# End Phase Evaluation

## HIV/AIDS Prevention Programme III (HAPP III) in Sierra Leone

(11-19 November 2017 Data Collection)
(15 December 2017 Draft Report Submission)

December 2017

## Executing Agency: National AIDS Secretariat (NAS) Sierra Leone

## Donor: KfW

**Evaluation Conducted By:**

Primson Management Services (PMS)
Harare, Zimbabwe
Lead: Dr Nyasha Madzingira (PhD)
Tel: +263 04 304 462
Email: admin@primson.org

## i. Table of Contents

## Figures



## Tables

## ii. Acknowledgements

Completing a national study like this necessitates the cooperation of various institutions at community, regional and national levels. At this moment, we wish to appreciate the collective effort of all the players in the evaluation of the HAPP III in Sierra Leone. We thank KFW for providing funds for both implementation and evaluation of the Project. Appreciation to the National HIV/AIDS Secretariat and CARE for providing the landscape and the conducive climate for the execution of this evaluation. Special thanks to the Director of the National HIV/AIDS Secretariat, Alhaji Momodu Sessay and his deputy Mr. Abdul Rahman Sessay for their robust response and cooperation during the evaluation process. We appreciate the tremendous contribution from CARE and SLaDA for providing the necessary reports and hosting the team at meetings, trainings and finding time to respond to interviews.

We want to acknowledge the good work of the various implementing agencies country wide in making sure that they delivered in the face of challenges (Ebola, difficulties in reaching some communities) and presenting their semester reports in real time.

We could not have completed our assignment without team spirit. We commend the cooperation of the spirited supervisors, research assistants and enumerators' who braved all odds to collect information country wide. We also recognise the cooperation of all the participants (traditional leaders, HIV Counsellors, youth leaders, community members and beneficiaries of the project) who spent time to respond to the various questionnaires.

## iii. Affirmation

We affirm that the information written in this report is original and all data and statistics are correct. This report is the work of The National AIDS Secretariat of Sierra Leone (NAS) except as acknowledged by the references in this report to other authors and publications.

The Evaluation was done to assess achievements made by the HAPP III project and inform future likeminded programming. Primary and secondary data collected throughout the evaluation process remain the property of the communities and families described in this evaluation report. Their identities will remain anonymous, information and data may only be used with consent from relevant parties.

Primson Management Services (PMS)
Harare, Zimbabwe
December 2017

## iv. Glossary/Acronyms and Abbreviations

| | |
|---|---|
| AHF | AIDS Health Foundation |
| AIDS | Acquired Human Immunodeficiency Syndrome |
| ART | Anti-Retroviral Therapy |
| BCC | Behaviour Change Communication |
| BSS | Behaviour Sentinel Surveillance |
| CADA | Community Advocacy and Development Agency |
| CAPI | Computer-Assisted Personal Interview |
| CBO | Community Based Organization |
| CCDP | Christian Community Development Programme |
| CECSHIP | Centre for Encouraging, Caring and Supporting HIV People |
| CEDA | Community Empowerment & Development Agency |
| BADWA | Badjia Women's Development Association |
| DAC | District AIDS Committee |
| DHS | Demographic Health Survey |
| DHMT | District Health Management Team |
| DVTC | Daughters Vocation Training Centre |
| EU | European Union |
| EVD | Ebola Virus Disease |
| FGD | Focus Group Discussion |
| FGM | Female Genital Mutilation |
| FGC | Female Genital Cutting |
| FSW | Female Sex Workers |
| GBV | Gender Based Violence |
| GD | Generation Dialogue |
| GDP | Gross Domestic Product |
| Geiko | German Kooperation – Sierra Leone |
| GISAWDO | Girls Institute for Self-Achievement Women development Organization |
| GNI | Gross National Income |
| HAPP | HIV and AIDS Prevention Program |
| HCT | HIV Counselling and Testing |
| HIV | Human Immunodeficiency Virus |
| IEC | Information Education and Communications |
| IGA | Income Generating Activities |
| IGD | Intergenerational Dialogue |
| IMF | Impact Mitigation Fund |
| KfW | KfW Development Bank |
| KII | Key Informant Interview |
| MDGs | Millennium Development Goals |
| MICS | Multiple Indicator Cluster Survey |
| MoU | Memorandum of Understanding |
| MSM | Men Having Sex with Men |
| NABFAO/SL | National Breastfeeding Advocacy Organization Sierra Leone |
| NaCSA | Nation Commission for Social Action |
| NAS | National AIDS Secretariat |
| NGO | Non-Governmental Organization |

| | |
|---|---|
| OECD/DAC | Development Assistance Committee of the Economic. Cooperation and Development |
| OVC | Orphans and Vulnerable Children |
| PLHIV | Person Living with HIV |
| PPP | Purchasing Power Parity |
| PREDEC | Potential Rescue and Development Centre – Sierra Leone |
| SBCC | Social Behaviour Change Communication |
| SLDHS | Sierra Leone Demographic and Health Survey |
| SRHR | Sexual Reproductive Health and Right |
| SLaDA | Sierra Leone Social Marketing and Development Agency |
| SWAASL | Society for Women and AIDS in Africa Sierra Leone Chapter |
| TFR | Total Fertility Rate |
| TIPDO | Tinap for Peace and Development Organization |
| UNAIDSJ | Joint United Nations Programme on AIDS |
| UNDP | United Nations Development Programme |
| WAHO | West Africa Health Organisation |
| YFSCs | Youth Friendly SRHR Service Centres |

## v. Introduction

This report presents the findings of end phase evaluation of the HIV/AIDS Prevention Program (HAPP) III implemented in Sierra Leone. HAPP III provided financial support for social marketing activities for condoms and the Impact Mitigation Funds (IMF) aimed at mitigating the social impact of HIV/AIDS. The overall goal of HAPP III is to contribute to improved sexual and reproductive health of Sierra Leone.

The evaluation process happened in four main phases: involved; inception, fieldwork, data analysis and reporting. This document is a comprehensive report developed based on triangulation and analysis of both quantitative and qualitative data. The report went through Primson internal quality control processes. Thereafter, a first draft report was circulated and reviewed by the client. Based on the review comments this second draft report was developed, and a presentation of the draft report is scheduled early February 2018.

## 1. Executive Summary

The HIV/AIDS Prevention Program (HAPP) III implemented in Sierra Leone, supports the financing of social marketing activities for condoms and the Impact Mitigation Funds (IMF) aimed at mitigating the social impact of HIV/AIDS. The project focuses on the prevention of GBV including FGC; prevention of HIV/AIDS and unplanned pregnancies as well as the empowerment of girls and women.[1] The overall goal of HAPP III is to contribute to improved sexual and reproductive health of Sierra Leone. The programme was implemented from June 2013 to July 2017 and granted a no-cost extension to March 2018. This was to make up for 18 months of programme implementation time lost during the outbreak of the Ebola Viral Disease from the 24th May 2014 through 17th March 2016,[2] (see pp 6-8).

The overall purpose of the HAPP III end phase evaluation is to measure improvements in SRHR outcomes (specifically decrease of risk contact of HIV, increased use of condoms by the 15-24 year old generation, reduced stigmatization against people living with HIV and ratio of mother's age 25-49 years who do not intend their daughters to be subjected to FGC).

The Evaluation integrated both quantitative and qualitative research methods. The respondents were identified from selected districts and chiefdoms from the four regions of the country – the Northern, Eastern, Southern and Western Area. The target respondents were beneficiaries of the HAPP III (young women and young men age 15-24 years; women age 25-49 years with at least one daughter), implementing partners, key partners (NAS, KPMG and Care Sierra Leone), and community leaders. Up to 1,216 young women and young men age 15-24 years and 446 older women age 25-49 years participated as respondents in the quantitative component (see pp 9-15).

**KEY FINDINGS:**

**a). Outcome Results (pp 15-21)**

The key findings from the HAPP III evaluation indicate that the programme was effective as the outcome - Prevention of HIV, unplanned pregnancies and gender-based violence including FGC, and empowerment of girls and women – revealed improvement for its indicators. Targets for three of the four indicators (increased condom usage by young people age 15-24 years with regular and non-regular partners; increase in mothers with at least a daughter who do not intend to have them circumcised) were surpassed while the fourth on reduced stigma and discrimination has an achievement rate of 96% (see Table 1).

***Indicator 1:*** Increased condom use among 15-24 year olds at last intercourse with regular partner: 4.7% (women) to 8% and 16.5% (men) to 20%: base years BSS 2012.

***Indicator 2:*** Increased condom use among 15-24 year olds at last intercourse with non-regular partner: 21.5% (women) to 25% and 23.9% (men) to 28%: base year BSS 2012.

The result for condom use with a regular partner among young women age 15-24 years is 18.6% against a target of 8% while it is 27.6% for men of the same age group against a target of 20%. Similar results were registered for condom use with a non-regular partner among women age 15-24 years at 27.4% (target 25%) and 28.4% for men age 15-24 years against a target of 28%. Both indicators show a remarkable improvement in condom usage from 2012, the base year. Observed results considerably exceeded the targets for condom usage (see pp 16-17).

[1] HAPP III Separate Agreement

[2] HAPP III Semester Report July-December 2016

*Table 1: HAPP III Outcomes, Outputs and Indicators*

| Level of Analysis | Indicators | Target | 2017 Result |
|---|---|---|---|
| **Outcome 1: Prevention of HIV, unplanned pregnancies and gender-based violence incl. FGC, and empowerment of girls and women.** | 2. Increased condom use among 15-24 year olds at last intercourse with regular partner:<br>a. 4.7% to 8% (women):<br>b. 16.5% to 20% (men). | <br><br>8%<br>20% | <br><br>**18.6%**<br>**27.6%** |
| | 2 Increased condom use among 15-24 year olds at last intercourse with non-regular partner:<br>b. 21.5% to 25% (women):<br>c. 23.9% to 28% (men). | <br><br>25%<br>28% | <br><br>**27.4%**<br>**28.4%** |
| | 3 Increase of mothers with at least one daughter who do not intend to have their daughter(s) circumcised from 8.9% (DHS 2008) to 15%. | 15% | **47.5%** |
| | 4 Reduce % of women and men that stigmatize people living with HIV from 65% to 45% (agree with the statement that people with the AIDS virus should be ashamed of themselves (BSS 2012: p.61)) | 45% | **47%** |

***Indicator 3:*** Increase of mothers with at least one daughter who do not intend to have their daughter(s) circumcised from 8.9% (SLDHS 2008) to 15%.

The findings from the HAPP III survey indicate that 47.5% of mother's age 25-49 years with at least one daughter do not intend to have their daughter(s) circumcised. Given that the percentage for the base year (SLDHS 2008) was 8.9%[3], and the HAPP III target was 15%, the observed result of 47.5% substantially surpass the set target (see pp 18-20).

***Indicator 4:*** Reduce % of women and men that stigmatize people living with HIV from 65% to 45% (agree with the statement that people with the AIDS virus should be ashamed of themselves (BSS 2012: p.61))

The HAPP III evaluation asked a question on stigma and discrimination to young people age 15-24 years: *'do you agree or disagree with the following statement: People with the AIDS virus should be ashamed of themselves'*. Forty-seven percent of young men and women age 15-24 years who responded to the stigma and discrimination questions indicated that they disagreed with statement. The base year rate was 65% (BSS 2012) and the target for HAPP III was 45%. Even though the target was not fully achieved, the observed result of 47% indicates an achievement rate of 96% for the indicator (see pp 20-21).

HAPP III contributed to the increase in the percentage of young women and men age 15 to 24 who correctly identify ways of preventing sexual transmission of HIV and reject major misconception about HIV transmission from 72.3% for women (BSS 2012) to 76.2%, surpassing a set target of 75%. However, there is a decline for men age 15-24 years from 79.8% (BSS 2012) to 76.3%. The target for men of 83% was not achieved and the result is even lower than that for the base year.

**Impact:** Improved sexual and reproductive health of the population

[3] The 2013 SLDHS collected information on FGC in Sierra Leone from all women age 15-49 years and sample size was 16,626 women

***Indicator 1:*** Reduced National HIV prevalence rate (national target from 1.5% in 2008 to 1.2% in 2015), specifically for women (decrease by 0,2% from SLDHS 2013 level)

***Indicator 2:*** Reduction in % of 15-19 years-old women who have begun childbearing by 9% until 2015 measured against SLDHS 2013 level

In conclusion, the HAPP III contributed towards the intended outcome of preventing HIV transmission, unplanned pregnancies and gender-based violence including FGC, and empowerment of girls and women and the evaluation has rated it as highly satisfactory. Condom use with a regular and non-regular partners increased for both women and men age 15-24 years. The Programme reduced the percentage of women and men that stigmatize people living with HIV from 65% (BSS 2012) to 47%. The percentage of mothers with at least one daughter who do not intend to have their daughter(s) circumcised increased from 8.9% in the 2008 SLDHS to 47%.

The results discussed above indicate that the Outcome of HAPP III has been achieved as presented per indicator. The contribution of HAPP III to the prevention of HIV, unplanned pregnancies and gender-based violence including FGC, and empowerment of girls and women translates into an improved sexual and reproductive health of the population of Sierra Leone. However, the specific impact indicators can best be assessed in representative national surveys such as the National HIV BSS and the LSDHS.

**b). Socio-economic impact of the vulnerable women who receive IMF (pp 25-27)**

The capacity development and economic empowerment of vulnerable girls and women, and PLHIV, an approach utilised by the IMF component motivated the community to work towards behaviour change and self-sustenance through established businesses. The beneficiaries were mainly vulnerable people in the community who are widows, the unemployed, traders, teenage and single mothers, PLHIV, housewives, school dropouts, farmers and youths. Beneficiaries were trained in different programmes that included agriculture, hair dressing, tailoring, catering, carpentry, soap making, tie and die, tailoring, weaving and welding. Some of the beneficiaries who were once involved in commercial sex work for example, have established businesses, or sell products from tailoring and catering ventures set up after receiving IMF support. The empowerment of vulnerable women and girls culminated in an improved socio-economic status as observed for an IMF beneficiary running a thriving retail business at Jomo Kenyata Road in Freetown.

**c). SLaDA management capacity and their funding strategies (pp 28-32)**

SLaDA has not passed the competence test that was set under HAPP III. Competence was measured through three indicators which were not achieved. On the procurement and distribution of 16 million Protector Plus condoms, a review of the project documents revealed that the organisation sold 12,018,832, a 75% achievement rate. The HAPP III evaluation had pegged a satisfactory achievement of an indicator at 90%. The second indicator on diversification in sources of funding and products, SLaDA has not secured any additional source of funding during the period. Lastly the trend on the efficiency in the CYP is not conclusive. There is need, therefore, for the agency to work towards improving the results of the three competence indicators capacity development, putting in place structures and systems that strengthen the organisation's programme implementation and revise its organogram and recruit relevant staff accordingly.

## KEY RECOMMENDATIONS (pp 40-41)

**Recommendations for NAS, CARE and SLaDA**

***Recommendation 1:*** Target HAPP III programme activities to specific districts with high burden of HIV, teenage pregnancy, GBV, and child marriage.

Working with the 21 implementing partners identified as effective in HAPP III, nonetheless HAPP IV can focus on districts with high burden of HIV and other sexually transmitted infections, teenage pregnancy, GBV, and child marriage. Condom sales and advocacy activities remain at national level, utilising structures and systems established during the implementation of HAPP III.

***Recommendation 2:*** SLaDA needs further support for capacity development before it is weaned off as an independent agency.

SLaDA has not achieved a high result on the three HAPP III indicators set for the assessment of organisational competence. Over the duration of HAPP III implementation, the agency has not secured additional funding; has not reached at least 90% in the sale of the Protector Plus condom; and efficiency in the CYP is inconclusive. Although SLaDA has made meaningful internal arrangements this far, the agency needs support for capacity development in social marketing, proposal writing, identifying partners to form consortia with in submitting bids, further strengthen its structures and systems (development of a National Strategy; review of the National Communication Strategy; and review the organogram and address staffing gaps).

***Recommendation 3:*** Increase HAPP III funding to enable continuous commitment to building the capacity of implementing partners.

The evaluation established that IPs lose staff especially in the area of finance due to lack of incentives. There is need to revisit remunerations for project staff of the IPs, which will in turn improve staff retention and adequate programme and financial management. Improve staffing levels and build their capacity where needs are identified.

**Recommendation for the Government of Sierra Leone**

***Recommendation 4****: Strengthen* the advocacy component of the project by increasing engagement with government and key stakeholders for Sierra Leone to adopt a 'Zero Tolerance' positon on FGC.

FGM/C constitutes a form of violence against girls and women that must be stopped. Sierra Leone has one of the highest rates of FGM/C worldwide, affecting almost 90%[4] of women aged 15-49 years. Every year, Sierra Leone joins the world in commemorating the International Day of 'Zero Tolerance for Female Genital Mutilation'. The Government has taken plausible step by being a signatory to international conventions and treaties relevant to safeguard girls' and women's human rights and to protect their health, and this is only a first step. The HAPP IV can build on this goodwill and advocate for 'Zero Tolerance' to FGC with the ultimate goal of encouraging the Government to sign on international FGC laws and their domestication.

**Recommendation for KfW Development Bank**

[4] https://sl.one.un.org/2017/02/06/statement-by-the-united-nations-in-sierra-leone-on-the-international-day-of-zero-tolerance-for-female-genital-mutilation/

***Recommendation 5:*** Commission a Value for Money audit[5] for HAPP III to ascertain the management of the program's financial, human and physical resources.

A Value for Money audit has not been commissioned from HAPP I to date. Secondly, the efficiency of the CYP need to be assessed over a period of time to ascertain trends. No conclusive trend has derived from the data availed in HAPP III.

[5] https://home.kpmg.com/sg/en/home/services/advisory/risk-consulting/internal-audit-services/value-for-money.html
Value For Money (VFM) audits can be defined as an objective, professional and systematic examination of systems and procedures that management has established to ensure:

- financial, human and physical resources are managed with due regard to economy, efficiency and effectiveness; and
- accountability relationships are served.

## 2. Evaluation Introduction/Background

The HIV/AIDS Prevention Program (HAPP) III implemented in Sierra Leone is funded by the Germany government through the KfW Development Bank. The programme implements social marketing activities for the Protector Condom and mitigating the social impact of HIV/AIDS under the Impact Mitigation Funds (IMF). The project focuses on the prevention of GBV including FGC; prevention of HIV/AIDS and unplanned pregnancies as well as the empowerment of girls and women.[6] The overall goal of HAPP III is to contribute to improved sexual and reproductive health of Sierra Leone. Implementation of the programme was from June 2013 to July 2017. It is worth noting that, the outbreak of the Ebola Viral Disease cost the project 18 months of time in implementation. The HAPP III was, therefore, granted a no-cost extension from August 2017 to March 2018. This Report presents the findings of the end phase evaluation of the Programme.

Implementation of HAPP started in 2006 and has evolved over three phases to date. HAPP III, with the third phase of the programme implemented between June 2013 and July 2017. The HAPP III is implemented in all the fourteen districts in the country (Bo, Bombali, Bonthe, Kailahun, Kambala, Koinadugu, Kono, Kenema, Moyamba, Porto Loko, Pujehun, Tinkolili, Western Area Urban and Western Area Rural) targeting the population in the reproductive age category with emphasis on girls and women (see Figure 1).

