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Studies on the effectiveness and resourcing of unintended early pregnancy prevention interventions in South Africa and Malawi

Final Report

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The eight organisations and programmes are as follows:

- **In South Africa**: loveLife; Partners in Sexual Health (PSH) Common Good Programme; Soul City's Rise Women Clubs; and the Department of Social Development's out of school comprehensive sexuality education (CSE) programme, including intergenerational dialogues.
- **In Malawi**: The Ana Patsogolo Activity – DREAMS model, led by the Bantwana Initiative of World Education Inc (WEI / Bantwana); the *Break Free!* programme, led by SRHR Africa Trust (SAT); Developing Radio Partners' youth journalist project, as implemented during the Health Policy Plus programme; and the Safe Spaces model, as implemented by the Girls Empowerment Network (GENET) for the Spotlight Initiative.

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Executive summary

The Embassy of France in South Africa, Lesotho and Malawi commissioned Southern Hemisphere (SH) to conduct a study on interventions to prevent early, unintended pregnancy in South Africa and Malawi. The study consists of two components: evaluating the effectiveness of existing interventions and analysing the associated expenditure. This report focuses on the findings of the first component, with a summary of the second component. A separate report presents the findings of the second component of the study, and should be read in conjunction with this report.

The study objectives were threefold: identifying current interventions, assessing their relevance and effectiveness, and providing practical recommendations for improvement. A mixed methods approach was employed, including a literature review, qualitative data collection through interviews and focus group discussions, and a meta-analysis of interventions. It should be noted that the study sample was small, with only one implementation site visited per selected programme. Therefore, the findings cannot be generalized, but they offer valuable insights for reflection and learning.

Based on the document and literature review, the study team developed a Theory of Change (TOC) for early, unintended pregnancy prevention interventions. The TOC indicates that, in order to tackle the complexity of a problem such as early, unintended pregnancy, a holistic or "layered" approach, including a package of interventions, is required.

Overall, this study provides evidence and recommendations to support the prevention of early, unintended pregnancy in South Africa and Malawi, offering insights into effective interventions and areas for improvement.

Findings for South Africa

An overview of the prevalence of early, unintended pregnancy found that South Africa has witnessed a rise in teenage pregnancy rates, particularly among girls aged 10-14, attributed to multiple factors including limited access to contraceptives during the COVID-19 pandemic. Other factors which contribute to early, unintended pregnancy at different levels include inadequate access to sexual and reproductive health services, stigma and discrimination, low contraceptive knowledge and usage, poverty, gender inequalities, and limited education opportunities.

Early, unintended pregnancy has significant health, economic, and psychosocial impacts. Complications during pregnancy and childbirth are a leading cause of death among adolescent girls, while economic consequences include poor academic performance, limited educational and employment opportunities, and increased healthcare costs. Psychosocial impacts encompass anxiety, depression, stigma, and a perpetuation of the cycle of poverty.

The report also highlights relevant domestic policies, plans, and strategies aimed at preventing teenage pregnancy. Ten key documents were identified, providing a framework for addressing this issue in South Africa.

Based on a synthesis of information provided by respondents and a review of documents, four interventions were selected for in-depth review, namely: the Department of Social Development's (DSD) out of school comprehensive sexuality education (CSE) programme, loveLife's sexual and reproductive health (SRH) programmes, Partners in Sexual Health (PSH) Common Good Programme and Soul City's Rise Women's Clubs (SCI). These interventions focus on empowering young people, providing sexual and reproductive health services, offering economic opportunities, conducting educational programmes, and fostering community engagement. The interventions target out-of-

school youth and community members across multiple provinces, aiming to address SRHR, HIV prevention, and teenage pregnancy.

The study findings on **relevance** reveal that adolescent girls and young women in South Africa face significant challenges related to SRH. Access to and utilisation of SRH services are hindered by both demand and supply side barriers. Social norms, including beliefs about the inappropriateness of sex and SRH for young girls, contribute to stigma and limited access to services. Patriarchal norms and gender-based violence further restrict girls' and women's agency in negotiating safer sex and accessing SRH resources. Risky behaviours, such as unsafe sex and intergenerational relationships driven by unemployment and poverty, also increase the risk of unintended early pregnancy.

The sampled programmes show some response to the identified needs and challenges. They address socio-economic drivers through skills development, awareness raising, and economic strengthening initiatives. Programmes also aim to combat social norms and patriarchal beliefs through community dialogues, education campaigns, and interventions targeting parents and caregivers. Efforts are made to improve knowledge, attitudes, and skills of service providers to deliver youth-friendly SRH services. Additionally, alternative access points, such as community-based services and door-to-door distribution, are provided to overcome barriers like stock outs, limited access, and confidentiality concerns.

Despite these efforts, several gaps remain. The programmes lack comprehensive approaches to address social norms and unemployment/poverty at the community level. Furthermore, the demand for services exceeds the available resources.

