Health (ARSH) approaches is an important part of prevention. The Strategy Plan notes that 18% of OVC are engaged in sexual activity before age 15.

SC Uganda also recognises the importance of sizable numbers of children living with HIV and AIDS (CLWHA) transitioning into adolescence and the needs they have for support in drug adherence, safe sex practices, and positive living. Their intention is to build strong partnerships with key providers especially local government districts to support early case finding and enrolment programmes for HIV positive children and youth.

SC Uganda has shown flexibility in setting objectives for its programming each year. In 2010 sub-themes included "Community and Home based psychosocial support to CLHV" with an objective "Mitigate the impact of HIV and AIDS on children and their families." Some of the reported results for that year were of the type that are reported for the OVC component in other countries. Another sub-theme that year is "Care and treatment for HIV affected Children" with the planned objective "Improved access to quality HIV and AIDS prevention, care and treatment services for children and their families". Again, under this, some of the reported results are of the type found for the OVC component. It is thus difficult to follow results from one year to the next because objectives change. In 2010, results for SCN´s knowledge for prevention indicator is not reported in the CAR. In 2012 and 2013, an additional sub-theme is added: Pediatric AIDS, Community and Home Based Care and Palliative care.

Ethiopia

Facts about Ethiopia

Population: 83 million §
Human development index rank: 173
Pattern of HIV spread: generalised §
Adult HIV prevalence: 1.5% §
HIV prevalence among young people 15 – 24: 2.6% (2009) §
Number of people living with HIV: 789,000 §
Children < 15 living with HIV: 170,000 §
Number of orphans and vulnerable children: 5,400,000 *
Anti-retroviral coverage: 86% (CD4 count < 200) 20% (CD4 count<350) §
Total SCN funding: NOK 3,095,084; 11% of SCN's HIV and AIDS investments

§ Country Progress Report on HIV/AIDS Response 2012
* *Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia II (SPMII) 2009 - 2014*

Country programme response to HIV and AIDS

Save the Children Norway in Ethiopia's (SCNE) Country Strategy 2010 – 2013 planned a comprehensive HIV and AIDS approach covering care and support for OVCs, prevention through school radio listening groups, and prevention of mother-to-child HIV transmission with the University of Gondar. A central concern that comes out of the Strategy Plan is the need to establish good practice in meeting the needs of OVCs and sharing that expertise with professionals so that there is a consistency of approach throughout the country. This was accomplished with the development of the *Hope for Life* best practice document that was disseminated a number of places including the 13th World Congress on Public Health in Addis Ababa in 2012. Similarly, the PMTCT collaboration with University of Gondar is developing a toolkit for good practice.

During the Skype interview with an implementing partner, we heard about the continued use of mass media through the Gondar Education Media Centre which has organised school radio listening groups that are the starting points of peer education efforts to reach children, young people, and communities. Listening groups are formed and follow a tightly structured 52 part programme that has a weekly message or topic discussed during a 25 minute radio segment. A manual accompanies the programme and draws upon children's and the wider communities' views and experiences on HIV, AIDS, and other important topics such as harmful traditional practices. The school listening groups discuss the week´s program and raise questions that they send by letter to the radio for discussion and answers. Children who perform "exemplary activities" in the community such as carrying water for elderly people, setting up fencing, caring for sick people may be identified and talked about during the broadcasts. Children who actively participate the entire year are awarded with a radio at a graduation ceremony. In 2013, there were 600 graduates but in earlier years, 1800 – 2000 graduates completed the programme.

Nepal

Facts about Nepal

Population: 27 million
Human development index rank: 157
Pattern of HIV spread: concentrated §
Adult HIV prevalence: 0.3% §
HIV prevalence among young people 15 – 24: 0.12 % §
Number of people living with HIV: 50,200 §
Number of orphans and vulnerable children: NA
Anti-retroviral coverage to those eligible: 24% §
Total SCN funding: NOK702,584; 2% of SCN's HIV and AIDS investment

§ Nepal Country Progress Report 2012

Country programme response to HIV and AIDS
The main focus in SC-Nepal's HIV and AIDS work has been on continuing the work of the long established Social Volunteers against AIDS (SOVAA) movement. With a national pattern of a concentrated epidemic, insufficient attention has been given to children affected by AIDS (CABA) at national level. Initiated by SC UK 15 years ago, this social movement works to create a protective environment in a western area of Nepal where people have traditionally migrated to India. An evaluation carried out in 2011 describes SOVAA as "a social movement against HIV and AIDS for creating an enabling environment for children affected by AIDS (CABA), single women and infected people to improve their access to social resources and mitigate the social impacts on the epidemic on individuals, families, and communities." [8] CABA and their families are supported to access priority health, nutrition, education, and livelihood services. In the areas where they work, it is reported that SOVAA´s approach has had an impact on reducing stigma and discrimination as measured by the Stigma Index carried out by Family Health International. The networks have mobilised local resources to support CABA and have been recognised and collaborate with the District AIDS Coordination Committees.

Recognition of SC Nepal´s work is demonstrated by its selection since 2010 as a principal recipient for the GFATM. The GFATM has tended to concentrate on most-at-risk groups such as people who inject drugs and female sex workers, while the SOVAA project has focussed on mobilising volunteers for community-based action.

The Government of Nepal has selected SC Nepal to implement its cash transfer project for CABA.

The CAP and CAR give very little feel for the nature of the SOVAA project. The 2011 evaluation and the Skype interview with SC Nepal´s senior program coordinator supplemented our understanding of the project.

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[8] Devkota, Bhimsen and Bhandari Jhabindra, 2011, "Social Volunteer Against AIDS (SoVAA), Programmatic Strategy Assessment" submitted to Save the Children Nepal

Nicaragua

Facts about Nicaragua

Population: 5.9 million
Human development index rank: 129
Pattern of HIV spread: concentrated
Adult HIV prevalence: 0.2% §
HIV prevalence among young people 15 – 24: NA
Number of people living with HIV: 7700 §
Number of orphans and vulnerable children: NA
Anti-retroviral coverage to those eligible: 41% §
Total SCN funding: NOK 3,022,425; 11% of SCN's HIV and AIDS investment

§ Espinoza, Henry et al, 2011 *Bulletin of the World Health Organization* 2011;89:619-620. doi: 10.2471/BLT.11.086124

Country programme response to HIV and AIDS
In the country programme, HIV and AIDS is not a stand alone thematic area but is included under Health and Nutrition as part of adolescent reproductive and sexual health. The programme is "co-implemented" with the Ministry of Health. Geographical areas for work are those districts that have difficult access to health services.

Two kinds of interventions were implemented: a) Preventing HIV transmission in adolescents at risk in five geographic areas and b) PMTCT

Although the national figures reported to UNAIDS point to a small concentrated epidemic, SC-Nicaragua considers this to reflect considerable under-reporting. They see the lack of good data to be one of the biggest challenges to addressing HIV and AIDS. In support of this assertion is the recognised fact that Nicaragua is the first Latin American and Caribbean country to have a larger number of females than males who are HIV positive.

The geographical areas selected for SC Nicaragua's HIV and AIDS work are those found to have had a rapid increase in HIV and AIDS. SC Nicaragua has chosen not to work with OVCs but to focus on capacity building for health care staff to raise their awareness and prepare them for a sensitive response to HIV positive women attending for health care services. Training in HIV guidelines and protocols strengthened the capacities of the local authority and MOH health unit teams and improved the quality of interventions in traditionally marginalised communities that have difficulty accessing health care facilities.

During this period, the MOH and the Ministry of Education identified schools at risk, making it possible for SC Nicaragua to target its efforts to raise the awareness of adolescents and pregnant adolescents about HIV prevention, using peer-to-peer methodology.

5 FINDINGS

The country visit to Zimbabwe was extremely valuable for understanding country level HIV and AIDS programming. Findings from the visit and the lessons learned provide a lens through which we examined documents from the other countries. Findings are therefore presented in two parts: the Zimbabwe country case study and findings from the other countries based on document review and the Skype interviews.

5.1 Zimbabwe case study

ZIMBABWE CASE STUDY

1. Scope and purpose of the country case study

The purpose of the country visit was to shed light on issues raised in the Review´s ToR (Annex 6) and to give the Review Team a better understanding of how HIV and AIDS investments were carried out within a country office setting.

2. Visit

Details of the case study methodology are given in Annex 7. Plans for the country visit were made on very short notice and SCZ made extraordinary efforts to arrange interviews and visits that demonstrated its HIV and AIDS work. An international consultant visited Zimbabwe between 8 – 15 April 2014 and was supported by a national consultant to conduct the field visit. Details of the itinerary for the country visit are shown in Annex 4

During the visit, SCZ provided key documents that had not been available in Oslo: the Mid-Term Review "Programme Review for Save the Children Programmes funded by Norad" (MTR)[9]; two evaluation reports of aspects of the HIV and AIDS Mitigation Project, and reports on SCZ global indicator monitoring and monitoring framework. A list of documents reviewed is found in Annex 5.

3. Country programming

The strategic priorities for 2012 – 2015 are:

1) Strengthen and Reposition the OVC Portfolio, building on current work
2) Build on EveryOne and MNCH programming to strengthen and expand role in pediatric HIV elimination (PMTCT) and care
3) Strengthen and expand youth prevention work

Many of the plans identified in the 2012 – 2014 Strategy were based on the expectation of more funding in each priority area. This, unfortunately, did not materialise which impacted most on the HIV Mitigation and PMTCT areas where funding including the EveryOne campaign was not found.

4. Findings

Findings are presented in relation to the issues raised in the ToR.

4.1 *Relevance*

The strategic priorities in SCZ HIV and AIDS thematic area are highly relevant to the needs of children and young people in Zimbabwe. The Mid-Term Review (MTR) for the overall SCN supported programme found: Relevancy is rated **very good.**

[9] JIMAT, 2014, "Programme Review for Save the Children Programmes funded by Norad"

The National HIV and AIDS Strategic Plan II 2011 – 2015 (ZNASP II) has two national priorities: 1) prevention of new adult and children HIV infections and 2) Reduction of mortality amongst PLHIV where there is an emphasis on the provision of ART. SCZ´s HIV and AIDS activities have 2010 – 2013 have focused on the mobilising community ownership of provision of basic services for OVCs which is not entirely aligned with national priorities. The other priorities in SCZ´s HIV and AIDS Strategy relating to PMTCT and youth prevention work are highly relevant to the ZNASP II priorities.

The current National Action Plan for Orphans and Vulnerable Children Phase II (NAP II) 2011 – 2015, moves to features such as cash transfers to families and a concern over a standardised level of care. SCZ´s 2012 – 2014 HIV and AIDS strategy notes this shift in focus away from the community capacity strengthening. SCZ´s participation in the Working Party of Officials (WPO) for NAP II is its Child Protection Advisor.

Lack of funding hampered carrying out SCZ´s priority "to strengthen and reposition the OVC portfolio, building on the current work". Instead, one finds the OVC work is reduced in geographical coverage from the earlier strategy period where SCZ had 12 local authority partners to four in 2013. Similarly, the prevention and PMTCT work have also been curtailed due to a lack of funding.

4.2 *Effectiveness*

In late 2013, SCZ commissioned an evaluation of their HIV mitigation project "with a focus on documenting the component of establishing the child protection committees (CPC) and their effectiveness in the protection, care and support for OVC." [10] This report provides a far better assessment of the effectiveness of SCZ´s work in SCN´s objective to protect OVCs than the country annual reports. [11] The Report is fully consistent with all of the observations made by the Review Team during the country visit.

4.2.1 *Doing the right things for the right people?*

Poverty is recognised as a significant underlying factor that leads to and results from vulnerability to HIV and AIDS. Through income generating activities (IGA) at ward and village level, CPC interventions are largely related to meeting the basic needs e.g. food, shelter, and clothes of OVC. Enabling children to attend schools is an important part of community level CPCs work – providing uniforms, ensuring caregivers understand the importance of school attendance, and providing stationery.

CPC are an effective way of finding local solutions to mitigate the impact on OVCs. Training on rights of children as well as the responsibilities of duty bearers is understood and taken on by communities. CPCs and ward focal points are appointed and respected by their communities. The MTR commented that "the evaluation team witnessed incredible CP work being done by local CPCs"[12] but adds a cautionary observation about their sustainability after SCZ´s support ends. (p. xiv). A significant part of CPC effectiveness has been attributed to being sensitive to local needs and opportunities but this is seen by some to result in a lack of a standardised level of care.