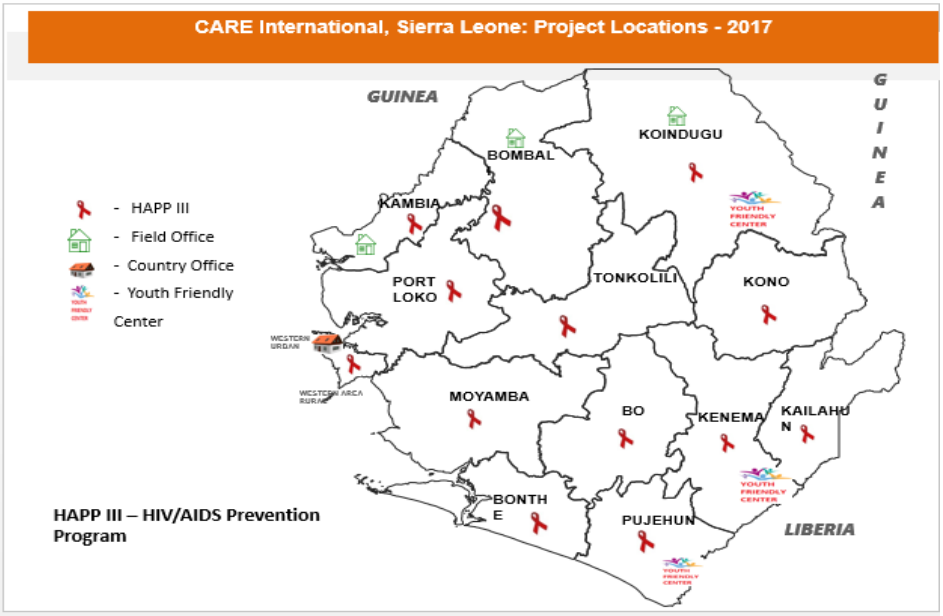



*Figure 1: Care International, Sierra Leone: Project Locations – 2017*

The strategy of the programme is to integrate HIV and GBV issues into the larger Sexual Reproductive Health and Rights (SRHR) using Social Marketing and Impact Mitigation. The estimated total Project cost ("Total Cost") underlying the Project appraisal is approximately EUR 6,55 million.

**The Social Marketing Component** deals with the use of commercial marketing principles and techniques to improve the welfare of people and the physical, social and economic environment in which they live. In HAPP III, emphasis is on contraceptive commodity supply and distribution and Behaviour Change

[6] HAPP III Separate Agreement

Communication (BCC). Information Education and Communication (IEC) activities are implemented by a newly established independent Social Marketing Agency (NGO) called SLaDA, which is mentored by CARE International. At the end of HAPP III, a target of 16 million condoms should have been sold with a projected income of about 54 000 Euros to be re-invested into the programme.

**The Impact Mitigation Fund (IMF) Component** supports local initiatives through community based organisations (CBOs) and NGOs to mitigate the impact of HIV/AIDS and GBV and to empower the young generation, especially girls, for improved SRHR including their economic empowerment. The IMF specific outputs are:

- Improved knowledge and attitudes of target groups regarding SRHR.
- Reduced vulnerability in SRHR and empowerment of vulnerable persons especially girls and women.

NAS, Care and SLaDA provided overall guidance to the evaluation, provided national and project documents for literature review, logistical arrangements and support for fieldwork, and input to the evaluation inception report and the final report. Together with staff from the Ministry of Health and Sanitation, they participated as key informants to the evaluation.

## 2.1 Purpose and Objectives of the Evaluation

### Purpose

The overall purpose of the HAPP III end phase evaluation is to measure improvements in SRHR outcomes (specifically decrease of Risk Contact of HIV, increased use of condoms by the 15-24 year old generation, reduced stigmatization against people living with HIV and ratio of mothers who do not intend their daughters to be subjected to FGC).

### Specific Objectives

The overall purpose of the end phase evaluation will

I. Assess the achievement of the project in relation to the following:
   - ✓ Increased use of condoms by 15-24-year-old generation and frequency of intercourse with regular and non-regular partners
   - ✓ Increased percentage of young women and men age 15 to 24 who correctly identify ways of preventing sexual transmission of HIV and reject major misconception about HIV transmission;
   - ✓ Reduced stigmatization against people living with HIV
   - ✓ Increased number of mothers with at least one daughter who do not intend to have their daughter(s) circumcised

II. Assess the socio-economic impact of the vulnerable women who receive IMF-support in the project intervention areas.

III. Assess SLaDA management capacity and their funding strategies to determine their potential for sustainability.

IV. Provide best practices and lessons learned from HAPP III that can inform future programming.

V. Evaluate relevance, effectiveness, efficiency, sustainability as well as important risks to the program.

VI. Provide recommendations for future programme.

## 2.2 Structure of the Report

The following in the structure of the evaluation report:

1. Executive Summary
2. Evaluation introduction/Background – encompassing description of HAPP III, the role of other partners in the HIV/AIDS arena, the purpose and specific objectives of the evaluation, and the structure of the report.
3. Methodology – covers the study sites, target population, methods of data collection, the survey sampling design, methods of data analysis, and the characteristics of the survey sample.
4. The Findings – the section focuses measurement of HAPP III at outcome and output levels; and the evaluation of the programme using OECD criteria of efficiency, effectiveness, relevance, sustainability and impact
5. Best practices/lessons learnt; and
6. Conclusions and Recommendations

## 3. Methodology

The evaluation used a combination of qualitative and quantitative research methods. Qualitative methods comprised of, Focus Group Discussions (FGDs); Key Informant Interviews (KIIs); and Most Significant Change (MSC) case study stories. Qualitative data collection approaches were used to answer the specific evaluation questions as detailed in the Evaluation Framework (Annex 4). In addition, qualitative data were utilised to document the probable mechanisms behind observed quantitative changes and to provide explanations to emerging themes in the analysis, together with lessons learned, key success factors and likely efficiency characteristics and options for future interventions. The evaluation ensured beneficiary/community participation through the use of participatory methods. Quantitative data were used to determine progress on the programme log frame (impact, outcome and outputs). These were complemented by data collected from population-based survey targeting youth (boys and girls) age 15-24 years; and women age 25-49 years.

### *3.1 The Study Sites*

The evaluation was conducted in all the four regions of Sierra Leone (South, North, East and Western). Within each region, districts were identified, from which Chiefdoms were selected (see Table 2). The geographical locations from which the assessment participants are drawn within the selected districts include urban- rural residence.

*Table 2: Regions, Districts and Communities Visited*

| Province/area | District | Chiefdom/Communities |
|---|---|---|
| Eastern | Kenema | Kpai, Heigbema, Simbeck, Lumbebu |
| | Kailahun | Gbeika, Levuma Sineh, Kailahun town |
| Western | Freetown | Wellington; Kissy; and Kalaba Town |
| Northern | Bombali | Makeni Lol; Gbendebu |
| | Tonkolili | Manepeh; Gbendehbu; Mile 91 |
| Southern | Bo | Kebbie Town; Mofindor |
| | Pujehun | Benduma; Gendema |

### *3.2 The Respondent Population*

The participants for the evaluation were selected based on age and sex, women and men in the reproductive age group targeted population by the HAPP III interventions (young men and women age 15-24 years; and women age 25-49 years).

- males age 15-24 years only
- females age 15-24 years only
- women age 25-49 years with at least one daughter
- Project staff from NAS, CARE, SLaDA
- IMF Implementing Partners - Society For Women and AIDS in Africa Sierra Leone Chapter (SWAASL); Fambul Initiative Network; ABSAL Women Development Organization; Daughters Vocation Training Centre (D.V.T.C.); Community Advocacy and Development Agency (CADA); Emerging Women Development Organisation; Community Empowerment & Development Agency (CEDA); Asphaleia Kabor Project Sierra Leone; Concern for the Development of Women and Children; Bagbwe Women's Development; Badjia Women's Development Association

(BADWA); Pure Heart Foundation; Community Action to Restore Lives (CARL); Potential Rescue and Development Centre – Sierra Leone (PREDEC); Kaheimoh Youth Development Organization; German Kooperation – Sierra Leone (Geiko); Tinap for Peace and Development Organization (TIPDO); Christian Community Development Programme (CCDP); National Breastfeeding Advocacy Organization Sierra Leone (NABFAO/SL); Centre for Encouraging, Caring and Supporting HIV People (CECSHIP); Planned Parenthood Association of Sierra Leone; and Girls Institute for Self-Achievement Women development Organization (GISAWDO).

- Other Stakeholders
  - ✓ Religious leaders / traditional leaders
  - ✓ HIV Counsellors
  - ✓ Retailer / wholesalers
  - ✓ Influential adult women
  - ✓ Youth Clubs

## *3.3 Methods of Data Collection*

This section looks at the sampling framework, data collection methods and tools, and the methods for analysis. The evaluation process was highly participatory (see data collection tools in Annex 8 and the Survey Questionnaire attached as a separate file). Each data collection tool was designed to address specific issues outlined in the terms of reference. Although, there was no baseline study or midterm review as a result of the Ebola outbreak (25 May, 2014 to 17 March, 2016), the consultants developed tools for the end phase evaluation based on Sierra Leone national tools adapted from the Behaviour Sentinel Surveillance.

***Qualitative Methods***

**Desk review:** Documents reviewed included, program proposal documents including the Separate Agreement to the Financing Agreement; national policy and strategy documents; surveys such as the Sierra Leone 2015 Population and Housing Census, the Demographic and Health Survey (SLDHS) 2013, the Multiple Indicator Cluster Survey (MICS) 2010; and studies on HIV and prevention, GBV, SRHR and FGC. A review of programme (monitoring and semester) reports for components of HAPP III was equally important to inform analysis of the evaluation data.

**Key Informant Interviews:** Thirty-one key informants were interviewed. These were identified from HAPP III implementing partners, IMF implementing partners, community leadership, direct beneficiaries of the programme and other key stakeholders as listed in Table 3.

*Table 3: Key Informants Interviewed*

| Organisation/Institution/Community | Number of Key Informants |
|---|---|
| National AIDS Secretariat | 1 |
| Care International | 1 |
| SLaDA | 3 |
| KPMG | 1 |
| UNAIDS | 1 |
| *IMF Implementing Partners:* | |
| Society for Women and AIDS in Africa; | 1 |
| Community Empowerment and Development Agency; Bagbwe Women's Development; | 1<br>1 |
| Pure Heart Foundation; | 1 |
| Kaheimoh Youth Development Organisation; | 1 |
| German Cooperation; | 1 |
| Christian Community Development Programme; | 1 |
| Tinap for Peace and Development Organisation; National Breastfeeding Advocacy Organisation; | 1<br>2 |
| Centre for Encouraging, Caring and Supporting HIV People; | 2 |
| Girls Institute for Self-Achievement Women Development Organisation | 1 |
| Religious / Traditional Leaders | 4 |
| HIV Counsellors | 3 |
| Retailer / Wholesalers | 2 |
| Influential adult women | 1 |
| Youth Clubs | 1 |
| **Total** | **31** |

**Focus Group Discussions (FGDs):** Twenty-five FGDs were convened in Bo, Pujehun, Kailahun, Kenema, Tonkolili, Bomboli, and Western Area (Urban). Focus Group Discussions were held with beneficiaries of the programme to capture their views on HIV prevention and the benefits of HAPP III interventions in order to have a clear picture of how the programme was rolled out and what key stories of change could be derived from it. Respondents for FGDs were categorised by age and sex as indicated below:

- Eight FGDs with young men and women age 15-24 years and another eight FGDs with young men and women age 15-24 years. The information derived from FGDs with young people was on condom availability and access; condom usage with regular/non-regular partner; condom promotion in the community; stigma and discrimination of PLHIV; HIV/AIDS information; HIV and AIDS misconceptions and how they are addressed in the community;
- Nine FGDs with women age 25-49 years only covering issues on practice and drivers of FGC; perceptions on FGC; decisions on circumcision of own daughter/s; and what needs to be done to reduce FGC.

**Case Studies:** Two significant stories and photos of HAPP III IMF beneficiaries are included in the report. The first story is of a woman who heads the *Sowes* narrating her benefits from the intergeneration dialogues on FGC and her participation in drawing up and enforcing by-laws on FGC in her community. The second one is of a former commercial sex worker who is now a trained caterer. Additionally, some

photos of beneficiaries from the IMF on tailoring, farming, and retail business are included. These transformative change stories provide rich perspectives of the project outcome and impact results.

***Quantitative Methods***

**The Survey:** The evaluation used real time data collection methodology for the one-on-one questionnaire using cell-phones linked to the KoBo Toolbox platform. The questionnaire was administered to young women and young men age 15-24 years with a sample size of 1,216 while that for older women age 25-49 years was 446. The one-on-one questionnaire was meant to capture demographic data and quantitative data on socio-economic status, educational status, living conditions, vulnerability and attitudes towards HIV prevention and FGC. The questionnaire has five main sections: condom use at last intercourse with regular partner; condom use at last intercourse with non-regular partner; knowledge of HIV prevention; misconceptions about HIV; stigma and discrimination, and rejection of FGC. Questions on rejection of FGC were asked specifically to women age 25-49 years with at least one daughter.

### *3.4 The Survey Sampling Design*

Probability sampling was used to derive the sample for the study based on the 2015 Population and Housing Census. All the country's 4 regions (North, South, East and Western) were included in the sample. Seven districts from 14 were purposively selected based on population and high level of investment from HAPP III and implementation of programme interventions. Similarly, 15 Chiefdoms were purposively selected from the 7 districts using the same criteria. A sample of 1,200 young men and women age 15-24 years and 300 women age 25-49 years were proportionately sampled using the distribution of population by district and by Chiefdom deriving a total sample of 1,500 (see Annex 3).

**Step 1**: Definition of total population – The total population of young women and males age 15-24 years of **1,106,789**[7] was used as the study population. The population is a total of young women and men age 15-24 years from the seven purposively selected districts of Bo, Pujehun, Kailahun, Kenema, Tonkolili, Bomboli, and Western Area (Urban) where respondents were identified for fieldwork. Proportions[8] were calculated to ascertain rates on how to estimate the sample.

**Step 2: Level of accuracy** – Study confidence level is set at 95%, with a margin of error of 3%.

**Step 3: The sample size** – At 95% confidence rate and a margin of error of 3% the sample size calculated using the Survey Monkey Calculator[9] produces a sample size of **1,067.**

The formula used to calculate the sample size follows:

$$\textbf{Sample Size} = \frac{\frac{z^2 \times p(1-p)}{e^2}}{1+\left(\frac{z^2 \times p(1-p)}{e^2 N}\right)}$$

[7] Statistics Sierra Leone, 2015 Population and Housing Census SUMMARY OF FINAL RESULTS, Page 48
[8] District population for young women and men age 15-24 divided by the total population for the seven districts
[9] https://www.surveymonkey.com/mp/sample-size-calculator/

Where:
N = *Population Size (*4 252 152)
*e = Margin of error = 3% (0.03)*
*z = z-score*. The z-score is the number of standard deviations a given proportion is away from the mean. A predetermined z-score for 95% confidence level is 1.96.
*p = probability of success/occurrence*
*Sample size = 1,067*

**Stage 3: The Evaluation sample** - Based on the estimated sample above, a sample size of 1,200 was, therefore, agreed upon young women and men age 15-24 years, and 300 you adult women age 25 to 49 years (see Tables 4 and 5). The proportions calculated using district population are utilised to distribute the sample to the seven districts.[10] The process explained above for the district level calculation of proportions is applied to the Chiefdom population. The proportions at Chiefdom level were used to determine how many respondents were to be interviewed in each Chiefdom.[11]

*Table 4: Sample for Young People Age 15-24 Years*

| List of Selected Districts from the project intervention area | Population of the Selected districts from the project intervention areas (age 15-24 years) | Proportion of Population for the 7 selected districts (age 15-24 years) | Estimated Sample Size per district (age 15-24 years) | Selected Chiefdoms for the list of intervention areas | Total Population of Selected Chiefdoms for the list of interventio n areas | Proportion of Population by Chiefdom | Estimated Sample size per Chiefdom (age 15-24 years) | Actual Sample size per Chiefdo m (age 15-24 years) |
|---|---|---|---|---|---|---|---|---|
| | | | | Kakua | 51074 | 0.7 | 94 | 125 |
| Bo | 123981 | 0.11 | 134 | Bagbwe | 20926 | 0.3 | 40 | 39 |
| | | | | Malen | 49263 | 0.5 | 144 | 139 |
| Pujehun | 265223 | 0.24 | 288 | Sorogboma | 42292 | 0.5 | 144 | 123 |
| | | | | Luawa | 81044 | 0.6 | 77 | 67 |
| Kailahun | 118297 | 0.11 | 128 | Njaluahun | 61216 | 0.4 | 51 | 51 |
| | | | | Small Bo | 29498 | 0.4 | 44 | 61 |
| Kenema | 100867 | 0.09 | 109 | Nougowa | 45562 | 0.6 | 66 | 68 |
| | | | | Yoni | 112511 | 0.6 | 70 | 69 |
| Tonkolili | 107014 | 0.10 | 116 | Kholifa Rowala | 66128 | 0.4 | 46 | 50 |
| | | | | Paki Massagbom | 19880 | 0.3 | 41 | 42 |
| Bomboli | 126184 | 0.11 | 137 | Gbendenbu Ngowahun | 38800 | 0.7 | 96 | 97 |
| | | | | Wellington | East 3/3 | | 96 | 112 |
| | | | | Kissy | East 3/3 | | 96 | 85 |
| Western Area Urban | 265223 | 0.24 | 288 | Kalaba Town | East 3/3 | | 96 | 88 |
| **Total** | **1106789** | **1.00** | 1200 | | | | **1200** | **1,216** |

[10] For example the number of respondents from Bo is calculated as 0.11 multiplied by 1,200 = 134.
[11] For example the number of respondents for Kakua is determined by multiplying the proportion for Kakua by the respondents to come from Bo district (0.7x134 = 94).

*Table 5: Sample for Women Age 25-49 years based on Female Population at District and Chiefdom Level*

| List of Selected Districts from the project intervention areas | Female Population of the Selected districts from the project intervention areas | Proportion of Female Population for the 7 selected districts | Estimated Sample Size per district - Respondent (Women age 25-49 years) | Selected Chiefdoms for the list of intervention areas | Female Population of Selected Chiefdoms for the list of intervention areas | Proportion of Female Population by Chiefdom | Estimated Sample size per Chiefdom (Women age 25 – 49 years) | Actual Sample size per Chiefdom (Women age 25 – 49 years) |
|---|---|---|---|---|---|---|---|---|
| | | | | Kakua | 26697 | 0.7 | 30 | 49 |
| Bo | 294909 | 0.137 | 41 | Bagbwe | 10482 | 0.3 | 12 | 25 |
| | | | | Malen | 24099 | 0.5 | 13 | 35 |
| Pujehun | 177592 | 0.082 | 25 | Sorogboma | 22001 | 0.5 | 12 | 19 |
| | | | | Luawa | 42379 | 0.6 | 22 | 23 |
| Kailahun | 265793 | 0.123 | 37 | Njaluahun | 30265 | 0.4 | 15 | 14 |
| | | | | Small Bo | 15365 | 0.4 | 17 | 24 |
| Kenema | 308787 | 0.143 | 42 | Nougowa | 23544 | 0.6 | 25 | 76 |
| | | | | Yoni | 57891 | 0.6 | 22 | 26 |
| Tonkolili | 268283 | 0.125 | 37 | Kholifa Rowala | 33307 | 0.4 | 15 | 22 |
| | | | | Paki Massagbom | 10393 | 0.3 | 14 | 16 |
| Bomboli | 309861 | 0.144 | 43 | Gbendenbu Ngowahun | 20302 | 0.7 | 28 | 30 |
| | | | | Wellington | East 3/3 | | 25 | 26 |
| | | | | Kissy | East 3/3 | | 25 | 26 |
| Western Area Urban | 527757 | 0.245 | 75 | Kalaba Town | East 3/3 | | 25 | 35 |
| | **2152982** | | **300** | | | | **300** | **446** |

**Training of Enumerators and Data Collection**

The assessment utilised the KoBo Toolbox digitalized data collection method, where the interviewer read all questions to the participant and enters answers on the tablet/smartphone. Sixteen tablets/phones were used for data collection. The Research team was trained and appraised on the use of tablets/phones in completing the digitalised questionnaire in a two day training programme, where day one was the basic training and understanding the questionnaire while day two was set aside for pretesting the tool, the data collection gadgets and the data platform.

