SOCIAL IMPACT REPORT OF GRAPEVINE DREAMS PROJECT

(Manicaland and Bulawayo Zimbabwe)

Graduation of GRAPEVINE adolescent deaf girls and young women at NZEVE Deaf Centre, 2017

Assurance Statement

This report was submitted to Social Value International. The assessment concluded that

"**The application demonstrates a satisfactory understanding of, and is consistent with, the Seven Principles of Social Value. The report has been assured.**"

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Acknowledgments

The project and research were done by the Manicaland team based at Nzeve Deaf Centre Mutare, and Bulawayo team based at King George VI Centre (KG6), funded by Johnson and Johnson Foundation.

The report and impact map were written and developed by Libby Foster, Selina Mlambo and Tatenda Mashayahanya with assistance from the teams. Mentoring was received from Tim Goodspeed of Social Value UK, to whom we are very grateful.

Our thanks to Cori Vail and Robert Bowden of J&J, who made this possible by believing in us and encouraging us right from the start.

1 Executive Summary

1.1 Objectives of analysis

HIV responses often overlook deaf people in Zimbabwe. The Deaf are denied access to information due to low literacy, use of radio for campaigns and lack of information in sign language. It is important to have knowledge about the Deaf and understand how they learn but few have the cultural competency to serve the Deaf effectively. Misinformation about HIV gets passed between sign language users and they remain unaware of the differences between HIV and other STI and do not comprehend basic treatment concepts. Deaf girls are reluctant to use health services as they are ignored, misunderstood and have little chance for confidentiality. Deaf people are often sent to remote rural homes from which it is difficult to access suitable education. Many never learn sign language and the few that do get to school rely on their peers to teach where teachers cannot sign well. Educational levels are low, and teachers are not equipped with skills to teach sensitive topics in a way that the deaf can understand. Many communities are discriminatory and deaf girls are isolated.

GRAPEVINE aims to reach out to the girls through two-week camps in which information sharing, life skills and confidence building activities are shared using approaches more accessible to visual learners. With skills gained and new connections made, girls will be able to create a network among themselves and other girls in their various communities; equipped to spread accurate HIV and life skills information like a grapevine.

This report and analysis are based on the results from a 26-month project in which 179 adolescent deaf girls and young women (ADGYW), took part in training in HIV and health; Business skills; Personal Development; sewing and dressmaking skills; hairdressing; baking and independent living. Families were involved – parents extended family members and spouses in meetings and on graduation day. 60 adolescent deaf boys and young men (ADBYM) took part in similar activities for a shorter time, with the aim to share information on health and HIV and to foster more respect for women.

From the girls' stories, many deaf adolescent girls and young women (ADGYW) enjoyed the GRAPEVINE experience simply by the fact that they were included in information dissemination in a way which was accessible to them. Many expressed other benefits to them as well and the teams noticed many positive changes in girls over the time in camp, it is impossible to record it all. However, a few stories will be included and used to illustrate the benefits of calling young deaf women together, allowing them to be involved in learning in an accessible way and providing experiences that were out of their usual daily lives, but normal for many young women around the world. Nzeve and KG6 staff saw lives were changed and young people gained new skills.

The results show that the biggest differences made were in the soft outcomes of feelings of isolation and acceptance. Some results were very clearly due to the experience, environment and culture of adolescent young deaf girls in Zimbabwe in 2017-8. Where necessary the additional explanation of these cultural or unique issues will be included.

According to the girls in predominantly rural Manicaland, (Nzeve Deaf Centre, Mutare), the most important outcome to them was the change in their relationships and reduced isolation; among the boys increased respect for girls was most important. Manicaland parents identified improved understanding of their daughters needs as key. Mostly urban King George VI Centre, (KG6) Bulawayo girls explained how they feel more valued as they are able to contribute financially to the family with profits earned from business ventures, and that has changed the way people look at them; Bulawayo boys said their risk for HIV had decreased and parents in Bulawayo also said all three outcomes (accepting their parenting responsibility, discussing HIV and understanding their daughter better) were closely valued.

The health outcomes for the girls, of improved management of my health and HIV risk reduction may have overlapped. Girls related increase in confidence to access health services alone to improved management of their health. The abstract nature of reduced risk was hard for girls and boys to understand but they did understand the importance of good health – which included HIV testing and going to the clinic early with any symptoms.

Involvement of the ADGYW's parents was critical. Parents acknowledged outcomes in understanding their daughters more, being more open to communicate about health and HIV and seeing changes in their daughters which led to them feeling more respected in the community. They also acknowledged a greater appreciation of their responsibility to their daughters. The support of their parents who experienced this outcome will help the girls to sustain their outcomes.

With a relatively small sample size, we have been careful not to put too much emphasis on any absolute figure. There are clearly some outcomes more valuable than others, but also some bunched closely together. We have looked at the final order of value of outcomes within each group and considered some differences between the stakeholder groups in Bulawayo and Manicaland shown by order of these. In addition, we have looked at outcomes which were not experienced by certain stakeholders and considered reasons for this. We acknowledge there is a danger of bias from the selection process, but great efforts were made to ensure a range of participants took part. In addition, we acknowledge since a sample of participants and stakeholders was chosen for this analysis, not all participants were included and therefore the results can only be applied to the scrutinised sample. Within this group we were careful to reach a point of saturation in the stories of change in order to present what we believe are widely experienced outcomes.

1.2 Recommendations for the Programme

The outcomes that appear to be most important in the lives of deaf adolescent girls and young women are to do with relationships and reduced isolation. This came through clearly in their stories of change. The inclusion of families in the project was important in improving relationships, both in the family and the community, and increased the sustainability of the project outcomes.

The model of bringing young deaf people together for an intense programme of a few weeks proved to be effective, especially for isolated rural deaf girls and young women. The soft outcomes of reduced isolation and acceptance cannot be planned for as easily as the health programme, but came about because of the inclusion of families, the visually accessible language and communication adopted and by relating to the girls as individual, valuable young women. Decentralising some social activities through empowering of the Deaf community to run social clubs can be one way of creating more value at lower cost. In addition, home visiting and counseling can increase the reach and impact. The inclusion of adolescent deaf boys and young men was important as these are the most likely partners of the deaf girls involved in the programme.

2 Introduction

2.1 Background

The Deaf community has been left out of many development initiatives. Many deaf people are aware of gaps in their knowledge. One of the most frequently occurring comments in the stories collected from the GRAPEVINE project participants was, "Before I did not know – now I know". Or from others, "Nobody ever told me- first time here". The GRAPEVINE project involved working with groups that required different approaches to addressing HIV education.

Young deaf people struggle with abstract concepts. This is especially true for those who started to learn sign language after 6 years old i.e. after the critical age for language learning. Early intervention is not widespread in Zimbabwe, and most deaf children only start to learn sign language when they go to school, in the year they turn 6 or 7 years. This sets them at a disadvantage right from the start as their peers already know one or two languages and are taught in one of those languages. The Deaf must learn the language at the same time as learning the content of the school curriculum, and inevitably lag behind. There is no universal screening for hearing loss either for newborns or at school entry in Zimbabwe.

> Early language exposure is a major contributor to a deaf individual's life. Typically, children learn language effortlessly. However, deaf children are not able to do so as effortlessly because they face an extra obstacle, a lack of access to a shared language. Remarkably, ~95% of deaf children are born to hearing parents who have limited or no knowledge of a signed language. Many deaf individuals are unable to benefit from exposure to spoken language, leaving them at a disadvantage in the early stages of development. Failure to access communication often denies deaf children their "rightful opportunity to learn and understand others". As a result, some deaf adolescents struggle to internalize appropriate behavior models, learn self-regulation strategies, and often misunderstand social norms. There are an inordinate number of psychological differences between deaf children of deaf parents and deaf children of hearing parents, some of which are linked to effective communication. For example, deaf children of deaf parents, who had a shared and early access to language, typically demonstrate better academic performance, exhibit a more positive self-image, are less prone to impulsivity, and are even more proficient in English. Researchers …..similarly concluded and emphasized the importance of a shared language for a deaf child's development of self-concept and identity. *Deaf adolescents in a hearing world: a review of factors affecting psychosocial adaptation* *Patrick J Brice and Gillie Strauss Adolesc Health Med Ther. 2016; 7: 67–76. Published online 2016 Apr 21. doi: 10.2147/AHMT.S60261*

3 Scope

3.1 About Nzeve Deaf Centre and King George VI Centre

Nzeve grew out of a voluntary work with young deaf children and their parents. It was started in 2000 as an early childhood development and family centre with both deaf and hearing staff. However, young deaf adults started to frequent the centre and started their own social club, Sanganai, ("Let's meet") Deaf Club), which met at weekends. Later a vocational training project (Project Sanganai) was started for deaf youth. Young deaf children and their families meet on the same site as deaf youth. This allows for interaction of parents and caregivers with deaf youth. They learn from natural sign language users and can see the potential of their own young children.

Sanganai Club grew to become self-governing, depending on Nzeve only for occasional administrative assistance. Project Sanganai is nested in Nzeve as one of its projects. Club members started outreach to different areas of Manicaland to reach deaf people who could not travel to Mutare; they train leaders in these locations to run their own activities and provide information about health and HIV.

Currently Nzeve runs as an NGO works across Manicaland through both centre- and community-based projects. The core activities include:

- Early identification and intervention through Families department that provides both ECD education, parenting and family support to raising a deaf child
- Working with Ministry of Primary and Secondary Education, support to schools in Manicaland with Resource Units for deaf learners through regular teacher workshops and school support visits
- Youth Vocational training and Life skills
- Administrative support and mentoring to 5 deaf lead social clubs in Manicaland
- Community outreach programmes to community leadership for identification and support of deaf children.
- Sign language training and Deaf Awareness.

King George VI Children's Rehabilitation Centre opened in 1957 and is an institution located in Bulawayo, run by the government and an autonomous Private Voluntary Organisation (PVO) registered in the welfare sector. King George VI Memorial School is registered and regulated by the Ministry of Primary and Secondary Education and the National Society for the Blind and Physically Handicapped.

The organisation was initially set up to look after children living with disabilities such as: the blind; the physically disabled; children with Down's syndrome; cerebral palsy, brittle bones or dwarfism; and those with multiple disabilities. As other specialized organizations were established in the region many of these children were moved to alternative schools.

Currently King George VI provides children living with physical disabilities and Deaf children with access to education and holistic therapy in an environment structured to cater for the child's specific needs including

training in independent living within and outside the institution. Key areas of service are:

- Primary and Secondary education
- Boarding Facility for children with disabilities
- Research and development in the areas of education and psycho-social support for the disabled child. Currently the centre is involved in research and development of the Zimbabwe National Sign Language Poster for Medical Practitioners.
- Advocacy
- Vocational Training for young people with disabilities
- Therapy: Physiotherapy, Occupational and Speech therapy

3.2 About GRAPEVINE Project for Adolescent Deaf Girls and Young Women – Part of DREAMS Innovation Challenge

GRAPEVINE project aimed to understand more about adolescent deaf girls and young women's lives. Deaf girls are frequently excluded from social and educational activities, limiting their opportunities to learn about boundaries. This compromises their ability to refuse sex and ultimately lowers their self -esteem. Rape and abuse are more common amongst deaf girls but poverty and communication breakdown cause problems for them in reporting abuse and in accessing healthcare. Deaf girls are reluctant to use health services as they feel they are often ignored, misunderstood and their confidentiality is often breached. The GRAPEVINE project reaches out to deaf girls providing them with a safe, deaf-friendly space in which to access information about their health and HIV, receive mentoring and support from older members of the deaf community, build their confidence and learn business and practical skills to increase opportunities for financial independence.

3.2.1 Project Background

The DREAMS programme was proposed because girls and young women account for 67 percent of new HIV infections among adolescents in sub-Saharan Africa. A core package was designed and funded based on evidence-based approaches that addressed structural drivers that increase girls' HIV risk. These include poverty, gender inequality, sexual violence, and lack of education The DREAMS Innovation Challenge brought additional resources to projects adopting innovative approaches to meet the urgent and complex needs of adolescent girls and young women.

The GRAPEVINE project is a DREAMS Innovation Challenge project based in Zimbabwe. It involved collaboration between Nzeve Deaf Centre, Manicaland province and King George VI centre, Bulawayo. The two centres are different in their history and governance, but both believe strongly in the need to reach out to deaf people using natural sign language alongside written English, work with deaf adults and respect the deaf community and their language.

The GRAPEVINE project responded to the need to provide accessible information and support for deaf girls including health education to reduce the risk of HIV infection in adolescent deaf girls and young women. The project used deaf peer educators as role models and also involved others with good sign language skills. Deaf community clubs were strengthened to address HIV issues amongst their members; HIV positive girls received counselling and treatment adherence support. Opportunities for income generating activities were increased through practical skills and business training. GRAPEVINE provided two-week camps in HIV and Health Education, Business and Life Skills coaching for deaf girls, meetings for parents for the promotion of acceptance and support to the girls, and workshops for deaf boys and young men in HIV, health, gender-based violence and relationships.

Deafness is a disability affecting communication. Gossip and false ideas spread quickly throughout the deaf community. It is therefore essential that information on the deaf grapevine is accurate. An accurate understanding of Deaf culture underpinned the project. This involved working with deaf role models, mentors and leaders including facilitators from Deaf Women Included, a deaf led advocacy organisation. All information exchange was done using appropriate visual methods. Home visits to the girls by deaf mentors was instrumental in empowering the girls. Their families and community members observed that the deaf girls travelled to meetings to learn new skills and that capable deaf women visited the girls. Opportunities for families to learn from each other and to learn sign language were also created. By providing a space in which the girls could feel valued and by equipping them with new skills and knowledge, the project designers believed this would result in the girls valuing themselves and become enabled to recognise their own roles in changing their own circumstances. Deaf girls frequently indicate their feelings of being powerless to make changes in their lives. They requested that deaf boys should also be reached through similar activities aimed at building their understanding of healthy relationships and the value of women.

Initially the target age group was 15-24 years, but it was recognized that slightly older girls (25-34 year olds) were in very similar situations and had also missed out on information. They were also included.

3.2.2 Inputs

The activity was funded by the Innovation Challenge grant from Johnson & Johnson under the DREAMS project. The total funding input for the GRAPEVINE project over 2 years was US$247,613.

Apart from the contributions made to salaries of the teams involved the largest cost was for food and transport for the camps ($52,574). Deaf people and their families are scattered all over the selected provinces and many families were not able to afford transport costs to and from the camps. Transport and accommodation for project staff working between the two sites was also high. The two sites are 600km apart. This journey takes 10-11 hours on public transport or 6-7 hours by private vehicle. Visits were made between the two centres involving 35 people visits over the 26 months of the project. Shared facilitators (a Drama Teacher from KG6 and a Business Skills Facilitator from Nzeve) travelled regularly between the two sites for each camp; Nzeve project leader visited Bulawayo with specialist staff for monitoring and evaluation, finance and administration. This gave the project support, staff capacity building and coordination. Ongoing communication, monitoring and evaluation were important to ensure overall project goals were achieved; lessons learned recorded and any unexpected outcomes monitored. GRAPEVINE was one of many projects and activities at both centres, so at times due busyness, both centres complained of lack of feedback and reports.

to

Technical inputs were necessary for communication and data collection:

- Regular Skype calls were held with the supervisors from J&J in the first 18 months for development of M&E and discussions about project progress.
- Kobo Collect data collection software was used by deaf mentors during support visits to girls' homes.