Assessment of **effectiveness** of the various programme activities found that PSH, loveLife, and SCI are making significant progress towards achieving their programme activities and are close to reaching their targets. Community health care workers and district government officials confirmed that programme activities for all four organizations have been implemented in the sampled sites.

Programme staff reported implementing complementary interventions that provide a layered approach to services for adolescent girls and young women (AGYW) and adolescent boys and young men (ABYM) across targeted districts. AGYW and ABYM confirmed their participation in a variety of programme activities, including club activities, life skills training, awareness raising, community dialogues, and access to contraceptives and skills training.

The **strengths and challenges of implementation** varied for each programme. The DSD CSE out of school programme benefits from standardized implementation guidelines and partnerships with youth-focused skills development centres. However, inadequate budget allocation and staff shortages hamper effective rollout. The loveLife programme also stands out for its use of standard operating procedures, collaboration with relevant organizations, and involvement of community leaders. Challenges include losing Groundbreakers (youth volunteers) to other programmes due to varying stipend amounts. Similarly, whilst PSH's Common Good programme successfully employed 2,000 young people as Health Promoters, retention is a challenge due to low stipends and the availability of better-paying jobs. The programme's structure, which includes mentors and team leaders, provides strong management and support.

In general, all of the programmes have strengths in terms of collaboration with external stakeholders and implementation of adolescent and youth-friendly services (AYFS). However, challenges such as limited resources and resistance from parents and caregivers regarding sexual and reproductive health topics need to be addressed.

The **key changes and outcomes** achieved by the four interventions at the level of the individual include improved understanding of sexual and reproductive health and rights (SRHR) issues among the target groups, such as knowledge about contraceptives, HIV care, gender-based violence, and substance abuse. The participants also reported increased self-belief, self-confidence, and self-efficacy as a result of their participation in the programmes. Additionally, the interventions contributed to the economic empowerment of adolescents and young people, with participants gaining job experience, skills, and income opportunities.

At the community level, the interventions led to improved access to AYFS and increased uptake of SRH services, including among younger adolescents. Referrals to clinics, the presence of youth-friendly zones, and the inclusion of young programme participants as service providers inside and outside of health care facilities were identified as key enablers. However, barriers to service access and uptake included negative attitudes of clinic staff, lack of confidentiality of services, and parental resistance to discussing SRHR needs with their children.

Measuring the **impact** of the interventions on the prevention of unintended early pregnancy proved challenging due to the complexity of the issue, time required to observe impact, and difficulties in collecting accurate data due to underreporting.

Assessment of **coherence** found that the four interventions are aligned to policies like the Integrated School Health Policy (2021), National Adolescent and Youth Health Policy (2017), and National Integrated Sexual Reproductive Health and Rights Policy (2020). The collaboration between organizations and government departments is crucial for comprehensive service provision. The report presents a summary table in Annexure 7, illustrating how various stakeholders collaborate in preventing unintended early pregnancy.

The analysis further reveals that two out of the three civil society organizations (CSOs) sampled are actively collaborating with other CSOs and government departments. However, meaningful engagement of community stakeholders in programme planning is limited, as most CSOs and government stakeholders only inform and consult community stakeholders during programme implementation. To improve the coherence and collaboration of programmes, the report recommends meaningful engagement of community stakeholders, establishing clarity in priorities and roles from the outset, and the establishment of local structures for addressing unintended early pregnancy.

The evaluation found several mechanisms and factors that enable or hinder **sustainability.** Programmes addressing social norms, such as patriarchy, religious beliefs and cultural practices, have shown positive outcomes in preventing early, unintended pregnancy. However, the inclusion of boys and men, religious and traditional leaders in these programmes remains a challenge. Government ownership of interventions is also critical for sustainability including the strengthening of health systems, particularly the capacity of government service providers to offer youth-friendly services and adequate resources. Long-term interventions like loveLife have demonstrated effectiveness, but funding constraints hinder sustainability within the government context. Economic strengthening support is important for addressing poverty as a driver of risky behaviour, but limited employment opportunities pose a threat to sustainability.

The overall finding on the **adequacy** of programme interventions in reducing the prevalence of unintended early pregnancy found that the existing models and programmes, such as centre- and community-based services, have demonstrated effectiveness but are insufficient to meet the demand for services. Healthcare workers lack sufficient support and training to implement youth-

friendly services, and there are challenges related to stockouts resulting in limited access to contraception, and service options. Insufficient quality programmes addressing social norms and targeting at-risk groups, including boys and men, substance abusers, rural populations, LGBTIQ+ individuals, and persons with disabilities, pose gaps in reaching the intended audience. Furthermore, limited messaging about the consequences of unprotected sex, inadequate psychosocial support for girls and women, and insufficient focus on addressing unemployment, poverty, and substance abuse as drivers of risky behaviour in communities are persistent challenges which still need to be addressed.

