End of Project Evaluation Report

"Narrowing the Gap: Scaling up Adolescent's Access to Quality Information and Utilisation of Services on HIV Prevention, Treatment and Support" – January 2013 to September 2016

Submitted to
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Abbreviations

AIDS	Acquired Immuno-Deficiency Syndrome
ALHIV	Adolescent Living with HIV
ART	Antiretroviral Therapy
FGD	Focus Group Discussion
HIV	Human Immuno Virus
HBC	Home Based Care
ICT	Information Communication Technology
KII	Key Informant
MDG	Millennium Development Goal
MOU	Memorandum of Understanding
MSC	Most Significant Change
MTR	Mid-term Review
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PRA	Participatory Reflective Appraisal
SPSS	Statistical Package for Social Sciences
SRH	Sexual and Reproductive Health
SRS	Simple Random Sampling
STI	Sexually Transmitted Infections
VCT	Voluntary Counselling and Testing
VPE	Volunteer Peer Educators
VfM	Value for Money
YP	Young People

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Executive Summary

Norwegian Church Aid (NCA), with technical support from GIZ through the Malawi German Health Programme (MGHP), supported the Ministry of Health (MoH) to implement a 4-year project (January 2013 - June 2016). The project titled "Narrowing the gap: scaling up adolescents' access to quality information and utilization of HIV prevention, treatment, care and support' was in two phases: phase one, January 2013 to December 2014, coordinated by UNICEF and phase two, May 2015 to June 2016, coordinated by Norwegian Church Aid. The adolescent project as it is commonly referred to, is a dual-prong intervention to prevent teen pregnancy and HIV infection; under the Malawi GIZ Health Programme of "Health systems strengthening with a Focus on Reproductive Health. The target group was10 -19 year old adolescents in 10 of the 28 districts of Malawi.

At project baseline Malawi adolescent population was 25% of the national population while the percentage of 19 year olds who had already started childbearing was as high as 63.5%. In order to respond to this obvious social-demographic challenge Malawi GIZ Health Programme went into collaboration with Ministry of Health HIV Department and UNICEF in designing and rolling out a two-prong adolescent focused intervention that would prevent teen pregnancy as well as HIV infection. The intervention addressed access to comprehensive sexuality education services in the form of correct basic SRH/FP/HIV prevention information on the one hand, and access to and uptake of quality SRH/FP/HIV youth friendly health services on the other.

The project was implemented in 10 focus districts[1]identified collectively by UNICEF, GIZ and the Ministry of Health following two baseline studies that were conducted. From the outset, the goal of the project was to demonstrate an integrated HIV mainstreaming and continuum of care cascade model in increasing adolescents' access to Teen pregnancy and HIV prevention, treatment and support services. During the four-year implementation period, the project was contributing towards achievement of the following objectives:

1. 80% of adolescents and young people in and out of school in 10 priority Districts in Malawi have correct information, relevant skills to reduce their risks and vulnerability to HIV by 2016;
2. 80% of vulnerable and at-risk adolescents have access to quality adolescent HIV prevention and SRH services and continuous utilization of services in 10 high prevalence districts by 2016; and
3. 80% of adolescents living with HIV accessing the treatment, care and support services in 10 priority districts by 2016.

Key implementing partners were District Councils (DACC, DEMs, DHOs and DYOs) with further collaboration from Baylor Children's Foundation; Pakachere Institute of Health and Development Communication; Banja La Mtsogolo (2013-2014); Quadria Moslem Association of Malawi; CCAP

[1]The 10 priority districts are Mzimba (North and South), Mchinji, Lilongwe, Dedza, Ntcheu, Balaka, Blantyre, Thyolo, Chikhwawa and Nsanje

Synod of Livingstonia and Catholic Health Commission (Dedza Diocese). All these supporting implementing partners were coordinated and managed by UNICEF in the first half of project duration and by Norwegian Church Aid in the latter.

UNICEF implemented the project from January 2013 up to December 2014 and NCA took over from May 2015 to June 2016. UNICEF coordinated and managed the baselines, designed, rolled-out and implemented the project for two years. A Mid-term Review, by an independent consultant, was conducted which recommended strengthening of the enabling environment for sustainability of results among the adolescents. GIZ thus commissioned NCA to strengthen the traditional and religious structures in the communities around the targeted health facilities of the 10 districts of focus in addition to continued adolescent HTC campaigns. Furthermore, included in the project was the strengthening of quality of adolescent SRH service delivery which is a key focus area of the 2012-2016 Malawi GIZ Health Programme *Health Systems Strengthening with a focus on reproductive - maternal and neonatal health*. The adolescent project and the MGHP operational and strategic design was perfectly in line with the MoH *Malawi Health Sector Strategic Plan 2011-2016* that focuses on Ministry of Health, together with non-state actors, guaranteeing effective and efficient health services of satisfactory quality with a special emphasis on maternal and neonatal health.

As the Narrowing the Gap adolescent project wounded down, Malawi GIZ Health Programme commissioned an external End of Project Evaluation to assess the outcomes and impact of the project, and to facilitate an understanding amongst MGHP, its partners and project beneficiaries of the extent to which the envisaged change has been realized.

Below is a summary of key findings of this evaluation:

Relevance and Appropriateness

The project was highly relevant with regard to the Malawi social demographic context and national health policies. The evaluation confirms that the project was designed to address priority Sexual and Reproductive Health, issues including HIV and AIDS service needs of adolescents as informed by empirical evidence gathered through extensive literature review and baseline analysis.

The project intended to provide accurate and youth friendly information and thus improve access to SRH services for adolescents aged between 10 and 19 years. As the project's baseline report acknowledged, it this age group of youth that start taking part in risky sexual behavior due to lack of information and access youth friendly SRH services. We therefore find that the target group was very relevant and appropriate as this group is critical in offers a strategic window of hope to combat HIV and Aids and reduce teen pregnancies by providing prevention messages and prepare youth at this age to avoid HIV and other STIs and where to access treatment, care and support. Beyond the knowledge the project also intended to provide life skills and livelihood options along the same lines of self-management and avoiding risky behaviors.

Secondly, we also found that the intention of increasing adolescent's access to SRH services was very relevant and appropriate especially the focus to ensure that SRH services were youth friendly. The project intended to support youth friendly corners and teen clubs which would make it easier for adolescents to access services. This was very relevant objective as most youths can't get basics SRH services like access to condoms. Even more important was the dual targeting of in and Out of School adolescents. The project intended to reach out to of school youth who tend to be missed by most interventions to be meaningfully engaged and reached. By working closely with existing traditional and religious community structures, the project ensured a quick buy-in of the stakeholders and thereby increasing its potential for smooth and successful implementation. The project further targeted in school youth who would normally adequate SRH information as the provision of these intervention remains sensitive and controversial. It however the opinion of the consultants that design was good in that school teachers were trained provided information to students on where and how to access which type of SRH services.

Thirdly, the design and activities of the project were harmonized and in line with the national priority response efforts in addressing SRH needs of young people in Malawi as detailed in the National Youth Friendly Health Services Strategy 2015–2020 and other SRH strategy and policy documents. The design positioned the project to contribute to country level efforts towards achieving the Millennium Development Goals (MDGs) particularly MDG 1 – Eradicate Extreme Poverty and Hunger, (through facilitating and promoting livelihood options for the youth,) and MDG - 6 Combat HIV/AIDS, malaria and other diseases.

Equally, the implementation strategy of the project was appropriate as it targeted and involved the youth and had them actively participating in leading the implementation of some of the project activities through delivering services and promoting uptake of good behaviours and positive attitudes. This evaluation has established that project delivery strategies were responsive and sensitive to context and age of information recipients; which facilitated learning, participation and significant uptake of both services and safe behaviour.

Knowledge among adolescents on HIV and SRH services

Interviews with sampled young people in five selected districts showed that all youths were aware of HIV/AIDS (transmission and prevention) and SRH services available at the health facilities for adolescent youth. 77% of the sampled teachers reported that students accessed SRH information through Youth Friendly Corners, GIZ/NCA project workshops or campaigns and health facilities. However none of the teachers from the control district mentioned these as source of information for the students, reporting instead that their students accessed this information from health facilities only. 81% of the sampled youth reported having received information about SRH and HIV through classrooms. There was no significant difference between those from the control district and those from the project districts. A 100% of respondents from both control and target districts correctly identified sexual unprotected intercourse with an infected partner as the main mode of HIV transmission. Students were also able to mention

other modes of transmission such as using unsterilized sharp objects which are contaminated with HIV infected blood and direct blood contact including transfusion. 100% (254) of respondents were also aware of how to protect themselves from HIV infection. The similarity in the knowledge levels among the students was attributed to the life skills lessons given universally in all primary schools. However the following observations were made: 50% of youths from the control district mentioned abstinence as the main means of preventing HIV and the other 50% mentioned both abstinence plus condom use as means of HIV prevention. They were however not as aware of prevention through consistent and correct condom use. Some 40% to 60% of respondents from the target districts were able explain that condoms were effective when consistently and correctly used every time that one had sex. Further analysis of the knowledge levels among young people on HIV and SRH showed no significant difference in terms of gender and areas of residence. In addition, there was difference in the knowledge level among students in project districts and the control district with respect to other STI apart from HIV. All (254 sampled) the students in both (control and project target) districts learn about HIV and SRH in schools through Life skills. In addition to the classroom life skills lessons, the majority of the students in the target districts also heard about HIV and SRH through youth groups and NGOs working in the areas. In both districts, the all the schools contributed to HIV/SRH education through Aids Toto Clubs.

Access and utilization of SRH among young people

In all districts, despite students being aware of available SRH services, less than 10% actually accessed the services. Most of the students mentioned lack of privacy as the main barrier to access the services. While some claimed that they did not access the services because they were still young to start indulging in sex. 84% of the teachers sampled reported that the youth had access to relatively youth friendly SRH compared to the period before the interventions. There was no significant difference between the one control district and the project districts. Regarding sexually transmitted infection screening, at least 10% of sampled youth reported to have ever gone for STI screening contrasted to the control district where none of the youth reported having gone for STI screening. About 6% of sampled youth reported to have ever received STI treatment. While none of the youth from the control districts reported to have ever received STI treatment. With respect to voluntary male medical circumcision, 13% of sampled youth reported to have accessed VMMC but none of those accessing this service were from the control district. 25% of all sampled youths reported to have had sex in the last 12 months. Of those that had sex in the last 12 months, 84% reported to have used condoms. There was no significant difference between respondents in control and project districts.

