PGB External Evaluation Report ASRH/HIV/AIDS, Geração BIZ Program, Mozambique
Progress and Challenges

NORAD COLLECTED REVIEWS 25/2007

Jaime Benavente, Ph.D. Independent Consultant
Jorge Matine, Consultant

Commissioned by the UNFPA in Mozambique and with the Embassies in Norway, Sweden and Denmark

Norad collected reviews
The report is presented in a series, compiled by Norad to disseminate and share analyses of development cooperation. The views and interpretations are those of the authors and do not necessarily represent those of the Norwegian Agency for Development Cooperation.

Norad
Norwegian Agency for Development Cooperation

P.O. Box 8034 Dep, NO- 0030 OSLO
Ruseløkkveien 26, Oslo, Norway
Phone: +47 22 24 20 30 Fax: +47 22 24 20 31

ISBN 978-82-7548-254-7

External Evaluation Report

Programa Geração BIZ
Mozambique

Progress and Challenges

This report was prepared by Dr. Jaime Benavente

With the collaboration of the other Members of the Evaluation Team

Evaluation Team:

Jaime Benavente, Ph.D. Independent Consultant
Atle Karlsen, Consultant, Scanteam/Norad
Jorge Matine, Consultant
Nina Strøm, Program Officer/Advisor, Norad

Submitted to
Pathfinder International
October, 2007

ACKNOWLEDGEMENTS

We would not have been able undertake this effort without the involvement of many organizations and individuals, who we thank for their support. The team presents its deep appreciation to the young people who shared their views and aspirations with us. We hope our work will help them to make sense of their options today and help them in their future paths. We wish them the very best. We also thank all the local, district, and provincial officials and individuals who gave generously of their time and expertise, for their gentle assistance, and useful information. We are grateful to the parents, members and leaders of the community who helped us understand their needs and circumstances. The willingness of all organizations participating in this evaluation to share their experiences was absolutely critical. Individuals at the MOH, MOE, and MYS, as well as members of NGOs and Youth Organizations, and many others dedicated time and energy to the effort, and we are grateful for the opportunity to learn from them. We are especially appreciative of UNFPA and Pathfinder International staff, who shared their thoughtful analyses of the Program with us, provided time for coordination and briefings, provided support for the Team's visits, made available resources and working space, and greatly facilitated our work.

Jaime Benavente, Atle Karlsen, Jorge Matine and Nina Strøm.

Table of Contents

ACRONYMS

AIDS	Auto-Immune Deficiency Syndrome
AJOCRI	Association of Christian Youth
AMODEFA	Planned Parenthood Association of Mozambique
APROGE	Management Improvement Processes
ARV	Antiretrovirals
AYSRH	Adolescent and Youth Sexual and Reproductive Health
AVIMAS	Association of Widows and Single Mothers
BCC	Behavior Change Communication
CFPP	Training Center for Primary School Teachers
CIADAJ	Inter-sector Committee in Support to the Development of Young People
CNJ	National Youth Council
CNCS	National AIDS Council
CPR	Contraceptive Prevalence Rate
DNEP	
DPEC	Provincial Direction of Education and Culture
FAIJ	Fund in Support to Youth Initiatives
FASE	Fund in Support to the Educational Sector
HIV	Human Immune-Deficiency Virus
HCM	Maputo Central Hospital
IDS	Demographic Health Survey
IEC	Information, Education and Communication
IMAP	Institute of Basic Teaching
INDE	National Institute for Education Development
INJAD	National Survey on Adolescents and Youth
KAPB	Knowledge, Attitudes, Practices and Behavior
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MIS	Management Information System
MOE	Ministry of Education and Culture
MOH	Ministry of Health
MSF	Médecins Sans Frontière
MYS	Ministry of Youth and Sports
NPAA	National Program Against AIDS
PAC	Post-Abortion Care
PARPA	Plan of Action for the Reduction of Absolute Poverty
PEs	Peer Educators
PEN	National HIV/AIDS Strategic Planning
PGB	Geração Biz Program
PT	Participatory Training
PTV	Prevention of Vertical Transmission
PVHS	People Living with HIV/AIDS
POSIDA	Operational Plan Against AIDS
SRH	Sexual and Reproductive Health

SDPs	Service Delivery Points
STIs	Sexually Transmitted Infections
TA	Technical Assistance
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly - Special Session
VCT	Voluntary Counseling and Testing
YFS	Youth Friendly Services

Executive Summary

This evaluation found that the *Programa Geracao Biz* (PGB) is one of most successful social programs of the last decades in Mozambique. It has constantly expanded its coverage of adolescent and youth and it is accepted and trusted by the young population. PGB has develop a sexual and reproductive health (SRH) service network that includes 180 service delivery points (SDPs) providing youth friendly services (YFS) and is now present in every province of the country; 66 sites have VCT services and the network has 754 trained service providers in SRH. Together they serve a population of 200,000 youth and adolescent per year. Considerable achievements were also reached in the area of HIV/AIDS for adolescent and youth. The involvement of peer educators in YFS, however, remains lower than desired, only 30 of the 180 SDPs include peer educators helping with services to youth. Also, the YFS need to strengthen the provision of contraceptives given that young clients are very receptive to start controlling their fertility. Overall, the health sector has made tremendous progress in coverage and quality of services. However, PGB support at the central level decreased over the years creating a risk for possible re-assignment of providers or the inclusion of adult patients in the YFS.

The education sector, has made some progress, slowly perhaps, but still significant. The most effective intervention is the counseling provided at counseling corners. However, the evaluation observed a decrease in use of such services - 70% of youth reached in school come from participation in 'schools events', despite of the elusiveness of these activities; the next most 'productive' activity representing 24% of youth reached in schools, is the face-to-face interaction of student-peer educator that also has some limitations; finally, services through counseling corners now represents only 2%. This component has potential and PGB should conduct a review of the low use of counseling corners and what can be done to return to a 10-15% share. PGB also needs to look at the outcomes of the different interventions: results from counseling sessions, face-to-face support and, participation in school events.

The out-of-school program has not obtained good results, in part due to limited emphasis on management issues. The program functions with little guidance and the results are vague. Peer educators have a hard time performing their tasks with weak support. What makes the situation more critical is that the MYS has been unable to find a physical point of reference in the communities to define as the PGB/Community place. Perhaps the issue was in selecting a unit in charge of the PGB activity -- the DNEP-- which has no direct communication channels with the youth at community level. A solution is to include another MYS unit with established channels linking it with the communities, in charge of operating the out-of-school program. This could open venues to the communities and enable them to reach the young population.

PGB BCC materials are very well designed and produced. The capacity of the BCC team is exceptional in its creativity and capacity to adapt materials to the audience. There are various products such as the latest video on intergenerational sex, '*Risco Zero'*, *Manual de Activista*, and radio program *Mama Biz*, that surpass the quality of other materials available in the development field in Mozambique. The BCC component is one of the best in the country and it has significantly added to PGB's solid performance.

PGB has established a thorough training program for officers and volunteers resulting in a skilled qualified team. To strengthen training further by integrating more the various components, we suggest the use of a Participatory Training Program for the PGB components, based on training needs assessment with a combination of class-room formation and on-the-job training. Once fully operational, the program will enable PGB to continuously assess training needs and conduct training activities in a timely manner, determining costs and ensuring quality.

The PGB Monitoring and Evaluation system is very good. It focuses on SRH services and appropriately captures the results from the service delivery level. But it is important to extend the capacity of the M&E system to measure and report progress in other important dimensions of PGB such us multi-sector coordination, advocacy, capacity building, management and leadership, and sustainability. The M&E focus on monitoring program activities has been very useful for the PGB. It would be important to define

a limited set of indicators dedicated to measuring SRH impact and to ensure that evidence of impact can be captured and reported.

It is clear that PGB programming results from four strategic paths: the multi-sector coordination which is the force that moves the entire program forward; capacity building which is the source of knowledge, skills and know-how; advocacy is the coach, always asking for a little more; and the services are the outputs of the system, received by the target population.

The services in the three sectors are functioning differently and it appears they are not following a unique leadership, and they have different management, monitoring, and supervision approaches. There is limited synchronization of program activities among the sectors. A new emphasis on multi-sector approach and a significant acceleration of capacity building could strengthen the services provided in the sectors.

Advocacy has been effectively used and PGB has become instrumental in promoting policy changes. All three sectors have played a role in the policy ventures, but the coordination has been led by the technical assistance arm, affecting the sectors' sense of ownership. PGB should clarify the responsibilities at local levels and their address the lack of knowledge and use of advocacy techniques.

Multi-sector coordination is the key management concept in the PGB and has been successful, though its development has been slow. It is very important to assess and strengthen the coordination capacity of each sector and develop a PGB global planning coming from the plans in each sector. This integration of sector plans will allow the definition of inter-related objectives and expected results.

Capacity building is needed and PGB should review the achievements to date under this component. It should conduct an inventory of activities implemented over the last three years, review the existence and quality of a capacity building database, review rationale for and expand definition of existing framework, review current indicators and select a subset associated to the framework, develop a model for gathering data, collect data timely, conduct analysis, and provide decision makers with information on capacity building progress.

The scaling up of the Program is ready to enter its final phase now that it has interventions in all provinces and with the latest expansion now cover about 45% of the districts. This latest success of the scaling up has demonstrated the replicable character of PGB. The expansion proceeded with significant involvement of the national partners. The design of PGB is also replicable in other countries of sub-Saharan Africa and its strategy for social programs is applicable beyond the realm of youth.

A conclusion on sustainability is that it continues to constitute a serious challenge for the Program, and it is critical to consider sustainability issues in analyzing or planning the future of the Program. The most crucial sustainability test is the building of local conditions for a sustainable development: the transferring of strategies, methodologies and know-how to local teams, and their institutionalization and use in running PGB; the decentralization of program and financial management; and the development of staff who can manage PGB with dedication and excellence. In thinking about the sustainability of PGB, it is critical to refocus on the need to strengthen the multi-sector collaboration and develop a strong capacity building component.

I. Introduction and Background

The *Programa Geração Biz* (PGB) has been in operation for eight years in Mozambique. It began in February, 1999 in the city of Maputo and in the province of the Zambézia, with the goal to provide adolescents and youth with sexual and reproductive health information, preventive services against HIV/AIDS and STIs and specialized services in the case of HIV infection. Over the last five years, PGB has expanded to reach all 11 provinces in Mozambique. The program is implemented through a multi-sector approach by the Ministries of Health (MOH), Education (MOE) and Youth and Sports (MYS), with collaboration from local NGOs and youth associations. PGB has become a tremendous support for the young population (adolescents and youth) of the country, not only because it has improved the immediate circumstances in which thousands of youth[1] live today in Mozambique, but also because, it has made possible an opening in the social and political system where currently youth issues can be discussed. This can bring about important structural transformations making possible, in turn, an end to the neglect under which young people have survived, particularly in the last half century.

Mozambique is one of the most impoverished countries in the world and, coincidentally, is among the countries hardest hit by HIV/AIDS. The AIDS epidemic is exacerbated by extreme poverty[2] resulting from the 500-year colonial system[3], twenty-five year national liberation struggle[4], seventeen years of civil war[5], the last fourteen years of internal and cross-border migration, inequitable distribution of income and power between men and women, and low literacy rates. In fact, young people (aged 10-24) are heavily affected by this socio-economic and health crisis. The young population of approximately 6.5 million people (more than a third of the country's population), have been suffering under considerable poverty, limited educational opportunities, and very discouraging job perspectives. In addition, the high prevalence of early and unwanted pregnancies, prevailing incidence of unsafe abortion, and increasing present-day risk of STIs and HIV/AIDS infection are dramatically reducing opportunities for a well-balanced development of this young population. Concurrently, the population between 15 and 24 years account for more than half of new HIV-infected people for the total infected under 30 years of age. In addition, it is apparent that girls and women have a much higher risk (2/1 ratio) of HIV infection than men, and this population is at serious risk of STIs and early and unwanted pregnancy. According to PGB data, approximately 70% of young women had at least one pregnancy. Thus, in Mozambique, this population[6] faces multiple risks and challenges on their way towards maturity.

In the early 1990s the Mozambican civil society began to unveil the problematic situation of adolescents and youth, exploring solutions that could address these issues. Of course, these solutions were not structural ones, as the country was not in a position to afford solutions that could require deep and long term social and economic changes. This consciousness was strengthened by the participation of the country in the 1994 International Conference of Population and Development in Cairo where the challenges of youth received special attention. The Conference resulted in a commitment form participating countries to develop and implement special programs focusing on in the sexual and reproductive health among adolescents and youth. At the core of this commitment was the need to create the conditions to empower adolescents, and as signatory to this agreement, Mozambique facilitated the passing of youth issues from mere general concern to concrete analyses and solutions.

Thus, in 1995 the MOH, in coordination with other Ministries and NGOs[7], started discussions around the development of a program of support for youth and establishment of a national agency, the CIADAJ.[8] The

[1] In 2006, PGB reached 600,000 (closed to 12% of the 10-24 population).
[2] Mozambique is one of the poorest countries in the world.
[3] The Portuguese arrived in Mozambique in 1498 and left in 1975.
[4] The independence struggle began in the late 1950s and ended in 1975.
[5] In Mozambique, the civil war began immediately upon independence in 1975 and lasted until 1992.
[6] Adolescent and youth: population aged 11 to 24 years of age.
[7] MEDEC, ONGs such as Muleide, Kulima, Amodefa, religious leaders,

multi-sector organism was charged with the mission to advocate for the needs and rights of adolescents and youth. This effort was further enhanced in 1996, when it was added to the tasks of the then Students Health Section, an adolescent health component as a way to facilitate the implementation of an institutional response to the needs of adolescents and youth by offering specific health services.

Finally, the open discussions resulted in consensus regarding the need to focus realistically on approaches that would lead the country out of the discouraging situation in which young people were forced to grow up in, which have lad to undesired pregnancies, unsafe abortions, the explosion of STIs, the growing risk of HIV infection, and unrelenting lack of employment. In 1999, three Ministries, MOH, MOE, and MYS, developed a multi-sector initiative aimed to support adolescents and youth. The main objective was to endow young people with needed knowledge and life skills, and access to quality sexual and reproductive health services. It was also expected that they would exercise a decisive and lead role in the protection of their peers. More importantly, this planning facilitated the development of a framework that produced an appropriate demarcation of key goals, including:

- Enable young people to have a healthy and responsible sexual and reproductive life, including voluntary abstinence, easy access to condoms and appropriate counseling and services;
- Eliminate institutional and attitudinal barriers limiting youth access to the information and services they need;
- Provide youth friendly services, ensuring privacy and respecting confidentiality; and
- Protect the rights of youth to access education, information, and health services and thereby reduce early and unwanted pregnancies and unsafe abortions.

II. The *Geração Biz* Program: a Programmatic Reality[9]

The *Geração Biz* Program addresses AYSRH, including HIV/AIDS, by increasing youth knowledge and skills regarding risky behavior and protective measures, and by increasing access to youth friendly services. It is a multi-sector program, working in partnership with the MOH, MOE, and MYS, as well as with selected NGOs, with support from UNFPA, DANIDA, SIDA, and NORAD. With technical support provided by Pathfinder International, PGB began in 1999 in Maputo City and Zambezia Province. In 2002, the program expanded to Gaza, Maputo and Tete provinces. In 2003, PGB initiated work in Cabo Delgado, though it took some time to settle implementation there. In 2004 the clinical component was expanded to Inhambane Province. In 2005, PGB expanded further to Niassa Province and the school and community components were added in Inhambane. By mid-2007, at the time of this evaluation, the program is in all the provinces although at various levels of access, and is expanding to new districts and the most secluded localities in those districts, including health posts, as a strategy to guarantee more equity of access.

Beneficiaries of the Program include: adolescents and youth aged 10 – 24 (primary beneficiaries); staff directly linked to service provision such as nurses, doctors, teachers, peer educators (PEs) or *Activistas* and Youth Associations (secondary beneficiaries); and program managers at central, provincial, district and community levels (tertiary beneficiaries).

Geração BIZ was includes three key components: a) school-based program with counseling corners in schools, in close collaboration with the MOE, b) a community-based program, with youth centers, under the leadership of the MYS, and c) youth friendly clinic services (SAAJs and YFS) within MOH health facilities. The components are fortified through two cross-cutting interventions: capacity building of the

[8] Intersectoral Committee for the Development of Adolescents and Youth

[9] This section was prepared keeping in mind several PGB reports and other materials, particularly useful was the piece: *Geração Biz Program. "7 years making the difference."* December 2006, Maputo – Mozambique. We are also indebted to Dr. Julio Pacca for his experiences and reflections shared over many meetings.

local implementing partners and advocacy for a more favorable environment for AYSRH. The implementation was permeated with the multi-sector character of the program enabling each component to depend not only on its own sector (Health, Education or Youth & Sports) but also on the support from the other two sectors in order to be successful. Thus, the activities implemented by the PGB are focused on three key components:

The clinic component is dedicated to the provision of clinical services designed to serve adolescents and young people. The clinic component combines two approaches to provide clinical services. The main approach is to create SAAJs, which are clinic spaces developed specifically to attend youth. Where SAAJs are not feasible, or when their creation is slow, PGB introduces youth-friendly services (YFS) within regular health services of the MOH. The SAAJs and YFS include information, counseling, contraceptives, emergency contraception, prevention and treatment of STIs, pre-natal care and post-partum/post-abortion counseling, HIV/AIDS information and condom distribution.

The school component activities are conducted by students (PEs) and teachers, trained by PGB. A key activity is the services provided at the counseling corners[10]. A key input in this area are the education and awareness raising activities for youth, where a large number of youth can be reached as well as adults (parents, teachers and school directors) who serve as role models in young people's lives. Also, it is here where youth prefer to seek counseling and information from their peers.

The community component: this component is different since they do not have a fixed institutional space to develop their activities. Thus, PGB implements its activities through any space where youth get together. It is harder to locate youth in the community and to identify where they gather in order to provide services. For this reason, a key step in developing these activities is to conduct community mappings to assess knowledge and behavior with respect to AYSRH as well as to identify youth social networks. This process facilitates the selection of sites for program implementation. At the community level, the PEs (trained from the community) play a key role in establishing connections with YFS and SAAJs, and refer youth to their services and sometimes accompany them to the clinics.

A. Organization and Coordination

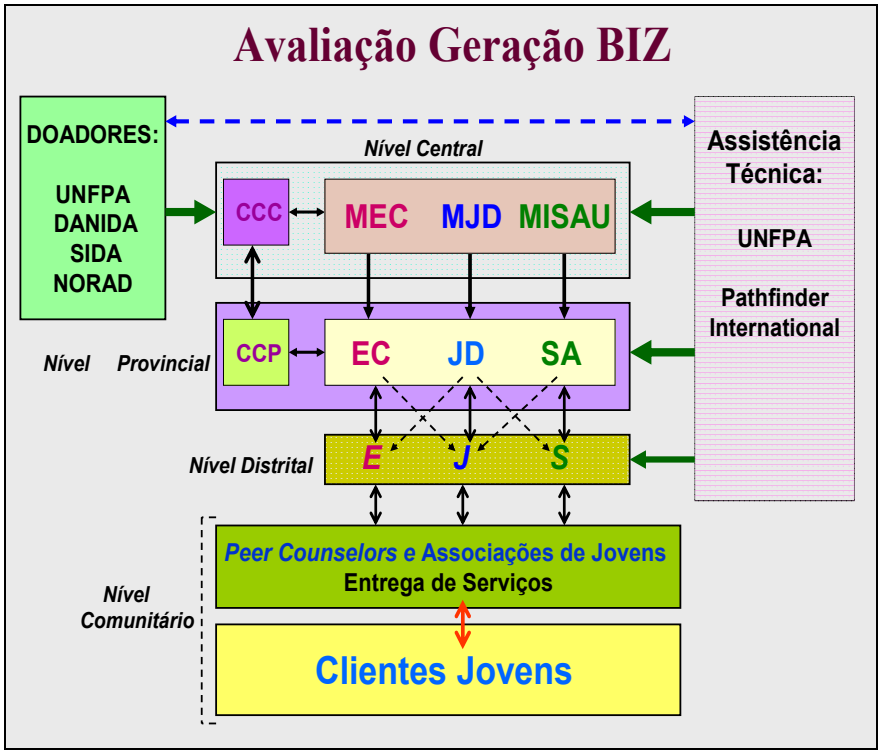
An important aspect in the functioning of PGB is the coordination capacity among the various institutions involved at all levels of implementation. The Program set up two management committees: one at central level, the GB Central Coordination Committee, and the other at the provincial level, the GB Provincial Coordination Committee – both are chaired by the participating sectors on rotating basis. These committees serve as steering and decision-making bodies for the management of the Program, ensuring the multi-sector approach is followed throughout program implementation.

The Central Coordination Committee includes representatives from the three ministries: the National Directorate of Health and Department of Community Health of the MOH, the National Directorate of Special Programs of the MOE, and the National Directorate of Studies & Projects, National Directorate of Youth Issues, the National Directorate of Sports of the MYS; and technical assistance from UNFPA and Pathfinder International. The Provincial committees include the Provincial Directorates of Health, Education, and Youth and Sports. Each sector is responsible for implementing one of the program components: the MOH is responsible for the clinical component, the MOE the school component (in-school adolescents and youth) and the MYS the community component (adolescents and youth in the community).

[10] Counseling corners are spaces that exist in schools where young people can go and talk to PEs, talk to the nurse (who is supposed to visit the corner on a weekly basis) or obtain condoms with more privacy and comfort.

PGB is supported by a complex organizational network that goes from the central level to the community. This is key to understanding the functioning of the program, and the evaluation needs to consider the network at every level of management and implementation. Graph 1 summarizes the organizational nature of PGB, describing the organizational complexity of the initiative with its multiple participants. It also describes the numerous interactions within program implementation. Some of them are established occurrences with stable participants, others, may be programmed and the attendance more flexible.

Graphic 1



As shown in Graph 1, the project functions at five levels. Activities are conducted at the central, provincial, district, and community levels. The first three levels are responsible for the strategy definition, work planning, logistical support, monitoring and evaluation and other central tasks. The last level –the community—is where the actual implementation takes place. At all levels, one can perceive the complex 'multi-sector' tasks and predict demanding challenges.

1. Central Level. The Ministries are responsible for strategy definition, global planning and resources allocation while the donors and the technical assistance organization are responsible for providing financial support of services as well as for introducing appropriate technology for adolescent and youth services and providing assistance M&E and supervision.

2. Provincial Level. The central level complexity is almost exactly reproduced at this level.

3. District Level. At this level the complexity of the PGB structure starts to lessen. However, the presence of the different Ministerial representatives still calls for a tight coordination (but without a Coordination Committee.)

4. Community Level. After the district level, the community level is where the Program has the actual implementation of activities. At this level, the evaluation needs to consider two sub-levels:

   - Peer Educators and *Associações de Jovens* Level. Implementation is planned and programmed at this level.
   - Target Population Level. Beneficiaries are found at this level and therefore program impact should be measured at this level.

Support systems for the program include: Central Planning and Programming, M&E with information production and use, Finance, Communication, Training, and Procurement.

B. Strategic Paths

The key Program activities are guided for four strategic paths: Service Provision, Multi-sector Support, Institutional Capacity-Building and Advocacy:

Service Provision. Service provision is the central focus of GBP since its main objective is to provide adolescents and youth with new knowledge and skills as well as offer them access to appropriate health services in order to enhance their sexual and reproductive health, particularly with the reduction of the incidence of early pregnancies and vulnerability to STIs and to HIV and AIDS. Adolescents and youth receive services through the activities conducted at schools, in the communities, and at the SAAJs.

Multi-Sector Strategy. This is a key element of PGB. Program activities to address youth needs are implemented by all three sectors at the central, provincial, district, and community levels. With this, PGB aspires to place its interventions within a holistic approach to promote young people's health. The multi-sector strategy is based on three assumptions: 1) young people are a heterogeneous and relatively scattered group, 2) PGB uses the efforts carried out by other institutions that target young people, and 3) youth not only need to receive counseling and information, but they need also services.

Institutional Capacity-Building. The PGB approach to institutional capacity-building is based on four components: 1) Skills, 2) Tools/Instruments, 3) Staff and Infrastructure, and 4) Structures, Systems and Roles. Skills are basically developed through training of the staff involved in the activities, tools and instruments are developed to improve MIS, staff and infrastructure are ensured through training, supervision and renovation and construction of infrastructures (YFS, Youth Centres and Counseling Corners). Institutional capacity-building includes technical assistance; training of staff; study visits, exchanges and participation in relevant meetings and conferences for peer educators; scholarships for program staff at governmental and non-governmental level, and access to the internet for the central and provincial level staff.