The beneficiary OVCs are identified by the CPCs and their registers make up the district´s OVC list. A comment in the 2013 reporting indicates SCZ´s awareness of the importance of ensuring the registers´ accuracy and that

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[10] Psychosocial Support, Research and Training Centre, 2013, "Strengthening Community Support for Orphans and Vulnerable Children (OVC); The Case of Matobo and Mberengwa Districts´ Child Protection Committees (CPC)"

[11] The study was mainly qualitative but used quantitative data in project reports to triangulate its qualitative data. Twelve focal group discussions (FGD) with adult CPCs, twelve FGD with children groups/child-led CPCs, 12 FGD with non-CPC adult community members, 10 key informant interviews with community and opinion leaders as well as five key in-depth interview with district leaders were held across two districts.(p 5 in the report).

[12] JIMAT Development Consultants, 2014, "Programme Review for Save the Children Programmes funded by NORAD, p 41

they may need to be re-visited.

For HIV prevention, the child-led groups and many activities seem to be focused on schools. The MTR observes that SCZ´s interventions are not effectively reaching out-of-school youth and concludes that there is little evidence showing the out-of-school youth are benefiting from the programme. [13] The Documentation report on Prevention found many SC prevention activities are not mentioned large proportions of the respondents. (p 17 – 18.)

4.2.2 *Selecting an effective partner?*
The HIV Mitigation project has worked with local authorities as SCZ´s main partner. This fits well with the overall institutional structure for NAP II where the District CPC is the interface between service providers and community level (ward and village) structures. It gives the SCZ district coordinator a good platform for reaching the different services across sectors: Department of Social Services, police, education, health, registry.

HIV prevention activities have been closely tied to child-led groups in schools and have worked through community edutainment activities. Activities taking place in schools require permission from the Ministry of Education´s District Education Officer. While there may be cordial and collaborative relations between the SCZ coordinator and the MOE, this is still a hindrance to working with children and young people. The MTR observed that children´s participation in decisions around HIV prevention is limited because so many of the activities take place in schools. (p 48).

4.2.3 *Making a difference?*
The MTR assesses the SCN supported programme impact as "good" [14] noting that community groups have been strengthened by the growth of income generating activities which support OVCs. [15]

The PMTCT reporting does not state the numbers of beneficiaries reached in 2010, 2011, and 2013and the MTR points out there are no target numbers for this component (p. 45).

Making a difference is partly related to scale. In 2012 and 2013, SCZ spent between 6 – 7% of its country budget on HIV and AIDS activities. This is severely inadequate in relation to need. In terms of directly reached beneficiaries SCZ´s OVC work is limited to four districts (out of 67) with a target group of 65 000 in a country where there are an estimated 1.6 million OVC. The country office has clearly stated that it would be happy to have a larger HIV and AIDS involvement and that it is the lack of funds that is preventing this.

4.3 *Have considerable results been documented when using SCN´s key HIV and AIDS indicators?*
SCN has one indicator for its HIV and AIDS work. It is related to the prevention objective and is defined as "% of targeted children in the SC project area (program participants "who can both correctly identify ways of preventing the transmission of HIV and who reject major misconceptions about HIV transmission." Five questions make up this indicator and correctly answering all five questions is considered to show "comprehensive knowledge of HIV".

Ascertaining the values for this indicator was not entirely straight forward. The MTR notes for the overall SCN supported programme, "The analysis of results achieved over the past four years is extremely difficult because of the varying annual report formats." (p 8). It also notes the lack of target numbers for this objective (p. 45). We found that the reported age groups changed throughout the 2010 – 2013 period. Objectives for which results are measured sometimes changed. For this indicator, annual surveys were carried out to measure it and Table CS-

[13] JIMAT Development Consultants, 2014, "Programme Review for Save the Children Programmes funded by NORAD, p 49

[14] Assessment is in four categories: very good, good, some problems, serious deficiencies

[15] JIMAT Development Consultants, 2014, "Programme Review for Save the Children Programmes funded by NORAD, p xii.

1 show the results:

Table CS-1 Results of the prevention indicator

	2010	2011	2012	2013
# of young people aged 10 - 24 giving correct answers on prevention and misconceptions	230	295	316	283
Total number of respondents	720	771	791	909
% young people aged 10 - 24 demonstrating comprehensive knowledge	32	38	40	31

One sees that there was a gradual increase in comprehensive knowledge among project participants between 2010 and 2012 but that there was a decline in 2013. In the annual reporting, this is attributed to "regular staff turnover on key positions responsible for monitoring day to day implementing activities." We note that in the electronic form for this indicator, in 2013, the sample was randomly drawn from in and out-of-school children and wonder if this represented a change or was the practice in the earlier years as well.

4.4 ***What types of results and how many beneficiaries have there been when using SC M & E systems for HIV and AIDS***

SCI´s monitoring system has one global indicator for OVCs. It is defined as " % of OVC receiving services that address priority needs. It measures children under 18 years of age who have been identified as orphaned or vulnerable and are accessing services through an OVC programme supported or implemented by SC".

An important component of SCZ´s mitigation project is the material support provided by the CPCs through their income generating projects.

Table CS-2 shows the results according to the SCI OVC global indicator and the numbers of children assisted by the CPCs. Figures are taken from the country annual reports (CAR). The table shows that the denominators changed between years as the project gradually reduced the number of districts where it was active. And the table shows some of the anomalies that can be found in the country annual reports (CAR) reporting where the numbers are inconsistent with the percentage and where the numbers reached are unclear. A target of 25% OVC benefiting from the "community coping mechanisms" was set for the period and it is clear that CPCs were effective as they surpassed this target early on.

Table CS-2 Results of the OVC Care and Support indicators

	2010	2011	2012	2013
# of OVC in project area accessing basic social services (food, health, shelter, school uniforms, and education)	74 107	47 399	47 935	62 434
% of OVC accessing protection & care	64	§73	74	96
# OVC getting support, care, & protection from the community coping mechanisms	19 244	6785	unclear	Not given
% OVC getting support, care, & protection from the community coping mechanisms	17	70	40	unclear

§ per cent reported as 87%

4.5 ***Wider impact on policy formulation, changes and response***

While the HIV and AIDS mitigation project was widely recognised as impacting on Zimbabwe´s national response to OVCs in the earlier strategic period, an equally significant policy impact was not found between 2010 and 2013. User fees in ante-natal care are an obstacle to attending for PMTCT. SCZ´s achievement in

having these reduced is important but it is not clear whether this policy change is universally implemented in all clinics.

4.6 ***Has SCZ´s HIV and AIDS programme covered special niches that are not covered by other HIV and AIDS donors?***

Key informants outside SCZ identified three main contributions that SCZ has made in its HIV and AIDS work: 1) getting children's issues on the agenda. District Councils recognize that vulnerable children are their responsibility and this recognition goes across party lines. 2) SCZ's way of working encourages local communities to find their own solutions. Local ownership makes them more sustainable in the long run, 3) SCZ has raised awareness of children's rights among children as well as duty bearers.

The Zimbabwe AIDS Prevention Programme (ZAPP) fills an often overlooked niche. ZAPP is concerned with non-clinical aspects of PMTCT. It focuses on community mobilization, test and counseling, education and training, mother, baby services, family-centered psychosocial services (PSS) for parents and children. Sadly, this programme has not been replicated or scaled-up nationally.

Following-up HIV exposed infants in the PMTCT programmes is a critical part of reducing poor health and mortality among young children. Five PPS centres for under 5s and one support group for school age children were established in Chitungwiza, a peri-urban area of Harare. Community volunteers (mainly women) are selected to work as child minders at the centres. After tra ining, volunteers promote child development through play; participate in CPC in their communities; sensitize communities to issues around child health, child rights, and child abuse; follow-up treatment defaulters; and make appropriate referrals for health and other social services.

The participation of under 5s into PSS centres grew steadily from 155 in 2007 to 345 in 2011.The number of graduates from the Under 5s PSS centre increased from 45 in 2007 to 100 in 2011. During the meeting with ZAPP, we were given the opportunity to talk with two of the volunteers (both mothers living with HIV) who came with three of their children. They were knowledgeable, enthusiastic, and aware of the benefits of support settings for children living with HIV. They valued their training and work as volunteers as this had opened up many new perspectives.

The 2012-2014 Strategy and early annual reporting called for establishing youth friendly corners in rural health centres. Many reports and our observations found that these had not been established.

4.7 ***Role and engagement of civil society and partnership among stakeholders***

SCN´s HIV and AIDS Mitigation Project works collaboratively with district level and with local community groups. SCZ is currently only funding the projects in two remaining rural districts – salaries for the district coordinators and their running expenses have been taken over by the other two local authorities.

World Education is SCZ´s key partner for work under NAP II but this falls under SCZ´s child protection work, not HIV and AIDS. SCZ´s OVC work carried out in Mberengwa national partner continues to be the MLPSSW.

The Review Team was not able to get a good sense of the collaboration among CSO and other partners perhaps reflecting that we had few interviews that provided an overall perspective of the national HIV and AIDS arena.

In its 2012 reporting to UNAIDS, all countries were expected to complete a National Commitments and Policies Instrument (NCPI). This tool provides information about the role of CSO, bilateral agencies, and UN organisations in their country´s HIV and AIDS response. CSO were asked to rate the extent to which they felt they were involved in their country´s response on a scale of 0 to 5 where 0 equals low and 5 equals high. In Zimbabwe´s reporting, 12 organisations completed the form - mostly UN organisations. They rated their involvement in the National HIV Strategy as 5, involvement in the national HIV budget as 3, involvement in national reporting as 5; and participation in the monitoring and evaluation plan as 4.

The selection of the Zimbabwe AIDS Prevention Project (ZAPP) as SCZ´s partner in PMTCT efforts provides a potential for further collaboration. ZAPP is part of the University of Zimbabwe´s Department of Community Medicine and has links with the Elisabeth Glaser Pediatric AIDS Foundation (EGPAF). Lack of funding appears to be the obstacle to more collaboration in this network.

4.8 *The integration of HIV and AIDS into other thematic sectors*

Integration of HIV and AIDS with other sectors can viewed in two arenas: within the country and within the SC country programme.

4.8.1 *Intersectoral efforts in the national arena*

The visit to Zimbabwe gave an opportunity to examine national intersectoral collaboration. The Ministry of Health and Child Welfare (MOH&CW) is the main GOZ ministry responsible for carrying out the ZNASP II which has a strong health perspective. Other ministries are expected to mainstream HIV and AIDS.

Several documents[16] and informants and point to weak coordination within the MOH&CW itself and by the National AIDS Council. The national reporting to UNAIDS notes the weak integration of TB and ART activities within the MOH & CW and that HIV and AIDS needs to be integrated with other programmes most notably sexual and reproductive health. This, of course, includes the PMTCT programming. The lack of an Integrated Database for HIV Programmes is a major challenge. [17] This means that tracking clients across programmes is not possible – especially those who access treatment from one site but then move to another without notification. Without an electronic database this can be recorded as loss to follow up but actually women may be accessing medication from a clinic closer to their new location or a clinic further away due to stigma and discrimination. This was confirmed by the visit with EGPAF which pointed out the difficulties of PMTCT follow-up when clinic registrations are only in hard copy.

The Ministry of Education, Sport, Arts and Culture has a "Life Skills, Sexuality, HIV and AIDS Education Strategic Plan 2012 – 2015 but we did not have the opportunity to learn about how this is being implemented.

4.8.2 Stand alone or integrated into SCZ´s other thematic areas?

In SCZ´s Zimbabwe Country Strategy 2010 - 2014, HIV and AIDS is a standalone thematic topic which is "to reinforce the prevention, mitigation, psychosocial support, and protection of the unborn child". It is also mentioned under the "Emergency" thematic area but no HIV and AIDS indicators or expected results are listed under the other thematic areas.

SCZ´s Child Rights Governance advisor suggested that there may be a place for HIV and AIDS in this thematic area as it involved child led groups and networks where HIV prevention issues are discussed. There is also the possibility that child-led groups would call for more appropriate health services that meet adolescent and CLWHA needs.