**Team Composition**

The team was composed of the Team Leader, National Consultant, 4 Fieldwork Supervisors, 16 Enumerators and 4 FGD Research Assistants. Data was collected in 4 regions and the Team Leader and National Consultant were each responsible for supervising 2 regions each. In each region, data was collected by a 6 member team composed of 1 fieldwork supervisor/enumerator and 4 survey enumerators and 1 FGD research assistant. Each team covered two districts per region, with the exception of Freetown which had 3.

### *3.5 Methods for Data Analysis*

The household survey questionnaire data was captured using tablets/phones, and data submitted was stored on the KoBo platform. Quantitative data was analysed through Excel and SPSS. Content analysis by themes was utilised for qualitative data. Data triangulation was used in the analysis of secondary data and primary data collected using both quantitative and qualitative methods.

Further, a Likert scale model was used to assess progress made towards achieving HAPP III outcomes and outputs. Target scores for each evaluation criterion were used for performance and results management. The assumptions used in this report are based on a five-point rating scale that introduces differentiation between ratings and allows for a more distinctive performance assessment. Performance status and ratings are presented in **Error! Reference source not found.**6 below.

*Table 6: Outcome and Output Assessment*

| Status | Percentage | Description |
|---|---|---|
| Highly Satisfactory | 90 -100 | • More than 90% of set targets achieved<br>• Within set timelines |
| Satisfactory | 75-89 | • Three-quarters of set targets were achieved<br>• Out of set timelines by less than 1 year |
| Moderate | 50-74 | • Half of set targets were achieved<br>• Out of set timelines by 1 year |
| Unsatisfactory | 25-49 | • A third of set targets were achieved<br>• Out of set timelines by more than 1 years |
| Highly Unsatisfactory | 0-24 | • A quarter of set targets achieved<br>• Way out of set timelines by 2 years |

## 3.6 Characteristics of the Sample

The survey for young people totalled 1,216 of which 51% were female and 49% male. The majority of the survey population (63.5% women and 59.3% men) are between age 15 and 19 years, are still in school and have never married. The survey for women age 25-49 years totalled 446 with most of them coming from the East (30.7%) and the South (28.7%). 31.6% of the women are age 25-29 years and 22.6% in the 35-39 years age category. The majority of the women (71.7%) are currently married, 45.5% have no education while 45.3% are in petty trading (see Annex 3).

# 4. Findings

## 4.1 Assessment of HAPP III Outcome

The HIV epidemic in Sierra Leone is considered as mixed, generalized and heterogeneous. HIV affects different population sub-groups and all sectors of the population through multiple and diverse transmission dynamics. The HIV prevalence in Sierra Leone increased from 0.9% in 2002 to 1.5% in 2005 and has stabilised since 2008 (2013, SLDHS).[12] The 2013 DHS in Sierra Leone reported adult HIV prevalence (15-49 years old) at 1.7% in women and 1.3% in men. An estimated 54,000 Sierra Leoneans are living with HIV in 2015; out of which 29,000 are women and 5,000 are children.[13]

Condom use is one of the main strategies for combating the spread of HIV. Social acceptance of condom use, especially among young people is an important determinant of condom use to prevent sexual transmission of HIV and other STIs, as well as preventing early pregnancy. In Sierra Leone, teenage pregnancy is a priority, as evidenced by the creation of the National Strategy for the Reduction of Teenage Pregnancy in 2013.[14] The National Strategic Plan 2016-2020 noted high rate of early marriage, low condom use and multiple sexual partners with early sexual debut among adolescents and young people. HAPP III social marketing of condoms through SLaDA is aimed at complementing Government efforts in reaching the population with free distributed condoms.

This section of the report presents the intended outcome of these efforts, which is an increase in condom use among young people, targeted by the programme. The indicators assessed are:

**Outcome 1:** Prevention of HIV, unplanned pregnancies and gender-based violence including FGC, and empowerment of girls and women.

***Indicator 1:*** Increased condom use among 15-24 year olds at last intercourse with regular partner: 4.7% (women) to 8% and 16.5% (men) to 20%: base years BSS 2012.

***Indicator 2:*** Increased condom use among 15-24 year olds at last intercourse with non-regular partner: 21.5% (women) to 25% and 23.9% (men) to 28%: base year BSS 2012.

In the survey, young people age 15-24 years were asked if a condom was used at last sexual intercourse with a regular and with a non-regular partner. As presented in **Error! Reference source not found.**7, condom use with a regular partner among women age 15-24 years is 18.6% against a target of 8% while it is 27.6% for men of the same age group against a target of 20%. Similar results were registered for condom use with a non-regular partner among women age 15-24 years at 27.4% (target 25%) and 28.4% for men age 15-24 years against a target of 28%. The estimated targets were not only reached, but the observed results considerably exceeded the targets for condom usage. Both indicators show a remarkable improvement in condom usage from 2012 and the end phase evaluation rated the result as **highly satisfactory**.

[12] Statistics Sierra Leone (SSL) and ICF International. 2014. Sierra Leone Demographic and Health Survey 2013. Freetown, Sierra Leone and Rockville, Maryland, USA: SSL and ICF International.

[13] Ibid

[14] Statistics Sierra Leone, 2014. Sierra Leone Demographic and Health Survey 2013. ICF International.

*Table 7: Results on Condom use with Regular/Non Regular Partner*

| Outcome | Indicator | Baseline | Target | Result 2017 | Increase ⇧ Decrease ⇩ |
|---|---|---|---|---|---|
| **Outcome 1:** Prevention of HIV, unplanned pregnancies and gender-based violence incl. FGC, and empowerment of girls and women. | 1. Increased condom use among 15-24 year olds at last intercourse with regular partner: | 4.7% (women)<br>16.5% (men) *(BSS 2012)* | 8%<br>20% | **18.6%**<br>**27.6%** | ⇧ |
| | 2. Increased condom use among 15-24 year olds at last intercourse with non-regular partner: | 21.5% (women)<br>23.9% (men) *(BSS 2012)* | 25%<br>28% | **27.4%**<br>**28.4%** | ⇧ |

*Highly Satisfactory: 90%-100%; Satisfactory: 75%-89%; Moderate: 50%-74%; Unsatisfactory: 25%-49%; Highly Unsatisfactory: 0-24%.*

In discussing with young people age 15-24 years in focus group discussions, young people indicated that they have no challenges in accessing condoms in their communities. Asked on which condom is common in their community 41.3% of young women and 44.4% of young men indicated that the Protector Plus condom was common, followed by the Love Condom (36.2% young women and 41.3% young men), and other condoms 22.4% and 14.3% respectively. This was confirmed in FGDs where Protector Plus condoms were mentioned to be available for sale at all times in commercial outlets. The message on condom use is that it should be used every time to prevent HIV, STIs and unwanted pregnancies. The evaluation asked young people if a condom was used the first time they had sexual intercourse. Condom use was very low at first intercourse as 90.9% of young women and 88.7% of young men said that a condom was not used.

Young people were able to identify places where they could get a condom such as government hospitals, health centres, pharmacies, shops, charity organisations, community centres, social clubs, outreach teams, Marie Stope centre, from implementing partners' offices and from peer educators that visit their communities for outreach and programme sensitization activities. Asked about the cost of buying condoms, young people noted that Protector Plus condoms were expensive. The price ranged from LE1,000 per packet in rural communities to LE2,000 in Freetown.

> *'Yes, it is available in our communities the only problem we have is we are ashamed to buy it. Sometimes the cost again is a challenge because it is sold for LE2,000 per packet'* (FGD young men 15-24 years, Wellington, Western Area).

> *'…LE1,000 per pack from the pharmacy'* (FGD, young men 15-24 years Simbeck Community, Nongowa Chiefdom, Kenema District).

> *'No, availability of condom within the community…the cost is very high, demand is high, …there are few pharmacies in the community that sell condom'* (FGD, young men 15-24 years NJaluahun Chiefdom, Kailahun District).

Young people noted, however, that while male condoms were available for free and for sale, female condoms were not.

> *'...but only male condom, female condom are not available here in Gbeika community'* (FGD, young women age 15-24 years, Gbeika community, Njaluahun Chiefdom).

***Indicator 3:*** Increase of mothers with at least one daughter who do not intend to have their daughter(s) circumcised from 8.9% (SLDHS 2008) to 15%.

The term 'female genital mutilation' (also called 'female genital cutting' and 'female genital mutilation/cutting') refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.[15] There are a number of international and regional treaties, conventions and legal instruments to protect girls and women against FGC.[16] Although the Government is a signatory to international conventions and treaties relevant to safeguard girls' and women's human rights and to protect their health, Sierra Leone remains one of the countries that has not taken a public position on 'Zero Tolerance' to FGC. However, Sierra Leone's decision to back the Maputo Protocol on the rights of women in Africa brings hope that a new law on FGC could be enacted in a country where the practice is rife.[17, 18] Sierra Leone, along with West African neighbours Liberia and Mali, are among a handful of FGC-affected countries in the continent which have not yet banned the practice. Through intergenerational dialogues, HAPP III focused on raising awareness on the dangers of FGC.

The evaluation asked mothers with at least a daughter if they intended to have their daughter circumcised. The findings from the HAPP III survey indicate that 47.5% of mothers with at least one daughter do not intend to have their daughter(s) circumcised. The result from the SLDHS of 2008 was 8.9%[19], and HAPP III target was 15%. The result observed is **highly satisfactory** (see **Error! Reference source not found.**8).

*Table 8: Percentage of Mothers who reported they do not intend FGC for their daughters*

| Outcome | Indicator | Baseline | Target | Results 2017 | Increase ⇧ / Decrease ⇩ |
|---|---|---|---|---|---|
| **Outcome 1:** Outcome: Prevention of HIV, unplanned pregnancies and gender-based violence incl. FGC, and empowerment of girls and women. | 3. Increase of mothers with at least one daughter who do not intend to have their daughter(s) circumcised from | 8.9% *(SLDHS 2008)* | 15% | **47.5%** | ⇧ |

*Highly Satisfactory: 90%-100%; Satisfactory: 75%-89%; Moderate: 50%-74%; Unsatisfactory: 25%-49%; Highly Unsatisfactory: 0-24%.*

Ninety-five percent of the women had heard about FGC. Seventy-two noted that they got information on FGC from parents/family; 26% identified peers as the main source while 22% indicated that they received the information through the mass media and other sources.[20] Asked if FGC was a requirement of their religion, 54.5% of women 25-49 years agreed, 35.7% noted that it was not while 9.8% did not know if it was required or not. From the study, it seems FGC is done mainly for social acceptance (49.5%); cleanliness (23%); better marriage prospects (20%); to preserve virginity/prevent premarital sex (8%); religious approval (6%); and sexual pleasure (3%). Further, the evaluation assessed their perception on whether

[15] WHO, 2008. Eliminating female genital mutilation: an interagency statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO.
[16] Equality Now International Law on FGM https://www.equalitynow.org/international-law-fgm
[17] The African Union, 2003. Maputo Protocol, Mozambique - July 2003.
[18] Sierra Leone's On Track To Ban Female Genital Mutilation https://www.huffingtonpost.com/2015/07/08/sierra-leone-urged-to-ban_n_7745410.html
[19] The 2013 SLDHS collected information on FGC in Sierra Leone from all women age 15-49 years and sample size was 16,626 women
[20] Note that this was a multiple response question, hence the percentages do not add up to 100.

the practice should be continued, or should it be discontinued. Forty-eight percent indicated that the practice should continue, 45% said that it should be discontinued and 7% were not sure.

Even though Harmful Traditional Practices including FGC continue to persist in communities, HAPP III has contributed towards the reduction of such practices. The Programme utilised 'Intergenerational Dialogue' (IGD) approach to educate the population against harmful traditional practices with emphasis on FGC, HIV/AIDS and SRHR issues in communities. The Approach adopts the Training of Trainers methodology, were the trainers in-turn organised full courses of Intergeneration Dialogue sessions in their communities. An implementing partner in Kenema District noted that:

> *'The program contributed immensely in changing the attitudes of women towards FGC through the IGD. The 'Sowes' were trained and discouraged from initiating girls and women without consent'.*

Responses from FGDs are indicative of the achievements of HAPP III sensitisation and community buy-in:

> *'FGC is an evil act and should not be reintroduced into this community'* (FGD women age 25-49 years – Kebbie Town, Kakua Chiefdom, Bo District).
>
> *'We welcome the MOU between the community and the organisation and agree that girls below 18 years should not be initiated. We are beginning to realize the health implications of female genital cutting' (*FGD women age 25-49 years, Kailahun District).
>
> *'Daughters will be circumcised based on their consent. If they refuse, they won't be coerced to do so. Our sons will marry women of their own choice whether circumcised or not'* (FGD women age 25-49 years Kpai Community-Small Bo Chiefdom -Kenema District).

Some of the traditional initiators of FGC (*Sowes*) have embraced the by-laws and teachings on the dangers and human rights abuses of FGC but have highlighted that they have been prejudiced of their form of livelihood. With the reduction in FGC initiations, their economic standing has been affected.

**Most Significant Case 2: Head of Sowes, Gbendebu Chiefdom, - North Region**

The program helped the community to know the hazards of initiating under aged children and women over eighteen years without their consent. There are now by-laws outlawing the initiation of children under 18 years and adult women without their informed consent and I have never violated those laws. I have not done any initiation since the introduction of this initiative. I was one of the members of the team of community stakeholders who met and made the by-laws outlawing the FGC practice in the Gbendebu community. Before this time I used to initiate or circumcise many girls using the same razor blade but when I was sensitized that such a practice could cause the transmission of HIV among my initiates, I have not done it again. I was further sensitized about condom use that it can help prevent the transmission of sexually transmitted diseases such as HIV.

We were earning our daily living from initiation fees but since the Ebola outbreak, we stopped and as a result, we have been finding it difficult to survive and to pay for our children's school fees. We are appealing to the government and NGOs to provide alternative sustainable sources of livelihood in the form of livestock, seedlings and finance.

Even though, some '*sowes*' have embraced the by-laws that prohibit the initiation of girls under the age of 18 and initiate those above that age by consent, there is stiff resistance from some of the *'sowes'* for whom *'bondo'* has been a major source of livelihood. They are unwilling to abandon the practice in the absence of any alternative support. Secondly, despite the positive results noted from community sensitisation and awareness activities, some community members still support FGC as a tradition that has been handed down from one generation to another and has to continue.

*'Yes, we practice FGC in our community. FGC is part of our culture and it helps to shape the characters of our daughters into a womanhood and maturity'* (FGD women age 25-49 years Kpai Community-Small Bo Chiefdom -Kenema District and Wellington, Western Area).

*'We practice circumcision because there we train them how to take care of their home, and how to take care of their husbands'* (FGD women age 25-49 years, Gbendehbu Ngowahun Chiefdom, Bombalili District).

***Indicator 4:*** Reduce % of women and men that stigmatize people living with HIV from 65% to 45% (agree with the statement that people with the AIDS virus should be ashamed of themselves (BSS 2012: p.61))

In Sierra Leone, people living with HIV (PLHIV) are protected by the National AIDS Act of 2011 against stigma and discrimination. Notwithstanding, PLHIV still experience stigma and discrimination on a daily basis. The Sierra Leone PLHIV Stigma 2013 Index noted that PLHIV stigma and discrimination exists and self-stigma is very high among PLHIV.[21] Stigma and discrimination can adversely affect people's willingness to get tested for HIV as well as adherence to antiretroviral therapy for those on treatment. Reduction of stigma and discrimination is, thus, an important indicator of the success of programmes targeting HIV prevention and control.

The survey asked a number of questions that assess stigma and discrimination. The question being analysed for the HAPP III indicator on stigma and discrimination was *'do you agree or disagree with the following statement: People with the AIDS virus should be ashamed of themselves'*. Forty-seven percent of men and women age 15-24 years who responded to the stigma and discrimination questions indicated that they disagreed with statement. The base year rate was 65% (BSS 2012) and the target for HAPP III was 45%. Even though the target was not fully achieved, the observed result of 47% is **highly satisfactory**, see **Error! Reference source not found.**9. The achievement rate for the indicator is 96%.

*Table 9: Results on Reducing Stigma among PLHIV*

| Outcome | Indicator | Baseline | Target | Results 2017 | Increase ⇧ / Decrease ⇩ |
|---|---|---|---|---|---|
| **Outcome:** Outcome: Prevention of HIV, unplanned pregnancies and gender-based violence incl. FGC, and empowerment of girls and women. | 4. Reduce % of women and men that stigmatize people living with HIV from 65% to 45% (agree with the statement that people with the AIDS virus should be ashamed of themselves (BSS 2012: p.61)) | 65% *(BSS 2012)* | 45% | **47%** | ⇩ |

*Highly Satisfactory: 90%-100%; Satisfactory: 75%-89%; Moderate: 50%-74%; Unsatisfactory: 25%-49%; Highly Unsatisfactory: 0-24%.*

Prevalence of stigma and discrimination is confirmed by results of this evaluation. Even though stigma and discrimination has declined from 65% (BSS 2012) to 47%, this is still an area of concern. An analysis of additional stigma and discrimination questions indicates that 72.8% of young people age 15-24 years would not buy vegetables from a shopkeeper or vendor who is HIV positive while 74.6% would not share a meal with a person known to have HIV or AIDS (see Table 10).

[21] Network of HIV Positives in Sierra Leone, 2015. People Living with HIV Stigma Index.

*Table 10: Additional Results on Stigma and Discrimination*

| Survey Question | No | Yes | Young People age 15-24 years |
|---|---|---|---|
| Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had the AIDS virus? | 72.8% | 27.2% | 1,083 |
| If a member of your family got infected with the AIDS virus would you want it to remain a secret or not? | 61.9% | 38.1% | 1,151 |
| If a member of your family became sick with AIDS, would you be willing to care for her or him in your own household? | 59.8% | 40.2% | 1,102 |
| In your opinion, if a teacher has the AIDS virus but is not sick, should he/she be allowed to continue teaching in the school? | 64.3% | 35.7% | 1,130 |
| If a student has HIV but is not sick, should he or she be allowed to continue attending school? | 65.1% | 34.9% | 1,126 |
| Would you be willing to share a meal with a person you knew had HIV or AIDS? | 74.6% | 25.4% | 1,103 |

Focus group discussions and one-on-one talks with PLHIV indicate that stigma and discrimination is still being experienced as highlighted in the FGD quote.

