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Taking Action against HIV and AIDS in the UK Overseas Territories

End of Project Evaluation for the South Atlantic Overseas Territories

Final report for DFID approval

Debra Stevenson

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DFID Human Development Resource Centre
HLSP, 10 Fleet Place
London EC4M 7RB

T: +44 (0) 20 7651 0305
E: just-ask@dfidhdrc.org

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HLSP, 10 Fleet Place
London EC4M 7RB

T: +44 (0) 20 7651 0305
E: just-ask@dfidhdrc.org

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List of Abbreviations

AI	Ascension Island
AIDS	Acquired Immunodeficiency Syndrome
COTs	Caribbean Overseas Territories
CSW	Commercial Sex Workers
CWP	Christopher Winter Project
DFID	Department for International Development
FI	Falkland Islands
HIV	Human Immunodeficiency Syndrome
IEC	Information, Education and Communication
LFM	Logframe Matrix
LTTA	Long Term Technical Advisor
MARPs	Most-at-Risk Populations
MSM	Men who have Sex with Men
OTs	Overseas Territories
SAOTs	South Atlantic Overseas Territories
SH	Sexual Health
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRE	Sexual Relationship Education
St H	St Helena
TA	Technical Assistance
TdC	Tristan da Cunha
STI	Sexually Transmitted Infection
UKOTs	United Kingdom Overseas Territories
VfM	Value for Money

EXECUTIVE SUMMARY

This report presents the final evaluation of the 'Taking Action Against HIV in the UK Overseas Territories' project focusing specifically on the 4 South Atlantic Overseas Territories (SAOTs). The UK Department for International Development (DFID) contracted Options to provide technical assistance to 10 UK Overseas Territories in the Caribbean and South Atlantic to manage and implement the project. The project was originally scheduled to run over 3 years (February 2008 – February 2011) with a budget of £1,268,945. In June 2010 a no-cost extension was granted for one year to extend the project period to the new end date of 31st January 2012.

The extent to which the SAOTs identified HIV/Sexual Reproductive Health Rights (SRHR) as a priority for intervention prior to DFID support being agreed is not clear and there is consensus that this was, and remains, a low priority issue in the SAOT context. However all SAOT respondents report that HIV/SRHR is an area which would have received little attention without project support. In light of the needs identified during the inception phase of the project it was agreed that the programme would address Sexual and Reproductive Health (SRH) more broadly, rather than just HIV/AIDS, focusing on HIV prevention and preparedness as part of a broader SRH strategy integrated within the islands' health programmes. The original logframe was revised following the Inception Phase and again in 2010 for the no-cost extension period, which included a revision to the Purpose statement and project Outputs and indicators.

Overall, implementation was slower than anticipated. The SAOTs were not proactive in requesting TA inputs and there was often little activity on-island between Long-Term Advisor visits. Work-plans were developed in 4 SAOTs and access to HIV/SRHR resource databases was provided. However planned TA and capacity building activities identified in the work-plan were only partially achieved. All SAOTs now have a multi-sectoral HIV/SRHR committee, or its equivalent, in place. The only committee that still meets regularly to review SRHR/HIV/AIDs action plans/programmes is St Helena, although stakeholders on Ascension and Tristan have been active particularly in 2011. All SAOTs have a community based programme targeting most-at-risk populations although most-at-risk populations and civil society has not been involved in policy development. Although progress has been made in drafting guidelines and protocols for SRHR/HIV prevention, care and support these are not yet finalised in any of the SAOTs. The follow-up youth survey shows that there has been an increase in the percentage of targeted school youths with improved HIV-related knowledge. One new policy has been adopted in St Helena, which is also the only SAOT to have an active programme or policy to address stigma and discrimination.

At Goal level Sexually Transmitted Infection (STI) and HIV incidence rates remain low and have been sustained during the lifetime of the project but given the very low or no incidence on commencement of the project it is difficult to attribute this to project interventions. The project Purpose has been partially achieved in that the SAOTs have had some strengthening of their capacity to lead an integrated HIV/SRSH response; however the indicator targets have not been met.

There would have been value in providing a higher level of on-island inputs particularly in the early part of the project in order to 'kick-start' some critical activities, produce some early outputs and achievements, and to ensure that the relevant infrastructure was in place that could be strengthened throughout the implementation period. The SAOT no-cost extension was granted on the basis of an overall slow response to operationalising work-plans on two of the four SAOTs. Maintaining momentum has been particularly difficult in the no-cost extension period where there were no field visits and interaction was dependent on communication by phone and internet.

It is too early to measure the full impact of the project however some positive outcome is already evident and can be directly attributed to the project. There is evidence that the project has provided a focus to bring together multi-disciplinary staff to address SRH issues.

The project has successfully raised awareness at strategic level of the need to consider how best to respond to HIV/SRHR-related issues and each SAOT now has a SRH framework in place which can be maintained and strengthened if there is sufficient motivation to do so. The project has clearly contributed to the provision of Sexual Relationships Education and raising the quality of the training provided. However, in general, systems are not yet institutionalised which is a risk to sustainability on conclusion of the project. Financial constraints are reported as a challenge by a number of respondents who cite this as a significant risk to sustainability in the absence of specific ring-fenced funds for SRH and the context of competing priorities across the health, education and social sectors.

Overall project management appears to have focused primarily on the Caribbean Overseas Territories which was a deliberate strategic decision in response to identified needs. This may have contributed to some of the delays in implementation in the SAOTs, however at SAOT level respondents report that project management arrangements have been satisfactory.

Retaining the capacity that has been built during the implementation period will also be challenging but if efforts are made on-island to conclude the outstanding activities and strengthen the systems developed this will provide mitigation to a certain extent. The HIV/SRHR systems developed with project support are not yet internalised and there is a risk that some will not be maintained when the project concludes and the SAOTs are faced with other competing demands and priorities.

Ouput scores:

	Output	**Score**
1	Increased capacity of OTs to access resources to implement annual HIV/SRHR plans;	A
2	An effective and efficient multi-sectoral mechanism in place to coordinate HIV/SRH programmes;	B
3	Most-at-risk populations successfully identified and reached through targeted interventions;	A
4	Number of adopted HIV/SRH policies and legislation increased.	B

1. INTRODUCTION

This report presents the final evaluation of the 'Taking Action Against HIV in the UK Overseas Territories' project focusing specifically on the South Atlantic Overseas Territories. The evaluation looks particularly at progress against the project logframe, sustainability of achievements as well as value for money aspects of the project. Terms of Reference for the evaluation are attached at Annex 1.

The objectives for the evaluation are to:

1. Assess progress made towards the achievement of results at the goal, purpose and output levels as measured against the indicators in the logframe for the SAOTs.
2. Identify the effectiveness and impact of the programme in the SAOTs and recommend ways that this can be improved and sustained.
3. Record and share lessons learned for the SAOTs between SAOTs and with other UKOTs and with a wider group of stakeholders.
4. Assess performance of the project in the SAOTs in terms of the relevance of results, sustainability, ownership and accountability, appropriateness of design, resource allocation, and informed and timely action.

1.1 Method and scope of work

The final evaluation for the SAOTs was conducted as an external desk-based review undertaken 15th November – 7th December 2011. It assesses the progress of the project against the logframe. In addition, the evaluation considers the questions presented in the PCR report namely: Costs and timescale; Evidence and Evaluation; Risk; Value for Money[1]; and Conditionality. In addition, the consultant has, so far as she is able in the time available, assessed the questions on Appropriateness, Efficiency, Impact, Coverage, Connectedness (including sustainability and linkages), Coherence; Management in addition to key constraints and lessons learned which are raised in Terms of Reference.

The evaluation comprised a review of project documentation and telephone interviews with key stakeholders. Details of the documents reviewed are attached at Annex 2 with details of the key stakeholders interviewed attached at Annex 3.

A major limitation of the evaluation was the availability of key stakeholders to participate in the interview process during the timeframe of the review. In particular it should be noted that stakeholders from the Falkland Islands were not available for interview and therefore the evaluation relies on secondary reporting for the Falkland Islands which was not validated during the review.

[1] Although Value for Money was not specifically included in the original project design

2 BACKGROUND

2.1 Context in which UK support was provided

The Department for International Development (DFID) is committed to supporting the Caribbean and South Atlantic UK Overseas Territories (OTs) to build up local capacity to lead an integrated national response against HIV/AIDS and Sexual & Reproductive Health and Rights (SRHR). Health is a devolved responsibility and consequently the SAOTs are responsible for ensuring a population-level SRHR/HIV programme is in place for prevention, care and support activities.

2.2 Support provided by the UK

DFID contracted Options to provide technical assistance to 10 UK Overseas Territories (OTs) in the Caribbean and South Atlantic to manage and implement the "Taking action against HIV & AIDS" project for 3 years with a one year no–cost extension. The 6 Caribbean OTs (COTS) are Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Montserrat and Turks & Caicos Islands. The 4 South Atlantic OTs (SAOTs) are St. Helena (St H), Ascension Island (AI), Tristan da Cunha (TdC), and the Falkland Islands (FI). This review focuses only on the 4 SAOTs.

The project was originally scheduled to run over 3 years (February 2008 – February 2011) with a budget of £1,268,945. In June 2010 a no-cost extension was granted for one year to extend the project period to the new end date of 31st January 2012.

2.3 Expected results

The **Goal** of the project is: Low transmission of STIs and HIV sustained amongst at risk populations and improved quality of life of people living with HIV in UK Overseas Territories.

The **Purpose** is: UKOT capacity strengthened to lead an integrated national HIV/SRHR response.

The original project Logframe was prepared as part of the Project Memorandum but this was revised in June 2009 based on the comprehensive set of activities identified during the Inception Phase. This was in order to reflect the new project focus and outputs. A further revision was undertaken in September 2010 when the no-cost extension was agreed. The final Logframe is attached at Annex 4.

The planned **Outputs** for the project (agreed in September 2010) are:

Output 1 Increased capacity of OTs to access resources to implement annual HIV/SRHR plans;

Output 2 An effective and efficient multi-sectoral mechanism in place to coordinate HIV/SRH programmes;

Output 3 Most-at-risk populations successfully identified and reached through targeted interventions;

Output 4 Number of adopted HIV/SRH policies and legislation increased.

3 APPROPRIATENESS

The Caribbean region has the second highest incidence of HIV/AIDS after sub-Saharan Africa and therefore DFID agreed to support the COTs requests for assistance to tackle HIV/AIDS taking the decision to include all OTs in the project, including those in the South Atlantic. DFID had already supported a HIV Educator to work on St H for a two-year period. That contract was scheduled to end in 2009 and therefore this project was expected to provide ongoing support as per identified needs. In addition, although the incidence of HIV in the SAOTs was low it was identified that preparedness needed to be strengthened.

The intervention logic was sound and was apparently supported by the relevant SAOT authorities at the time. However, respondents suggest that HIV/SRHR was not seen as a priority area for DFID support and, overall, the limited stakeholder ownership has been evident throughout the implementation period.

Although all SAOT respondents report that HIV/SRHR is an area which would have received little attention without project support and subsequently recognise the value of the project, there is consensus that this was, and remains, a low priority issue in the context of competing priorities and limited resources. This presents a significant challenge for successful project implementation.

3.1 Project approach

The project approach was characterised by the allocation of long term technical advisors (LTTAs) to identify technical assistance (TA) needs, develop a TA work-plan and to manage short-term technical inputs in order to tailor inputs to priority issues and absorptive capacity. It was anticipated that, by establishing relationships with key stakeholders, the LTTAs would gradually build the capacity of the counterparts to assess, plan, monitor and control the quality of TA. The decision to provide LTTAs was critical to raising awareness of the need to address HIV/SRH issues (which were not seen as being important and therefore not a priority), and to maintain momentum for implementation. Respondents suggest that the face-to-face interaction was critical.