Advocacy. PGB plays an instrumental role in advocating for the rights and needs of adolescent and youth. The establishment of national guidelines for YFS and the introduction of the SRH/HIV/AIDS topics in formal education as well as the development of the SRH Policy are some of the examples of the advocacy work developed by the Program. PGB also assists the advocacy efforts of youth groups, including the training of activists from various youth associations who are organized in three thematic groups: policy coordination, communication and events, monitoring and evaluation, and research. In this Chapter, we have described the basic characteristics of PGB, let us finalize by listing the objectives of the Program in order to complete the picture of the work conducted by PGB managers:

- Promote an enabling environment for informing, educating, changing behavior, and providing services through public policy and information at community, provincial and national levels.
- Provide information, education and counseling to youth in schools and in the communities to improve knowledge, skills, behavior and practices with respect to SRH.
- Ensure quality YFS are accessible to youth in school and in the community.

- Strengthen the capacity of ministerial agencies and their civil society partners to plan, implement and monitor each sector activities.
- Strengthen multi-sector coordination.
- Strengthen mechanisms for involvement of youth in all program aspects
- Ensure gender recognition and promote gender equality as a fundamental component of all SRH/STI/HIV/AIDS activities.

III. Evaluation of *Programa Geração Biz*

A. Purpose and Objectives of the Evaluation

The *Programa Geração Biz* is completing its eighth year of implementation. Longitudinal review of project data would clearly indicate that the Program has accomplished important progress in its objectives and, because of this, the lives of significant segments of adolescents and youth have changed for the better. It is perhaps not yet possible to discuss an effective impact of the PGB action on its target population. Though, advances are likely to be found in almost every area of the Program scope of work, there are two areas where the positive effect is impossible to overlook: SRH services and policy and advocacy. The former has positively changed young people's knowledge, attitudes and practices in relation to SRH and STI/HIV/AIDS. The latter, has changed the political and social environment in relationship to sexual and reproductive health for youth, advocating for new social openings and new policies that would allow adolescents and youth to have better lives by reducing traditional barriers that prevented these changes. At this stage in the implementation of PGB where focus is now necessarily on total coverage and more program responsibilities are transferred to the Government, it is opportune to conduct a wide and systematic review of its main components, including analysis of the empirical evidence gathered by PGB in order to understand its successes and challenges[11]. The evaluation was led by Dr. Jaime Benavente, independent consultant. Team members included Nina Strøm, Program Officer/Advisor, NORAD; Atle Karlsen, Consultant, Scanteam/NORAD; and Jorge Matine, independent consultant. The team also worked closely with various Government officers, particularly MOH, MEC and MYS, and with officers from UNFPA and Pathfinder International. Valuable support was also provided by the young men and women from local Youth NGOs in Maputo.

B. Methodology

This evaluation uses multiple sources of evidence to obtain a comprehensive and in-depth understanding of complex, diverse and multiple phenomena present in PGB, control the errors implicit in any chosen research method, support sound analyses, arrive at practical conclusions, and make accurate inferences.

▪ Instruments for Data Collection and Key informant interviews

The primary means of data collection included document and systems review, individual interviews, group interviews, and observations. Instruments were developed in Maputo by the Evaluation Team to guide interviews and observations. The Program activities include various groups of people whose actions significantly affect the final results of the interventions. At the core of the project, is the target population who are the beneficiaries of project interventions: adolescents and youth. Second, we have the service providers who are key to the implementation of activities and to achieving results: Health Service Providers, Peer Educators, Facilitators, Supervisors, Social Workers, Teacher Activists, Education Officers and others. Third, we have the health managers at local, district and provincial levels: PGB district implementing Officers, District Health Managers, PGB Provincial Officers, AIDS Coordinators

[11] The Terms of Reference for this assignment are attached in Appendix X.

and Senior Medical Officers. Finally, we have the country level managers directly involved in guiding project interventions and operations: Project Managers from MOH, MEC and MYS, Technical Assistance Officers from UNFPA and Pathfinder, Donor Officers and others.

- **Review of relevant documents.**

Many publications were consulted and reviewed in order to obtain a comprehensive understanding of the economic, legal, social, and health situation of adolescents and youth in Mozambique. They include: project annual reports, and other reports, financial documentation, monitoring reports and accompanying databases, research reports and accompanying databases, training reports, curricula, protocols, as well as BCC materials such as brochures, posters, leaflets, videos, and other materials. The DVD with PGB information prepared for this evaluation, contains lists of documents collected and reviewed. The list is complemented by the References section listing technical documents consulted during the assignment.

- **Design and preparation**

The agenda and protocol as well as evaluation instruments were developed in Maputo before departing to the provinces. The detailed agenda of visits to various sites was prepared with UNFPA/Pathfinder International. Instruments, schedule and interviewee criteria were also developed by the evaluation team.

- **Field Work**

This assignment was scheduled from August 27 to September 17, 2007. The evaluation team spent two days (August 27 and 28) organizing the evaluation at the UNFPA office in Maputo, and three days (August 29 and 30) interviewing Ministry and PGB managers, NGO leaders and staff as well as visiting Program sites in Maputo Province and Maputo city. In addition, the team spent four days (September 1 to 4) visiting Program sites and interviewing provincial and district managers and local NGOs and community members in the provinces of Inhambane and Cabo Delgado. Finally, the team spent four additional days (September 6 to 15) reviewing project documents, reports and records and briefing managers and partners on the preliminary results and recommendation. Two members of the evaluation team (Ms. Nina Strøm and NORAD; Mr. Atle Karlsen) could only participate in the assignment up to September, 5.

In summary, the team visited three provinces (Maputo, Inhambane and Cabo Delgado) and Maputo City, visiting a total of 8 districts and a total of 15 SAAJs, 12 counseling corners in schools and 12 youth centers in communities. Appendix 2 includes a list of the sites visited. The visited districts were selected by the evaluation team. In each district, the Evaluation Team interviewed young people, PEs, ministerial and PGB officers, health officers, teachers and school directors, and community leaders and members. In addition, several health and educational facilities were visited and staff interviewed. Most supervisors, middle managers and top managers from each sub-project (or NGO) were interviewed.

IV. Findings and Recommendations

In this Chapter we describe and discuss the findings of this evaluation. We do this with deep sense of respect since the work implemented by the PGB staff and volunteers has been outstanding. Hence, the shortcomings we have identified need to be balanced with the enormous accomplishments of this team.

A. PGB Goals and Services

The PGB service strategy combines an integrated approach of school- and community-based interventions strongly connected to a clinic-based program. In this way, any action implemented at one point could

reinforce initiatives developing at other points. A multi-sector coordination approach was expected to facilitate this. The multi-sector methodology proposes that the inter-coordination of sectors involved in the making of a specific phenomenon, would advance a rapid and sustainable solution if the sectors involved work all closely together producing a strong synergistic interaction.

Already in 2004, an external evaluation indicated there were not always significant synergies among the three sectors. Furthermore, it reported the existence of important duplication of activities. This team also found a relative lack of reinforcement among the three ministries, though serious duplications and overlapping were not found.

The three Ministries involved with adolescents and youth were expected to advance (together) PGB and its objectives bringing about the desired solutions to the acute problems to which this population is subjected. If this approach is unsuccessful, the progress of PGB could be jeopardized and its future put at risk. Serious attention should be given to the weaknesses in coordination among sectors in order strengthen their capacities to work together in favor of youth. The replenishment of the original pledge for multi-sector coordination must not only include the updating of decision making process at central and provincial levels but also includes the rethinking of collaboration at the local levels and districts. This last point would imply a commitment to introduce the three components (health, education and community) simultaneously or quasi-simultaneously in each local area selected for intervention, and thus maximize the synergistic benefit of the three sectors. Having interventions in the three sectors launched at the same time is paramount to setting up mechanisms to secure an appropriate degree of coordination, generating an interactive program fed by the synergies of the partner interventions. It would nourish a productive collaboration among health service providers, teachers, and PEs working at SAAJs or in schools.

This dynamic interaction needs to be developed through group sessions to review the need for collaboration and how to achieve it, introduce some techniques for conflict resolution, and build a team approach. This would guarantee that in every SAAJ and communities would include PEs, and that every SAAJ carries out outreach activities in the schools in their areas, encouraging young people to come to the clinic.

The sector PGB teams should pay attention to what is going on in their respective interventions and identify opportunities for interaction with the interventions of the other sectors: analyze these opportunities jointly with managers from the other sectors, determine how to foster operational interaction, estimate and depict the expected synergy, and develop simple but careful plans and implement them making sure that there is an appropriate monitoring system to follow the intervention. The best opportunity for interaction and synergy lie in PGB's three key interventions: the SAAJs, the counseling corners and the youth points in the community. Adolescent and youth live in a community, a good portion of them go attend school, the ones who do not go to school can be served in the community points, and if they need SRH services they go to the SAAJs.

Our team was able to observe in Inhambane an example of coordination between a school counseling corner and a SAAJ that presented two types of excellent coordination: some youth go from the school to the clinic for services with school director's authorization during school hours and health service providers visit the school to provide SRH services with authorization from the head of the SAAJ and the welcome of the school director. PEs facilitate the flow in both directions, making sure that everything is ready at the receptor point. For this initiative to work, the school director should meet with the head of the SAAJ and health providers, with the participation of PEs.

B. The working and outcomes of the Program

1. Youth Participation

In this section, we review the level and nature of youth participation in PGB and their involvement in program design and implementation. The PGB target population is 10 to 24 years old. As indicated at the beginning of this Chapter, the Program expects to reach and serve around 1,200.000[12] young people[13] in 2007, representing close to 23% of the youth population. Since there are at least four million youth in need in Mozambique who have not been reached by Program, the youth initiative is still important. However, the complete coverage of youth will not be an easy undertaking. To continue the quality services to 1.2 million young people and at the same time expand services to reach a total of 6.5 million will require considerable and generous support. To achieve this, PGB needs to expand the participation of youth at all the levels in resolving and establishing programmatic objectives and strategies, and management and finance. As PGB calls on youth to participate in the program, it also needs to develop a plan for the growth and strengthening of youth organizations, including the development of a network of youth groups, as a lasting strategy for organizational independence of these organizations, and not to become dependent on any public or private institution.

PGB is well known and liked by the young population and has worked very well with youth organizations. As a result, PGB has become a key contributor to the development of the new contingent of young people in Mozambique who are making enormous progress in their managerial, technical and political capacities. Some of them are already prepared to start providing managerial and technical assistance in the SRH programmatic areas. There are good reasons for the youth to feel ownership of the Program since it has been responsible for the emergence of new opportunities for them. Also, PGB is helping to move forward the growth of a new leadership among this population.

There are many ways youth can participate in PGB. The prevalent view has been that the relationship between PGB and youth can be achieved through Youth Associations. PGB has done an excellent job supporting and strengthening these organizations. Some have grown and become strong and relatively powerful associations, producing outstanding leaders. All this is very encouraging. However, these achievements are few and are concentrated in the city of Maputo. In the provinces, youth associations are fragile or do not exist and the small number of youth organizations PGB has tried to support in order to expand and improve in the provinces have been, and are, rather mixed experiences; furthermore, these ventures are expensive and PGB cannot embark on a costly strategy to reinforce youth organizations in every province. Given the limited strength and number of youth associations, PGB could expand its work with the young population by reaching out to local cultural groups and open the PE training to youth coming from these cultural associations or groups. This will require the development of a network that could assist in the coordination of a productive interaction between the PGB and these groups. This is an additional option that could be explored. However, the Program should not disregard its work with youth associations as they can play an important role in advocacy for youth rights and policies.

There are two other important venues through which youth can become associated with the Program: the first is as clients at the SAAJs, counseling corners, and community-based PEs; and the second is to participate as PEs. The interaction between the young client and the PE is extremely important as this is the key step to achieving the desired outcome and impact - that is, to have improved SRH in the target population. As discussed earlier, PGB currently reaches around 1.2 million youth. The total number of youth reached at the beginning of 2007 was 1,145,000 (47% were attended at schools, 38% at the communities and 15% at YFS.) Most of these youth stay for the long term, coming back for subsequent services and/or enlisting as a peer educator. Thus, PGB can benefit from the target population – that is, it can recruit PEs from this population, perhaps, double it. This population can be called upon to help in short-term specific activities and support concrete advocacy initiatives. The development of the relationship between PGB and the youth it serves opens lays the groundwork for the adolescents to become strong supporters for the future sustainability of PGB.

[12] In 2006, PGB reached a total of 1,145,000 youth. During the first half of 2007, the SAAJs had served 337,924 adolescents and youth.
[13] Including those served through SAAJs, reached at their schools and in their communities.

The second form of participation is as peer educator. In general, the PEs are committed volunteers. They feel part of PGB and some have spent a good part of their lives working in SAAJs, counseling corners or in the communities. It is clear that the PE work is highly regarded, attracting many candidates for the position. At the time of the evaluation, around 3,000 PEs were involved in PGB. This is not a small number and it is a delicate undertaking to pull together and manage the human and material resources to make sure they continuously have the needed programmatic inputs: supervision, materials, and logistics and emotional support that it is needed for them to carry out their tasks. PGB has done an extraordinary job supporting the PEs. It is not easy to fully and productively involve a party of this size and problems do arise. The key is for the organization to be able to identify the problems, have the energy and mechanisms to solve them, and learn from these shortcomings. PGB has developed much of the needed systems to identify and address problems. However, considering the future tasks, this is not sufficient because the work with youth associations does not necessarily permit wide access to grassroots adolescent and youth segments. Up to this point, youth participation has been very robust in the implementation of activities and interventions[14] but it has been marginal in the management of the Program. Youth are rather absent from the list of key decision makers involved in running PGB and its activities. Given this, the active participation of the youth is still limited, and PGB needs to conduct a comprehensive review of its youth strategy to design ways for a grassroots approach to become operational.

To achieve a grassroots approach PGB needs to adjust its youth strategy, which does not necessarily imply forgetting what it has been doing until now. Instead PGB should focus its attention on how to incorporate better youth into the program avoiding the easy option of treating them as 'target population'. If PGB follows this route, the youth who indeed is prey to many social and economic injustices will continue to be perceived as the problem rather than part of the solution. In order to have a productive partnership with the youth, PGB needs to promote their active participation at every level of the initiative. For adolescents and young people to become a true partner in PGB they need to become involved at the programmatic level in the strategic and tactical decision-making processes, as well as in the planning, management, implementation and evaluation of interventions, at all levels. Youth also need to be included in the formulation of youth policies, strategies and governance.

The youth of Mozambique who are organized and actively participating in social services will be effective representatives who can advocate for support of youth initiatives, and assist in the development of new proposals. One could say that the Ministry of Youth and Sports is the institution that best represents the interests of youth; however, the youth do not necessarily feel any connection with the MYS because they see it more involved in sport activities than with the improvement of the well being of youth. In addition, the MYS does not possess sufficient technical, financial, human and material resources to develop activities, despite its considerable influence in the policy setting. Additional support to the MYS should be considered to strengthen its capacity to provide assistance to youth. PGB can only play a facilitator role, supporting and accelerating youth activities and ventures, particularly community-based initiatives. In the end, the youth themselves, through their organizations, need to create the mechanisms to defend adolescents and youth rights. This requires society to recognize youth as a valuable segment of the social fabric, and their representatives should be accepted among social leaders of the country.

2. Peer Educators

PGB includes a well-trained cadre of more than 2,700 Peer Educators, also known as Activists, who are at the vanguard of the Program's outreach to adolescents and youth. The PE is without any doubt an essential factor in PGB's capacity to reach young people. These young women and men and volunteer people are the reference points to whom the adolescent adolescents and youth come to obtain information and advice as well as to obtain referrals for SRH or other services. The PEs work in schools, clinics, and in out-of-school activities in the communities. As mentioned earlier, the PEs are dedicated volunteers, and

[14] Mostly youth involved as peer educators in many different endeavors of the Program.

some have spent a good part of their life working in it. The majority work between 8 and 14 hours per week assisting young people in SAAJs, counseling corners or in the communities. At the same time, it is clear that the PE work is highly regarded attracting many candidates for the position, frequently exceeding the available absorptive and supervisory capacity of the Program. The problem is the drop out rate of PEs, especially female drop outs continues to be higher than males.

The material reviewed, the opinion of people acquainted with the Program, and our contact with PEs indicate that, overall, PEs have solid proficiency in what they do and have deep conviction in the need to improve the lives of young people in the country. Their interaction with youth as peers is respectful and warm and they are willing to share their own experience if they can help in educating their customers. Finally, female PEs tend to be more aware of gender inequality and have greater self-esteem than the other girls their age; while young male PEs tend to recognize more than other boys their age that they have more opportunities than girls. Although PEs know how to carry out their work well, the majority of people interviewed (including District Managers and PEs) indicated that PEs and aspirants to PE need more training. This seems to be a persistent need that was also noted during the 2004 PGB evaluation[15]. However, this need for additional training seems to be unrelated to the quality of the educational material and curricula used in the training they received; our review of the materials indicate that they have appropriate content, adequate presentation format and useful practical guides.

The source of this need appears to be more associated with the desire of PEs to receive continuous guidance and training in their work by an educator-supervisor who is reachable and who has experience in problem solving and willingness to transfer those skills to the PE. The initial training is thorough and excellent. However, since BCC material is constantly being updated and new approaches to reaching youth are continuously being identified or fine tuned, it is recommended that PGB set up a system for ongoing or continuing training of the PEs, which could last for couple of years. Thus, a continuing training component would ensure that the PGB has a more homogenous cadre of P.E.

PGB needs to analyze the possibility to frame its training efforts into a training program that not only includes classroom training but also pays particular attention to the continuing education. This would ensure that the PE training begins with conventional classroom pedagogical events followed by a continuous on-the-job training process. By organizing the training within a program based on an alternative educational process will ensure quality training is constantly enhanced through continuous updating and improving of training topics, training materials and training protocols. Finally, the training will facilitate the preservation of a high level of skills, motivation and communication among all involved in training. It would be useful for PGB to establish an initiative through which PEs are invited to become trainers (first as helpers, then as assistant and later as co-trainers) bringing their views and perspectives to improve training. Finally, once the training program is fully operational PGB will be able the continuously assess training needs and program the required training activities in a timely manner.

Another persistent[16] issue is the lack of non-printed and printed BCC materials, basic supplies such as notebooks and pens, and particularly condoms needed to carry out their assignment. In every place where we contacted PEs, the complaint was the same: either they did not have condoms or they had just a few (e.g., about half a box in a school of about 3,000 students.) Often, the lack of inputs or materials is not related to limited procurement or production by PGB but rather is a distribution problem that according to our cursory review is more associated to logistics limitations at the provincial and district levels. Although it is opportune to examine this in detail, and upgrade accordingly the entire procurement and distribution plan, perhaps it is urgent to design a plan to solve the lack of condoms at the service level be it the SAAJ, counseling corners in schools or other school initiative, and at community points. It is a huge risk to be urging youth to use condoms, convince them, and then not to supply them with condoms. After

[15] The 2004 Evaluation report indicated 'that peer educators identify needs for more training, or updated training through refresher courses' which is basically the same of what we found in the field.
[16] This was also a finding in the PGB 2004 evaluation.

reviewing the 2004 Evaluation Report we asked how the PEs felt about the stock-outs. They felt a significant level of frustration with PGB for its unreliable supply of condoms, and with themselves because they believe it is their duty to ensure they are well stocked but do not know how the re-supply system works. PEs working at a SAAJ felt less constrained by this deficiency because they can obtain condoms from the health center to which the SAAJ is linked. However, this does not solve all their problems since what they procure there is just for the clients the served at the unit; they still need condoms to cover their out-school counseling and community activities. In Inhambane we had a very interesting meeting with a group of youth. They had received new audio-visual set by the 'system' but had not received any of the excellent audiovisual materials produced by the 'system', so, they show popular movies. This is a serious missed opportunity.

PGB should consider addressing the economic suffering affecting PEs. The main worry for the majority is to find a place to work. Everyone involved in PGB, including PEs, know that the Program cannot transform their volunteer work into a paid job – this would absorb all the funds available to PGB, leaving no funds for interventions. Employment with salary is not equal to a volunteer position that includes stipends or incentives in the form of meals, personal hygiene materials, transportation, t-shirts, etc. However, PGB can find more specific strategies to partially compensate PEs for their effort –because they really need this help-- and, at the same time, minimize drop outs and disruptions in the working of the Program, and finally to complete the task of forming them as *quadros*.[17]

The gender issue is a very pertinent topic related to PEs since there is the drastic disparity in gender distribution, more than three fifths are male and less than two fifths are female. Progress has come slowly but it is unrealistic to expect fast changes in this domain. Nonetheless, it is apparent that some Program interventions have brought about changes. For example, in 2004 the gender distribution of the peer educators in PGB showed an even greater disparity - only one third female and two thirds were males - than what we currently see. But we will discuss this point in detail in the next section on the gender issue.

3. Gender Issues

One of the most important concerns of PGB is to improve the socio-psychological and economic situation of young and impoverished women, particularly because they are the ones receiving such a heavy additional burden in their lives which boys will never experience simply because they are females. Accordingly, the Program has placed gender as an essential element in the Ministry programs and placed it at the core of every intervention in order to foster changes in the lot of girls in Mozambique.

Between 1999 and 2003, the Program saw little progress in addressing the gender gap. This was apparent, for example, when reviewing the data from the KAP surveys conducted in Maputo City and in the province of Zambezia during this period[18], none of the indicators associated with gender differences seem to reflect a significant change between the beginning and the end of the period. Although PGB did not experience a significant improvement in reducing the gender gap, important advances were achieved in other areas. Adolescent knowledge of sexual and reproductive health and behaviors related to HIV/AIDS significantly improved in Maputo City and in Zambezia province. One of the most important changes was a substantial increase in demand (by girls and boys) for the services offered by the PGB, both in terms seeking out the PEs for information and condoms and accessing SRH care and HIV testing.

[17] We also found a volunteer whose brother, also a volunteer, had been offered a much better deal, a "voluntary"-based post in a development project with monetary incentives that, not constituting a minimum salary, was far ahead of what real volunteers received in most development projects.

[18] PGB, Comparative Analysis of KAPB Studies Among In-School Adolescents on Adolescent Sexual and Reproductive Health and HIV/AIDS: Maputo City and Zambezia Province, Pathfinder International, Ministry of Education and UNFPA, Mozambique 2004.

The point that emerges when looking at the results coming from these KAP reports is that the data could be analyzed focusing on more specific issues, in order to yield more practical findings[19]. For example, in the study of the Maputo Clinic at the Hospital Central de Maputo (Pathfinder International, 2001), focusing on '*Sexual and Reproductive Health and Prevention of STI/AIDS among Adolescents and Youth*', we find an interesting situation associated with progress in gender gap; when analyzing the data, the variables 'Gender Awareness', 'Information about Sexuality' and 'Contraceptive Methods' show that girls seem to be somewhat at same level of knowledge than boys. And if we explore further, we could conclude that, at that time, the girls were already catching up with the boys and that girls were developing greater gender awareness, information about sexuality and contraceptive methods. Concerning any reduction in the gender gap among peer educators, PGB has detailed data on the PEs in their background and progress folders; unfortunately, this information was not available at the time of this evaluation. But, since the data exist, it would be useful to organize, process, and use them since they could yield results showing gains among the girls.

Today, the only available data the Program has concerning progress in gender inequalities among PEs, come from the study '*Improving Female Recruitment, Participation, and Retention among Peer Educators in the PGB*' (PGB, 2006) for the period 2001-2004. In general, the study results indicate non-significant changes in the gender gap; though it presents isolated pieces of positive results one cannot necessarily infer programmatic progress. It is not enough to concentrate the analytical efforts in one or two variables that may be significant in the direction we need to make our programmatic point. Looking at one of these findings, tenure of leadership positions, in 2004, there is a serious difference between boys and girls in tenure of leadership positions, 62% for boys and 38% for girls. Also the study shows that girls drop out of the program more when compared to the boys 30% for girls and 25% among boys. Finally, an interesting result from this research is that the comparison between 'intervention group' and 'control group,' out of 13 variables we found that in six there was a substantive difference in favor of the intervention group while five other variables we also found a substantive difference in favor of the control group, and in two variables we found no difference. To understand better the meaning of this result, we need to undertake further analysis of data.