Access to HIV Testing and Counselling

Based on an analysis of HTC records between July 2015 and June 2016 data from public Health Facilities showed that there were more youth accessing HTC service in the project districts than in the control district where access was very low . In the project districts access to HTC ranged from 2 to 222 adolescents per month per district. There were periods in some months when adolescents aged 10 -19 accessing HTC showed sharp increase to above 20 adolescents per month suggesting that a HTC demand creation campaign or some outreach interventions had

been carried out. This will be correlated in the final report. In the control districts access to HTC ranged from 0 to 16 adolescents per month with an average of 3 adolescents accessing HTC in the 3 sampled health facilities. In the project districts we also observed that the number of adolescents aged 15 to 19 accessing HIV Testing and Counselling was almost double the number of adolescents between the ages 10 to 14.

HIV Treatment and support among adolescents living with HIV

In terms of findings through Teen Clubs the evaluation has established that young people living with HIV have access to ART treatment and support. The project was able to set up teen clubs in 13 out of 17 health facilities that were referred to by the client. Overall the teen clubs were effective in providing psychosocial support to the teens and education them on how take medication and live a positive life. In Golomoti, the Teen club that was established stopped being active in 2015 at the facility while at Mayani there was no Teen Club established. In the control district, the sampled facilities had no Teen Club established at Msakambewa, Mangwala and Thonje Health centers. The Teen Clubs established at Dowa district hospital and other health centers were supported by Partners in Hope. The challenges faced by ALHIV in the teen clubs include discrimination by fellow adolescents, lack of recreational resources lack of dedicated space to be used as Teen club as well as youth friendly corner. The majority of the Teen Clubs were aware of the prevention measures on HIV and STIs. All of the teens attending the FGDs were aware of their status and were initiated on treatment.

Sustainability of the Project

The design of the Project made efforts to ensure sustainability of the Project in 2 ways: establishing collaborations with other stakeholders and capacity building. The study found that Health Facility Staff, school teachers, and community leaders were trained and would likely continue to promote positive SRH seeking behavior among adolescents. We didn't see any deliberate efforts to engage Ministry of Education Science and Technology in a way that the lessons around mobilization of students through Youth clubs from the project would be institutionalized.

Partnership and coordination

This study has established that partnership in interventions targeting young people is perhaps the best if development agencies should reach them adequately. However, such partnership should have been clear with agreed 'rules of engagement' from the outset. It has also been established that achievements and gains relate to the amount of time invested and that the shorter the period of roll out the greater the compromise of even the best of intentions.

Lessons Learnt and Good Practices

- If young people are afforded an opportunity and support, they can facilitate accurate SRH information transfer amongst themselves. They are an efficient and effective mode of information dissemination among their peers.

- Availing Youth Friendly SRH Services and constant attention being given to needs of young people invariably increases uptake of such services by the young people in any context they might be.
- Young people can work independently and effectively manage themselves. Teen Club are able to cope with the demands of their assigned responsibilities and become self-organizing and self-governing as long as they themselves see the benefit
- Putting Project beneficiaries at the forefront of implementation promotes Project ownership and support sustainability. The greatest guarantee of sustainability for Projects targeting young people is the degree of leadership and involvement among the young people themselves.
- An exit/ transition strategy needs to be communicated in good time with Project beneficiaries and other stakeholders to ensure that there is no confusion as to whether Project is still under the support of GIZ or not.

Recommendations

The findings of this study provide room for a number of recommendations not least the opportunity for a second generation project to scale-up the winning interventions, sustain gains and incorporate robust mechanisms for inclusion of lessons to the SRH health and social benefit of young people. The evaluation therefore makes the following recommendations:

1. In order to promote youth participation and leadership, strengthen early engagement of youth in the project. This should include consultations with the youth on key activities and of the project, how these activities would be implemented and clear mapping of how the youth will participate in such activities. This will further help prepare future actors in matters of SRHR.

2. Consider continued investment in the development and support of youth organizations, not least Teen Clubs, Child-to-child and the Sister to Sister Model. The Teen clubs and Youth Friendly corners proved to be effective vehicle for promoting youths' access to SRH, HTC and ART and care. However, in future similar projects, GIZ Health Programme should address weaknesses among that were observed such as lack privacy for adolescent; timing of teen clubs on with other activities such as antenatal clinics and availability of dedicated rooms youth friendly corners.

3. Further to 3 above, GIZ should consider adding comprehensive economic development (including IGA and VSL) as part of activities under youth clubs and teen clubs. This may contribute to the sustainability of such teen clubs as other members of teen clubs do often require support to travel long distances to participate in the Teen clubs.

4. Community and religious leaders interviewed could not associate the project nor with the donor or fully champion the activities of the project, we recommend that in future projects GIZ should identify key community liaisons/volunteers or SRH champions. These

would be the key people that would be trained and motivated to lead in the implementation of project activities at districts including dissemination of SRH information and distribution of SRH items such as condoms among the youth.

5. As we could not trace whether all youth that tested HIV positive were receiving treatment, we recommend that future projects in future have a more robust post HTC and STI screening referral system with other health facilities within the districts. Most importantly such data should be made available by implementing NGOs to the DHOs. This would allow the follow up on treatment defaulters through the community SRH champions and extension health workers.

6. GIZ Health should ensure, as a requirement for its lead implementing agency, the development and rollout of comprehensive M&E systems that focus on routine monitoring, quality assurance and learning among stakeholders (vertical and horizontal). This should include development of quality benchmark or minimum standards for key interventions such as teen clubs and other youth school youth clubs. Monitoring need to an integral part and routine as opposed to ad-hoc or quarterly site visits based small sample of project sites.

7. With regards to project management, we recommend that future partnerships should rollout with more comprehensive start-up/kick off workshops. Among the key deliverables for these workshops should clear implementation arrangements informed by well documented project structure, harmonized M&E, financial systems among partners, close out plans and exit strategy (sustainability plans).

8. In the context of growing population urgency for Malawi, future SRH youth projects should also aim at addressing population growth by promoting more SRH (family planning and preventions of early pregnancies). There is a need to address population issues more holistically in the next decade.

9. In terms of visibility, the client should consider having implementing a stronger visibility strategy. This should include development of catchy, youth/community friendly project names (e.g. one word acronym in vernacular) that can be easily popularized amongst the beneficiaries for similar future projects. GIZ should also invest in some visibility materials that could promote a stronger association of their project interventions and outcomes to the funding agency.

1. INTRODUCTION

This is a technical report for an End of Project Evaluation of a Malawi GIZ Health Programme supported four year project, January 2013 to June 2016 titled "Narrowing the Gap: Scaling up Adolescent's Access to Quality Information and Utilisation of Services on HIV Prevention, Treatment and Support. After implementing the project for six months, in June 2013 UNICEF and GIZ decided to incorporate and address prevention of unintended teen pregnancies as part of the project. Resulting from this decision a second component of the project *Addressing the Sexual and Reproductive Health Rights and Unintended Teen Pregnancy* was added to the operational plan. The project target group was adolescents between 10 and 19 years of age and it was implemented in 10 of the 28 districts of Malawi.

At project baseline Malawi adolescent population was 25% of the national population while the percentage of 19 year olds who had already started childbearing was as high as 63.5%. In order to respond to this obvious social-demographic challenge MGHP went into collaboration with UNICEF in designing and rolling out a two-prong adolescent focused intervention that would prevent teen pregnancy as well as HIV infection. The *Adolescent Project* that emerged from this collaboration addressed demand creation through access to comprehensive sexuality education on correct basic SRH/HIV prevention information on the one hand, and addressed supply side barriers to access and uptake of quality SRH/HIV/FP youth friendly health services on the other.

1.1. Overall objective the evaluation

The Adolescent project came to an end June 30, 2016 and the purpose of this End of Project Evaluation was to assess whether the project objectives within the specified result areas were achieved and to document the lessons which should be used to develop and design a follow-on project.

1.2. Specific objectives

This end of Project Evaluation seeks to:

1. Assess ***effectiveness*** in how the project addressed adolescents' access to correct information and relevant skills on teen pregnancy and HIV prevention (demand side) and access to quality youth friendly health services (supply side).
2. Assess the ***quality*** of demand and supply side of adolescent SRH services
3. Ensure that qualitative and quantitative data to all the indicators is part of the findings report
4. Gather ***evidence*** whether vulnerable and at-risk youth access and utilize HIV prevention, and contraceptive services in the target districts;
5. Assess whether by addressing the demand and supply side and quality constraints, there is evidence that adolescents living with HIV are accessing treatment, care and support services in 10 priority districts; and
6. Assess if the PPP (GIZ/UNICEF/NCA and IPs), including coordination among partners has worked during the implementation duration

7. Include ***evidence-based ideas*** on how to link HIV and AIDS response to Health Systems Strengthening with a focus on reproductive health services
8. Provide a ***basis for planning*** a follow-on measure through an analysis of the actual situation

The evaluation covered conceptual, content-related and organizational aspects of the project and the appraisal of a follow-on measure. It also covered January 2013 to December 2014 UNICEF coordinated activities and May 2015 to June 30, 2016 NCA coordinated activities. While the two institutions followed the same project framework, activities of the first two years were expected to roll-out monitoring systems and operationalize all activities while the latter part needed to sustain the progress and strengthen the community enabling environment for adolescent health seeking behavior. The evaluation findings and recommendations are to feed into the 2017-2020 Malawi GIZ Health Programme.

1.3. Scope of Work

The selected national consultant was expected to deliver on the following specific scope of work:

a. Review project documents including work plans and periodic project reports;
b. Conduct consultations with key implementing partners in sampled priority districts;
c. Conduct consultations with direct project beneficiaries (adolescents, young people and ALWH) in sampled priority districts;
d. Collect HIV testing data from HTC registers from health facilities in the impact areas in sampled priority districts; and
e. Based on data collected compile two reports: one report covering qualitative component while the second report should cover the quantitative component of the End of Project Evaluation. The reports should contain major findings, conclusions and recommendations.

1.4. Deliverables

1. Inception Report containing detailed methodology, questionnaires and other interview tools and roadmap;
2. Stakeholder analysis and schedule of those to be consulted
3. Quantitative report based on data from HTC registers; and
4. Qualitative report based on consultations with implementing partners, stakeholders and direct project beneficiaries.
5. Consolidated report of the quantitative and qualitative assessment.

2. METHODOLOGY AND APPROACHES

2.1. Study Design

The evaluation used a Cross-sectional Analytic Study Design employing a Mixed Method Approach based on a combination of qualitative and quantitative techniques to analyze primary and secondary data. The primary data was mainly drawn from project's target group (adolescents), other community members, community and national level stakeholders, policy developers, funding and strategic partners. The design enabled the documentation of the current situation regarding the factors under review (cross-sectional) and allowed for a comparison with the baseline and pre-intervention scenarios. The analysis also considered exposure to the Project in order to assess associations between outcomes and the Project.