In the SAOTs it was agreed that the programme would focus on sexual and reproductive health more broadly, rather than just focus on HIV/AIDS, in light of the SRH needs identified during the inception phase of the project. Technical support was provided during a number of field visits with follow-up support provided via phone and email. Short-term TA inputs were also provided as required, primarily in respect of Sexual Relationship Education (SRE) and SRHR issues.

Three LTTAs have been allocated to work with the SAOTs during the lifetime of the project. At the end of the original 3-year project period Options proposed that no further support should be provided to the SAOTs because they did not feel an extension would be cost–effective, but DFID felt that there was an opportunity to consolidate and conclude some of the outstanding components of work, so the decision was made to continue support on a minimal basis for the final year of the project. Work streams during the no-cost extension period prioritised SRE provision, the follow-up youth survey and the implementation of HIV and SRH related policies. These inputs were to be supported with reduced LTTA inputs in line with the agreed workplan. However, when this was agreed it was not known that the second LTTA would not be available to provide ongoing support, and it is acknowledged that the third LTTA faced particular challenges in engaging stakeholders for much of the extension period.

3.2 Needs assessment

DFID had previously funded a HIV Advisor to work on St H for a two year period in response to concerns about the potential impact of the new airport, so there was already a

basic level of awareness on the island. FI had a number of staff who were UK-trained so again there was some awareness. Awareness in AI and TdC was limited. Key stakeholders were identified and engaged during in-country rapid assessment visits to St H, AI and FI and a remote assessment of TdC in 2008.

The needs analysis undertaken via interviews and focus groups identified that in the absence of a government level strategic plan, the response to date had been clinically reactive, and therefore institutional strengthening for SRHR/HIV was a prerequisite to moving forward. At the time of the initial assessments the SAOTs had no reported cases of HIV and few reported sexually transmitted infections (STIs). As a result the recommended focus for the project was on HIV prevention and preparedness as part of a broader sexual and reproductive health (SRH) strategy integrated within the islands' health programmes.

TA was identified to build capacity to respond to SRHR/HIV, including support to better understand vulnerability amongst populations; addressing policy development at strategic and operational levels (e.g. government, clinical and education); implementing strategic information management for surveillance and monitoring; multiagency training; and professional and public awareness-raising. The Logframe presented in the Project Memorandum was subsequently revised to better reflect the needs and objectives identified during the inception phase.

3.3 Project Logframe

The original logframe was presented in the Project Memorandum October 2007 but was revised following the Inception Phase although there were some delays in finalising the overall project logframe, mainly related to the COTs, and it was not finalised until June 2009. The logframe was changed significantly in August 2010 for the no-cost extension period, including a revision to the Purpose statement and project Outputs and indicators. The revised Purpose statement is 'UKOT capacity strengthened to lead an integrated national HIV/SRH response' which more closely reflects the original Purpose of the project described in the Project Memorandum. Changes to objectives at Output level emphasise HIV and SRH integration to improve health service provision, the development of a multi-sectoral response to HIV and SRHR and the delivery of comprehensive rather than vertical programmes. However, the milestone targets identified in the revised logframe for the SAOTS during the extension period are ambitious given the agreed scale-down of inputs and, although some progress has been made during the extension period, several of these targets will not have been met on conclusion of the project.

The Goal level indicators address transmission rates but do not allow for an assessment of the 'improved quality of life' component of the Goal statement. Reporting against Goal level indicators relies on access to HIV/STI data which has proved difficult during the project period. Efforts have been made to agree data sets and reporting arrangements but the quality of reporting has been poor and analysis challenging, especially regarding STIs.

At Goal level the logframe identifies an assumption that there is OT Government commitment for SRHR/HIV programming and funding. This commitment has been made during the project lifetime however funding has not been identified. At Purpose level the assumptions are that there is Government commitment to improving legislation and policies on stigma and discrimination and HIV, and high level commitment to an integrated approach to health, SRHR and HIV/AIDS. The SAOT Governments have been in agreement with the implementation of an integrated approach and the SAOT policies that have been finalised were subsequently adopted by Government.

3.4 Implementation of TA

Island-specific work-plans were developed for all islands in wide consultation and collaboration with key stakeholders, tailored to the needs identified during the assessment process. DFID agreed the allocation of financial resources based on the activities in the

work-plans, thereby ensuring that the inputs were demand-led. However, the work-plans appear to have been overly ambitious given the demands placed on the small number of people responsible for implementation at island level; the fact that those people often have dual or multiple responsibilities; that HIV and SRHR are not viewed as priority issues in the SAOTs; and the expectation that work would be progressed independently in between LTTA visits.

Overall, implementation was slower than anticipated as reflected in project reports, the reports from the two Annual Reviews and the request for the no-cost extension. The SAOTs were not proactive in requesting TA inputs and there was often little activity on-island between LTTA visits. However, the respondents report that when TA was provided, it was always relevant and of high quality.

There are two particular issues of note regarding TA inputs. Firstly SRE inputs from the Christopher Winter Project (CWP) were considered as being particularly successful. Whilst recognising that this was agreed in response to requests for support from the SAOTs, had this been provided earlier in the implementation period it would likely have resulted in greater progress being made by conclusion of the project. However factors affecting the timing of these inputs include logistics such as travel and school terms, as well as stakeholder capacity to absorb the TA provided. Secondly, the awareness raising visit to St H of a person living with HIV from the UK successfully stimulated debate and was well received on-island. However, respondents from St H report that that people are now less motivated to come forward for voluntary HIV testing because that person was seen as being ‘too healthy’.

Stakeholders were involved in reviewing progress against the work-plans during each field visit and this provided the tool for monitoring implementation and progress against the logframe. Although the work-plans are, in effect, the SAOT SRHR plans they are still referred to as ‘DFID project’ plans suggesting that the activities identified in the plans are not yet internalised.

Better prioritisation of needs and more effective targeting of priority interventions during the inception phase may have resulted in better achievement of key deliverables in the early part of the project, which could then have been consolidated and expanded if time and resources allowed.

3.5 Conditionality

There is no conditionality attached to the project.

4 ACHIEVEMENTS AND RESULTS

4.1 Output 1: Increased capacity

Increased capacity of UKOTs to access resources to implement annual HIV/SRHR plans.

Final score: A

Performance description

Indicator 1.1 Percentage of planned TA and capacity building activities delivered in proposed year of the work-plan

Indicator score: A

Options have adopted a capacity building approach to project implementation but faced significant challenges given the turnover and absence of personnel on island in key posts, the small number of personnel to work with the project given the small population and workforce, and the demands on workload and financial restraints.

Options worked with the SAOTs to develop work-plans at the beginning of the project and these were finalised in March 2009 and updated following telephone meeting with the relevant 'committees' on each island. The work-plans include plans for the delivery of TA. They have provided the framework for activities throughout the implementation period. The work-plans are comprehensive and identify objectives related to the logframe, specific actions required, key measurables for each activity and responsible person or partner. The LTTA have supported the SAOTs to review progress against the work-plans and to update them and amend accordingly. They provided the basis for activities undertaken by the LTTAs during the field visits.

Feedback from the project team is that St H reports to have made good progress against the work-plan and are confident that all planned activities will have been achieved by the end of project. FI are reported to have achieved 80% of planned activities but have been unable to provide training for people with learning disabilities due to lack of budget. AI TA has been delivered as planned but progress in concluding some activities has been delayed as a result of change in Administrator. TdC has achieved all activities in the education sector but there has been no achievement in the medical sector because of staffing constraints. These assessments appear ambitious given the number of activities that have yet to be concluded with only weeks remaining before the end of project.

The planned Youth Survey is currently underway involving all 4 SAOTs and will be concluded by the end of project.

Indicator 1.2 Number of OTs that take full responsibility for TA procurement and management during the preceding year

Indicator score: No score as no target in logframe

This indicator has only applied to the SAOTs during the no-cost extension period when LTTA inputs were scaled-down – prior to that it only applied to the COTs. It has not therefore been reported against in progress reports to date and there is no SAOT target for this indicator in the logframe. The TA procurement guidelines produced for the COTs were shared with the SAOTs and informal training provided by the LTA during his last field visit.

This included working with them to determine what their TA needs might be. The only TA requested was support for SRH training for people with disabilities in FI but this request was not made until the extension phase at which time no funding was available.

Indicator 1.3 Number of SAOTs who have access to SRHR/HIV database of resources.

Indicator score: A

In addition to resource materials provided as outputs of TA activities all SAOTs have been provided with an extensive range of SRHR/HIV resources stored electronically on a memory stick. However some respondents interviewed were not aware that these resources were available, suggesting that the resources are not being used as yet or that their availability is not being communicated internally.

Options are currently exploring the feasibility of establishing a mechanism for sharing resources between the SAOTs via the internet in line with recommendation of the Annual Review 2010. This may have been a useful activity earlier in the implementation period but at this stage it may prove difficult to achieve in the remaining few weeks of the project.

Options have been active in pursuing opportunities to develop sustainable links with regional bodies including World Health Organisation, UNFPA, International Labour Organisation, UNICEF, UNAIDS as well as UK Department of Health. However, these efforts have been unsuccessful, either because of a lack of response despite repeated follow-up; because the SAOTs are not UN member states; or because the SAOTs are regarded as falling under the responsibility of the UK. Efforts are on-going to establish linkages with the UK Department of Health in respect of them acting as a technical / advisory resource in the future but as yet no agreement has been reached and progress to date suggests that this will not have been established on conclusion of the project.

Final results: Work-plans have been developed in all SAOTs (Target 3/4 - 75%) therefore this target has been exceeded. All SAOTs have access to HIV/SRHR resource databases therefore this target has been met.

Impact Weighting: 20%

Revised since last Annual Review: No

Risk: Medium

Revised since last Annual Review: No

4.2 Output 2: An effective and efficient multitsectoral mechanism

An effective and efficient multitsectoral mechanism in place to coordinate HIV/SRHR programmes (disaggregated by island)

Final score: B

Performance description

Indicator 2.1 Percentage of UKOTs with an established multi-sectoral HIV/SRHR committee and
Indicator 2.2 Percentage of UKOTs with committees which regularly meet and review SRHR/HIV-AIDS action plans/programmes

Indicator score: B (for both 2.1 and 2.2)

An early project activity was to support the establishment of multi-sectoral committees in each of the SAOTs with responsibility for coordinating HIV/SRHR programmes. These have been established in all SAOTs with the exception of TdC, where it was agreed that this would be incorporated into the existing Public Health Committee. There is no evidence that this actually happened given the frequent turnover of senior medical staff (four during the project period).

Each committee has ToRs and an agreed meeting schedule although their level of activity has varied throughout the project. The committee on AI did not meet at all during 2010 but has been more active during 2011, led by the education sector. The committee in St H met regularly during the first 3-years of the project and also established a number of working groups reporting to the committee, all of which were active and reported progress on a regular basis. Respondents report that this committee is still in place but membership has dwindled and there are now only 2 active working groups. It is intended that the committee will remain in place on conclusion of the project but respondents suggest that it will be difficult to maintain momentum and focus without external support from the project, suggesting it is not yet institutionalised within health management systems. FI established a committee but there is no information available to suggest that the committee is still active and meeting on a regular basis, given that communication between Options and key personnel on FI has been difficult and that they were unavailable for interview during this evaluation.

The work-plans produced with support from the project have clearly provided a mechanism to guide the work of the relevant committees but respondents still refer to them as ‘project work-plans’ and there does not appear to be any arrangements in place for the committees to develop their own plans once the project has concluded.

Final results: All SAOTs now have a multi-sectoral HIV/SRHR committee, or its equivalent, in place. However the scoring reflects the fact that only the committee in St Helena meets regularly to review SRHR/HIV/AIDs action plans/programmes.