Although the idea of gender equality constituted a unanimous concern for all involved in the development of PGB from the beginning, the Program started without an operational plan to increase and maintain the participation of girls in place. However, in response to the finding of the aforementioned study, PGB managers were able to understand key factors driving the gender gap: household chores come before many other activities, especially social or humanitarian voluntarism; traditional taboos that forbid a woman, particularly a young one, to talk outside the home about sexuality; the control that family members have on young women makes it impossible to join community or social activities without the express authorization of the head of the family; and daughters, especially unmarried ones, are regarded as caregivers by their parents and family.

As a result, PGB developed a specific strategy to attract young women to become PEs. The strategy included setting up a new enrollment process that would encourage the recruitment and participation of females; incorporating procedures to encourage their retention for a longer time; and instituting a substantive shift in the treatment of parents who were called to serve as catalysts for their daughters' participation instead of being a barrier. This thinking about young women guided PGB gender related interventions centered on female PEs and young women who receive the services offered by PEs at the SAAJs, school counseling corners, or in their communities. Nevertheless, the recruitment of male PEs continued to outnumber female recruits. In response, in order to reach an equitable participation of both boys and girls at PEs, PGB explicitly recruited more young women. Although the number of young

[19] Perhaps these scanty results are more an issue associated with basic and descriptive treatment of the data rather than the quality of the information. Therefore, PGB has wealth of data in all the surveys that conducted that should be further exploited.

women began to change after 2003[20], the process has proceeded slowly, and still today, boys continue to outnumber girls, have lower drop out rates, and have more chances to take on leading positions in the PE activities.[21] Independent of the speed or impact of the interventions, the entire process enabled PGB to identify a key problem, explore a solution, and implement it – this is valuable achievement.

There should be not doubt that the Program has made progress in this area. We need to unveil the results. There are many small and specific indications of improvement in the situation of girls in the Program. PGB should develop a plan of analysis to work this information in a more complete fashion. Frequency 2x2 tables and mostly bi-variate relationships are too basic tools to yield well grounded results. Usually, we do not see multivariate analysis in search for probed causality. Though the Program currently is not able to indicate with certainty how much progress PGB has achieved in reducing the gender differences, PGB has the information and capacity to determine definitive results.

In summary:

- There have been lingering questions regarding PGB's performance in addressing gender differences, and perhaps early on the Program did not fully address issues such as intergenerational sex. However, PGB has begun to move more aggressively and creatively in this area. For example, the recent video on intergenerational sex is excellent: the messages are direct and clear, there are no sexual stereotypes, the script is well balanced without slogans, and includes a very convincing conclusion. It is a valuable product for young people.
- A good start has been the PGB materials challenging sex role stereotyping in, for example, content and depiction of roles for males and females. Indeed, as mentioned earlier, this is one of several areas where the PGB has excelled: appropriate material, friendly and engaging to and for a young person, beautifully completed, editions of appropriate size, and, all in all, very acceptable distribution.
- Promoting greater equity between boys and girls in the groups of peer educators is an important objective, but not only as a number to show but also because of the unique inputs girls can bring to the program. This must continue following the special procedures for the recruitment and retention of more females as peer educators. The Program must put special emphasis on securing materials readily available (leaflets, CDs, posters, job aids, etc.) for the work of these volunteers.
- The supervision and support for female peer counselors is a critical factor in their development as outstanding volunteers. Girls need a supportive and knowledgeable female as their supervisor. This supervisor must make it a key objective of her action to give positive feedback to girl PEs. In addition the supervisory process must be systematic, regular and with frequent visits and meetings. Simultaneously to working alone covering her regular tasks, the female PE needs a group of reference, a support group where she belongs. This support group should be another venue to grow as a mature PE Between the supportive supervisor and the help from the support group the female PE will be able to address her fears and concerns and develop her proficiency and self-esteem.
- In order to continue to strengthen PGB's capacity to address gender issues, program staff should receive ongoing sensitization workshops on the importance of understanding gender concerns. The Program should continue to pursue the total elimination of sex role stereotypes in the interactions in the program at all levels in order to shape the PGB into a model of horizontally in all respects.

[20] In 2003 30% of girls dropped out of the Program while only 25% did so, although we have no evidence available regarding the level of significance of these data.

4. PGB Services

The provision of quality and easily accessible sexual and reproductive health services to improve the wellbeing of the young population is key to the PGB strategy. The PGB service strategy combines an integrated approach of school- and community-based interventions strongly connected to a clinic-based program. In this way, any action implemented in one point could reinforce initiatives developed at other points. A multi-sector coordination approach was expected to facilitate the interaction among the services provided by each sector. There is no doubt that one of the main achievements of the Program has been to make quality AYSRH services available through clinical appointments, counseling sessions and educational and information gatherings. Similarly, the coverage of young population being served by PGB has been growing continuously since the beginning of the Program in 1999.

Nevertheless, since 2004 this pattern of growth started speeding up, as it can be observed in the cases of Youths Reached by the PGB, Peer Educators Deployed and Condoms Distributed between 2004 and 2007 grew 114%, 211% and 73% respectively. Table 1 presents data on three indicators: Number of Youths Reached by the PGB, Number of Condoms Distributed by the Program, and Number of Active Peer Educators Active in the PGB during the period 2004 to 2007. Figures for this last year, however, are estimates based on partial information for the same year, sometimes also supported by trends in 2006[22], for further detail in the estimation of these values please see Appendix 5.

Table 1
Total Number of Youths Reached, Peer Educators and Condoms Distributed
Geracao Biz Program, 2004-2007

Youths Reached 2004-2007	**2004**	**2005**	**2006**	**2007**
Youths reached through School Program	355,000	477,279	554,344	683,263
Youths reached through Community Program	345,500	304,973	438,889	617,263
Youths reached through YFS Clinic Program	65,000	230,397	188,036	337,691
Total Youths reached by the PGB	**765,500**	**1,012,649**	**1,181,269**	**1,638,217**
Percentage Annual Increase		32%	17%	39%
Percentage Increase 2004-2007				114%
Peer Educators 2004-2007	**2004**	**2005**	**2006**	**2007**
Peer Educators in School Program	1,900	2,362	2,577	5,386
Peer Educators in Community Program	1,008	1,756	1,917	3,592
Peer Educators in YFS	25	119	67	129
Total Peer Educators in PGB	**2,933**	**4,237**	**4,561**	**9,107**
Percentage Annual Increase		44%	8%	100%
Percentage Increase 2004-2007				211%
Condoms Distributed in 2004-2007	**2004**	**2005**	**2006**	**2007**
Condoms Distributed through School Program	141,590	186,302	320,411	236,931
Condoms Distributed through Community Program	70,540	271,307	557,247	246,231
Condoms Distributed through YFS	891,064	1,138,013	987,241	1,420,252
Total Condoms Distributed through PGB	**1,103,194**	**1,595,622**	**1,864,899**	**1,903,414**
Percentage Annual Increase		45%	17%	2%
Percentage Increase 2004-2007				73%

[22] Given the fact that this evaluation was conducted in September 2007, the entire database for this year was not available. For this reason, the values corresponding to 2007 are estimations based on partial information, in some cases, corresponding to the three first quarters of the year, January to September [(Q1+Q2+Q3)* 1.25] and, in few cases, based on data for the first quarter of the year, (January to March [Q1*4] combined with the existing 2006 data. In Appendix Z a full description for these estimations are provided.

a. SAAJs and the Ministry of Health

When you ask any youth or adolescent attending a PGB service about their most the most important health concern, it is most likely HIV/AIDS and is often the key interest in accessing SRH services. An important achievement of PGB was to understand this concern, analyze it and come up with a specific plan, and put it out as a service that specifically responds to the needs of youth.

The health sector was the first to develop adolescent and youth interventions during the first period (1999-2004) by establishing and scaling-up SAAJs (YFS) which were included in the Health Plan 2004-08 and by establishing an AYSRH policy. All these steps confirm the MOH commitment to AYSRH-HIV/AIDS. Thus, PGB and the MOH developed and implemented an outstanding youth program which has resulted in the provision of a remarkable quantity of AYSRH services, particularly to girls, plus it has produced rich experiences and lessons learned for the future.

Most YFS clinics have well trained sexual and reproductive health services providers. They focus exclusively the population 10-24 years of age, promote condom use and dual protection, answer questions and provide helpful advice, they assure privacy and confidentiality, and work closely with VCT services and maternity wards to assist with PAC cases. And they serve a significant number of young clients. Most of the providers interviewed appeared to be comfortable in their work, able to relate well to their young clients, who, in return find them respectful, caring, and able to deal with their needs. The desire for confidentiality by youth regarding SRH is a strong requirement. The SAAJs are doing extremely well in this respect. The people in charge of this aspect are very protective of their task, particularly at sites with HIV/AIDS services. In general, services are very good with proper level of quality in an environment where good attitude is the norm.

During the period 2004 to 2007, there was a significant increase in the AYSRH services in both counseling and clinical services. The total number of young people served grew from 765,500 in 2004 to 1,012,649 in 2005 to 1,181,269 in 2006, and an estimated figure of 1,638,217 in 2007. The coverage of young population at the YFS more than quadrupled between 2004 and 2007, increasing from 65,000 to 337,691 - a yearly rate of 105%. Similarly, the numbers of SAAJs (or YFS) continuously increased since 2005. At that time, there were 80 YFS, by the end of 2006 there were 149, and by mid-2007, they totaled 180 - very close to the target of 200 YFS by 2008 set by the Health Plan 2004-08. The network of SAAJs has already a capability to attend more than 300,000 people. This is an outstanding achievement that needs to be well protected and nurtured and properly supervised to assure continued expansion of coverage, maintaining the quality of services.

Contraceptive services at YFS sites between 2004 and 2007 do not reflect the same pattern of increase than that observed in the total SRH services. Although contraceptive services also increased during this the same period, its changes showed a much slower rate. In 2005 only 15% of young women attending an YFS clinic received contraceptives, in 2006 this percentage went up slightly to 18%, and for the first half of 2006, the contraceptive prevalence rate (CPR) among young women, although close, did not reach 20%. The 2004-2008 Health Plan considered at least a 50% increase in CPR by 2008. It is difficult to expect PGB to reach this goal since only 22,000 of the 148,000 young women estimated to attend YFS during 2007 are expected to receive a contraceptive – that is, close to 1,833 young women per month. It is urgent to develop a specific strategy to increase availability of contraceptives, beyond the exclusive use of condoms. This strategy should also include the expansion of method mixed (now still stagnated at two methods, pills and injectables[23]) and an aggressive campaign to increase awareness and use of double protection.

[23] DEPO-Provera

The 2004-08 Health Plan also projects a significant growth in the distribution of free condoms. The plan began in 2004 with 1.2 million condoms, estimated to reach a distribution 2 million condoms in 2005, 2.5 million in 2006, 3 million in 2007 and 3.6 million in 2008[24]. However, the actual results showed a much lower performance: in 2004 PGB YFS only reached a distribution of 1.1 million (92% of target), in 2005 it distributed 1.6 million condoms (80% of target), in 2006 1.9 million condoms (75% of target). By April 2007, YFS have distributed 650,000 condoms; and if we project out to the end of the year, the PGB YFS will have distributed around 2 million condoms or 63% of what was planned for the year.

It seems that this continuous decline in performance in condoms distribution is related to the capacity of the contraceptive/HIV supply system to stock the Youth Program sites than to the capacity of the PGB PEs and service providers to distribute condoms to adolescents and youths. We believe that with an efficient supply of condoms, PGB is well positioned to exceed the targets set in the Health Plan for condom distribution by 2008. Unfortunately, this is not the case. In our field visits, we found the same picture of condom stock-outs at YFS, counseling corners and community youth sites. The reason seems to be that not all PGB sites are considered in the condom supply system and many times there is no place where they can obtain condoms. This is a serious limitation for the Program since it appears that Mozambique has been well provided with this contraceptive as an HIV protection method. This brings us back to the issue of sector coordination since it is the MOH that is in charge of distributing condoms. This would be an opportunity to test the capacity for change in the MOH and the flexibility of the sector coordination mechanisms to steer a solution that can supply condoms to all the PGB sites on a regular basis.

In 2005, an ART therapy pilot-project was introduced in two PGB clinics in Maputo City and Xai-Xai City. From these pilot sites PGB has gathered experience to continue expanding the initiative, representing a comprehensive initiative covering the prevention to treatment continuum. In 2005, the Maputo Central Hospital YFS performed around 2,000 HIV tests, 132 young seropositive persons are receiving anti-retrovirus treatment, close to 900 seropositive patients are under clinical follow up, 163 young pregnant women are enrolled in a PMTCT program and 162 families receive home visits regularly. Today, PGB has VCT services in 66 YFS compared to 18 in 2005. That is, YFS with VCT has increased from 23% in 2005 to 44% in 2007. In 2006, 77,500 adolescents and youth were tested for HIV[25] - that is, around 3% of the young population in the country. This is a good start but is still far from meeting the need in this area. Though modest, it is an achievement that can develop into a promising PGB initiative to expand access to HIV/AIDS services to all possible segments of the young population. Given a national seropositive prevalence of 16%, whatever PGB can accomplish in this area will be critical to protect the youth of Mozambique against HIV/AIDS.

In summary, PGB has developed a SRH service network that has 180 service delivery points (SAAJs or YFS) and is present in every province of the country; 66 of them have VCT services but only 30 have PEs assisting with AYSRH services. The network includes 754 well trained SRH service providers. All together they serve a population of 1.6 million youth and adolescents per year. Significant achievements were also reached in the area of HIV/AIDS for adolescent and youth; this is an area where PGB has had a fast learning curve and soon, the VCT initiative and the pilot- initiatives for seropositive young people will start producing ample results.

Lessons Learned and Next Steps:

- Logistics for condoms is in urgent need of an overhaul to become fully operational and secure the availability of condoms for HIV protection and contraception. This should be a key action of the National Coordination Committee and MOH, with the support of the PGB technical assistance.

[24] In Health Plan (2004), the Expected Distribution of Condoms was 2 million for 2005, 2.5 million for 2006, 3 million for 2007 and 3.6 million in 2008.
[25] At any clinic in the country.

- The coverage rates for HIV tests are still low, however this is a component that just began in 2005 and PGB needs time to learn more and set up services. This component has had some success, which helps point toward future directions. However, it would be important to increase the access to HIV testing and augment the sites with this capability.
- It is clear that young women are very receptive to start controlling their fertility. It is essential to change the approach to contraceptives distribution in the YFS, and expand the access to contraceptives and treatment of STIs. Both should be advanced through a special plan prepared by PGB to reach a CPR level between 25-30% in the shortest time possible.
- Two critical shortcomings were found in YFS: there are fewer health providers than needed and there is a serious shortage of PEs working permanently in YFS - only 30 of 149 YFS have PEs.
- It is important to work from every angle to ensure effective coordination between the three basic PGB interventions, particularly around the YFS which are needed by youth both in school and in the community.
- At this writing, PGB schools and community activities are not yet available in all the areas covered by YFS. It would be useful to develop a formal referral system to facilitate the access to any of the three services, including a methodology to follow up these referrals.
- Increase the training possibilities for health providers so they are ready for an expansion of AYSRH services. As part of the training program, PGB should train teachers in SRH preventive care so that they can help adolescents and youth when they have a serious problem, and also to become an additional element of support to the PEs when they face difficult situations.

b. Counseling Corners, Schools and Ministry of Education

The PGB School Program has done a good job in reaching youth and adolescents in schools over the past eight years. The educational sector seems to be making good progress, perhaps not as fast as in the health sector, but still significant. For example, in 2004, PGB reached 355,000 adolescents and youth, and in 2007 it reached 683,263 - a 93% increase in three years.

Summarizing program performance by this sector in 2004, PGB conducted activities in 120 schools with 54 teacher activists and 1,900 active PEs, reaching close to 355,000 youth during the year; they distributed close to 140,000 condoms, less than half a condom per person reached. In 2005, PGB conducted activities in 233 schools with 54 teacher activists and 2,400 PEs, reaching close to 480,000 youth; they distributed 190,000 condoms, again less than half a condom per person reached. In 2006 PGB held activities in 225 schools with 83 counseling corners and 2,577 PEs, and reaching around 554,000 adolescent and youth; the distribution of condoms was 320,411 during the year. For 2007, PGB implemented activities in 367 schools (a 61% increase from the previous year) with 83 counseling corners (same as in 2006), and an estimated 5,386 PEs (a 110% annual increase), reaching an estimated 683,263 adolescent and youth (a 39% increase related to the previous year); the distribution of condoms is estimated at 237,000, about a third lower than the previous years due to the increase in condoms stock out in the PGB sites.

However, behind this considerable growth there are some aspects that would be useful to examine more closely. Though challenging, PGB has the experience needed to understand how to provide youth friendly clinical SRH services, how to develop the capacity to provide the services as well as to evaluate their effectiveness and results. However, when the focus shifts to adolescent and youth needs in the educational sector, the task becomes somewhat less specific as most of the 'services' in this sector are associated with provision of counseling and information. The main goal of PGB is the improvement of youth sexual and reproductive health. To achieve this, the Program has focused on the fulfillment of two basic adolescent needs: a) the need for counseling on how to have a positive life regarding SRH and b) the need for information and services to protect themselves against unwanted pregnancies and STIs, particularly HIV. At the school level, the goal can be greatly advanced through counseling and attendance to school events.

The second purpose can also be developed through a friendly and informed distribution of condoms and referral to YFS services.

To address youth and adolescent needs, PGB conducts three main activities in schools: youth counseling by PEs at counseling corners, face-to-face support to youth by PEs, and school events where SRH issues are presented and discussed. Perhaps, the most effective interaction may be the counseling received at the counseling corners: there is enough privacy and the proximity of counselor to client to permit an effective interaction; the issue is whether there is any follow up. The face-to-face support seems to be effective but its results may be largely affected by environmental conditions; the interaction between student and PE can take place in diverse places within the school making it challenging to control for obvious disorder. Finally, the school events are the activity over which PGB may have the least control and we did not find evidence of any monitoring of results other than attendance. The events include activities focusing on information sharing and education and can take the shape of debates, video sessions, interactive exhibitions, cultural events, sport events, and others. Also there is interactive theater, access to IEC/BCC materials, radio broadcasting, and condom distribution.

In Table 2, the distributions of the young population reached through these interventions are presented for the last four years. Considering the three interventions --Counseling Corners, Face-to-face Support and School Events--, it seems that the trend taking shape is the reduction of the proportion of youth reached through the Counseling Corners and the growth of young people reached through School Events. In 2004, our estimations indicated that 13% of people reached in this sector where served through the Counseling corners, which in number means that 46,150 youths were attended there. In 2006, the data shows that the 6.5% of youth were reached through the Counseling Corners, or 36,010 youths (a reduction of 10,000); for 2007, the estimation (based on the first semester) indicates that only 2.1% of youths were reached through this intervention, implying that the actual number of those attended there would totaled only 14,349. This is indeed an important reduction in the efficiency of the Program if we consider that is in this intervention where young people can obtain the best assistance. This is an issue the PGB should look closer and find ways to turn it around.

Table 2
Young People Reached at School
Through the Different Interventions

Year	Counseling Corners	Face-to-face Support	School Events	No. of Youth Reached
2004	13%	39%	48%	355,000
2005	9%	37%	56%	480,000
2006	6.5%	24%	70%	554,000
2007	2.1%	40%	60%	683,263

On the other hand, when we consider the number of youth reached through School Events we observe a rising trend in the percentage reached through this intervention – an increase from 48% in 2004 to 56% in 2005, 70% in 2006 and 60% in 2007. This implies that the number of youth reached through School Events went from 170,000 in 2004 to 269,000 in 2005, to 388,000 in 2006 and to 410,000 in 2007. The other intervention of Face-to-Face Support remains at the same percentage level in 2007 as in 2004 (39-40%) but represents an important increase in absolute numbers from 139,000 in 2004 to 273,000 in 2007.

Counseling Corners not only have lost importance in the percentage of youth they reach but also the actual number of youth attended have diminished. A review should be carried out to consider: a) the reason for the reduction of the share of activities in the counseling corners and b) what can be done to

return to at least the 10-12% share. This review should also find more exactly what can be specified as outcomes from the different activities or interventions in this sector. What can be defined as the results from a counseling session or sessions; what could be the results from a face-to-face support interaction; and, finally, what can be obtained as results from participating in a school event. Of course, the final consideration is that all these results must have concrete means to be measured. This would permit outcomes and maybe an impact evaluation regarding behavioral changes. This is an exercise for which PGB has very competent professionals, particularly in the technical assistance.

The MOH announced that it included AYSRH into the curriculum (grades 1-7) and the teachers are being trained to teach the material. However, there has been little action in this matter lately. It would be important to determine to what extent the content related to SRH and HIV/AIDS have been appropriately included into the school curriculum, and make sure their inclusion is useful and operational. Also, the training of teachers in SRH and HIV/AIDS has been announced but it is not clear how much training has taken place. There is a pressing need to extend the training with PGB activities; generally, the PEs have more knowledge about SRH and HIV/AIDS than their teachers. PGB has developed a new approach to teaching about HIV in the schools that has already produced very good results; this can also be used by the school system, particularly in the training of teachers. It would be important to review this point. In general, PGB has made progress in this sector: there are a significant number of schools in the Program, the counseling corners are popular sites and young people go there, face-to-face support interactions have developed a great demand, and school events are very well attended. Unfortunately, the continuous shortage of condoms jeopardizes this intervention. What is the point of promoting the use of condoms if the system does not provide them? It can be said that PGB has established a channel to reach youth in schools and help them to adjust their behaviors. What is still needed is for PGB and the MOE to streamline the interventions toward specific results and, monitor them closely. Recently, it was announced that UNICEF`s “Family Life Education” which included SRH and HIV/AIDS is ending. This is going to increase the burden on PGB and the MOE to ensure youth are informed, educated and counselled regarding SRH and HIV/AIDS.

PGB has placed significant attention on reaching new schools and has amply succeeded in this course of action. Currently, the PGB school network with AYSRH counselling, information/education and referral for services encompass close to 400 schools with 83 counseling corners, it has a team of more than 5,300 active PEs, and it is able to reach, at least, 680,000 youth per year. In general, the educational sector has significant potential to reach youth and help them take control of their sexual and reproductive health. However, the counselling corners have dramatically decreased their role in providing services. It is very important to refocus PGB attention in strengthening counselling corners which are the point where the Program can provide the most substantial service to youth through this sector. In addition to the suggestions that have been presented above, we believe it is critical for the MOE to develop mechanisms to strengthen its management of school interventions - for example a system to monitor and supervise youth activities. PGB can supervise PEs but it would difficult for the Program to monitor or supervise teachers.

c. Out-of-school Services and the Ministry of Youth and Sports

If we had problems trying to understand the outcomes produced by the school-based interventions, the challenges are multiplied when dealing with out-of-school or community-based interventions by the Youth and Sports sector. In the educational sector, for example, we found statistics that revealed trends, though with some effort. However, statistics of the community interventions do not always follow a pattern and in order to understand the development, or evolution, of this PGB sector one has to check into other possible sources.

In 2005, PGB involved 233 youth associations and groups, in 2006 the number grew to 272, and in 2007, they remained at 272. Considering the number of active PEs in this sector, we found 1,008 in 2004, 1,756 in 2005, 1,917 in 2006 and, 3,592 in 2007. The Program reached a total of 345,000 adolescents and youth

in 2004, and 304,000 in 2005, it grew considerably in 2006 reaching 439,000, and it is estimated to reach 617,000 in 2007. In 2005, 40,000[26] youth were reached through face-to-face support in the communities; in 2006 PGB reached 124,000, and 2007 we estimate they will reach 145,000. In 2004 PGB reached 295,044 adolescents and youth through open community youth events; in 2005 it reached 255,000; in 2006 it reached 315,285 and in 2007 we estimate that 490,000 youths will be reached in the communities.

Finally, regarding the number of condoms distributed in the communities, in 2004, PGB dispensed 71,000 condoms to adolescents and youths; in 2005 it distributed 270,000 condoms to these groups, and in 2006 this figure almost doubled to 560,000 condoms. However for 2007, the most we could estimate for condom distribution would be less than 300,000, an important decrease compared to those distributed in 2006 but only a 10% decrease from those distributed in 2005. It would be interesting to research the reasons why condom distribution could almost double between 2005 and 2006 and then decrease by 55% from 2006 to 2007. When considering the stock-out factor, the answer people gave is that stock-outs have existed from the beginning of PGB. In any case, stock-outs would affect the school based interventions in the same way, but in this sector the condom distribution only decreased by 20%. Perhaps it would be advisable to conduct an evaluation of the out-of-school interventions in order to find well-grounded answers to these questions. This review could start with a thorough examination of the statistics from the community interventions – we might have a combination of faulty data and a performance down turn.