4.9 *Existing capacity at country level and capacity needs for better HIV and AIDS intervention in the future*

The underfunding of SCZ´s HIV and AIDS programming in Zimbabwe impacts on the country office's capacity to work with it. Due to the lack of long-term funding, over the past 18 months, the country office has struggled to retain an HIV programme officer. During this time, there have been short-term holders of that position. The HIV and AIDS Advisor has often covered the work but she is also the Health Advisor. In addition, she has other

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[16] See ZNASP II 2010, p. 48, *Global AIDS Response Progress Report 2012, Zimbabwe Country Report, Reporting Period: January 2010 – December 2011* and Ministry of Health and Child Welfare *et al*, 2012 *z Zimbabwe Rapid Assessment of Sexual and Reproductive Health and HIV Linkages*

[17] See *Global AIDS Response Progress Report 2012, Zimbabwe Country Report, Reporting Period: January 2010 – December 2011*

responsibilities related to quality assurance, advocacy, and fund raising. At the time of our visit, SCZ was attempting to recruit a Health manager but due to financial constraints, is only able to offer a three-month contract.

The HIV & AIDS and Health Advisor has a professional nursing background and long experience in HIV and AIDS work that is highly relevant for her post. She has been with SC for more than ten years. Earlier she worked for SC- US and the Ministry of Health where she was responsible for training of trainers.

It was initially hoped that district coordinators for the mitigation project would be qualified social workers. It was soon found that the national lack of qualified social workers made it necessary to fill these posts with graduates with other relevant qualifications e.g. teachers, nursing. The District HIV and AIDS coordinator we met in Mberengwa had been a teacher. He has been with the SCZ mitigation project for ten years.

On the job training and exchanges have been extensively used to enhance the competence of all those working on the OVC project: district coordinators, local authority district staff, CPC members. Cascading training of trainers is a frequently used technique but of course, requires funding. Anecdotally, we heard that in districts where SCZ is no longer giving financial support, these types of activities have been cut back.

CAR and the MTR identified lack of transport as a constraint on monitoring and supporting HIV and AIDS activities at district level. Monitoring and evaluation in the country office has been strengthened in the past few years. At present, there is an M & E advisor, three M & E officers, and two assistants. An M & E plan for 2013 was developed. We were given copies of a three evaluations on aspects of SCZ's HIV and AIDS work. A new output tracking system was put into place last year. Five per cent of the country office budget goes to M & E.

To summarise the capacity needs for future HIV and AIDS programming, the main issue is long-term funding. Recruiting and retaining competent staff is hampered when only short-term contracts are offered. Supportive supervision also incurs expenses as face-to-face encounters are needed to maintain quality programmes.

5. Conclusions

Conclusions given here relate to SCZ´s overall HIV and AIDS programming but the purpose of the case study was to give better understanding into what can lie "behind" the reports when reviewing documentation for the other Review countries.

1. SCZ´s work during 2010 – 2013 has been relevant and effective in the thematic area HIV and AIDS.
2. HIV and AIDS greatly affects the well being of children in Zimbabwe. Continued interventions to address prevention, treatment, care, support, and mitigation are needed.
3. The amount of the country programme going to HIV and AIDS is disproportionately small (6 -7%) in relation to need. HIV and AIDS programming was reduced compared to the previous period due to the lack of funding.
4. Adolescent sexual reproductive health is an often overlooked area in the prevention, support, and mitigation of HIV and AIDS – especially the sexual reproductive health of adolescents living with HIV.

6. Recommendations

The recommendations relate to possible entry points for continued HIV and AIDS work in Zimbabwe

5. PMTCT is a potential area for further work with the MOH&CW. It is, however, important to remember that PMTCT includes four pillars: 1) prevention of new HIV infections, 2) prevention of unwanted pregnancies, 3) prevention of vertical transmission of HIV, and 4) provision of treatment and care. SCZ should work on all four pillars and in its work with the MOH& CW.
6. The Adolescent Sexual Reproductive Health Strategy 2010 – 2015 provides another potential area

for SCZ engagement in ADRH. SCZ should look at the Community Participation Project it has with the MOH&CW to see whether there is scope to include youth friendly services in this initiative.

7. Similarly, SCZ should examine whether there is scope for advocating for adolescent services within its Child Rights Governance work with child-led groups perhaps in connection with the regional child and young people network.
8. The Ministry of Education, Sports, Arts and Culture has a "Life Skills, Sexuality, HIV and AIDS Education Strategic Plan 2012 – 2015". SCZ should examine whether this provides an entry point for collaboration with the MOESAC on school-based and other prevention activities. The Plan notes that curriculum needs to be revised and perhaps provides a starting place for SC involvement.

7. Lessons learned

The lessons learned from the Zimbabwe case study are perhaps more important than the case study onclusions and recommendations because they shed light on the way we viewed and interpreted the documents for the other countries.

1. The first, nearly immediate impression that was confirmed throughout the visit was that the documents do not give an adequate picture of the breadth and depth of SCZ´s work in HIV and AIDS. The OVC indicator does not give a picture of SCZ´s effective community-based work.

2. Considerably more documentation of project work was available at country level than was shared by SCN. SCN document archiving and reporting leads to a fragmented picture of the HIV and AIDS programming.

3. Caution must be exercised when reviewing the results reporting in Annual reports. Careful attention should be given to the denominators in the reporting in terms of who is included. We note that the OVC indicator is reported for a denominator of 65 000 OVCs while the MTR reports about a targeted 52 000 (MTR p 40). The teenage pregnancy figures are derived from the Ministry of Health facilities which sometimes were late in reporting and which does not have an electronically based system that can share information between health facilities.

4. Logframe reporting has limited value in assessing results in some areas such as the role and engagement of civil society and partnerships. Moreover the emphasis on quantitative results which is most often presented in a table matrix may over-shadow documentation that would show the scope and effectiveness of SCZ´s work. We understand that frequent and regular meetings are held at district level to review the work but found no written documentation about decisions that were made which improved the programming.

5. Increased use of documenting programme results using a theory of change perspective would perhaps give a better picture. We found the MTR and the report on the CPCs to be rich in detail that gave a better understanding of the results. Both of these reports used a theory of change framework for analysis. Because more attention was given to the "pathways" to results, they gave greater confidence in their assessments.

6. The recently developed Output Tracking reporting may allow better tracing of outcomes along pathways to results.

7. Since HIV and AIDS is a standalone thematic area for Zimbabwe and health was not, it was difficult to see in the document review how HIV and AIDS activities related to PMTCT could be included in future health programming. We were unable to see HIV and AIDS related work in the **reporting** on maternal newborn child health (MNCH) or in Child protection.

8. Policy impact and scale-up are difficult to assess within a short timeframe of a 4 year strategic period. Policy formulation and/or changes in practice result from pushes and pulls from different directions for different reasons all within a legal, regulatory, economic, and social framework and take time. The Review´s type of document review should be cautious in making assessments about wider policy impacts based on the documents available.

5.2 Findings from the other countries

Findings for the other four countries are based on the periodic results reports and the annual planning and reporting documents. Planning and reporting basically follows a logframe approach with expected results/outcomes often expressed quantitatively i.e. “an increase of x”. The definition and usefulness of indicators used is discussed in detail in Section 6.

SCN comments on the limits of these types of indicators in two papers:

> “Baseline, targets and results in each country can only be understood against the context in which the programme is implemented.” (SCN 2010, SCN Baseline 2010)
>
> “Standardized global indicators is but one of several methods to collect information about progress and results. They should be combined with project indicators, narrative reports and evaluations to give a fuller picture of the results and quality of SCN supported interventions” (SCN 2013, SCN Global Indicators 2010 – 2012; Mid-term status report on Programme results & Lessons Learned)

The annual planning documents are confusing to someone with little experience of SC. Sub-themes could change from year to the next in a country´s planning so that it was difficult to follow results and to ascertain which objective it was meant measure. Uganda is a good example of this. Sometimes the objectives changed from one year to the next without explanation (example, Ethiopia).

As noted in the Zimbabwe case study, we found the evaluations to be very useful in supplementing information in the planning documents. Unfortunately, we received only one evaluation report from the other countries i.e. the 2011 SOVAA evaluation in Nepal although some documents indicated that evaluations were planned. We noted reference to plans for mid-term reviews in other countries but did not see these reports.

5.3 Relevance

SCN’s care and support objective: “Strengthened capacity within the community to protect children against the impact of HIV and AIDS” is highly relevant in countries with a generalised pattern of HIV and in Nepal with geographical areas that present pockets of vulnerability.

The countries´ selection of areas for their HIV and AIDS work are relevant to their country´s need. In Ethiopia and Uganda where there is a mature national response, SC activities are implemented in geographical areas that are often not reached by others. In Nepal, SC´s SOVAA project has been implemented in communities especially vulnerable to HIV and AIDS.

One question that has been raised is the whether HIV and AIDS programming was based on needs assessments in each country. The Strategy Plans indicate that a template is used for each country´s plan. They start with a summary of the plan and context that includes 1) the overall goal for the strategy period, 2) Strategic intent/ Thematic programming, 3) Country context, and 4) Internal context. Strategic and management/operational objectives are given in a logframe of thematic area, planned objective, expected results related to each objective, and baseline information.

The rationale for the programming is often given in the Strategy Plan sections on strategic intent and country context. A needs assessment of the kind found with new projects is seldom done. Indeed much of the SC HIV and AIDS programming evolves from earlier work e.g. the OVC work in Zimbabwe, the radio listening groups in Ethiopia, CLWHA work in Northern Uganda, the continuing work with SOVAA in Nepal, the health work in Nicaragua which was earlier supported by SC Canada. We cannot tell from the available documents whether earlier needs assessments had been done.

When asked about a needs assessment, two countries said they had done a document review of needs. Others pointed to the way SC works – promoting a total package of interventions in selected geographical areas so that their familiarity with the local circumstances alerts them to the issues related to HIV and AIDS.

Informants from Ethiopia referred to a workshop held in 2009 where six African SC country offices met (including Ethiopia and Zimbabwe) and mapped out needs, objectives, and plans for HIV and AIDS programming. We were not able to see whether needs assessments were done after the workshop because country specific presentations and reporting were placed on a CD which is not available.

The lack of a needs assessment with baseline data and output statements hampers an assessment of results.

There is clearly a need for SCN's HIV and AIDS investments in the African countries where there is a generalised epidemic with millions of vulnerable children and large numbers of CLWHA transitioning to adolescence. In Nepal, with its concentrated epidemic, creating a safe environment for the protection of children affected by AIDS (CABA) in communities of high HIV prevalence is directed to a potentially overlooked group. One might question whether HIV work is relevant in Nicaragua which is not an HIV priority country but here HIV work is integrated into the overall adolescent reproductive health work in potentially high prevalence areas where staff may, in the future, need strengthened HIV and AIDS competence.

Country office HIV and AIDS programming is consistent with national strategies with the exception of Nicaragua and possibly, Nepal. With a concentrated pattern of HIV spread, national efforts have been directed to working with most at-risk groups (MARG). SC Nicaragua's response reflects their concern over the gendered aspects of the spread of HIV and the signs that HIV is more generalised than the national response indicates. SC Nepal could be viewed as filling a niche while national efforts are centred around MARG.

5.4 Effectiveness

Table 1 showing country programming also shows how the countries themselves assessed whether they had achieved their expected results. Of the 29 expected results, 17 were either met or exceeded their target. Only in two cases were plans not implemented or the expected result was not met.

Annex 1 "Reported results for care and support", Annex 2 "Reported results for HIV prevention", and Annex 3 "Reported results for PMTCT" provide more detailed information about activities and results related to the reporting in Table 1.

5.4.1 Doing the right things for the right people?

In Ethiopia and Uganda - countries with a generalised epidemic - meeting the needs of OVCs is highly relevant. Reporting from the CAR on the OVC indicator was: Ethiopia only reported on

the OVC indicator in 2012 (10.5%). Uganda only reported in 2012 (OVC: 14 395) and 2013 (40 599).

Uganda directs its attention to identification and care of children living with HIV and AIDS (CLWHA) by creating a child friendly environment in communities and health facilities. Access to appropriate health facilities for CLWHA and OVCs features centrally in SC Uganda. Moreover, reducing stigma through psychosocial interventions is an integral part of empowering CLWHA develop resilience over social labelling and stigmatisation.

Uganda also addresses the needs of an often overlooked group - adolescents living with HIV, by expanding access to youth friendly HIV and AIDS, ASRH, and PMTCT services. The Gulu Network for Young Positives is part of this adolescent focused work.

Nepal has selected the most vulnerable children – those affected by HIV and AIDS who they feel often are more vulnerable than orphans. Their work complements the efforts of the GFATM which directs most its resources to MARG in Nepal while SC appears to be strengthening communities where there are many most-at-risk people, in this case, migrants to India.