Impact Weighting: 20%

Revised since last Annual Review: No

Risk: High

Revised since last Annual Review: No

4.3 Output 3: Most-at-risk populations

Most-at-risk populations in UKOTs successfully identified and reached through targeted interventions (disaggregated by island)

Final score: B

Performance description
Indicator 3.1 Number of targeted OTs with evidence informed community based programmes reaching priority most-at-risk populations

Indicator score: A

All SAOTs have undertaken some level of activity to target most-at-risk populations (MARPs). During strategic development training early in the implementation period youths were identified as a specific target group in all SAOTs and this is an area where the project has had its greatest achievements primarily through its support to schools. St H and FI launched new young people's drop-in clinics at health facilities but both were subsequently discontinued because of lack of attendance. Discussions for a youth drop in clinic at a youth centre on St Helena have been recently revitalised.

The project has supported the SAOTs to develop appropriate communication materials adapted to the local context as requested including posters and leaflets on topics such as confidentiality and emergency contraception. 'Contraception and Sexual Health' booklets for AI, TdC and FI have been produced but these have only been provided on island in recent weeks and dissemination plans are currently under 'development'. It is therefore too early to evaluate any impact.

Men who have sex with men (MSMs) and commercial sex workers (CSWs) were identified as high risk groups in both FI and St H but the cultural context on both islands means that it is difficult for the project to access these groups, and no specific targeted activities were implemented. Respondents from St H report that some MSMs have come forward to access services as a result of the general awareness raising activities undertaken, which is a positive development, but obviously numbers are small and significant cultural challenges remain as barriers to access in all SAOTs.

In line with the agreed work-plans the project has supported the procurement and distribution of condoms in the SAOTs, with varying success. Condoms have been made available in community locations in St H and AI but this has been less successful in Falklands and TdC, although condoms are made available via health services. Other than St H there are no established mechanisms as yet for on-going procurement and distribution. A data collection form has been produced with project support to monitor distribution but data collection is not well institutionalised and appears to be collected mainly because the project asks for it. The project also arranged for a wide range and variety of condoms and lubricant to be supplied to St H in response to requests, and procurement details and mechanisms have been provided for the Health Authority's Procurement Officer.

In St H efforts have been made to work with those community members trained as Peer Educators prior to commencement of this project to revitalise this role to include a focus on SRSH/HIV. During the last LTTA visit in 2010 the group was brought together to refocus the role and agree the way forward however communication with this group has proved difficult and the recent CWP visit confirms that the Peer Educators have not been active since this time however CWP did engage the new Health Promotion Coordinator in discussions about how this role can be revitalised.

Indicator 3.2 Percentage of OTs with evidence-informed guidelines/protocols/ strategies for SRHR/HIV prevention, care and support services targeted at vulnerable groups

Indicator score: B

Efforts have been made to support the development of various relevant guidelines, protocols and strategies, including HIV care pathways, STI management guidelines, contraception guidelines and abortion care pathway with variable success. Both St H and FI are reported as having strategies to address young people, MSM and those with multiple partners. St H also addresses Royal Mail Ship workers. UK STI management guidelines and contraception management guidelines have been adopted on all 4 SAOTs. In addition St H have drafted HIV Care Pathway and an abortion care pathway however both are still under review and have not yet been finalised. The abortion care pathway has very recently been submitted to the Clinical Guidance Group and can be quickly finalised once approved by the Group, although it is noted that this was submitted without taking into consideration inputs from the project LTTA.

AI has a HIV care guideline included in Standard Operating Procedures and an abortion care pathway is in place. Additionally the Senior Medical Officer initiated the development of HIV testing policy in first half of 2011. HIV testing pathways have been adopted on FI and St H. STI guidelines have been adopted on FI and St H and guidelines for managing youth SRHR services have also been drafted for both islands.

Summary of status of outstanding guidelines for the SAOTs (as of December 2011)

Key Output	Island	Status
HIV Management guidelines	Ascension	Ongoing
	Falklands	Ongoing
	St Helena	Ongoing
	Tristan	Outstanding
Abortion Care Pathway	Ascension	Ongoing
	Falklands	Outstanding
	St Helena	Ongoing
	Tristan	Outstanding

Indicator 3.3 Not applicable to SAOTs

Indicator 3.4 Percentage of targeted Secondary school youth with improved HIV knowledge

Indicator score: B

A youth health and behaviour survey was undertaken on all islands as an early project activity and survey results provide a mechanism to monitor performance against this indicator. The survey has recently been repeated on all islands as an on-line survey except TdC where a brief paper-based survey was undertaken. An overall measure of HIV-related knowledge was derived by calculating the proportion of pupils who answered 5 key questions correctly. These questions were:

1 Condoms are reliable to prevent infections like HIV/AIDS YES

2 Contraceptive Pill is reliable to prevent infections like HIV/AIDS NO

3 HIV/AIDS can be treated but not cured YES

4 HIV virus can be passed on by sharing a needle used to take drugs YES

5 HIV virus can be passed on by sex without using condoms YES

In 2009, 5% of Year 10 pupils got all 5 questions correct; the equivalent figure for 2011 was 11%, while the figures for a score of at least 4/5 were 61% in 2009 and 54% in 2011. These differences are not statistically significant. This is useful in demonstrating that there has been some increase in knowledge but that the level of knowledge remains low. Further data interrogation is required before the survey report is finalised to determine whether or not the project has met the logframe milestone targets for this particular indicator.

Both St H and AI have SRE policies in place and both have recently been provided with SRE training provided by CWP. During this activity 36 staff working with young people from 4 schools were given training. Feedback from respondents suggests that this training was well received and valued by participants who now state that they are more confident in delivering SRE in the future. The trainers also interacted with pupils from Years 5-11 but the number of pupils reached is not reported.

The TdC SRE curriculum has been revised and training materials provided by the project and as a result the first SRE lesson took place this school year after many years without any SRE inputs at all. Three lessons have been delivered to date although the number of children in the relevant age group is very small (5-7 children). There are plans to extend SRE resources to youths who have left school given that they have had no access to SRE during their formal education and there is a very high level of commitment to continue with the delivery of SRE after conclusion of the project.

Final results: All SAOTs have a community based programme targeting MARPs therefore this target has been achieved (100% of SAOTs). Preliminary data from the youth survey suggests that there has been some increase in HIV-related knowledge amongst targeted school youths. Although progress has been made in drafting guidelines and protocols for SRHR/HIV prevention, care and support, these are not yet finalised and approved therefore the target in the logframe (100% of SAOTs) has not been met. This is reflected in the scoring against this Output.

Impact Weighting: 25%

Revised since last Annual Review: No

Risk: High

Revised since last Annual Review: No

4.4 Output 4: HIV/SRHR related policies and legislations

Number of adopted HIV/SRHR related policies and legislations increased in UKOTs

Final score: B

Performance description

Indicator 4.1 No. of new/amended policies/legislations adopted per UKOT

Indicator score: B

A HIV in the Workplace Policy has been ratified in St H which is now included in the government's Code of Management. A SRE policy has also been developed and implemented. FI have drafted a HIV in the Workplace Policy but it has not yet been formally adopted. A SRE policy has been developed and implemented in AI a HIV in the Workplace Policy has also been developed but is currently under review and has not yet been adopted.

The Social Worker supporting the St H Safeguarding Children Committee has agreed to support the TdC Education Advisor to advocate for a review of relevant TdC policies but this work will not have been actioned on conclusion of the project.

Summary of status of key policies for the SAOTs (as of December 2011)

Key Output	Island	Status
Workplace Policy	Ascension	Ongoing
	Falklands	Ongoing
	St Helena	Completed
	Tristan	Outstanding
SRE Policy / curriculum	Ascension	Completed
	Falklands	Completed
	St Helena	Completed
	Tristan	Completed

Indicator 4.2 No. of OTs with MARPS /civil society empowered and actively involved in the development of policy and legislation that reduces stigma and discrimination

Indicator score: C

Project activities focusing on the engagement of youths – identified as one of the MARPs in all 4 SAOTs – have been described elsewhere but there has been no involvement in the development of policy and legislation relating to stigma and discrimination. There have been no specific activities to engage other MARP groups in implementation or to secure their inputs into policy development.

Overall there has been limited project engagement with civil society primarily because there are so few civil society organisations on the islands. The main SAOT to have achieved Civil Society engagement has been St H where efforts have been made to collaborate with 'New Horizons' who are working with youths on the island and where the project has tried to

revitalise the role of the Peer Educators, albeit with limited success. The Peer Educators have been brought together during LTTA visits and their SRHR training needs identified but the follow up visit recently by CWP indicates that the group has not been active since the last LTTA visit and it not clear how proactive they will be once the project concludes. St H also reports that the project has provided opportunities to engage with the media, church leaders, and local employers on HIV/SRH which have then provided a platform for collaborative working on wider health issues. Respondents report that these relationships will now be sustained.

CWP have recently explored the possibility of developing the role of peer educators in schools on St H and AI but it is unlikely that this can be actioned in the remaining project period and it is unclear whether or not this is something that stakeholders would agree to pursue without external support. There has been little or no civil society engagement on the other 3 SAOTs.

Indicator 4.3 Percentage of UKOTs with active programmes/policies addressing HIV/STI/SRHR related stigma and discrimination

Indicator score: B

Although both AI and FI have been involved in some discussion about how they can best address stigma and discrimination in their policy development, and project support has been offered, no concrete actions have been taken and thus far St Helena is the only SAOT to have formally agreed a HIV in the Workplace Policy to help address stigma and discrimination. Elsewhere stigma and discrimination is addressed mainly through the general awareness raising activities identified in the work-plans.

Final results: St H has produced a Workplace Policy and a SRE policy. AI has also produced a SRE policy therefore the targets against this indicator have been met (Target 2 in St H and 1 in 2 other SAOTs). There has been no MARP/civil society involvement in policy development (Target 3/4 SAOTs) and only St Helena has an active programme or policy to address stigma and discrimination (Target 75%). The scoring reflects the fact that these targets have not been met.

Impact Weighting: 15%

Revised since last Annual Review: No

Risk: High

Revised since last Annual Review: No

Summary of overall Output and Indicator Scores

	Output	Score
1	Increased capacity of OTs to access resources to implement annual HIV/SRHR plans;	A
2	An effective and efficient multi-sectoral mechanism in place to coordinate HIV/SRH programmes;	B
3	Most-at-risk populations successfully identified and reached through targeted interventions;	A
4	Number of adopted HIV/SRH policies and legislation increased.	B

	Indicator	Score
1.1	Percentage of planned TA and capacity building activities delivered in proposed year of the work-plan	A
1.2	Number of OTs that take full responsibility for TA procurement and management during the preceding year	N/A
1.3	Number of SAOTs who have access to SRHR/HIV database of resources.	A
2.1	Percentage of UKOTs with an established multi-sectoral HIV/SRHR committee	B
2.2	Percentage of UKOTs with committees which regularly meet and review SRHR/HIV-AIDS action plans/programmes	B
3.1	Number of targeted OTs with evidence informed community based programmes reaching priority most-at-risk populations	A
3.2	Percentage of OTs with evidence-informed guidelines/protocols/ strategies for SRHR/HIV prevention, care and support services targeted at vulnerable groups	B
3.3	Not applicable to SAOTs	
3.4	Percentage of targeted Secondary school youth with improved HIV knowledge	B
4.1	No. of new/amended policies/legislations adopted per UKOT	B
4.2	No. of OTs with MARPS /civil society empowered and actively involved in the development of policy and legislation that reduces stigma and discrimination	C
4.3	Percentage of UKOTs with active programmes/policies addressing HIV/STI/SRHR related stigma and discrimination	B

5 EFFICIENCY

In the South Atlantic the no-cost extension was granted on the basis of an overall slow response to operationalising work-plans on two of the four SAOTs. Both TdC and AI suffered from other priorities taking precedent over the SRHR/HIV programme. For AI, the leading priority has been the island's financial crisis that resulted in significant public sector changes, including staff redundancies. As a result the ability to draw together a multi-sectoral response has been difficult for those involved. At the time the no cost extension was granted it was felt that good momentum had been achieved in the SAOTs – particularly in the FI and St H and the opportunity to provide further support to these two islands through a no-cost extension would ensure greater sustainability of the achievements to date. TdC and AI had made less progress, but it was felt that these small achievements had the potential to be strengthened and enhanced through sustained technical support during the course of a 12 month extension. For all the SAOTs the project scope was reduced during the extension period to provide technical assistance (TA) based on the requests of the SAOTs to support the identified key priority outputs.