> *'Yes, they think that if they get in contact with people living with HIV they would be infected'.* FGD, young men 15-24 years, Luawa Chiefdom, Kailahun District.

In most communities, respondents indicated that they cannot identify PLHIV in their communities. This shows either that confidentiality on PLHIV status is upheld or there is denial of the existence of the disease.

Overall, the results of HAPP III indicate that the programme outcome - Prevention of HIV, unplanned pregnancies and gender-based violence including FGC, and empowerment of girls and women – was achieved. Targets for three of the four indicators (increased condom usage by young people age 15-24 years with regular and non-regular partners; increase in mothers with at least a daughter who do not intend to have them circumcised) were surpassed while the fourth on reduced stigma and discrimination has an achievement rate of 96%. These results at outcome level contribute to the reduction of the national HIV prevalence rate and the reduction in the percentage of 15-19 years-old women who have begun childbearing leading to improved sexual and reproductive health of the population of Sierra Leone.

## 4.2 Review of HAPP III Outputs

**Output 1:** Improved access to affordable condoms of good quality
***Indicator 1.1:*** Number of couples protected against STIs, HIV and unplanned pregnancies during one year (4 Mio.:120)

HAPP III measured this through an assessment of the number of couples protected against STIs, HIV and unplanned pregnancies as indicated in **Error! Reference source not found.**11. Apart from the free condoms distributed by government, the 'for sale' Protector Plus condoms were mentioned as readily available, affordable and of good quality. Key informants from selected outlets noted that the clientele for Protector Plus were mainly between the ages of 18 and 35 years and some were commercial sex workers. A review of the project progress reports reveal that sixty-eight percent of the target was achieved and the result for the indicator is rated as **moderate**.

*Table 11: Improved Access to Affordable Condoms of Good Quality*

| Output | Indicator | Target for 2013 - 2017 | Results by 31st October, 2017 | Results as a % of Target by October 31st 2017 |
|---|---|---|---|---|
| ***Output 1:*** Improved access to affordable condoms of good quality | 1.1 Increased number of couples protected against STIs, HIV and unplanned pregnancies during one year. Progress Reports (4 Mio. :120) | 133,333 | 90,576 | 68% |

*Highly Satisfactory: 90%-100%; Satisfactory: 75%-89%; Moderate: 50%-74%; Unsatisfactory: 25%-49%; Highly Unsatisfactory: 0-24%.*

**Output 2:** Improved knowledge and attitudes of target groups regarding SRHR

***Indicator 2.1:*** Increased % of young women and men age 15 to 24 who correctly identify ways of preventing sexual transmission of HIV and reject major misconception about HIV transmission: 72.3% (women) *(BSS 2012);* 79.8% (men) *(BSS 2012).*

One of the most important prerequisites for reducing the rate of HIV infection is accurate knowledge of how HIV is transmitted and strategies for preventing transmission. Correct information is the first step towards raising awareness and giving adolescents and young people the tools to protect themselves from infection. Misconceptions about HIV are common and can confuse adolescents and young people and hinder prevention efforts. In the survey, the HIV module was administered to women and men age 15-24 years, where several statements were read to them about HIV transmission mechanisms, prevention methods and misconceptions.

Young people were asked if they have heard about AIDS. Awareness of HIV and AIDS for women and men age 15-24 was 85.9% and 87.9%, respectively. To ascertain improved knowledge on HIV, young people were asked questions on 1) knowing that consistent use of a condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting HIV, 2) knowing that a healthy-looking person can have HIV and 3) rejecting the three most common local misconceptions about transmission/prevention of HIV (that HIV can be transmitted by mosquito bite, sharing food or witchcraft), amongst others.

In answering these questions, 76.2% of young women identified correctly ways of preventing sexual transmission of HIV and rejected three major misconceptions about HIV transmission. HAPP III contributed to the increase in the percentage from 72.3% (BSS 2012) to 76.2%. The increase in the knowledge levels for women surpassed the set target of 75% (**highly satisfactory**). The indicator for young men age 15-24 years was not achieved as a decline is observed from 79.8% (BSS 2012) to 76.3%. The result of 76.3% against a target of 83% is rated as **highly unsatisfactory** as it is even lower than the base year (see **Error! Reference source not found.**12). A determination on if HAPP III reached more young women than young men is not conclusive through this evaluation. As such, implementer partners may need to carry out a rapid assessment on why this indicator was not achieved and utilise the results to guide their activities.

*Table 12: Knowledge of HIV Prevention and Misconceptions*

| Output | Indicator | Baseline | Target | Results 2017 | Increase ⇧ / Decrease ⇩ |
|---|---|---|---|---|---|
| **Output 2:** Improved knowledge and attitudes of target groups regarding SRHR | 2.1 Increased % of young women and men age 15 to 24 who correctly identify ways of preventing sexual transmission of HIV and reject major misconception about HIV transmission: | 72.3% (women) *(BSS 2012)*<br>79.8% (men) *(BSS 2012)* | 75%<br>83% | **76.2%**<br>**76.3%** | ⇧<br>⇩ |

*Highly Satisfactory: 90%-100%; Satisfactory: 75%-89%; Moderate: 50%-74%; Unsatisfactory: 25%-49%; Highly Unsatisfactory: 0-24%.*

The evaluation further assessed HIV knowledge and HIV misconception questions asked in the evaluation by categorising young women and young men separately. The SLDHS 2013 presented similar results in this manner. The rates between women age 15-24 years are more or less the same to their male counterparts in the same age group. More young people know that HIV cannot be transmitted by supernatural means (young women 94% and young men 94.9%) than those who know that a healthy looking person can be HIV-positive (62.6% and 61.3%, respectively). Knowledge on ARVs for prevention of mother to child transmission and ARVs for PLHIV to live longer is lower than for all the other indicators assessed, ranging between 43% and 53% (see **Error! Reference source not found.**13).

*Table 13: Knowledge of HIV Prevention and Misconceptions by Indicator*

| Indicator | % of Young Women 15-24 years | Young women age 15-24 years | % of Young Men age 15-24 years | Young Men age 15-24 years |
|---|---|---|---|---|
| % who know transmission can be prevented by having only one faithful uninfected sex partner | 71.8% | 515 | 73.2% | 511 |
| % who know that a person can get the AIDS virus by getting injections with a needle that was already used by someone else who is infected | 91.9% | 534 | 91.5% | 519 |
| % who know transmission can be prevented using a condom every time | 78.3% | 460 | 76.9% | 481 |
| % who know that people can reduce their chance of getting the AIDS virus by not having sexual intercourse at all | 67.6% | 488 | 69.3% | 505 |
| % who know that a healthy looking person can be HIV-positive | 62.6% | 522 | 61.3% | 514 |
| % who know that HIV cannot be transmitted by mosquito bites | 73.7% | 475 | 72.0% | 472 |
| % who know that HIV cannot be transmitted by supernatural means | 94.0% | 486 | 94.9% | 494 |
| % who know that HIV cannot be transmitted by sharing food with someone with HIV | 69.6% | 490 | 70.7% | 485 |
| % who know that the virus that causes AIDS can be transmitted from a mother to her baby: During pregnancy<br>During delivery<br>By breastfeeding | 65.0%<br>64.1%<br>75.7% | 552<br>521<br>548 | 67.4%<br>67.4%<br>79.8% | 530<br>485<br>521 |
| % who know that there are special drugs (ARV) that a doctor or a nurse can give to a woman infected with the AIDS virus to reduce the risk of transmission to the baby | 43.7% | 403 | 45.3% | 415 |
| % who have heard about special antiretroviral drugs (ARV) that people infected with the AIDS virus can get from a doctor or a nurse to help them live longer | 51.1% | 444 | 53.3% | 471 |

**Output 3:** Reduced vulnerability in SRHR and empowerment of vulnerable persons especially girls and women

Impact Mitigation Fund activities targeted various categories of vulnerable people, especially vulnerable women and girls, with information and with technical support. Peer educators, animators, Local Legal Practitioners and Teacher facilitators were equipped with SRHR Life Skills to sensitise communities. SRHR Community awareness activities included training and supporting peer educators and animators required provisions such as public address facilities, logistics, stationery, manuals, T-shirts as well as condoms to organize community events that promoted the dissemination of SRH messages.

Through these activities, communities were sensitized and motivated to act on sexuality and rights, GBV, HIV/AIDS, STIs prevention and general community development issues. The messages were intended to encourage in-school girls to abstain from sex and give priority to their education, while the sexually active population was also targeted with an uncompromising message on condom use as the preventive method against sexually transmitted infections including HIV and for family planning. Information, Education and Communication (IEC) materials relating to sexual and reproductive health and HIV/AIDS such as brochures, booklets and posters were distributed through youth friendly service centres.

***Indicator 3.1:*** Increase number of MOUs/ field level agreements reflecting actions to address GBV

One hundred and fifty MOUs were signed with communities under Indicator 1 against a target of 160. This is a 94% achievement rate of the HAPP III set target, which is **highly satisfactory** (see Table 1414).

*Table 14: MOUs signed to address GBV*

| Output | Indicator | Target | Results 10/2017 | Results as a % Target 2017 |
|---|---|---|---|---|
| ***Output 3:*** Reduced vulnerability in SRHR and empowerment of vulnerable persons especially girls and women | 3.1 Increase number of MOUs/ field level agreements reflecting actions to address GBV | 160 | 150 | 94% |

*Highly Satisfactory: 90%-100%; Satisfactory: 75%-89%; Moderate: 50%-74%; Unsatisfactory: 25%-49%; Highly Unsatisfactory: 0-24%.*

HAPP III engaged communities to own the FGC debate and action by involving community members (especially women and girls), political and traditional leaders, *bondo*[22] initiators, and other relevant stakeholders. In order to strengthen implementation of the Intergenerational dialogues (IGD) through which FGC issues were debated, MOUs with concrete actions which translated into community by-laws were signed between community members, government representatives and sub-grantees to foster compliance and sustainable implementation. The MoUs were signed by Community Chiefs, Paramount chiefs, Ward HIV Counsellors, Representatives from the Family Support Units of the Sierra Leone Police, Religious Leaders, and representatives of community members who attended the Intergenerational Dialogue sessions. *Sowes* are members of committees that enforce the set by-laws in their communities. Each community agrees on a set of penalties to punish violators of the FGC by-laws.

[22] The process of initiating young girls into womanhood through FGC

Below are excerpts from some of the community MOUs focussing on FGC.

…"We the members of community XXX acknowledge that the practice of female genital cutting violates the sexual reproductive health and rights of women and girls. Therefore, we have unanimously agreed strictly prohibit the initiation of girls below the age of 18 years. In addition, forceful initiation into the '*Bondo*' society is not allowed. Defaulters shall pay the sum of Le 1,000,000. Whereas traditional practitioners shall pay a fine of Le 500,000, parents or guardian shall pay a fine of Le 500,000. The total amount paid shall be shared equally among the victim, the community members and the local authorities".

…" We denounce forced/child marriage in our community therefore take a commitment that defaulters shall pay a fine of Le 500,000 and such amount shall be shared evenly among the victim and the local authorities".

…"We are deeply worried by the increased teenage pregnancies in our community, and we have unanimously agreed to impose a fine of Le 500, 000 on the perpetrators".

***Indicator 3.2:*** Increased number of vulnerable girls and women who receive support by type and age (from 4,850 to 8,000).

HAPP III surpassed the set target of 8,000 beneficiaries for Indicator 3.2. The programme reached 8,781 beneficiaries. This is a 110% achievement rate for the indicator, which is **highly satisfactory** (**Error! Reference source not found.**5).

*Table 15: Vulnerable Girls and Women who benefited from IMF Livelihood Support*

| Output | Indicator | Target | Results 2017 | Results as a % of Target 2017 |
|---|---|---|---|---|
| ***Output 3:*** Reduced vulnerability in SRHR and empowerment of vulnerable persons especially girls and women | 3.2 Increased number of vulnerable girls and women who receive support by type and age (from 4,850 to 8,000) | 8,000 | 8,781 | 110% |

*Highly Satisfactory: 90%-100%; Satisfactory: 75%-89%; Moderate: 50%-74%; Unsatisfactory: 25%-49%; Highly Unsatisfactory: 0-24%.*

Identified vulnerable people, especially women and girls, were trained in different business skill programmes; ranging from hair-dressing, tailoring, catering, carpentry, soap making, tie and die, tailoring, agriculture, weaving to welding. The HAPP III supplied start-up merchandise for each beneficiary's business. In the 2015/16 period, the beneficiaries were trained in agriculture, business, hair dressing, tailoring and catering, as shown in Figures 2 and 3. During this period, a total of 991 vulnerable people received start-ups (92% female and 8% males) while 1,599 beneficiaries were reached in 2016/17, (91.5% females and 8.5% males). The total number of beneficiaries reached between 2015 and 2017 and are located in all the districts.

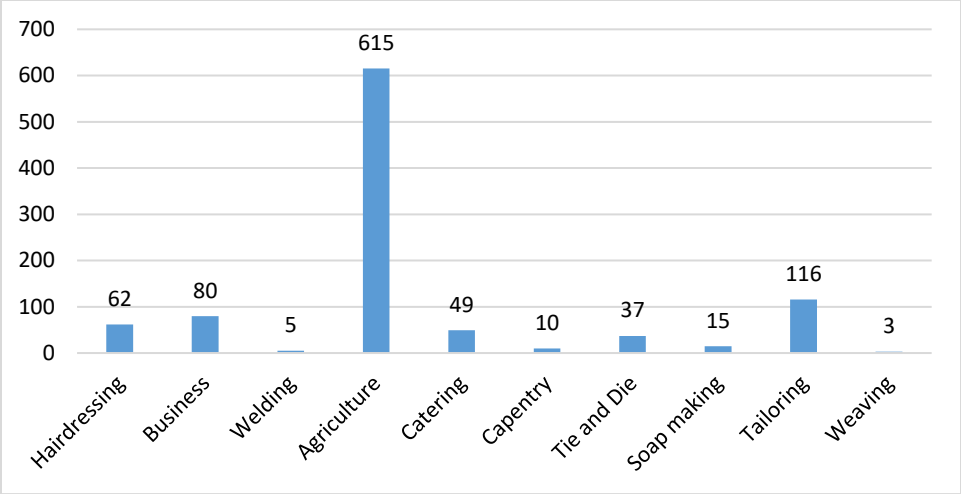



*Figure 2: IMF Support to Beneficiaries 2015/16*

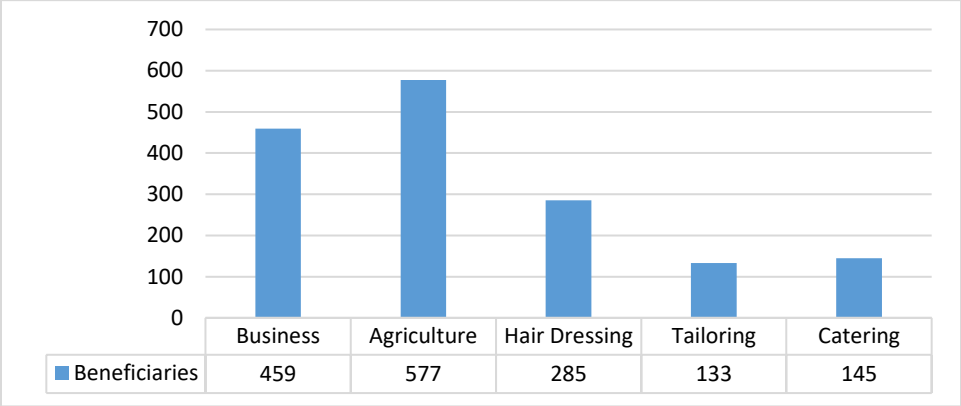



*Figure 3: IMF Beneficiaries 2016/17*

An assessment of the 2016/17 beneficiaries by age indicates that while start-up kits are extended to vulnerable people of all ages, the majority of beneficiaries in agriculture and business were within the age bracket of 25 to 44 years. On the other hand, the majority of beneficiaries in tailoring, hairdressing and catering are younger falling between age 15 and 30 years, as shown in **Error! Reference source not found.**4.

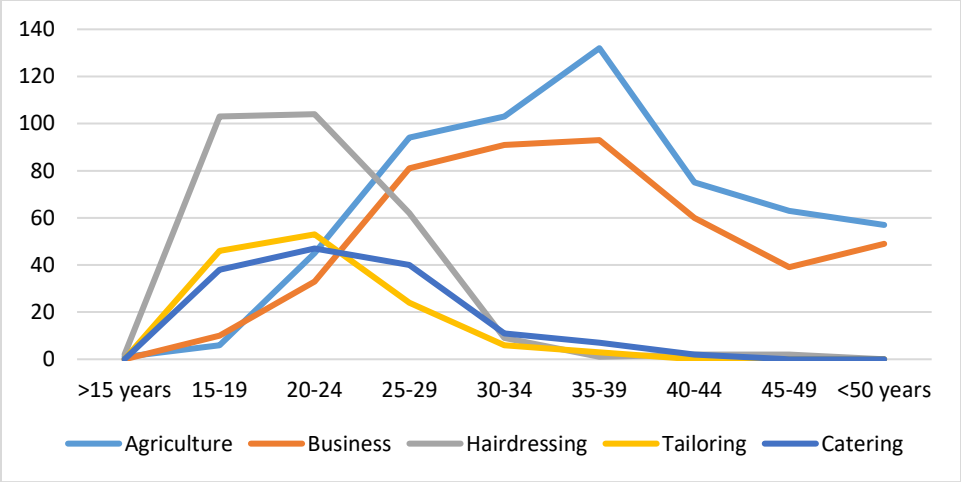



*Figure 4: IMF Support by Age and Activity*

***Indicator 3.3:*** Increased number of OVC (0-17 years) receiving support by gender (nationwide data) from 3,150 to 6,000.

The third Indicator under Output 3 focuses on increasing the number of OVC (0-17 years) receiving support by gender (nationwide data) from 3,150 to 6000. After the Ebola Virus outbreak, the Government of Sierra Leone took over the support of OVC nationwide. By the time this decision was taken, HAPP III had reached 1,262 OVC with support with a semester period target of 2,412.[23] This is a 52.3% achievement of the semester target was **moderate**. Due to the suspension of the activity from HAPP III, the evaluation is not rating this indicator over the duration of HAPP III.

## Socioeconomic Impact of IMF-support to Beneficiaries

The capacity development and economic empowerment of vulnerable girls and women, and PLHIV, an approach utilised by the IMF component motivated the community to work towards behaviour change and self-sustenance through the establishment of businesses from skills learnt. The empowerment of vulnerable women and girls culminated in an improved socio-economic status as presented text and pictures below.

**Most Significant Change Case Study: Former Commercial Sex Worker - Age: 32 years**

I was in the street as a Commercial Sex Worker. Some clients would not pay after providing them the services. I am a mother of four, two boys and two girls. One day, a trainer from this institution saw me smoking and drinking alcohol. She advised me to stop selling sex for money and learn a skill through training. I decided to join the Institute and now I am training as a caterer.

I am now a caterer and my children and other people who knew me before rejoice with me. My condition of living now compared to my previous position is much better and I no longer smoke cigarettes. After completing my skills training, I intend opening a restaurant. I advise those still practising commercial sex work to stop and join us to learn skills training as this can help them be better people tomorrow. I say thank you to the NGO supporting us, we really appreciate this life changing support.