Outside facilitators were invited to provide additional skills and services not available at the centres. They also helped to connect the girls with services they could access after camp. This helped bring the application of concepts learnt, transferring skills and information gained during camp sessions to their everyday lives. These services included:

- HIV testing and counseling services
- Population Services International of Zimbabwe in Bulawayo taught about sexual reproductive health and the use of contraceptives
- A clinical psychologist worked with some families in Bulawayo.
- Gender Based Violence (GBV) issues were introduced and discussed by Deaf Women Included.
- Family Support Trust provided counselling to GBV survivors
- Women trading and sewing came to teach the girls embroidery and share their experiences as business women.
- Mothers of younger deaf children helped with cooking in the evenings and taught girls to improve the quality of meals provided to participants.
- Local teachers and community artists helped with art and the development of posters for the girls to use to share messages about HIV with friends and family back home
- Local models came to teach about grooming.
- Youth Advocates Zimbabwe visited Mutare and Bulawayo to introduce their mobile phone app and explain about their services and how to access them

The involvement of boys was a later addition and was done differently at the two centres. A one-week camp with them was included which in addition to health issues, had an emphasis on gender-related issues.

3.2.3 Outputs

Camps were held in Mutare and in Bulawayo, in total 13 camps were held, each one lasting 2 weeks with ADGYW and one week with each group of ADBYM. Parents or caregivers travelled with the girls on the first day of each camp to ensure the safety of girls since many were not used to travelling alone and because many parents were extremely protective of their deaf daughters. But this requirement was put in place mainly to ensure their attendance at a meeting at which the goals of the GRAPEVINE project were explained; misconceptions clarified; their continued involvement in the project and discrimination were discussed; sign language was taught; and they were encouraged to share parenting experiences.

Potential leaders were chosen from each camp and invited back to the next camp to help.

As follow up to the camps home visits were arranged in Manicaland and Bulawayo. Initially these were done by hearing staff in Bulawayo, but later, after training, deaf mentors took over. These were mature Deaf ladies who were trained as mentors and home visitors. They visited girls in at their homes or arranged meetings where it was possible to get some girls together.

Girls were invited to Deaf community events during the project lifetime- modeling, club meetings, Deaf Awareness, 60th anniversary of KG6, sports events and regular club

meetings which were social or educational in nature. Some girls living in Bulawayo and Mutare were involved in projects meeting daily at the centres, where they learnt vocational skills and prepared for national exams. Girls still in school went back to their schools following camps and performed drama to their classmates.

3.3 About the Social Value Analysis

This report is an evaluation of 26 months delivery of GRAPEVINE activities with adolescent deaf girls and young women and their families from September 2016 to November 2018. Three groups of stakeholders were included from each site, however, the main target group was girls.

This is a social value report, including the relative value to stakeholders of all material outcomes.

Stakeholders

3.4 Stakeholder Analysis

Potential stakeholders and their outcomes were identified in consultation with the teams and from the girls' interviews. Some proposed stakeholders (staff members and deaf adults at KG6 and Nzeve) were involved in discussions and some results of these consultations are included in the discussion of results.

Discussions of possible material outcomes with stakeholder groups, and consideration of technical constraints determined that three groups - ADGYW, ADBYM and parents- were included in the assessment.

3.5 Deciding which Stakeholders to Include

Parents of the participants were included in the analysis. Parents were involved in meetings at the beginning and end of the camps, and camps concluded with a graduation celebration to which families were invited. Those coming from a distance would often have just one relative, whilst those living close to the centres came with extended family members.

Early in the project it was understood that some stakeholder groups proposed in the original proposal would not be included systematically in the project. The project proposed that parents should approach traditional leaders and health workers with their daughter. Parents were questioned about the involvement of traditional leaders and it became apparent that very few parents had done this. Parents in urban Bulawayo explained that the traditional leaders were not functional in town. Parents agreed that the effect of the project on traditional leaders was likely to be negligible.

However, under another project at Nzeve traditional leaders are included in community dialogue on disability. Most stated that they had never considered people with disabilities (PWD) before the dialogues and expressed unease about communication with deaf people. (Vital Signs project report June 2019 TEAR Aus) In addition, when Deaf youth were interviewed, they insisted that traditional leaders were difficult to approach,

and they found the protocol needed to meet them difficult to follow. Deaf youth interviewed did not feel they could approach traditional leaders themselves. (Youth Research Academy, HIVOS and Restless Development)

The main beneficiaries of GRAPEVINE are adolescent deaf girls and young women from Manicaland and Bulawayo, between the ages 15 – 34 years. Parents or caregivers of the girls, adolescent deaf boys and young deaf men were also beneficiaries. The impact on the whole family of the ADGYW was important to understand. However, due to technical and financial constraints of the project they were not interviewed individually. 16/179 ADGYW were married, outcomes for parents provided a proxy for other family members, to ensure that any positive outcomes for the ADGYW were not at the expense of other stakeholders: parents, spouses, siblings and children. In this way we believe that all stakeholders in the families with material outcomes were represented.

There were 5 girls in Manicaland identified when they arrived for the camp, who were not able to be included in the activities due to additional and severe learning, behavioral or self-care challenges. Meaningful communication was not possible with these girls. The project was never aimed at girls with such challenges and they were not included in the project and were therefore not included in this report.

Due to the different living situations of the two geographical groups of ADGYW, we decided to investigate results from Bulawayo and Manicaland separately. We wanted to see if there were significant differences in their stories and in their responses. The most relevant outcomes were judged to be for the ADGYW, ADBYM and the parents. All these outcomes were included.

Decisions to include or exclude stakeholders from the analysis were based on their potential (or actual, where known) outcomes as follows:

Stakeholder	Potential Outcomes	Justification for inclusion/exclusion
GRAPEVINE facilitators at Nzeve and KG6.	Shared ideas and learnt different teaching and communication skills for the Deaf.	Decided **not to include** in analysis but to include comments in the narrative. We considered potential outcomes will not be wholly down to GRAPEVINE. Their involvement in several concurrent projects, activities and training caused us to conclude that these stakeholders do not have material outcomes attributable solely to the project. By excluding the facilitators they were able to concentrate on the analysis of the 3 chosen groups at each site.
Adolescent deaf girls and young women from Manicaland and Bulawayo	Social skills. Health and HIV information Improved self esteem Vocational and business skills	**Included.** An urban (Bulawayo) – rural (Manicaland) divide was noted in analysis of the girls' stories and responses to the survey. The two groups were kept separate.

	Drama competence	
Adolescent deaf boys and young men from Manicaland and Bulawayo	Improved respect for girls Health and HIV information Greater awareness of risky behaviour	**Included.** The two groups were kept separate.
Parents from Manicaland and Bulawayo	Improved communication with their daughter Appreciation of daughters' independence	**Included.** The two groups were kept separate.
Traditional leaders	Awareness of deaf people in the community. Greater understanding of diversity in community.	**Not included.** Traditional leaders and health workers were not directly involved in the project. Any potential wider outcomes will not be wholly down to GRAPEVINE and will have high attribution. In discussions with parents it was judged that traditional leaders and health workers would not have any relevant or significant material outcomes from the project activities. Families of the girls were represented by the parents.
Health workers	Awareness of deaf people in the community. Ability to include the Deaf in health- related activities	
Spouses of married young women, siblings or children.	Improved communication Discussions about health and HIV.	

Adolescent Deaf Girls and Young Women (ADGYW): The GRAPEVINE project identified 184 adolescent girls, of whom 179 completed the course. In Manicaland 64/84, (76%) of the group were rural whilst in Bulawayo only 18/95 (19%) were rural. Some deaf girls living in towns either Mutare or Bulawayo, can access services (vocational training) daily, but the majority of the Manicaland sample live in remote areas and are poor, isolated, often abused and have low self-esteem. They are extremely vulnerable to HIV, 10% of girls (averaging 21 years in age) among the Nzeve sample disclosed their positive status. All were on treatment, although one girl was defaulting and needed extensive support. The Bulawayo girls did not disclose their status.

75% (69/95) of the Bulawayo ADGYW had attended secondary school. In Manicaland only 64% (59/84) of ADGYWs went to secondary school education, and 6 had never been to school at all. The 6 girls had poor sign language, but some residual hearing and managed to understand some of the information at camp. They benefited socially.

Special Schools in large towns in Zimbabwe often provide a better opportunity for deaf students to learn in an adapted environment with a greater number of trained specialist teachers who can effectively communicate. Opportunities for mainstreaming may be better in Resource Unit settings (small classes set up in a mainstream school), but the expertise and environment are often less suitable for profoundly deaf children.

In Bulawayo, 54/95 (55%) girls had attended school at King George VI (a special school) or another special school and reached secondary education. The rest (45%) attended Resource Units for the Deaf. Educational backgrounds of Manicaland participants was varied. Of the girls that completed the course, 2/84(2%) participants attended special school for the deaf; 20/84 (24%) attended school in mainstream settings with the hearing or not at all and met with deaf people at Nzeve for the first time in GRAPEVINE project; and 62/84 (74%) attended Resource Units for the deaf in mainstream schools. Results from the two geographical groups were analysed separately.

Parents / Caregivers of ADGYW. Most deaf people are born and raised among hearing families. Few services in Zimbabwe equip parents with sign language or enable them to understand how to raise a deaf child. Parents often have little knowledge or confidence on how to share information about sexual reproductive health and HIV with their adolescent child. Many relatives adhere to traditional religious and cultural beliefs which leads to discrimination against children with disabilities through exclusion from social interactions and education. At the start and end of each two-week camp for girls, staff met with parents (a total of 121 parents and an additional 133 other relatives), to explain the purpose of the GRAPEVINE project; parents were introduced to deaf adults who were role models in the deaf community. Parent buy-in was needed to ensure that girls received support in the application of skills and information learned during the camp when they returned to their communities. Parents reported during Social Impact interviews positive changes they had noticed in the girls and in their relationships as a result of the GRAPEVINE project.

Adolescent Deaf Boys and Young Men. Early in the project girls reported receiving criticism from boys about their involvement in GRAPEVINE. Deaf boys and young men lacked understanding on health and HIV matters. This put girls who were already married or who might enter romantic relationships at risk. As a result, 60 boys and young men were included in project activities. These males were included in the Social Impact analysis to establish whether their contact with the project had changed their perceptions of young deaf women.

Teachers and Staff. The decision was made not to include the staff outcomes in the analysis since potential outcomes could not be considered wholly due to GRAPEVINE and so not relevant, due to high attribution. Teams at KG6 and Nzeve reported the benefits they had received through their involvement with the project. They learnt problem solving techniques, participatory and storytelling methods, the use of drama and visual aids. and improved their networking leading to better information sharing.

The strategy of residential camps was to bring together girls from large geographical areas, so they could be involved in health and personal development activities as well as learn life skills such as cooking and cleaning for themselves. The 2-week event was intensive with many activities. The programme with the participants being resident added to the social benefits for isolated deaf adolescent girls. Weekend outings were used to build on the teaching in personal development and broaden the experience of the girls. Graduation Day at the end of each camp was attended by relatives. In Manicaland, many travelled long distances whilst in Bulawayo many relatives lived nearby, and there was pressure due to large numbers attending. Careful planning was needed to address these diverse challenges. Camps were demanding on staff who worked long hours. Additional people were included as overnight caregivers, cooking teachers and drivers.

4 Methodology – Data Collection

Stakeholders to include were identified and discussions held on how they should be included.
A sample of girls (37/179, 21%), boys (12/60, 20%) and their parents (19/122,16%) were involved in the evaluation of the project. An initial selection including older and younger; school attenders and those who did not go to school; urban and rural; special school and mainstream students; married and single girls; and young women was invited to attend. However, communication challenges, distances, involvement in other programs and lack of permission from the parents or spouses were factors that influenced responses to the invitation. A wide selection of participants was invited, but the evaluation results are based on a relatively small sample, so we acknowledge that results could be affected by selection biases.

Meaningful discussions and analysis with the GRAPEVINE deaf participants were not straightforward due to their different life experiences, communication and learning styles. The collection of stories of change and surveys were all done individually in face to face situations. FGD were used to check the veracity of results.

4.1 Data collection - Qualitative

The first activity to discover and understand outcomes was an individual meeting with each person in the stakeholder group sample (ADGYW, ADBYM and parents). Stakeholders were asked to relate their stories of change. These stories defined a chain of changes leading to the outcomes. Further participants were included till no new changes were reported and we were confident that a situation of saturation had been reached.

The girls and boys included were determined by:

4.2 Formal sign language proficiency.

Girls and boys with very low literacy and greater difficulties in sign language communication were not included in the representative group because of the difficulties they would experience in understanding the concepts of the analysis (6 girls in original total Manicaland sample). In order to make sure the views of this group were included, parents were able to be proxies for two girls with poor communication skills, and their interviews helped us to understand more about the girls' outcomes.

4.3 Geographical considerations.

Stakeholders for GRAPEVINE did not all live locally, and some were not easily reachable by regular communication channels; therefore, selection was partly determined by convenience, availability, accessibility and ease of travel. Efforts made to have more remote and less educated participants included were successful, but actual numbers of representative stakeholders during the analysis depended on whether they were available on scheduled dates for analysis.

4.4 Techniques for collecting information.

Stories were collected using open ended questioning. Competent sign language interpreters were chosen to collect the participants stories. Due to the use of sign language, note taking during an interview at the same time as interpreting sign language can result in missing some crucial information. To overcome this, when the girls were interviewed, about their experiences, they were recorded on video and this was later transcribed into their stories.
The changes resulting from the GRAPEVINE activities from the perspective of stakeholders were recorded and extracted from their stories. Both positive and negative changes were recorded, and several unexpected changes were mentioned consistently. Although the girls did not record negative changes, several girls did report some of the final outcomes where they experienced no change.
The chains and outcomes were discussed by GRAPEVINE staff in Bulawayo and Manicaland, and presented to the girls prior to the survey, where they confirmed the results by verifying their experience of change (positive or negative), or no change, in each outcome. The team decided that following the collection of stories, surveys with girls and boys should be done face to face and individually by competent sign language interpreters.

Some parents however, were interviewed over the phone.
Images and videos were useful aids to give context to a discussion among deaf youth. For the focus group discussion, a Power Point slide was used.