Feedback from respondents highlights the critical importance of the face-to-face interaction to engage stakeholders with the project and maintain momentum in the implementation of activities. The field visits undertaken by the LTTAs provided the focus for SAOT stakeholders to undertake the activities identified in the agreed work-plans and project reports suggest that a major challenge to implementation was ensuring that planned activities were undertaken between LTTAs visits. The field visits served to stimulate SAOT activity as well as raise awareness and build effective working relationships.

Maintaining momentum has been particularly difficult in the no-cost extension period where there were no field visits and interaction was dependent on communication by phone and internet. In addition the LTTA has never met the key stakeholders or visited the islands and does not have the personal connections which are important in small communities. It has proved difficult to engage a number of stakeholders, especially in St H and FI, and it has therefore been difficult to take forward a number of planned activities identified in the extension period work-plan and to monitor progress to date.

Whilst it might have been more cost-effective to provide TA inputs remotely – thereby reducing flight and accommodation costs – it is unlikely that the same level of progress would have been made. In fact there would have been value in providing a higher level of on-island inputs particularly in the early part of the project in order to 'kick-start' some critical activities, produce some early outputs and achievements, and to ensure that the relevant infrastructure was in place that could be strengthened throughout the implementation period, for example the systems for condom distribution and data collection. This could probably have been achieved with the same number of visits but with longer periods of time on island. Clearly increased inputs in first year of the project would have had cost implications but may have significantly contributed to greater commitment and increased outputs over the project lifetime.

The project has been flexible in responding to SAOT needs within the framework of the agreed work-plans evidenced by amendments to the logframe, revisions to work-plans, correspondence and minutes of meetings as well as project reports and the no-cost extension work-plan.

5.1 Value for Money

The project was not subject to Value for Money (VfM) appraisal prior to its approval and therefore there are no specific VfM measures applied to the project. VfM measures are not documented in project reports. However the project has made important progress in raising awareness in the SAOTs of the need for HIV/SRHR inputs and although it has not delivered

all of the planned inputs this has been achieved utilising only a small proportion of the overall project budget. Therefore, retrospectively, it can be argued that the SAOT components of the project do present VfM.

The majority of project technical inputs have been provided by the LTTAs which will have reduced cost in comparison to having inputs provided by a range of short term consultants. High travel costs associated with field visits in the SAOT were unavoidable given how critical face-to-face interaction has been in progressing the project and ensuring planned activities are carried out.

Project management arrangements have been closely monitored by the DFID Health Advisor via regular meetings with the implementing agents to ensure focus on timeliness of implementation and achievement of results. Financial reporting has also been monitored via regular project management reporting.

6 IMPACT

At Goal level STI and HIV incidence rates remain low and have been sustained during the lifetime of the project but given the very low or no incidence it is difficult to attribute this to project interventions. There has been only one person diagnosed as being HIV positive during the 4-year period and therefore the extent to which the project contributed to an improved quality of life for people living with HIV cannot be determined.

The project focus in the SAOTs has been on prevention which means that impact cannot be meaningfully determined in the project period, but is instead better evaluated in the longer term. However some positive outcomes are already evident and can be directly attributed to the project. There has undoubtedly been an increase in the level of awareness in regard to SRH and HIV issues at both strategic and operational levels. Although still not viewed by stakeholders as a priority area the project has successfully raised awareness at strategic level of the need to consider how best to respond to HIV/SRHR-related issues and some islands have successfully addressed this through the development of relevant strategies, policies and guidelines. Each SAOT now has a SRH framework in place which can be maintained and strengthened if there is sufficient motivation to do so. The project has encouraged the relevant agencies to assess SRH service provision and efforts have been made to develop services relevant to the local context. The project's multi-disciplinary approach to working across Health, Social and Education Sectors has facilitated collaborative working and a joint response to HIV and SRH challenges. These actions would not have been undertaken without project intervention.

Respondents report a much higher level of community awareness about HIV and SRH and although it is difficult to determine the extent to which this awareness has contributed to behaviour change and the adoption of safer sexual practices, it is unlikely that this level of awareness would have been reached without project support.

Within the Education Sector the project has had significant achievement in supporting the provision of SRE and raising the quality of the training provided. It is unlikely that this would have happened without direct project intervention given that it was viewed as low priority.

6.1 Monitoring and evaluation

The project uses a number of different tools to evaluate the effectiveness of their interventions. The primary tool for evaluating progress is the logframe which identifies specific indicators for each output. The project reports both qualitative data and quantitative data (where it is available) in both the bi-annual narrative and quarterly project reports. The bi-annual reports are widely circulated as a mechanism for sharing information and reporting on progress to key stakeholders. A Youth Survey was undertaken in 2009 to collect baseline data specific to youths who were identified as a particularly vulnerable group during the baseline assessment and a follow-up survey was undertaken in the final months of the project. The island-specific work-plans were evaluated in collaboration with

key stakeholders during each LTTA field visit and amended where necessary to ensure their contextual relevance. Annual Reviews were undertaken in 2009 and 2010.

An important activity in the final stages of the project will be to encourage key stakeholders to evaluate their own contribution to successful implementation of the project. This will provide a useful mechanism to strengthen stakeholder capacity in project evaluation, help them to determine how the various achievements to date will be sustained in the future in the absence of on-going external support, and an opportunity to identify lessons learned.

6.2 Sustainability

The agreed project extension period work plan focuses on completing outstanding actions identified in the SAOT work plans rather than promoting sustainability, however a number of systems have been put in place with project support that can be continued and sustained if there is the commitment to do so on conclusion of the project. A number of relevant policies and guidelines have been drafted with project support which can be submitted through formal approval processes and adopted where this has not already happened. Some care pathways have been developed which can be operationalised when required. A major success has been the systems developed for the delivery of SRE to youths in schools in FI, AI and St H.

Each SAOT has a mechanism in place to coordinate HIV/SRHR programmes although it is difficult to determine the extent to which these mechanisms will be maintained on conclusion of the project. Respondents acknowledge this as a challenge. These systems are more likely to be sustained on St H and FI, rather than AI and TdC, where there is greater dependence on the commitment of specific individuals, both of whom are contracted staff rather than residents.

The project has provided support for the establishment of condom distribution systems although success is varied across the SAOTs. Respondents report that condom distribution will continue in St H and AI providing that supplies are maintained.

Overall the systems that have been put in place across the youth sector seem to be more robust than those established within the health sector, where project activities still appear to be regarded as ‘extra work’ rather than integral to health systems. Overall systems are not yet institutionalised which is a risk to sustainability on conclusion of the project.

The project has provided the SAOTs with a number of resources (training materials, Information Education and Communication (IEC) materials, resource documents etc.) which will be adequate to allow SAOTs to continue activities in the short to medium term. However, ultimately the SAOTs will be responsible for securing their own resources and it is noted that there appears to have been no budget allocation made to support on-going activities where there is a financial implication to doing so. Financial constraints are reported as a challenge by a number of respondents who cite this as a significant risk to sustainability in the absence of specific ring-fenced funds for SRH and the context of competing priorities across the health, education and social sectors.

7 COVERAGE

A baseline assessment was undertaken during the inception phase which identified most-at-risk and vulnerable populations which then informed decision-making for the development of the island specific work-plans. MARPs were identified as being youths, MSMs, CSWs and transient workers. Work-plans focused primarily on youths with limited project interventions targeting other MARP groups. 36 staff working with young people from 4 schools were given SRE training provided by CWP. Activities included improving the quality of SRE in schools, the development of youth-friendly IEC materials, efforts to establish youth clinics as well as general awareness raising activities. A baseline youth survey was undertaken and a follow-up survey conducted in the final stages of the project. The logframe includes specific indicators targeting MARPs at Goal and Purpose levels (i.e. youths) as well as at Output level (i.e. MARPs and civil society).

8 CONNECTEDNESS

8.1 Capacity building

The project design endeavours to take account of the longer term context in which the project is being implemented, and the Project Memorandum describes the adoption of a capacity-building approach. This influenced the decision to have LTTA with the skills and expertise to work with SAOT counterparts to strengthen the capacity of local personnel. This is an entirely appropriate approach to take as a mechanism for promoting sustainability. However, this has presented a challenge during the implementation period when there has been some turnover of key staff in the SAOTs and gaps in staffing.

Ensuring continuity has been difficult throughout the project period because of SAOT staff turnover, but changes in the LTTAs identified by Options have also had a potential impact on the rate of implementation. There have been 3 LTTAs during the project. It has been particularly difficult for the current LTTA who has been supporting the project remotely during most of the project extension but has not had the opportunity to visit the SAOTs or meet many of the key people on island. It has already been noted that respondents feel that face-to-face interaction has been critical in maintaining motivation and ensuring progress in implementation during the first 3 years of the project and this has clearly been missed during the majority of the extension period.

Capacity building is also very difficult in small organisational structures where there are only one or two individuals responsible for a particular area of work and capacity building inputs cannot be spread more widely. If those persons leave post, and there has been no succession planning and training, then inevitably there will be gaps and sustainability is at risk.

A specific area where capacity has been built is the SRE training for teachers and the subsequent revision and adoption of a new SRE curriculum. Respondents report that there is now increased capacity and confidence to deliver SRE training using the teaching tools and IEC materials provided by the project.

8.2 Linkages

The project has made effort to establish linkages and share project outputs between the SAOTs as appropriate. Policies, guidelines and care pathway documentation for example have been shared across the SAOTS, with some information sharing between the COTs

and SAOTS, and the project has offered support where requested to adapt documentation to the local context. Additionally a social worker from St H has agreed to provide advice to TdC Education Advisor and the TdC Child safe guarding Board on child safeguarding where required. However these linkages have been driven by the LTTAs and there are no formal systems in place for collaborative working and information sharing on SRH across the SAOTs that will be sustained in the longer term without inputs from the project.

At the request of the DFID Health Advisor the project has pursued options to develop sustainable links with regional and international bodies (WHO, UNAIDS etc.) which have the expertise to act as a resource offering technical advice to the SAOTs in relation to project related issues but arrangements have not been finalised. Similarly there have been discussions about establishing long-term support links between the SAOTs and the UK Department of Health, but negotiations between DFID, FCO and DoH are ongoing.

9 COHERENCE

There is evidence that the project has provided a focus to bring together multi-disciplinary staff to address SRH issues. On AI and TdC there is evidence of the Health and Education sectors working together to implement project activities. On St H the multi-disciplinary Sexual Health Management Group has been established and wider collaboration on project activities has involved Police, New Horizons youth project, church leaders, the media and private sector employers. Although primarily brought together to work specifically on the project these linkages are now being utilised as a mechanism for looking at other health-related issues. Advocacy activities on St H have included a number of radio broadcasts and newspaper articles, visits to local industries, and a local market display to recognise World AIDS Day in 2011. Church leaders have also been involved in giving relevant sexual health messages via sermons. Advocacy activities on the other SAOTs appear less robust.