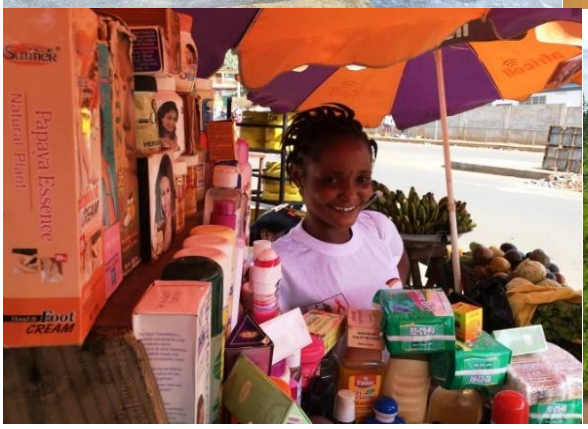
Asked on HIV prevention and FGC she said: For us to prevent HIV, we must use condoms, stay with one partner and avoid irregular partner. I will not let my children undergo FGC it is a dangerous practice.

[23] Care Sierra Leone, HAPP III Semester Report July to December 2016 – page 3.

## IMF Beneficiaries:

**At Mile 91 Tonkolili District, Northern Province**

**In Gbedebu Gowahun, Bombali District, North Province**




**Business Beneficiary at Jomo Kenyata Road, Freetown**

**Beneficiaries in their farm at Nyandehun village, Pujehun**

> *With the groundnut seed the project provided them, immediately they harvested, they did not wait for another supply. They planted potatoes…, project also taught them to do rotational farming. With this assistance from CARA through TIPDO, women are no longer economically dependent on men for sustenance. Other surrounding communities are now demanding for the extension of this project to their communities* (KII, Tonkolili District).

Output 4 indicators measure the competence of SLaDA. SLaDA was established for HAPP III to be mentored by CARE Sierra Leone in the implementation of the Social Marketing component of the programme for the promotion and sale of the Protector Plus condom. As such, three indicators were set, against which the competence of SLaDA was to be measured.

**Output 4:** Improved competence of SLaDA (Social Marketing organization)

***Indicator 4.1:*** Procurement, stocking and distribution of 16 million condoms with an annual target of 4 million over four years.

SLaDA procured and sold **12,018,832** Protector Plus condoms against a four year target of 16 million. The organisation received these condoms in 5 tranches from KfW for marketing in the HAPP III implementation

period. A total of 18,298,557 units of Protector Plus condoms were received as indicated in Table 166. The result observed on the first indicator is 75% of the set target and is rated as **satisfactory**.

*Table 16: Condom Stocking and Sales Analysis for the HAPP III (2013 -2017)*

| Stock of Condom Received for Sales | | | |
|---|---|---|---|
| **NO** | **Month and Year** | **Quantity (Gross)** | **Quantity (Units)** |
| 1 | PP Condoms Stock received in June 2013 in units | 1,528 | 1,099,872 |
| 2 | PP Condoms Stock received in June 2014 in units | 2,398 | 1,726,560 |
| 3 | PP Condoms Stock lot1 received in February 2015 in units | 9,012 | 6,488,325 |
| 4 | PP Condoms Stock received Lot2 in October 2015 in units | 9,705 | 6,987,456 |
| 5 | Total Stock received from KfW as in February 2017 in units | 2,773 | 1,996,344 |
| | **Total Stock Received (2013-2017)** | **25,415** | **18,298,557** |

The total amount received was slightly higher than the target of the condoms to be sold (16,000,000) over the period of four years. Of the total 18,298,557 condoms received, **12,018,832** were sold, which is **66%** of the total received (see Table 17). The HAPP III was granted a no-cost extension to March 2018 during which time the remaining 6,279,725 Protector Plus condoms are to be sold.

As indicated above, a target of 16 million was set for the HAPP III for four years. However, due to the delays in programme implementation caused by the Ebola Virus outbreak and delays in funding disbursements, the programme was granted a no-cost extension from March to the end of December 2017, and further extended to the end of March 2018. The target set was increased by 333,333 condoms to 16,333,333. As at the 31st of October 2017, the HAPP III had achieved 75% of the project sales target of 16 million (74% against the new target of 16.3 million).[24] SLaDA surpassed set targets for 3 semesters - Jan to June 2015 (106%); January to June 2016 (122%); and July to October 2017 (128%). Low condom sales were recorded for January to June 2014 (14%) and January to June 2017 (36%). Table 177 shows the analysis of the product received, product sold by semester and the current stock balance as at 31st October 2017.

*Table 17: Condoms Received, Sold and Current Stock*

| Annual Sales | | | | | |
|---|---|---|---|---|---|
| **Period (Semester)** | **Target (Gross)** | **Target (Pieces)** | **Actual (Gross)** | **Actual (Units)** | **Sales as % of Target** |
| Oct-Dec, 2013 | 1,389 | 1,000,000 | 1,176 | 846,720 | 85% |
| Jan-Jun, 2014 | 2,778 | 2,000,000 | 393 | 282,960 | 14% |
| Jul-Dec, 2014 | 2,778 | 2,000,000 | 1,952.8 | 1,406,016 | 70% |
| Jan-Jun, 2015 | 2,778 | 2,000,000 | 2,950 | 2,124,000 | 106% |
| Jul-Dec, 2015 | 2,778 | 2,000,000 | 1,542 | 1,110,240 | 56% |
| Jan-Jun, 2016 | 2,778 | 2,000,000 | 3,381 | 2,434,320 | 122% |
| Jul-Dec, 2016 | 2,778 | 2,000,000 | 1,926 | 1,386,720 | 69% |
| Jan-Jun, 2017 | 2,778 | 2,000,000 | 998 | 718,560 | 36% |
| Jul-Oct, 2017 | 1,852 | 1,333,333.33 | 2,374 | 1,709,296 | 128% |
| | 22,687 | 16,333,333 | 16,692.82 | 12,018,832 | 74% |
| | | **16,000,000** | | **12,018,832** | **75%** |

[24] Additional information from July to October 2017 was obtained from the SLaDA database

The decline in Protector Plus condom sales in the semester January to June 2014 may be attributed to the Ebola Virus Outbreak which started on the 24th May 2014 through 17th March 2016. A similar decline that was noted for the January to June 2017 semester may be attributed to low sales recorded in some districts for example there were no sales in Koinadugu district due to excess of old stocks; and Pujehun and Tonkolili performed relatively low in condom sales at 5% and 6.3%, respectively. Generally, the HAPP III did not meet set semester targets, except for January to June 2015, January to June 2016 and July to October 2017.

The HAPP III approach of using behaviour change messages through multiple dissemination channels raised community awareness on HIV and AIDS and promoted condom sales. SLaDA engaged in massive awareness raising, promotional sessions, and mass district level sales and outreach activities. Mass media education encompassed both print and electronic media campaigns through the internet, radio, television, newspapers and billboards capable of reaching the target population with consistent information to stimulate a positive behaviour change. In 2016, SLaDA re-branded 14 Billboards that were positioned in strategic areas and at cross boarder points with specific messages focused on the dual impact of condoms on prevention of HIV and pregnancy. SLaDA improved visibility through media campaigns and programmes, sign posting and rebranding.

The agency established 1,516 traditional and non-traditional distribution outlets for the distribution of condoms between 2013 and 2017 including pharmacies, hostels, guest houses, gas stations, ghettos, kiosk, night clubs, disco clubs, '*poyo joints*[25]', and institutions (military and police). The increase in sales can also be attributed to the continuing presence of sales agents and the increased awareness on the use of condom for the prevention of STIs and HIV. It is noteworthy that during the implementation of HAPP I and II, a total of 2,393 retailers were recruited and these retailers were successfully linked to 50 wholesalers nationwide taking care of condom needs of communities within their proximity.[26] In a bid to promote extension and improvement of the distribution system among targeted wholesalers, refresher training was conducted for the traditional and non-traditional outlets.

Other supporting mechanisms to Protector Plus sales included the establishment of a coalition of all sales outlets dealing with pharmaceutical products by the pharmacy board of Sierra Leone. In some districts, such as Bonthe, some wholesalers included Protector Plus condoms together with other health commodities which he delivers to his retail network using his own delivery van had some major benefits in promoting accessibility and eliminating additional costs to SLaDA operations.[27]

***Indicator 4.2:*** Increased efficiency in supplying products (costs per CYP)

By definition, the indicator describes the (average) cost for a CYP achieved and can be calculated by transforming (factor 0.009) the number of sold condoms into CYP. The invested costs (condoms, distribution, promotion etc.) should be divided by this number of CYP. The indicator on increased efficiency in supplying products (costs per CYP), calculated by KfW, shows a cumulative total of 71 for the implementation period of HAPP III. The result was 19 in the July/December 2015 semester, and 26 apiece for January/June and July/December 2016 and zero for January/June 2017. The indicator should be calculated for longer periods, to establish a trend in efficiency. A decrease in the cost per CYP shows an

[25] 'Poyo' joints are local beverage spots attracting mostly young people and older men within the 15-49 years age bracket
[26] HAPP III Semester Report January to June 2016
[27] HAPP III Semester Report July to December 2015.

improved efficiency. KfW may need to consider carrying out this analysis for the programme to determine value for money.

**Indicator 4.3:** Diversification in sources of funding and products: identify at least one additional source of funding

SLaDA has not secured a single additional source of funding over the duration of the programme. The main reason for failure to submit a bankable proposal may be due to a capacity gap at SLaDA. There was no proposal submission between 2013 and 2016. However, as from 2017, the agency has been working on two funding proposals to be submitted to the European Union (EU) and West African Health Organisation (WAHO). This will only translate into success if the proposals are approved. The third indicator is thus rated as **highly unsatisfactory**. The three output indicators are presented in Table 188.

*Table 18: Summary of Results on SLaDA Competence*

| Output | Indicator | Target | Results October 2017 | Results as a % Target |
|---|---|---|---|---|
| ***Output 4:*** improved competence of SLaDA (SM organization) | 4.1 Procurement, stocking and distribution of 16m condoms (annual target of 4m over 4 years) | 16,000,000 | 12,018,832 | 75% |
| | 4.2 Increased efficiency in supplying products (costs per CYP) | 0 | 71 | |
| | 4.3 Diversification in sources of funding and products: identify at least one additional source of funding | 1 | 0[28] | |

*Highly Satisfactory: 90%-100%; Satisfactory: 75%-89%; Moderate: 50%-74%; Unsatisfactory: 25%-49%; Highly Unsatisfactory: 0-24%.*

SLaDA attempted to strengthen its management and leadership capacity by restructuring the organisation between April and June 2017. During this management and leadership transition, SLaDA has put in place systems, processes and procedures to strengthen the agency including:

- Restructuring of the organogram, and the recruitment of staff was done with technical support from SLaDA Board. A total of 8 staff were hired including; National Director, Programme Manager, Finance and Admin Manager, Monitoring and Evaluation Officer, SM & BCC Officer and sales Agents.
- Development of operational organogram with a clear separation of roles and responsibilities of the Finance Manager and the Procurement Officer;
- Endorsement of SLaDA guidelines for human resource management by the Ministry of Labour and Social Security in 2016.

SLaDA has **established and strengthened partnerships** with other HIV/AIDS related institutions at the local and international levels. In Sierra Leone, SLaDA has partnered with AIDS Healthcare Foundation Sierra Leone, Plan Parenthood Association Sierra Leone (PPASL), the Sierra Leone Red Cross, Marie Stopes, Care Sierra Leone, and UN agencies to foster collaboration, partnership, knowledge sharing and to enhance the visibility of SLaDA. In 2017, Sierra Leone Red Cross Society became SLaDA's vendor for the sales of the branded Protector Plus condom. SLaDA also initiated partnership with the Department of Public Health, Njala University and the Rainbow Initiative Sierra Leone and discussion for partnership agreements has already started. International partnerships were established with Ghana Social Marketing

[28] SLaDA currently working on two funding proposals to the EU and to WAHO

Team training who trained SLaDA staff, the West Africa Health Organisation and the AIDS Health Foundation.

In promoting its sales agenda, SLaDA collaborated with other SRHR actors and beverage companies, (UNFPA and Sierra Leone Brewery Limited) and hosted a Trade Fair organized by the Sierra Leone Chambers of Commerce and Industry in 2015. SLaDA collaborates with NAS and other development partners to commemorate the annual World AIDS Day event.

In 2016, UNFPA and UNAIDS Country Offices in Sierra Leone provided funding for SLaDA's participation in a West African fast tracking condom repositioning meeting in Senegal. In the same year, SLaDA diversified its Social Marketing activities on reproductive health products, to include I-Pills (Family Planning) and Misoclear (Post-partum haemorrhage) in partnership with Marie Stopes International. SLaDA's collaboration with Marie Stopes Sierra Leone resulted in SLaDA being added as one of the key national distributors for reproductive health commodities in the country.

Overall, the competence of **SLaDA is rated as moderate** based on the indicator analysis above.

## 4.3 Programme Relevance, Effectiveness, Efficiency and Sustainability

- **Efficiency**

HAPP III efficiently utilised available resources in most timely execution possible to achieve the desired results. KPMG dutifully provided financial management, mentoring and field supportive supervision to sub-grantees of HAPP III. Two successful Independent Financial Audits were conducted for the 2015 and 2016 financial years. The 2016 audit report identified one weak implementing partner who has since been dropped from the twenty-two. A no cost extension granted to March 2018 is justified due to the delays in the programme caused by the outbreak of the Ebola Virus, and to exhaust funds gained through the exchange rate.

IMF increased the number of MOUs/ field level agreements reflecting actions to address GBV. The indicator (Output 3, Indicator 1) is **rated as highly satisfactory** as a 150 MOUs, were thus signed with implementing partners to service the communities against a target of 160. This is a 94% achievement rate of the HAPP III set target.

In Phase II (2016), 23 implementing partners were dropped from the programme for failure to perform. This was effected after an assessment of the capacity of the IPs was done (assessed by region; how well they implemented; and their financials). The IPs were dropped on both programmatic and fiduciary issues. On the programmatic side, IPs could not show value for money on most of their implemented activities. On financial issues, financial records were not properly documented and they were not submitted in real time. The capacity of the remaining 22 sub grantees was strengthened through orientation and training sessions focusing on project financial management focusing largely on the financial management guidelines developed.

SLaDA and the IMF component of the HAPP III have put in place monitoring tools for the programme. SLaDA has managed to carry out monthly sales analysis, reconciliation and reporting of condom procurement and sales. Further, the agency carried out physical count/stock take at its warehouse to tally with the monthly analysis report. At the field level, sales agents deposited funds on a daily basis, and subsequently developed weekly summaries of sales and deposits copied and forwarded to the M&E officer for data capture at SLaDA. A Rapid Assessment of products carried out in 2017 identified some

gaps in monitoring and noted some missing quantities. Monitoring systems for the programme have been strengthened based on these findings. The Programme has in place an electronic data collection system using mobile data, a system that should be strengthened and adopted for all components of HAPP IV.

Field financial monitoring and supervision of IMF sub-grantees were undertaken by KPMG during programme implementation. The objectives of the field visits were to provide support to sub-grantees to comply with the financial and contractual requirement of the fund, supervise and control the absorption of the funds according to the plan, provide technical assistance to sub-grantees, complement periodic financial audit of the sub-grantees and check documentation to ensure that approved sub-grantees comply with financial regulations. However, field supervision of the IMF component could have been better coordinated between Care and KPMG.

Reporting by Implementing Partners was timely. Reports are due on the 10th, a month after the last month of implementation. KPMG in turn reports to NAS quarterly. IPs sign a contract in each phase and KPMG disbursement is done upon request by IPs. The financial request is signed off by NAS.

- **Effectiveness**

This section links the results of the project at outcome level to the overall goal and assess the effectiveness of HAPP III. The Outcome for HAPP III was the prevention of HIV, unplanned pregnancies and gender-based violence including FGC, and empowerment of girls and women. This is done through an assessment of five outcome indicators. Overall, the HAPP III was effective and contributed to the goal of the project.

**Condom usage by young people age 15-24 with regular /non-regular partners**

Appropriate use of condoms continues to be at the core in addressing both HIV and unplanned pregnancies world over. Even though the SLDS, 2013 reported a reduction of condom use from 7% to 5% for women and 14% to 13 % for men with more than two sexual partners yet the younger population were better in condom use in their last intercourse. This gain could be attributed to the country's strategy for which HAPP III is an embodiment. Results of the study show condom use among young women 15-24 years at last intercourse with regular partner had increased from 4.7% to 18.6% and for men of the same age group from 16.5% to 27.6%. Similarly, condom use among women and men 15-24 years at last intercourse with non-regular partner increased from 21.5% to 27.4% and 23.9% to 28.4% (base year BSS 2012) an increase in condom use from. While government is distributing free condoms, SLaDa through its numerous sales outlets is ensuring the availability of protector plus condoms country wide.

**Stigma and discrimination**

Providing a safe space for people living with HIV is critical in the overall response to the disease. Ensuring their right to treatment and other social amenities in communities has increased their confidence to adhere to the therapy and has also increased the willingness in the general population to go for HIV tests. In addition to the national policy which provides them a legal space, Government in consonance with partners are putting measures in place to reduce the stigmatisation of HIV positives. The SLDHS (2013) indicated a high percentage of women and men (73% and 83%, respectively) with a positive attitude concerning the question on care for a family member sick with AIDS. Implementation of HAPP III aimed at reducing the percentage of women and men that stigmatise people living with HIV. The project aimed to reduce the percentage of women and men that stigmatize people living with HIV from 65% to 45% (agree with the statement that people with the AIDS virus should be ashamed of themselves (BSS 2012: p.61). The data showed an improvement in attitudes towards those with HIV between 2012 and 2017 with a result of 47%. The result also indicates that more young people age 15-24 years are showing accepting

attitudes towards people infected with HIV/AIDS. Based on this finding, it could be seen that HAPP III is contributing the government's priority nationwide.

***Female Genital Cutting:***
Female genital cutting, particularly with unsterilized sharps, has been cited as contributing to HIV cases in most countries where it is carried out. Type II or excision is the form of (FGC) widely practiced on women and girls countrywide. The percentage of women and girls who undergo this procedure is estimated to be between 80% and 90%. There has been pressure from Human right organisations, civil society groups on government to discourage FGC in a bid to secure the rights for girls and women. HAPP III results indicate an increase of mother's age 25-49 years with at least one daughter who do not intend to have their daughter(s) circumcised from 8.9% (SLDHS 2008) to 47.5%. The rate is higher than the 2013 SLDHS where 23% of women age 15-49 indicated that the practice should be discontinued.[29] The program contributed immensely in changing the attitudes of women towards FGC through the IGD with community members and the training of the *soweis* to undertake *bondo* within the bylaws agreed by the community.

***HIV Knowledge, Attitudes and Practice:***
Responsible and un-risky sex behaviour is most time linked with comprehensive Knowledge of HIV. Since 2000, the country with support from partners is constantly communicating information on HIV/AIDS to the general population. SLDHS, 2013 results show that 29% of young women and 30% of young men age 15-24 years have comprehensive knowledge about AIDS. Despite the low levels of comprehensive knowledge, they are an improvement from the 2008 SLDHS, in which 17% of women and 28% of men had comprehensive knowledge of AIDS. Furthermore, the 2013 survey shows that 64% of young women and 80% of young men age 15-24 years know a place where people can get condoms—a substantial improvement relative to 2008, when 27% of women and 43 of men age 15-24 years knew of a place where they could get condoms.