4.5 Parents

Initial parent interviews and story collection were conducted by interviews (14 Manicaland; 8 Bulawayo). The changes resulting from the GRAPEVINE activities from the perspective of parent stakeholders were recorded from their stories; positive, negative or unintended were all recorded. Once the relevant outcomes to include were decided, 11 surveys were done over the phone. This was because the survey was done during the prime farming season and people were not willing to leave their homes at this time. The parents (11 Manicaland; 8 Bulawayo), were later invited to the centres for further analysis, confirmation and quantification of the identified outcomes. Some families were unable to travel to the urban centres for the evaluation due to distances involved, but representatives from remote areas were included. All the parents involved in the surveys were related to girls who took part in surveys.

4.6 Data collection – Quantitative

Indicators were developed for each outcome, and surveys were conducted to measure the quantity of outcomes. 37 girls (20 from Manicaland, 17 from Bulawayo), 11 boys (6 from Manicaland, 5 from Bulawayo) and 19 parents (11 parents in Manicaland and 8 in Bulawayo) participated in the surveys.

Girls and boys were invited to the centres for one-on-one discussions on separate occasions. Deafness and life experience influence how an individual interprets information during a discussion. To overcome this, pictures were carefully chosen and used to represent each outcome in the context of GRAPEVINE and give standard understanding. During the survey each picture was explained to the participant relating it to the outcomes and statements from their stories. The same pictures for each group were used in other activities of the analysis where reference to outcomes was made.

Picture prompts were not necessary with the parents and surveys were conducted over the phone with 11 Manicaland parents. They then attended in person for the activities of quantifying and importance of change. 10 parents in Bulawayo attended the centre for interviews and quanitification.

4.7 How much change?

To measure how much change participants experienced in each outcome, a presentation was shown telling a story of three women/ men who had experienced changes in their lives and their responses about how much change had occurred. Each outcome and indicator were described to the group of participants using pictures. The score sheet shown in the presentation was later used by the participants. Each person had to decide for themselves how much change they had experienced on a scale of 0-5 (or 0-6 for the boys at Nzeve in error). They each marked this on a score sheet.

The exercise of “How Much Change?” was omitted with the girls in Bulawayo, and a different scale was used with the boys. Therefore, extra caution when looking at absolute figures was adopted and the order of scores rather than actual scores were used in the analysis of the impact map. However, the material outcomes and final conclusions of the report were not affected by these differences.

4.8 Duration.

In each survey, girls, boys and parents were asked about duration of each outcome. “If DREAMS camps come to an end, or you stopped coming to DREAMS, how long after you finished being involved do you think you would still experience”….. this change? To measure how long a feeling or impact of an experience will last is an abstract concept and difficult for deaf participants to interpret. Stakeholders were given options of time periods from which to select duration and each asked how long they felt the change would last for- the longest being “more than 3 years”.

An average duration in years was taken from all participants surveyed and included in the impact map. However, this is expressed as an ordinate number rather than in the exact way it was expressed in the survey.

Each participant thought carefully before answering, but we did not ask how they came up with their answer. A few answered "more than 3 years" for all questions, but most had a variety of answers.

4.9 Weighting (How important?)

The abstraction of relative importance of outcomes or ranking was difficult to explain. ADGYW in Bulawayo scored the outcomes on a scale of 0-3 following each explanation of the outcome, but in Manicaland visual and participatory activities were required to help with understanding these concepts. Weighting was considered the preferred valuation method as it provides direct individual preferences and more opportunities for including the stakeholders' perspectives.

Participants took part in an activity – explained in detail in Annex E. In order to prevent confusion, this activity had to be done on a different day and in a different way from the "How much?" activity. Each participant had to decide how to rank the outcomes experienced in order of importance, and then share a number of counters between each of the outcomes in which they had experienced change. This would show how they valued change in one area compared to change in another.

A PowerPoint presentation was again used to explain importance prior to an active and participatory activity which allowed the ADGYW and the ADBYM to place pictures of the outcomes in order, and then share counters out on each. In this way they could see and understand which outcome they felt was most important to them. Plenty of time and privacy was given to do this, so we ensured everyone had reflected sufficiently.

4.10 Deadweight/displacement

To measure both deadweight and displacement (another service totally serving the same purpose as the service under consideration), stakeholders were individually asked about each of the outcomes in turn and what they would have done without GRAPEVINE, or how they would have accessed a similar service if the GRAPEVINE camps had not happened. Four response options were given, and each response scored as outlined below.

If DREAMS camps had never happened for parents, boys and girls what would have happened?

- *I would have done nothing like DREAMS (0)*
- *I would have done something, but less than I have done with DREAMS (1)*
- *I would have found another way to do the same thing (2)*
- *I would have done more than I have done with DREAMS (3)*

Responses with scores 0 and 1, were ascribed to deadweight. Expressed as a percentage, a score of 0 meant that the participant credited the outcome entirely to DREAMS (0% deadweight). A score of 1 was expressed as 25% of what was achieved through GRAPEVINE may have been accessed elsewhere.

4.11 Displacement

Using the same question above, where participants responded either of the second 2 responses (in bold), these were measured as displacement.

If DREAMS camps had never happened for parents, boys and girls what would have happened?

- *I would have done nothing like DREAMS (0)*
- *I would have done something, but less than I have done with DREAMS (1)*
- ***I would have found another way to do the same thing (2)***

- ***I would have done more than I have done with DREAMS (3)***

For displacement, a score of 2 for "I would have found another way to do the same" was expressed as 50%. Whist there are youth centres and organisations that offer some of the courses covered in GRAPEVINE, there are no known services currently providing all 5 courses (HIV and health education testing and counselling, personal development, business training, vocational skills and visual arts) including home visits and family support adapted for deaf adolescents, young men and women. This was verified by the participants. In addition, many of the services identified by the deaf youth as able to offer the same rely on the support of the two centres (Nzeve and KG6) to provide this support; therefore 50% was considered a reasonable allotment to account for some of the same outcomes being achieved in another way.

A score of 3 for "I would have done more" was equated to 100% displacement. None of the sampled girls or parents said they would have done better in either site, but one boy thought he would have done more in learning about HIV and reducing his risk. It is possible he has seen different activities and possibilities and felt confident in his ability to cope without support. However, alternative services are rarely adapted for Deaf access.

4.12 Attribution

Each participant was asked about the changes they had described: "did anyone, any activity or any other programme also help to bring about the change spoken of in each outcome?" A value of 5% was given to represent each member of the family or activity mentioned, and the final figures for each outcome were averaged.

5 Understanding Outcomes

5.1 Outcomes Consultation

Each participant was asked to tell their story of the GRAPEVINE experience before, during and after the camps. Stories were told freely but prompts were used to understand the situation clearly:

- Before GRAPEVINE – "What were you doing at home? How did you spend your days? Describe your life"

  Baseline data had been collected during camps, so where needed, further information was taken from these stories e.g. to clarify details of their family situation.

- During GRAPEVINE camp – "What did you learn? What did you experience?"
- After GRAPEVINE camp – "What changed for you in your life? (HIV health, business, social and family relationships) Tell me about both changes that were good and any that were bad.
- Is there anything else you would like to tell us about your involvement in GRAPEVINE?

5.2 Deciding on relevant outcomes to include

Outcomes were drawn from the stories that stakeholders told during interviews. Stakeholders' outcomes were considered material where:

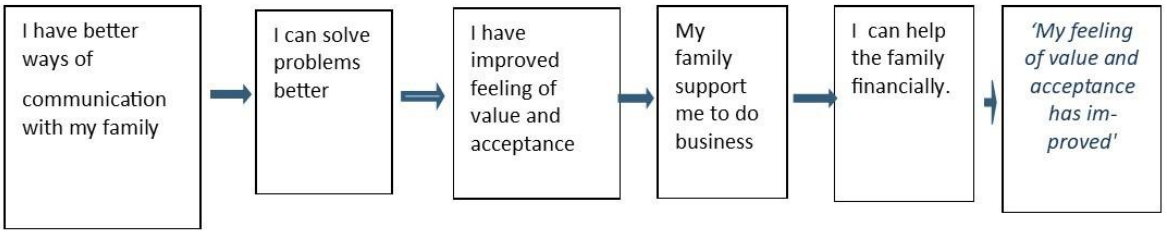
- Outcomes recurred in several stories
- Any negative outcome was included regardless of frequency of occurrence in stories
- Background knowledge and understanding gained through other projects run by the centres on cultural community practices, Deaf Culture and known perceptions of disability and acceptance within deaf and hearing communities, were also used to determine materiality of outcomes.

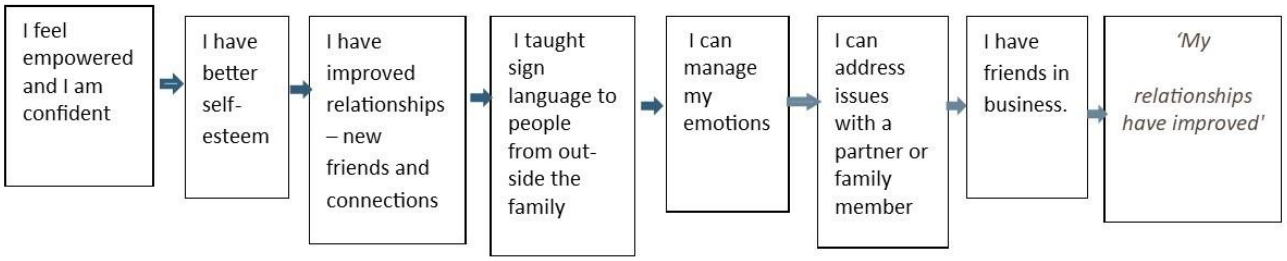
The outcomes were pulled out from stakeholders' stories using the following steps:

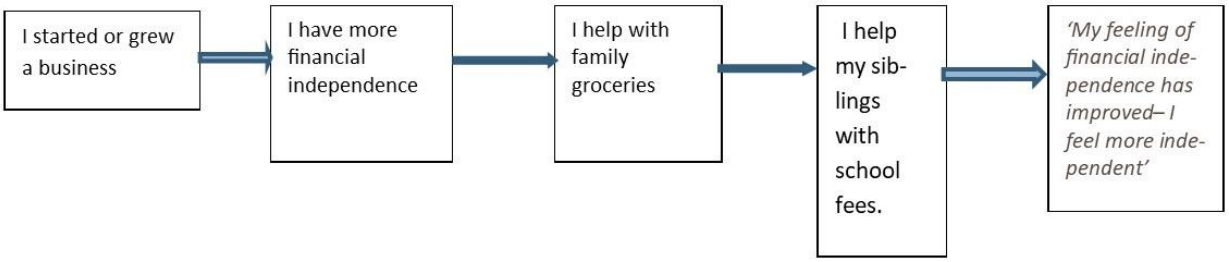
- Statements of change from each participant's story were identified and listed e.g. "I now argue less with my partner." In some instances, the story lists several things the girls said she learned. These were included were it appeared to affirm the statement of change e.g. "I learned business/ learned to manage my business; "I am motivated to do business"; "I started a local shop"
- Similar statements were grouped e.g. "I went to the hospital [on my own]"and "I have confidence to go to the hospital"; "I am empowered and confident" and "I feel empowered/confident"; " I paid school fees for my sister/cousin" to just "paid school fees"
- Statements were renamed i.e. "I can do hairdressing", "I can do sewing", "I learned the importance of using patterns" were combined to "Improved skills (sewing/ hairdressing)" i The girls did not report any significant change relating specifically to the stated skill.
- Where statements were similar but not dependent on one another, these were not combined e.g. "I was tested" and "I went with my husband for testing"; "I am now a mentor" and "I feel respected as a mentor". Being able to go for HIV testing alone and going with a partner/husband were considered two different changes as the latter would require confidence in negotiation skills with the partner whereas the former would not.
- Statements that formed a common theme were grouped to form chains. For example, among the girls' stories - (1) Understanding HIV issues, getting tested, negotiating safer sex, etc; (2) Problem solving, managing emotions, fewer problems with people at home etc; (3) learning about business, being financially independent, contributing to the family. A first set of 10 outcomes were drawn from these chains, and then reviewed to 6 when it was determined that some outcomes could be combined.

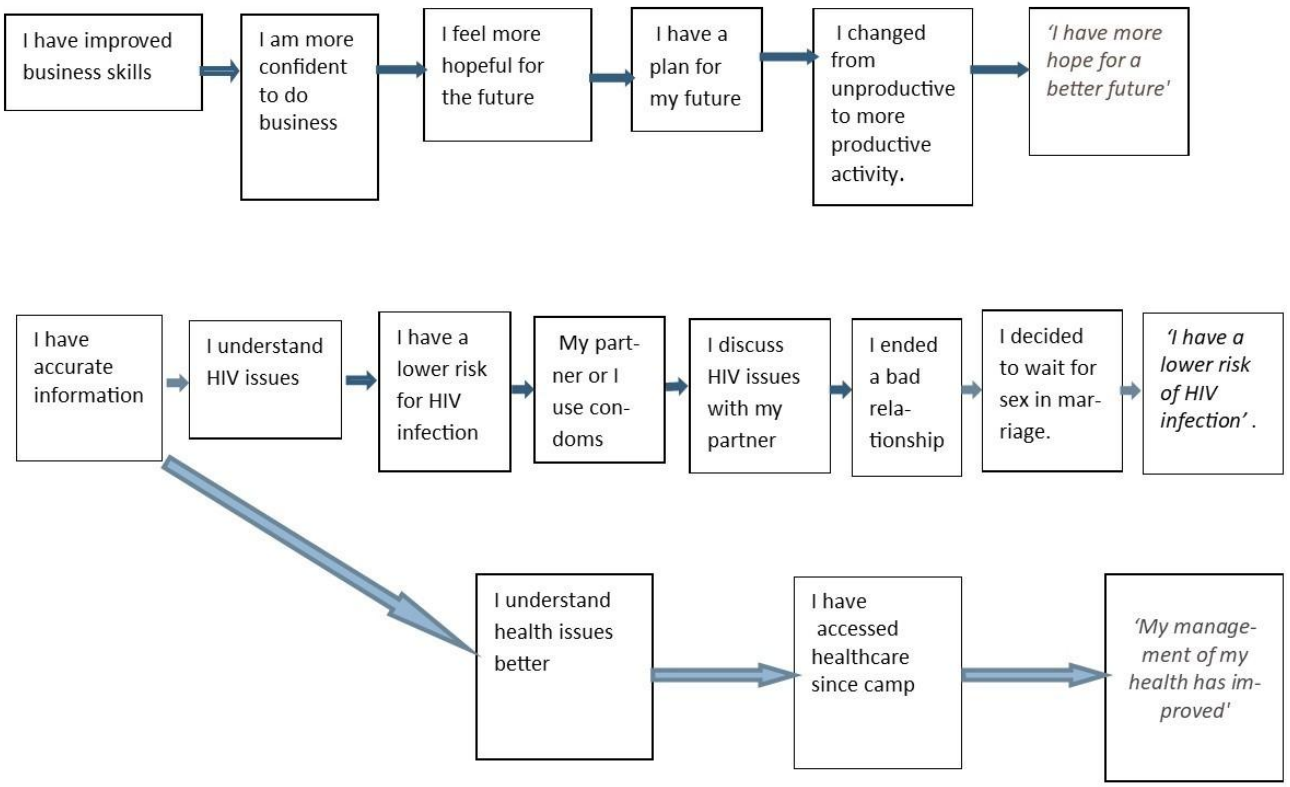
- Outcomes were checked by the participants and team members and assumptions tested. For example, problem solving was noted as a challenge for any deaf girls and young women attending the GRAPEVINE project. Many expressed despair about their home situations and claimed there was no one with whom they could communicate well or rely on for help. Sessions on “my strengths”, “my emotions” and “my solution team” were used to help the participants explore their situations. Later in the activities, scenarios were described, and girls discussed how they thought the characters could solve the issues. In follow up visits, stories were told of how girls had cooperated with different people in their communities and helped others to learn sign language. Families and others responded positively to their calmer behavior and gave support to them. This contrasted with many previous experiences when frustration and lack of communication had marred relationships. Girls reported the new skills gave them confidence, improved acceptance and feeling of value especially when families included and supported them in their business activities.