The DFID Health Advisor has played an important advocacy role and a number of respondents said that that her field visits have provided motivation to re-focus and continue implementation activities when progress has been slow because the SAOTs have seen other issues as being more of a priority. Efforts have also been made to work with on-island FCO representatives where appropriate.

10 PROJECT MANAGEMENT

As well as facing the challenges of key staff turnover on-island, there was also a high level of project management staff turnover. This may also have contributed to the slower than anticipated implementation of project activities. However, at SAOT level respondents report that project management arrangements have been satisfactory. In particular on-island respondents appear to have valued the inputs from Kevin Miles, the second LTTA appointed by the project, who made a number of visits to the islands, who was clearly well-known and who was able to maintain very good working relationships with key stakeholders. The arrangements in the latter part of the project whereby LTTA inputs were provided remotely has been less successful because the personal relationships with key stakeholders were not established, inputs were reduced and financial resources were limited in accordance with the agreement for the no-cost extension. Sub-contracting arrangements for short term TA have been well managed.

Bi-annual narrative reports are submitted to DFID and shared with key stakeholders and in addition DFID receives a quarterly progress report. Project management documentation is of good quality. Reporting is timely, project reports are well written, and both the quarterly and bi-annual reports report progress against the logframe, which is important for monitoring and evaluation purposes. Quarterly brochures summarising key challenges and successes are circulated to islands to share best practice and foster a sense of community across regions and islands Quarterly project teleconference meetings are also held with

DFID as a mechanism for monitoring performance and the minutes from these meetings provide evidence of strategic decision-making. The project has been submitted to Annual Review in 2009 and 2010. Both reviews were undertaken by the DFID Health Advisor. Financial reporting is undertaken in accordance with contractual requirements and meets DFID quality standards. Independent financial audit is not a contractual requirement.

10.1 Costs and timescales

The project experienced low expenditure against forecast across the overall project budget (COTs and SAOTs) as a result of lower than anticipated implementation. Expenditure at the end of Year 3 was £782,799 against an overall budget of £1,268,945 resulting in an underspend of £486,146 (approximately 38% of available budget). In response to this significant underspend a 12 month no-cost extension was agreed. Expenditure as of end of October 2011 was £1,127,842 leaving a remaining budget of £141,103 indicating that underspend on conclusion of the extension period will be minimal or on target. It is noted that specific SAOT activities were allocated significantly less funds from the overall project budget than the COTs – only 9% in comparison to 67% for the COTs:

% allocated budget	Original Budget	Revised Budget incl. No-cost Extension	Actual Expenditure (to end Oct 11)
Overall management	36%	23%	24%
COTs	48%	67%	67%
SAOTs	**16%**	**10%**	**9%**
Total	100%	100%	100%

10.2 Risk

Fixed term contracts and extended leave periods are characteristics of many posts in the SAOTs particularly at a senior level, but this is not recognised as a risk to implementation, nor the capacity building approach, in the Project Memorandum. Where this has happened the project has tried to mitigate by targeting new staff in key positions but staff absence from key posts has had some impact on the implementation of planned activities.

Overall project risk is rated as Medium. This rating was reviewed as part of the two Annual Reviews but has not been changed over the life of the project.

10.3 Evidence and Evaluation

The sources of evidence have been revised during the project lifetime to reflect the amendments to the project logframe. This report comprises the external independent End of Project evaluation. In addition the project team have agreed with DFID that internal reviews will be undertaken for each of the SAOTs involving key stakeholders to inform the evaluation process and identify lessons learned.

11 CONCLUSION

For the lifetime of the project the project Goal has been achieved in that there has been low transmission of STIs and HIV sustained amongst at-risk populations and the Goal level targets have been met. However, given the very low incidence prior to the project, this cannot be attributed to project interventions

The project Purpose has been partially achieved in that the SAOTs have had some strengthening of their capacity to lead an integrated HIV/SRSH response, but the indicator targets have not been met. St Helena is the only SAOT to have a strategic health plan that integrates HIV/SRHR and to have a policy that addresses HIV-related stigma and discrimination (Target for both indicators is 75%).

The project has successfully raised awareness of the need to strengthen capacity to respond to HIV/SRHR issues and the foundations for an integrated response have now been put in place. Relevant policies and guidelines have been drafted which can be adopted with minor adjustment. The project has provided a useful mechanism for collaborative working on-island which can be replicated to address emerging SRHR issues and is transferable across other sectors where appropriate. Resource materials have been provided and there is a greater level of awareness about HIV and SRHR at community level as a direct result of project inputs. A major achievement has been the development of a SRE curriculum in all SAOTs.

However, project implementation has been challenging and achievement of planned outputs less successful than anticipated. A number of planned activities are still on-going and others were delivered in the later stages of the implementation period therefore the overall project impact is difficult to determine, particularly as the project focused on prevention and preparedness – meaning that the impact of the project may not be evident until some point in the future. There would have been value in providing a higher level of on-island inputs particularly in the early part of the project in order to 'kick-start' some critical activities, produce some early outputs and achievements, and to ensure that the relevant infrastructure was in place.

The project has made progress in key areas and has at least partially achieved its objectives but sustainability of the progress to date remains a critical issue. A number of deliverables have been produced but the extent to which capacity has been strengthened remains unclear. The project has obviously provided impetus to address HIV/SRHR and although there are some examples of excellent engagement at individual level amongst key stakeholders there is limited evidence of organisational ownership.

Retaining the capacity that has been built during the implementation period will also be challenging given the regular staff turnover in the SAOTs particularly at senior level but this is beyond the control of the project. However, if efforts are made on-island to conclude the outstanding activities and strengthen the systems developed this will provide mitigation to a certain extent. Respondents acknowledge the need to update and train future staff on an on-going basis.

Without a commitment to conclude activities there is a high risk that progress to date will not be maintained. A number of HIV/SRHR systems developed with project support are not yet internalised and there is a risk that some will not be maintained when the project concludes and the SAOTs are faced with other competing demands and priorities. Financial constraints remain and the allocation of recurrent funding to support and further develop HIV/SRH services has not been identified.

12 **RECOMMENDATIONS**

It is recommended that:

1. A project closure meeting via teleconference should be scheduled with key stakeholders in each SAOT to agree activities to promote sustainability and identify lessons learned. As far as is possible within time limitations this should bring stakeholders together in each SAOT to collectively identify:
   - What was achieved and why?
   - What was not achieved and why?
   - What workplan activities are still outstanding and what action needs to be taken, by whom and by when? (this may include identifying individuals outside of current 'leads; with capacity or motivation to take responsibility)
   - What specific support, if any, needs to be provided to promote sustainability?
   - This should include agreement of the mechanism for dissemination of findings. If schedules permit these meetings should be called by DFID as funding agent to emphasise the shared accountability of stakeholders for achievement of results.

2. DFID should encourage SAOTs to finalise and submit outstanding policies and guidelines for approval and adoption, the timeline for such should be agreed with stakeholders during the project closure meeting to ensure there is commitment to conclude work undertaken to date.

3. UK Government should review linkages with relevant UK regional and international organisations to determine if there is any arrangement that can be put in place for them to provide technical advice on HIV/SRHR and other related issues to the SAOTs if needed in the future. Approaches at a strategic level may receive more positive responses than approaches made at a project level.

4. The end of project report submitted by Options should include an assessment of the extent to which the activities undertaken and the results achieved have attributed to achievement of the project Goal and Purpose. This is important to enable DFID to make an assessment of VfM.

13 **LESSONS LEARNED**

1. The participatory approach to identifying SAOT HIV/SRHR needs and agreeing workplans once DFID support had been agreed was entirely appropriate. However, although the SAOTs were in agreement with the intervention logic when DFID support was initially offered, increased advocacy to gain consensus prior to funding being agreed – specifically about why HIV/SRHR needed to be addressed - would probably have secured better ownership and greater commitment to achieving project outcomes.

2. The SAOT work-plans were too ambitious. A further step to prioritise focal interventions during the inception phase would have made deliverables more realistic and achievable.

3. Adequate opportunity for face-to-face engagement with key stakeholders must be integral to project design in the SAOTs. Projects that rely primarily on remote inputs are likely to have limited success.

4. Wider inclusion of long term key island staff, rather than the many staff on short and medium term contracts, is important for knowledge retention and project sustainability.

ANNEX 1 TERMS OF REFERENCE FOR EVALUATION

Terms of Reference for the End of Project Evaluation for the South Atlantic OTs, and for the completion of the DFID Project Completion Review of the programme.

Purpose of Consultancy

To carry out the final evaluation of the Taking Action Against HIV in the UK Overseas Territories project (South Atlantic focus) looking particularly at progress against the programme logframe (separate file, but see Annex 3), sustainability of achievements as well as value for money aspects of the project; and complete the new-format DFID PCR report for the whole programme (SA and Caribbean)

Project Description
See Para 10 below

Project Management
The project is managed by Options consultancy in the UK. The Options Project Manager is Kate Gray, who manages both the COTs and the SAOTs, supported by another Project Manager, Caroline Baker (from June 2011 only), and the Team Leader, Marilyn McDonagh, who is responsible for overall technical oversight of the project (SAOT and COT). For the SA OTs, Sara Nam took over as the Technical Lead at Options for the project in April 2011.

Biannual detailed progress reports are prepared and shared with a wide audience. In-between short quarterly updates and quarterly project brochures are prepared and shared with regional and country stakeholders. Quarterly teleconference meetings are held with DFID and Options.

Objectives of the evaluation

Assess progress made towards the achievement of results at the goal, purpose and output levels as measured against the indicators in the logframe for the SAOTs.

Identify the effectiveness and impact of the programme in the SAOTs and recommend ways that this can be improved and sustained.

Record and share lessons learned for the SAOTs between SAOTs and with other UKOTs and with a wider group of stakeholders.

Assess performance of the project in the SAOTs in terms of the relevance of results, sustainability, ownership and accountability, appropriateness of design, resource allocation, and informed and timely action.

Synthesise the evaluation of the SA and CA components of the programme

Deliver a completed DFID Project Completion Review report

Methodology and Scope of Work

The final evaluation for the SAOTs will be conducted as an external desk-based review.

The evaluation will assess the progress of the project against the logframe.

In addition, the evaluation will consider the questions raised in the PCR report (numbering as in the PCR report itself, see separate file)

2. Costs and timescale
2.1 Was the project completed within budget / expected costs: Y/N
2.2 Key cost drivers
2.3 Was the project completed within the expected timescale: Y/N
3. Evidence and Evaluation
3.1 Assess any changes in evidence and what this meant for the project.
3.2 Set out what plans are in place for an evaluation.
4. Risk
4.1 Risk Rating (overall project risk): Low/Medium/High
4.2. Has the Risk Rating change over the life of the project? Y/N
4.2 Risk funds not used for purposes intended
5. Cimate and Environment Impact

5.3. In addition, the consultant should consider, so far as she is able in the time available, the questions on Appropriateness, Efficiency, Impact, Coverage, Connectedness (including sustainability and linkages), Coherence and Management which are raised in Annex 1.

5.4. The consultant will also be expected to provide evidence of the key constraints and challenges that affected the project, and how the different stakeholders dealt with them.

Tasks

South Atlantic only

1. Familiarise herself with the project documentation, the history and scope of the project activities and DFID requirements for an Annual Review; This will include an introductory meeting/conference call with DFID and Options team to further clarify the ToR and scope of the review and to respond to any queries.
2. In consultation with the project team and DFID, prepare a programme for the review detailing telephone meetings to be held with a range of groups and individuals (Options, SAOT stakeholders, donor and civil society where possible), and the topics to be covered;
3. Hold the telephone meetings detailed in the programme. Discussions should be focused around the outputs from the original and revised log frames.
4. Liaise with the Options team throughout the review as/when required. The Options team will be available throughout the review to facilitate the collation of additional documents and setting-up of meetings as required/requested.
5. Prepare a report detailing:
    1. progress towards the achievement of the different outputs;
    2. an overall assessment (with justification) of whether the project purpose was achieved, assumptions in the original and revised log frame, and other external factors which have influenced the activities and progress of the project;
    3. an assessment (with justification) of the attribution of any progress made by the project;
    4. an analysis of lessons learned and any best practices that may be helpful to share across the South Atlantic OTs.