HAPP III contributed to improved knowledge and attitudes of women age 15-24 years regarding HIV and AIDS, and SRHR. There is an increase in percentage of young women age 15 to 24 who correctly identified ways of preventing sexual transmission of HIV and reject major misconception about HIV transmission from 72.3% at base year *(BSS 2012)* to 76.2% in 2017. However, the result for men of the same age has indicated a decline from 79.8% at base year to 76.3%. The results can be attributed to a diverse BCC strategy that included peer education and intergenerational dialogues, IEC material distribution, and radio programming. SLaDA intensified its BCC campaign utilizing multiple channels to meet the information needs of target priority groups across the country. The effective utilization of the mass media including radio, newspapers, internet and other social media platforms to disseminate BCC messages on correct and consistent condom use to prevent HIV and other STIs and cross cutting messages like GBV and girl child education played a pivotal role in the BCC intervention. SLaDA also engaged both state and non-state actors in its BCC activities as a strategy towards strengthening collaborative partnership with key stakeholders.

***High turnover of IPs Finance Staff:*** The Finance personnel of implementing partners have low capacity to manage the finance portfolio of the CBO as clearly highlighted through all KPMG assessments. This is compounded by the fact that the positions are not full time, hence staff is only paid a stipend. Retention of high level finance personnel for better financial management of resources is, therefore, not possible. Technical assistance was provided to sub-grantees especially to those whose finance officers did not have sufficient accounting/finance knowledge and/or who as a result of the high finance staff turnover could

[29] Statistics Sierra Leone (SSL) and ICF International. 2014. Sierra Leone Demographic and Health Survey 2013.

not retain the staff that had been previously trained. In 2015, refresher training on financial management procedures was conducted for the 45 sub-grantees from Phase I, as a response to the observations noted from monitoring exercises and from the review of liquidation that had been submitted that showed weak areas to be addressed. The objectives were to provide support to sub-grantees to comply with the financial and contractual requirement of the fund, supervise and control the absorption of the funds according to the plan and to provide technical assistance to sub-grantees.

**Role of other agencies in the HIV/AIDS arena**

Since 2005, over three hundred agencies are engaged in the HIV/AIDS response countrywide (UNAIDS, 2005). HIV/AIDS implementation in Sierra Leone is principally funded by Global funds, KfW, Christian Aid while UNAIDS provides technical support. To avoid duplication and maximise the utilisation of available resources, donors in agreement with government are funding specific activities. Most of these are in consonance with the National Implementation plan. In the HIV/AIDS arena, in addition to other key capital investments, the Global Fund is providing funds for the procurement of ARVs, providing livelihood support to people living with HIV. UNFPA is key in the procurement of free male and female condoms.

## ➢ Relevance

The objectives and outputs of the HAPP III are consistent with the evolving needs and priorities of the beneficiaries, partners, and stakeholders. Further, the programme is aligned to HIV and AIDS, SRHR, GBV, and FGC conventions, treaties, policies and strategies at international, regional and national levels. Among the global commitments are those emanating from the Millennium Development Goals (MDGs) Special Session on Children documents the Convention on The Rights of The Child - World Fit for Children Declaration and Plan of Action.[30] The Sustainable Development Goals (SDGs) build on the work of the MDGs with the aim of eradicating all forms of poverty, and promote prosperity while protecting the planet.[31] Additionally, HAPP III contributed to the requirements of the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) often described as an international bill of rights for women and the elimination of FGC. [32]

At continental and regional levels, members of the African Union, including Sierra Leone, have agreed on the African Charter on the Rights and Welfare of the Child[33] which stresses the need to end early marriages and provide equal access to information on SRHR between the rural and urban youths; and the revised Maputo Plan of Action 2016-2030 providing a framework to achieve universal access to comprehensive sexual and reproductive health rights and services in Africa in the post-2015 period. It was developed by the African Union Commission and follows on from the Maputo Plan of Action 2007-2015.[34]

A number of policies and strategies guide health service provision in Sierra Leone. The National Strategic Plan on HIV/AIDS 2016-2020[35] charts the roadmap for the national HIV and AIDS response in Sierra Leone, The Health Sector Recovery Plan 2015-2020 is framed around the vision of the Ministry of Health and

[30] UNICEF, Millennium Development Goals (MDGs) Special Session on Children documents the Convention On The Rights Of The Child

[31] UN, 2016. Sustainable Development Goals.

[32] UN General Assembly 1979. Convention on the Elimination of all forms of Discrimination Against Women.

[33] African Union, 1999. The African Charter on the Rights and Welfare of the Child.

[34] African Union, 2016. Maputo Plan of Action 2016-2030

[35] National AIDS Secretariat, 2015. The National Strategic Plan on HIV/AIDS 2016-2020 – Rapid response Initiative to Ending HIV as a Public Health and Development Problem.

Sanitation and is aligned with the broader national rebuilding efforts across the nation's various sectors.[36] The Plan contributes to the development of Sierra Leone as articulated in the Agenda for Prosperity 2013-2018.[37] The Agenda for Prosperity is hinged on eight pillars[38], three of which speak to the activities implemented by HAPP III. The third Pillar, accelerating Human Development, seeks to develop human capital, to empower people to reduce poverty, and to accelerate the achievement of the Millennium Development Goals following significant strides 2008-12. Human development is accelerated through improving education quality and access, providing extensive health services, controlling HIV/AIDS, providing safe water and improved sanitation, population policy including reducing migration to the cities and slowing fertility, and mainstreaming gender parity. The sixth Pillar on Social Protection, aims to reduce poverty, inequality and vulnerability to risks by implementing the 2011 National Social Protection Policy, to complement the effects of economic growth in building resilience. Pillar 8 – Gender and Women's Empowerment – aims at empowering women and girls through (a) education, reducing socio-economic barriers and supporting formal and non-formal education; (b) increasing their participation in decision-making in public, private, and traditional institutions, and access to justice and economic opportunities; (c) strengthening prevention and response mechanisms to violence against women and girls; and (d) improving the business environment for women, with access to finance and capacity development.

Further, the Ministry of Health and Sanitation developed the Sierra Leone Basic Package of Essential Health Services 2015-2020**[39]** whose goal is to maintain and improve the health of all citizens of Sierra Leone by defining a functional and resilient national health system, which delivers efficient, high quality primary and secondary health care services that are accessible, equitable and affordable for all. It emanates from the Ministry of Health and Sanitation's core principle that health is a human right, and represents a firm commitment from the government of Sierra Leone to improve the health of all citizens of Sierra Leone.

The National HIV and AIDS Commission Act 2011 was enacted to establish the National HIV and AIDS Commission (NAC) which is responsible for making policies for all HIV and AIDS related services in the country. The Act makes provision for the monitoring of the HIV prevalence and contains penalties for discriminatory acts against those infected and affected by HIV and AIDS. The NAC and the National HIV/AIDS Secretariat (NAS)[40] have been established in the Office of the President with the responsibility of providing leadership in coordinating, monitoring and mobilising resources for the national response. With the support of the key stakeholders, NAS is providing strategic direction for the national multi-sectoral and decentralized response in the programmatic areas of HIV prevention, treatment of HIV and other related conditions, care and support, policy and advocacy. The Prevention and Control of HIV and AIDS Act, 2007 provides for the prevention, management and control of HIV and AIDS, for the treatment, counselling, support and care of persons infected with, affected by or at risk of HIV and AIDS infection and for other related matters.[41] Finally, The National HIV/AIDS Policy 2002[42] lays the foundation of HIV and AIDS programming and implementation of interventions. HAPP III activities are geared towards reducing

[36] Ministry of Health and Sanitation, 2015. Health Sector Recovery Plan 2015-2020.
[37] Government of Sierra Leone (2013). The Agenda for Prosperity – Road to middle income status. Sierra Leone's third generation poverty reduction strategy paper (2013 – 2018)
[38] Government of Sierra Leone, The Agenda for Prosperity – Road to Middle Income Status; *Sierra Leone's Third Generation Poverty Reduction Strategy Paper (2013 – 2018)*
[39] Ministry of Health and Sanitation, 2015. Sierra Leone Basic Package of Essential Health Services 2015-2020.
[40] The NAS is the Executing Agency of the HAPP III grant with a coordinator in charge of project implementation and operation.
[41] Government of Sierra Leone, 2007. The Prevention and Control of HIV and AIDS Act, 2007
[42] Government of Sierra Leone, 2002. The National HIV/AIDS Policy.

new HIV infections and the spread of HIV, the prevention of unwanted pregnancies, and addressing stigma and discrimination directed at PLHIVs.

The Programme was very relevant as it achieved its intended purpose as confirmed by the findings of the evaluation. The outcome and outputs of the programme were highly achieved. These encompass curbing risky sexual behaviour; improved HIV knowledge and misconceptions; increased use of condoms with regular and non-regular partners; reduction in stigmatization and discrimination against PLHIV; and a reduction in traditional practices like FGC, and GBV. Before the implementation of HAPP III, condom use for example, was regarded as a taboo due to religious but this has changed through community sensitisation on the hazards associated with none use and the benefits thereof.

## ➢ Sustainability

Sustainability is concerned with measuring whether the benefits of an activity are likely to continue after donor funding and some aspects of community ownership. The evaluation noted that strategies put in place for HAPP III are working and can continue based on the benefits accrued to date from the interventions.

### (i) Capacity development of community members and leaders

Communities have been at the heart of programme implementation in the various components of HAPP III. Experience from other countries has shown that engaging community members to play a lead role in solving community problems yielded positive results at all levels. HAPP III employed intergenerational dialogue where community members of varying ages and levels were brought together to have frank discussions on HIV/AIDS, GBV, FGC and SRH issues, leading to the design of community owned strategies to address identified challenges. These culminated, for example, in the formulation of FGC bye-laws and its associated penalties enforced by the community. The results of this study have shown successes at outcome level. Although other players could be contributing in their own ways, yet the overall national success cannot be fully explained without mentioning the contribution of HAPP III.

HAPP III has worked well with community structures; community based organisation (CBOs) to alleviate the situation of vulnerable girls and women together with people living with HIV/AIDS. A component of the project used the Impact Mitigation Funds to create the enabling space for self-fulfilment of the vulnerable population. The results of this implementation have been distilled in the most significant change stories highlighted in this report.

SLaDa has also worked through already established marketing agents to promote the availability of Protector Plus condoms in communities. These institutions will continue to ensure the availability of the product while the sensitisations on its use by community members are creating the demand.

From the above, it could be seen that the communities have the potential to continue on this implementation if given a slight financial boost. Responses from the FGDs suggest that If NAS continue to have community members at the core of activities, it will increase their confidence and at the same time prepare the climate for a smooth take over in the event funds run dry.

### (ii) Intergenerational Dialogue at Community level

Intergenerational dialogue is a community driven initiative that brings together community members to discuss sensitive issues that affect their communities. On FGC, for instance, communities established

MOUs and enforceable by-laws that enhance the implementation the program. The structures included the local chiefs, mummy queens, the *Sowes* (initiators), the religious leaders, youth leaders, and the community peer educators and facilitators who monitor the community to adhere to the set bylaws. These leaders formed follow up teams that monitors the adherence to the by-laws to ensure that nobody initiates girls below 18 years or women above 18 years without their free consent which has resulted to reducing FGC in the communities. The communities own the programme and ensure its success.

Established Village Savings and Loan Scheme can be used to sustain the gains of the programme by using these groups as platforms for IGDs on HIV and AIDS, SRHR, and FGC. The community is directly involved in the running of the project and linking members to support groups where necessary.

(iii) **Working through Community Based Organisations**

Implementing Partners for HAPP III are Community Based Organisations (CBOs) and local NGOs based in the communities they are working in. Mobilising communities to gather for sensitisation and outreach activities are easily facilitated due their presence in the community. IPs are supported by community facilitators in organising community sessions which are delivered within the community. Due to their presence in the community, IPs employ frequent on site-visit monitoring mechanism to beneficiaries of the project livelihood support to ensure that they are using the resources given to them prudently and also assess progress. This ensures continued interaction between the organisations and beneficiaries of the programme. Programme activities are carried out within the community making the programme efficient and effective in its utilisation of time and financial resources.

Implementing Partners within the same community use a coordinated approach to service provision in areas of common interest. Further, the IPs implement their activities within government parameters as they work with the Ministry of Health and Sanitation and the Ministry of Social Welfare, Gender and Children's Affairs.

## 5. HAPP III Best Practices/Lessons Learnt

A number of good/best practices can be drawn from the implementation of HAPP III, from which some lessons can be drawn that can add value to the implementation of HAPP IV or for replication in the implementation of other national programmes. Having communities at the heart of HIV/AIDS response is an innovative strategy of addressing epidemics. The intergenerational dialogue (IGD) provided the required climate for individuals in their communities to deeply understand the nature of HIV/AIDS and its associated problems. The IGDs also created a safe space for communities to fairly and honestly exchange ideas on FGC, its implication on the rights of girls/women and the medical interpretation on its victim. Working with communities has the potential of generating build to last techniques in addressing issues that are of concern in the community. Where community based organisations are playing a role as in HAPP III, it enhances the managerial and leadership competencies of the people in that institution.

HAPP III implementation strategies have also allowed communities to own the project; their collective positions in formulating by-laws have triggered changes in traditional harmful practices on FGC and reduced stigma for PLHIVs. This strategy has and will continue to see communities having a pool of resource persons to respond to could be health emergencies.

The vulnerable that were at the verge of societal exclusion have been revived and their usefulness realised in their communities with the Impact Mitigation funds. Implementation under the IMF has identified the potential of vulnerable individuals and together they have contributed to community development. This has positive implication in nation building.

## 6. Conclusions and Recommendations

**Conclusions**

The HAPP III is implemented in all fourteen districts of Sierra Leone which means programme activities contribute to the national response in areas of HIV/AIDS, GBV, unplanned pregnancy and capacity building for the vulnerable population. HAPP III contributed towards the intended outcome of preventing HIV transmission, unplanned pregnancies and gender-based violence including FGC, and empowerment of girls and women. Condom use with a regular and non-regular partners increased for both women and men age 15-24 years who participated in the HAPP III evaluation. Condom use among young women age 15-24 years at last intercourse with regular partner increased from 4.7% in 2012 to 18.6%, and from 16.5% to 27.6% for young men in the same age group. Similarly, condom use among young women age 15-24 years at last intercourse with non-regular partner increased from 21.5% in 2012 to 27.4%, and from 23.9% to 28.4% for young men in the same age group. SLaDA procured, stocked and sold the Protector Plus condoms to communities complementing the government condom free distribution programme. While the results for condom use are satisfactory, future programmes need to do more in condom sales and ensure that communities have easy access to condoms. Sentiments expressed from FGDs indicate that while male condoms were available for free and for sale, female condoms were not.

The Programme reduced the percentage of women and men that stigmatize people living with HIV. Forty-seven percent of respondents age 15-24 years disagreed with the statement that people with the AIDS virus should be ashamed of themselves. The result for the base year (BSS 2012) was 65% and the HAPP III target was 45%. Even though the target was not achieved, the rate of achievement of 96% is highly satisfactory. The results of this evaluation and a review of literature shows that stigma is still being experienced in Sierra Leone.

The percentage of mothers with at least one daughter who do not intend to have their daughter(s) circumcised increased from 8.9% in the 2008 SLDHS to 47.5%. This is highly satisfactory. Nevertheless, FGC is a cultural practice that the Government and stakeholders need to continue to address until it is practiced within the dictates of the law. Communities have initiated this process through the by-laws they agreed and acted upon, which can be taken on board at national level. Government can draw from the successes and lessons learnt from the by-laws initiative adopted by communities in addressing FGC and enact legal instruments at national level.

HAPP III contributed to the increase in the percentage of young women and men age 15 to 24 who correctly identify ways of preventing sexual transmission of HIV and reject major misconception about HIV transmission from 72.3% for women (BSS 2012) to 76.2%, surpassing a set target of 75%. However, there is a decline for men age 15-24 years from 79.8% (BSS 2012) to 76.3%. The target for young men of 83% was not achieved and the result is even lower than that for the base year. This indicates that the programme has reached more young women than men. The programme needs to continue with its focus on improving knowledge of HIV and AIDS and to dispel some misconceptions held around disease by targeting both young men and young women.

SLaDa has not satisfactorily achieved its competence indicators especially on diversification of funding sources and increasing efficiency in supplying products. There is a need for the agency to work towards improving the results of the three competence indicators.

Monitoring tools and systems for HAPP III are in place for the collection of quantitative data. The IMF has adopted an electronic data collection system using mobile data for timely data collection, capture and

analysis. However, the focus is more on quantitative data collection at the expense of qualitative data. The programme has limited qualitative results on the programme. These can easily be highlighted through documentation of most significant stories, best practices and lessons learnt bringing to the fore the socio-economic impact of the project.

Overall, the HIV Prevention Programme remains relevant as it addresses specific issues identified as such at national, regional and international levels.

**Key Recommendations**

**Recommendations for NAS, Care and SLaDA**

***Recommendation 1:*** Target HAPP III programme activities to specific districts with high burden of HIV, teenage pregnancy, GBV, and child marriage.

Targeted programming is cost effective and accrues higher yields. Working with the 21 implementing partners identified as effective in HAPP III, nonetheless HAPP IV can focus on districts with high burden of HIV and other sexually transmitted infections, teenage pregnancy, GBV, and child marriage. Condom sales and advocacy activities remain at national level, utilising structures and systems established during the implementation of HAPP III.

***Recommendation 2:*** SLaDA needs further support for capacity development before it is weaned off as an independent agency.

SLaDA has not achieved a high result on the three HAPP III indicators set for the assessment of organisational competence. Over the duration of HAPP III implementation, the agency has not secured additional funding; has not reached at least 90% in the sale of the Protector Plus condom; and efficiency in the CYP is inconclusive. Although SLaDA has made meaningful internal arrangements this far, the agency needs support for capacity development in social marketing, proposal writing, identifying partners to form consortia with in submitting bids, further strengthen its structures and systems (development of a National Strategy; review of the National Communication Strategy; and review the organogram and address staffing gaps). Even though SLaDA has recently revised its organogram, the review established that there are other relevant positions and personnel requirements that have been identified (for example Communications Manager; Health products expert) for the efficient running of the organisation.

***Recommendation 3:*** Increase HAPP III funding to enable continuous commitment to building the capacity of implementing partners.

The evaluation established that IPs lose staff especially in the area of finance due to lack of incentives. There is need to revisit remunerations for project staff of the IPs, which will in turn improve staff retention and adequate programme and financial management. Improve staffing levels and build their capacity where needs are identified.

**Recommendation for the Government of Sierra Leone**

***Recommendation 4****: Strengthen* the advocacy component of the project by increasing engagement with government and key stakeholders for Sierra Leone to adopt a 'Zero Tolerance' positon on FGC.