Although the MYS contributed significant policy advances regarding youth and HIV planning[27], it may not be completely proactive in leading and managing the PGB program under its responsibility. As a consequence, the out-of-school program functions with little guidance, their central and provincial planning are not always reflected in the actions at the base - that is, the communities. In addition, its out-of-school PEs have a hard time implementing their tasks in the field. Although they implement multiple community activities they have very few resources to carry out their activities and become truly effective; they have very fragile and inconsistent supervision and support; they lack transport and materials; they also lack continuous training and guidance to help them to grow as PEs. Finally, they do not know what team and what institutions are responsible for supporting their day-to-day work in the field.

What makes the implementation of PGB activities more cumbersome and weak at the community level (compared to the MOH and MOE) is the fact that out-of-school interventions do not have a physical point of reference in the communities. The MOE has schools and the MOH has health facilities, but the MYS has no natural place to base the Program's activities. This is a serious challenge for the community-based activity and needs to be addressed by the MYS with the support of the technical assistance. A well working multi-sector coordination could also be a tool to find a solution to this lack of grounding in the community.

Some have proposed that the needed reinforcement of leadership could be supplied by extending the scope and responsibilities of youth associations. However, this would only be productive in the case of Maputo City which has youth associations that are stronger and better developed than those in the provinces - youth associations and groups cannot help solve the leadership and management shortcomings in the provinces. The MYS may have very limited technical capacity to support youth groups to develop PGB actions: MYS personnel assigned to PGB in the provinces have limited or no background in AYSRH, or social and humanitarian project implementation and the MYS has limited capacity to work with youth groups in the communities and lack understanding of needs and issues of youth. Within the MYS organizational chart, PGB is under the responsibility of the department of Projects and Studies. Before PGB, this department had no functions linked to the communities and youth groups.

We met with several youth associations and groups during our visits to the provinces of Maputo, Inhambane and Cabo Delgado. Some of them were weak despite the fact that they had received important

[26] It could assume somewhat the same level for 2004.
[27] The development National Youth Policy and POSIDA.

support from PGB, those without substantive support were not clear about their relation with PGB and tended to focus on their legalization as an association to become eligible for funding from different sources, and on the organization of football games. The provincial groups did not have the same characteristics as AMODEFA and COALITION, the two main associations collaborating with PGB in Maputo City. The number of loose youth groups increased from 39 in 2005 to 41 in 2006, and remained steady at 41 in 2007. These youth groups lack basic organizational structure and have minimal outreach capabilities, including many of those in Maputo city.

Beyond the question regarding specific performance issues of the out-of-school youth intervention, there is in general a question about the global functioning of the sector. From an evaluators' perspective, the MYS is the sector where the Program has more shortcomings than in the other two sectors.

A general conclusion regarding Services and next steps:

In summary, the Geração Biz AYSRH services are the most important endeavor of the Program and the teams involved in its implementation have done an outstanding job. The Program's achievements are considerable and the future of PGB is even more promising. To be reaching close to 2 million young people per year is not an easy task and PGB has achieved this by effectively addressing the neglected AYSRH issues, implementing realistic strategies to provide services to meet the needs of youth. Thus, over eight years PGB has laid the foundation of a potentially sustainable AYSRH system, and this base is firmly planted in Mozambique. It is essential to continue strengthening the base since the work to date has been a heavy and delicate task to accomplish. Yet, the task ahead regarding AYSRH is not an easy one: there is a need to strengthen and perfect service delivery strategies in each of the sectors involved in the Program, including the face-to-face interaction between young clients and providers as well as the support systems required to provide quality services.

C. Support Systems

1. Communication and Development of BCC and Training Materials

PGB BCC and training materials are very well designed and produced. The capacity of the communication team is exceptional in its creativity and ability to adapt materials to the audience. There are various products – e.g., a recent video on intergenerational sex, video '*Risco Zero'*, *Manual de Activista*, the radio program *Mama Biz*, the poster with the hands of a girl and a boy, and others, that by far surpass the quality of other materials available in the development field in Mozambique. In general, the communications support system produced materials that are particularly well prepared for young people. Some of the materials are designed to assist in carrying out a specific activity while others are put together as material for any PGB implemented activity. In any case, they always use appropriate words to express content and a balanced approach to controversial issues, avoiding the use of stereotypes to express an opinion or a belief.

These materials are quite diverse, and this technical diversity could have resulted in materials that do not relate perfectly to each other. However, one of the most interesting aspects when comparing the materials is that every one of them connects with the others. It is as though PGB has been able to develop a trade mark for its BCC materials – through colors and tones, lines and borders, photographs and drawings, sizes, and so forth. This capacity to use different media in the development of materials has been very helpful to the Program because it is possible to choose a specific medium that could helpful in reaching a particular population, or to treating a precise topic.

The BCC and training materials are updated on a regular basis. The communication team, in coordination with other technical PGB staff, search for new approaches or techniques to reach youth; when new methods are identified and selected, the team adapts and fine tunes them to ensure the content and style

are effective in working with youth and providers. For this reason, PGB also continuously assesses the need for new materials, be they for reaching a new population, or to add a new content to the Program, or to include the emergence of a new approach that can help the implementation of a specific intervention. Given this continuous evolution of the BCC and training materials, we recommend PGB implement periodical training courses to assure a continuous updating of the PEs on the use of new materials. The training program would accompany the development of the materials guaranteeing that PGB will have more homogenous cadre of PEs who know how to use all PGB materials.

A few PGB services providers and managers expressed a need for specific materials that could help treat particular topics (i.e. such as on intergenerational sex), materials that can be better understood by non-literate or barely literate people, and materials in local languages. It seems that the PEs are always in need of more materials; sometimes they request more of the current materials and at other times they request fresh materials to treat usual topics or to use on new topics.

The dearth of non-printed and printed BCC and training materials is a persistent problem. Everywhere we heard similar complaints from the PEs. They needed more material to carry out their assignments - condoms and appropriate BCC material. They claim that usually they are missing one of them, and some times both. However, it might be that this issue does not belong to this section because it is may be related to limited procurement of some materials or associated to distribution shortcomings. In any case, it needs to be addressed and continuously monitored. It would be a shame that some PEs could not have access to these first-class materials especially given they were produced specifically to support their work.

Another concern related to BCC materials is that, according to some provincial youth, PGB has materials (mostly posters) that were misleading to them and, therefore, they concluded the materials were produced with Maputo City in mind and the opinions of provincial youth were not considered. In the future, it would be appropriate to involve provincial level youth in the validation of these materials.

There is no doubt that this component of the Program is one of the best and has contributed significantly to PGB's solid performance. The communication team runs an impeccable process in the development of BCC and training materials, and the resulting products have proven to be extremely useful and educational. It would be important to ensure this team will remain in place throughout the life of the Program.

2. Training Component

We conducted a review of the training materials and conclude that they include appropriate content and practical guides presented in a clear format. The curricula, protocols and tools, are very relevant, of good quality and have a very practical structure and organization. The materials can be used with ease, are not voluminous or fragile, and are of sturdy material for field work. The evaluation team observed two AYSRH training events that were very well organized with 22 to 26 participants, two trainers, and one or two assistants. The training program was comprehensive, the materials used had appropriate subject matters, and the instructors were direct and clear in presenting the scheduled topics. In both cases, the trainees participated actively and their high level of engagement indicates they may very well be able to apply their new skills in their work. If most of the training events are similar to the observed workshops, the training can be considered a success.

The evaluation team was very impressed with the general knowledge of PEs. They use what they know well, they express themselves with clarity and, they are learning to say '*excuse me but I do not know that, I will ask my supervisor and have the answer the next time*.' Even young PEs were proficient communicators which is big plus in working with youth. All the PEs have been trained by PGB using the same teaching principles and materials, which may facilitate the monitoring of changes in attitude as a product of training inputs.

Although PEs know how to carry out their job well, there is consensus that they need more training and PE candidates need a more comprehensive training. This was a persistent concern, also noted in the 2004 PGB evaluation, and it has been fully supported by the PEs themselves. As we indicated in a prior section, this perceived need for additional training is not related to the quality of the teaching, the educational material or curricula used for training PEs. Furthermore, we strongly believe that the training materials and other BCC materials should be shared with other programs in sub-Saharan Africa. The PGB level of effort in training is immense. However, it seems it is planned to happen on one-to-one base. We are sure this is not the case but it looks that way. This way, the training component may disappear when outside funding is phased out. A sound initiative in this regard would be to insert the trainings scheduled in PGB for the four following years within a Training Framework.

Thus, we propose to develop a Participatory Training (PT) Program based through a participatory strategy for service delivery, community development, management, and training management, based on a training needs assessment in the areas of management of services. The methodology for the PT Program should center on trainee participation and used case studies, participatory exercises, demonstrations and persistent dialogue. This program should not only be based on classroom sessions but also should pay particular attention to the continuing education aspect of training – that is, begin with conventional classroom pedagogical events followed by a continuous on-the-job training process. Also, PGB should organize the training within a program based on an alternative educational process which will guarantee that quality is continuously enhanced through regular updating of training topics, training materials and training protocols. The following activities should be implemented:

- Develop Participatory Training Strategy for service delivery, program management, and training management. The Project team developed a comprehensive training strategy that served as the framework and guide for the design and implementation of all training efforts.
- Conduct a training needs assessment in the areas of intervention in order to determine the programmatic priorities for training providers in the three sectors.
- Establish a formal training program (in classrooms) and prepare a training work-plan for all three sectors health, education or youth & sport sectors.
- Emphasize in-service training in AYSRH including service organization and planning as well as community development and management. The training should following the protocols taught in formal training, covering specific delivery practices, critical issues and possible solutions. PGB managers should make periodic visits to PGB sites to observe service delivery, to provide immediate feedback on practices, and to reinforce appropriate routines.
- Design and implement a Training-of-Trainers Program to offer participants the opportunity to acquire knowledge about training theories, to develop necessary abilities and attitudes for effective coordination and management of training in AYSRH, and contribute to human resource development.

The PT Program should also include a component to encourage trained PEs to share their knowledge with colleagues; PGB should support workshops in order to keep the PEs up to date. This program should also be expanded to educate parents and community PEs in the PGB community-based component. To implement the PT Program, PGB should establish agreements to contract outside AYSRH trainers and work with others, particularly the MOH, MEC and MYS, to reinforce and assist existing training efforts, rather than introduce an independent training component.

Finally, the participatory training strategy will facilitate the preservation of a high level of skills, motivation and communication among all those involved in the training process. The Program should consider launching an initiative through which PEs are invited to become involved as educators in the training processes and courses (first as helpers, then as assistant and later as co-trainers) to bring their views and perspectives to improve training. Finally, when the training program is fully operational, PGB will be able the continuously assess training needs and implement training activities in a timely manner.

3. Monitoring and Evaluation

The Monitoring and Evaluation (M&E) system developed by Pathfinder and UNFPA is very good. There are, however, a few challenges that need to be reviewed. The system appropriately captures results from the service delivery level. Indeed, the focus of the PGB evaluation system is service delivery, with primary focus on AYSRH services; and this approach has continued to be reinforced in the work of the program management and technical assistance at central level and in the provinces. The incentive for focusing in service delivery is very high, since its related outcomes are relatively easy to measure.

There are some important pieces of information which are not captured through the system – namely the other PGB interventions such as capacity building, multi-sector coordination, advocacy and building of civil society. In addition, the system does not pay much attention to the outcomes from the services provided by the PEs, particularly those in the education and youth and sports sectors. This needs to change if PGB wants to report all the successes achieved by the Program, particularly those associated to the strategic working of the PGB model and the evolution of each of the four strategic components (services, advocacy, multi-sector coordination and capacity building), and their interactions. Also, reporting only the advances in SRH services provided through SAAJs is not sufficient, since there are other equally important service points such as the counseling corners, community youth groups and youth associations. PGB needs to focus on key indicators of organizational dynamics and management in order to reflect the national ownership of the initiative.

The M&E system is mainly concerned with monitoring program activities. Of course, this is not bad for PGB; it is, indeed, a good thing to monitor interventions. Plus, the monitoring component of the system is user friendly, dynamic and could accommodate an appropriate level of analytical complexity. Then, the monitoring component constitutes a substantive plus. The monitoring component was improved in 2006, after a significant amount of data was lost due a malfunctioning of the subsystem. The problem of the old system was quite serious and PGB had to develop new software that is functioning well but still is underused[28].

Although the monitoring system is well designed and works well, PGB has not developed yet indicators to measure final results and be able to evaluate impact, nor has it developed suitable sub-routines in the MIS system[29] for registering and processing impact. PGB has the results from the KAP studies which have been conducted at regular intervals, and have good quality baseline surveys as each new province is added to the program. PGB has captured a substantial amount of valuable information from the surveys. This information is extremely useful in analyzing discrete aspects of the Program, but there is consensus that the KAP data do not fully answer the question of whether PGB is having real impact because they cannot connect the KAP results with service data. Moreover, data from the KAPs cannot be used to evaluate progress in the strategic organizational model of the PGB, specifically, capacity building, advocacy multi-sector coordination and civil society.

Also, in 2006, after the MIS crisis, technical assistance was strengthened with the hiring of a new M&E Responsible, a Sociologist with background in survey research and statistical analysis. Now PGB has the human resources to lead evaluation efforts related to processes and impact. The following tasks should to be carried out with urgency:

- It is very important to define and make operational a limited set of indicators dedicated to measuring the AYSRH impact of PGB interventions and examine current process indicators.

[28] Versions of this new software have been installed in all provinces.

[29] The MIS to support M&E is excellent and works very well; however the databases are either not up to date or incomplete.

- Complete an inventory of data available to measure these indicators and establish the cost and time for recuperating the data vis-à-vis the cost to obtain the missing data through new means.
- The M&E system should define a framework for quality of data production and processing as well as timely reporting results on quality in order to support decision-making processes.
- There is some, though incomplete, empirical evidence indicating the probability of substantial impact of PGB on AYSRH; however, there is no appropriate data available to actually measure the final effects of PGB on AYSRH. This can be solved by reviewing the data that disappeared in the MIS crash through the use of the KAP data as well as through the streamlining of the impact component of the M&E system which could provide solid information for the coming years of implementation.
- The M&E component needs to be reviewed to identify priorities and ensure PGB can capture evidence of impact. For this, it is necessary to develop an analytical framework and organize the framework, MIS and databases into one system.
- The M&E system needs to be continuously used and managed and the databases need to be updated on monthly bases. For this, the M&E team needs to be complemented with additional human resources.
- PGB needs to develop a plan to recuperate as much data as possible that was lost as a result of the malfunctioning of the MIS software in 2006.

4. Research

Research is always a good support for decision-making, M&E, and planning. However, the usefulness of this support is tightly related to the organizational capacity to process and analyze information in a timely manner and to the existence of conditions for sharing information and introducing findings into the programmatic planning. PGB has conducted an important number of studies, most of them of excellent design and extremely useful results (information.) At the center of this survey scheme are the KAPs, population-based surveys focusing on knowledge, attitudes and practices of the young population, and conducted in each province where PGB is being implemented. This is a very important body of data that can help determine results, maybe including results very close to impact, considering that the most important use of these KAP data is to assess increase in knowledge and behavioral change in the target population, which is a particular type of impact.

At this point, PGB has made only sporadic use of the data produced from by its research program. The consultant who conducted the surveys only completed very sketchy surveys. The reports include only a basic analysis, univariate or bivariate, and do not attempt to put together multivariate models for analysis or do they consider finding proved explanations. In summary, the PGB has put limited effort into conducting exhaustive analysis that can feed decision making and planning. And the technical assistance does not have the resources to tackle this task. For these reason it would be important to:

- Decide whether to implementation additional research studies after a serious assessment is conducted regarding their usefulness for achieving project objectives and their cost.
- Adjust the PGB research component vis-a-vis the objective of the Program so that their findings can help streamline current interventions and plan future expansion.

D. Four Strategic Paths

The organizational growth of the PGB is expected to come from the functioning of four strategic paths – services, advocacy, multi-sector coordination, and capacity building—and their interactions with each other. According to those involved in PGB, the engine driving the entire system is the multi-sector coordination, while the capacity building support would enable the engine to run better. Advocacy has a role pressing for the rights and needs of adolescents and youth, - while services is the mechanism to the reach adolescents and youth. Another way of looking at this program is that the multi-sector interaction is the force that moves the entire model forward, capacity building is the source of knowledge, skills and

know-how, advocacy is like the coach, always asking for a little more, and the services are the outputs of the system that are received by the target population.

Though this model has proven successful, there are some questions to consider: Is it acceptable to leave the target population as a passive receptor of PGB services, or should the youth participating in this venture as PEs be a key element in the implementation of the services? Thus far, their role seems to be limited. While the sectors are at the core of the working of three of paths (multi-sector coordination, capacity building and service delivery) and clearly present in the fourth one (advocacy), the youth do not figure prominently in the model. Actually, the youth seem to be at the margin of decision-making, as they are beneficiaries of the outcomes of the system. This is also a strategic issue since it has to do with the dynamics of the system (PGB) and also with the future replication and sustainability. As we review the four strategic paths, we should keep in mind the role of the adolescents.

1. Service delivery

Service provision is the central focus of GBP since its main objective is to provide adolescents and youth with new knowledge and skills as well as offer them access to appropriate services to enhance their sexual and reproductive health, particularly the reduction of the incidence of early pregnancies and vulnerability to STIs and HIV/AIDS. Adolescents and youth receive services through the activities conducted at schools, at youth points in the communities, and at the SAAJs. And each one of these service sites is under the responsibility of one of the three Ministries. Our analysis of service delivery in previous sections of this report concluded:

- The services in the three sectors are functioning very differently but it appears they do not follow one unique strategic leadership, and, because of that they do not respond the same management, monitoring, and supervision approaches.
- There is no systematic synchronization of program activities among the sectors that could assure a successful and smooth multi-sector coordination at all levels and in particular at the local level (districts and communities).

There is consensus that the MOH leads the activities under the service element. The SAAJs are considered the most successful service venue in PGB. The MOH made significant political investments at the beginning of PGB and it is still very much responsible for the running of these youth friendly services. Here, the only component that we found not to be functioning at the expected level was the involvement of the PEs in the delivery of services, in great part due to the resistance from health service providers to accept PEs as partners in the provision of AYSRH services; implying that the PEs do not belong in the SAAJs. Of course, there are very good exceptions indicating that services where the health service provider and PE work as a team can produce better results than the conventional model of the service provider working without the support of a PE. In this model, the young client would have a PE orienting and assisting her or him in making decisions regarding SRH options.

The indications that services are not progressing in concert, and each sector is not necessarily benefiting from the positive effect of services in the other two may signal insufficient multi-sector coordination. That this, the sectors are not receiving the effect of the expected synergies possibly due to political barriers or because there is not enough or appropriate know-how to operationalize the mechanisms for coordination. In any case, it is clear that the coordination among the sectors as well as the technical, organizational and managerial capabilities of the three Ministries can affect the outcomes of services in each sector. We believe that to some extent the coordination is happening within PGB. A renewed emphasis on multi-sector coordination and a significant acceleration of the capacity building activities could strengthen the services provided by all three sectors and will help develop a sense of PGB services over sector-specific services.

2. Advocacy and Policy

Advocacy is a key component in bringing to the surface the rights and needs of adolescents and youth and in developing the legal mechanisms to protect them. Similar to Service Delivery, this component or path has been making significant progress over eight years, particularly in the last three years. In addition, it is important to indicate that the three sectors have been willing to collaborate to mobilize ideas and resources to implement various advocacy campaigns and push forward policy initiatives in their areas of concern and influence. Major achievements reached by PGB in the development and establishment of policies include playing an advocacy role in the protection and provision of services to youth, the establishment of guidelines for a YFS model, the introduction of SRH/HIV/AIDS subjects in formal education, and the development of a national AYSRH policy. PGB has also assisted the advocacy efforts of youth groups by providing technical assistance to the Advocacy Group, which includes PEs from various youth associations, organizing them by thematic area such as policy coordination, communication and events, monitoring and evaluation, and research. Furthermore, the results of PGB's advocacy and policy activities are reflected in the continuous advances in understanding of AYSRH issues and the significant increase in condom use.

Though PGB has been instrumental in promoting positive policy changes, the multi-sector coordination has not necessarily played a significant role. Here the coordination role was played by the technical arm of the program, UNFPA and Pathfinder, providing operational support to push forward advocacy initiatives and policy proposals. This could have hindered the growth of ownership by the three sectors, but it was a critical initiative to be undertaken. Moving forward, however, UNFPA and Pathfinder should develop a plan to transfer the coordination responsibility to the PGB National Coordination Committee. PGB should continue placing special attention to the following:

- Address and clarify, from a conceptual and practical point of view, who is responsible to advocate for national government policies needed to protect youth: NGOs, UNFPA, and PEs.
- Address the lack of knowledge and use of advocacy techniques among PEs at district and local levels.
- PGB has successfully advocated for a national AYSRH policy, now is the time to push for the full implementation of the policy.
- In all three sectors there are discrepancies between policy, allocation of resources, and action. These should be addressed in order to develop the conditions for full transfer of the PGB to the Government and facilitate the sustainability of the Program.
- Some government officials still perceive PGB as external rather than as a government program. This affects the transfer of PGB to the Government and requires the full attention of the Program to be corrected.
- Community support has helped foster a positive environment, but broader support would be useful for the success of the community-based program.

3. Multi-sector coordination

Multi-sector coordination constitutes a central concept of PGB and its implementation is critical to the working of the Program. However, there is not much evidence that this coordination is fully operational or that it has produced the expected level of synergetic effects among the sectors. Multi-sector coordination is a very good mechanism for social programs where more than one governmental institution is involved or responsible for the outcomes of the program. This approach is widely used in the development field, particularly in health, education, environment, and water sanitation programs. Our review of several multi-sector coordination programs indicate that this is a harsh approach to carry out and the results only come very slowly. Perhaps, the most important advice to accomplish this is to be persistent.

It is not uncommon for public sector institutions to clash over organizational domains. However, despite these clashes one could find instances of coordination and cooperation. For a program to be well coordinated its different components need to be compatible and their interactions should not generate frictions. Thus, coordination requires a capacity for adjustment and the establishment of collective goals (Alter and Hage, 1993.) External coordination beyond organizational boundaries is a more difficult task because it requires much more cooperation. In this case, cooperation is understood as an organizational behavior in complex societies, where the normal rules or rewards and punishment do not exist (Axelrod, 1984, Lincoln, 1985.) But before organizations can achieve this level of coordination and cooperation, they need to trust each other. And this is also a step by step process.

At the central level, multi-sector coordination needs to be strengthened and more efficient mechanisms to encourage interactions among the sectors at all levels should be put in place. We perceived that PGB understanding of multi-sector coordination is satisfied by holding multi-sector meetings. The meetings are thus transformed into an indicator reflecting the multi-sector coordination accomplishments. Meetings can be useful and necessary but they are one element in actual coordination; a more important element is the actual working together: field work, conducting analysis, procurement of materials, assessing progress, and training people. By working together, the multi-sector coordination will start growing from the bottom up and will remain stable. PGB should promote the concept of a transition from 'sector implementation' to one based on 'multi-sector team work.' At the provincial levels, coordination works moderately as people work easily together in planning, monitoring and field assistance. However, it is necessary to involve the top leaders of each sector in multi-sector team work in order to protect initiatives that could be easily stopped if it does not have the approval of the sector chief. At the district level, though coordination is still insufficient, although there is significant potential for more interaction since people know each other better and there are some resources to invest in the communities which will necessarily require for people to coordinate. At this point, it is important to minimize the development of sector by sector PGB implementation and instead facilitate the full establishment of the multi-sector approach.

There are operational shortcomings that could be easily solved through coordination such as securing condoms for the counseling corners and out-of-school youth activities, placing PEs all SAAJs, incrase outreach to schools from the health units, and control bias against PGB volunteers in both schools and health units. Thus, the opportunity for working together to solve specific problems could constitute an opportunity to encourage multi-sector approach.

The effective working of coordination will be extremely important in the future success of PGB once the donor begins to phase out. Consequently, it is very important to assess and strengthen the coordination capacity in each sector at all levels. This strengthening should start with creating the opportunity to know –or re-know - each other and follow this with a well focused team building experience. PGB should begin to work with the idea of creating a global plan out of the plans of each sector. This globalization of sector plans will permit PGB to think in inter-related objectives, implementation, and expected results. Also, PGB should develop inter-related activity monitoring and supervision, and design inter-related evaluation plans with specific targets for each sector.