South Atlantic and Caribbean combined

1. Read the evaluation report on the Caribbean component of the programme
2. If necessary, ask Options and the CA consultant to add or amend any material needed for the DFID PCR report
3. Complete a DFID PCR report (Jan 2012 format) for the whole programme
4. Present a summary of the PCR report to DFID on January 6th
5. Finalise the PCR in light of any issues arising from the meeting

7. Time frame

This work will take 21 person days. The proposed timing is in Annex 5:

Key dates

By Monday Nov 14th, Debra gets all the main documentation so that she can start reading
By Fri 17th Debra receives remaining documents
Wednesday Nov 15th, telephone call Debra, DFID and Caroline of Options (DFID to set up virtual room)
By Monday Nov 28tht, Options have set up telephone interviews for Debra for that week beginning 28th November – 2nd December

Dec 13th at 9am - Debra sends draft SA report to Options
Dec 15th at 9am - Options send comments back to Debra.
Dec 16th at 9am - Debra sends draft to HDRC for QA and formatting
Dec 16th at 1pm - formatted draft and comments back to Debra
Dec 16th at 5pm - Debra final changes to HDRC,
Dec 16th at 6pm - HDRC sends first draft of SA to DFID, copy to Options
Dec 22nd - DFID send comments back to Debra. (If Options have comments, they send them to Nicolet before Dec 21st)
Dec 28th - Revised draft of SA to HDRC, for QA
Dec 29th - HDRC send final SA report to DFID

By Dec ?th, Options sends Debra the Caribbean report
Jan 3rd end of the day, Debra sends draft 1 of new-format PCR report to DFID (NB not QA'd by HDRC as office closed)
Jan 6th meeting East Kilbride
Jan 6th after meeting DFID send their comments on PCR report to Debra, who starts amending synthesis report
Jan 10th Debra sends final PCR report to HDRC for QA & formatting, and HDRC sends on to DFID.

8. Reference Material

The consultant will be supplied with key background material by Options, including contact details for key informants. The below is an indicative list of the documents to be provided:

- Project Memorandum (October 2007)
- All 6-monthly quarterly reports
- Inception Report
- Logframe
    1. Original Logframe (Annex 1 project memorandum)
    2. Revised Logframe (June 2009)
    3. Current/Final Logframe (Sep 2010)
- Report Inventory (with consultant names, contact details and link to final reports)Preliminary Youth survey report: baseline and end-line survey report (available 5 December)
    1. Final Youth survey report (available 19 December)

2. Training completion reports
3. SAOT Island visit reports

- DFID-Options meeting minutes
- Budget and expenditure reports, including No Cost Extension Documentation
- DFID annual review reports 2009, 2010
- Country specific HIV/health strategic plans, SRHR committee workplans and TA plans
- Matrix summarizing status of workplace policies, pathways adopted by SAOTs

9. Reporting

The consultant will report to the DFID health advisor or his/her designated representative.

Note that contractually, the consultant must send all drafts and final reports to HDRC, which will send them to DFID.

10. General Background

The Department for International Development (DFID) is committed to supporting the Caribbean and South Atlantic UK Overseas Territories (OTs) to build up local capacity to lead an integrated national response against HIV/AIDS and Sexual & Reproductive Health and Rights (SRHR).

DFID contracted Options to provide technical assistance to 10 UK Overseas Territories (OTs) in the Caribbean and South Atlantic to manage and implement the "Taking action against HIV & AIDS" project for 3 years with a one year no–cost extension. The 6 Caribbean OTs (COTS) are Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Montserrat and Turks & Caicos Islands. The 4 South Atlantic OTs (SAOTs) are St. Helena, Ascension Island, Tristan da Cunha, and the Falkland Islands. Options is working closely with the Sexual and Reproductive Health Groups (or the local version of this) in the 4 SAOTs.

The project was originally scheduled to run over 3 years (February 2008 – February 2011). In June 2010 a no-cost extension was granted for one year to extend the project period to the new end date of 31st January 2012. Further, the original project logframe (which was based on the initial set of activities following the needs assessments (Inception phase)) was revised to reflect the new project focus and outputs and after various revisions was approved by DFID in September 2010.

The **Goal** of the project is: Low transmission of STIs and HIV sustained amongst at risk populations and improved quality of life of people living with HIV in UK Overseas Territories. The **Purpose** is: UKOT capacity strengthened to lead an integrated national HIV/SRHR response.

11. Specific Background to the South Atlantic Overseas Territories

Health is a devolved responsibility and consequently the South Atlantic Overseas Territories (SAOTs) are responsible for ensuring a population-level sexual and reproductive health and rights and HIV (SRHR/HIV) programme is in place for prevention, care and support activities. Through in-country rapid assessment visits to St Helena, the Ascension Islands and the Falkland Islands and a remote assessment of Tristan Da Cunha in 2008, key Informant interviews identified that in the absence of a government level strategic plan, the response to date had been clinically reactive, and therefore institutional strengthening

for SRHR/HIV was a prerequisite to moving forward. At the time of the initial assessments, the SAOTs had no reported cases of HIV and few reported sexually transmitted infections (STIs). As a result the recommended focus for the project was on HIV prevention and preparedness as part of a broader sexual and reproductive health (SRH) strategy and integrated within the islands' health programmes. Technical assistance was identified to build island capacity to respond to SRHR/HIV, including support to better understand vulnerability amongst population; addressing policy development at strategic and operational levels (e.g. government, clinical and education); implementing strategic information management for surveillance and monitoring; multiagency training and professional and public awareness raising.

In the South Atlantic the no cost extension was granted on the basis of an overall slow response to operationalising work-plans on two of the four SAOTs. Both Tristan da Cunha and Ascension Island suffered from other priorities taking precedent over the SRHR/HIV programme. For Ascension Island, the leading priority has been the island's financial crisis that resulted in significant public sector changes, including staff redundancies. As a result the ability to draw together a multisectoral response has been difficult for those involved. At the time the no cost extension was granted it was felt that good momentum had been achieved in the SAOTs – particularly in the Falkland Islands and St Helena and the opportunity to provide further support to these two islands through a no-cost extension would ensure greater sustainability of the achievements to date. Tristan da Cunha and Ascension Island had made less progress, however, it was felt that these small achievements had the potential to be strengthened and enhanced through sustained technical support during the course of a 12 month extension. For all the SAOTs the project scope was to be reduced to provide technical assistance based on the requests of the SAOTs to support the identified key priority outputs.

Appropriateness	Were assessments undertaken appropriate to identification of need and undertaken with the beneficiary population and key stakeholders on the South Atlantic OTs? Was the Technical Assistance agreed and provided appropriate to the context of the needs? Was sufficient attention given to the identification of clear objectives and activities that would ensure objectives were met? To what extent were potential and actual stakeholders and beneficiaries consulted as to their perceived needs and priorities? What was the level of beneficiary and stakeholder involvement in project design, implementation and monitoring? How effective and appropriate were these processes in ensuring relevant and timely project delivery in support of the most needy and vulnerable? Was the assistance provided in a timely manner?
Efficiency	Were resources used efficiently? For instance, were more expensive forms of response (such as air transport) used when other mechanisms of delivering TA could have been used (for example, on line training for clinical and education staff)? Would greater investment in preparation have resulted in more effective and less costly responses? Does the project demonstrate value for money?
Impact	What direct and indirect evidence is available that the project contributed towards the project goal (refer to logframe)? What systems or indicators did the project use to evaluate the effectiveness of their work?
Coverage	What efforts were made to ensure that appropriate populations were identified and targeted and that particular populations, vulnerable groups and areas were not overlooked?
Connectedness *(including sustainability and linkages)*	Was the assistance provided in a way that took account of the longer-term context? What systems are in place to ensure continuity and sustainability of the programmes achievements? Did the assistance seek to strengthen the capacity of local agencies and personnel? To what extent did the project achieve linkages across the South Atlantic Territories, the Caribbean Territories and wider?
Coherence	What steps were taken by participating agencies to ensure their responses were coordinated with each other and with other actors in relevant fields? Were other actions, such as advocacy work, undertaken to complement their activities?
Management	Were the accounting, monitoring and reporting processes by Options and their field-level partners frequent, transparent and timely? Were finances kept accurately and managed appropriately with accurate forecasts and appropriate expenditure?

	November													December																								January											
Debra	14	15	16	17	18	21	22	23	24	25	28	29	30	1	2	5	6	7	8	9	12	13	14	15	16	19	20	21	22	23	26	27	28	29	30	2	3	4	5	6	9	10	11	12	13
21 Days		x			x	x	x				x	x	x	x	x				x	x	x	x	x										x	x	x	x	x			x		x					
Activity		R			R	R	R				T	T	T	T					W	W	W	W	W										W	W	W	W	W			M		W					
Deliver																								D									F				D					F					

X= days working, R=reading, w-writing, T=telephoning, D = draft, F=final, M = meeting

SHOWING METHODS ADOPTED TO REVIEW PROJECT PROGRESS AGAINST LOGFRAME

Indicator	Baseline	Target February 2012	Proposed means of verification	Comments
GOAL	**Low transmission of STIs and HIV sustained amongst at risk populations and improved quality of life of people living with HIV in UK Overseas Territories. (All indicators disaggregated by island /region and age/sex and target groups as feasible)**			
Indicator 1: Percentage of young women and men aged 15-24 who are HIV infected*	<1% in all 4 SAOTs	To remain <1%	• Review of clinical data (liaise with Laboratory managers on each island and other clinicians where appropriate) • Review of Public Health Reports • Interviews with Clinical staff	
Indicator 2: Percentage of women and men diagnosed with STIs during the last year	<1% in all 4 SAOTs	To remain <1%		
Indicator 3: Percentage of HIV positive adults/children still alive 12 months after initiation of ART.	SAOT: no known HIV+ cases at baseline	> 95%		
PURPOSE	**UKOT capacity strengthened to lead an integrated national HIV/SRHR response**			
Indicator 1: & 2 to SA OTs for COTS only				
Indicator 3: Percentage of OTs in which new supportive legislation/policy addressing HIV related Stigma & Discrimination is adopted and implemented	SAOTs: 0%	75%	• Policy/legislation review, Baseline audit and evidence of legislation/policies drafted and enacted. • Project progress reports • Interviews with Island Administrators and Chairs of SHRS groups where these exist	
Indicator 4: Percentage of OTs with operational strategic health plans in which HIV and SRHR are integrated	0%	75% (3/4)	• Review of annual public health reports • Interviews with Key Clinical Staff & Chairs of Sexual Health Strategy Groups (or similar)	
OUTPUT 1	**Increased capacity of UKOTs to access resources to implement annual HIV/SRHR plans (SAOTs & COTs) disaggregated by island**			
Indicator 1: Percentage of planned TA and capacity building activities delivered in proposed year of the work-plan	0%	SAOTs: 75% (3/4)	• TA plans, records of TA procured, project progress reports. • Interviews with Chairs of Sexual Health Strategy Groups (or similar)	
Indicator 2: to SA OTs COTS only				