Sensitivity to cultural norms is demonstrated in the community-based manner that characterises much of SC's work. Communities identifying their own solutions is a characteristic of SC´s implementation. This is especially seen in the SC work in Zimbabwe, Nepal, and Uganda.

5.4.2 Selecting an effective partner?

Selection of an appropriate partner has been a key factor in the effectiveness of SC´s interventions. In Nepal, there is close collaboration between the SOVAA networks and district and village AIDS committees. In Ethiopia collaborating with pubic authorities from the federal down to kebele level means they can draw upon these links when developing tools for good practice. Moreover, Ethiopia works with the University of Gondar on a couple of projects and this brings a type of expertise that is not often found in HIV and AIDS programming. Further, it widens SC´s network so that it extends to students. The Skype interview revealed that University of Gondar students had carried out three evaluations of the radio programmes.

In Nicaragua there is close collaboration between SC Nicaragua and local authorities and the ministries of health and education. SC Nepal has been a principal recipient for the GFATM since 2010. Clearly it is in a trusted position with a central actor in the HIV and AIDS arena.

5.4.3 Are the interventions making a difference?

Part of making a difference relates to matters of scale. The document review did not reveal any activities that had been replicated in other areas during the Review period. In Zimbabwe, the OVC and HIV prevention work has cut back and is taking place in only four districts. In Ethiopia the number of radio listener groups has been cut back due to lack of resources. SC Nepal is working through an exit process with SOVAA.

However, small-scale projects have the potential for wider impact when governments use a project as a pilot. SC Nepal has advocated for CABA qualifying to receive cash transfers under the national programme. It has recently been selected by the Government of Nepal to implement the cash transfer programme in a pilot district.

Moreover, identifying and establishing good practice is another way of making a difference. In 2012, SC Ethiopia together with the national AIDS coordinating office, HAPCO, developed minimum standards for a comprehensive package of OVC services. These have been

disseminated and SC Ethiopia has led capacity building around them so organisations are using them. Together with the University of Gondar, best practices documentation and a toolkit have been developed and disseminated for use in woreda health centres for improvements in PMTCT and care at woreda level.

5,4.4 Innovative approaches used?

Through the available documents, innovative approaches were not easily identified. This does not mean there were none – rather that the logframe annual reporting and templates for narrative reporting do not easily lend themselves to revealing new things. The CAR reporting may mask innovation e.g. Uganda´s work with children living with HIV transitioning to adolescence and their needs. Innovation may be more visible in a different type of reporting. – something which is discussed in Section 5.4.4 of this report.

5.5 Stand alone or mainstreamed?

One of the issues identified in the ToR is the extent to which HIV and AIDS are integrated into the other thematic areas. This is an interesting question as it raises the same issues one finds with regard to gender: should HIV and AIDS be kept separate and visible or should it be mainstreamed into SC's other work? This is important when preparing for future SCN HIV and AIDS investments.

In Nicaragua, health and nutrition includes HIV and AIDS. Three out of five of the health objectives are related to HIV and AIDS. The child protection work includes issues that are closely linked to HIV and AIDS vulnerability – sexual abuse and trafficking (cross border and internal). The logframe includes six results related to these.

In Nepal, HIV and AIDS is a stand alone thematic area with a focus on most at risk groups and children affected by AIDS (CABA). A related topic, adolescent reproductive and sexual health is included under health and nutrition and there is one result which would capture adolescent knowledge about HIV and AIDS and one result which, when capturing STI, might reveal HIV.

In Ethiopia, HIV and AIDS is a stand alone thematic area but linkages with other areas are identified: education and protection against violence abuse, neglect and exploitation. However, there are no results in the logframe for these other areas that might capture HIV and AIDS results.

In Uganda, HIV and AIDS is seen as both a cross cutting and a stand alone area. As noted, above, children living with HIV and AIDS are identified as a target group for education. Moreover, integrated programming in schools can address issues relevant to HIV and AIDS. One of the education objectives includes targeting CLWHA.

In Zimbabwe, in addition to being a standalone thematic topic which is "to reinforce the prevention, mitigation, psychosocial support, and protection of the unborn child"[18], HIV and AIDS is mentioned under emergency. HIV and AIDS results are not captured under any other thematic areas.

These findings are summarised in the following table.

[18] Country strategy 2010 – 2014, p 3

Table 2 HIV and AIDS: Stand alone or mainstreamed?

	Country programming: stand alone or cross cutting	Other thematic areas that include HIV & AIDS	Indicators in other thematic areas?
Zimbabwe	Stand alone	Emergency	No
Uganda	Cross cutting and Stand alone	Education	Yes
Ethiopia	Stand alone	Education Child protection	No
Nicaragua	Cross cutting	Health Child protection	Yes
Nepal	Stand alone	Health	Yes

Given the importance HIV and AIDS has in the Africa region, it is worrying that does not have a more visible presence i.e. is mainstreamed with expected results in SC´s other thematic areas: health, education, and child protection.

In health, more attention could be given to all the four "prongs" of PMTCT: primary prevention of HIV, birth planning, vertical transmission of HIV, and provision of care, treatment, and support of women living with HIV.

The EveryOne campaign does not appear to be well suited for capturing HIV and AIDS results and is not funded in all countries. However, if if all four pillars of PMTCT were explicitly included in EveryOne, this would go some way to protecting children and young people from the impact of HIV and AIDS.

Similarly, although SC Uganda notes how HIV and AIDS issues could be included in the learning environment, it of concern that other countries have not included this in their education work. Under education, clear targets to ensure the enrolment and timely school progression of OVCs would give visibility to this group´s need for formal education

Child protection is a potential thematic area for continuing the work protecting OVCs but it is not clear how this work would fit into the type of child protection interventions currently implemented.
Sexual abuse and gender-based violence are linked with HIV vulnerability and children need protection from them. We were told that when HIV and AIDS ceased to be a global initiative, the OVC work would fall under child protection. But, we do not see that it is included in child protection planning.

For HIV and AIDS to be incorporated in the other thematic areas, it needs proper funding, reporting i.e. identified expected results, follow-up, and an easily incorporated place in the other thematic area's data set structure. Nepal has included the knowledge indicator under its adolescent health work indicating that it is perhaps not so difficult to incorporate across thematic areas.

5.6 Role and engagement of civil society and partners

The role and engagement of civil society and partnership stakeholders towards HIV and AIDS intervention is important because of the potential synergies that can arise from different networks and partners.

As noted in the Zimbabwe country case report in Section 5.1, part of reporting to UNAIDS includes completion of the National Commitments and Policies Instrument (NCPI). In 2012, all the Review countries except Nicaragua completed this. Table 3 show the NCPI reporting from four countries.

Nepal and Ethiopia asked the largest number of CSO to complete the form and in these countries, CSO felt they had moderate involvement in their country's HIV and AIDS response. In Zimbabwe, participating organisations thought they have a high degree of participation in Zimbabwe's HIV and AIDS response but that may be because a large number of those completing the form were from the UN agencies.

SC has a range of both state and civil society partners in implementing its HIV and AIDS interventions. SCZ´s OVC partner in the Ministry of Public Service, Labour, and Social Welfare (MPSLSW) was undoubtedly critical to the sustainability of its OVC interventions during the period of great economic constraints. SC – Nicaragua's links with its local municipal health services are invaluable for maintaining an overview of vertical transmission of HIV. Similarly, SC Uganda's community and local government links have facilitated its work to improve access to youth friendly HIV and AIDS services.

Table 3 Civil society involvement in the recent national HIV strategy

	Nepal	Ethiopia	Uganda	Zimbabwe
No. of organisations completing the form	24	24	12	12 (mainly UN organisations)
To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan				
• National HIV strategy	4	3	4	5
• National HIV budget	3	3	4	3
• National HIV reports	4	3	4	5
• National M & E plan	1	3	2	4

0 = Low and 5 = High

It may be that the lack of SC integrated programming reflects the extent to which a national response is multi-sectoral. Of the four countries submitting a NCPI, Uganda was the country with the largest number (9) of government ministries that had an earmarked budget for HIV and AIDS work. The other countries had far fewer: Nepal (3); Ethiopia (5), and Zimbabwe (possibly 3).

5.7 Policy impact

The question is whether the HIV and AIDS investments have had a wider impact in terms of contributing to any policy formulation, changes, and response in the respective countries, and if not, why not. Zimbabwe reported that it was instrumental in having user fees for ante-natal care removed. Ethiopia reported on its development of and training in good practice guidelines for OVC.

In 2013, Nepal reported that SC advocacy in the HIV and AIDS program was successful in influencing the government to integrate CABA in its policy and social protection scheme. The

government has prepared a plan for delivering services to CABA from its social protection scheme and SC-Nepal has been selected to implement the cash transfer programmes to CABA. In addition, SC Nepal has been a principal recipient for the GFATM since 2010 for working with PLWHA.

When discussing the lack of policy impact in Uganda, the implementing partners suggested that this may be due to a lack of critical mass of their interventions at the national level because the scope has been very small in the previous years. However, it has had impacts on the district level development plans in the districts of implementations. Moreover, in Ethiopia we see that SC work involves capacity building activities which are likely to have an impact on practice.

6. INDICATORS

Documenting and assessing results raises the the issue of the usefulness of the indicators and reporting. The Review´s ToR call for comments on SCN´s HIV and AIDS indicators and SC´s monitoring and evaluation for HIV and AIDS.

Five indicators have been used for reporting SCN´s HIV and AIDS interventions. They are of limited value for documenting SCN´s overall HIV and AIDS portfolio. Figures in SCI´s M & E system are disaggregated by age: under 15, 15 – 24, and adults and by gender. Because the 15 – 24 age category is so broad, figures provided in this category are of limited value in showing of changes among school age young people or among children.

6.1 SCN's HIV prevention indicator

More adolescents protect themselves and other against HIV infection has been measured using an indicator used by UNAIDS often referred to as the "comprehensive knowledge" indicator. It comprises 5 questions – all of which the respondent needs to answer correctly and makes up the nominator. The denominator is defined as "*targeted children in SC project area (program participants)*". This indicator was adopted as SCN´s single HIV and AIDS indicator. The challenges to this indicator are:

- *Denominator*

In Zimbabwe, considerable effort is made each year to conduct a survey in the schools in the wards that were visited in 2010 when the baseline was established. Students are randomly selected from the schools as respondents. In 2011, 12 wards were visited and there were nearly 800 respondents.

In the Skype interviews with implementing partners, in one country it was pointed out that the survey was only conducted among school club participants. Another interviewee noted difficulties selecting respondents from an ever shrinking group of project participants.

- *Data collection*

This indicator is taken from internationally established methodologies which use national resources such as a country´s central statistics office to carry out the survey on a population base. It is very demanding for an organisation to attempt to replicate this in a smaller project setting.

- *Prevention requires more than knowledge about the HIV virus*

While correct knowledge is critical to preventing the spread of HIV, it is not sufficient on its own. Knowledge of where to go for prevention and care services is important. Knowledge

needs to be accompanied by being able to make and carry out decisions. Athough some countries assert that young people have been equipped with life skills (for prevention), there is no indicator that demonstrates that youth have acquired these skills. Both knowledge and competency-based skills are insufficient if there is no behaviour change – an additional issue that is not measured.

6.2 Proxy indicators

Zimbabwe has reported on proxy indicators in an attempt to provide more information on their prevention activities than the knowledge indicator provides. They adopted a) reduction in teenage pregnancy and b) reduction in (sexually transmitted infection) STI incidence. Information was to be provided by health facilities in the areas where the prevention activities were implemented. The challenges with these indicators are:

- *Denominator*

These indicators require that all ante-natal clinic and STI service providers in the areas where SC interventions take place provide information to SC. This is the case in Zimbabwe where Ministry of Health facilities collaborate with SC. But the STI reporting may be incomplete. Men often seek STI treatment outside the formal health care system. For use in other settings, it may be that there are NGO or private-for-profit providers whose service information would need to be included to give a accurate and complete picture.

- *Accurate data on clinic attenders is required (numerator)*

Health facilities in Zimbabwe do not have an electronic system whereby patient information can be shared. All facilities rely on a paper-based system. This means there is no way to check whether a young person has moved or gone to another clinic to access services. SCZ reported further that information coming from the health facilities sometimes was late. Apparently, MOH recognises the weaknesses with their system as SCZ sometimes found that health facilities turned to them for information about attendance.

- *Population coverage*

It is important to know the population size and the coverage (e.g. distance to health provider or in terms of travel time to a provider) that health facilities provide in the area of SC HIV prevention activities.