Priority tasks to strengthen multi-sector coordination include:

- Review the accomplishments of this component, identifying the barriers that slow down the process as well as the areas where the process could be accelerated.
- Identify the points in the PGB system where the definition of teams could facilitate coordination.
- Schedule team building workshops at all levels.
- Promote development of multi-sector plans in each province and district.
- Plan PGB multi-sector activities and implement them with a multi-sector team.

- Develop a strategy with youth organizations to include youth as a partner, or as a 'sector' in the PGB.
- Promote and strengthen youth associations as a potential key element in clarifying youth issue in the civil society.
- Jointly discuss the availability of supplies, particularly condoms, in each sector

4. Capacity Building

Capacity Building[30] is well known throughout the for-profit field. However, this has not been the case in the nonprofit area (government programs or private nonprofit ventures.) There is limited information about what works and what does not in building organizational capacity in the nonprofit area. Therefore, the task of building high-performing *organizations*, rather than just strong programs, can be difficult. Often, while the benefits of capacity may be compelling, the actual effort of building capacity can seem discouraging. We now recognize that most of the issues – reproductive health, family planning, malnutrition, HIV/AIDS, maternal and infant mortality – will not be "solved" in our lifetime, and therefore will require stronger organizations to continue addressing them. Organizations or institutions have an obligation to seek new and ever more effective ways of making tangible progress toward their missions, and this entails building organizational capacity.

The fact that PGB was designed with a capacity building component was an outstanding choice. It is not common for a program like this to consider in its design the weight of capacity building. It is, indeed, a big positive point for the designers. It is an even better input because in the case of PGB since capacity building constitutes an important element for several reasons: a) the Program comprises three institutional 'organizations' with a huge audience (adolescents and youth)[31] who need the Program services and b) the Program needs to create the conditions for these three organization to learn to work together and coordinate with each other. For this coordination to have any meaning organizationally it must have a sense of 'cooperation.' Thus, the organizations should learn to support each other and cooperate with each other. This is indeed a mighty task! And we believe capacity building is a methodology that can help PGB get there. It is important to have a very clear plan for what needs to be done in order to achieve the objectives. The goal of capacity building is to build knowledge, power, and effectiveness to better engage adolescents and youth at the different programmatic sites, in their schools, and community.

The PGB approach to institutional capacity-building is based on four components: (1) Skills, which are developed through training of staff and volunteers involved in the program activities; (2) Tools/Instruments, which are prepared by PGB to improve MIS, develop and maintain a computerized M&E system, and build the capacity of PEs to enter data and report through the PGB computerized monitoring system; (3) Staff and Infrastructure, which is ensured through training, supervision, and rehabilitation/construction of infrastructures (YFS, SAAJs and counseling corners); and (4) Structures, Systems and Roles, developed and defined by the top management team in consultation with second or third level managers and technicians, and is characterized by the adoption of a multi-sector approach to develop mechanisms to reinforce the coordination system.

The PGB capacity development component is somewhat diffuse, only few top members can describe this as a specific component with a specific plan and expected results. This is a point the evaluation team discussed at length while in Mozambique. There are a number of activities and outputs proposed and planned described in various Program documents. However, there is limited evidence to determine whether the activities were implemented and the expected results obtained.

[30] By "capacity-building," we mean building the capacity to fulfill an organization's mission. In the widely-accepted definition given by authors Letts, Ryan and Grossman (1999) it means the capacity for an organization to deliver a program, to expand it and to adapt to change.

[31] Around 6.5 million people aged 10-24 years.

The four-component paradigm adopted by PGB is an acceptable model, however its components need to be clarified. Are they within a framework that makes their presence explicit in the model? What are the assumptions that permitted the selection of the four components and not others? Why are some elements together in a component, e.g., '*Staff and Infrastructure'* and '*Structures, Systems and Roles,'* and not by themselves? PGB may have an implicit framework but it needs explicit explanations to help translate the capacity components into operational, or measurable, definitions. In turn, these capacity components would call for capacity building interventions and these interventions must be monitored and measured.

The focus of the main intervention in capacity building is institutional training and, indeed, training is an important input to strengthen institutional capacity. However, the most critical aspect of capacity building is the use of new information on the job. To accomplish this, PGB needs to develop specific processes to enable the trained staff to use and incorporate the information received into his/her work responsibilities. However, we are not sure if this critical intervention, 'training' is consider as a having an expected result in component 1 '*Skills*' or component 3 '*Staff and Infrastructure*.' or whether training supposed to have an impact on both. And, how is training going to affect these components? The development of tools to support institutional capacity is another important issue.

Although Pathfinder has developed instruments, mostly associated with computer use, to conduct such activities, the results of their applications are limited. This application needs to be monitored and evaluated for appropriateness, and adjustments should be made if deemed necessary. In addition, there is a need to develop additional instruments and tools that are more conceptual – e.g., an index able to measure the complexity of capacity building. The last two components, '*Staff and Infrastructure'* and '*Structures, Systems and Roles',* perhaps due to their combination into sub-components, are even more difficult to define operationally.

Table 3
Capacity Building Indicators

#	Indicators	Measurement and Sources
1	Districts implementing PGB	PGB records
2	Administrative posts involved in PGB (school)	PGB records
3	Administrative posts (community)	PGB records
4	Technical staff trained	Training records
5	Active trainers	Training records
6	Trained leaders	Training records
7	Scholarships granted	Grants records
8	Study visits & Conferences	Grants records
9	Access to internet	IT records
10	Equipment and vehicles	Car pool inventory
11	Community radios	Community records
12	Number of bicycles	Community inventory

Sometimes the selection of indicators helps to clarify the definition of the dimensions or components. In addition to the four capacity components, PGB identifies twelve indicators – see Table 3. However, these indicators do not present any explicit association to any of the four capacity components described above. We may be able to guess, but this is not the best way to assess a social or management phenomenon.

The easiest indicators to measure are those related to training - e.g., the number of persons trained - and those indicators that just need to be counted. However, there is no connection from training to capacity –

for example, we could find the connection between organizational capacity and training in 'strategic planning' or in 'time management' and, maybe, we could predict how much capacity would increase with the training program covering seven or nine key topics. But, not every training subject will have this connection or will produce a change in capacity. Therefore, we need a training program specifically associated with capacity building that takes into account all levels of the organization (in this case PGB). And all the indicators should be integrated into a plan of analysis that specifies the expected results for every interaction.

It would be useful to search for a specific theoretical model of capacity building. If this already exists within PGB, it needs to be disseminated. PGB should check to what extent the selected indicators are capable of expressing results in capacity building. With this theoretical framework in hand, PGB should determine the information that is needed to observe the variations in capacity. It will be necessary to expand the number of indicators and to incorporate them into an analytical plan to define the modes how they could determine the level of capacity. Capacity building is a phenomenon that is harder to measure than what is happening with the services in a SAAJ, for example. However, this is not a reason to become discouraged, and not to measure the level of improvement in organizational capacity.

The PGB institutional capacity-building component also includes technical assistance as an important input for capacity development. Its task is broad: training of staff, study visits, exchanges and participation in relevant meetings and conferences for PEs, scholarships for program staff at governmental and non-governmental level, and access to the internet for the central and provincial level staff. This assistance has been very important in the development of the component. Moreover, it has been agreed that the implementation of this component is responsibility of the Technical Assistance. The top Ministry officers interviewed both at national and provincial levels, complained about the lack of ownership of the organizational capacity component of the Program. However, if the Technical Assistance (UNFPA and Pathfinder) is a provider and facilitator for capacity building, they need an 'organization' that requires to more capacity. Without this 'organization' the provider-facilitator achieves nothing, no matter how many training it conducts, how many e-mail stations it installs, how many scholarships it grants. We believe it is a mistake to consider the TA as responsible for the Capacity Development component. The TA should be the provider of overall facilitation for the capacity building process, not more or less.

At this point, all parties involved should to review their roles. The Government should lead PGB and if the current management is not able to lead the entire implementation, the Government should change the management. At this point, after eight years of trials and errors, the Government needs to take charge. And capacity building can become a tremendous assistance to this process. PGB as a whole should be the subject of the capacity building. On t he other hand, the challenge for UNFPA and Pathfinder will be to be very clear regarding their involvement in taking on management tasks in PGB, and particularly in capacity building. Their role in this component is to facilitate the process but not to manage it, also to assist with the training and the development of mechanical or conceptual instruments.

We believe the PGB team should review, streamline, and strengthen its capacity building framework. In doing so, they should pay more attention to the theoretical definitions and organizational arrangements, which could facilitate the pursuit of appropriate and sensitive indicators at both national and provincial levels. The PGB team could conduct data collection, measurements, and analysis as a collaborative task among the sectors. This review process could begin by looking at other capacity building modelling and best practices in order to find alternative capacity building models for implementation in PGB. For example, an alternative and somewhat more holistic capacity framework defines nonprofit capacity in seven necessary capacity elements:

a) Three higher-level elements: the first, *aspirations* that contains the mission, vision, and goals is at the peak of the organization; under this definitional element is the second element, *strategy,* that

sums up the plans to achieve the objectives; and the third element *organizational skills* that constitutes the existing organizational resources.

b) Three foundational elements, that, unlike the higher elements, these are all at a same level, like pillars of a building providing the operational bases for implementation: *systems and infrastructure,* constitutes the material ingredients of the organization; *human resources,* the people to operate the material resources; and the *organizational structure*, that defines how individuals interact to use the material resources to achieve objectives.

c) The *culture* element includes the above six elements permitting their inter-connectivity (McKinsey, 1998.)

The use of this framework has generated several key lessons that may be useful to consider in building the capacity of PGB:

1) there is not much capacity to gain by focusing on the periphery of the organization, as the largest return in organizational capacity will come from resetting aspirations (that is, mission, vision, and goals) and strategy;
2) recognize that investing in good management will increase capacity; and
3) one needs to be patient, since capacity building takes time and is complicated. In fact, capacity building is a step-by-step process requiring time for reflection, experimentation, and discussion.

Table 4, below, summarizes the elements of this framework.

Table 4
Effective Capacity Building for Nonprofit Organizations

Category	Element	Definition
Higher-level elements	**Aspirations**	An organization's mission, vision, and overarching goals, which collectively articulate its common sense of purpose and direction.
	Strategy	Coherent set of actions and programs aimed at fulfilling the organization's overarching goals.
	Organizational skills	The sum of the organization's capabilities, including such things as performance measurement, planning, resource management, and external relationship building.
Foundational elements	**Human resources**	The collective capabilities, experiences, potential and commitment of the organization's board, management team, staff, and volunteers
	Systems and infrastructure	The organization's planning, decision making, knowledge management, and administrative systems, as well as the physical and technological assets that support the organization
	Organizational structure	The combination of governance, organizational design, inter-functional coordination, and individual job descriptions that shapes the organization's legal & management structure
Connecting element	**Culture**	The relational mechanisms that binds together the organization, including shared values and practices, behavior norms, and most important, the organization's orientation towards performance.

Building capacity doesn't just happen, it takes work and time. It takes leadership, a plan, and support from the top. Having the ability to build capacity is vital to the long-term effectiveness of an organization. In order to build capacity we need to know how much capacity we have and what still needs to be developed. To achieve this, it is necessary to be able to measure the above seven elements. Any serious assessment would identify key gap, determine what should be tackled first, and what intervention would give the greatest return on investment.

It is not possible to continue focusing on programmatic improvements while maintaining organizational capacity at a minimum level. Actually, excellence in programmatic innovation and implementation are insufficient for nonprofits to reach lasting results and to achieve their missions. Great programs need great organizations behind them and the only way to build great organizations is to build capacity. PGB is a great Program and now it needs to focus on building the capacity of the entire organization if they want to maximize their social impact. To ascertain a direct relation between building capacity and social impact is a difficult and elusive task. However, a more systematic focus on capacity building will produce better information, and this will make possible the establishment of more substantial connections between capacity building interventions and social impact.

Some Reflections on Capacity Building and Immediate Task:

Robust capacity-building is the result of a strong, respectful relationship between a ready and willing organization and a provider-facilitator working with a set of core consensual principles. Though these principles may vary from one framework to another, in the end all models tend to share very similar principles. As an example, following is a holistic view to keep the interaction organization-facilitator moving and healthy, based on the following values:

1. Every organization is capable of building its own capacity. Accordingly, it is not just enough to innvite an organization to become part of the capacity building process, but it is critical to recognize that the organization is in charge of its own capacity building.

2. Trust between the organization and the provider is essential. Trust is at the heart of any capacity building principles. Trust is also a value that reinforces itself: the greater the trust, the better the principles work; and the better they work, the greater the trust in the process.

3. An organization must be ready for capacity-building. Groups can gain from capacity building at different stages of organizational life, if they are: open to change and willing to question themselves; can clearly describe their mission; key members think capacity building can further the mission; and are prepared to commit the necessary time/resources to the process.

4. Ongoing questioning means better answers. It is better for organizational growth to work in a setting in which questioning and feedback is encouraged, and true understanding is welcomed, not avoided. Also, this is the way to finding out the organizational needs and getting a better idea of how external skills can help.

5. Team and peer learning are effective capacity-building tools. Peer learning (whenever peers engage one another in an exchange) and team learning (experiences designed specifically for people who work on teams) are good for capacity-building. These processes enable more people to contribute to further an organization and can supply the additional drive needed for change.

6. Capacity-building should accommodate different learning styles. Individuals have different ways of learning, some learn by doing, others by experimenting, others by talking, and others by observing, etc. Often these differences reflect culture or class. Wherever these diversities come from, sound capacity building should consider them all.

7. Every organization has its own history and culture. Effective capacity-building must take into account all of the forces that shape an organization: mission, values, organizational culture, environment in which it has to navigate, and the culture(s) of its affiliates.

8. All people and all parts of an organization are interrelated. An organization is a system in which, everything that happens within it affects everything else. A holistic perspective looks at all of the parts and connections that make up the whole.

9. Capacity-building takes time. Intensive long-term training prepares people to develop organizations, later on, capacity-building tasks continue imbedded in the daily work. But short-term capacity-building sessions are also valuable, strengthening particular skills or solving specific problems.

PGB should review the implementation of the capacity building component, including:

- Inventory the capacity building activities implemented over the last three years.
- Assess the existence and quality of the capacity building activities database.
- Examine the rationale of the current framework and expand the conceptualization, if necessary.
- Clearly identify a provider-facilitator who can accompany PGB in its organizational capacity building component.
- Define the limits of the organization (PGB) and of its effective leadership and decision-makers. Organize this process through workshops, ensuring the participation of all segments.
- Define an operational methodology to address capacity building and allow for timely measuring of progress.
- Review the current indicators and select a set directly associated with components of framework.
- Organize a data collection model and plan.
- Conduct an organizational capacity needs assessment.
- Identify specific areas of capacity that are strong and those that need improvement.
- Draw out different views (at different levels) within an organization regarding its capacity.
- Following the findings from the capacity needs assessment, develop a work plan for capacity building.
- Measure changes in the organization's capacity over time, collect data periodically and conduct analysis.
- Adjust work plans according to the findings.
- Feed decision makers with information on progress in capacity building.

E. Sustainability of the PGB

In general, health development or humanitarian programs should consider four critical dimensions to achieve the expected use of services and improved health status: Access, Quality, Demand, and Sustainability of services. Sustainability of any program always constitutes a considerable concern and, more often an overwhelming challenge for local institutions, including MOHs, to attempt and to achieve.

To begin a discussion of sustainability one must first address its definition and, second, consider the real possibility for a resource poor country to achieve sustainability for its health programs. There are many opinions, but let me present two to illustrate the difficulties in assessing the sustainability of PGB. The two points of view are at a different ends of a spectrum. The first is the position of development agencies that propose the need for sustainable health programs as a measure of development. The second is the position of emergency organizations that believe most of the problems addressed with development funding are really emergency situations; and for emergency, sustainability does not have a role to play.

A good example of a development agency framework was developed by the Office of Sustainable Development of USAID's Africa Bureau. Its health and family planning results framework defines sustainability as: "*...the ability of host country entities (community, public and/or private) to assume responsibility for programs and/or outcomes without adversely affecting the ability to maintain or continue program objectives or outcome*s…" (Mehdi S, 1999.) This model, a rather comprehensive one, was developed to help program officers and managers to define indicators of sustainability for health programs. The model includes sustainability indicators for health programs that examine aspects of

ongoing activities that can be used to predict future sustainability; they are also used for monitoring and process evaluation purposes.

The measurement of sustainability is based on a conceptual framework for Africa where the importance of sustaining health status is acknowledged, and not only the delivery system. The model includes several elements that contribute to sustainability, encompassing both supply and demand issues as well as the socio-economic context of health systems. It distinguishes between sustainability of systems and sustainability of demand, both necessary to achieve a viable system that produces healthy outcomes. Within systems, it identifies three components: financial sustainability (10 indicators), institutional capacity (13 indicators) enabling environment (14 indicators). Demand sustainability has two main components: ability to pay (1 indicator) and attitude (8 indicators). In total, 50 sustainability indicators, the values of which could be combined together to indicate the level of sustainability of a given program.

The other extreme, in our example, is represented by the position on sustainability sustained by Medecins Sans Frontier (MSF). They are critical of the health development approaches pointing that measuring sustainability is useless since this is 'illusionary' in the world's poorest countries.' This stance is very well presented in a paper by Gorik Ooms from MSF (Belgium), written in 2006. Dr. Ooms suggests that development agencies want their interventions to be sustainable, which implies that countries where programs are being implemented need to have adequate and reliable funding of their own to secure the running of the programs (Salomon J, Hogan D, Stover J, Stanecki K, Walker N, 2005). Furthermore, the emphasis on sustainability of health programs generates a dichotomy between medical relief and health development, and a competition that has brought about senselessness turf battles. In many cases it is difficult to determine whether to address a severe health problem using a development approach makes sense when the health situation is defined as an emergency as in case of an epidemic such as HIV/AIDS.

He further indicates that, the focus on development sustainability has stopped urgent initiatives in Africa, particularly in HIV/AIDS. A good example of this is the case of Mozambique, a country highly affected by HIV/AIDS with many HIV positive people who need antiretroviral therapy (ART), which in Mozambique is also unsustainable. When the Minister of Health included ART pilot projects in its 2000 proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria, the development agencies opposed ART funding. This position has since shifted from prevention toward a balanced approach that includes prevention and treatment. However, some of the development advocates proposed at the time the rationing of ART to make sustainability possible, which is just a new way to assume that universal access to ART is unsustainable. This strong opinion proposing that sustainability promoted by development agencies is an illusion (Ooms, 2006; Kremer, 2004; Salomon, 2005; MSF, 2005) and sustainability is not possible in the poorest countries. Therefore, foreign aid will be required for a long time if the developed world wants to assist in solving the health problems in developing countries.

The presentation of these two positions regarding sustainability illustrates the difficulties we may encounter in pursuing sustainability for PGB. The last opinion presented which advocates that sustainability is an illusion puts programs managers in a dreadful situation. What would happen in those poor countries that cannot achieve sustainability if the donor agencies decide to stop their assistance programs? In this situation, the development position could be rather helpful, but only if we can find methodological paths that can measure the real capacity of the programs to achieve a sustainable operation. The determining of indicators is difficult and sometimes controversial because program managers need to consider whether the program was designed to address sustainability and specify how it was addressed and proposed to be measured. If sustainability was not considered in the design, it becomes difficult to measure progress in this area.
Beyond the issue of appropriate funding, sustainability is always a product of a process, the implementation of interventions, and not a discrete input that we can be put in at a given time into a project. It is a component that needs to be designed, developed and continuously strengthened in order to obtain sustainability results.

The 2004 evaluation of PGB noted that funding is not the main issue in sustainability. We believe that funding is very much a main issue for sustainability. Though the Government could progressively begin to assume some PGB costs [32], this will not eliminate the need for external aid for such programs. In addition to financial support, the most pressing issue to assure sustainability is to have a technical and management team that knows the PGB approach and technology.

We believe the developers of PGB had sustainability in mind when they framed the leadership of the Program in a multi-sector approach and included a strong capability building component. For that reason, we need to return to these two aspects that were already presented in previous sections: the need to strengthen the multi-sector collaboration strategy and develop a strong capacity building component. PGB has a strategy but it is still not fully applied. And as mentioned earlier, PGB should redirect this component, re-think it in the broader framework of sustainable development in which it can more easily include the differences that may exist in the local settings, as well as all possible social, political, economic, and cultural relationships so essential to the social system (Innes and Booher, 1997) where youth survive today in Mozambique. Sustainable development demands a look at the big picture, in this case the youth environment, in order to critically analyze and adjust managers thinking regarding the complex relationships among this population (De Vita, C.J. and Fleming C. 2001.)

In the following sections, we review various aspects –management, technical assistance, scale up and relations with other projects-- that may have affected or can affect the sustainability of the Program.

1. Management and Program organization

Management is a critical component for Program sustainability when PGB is fully in local hands. For the last few years, Program management and its organization has continued to run well. The attention to the provinces seems to be timely, though Inhambane and Cabo Delgado reported they experienced delays and irregular flow of funds, causing problems in program implementation. UNFPA confirmed that some times the funds have been sent late to the provinces and the team was making changes to ensure a regular and timely flow of funds. Supplies and other materials are well managed, with the exception of the supply of condoms which continues to be a big problem for the PEs and the clients.

In general, it is difficult to assess the functioning of the Program management. At the Office of the temporary Coordinator of the PGB[33] in the MYS, we did not see it functioning as a coordinating body but rather as a unit of the MYS, where they shared information regarding the out-of-school program under the supervision of the MYS.

Nevertheless, we PGB is being managed - after all, PGB is not a small Program. It has a service network of 853 different types of delivery points, about 9,107 peer educators, reaching on average **136,518** young people per month and distributes at least 160,000 condoms per month[34]. This massive venture could not

[32] In fact, in some provinces they already doing this, for example, the MOH in Inhambane has provided funding for the development of YFS structures.

[33] At the time of the evaluation the sector in charge of the Program coordination was the Ministry of Youth and Sports.

[34] For this year, 2007, the figures indicate that the PGB reached 1,638,217, deployed 9,107 peer educators and distributed 1,903,414 condoms.

move without administrative and managerial support. The partial answer to the question lies in the fact that there are three PGBs: one managed by the MOE, another by the MOH, and a third managed by the MYS. They are run with substantial independence, have separate budgets and even have their own technical assistance. I believe a situation like this, with separate management, could provide more room for efficiency, better coverage and closer monitoring and supervision. However, where does it go beyond coordination to work as a single undertaking? And how does such a system facilitate synergies? We believe the answer is in technical assistance.

Technical assistance providers from UNFPA and Pathfinder indicated they did not believe they should be involved in management aspects of PGB. However, they had undertaken tasks which were not in their scope of work to ensure the launching and implementation of program activities. In some cases they begin by supporting an activity in a province and end up in charge of the entire endeavor. On occasions they make up for the limitations of the sectors involved because there are few human resources and their skill levels are low. After eight years, the sectors were expected to have a relatively sizeable group of people with sufficient technical and managerial qualifications to replace the technical assistance. This has not happen yet and it is very difficult to foresee when the replacement process could start. It is important for the sector officers who sometimes complain that 'the technical assistance is running the show', that often what technical assistance is doing should be executed by their staff. In any case, there is a powerful reason to ground and streamline the capacity building component in order to be ready for the transfer of functions within at the most in two years.

In conclusion, PGB Management over these eight years has been implemented by five teams, two of them made up by technical assistance. In the future, in order to ensure sustainability, the sectors should minimize the fragmentation of management and the technical assistance should play a supporting role.

2. Technical Assistance

The technical assistance (TA) support that is provided for the implementation of PGB is considered by everybody to be very effective. We are happy to share this view. The TA works in two tiers. The first tier is at the central level, either with the sector headquarters and another team in charge of providing technical support in programmatic areas. These two segments of the technical assistance are organized and managed by Pathfinder International. The second tier is installed at the provincial level, and each province has a technical advisor who is paid and coordinated by the UNFPA.