The study population comprised of project beneficiaries (adolescents) from five operational districts and one control district, key informants at community, district and institutional level. The beneficiaries were adolescents, some of which directly participated in the project interventions. The sampling strategies included purposive sampling for key informants and systematic sampling for the adolescents. The adolescents were selected from the purposively selected health facilities and surrounding schools and communities for the out-of-school youths where the project was implemented. GIZ provided a list of health facilities and schools were the project was implemented. In other words, study participants were drawn from five sampled GIZ/UNICEF/NCA project districts and one non-GIZ/UNICEF/NCA project district within the evaluation, for control purpose. Therefore the sampling frame included teen high pregnancy prevalence district; high HIV prevalence district and low HIV prevalence district. The consultants used purposive, sampling to identify health facilities and project beneficiaries based on information provided by the client. Due to the nature of the project, the consultants understood the difficulty to obtain a sampling frame for at-risk youth accessing and utilizing HIV prevention, and contraceptive services in the target districts, as such used respondent driven sampling which is a refined method of snowballing. Lot quality assurance sampling for health service providers was also used to assess SRH service delivery coverage. Overall, sample size of 254 adolescents was determined based on the list of health facilities and schools that was provided by the client, financial resources available to carry out the evaluation.

Table 1: Evaluation Reach Table (number of interviews & observations)

District	No. of Health facilities	No. of teen clubs	No. Health Facility staff	No. of teachers[1]	Number of youths	No. of Community leaders FGDs	Number of DHOs	Number of DYOs
Nsanje	3	3	3	12	30	2	1	1
Thyolo	4	3	3	12	40	2	1	1
Dedza	3	1	3	12	60	2	1	1
Lilongwe	3	3	3	12	40	2	1	1
Dowa	4	0	3	9	44	2	1	1
Mzimba	3	3	3	12	40	2	1	1
Total	**20**	**13**	**18**	**69**	**254**	**12**	**6**	**6**

2.2. Theoretical framework

The evaluation applied the *DAC Model of Evaluation Criteria* which underlines five aspects of relevance, efficiency, effectiveness, impact and sustainability as a basis for effective evaluation. And we note that this framework is in line with the ToRs for the present assignment.

In examining ***relevance*** the Consultants objectively assessed the technical design of the project with regard to clarity and hierarchical balance from goal to activities and completeness of activities measured to the degree that they met the needs of the target beneficiaries. This involved an assessment of how suited and aligned activities were to critical needs of girls and boys and how the activities addressed their contexts; for example expectations of quality of services; accessibility; communication for knowledge and for behaviour change as well efficacy. Relevance in project design is vital as ensures that actual needs and intents of both the benefactor and beneficiary are met and that they support productive collaboration satisfactory to both parties.

The Consultants also measured ***effectiveness***; that is the extent to which project activities have met set objectives and articulate factors which influenced achievement or non-achievement of objectives. Assessment of effectiveness meant analysing the objectives of the project in detail as summarised above; assess the nature of action that was selected to meet each of the objectives and the approaches used. It is also vital in an evaluation to assess methods and approaches because what is achieved is often influenced by how action is rolled out.

A major measure of project performance is ***impact*** and is always linked to the ultimate goal which was set out as to demonstrate an integrated HIV mainstreaming and continuum of care cascade model in increasing adolescents' access to teen pregnancy and HIV prevention, treatment and support services. Impact albeit hard to measure in such a rapid assessment, ought to be the attribution of what actually happened as a direct result of the inputs and interventions made through the project. For example has knowledge of HIV prevention actually

increased and by what measure? Are more girls and boys accessing SRH and ART services and how does the number differ from previous levels of access? To what extent are services integrated as planned?

Furthermore the evaluation assessed changes in attitudes, knowledge and practices as a result of introducing the project. And as noted above in assessing impact the Consultants have kept close to the original intent, the original indicators and original objectives while examining other sources of influence that could have shaped the final results. In particular, the study assessed whether adolescents living with HIV are accessing treatment, care and support services as a direct result of creating demand and increasing supply and what lessons can be learnt in the nature of organization and coordination which can support efforts to sustain the gains over time.

Not least, the DAC Evaluation Model stresses ***sustainability*** which is basically a measure of whether or not the benefits of an activity or sets of activities are likely to continue after the end of funding and interventions. It is an identification of mechanisms and systems which are put in place to ensure continuity and quality improvement over time. In the present assignment sustainability will include the capacity of health units to maintain procedures, practices, support systems and infrastructure to keep services going. But sustainability could also mean government funding towards the initiative directly and through developments in health systems strengthening, supervisory mechanisms or monitoring.

Further a study of sustainability of a project must include an understanding of factors leading to achievement or non-achievement. This presents an opportunity to study ***strengths*** and ***weaknesses*** of the project. Ultimately, the outcomes of the evaluation will provide a basis for planning a follow-on measure through an analysis of the actual situation. That is the Consultants had identified outstanding challenges, needs and expectations not full addressed and met by the present interventions and suggest a simple framework for programmatically tackling these outstanding issues.

2.3. Limitations of the Study

- The topic of SRH remains a sensitive topic especially for both boys and girls, which may have contributed to subjective responses. While the evaluation emphasized confidentiality, we cannot entirely rule out possibilities of over and underreporting on some questions.
- The client did not provide geographic targeting data and beneficiary reach database which could have allowed for stronger sampling methodology especially for calculating sample size and effect size. However information was provided on where the project was implemented and the evaluation team was able to interact with a good number of the project beneficiaries.
- The project design was revised during implementation to include other interventions such as provision of Teen Pregnancy Prevention. As such the baseline that was done in 2012 does not provide good basis for measuring the project impact, however a control district was identified to provide comparison of findings in the targeted project districts.

3. FINDINGS OF THE EVALUATION

3.1. Contextual Analysis – Youth Profile SRH, HIV and AIDS Situation

The youth profile in Malawi indicates that out of the population of 17.6 million according to the 2008 Population and Housing Census, 19.5 % are young people between the ages of 15-24 years. Because of poverty and minimal investment in social sector such as health and education the majority of young people lack basic opportunities that would enable them develop to their full potential generally. Unequal access to the already limited opportunities has further increased the vulnerability among adolescent girls and young women and put them at greater risk of HIV, teen pregnancy and other sexual transmitted infections. Adolescents' pregnancies comprise 29% of all births. 20% of the adolescents have had a live birth, 6% are pregnant with their first child and they contributed to 20% of the maternal deaths (MDHS 2015). Overall HIV prevalence among young people aged 15-24 is estimated at four percent and the prevalence is higher among young women (5 %) than young men at 2 %.(MDHS 2015). There are 49,000 young males (15-24 years) and 81,000 adolescent females living with HIV in the country. Over the decades statistics indicate that HIV disproportionately affects Malawian women and girls as compared to men and boys. The rate of new HIV infections is estimated to be very high in key populations at higher risk of HIV exposure such as sex workers (2012 Global Aids Response Unit). Available HIV services do not adequately meet the needs of groups most affected as uptake is limited by stigma and discrimination in health facilities and the community. Gender discrimination and GBV undermine efforts to enable positive health outcomes for women and girls, making them more vulnerable to HIV. Young people often have challenges in accessing vital HIV and Sexual and Reproductive Health (SRHR) services in their families and at the health facilities.

Indeed the majority of the young people have limited access to sexual and reproductive health services and yet their knowledge and practices related to sexual and reproductive health still needs to be improved (UNFPA Report 2010). Less than half of the population has correct knowledge on HIV/AIDS (42.1% for both male and female) and less than half of them use condoms during high risk sex (47% for male and 30% for female) UNFPA Report 2010.

Table 2: Projected Population

Total population (NSO projected 2014)	15 million
Female youth	1,501,490
Male youth	1,342,316
Adolescents 10-19	2,947,083
Girls 10-19	1,495,343
Boys 10-19	1,451,700
National Enrolment retention (primary)	83%
National Enrolment retention (secondary)	26%
HIV prevalence 15-24	4.9%
HIV prevalence 15-24 -Male	3.1%
HIV prevalence 15-24 - Female	6.8%
Adult HIV prevalence	10.3%

Comprehensive knowledge of HIV 15-24 – Male	45%
Comprehensive knowledge of HIV 15-24 - Female	42%

Generally, the young people are particularly more vulnerable to SRH problems not only due to lack of knowledge and information about SRH issues and services but also of legal and policy provisions in place to protect their SRHR. These are also compounded by other factors such as peer pressure, sexual abuse, economic pressure, forced marriage, lack of parental guidance, lack of life skills, drug and alcohol abuse, socio-cultural factors regarding gender and sexual relationships. Adolescence itself is a developmental stage in which young people are overwhelmed by the desire to experiment and engage in risk taking behaviours and become sexually active and may experiment with drugs, increasing their levels of vulnerability to HIV infection. Unmarried sexually active young people are particularly negatively affected by limited access to and use of contraceptives resulting in unwanted/planned pregnancies, unsafe abortions, pregnancy complications and even death of mothers and new-borns.

Government of Malawi and development partners have increased their support to invest more resources in the health and economic development of adolescent and young people. Youth friendly strategy and implementation framework was developed in 2014 and implementation of this strategy and framework has made a progress in capacity building of youth friendly service providers at national and district level including pre-service training. To facilitate the implementation and coordination of youth Project, Youth Technical Sub-committee at district level and youth action committees at TA level were formed. Operational standards for implementation of youth friendly health services, monitoring and supervision tools are used for quality assurance of the implementation. However, inadequate coordination at district level, low sensitization at community level and linkage between Ministry of health and Ministry of Youth still need to be strengthened to scale up implementation of quality YFHS at all levels. Furthermore, socio-cultural issues such as harmful traditional practices that increase the SRH risks, availability and access to health and social services and poverty remain major challenges. In addition, only out of school adolescents access YFHS, movement of service providers from one health facility to another affect delivery of services at the former site.

For the purpose of this study Adolescents and youth Friendly Health services: Adolescents and youth-friendly services are those that are based on a comprehensive understanding of, and respect for, young people's rights and realities of their diverse sexual and reproductive lives. They are services which young people trust and feel are there for them. To be considered adolescent friendly, health services should be:

- Accessible: Adolescents and youth *are able to* obtain the health services that are available.
- Acceptable: Adolescents and youth feel health services are suitable for them and *are willing to* obtain services that are available.
- Equitable: *All adolescents and youth*, not just selected groups, are able to obtain the health services that are available. Serving a selected group could mean that some barriers including stigma, or services not being available in some areas, are preventing

the others from accessing the services. It is because of discrimination which is intentional or by failing to do something about the barriers.