6.3 OVC indicator

SCN´s care and support objective, "Strengthened capacity within the community to protect children against the impact of HIV/AIDS" was measured by SCI´s "% of OVC receiving services that address priority needs. It will measure children under 18 years of age who have been identified (by program, family or community) as orphaned or vulnerable and are being supported by an OVC program through Save The Children, its partners or through linkages with other partner services"". Definitions for this indicator are: Nominator = number and percent of children receiving services that address priority needs. Denominator = numbers of children under 18 years of age who have been identified as vulnerable. The challenges with this indicator are:

- The number of children receiving care and support does not measure community capacity
- *Denominator* Determining an agreed denominator. How the number of OVC is determined is unclear from country reporting. We note that while the annual planning and reporting in Zimbabwe often used 65 000 as their target OVC group, the MTR used

52 000 for reporting. Other countries may have used estimated figures from local authorities.

- *Nominator* Required accurate information from public and private (e.g. NGO) service providers about the numbers of children receiving services

- The figures do not reveal information about whether the service is appropriate to the child´s needs, whether (s)he is actually using them, and length of time the service is used.

- The figures do not give information about the quality of the service provided e.g. whether it is functioning or youth friendly

- Reporting on this indicator in the annual reports is highly variable with changes in the denominator from year to year, reporting of numbers, percentages, and/or both.

6.4 SCI´s mandatory preventive indicator

In 2013, SCI introduced a mandatory preventive indicator is defined as "Number and % of young people at higher risk of HIV reached by SC prevention programs who show care seeking behaviour by utilizing key preventive services in these settings". Zimbabwe did not report on this indicator. Challenges with this indicator and those similar to it are:

- *Denominator* Agreeing a definition of the target group ("young people at higher risk of HIV") will be difficult. It is not clear what "at higher risk" means.

- *Nominator* Key preventive services need to be agreed. Comments above about close collaborative arrangements and information exchange between SC and services providers applies here as well.

- The services themselves need to ensure that they are appropriate, available, affordable, and welcoming to a young person at higher risk

6.5 Total reach

Total reach is measured within the different sub-themes is measured as in terms of "directly reached" and "indirectly reached". This indicator builds upon different activities and total reach is measured accordingly. For example, the number of people attending a workshop provides the number of children and adults who are "directly reached". The "indirect reach" is calculated based on the an estimated number of people that the "directly reached" person is likely to share the benefits of the activity with. Total reach children and adults are disaggregated by gender. The challenges are:

- The quality and nature of the direct contact
- The basis for calculating the indirect reach

7 CONCLUSIONS AND RECOMMENDATIONS

Conclusion 1: HIV and AIDS continue to significantly impact on the lives of children in medium and high HIV prevalence countries. SCN´s programming in the five Review countries were relevant to their country context in terms of their HIV prevalence, pattern of infection, and

national responses. In Zimbabwe, where a coordinated response was needed for orphans and vulnerable children, working in at district level with national coordination was highly relevant and effective in 2003. In Uganda and Ethiopia with mature national responses, underserved geographical areas were selected for activities. In Nepal and Nicaragua, gaps existed in the national responses, which SCN interventions filled.

Recommendation 1: SCN should continue with HIV and AIDS investments in countries and situations significantly affected by HIV and AIDS. SCN should continue to be selective about where and how it can most effectively work given the national context. SCN should bring together country offices in those countries with high HIV prevalence to discuss how to take HIV work forward.

Conclusion 2: The reasons for SCN´s projects successes are:

a) **Care and support interventions have been well anchored in communities** which have identified the children in need, identified their problems, and found solutions to assisting. The rights-based perspective has enabled child protection committees and village communities in Zimbabwe see their responsibilities as duty holders for vulnerable children in their midst.

b) **Strategic choice of partners** All the programmes work closely with authorities ranging from the national to local levels. In Ethiopia, there is close collaboration with HAPCO, the federal HIV prevention and control office, and with the University of Gondar. Not only has this provided a different type of expertise, it has also widened SC´s network.

c) It has worked from **platforms that provide a range of central actors.** SC country offices have shown that they can work effectively with national authorities and UN agencies as well as with local communities. SCZ´s collaboration spanned from national to district level authorities. At district level, it works across sectors relevant to the care and support of OVCs. SC Nepal´s SOVAA project works closely with district and village AIDS and development committees. SC Nepal has been a GFATM principal recipient since 2010. It has recently been selected by the Government of Nepal to carry out its cash transfer programme for children affected by AIDS in a pilot project.

Recommendation 2: Country programming should continue its strategic choice of partners and where appropriate, anchoring programming in local communities. For new initiatives where there is a fragmented national response, SC should seek or establish a platform that includes a range of actors representing different sectors (e.g. health, social services, education, justice, police, labour and livelihoods), levels of government, types of NGOs, UN organisations, and the donor community.

Conclusion 3 Available documents give an insufficient picture of breadth and depth of SC´s HIV and AIDS work.

Recommendation 3 Reporting should focus more on documentation for learning rather than on documentation for accountability with a reliance on quantitative indicators. The links between interventions and expected changes should be more clearly spelled out. When they occur, evidence for them and why they occur should be presented. Analysis of why they do not occur as planned should also be presented with alternative ways to achieving an objective.

Future country programming should include detailed information about how activities relate to outputs, outputs to outcomes, and outcomes to achieving the stated objective. When changes

are made in annual programming, reasons for the adjustments should be documented. Greater use should be made of diagrams to show the relationships among the outputs, outcomes, objectives, central actors, and structural institutions affecting these. Case studies could be used to show outcome results along the pathways to change. These would supplement the currently used case stories of individual people.

Conclusion 4: Although HIV and AIDS is no longer a global initiative for SCI, there is a need to sharpen or keep a focus on HIV- related issues in the non-HIV programme areas.

Recommendation 4: SCN should have an HIV focal person in the other thematic areas who will ensure opportunities for HIV and AIDS programming are not lost. The focal person should help identify the HIV-related interventions, ensure that these are adequately funded, and ensure that these are kept on the radar by clearly identifying the results to be achieved, reporting, and follow - up.

Conclusion 5: Although HIV and AIDS is no longer a global initiative for SCI, there are many HIV and AIDS issues that can be addressed in other programme areas.

Recommendation 5: SCN and country offices should examine programme areas for HIV relevant links. For example, in:

- Education
  - Targeting orphans and vulnerable children for school enrolment and completion
  - Meeting the emotional and psychological needs of children and young people living with HIV
  - Addressing the HIV stigma and discrimination in learning settings, among children, teachers, parents, and school authorities, and in learning materials
  - Including HIV prevention skills and competency based learning in child-centered learning
- Health and nutrition
  - Adolescent sexual and reproductive health and rights (ASRH) opens for a wide range of prevention, treatment, and care activities. Advocating, establishing guidelines and standards, and developing monitoring and evaluation systems for good quality youth friendly services should include the needs of young people living with HIV
  - All four PMTCT "prongs" should be included in programming aimed at reducing vertical transmission of HIV. The "prongs" are: prevention of HIV, prevention of unwanted pregnancy, prevention of HIV transmission from mother-to-child, and provision of care and support to mothers, children, and their families.
- Child protection
  - Ensuring that children affected by HIV and AIDS receive adequate care and support
  - Include interventions to address the HIV-related prevention, care, and treatment needs among victims of abuse, young migrants, and children in emergency situations
- Child rights governance
  - Promoting the voices of children and young people living with HIV in establishing appropriate, acceptable, affordable, and technically high quality youth friendly health services
  - Ensuring that the rights of children living with HIV and affected by HIV are fulfilled

Conclusion 6: SCN´s three HIV and AIDS objectives were broad enough to allow country offices to place their HIV and AIDS activities under one or more of them. Adjustments were made in

the annual logframe planning over the strategy period. This probably enables more effective responses adapted to local circumstances but led to confusing reporting

Recommendation 6: Annual programme planning should continue to be flexible but better document the reasons for changes in focus.

Conclusion 7: The use of the comprehensive knowledge indicator and the care and support OVC indicator do not give a good picture of the work carried out under SCN´s three HIV and AIDS objectives. Knowledge about HIV needs to be supplemented with knowledge about HIV and health services, services for voluntary counselling and testing, and how to obtain affordable condoms. The attention given to the comprehensive knowledge indicator may have over-shadowed other prevention results such as Nepal´s efforts to increase access to attending HIV services. Moreover, prevention should be accompanied by skills competency for autonomous decision-making and behaviour change for use of services and safe sexual behaviour.

Recommendation 7: HIV prevention is a complex area that cannot be reduced to knowledge acquired. SCN should find other ways to report on HIV prevention. This may be by not using a quantitative indicator but through more qualitative reporting that includes output results that impact on more than one outcome – but all leading to prevention of the spread of HIV.

Conclusion 8: SCI´s OVC indicator does not provide information about "Strengthened capacity within the community to protect children against the impact of HIV and AIDS". A definition of "community capacity" was not found in the documents reviewed. It was measured in one outcome: "percentage of OVCs receiving care and support".

Recommendation 8: Strengthened community capacity should be defined. Suggested dimensions on which it could be assessed are participation, social networks, involvement in policy-making, problem solving, formal linkages, delivering services, and/or increased trust among individuals and groups.

8 LESSONS LEARNED and DISCUSSION

1. HIV and AIDS is not simply a health issue or a child protection problem. An ecological framework for HIV and AIDS takes into account an individual´s resources, capabilities, behaviour, and socioeconomic position within family and community settings where there are many social and cultural factors. All these are affected by structural factors such as legal structures, policy environment, structural violence and discrimination, presence or absence of armed conflict, and demographic change factors. [19]

Applying a theory of change approach to HIV and AIDS programming in the future could provide a better basis for reviewing country results. Starting with information about the context, it would take into account political, social, and cultural factors as well as the policy environment in which the programming is situated. HIV and AIDS programming planning would show the expected processes or sequences of changes, assumptions about how these changes might happen, and a summary of outcomes. It should provide information about the different actors and their roles. HIV and AIDS present a dynamic situation and are situated in an every changing context. Annual reporting on results (or lack of such) within an overall picture of pathways to

[19] See Poundstone *et al*, 2004, "The Social Epidemiology of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome" in *Epidemiologic Reviews, Vol. 26, 2004.*

change would help document reasons for shifts in annual planning. The development of the output tracker could assist with this provided it includes HIV-related outputs.

The social epidemiology approach provides a framework for mapping outcome pathways that is highly compatible with SC´s theory of change with its focus on voice, innovation, results at scale, and partnerships. It requires inputs that include children´s voices, advocacy, capacity building, and most importantly, linkages with non-heath sectors.

2. Children´s participation and their self-articulated perspectives are not clearly featured in reporting. When planning HIV and AIDS programming, specific space should be given to the active participation of children in identifying needs, finding different potential solutions, and assessing results. This is especially true for issues relevant to children living with HIV and for developing interventions addressing stigma and discrimination.

3. Concern with adolescents most often focuses on programming that focuses on the prevention of HIV transmission. With the growing numbers of children and young people who are living with HIV, there is a need to systematically meet their wider needs. Programming that is adapted to children´s evolving capacities will be different depending on whether efforts are directed to young children, young teens, and/or young adults. Their needs cover a wide range such as *health issues* e.g. access to ART, drug compliance, youth friendly services; *psychosocial support* e.g. disclosure of HIV status, bereavement, meeting stigma and discrimination, loneliness; and *transitioning to the adult world* e.g. adolescent sexuality, forming their own families, barriers to formal education and jobs. Especially for adolescent programming, young people can make important contributions and it is essential that they participate actively. SCN´s earlier work with around key quality elements in programmes noted that participation is essential to the quality of a programme. It is also a route to self-esteem, taking control over one´s own life and has a strong resilience strengthening effect.[20]

4. A number of SC country programmes appear to be working in these areas but we did not find any systematic documentation of SC work with these issues. As the MTR of the SCN programmes funded by Norway in Zimbabwe noted, there is a lack of documentation and publishing of good practice. SC is well placed to document how HIV and AIDS affects children. With a large number of country offices including HIV and AIDS programming, SC can also provide evidence of good programming and practices. This is an area where sharing of SC´s work would benefit others.

5. Adolescent sexual and reproductive health provides many concrete opportunities for HIV and AIDS programming. The four "prongs" of PMTCT can be included in adolescent health care settings. Developing youth friendly services that are relevant, accessible, acceptable, and affordable requires active inputs from young people themselves.