It is thus concluded that interventions in South Africa are inadequate for the purpose of reducing the prevalence of early, unintended pregnancy to a satisfactory level.

Findings for Malawi

A literature review found that almost one third of total pregnancies in Malawi occur among adolescent girls aged 15 to 19 years. Factors contributing to high levels of early, unintended pregnancy in the country are myriad and include limited access to SRH services, particularly for those living in rural or hard-to-reach areas; discrimination and stigmatisation of those seeking SRH services, particularly young people; limited knowledge about SRHR and available services; poverty; limited education opportunities; and social and cultural norms and practices.

As for South Africa, the study found that early, unintended pregnancy has a number of health, economic and social impacts. In terms of health, both mothers and children face negative consequences such as increased risk of maternal mortality, pre-term birth, low birth weight, maternal depression, neonatal mortality, obstetric fistula, and anaemia. Economically, teenage mothers often face barriers that prevent them from continuing education and obtaining employment, perpetuating cycles of poverty and inequality; while social impacts of early, unintended pregnancy include stigmatization, discrimination and marginalization, coupled with limited access to healthcare, education and employment opportunities for young mothers and their children. It is clear that addressing these impacts requires comprehensive strategies.

In terms of relevant domestic policies, plans, and strategies aimed at preventing early, unintended pregnancy, the study identified nine key documents, which provide a framework for addressing this issue in Malawi.

Based on a synthesis of information sourced via primary and secondary data collection, four interventions were selected for **in-depth review** for the purposes of this study. These are the Ana Patsogolo Activity – DREAMS model, led by the Bantwana Initiative of World Education; the *Break Free!* programme, led by SRHR Africa Trust (SAT); Developing Radio Partners' youth journalist project, as implemented during the Health Policy Plus programme; and the Safe Spaces model, as implemented by Girls Empowerment Network (GENET) for the Spotlight Initiative. These interventions focus on empowering young people while providing information about – and facilitating access to – SRH health services. In addition, the four programmes offer psychosocial support, skills development and training, education support and reintegration, economic empowerment, and financial literacy training. The programmes target areas where there are high levels of HIV, SGBV, child marriage, and early, unintended pregnancy. Target groups include AGYW and ABYM as well as parents / guardians, community and traditional leaders, and members of the broader community.

The study findings on **relevance** indicate that demand and supply-side barriers exist, limiting young people's access to SRH information and services. On the demand side, these barriers include a lack

of information about available services, cultural and religious norms, stigmatisation of those seeking SRH services, and myths and misconceptions about contraceptives and their use. On the supply side, lack of infrastructure, stockouts of SRH commodities, and inadequate human resources, also hinder access to SRH services. Long distances and transportation costs pose additional challenges, especially for those in hard-to-reach areas. Limited access to youth-friendly health services and negative attitudes from healthcare staff also hamper delivery of SRH services to young people.

The study findings indicate that the four sampled programmes address the needs of young people to a large extent by providing education and information-sharing on SRH services and SRHR. In addition the programmes facilitate access to SRH services through linkages with service providers. The programmes also seek to create an enabling environment for young people to access SRH services through community and parent / guardian engagement activities. The study also found that the programmes take a holistic approach, addressing underlying socio-economic factors and empowering young people to advocate for change. However, some gaps exist, such as the need for comprehensive service delivery in communities and the limited number of interventions that focus on prevention of early, unintended pregnancies. Engagement of key populations, such as youth with disabilities, also appears to be limited.

The assessment of **effectiveness** of the various programmes found that all four programmes are successfully implementing planned activities within allocated programme time frames. In addition, standard operating procedures or guidelines are in place for all four programmes, and these are aligned to national and district-level strategies and action plans related to adolescent and youth-friendly SRH services, HIV/AIDS prevention, and the rights of AGYW and ABYM. Of note is that all of the reviewed programmes offer a range of activities or services, allowing for a holistic response to the SRH needs of young people. For example, in addition to the implementation of youth-focused programme activities, all of the selected programmes include extensive engagement with local community leaders as well as collaboration with district government officials and community structures. This collaboration ensures high levels of support and cooperation within targeted districts.

Feedback from AGYW and ABYM confirmed their engagement in the programmes as well as the activities being implemented. Programme **strengths** highlighted by study participants include the quality and relevance of the information and services provided; the high levels of technical expertise among programme staff; the localisation of programmes through the appointment of local coordinators and implementers; and the use of participatory, consultative and collaborative approaches, including community engagement. Other key strengths include the implementation of monitoring and evaluation (M&E) systems for tracking programme roll-out and recording outcomes; the adoption by all programmes of a youth-led and youth empowerment approach, and the inclusion of interventions targeting ABYM and fathers.

Reported **challenges** related to programme implementation include capacity and resource constraints, which are also limiting programme reach; limited budgets for programme overheads and equipment; personal costs incurred by participants, such as airtime and travel expenses; and challenges with youth club participation and retention, which may be related to confidentiality breaches. The loss of interest among community-based youth distribution agents due to a lack of incentives was also noted.