- Appropriate: The *right health services* (i.e. the ones they need) are provided to them
- Effective: The *right health services are provided in the right way*, and make a positive contribution to their health.

3.2. Profile of Respondents

A total of 254 young people, 58 key informants, and 14 community leaders participated in this review through interviews, discussions and questionnaire completion. The total sample size of those who responded to the questionnaire represents 108% of the target sample size. Of these, the majority (23.6%) were from Dedza District and females represented 50.4% of the total number of respondents. The mean age of the respondents was 16 years. (Figures 1, 2, and 3 do indicate the demographic data)

Figure 1: Gender representation of student participants

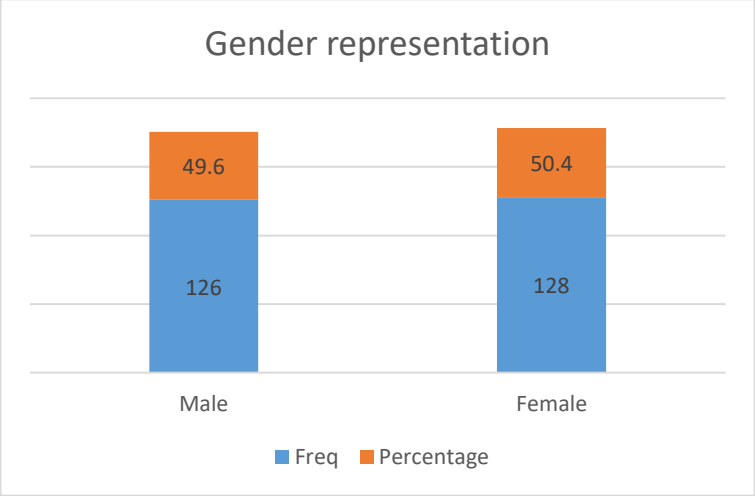
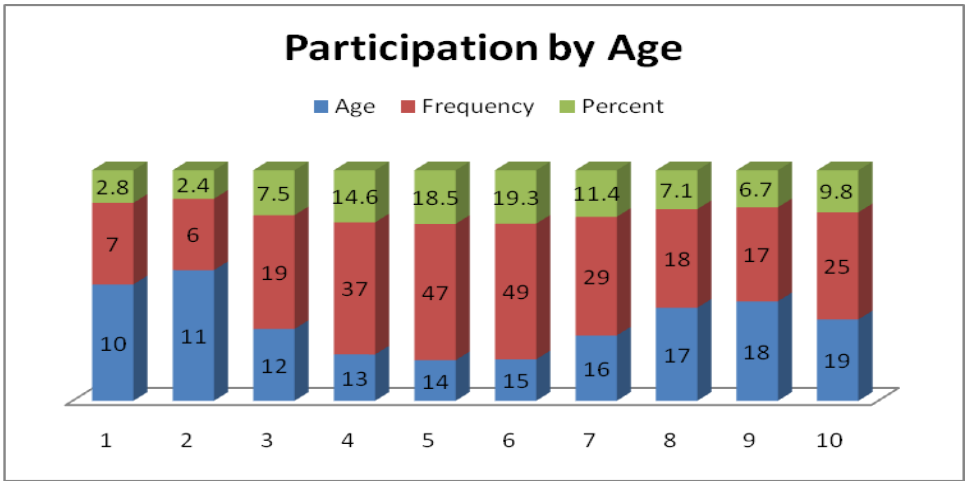


Figure 2: Participation by age



3.3. Relevance and Appropriateness of the project

As already highlighted in the foregoing sections of the report the review of the Project was guided by the DAC criteria beginning with Relevance and Appropriateness. This criterion assesses the extent to which Project design was suited to the issues being addressed, if expected outcomes are consistent with probe diagnosis and of objectives and activities remain valid and within the context of existing challenges.

To start with the relevance of the project and its interventions cannot be overemphasised. The project was noted to address priority SRH, HIV and AIDS needs of young people as informed by empirical evidence gathered through extensive literature review and baseline analysis of which some of the results were:

- Lack of knowledge of both SRH information and available services,
- Limited access to such services and unavailability of youth friendly SRH services,
- Unavailability of youth friendly SRH services
- Lack of life skills and livelihood options,
- High rates of school drop - out as a result of lack of early pregnancies and other SRH related problems.

Furthermore, the evaluation learnt that the Project design and its activities were well aligned and in sync with the national priority response efforts in addressing SRH needs of young people. The project was based upon and informed by the various documents in use in SRH sector? among them the National sexual and reproductive health and rights strategy (2011-2016); National Youth Friendly Health Services Strategy 2015–2020 whose overall purpose is to improve the sexual and reproductive health status of young people (10-24 years) in Malawi through four key interventions and strategies: Social and Behaviour Change Communication, Life Skills and Livelihoods, Service Delivery, Policy and Advocacy and Networking and coordination. These policies, guidelines and strategies seek to facilitate high quality, safe, context appropriate SRH service provision at all levels of the health system.

With the foregoing we find that project was highly relevant with regard to the Malawi social demographic context and national health policies. The evaluation confirms that the project was designed to address priority Sexual and Reproductive Health, issues including HIV and AIDS service needs for adolescents as informed by empirical evidence gathered through extensive literature review and baseline analysis.

The project intended to provide accurate and youth friendly information and thus improve access to SRH services for adolescents aged between 10 and 19 years. As the project's baseline report acknowledged, it this age group of youth that start taking part in risky sexual behavior due to lack of information and access youth friendly SRH services. We therefore find that the target group was very relevant and appropriate as this group is critical in offers a strategic window of hope to combat HIV and Aids and reduce teen pregnancies by providing prevention messages and prepare youth at this age to avoid HIV and other STIs and where to access

treatment, care and support. Beyond the knowledge the project also intended to provide life skills and livelihood options along the same lines of self-management and avoiding risky behaviors.

Secondly, the study also found that the intention of increasing adolescent's access to SRH services was very relevant and appropriate especially the focus to ensure that SRH services were youth friendly. The project intended to support youth friendly corners and teen clubs which would make it easier for adolescents to access services. This was very relevant objective as most youths can't get basics SRH services like access to condoms. Even more important was the dual targeting of in and Out of School adolescents although. The project intended to reach out to of school youth who tend to be missed by most interventions to be meaningfully engaged and reached. However the study found that out of school youth were not reached by the project. By working closely with existing traditional and religious community structures, the project ensured a quick buy-in of the stakeholders and thereby increasing its potential for smooth and successful implementation. The project further targeted in school youth who would normally not access adequate SRH information as the provision of these intervention remains sensitive and controversial. It is however the opinion of the consultants that the design was good in that school teachers were trained and provided information to students on where and how to access which type of SRH services. In addressing the needs of young people, the project targeted and involved the youth and had them actively participating in the implementation of the project through delivering services and promoting uptake of good behaviours and positive attitudes

Thirdly, the design and activities of the project were harmonized and in line with the national priority response efforts in addressing SRH needs of young people in Malawi as detailed in the National Youth Friendly Health Services Strategy 2015–2020 and other SRH strategy and policy documents. The design positioned the project to contribute to country level efforts towards achieving the Millennium Development Goals (MDGs) particularly MDG 1 – Eradicate Extreme Poverty and Hunger, (through facilitating and promoting livelihood options for the youth,) and MDG - 6 Combat HIV/AIDS, malaria and other diseases.

Equally, the implementation strategy of the project was appropriate as it targeted and involved the youth and had them actively participating in leading the implementation of some of the project activities through delivering services and promoting uptake of good behaviours and positive attitudes. This evaluation has established that project delivery strategies were responsive and sensitive to context and age of information recipients; which facilitated learning, participation and significant uptake of both services and safe behaviour.

The evaluation has further established that core interventions were designed to provide support to the national efforts towards improving access to SRH services through strengthening the capacity of existing community structures by training local health centre personnel in providing youth friendly SRH services, building the skills and capacity of local school teachers to enable them to monitor school based SRH activities, and creation of teen clubs which were relevant in the dissemination of SRH, HIV and AIDS information. The appropriateness of the project

interventions was visibly observed through its targeting of the project beneficiaries... By working closely with existing community structures, the Project ensured a quick buy-in of the stakeholders and thereby increasing its potential for smooth and successful implementation. Nonetheless, the withdrawal of some principal lead and coordinating partners such as UNICEF and implementers like Banja La Mtsogolo had a profound negative impact on the overall implementation of the project. Closer look at the institutional arrangements indicated that proper agreements in terms of deliverables for the partners were somehow compromised.

3.4. Effectiveness

This criterion is concerned with whether and to what extent the desired results of the Project are attained and what factors influenced achievement or indeed non-achievement of desired outcomes. The context of the extent to which the Project met its purpose and objectives was critical in the assessment of its effectiveness. From the outset the specific objectives of the Project were:

1. 80% of adolescents and young people in and out of school in 10 priority Districts in Malawi, have correct information, relevant skills to reduce their risks and vulnerability to HIV by 2016
2. 80% of vulnerable and at-risk adolescents have access to quality adolescent HIV prevention and SRH services and continuous utilization of services in 10 high priority districts by 2016
3. 80% of adolescents living with HIV accessing the treatment, care and psycho social support services in 10 priority districts by 2016

In addition to review of Project performance documents, feedback and analysis of the survey data was conducted in line with the Project objectives. Particular focus was placed on ascertaining the levels of access to SRH information and services; SRH, HIV and AIDS Knowledge levels, and the availability of livelihood options for the youth.

3.4.1. Knowledge among adolescents on HIV and SRH services

The project aimed at providing 80% of adolescents and young people in and out of school in the 10 target districts in Malawi with correct information, relevant skills to reduce their risks and vulnerability to HIV by 2016. The evaluation team asked the sampled youth various questions to assess their levels of knowledge about HIV transmission, prevention and availability of other SRH services. Through interviews with young people in the sampled areas this evaluation has revealed that all sampled youths were aware of both transmission and prevention of HIV. Youths in the targeted districts were also aware of the various HIV/AIDS and SRH services available at the health facilities for adolescent youth. More than 80% of the sampled teachers reported that students were aware of and accessed SRH information through Youth Friendly Corners, GIZ/NCA project workshops or campaigns and health facilities. There was evidence of high confidence and motivation to learn more about HIV, AIDS and SRH and readiness to access what resources were available achieve increased understanding. In contrast, none of the teachers from the control district identified these as source of information for the students, reporting instead that their students accessed this information through ad-hoc health campaigns done by health extension workers as well as from classroom learning through subject such as Life Skills which are universally accessible in primary and secondary schools.