6. Document review does not give an adequate picture of the scope and depth of SCN´s HIV and AIDS investments in country programming. One reason for this is that the reporting format does not provide sufficient detail to show the links between activities and outputs which led to outcomes related to the programme objectives. Country strategic plans lack output statements and information showing the links between these and expected outcomes. Subsequent annual reporting reflected this weakness and made it difficult to follow annual progression especially since countries were undergoing substantial organisational changes which also contributed to inconsistencies in reporting.

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[20] Personal communication with Elisabeth Jareg

7. Another reason for an incomplete and often fragmented picture emerging from SCN documents is that more documents are available at country offices than at SCN. The Zimbabwe country visit provided additional documents about its HIV and AIDS work. Skype interviews with the other countries indicated that this was the case those countries as well. SCI´s OneNet system is difficult to navigate through for the inexperienced user. Annual reporting earlier than 2013 is not easy to find. Annexes referred to in CAR are not consistently accessible. Moreover, documents in SCN´s archives are not always dated and can be difficult to find when there is rapid staff turnover.

Annex 1

Reported Results for Care and Support

Objective 1 Capacities of communities are strengthened to protect children against the impact of HIV/AIDS.

	Expected results	Achieved result/outcome	Analysis	Remarks
Nepal	a) Increased numbers of Children and youth mobilized as Social Volunteers against HIV and AIDS (SOVAA) in four Districts (Achham Doti, Jhapa and Morang) b) At least one District Level network of SOVAA is established and functional in the HIV programme area c) Increased Social Acceptance and community response. d) CABA has increased access to education and other basic needs	a) 5987 Children and youth people developed as SOVAA and 40% SOVAA engaged in the communities to protect children against the impact of HIV and AIDS b) Three district levels SOVAA network in Achham, Doti and Jhapa have been established and are functional. c) They have significantly contributed to reducing stigma and discrimination in the families and communities and have increased networking and Advocacy for Children affected by AIDS. d) 97% of the CABA continue their education with promoting grades each year in the project areas.	The networking among CABA, single women, adolescents, youth and people living with HIV and AIDS has been effective with the support from SOVAA networks . VDC level SOVAA networks have been started to approach health facilities and social institutions for care and support for CABA and PLHIV. Their access to ART in the local hospital has improved as SOVAA networks are continuously creating a supportive environment for referral to health facilities. Due to ongoing advocacy for their rights to health care and education for CABA, VDC have started to allocate funds for HIV and AIDS.	
Nicaragua	90% of children and adolescents who are orphans and vulnerable to the impact of HIV receive comprehensive attention in the intervention areas	Plans were for work on this result to begin in 2011, in conjunction with the MOH and MIFAMILIA, after establishing negotiations with this partner. However, during the coordination phase, an analysis showed that there needed to be investment of resources that were not available through the project funds and that were not listed as a line of work under primary care for the Ministry of Health.		
Ethiopia	Sustainable and quality community based support for OVC in place, reflected in terms of children getting comprehensive services.	The capacity of different community based structures such as CSOs, CBOs/FBOs, PLHIV associations, schools and volunteers was strengthened through different trainings, grant and technical support to enable them to provide basic care and support for OVC. Accordingly, a total of 22,985 OVC (51% girls) got basic care and support from these community based structures in the years 2010 to 2013 in the target areas.	The capacity development activities highly contributed to the fulfillment of the objectives set, thereby ensuring the sustainability of the services provided to Orphan and Vulnerable Children.	

	Minimum standards developed with regards to a comprehensive 'package' of services for OVCs. Organizations adhering to this standard.	Standard service delivery guideline for OVC care and support programmes in 2010 by Ministry of Children and Youth Affairs in collaboration with Federal HIV/AIDS Prevention and control Office in 2010. Save the children played active role in the initiation, preparation (as part of the national steering committee), development, duplication, translation and distribution of the guideline. The services in the guideline	The development of the standard service delivery guideline has created a benchmark to the services delivered to OVC. Distribution and adoption to the local target community enabled all the stakeholders to get the awareness of the different dimensions of care and support to OVC thereby making interventions more systematic and relevant to the needs of the children.	
	An inventory of best practices in OVC care and support developed and disseminated to key national and international stakeholders resulting in a change in current service provision.	Best practice document entitled *'Hope for life'* was developed in 2010. This document was disseminated in different platforms including the 13th World Congress on Public Health held in April 2012.	The best practice documentation and sharing has contributed to learning among stakeholders. This in-turn contributes to the enhancement of capacity.	
	A doubling of the number of children (2009 baseline) having access to education, health and psychosocial support through SCNE supported efforts.	Total of 23,575 OVC got access to education, health, psychosocial, economic and other supports in the period 2010 - 2013. This amount is more than triple the amount reached in the strategic period 2006-2009.	This result highly contributes to the objective of impact mitigation	
	An orphan fund established in Amhara region and has started dispensing funds in support of OVCs.	This was not accomplished because the Federal Government has taken-over the task of developing a policy. But a local initiative, the social fund was established and supported at the woreda level in the intervention Woredas. On yearly basis, sensitization workshop was prepared in Alefa, Takussa and Chilga Woredas of North Gondar Zone.	The local initiative partially contributed to sustainability of support for OVC.	
Uganda	Empower community members including children and youths to handle the socio-economic impacts of HIV and AIDs	• Psychosocial Support: Anti-stigma, empowerment and resilience building: Children and youth have built self-esteem, resilience and empowerment against stigma and discrimination on HIV/AIDS which influenced their decisions making on their own lives. This has made them more able to withstand the negative impacts of HIV and be		

		accepted as viable actors who can 'live a normal life' and participate in decisions regarding their own lives, including advocating for their own rights in their communities • Access to child and youth friendly HIV and AIDS information and services. SCI improved access to HIV/AIDS Services including testing for earlier diagnosis and timely initiation of treatment/care that was responsive to the developmental needs of adolescents • The Home based care services (HBC) rendered by the CHW has led to reduced cases stigma and discrimination of children in the schools and community, facilitated quick and timely referrals of children for appropriate treatment and has created a child friendly environment for the children both within the community and at the health facilities.		
Zimbabwe	% of OVC assisted to access priority needs (food, fees, uniforms etc) % of targeted OVC benefitting from community coping mechanisms	96% of OVC accessed priority needs 47 % of targeted OVC benefitted from community coping mechanisms...	Marked improvement in the way communities cared and supported OVC.	Exceeded target

Annex 2

Reported results: More adolescents protect themselves and others against HIV infection

	Expected results	Achieved result/outcome	Analysis	Remarks
Nepal	a. Increased numbers of Children 12-18 Years who can state at least three ways to protect themselves from HIV transmission increased from the base line of 2009 in the program areas. b. Increased access of PLHIV /CABA to HIV and AIDS related services in the program Districts.	91% Children and youth (10-24 years) who can state at least five ways to protect themselves from HIV transmission and reject misconceptions in the programme areas. 97% of the PLHIV/CABA received necessary health and counseling services (e.g. STI treatment ,VCT services , BCC,ART,CCC,CHBC , OIs treatments) as per their needs.	With the peer education campaign that children , adolescents , youth and adults are more empowered to protect themselves from HIV and AIDS and communicating and disseminating information about HIV and AIDS prevention , care and treatments services including issues around reducing stigma and discrimination have been quite effective in community response	

Nicaragua	Increase by 50% the result obtained in the baseline of 9% of adolescents that know at least 3 ways of preventing the transmission of HIV.	A 68% increase was achieved in the number of at-risk adolescents that know at least three ways of preventing HIV and that reject erroneous ideas, in 35 schools, from 9% (2010) to 77% (2013).	Increase from 9% in 2010 to 77% in 2013, reaching more youth and teaching personnel during the period.	Met
Ethiopia	a) The targeted children and youth have been empowered with knowledge and life skills to protect themselves from HIV and AIDS. This will include the number of children and youth who can identify three means of protection and two most common misperception of AIDS transmission. b) Significantly reduced rate in new HIV and AIDS infections in the target population in the period covered by the Strategy.	a) Comprehensive knowledge of HIV and AIDS among young children of age <15 increased from 35% at baseline to about 42% in 2011 and 2012. Among children of age 15-24, the comprehensive knowledge of increased from 42% at baseline to 47% in 2011 and 49% in 2012. b) The rate of new infection in the target areas is not measured	a) Comprehensive knowledge on the major ways of transmission of HIV among adolescents and young adults contributes to positive behavior. b) Not measured	a) Partially met (the data for 2013 is being further analyzed) b) Not measured
Uganda	The proportion of young people who know ways HIV can be avoided and able to reject major misconceptions about HIV and AIDS increased from 16 %	40% female and 44% male youths are knowledgeable about ways to avoid HIV and can reject major misconceptions, an increase from 15% at baseline		Met
Zimbabwe	% increase among 15-24 year olds who correctly identify ways of preventing the transmission of HIV and reject major misconceptions. % reduction in teenage pregnancies % reduction in teenage STIs	Average 34% of targeted 15-24 year olds who correctly identify ways of preventing the transmission of HIV and reject major misconceptions. Overall-70 % reduction in teenage pregnancies Overall 72% reduction in teenage STIs	Project contributing towards HIV prevention of new infection in the target group that has been identified as high risk.	Partially met

Reported results: Newborn children are protected from Mother – to – child transmission of HIV

	Expected results	Achieved results	Analysis	Remarks
Nepal	It has not planned under HIV theme however heath theme SNL program implementing as of its integrated saving new born life program.			
Nicaragua	a. 5% annual increase from in pregnant mothers picked undergoing rapid HIV testing in intervention areas.	There was annual increase of 9%, from 51% of pregnant women undergoing rapid HIV detection tests in 2010 to 88% in 2013 in the three intervention provinces.	Training of health care personnel and raising the awareness of pregnant mothers created a culture of prevention and protection for the babies. There was an average annual increase of 17,500; an outstanding aspect considering the myths and discrimination	Met
	100% of pregnant mothers in the AIM program diagnosed as HIV positive receive the indicated antiviral treatment	During the entire period, 100% of the cases diagnosed as HIV-positive received retroviral treatment.	Fifty infants born to mothers who were diagnosed as HIV-positive were protected from the transmission of HIV through retroviral	Met
	80% of adolescent mothers know the contraindications for breastfeeding children in cases of HIV infection.	From 2011 to 2013, knowledge about the contraindications for breastfeeding by mothers that are HIV-positive increased by 5% in pregnant adolescents.	The personnel from the MOH Comprehensive Women's Care Programme included this issue in the individualised counselling for adolescent mothers.	Met
	12 municipal health services in intervention areas have HIV prevention actions incorporated into the Community Family Health Model (MOSAFC).	The proposed goal was tripled, from 12 to 35 municipal health services. This means that 100% of the municipal services of Leon, Matagalpa and Jinotega incorporated actions for HIV protection and prevention into care of pregnant women.	The MOH only takes an integrated approach to the prevention of vertical transmission of HIV in community activities in the project intervention areas.	Met

Ethiopia	a. The number of new cases of MTCT is significantly reduced compared to baseline. b. Total number, as well as relative ratio, of pregnant women who has access to voluntary testing and counselling (VCT) and prevention of mother to child transmission (PMTCT) services significantly increased. c. Best practices documentation and tool kit developed and disseminated for use in woreda health centers across the region - resulting in improved level of services in term of prevention and care at the woreda level.	a. The rate of new cases of MTCT in the target areas is not measured b. A total of 8526 pregnant and delivering mothers have utilized PMTCT service by Gondar University Hospital through Save the Children Support in the period 2010- 2013. There is a significant increase when compared to 2006-2009 strategic period, where 4,367 mothers utilized PMTCT service. c) Group discussion guide for HIV positive adolescents and couple counseling guide has started to be developed and is on its finalization stage.	a. Not measured b. Delivering PMTCT service significantly contributes to the protection of children against HIV infection c) This activity contributes to the improved service delivery to pregnant mothers and HIV positive adolescents, indirectly contributing to the result	a. Not measured b. Met Partially met
Uganda	Strengthen capacities of communities to reduce mother to child transmission of HIV	• Young mothers have increased uptake of antiretroviral therapy for mothers eligible for treatment, continued follow up with mothers for comprehensive PMTCT services and access existing health care services to prevent mother-to-child transmission of HIV • Mothers and care givers of children living with HIV/AIDS were empowered with skills in preparation of nutritious foods using the available local materials. • SCI focused on sensitization and mobilization of communities for		Met