The study found that the programmes are achieving positive **outcomes** at both individual and community level. At the **individual level**, there have been improvements in knowledge and understanding of SRH issues amongst the targeted youth, leading to changes in behavior. Young people have gained self-belief and self-confidence, which has empowered them to express their needs and participate in community development and decision-making platforms. In addition, their involvement in programme activities has kept them engaged, thus reducing risky behaviours. Financial and psychosocial support provided by the programmes has also led to improved school attendance and retention rates. At the **community level**, the programmes have contributed to improved access to - and uptake of - SRH services. This is linked to youth gaining knowledge about where and how to access SRH services, as well as their right to do so. The combination of community information dissemination, sensitisation events, mobile clinics, peer educators and youth distribution agents has increased SRH service utilisation. The programmes have also addressed barriers such as limited access to health facilities, negative attitudes among staff, and stock-outs through advocacy efforts and referral mechanisms. There has also been a positive shift in family and community awareness of the SRHR of AGYW, resulting in support for education and discouragement of early marriages.

Data on the **impact of the programmes** on early, unintended pregnancy was not available due to various reasons. Study participants highlighted limitations in data collection, including under-reporting as a result of the stigma associated with early, unintended pregnancy. The complexity of measuring the contribution of specific programmes or programme elements to changes in prevalence also poses challenges. Additionally, the short implementation timeframes of three of the selected programmes means that more time is required before impact can be assessed. Lastly, health facilities experience a number of staff and resource challenges, making regular and accurate data collection on early, unintended pregnancy difficult.

In terms of **coherence**, all four programmes demonstrate a significant level of alignment with national priorities and policies regarding the prevention of early, unintended pregnancy. These include Malawi's National Youth Policy and Youth Friendly Services Policy, the National Sexual and Reproductive Health and Rights Policy, the National Strategy for AGYW, and the Ending Child Marriage strategy. All four programmes collaborate with various partners, including government actors, other CSOs, and community structures. Collaboration activities range from community sensitization meetings and the provision of mobile clinic services to joint capacity-building sessions. Periodic reviews are undertaken to ensure that effective coordination is taking place and to avoid any duplication of services. It was also reported that relevant stakeholders participate in meetings to review AGYW programming plans and discuss district interventions and events. Formal agreements and arrangements have also been put in place to define roles and responsibilities among implementing partners.

Despite these positive findings, it was noted that not all relevant stakeholders are participating in coordination initiatives and that there is a high reliance on the government to initiate such meetings. Additionally, study participants noted a somewhat 'narrow' approach to AYF SRH service provision, which is viewed as the responsibility of the Ministry of Health, thus neglecting the potential contributions of other sectors such as Education and Youth. Actively involving and recognizing these sectors could expand opportunities for AGYW to access services beyond traditional health facilities.

In terms of **sustainability**, the study highlighted the importance of strong coordination and collaboration among key actors, including government and other CSOs, for effective and sustainable programme implementation. Involving community structures and leadership from the programme

design stage ensures buy-in, community support and legitimacy, while also helping to address patriarchal socio-cultural norms and harmful traditional practices. Engaging parents / guardians helps in building their support for early, unintended pregnancy prevention initiatives as well as their knowledge and recognition of the SRHR of AGYW and ABYM. Other enablers of sustainability include building local capacity and including economic empowerment components in programmes to keep AGYW in school and promote self-sufficiency. Barriers to sustainability include limited engagement with parents / caregivers and the broader community, a high level of reliance on donor support, lack of resources for SRHR programmes, transportation challenges, and inactivity of some youth clubs. Transitioning larger programmes to government-led models is key for sustainability, but requires careful planning and sufficient resources.

The overall finding on the **adequacy** of the four programmes in reducing the prevalence of early, unintended pregnancy found that the comprehensive and holistic approach adopted by the programmes is highly effective. However, resource and capacity constraints limit programme reach and current coverage is insufficient in meeting the high demand for SRH services. Furthermore, while the programmes have successfully gained support from parents / guardians, religious leaders and traditional authorities, child marriage remains a threat to the effectiveness of early, unintended pregnancy prevention efforts. The study also indicates that those living in rural or hard-to-reach areas, LGBTIQ+ individuals, and persons with disabilities, are currently being underserved, while challenges related to public SRH service provision, such as limited infrastructure, stockouts and the lack of AYFS, also pose barriers to the effectiveness of interventions aimed at reducing early, unintended pregnancy.

It is thus concluded that, while a number of highly effective and holistic Malawi-based interventions that include components to prevent early, unintended pregnancy are in place, they are insufficient to reduce early, unintended pregnancy prevalence to a satisfactory level. Further support and funding is required to allow programmes demonstrating good practice to scale and expand their reach, while strengthening their ability to meet high levels of demand for SRH information and services, and protect the SRHR of young people.