FGM/C constitutes a form of violence against girls and women that must be stopped. Sierra Leone has one of the highest rates of FGM/C worldwide, affecting almost 90%[43] of women aged 15-49 years. Every year, Sierra Leone joins the world in commemorating the International Day of 'Zero Tolerance for Female Genital Mutilation'. The Government has taken plausible step by being a signatory to international conventions and treaties relevant to safeguard girls' and women's human rights and to protect their health, and this is only a first step. The HAPP IV can build on this goodwill and advocate for 'Zero Tolerance' to FGC with the ultimate goal of encouraging the Government to sign on international FGC laws and their domestication.

**Recommendation for KfW Development Bank**

***Recommendation 5:*** Commission a Value for Money audit[44] for HAPP III to ascertain the management of the program's financial, human and physical resources.

A Value for Money audit has not been commissioned from HAPP I to date. Secondly, the efficiency of the CYP need to be assessed over a period of time to ascertain trends. No conclusive trend has derived from the data availed in HAPP III.

[43] https://sl.one.un.org/2017/02/06/statement-by-the-united-nations-in-sierra-leone-on-the-international-day-of-zero-tolerance-for-female-genital-mutilation/

[44] https://home.kpmg.com/sg/en/home/services/advisory/risk-consulting/internal-audit-services/value-for-money.html Value For Money (VFM) audits can be defined as an objective, professional and systematic examination of systems and procedures that management has established to ensure:

- financial, human and physical resources are managed with due regard to economy, efficiency and effectiveness; and
- accountability relationships are served.

## 7. Annexes

### Annex 1: Documents Reviewed


1. Government of Sierra Leone (2013). The Agenda for Prosperity – Road to middle income status. Sierra Leone's third generation poverty reduction strategy paper (2013 – 2018).
2. Government of Sierra Leone, 2009. National Youth Commission Act No.11, of 2009
3. Government of Sierra Leone, 2007. The Prevention and Control of HIV and AIDS Act, 2007
4. Government of Sierra Leone, 2003. Sierra Leone National Youth Policy launched Monday June 30th 2003.
5. Government of Sierra Leone, 2002. The National HIV/AIDS Policy.
6. Ministry of Health and Sanitation, 2015. Sierra Leon Basic Package of Essential Health Services 2015-2020.
7. Ministry of Health and Sanitation, 2015. Health sector Recovery Plan 2015-2020.
8. Ministry of Health and Sanitation, 2015. Sierra Leon Basic Package of Essential Health Services 2015-2020.
9. National AIDS Secretariat, 2015. The National Strategic Plan on HIV/AIDS 2016-2020 – Rapid response Initiative to Ending HIV as a Public Health and Development Problem.
10. NAS - Terms of Reference
11. NAS, 2017. HIV/AIDS Prevention Program III Progress Report January 2017 – June 2017
12. NAS, 2016. HIV/AIDS Prevention Program III Progress Report January 2016 – June 2016
13. NAS, 2016. HIV/AIDS Prevention Program III Progress Report July 2016 – December 2016
14. NAS, 2015. HIV/AIDS Prevention Program III Progress Report July 2015 – December 2015
15. NAS, 2015. HAPP III Separate Agreement (Project Document).
16. Network of HIV Positives in Sierra Leone, 2015. People Living with HIV Stigma Index.
17. Statistics Sierra Leone, 2016. 2015 Population and Housing Census: Summary of Final Results – Planning a better Future.
18. Statistics Sierra Leone (SSL) and ICF International. 2014. Sierra Leone Demographic and Health Survey 2013. Freetown, Sierra Leone and Rockville, Maryland, USA: SSL and ICF International.
19. Statistics Sierra Leone, 2008. Sierra Leone Demographic and Health Survey 2008. ICF International.
20. The African Union, 1999. The African Charter on the Rights and Welfare of the Child.
21. The African Union, 2003. Maputo Protocol, Mozambique - July 2003.
22. The OECD/DAC Criteria for International Development Evaluations: An Assessment and Ideas for Improvement http://www.ipdet.org/files/Publication-The_OECD-DAC_Criteria_for_International.pdf
23. UNAIDS, 2017. Global HIV Statistics. Fact Sheet July 2017.
24. UNDP, 2016. Human Development Report.
25. UNICEF, Millennium Development Goals (MDGs) Special Session on Children documents the Convention On The Rights Of The Child.
26. UN, 2016. Sustainable Development Goals.
27. UN General Assembly 1979. Convention on the Elimination of all forms of Discrimination Against Women.
28. WHO, 2008. Eliminating female genital mutilation: an interagency statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO.

## Annex 2: Key Performance indicators of the HAPP Project

| Indicators | Target for 2013 – 2017 | Results by 31st October, 2017 | |
|---|---|---|---|
| Increased condom use among 15-24 year olds at last intercourse with regular partner: | 4.7% (women)<br>16.5% (men)<br>*(BSS 2012)* | **18.6%**<br>**27.6%** | |
| Increased condom use among 15-24 year olds at last intercourse with non-regular partner: | 21.5% (women)<br>23.9% (men)<br>*(BSS 2012)* | **27.4%**<br>**28.4%** | |
| Reduce % of women and men that stigmatize people living with HIV from 65% to 45% (agree with the statement that people with the AIDS virus should be ashamed of themselves (BSS 2012: p.61)) | 65%<br>*(BSS 2012)* | **47%** | |
| Increase of mothers with at least one daughter who do not intend to have their daughter(s) circumcised from | 8.9%<br>*(SLDHS 2008)* | **47.5%** | |
| Increased % of young women and men age 15 to 24 who correctly identify ways of preventing sexual transmission of HIV and reject major misconception about HIV transmission: | 72.3% (women)<br>*(BSS 2012)*<br>79.8% (men)<br>*(BSS 2012)* | **76.2%**<br>**76.3%** | |
| **Indicators** | **Target for 2013 – 2017** | **Results by 31st October, 2017** | **Result as a % Target by October 31st 2017** |
| Number of couples protected against STIs, HIV and unplanned pregnancies during one year (4 Mio. :120) | 133,333 | 90,576 | 68% |
| Increase number of MOUs/ field level agreements reflecting actions to address GBV | 160 | 150 | 94% |
| Number of vulnerable girls and women who receive support by type and age (from 3,610 to 6,000) | 8,000 | 8,781 | 110% |
| Increase number of OVCs (0-17 years) receiving support by gender (nationwide data) from 3,150 to 6,000 | - | 1,262 | - |
| Procurement, stocking & distribution of 16m condoms (annual target of 4m over 4 years | 16,000,000 | 12,018,832 | 75% |
| Increased efficiency in supplying products (costs per CYP) | 0 | 71 | |
| Diversification in sources of funding and products: identify at least one additional source of funding | 1 | 0 | |

## Annex 3: Characteristics of the Sample

*Background Characteristics of Young People in Survey age 15-25 Years*

| Characteristic | Number of Young People | | | |
|---|---|---|---|---|
| | Number of women | Percentage | Number of Men | Percentage |
| **Total** | **617** | **100.0** | **599** | **100.0** |
| Region | | | | |
| **Western Area** | 148 | 24.0 | 137 | 22.9 |
| **North** | 145 | 23.5 | 113 | 18.9 |
| **East** | 92 | 14.9 | 155 | 25.9 |
| **South** | 232 | 37.6 | 194 | 32.4 |
| Age | | | | |
| **15-19** | 392 | 63.5 | 355 | 59.3 |
| **20-14** | 225 | 36.5 | 244 | 40.7 |
| Marital/Union status | | | | |
| **Currently married** | 121 | 19.6 | 72 | 12.0 |
| **Co-habiting** | 20 | 3.2 | 16 | 2.7 |
| **Divorced** | 4 | 0.6 | 7 | 1.2 |
| **Separated** | 2 | 0.3 | 4 | 0.7 |
| **Widow/Widower** | 2 | 0.3 | 1 | 0.2 |
| **Never married/in union** | 468 | 75.9 | 499 | 83.3 |
| Education | | | | |
| **None** | 101 | 16.4 | 102 | 17.0 |
| **Primary** | 60 | 9.7 | 53 | 8.8 |
| **Junior Secondary** | 255 | 41.3 | 182 | 30.4 |
| **Vocational/Commercial/Nursing** | 191 | 31.0 | 237 | 39.6 |
| **Technical/Teacher training** | 4 | 0.6 | 7 | 1.2 |
| **Higher** | 6 | 1.0 | 18 | 3.0 |
| Religion | | | | |
| **Christianity** | 221 | 35.8 | 197 | 32.9 |
| **Islam** | 396 | 64.2 | 401 | 66.9 |
| **Traditional** | 0 | 0.0 | 1 | 0.2 |
| Main Occupation | | | | |
| **Petty trading** | 115 | 18.6 | 81 | 13.5 |
| **Crop Farming** | 63 | 10.2 | 65 | 10.9 |
| **Animal Farming** | 1 | 0.2 | 1 | 0.2 |
| **Fishing** | 1 | 0.2 | 5 | 0.8 |
| **Housewife** | 33 | 5.3 | 4 | 0.7 |
| **Truck driver** | 3 | 0.5 | 19 | 3.2 |
| **Civil servant** | 6 | 1.0 | 20 | 3.3 |
| **Student** | 395 | 64.0 | 404 | 67.4 |

*Background Characteristics of Women in Survey age 25-49 years*

| Background Characteristics | Number of women | |
|---|---|---|
| | Number of women | Percentage |
| **Total** | **446** | **100.0** |
| Region | | |
| **Western Area** | 87 | 19.5 |
| **North** | 94 | 21.1 |
| **East** | 137 | 30.7 |
| **South** | 128 | 28.7 |
| Age | | |
| **25-29** | 141 | 31.6 |
| **30-34** | 87 | 19.5 |
| **35-39** | 101 | 22.6 |
| **40-44** | 62 | 13.9 |
| **45-49** | 55 | 12.3 |
| Marital/Union status | | |
| **Currently married** | 320 | 71.7 |
| **Divorced** | 12 | 2.7 |
| **Separated** | 23 | 5.2 |
| **Widow/Widower** | 29 | 6.5 |
| **Never married/in union** | 62 | 13.9 |
| Education | | |
| **None** | 203 | 45.5 |
| **Primary** | 69 | 15.5 |
| **Junior Secondary** | 63 | 14.1 |
| **Vocational/Commercial/Nursing** | 89 | 20.0 |
| **Technical/Teacher training** | 12 | 2.7 |
| **Higher** | 10 | 2.2 |
| Religion | | |
| **Christianity** | 132 | 29.6 |
| **Islam** | 312 | 70.0 |
| **Traditional** | 2 | 0.4 |
| Main Occupation | | |
| **Petty trading** | 202 | 45.3 |
| **Crop Farming** | 84 | 18.8 |
| **Animal Farming** | 1 | 0.2 |
| **Housewife** | 70 | 15.7 |
| **Civil servant** | 20 | 4.5 |
| **Student** | 45 | 10.1 |
| **Other** | 24 | 5.4 |

## Annex 4: Evaluation Matrix

| Desired Data | Method of data collection | Tool | Respondent category/data source | Targets/coverage |
|---|---|---|---|---|
| 1. Increased condom use among 15-24 year olds at last intercourse with regular partner:<br>**a.** 4.7% to 8% (women): 16.5% to 20% (men). | HH Survey<br><br>Literature review<br>FGDs | Questionnaire<br><br>Literature Review<br>FGD Guide | Females and males age 15-24 in HH<br>SLDHS; BSS | 1,200 respondents age 15-24 years from 7 districts from the four regions |
| 2. Increased condom use among 15-24 year olds at last intercourse with non-regular partner:<br>b. 21.5% to 25% (women): 23.9% to 28% (men). | HH Survey<br><br>Literature review<br>FGDs | Questionnaire<br><br>Literature Review<br>FGD Guide | Females and males age 15-24 in HH<br>SLDHS; BSS | 1,200 respondents age 15-24 years from 7 districts from the four regions |
| 3. Increase of mothers with at least one daughter who do not intend to have their daughter(s) circumcised from 8.9% (DHS 2008) to 15% from DHS 2013 levels | HH Survey<br><br>Literature review | Questionnaire<br><br>Literature Review | Females age 25-49 years in HH<br>SLDHS; BSS | 300 respondents age 25-49 years from 7 districts from the four regions |
| 4. Reduce % of women and men that stigmatize people living with HIV from 65% to 45% (agree with the statement that people with the AIDS virus should be ashamed of themselves (BSS 2012: p.61)) | HH Survey<br><br>Literature review | Questionnaire<br><br>Literature Review | Females and males age 15-24 years in HH<br>SLDHS; BSS | 1,200 respondents age 15-24 years from 7 districts from the four regions |
| 5. Increased % of young women and men age 15 to 24 who correctly identify ways of preventing sexual transmission of HIV and reject major misconception about HIV transmission;<br>a. 72.3% to 75% for women (BSS 2012);<br>b. 79.8% to 83% for men (BSS 2012) | HH Survey<br><br>Literature review | Questionnaire<br><br>Literature Review | Females and males age 15-24 years in HH<br>SLDHS; BSS | 1,200 respondents age 15-24 years from 7 districts from the four regions |
| Increased % of young women age 15 to 24 years who reject major misconception about HIV transmission from 26.7% (BSS 2013) | HH Survey<br><br>Literature review | Questionnaire<br><br>Literature Review | Females and males age 15-24 years in HH<br>SLDHS; BSS | 1,200 respondents age 15-24 years from 7 districts from the four regions |
| Increased % of young men aged 15 to 24 who reject major misconception about HIV transmission from 38% (BSS 2012) | HH Survey<br><br>Literature review | Questionnaire<br><br>Literature Review | Females and males age 15-24 in HH<br>SLDHS; BSS | 1,200 respondents age 15-24 years from 7 districts from the four regions |

| Desired Data | Method of data collection | Tool | Respondent category/data source | Targets/coverage |
|---|---|---|---|---|
| Increase number of couples protected against STIs, HIV and unplanned pregnancies during one year. Progress Reports (4 Mio. :120) | Literature Review | Literature review | Programme Reports | National |
| Increase number of MOUs/ field level agreements reflecting actions to address GBV | Literature review<br>KII | Literature review<br>KII Guide | Programme Reports<br>NAS, Care, SLaDA, IMF | National |
| Increase number of vulnerable girls and women who receive support by type and age from 3,610 to 6,000 | Literature review | Literature review | Programme Reports | National |
| Increase number of OVC (0-17 years) receiving support by gender (nationwide data) from 3,150. Programme Reports | Literature review | Literature review | Programme Reports | National |
| Procurement, stocking and distribution of 16m condoms (annual target of 4m over 4 years) | Literature review | Literature review | Programme Reports | National |
| Increased efficiency in supplying products (costs per CYP) | Literature review<br>KII | Literature review<br>KII Guide | Programme Reports<br>NAS, Care, SLaDA, IMF | National |
| Diversification in sources of funding and products: identify at least one additional source of funding | Literature review<br>KII | Literature review<br>KII Guide | Programme Reports<br>NAS, Care, SLaDA, IMF | National |

## Annex 5: List of Respondents

| Name | Position | Organisation/Community |
|---|---|---|
| Abdul Sesay | Deputy Director | National AIDS Secretariat |
| Christiana Momoh | IMF Team Leader | CARE International |
| Ruth Marcella Davies | National Director | SLaDA |
| Michaella Famajai | HR/Procurement Officer | SLaDA |
| Shekuh Kanneh | M&E Officer | SLaDA |
| Rakiatu Mansaray | Financial Specialist | KPMG |
| Samba Bockarie | National Programme Officer | UNAIDS |
| | | |
| **EAST REGION – Kenema and Kailahun Districts** | | |
| Mr Mohamed M. Tailu<br>Jimmy Johnson<br>Alhaji Yusuff A. Kallon<br><br>Feika Francis Abdulai | | Centre for Encouraging, Caring and Supporting HIV People (CECSHIP)<br>National Breastfeeding Advocacy Organisation-Sierra Leone (NABFAO-SL) |
| Mr Momoh A. Moseray | Community Leader | Kpai Community |
| Mr Tejan | HIV Counsellor | Kenema Government Hospital |
| Bintu Bangura | PLHIV | Kenema District |
| | | |
| **SOUTH REGION – Bo and Pujehun Districts** | | |
| | Project Director | Kaheimoh Youth Development Organization (KYDO) |
| Francis A. Musah | Project Officer | Pure Heart Foundation (P.H.F) |
| Mohamed Jalloh | Project Director | Community Empowerment & Development Agency (CEDA) |
| Frank Kposowa | Project Director | Bagbwe Women's Development Organization |
| | | |
| **NORTH REGION – Bombali and Tonkolili Districts** | | |
| Sheik Abu-Bakr Sankoh | Imam, Manepeh Village | Chiefdom: Kolifa Rowala |
| Mr. Jamil Musa | Program Manager | Tinap For Peace And Development Organization (TIPDO) |
| Racheal Sallay Sesay | Representative | Christians Community Development Program (CCDP) |
| Mr. Edward Christopher Sesay | TIPDO Community Facilitator | Chiefdom: Kolifa Rowala |
| Ya Koloneh Sesay Gbonsho | Digba (Head Of Sowes) | Chiefdom: Gbendebu |
| Beatrice Alice Lebbie | MCH Aid Nurse and HIV/AIDS Counsellor | Chiefdom: Gbendebu |
| Miss Mariatu Tarawally | Maternal and Community Health Aid Nurse/ HIV/AIDS Counsellor | Chiefdom: Makeni Lol |
| | | |
| **WESTERN AREAS – Wellington, Kissy and** | | |
| Madam Salamatu Kanu | | Girls Institute For Self-Achievement Women Development Organization (GISAWDO) |
| Madam Aminata Kamara | Influential Women Leader | Wellington |
| Malvin Success Kanteh | President | Youth Club |
| Jeneba Conteh | | Most Significant Story Contributor |
| Mariatu kamara | | Most Significant Story Contributor |
| Mariama Seray Fofanah | | Most Significant Story Contributor |

## Annex 6: IMF Implementing Partners

| Implementing Partner | District |
|---|---|
| **1.** Society For Women and AIDS in Africa Sierra Leone Chapter (SWAASL) | Kailahun |
| **2.** Fambul Initiative Network | Kambia |
| **3.** ABSAL Women Development Organization | |
| **4.** Daughters Vocation Training Centre (D.V.T.C.) | Kono |
| **5.** Community Advocacy and Development Agency (CADA) | Bonthe |
| **6.** Emerging Women Development Organisation | |
| **7.** Community Empowerment & Development Agency (CEDA) | Pajehun |
| **8.** Asphaleia Kabor Project Sierra Leone | Port Loko |
| **9.** Concern for the Development of Women and Children | |
| **10.** Bagbwe Women's Development | Bo |
| **11.** Badjia Women's Development Association (BADWA) | |
| **12.** Pure Heart Foundation | |
| **13.** Community Action to Restore Lives (CARL) | Moyamba |
| **14.** Potential Rescue and Development Centre – Sierra Leone (PREDEC) | Konaidugu |
| **15.** Kaheimoh Youth Development Organization | Pujehun |
| **16.** German Kooperation – Sierra Leone (Geiko) | Bombali |
| **17.** Tinap for Peace and Development Organization (TIPDO) | |
| **18.** Christian Community Development Programme (CCDP) | Tonkolili |
| **19.** National Breastfeeding Advocacy Organization Sierra Leone (NABFAO/SL) | Kenema |
| **20.** Centre for Encouraging, Caring and Supporting HIV People (CECSHIP) | |
| **21.** Planned Parenthood Association of Sierra Leone | Konaidugu |
| **22.** Girls Institute for Self-Achievement Women development Organization (GISAWDO) | |

## Annex 7: Terms of Reference

REQUEST FOR PROPOSALS (TECHNICAL AND FINANCIAL)
End Phase Evaluation of the HIV Prevention Programme III (HAPP III)in Sierra Leone
The National HIV/AIDS Secretariat (NAS) acting on behalf of the German Development Bank (KfW) as the Executing Agency of the HAPP III Grant invites proposals from consultancy firms to undertake a final evaluation of the HIV Prevention Programme III (HAPP III) implemented by CARE Sierra Leone, ending in December 2017. The date for submission of Technical and Financial Proposals is August 25, 2017.