The provincial technical assistance is seconded to the PGB Provincial Coordination in each province. Currently PGB has seven provincial level TAs (in Maputo, Gaza, Inhambane, Tete, Zambézia, Cabo Delgado and Maputo City). There are also three health technical advisors to support the Health Provincial Directions as regional advisors. In general, they are very committed and hard working professionals, most of them have training in public health. You see them everywhere and they seem to be responsible for every piece of action in the province. However, they can hardly be considered a team and, it seems, they are not managed as a team, but rather on an individual basis. Therefore, they are generally on their own. An additional issue is the frustration of the provincial PGB management because they feel the T.A. personnel is not totally under the provincial PGB leadership since they claim they are ready to respond to requests from their central levels, without passing them through the clearance of the provincial TAs. These resources are used to carry out an incredible portion of the work in each province, including monthly or quarterly report, to data entry and analysis, to guiding guests, etc. They are trusted by the provincial managers and respected in the districts and communities.

The three technical assistants assigned to the sectors in Maputo City are well experienced specialists in the areas of education, public health of youth. They work well in their assignments, sharing information and helping each other, particularly with problem solving and strategizing. They also seem to have some

coordination from their managing organization. In addition because they are in Maputo city, the have more opportunities to ask for help. They are recognized as valuable human resources by the three Ministries.

In addition, there is the Pathfinder and UNFPA central technical assistance team formed respectively by teams of twelve and six professional staff, who are central to the operation of the Program. They lend support without interfering in the actual running of the Program by the PGB Coordination Team or by the Ministries. They provide support when requested and maintain excellent relationship with individuals and organization involved in PGB. Their tasks are extensive and it is surprising they do not experience more frequent burnouts. Summarizing theirs tasks we found that they: a) respond to the tasks in their own scope of work, b) facilitate coordination of events, c) assist PGB Coordination Committee and/or the any of the three Ministries in problem solving, d) manage any special activity that may have been left unplanned of unattended. There may be other tasks but the ones described can easily fill the time of 12 well qualified professionals, and more. They are a valuable staff, trusted and respected by the PGB National Coordination, by the Ministries, and the provincial teams.

As discussed briefly in the previous section, there is a pressing need to discuss the technical assistance role and scope within the Program. It is important for the development of PGB to fix a timetable for transferring functions to a national team; this transfer should be initiated well before the phase-out of the technical assistance team, in order to have plenty of time to accomplish the goals of the capacity development component. Hence, one of the goals of the technical assistance should be to provide technical backing to all implementing and managerial teams in order to secure the strengthening of the institutional capacity building process. This technical support should be framed in a training model that includes the transfer of knowledge and skills while focusing on securing the completion of the task – this could be called a reflection in action process.

In summary, the central and provincial levels Technical assistants should be maintained, at least for the next two to three years in order to ensure proper technical transition and enable the district level to have received the technical support they need to start planning and implementing more effectively.

3. Scaling up

The scaling up of PGB is ready to enter its final phase now that it has interventions in all the provinces of the country and it covers about 45% of the districts. The expansion of the PGB to all provinces was a task that faced and resolved many critical challenges, but at the same time, the final success of scaling up demonstrated the replicability of the PGB. This replicable character facilitated the process of organizing the provincial and district leadership, the development of systems and the introduction of specific interventions. In addition, the design of PGB makes its replication possible in other countries of Africa. Moreover, PGB considered as an implementation strategy could support the development of social programs outside the realm of adolescents and youth.

This expansion proceeded with significant involvement of the Ministries; although, the donors were also very involved. In fact, the Government has been closer to the implementation activities in the new provinces. This represents an important step forward in the forging a national ownership of the Program, because although GBP has made progress in institutionalizing activities, methodologies, tools and instruments within government institutions, the actual appropriation of PGB by the government had been limited. The expansion to all provinces has been successful despite the doubts people involved with PGB had regarding the need to develop human resources for a successful scaling up and, also the view at the central level that there was a need to continue to strengthen support to the provinces already in the Program before expanding to new provinces. Nevertheless, the expansion proceeded with significant interest in and commitment to the Program.

4. Coordination with related projects

There is no doubt that the PGB is a leading AYSRH Program and all other initiatives associated with this broad concept of health. Perhaps the most important issue associated with health today in Mozambique is HIV/AIDS since about half the infected people in the country are young. Another important health area for youth are contraception, post-abortion care and safe abortion, and maternal and child health care. Of the issues outside the realm of health, the most important one is expansion of employment opportunities and the fight against poverty. In Mozambique, we find initiatives in all these areas and it is would be important for PGB to establish coordination mechanisms with all these venture to be able to seize opportunities the youth can use in extending their influence over what it is being done and also to increase their control over their own situation.

PGB should increase its coordination efforts with HIV/AIDS initiatives. The evaluation team perceived that this coordination and integration is limited and, perhaps, is only effective at the level of information sharing. This low profile in coordination with HIV is understandable given the enormous volume of work that has to be done by PGB. Some times, we found better coordination of youth associations with HIV/AIDS projects. At provincial level it was reported that PGB is not always part of the HIV/AIDS coordination but in most provinces some measures have been taken in order to share information. However, this does not imply a strong or moderate integration. Significant amounts of funds are channelled directly to the province and district levels for HIV/AIDS, these are mainly World Bank funds. At the provincial level it was reported that youth groups and community groups within PGB could apply for these grants. It was also reported that the various ongoing youth activities at provincial and district level should try to include and use the YFS.

PGB misses out on additional funding opportunities by not coordinating with, or rather integrating into HIV/AIDS initiatives. The importance of coordination goes beyond funding opportunities since it has to do with information, networking and control of the environment of health programs and the possibility to increase the opportunities for PGB to get closer to its goals. We believe that it will be a critical task for PGB in the coming years to network throughout the health, social and economic programs that could make a positive difference for youth in Mozambique, and try to coordinate efforts for the best combined results. We have little doubt that the development of a network of initiatives aiming to assist those young segments of the Mozambique population most affected by the drastic changes in the country during the last thirty years will solidify the options for sustainability of the Program. Because, if the PGB becomes a leading initiative in the programs aiming to the upturn of the youth share in the Mozambique society, its presence among social programs and policies will become essential to the country.

Wrapping up the issue of sustainability:

Even with all the positive signals for the future, sustainability continues to constitute a serious challenge for the Program, and it is critical to consider some serious sustainability issues in analyzing or planning the future of the Program. Doubtless, the quality of PGB services has clearly established it as a leading AYSRH program and this could help convince the Government of the need to ensure its continuity. After all, the need for sustainability has been always on the minds of those working on PGB and its transition from a pilot project to a national program. The most important sustainability test for the PGB is the generation of local conditions for sustainability: including the transfer of strategies, methodologies and instruments to the Ministries and their institutionalization, the development of a top management team able to work on their own with limited technical assistance, the decentralization of program and financial management, and the development of staff who can manage PGB with dedication and excellence.

In summary, with regard to the sustainability of PGB, it would wise to invest in two original components which have not made major advances: multi-sector coordination and capacity building. All this is actually in the hands of the current management of PGB, and it should be their main task for the next few years.

To better frame the interrelation of multi-sector coordination, capacity building and sustainability, we would like to change somewhat the focus of our analysis from the broad concept of sustainability to a more operational concept of sustainable development that to some extent represents better the tasks that PGB has to undertake to become a well grounded national program for adolescents and youth health. We focus on sustainable development because it places the management of the process of change at the core of the framework, recognizing uncertainties as a normal part of the environment, and therefore, the need for flexibility in order to move toward the objectives. In this broader framework of sustainable development we can more easily include diversity and differences that may exist in the local setting. Moreover, "inherent in this concept is consideration of the social, political, economic, and cultural relationships fundamental to the organization of society" (Innes and Booher 1997). Sustainable development always demands having in mind the big picture of, in our case, the youth environment, and "thinking critically about and fine-tuning the small intricacies of the relationships that ultimately shape these communities (De Vita, C.J. and Fleming C. 2001.) We think this could help in re-organizing PGB thinking for the future and facilitate the necessary focusing in the organizational and managerial development of the Program to adding flexibility to the organizational system.

E. The Financial Situation of the PGB

This evaluation did not have the opportunity to focus in detail on a financial assessment of PGB. However, in conducting the program evaluation, it was possible to obtain an overall idea of the financial situation of the Program. This overview allows us to determine that there are no substantive programmatic shortcomings in PGB from the financial management. This is not a marginal achievement given the complexity of the management of the Program. In Table 5, below, shows that PGB has expended US$18.9 million through 2006. It also indicates that between 2002 and 2005, PGB expended around 3 million per year but, while in 2006 it expenditures increased to US$5.2 million, almost 82% of the available budget. It seems that it was a normal trend in PGB to expend less than what was budgeted because in 2005 only 72% of total budgeted funds were spent. If one estimates the funds available between 2006 and 2004, we conclude the total budget available to PGB between 2002 and 2006 was almost $24 million, and the Program expended only 80% of it. If this is the case, we believe the annual budget may be too high and PGB should review the causes of this low level of expenditure.

Table 5
Annual Expenses (in Million US$)
Sexual & Reproductive Health Services for Adolescents and Youth Project

Year	2002	2003	2004	2005	2006	Total
US$ Expenditure	2.9	3.7	3.8	3.3	$5.2	**18.9**
US$ Available	3.6 estimate	4.6 estimate	4.7 estimate	4.6	$6.4	**23.9**

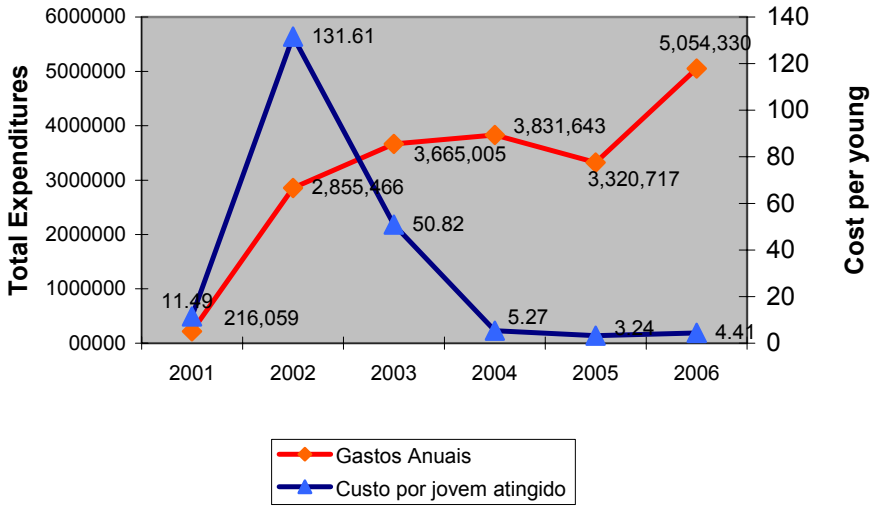
Our program review in the field enabled us to identify some issues affecting field work. For example, as mentioned earlier, sometimes the flow of funds to the provinces has been delayed and irregular. Provinces reported delays in funding reaching their areas causing problems in program implementation. In our conversations with UNFPA, they recognized delays had occurred and assured they have taken steps to solve the problems. The new measures will ensure regular flow of funds reach implementation areas.

The Program has been successful in decentralizing some of its financial activities. The goal of PGB was to decentralize 40% of the financial resources[35] assigned to the Provincial Health and Education Directorates and 30% of those for the Provincial Directorate of Youth and Sports, with purpose to be executed at district level. This goal has been also achieved. Another promising finance consideration is the potential for some PGB costs to be absorbed into government budgets. In some provinces (e.g., Inhambane) sectors (health and education) have made significant investment in equipment and

[35] From the support coming from UNFPA

infrastructures (SAAJs). However, the most outstanding financial result we identified in reviewing the 2006 annual report was the analysis of the cost per adolescent or youth served by PGB, and the systematic stabilization of this cost after 2002, when it reached it highest cost level of US$131.6 per capita. Since then the programmatic cost per capita decreased to $50.8 in 2003, $5.3 in 2004, $3.3 in 2005 and, it has stabilized at $4.4 in 2006 – see Graph 6 above. We conducted an overall review of results and they appear to be representative of the actual cost trend. Without a doubt, this is an outstanding product of the PGB management. This is a good indicator to plan more precisely what the Program could achieve with the funds available as well as to determine how much funding PGB would need to achieve expected goals.

Gráfico 6. Gastos totais anuais e custo por jovem atingido. PGB, 2001-2006



V. Conclusions

Mozambique is one of the most impoverished countries in the world and is among the countries hardest hit by HIV/AIDS. The AIDS epidemic is exacerbated by extreme poverty that has dramatically affected the young population aged 10-24 (about 6.5 million people and more than a third of the country's population). The population between 15 and 24 years are more than 50% of the new HIV infected people under 30 years of age. In addition, girls and women have a much higher risk (2/1 ratio) of HIV infection than men. According to PGB data, approximately 70 % of adolescent girls had been pregnant once. Thus, Mozambique's youth population faces multiple risks and challenges on their way toward maturity.

The evaluation found that PGB is one of most successful social programs of the last decades in Mozambique. It has a wide coverage, it is accepted and trusted by the young population, and it has provided opportunities for the development of new leadership among the youth, enhancing the technical, managerial and political capacities of the country.

A. Sexual and Reproductive Health Services for Youth

PGB is present in every province and has developed a SRH service network consisting of 180 YFS service delivery points; 66 of which offer VCT services. The network has 754 services providers well trained in SRH who serve a population of 200,000 youth and adolescents per year. Considerable achievements were reached in the area of HIV/AIDS for adolescent and youth. The main concern regarding the health service network is the low involvement of PEs in YFS as only 30 of the 180 SDPs have peer educators assisting in the attention of youth. Another concern is the readiness of these YFS to serve young women with contraceptives despite the fact that they are very receptive to start controlling their fertility. The YFS need to adjust their service delivery to ensure and expand access of youth to contraceptives and STI treatment. PGB should aim for a CPR of its target population of 25-30%. The health sector has made tremendous progress. However, MOH support for the Program has weakened compared to its initial commitment, putting at risk the functioning of YFS with the possible re-assignment of providers or the inclusion of adult patients in the SAAJs. This is an aspect PGB needs to analyze closely and look for possible venues to reverse the situation.

In the educational sector, PGB has made some progress, slowly perhaps, but still significant. There are three PGB activities in schools: counseling of youth by PEs at counseling corners, face-to-face support to youth by PEs, and school events where SRH issues are presented and discussed. The most effective interaction is the counseling received at the counseling corners. However, it seems there is a downward trend in the use of the counseling corners, as PGB is reaching more youth through 'schools events', 70% of the students reached by PGB are through these elusive activities; the next most 'productive' activity is the face-to-face interaction of student with peer educators representing 24% of all students contacted. Unfortunately, assistance in the counseling corners has decreased to 2% in 2007. The school component has very good potential for impact, however, in order to make this a reality PGB should conduct a thorough review of this component, considering: a) the reason for the reduction of share of activities by the counseling corners and b) what can be done to return their share to at least 10%. The review should also identify what can be specified as outcomes from the different activities or interventions in the sector; what can be defined as the results from a counseling session or sessions and the results from a face-to-face support interaction; and, finally, what is expected from participation in school events. Finally, the MOE should develop mechanisms to strengthen the overall management of school interventions, develop a system to monitor and supervise youth activities, supervise and retrain PEs, find solution to supply shortcomings, and define methods to guide and account for teachers' participation in the Program.

The Management of the out-of-school program has not been sufficiently proactive in leading and managing the PGB component under the responsibility of the MYS. This evaluation found that PGB functions with little guidance, the central and provincial planning are not reflected in the actions at the base --that is, the communities -- and, consequently, the results are vaguely described. Its PEs have a hard time in doing their tasks, though they engage in multiple community activities they have no resources to be truly effective; they receive inconsistent supervision and fragile support, they lack transport and materials; and they lack continuous training and guidance that can help them to grow as PEs. What makes the implementation of the MYS/PGB activities more difficult is that the MYS has been unable to find physical points of reference in the communities that could be clearly defined as PGB/Community sites. Perhaps the issue is in the selection of the unit responsible for the management of the MYS/PGB component: the National Directorate of Studies & Projects since it does not have, institutionally and organizationally, direct communication channels with the youth at community level. Its institutional task is more analytical than managerial, and its involvement with community seems to be even less pertinent. A possible solution, then, could be to include another MYS unit that has established channels linking it with the communities, in charge of the operational side of the out-of-school PGB program. This could open more doors at the community level and PGB could target the young population with more information and expect much better results than the current low performance.

In summary, GPB SRH-HIV/AIDS services to adolescents and youth can qualify as a really outstanding job. The Program's achievements are considerable and the future of PGB is even more promising. To be reaching more than 2 million young people per year is not an easy task; and PGB has achieved this by

effectively addressing neglected AYSRH issues, implementing realistic strategies to provide services to meet youth needs and, with these, create an important demand from the young population. Yet, the task ahead is not an easy one: there is a need to strengthen and perfect service delivery strategies in each of the sectors involved in the Program, including the face-to-face interaction between young clients and providers and the support systems required to provide quality services. It is also important to work from every angle to ensure the coordination among the three PGB interventions, particularly around YFS which are needed by both in-school and community youth. PGB should develop a formal referral system to facilitate the access of youth to services and have a unique methodology to manage these referrals.

In almost every site visited –YFS, counseling corners and community youth sites, the team found some level of stock out of condoms. Not all PGB sites are included in the condom supply system. This is a serious limitation but it could also be an opportunity to strengthen the MOH capacity and increase the flexibility of sector coordination mechanisms to find a solution to bring condoms to all PGB sites.

B. Communication and Training

The PGB BCC and training materials are very well designed and produced. The capacity of the communication team is exceptional in its creativity and capacity to adapt materials to the audience. There are various products –the last video on intergenerational sex '*Risco Zero'*, the *Manual de Activista*, the radio program *Mama Biz*, the poster with the hands of a girl and a boy, and others), that by far surpass the quality of other materials available in the development field in Mozambique. In general, the communications support system produced materials that are particularly well prepared for young people. These materials are quite diverse; this technical diversity could have resulted in materials that do not relate perfectly to each other. However, one of the most interesting aspects when comparing the materials is that every one of them connects with the others. It is as though PGB has been able to develop a trade mark for its BCC materials – through colors and tones, lines and borders, photographs and drawings, sizes, and so forth. This capacity to use different media in the development of materials has been very helpful to the Program because it is possible to choose a specific medium that could help in reaching a particular population, or in treating a precise topic. There is no doubt that the materials are among the best in the country and have contributed significantly to PGB's solid performance.

PGB has a strong training component for Program officers and volunteers. The materials used and organization of training sessions are outstanding. PGB trainings are demanding and relatively long duration but they always experience active participation of trainees; and as a result, PGB has a skilled staff and volunteers. The main concern with this component is that training activities do not seem necessarily to come from a single program and, sometimes or some of them, seem to exist in isolation. For this reason, we recommend PGB develop a Participatory Training (PT) Program for service delivery, community development, management, and training management, based on training needs assessments. The program should be a combination of classroom and on-the-job training; ensuring trainees first receive conventional pedagogical training followed by a systematic on-the-job training process, which will guarantee that the quality of the training is constantly enhanced through periodic updating of topics, materials and protocols. The PT Program will also educate parents and community PEs in the PGB community-based component. Finally, when the training program is fully operational, PGB will be able the continuously assess training needs and program the training activities in a timely manner, ensuring a high level of skills, motivation and communication among all those involved in the training process.

C. M&E and Research

The Monitoring and Evaluation system developed by Pathfinder International and UNFPA is very good. It focuses on SRH services and it appropriately captures the results at the service delivery level. This has been recognized and reinforced by the program management and technical assistance as well as central

and provincial levels. The incentive for focusing in SRH service delivery is high, since its related outcomes are easy to measure. It is important to extend the power of the system to measure and report progress in other important dimensions of PGB such us multi-sector coordination, advocacy, capacity building, management and leadership, and sustainability. The M&E system is mainly concerned with monitoring program activities which is very useful for PGB. Plus, the monitoring component of the system is user friendly, dynamic and could accommodate an appropriate level of analytical complexity. The monitoring component constitutes a substantive plus. Although the monitoring subsystem is well designed and works well, PGB has not yet developed appropriate indicators to measure final results and to evaluate impact, nor has it developed suitable sub-routines in the MIS to register and process impact. The KAP surveys have captured substantive amounts of valuable, information. This information could be extremely useful to analyze certain discrete aspect of PGB, although there is consensus that these data can not fully answer the question of whether PGB is having real impact, because they cannot connect the KAP results with service data.

M&E it is important to accomplish the following: a) to define and make operational a limited set of indicators dedicated to measuring the SRH impact of PGB interventions on target population; b) to complete an inventory of data available to measure the indicators and what the data would be needed establish the impact of the Program; c) to organize data production and processing as well as timely reporting of results on quality in order to support decision-making processes; d) there are some incomplete empirical evidence indicating the probability of a substantial impact of the PGB on youth SRH, it is very important to access appropriate data to measure this final effects of the PGB interventions on the SRH of youth; and e) the M&E system should be continuously used and managed and its databases need to be updated on monthly bases. The M&E team needs to be complemented with additional human resources.

Research is a good support for decision-making, M&E, and planning. However, the usefulness of this support is related to the organizational capacity to process and analyze data in a time manner and use the findings in planning. PGB has conducted significant research during the last 5-6 years. However, the capacities expressed above are not reflected in the PGB analytical capacities. There is a lot of data and rather low capacity to use it. For this reason, the PGB research study component requires an adjustment vis-à-vis the objective of the Program in order for the results to really help streamline current interventions and help pan future expansion.

D. The Strategic Paths

PGB success is expected to result from the functioning of the four strategic factors –services, advocacy, multi-sector coordination and capacity building—and their interactions with each other. The multi-sector coordination is the force that moves the entire model forward; capacity building is the source of knowledge, skills and know-how; advocacy is the coach always asking for a little more; and the services are the outputs of the system, received by the target population.

This section reviews the progress in implementing the strategy. But before reviewing the four strategic paths, it is worth reviewing the role of the target population –adolescents and youth. Are they just passive beneficiaries of the services? The youth participating in PGB as PEs are a key element in the implementation of the services as well as in the advocacy initiatives though their associations. However, thus far their role seems to be limited. While the sectors are at the core of three of the four paths (multi-sector, capacity building and service delivery) and are involved in the fourth (advocacy), the youth do not figure prominently in the model. They seem to be at the margin of the decision-making process, and are viewed only as beneficiaries of the outcomes of the system. This is a strategic issue that has to do with the entire dynamics of the PGB system and its future sustainability.

The services in the three sectors are functioning differently and it appears they are not following a unique leadership; they do not have a similar management, monitoring, and supervision approaches. There is no systematic synchronization of program activities among the sectors that could assure a successful and smooth multi-sector coordination at all levels and in particular at the local level. The indications that services are not progressing in concert, and each sector is not necessarily benefiting from the positive effect of services in the other two may indicate an insufficiency of the multi-sector coordination. That is, the sectors are not receiving the effect of the expected synergies possibly due to political barriers or because there is not enough or appropriate know-how to set the mechanisms for the coordination to occur smoothly. A renewed emphasis on the multi-sector coordination and a significant acceleration of the capacity building activities could strengthen the services provided in the sectors.

Advocacy has been effectively used and PGB has become instrumental in promoting positive policy changes. Though the sectors have played a role in these successful policy ventures, the coordination role was played by the TA (UNFPA and Pathfinder) that provided operation support in pushing forward various advocacy initiatives and policy proposals. This may have somewhat affected the sense of ownership from the part of the sectors but it may have been a critical situation that needed coverage. Although the assistance of UNFPA and Pathfinder is commendable, they should develop a plan for the progressive transfer of the coordination to the PGB National Coordination Committee. PGB should clarify who is responsible to advocate for national government policies needed to protect youth and address the lack of knowledge and use of advocacy techniques by PEs at district and local levels. In all three sectors there are discrepancies between policy, allocation of resources, and action. These should be addressed in order to develop the conditions for full transfer of PGB to the Government and foster the sustainability of the Program.

Multi-sector coordination constitutes a central concept in PGB and its implementation is critical to the working of the Program. However, there is little evidence about the operational effect of this coordination. For this reason the expected level of synergetic effects among the sectors has not materialized. The effective working of the multi-sector coordination will be extremely important in the future success of PGB, particularly when the donor starts phasing out. Consequently, it is very important to assess and strengthen the coordination capacity in each sector at all levels and procure technical assistance to facilitate the integration of the sector' work. Keep sector plans but also develop a PGB global plan that would come from the development of plans in each sector. This globalization of sector plans will help create inter-related objectives, implementation and expected results. PGB should also develop integrated monitoring and supervision activities, and design inter-related evaluation plans with specific targets for each sector.