Lessons learned and recommendations for preventing early, unintended pregnancy

Layered Interventions and Adoption of a Holistic Approach: Addressing early, unintended pregnancy requires a comprehensive approach that tackles multiple contributing factors, including social, cultural, behavioural, and structural drivers. This approach involves layering interventions such as comprehensive sexuality education (CSE) in and out of school, youth-friendly services in clinics, and economic empowerment programmes, and addressing misconceptions through information, education, and communication.

Improving Access to Youth-Friendly Services: It is important to scale up access to youth-friendly services that provide confidential, non-judgmental, and accessible options for young people. Starting in areas with a high prevalence of early and unintended pregnancy is recommended.

Addressing Structural Barriers: Efforts should be made to address the structural barriers that contribute to increased risk, such as poverty and unemployment. Programmes that link girls and women to economic opportunities, including skills development, entrepreneurial skills, and job opportunities, should be implemented.

Behaviour Change Programmes: Expand behaviour change programmes that target social norms and involve the entire ecosystem of young people, including girls, boys, parents/caregivers, traditional and religious leaders, and service providers.

Psycho-Social Support: Widely offer psycho-social support and programmes that address substance abuse, integrating sexual and reproductive health and HIV services into such programmes.

Targeted Interventions: Develop differentiated interventions for boys, persons with disabilities, substance users, young people living with HIV, and LGBTQI groups. Age-specific interventions should also be considered.

Exit Strategies: Implement exit strategies or support packages for those graduating from programmes to ensure sustainable outcomes. These strategies can focus on post-school education opportunities, economic empowerment, internships, and entrepreneurial opportunities.

Sustainable and Scalable Solutions: Emphasize the need for evidence-based sustainable and scalable solutions for youth-friendly services and programmes addressing early and unintended pregnancy. These solutions should be feasible within government resources and institutionalized and owned by the government.

Stakeholder Engagement and Coordination: Engage all stakeholders at different levels (provincial/district/community) to collaborate and address the multi-dimensional nature of early and unintended pregnancy. Regular meetings should be scheduled to provide updates on progress and programme impact.

Coordinated Efforts: Strengthen coordination between organizations and departments involved in early and unintended pregnancy prevention. Provide technical support and funding to improve coordination efforts.

CSO Roles: Civil society organizations (CSOs) play a vital role in expanding and deepening SRHR programmes and services. Clearly define the role of CSOs and key departments in tackling early and unintended pregnancy, and improve collaboration between CSOs and schools.

Youth Participation and Engagement: Involve young people in the design and implementation of pregnancy prevention programmes to ensure relevance. Create safe spaces for youth to engage with each other, express their opinions, and provide peer-to-peer education and outreach.

Inclusion of Boys: Target both boys and girls equally to reduce early and unintended pregnancy, promoting gender equality and responsible sexual behaviour. Empower boys with knowledge about sexual and reproductive health, contraception, sexually transmitted infections, and healthy relationships.

Inclusion of Parents/Caregivers: Involve parents and caregivers in sexual and reproductive health programmes to equip them with accurate and age-appropriate information. Improve communication and create a supportive environment at home for healthy decision-making by young people.

Inclusion of Traditional and Religious Leaders: Engage traditional and religious leaders to mobilize communities, promote acceptance and support, and address cultural barriers and stigmas related to prevention efforts.

Intergenerational Dialogues: Utilize intergenerational dialogues as a tool to involve parents/caregivers and community members in tackling early and unintended pregnancy. Create inclusive spaces that respect cultural and generational differences and power dynamics.

Training and Mentoring: Provide regular training and mentoring for SRHR service providers to ensure the dissemination of accurate and up-to-date information and services.

Monitoring and Evaluation: Establish a robust system to collect disaggregated data, analyse, report, and learn from pregnancy prevention interventions. Sharing evidence of successful interventions across sectors promotes learning and collaboration.

List of abbreviations

ABYM	Adolescent boys and young men
AGYW	Adolescent girls and young women
AYFS	Adolescent and youth friendly services
APA	Ana Patsogolo Activity
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEFM	Child, Early and Forced Marriage
COVID-19	Coronavirus Disease of 2019
CSE	Comprehensive sexuality education
CSO	Civil society organisation
DAC	Development Assistance Committee
DBE	Department of Basic Education
DOH	Department of Health
DRP	Developing Radio Partners
DSD	Department of Social Development
ESA	Eastern and Southern Africa
FAWE	Forum for African Women Educationalists
FGD	Focus group discussion
FP	Family planning
GBV	Gender-based violence
GENET	Girls Empowerment Network
HIV	Human immunodeficiency virus
HTS	HIV Testing Services
HIVST	HIV Self-Testing
M&E	Monitoring and evaluation
MPoA	Maputo Plan of Action
PEP	Post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis
PSH	Partners in Sexual Health
SAT	SRHR Africa Trust
SCI	Soul City's Rise Women's Clubs
SDG	Sustainable Development Goal
SGBV	Sexual and gender-based violence