This chain of events for each outcome is shown in the flow charts below:









5.3 Adolescent Deaf Girls and Young Women

All 37 of the girls interviewed in Bulawayo and Manicaland, stated that they had experienced some changes through the activity and parents corroborated these impressions.

Of the girls who attended the GRAPEVINE camps at in the Manicaland sample, 76% of adolescent deaf girls and young women (ADGYW) lived in rural areas, whilst 24% lived in Mutare, a small provincial town, compared to only 33% of the Bulawayo sample living in rural areas. In rural areas, the family unit is very important, and the community is more conservative. Bulawayo is the second largest city in Zimbabwe, and Mutare is a significantly smaller city; this therefore exerts varied societal influences and expectations on young people in the two provinces. The effects of this difference were noticeable in the girls' stories of change and in how they rated their outcomes. The sample of girls interviewed was not truly representative of the urban/rural makeup of the original sample. Bulawayo girls interviewed were 1/17 (1%) rural, Manicaland 13/20 (65%). This was largely due to the difficulty of getting scattered participants to a central place again.

The changes resulting from the GRAPEVINE activities from the perspective of stakeholders were recorded and extracted from their stories, some were unintended changes. Less intentional changes included greater emotional control, reduced anger and better relationships at home. Both positive and negative changes were recorded and several unexpected changes were mentioned consistently. Although the girls did not record negative changes, several girls did report some of the final outcomes where they experienced no change.

Coming to DREAMS helped me have knowledge on HIV transmission. I learnt ways of HIV transmission. I had little knowledge because when I went to hospital the nurse tried to communicate with me. I would write and sometimes sign to her, that nurse is good in Sign Language but no other nurse knows Sign Language at that local clinic. I then used to go to the clinic to teach other nurses Sign language but that one nurse is good, I like her. When I went to the police, I used paper and pen to communicate. In all of this I gained confidence through attending DREAMS Camp. I also teach my family members Sign language.

Stories and interviews with the deaf girls showed that GRAPEVINE contributed to the following chains of events leading to the final outcomes. (Figures in brackets show quantities of respondents indicating changes in these areas through the survey)

- *'My management of my health has improved'* This is true for me and shown by at least 2 of the following:
  - ✓ I have accurate information
  - ✓ I understand health issues better
  - ✓ I have accessed healthcare since camp by visiting the clinic, getting an HIV test, or by adhering to ARV treatment

(*18/20 Manicaland; 16/17 Bulawayo)*

- *'My relationships have improved'* This is true for me and shown by at least 2 of the following:
  - ✓ I feel empowered and I am confident,
  - ✓ I have better self-esteem
  - ✓ I have improved relationships – new friends and connections
  - ✓ I taught sign language to people from outside the family
  - ✓ I can manage my emotions
  - ✓ I can address issues with a partner or family member
  - ✓ I have friends in business.

(*20/20 Manicaland; 11/17 Bulawayo)*

- *'My feeling of value and acceptance has improved'* This is true for me and shown by at least 2 of the following:
  - ✓ I can solve problems better
  - ✓ I have better ways of communication with my family
  - ✓ I have improved feeling of value and acceptance
  - ✓ My family support me to do business
  - ✓ I can help the family financially.

(19/20 Manicaland; 17/17 Bulawayo)

- *'My feeling of financial independence has improved– I feel more independent'* This is true for me and shown by at least 2 of the following:

- I started or grew a business
- I have more financial independence
- I help with family groceries
- I help my siblings with school fees.

(*19/20 Manicaland; 10/17 Bulawayo)*

- *'I have more hope for a better future'* This is true for me and shown by at least 2 of the following:
  - ✓ I have improved business skills
  - ✓ I am more felt confident to do business
  - ✓ I feel more hopeful for the future
  - ✓ I have a plan for my future
  - ✓ I changed from unproductive (e.g. at home doing nothing) to more productive activity (e.g. participation in a community project)

(19/20 Manicaland; 17/17 Bulawayo)

- *'I have a lower risk of HIV infection'* This is true for me and shown by at least 2 of the following:
  - ✓ I have accurate information
  - ✓ I understand HIV issues
  - ✓ I have a lower risk for HIV infection
  - ✓ My partner or I use condoms
  - ✓ I discuss HIV issues with my partner
  - ✓ I ended a bad relationship
  - ✓ I decided to wait for sex in marriage.

(*15/20 Manicaland; 16/17 Bulawayo.)*

OUTCOMES AND ASSUMPTIONS ADGYW
ADGYWs had accurate information, and a better understanding of health issues, felt empowered and confident, were able to access health services on their own (including HIV test), leading to "I have better management of my health" • KAP survey showed greater correct answers. ADGs reported they understood accurate information and had a better understanding of health issues. Misconceptions were addressed (eg. mosquitoes, utensils, casual contact and toilet seats being dangerous for HIV transmission). • ADGYW discussed HIV issues with their partners and negotiated safer sex including breaking up with unsuitable partners.
ADGYWs felt empowered and confident, better self -esteem, problem solving skills, managing emotions better, better ways of communication, fewer quarrels with family, improved communication in families and with other business people, resulting in improved relationships -" I am less socially isolated" • ADGYWs improved their skills (eg. in costing and records). • They were more successful in their business and busy and productive rather than "sitting at home" - a

common description of what they did at home before the GRAPEVINE camps. ADGYWs learnt to run their income generating activities better, some started business for the first time and helped the family with groceries or to pay school fees for younger siblings.
ADGYWs learnt problem solving skills, better ways of communication, family support me in my plans, leading to "I feel valued and accepted in the family" • ADGYWs learnt ways of solving problems. • They identified their feelings, managed their emotions better and improved ways of communication. These all improved relationships within family. Girls learnt to work and share in groups and pairs. They identified people who could support them and help them solve problems within the family and the community. • ADGYWs shared experiences and showed confidence. They learnt accurate information and understood more about their rights. The deaf facilitator was an example to the girls of successful living.
ADGYWs learnt to manage business, started a business, help my family with groceries, pay school fees for siblings, leading to "I feel more financially independent • ADGYWs worked together as a team, solved problems (eg. how to tell a story through drama) and expressed themselves through drama. • Team building, communication skills and confidence developed.
ADGYWs have improved skills, feel capable and confident to do business, leading to busy and productive life, "I have hope for a better future" • ADGs learnt skills they could use on their projects. They increased in confidence and showed pride when they showed their families their products.
ADGs have accurate information, I understand HIV issues, can discuss HIV issues with partner, can negotiate safer sex, (including being tested with partner),I am able to make safer relationship choices, resulting in "I have lower risk of HIV infection."

5.4 Adolescent Deaf Boys and young men (ADBYM)

Jealousy over the attention being given to girls and lack of understanding among the boys themselves bore the risk of gossip and bullying of girls within the Deaf community. Shorter activities, with two groups of boys were conducted to address this; however, follow up of the boys was less sustained.

Figures in brackets show quantities of respondents indicating changes in these areas through the survey.

The changes resulting from the GRAPEVINE activities from the perspective of stakeholders were recorded from their stories, positive, negative or unintended were all recorded. Through the boys' stories and interviews we were able to extract the following chains of events leading to the final outcomes:

- *'I have more respect for girls* 'as shown by at least 2 of the following:

✓ I accept girls who can earn money

✓ I argue less with girls now

✓ I believe women who have a business can make good wives

✓ I respect women who share the burden of providing for the family

(6/6 Manicaland; 5/5 Bulawayo.)

- *'I have reduced risk for HIV'* as shown by at least 2 of the following:

✓ *I now have accurate HIV information*

✓ *I have been tested for HIV testing*

✓ *I use condoms for sexual intercourse*

✓ *I shared information about HIV*

✓ *I discussed HIV issues with my partner*

(*6/6 Manicaland; 5/5 Bulawayo.)*

One negative outcome was reported:

- *'I refuse to change my life to allow my partner to do business*'

✓ I will not make changes in my life for my partner to have a business

✓ I will not allow my partner to get home late

✓ I am concerned for the safety of the woman

✓ I will not want to help with household chores

✓ *(1/6 Manicaland; 2/5 Bulawayo).*

OUTCOMES AND ASSUMPTIONS ADBYM
ADBs observed girl's behaviour change because of DREAMS, girls make less financial demands on the boys, girls have improved grooming, girls are not sleeping around which lead to boys having more respect for the girls. • ADBs learnt accurate health information and clarified some misconceptions. They learnt their status, understood the importance of adherence to treatment. • ADBs felt more able to discuss HIV with their girlfriends.
ADBs have accurate information, leads to changes in substance use and changes in risky sexual behaviour leading to reduced risk for HIV • ADBs discussed respecting girls and women and gained an understanding of the need for partnership, sharing duties at home and not using violence. Boys shared views on women and their girlfriends going to work or running their own projects.
ADBs report they don't like their partner coming home late from doing business and they will not do household chores leading to refusal to change their life in order to allow partner to do business.

5.5 Parents

Parents/caregivers were included in GRAPEVINE to give greater opportunity for girls to employ skills learned with the support of their families. Parent meetings during GRAPEVINE explained the relevance of the project and their role in promoting healthy and independent living among the girls. In interviews parents were asked to share their stories of change before, during and after their involvement in the camp meetings. In their stories the parents also confirmed various changes in their daughters. Figures in brackets show quantities of respondents indicating changes in these areas through the survey.

Through the parents' stories and interviews we were able to extract the following chains of events leading to the final outcomes:

- *'I have improved understanding of my daughter's needs"* as shown by at least 2 of the following:

✓ My daughter is happier

✓ My daughter has a changed attitude – more cooperative

✓ I have improved understanding of her needs

✓ I have improved communication with my daughter

✓ I learnt some sign language

✓ My daughter communicates more to me

- ✓ I feel more respected as a parent

(10/10 Manicaland; 7/7 Bulawayo).

- *"My family is more open about discussing HIV issues"* as shown by at least 2 of the following:
  - ✓ I learnt HIV information from my daughter
  - ✓ My family are more open about discussing HIV issues
  - ✓ My daughter shares information with others, family members and siblings.

*(*10/10 *Manicaland; 7/7 Bulawayo).*

- *"I have a greater acceptance of my parenting responsibility"* as shown by at least 2 of the following:
  - ✓ I met with other parents and shared experiences of raising deaf girls
  - ✓ I learnt to share health issues with my daughter
  - ✓ I provide toiletries (sanitary wear) for my daughter
  - ✓ I accepted more parenting responsibility.

(9/10 *Manicaland; 6/7 Bulawayo).*

- *'I have increased acceptance in the community/ less discrimination'* as shown by at least 2 of the following:
  - ✓ My family learnt some sign language
  - ✓ I have better communication with my daughter
  - ✓ My daughter now greets people in the community (a sign of respect and considered a positive reflection on parents)
  - ✓ My daughter has more friends
  - ✓ We are less isolated in the community
  - ✓ We have increased acceptance and less discrimination.

*(*10/10 *Manicaland; 5/6 Bulawayo).*

One negative outcome was reported where

- *"I feel disrespected as a caregiver'*
  - ✓ Since GRAPEVINE my daughter has become over confident
  - ✓ My daughter does not take advice

*(*2/10 *Manicaland; 0/6 Bulawayo).*

Two parents told of their daughters who had been through GRAPEVINE and then went on to make negative choices. We learned from one parent how after camp, one girl was very keen to be more involved in deaf community social events and after one such event she eloped with her boyfriend. Another girl insisted on moving out of the family home, which the grandmother saw as disrespect. Her later behaviour of having many boyfriends confirmed this belief.

Acceptance of disability and deafness among families in Zimbabwe does not often occur without counselling and support. Deafness, a disability that affects communication often affects the bond between parent and child right through to the child's adult years. In some cases, a response is to over protect deaf girls; if these

wrong attitudes exist parents may find it hard to allow increased independence and sometimes wrongly interpret their daughters' behaviour in trying to gain independence as disrespectful.

In this analysis it was not possible to compare the results for the ADGYW whose parents came to the activities during GRAPEVINE with those whose parents did not come.

OUTCOMES AND ASSUMPTIONS PARENTS
I feel my daughter Is happier, has a change in attitude, she is more approachable, I learned sign language, I have improved communication with my daughter, daughter expresses herself more, is more open about what she needs/wants, resulting in I feel respected as a parent " I have improved understanding of my daughter's needs" • Deaf mentors were well received by parents, girls and communities, and able to discuss progress of the girls since camp with them and their families.
I learned HIV information from my daughter, daughter shares HIV information with siblings and other family members now , leading to " my family is more open about discussing HIV issues" • Many parents were surprised to see what their daughters could achieve. They shared positive feelings about their daughters' involvement in drama and presentations. Parents of girls who had never been to school were surprised to see them included in activities.
I and other family members learned sign language, daughter has improved communication with other family members, daughter greets/communicates with other people, daughter has more friends, improved socialisation and this led to "I have increased acceptance in the community/ less discrimination" • Many shared the determination to learn better communication with their daughters.
Meeting with other parents, sharing experiences of deaf girls at home, I learned I need to talk to daughter about HIV/health and buy sanitary wear so now "I have a greater acceptance of my parenting responsibility" • Meeting with other parents gave time to discuss parenting a deaf girl.
I feel my daughter is over confident, she feels she doesn't need parent/caregiver advice leading to I feel disrespected as a caregiver

6 Measuring Outcomes

6.1 Quantity of Outcomes

Numbers indicating the achievement of each outcome were recorded above. Different experiences within the Manicaland group were seen by scores ranging from 0-5 (0-6 in Manicaland ADBYM) in each outcome, so the average scores of the amount of change experienced are indicated. We noted the number of girls recording no change in each category and discussed these results with them.