Figure 3: Knowledge of existing

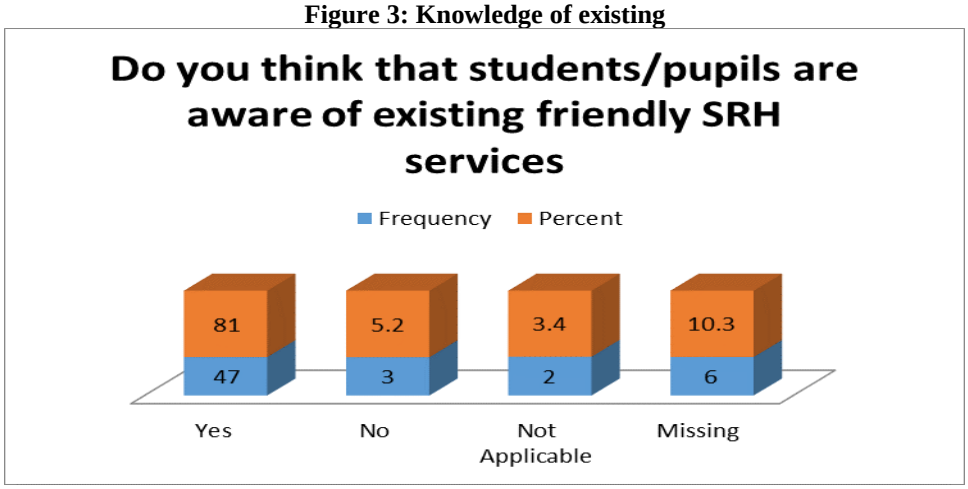
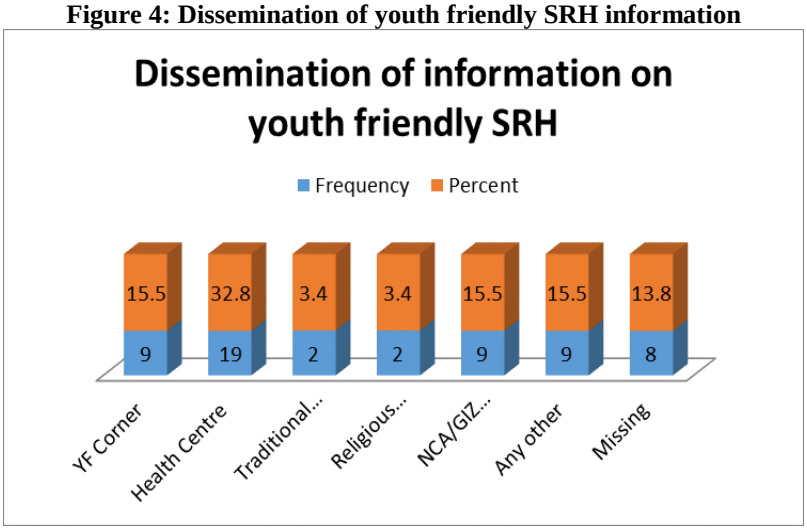


Figure 4: Dissemination of youth friendly SRH information



In respect of learning through formal school curriculum, the evaluation has established that 81% of the sampled youth reported having received information about SRH, HIV and AIDS through classroom learning and extra-curricular activities that have for the past three decades sought to prevent HIV infection through school interventions. The study showed no significant difference between those from the control districts and those from the project districts, and this may be attributed to the role that life skills education and community based interventions are playing in disseminating information on HIV, AIDS and SRH

Perhaps not uniquely, 100% of all respondents from both control and target districts were able to correctly identify unprotected sex with an infected partner as the main mode of HIV transmission. Students were also able to identify other modes and or risks of transmission such using tainted and unsterilized sharp objects and direct contact with HIV contaminated blood including transfusion. As noted above such striking similarity in the levels of knowledge among the students can only be attributable to the life skills lessons in schools., although it could demonstrate the extent of general awareness achieved through a multiplicity of projects by

different partners including through health facilities All respondent (100%) were aware of how to protect themselves from HIV infection and in like ways, there was no significant difference between respondents from the control districts and those from the intervention districts.

However the following observations were made, that 50% of youths from the control district mentioned abstinence as the main means of preventing HIV while another 50% mentioned both abstinence condom use as means of HIV prevention. They were however not aware of how to use condoms. However, 40% to 60% of respondents from the target districts were able to explain that condoms were effective only when used correctly and consistently each time one has sex. This finding was collaborated by the community leaders expressed that project helped the youths know the importance of consistent condom use and that it also made condoms accessible to the youths thereby eliminating the possibility of youths indulging in sex without protection. It is also important to mention here that further analysis of the knowledge levels among young people on HIV and SRH showed no significant difference in terms of gender and or area of residence. But importantly, there was a significant difference in the knowledge levels among students in project districts compared to the control district with respect to other STIs apart from HIV.

In addition, health facilities reported that there was a general increase in the number of young people visiting the health centres for various SRH services including HCT and contraceptives. The young people infected with STIs presented much earlier for treatment unlike way back when they only visited health facilities in late stage with more serious complications. All health facilities in the intervention areas have a dedicated staff member to provide youth friendly services to young people, a development resulting from advocacy and appreciation of gains made where such commitment is maintained.

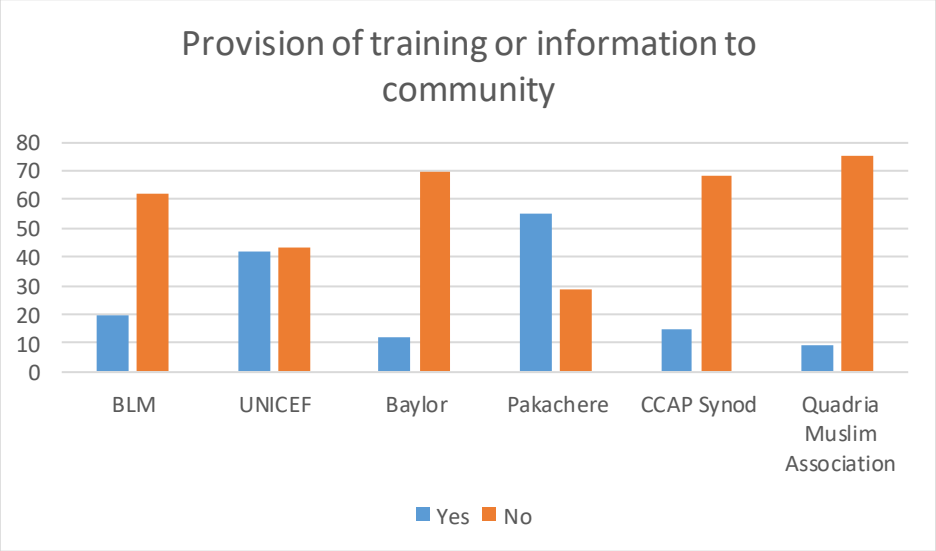
We therefore conclude that the project was effective in providing correct and comprehensive information about HIV and available SRH services available in public health facilities. We have however noted that the project did not reach the 80% target aspiration as the project was not rolled out district wide as per plans as the outset. Nonetheless within the small population on this objective are commendable.

3.4.2. Role of Partners in Information Dissemination

The study indicates what role other partners continue to play in information dissemination and behaviour change. In intervention and control districts adolescents learn considerably about HIV and SRH from what they study in Life skills. In addition to the classroom life skills lessons, a good majority of the students in the target districts heard about HIV and SRH through youth groups and a number of NGOs working in the areas of health and HIV and AIDS alongside the present interventions under review. This points to the value of partnership and integration of critical development issues such as HIV, AIDS and broader SHR across sectors and need for effective coordination of efforts. It also advises organizations to carry out comprehensive partner mapping for synergies and for eliminating duplication For example in Dowa the control district the study showed that few students attended awareness campaigns organized by NGOs

such as FPAM and BLM, pointing to the need for greater mobilization so interventions are met with a motivated target people. In both intervention and control districts, the majority of schools contributed to HIV/SRH education through AIDS Toto Clubs. The students composed poems, songs and drama which they perform during school assemblies. The down side of this prospective strategy is that most of the AIDS Toto Clubs are not active. Regarding performance of implementing partners this evaluation suggests that Pakachere scored high amongst other partners in reaching out to the young people. This could also be reflection on the partners' visibility strategies as most of the communities are not likely to tie events to NGOs unless they have very good visibility and branding materials. Most importantly, the evaluation confirms that all partners played their roles to varying degrees. Figures Below compare implementing partners across districts when community members including youth were asked if any interaction (campaigns, training or edutainment) with the partners had taken place during project's life.

Figure 5: Provision of training or information by partners



3.4.3. Capacity of community leaders to promote SRH services for the youth

Another key intervention in the project was to build capacity of community leaders to promote access to SRH services among the youth at designated places including within the communities. The community leaders sampled for the evaluation included both chiefs and religious leaders of various faiths (both Christian and Muslim). Following the interviews with the community and religious leader it was difficult for the evaluation team to establish whether the community leaders had received any training by the project or not as none of the interviewed local community/religious were aware of the GIZ/NCA project. What was clear however, was that the community leaders had received training on how to promote access HIV and SRH among young people.

However the leaders were aware of the related SRH interventions and trainings that have happened in their communities. A few leaders from Lilongwe, Mzimba were aware of the activities. CADECOM was mentioned as having provided community training for the leaders.

- *"The youth in this village do not usually go for HTC services. We have noted that most youth who go to the hospital for HIV testing usually are the ones who are escorting their wives to the hospital as per rules of the male championship program" said one of the religious leaders from Thonje Health Centre catchment area.*

Community leaders from the 5 sampled project districts reported that they started supporting the provision of SRH services following the trainings they had received. Interviews at community level showed that only 30% of the community and religious leaders in all target districts were trained or orientated in SRH and HIV/AIDS. They mentioned that they were implementing the following activities as a result of the trainings; they set up village committee that help in dissemination of SRH information by organizing and holding meetings to sensitize the people in the villages about HIV and SRH. They further reported that they supported holding of outreach programs and distribution of educative materials such as posters and T-shirts. Other actions included the following:

- *Counselling of youth through youth groups and recreational activities for the youth*
- *Church elders provide advice to the youth based on biblical principles abstinence and have classes at all levels of the adolescent to teach them on SRH*
- *Islam faith promote circumcision, counselling the youth on SRH*
- *discourage discrimination, and encourage HTC among the youth and ART adherence*

In the control district however, none of the community and religious mentioned any activities they had ever done or were supporting with regards to promoting SRH uptake among the youth. They were also not aware of any SRH related activities within their communities despite receiving training from other stakeholders on SRH. This was a sharp contrast with the project target districts were the community and religious leaders were aware of schools educating students on SRH & HIV/AIDS and disseminating other IEC materials.