SCI	Soul City Institute
SH	Southern Hemisphere
SOP	Standard Operating Procedure
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health rights
SSI	Semi-structured interview
STI	Sexually transmitted infection
TOC	Theory of change
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
VSLA	Village savings and loan association
YFS	Youth friendly services

Contents

1 Introduction 17
2 Study objectives 17
3 Study methodology 18
3.1 Study design, methodology and process 18
3.2 Selected programmes 19
3.3 Data collection 20
3.4 Data analysis 20
3.5 Interpretation of study findings 21
4 Definition of terms 21
5 Tentative Theory of Change for early, unintended pregnancy prevention interventions 22
6 Findings on international and legal frameworks 23
7 Presentation of findings for South Africa 24
7.1 Background and context 24
7.1.1 Prevalence of early, unintended pregnancy in South Africa 24
7.1.2 Factors contributing to early, unintended pregnancy 25
7.1.3 Impact of early, unintended pregnancy 26
7.1.4 Domestic policies, plans and strategies 27
7.2 Overview of interventions 27
7.2.1 Key objectives, description of services, target group and reach 27
7.3 Relevance 29
7.3.1 Major problems or needs faced by adolescent girls and women 29
7.3.2 Programme response and relevance to these needs 31
7.4 Effectiveness 33
7.4.1 Extent to which programme activities have been achieved 33
7.4.2 Strengths and challenges of implementation 35
7.5 Emerging outcomes 42
7.5.1 Key changes / outcomes achieved 42
7.5.2 Impact on prevention of unintended, early pregnancy 46
7.6 Coherence 47
7.6.1 Programme alignment to national priorities and policies 47
7.6.2 Collaboration with other, similar programmes and services implemented by government or NGOs 47
7.7 Efficiency: summary of findings from the costing exercise 48
7.8 Sustainability 50
7.9 Assessment of adequacy 52
7.10 Conclusion 53
8 Presentation of findings for Malawi 55

8.1 Background and context 55
8.1.1 Prevalence of early, unintended pregnancy in Malawi 55
8.1.2 Factors contributing to early, unintended pregnancy 55
8.1.3 Impact of early, unintended pregnancy 56
8.1.4 Domestic policies, plans and strategies 57
8.2 Overview of interventions 58
8.2.1 Key objectives, description of services, target group and reach 58
8.3 Relevance 64
8.3.1 Major problems or needs faced by adolescent girls and young women 64
8.3.2 Programme response and relevance to these needs 67
8.3.3 Programme gaps 68
8.4 Effectiveness 69
8.4.1 Extent to which programme activities have been achieved 69
8.4.2 Strengths of implementation 72
8.4.3 Challenges of implementation 74
8.5 Emerging outcomes 75
8.5.1 Key changes / outcomes achieved 76
8.5.2 Impact on prevention of unintended, early pregnancy 79
8.6 Coherence 80
8.6.1 Programme alignment to national priorities and policies 80
8.6.2 Collaboration with other, similar programme and services implemented by government or NGOs 80
8.7 Efficiency: summary of findings from the costing exercise 83
8.8 Sustainability 85
8.8.1 Enablers to sustainability of changes achieved 85
8.8.2 Barriers to sustainability of changes achieved 87
8.9 Assessment of adequacy 87
8.10 Conclusion 88
9 Lessons learnt and recommendations for programme scaling and replication 90
Annexure 1: Ethical clearance letters 95
Annexure 2: Literature review 96
Annexure 3: Theory of change for prevention of early, unintended pregnancy 97
Annexure 4: Sample of study participants 98
Annexure 5: TOC assumptions 101
Annexure 6: Detailed overview of interventions 103
Annexure 7: Nzululwazi Model 111
Annexure 8: Collaboration between CSOs and Government in South Africa 111

List of tables

Table 1 Factors contributing to early, unintended pregnancy in South Africa 25
Table 2 Overview of South African interventions selected for in-depth review 28
Table 3 Programme response to AGYW needs 32
Table 4 Reach for South African interventions under review 34
Table 5 Feedback from AGYW and ABYM on their engagement in programme activities 34
Table 6 AGYW and ABYM perceptions of programme strengths and challenges 38
Table 7 Factors contributing to early, unintended pregnancy in Malawi 56
Table 8 Overview of Malawi models selected for in-depth review 59
Table 9 Programme response to AGYW and ABYM needs 67
Table 10 Feedback from AGYW and ABYM on their engagement in programme activities 70
Table 11 Summary of stakeholders with whom the programmes collaborate 80
Table 12 Key assumptions underpinning the TOC in the South African Context 101
Table 13 Key assumptions underpinning the TOC in the Malawi context 101
Table 14 South Africa interventions 103
Table 15 Malawi interventions 106