**Program Background**

The German Government through KfW has been supporting the national response to HIV and AIDS through its HIV/AIDS Prevention Programme (HAPP) since 2006 with the overall goal to contribute to an improved sexual and reproductive health of Sierra Leone population; with the expected outcome of preventing of HIV, unplanned pregnancies and gender-based violence including female genital cutting and empowerment of girls and women. This program is being implemented country wide and the current financing for the HAPP III since 2013 amounting to EUR 6 Million is ending in December 2017.

**The current programme (HAPP III) focuses on;**

i. Social marketing of condoms and behaviour change communication measures implemented by CARE through the Sierra Leone Social Marketing and Development Agency (SLaDA)
ii. Providing grants to support civil society organisations (NGOs and CBOs) interventions to mitigate the impact of HIV/AIDS and gender-based violence (GBV) including Female Genital Cutting (FGC) managed by KPMG.

**The result of the program is measured by four indicators:**

1. Use of condoms among young people of 15-24 years at last sexual contact
2. Cost efficient realization of Social Marketing Component
3. Percentage of mothers with at least one daughter who do not intend to have their daughter(s) circumcised
4. Reduction of stigmatization of HIV/AIDS positive people (Accepting Attitude to PLHIVs)

**Design of the HAPP III**

The strategy of the programme is to integrate HIV and GBV issues into the larger Sexual Reproductive Health and Rights (SRHR). The approach uses Social Marketing and Impact Mitigation. Both approaches are directly linked to each other to create strong synergies.

The Social Marketing Component (including contraceptive commodity supply and distribution) and Behavior Change Communication and Information Education and Communication (BCC/IEC) activities are implemented by a newly established independent Social Marketing Agency (NGO) called SLADA, which is mentored by CARE international. At the end of HAPP III, a target of 16 million condoms would have been sold with a projected income of about 54.000 Euros to be re-invested into the programme.

The Impact Mitigation Fund (IMF) Component supports local initiatives through community based organisations (CBOs) and NGOs to mitigate the impact of HIV/AIDS and Gender Based Violence (GBV) and to empower the young generation, especially girls, for improved SRHR including their economic empowerment. The component adopts several approaches in achieving the objectives of the component such as:
· raising awareness of the population about sexual and reproductive health and rights (SRHR) and including HIV and GBV and their implications on healthy lives,
· contributing to the reduction of vulnerability of women and girls
· implementing strategies to decrease traditional harmful practices and gender based violence using community based approaches

The activities of the Impact Mitigation Fund are coordinated by a steering committee while that for Social Marketing implemented by SLaDA is mentored by CARE. All Districts in the country have benefitted from the HAPP III intervention and the target population is people within the reproductive age category with emphasis on girls and women.

**Objectives and Scope of the Final Evaluation**

The overall evaluation framework for HAPP III will use a mixed methods approach, involving quantitative and qualitative methods. The Final evaluation is slated for the last quarter of 2017.

The draft report is due to reach KfW by 31st December 2017 and the final report by 31st January 2018.

**The overall purpose of the end phase evaluation** will measure improvements in SRHR outcomes (specifically decrease of Risk Contact of HIV, increased use of condoms by 15-24 year old generation, reduced stigmatization against people living with HIV and ratio of mothers who do not intend their daughters to be subjected to FGC). The evaluation shall also provide information on the socio-economic impact of the vulnerable women who receive IMF-support. . Institutional and management capacity as well as the aspect of funding strategies of the Social Marketing Component (SlaDA) are to be evaluated. In addition, the end phase evaluation should generate important lessons learned and inform existing and future KfW programmes using the current project models of Social Marketing and IMF. Relevance, Impact, Effectiveness, Efficiency and sustainability of the program as well as important risks and assumptions should be considered. Options/Recommendations for future similar project strategies and activities should be developed based on the findings of the evaluation.

**The primary questions for the final evaluation are:**

i. Did the programme contribute towards any observed statistically significant changes in decreasing risky sexual behaviour and attitude towards PLHIVs?
ii. Did the programme contribute towards any observed changes in the behaviour of women and opinion leaders towards FGC
iii. What is the probable impact of the Behaviour Change Communication Interventions within the social marketing and IMF interventions on Adolescents and young people?
iv. Did the planned IMF outputs contribute to achieving the programme outcome
v. Is the steering structure of the program appropriate for delivering the required outcome
vi. Is the institutional and managerial capacities of SLADA effective for resource mobilization to guaranty sustainability

vii. Did the programme have any limitations, risks and threats and unintended results?
Quantitative assessment should be based on available information (DHS, other surveys and study reports) complemented by population-based sampling methods to assess changes in the project impact indicators.
Qualitative methods should document the probable mechanisms behind observed quantitative changes together with lessons learned, key success factors and likely efficiency characteristics and options for future interventions.
The evaluation would ensure beneficiary/community participation through the use of participatory methods.

**Scope of Services Requested**

The consulting agency/firm will design and implement an end phase evaluation, fully addressing its objectives and evaluation questions and encompassing the full scope of the evaluation, which includes an overview of available information, the need for specific surveys and studies, as well as developing the overall design and detailed protocol for the household surveys and the qualitative study.

The agency will provide an inception report/technical report that demonstrates correct understanding and interpretation of the objectives and scope of the assignment, explains the methodology (including the sampling design for the household surveys) for the evaluation and gives an action plan with timelines and the data management process.
4
Following approval of the inception report/technical report (specifically the design aspects of the evaluation), the agency will prepare the survey methodology (including a sampling design and its rationale), detailed plan and protocol for collecting, processing and analyzing data.

NAS and CARE will provide all documents relevant to understanding the HAPP III, provide feedback/approve inception report and detailed methodology/protocol and input to the draft evaluation report to be presented and discussed in a workshop.

The selected agency will be required to deliver to NAS the cleaned data sets. The primary deliverable is the final evaluation report to be finalized after the workshop and the feed-back of the commissioning institution NAS, CARE and KfW.

**Expected Deliverables and Timeline (Proposed)**

Activity Expected Timeline
Submission of Proposals (Technical and Financial) August 25, 2017
Award/Signing of Contract September 6, 2017
Draft Evaluation Report December 6, 2017
Response from NAS, CARE and KfW December 19, 2017
Final Report January 31, 2018

**Management of the Evaluation**

The Deputy Director will be the NAS primary point of contact for this assignment. The NAS M&E Specialist and Health Coordinator & Senior Program Officer from CARE will provide technical and managerial input at the various stages of the evaluation.

**Evaluation Team, Skills and Experience**

The Firm should have extensive experience in similar assignments in HIV and AIDS, health and other social science programmes. At least ten (10) years of experience in conducting final evaluations and a solid understanding of Sierra Leone and demonstrate experience leading teams and strong critical analysis and report writing skills required. The Firm requires a multi-disciplinary team providing technical expertise and experience in the fields of Public Health, Social Sciences, Management, Statistics, Monitoring and Evaluation.

**Selection Process**
Technical Proposal
i. Qualification Summary (Maximum 2 Pages)
Describe your firm's interest and capability for undertaking this assignment. Include relevant qualifications, skill sets and experience.
ii. Evaluation Methodology (Maximum 5 Pages)
Propose a design and methodology that takes into account the objectives and scope of the assignment. Work plans and timelines should be included.
iii. Team Members' Profile and Qualifications (Maximum 2 Pages)
Concise abstract of experiences that explains the background and expertise the team members will bring to the evaluation. Include CVs/resumes as attachments.

**References:**

Include a minimum of three references familiar with the quality and reliability of the firm's work. Contact phone number and email address should be provided with a brief description of services provided, and the time frame in which services were provided.
Work Samples:
Provide two written samples of previous work done in the past three years, at least one of which is an evaluation report.
The technical proposal will be graded as follows:
Component Marks
Qualification Summary 20
Evaluation Methodology 60
Team Members' Qualifications 20
TOTAL 100
Financial Proposal
Details of financial offer should be presented in Euros indicating remuneration and reimbursable.

Selection Process
The technical and financial proposals will be evaluated separately. Financial proposals will be opened only for those applicants scoring at least 80%.
The final score will give a weightage of 80% to the technical proposal and 20% to the financial proposal.
NAS will contact shortlisted applicants only, for the next stages in the selection process.
Proposals (both technical and financial in two separate sealed envelopes) shall be placed in a single envelope and clearly marked "Proposal for end phase evaluation of the HIV Prevention Programme III (HAPP III) in Sierra Leone" to reach the address below on or before close of business on August 25, 2017
Director-General

National HIV/AIDS Secretariat (NAS)
15 Kingharman Road, Brookfields, Freetown
SIERRA LEONE

## Annex 8: Evaluation Tools

### *i.* Key informant interview (KII) Guide for NAS, CARE and ***SLaDA***

**Introduction and Consent**

My name is ……I work for PRIMSON Management Services. We have been contracted by the National HIV/AIDs secretariat to do and evaluation of the HAPP III project that started in 2013 to present. The overall purpose of this exercise is to measure improvements in sexual reproductive health (SRHR) outcomes specifically decrease of Risk Contact of HIV, increased use of condoms by 15-24 year old generation, reduced stigmatization against people living with HIV and ratio of mothers who do not intend their daughters to be subjected to FGC. I will be asking you some questions on implementation so far. Your comments are valuable to the overall process.

**A. Relevance**

1. To what extent are the objectives and activities of the HAPP III consistent with the evolving needs and priorities of the beneficiaries, partners, and stakeholders?
2. Is the program adequately addressing the factors influencing individual behaviours and policies?
3. Is the project contributing to addressing condom use, HIV knowledge and misconceptions, stigma and discrimination, traditional practices (FGC), GBV, HIV, and SRHR?

**B. Effectiveness**

4. To what extent were the outcomes, outputs and objectives of the HAPP III achieved?
5. What monitoring and evaluation mechanism were in place? (Was the programme systematically collecting, collating and utilising data?)
6. To what extent were partnerships complementary and synergistic in the implementation of the intervention?
7. What coordination structures and mechanisms were in place – Steering Committee structure, NAS (successes and challenges)?
8. Is the institutional and managerial capacities of SLaDA effective for resource mobilization to guarantee sustainability?

**C. Efficiency**:

9. To what extent did the programme use the least costly resources possible in order to achieve the desired results? (convert inputs (e.g. funds, expertise, time, etc.) to results)
10. How successful was the programme in building on other initiatives or creating new synergies with other programmes?

**D. Sustainability**:

11. To what extent did the project contribute towards building community capacity and leadership in a manner that would lead to community ownership and sustainable results?
12. What sustainability challenges were identified and strategies to mitigate them?

**E. Strategic Positioning**

**13.** *Responsiveness:* How have you aligned HAPP III towards changing priorities at national and regional level?

**14.** *Value Addition:* What added value has been shown by the project to existing government and other donor support?

**Challenges:** What challenges were encountered during the implementation of HAPP III? How were they addressed?

**Lessons Learnt:** What lessons can we draw from HAPP III for future programming?

**Recommendations:** What are your recommendations?

## ii. Key informant interview (KII) Guide for Implementing Partners

**Introduction and Consent**

My name is ……I work for PRIMSON Management Services. We have been contracted by the National HIV/AIDs secretariat to do and evaluation of the HAPPIII project that started in 2013 to present. The overall purpose of this exercise is to measure improvements in sexual reproductive health (SRHR) outcomes→specifically decrease of Risk Contact of HIV, increased use of condoms by 15-24 year old generation, reduced stigmatization against people living with HIV and ratio of mothers who do not intend their daughters to be subjected to FGC. I will be asking you some questions on implementation so far. Your comments are valuable to the overall process.

**A. Relevance**

**1.** Is the project contributing to addressing condom use, HIV knowledge and misconceptions, stigma and discrimination, traditional practices (FGC), GBV, HIV, and SRHR?

**B. Effectiveness**

**2.** To what extent were the outcomes, outputs and objectives of the HAPP III achieved?
**3.** What monitoring and evaluation mechanism were in place? (Was the programme systematically collecting, collating and utilising data?)
**4.** Did the program contribute towards any observed changes in the behaviour of women and opinion leaders towards FGC?
**5.** Did the planned IMF outputs contribute to achieving the program outcome?
**6.** To what extent were partnerships complementary and synergistic in the implementation of the intervention?
**7.** What coordination structures and mechanisms were in place (successes and challenges)?

**C. Efficiency**:

**8.** Could the project have been implemented with fewer resources without reducing the quality and quantity of results?
**9.** How successful was the programme in building on other initiatives or creating new synergies with other programmes?

**D. Sustainability**:

**10.** To what extent did the project contribute towards building community capacity and leadership in a manner that would lead to community ownership and sustainable results?
**11.** What sustainability challenges were identified and strategies to mitigate them?

**Challenges:** What challenges were encountered during the implementation of HAPP III? How were they addressed?

**Lessons Learnt:** What lessons can we draw from HAPP III for future programming?

**Recommendations:**
What are your recommendations?

iii. Key informant interview (KII) Guide for Community Level (Religious leaders; HIV councillor; Retailer/whole sellers; Influential adult women; Youth clubs

**Introduction and Consent**

My name is ……I work for PRIMSON Management Services. We have been contracted by the National HIV/AIDs secretariat to do and evaluation of the HAPPIII project that started in 2013 to present. The overall purpose of this exercise is to measure improvements in sexual reproductive health (SRHR) outcomes→specifically decrease of Risk Contact of HIV, increased use of condoms by 15-24 year old generation, reduced stigmatization against people living with HIV and ratio of mothers who do not intend their daughters to be subjected to FGC. I will be asking you some questions on implementation so far. Your comments are valuable to the overall process.

**A. Relevance**

**1.** Is the project contributing to addressing condom use, HIV knowledge and misconceptions, stigma and discrimination, traditional practices (FGC), GBV, HIV, and SRHR?

**B. Effectiveness**

**2.** How effective was the project in addressing condom use, HIV knowledge and misconceptions, stigma and discrimination, traditional practices (FGC), GBV, HIV, and SRHR?

**3.** Did the program contribute towards any observed changes in the behaviour of women and opinion leaders towards FGC?

**C. Efficiency**:

**4.** Could the project have been implemented with fewer resources without reducing the quality and quantity of results?

**D. Sustainability**:

**5.** To what extent did the project contribute towards building community capacity and leadership in a manner that would lead to community ownership and sustainable results?

**6.** What sustainability challenges were identified and strategies to mitigate them?

**Challenges:** What challenges were encountered during the implementation of HAPP III? How were they addressed?

**Lessons Learnt:** What lessons can we draw from HAPP III for future programming?

**Recommendations:**
What are your recommendations?

## iv. Focus Group Discussion Guide - Women and Men age 15-24 years

My name is ……I work for PRIMSON Management Services. We have been contracted by the National HIV/AIDs secretariat to do and evaluation of the HAPP III project that started in 2013 to present. The overall purpose of this exercise is to measure improvements in sexual reproductive health (SRHR) outcomes specifically decrease of Risk Contact of HIV, increased use of condoms by 15-24 year old generation, reduced stigmatization against people living with HIV and ratio of mothers who do not intend their daughters to be subjected to FGC. I will be asking you some questions on the subject matter. Your individual and collective responses will never be linked with your names. You are at liberty not to respond to certain questions and you may leave the group at any time you choose to. Please register your approval to the process by raising your hand.

| **Indicators** | **FGD Questions** |
|---|---|
| Increased condom use among 15-24 year olds at last intercourse with regular partner: from 4.7% to 8% (women) | Are condoms readily available in your community?<br><br>When do you use a condom? (every time; with regular partner; with non-regular partner).<br><br>If you needed a condom now, would you get it? Discuss (where, cost, challenges)?<br><br>What are your sources of getting condoms?<br><br>Is the situation better today that it was a year ago?<br><br>In your view, what are the ways of promoting condom use in your community? |
| Increased condom use among 15-24 year olds at last intercourse with regular partner: from 16.5% to 25% (men). | |
| Increased condom use among 15-24 year olds at last intercourse with non-regular partner: from 21.5% to 18% (women) | |
| Increased condom use among 15-24 year olds at last intercourse with non-regular partner: from 23.9% to 23% (men). | |
| Reduce % of women and men that stigmatize people living with HIV from 65% to 45% (agree with the statement that people with the AIDS virus should be ashamed of themselves (BSS 2012: p.61))' | Are people living with HIV stigmatised in your community?<br><br>How are OVC supported under HAPP III, community? (Psychosocial, education, health, material support)? |
| Increased % of young women 15 to 24 who correctly identify ways of preventing sexual transmission of HIV (from 72.,3% to 75% for women (BSS 2012) | How is HIV prevented?<br><br>What needs to be done to increase HIV prevention knowledge among young people? |
| Increased % of young men aged 15 to 24 who correctly identify ways of preventing sexual transmission of HIV 79.8% to 83% for men (BSS 2012) | |
| Increased % of young women age 15 to 24 years who reject major misconception about HIV transmission from 26.7% (BSS 2013) | What HIV misconceptions do you know about?<br><br>How can misconceptions be addressed among young people?<br><br>How can misconceptions be addressed among in your community? |
| Increased % of young men aged 15 to 24 who reject major misconception about HIV transmission from 38% (BSS 2012) | |

v. Focus Group Discussion Guide - Women age 25-49 years

My name is ……I work for PRIMSON Management Services. We have been contracted by the National HIV/AIDs secretariat to do and evaluation of the HAPPIII project that started in 2013 to present. The overall purpose of this exercise is to measure improvements in sexual reproductive health (SRHR) outcomes specifically decrease of Risk Contact of HIV, increased use of condoms by 15-24 year old generation, reduced stigmatization against people living with HIV and ratio of mothers 25 -49 years who do not intend their daughters to be subjected to FGC. I will be asking you some questions on the subject matter. Your individual and collective responses will never be linked with your names. You are at liberty not to respond to certain questions and you may leave the group at any time you choose to. Please register your approval to the process by raising your hand.

| **Indicators** | **FGD Questions** |
|---|---|
| Increase of mothers with at least one daughter who do not intend to have their daughter(s) circumcised by 6% from DHS 2013 levels | Is FGC being practiced in your community?<br><br>If yes what are the drivers for the practice?<br><br>How many of you have daughters?<br><br>Among those with daughters, do you intend to have your daughter/s circumcised?<br><br>If you had a daughter, would you have her circumcised?<br><br>How many would want to see their son(s) married to a circumcised woman?<br><br>What are your views on circumcision in your community?<br><br>What more needs to be done to reduce FGC? |

## vi. Case Studies Guide

Most significant change stories will be recorded with males and females age 15-24 years and women age 25 -49 years.

**Themes**

HIV and AIDS
SRHR
FGC
GBV
Stigma and discrimination

**Areas of IMF Support**

Agriculture
Business
Catering
Tailoring
Hair Dressing
Carpentry
Tie and Die
Soap Making