We however observed that the religious leaders in both control and project districts were not effectively trained and were underutilized to promote increased SRH uptake among the youth. From the interviews we observed that community leaders had not embraced the significant role that they can play in promoting SRH uptake among the youth. Interviewees reported that it was still a challenge for them to explain issues surrounding condom use and SRH among the adolescents. In fact the community leaders reported that there were still no *"unity in the message preached by religion, culture and secular education like SRH"*. This they explained was because none of the religions promote condom use among unmarried youth. The majority of the sampled religious leaders (70%) further reported "*it's hard for us to open up and tell our youth on the use of condoms and family planning because it's against our belief but we encourage them to abstain and get tested to know their status*".

On this intervention the study concludes that the community had their capacity built but were not effectively supporting the provision of SRH services in the communities. Further, the evaluation cannot confirm whether the trainings provided by the project were the only reason why some of the community chiefs and religious leaders reported to be supporting SRH activities at community level as they could not link the trainings they received to either NCA or GIZ or indeed the project.

3.4.4. Access to and utilization of SRH services among adolescents

The study established that all sampled health facilities (17) had "designated services with specific aim to encourage youth/adolescent utilization". These mostly included Youth Friendly Corners (YFCs) as part of their youth friendly health services provision efforts. Although all health facility representatives claimed to have designated services for adolescents only 15 facilities (representing 72% of the sampled facilities) actually had a youth friendly corner. The study found that youths were regularly making use of these YFCs in these facilities were they were available.

The study also found that majority of the health workers (83%) in the sampled facilities had received in-service training or training updates on topics specific to youth or adolescent friendly services. This claim corresponded well with what the youth said that they experienced a positive relationship with majority of the health workers.

Despite the levels of knowledge and training the study shows that the health facilities rarely provide SRH outreach services to the adolescents. As seen below only 38.95 of the sampled facilities in the project districts provide outreach services. However even though seems to be low, there were no such outreach activities by health facilities in the control districts. This shows that there some levels of influence by the project interventions (specifically, trainings) among health workers to provide outreach services through in the target districts. In fact interviewed students in the control district reported that they are not allowed to access condoms if they are under the age of 18. Primary school students reported that they have never received any information or attended SRH campaign by the health facilities.

Table 3: Health facilities providing outreach SRH services to adolescents

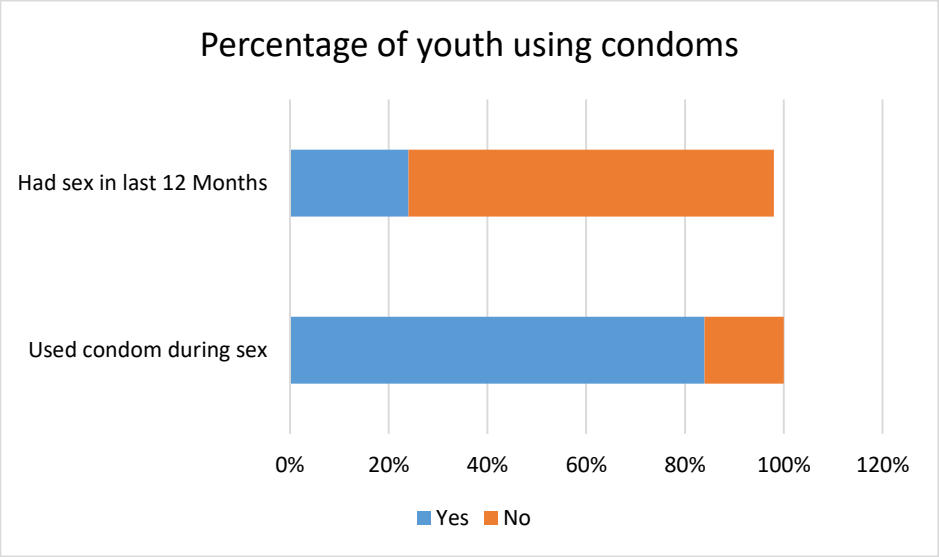
Do you provide outreach SRH services to adolescents?	Frequency	Percent
Yes	7	38.9
No	11	61.1
Total	18	100

In all sampled project districts, primary school students demonstrated knowledge of the available SRH services but only few of them actually accessed the services. Most of the students identified lack of privacy as the main barrier that restricted them from freely accessing the services. Some of the students said they do not access the services because they were still young to start indulging in sex. From FGDs, most youth and community leaders expressed concern that young people still faced barriers in terms of adolescent access to SRH services, such as 'lack of proper private rooms for accessing the SRH services and stock outs of condoms and testing kits'. Some 84% of the teachers sampled reported that Youth have access to youth friendly SRH. There was no significant difference between control and project districts. With regard to screening 10% of sampled youth reported to have ever gone for STI screening, but none of the youth from the control districts reported ever going for STI screening. In the same manner, while 6% of sampled youth in intervention districts reported having ever received STI

treatment, none of the youth from the control district reported ever receiving STI treatment. The pattern is largely similar with regard to voluntary male circumcision where 13% of sampled youth in intervention districts reported to have accessed VMMC and none from the control district.

Sexual activity is still an issue. Some 25% of all sampled youths in interventions areas reported to have had sex in the last 12 months. Of those that had sex in the last 12 months, 84% reported to have used condoms. There was no significant difference between respondents in control and project districts. Figures below illustrate condom use by the youths, among other SRH interventions

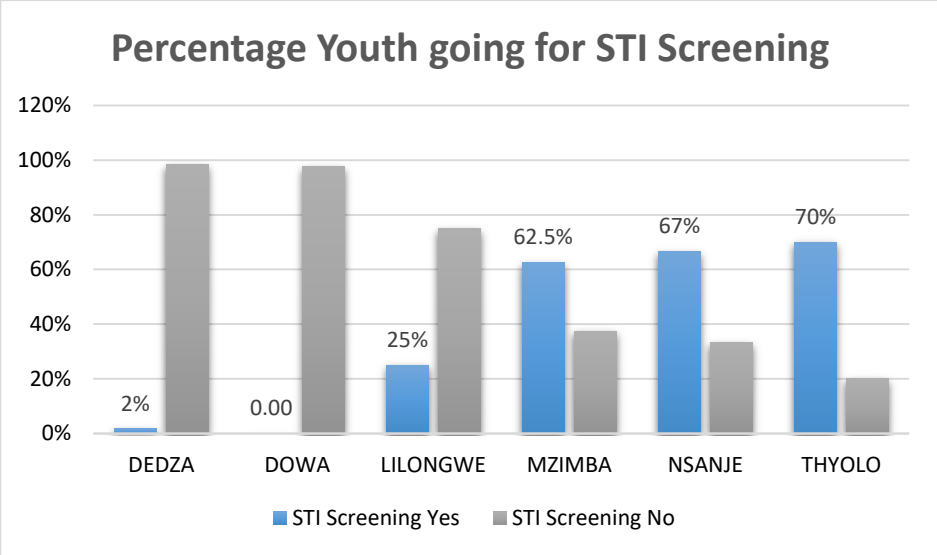
Figure 6: Percentage of Youth that used condom during last sexual intercourse



The study showed that among those not using condoms girls were at a disadvantage. Most of the girls that had been involved in unprotected sex, reported that they were just asked to go and have sex unexpectedly as such they were not prepared as would allow them to have condoms. In fact they reported that they were not fully aware of the consequences of the act they were about to engage in.

Further to the above data the study also found that even though they did not report to have had sex in the last 12 months, students in the intervention districts reported that they were accessing STI screening at the nearest health facilities after being given information through youth clubs established by their teachers or community leaders. None of the students in the control students reported to be accessing STI screening or treatment.

Figure 7: Percentage of Youth going for STI Screening



Beyond going for STI screening the evaluation also found that youth were accessing STI treatment in the GIZ project districts. This is a positive result for the project and shows the extent to which the project was relevant as there is a proportion of youth contracting STIs. It is worrisome that none of the youth in the control district were going STI screening and treatment when they were engaging in sex likely also contracting STIs.

Table 4: Percentage of youth accessing STI treatment

	Accessing STI Treatment	
District	Yes	No
Dedza	2%	98%
Dowa	0.0%	100.0%
Lilongwe	5%	95%
Mzimba	25%	73%
Nsanje	2.9%	97.1%
Thyolo		

3.4.5. Access to HIV Testing Counselling (HTC)

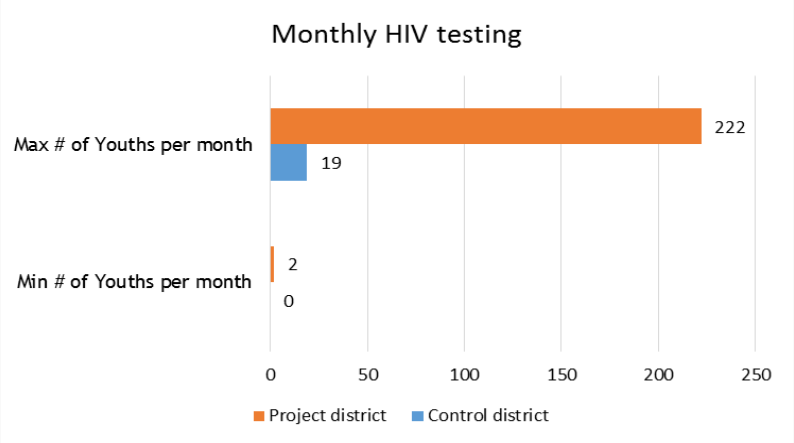
One of the key objectives of the project was to promote access to HTC services among adolescents through various community mobilization efforts. Literature indicates that when people are aware of their HIV status they tend to avoid risky behaviours. The study confirmed that the project partners had implemented several outreach campaigns to mobilize the adolescents to go for HTC. From public health facilities where the HTC data was extracted, the evaluation has showed that there were more youth are indeed accessing HTC service in the project districts than in the control district where access was very limited as shown on table 2 below.

Table 5: Access to HTC among adolescents (10-19 YO)

SUMMARY OF HCT REGISTER (July 2015 - June 2016)			
DISTRICT	TOTAL PARTICIPANTS	HIV TESTING	HIV POSITIVE
NSANJE	3951	3805	146
MZIMBA	9227	9041	186
DOWA	923	900	23
DEDZA	16311	15470	841
THYOLO	8824	8584	240
LILONGWE	8332	8252	80
TOTAL	47568	46052	1516

Analysis based on HTC records above in the project target districts shows that access to HTC ranged from 2 to 222 per month per district. In the control districts however there was significant low number of youth accessing HTC, this ranged from 0 to 19 per month with an average of 3 youth accessing HTC in the 3 facilities that were sampled in Dowa; there was actually only 1 youth per month accessing HTC services per facility. Further analysis of data from the project target districts shows that there were periods within the months where 10-19 year olds accessing HTC spiked to as 20 per facility per month confirm campaign or other forms of deliberate mobilization by implementing organizations and or the health facilities. In the project districts it was also observed that the number of youth age 15-19 accessing the services was almost double the number of youth between the ages 10 to 14, this is consistent with 2015 MHDS findings Details of the HTC data are as submitted in Appendix 1.