List of figures

Figure 1 Three-phase study process 18
Figure 2 Thematic data analysis process 21
Figure 3 Reviewed policies, strategies and guideline documents (South Africa) 27
Figure 4 Demand and supply side barriers affecting access and utilisation of SRH services 29
Figure 5 Key changes achieved by the programme interventions 42
Figure 6 Young Women's Rise Clubs overview of cost 48
Figure 7 PSH Common Good overview of costs 49
Figure 8 PSH Common Good per unit cost 49
Figure 9 Sustainability mechanisms 51
Figure 10 Reviewed policies, strategies and guideline documents (Malawi) 58
Figure 11 Demand and supply side barriers affecting access and utilisation of SRH services 64
Figure 12 Key changes achieved by the programme interventions 76
Figure 13 GENET overview of cost 83
Figure 14 Developing Radio Partners overview of cost 84
Figure 15 Sustainability mechanisms 86

1 Introduction

The Embassy of France in South Africa, Lesotho and Malawi commissioned Southern Hemisphere (SH) to undertake a study for evidence generation on interventions aimed at preventing early, unintended pregnancy interventions in South Africa and Malawi. The study, which falls under the framework cooperation programme *Strengthening of the prevention of unintended early pregnancy in South Africa and Malawi*, funded by the French Embassy[1], consists of two components; namely:

- A study on the relevance, effectiveness, coherence and adequacy of interventions for the prevention of early, unintended pregnancy in South Africa and Malawi; and
- An expenditure analysis/review and building of costing models for selected interventions aimed at preventing early, unintended pregnancy in South Africa and Malawi.

This report presents the findings for the first component of the study and includes a summary of the findings for the second component. It starts with a description of the study objectives and methodology; definitions of the terms *early, unintended pregnancy* and *prevention*, which were formulated for the purpose of this study, and a tentative theory of change for comprehensive interventions addressing early, unintended pregnancy. Thereafter, two main sections present the study findings for South Africa and Malawi with each section following the same structure. This includes an overview of selected interventions and findings related to their relevance, effectiveness, outcomes, sustainability, and coherence. Each section also presents an assessment of the adequacy of programmes tackling early, unintended pregnancy. A summary of the findings of the expenditure review and costing exercise is also provided. The report concludes with a set of lessons learnt and recommendations for programme scaling and replication.

2 Study objectives

The aim of this study is to gather and present information that will allow for reflection and learning in relation to programming that seeks to address the *"… unabated – if not increasing – number of cases of unintended pregnancy amongst adolescent girls in South Africa and Malawi…",*[2]. As such this study seeks to achieve the following three key **objectives**, namely:

- To identify **current interventions** aimed at preventing early, unintended pregnancy in South Africa and Malawi;
- To assess the **relevance, effectiveness, coherence and adequacy** of a selected set of interventions; and
- To draw **practical recommendations** to improve the relevance, effectiveness, coherence, and adequacy of such interventions.

[1] For further information regarding the two studies, please see https://en.calameo.com/read/007205212d81cd50b1789.

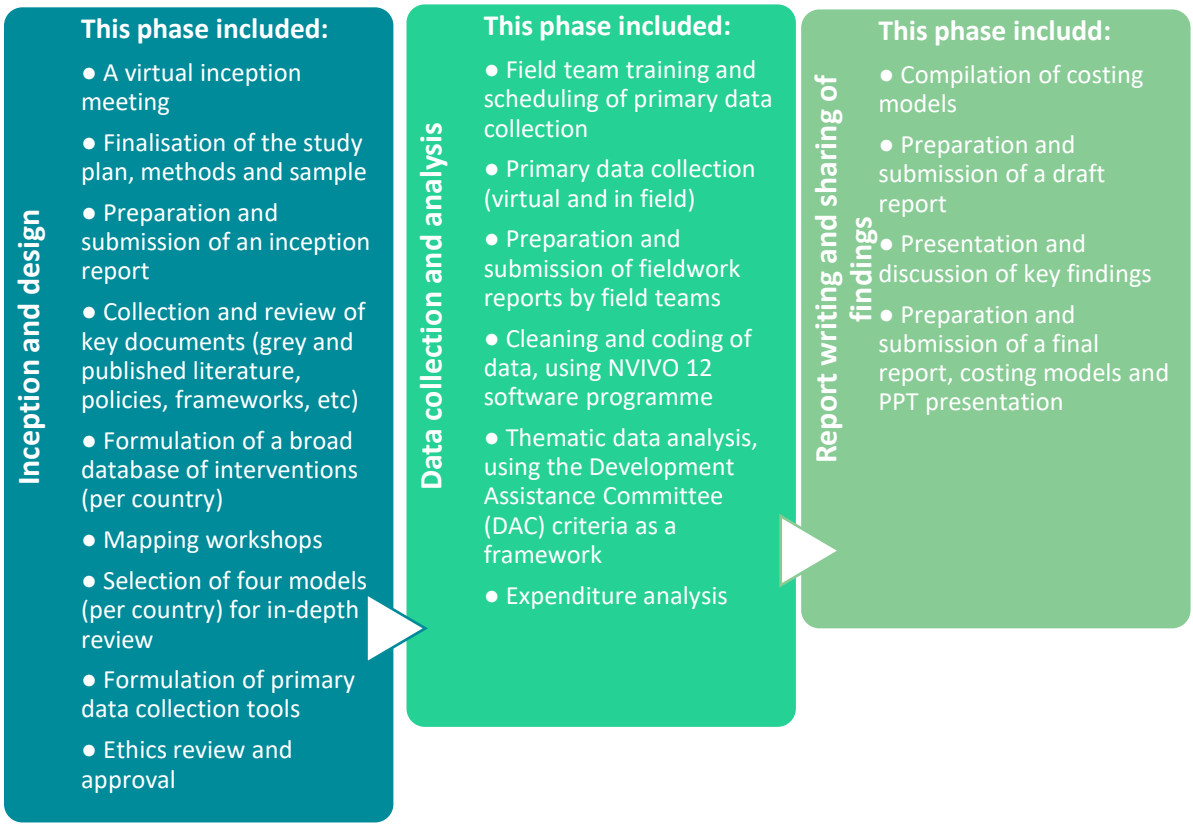
[2] Terms of Reference for *Study on the relevance, effectiveness, coherence and adequacy of interventions for the prevention of unintended early pregnancy in South Africa and Malawi* (undated); page 2.