* Millennium Development Goals indicator

Indicator	Baseline	Target February 2012	Proposed means of verification	Comments
Indicator 3: Number of SAOTs who have access to SRHR/HIV database of resources. (SAOTs only)	0	4/4	• Project progress reports • Interviews with Chairs of Sexual Health Strategy Groups (or similar)	
OUTPUT 2 **An effective and efficient multisectoral mechanism in place to coordinate HIV/SRHR programmes (COTs & SAOTs) disaggregated by island**				
Indicator 1: Percentage of UKOTs with established multi-sectoral HIV/SRHR committee	**SAOTs: 1/4 (25%)** **St Helena:** Sexual Health Advisory Group (SHAG) and ToR in place **TdC**: No SRHR strategy but Health Committee and island health policy **AI:** No SRHR strategy but Island Council responsible for health issues **FI:** No SRHR strategy but MDT Health and Social Service team	100%	• Multisectoral committee ToRs, membership lists. Project progress reports • Interviews with Chairs of Sexual Health Strategy Groups (or similar)	
Indicator 2: Percentage of UKOTs with committees which regularly meet and review SRHR/HIV-AIDS action plans/programmes	SAOTs: 25% **St Helena:** SRHG meets quarterly; SRHR action plan prepared and reviewed by group	100%	• Agendas and minutes of meetings and project progress reports • Interviews with Chairs of Sexual Health Strategy Groups (or similar)	
OUTPUT 3 **Most-at-risk populations in UKOTs successfully identified and reached through targeted interventions (COTs & SAOTs disaggregated by island**				
Indicator 1: Number of targeted OTs with evidence informed community based programmes reaching priority most-at-risk populations (disaggregated by OT and by vulnerable group)	0%	100%	• Progress reports • Interviews with Chairs of Sexual Health Strategy Groups (or similar)	

Indicator	Baseline	Target February 2012	Proposed means of verification	Comments
Indicator 2: Percentage of OTs with evidence-informed guidelines/protocols/ strategies for SRHR/HIV prevention, care and support services targeted at vulnerable groups (disaggregated by OT and by identified vulnerable groups).	**0%**	100%	• Programme progress reports, service reviews. Relevant guidelines, protocols and strategies. • Interviews with Chairs of Sexual Health Strategy Groups (or similar), Island Administrators, key Clinical Stakeholders	
Indicator 3: N/A to SA OTs				
Indicator 4: Percentage of targeted Secondary school youth with improved HIV knowledge [as a result of implemented HFLE policies and programmes in education sector]	0%	75%	• Youth survey results from SHEU using baseline from 2009 and repeat (planned for end of 2011) • Interviews with key education sector stakeholders	
OUTPUT 4 **Number of adopted HIV/SRHR related policies and legislations increased in UKOTs**				
Indicator 1: No. of new/amended policies/legislations adopted per UKOT	0	2 in St Helena and 1 in 2 other SAOTs	• Programme progress reports • Interviews with key stakeholders including administrators, clinicians and Chairs of Sexual Health Strategy Groups (or similar).	
Indicator 2: No. of OTs with MARPS /civil society empowered and actively involved in the development of policy and legislation that reduces stigma and discrimination	0	3/4		
Indicator 3: Percentage of UKOTs with active programmes/policies addressing HIV/STI/SRHR related stigma and discrimination	0	75%		
OUTPUT 5 **N/A to SA OTs**				

ANNEX 2 DOCUMENTS REVIEWED

- Project Memorandum, October 2007
- Original Budget Summary, 2008
- Revised Project Logframe, June 2009
- Revised (Final) Project Logframe, September 2010
- Inception Report, October 2008
- Quarterly Project Reports
- Bi-annual Project Narrative Reports
- Request for No-cost Extension, June 2010
- No-cost Extension Work-plan, 2010
- Contract Amendment, September 2010
- Revised project Budget for No-cost Extension
- Expenditure to Date Summary, October 2011
- Annual Review Reports 2009 and 2010
- St Helena Work-plans 2009-2010 and 2011
- Falkland Islands Work-plans 2009-2010 and 2011
- Ascension Island Work-plans 2009-2010 and 2011
- Health and Lifestyle Survey in Schools, Options, 2009
- Focusing on the Future: Health and Social Services Development Strategy 2008-2013, St Helena
- Social Policy Plan 2009/10 -2014/15, St Helena
- Diagnosis and Management of Adults and Adolescents with HIV, St Helena, March 2011
- Health and Healthcare in the British Overseas territories: Regional and UK Government Support, Sept 2010
- Priority Intervention, Treatment and Care in the Health Sector, World Health Organization, 2009
- Handover Notes from Kevin Miles, Options, March 2011
- Briefing Notes for Final Evaluation, Options, November 2011
- CWP Evaluation Report: Ascension Island SRE Staff Training, October 2011
- CWP Evaluation Report: St Helena SRE Staff Training, November 2011
- Health and Lifestyle Survey in Schools 2009, School Health Education Unit
- Health and Lifestyle Survey in Schools 2009, School Health Education Unit (Draft)

ANNEX 3 STAKEHOLDERS INTERVIEWED

DFID	
Dr Nicolet Hutter	DFID Health Advisor
Project Team	
Mrs Marilyn McDonagh	Senior Technical Advisor
Mrs Caroline Baker	Programme Manager
Ms Sara Nam	Long Term SAOT Technical Advisor
Mr Kevin Miles	Former Long Term SAOT Technical Advisor
Mr Peter Carter	Former Long Term SAOT Technical Advisor
Ms Paula Power	Managing Director, Christopher Winter Project
Dr David Regis	Research Manager, Schools Health Education Unit
St Helena	
Mrs Carol George	Chief Administrative Officer, Health and Social Services
Dr Deon du Toit	Medical Officer and Chair of SH Management Group
Ms Wendy Henry	Acute and Community Health Manager
Ms Cheryl Bedwell	PSHE Lead
Mr Clive Jones	Locum Senior Biomedical Scientist
Ms Fay Howe	Social Work Manager/Trainer
Ascension Island	
Dr Bill Hardy	Senior Medical Officer
Mr Chris Short	Head Teacher, Two Boats School
Tristan da Cuhna	
Mr Jim Kerr	Education Advisor
Contacted but unavailable	
Ms Jacqui Bailey	Nurse and Chair of SH Group, Falkland Islands
Ms Mandy Heathman	Chief Nurse, Falkland Islands
Mr Sean Burns	Island Administrator, Tristan da Cunha

ANNEX 4 FINAL PROJECT LOGFRAME

PROJECT TITLE	Taking Action against HIV and AIDS in the UK Overseas Territories					
GOAL	**GOAL: Indicator 1**	**Baseline + year 2007/08**	**Milestone 1 December 2010**	**Milestone 2 June 2011**	**Target February 2012**	**Assumptions**
Low transmission of STIs and HIV sustained amongst at risk populations and improved quality of life of people living with HIV in UK Overseas Territories. (All indicators disaggregated by island /region and age/sex and target groups as feasible)	Percentage of young women and men aged 15-24 who are HIV infected* (COTs & SAOTs)	COTs: <0.5% SAOTs: <0.1%			Remain <0.5% Remain <0.1%	Political commitment of governments for SRHR/HIV programming and funding. No major disaster or emergencies occur EU funded regional HIV project will complement ongoing HIV/SRHR related activities, including surveillance
		Source				
		ANC VCT, PICT and blood donor surveillance Assessment/survey/annual public health reports, including those from EU/PAHO				
	GOAL: Indicator 2	**Baseline + year 2007/08**	**Milestone 1 December 2010**	**Milestone 2 June 2011**	**Target February 2012**	
	Percentage of women and men diagnosed with STIs during the last year (COTS & SAOTs)	COTs: *(To be collected by AIDInc in August-Sep 2010)* SAOTs: <1% in all 4 SAOTs			*To be determined based on baseline data* Remain <1%	
		Source				
		SAOTs: EMIS records. M&E surveillance data report from clinics and laboratories, programme reports, and clinical audit reports. COTs: Assessment/survey/annual public health reports, including				

* Millennium Development Goals indicator

		EU/PAHO supported surveys				
	GOAL: Indicator 3	**Baseline 2007/08**	**Milestone 1 December 2010**	**Milestone 2 June 2011**	**Target February 2012**	
	Percentage of HIV positive adults/children still alive 12 months after initiation of ART. (COTs & SAOTs)	COT: TCI – 96% (2007) *(Other COTs data to be collected in Aug/Sep 2010)* SAOT: no known HIV+ cases at baseline			>95% > 95%	
		Source				
		Country annual progress reports, clinical records, clinical audit reports, EU/PAHO supported surveys				

PURPOSE	PURPOSE: Indicator 1	Baseline + year 2009	Milestone 1 December 2010	Milestone 2 June 2011	Target February 2012	Assumptions
UKOT capacity strengthened to lead an integrated national HIV/SRHR response	Percentage of targeted tourism establishments that have adopted and successfully implemented HIV/AIDS policies and programmes in the workplace. (to be measured in 3 COTs Anguilla, Cayman Islands, Turks and Caicos Island; disaggregated by country) **Note TCI TBD*	Anguilla : 0% Cayman : 0% TCI : 0%	Estimated # establishments involved in the project for Anguilla, Cayman and TCI	Anguilla : 60% Cayman : 60% TCI : 60%	Anguilla : 100% Cayman: 100% TCI : 100%	Governments of OTs committed to improving legislation and policies on stigma & discrimination and HIV. High level commitment to an integrated approach to health, SRHR and HIV/AIDS .
		Source				
		Tourism sector baseline data analysis. Project progress reports. Evaluation at the end of interventions.				
	PURPOSE: Indicator 2	**Baseline + year 2009**	**Milestone 1 December 2010**	**Milestone 2 June 2011**	**Target February 2012**	
	Percentage of secondary school youth (13-15 yrs) who ever had sex who used a condom on last sexual intercourse. (COTs **except Bermuda* & SAOTs)	BVI 2009: 71.6% CI 2009: 71.0% ANG 2009: 68.5% TCI: 2006: 75.0% MONT: 2006: 61% (males); 78% (females) St Helena: 25% Ascension: 25% Tristan: 50% Falklands: 45%	NA	NA	BVI 75% CI: 75% ANG: 73% TCI: 80% MONT: 66% (males); 82% (females) St Helena: 50% Ascension: 50% Tristan: 75% Falklands: 65%	
		Source				

		COTs: CDC Global School-based Student Health Survey (GSHS) (http://www.cdc.gov/gshs/); EC/PAHO: KAPB on adolescents and health, with emphasis on HIV/STI and sexual/reproductive health in five territories to be initiated in October 2009 SAOTs: Youth health survey (baseline data) & final year behavioural survey				
	PURPOSE: Indicator 3	**Baseline + year 2009**	**Milestone 1 December 2010**	**Milestone 2 June 2011**	**Target February 2012**	
	Percentage of OTs in which new supportive legislation/policy addressing HIV related Stigma & Discrimination is adopted and implemented (COTs & SAOTs) **Excluding Bermuda*	COTs: 0% SAOTs: 0%	20% COT (Montserrat) 25%	40% (2/5) 50%	80% (4/5) 75%	
		Source				
		Policy/legislation review, Baseline audit and evidence of legislation/policies drafted and enacted. Project progress reports				
	PURPOSE: Indicator 4	**Baseline + year 2007/08**	**Milestone 1 December 2010**	**Milestone 2 June 2011**	**Target February 2012**	
	Percentage of OTs with operational strategic health plans in which HIV and SRHR are integrated (COTs & SAOTs) **Excluding Bermuda*	COTs: 20% (Montserrat) SAOTs: 0%	40% (2/5) (Montserrat & Anguilla) 25% (1/4 - St Helena).	60% (3/5) 50% (2/4) Tristan drafted island health policy, which includes SRHR	80% (4/5) 75% (3/4)	
		Source				
		Situation analysis reports (COTs), integrated strategic heath plans, annual public health reports				
INPUTS (HR)	**DFID (FTEs)**					