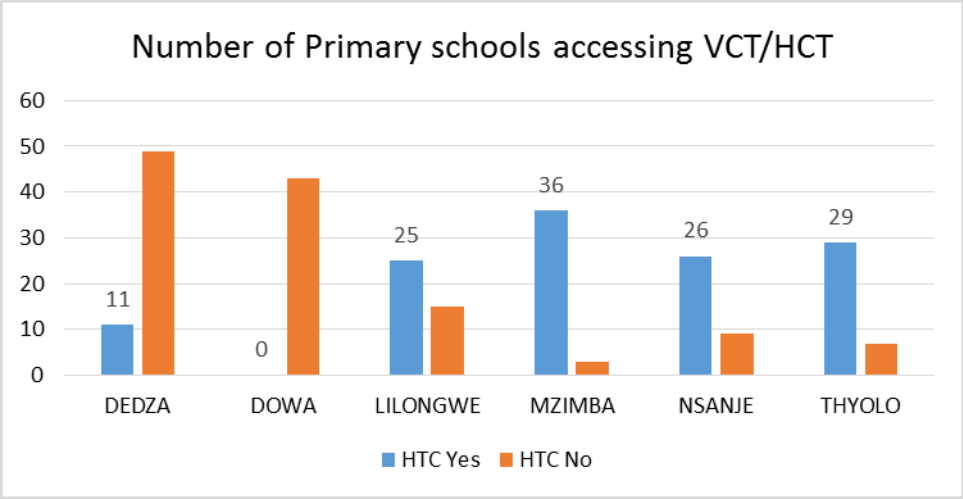
Figure 8: Number of Youth going for HTC per Month per district



The above findings show clearly that the project partners were able to mobilize the youth and create effective demand to HTC among adolescents.

Apart from the HTC records the study also found that primary school students were accessing HTC in all the project target districts. Students in the target districts were sensitized and encouraged by the teachers who were trained by the project to go for HTC and where necessary access treatment. There were no students in the control district (Dowa district reporting to have gone for HTC or VCT.

Figure 9: number of Primary school students accessing HTC



(Frequencies based on sampled students)

3.4.6. HIV treatment, care and support for ALHIV

The study found a positive response in terms of HTC and seeking of treatment among the young people. Data from the HTC and ART registers shows that HIV positive youths are able to seek treatment from the health facilities that were made youth friendly. The table below shows that teens that had tested for HIV were getting treatment from the health facilities.

Table 6: Percentage of tested youth on ART

	Frequency	Percent
Teens on ART	174	11.4%
Tested Positive but no info if they are on ART	1342	88.5%
Total	1516	100

The table above shows that you were getting treatment after testing positive for HIV. The study did not seek to trace whether all those that had tested positive were getting treatment. The study could therefore not confirm whether 88.5% of the teens that tested positive had started receiving ART treatment.

However among those teens that had started treatment, the study found that there were very low levels of defaulting. The study shows that on average 95% of all teens accessing treatment in the intervention districts were adhering to treatment. In terms of defaulting there was no significant difference between the control district and the project districts. See table below for summary.

Table 7: ART Defaults Summary

District	on ART	ART defaulters
Nsanje	21	0

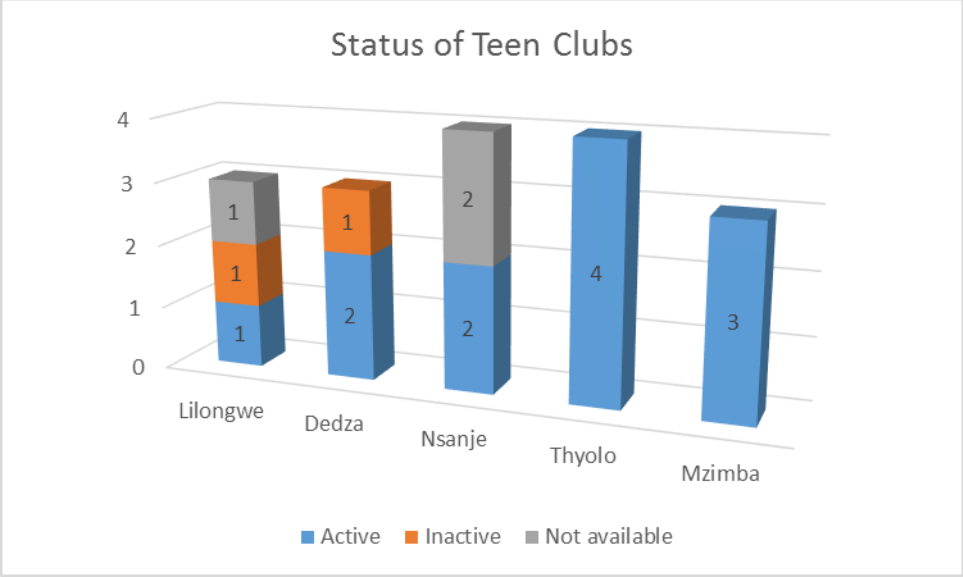
Mzimba	60	1
Dowa	7	1
Dedza	45	6
Thyolo	22	0
Lilongwe	19	1
Total	174	9

Although default rates where low, teen club members reported that they find it difficult to take mediation without proper food, as it "makes our bodies weak". They further reported that there's some discrimination both at home and at school as such they find it hard to take medication because other kids do not want to play with them when they learn that they take ART.

3.4.7. Care and support for ALHIV through Teen clubs.

The project purported to establish teen clubs in all target health facilities through Baylor Children Foundation. The teen clubs were seen as a key vehicle for providing care, counselling and psychosocial support to teens living with HIV. The study confirms that in the 5 sampled target districts, Baylor established teen clubs in 13 out of 17 list of health facilities that the client provided. We found that 10 out if the 13 established teen clubs were still functional to varying extents. One of the teen clubs (at Nkhoma Mission Hospital) had already been established by another INGO but Baylor reoriented the staff and gave them support. The chart below provides summary of the status of the teen clubs.

Figure 10: Status of teen clubs



The study found that 2 teen clubs had not been set up in Nsanje while, teens at Kang'oma health centre said there was no teen club established but only recalled the existence of a youth club. On a positive note all teen clubs in Mzimba and Thyolo were active. However In Golomoti,

a teen club was established after trainings were conducted by Baylor Children's Foundation, however the nurse interviewed at the health facility reported that teen club stopped being active in 2015 due among other things "lack of mentorship and supervision" from any of the project stakeholders. Another observation was made at Dzenza in Lilongwe where the teen club also stopped meeting regularly after the health workers who was trained to facilitate the teen club activities were transferred in 2015. This raises questions on the involvement of the District Councils in project and their capacity to orient new staff to take over the project initiatives. The teen club in Dzenza is inactive (barely meets). Overall the evaluation established that the teen clubs were not effectively managed, however from the few meetings that took place, teens experienced a lot of positive changes in their lives. This points to the potential of the teen clubs to improve the well-being of ALHIV, GIZ and partner ought to exploit this potential.
Focus Group discussion with the teens established that ALHIV had increased access to treatment, care and support through the teen clubs. Teen club members included both boys and girls and young children from the age of 10 to 19 years. From teens themselves, it was learnt that "there were positive changes in the ways they were handled and supported" both psychologically and in terms of treatment related issues. Most of them acknowledged that they had "benefited a lot from the teen clubs" in terms of being part of and among fellow youths with the same condition. The teens generally reported that they experienced a positive relationship with health workers. They highlighted they were able to access medication and received counselling in the most professionally acceptable manner from the health workers. It was clear that the health workers had established a very good relationship with the teens that made the teens feel supported and accepted. This aspect is very pivotal for ALHIV who report that they normally face some level of stigma and thus make them look down on themselves "as half people" to borrow their language. However other teens reported they do not discrimination, but said within their social circles insensitive remarks are made by friends about HIV. They therefore find health workers as their "source of hope and encouragement". The health workers have turned up to be the centre where they dream of a future again and feel being alive. This is one of the strongest impact of the teen clubs, psychosocial support in disease management is a vital ingredient.

Beyond the improved the relationships with the health workers who facilitated the teen clubs, the teens (ALHIV) also reported positive other significant outcomes from the clubs. They reported to have learned how to associate with everyone around them because at first they used to segregate themselves from those around them. They also learnt the importance of taking medication properly and the benefits of doing physical exercises. The teens said they have learnt that they can live a long and better happy life as everyone else and they were actually "living a happy and less stressful life now". There felt that most of the youth that attend the teen clubs access treatment from the health facilities are attending schools more regularly as their health has improved.

The challenges faced by ALHIV include some levels of discrimination by fellow adolescents, lack of recreational resources in the teen clubs, lack of dedicated space to be used as Teen Club as well as youth friendly corners. The teens at Dzenza reported that there were some health

workers who are very serious (not approachable) which makes it difficult to be free with them or ask them a question. The teens generally also complained that the hospitals/facilities put the teen club meetings on the same day as pregnant women which instils fear in the youths that the women will "gossip" about them in the community. In addition the study found out that it had become hard for young people to attend teen club sessions now that the project had phased out and there was limited support with regard to food and transport. Clearly this points to a serious sustainability challenge.

The evaluation find that's the project was effective in establishing teen clubs which were an operative vehicle for providing psychosocial support and accessing ART treatment. The efficiency and sustainability of the intervention was lacking, detailed comments will be made on in subsequent sections.

3.5. Project Influence on adolescent SRH Related Behaviour

Generally, the young people and key persons interviewed in this evaluation provided insight into the extent to which the project has influenced health behaviours and practices amongst young people, particularly those that directly participated in the interventions. However, nearly all groups of respondents also noted that significant strides are still to be attained with regards to eliminating risk-taking behaviour amongst young people. Although the proportion of young people reporting primary abstinence is high, those engaging in sexual activity further expose themselves to higher risk due to non-condom use and having sex with multiple partners. Of the 254 individuals who responded to the question, 24% reported having had sexual intercourse in the last 12 months; and out of those who had sex 79.1% used condoms, leaving a fairly large proportion n of nearly 20% who had not used condoms. Less than 5% of those interviewed reported having used other contraceptive methods in their previous sexual encounter other than the condom. In any case, high rates of HTC and low rates of ART default are positive indicators of behaviour change which may not be attributed to the project intervention as rates were also low in the control district.