Manicaland ADGYW **How much change?** **Outcomes**	**Average quantity of change (0-5)**	**Number stating no change**
I have hope for a better future	4.0	1
I feel valued and accepted in the family	3.4	1
Improved relationships - less socially isolated	3.3	0
I feel more financially independent	2.8	1
Better management of my health	2.6	2
I have lower risk of HIV infection.	2.5	5

ADBYM **How much change?** **Outcomes**	**Average quantity of change (0-6)** **Manicaland ADBs**	**Average quantity of change (0-5)** **Bulawayo ADBs**
I have more respect for girls	2.7	4.4
I have reduced risk for HIV	2.5	4.6
I refuse to change my life to allow my partner to do business	-	-

Boys had two positive outcomes and a third negative outcome.

Parents **How much change?** **Outcomes**	**Average quantity of change (0-5)** **Manicaland**	**Average quantity of change (0-5)** **Bulawayo**
I have improved understanding of my daughter's needs	4.4	4.3

My family is more open about discussing HIV issues	4.2	4.0
I have increased acceptance in the community/ less discrimination	4.8	3.7
I have greater acceptance of my parenting responsibility	4.6	3.3
I feel disrespected as a caregiver	-	-

Parent outcomes

6.2 Duration of Outcomes

Participants were asked about the length of time they believed each change would last. They answered from 0-3 years. There was very little variation in duration for outcomes for the girls, boys or parents.

Average Duration of Outcomes	Manicaland ADGs years	Bulawayo ADGs years
Better management of my health	2	3
Improved relationships - less socially isolated	3	3
I feel valued and accepted in the family	3	3
I feel more financially independent	3	3
I have hope for a better future	3	3
I have lower risk of HIV infection.	3	2

6.3 Value of Outcomes

A weighting activity was done in Manicaland, in which the participants weighted the importance of the outcomes they achieved. (See Annex E) The activity in Bulawayo was done differently with the girls using a scale of 0-3.

With a small sample size and different activities used, we have been careful not to conclude an absolute order in terms of value alone. There are clearly some more important than others, but also some bunched closely together. The combination of these values with quantity, duration and causality data resolved this.

By value alone, the girls stated the most important outcomes to them as seen by the relative order:

Outcomes	Weighting of average value of change Manicaland ADGs Range 0-5	Outcomes	Weighting of average value of change Bulawayo ADGs Scale 0-3
Better management of my health	2.1	I feel valued and accepted in the family	2.8
I feel valued and accepted in the family	1.9	I have hope for a better future	2.8
I have hope for a better future	1.9	I have lower risk of HIV infection.	2.8
Improved relationships - less socially isolated	1.8	Better management of my health	2.5
I have lower risk of HIV infection.	1.1	I feel more financially independent	2.5
I feel more financially independent	1.8	Improved relationships - less socially isolated	2.1

Boys results:

ADBYM Manicaland Outcomes	Weighting of average value of change Range 0-5	ADBYM Bulawayo Outcomes	Weighting of average value of change Range 0-5
I have more respect for girls	2.8	I have reduced risk for HIV	4.4
I have reduced risk for HIV	1.7	I have more respect for girls	4.2
I refuse to change my life to allow my partner to do business	-	I refuse to change my life to allow my partner to do business	-

Parents did a similar activity, using the relevant outcomes for their stakeholder group.

Manicaland Parents Outcomes	Weighting of average value of change Range 0-5	Bulawayo Parents Outcomes	Weighting of average value of change Range 0-5
I have improved understanding of my	4.3	I have improved understanding of my	4.9

daughter's needs		daughter's needs	
My family is more open about discussing HIV issues	3.4	My family is more open about discussing HIV issues	4.7
I have greater acceptance of my parenting responsibility	3.2	I have increased acceptance in the community/ less discrimination	4.6
I have increased acceptance in the community/ less discrimination	3.1	I have greater acceptance of my parenting responsibility	4.5
I feel disrespected as a caregiver	-	I feel disrespected as a caregiver	-

Whilst acknowledging the small sample size of the parents, those involved in the survey suggest that the Bulawayo families found all three outcomes equally important, whilst the Manicaland parents had greater differences, with accepting parenting responsibility and understanding their daughters being most important. The valuation of outcomes by Bulawayo parents was particularly close and was not resolved enough by other data on duration, quantity and causality (see sensitivity analysis).

6.4 Causality

In the survey, participants were asked to name any other service or person that had contributed to their feeling of change in each outcome. It also sought to identify any other programmes doing the same and whether they had to change their plans and activities to attend the GRAPEVINE activities.

6.5 Deadweight

Deadweight is the percentage of change that would have happened even if the intervention had never happened. Whilst many services have been established for HIV epidemic control in Zimbabwe, these are not designed to cater for the needs of the Deaf or other persons with communication difficulties. Access to services for young deaf people is limited in Zimbabwe. Access to information for deaf persons is greatly dependent on literacy levels or access to an interpreter when visiting health, HIV testing and counselling services. Although sign language has recently been recognised as an official language it is still not well known outside of the Deaf community and disability organisations that cater for the Deaf. Health professionals are not trained in sign language nor are service providers required to provide an interpreter consequently support services for deaf persons in health and health information facilities is largely dependent on the deaf person being accompanied by a relative or friend who can interpret for them. Young deaf people may have some access to information and services through schools.

Among the girls, in Bulawayo some identified family and other health and deaf support services as where they might have accessed some of the same support. Among Manicaland girls, those who spoke of other services mostly identified other Nzeve staff, projects and organizations that receive interpretation and adapted information support from Nzeve outside of the GRAPEVINE project. Boys and girls who are participants and beneficiaries of other projects offered by the center had some difficulty distinguishing between GRAPEVINE activities and these other services. Follow on questions were used to clarify and help participants give more accurate responses.

The question we asked was "if GRAPEVINE had not happened what chance was there that ADGYWs/parents/ ADBYM would have achieved the same outcomes?"

Some judgement was needed to interpret the answers. It was made clear by many stakeholders that their need for HIV information, training in problem solving, emotional literacy and business skills was previously unmet. We were informed by asking the stakeholders and believe that most of the outcomes were due to the camps and follow up activities. A maximum 35% impact made was attributed to sources other than

GRAPEVINE by an individual. A few stakeholders felt there were alternative services that could have helped them. We asked them to detail these possible services and made judgements on their accessibility. Our judgement was that some of this expectation was not realistic, (eg. referring to spoken health talks at hospitals) since interpreted services are rare and girls frequently complained that they saw services offered but could not access them themselves.

6.6 Attribution

The results from the interviews with rural Manicaland group sample, implied there were no other factors affecting the outcomes and explaining the changes. However, whilst we are aware of this situation on the ground, we acknowledge the results came from a relatively small sample, giving the risk of biases from interviews and selection. The need for further data led to conversations with projects not specifically aiming at people with disabilities. For example, Children Tariro project partners (USAID funded Orphans and Vulnerable Children programme) in Manicaland requested Nzeve to include deaf girls from their programme as they did not have the skills to include them. They described how deaf girls attended their event but could not be included or benefit due to communication breakdown.

It is our experience that rural Manicaland does have many isolated deaf girls, and it is more difficult for them to get together. Most deaf youth come from hearing families with little or no formal sign language to communicate with their deaf child. They often rely on friends (hearing and deaf with some sign language), organisations and community groups with programmes for the deaf for information and socialisation.

In Bulawayo girls recorded many answers of who else helped them – including church programmes, extended family members, friends and different events commonly accessible in urban settings. Other activities and projects run by KG6 accounted for some of the response on input from family members. KG6 provides schooling for older children and youth in high school and has more frequent contact with the parents of ADGYW within Bulawayo. Regular sign language classes are offered. The impact of this was seen in the responses the girls gave about gaining some help and support from their families. At Nzeve, parents who attend the centre's preschool and parenting sessions regularly learn sign language, but many parents of older children and those of girls who participated in GRAPEVINE, came long distances and live in remote areas too far from the centre to access this service.

6.7 Displacement

For displacement, a score of 2 for "I would have found another way to do the same" was expressed as 50%. Whist there are youth centres and organisations that offer some of the courses covered in GRAPEVINE, there are no known services currently providing all 5 courses (HIV and health education testing and counselling, personal development, business training, vocational skills and visual arts) including home visits and family support adapted for deaf adolescents, young men and women. This was verified by the participants. In addition, many of the services identified by the deaf youth as able to offer the same rely on the support of the two centres (Nzeve and KG6) to provide this support; therefore 50% was considered a reasonable allotment to account for some of the same outcomes being achieved in another way.

A score of 3 for "I would have done more" was equated to 100% displacement. None of the sampled girls or parents said they would have done better in either site, but one boy thought he would have done more in learning about HIV and reducing his risk. It is possible he has seen different activities and possibilities and felt confident in his ability to cope without support. However, alternative services are rarely adapted for Deaf access.

7 Future Value

Answers to the question of duration of outcomes have been discussed. Most answers for duration in girls, boys and parents was more than 3 years. By this we judged that they thought the change was long lasting and that it would continue to be a factor in their lives for a considerable length of time. The only exceptions, which had an average score of "more than 2 years" were "management of my health" in Manicaland, and "lower risk of HIV" in Bulawayo.

Teachers of deaf children frequently complain about retention of information e.g. children are taught concepts which they forget over the long summer break. The research done on memory suggests that multisensory teaching does improve people's ability to remember. Deaf people rely on visual memory and do not have the added input from listening. Active and participatory learning improves everyone's learning but the Deaf still miss out on one sense. The two outcomes which were chosen as lasting for a shorter time were both based to some extent on information. The retention of facts is expected to drop off after GRAPEVINE but then to have some continued long-lasting effects as they experience, practice and see some information and can relate it to what they had learnt and understood through GRAPEVINE.

We judged that although the ADGYW will forget a lot of the facts they were taught, some of the information and experience they gained will remain and may assist them to learn from other sources in the future due to the foundation they received during GRAPEVINE. This judgement was made, taking into consideration the way deaf people learn and the way information was shared during the intervention. Active and participatory learning was used, and the participants were fully involved. Activities emphasized relating one activity to another, for example, a Game of Life was used with scenarios in which characters had to make life decisions and responses were related to what the girls had learnt in personal development and HIV sessions. This was a difficult session but has been referred to in mentor visits and follow up activities since. Connections have been emphasized and ideas reinforced. In our judgement, even though after 2 -3 years any lasting effect will be less attributable to the project, there may still be some effects from the project for several years, even if nothing more is done.

Changes to do with isolation and financial status, though heavily dependent on the environment, can also be affected by the girls' own behavior and practice, but the economy could easily erode these changes. The girls involved in income generating activities and record keeping will retain more of this change by practicing what they learnt, than those who were not active in their own small business. Hope is also closely linked with financial independence and the economic situation in Zimbabwe. During the project period the currency has devalued, and prices have more than doubled. This has a huge effect on the ADGYW small projects and will inevitably affect their view of the future. However, habits and good practices developed will continue to last if actively pursued. In our judgement, feeling valued and hope for the future were also both affected by the families' involvement in the intervention. If families continue to value and support their ADGYW it will assist in sustaining the value of the outcomes experienced by the ADGYW.

Parents all felt the changes they had experienced would last the maximum duration offered. If their changes of understanding their daughters needs and accepting their parenting responsibility lasts, it will continue to have effect on the girls' feelings of feeling more valued.

8 Sensitivity Analysis

The resulting model, shown in the value map, was tested for sensitivity.

Variables were tested to see if a change in the effect of any variable resulted in a change to the relative order of most important outcomes within stakeholder group.

An example is shown below.

Variable	test applied	example: ADGs feel valued and accepted in the family				
		BEFORE		AFTER		% change
		variable	value	variable	value	
Value	25% change	3.4	104.4	2.6	79.3	24%
Deadweight	25% change	31%	104.4	40%	90.2	14%
Attribution	25% added	0%	104.4	25%	78.3	25%
Displacement	25% added	0%	104.4	25%	78.3	25%
Drop off	25% change	25%	104.4	33%	95.6	8%

Results

Variations to quantity and value did not change the relative order of the most important outcomes, although they did bring outcomes for ADBYMs in Manicaland closer together (ranging from 35-49). So there is some sensitivity in the model here, most likely due to sample size, but it does not appear material.

Variations to duration did not change the relative order of the most important outcomes, except for Bulawayo parents. The top 3 outcome for this group were all within +/- 3% of each other (63-65), so they are sensitive to any small variations. The outcome for acceptance in the community/ less discrimination was shown overall to be the lowest with or without variation; but the remaining 3 outcomes should be considered as equal first within this group.

Variations to deadweight, attribution, displacement and drop-off did not change the relative order of the most important outcomes (beyond any sensitivities already identified above).

9 Conclusions

9.1 Most Important Outcomes

Social value was calculated by combining the quantity, duration, value and causality of each outcome for each participant in GRAPEVINE activities. We were not able to combine the absolute figures for the different groups of ADGYW, as the valuation unit used was not the same for all. Different activities were used. However, we can contrast and compare the most important relative value for each group and learn from that.

Although data for duration and value did not contrast every outcome completely, the combination of quantity, duration, value and causality of each outcome for each participant in GRAPEVINE activities has shown a clear contrast and conclusion:

Manicaland ADGYW		**Bulawayo ADGYW**	
'My relationships have improved- I feel less isolated'	143.0	*My feeling of value and acceptance has improved'*	77.9
I have more hope for a better future'	118.4	*I have more hope for a better future'*	57.7
'My management of my health has improved';	107.1	*'My management of my health has improved'*	54.9
My feeling of value and acceptance has improved'	104.4	*'My relationships have improved- I feel less isolated'*	42.1
I have a lower risk of HIV infection.	60.1	*"I have lower risk of HIV infection"*	34.2
My feeling of financial independence has improved– I feel more independent	53.6	*My feeling of financial independence has improved– I feel more independent'*	20.1

Results showed girls from Manicaland valued reduced isolation and increased hope most highly, whilst girls from Bulawayo valued feeling valued and having hope. These relate strongly to the social aspect of the intervention and to the involvement of the families. Those from remote rural areas are much more isolated and restricted in their experience and dependence on their families. The participants in Manicaland spoke of family as their support and company in their stories but complained a lot about the lack of good signed communication in the family and loneliness at home. The Bulawayo sample of girls described town life and the importance and influence of friends in their stories. The girls from Bulawayo described the dangers of multiple partners, party life and drugs or spiked drinks- something the rural girls did not mention. Urban life provides more opportunities to be involved in the Deaf community. Girls who have this experience often display more confidence, a wider experience and are more influenced by their peers. The urban girls appreciate feeling valued and accepted by friends and family but experienced less change and gave less value to changes in isolation.

Isolation was high in the Manicaland sample of girls before camp. 20 of the girls were included in a group of deaf people for the very first time. An activity was used during camp where the girls had to identify with characters in a drawing. Many Manicaland girls identified the character alone under a tree as a deaf person. The girl's stories, parents' stories and observations all showed the importance of bringing groups of adolescent deaf girls to a central place. Reports from Bulawayo explained how they could not get girls to leave at the end of camp and whenever girls came back for a meeting, interview or FGD, they did not want to leave. It is well known that Deaf communities value meeting together. Whereas hearing people value time alone and having their space, the Deaf community generally values community and meeting together. The

results show that this was more important to adolescent deaf girls in Zimbabwe in 2016-18 than the original intended outcome around reduced HIV risk and knowledge. Adolescent deaf girls need to feel valued and then they can value themselves and seriously consider HIV risk reduction behaviours.