		PMTCT services, encouraging women (accompanied by their male spouses) to attend all the ANC services and visits, receive couple HIV-testing, undertake couple-disclosure, deliver at the health facilities and attend post-natal care.		
Zimbabwe	% of HIV exposed babies born to positive mothers on treatment testing negative % of HIV positive babies initiated on ART.	99.5% of exposed babies tested negative. 57% of positive babies initiated on ART (2012 and 2013 results).	Significant impact in the project, fewer babies being testing positive as project is contributing by increasing demand for PMTCT and urging pregnant mothers to book early for ANC.	Met

Annex 4

Key informants and people met

Date	Name
Friday 28 March	Nora Ingdal, Director of Strategic Analysis, SCN Channe Gebre, SCN, Senior Advisor, Monitoring and Evaluation Marte Bøe Wensaas, SCN, Senior Advisor Health and HIV Anne Pedersen, SCN, Area Director West, Southern and Central Africa Helene Andersson Novela, SCN Acting director, Child rights, Policy and Programme Quality
Tuesday 8 April	Amos Meki, SCZ, Manager Security Protocols & Transport Start-up meeting with Brian Hunter, SCZ country director, Sharon Hauser, Director of Program Operations, Linile Malunga, HIV & AIDS and Health Advisor, Teddy Sigwadhi **,** Brian Svesve, Monitoring and Evaluation assistants.
Wednesday 9 April	Nellie Dhlembeu, formerly Deputy Director, Ministry of Public, Labour and Social Services, Dept of Social Services Allet Sibanda. UNICEF, Child protection officer
Thursday 10 April	Robson Shumba, Mberengwa SC District coordinator Vudzaishe Maidza, College student, translator Mberengwa Rural District Council CEO - Julias Mashavakure Mberengwa Rural District Council Chairman – Mr. Ncube Mberengwa District Child Protection Committee – (8; 2 women, 6 men) Ruzivo Child Protection Committee (approx. 10 people; 9 women, 1 man plus young girl and a teenage boy) Chingoma B Child Protection Committee, (approx. 20 people; 18 women, 2 men) Nurse, Health Center clinic, near Mberengwa District Council
Friday 11 April	Takashinga CPC, (approx. 8 women : plus 3 girls) Chapungu Secondary school. Mr. Kamashu, Headmaster 2 child-led groups (12 & 10; half girls, half boys) Makwava School child protection committee, (4 teachers; 2 women, 2 men) Makuva Child Led group –(6 ; 3 18 year old boys, 3 15 year old girls) Tsungirirai Child Protection Committee (27; all women) Wellwishers Child Protection Committee (7; 6 women, 1 man) Grandmothers group (10)
Saturday 12 April	Linile Malunga, SCZ,HIV & AIDS and Health Advisor
Monday 14 April	Amos Chinyama, SCZ Monitoring and Evaluation Officer Timothy Makwarimba, Director, Citizen Child Alice Mazarura , SCZ Director, Accountability Project Miriam Mutandwa, SCZ Provincial Engagement Officer, Accountability Project

	Formerly programme officers for the HIV and AIDS programme Moses Mukabeta, SCZ Advisor, Education Godwin Kudzotsa, SCZ. Advisor, Child Rights Governance Talent Juno, Coordinator, Katswe Sistahood Lloyd Muchemwa, Child Protection Coordinator, World Education Collen Marawanyika, USAID, OVC specialist, USAID Alpha Chapenokma, USAID Winfreda Chandisarewa, Zimbabwe AIDS Prevent Project, Deputy Programme Director; Saimon Zvidzai, Accountant; Vimbainashe Makani, Prorgamme Coordinator; Andrew Saruchera, Progamme Assistant Tsitsi Chigariro Linda Ngerenge Psychosocial support service caregivers and their children (3)
Tuesday, 15 April	Debriefing with SCZ staff who had been at the Start-up meeting and Clement Mhlanga, SCZ Program Director Operations Agnes Mahomya, Elizabeth Glazer Paediatric AIDS Foundation, Country director, Simba Rusakaniko, Executive director
Friday 2 May	Uganda Benon Orach Odora, Program Manager, GREAT and REAL Fathers Projects Falal Rubanga Faith, Straight Talk Foundation, Centre Manager Martin Ongune, Programme Coordinator LIDFOPHAN
Monday 5 May	Nepal Lok Raj Bhatta, Senior Program Coordinator Nicaragua Dixmer Rivera Maria de Jesus Tenoria Diaz, Director, Education, Research and Political Action, IP
Tuesday 6 May	Ethiopia, Lensse Gobu, HIV and AIDS Programme Manager, SC Kinfe Wubetu, Child Protection Program Manager Getnet Eshetu, Educational Media, Gondar

Annex 5

Documents consulted

Save the Children Norway

"Save the Children Norway´s strategy 2010 – 2013"

"SCN Baseline 2010"
DOCS-#170267-v3-SCN_Baseline_2010_-_FINAL_PDF_file_to_Norad

"SCN Global Indicators 2010-2012, Mid-term status report on Programme results & Lessons Learned"
DOCS-#242027-v2-SCN_indicator_report_2010-2012.doc
DOCS-#244733-v1-SCN_indikator_report_2013_-_Read_Only_version.doc

"2013 SCN/Norad reporting requirements, SCN global indicators"

Investing in Children, Save the Children Norway Strategy 2014-2017

Save the Children International

HIV/AIDS webpage:
https://onenet.savethechildren.net/whatwedo/health/hiv_aids/Pages/default.aspx
and links to further pages

Country Planning and Reporting webpage:
https://onenet.savethechildren.net/tools/cap-car/Pages/default.aspx
and links to individual countries´reporting

HIV and AIDS Global Initiative M & E Annual Report 2012
HIV GI Report_final_may 2013.pdf

HIV and AIDS Global Initiative 2012 CO Annual Planning Guidance Note
DOCS-#191384-v1-HIV_and_AIDS_GI_2012_country_planning_guidance_final.doc

"Appendix 2 Theory of Change"
02 Theory of Change - Strategy 2010-2015.pdf

"Health and Nutrition Global Initiative Annual Report 2013
2013 HN GI Report Final Report.pdf

DOCS-#241924-v1-CAR_2012_Total_Reach_SCN_compiled_xls.XLS

DOCS-#243914-v1-SCN_indicator_-_HIV_-_compiled_per_2013_XLS

INVESTING IN IMPACT FOR CHILDREN, Save the Children 2013 – 2015 Strategic Plan

Knowledge indicator results 2010 - 2012

DOCS-#243914-v1-SCN_indicator_-_HIV_-_compiled_per_2013_XLS
Same as DOC # 237009

Zimbabwe

Author	**Title**
SCN, 2014	2010-2013 Periodic Results Report: Zimbabwe
SCZ	Country Strategy 2010 - 2014
SCZ	Country Annual Plan 2010, 2011, 2012, 2013
SCZ	Country Annual Report
SCZ	Annual Report for Funding from Save the Children Norway and/or NORAD 2012, 2013
SCZ	Country Annual Report 2010, 2011, 2013
SCZ	Country Strategy for the Zimbabwe Programme, Final draft
SCZ	HIV AND AIDS STRATEGY, Save the Children in Zimbabwe 2012 – 2014 DOCS-#203395-v3-Zimbabwe_final_HIV_strategy_Feb_2012
Jimat Development Consultants, SCZ, 2014	Programme Review for Save the Children Programmes funded by NORAD
Psychosocial Support, Research & Training Centre, SCZ, 2013	Strengthening Community Support for Orphans and Vulnerable Children (OVC), The Case of Matobo and Mberengwa Districts´ Child Protection Committees (CPCs)
SCZ	Documentation Report: Based on the Global Prevention Indicator, Save the Children HIV and AIDS Mitigation Project in Kadoma and Mbire Districts: Zimbabwe
SCZ	HIV & AIDS Global Indicator Monitoring 2011 Report
SCZ	Zimbabwe Country Monitoring & Evaluation Framework for 2013
SCZ	HIV GI Draft Report_1
GOZ, Ministry of Labour and Social Services	National Action Plan for Orphans and Vulnerable Children Phase 211 2011 - 2015
GOZ	Zimbabwe National HIV and AIDS Strategic Plan (ZNASPII) 2011 - 2015
GOZ	Global AIDS Response Progress Report 2012, Zimbabwe Country Report
GOZ	Global AIDS Response Progress Report, Zimbabwe 2014
National AIDS Council	Zimbabwe Report NCPI 2012
GOZ and National AIDS Council	Monitoring and Evaluation PLAN for Zimbabwe HIV and AIDS National Strategic Plan (2011 – 2015)
Zimbabwe National Statistics Agency (ZIMST A T) and ICF International. 2012	*Zimbabwe Demographic and Health Survey 2010-11.* Calverton, Maryland: ZIMSTAT and ICF International Inc.
Ministry of Health and Child Welfare, Zimbabwe, IPPF, UNFPA, WHO, UNAIDS, 2012	*Zimbabwe, Rapid Assessment of Sexual and Reproductive Health and HIV Linkages*

Ministry of Education, Spot, Arts and Culture	*Life Skills, Sexuality, HIV and AIDS Education Strategic Plan 2012- 2015*

Uganda

Author	**Title**
SCN	Periodic reporting to SCN DOCS-#265473-v1-UGA_SCN_reporting_2010-2013.docx
SCiUG	Country Strategy Plan (2010 – 2014)
SCiUG	Country Annual Plan 2010, 2011, 2012, 2013
SCiUG	Country Annual Report 2010, 2011, 2012, 2013
SCiUG	Annual Reports for Funding from Save the Children Norway and/or Norad 2012, 2013
SC in Uganda	Internal documents
Republic of Uganda	National Strategic Plan for HIV & AIDS 2011/12 – 2014/15, Draft
Uganda AIDS Commission	Country Progress Report, Uganda 2012
Uganda AIDS Commission	Uganda Report NCPI, 2012
Ministry of Health, Uganda, ICF, CDC Entebbe, USAID Kampala, WHO Kampala, 2012	Uganda AIDS Indicator Survey 2011

Ethiopia

Author	**Title**
SCN	2010-2013 Periodic Results Report
SC Ethiopia	Country Strategy 2010 -2013
SC Ethiopia	Annual Plan 2010, 2012, 2013
SC Ethiopia	Country Annual Reports 2010, 2011, 2012, 2013
SC Ethiopia	Annual Report for Funding from Save the Children Norway and/or Norad 2012, 2013
Federal Democratic Republic of Ethiopia	Country Progress Report on HIV/AIDS Response 2012
Federal Ministry of Health	Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia II (SPMII) 2010-11-2014/15
Federal HIV/AIDS Prevention and Control Office	Ethiopia Report NCPI 2012
Central Statistical Agency [Ethiopia] and ICF International, 2012	Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ICF International.

Nicaragua

Author	Title
SCN	2010 Periodic Results Report
SC in Nicaragua	4 Year Plan 2010 – 2014 Nicaragua Programme
SC in Nicaragua	Annual Plan 2010, 2011, 2012, 2013
SC in Nicaragua	Country Annual Report 2010, 2011, 2012, 2013
SC in Nicaragua	Annual Report for Funding from Save the Children Norway and/or Norad 2012, 2013
UNAIDS	Epidemiological Factsheet

Nepal

Author	Title
SCN	2010-2013 Periodic Results Report
SC Nepal & Bhutan	Country Strategy Plan 2010 – 2013
SC Nepal & Bhutan	Country Annual Plan 2010, 2011, 2012, 2013
SC Nepal & Bhutan	Country Annual Report 2010, 2011, 2012, 2013
SC Nepal & Bhutan	Annual Report for Funding from Save the Children Norway and/or Norad 2012, 2013
DRC, Nepal, 2011	Social Volunteer Against AIDS (SoVAA), Programmatic Strategy Assessment
GON, National Centre for AIDS and STD Control, 2011	National HIV /AIDS Srategy 2011-2016
GON, National Centre for AIDS and STD Control	Nepal Country Progress Report 2012 (To contribute to Global AIDS Response Progress Report 2012)
National Centre for AIDS and STD Control	Nepal Report NCPI 2011

Annex 6

Terms of Reference
Review of Save the Children Norway`s HIV and AIDS Portfolio

1. Background

Save the Children is the world's leading independent organization for children. ***Our vision*** is a world in which every child attains the right to survival, protection, development and participation. ***Our mission*** is to inspire breakthroughs in the way the world treats children, and to achieve immediate and lasting change in their lives. *Accountability*, *Ambition*, *Collaboration*, *Creativity* and *Integrity* are our shared values. Save the Children's theory of change describes how we work to create immediate and lasting results for children: we will be the voice, we will achieve results at scale, we will be the innovator and we will build partnerships.