3.6. Leadership, coordination and M&E

It is the finding of this evaluation that both national coordinating agencies (UNICEF, NCA) and implementing organizations (ie. Pakachere, BLM, Baylor etc) angaged with different degrees of readiness, capacity and experienced the support from GIZ differenly too. At lower levels operations were slowed down by delys in resource flows and limitations in mobility. One partners says "the flow of funds was not as expected until the project was abruptly suspended". This affected the implementation of the project. In addition, the set up of using GIZ vehilces was a big setback in the planning. We had to plan and implement our activities based on the availability of the GIZ vehicle which meant we had to adjust our work plans most of the times'.

While there were MOUs developed and signed among invoved partners, the evaluation established that there was no clear implementation map that was developed. In fact there was no documented shared understanding among of the key roles and responsibilities especialy between NCA and GIZ.

With regards to monitoring and evaltuation, the study has found that while there was results framework developed at leading implementing agency and the donor, there were no comprehesnive M&E tools developed by the lead implamenting agencies. Tools such as perfamance management plan, monitoring plan and indiciator tracking tables were not developed. Further to this, the study could also not confirm the availability of quality benchmarks or minimum standards for key project interventions which promote quality assusrance and guide monitoring of project activities. The project also did alo not develop beneficary reach tables and geographic targeting database to clearly map out how many youths were to be reached and where. The absence of the monitoring plan at both national and district level led to infrequent monitoring which contributed to the death of many teen clubs or their irregualr meetings. As one beneficary said "*..monitoring of the project would have helped NCA note that Dzenza teen club was long dead*". In fact when we asked teen club members what project should have done differently, some of the teen said "*monitoring and visits by the identified project role models so as to encourage peer learning*". The last quote also brings us to the last observation on M&E, the evaluation team noted that there was littile to no learning promoted among implementing partners or beneficiaries. We did not find evidence of joint partner planning and review meetings which would have fostered learning among the partners but also contribute to a well coordinated implementation. District Councils, health facilities, schools, implementing partners such as Pakachere, BLM were very disjointed in their approach.

The evaluation concludes that leadership, coordination and M&E for the project were poorly rolled out to say the least. In subsequent projects GIZ should require partners to have a clear project structure and comprehensive monitoring, evalualtion and learning plans.

3.7. Sustainability of the project

The design of the Project made efforts to ensure sustainability of the Project in 2 ways: establishing collaborations with other stakeholders and capacity building. The study found that Health Facility Staff, school teachers, and community leaders were trained and would likely continue to promote positive SRH seeking behavior among adolescents. We didn't see any deliberate efforts to engage MoEST in a way that the lessons around mobilization of students through Youth clubs from the project would be institutionalized.

Health centre staffs were trained in providing youth friendly services and there is a good chance that these will continue to be supported as it also remains the mandate of the MoH to achieve its objectives in addressing the SRH needs of Young People as stipulated in the National Youth Friendly Health Services Strategy 2015–2020 Strategy. However, there were no measures to ensure continuation of YFHS services when health personnel (trained by project) were transferred. In several cases we found that teen clubs had stopped meeting because a trained mentor or health work had been transferred or died.

Partners in all sectors were made part of the planning from ten outset; for example schools were involved and supported in managing SRH and HIV/AIDS youth friendly service. Asked what

aspect of the project would be easy to sustain, one implementing partner said 'the adolescent clubs revamped and established in most of our schools can be sustained more so if the School Management is eager. Ministry of Health can sustain HTC by targeting adolescents through youth and school clubs by incorporating them into their plans. Importantly, the participation of traditional leaders and religious leaders promotes sustainability of the project.

3.8. Establishing collaborations with other stakeholders

The project signed Memorandum of Understanding (MoUs) with the Government Ministries of Health and Education which enables it to continue lobbying the government to assist the young people and making sure that they receive the necessary support to access appropriate and up to date SRH services. Health Facility staffs were trained in providing youth friendly services. As noted above linking schools with SRH services will be a great innovation.

3.9. Involvement and Participation of young people in implementation

The evaluation has confirmed that young people especially ALHIV were actively involved in the project. The study established that all the teen clubs were set up operated on voluntary basis. This approach encouraged active participation and cultivated a spirit of ownership of the project by the young people. The young people drawn from the community to become the leaders and agents of information and knowledge sharing, somewhat contributes to the Project sustainability. In fact some of the teen club members reported to have participated in door to door youth mobilizing campaigns for the outreach program. Nonetheless, although the Project put in place a system that enables trained young people to cascade life skills to their peers, the training may not have been adequate to facilitate a focused transfer of skills to enable management of a structured intervention. Similarly, the quest for allowances by other NGOs and government staff had some negative impact on the project. While young people were willing to meet on voluntary basis, the facilitators who normally came from the implementing partners could only do so when there was an allowance to be received afterwards.

3.10. Visibility of the project, Implementers and Funders

The visibility of the Project, implementers and funders was a key component of any project. Like other aid financing scenarios, it is essential that there is a visibly link between the project and financier as it also provides the funders with a sense of presence, goodwill in their corporate social responsibility and strengthens the partnership. Similarly, the visibility of the implementers allows for transparency and accountability with stakeholders, communities and beneficiaries. Funders are likely to continue investing in initiatives that have positive benefits and that they can be linked with. Our evaluation has established that visibility of the funders and implementers was not quite notable. In schools and health facilities which were visited there were no visible billboards, IEC materials, placards among other about the project. Further, respondents at community level were unable to associate trainings which they attended with either NCA, GIZ or UNICEF. The project did not have a catchy or youth oriented name that could have been well popularized amongst the stakeholders or the youth at least. In many instances project beneficiaries were unable to link remember the project name nor its

donor although they could recall some of the activities that were done. This was a weakness on the part of project design and implementation.

4.0 CONCLUSION

The project by design, was very relevant in addressing the priority SRH needs of young people and was aligned to the national SRH strategy. HIV and AIDS has remained one of the major causes of mortality and morbidity in Malawi and this project contributed well in complementing the national efforts to curb its effects. While the project was not rolled out district wide in the selected districts as intended, we found sufficient evidence that the project was effective in delivering key planned interventions such as bridging knowledge gap among the youth about HIV and SRH services, improving access to SRH services including HTC, and improving access to HIV treatment, proving care and support to ALHIV. Youth demonstrated and good knowledge about HIV and SRH services and reported to have experienced improved relationship with heath workers in accessing SRH and HIV services (care, HTC, screening and treatment) especially through the teen clubs. The multi-thematic partner approach promoted active participation of young people in bringing change amongst themselves and their community. This approach proved to be effective in ensuring reach and breaking one of the major barriers to communication about SRH in the community as specialist NGOs that work with youth on various areas were part of the project. The participation of YP in the project was observed to be fairly adequate from Project design, its implementation as well as beyond the project lifespan. However, weak coordination and linkages among key implementing partners highly compromised project implementation. District councils, health facilities, schools, implementing partners such as Pakachere, BLM were very disjointed in their approach. The pulling out of UNICEF and BLM from the project was also a huge challenge to consistent, effective and efficient implementation of the project. We note that the project was not well managed, from a project management perspective; planning, communication, coordination and M&E were not deliberately and comprehensively done.

5.0 RECOMMENDATIONS

1. There is a real opportunity for GIZ to develop a better rationalized partnership which capitalises on the experience of one Coordinating Partner and a select number of Implementing Partners operating within the District Council framework to exploit multi-sector options and assure public sector driven implementation. In this GIZ will further grasp the potential for developing specific Partnership Guidelines, Standards and Rules of Engagement while maintaining ultimate accountability oversight.

2. In order to promote youth participation and leadership, strengthen early engagement of youth in the project. This should include consultations with the youth on key activities and of the project, how these activities would be implemented and clear mapping of how the youth will participate in such activities. This will further help prepare future actors in matters of SRHR.

3. Consider continued investment in the development and support of youth organizations, not least Teen Clubs, Child-to-child and the Sister to Sister Model. The Teen clubs and Youth Friendly corners proved to be effective vehicle for promoting youths' access to SRH, HTC and ART and care. However, in future similar projects, GIZ Health Programme should address weaknesses among that were observed such as lack privacy for adolescent; timing of teen clubs on with other activities such as antenatal clinics and availability of dedicated rooms youth friendly corners.

4. Further to 3 above, GIZ should consider adding comprehensive economic development (including IGA and VSL) as part of activities under youth clubs and teen clubs. This may contribute to the sustainability of such teen clubs as other members of teen clubs do often require support to travel long distances to participate in the Teen clubs.

5. Community and religious leaders interviewed could not associate the project nor with the donor or fully champion the activities of the project, we recommend that in future projects GIZ should identify key community liaisons/volunteers or SRH champions. These would be the key people that would be trained and motivated to lead in the implementation of project activities at districts including dissemination of SRH information and distribution of SRH items such as condoms among the youth. These could be serve as role models to champion SRH issues and training to youths. Further, community leaders recommended that future project should also target parents so that HIV/SRH learning continues at home.

6. As we could not trace whether all youth that tested HIV positive were receiving treatment, we recommend that future projects in future have a more robust post HTC and STI screening referral system with other health facilities within the districts. Most importantly such data should be made available by implementing NGOs to the DHOs. This would allow the follow up on treatment defaulters through the community SRH champions and extension health workers.

7. GIZ Health should ensure, as a requirement for its lead implementing agency, the development and rollout of comprehensive M&E systems that focus on routine monitoring, quality assurance and learning among stakeholders (vertical and horizontal). This should include development of quality benchmark or minimum standards for key interventions such as teen clubs and other youth school youth clubs. Monitoring need to an integral part and routine as opposed to ad-hoc or quarterly site visits based small sample of project sites.

8. With regards to project management, we recommend that future partnerships should rollout with more comprehensive start-up/kick off workshops. Among the key deliverables for these workshops should clear implementation arrangements informed by well documented project structure, harmonized M&E, financial systems among partners, close out plans and exit strategy (sustainability plans).

9. In the context of growing population urgency for Malawi, future SRH youth projects should also aim at addressing population growth by promoting more SRH (family planning and preventions of early pregnancies). There is a need to address population issues more holistically in the next decade.

10. In terms of visibility, the client should consider having implementing a stronger visibility strategy. This should include development of catchy, youth/community friendly project names (e.g. one word acronym in vernacular) that can be easily popularized amongst the beneficiaries for similar future projects. GIZ should also invest in some visibility materials that could promote a stronger association of their project interventions and outcomes to the funding agency.

6.0 REFERENCES

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