10% Manicaland sample of girls were HIV positive. There were HIV + girls in almost every group that came for GRAPEVINE. During the intervention information was shared in visual ways and with lots of stories, role plays and demonstrations and girls were given the opportunity for HIV testing. Facilitators spent time illustrating basic health and hygiene issues like menstruation, blood cells and the immune system before other sexual reproductive health topics could be introduced. The pre and post KAP survey showed girls learnt facts over the camp period.

ADGYW who said there was no change in their risk for HIV were interviewed. From the interviews it became clearer that many girls feel their risk for HIV is outside of their control. One lady said there was no change on her feeling safe from HIV. She explained how she has the knowledge and knows what to do but when she suggests to her husband that they go for testing he refuses. Another suggested that her husband (who she suspects of sleeping with other girls) should use condoms and he refused. So long as the women do not have control of these things. they are still unsafe. They do not have the strategies or the cultural standing to be able to insist. Therefore, it is appropriate to suggest that deaf men should be included in activities that include teaching HIV facts, as well as respect for women and girls. Young deaf women have limited control over their sexual health and in some ways, this decreases even more once they are married. One of the biggest risks a girl in Zimbabwe takes is that of getting married. Their husbands insist on unprotected sex since she is the wife, and yet still feel they have the right to sleep with other women. Once married they have little control over the use of condoms or their husbands extra marital relationships. Although HIV information and health understanding were mentioned as a change by most of the girls in their stories, they did not feel that learning about HIV changed their lives as much as other outcomes.

Many girls felt their risk for HIV was not in their control. However, one mother told the story of how her son in law did not come home one night. The next day, his wife, a GRAPEVINE participant, refused to have sex with him and talked about the dangers of him having girlfriends and the need to go for testing. She kept this up for 2 days till he agreed to go for testing.

Whilst all the girls knew the idea of going for testing with their partner, many spoke about doing this, whilst others recounted how their partners had refused and they felt they could not do anything.

In both provinces, Bulawayo and Manicaland, those outcomes over which they have less control, particularly finances and risk of HIV, scored lower. Problem solving, and decision making were skills addressed during personal development sessions and helped the girls to have more control over their emotions and environment. Many of the girls spoke of these sessions in their stories and FGD. These were areas in which they had never had teaching and demonstrates the effects of lack of information and socialisation with their peers. The personal development sessions gave them tools to cope with problem situations, to find support and to start to think carefully at times when they get emotional. A common response from both girls and caregivers was that after camp they were not

so emotional and did not get so angry. Frustration is a common complaint of deaf adults and children who are not understood by the people around them, so they need tools and strategies to cope. Inclusion of personal development was appropriate to the population of ADGYW and should be replicated in further activities.

Whilst the experience of HIV for most of the girls was abstract and difficult to apply to themselves personally. it is important to see how the other aspects of the program facilitated the inclusion of HIV topics. Without the understanding of factors affecting relationships, hope, financial independence and personal development, HIV and health information would not be valued by the girls. The other outcomes were needed as the foundation for the HIV risk reduction activities. The effect of problem-solving skills on HIV risk reduction though not measured may well have a significant effect.

Within the health education sessions, facilitators needed to spend time explaining basic health issues like menstruation to many of the girls. These must be understood before other sexual reproductive health topics can be introduced. Basic principles of health and sexual development, which are culturally taught to girls by aunts and other older women in the community, are missed by the deaf girls because of limited communication. The isolation the girls felt is partly due to communication barriers with families and immediate communities. Adolescent girls who had completed schooling through to secondary level, had more exposure to information, but other girls shared, during sessions that they did not have a clear understanding of these concepts.

Many of the described feelings of hope were related to the feeling of reduced isolation. Being able to identify and name people who could help them, recognising that they were not alone, helped the girls to feel they had something worth living for. Their hope for the future meant they planned for more and so needed the finances. They wanted to be more independent, saw the need to plan for it and became active in contributing financially to the family. The response they got from other family members helped them to feel valued. One section of the Grapevine project was discussion of "My Solution Team". This helped girls to feel they were not alone but could identify different people in their lives and communities who they could go to for support. This helped develop feelings of less isolation which in turn gave them more confidence. For example, girls described how they now accessed services by having the courage to use services.eg at the hospital. It was interesting to note the differences with the Bulawayo girls, more of whom were still at school than the Manicaland sample. In our judgement, at this point in their lives financial independence is not so important to them and since more were in school, surrounded by other girls all day, in contrast to the Manicaland sample, they are not so isolated. They reported less change in these outcomes.

A feeling of helplessness and fatalism was noticeable in the general youth population in Zimbabwe in the early days of the HIV epidemic. "Why change our behavior? We're all going to get it anyway" youth often said. Hearing youth have had a long time and been targeted in many interventions, in which they have learnt differently. Deaf youth may just be coming to understand what they can do protect themselves, but still deaf adolescent girls and young women are some of the least powerful in society.

The original expected outcomes for the GRAPEVINE project were described in the acronym DREAMS.

	Expected outcome	***Actual outcome***

D	DETERMINED	*Hope for a better future*
R	RESILIENT	*Less isolated/ valued and accepted/ management of health*
E	EMPOWERED	*Financial independence/ management of health*
A	AIDS FREE	*Reduced risk for HIV/ management of my health*
M	MENTORED	*Valued and accepted/ management of health/ less isolation*
S	SAFE	*Reduced risk for HIV/ less isolated*

PARENTS

Manicaland Parents		**Bulawayo parents**	
"I have improved understanding of my daughter's needs"	99.4	*" I have improved understanding of my daughter's needs"*	65.0
"I have a greater acceptance of my parenting responsibility"	95.4	*" My family is more open about discussing HIV issues"*	63.5
" My family is more open about discussing HIV issues"	78.6	*"I have a greater acceptance of my parenting responsibility"*	*63.3*
" *I have increased acceptance in the community/ less discrimination"*	71.7	" *I have increased acceptance in the community/ less discrimination"*	41.7

The most valued outcome of parents for both KG6 and Nzeve was the same, "improved understanding of my daughter's needs" and this was in line with the planned outcome of the project. However, the top three outcomes for Bulawayo parents were too close to show any difference and were all considered equally valued.

Although it came out as the least valued, parents (particularly the rural parents in Manicaland), related stories of the increased respect they now felt from the community. "I feel respected as a parent." This is an issue which needs to be understood in the Zimbabwean context. In Zimbabwe, being a parent gives a person status in the community. It is common practice and considered respectful to be referred to as Mother of X or Father of X. When a child grows older, they affirm that status through their behaviour and the parent-child relationship. Children are raised and cared for, so that they in return will give care and support to their parents (and the larger family) – "I do my part as a parent, my child recognizes and appreciates this and responds by showing me respect".

The parent feels the respect, because of what the child does and how they now relate to the parent. In addition, the community can see this relationship and the "parent status" is strengthened.

This was important in stories parents told of improved acceptance and less discrimination in the community. The fact that their daughters now greeted people in the community helped the families to feel more accepted and less stigmatized. People in Zimbabwe have a system of clapping and a small curtsy for the women, as they greet another person. This is visual and can easily be done by the Deaf.

Early in the project the idea of "lobola" or "bride price" was discussed. We asked mothers at Nzeve to help us to understand how they felt the community viewed and valued deaf girls. They explained that most people look down on the Deaf in society. Many deaf girls do not get married; they just get pregnant and are then abandoned. Other girls are taken by the boy friends' family to their homestead and they live together, but the

families never meet to discuss in the cultural way, and no money is paid to the girl's family in the traditional way. The mothers at Nzeve felt this showed that families do not value deaf girls.

If the girl is smartly dressed and is hardworking because she has a business or a job; she is valued more by the community. The husband's family can agree to pay ZW$5000 bride price for such a person because she 'benefits' the family, she is an asset. However, people often judge according to the disability. A statement that is commonly heard is 'remember that their daughter has got a disability.' This is heard even more commonly if she is to marry a hearing person rather than a deaf man. In these instances, families may pay just ZW$500 or even ZW$100. A family may need to pay 10 heads of cattle for a hearing girl but only 5 for a deaf girl. This is because of fear of complaints from the boy's family. Complaints about the girls' deafness are less when both of the couple are deaf. The GRAPEVINE project instilled good grooming and hygiene to the girls. People often refer to well-dressed deaf people as "they do not look deaf." This outward appearance and way of dressing is important to people in Zimbabwe. The girls' business skills were increased, and they were encouraged to be presentable. Although we have no evidence to show increased payments of lobola for GRAPEVINE graduates, according to the mothers at Nzeve, these are aspects which should increase the value placed on them by communities.

ADOLESCENT DEAF BOYS AND YOUNG MEN

Manicaland Boys		Bulawayo Boys	
I have more respect for girls.	38.5	*I have reduced risk for HIV*	41.5
I have reduced risk for HIV	8.1	*I have more respect for girls.*	37.0

Boys in Zimbabwe have much more control over their sexual activity than girls. Boys in Bulawayo had very little difference between their valuing of change in their respect for girls and their reduced risk for HIV. Boys at Nzeve however, gave a far greater value to learning to respect girls. It is our judgement that this simply reflected the differences in the two programmes. In the short time put aside for the boys' camps, Nzeve emphasized the need for respect for girls and healthy relationships. HIV lessons were included. The programme at KG6 was more health orientated.

Our lesson learnt from the boys' involvement was the need to include the boys more, even in a programme aimed at girls. The Deaf community is small and deaf girls most commonly marry deaf boys in the same Deaf community. It is therefore important that boys and girls should get the same information and interventions, so they can have a common understanding. For example, this became clear when girls whose partners had not attended a camp explained how difficult it was to bring up the topic of condoms with their partners.

10 Verification

The results of the consultations to establish outcomes were verified by stakeholders in 2 ways. Firstly, consultation with early groups, was analysed and the well-defined outcomes that resulted were verified by the consultations with later groups. For example, the outcomes derived from consultation in Manicaland were checked with groups in Bulawayo. This showed 1 or 2 differences in emphasis (that was born out later by the data on value discussed above) but largely confirmed that the outcomes were correct from stakeholders'+ perspectives and there was nothing material missing.

Secondly, the data collection quantitative survey (see annex F) sought confirmation of each outcome and gave stakeholders the option to say that the outcome was either appropriate to them, or indeed the opposite. For example:

> ***Outcome 1*** *(Some girls said they had)* ***Better management of their health.***
>
> *1.1 After DREAMS camp and activities, would you say it is true for you that you have improved management of your health?*
>
> - *My **management of my health** has improved*
> - *My **management of my health** has not changed*
> - *My **management of my health** has worsened*

We acknowledge that since the evaluation results are based on a relatively small sample, it is possible that results could be affected by selection biases. More information is needed to include some of the excluded stakeholders e.g. girls and boys with low sign language ability, and spouses and children of GRAPEVINE participants. However, in this evaluation parents' responses counted as proxies for the other family members.

The results of the analysis will be reviewed by stakeholders in the same way that they were consulted and involved in the qualitative stages of this analysis. Specifically, we want to be confident that the final order of the most important outcomes reflects stakeholders' priorities; and that our conclusions and recommendations for future delivery are appropriate to their felt needs.

11 Recommendations

1) HIV and health projects are needed by the Deaf community. Deaf youth are aware that they miss out on information. The Deaf community has been sidelined and expected to follow long lectures through interpretation only. This is very tiring and often does not make sense. Projects must include practical activities and consider the special learning needs of deaf learners, providing clear visual and participatory supports to the topics.

2) Most deaf youth have large gaps in their knowledge, and it should not be assumed they know what hearing people their age would know. Sometimes it is necessary to start from a lower point, filling in the gaps, before teaching what was originally planned.

3) There have been projects for girls and young women in recent years and this is necessary considering their additional vulnerabilities. However, deaf girls marry deaf boys who are also excluded from much of the information needed to live an HIV free life. Deaf boys and young men need to be included in health and HIV teaching as well teaching to help them understand gender issues.

4) The inclusion of families in the projects improves relationships, both in the family and the community, increases the likelihood of sustainability of the project outcomes. Projects aimed at deaf youth should also encourage family involvement.

5) The Deaf community value opportunities to meet. Deaf people are scattered, and some are hard to reach. The model of bringing young deaf people to a central place for a programme proved to be effective, especially for isolated rural deaf girls and young women. Special efforts need to be made to include them.

6) Decentralising some social activities through empowerment of the Deaf community to run social clubs can be one way of creating more value following the initial activities. In addition, home visiting and Deaf to Deaf counseling can increase the impact.

7) The GRAPEVINE project showed that ADGYW valued the holistic programme. The personal development and business sessions were even more important to them than the HIV and health. It is important to connect the sessions, for example teaching on problem solving should include how to refuse unwanted sexual advances.

12 Annex A: References

1. *Deaf adolescents in a hearing world: a review of factors affecting psychosocial adaptation Patrick J Brice and Gillie Strauss Adolesc Health Med Ther. 2016; 7: 67–76. Published online 2016 Apr 21. doi: 10.2147/AHMT.S60261*
2. *Nzeve Vital Signs Report to TEAR Aus July 2019*
3. *Nzeve communication Children Tariro Project FACT Zimbabwe*

13 Annex B: Value Map

See attached value map.