Save the Children Norway (SCN) has set out priorities in the 2010-2013 Strategy. Those priorities were: Strengthen child rights governance, Fulfil children's right to basic education, Fulfil the rights of children affected by emergencies, Fulfil children's right to protection from violence and sexual abuse and Fulfil the right of children to protection from the impact of HIV/AIDS.

In order to fulfil the right of children to protection against the impact of HIV/AIDS SCN proposed three objectives in the strategy period:

a. Strengthened capacity within the community to protect children against the impact of HIV and AIDS;
b. More young people protect themselves and others against HIV infection;
c. Newborn children are protected from mother to child transmission of HIV.

HIV and AIDS activities in four countries have been supported in Africa (Ethiopia, Mozambique, Uganda and Zimbabwe), two countries in Asia (Cambodia and Nepal), one country in Latin America (Nicaragua) and Europe (Albania) respectively. Around 30 million NOK was invested during the period of 2010 – 2013 for HIV and AIDS related intervention through SCN and Norad funding. The amounts invested in the main countries are presented below.

Table 1: Investment for HIV and AIDS[21] for the period 2010 – 2013 by some selected countries (Norwegian kroner)

Country	2010	2011	2012	2013	Total (NOK)
Africa					
Ethiopia	881,430	659,673	800,155	753,825	**3,095,084**
Mozambique	1,191,358	1,135,828			**2,327,186**
Uganda	2,868,698	1,454,662	950,776	504,917	**5,779,053**

[21] The Investment includes funds from SCN, Norad, MFA and private donations and spent by respective countries

Zambia	1,482,344	47,112			**1,529,456**
Zimbabwe	2,743,833	3,212,212	2,681,583	2,522,342	**11,159,969**
Asia					
Cambodia	616,606				**616,606**
Nepal	283,860	55,001	76,163	287,559	**702,584**
Latin America					
Nicaragua	1,067,341	,649	626,113	691,322	**3,022,425**
Total (NOK)					**28,232,363**

In the new SCN Strategy 2014 – 2017 and Save the Children International's Global programme strategy revised in 2013, HIV and AIDS is no longer a separate thematic area. Vulnerable children living with HIV and AIDS will be included within the Child Protection Global Initiative,[22] projects targeting mother-and-child transmission will be included within the Health and Nutrition Global Initiative[23] and promoting children and youth rights at national and local level will be included within the thematic area of Child Rights Governance.[24]

2. Purpose of the Review

The ultimate purpose of the review is to document results achieved as a result of the investment made (by SCN, Norad and MFA) to fulfil the right of children to protection against the impact of HIV and AIDS during the period of 2010 - 2013. In addition the review should help SCN in documenting key successes, challenges and make feasible recommendations for SCN and country offices in how to ensure that the rights of children within the field of HIV and AIDS are taken care of or get enough consideration in future programming.

The results emerged from the review process will be included in the Norad interim report 2010-13 and key learning areas will be shared with various stakeholders.

3. Objectives and key review questions

The overall objective of the review is to assess if the planned objectives in the strategy have been achieved and document any significant lessons and evidences that can be drawn from country specific experiences in the area of HIV and AIDS intervention.
The review process shall respond to the following issues:

1. Assess SCN's HIV and AIDS investment in terms of relevance and effectiveness.
2. Assess if considerable results have been documented when measuring against SCN's key HIV and AIDS indicators; if not why and have there been any unintended consequences;
3. Analyze data from Save the Children´s monitoring and evaluation systems within HIV and AIDS and assess type of results, number of children and youth benefiting from holistic HIV and AIDS programmes;

[22] http://resourcecentre.savethechildren.se/child-protection/about-initiative

[23] Save the Children Health and Nutrition Global Initiative, fact sheet.

[24] http://resourcecentre.savethechildren.se/child-rights-governance

4. To which extent HIV and AIDS programs financed by SCN in Zimbabwe covered specific niches that were not covered by other partners/donors that financed work against HIV and AIDS?
5. Assess the existing capacity at country office levels and identify capacity needs for better HIV and AIDS intervention in the future (in the case of Zimbabwe program);
6. Assess if the investment in HIV and AIDS has contributed (based on desk review) to any policy formulation, changes and response in the respective countries, and if not why;
7. Assess the role and engagement of civil society and partnership (based on desk review and interview of selected partners) among stakeholders towards HIV and AIDS intervention in the intervention countries;
8. Assess to which extent HIV and AIDS is integrated, referring country reports and information available) into other thematic sectors like education, health, protection and child rights governance and the potential benefits or disadvantages with this approach.
9. Document lessons learned and challenges encountered during the intervention period;
10. Advise how to ensure the rights of children are taken care of in future programming.

4. Scope of the Review

The review should cover the strategy period 2010 – 2013. The geographical scope of the review is some selected countries from Africa (Ethiopia, Mozambique, Uganda, Zambia & Zimbabwe), Asia (Cambodia & Nepal) and Nicaragua in Latin America. We expect the consultant to conduct country visits to one of the main HIV and AIDS investment recipient countries and collect primary and secondary data. Mainly, the review focuses on addressing the aforementioned questions. The review process mainly utilizes country annual reports, field visit reports and evaluation reports. In addition to that country specific reports published by credible international agencies will be consumed. The scope will be further discussed and finalised in the inception report.

5. Design and methodology

The review should include but not necessarily limit to the following methods:

- Desk review of relevant documents (Country annual plans, Annual reports, field visit reports, relevant national policy documents etc.);
- Key informant interviews with thematic advisor in Oslo, country level focal points, focus group discussions with beneficiaries, representatives of civil societies, government authorities and other stakeholders
- Field visits to one country and individual and group interviews and collect relevant primary data

The consultant should present a detailed statement of proposed evaluation methods in the technical proposal. The evaluator has to take into account the guiding principles mentioned in the Save the Children International (SCI) Evaluation Handbook.[25]

6. Organization, role and responsibility

[25] http://resourcecentre.savethechildren.se/library/evaluation-handbook

The entire review process will be led by one lead consultant. However, the consultant will be responsible to identify potential researchers to assist him/her during field visits as well as the review process. The lead consultant should have better understanding of HIV and AIDS programming and with extensive research experiences in RH/HIV and AIDS. SCN will select the potential candidate based on the technical and financial proposals submitted.

The consultant will be responsible for developing a sound research methodology, planning and conducting consultative review and managing the data collection, as well as writing up the reports and presenting the findings and recommendations.

SCN will be responsible to facilitate the review process through availing relevant documents and covering the entire review cost. Moreover, SCN will contact country offices seeking their collaborations for smooth data collection process.

7. Deliverables

Upon the selection, the consultant is expected to submit the inception report. Within the agreed timeline, it is expected to submit the draft review report for comment and feedback from the respective technical people at SCN. The consultant will present the preliminary findings to SCN. Eventually, the consultant is responsible to incorporate feedbacks provided and submit the final report. SCN will share the report template to be used for report writing.

8. Timeline

The review process will take the maximum of 30 days. Activities are outlined as per the expected timeline as follows.

Table 2: Tentative dates for the consultancy work

Task	Proposed date	Responsibility
Receive proposals from consultants	14th March 2014	SCN
Finalize the recruitment process of the consultant	17th March 2014	SCN
Contract signed with the potential consultant	18th March 2014	SCN & Consultant
Review start up	19th March 2014	Consultant
Receive inception report	27th March 2014	Consultant
Travel to Zimbabwe	2nd April 2014	Consultant
Present preliminary findings	22th April 2014	Consultant
Submit draft report	1st May 2014	Consultant
Receive comments from SCN	13th May 2014	SCN
Submit final report	20th May 2014	Consultant

Table 3: Timeframe for consultancy work

Activities	Duration (in days)
Desk review	4
Development, review and finalization of evaluation methodology and tools (Inception report)	2
Key informant interviews with technical staff (Skype)	4
Country visit to Zimbabwe	7

Compilation of findings and first draft report	5
Development of debrief presentation	1
Debrief with SCN on draft report	0.5
Review of draft report	1.5
Finalization of evaluation report and submission to SCN	3

9. Budget and resource

Save the Children Norway will fund the assessment by covering consultancy fees, local and international travel costs, accommodation and daily subsistence during field visits for the consultant and researchers.

10. Desired competencies and skills of the consultant

- Advanced university degree in social sciences, medicine or public health, with specialized training in RH or HIV and AIDS evaluation and project/program management;
- Extensive international experience in designing and managing program/project evaluations including in the area of HIV and AIDS prevention and care services for children most-at-risk and vulnerable groups;
- Proven experience in conducting independent evaluations of HIV prevention projects/programmes; experience in evaluating HIV prevention projects targeting children and youth is an asset.
- Familiarity with HIV and AIDS epidemics and global dynamics and most importantly experience in Sub Saharan African countries including Zimbabwe;
- Knowledge of the SCI evaluation guiding principles/recommendations on HIV and AIDS prevention and care in various settings;
- Be familiar with the concept of children participation; Personal skills: good communication, analytical and drafting skills;

11. Contract and payments

Save the Children Norway will sign a consultancy contract with the consultant. Thirty percent of the total amount will be paid upon signing the contract and the remaining amount upon submission and approval of the final report and all deliverables.

For further information please contact any of the following:
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Annex 7

Methodology used for the Zimbabwe case study.

An international consultant visited Zimbabwe between 8 – 15 April 2014 and was supported by a national consultant to conduct the field visit. Prior to the visit, documents pertaining to SCZ´s HIV and AIDS programme e.g. the Periodic results report, country annual reports, SCZ´s HIV and AIDS strategy 2012 – 2014, and reports on Zimbabwe´s national context (ZNASP II, National Action Plan for Orphans and Vulnerable Children II, country reporting to UNAIDS) were reviewed.

During the visit, SCZ provided key documents that had not been available in Oslo. These greatly deepened our understanding of the programme - for example these included: the Mid-Term Review "Programme Review for Save the Children Programmes funded by Norad" (MTR); two evaluation reports of aspects of the HIV and AIDS Mitigation Project, and reports on SCZ global indicator monitoring and monitoring framework. A list of documents reviewed is found in Annex X.

Plans for the country visit were made on very short notice and SCZ made extraordinary efforts to arrange interviews and visits that demonstrated its HIV and AIDS work.

The Review Team met with SCZ and key partners in Harare at the beginning of the visit. They then travelled to Mberengwe, one of SCZ´s rural district partners. There an extensive two-day programme was arranged on five sites where we met with the district child protection committee (CPC), district officers, and four child protection committees plus a grandmothers group. Visits were made to two schools where school officials welcomed the us and small group discussions were held with a school CPC and three child-led groups. A brief visit was made to a local health centre clinic. Most of the participants in the CPCs were women. Two of the CPCs included children.

SCZ´s HIV and AIDS and Health Advisor accompanied the Review Team during the field visit but participated in only one of the CPC focus group discussions. The long drive to Mberengwe provided opportunities to learn more from SCZ staff about the SCZ country programme.

In Mberengwe, SCZ´s district HIV and AIDS coordinator accompanied the Review Team to the different sites and made the introductions to the community groups. The district provided an interpreter who was especially useful when talking to the CPCs and the younger child-led group. As with the HIV and AIDS and Health Advisor, the district coordinator did not participate in the discussions with the community groups or with key informants.

Upon return to Harare, key informant interviews were held with five SCZ staff, six partner organisations, and one local sexual reproductive health and rights NGO. A debriefing to SCZ staff was held on the last day of the country visit.

Altogether, among the SCZ staff met, four were female and eight were male. Among the key informants in Harare, nine were women and six were men.

Details of the itinerary for the country visit are shown in Annex 4. As noted in Section 3 in the main report, data collection tools were prepared before the visit and are available upon request.

Limitations of the country visit review

- Due to the visit being arranged at such short notice, some key informants were not available for interview. The visit would have benefited from gaining the views of the Ministry of Health and Child

Welfare, UNICEF´s HIV and AIDS advisor, and from national HIV and AIDS coordinating entities. This means that our understanding of the national arena for HIV and AIDS could have gaps.

- Sensitive issues are raised when talking to orphans and vulnerable children (OVC) and to young people about sexual reproductive health and rights (SRHR) issues. Sharing of views usually only takes place after trust in established and this takes time. The brief nature of our meetings with the child-led groups and OVCs (on the CPCs) gave little opportunity to establish such trust. This review could have benefitted from more substantial views of children and young people.