<table>
<tr><th>OUTPUT 1</th><th>OUTPUT 1: Indicator 1</th><th>Baseline + year End 2008</th><th>Milestone 1 December 2010</th><th>Milestone 2 June 2011</th><th>Target February 2012</th><th>Assumptions</th></tr>
<tr><td rowspan="6">Increased capacity of UKOTs to access resources to implement annual HIV/SRHR plans (SAOTs & COTs)

disaggregated by island</td><td rowspan="2">Percentage of planned TA and capacity building activities delivered in proposed year of the work-plan
(COTs & SAOTs)</td><td>COTs: 0%
SAOTs: 0%</td><td>TA and capacity building plan developed.</td><td>COTs: 60% (3/5)
SAOTs: 50% (2/4)</td><td>COTs: 80% (4/5)
SAOTs: 75% (3/4)</td><td rowspan="6">OTs able to manage and absorb TA needed</td></tr>
<tr><td colspan="4">Source
TA plans, records of TA procured, project progress reports.</td></tr>
<tr><td>OUTPUT 1: Indicator 2</td><td>Baseline + year End 2008</td><td>Milestone 1 December 2010</td><td>Milestone 2 June 2011</td><td>Target February 2012</td></tr>
<tr><td>Number of OTs that take full responsibility for TA procurement and management during the preceding year
(COTs only)</td><td>No plan at baseline 2008</td><td>All COTs aware of and trained in use of Toolkit</td><td>4/6 COTs using toolkit and ‘partially engaged in all aspects of TA procurement (scenario 2)

2/6 COTs using toolkit and fully engaged’ in all aspects of TA procurement (scenario 3)</td><td>6/6 of COTs using tool kit and ‘fully engaged’ in all aspects of TA procurement process (scenario 3)</td></tr>
<tr><td>Source</td><td></td><td></td><td></td></tr>
<tr><td colspan="4">Project ‘OT Engagement in TA Procurement Tracking Sheets’, project progress reports</td></tr>
<tr><td>IMPACT WEIGHTING</td><td>OUTPUT 1: Indicator 3</td><td>Baseline + year End 2008</td><td>Milestone 1 December 2010</td><td>Milestone 2 June 2011</td><td>Target February 2012</td></tr>
<tr><td>20%</td><td>Number of COTs accessing HIV</td><td>COTs: 0</td><td>Regional HIV resource</td><td>Draft data base shared with</td><td>5/6 COTs report knowledge and</td></tr>
</table>

	mapping database. (COTs only) Number of SAOTs who have access to SRHR/HIV database of resources. (SAOTs only)	SAOTs: 0	mapping database rolled out to COTs 3/4	COTs and training/guidance provided as/if required 4/4	use of regional HIV mapping database. 4/4	
		Source				**RISK RATING**
		Project progress reports				medium
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 2	OUTPUT 2: Indicator 1	Baseline + year End 2008	Milestone 1 December 2010	Milestone 2 June 2011	Target February 2012	Assumptions
An effective and efficient multisectoral mechanism in place to coordinate HIV/SRHR programmes (COTs & SAOTs) disaggregated by island	Percentage of UKOTs with established multi-sectoral HIV/SRHR committee	**COTs: 30% (2/6)** **Anguilla**:– NAPC and programme assistant in place. No multi-sectoral committee. **BVI**: NAPC in place. Approved post of Assistant Coordinator remains vacant. HIV/AIDS **Bermuda**: AIDS Task Force (headed by CMO) and NAPC in place Composition mainly public health officials and director of local NGO **Montserrat:** NAPC sits within MOH. Multisectoral committee established in Dec 08 **TCI:** NAPC in place. Community run AIDS subcommittees in place on each	COTs: 50% (3/6) SAOTs: 75%	COTs: 70% SAOTs: 100%	All UKOTs: 100%	

		Island. NAP reviving National AIDS Committee in 2009 **Caymen**: NAP within Public Health Department.. Awaiting nomination of multisectoral committee. **SAOTs: 1/4 (25%)** **St Helena:** Sexual Health Advisory Group (SHAG) and ToR in place **TdC**: No SRHR strategy but Health Committee and island health policy **AI:** No SRHR strategy but Island Council responsible for health issues **FI:** No SRHR strategy but MDT Health and Social Service team				
		Source				
		Multisectoral committee ToRs, membership lists. Project progress reports				
	OUTPUT 2:	**Baseline + year**	**Milestone 1 December 2010**	**Milestone 2 June 2011**	**Target 2012**	

	Indicator 2	**End 2008**				
	Percentage of UKOTs with committees which regularly meet and review SRHR/HIV-AIDS action plans/programmes	COTs: 0% **Anguilla:** No committee **BVI**: HIV/AIDS Public Coordinating Council since 2003 – has never officially met **Bermuda**: No committee **Montserrat:** No committee **TCI:** No committee **Cayman Island**: No committee SAOTs: 25% **St Helena:** SRHG meets quarterly; SRHR action plan prepared and reviewed by group	COTs:30% SAOTs: 75%	COTs: 70% SAOTs: 100%	All UKOTs: 100%	
		Source				
		Minutes of meetings and project progress reports				
IMPACT WEIGHTING	**DFID (£)**					**RISK RATING**
20%	**DFID (£)**					High
INPUTS (£)	**DFID (FTEs)**					

OUTPUT 3	OUTPUT 3: Indicator 1	Baseline + year End 2008	Milestone 1 December 2010	Milestone 2 June 2011	Target February 2012	Assumptions
Most-at-risk populations in UKOTs successfully identified and reached through targeted interventions (COTs & SAOTs disaggregated by island	Number of targeted OTs with evidence informed community based programmes reaching priority most-at-risk populations (disaggregated by OT and by vulnerable group) (COTs & SAOTs) **No planned MARP intervention for Bermuda*	COTs: 0% SAOTs: 0%	50% TCI (Haitian Creoles) and BVI (Youth); intervention) 50% St Helena: MSM & YP Falklands: YP	100% Anguilla (CSW) and Montserrat (TBD). 75%	100% (CI will be targeted through tourism) 100%	
		Source				High level of commitment from tourism sector to move forward with implementation of HIV workplace/ community based intervention
		Progress reports				
	OUTPUT 3: Indicator 2	**Baseline End 2008**	**Milestone 1 December 2010**	**Milestone 2 June 2011**	**Target February 2012**	
	Percentage of OTs with evidence-informed guidelines/protocols/ strategies for SRHR/HIV prevention, care and support services targeted at vulnerable groups (disaggregated by OT and by identified vulnerable groups).	COTs: 0% SAOTs:	25% 25%	50% 50%	100% 100%	
		Source				
		Programme progress reports, service reviews. Relevant guidelines, protocols and strategies.				

	(COTs & SAOTs)				
	OUTPUT 3: Indicator 3	**Baseline + year End 2008**	**Milestone 1 December 2010**	**Milestone 2 June 2011**	**Target February 2012**
	Percentage of targeted tourism workers with improved HIV knowledge [as a result of implemented sector policies and programmes] (relevant for 3 COTs Anguilla, CI, TCI; disaggregated by country) **Note TCI TBD*	0% (COTs)	Number of tourism workers reached in COTs Anguilla: CI: TCI:		Of tourism sector workers reached, 60% show improved HIV/SRHR knowledge
		Source			
		Tourism strategic plan; workplace policies, baseline and follow-up survey which will be part of tourism strategy			
IMPACT WEIGHTING	**OUTPUT 3: Indicator 4**	**Baseline**	**Milestone 1 December 2010**	**Milestone 2 June 2011**	**Target February 2012**
25%	Percentage of targeted Secondary school youth with improved HIV knowledge [as a result of implemented HFLE policies and programmes in education sector] (COTs & SAOTs)	COTs: 0% SAOTs: 0%	No. of schools/pupils reached per OT with life skills education based on updated policies and curriculum (COTs & SAOTs) 25%	NA 50%	65% 75%

	**Excluding Bermuda*					
		Source				**RISK RATING**
		Global School-based Student Health Survey (GSHS) (done in all OTs except Bermuda & TCI); national youth survey where applicable and the EC/PAHO planned KAPB on adolescents and health, with emphasis on HIV/STI and sexual/reproductive health in five territories				High
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 4	OUTPUT 4: Indicator 1	Baseline + year End 2008	Milestone 1 December 2010	Milestone 2 June 2011	Target February 2012	Assumptions
Number of adopted HIV/SRHR related policies and legislations increased in UKOTs (COTs & SAOTs)	No. of new/amended policies/legislations adopted per UKOT (COTs & SAOTs) **Excluding Bermuda*	COTs: ANG: 0 BVI: 0 CI: 0 MONT: 0 TCI: 0 SAOTs: 0	ANG: TBD BVI: TBD CI: TBD MONT: 0 TCI: TBD 1 in 1/4 SAOTs	ANG: TBD BVI: TBD CI: TBD MONT: 5 TCI: TBD 1 in 2/4 SAOTs	ANG: TBD BVI: TBD CI: TBD MONT: 10 TCI: TBD 2 in St Helena and 1 in 2 other SAOTs	
		Source				
		Programme reports. Reports from stakeholder forum. Policy reviews *Re milestones they are to be determined in August- October 2010 through consultancy which will develop country consensus papers with all agreed policy and legislative recommendations. This has already been done in Montserrat where 10 recommendations were agreed upon and fast-tracked to the legislative agenda.				
	OUTPUT 4: Indicator 2	**Baseline 2008/09**	**Milestone 1 December 2010**	**Milestone 2 June 2011**	**Target February 2012**	
	No. of OTs with MARPS /civil society empowered and actively involved in the development of policy and legislation that reduces stigma	COTs: 0 SAOTs: 0	1/6 1/4	3/6 2/4	5/6 3/4	
		Source				
		Report on forum for consensus building for S&D related policy and legislation, programme progress reports				

	and discrimination (COTs & SAOTs)					
IMPACT WEIGHTING	**OUTPUT 4: Indicator 3**	**Baseline**	**Milestone 1 December 2010**	**Milestone 2 June 2011**	**Target February 2012**	
15%	Percentage of UKOTs with active programmes/policies addressing HIV/STI/SRHR related stigma and discrimination (COTs & SAOTs)	COTs:0% SAOTs: 0%	50% 25%	75% 50%	100% 75%	
		Source				**RISK RATING**
						High
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 5	**OUTPUT 5: Indicator 1**	**Baseline + year**	**Milestone 1 December 2010**	**Milestone 2 June 2011**	**Target February 2012**	**Assumptions**
DFID,PANCAP, EC/PAHO and other regional resources aligned and harmonised in support of OTs national Health and	No. of COTs with integrated Workplans/budgets, reflecting plans and budgets from all partners **Excluding Bermuda*	0	1/5	3/5	5/5	Donors committed to harmonization and alignment principles.
		Source				
		Annual plans/budgets.				

HIV/AIDS strategies (COTs)		Annual plans/budgets.				
IMPACT WEIGHTING	**OUTPUT 5: Indicator 2**	**Baseline**	**Milestone 1 December 2010**	**Milestone 2 June 2011**	**Target February 2012**	
20%	Percentage of UKOTs in which, DFID, PANCAP, EU/PAHO and other relevant institutions undertake joint planning and reviews (COTs)	No system set up	Joint planning in 50% of OTs	Joint planning in 100% of OTs	Joint planning and review for 100% of OTs (lead by COTs)	
		Source				**RISK RATING**
		Joint Annual Review Reports				High
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
INPUTS (HR)	**DFID (FTEs)**					

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DFID Human Development Resource Centre
HLSP, 10 Fleet Place
London EC4M 7RB

T: +44 (0) 20 7651 0305
E: just-ask@dfidhdrc.org
W: www.hlsp.org