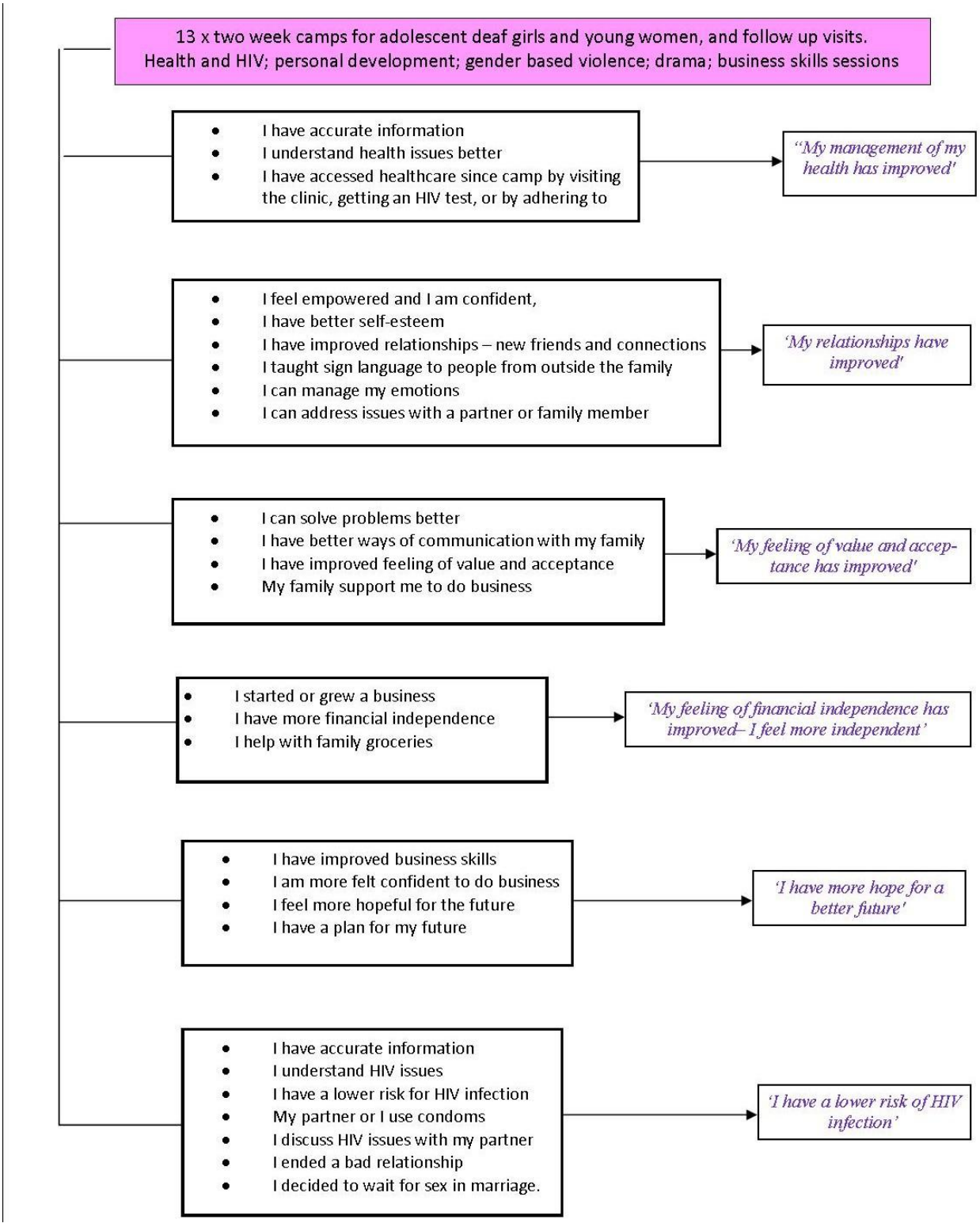
14 Annex C: Outcomes Consultation Questions (Qualitative)

20 ADGYW in Manicaland and 17 in Bulawayo (21% total participants) were invited to tell their story of change. "Start before DREAMS camp, then tell me what happened at DREAMS camp and finally what has happened after DREAMS camp." ADGYW were prompted to explain why various changes were important to them. For some a time line was drawn and they were encouraged to talk about life before and then life after DREAMS activities. Sometimes interviews were recorded and transcribed.

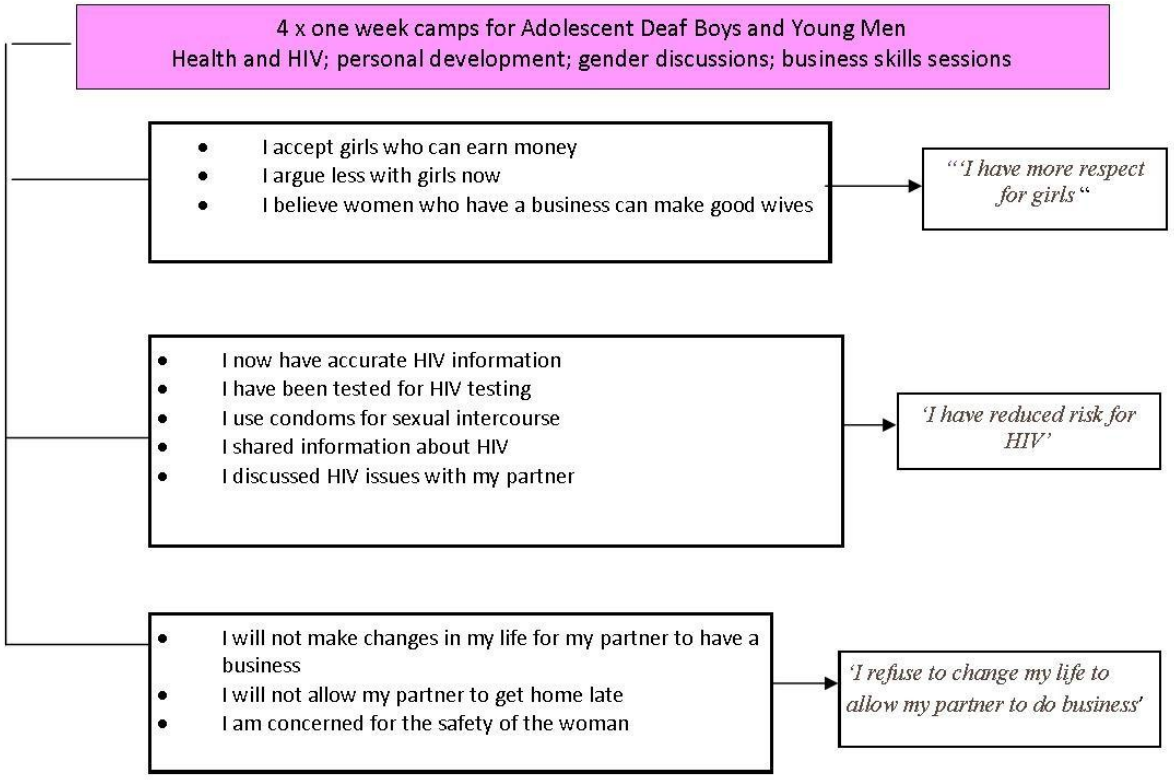
Changes mentioned in the stories:

I have information
I have confidence
I am more connected to others in my local area and through deaf community
I have learnt/improved my practical skills
I have increased income
I have courage to speak to shopkeepers and negotiate a job (even when my family try to dissuade me)
I help my grandmother/family by buying groceries – I have empathy and can help others
I have improved communication with the community
I stood up to and broke up with my boyfriend
I went for an HIV test on my own
I have courage to communicate with health workers
I can solve problems myself.
I am less frustrated and can control my anger more (reduced anger; better communication; I respect my parents more; improved relationships at home)I have better relationships with my extended family
I have more to do and I am less isolated
I am seen as part of the family and I can play my part – buying groceries and help siblings with school fees- I am respected by my extended family
I have changed from a victim mentality and now see I can help to solve things myself
I no longer assume I am HIV+
Communication has improved because I teach sign language
I have better personal hygiene and make myself smart for business
These are the important and often mentioned outcomes we see coming out, after the mass of things mentioned by the girls.
I am informed (understand HIV, I have information about services. Access to information – I understood things told, increased knowledge on HIV,
I am accepted in the hearing community (Negotiation for job or business, increased communication with business people, networking with others, confident with the hearing, increased socialisation)
I am respected and confident in my extended family (teach cousin sign language, help cousin with business, now better relationship with family members, family surprised at the skills they learnt, family
I am part of the solution to my own problems – no longer have a victim mentality
I help others
Chains of changes resulting in outcomes were found and tested by asking the ADGYW if they agreed with these outcomes.

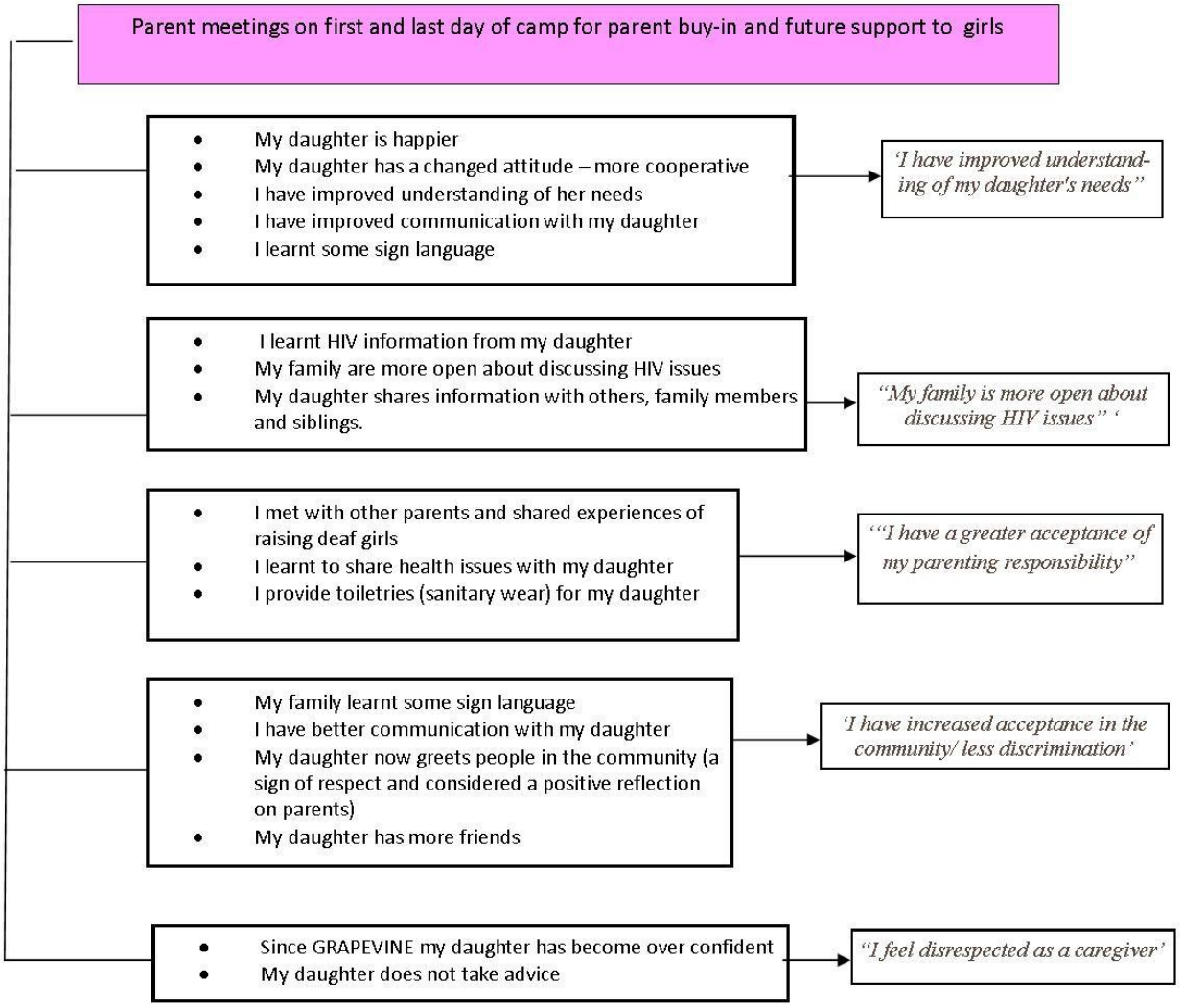
Evaluation of Change: Adolescent Deaf Girls and Young Women



Evaluation of Change : Adolescent Deaf Boys and Young Men



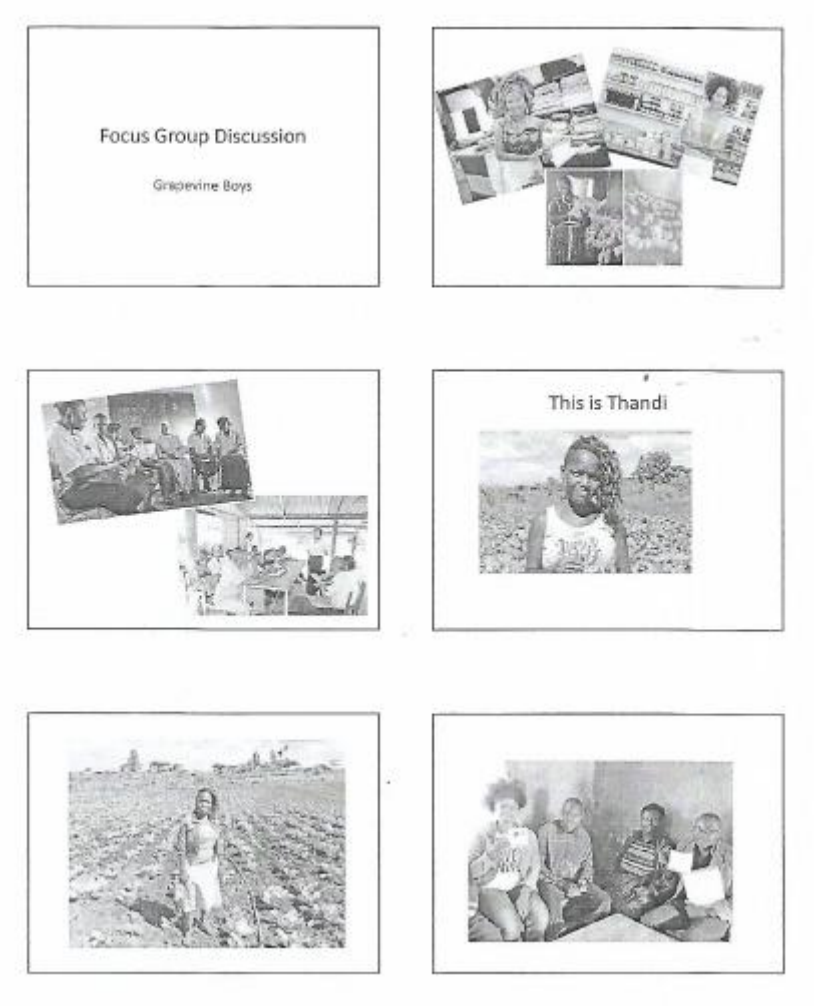
Evaluation of Change : Parents



15 Annex D: Examples of tools used with ADGYW & ADBYM

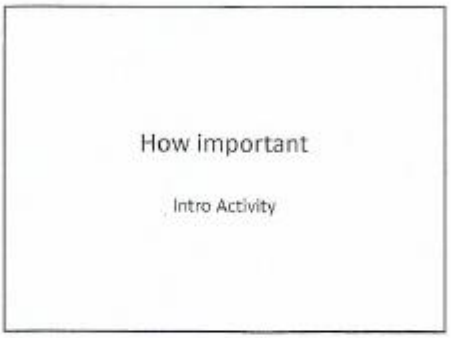
Tools for the Boys

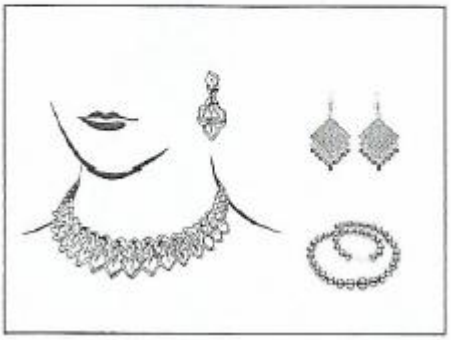
Pictures of women in leadership roles and pictures telling the story of a successful business woman, married with 3 children were used to start a discussion with 6 ADBYM who had attended camp in Manicaland and 5 ADBYM who had attended camp in Bulawayo. The pictures and story were discussed relating them to changes (before, During, After GRAPEVINE) in opinions regarding girls and young women.