Capacity building is an urgent need in PGB. The Program should review the achievements in this component and conduct an inventory of all the activities implemented in this area during the last three years. It should also assess the existence and quality of a capacity building activities database, examine the rational of the current framework and if needed expand it, review the current indicators and select a set directly associated with the components of framework. PGB should organize a data collection model and plan, collect data periodically, conduct analysis, and provide decision makers with information on progress in capacity building.

As a conclusion of this section on the four paths, this evaluation found limited synergies and reinforcement between the three ministries. Attention should be given to the coordination weaknesses among the sectors and strengthen their capacities to work together. The PGB teams in each sector should pay attention to their interventions, identifying opportunities for interaction with interventions from the other sectors.

Finally, in the area of finance, an outstanding PGB accomplishment has been the systematic de-acceleration of the cost per youth served after 2002, when it reached it highest point of US$131.6 per capita. Since then the cost per capita has progressively decreased to $50.8 in 2003, $5.3 in 2004, $3.3 in

2005 and, stabilized at $4.4 in 2006. This is an excellent result of the management of the Program and it is a useful indicator to plan more precisely what the Program could achieve with the funds it attracts.

E. Sustainability of the PGB

Though the Government could progressively assume some costs of PGB, this will not eliminate the need for external aid. Thus, we believe funding is a key issue for sustainability and should be considered for future planning. However, beyond financial support, the most pressing issue to ensure sustainability is to have a technical and management team that knows the PGB technology and know-how. We believe the developers of PGB had in mind the issue of sustainability when they framed the leadership of the Program in a multi-sector approach and included a strong capability building component. For that reason, we need to return to these two aspects: the need to strengthen the multi-sector collaboration strategy and develop a strong capacity building component. PGB has a strategy but it is still not fully applied.

During these eight years, an outside observer could conclude that the Management has been implemented by five teams: the three sectors, and the TA teams. The former had relatively low coordination while the latter, given their roles, coordinated more systematically. In the future, in order to ensure sustainability, the management of the program should have one leadership with minimum of fragmentation, and the TA must play a supporting and facilitating role for management development.

There is the need to discuss the technical assistance role in PGB, particularly regarding decision making responsibilities that they have taken on occasion. It is important for the development of PGB to fix a schedule to transfer functions from the TA to a national team; this transfer should be initiated well before the phase out of the technical assistance team in order to have plenty of time to accomplish the goals of the capacity development component. Hence, one of the goals of the technical assistance should be to provide technical backing to all managerial teams in order to strengthen the institutional capacity building process. This technical support should be framed in a model that includes the transfer of knowledge and skills while it focuses on completing tasks. TA positions at central and provincial levels should be maintained for at least two to three more years in order to ensure successful program implementation and transfer of technical capacity.

The scaling up of the Program is ready to enter its final phase now that it has interventions in all the provinces of the country and covers about 45% of the districts. The expansion of PGB to all provinces was a task that faced and addressed many critical challenges, but at the same time, the final success of this scaling up demonstrated the replicable character of PGB. The expansion to all provinces has been successful and proceeded with significant involvement of the Ministries. In fact, the Government has been closely involved in the implementation activities in the new provinces. This represents an important step forward in the forging of the national ownership of the Program, because although GBP has made progress in institutionalizing activities and methodologies within the government units, the appropriation of PGB by the government had been somewhat limited. The design of PGB could also be replicated in other countries of Africa. Moreover, the PGB strategy could be useful for the development of social programs outside the realm of adolescents and youth.

A general conclusion in the topic of sustainability is that despite progress sustainability continues to constitute a challenge for the Program, and it is critical to consider sustainability issues in planning the future of the Program. Doubtless the quality of the Program has clearly established it as a leading AYSRH program which helps the Government in seeking funding for its continuity. The most crucial short-term sustainability challenge is the building of local conditions for a sustainable development of the PGB: the transfer of strategies, methodologies and instruments to the Ministries and their institutionalization, the development of a top management team able to work with little or no external technical assistance, the decentralization of management, and the development of outstanding staff who can run PGB with dedication and excellence. With sustainability in mind, PGB should invest in two of the

original components of the Program: multi-sector coordination and capacity building. The two would serve as a basis for the sustainability of PGB.

Any evaluation of a program of the dimension and scope of PGB will easily find many critical aspects that could have achieved better results. However, any shortcomings must be seen in the context of the overall achievement of the program. PGB's overall accomplishments are well above any of the identified failings. Most importantly, PGB has transformed itself into an outstanding and productive AYSRH program. This is a great achievement. Still, there is yet much to be done, and if the staff and volunteers where able to get PGB to where it is, there is no doubt they will be able to take the Program to the finish line.

References

1. Alter, Catherine and Hage, Jerald. 1993. Organizations Working Together. Sage Library for Social Research. London.
2. Azevedo, Mario. 1991. *Historical Dictionary of Mozambique*. Metuchen, NJ: Scarecrow Press.
3. Axelrod, R. 1984. The Evolution of Cooperation. New York: Basic Books.
4. Badiani, R., Guirao, L., Pacca, J., Senderowitz, J., Mello, M. 2004. "Preliminary Report: Improving Female Recruitment, Participation and Retention among Peer Educators in the Geração Biz Program in Mozambique."
5. Bianco, Reginaldo. 2004. "Risco Sero." (Video) Pathfinder International.
6. Bianco, Reginaldo. 2004. "TPC." (Video) Pathfinder International.
7. Creese A, Royd K, Alban A, Guiness L (2002) Cost-effectiveness of HIV/AIDS interventions in Africa: A systematic review of the evidence. Lancet 359: 1635–1643.
8. Davies, Robert. 1985. *South Africa Strategy Towards Mozambique in the Post-Nkomati Period. A Critical Analysis of Effects and Implications.* Uppsala: Research Report 73, Scandinavian Institute of African Studies.
9. Department for International Development (2004) Taking action: The UK's strategy for tackling HIV and AIDS in the developing world. London: Department for International Development.
10. Devaranjan S, Miller M, Swanson E (2002) Goals for development: History, prospects, and costs. Washington (D. C.): World Bank.
11. De Vita, C.J. and Fleming C.(Edit.) Building Capacity in Nonprofit Organizations. The Urban Institute, 2001.
12. Direction Générale de la Coopération au Dévelopement (2002) Note stratégique: Soins de santé primaires. Brussels: Direction Générale de la Coopération au Dévelopement.
13. "Final Evaluation: Adolescent RH in Maputo city and Zambezia (draft)." 2001.
14. Gboun, M. 2004 "Provisional Briefing Notes." Finalization of M & E Framework of the Joint Project (Zambezia). (Power Point presentation).
15. Geração Biz. 2002. "Monitoring and Evaluation Plan, Multisectoral ASRH/STD/HIV/AIDS Program."
16. Geração Biz. 2004. "Overview of Geração Biz Program."
17. Geração Biz. 2004. "Sexual and Reproductive Health and STI/AIDS Prevention Among Adolescents and Young People." (Power Point presentation).
18. Geração Biz. Various years. Pamphlets, posters, handouts.
19. Hainsworth, G. 2002. "Providing Sexual Reproductive Health and STI/HIV Information and Services to this Generation."
20. Hammonds R, Ooms G (2004) World Bank policies and the obligation of its members to respect, protect and fulfil the right to health. Health Hum Rights 8: 26.
21. Innes, Judith E., and David E. Booher. 1997. *Metropolitian Development as a Complex System:A New Approach to Sustainability.* Institute of Urban and Regional Development, Working Paper 669. Berkeley: University of California at Berkeley
22. Isaacman, Allen. 1976. *The Tradition of Resistance in Mozambique. Anti-colonial Activity in the Zambezi Valley 1850-1921*. London: Currey.
23. Kremer M, Miguel E (2004) The illusion of sustainability. Cambridge: Center for International Development at Harvard University.

24. Kaphesse, C. 2004. "Núcleo Provincial De Combate Ao HIV/SIDA, Cabo Delgado: Relatório de Actividades (Janeiro-Julho de 2004.)"
25. Letts, Christine, Ryan and Grossman "High Performance Nonprofit Organizations: Managing Upstream for Greater Impact", 1999, Wiley.
26. Lincoln, Y. 1985. *Organizational theory and inquiry: The paradigm revolution*. Beverly Hills, CA: Sage.
27. MacKellar L (2005) Priorities in global assistance for health, AIDS and population. Paris: Organisation for Economic Co-operation and Development.
28. McKinsey & Company, 1998, "Effective Capacity Building in Nonprofit Organizations." Venture Philanthropy Partners, N.Y.
29. Malahe, J. 2003. "Report: Mozambique: Joint UN Project to Support the Provincial HIV/AIDS Operational Plan in Zambezia." SAY Funded Mozambique Project Process Evaluation Report.
30. Mehdi S (1999) Health and family planning indicators: Measuring sustainability. Washington (D. C.): US Agency for International Development. Office of Sustainable Development. Bureau for Africa.
31. Marseille E, Hofmann P, Kahn J (2002) HIV prevention before HAART in sub-Saharan Africa. Lancet 359: 1851–1856.
32. Médecins Sans Frontières (2005) Access to health care, mortality and violence in Democratic Republic of the Congo. Brussels: Médecins Sans Frontières.
33. Mehdi S (1999) Health and family planning indicators: Measuring sustainability. Washington (D. C.): US Agency for International Development. Office of Sustainable Development, Bureau for Africa. 2006.
34. Ministério da Saúde, Republica de Moçambique. 2002. "Programa de Saúde Escolar e do Adolescente: Linhas de Orientção para os Serviços Amigos dos Adolescentes e Jovens (SAAJ)."
35. Philips M, Vazquez I, Sprecher A (2005 March 29) Good donorship in practice: The case of Burundi. Humanitarian Exchange: 21
36. Ooms G (2006) Health Development versus Medical Relief: The Illusion versus the Irrelevance of Sustainability. PLoS Med 3(8): e345.
37. Oster, Sharon M. *Strategic Management for Nonprofit Organizations: Theory and Cases*. Oxford University Press, New York, 1995.
38. Piot P (2003) The need for an exceptional response to an unprecedented crisis. Presidentials Fellows Lecture Washington (D. C.): World Bank.
39. Pathfinder International and UNFPA, 'Sexual and Reproductive Health and Prevention of STI/AIDS among Adolescents and Youth (Geração BIZ Program)', Maputo, 2001.
40. PGB, "Improving Female Recruitment, Participation, and Retention among Peer Educators in the Geração BIZ Program in Mozambique *(2001-2004.)"* Maputo, April. 2006.
41. "Program Document Agreement Between the Government of Mozambique (Ministry of Health) and The United Nations Population Fund." 2002.
42. "Project Document between the Government of Mozambique (Ministry of Youth and Sports) and The United Nations Population Fund." 2002.
43. Provincial AIDS Council (Zambezia), Republic of Mozambique. 2003. "UN Support to the Provincial HIV/AIDS Operational Plan of Zambezia: Joint Project Monitoring and Evaluation Framework."
44. Rosen S, Sanne I, Collier A, Simon J (2005) Rationing antiretroviral therapy for HIV/AIDS in Africa: Choices and consequences. PloS Med 2: e303. DOI

45. Sachs J, McArthur J (2005) The Millennium Project: A plan for meeting the Millennium Development Goals. Lancet 365: 347–353.
46. Salomon J, Hogan D, Stover J, Stanecki K, Walker N et al. (2005) Integrating HIV prevention and treatment: From slogans to impact. PLoS Med 2: e16. DOI:
47. "SAY Assessment Matrix Mozambique." N.d.
48. UNAIDS Secretariat (Maputo). 2004. "Joint UN Support to the Provincial HIV/AIDS Operational Plan of Zambezia Province, Mozambique: Project Progress Report, 2003" UN.
49. UNAIDS. N.d. "Joint UN Support to the Provincial HIV/AIDS Operational Plan of Zambezia Province." (Power Point presentation).
50. "UNFPA and Pathfinder International: Geração Biz, Youth Friendly Health Clinics" N.d. in Education and HIV/AIDS: A Sourcebook of HIV/AIDS Prevention Programs.
51. Wolf, Thomas. *Managing a Nonprofit Organization in the Twenty-First Century*. Simon & Schuster, New York, 1999.

List of Appendices

Appendix 1. Terms of Reference Mid-Term Evaluation – ASRH/HIV/AIDS Program, Geração BIZ Programme(GBP), Mozambique

Introduction/background:

Mozambique is one of the poorest countries in the world and among the hardest hit by HIV/AIDS. The AIDS epidemic is exacerbated by extreme poverty following a long civil war, urban and cross-border migration, unequal distribution of power between men and women, stigma and low literacy. The scale and future impact of HIV/AIDS in Mozambique can only be understood by looking at it in relation to the young population. Youth, aged 10-24, comprise 34% of Mozambique's population, and youth (aged 15-24) account for 60% of new HIV infections in a country estimated to have an HIV prevalence rate of over 13%. Half of the nearly 1.5 million people living with HIV/AIDS in Mozambique are between the ages of 15 and 29. Girls and women are at especially high risk and are being infected at a ratio of two to one over men.

Not less problematic is the issue of adolescent pregnancy and STI**.** According to the latest youth survey almost 70 % of adolescent girls had been pregnant once. STI are the third reason for seeking for services among GB youth friendly clinics.

Considering this scenario, in 1999 the multi-sectoral Geração Biz Program was conceived and began to implement activities aimed at equipping young people with needed knowledge, skills, and access to quality sexual and reproductive health services. The program consists of several components: a school based program and a community based program, both linked to clinic services. The programs are strengthened with two cross cutting strategies: capacity building of the local implementing partners and advocacy for a more favorable environment for ASRH activities. Geracao Biz began at the central level, followed by implementation of activities in two provinces. Over five years, the program has expanded and now reaches 9 of the 11 provinces in Mozambique. The program is implemented in a coordinated manner by Ministries (Health, Education and Youth and Sports) and includes collaboration of local NGOs and youth associations. Major support for this program is provided by UNFPA, DANIDA, NORAD and SIDA. Pathfinder provides long term technical assistance to partners at the central and provincial levels.

The Geração Biz program has been in operation for 8 years, consistently expanding both its geographical scope and program components. During this period a systematic approach to monitoring and evaluation was developed and implemented. However, the emphasis to date has been on collecting data, with much less time devoted to analysis. At the same time there have been some small research studies, such as school based KAPB and a gender study. In 2004, it was conducted an external evaluation and it could be a basis for this initiative.

General Objective:
To conduct a broad, systematic evaluation including analysis of collected data to better understand program successes and weaknesses in the light of Geração Biz expansion.

Specifically the evaluation will be focusing on:

1. To review and discuss objectives and goals of the program (the goal hierarchy)
2. To assess design, strategies, implementation and outcomes to the extend possible the overall impact of the GBP according to planned objectives and goals
3. To identify and better understand the challenges, shortfalls, successes and lessons learned of key components of the GBP approach
4. To assess and understand the contribution of key focus area in GBP, including multi-sectoral planning, implementation and coordination, capacity building in, and program transfer to, the public sector, in various phases and aspects of the program

5. To review the activities and the program in relation to:
    - Relevance of outreach activities offered
    - Changes in quality of service.
    - Nature and appropriateness of activities
    - Sustainable changes identified
    - Support still needed and requested.
6. To assess the level and nature of youth participation in GBP including how the target audience participates in program design and implementation
7. To assess the extent to which gender issues have been incorporated into program approach and implementation
8. To assess the process for development of materials (BCC, training) and the resulting products
9. To assess coordination and support from the central level project to the provinces, multisectorially and by each sector
10. To assess relevance and quality of research conducted
11. To assess the adequacy and contribution of technical assistance provided by Pathfinder Int'l
12. To analyze financial implementation
13. To assess appropriateness of GBP monitoring efforts and strategic use of data and information acquired from monitoring & evaluation in programming
14. To make recommendations based on evaluation findings for further strengthening and expanding the GBP
15. To assess the degree of replicability of the program in other settings.
16. To compare with the previous evaluation and its implementation.

Consultant Tasks:

1. Participate on a team to carry out an evaluation of the GBP
2. Plan, in consultation with team members, donor agencies and GBP staff, a process for evaluating GBP activities in order to achieve the objectives stated above.
3. Review program proposals, documents and materials
4. Obtain information directly from GBP related staff, counterparts, intermediaries and members of the target group through interviews and other interpersonal approaches
5. Observe GBP activities in all three program settings: School, Clinic and Community based activities.

Deliverables:

1. Prepare a report of max 50 pages of findings and recommendations in concert with the evaluation team
2 Brief donors and GBP leadership on major findings and recommendations

Timing and Duration: It is estimated 3 weeks in country, beginning August 27th 2007

Qualification of the consultants:

Master degree in public health or related subject
Extensive experience in planning, management and assessment and evaluation of ASRH programs
Excellent analytical and writing skills, knowledge of Portuguese is desirable
Familiarity with Mozambican context and programs
Previous experience as member of evaluation time (s)
Experience and skills of working with people from diverse culture and backgrounds

Consultant team

1 international and 2 national plus a representative of each government sector, MOH, MOE, MYS and representative of youth NGO

Budget:

Consultant fees
Perdiem
Travel (international and national)

Funding Source: P05

Appendix 2. Draft Evaluation Agenda

Time	Activity	Location
Day 1- Monday 27 August 2007		
2 PM	Working session with Evaluation Team	UNFPA Office
Day 2-Tuesday 28 August		
AM	Working session with Evaluators and UNFPA/Pathfinder (discussion and common understanding of evaluation approach: document review, data review, interviews and observation of program activities)	UNFPA Office
PM	Interviews with Central Level Counterparts (including Minister or Vice-Minister, Pathfinder and UNFPA)	UNFPA Office
Day 3-Wednesday 29 August		
AM	Observation of program activities in Maputo City and Maputo Province - proposed provinces that could be changed accordingly Evaluator's criteria (the team will be divided in two)	TBD
Late pm	Working Sessions with Evaluation Team	TBD
Day 4- Thursday 30 August		
am	Working Sessions	
Late pm	Observation of out of school activities in Maputo city with Evaluation Team	TBD
Day 5- Friday-31 August		
am	Working sessions	TBD
Late pm Interview with Youth NGOS representatives	Interview with Youth NGOS representatives	TBD
Day 6 (Saturday-1 September to Day 10 to Wednesday-05 September)		
	Departure to Provinces (one team to Inhambane and another to Cabo Delgado - proposed provinces that could be changed accordingly Evaluator's criteria)	TBD
	Observation of program activities in Districts to be selected	TBD

	accordingly Evaluator's criteria.	
Day 11 (Thursday-06 September) to day 12 (Friday-07 September)		
	Report writing	
Day 13 (Saturday-08 September)		
am	Observation of program activities in Districts to be selected accordingly Evaluator's criteria.	
Day 14 (Sunday-09 September)		
	Working sessions	
Day 15 (Monday-10 September)		
Am	Presentation of the preliminary results and recommendation to the partners	TBD
Pm	International Consultants Departure	

Appendix 3. People Contacted during the Evaluation

Central Level

Clarisse Barbosa, Embaixada da Noruega
Jaime Benavente, Consultor Independente
Atle Karlsen, Scanteam
Petra Lantz, UNFPA
Alex Muianga, Coalização
Jorge Matine, Consultant
Albertina A. Manhenje, MISAU – SEA
Natércia Monjane Matule, MISAU – SEA
Shadit Isaac Murargy, UNFPA
Júlio Pacca, Pathfinder International
Esther M. Rwamushaisa, MISAU – SEA
Celmira Silva, Ministério da Juventude
Nina Strøm, NORAD
Ivone Zilhão, Pathfinder International

In Maputo province

Angelina Cossa - DPS - Coordenator of program
Gilda Missica - DPEC- Coordenator of program
Lázaro Nhaca - DPJD - Coordenator of program
Teacher Miguel - Escola secundária da Moamba- Peer educatos coordenators
Luisa Angelo Custódio - Health provider at Health center da Moamba
Aurélio Miambo - TA

In Maputo City

Mrs. Celmira Silva - National Director MYS
Mrs. Teodora Cassama - Departament of special projects Moec
Dr. Mouzinho Saide . National Director of Health - MOH
Mrs. Ornila Machel - Head of the department of subjects youth - DPJD Cidade Maputo
Director of the School Estrela Vermelha
Youth - Coalisão
Community leader of Distric number 2
Youth - Associação Juvenil Valai
Peer educators - Amodefa
Nurse Maria - Health center Xipamanine

In Inhambane

Director Porvincial da Educação e Cultura - Baptista Pedro
Directora Provincial da Saude - Edite Tuzine
Director Provincial da Juventude e Desportos - Fernando Pedro
Coodenador do NPCS - José da Conceição Júnior
Coordenador porvincial do PGB DPEC - Francisco Wetimane
Coordenador Provincial do PG B DPJD - Marcos Binguanhane
Ponto focal DPEC - Maria Elisa
Ponto focal DPS - Catarina Angelo Langa
Chefe do SMI DPS - Rutha dos Santos josé Massunguine
AAF do PGB DPJD Agostinho Macuacua
AAF do PGB DPJD Talita Mussalafuane
AAF DPS Fernando Artiel

Assessor do PGB na DPS Amir Modan
Assessor do PGB na DPJD e DPEC

In Cabo Delgado

In Pemba

Director Provincial da Juventude e Desportos
Director Provincial da Saúde
Director Provincial Adjunto da Educação e Cultura
5 Activistas em representação de duas Associações Juvenis ("Novos Horizontes" e ACROCIP)
5 Activistas em presentação, de quatro escolas de Pemba
1 Provedora do SAAJ

In Chiure

Director dos Serviços Distritais de Educação, Juventude e Tecnologia (SDEJT)
10 Activistas de Base Comunitária, no Centro Juvenil; e 10 Activistas de Base Escolar, nos Cantos de Aconselhamento da EPC-Sede e Escola Secundária
Director dos Serviços Distritais de Saúde, Mulher e Acção Social (SDSMAS)
1 Provedora de SAAJ

In Montepuez

Director dos SDEJT
10 Activistas de Base Comunitária, no Espaço Juvenil; e 8 Activistas de Base Escolar, nos Cantos de Aconselhamento da EPC-Sede e Escola Industrial
Substituta do Director dos SDSMAS
1 Provedor de SAAJ
Assessor Técnico Multisectorial, António Tuzine

Appendix 6. Adjustment Procedures for 2007 PGB Data

PROVINCE	M.C.	Zamb	Gaza	M Pr	Tete	CD	I'bane	Niassa	Sofala	TOTAL 2007
School Based Program										
School Active peer educators	192	1,263	330	342	209	294	267	177	60	3,134
Adjusted School Active peer educators	768	1,579	413	1,368	261	368	334	221	75	**5,386**
Adjustemnt procedure	(Qter.1)*4		(Qters.1+2+3)* 1.25	(Qter.1)*4	(Qters.1+2+3)* 1.25					
Condoms distributed in school (2007)	7,400	66,250	12,180		14,544	12,895	1,744	28,000		143,013
Adjusted Condoms distributed in school	29,600	82,813	15,225	28,702	18,180	16,119	2,180	35,000		**227,818**
Adjustemnt procedure	(Qter.1)*4	(Qters.1+2+3)* 1.25		From 2006	(Qters.1+2+3)* 1.25					
Total Number of Young people reached through schools	93,542	53,611		0	6,159	61,502	21,789	14,041	0	289,277
Adjusted Tot Youths reached through schools	374,168	67,014	0	130,647	7,699	76,878	27,236			**683,641**
Adjustemnt procedure	(Qter.1)*4	(Qters.1+2+3)* 1.25		From 2006	(Qters.1+2+3)* 1.25					
Community Based Program										
Community Active peer educators	249	774	201	275	189		166		134	1,854
Adjusted Community Active peer educators	996	968	251	344	236	298	208	124	168	**3,592**
Adjustemnt procedure	(Qter.1)*4	(Qters.1+2+3)* 1.25				From 2006	Qters. 1-3 * 1.25	From 2006	(Qters.1+ 2+3)* 1.25	
Condom distributed in community (2007)	20,438	42,483	3,640	2,004	14,544	913	3,904	34,482	142	122,550
Adjusted Condom distributed in community	81,752	53,104	4,550	2,505	18,180	3,652	4,880	43,103	178	**211,903**
Adjustemnt procedure	(Qter.1)*4	(Qters.1+2+3)* 1.25				(Qter.1)*4	(Qters.1+2+3)* 1.25			
Young People reached through community	106,110	41,924	21,108	8,960	15,726	16,673	8,720	1,986	2,481	223,688
Adjusted Tot Youth reached through community	424,440	52,405	26,385	11,200	19,658	66,692	10,900	2,483	3,101	**617,263**
Adjustemnt procedure	(Qter.1)*4	(Qters.1+2+3)* 1.25				(Qter.1)*4	(Qters.1+2+3)* 1.25			
Clinic Based Program										
Youths Reached Trough YFS	25,607	19,709	14,052	16,790	13,986	7,986	6,647	7,606	10,803	123,186
Adjusted Total Youths Reached Trough YFS	32,009	78,836	56,208	20,988	17,483	31,944	26,588	30,424	43,212	**337,691**
Adjustemnt procedure	(Qs.1+2+3)*1.25	(Qter.1)*4		(Qters.1+2+3)* 1.25		(Qter.1)*4				
Number of YFS with peer educators		5	3	10	4	?	5	2	1	30
Adjusted YFS Peer educators	68	5	34	10	4	?	5	2	1	**129**
Adjustemnt procedure	Trainned in 2006	As reported	Trainned 2006	As reported		N.D.	As reported			
Condom distributed at YFS	293,677	96,224	29,175	84,272	99,110	30,117	10,433	7,642	32,391	683,041
Adjusted Condom distributed at YFS	367,096	384,896	116,700	105,340	123,888	120,468	41,732	30,568	129,564	**1,420,252**
Adjustemnt procedure	(Qs.1+2+3)*1.25	(Qter.1)*4		(Qters.1+2+3)* 1.25		(Qter.1)*4				

Columns in Grey indicate data only available for Quarter 1 2007. Otherwise, data available for Qters. 1, 2 & 3

List of Appendices

Appendix 1. Terms of Reference Mid-Term Evaluation – ASRH/HIV/AIDS Program, Geração BIZ Programme(GBP), Mozambique

Introduction/background:

Mozambique is one of the poorest countries in the world and among the hardest hit by HIV/AIDS. The AIDS epidemic is exacerbated by extreme poverty following a long civil war, urban and cross-border migration, unequal distribution of power between men and women, stigma and low literacy. The scale and future impact of HIV/AIDS in Mozambique can only be understood by looking at it in relation to the young population. Youth, aged 10-24, comprise 34% of Mozambique's population, and youth (aged 15-24) account for 60% of new HIV infections in a country estimated to have an HIV prevalence rate of over 13%. Half of the nearly 1.5 million people living with HIV/AIDS in Mozambique are between the ages of 15 and 29. Girls and women are at especially high risk and are being infected at a ratio of two to one over men.

Not less problematic is the issue of adolescent pregnancy and STI**.** According to the latest youth survey almost 70 % of adolescent girls had been pregnant once. STI are the third reason for seeking for services among GB youth friendly clinics.

Considering this scenario, in 1999 the multi-sectoral Geração Biz Program was conceived and began to implement activities aimed at equipping young people with needed knowledge, skills, and access to quality sexual and reproductive health services. The program consists of several components: a school based program and a community based program, both linked to clinic services. The programs are strengthened with two cross cutting strategies: capacity building of the local implementing partners and advocacy for a more favorable environment for ASRH activities. Geracao Biz began at the central level, followed by implementation of activities in two provinces. Over five years, the program has expanded and now reaches 9 of the 11 provinces in Mozambique. The program is implemented in a coordinated manner by Ministries (Health, Education and Youth and Sports) and includes collaboration of local NGOs and youth associations. Major support for this program is provided by UNFPA, DANIDA, NORAD and SIDA. Pathfinder provides long term technical assistance to partners at the central and provincial levels.

The Geração Biz program has been in operation for 8 years, consistently expanding both its geographical scope and program components. During this period a systematic approach to monitoring and evaluation was developed and implemented. However, the emphasis to date has been on collecting data, with much less time devoted to analysis. At the same time there have been some small research studies, such as school based KAPB and a gender study. In 2004, it was conducted an external evaluation and it could be a basis for this initiative.

General Objective:
To conduct a broad, systematic evaluation including analysis of collected data to better understand program successes and weaknesses in the light of Geração Biz expansion.

Specifically the evaluation will be focusing on:

17. To review and discuss objectives and goals of the program (the goal hierarchy)
18. To assess design, strategies, implementation and outcomes to the extend possible the overall impact of the GBP according to planned objectives and goals
19. To identify and better understand the challenges, shortfalls, successes and lessons learned of key components of the GBP approach
20. To assess and understand the contribution of key focus area in GBP, including multi-sectoral planning, implementation and coordination, capacity building in, and program transfer to, the public sector, in various phases and aspects of the program

21. To review the activities and the program in relation to:
    - Relevance of outreach activities offered
    - Changes in quality of service.
    - Nature and appropriateness of activities
    - Sustainable changes identified
    - Support still needed and requested.
22. To assess the level and nature of youth participation in GBP including how the target audience participates in program design and implementation
23. To assess the extent to which gender issues have been incorporated into program approach and implementation
24. To assess the process for development of materials (BCC, training) and the resulting products
25. To assess coordination and support from the central level project to the provinces, multisectorially and by each sector
26. To assess relevance and quality of research conducted
27. To assess the adequacy and contribution of technical assistance provided by Pathfinder Int'l
28. To analyze financial implementation
29. To assess appropriateness of GBP monitoring efforts and strategic use of data and information acquired from monitoring & evaluation in programming
30. To make recommendations based on evaluation findings for further strengthening and expanding the GBP
31. To assess the degree of replicability of the program in other settings.
32. To compare with the previous evaluation and its implementation.

Consultant Tasks:

1. Participate on a team to carry out an evaluation of the GBP
2. Plan, in consultation with team members, donor agencies and GBP staff, a process for evaluating GBP activities in order to achieve the objectives stated above.
3. Review program proposals, documents and materials
4. Obtain information directly from GBP related staff, counterparts, intermediaries and members of the target group through interviews and other interpersonal approaches
5. Observe GBP activities in all three program settings: School, Clinic and Community based activities.

Deliverables:

1. Prepare a report of max 50 pages of findings and recommendations in concert with the evaluation team
2 Brief donors and GBP leadership on major findings and recommendations

Timing and Duration: It is estimated 3 weeks in country, beginning August 27th 2007

Qualification of the consultants:

Master degree in public health or related subject
Extensive experience in planning, management and assessment and evaluation of ASRH programs
Excellent analytical and writing skills, knowledge of Portuguese is desirable
Familiarity with Mozambican context and programs
Previous experience as member of evaluation time (s)
Experience and skills of working with people from diverse culture and backgrounds

Consultant team

1 international and 2 national plus a representative of each government sector, MOH, MOE, MYS and representative of youth NGO

Budget:

Consultant fees
Perdiem
Travel (international and national)

Funding Source: P05

Appendix 2. Draft Evaluation Agenda

Time	Activity	Location
Day 1- Monday 27 August 2007		
2 PM	Working session with Evaluation Team	UNFPA Office
Day 2-Tuesday 28 August		
AM	Working session with Evaluators and UNFPA/Pathfinder (discussion and common understanding of evaluation approach: document review, data review, interviews and observation of program activities)	UNFPA Office
PM	Interviews with Central Level Counterparts (including Minister or Vice-Minister, Pathfinder and UNFPA)	UNFPA Office
Day 3-Wednesday 29 August		
AM	Observation of program activities in Maputo City and Maputo Province - proposed provinces that could be changed accordingly Evaluator's criteria (the team will be divided in two)	TBD
Late pm	Working Sessions with Evaluation Team	TBD
Day 4- Thursday 30 August		
am	Working Sessions	
Late pm	Observation of out of school activities in Maputo city with Evaluation Team	TBD
Day 5- Friday-31 August		
am	Working sessions	TBD
Late pm Interview with Youth NGOS representatives	Interview with Youth NGOS representatives	TBD
Day 6 (Saturday-1 September to Day 10 to Wednesday-05 September)		
	Departure to Provinces (one team to Inhambane and another to Cabo Delgado - proposed provinces that could be changed accordingly Evaluator's criteria)	TBD
	Observation of program activities in Districts to be selected accordingly Evaluator's criteria.	TBD
Day 11 (Thursday-06 September) to day 12 (Friday-07 September)		

	Report writing	
Day 13 (Saturday-08 September)		
am	Observation of program activities in Districts to be selected accordingly Evaluator's criteria.	
Day 14 (Sunday-09 September)		
	Working sessions	
Day 15 (Monday-10 September)		
Am	Presentation of the preliminary results and recommendation to the partners	TBD
Pm	International Consultants Departure	

Appendix 3. People Contacted during the Evaluation

Central Level

Clarisse Barbosa, Embaixada da Noruega
Jaime Benavente, Consultor Independente
Atle Karlsen, Scanteam
Petra Lantz, UNFPA
Alex Muianga, Coalização
Jorge Matine, Consultant
Albertina A. Manhenje, MISAU – SEA
Natércia Monjane Matule, MISAU – SEA
Shadit Isaac Murargy, UNFPA
Júlio Pacca, Pathfinder International
Esther M. Rwamushaisa, MISAU – SEA
Celmira Silva, Ministério da Juventude
Nina Strøm, NORAD
Ivone Zilhão, Pathfinder International

In Maputo province

Angelina Cossa - DPS - Coordenator of program
Gilda Missica - DPEC- Coordenator of program
Lázaro Nhaca - DPJD - Coordenator of program
Teacher Miguel - Escola secundária da Moamba- Peer educatos coordenators
Luisa Angelo Custódio - Health provider at Health center da Moamba
Aurélio Miambo - TA

In Maputo City

Mrs. Celmira Silva - National Director MYS
Mrs. Teodora Cassama - Departament of special projects Moec
Dr. Mouzinho Saide . National Director of Health - MOH
Mrs. Ornila Machel - Head of the department of subjects youth - DPJD Cidade Maputo
Director of the School Estrela Vermelha
Youth - Coalisão
Community leader of Distric number 2
Youth - Associação Juvenil Valai
Peer educators - Amodefa
Nurse Maria - Health center Xipamanine

In Inhambane

Director Porvincial da Educação e Cultura - Baptista Pedro
Directora Provincial da Saude - Edite Tuzine
Director Provincial da Juventude e Desportos - Fernando Pedro
Coodenador do NPCS - José da Conceição Júnior
Coordenador porvincial do PGB DPEC - Francisco Wetimane
Coordenador Provincial do PG B DPJD - Marcos Binguanhane
Ponto focal DPEC - Maria Elisa
Ponto focal DPS - Catarina Angelo Langa
Chefe do SMI DPS - Rutha dos Santos josé Massunguine
AAF do PGB DPJD Agostinho Macuacua
AAF do PGB DPJD Talita Mussalafuane
AAF DPS Fernando Artiel

Assessor do PGB na DPS Amir Modan
Assessor do PGB na DPJD e DPEC

In Cabo Delgado

In Pemba

Director Provincial da Juventude e Desportos
Director Provincial da Saúde
Director Provincial Adjunto da Educação e Cultura
5 Activistas em representação de duas Associações Juvenis ("Novos Horizontes" e ACROCIP)
5 Activistas em presentação, de quatro escolas de Pemba
1 Provedora do SAAJ

In Chiure

Director dos Serviços Distritais de Educação, Juventude e Tecnologia (SDEJT)
10 Activistas de Base Comunitária, no Centro Juvenil; e 10 Activistas de Base Escolar, nos Cantos de Aconselhamento da EPC-Sede e Escola Secundária
Director dos Serviços Distritais de Saúde, Mulher e Acção Social (SDSMAS)
1 Provedora de SAAJ

In Montepuez

Director dos SDEJT
10 Activistas de Base Comunitária, no Espaço Juvenil; e 8 Activistas de Base Escolar, nos Cantos de Aconselhamento da EPC-Sede e Escola Industrial
Substituta do Director dos SDSMAS
1 Provedor de SAAJ
Assessor Técnico Multisectorial, António Tuzine

Appendix 4. Adjustment Procedures for 2007 PGB Data

PROVINCE	M.C.	Zamb	Gaza	M Pr	Tete	CD	I'bane	Niassa	Sofala	TOTAL 2007
School Based Program										
School Active peer educators	192	1,263	330	342	209	294	267	177	60	3,134
Adjusted School Active peer educators	768	1,579	413	1,368	261	368	334	221	75	**5,386**
Adjustemnt procedure	(Qter.1)*4		(Qters.1+2+3)* 1.25	(Qter.1)*4	(Qters.1+2+3)* 1.25					
Condoms distributed in school (2007)	7,400	66,250	12,180		14,544	12,895	1,744	28,000		143,013
Adjusted Condoms distributed in school	29,600	82,813	15,225	28,702	18,180	16,119	2,180	35,000		**227,818**
Adjustemnt procedure	(Qter.1)*4	(Qters.1+2+3)* 1.25		From 2006	(Qters.1+2+3)* 1.25					
Total Number of Young people reached through schools	93,542	53,611		0	6,159	61,502	21,789	14,041	0	289,277
Adjusted Tot Youths reached through schools	374,168	67,014	0	130,647	7,699	76,878	27,236			**683,641**
Adjustemnt procedure	(Qter.1)*4	(Qters.1+2+3)* 1.25		From 2006	(Qters.1+2+3)* 1.25					
Community Based Program										
Community Active peer educators	249	774	201	275	189		166		134	1,854
Adjusted Community Active peer educators	996	968	251	344	236	298	208	124	168	**3,592**
Adjustemnt procedure	(Qter.1)*4	(Qters.1+2+3)* 1.25				From 2006	Qters. 1-3 * 1.25	From 2006	(Qters.1+ 2+3)* 1.25	
Condom distributed in community (2007)	20,438	42,483	3,640	2,004	14,544	913	3,904	34,482	142	122,550
Adjusted Condom distributed in community	81,752	53,104	4,550	2,505	18,180	3,652	4,880	43,103	178	**211,903**
Adjustemnt procedure	(Qter.1)*4	(Qters.1+2+3)* 1.25				(Qter.1)*4	(Qters.1+2+3)* 1.25			
Young People reached through community	106,110	41,924	21,108	8,960	15,726	16,673	8,720	1,986	2,481	223,688
Adjusted Tot Youth reached through community	424,440	52,405	26,385	11,200	19,658	66,692	10,900	2,483	3,101	**617,263**
Adjustemnt procedure	(Qter.1)*4	(Qters.1+2+3)* 1.25				(Qter.1)*4	(Qters.1+2+3)* 1.25			
Clinic Based Program										
Youths Reached Trough YFS	25,607	19,709	14,052	16,790	13,986	7,986	6,647	7,606	10,803	123,186
Adjusted Total Youths Reached Trough YFS	32,009	78,836	56,208	20,988	17,483	31,944	26,588	30,424	43,212	**337,691**
Adjustemnt procedure	(Qs.1+2+3)*1.25	(Qter.1)*4		(Qters.1+2+3)* 1.25		(Qter.1)*4				
Number of YFS with peer educators		5	3	10	4	?	5	2	1	30
Adjusted YFS Peer educators	68	5	34	10	4	?	5	2	1	**129**
Adjustemnt procedure	Trainned in 2006	As reported	Trainned 2006	As reported		N.D.	As reported			
Condom distributed at YFS	293,677	96,224	29,175	84,272	99,110	30,117	10,433	7,642	32,391	683,041
Adjusted Condom distributed at YFS	367,096	384,896	116,700	105,340	123,888	120,468	41,732	30,568	129,564	**1,420,252**
Adjustemnt procedure	(Qs.1+2+3)*1.25	(Qter.1)*4		(Qters.1+2+3)* 1.25		(Qter.1)*4				

Columns in Grey indicate data only available for Quarter 1 2007. Otherwise, data available for Qters. 1, 2 & 3

Appendix 5. Comments from Members of Evaluation Team

From Nina Strøm and Atle Karlsen

Dear Jaime,

What a job! Atle and I have read the report, and we have the following comments/suggestions:

- The report includes loads of information incl. new statistics - this is impressive. We recognise and support most of what you have presented as findings, but we have some difficulties with regards to the length and the structure of the report (findings/data, analysis and recommendations). Could the report be narrowed down/shortened by pooling out al the recommendations included under the various themes and rather having them listed at the end of each section/theme (for example in built points, which you also have done in a few places)? We believe that it would make the document easier to use or more "user-friendly" if you like.

- UNFPA and Pathfinder's roles in the programme should be mentioned in the introduction part, as it is now one gets the impression that UNFPA is only a funding agency. Other roles are not really specified before the part on "technical assistance" on page 45. We have taken a rather opposite angle in our appraisal report (which should be attached to this E-mail for your reference and use if you like!). Althugh the appraisal report is developed for the purpose of facilitating a donor's decision; evaluations also have many "users" including donors. Pathinder might also get too many complements, I trust that Atle will fill me in on this point!

- The evaluation is external, yet the term MTR popes up from time to time in communication with Julio and others. In the Norwegian development cooperation an MTR would focus on broad participation in data collection, analysis and conclusions. As to make sure that the implementers would "own the decisions". This exercise has been somewhat inbetween. You might want to raise/clarify this in the introduction part. The headline "External Evaluation Report" is correct as fare as we see it.

- Evaluation team: The set-up was a bit strange and it was probably due to a lack of communication before the mission to Mozambique. Anyway, Jorge and you should figurate nicely at the front page. Atle and me are happy and grateful to have taken part and hope that we were of use, but since we haven't been involved in the report writing, our names should only be on page 15 where it can be explained that we represented donors on the team, (I am not sure about the inclusion of our names on page 2). By the way: I am an advisor with Norad, please change from NORAD to Norad .

- Last but not least: I would like to suggest that the issue of (or rather lack of) "sex education" in schools, teachers training and school and teachers curriculums on page 27 is brought forward to the Executive summary page 5-8 and Conclusions page 50-55.

- Let me also mention that some of the gender challenges or gender gap, might have looked different if young people were part of programme planning and development. Then the program could have worked out the role and needs of girls in dialogue with boys both on the drawing board as well as in practice, through organised and real time participation. The out of school & sport activities also have a potential in developing and using activities which mix and equalises the different sexes. I also want to point out that most of the users/clients or beneficiaries of the YFS and school corners are girls, have their opinions been requested regarding preferences for female PE`s or female nurses for example?

From Jorge Matine

Page 6 on out-of-school program

Nao penso que a questao (1) do espaco seja o maior problema da intervencao fora da escola. A capacidade das associacoes em liderar e gerenciar melhor as intervencoes na comunidade afecta a qualidade da intervencao. Os espacos fisicos/clubes juvenis nao sao espacos para estarem sob tutela do MJD mas de estruturas locais e CBOs juvenis. (2) A solucao seria como transferir sistemas e metodologias de intervencao baseadas numa politica de expansao e cobertura do programa ao estilo top-down para niveis down to top. (3) outro aspecto o geracao biz respondeu em grande medida a uma situacao de problemas de saude e social dos adolescentes e jovens urbanos, o programa ainda nao conseguiu, mesmo com a valiosa experiencia da zambezia e provincia de maputo, um pacote eficiente de intervencao comunitaria. (4) a expertise dos TAs vem da educacao formal (instituicoes publicas: a escola e centros educacionais), o que influencia o nivel de assessoria tecnica dispensada para grupos ou instituicoes com intervencao comunitaria e informal. (5) geracao biz deve definir os conceitos conceptuais e operacionais da definicao intervencao comunitaria, importa talvez a nivel operacional trabalhar definicoes politico-administrativas de localidade, Bairro e quarteira/aldeia, o que podera individualizar e especificar as qulidades e actividades desenvolvidas para e com jovens fora da escola.

Page 6 on Training

Segundo o resultado da nossa avaliacao novos componentes presisam de ser incorporados nos conteudos de treinamento e precisa-se fazer uma avaliacao constante do uso e utilidade do material (urbano-rural). Podia ver como contractar alguem que trabalhasse so na area de treinamento, assim como , o programa tem um oficial de monitoria e avaliacao.

Page 6 on M&E

Institutionalisation of PGB level of M&E within government approach. Evaluation have to focus on "what works, what does not works and why?" rather than an overly strong emphasis on monitoring ("obsession with data"); can it become as integrated into our work processes as "planning", "budgeting", "supervision", "communicating"? Substantive government demand to place and manage PGB M&E system (demand made by MJD and MEC) is a prerequisite for successful institutionalisation within government system.

Page 7 on Services

Improving service delivery means focusing above all on more efficient service management and resource mobilization. Shifting from institutional oriented capacity building approach (which is no relevant nor creative to program impact) to a more imput-oriented, cost-benefit and expert-led practices which focus on improving services standards. Delivering better services is the key to improving the quality of life for many adolescents and young people.

Page 7 on Advocacy.

In the long term - work to mainstream evaluation and advocacy effectively into other courses - management, counseling, community mobilization, etc.Using CBO's, youth associations, service providers to share with governments strategically and systematically case studies and models, show benefits and create opportunities for interaction and exposure

Page 7 on Multi-sector coordination.

The M&E process can be use as valuable process of strength and promote coordination capacity for enhanced accountability, learning - for collective decision-making, and informed participation in development processes.

Page 9 on School-based program

And youth associations and groups (colizao, nucleo de mavalane por exemplo na cidade de Maputo)

Page 10 on SAAJs and YFS

Em algumas provincias e cidade em colaboracao tambem com associacoes juvenis ou grupos organizados de suporte psico-social.

Page 10 on adults in School component

Adultos como role models nao tem fundamneto na estrategia do programa, funciona na componenete de advocacia or supportive environment/ components.

Page 10 on The community component

A componente for a da escola tem dois actors: As instituicionais publicas e governamentais a nivel local e as organizacoes da sociedade civil (entenda-se associacoes, grupos organizados de jovem, etc), entao qual destes grupos nao tem lugar fixo para gerir actividades do programa?

Page 11 on Provincial Level complexity.

How? Como se manifesta essa complexidade a nivel provincial? (budget management, resources allocation, division of labour, absence of clear rules and responsibilities, political agenda, conceptual analysis?)

Page 12 on Multi-Sector Strategy.

At district level o program é coordenado por tres sectores mais implementados por outros sectores, o caso dos servicos distritais e associacoes juvenis.

Page 12 on Institutional Capacity-Building.

E alguns programas de estudo e visitas. Incluindo bolsas de estudo para cursos cursos universitarios de especializacao e pos-graduacao

Page 16 on youth organizations

As organizacoes juvenis podem ser dependents da ajuda do governo e das instituicoes publicas, mas devem ser autonomas na gestao e na implementacao de suas prioridades/actividades.

Page 25 on teaching about HIV in the schools

A necessidade de trabalhar com a questao da confidencialidade nos cantos de aconselhamento, e as salas de aconselhamento as vezes sao usadas pelos activistas professors, nao da espacos para o encontro entre os activistas e os jovens, a necessidade de aumentar o numero de activistas professoras, que pode em grande medida ajudar o incremento e a mobilizacao de activistas raparigas.

Page 26 on frozen expansion of youth associations in the PGB

Como se explica este numero se o programa fez a expansao para novas provincias e distritos durante os ultimos dois anos? Assistiu-se que as organizacoes expandiram o seu raio de accao, passando a desenvolver actividades de prevencao em areas que nunca la trabalharam ou tem alguma ligacao natural com os jovens. O outro problema tem haver que capacity building para associacoees juvenis, é decidido no programa por sectores centrais e provinciais do governo, que nao é muito eficiente em expandir e descentralizar as suas actividades para associacoes juvenis

Page 32 on adjustment of Research bullet

Complementarily with existing statistical systems and statistical planning - should have resources and mandates. Linking the system to the budget process - but avoid perverse incentives. Can encourage empowering research processes that stimulate use of evaluation and research information

Page 33 on synchronization of program activities among the sectors

PGB needs an spatial approaches focus on promoting rapid access to SRH services in a particular area by either focusing interventions on a particular pole or cluster of service with high potential. In addition, systematically removing obstacles to their development, by strengthening local governments and CBO's/youth association's actors to plan and initiate locally controlled projects that are highly valued by a majority.

Page 35 on Scheduling team building workshops

Focus on realizing short-term benefits in order to maintain interest in long-term processes of institutional transformation and upgrading.

Page 35 on Promote development of multi-sector plans

Use material and political incentives to obtain coordination among reluctant partners with the hope that over time that the benefits of cooperation and coordination will become self-evident

Page 35 on Joint discussions on availability of supplies, particularly condoms

The top-down structure of multi-sectorial approach at provincial have to avoid complex institutional arrangements to manage development project interventions—without a clear understanding of incentives, expectations, good information on impact and effectiveness, and with little real consideration paid to sustainability.