Tools for the Girls

Similar ideas were used with the girls – pictures were put up on the screen to assist in telling a story. Deaf youth found it especially difficult to understand the idea of putting ideas in relative order. Therefore, some different examples were used in which they were asked to order different items as to how important they were to them and which they would want most of all before the analysis of the outcomes of GRAPEVINE activities.





16 Annex E: How Important Exercise

How important is that change in my life to me?

Deaf people have trouble understanding and expressing abstract concepts. Grading and comparison of clearly different outcomes is also difficult.

We addressed the issue by producing presentations and activities to assist them in this. Details of these are explained below, and the PPT slides also attached in annex F.

For this exercise of how important, we needed each girl to answer each outcome separately.

We started with reviewing the outcomes- girls need to understand the outcomes – the changes they are referring to and the things that make up that change. We made a power point presentation with pictures to help remind the girls of each change.

1) We made little pockets/ envelopes to which we attached pictures of the outcomes (the same ones we used in the power point).

2) Some had all 6 outcomes, some had 5 others 4. These were the outcomes they had picked out as having changed in their lives.
3) These were put in a plastic bag and each girl had a plastic bag with the outcome pictures on the little pockets.

   In each bag there were also counters- the equivalent of 3 per picture/outcome

4) We explained to them we wanted them to tell us how important each change was to them. First they should place the pictures in order of importance, then they should share the counters out according to how important each change was to them.
5) The girls went off individually to think about the pictures and to share the counters between the outcomes.

   After some time of thinking they put the pictures in order of importance- starting with the most important to them at the top.

6) Then they shared the counters between the pictures. They shared the counters between the changes they think are important to them. If they think one is much more important then, they must put more counters in that packet. If two are the same they put the same number counters in the two.
7) The girls put everything back in the bag and sealed it.
8) Then counting and recording then took place.

17 Annex F: Data Collection Survey (Quantitative)

SAMPLE SURVEY FOR ADGYWS

Please circle one in each line:

Site:	**KGVI**	**NZEVE**	
AGE RANGE:	**15-25**	**26-35**	
MARITAL STATUS	**NOT MARRIED**	**MARRIED**	**IN A RELATIONSHIP**
CURRENTLY LIVING	**URBAN**	**RURAL**	

CONSENT:

Are you happy for us to ask questions which we will use in a report? We will keep it in the computer, and we will share with the donor. We will not use your name.

I agree to having this interview and allow Nzeve/KG6 to use the answers in their survey and with the donor

…… Date ……

Today we are trying to find out how many girls experienced the same changes; how much change was made and how long it will last. We will also find out if they think the change would have happened anyway or if it only happened because of DREAMS activities.

Outcome 1 *(Some girls said they had)* **Better management of their health.**

1.1 After DREAMS camp and activities, would you say it is true for you that you have improved management of your health?

- My **management of my health** has improved
- My **management of my health** has not changed
- My **management of my health** has worsened

ONLY if the girl has answered yes to a change for the outcome above then ask the following questions:

1.2 If DREAMS camps had never happened what would you have done?

- I would have nothing like DREAMS (learn about HIV /AIDS, meet other deaf girls, hair dressing and sewing; personal development; learnt business skills)
- I would have done something, but less than I have done with DREAMS
- I would have found another way to do the same thing
- I would have done more than I have done with DREAMS

1.3 Has anyone or anything else other than DREAMS camp helped you **have better management of your health?**

- I have not had any other help to get **better management of my health**
- Other people outside of DREAMS have helped me get **better management of my health.**

Please state who _____

- Other projects and programmes helped me get **better management of my health.**

Please state which programmes / projects _____

- Something else has helped me get **better management of my health.**

Please state what/who helped you _____

1.4 If DREAMS camps come to an end, or you stopped coming to DREAMS, how long after you finished being involved do you think you would still experience a change in the management of your health? (The things you learnt and have changed your life – how long will you remember and do those things?)

- For a few weeks or less
- For a few months
- For at least a year
- For at least 2 years
- For 3 years or more

1.5 How does this change show?

Indicator	Yes/No	Comments
No. of ADGs who 1) report: 'my management of my health has improved'; and also any of the following:		
a) initiated access to health services at least once when needed since camp		
b) had repeat HIV test since camp; or		
c) HIV+ girls adhere to ARVs treatment		

Outcome 2: *(Some girls said): They had* ***improved relationships – less socially isolated***
2.1 After DREAMS camp and activities, what would you say is true for you?

My **relationships have improved, I am less socially isolated**
My **relationships have not** changed, **I am no less socially isolated**
My **relationships have** worsened, I am more socially isolated

ONLY if the girl has answered yes to a change for the outcome above then ask the following questions:

2.2 If DREAMS camps had never happened what would you have done?

- I would have nothing like DREAMS (learn about HIV /AIDS, meet other deaf girls, hair dressing and sewing; personal development; learnt business skills)
- I would have done something, but less than I have done with DREAMS
- I would have found another way to do the same thing
- I would have done more than I have done with DREAMS

2.3 Has anyone or anything else other than DREAMS camp helped you feel less socially isolated?

- I have not had any other help to feel less socially isolated

- Other people outside of DREAMS have helped me feel less socially isolated**.**

  Please state who _____
- Other projects and programmes helped me feel less socially isolated

  Please state which programmes / projects _____
- Something else has helped me feel less socially isolated

  Please state what/who helped you _____

2.4 If DREAMS camps come to an end, or you stopped coming to DREAMS, how long after you finished being involved do you think you would still experience a change in feeling of isolation? (The things you learnt and have changed your life – how long will you remember and do those things?)

- For a few weeks or less
- For a few months
- For at least a year
- For at least 2 years
- For 3 years or more

2.5 How does this change show? (*the next questions in the table will be asked to try and answer this question – they are from the indicators*)

Indicator	**Yes/No**	**Comments**
No. of ADGs who report *'my relationships have improved'* and also any of the following:		
a) who report they made new friends and connections through the project		
b) shared information from the camp with someone else		
c) report they taught sign language		
d) report better management of emotions (especially anger) and fewer quarrels		
e) confident to address issues with their partner and/or family		
f) report friends doing business/at the market		
g)have people outside the family interested to learn sign language from them		

Outcome 3: I feel more valued and accepted in my family

3.1 After DREAMS camp and activities, what would you say is true for you?
My **feeling of value and acceptance has improved**
My **feeling of value and acceptance** has not changed

My **feeling of value and acceptance** has worsened

ONLY if the girl has answered yes to a change for the outcome above then ask the following questions:

3.2 If DREAMS camps had never happened what would you have done?

o I would have nothing like DREAMS (learn about HIV /AIDS, meet other deaf girls, hair dressing and sewing; personal development; learnt business skills)
o I would have done something, but less than I have done with DREAMS
o I would have found another way to do the same thing
o I would have done more than I have done with DREAMS

3.3 Has anyone or anything else other than DREAMS camp helped you feel valued and accepted?

- I have not had any other help you feel valued and accepted
- Other people outside of DREAMS have helped you feel valued and accepted
  Please state who _____
- Other projects and programmes helped you feel valued and accepted

  Please state which programmes / projects _____
- Something else has helped you feel valued and accepted

  Please state what/who helped you _____

3.4 If DREAMS camps come to an end, or you stopped coming to DREAMS, how long after you finished being involved do you think you would still experience a change in feeling valued and accepted? (The things you learnt and have changed your life – how long will you remember and do those things?)

o For a few weeks or less
o For a few months
o For at least a year
o For at least 2 years
o For 3 years or more

3.5 How does this change show?

Indicator	**Yes/No**	**Comments**
No. of ADGs who report '*my feeling of value and acceptance has improved*' and		
a) they can help the family financially		
or/and b) feel supported by family to do business		

***Outcome 4**: ADGs said they had improved financial independence*
4.1 After DREAMS camp and activities, what would you say is true for you?

My **feeling of financial independence has improved – I feel more independent**
My **feeling of financial independence** has not changed
My **feeling of financial independence** has worsened – I feel less independent

ONLY if the girl has answered yes to a change for the outcome above then ask the following questions:

4.2 If DREAMS camps had never happened what would you have done?

- I would have nothing like DREAMS (learn about HIV /AIDS, meet other deaf girls, hair dressing and sewing; personal development; learnt business skills)
- I would have done something, but less than I have done with DREAMS
- I would have found another way to do the same thing
- I would have done more than I have done with DREAMS

4.3 Has anyone or anything else other than DREAMS camp helped you feel valued and accepted?

- I have not had any other help you feel valued and accepted
- Other people outside of DREAMS have helped you feel valued and accepted

  Please state who _____
- Other projects and programmes helped you feel valued and accepted

  Please state which programmes / projects _____
- Something else has helped you feel valued and accepted

  Please state what/who helped you _____

4.4 If DREAMS camps come to an end, or you stopped coming to DREAMS, how long after you finished being involved do you think you would still experience a change in your feeling of independence? (The things you learnt and have changed your life – how long will you remember and do those things?)

- For a few weeks or less
- For a few months
- For at least a year
- For at least 2 years
- For 3 years or more

4.5 How does this change show?

Indicator	**Yes/No**	**Comments**
No. of ADGs who report *'my feeling of financial independence has improved – I feel more independent'* and		
I contribute to groceries / school fees		

Outcome 5: *ADGs said* ***I have hope for a better future***

5.1 After DREAMS camp and activities, what would you say is true for you?

I have more **hope for a better future**
My **hope for a better future** has not changed
I have less **hope for a better future**

ONLY if the girl has answered yes to a change for the outcome above then ask the following questions:

5.2 If DREAMS camps had never happened what would you have done?

- I would have nothing like DREAMS (learn about HIV /AIDS, meet other deaf girls, hair dressing and sewing; personal development; learnt business skills)
- I would have done something, but less than I have done with DREAMS
- I would have found another way to do the same thing
- I would have done more than I have done with DREAMS

5.3 Has anyone or anything else other than DREAMS camp helped you have hope for a better future?

- I have not had any other help you have hope for a better future
- Other people outside of DREAMS have helped you have hope for a better future

  Please state who _____
- Other projects and programmes helped you have hope for a better future

  Please state which programmes / projects _____
- Something else has helped you have hope for a better future

  Please state what/who helped you _____

5.4 If DREAMS camps come to an end, or you stopped coming to DREAMS, how long after you finished being involved do you think you would still experience a change in your hope for the future? (The things you learnt and have changed your life – how long will you remember and do those things?)

- For a few weeks or less
- For a few months
- For at least a year
- For at least 2 years
- For 3 years or more

5.5 How does this change show?

Indicator	Yes/No	Comments
No. of ADGs who report *'I have more hope for a better future'* and		
a) report a positive future plan for themselves		
b) show positive change from unproductive to more		

productive activity		

Outcome** 6 (some girls said): They now had a **lower risk for HIV infection
6.1 After DREAMS camp and activities, what would you say is true for you?

My **risk for HIV infection has decreased**
My **risk for HIV infection** has not changed
My **risk for HIV infection** has increased

ONLY if the girl has answered yes to a change for the outcome above then ask the following questions:

6.2 If DREAMS camps had never happened what would you have done?

- I would have nothing like DREAMS (learn about HIV /AIDS, meet other deaf girls, hair dressing and sewing; personal development; learnt business skills)
- I would have done something, but less than I have done with DREAMS
- I would have found another way to do the same thing
- I would have done more than I have done with DREAMS

6.3 Has anyone or anything else other than DREAMS camp helped you reduce your risk for HIV?

- I have not had any other help you reduce your risk for HIV
- Other people outside of DREAMS have helped you reduce your risk for HIV

  Please state who _____
- Other projects and programmes helped you reduce your risk for HIV

  Please state which programmes / projects _____
- Something else has helped you reduce your risk for HIV

  Please state what/who helped you _____

6.4 If DREAMS camps come to an end, or you stopped coming to DREAMS, how long after you finished being involved do you think you would still experience a change in your risk for HIV infection? (The things you learnt and have changed your life – how long will you remember and do those things?)

- For a few weeks or less
- For a few months
- For at least a year
- For at least 2 years
- For 3 years or more

6.5 How does this change show?

Indicator	**Yes/No**	**Comments**
No. of ADGs who report 1)feeling *'my risk for HIV infection has decreased'* and also any of the following:		
a) report use of condoms		

b) stating decision to wait for sex marriage		
c) reports discussing HIV issues with their partner (including testing)or		
d) or girls report broken/stopped bad relationship		
e) I have reduced risky behavior (parties, hanging out with lots of boys, multiple sexual partners)		

18 Annex G: Tools for Outcomes

Pictures were used to remind the girls of each outcome. For example:
My relationships have improved' The girls felt empowered and confident, and better self-esteem which resulted in improved relationships – girls made new friends and connections; reported they had taught sign language and had people from outside the family interested in learning from them; reported better management of emotions; were confident to address issues with a partner or family member; and had friends in business.

19 Annex H: How Important Exercise - Bulawayo

Nzeve led the Social Impact evaluation process and sent the surveys and exercises to Bulawayo. Due to distance it was not possible to meet more than once during the process and so when misunderstandings took place it was sometimes too late to correct it. The exercise Bulawayo team did with the girls to ascertain importance of change was not the same as was done in Manicaland. Bulawayo girls only answered the question, “How important to you was the change?” And not, “How much change?” Therefore, we have not combined the absolute figures for different stakeholders, or for Manicaland and Bulawayo, as we know the valuation unit was not the same for all of them. However, we have contrasted and compared the most important relative value for each group and discussed what we think it tells us.

The Process

We began by a briefing meeting, explaining the tool to the girls and giving them an opportunity to ask questions where clarity was needed. We then proceeded to do the quantitative survey where each girl was interviewed individual. At times girls would get stuck but the interviewers made sure that the girls understood the questions and gave honest answers.

Some girls had all six out comes while others had 4 or 3. It was an intense exercise and we managed to get the work done with the help from mentors, who were trained before this exercise.

Bulawayo - How Important?

We started with a PowerPoint presentation we received from Nzeve. Explaining the pictures together with the outcomes.

1) We had pictures set on our television set to remind the girls of each outcome.
2) Each girl had a paper with outcomes according to the answers given from the survey. We explained to them how to show how important each outcome was to them on a scale of 1-3
3) The exercise was done individually with the help from facilitators and mentors where clarity was needed.

20 Annex I: How Important Exercise – Manicaland

To help the girls understand about rating the importance of an outcome, a story was told about three women who moved from town to a rural area. Each of them was asked how their lives had changed and how much change they had experienced. Each responded differently.
The score card at the end was introduced and a similar card was used when they scored their own changes. Following this presentation, the girls were reminded of the outcomes they had told us of the GRAPEVINE project, and pictures were shown to remind them of each. They were left up as the girls scored each of the outcomes they had experienced.