3 Study methodology

3.1 Study design, methodology and process

The study applied a mixed methods approach including a literature and document review and primary qualitative data collection (focus group discussions and face-to-face or virtual semi-structured interviews). Triangulation of sources and techniques was central to our data collection method and analysis. The three phases of the study are summarised in the figure below.

Figure 1 Three-phase study process



A participatory and utilisation-focused approach was used. Therefore, SH worked closely with the French Embassy and with the country study advisory groups throughout the research process.

The section below outlines the key steps in the study process.

- A virtual inception workshop was held on 12 October 2022 to kick-start the study and to finalise the study design, questions and sample. The workshop included a brainstorming session regarding key interventions for prevention of early, unintended pregnancy in South Africa and Malawi.[3] An inception report was then prepared and submitted to the French Embassy and advisory groups for comment and review.

[3] A total of 19 people attended the workshop including representatives from the European Union Delegation, the National Population Unit (NPU) within the Department of Social Development (DSD) in South Africa, the Department of Women,

- The reference groups approved the inception report, following which data collection tools were designed and submitted, together with the research protocol, to two review boards, the Sociology Department at the University of Cape Town, South Africa and the National Committee on Research in the Social Sciences and Humanities in Malawi, for review and ethical approval[4].
- The study also included an extensive literature review (contained in Annexure 2) to establish a non-exhaustive inventory of policies, plans, strategies and programmes focusing on the prevention of early, unintended pregnancy in South Africa and Malawi. A curated list of interventions was compiled together with an analytical framework, to analyse each of the identified programmes.
- This was followed by a meta-analysis of the identified interventions, the purpose of which was to identify key enablers and determinants of successful models, and where these possibly overlapped. The literature review and meta-analysis also allowed for development of a tentative theory of change (TOC) for interventions aimed at preventing early, unintended pregnancy.
- Following completion of the literature review, two mapping workshops were conducted (one per country). These allowed for presentation of the literature review findings as well as consultation with key stakeholders from government and civil society organisations regarding interventions being implemented within their respective countries. During the workshops, the criteria for selection of the four programmes per country for in-depth review were discussed and refined. These are outlined below:
    - **Type of programme or intervention**: It was decided that the study should include a mix of interventions that included components depicted in the tentative TOC, thus allowing for the delivery of a holistic or 'layered' package of services including social behaviour change interventions, biomedical interventions and interventions addressing structural issues and key predictors of early, unintended pregnancy[5];
    - **Type of implementer**: The study would, as far as possible, select interventions implemented by government, as well as local and international NGOs;
    - **Geographic location**: A mix of rural, semi-urban and urban intervention sites were to be selected;
    - **Availability and consent**: Only those programmes where implementing organisations were willing and available to participate in the study, were to be selected.

3.2 Selected programmes

The selected programmes are outlined in the table below:

Youth and Persons with Disabilities in South Africa, the Ministry of Gender, Community Development, and Social Welfare in Malawi, and the Association of Social Workers in Malawi amongst other stakeholders.

[4] See Annexure 1 for communication regarding the granting of ethical clearance

[5] See the TOC in section 5 below for further detail

South Africa	Malawi
loveLife	***Ana Patsogolo Activity – DREAMS model*, led by the Bantwana Initiative of World Education Inc (WEI / Bantwana)**
Partners in Sexual Health (PSH) *Common Good Programme*	***Break Free! programme*, led by SRHR Africa Trust (SAT)**
Soul City's *Rise Women Clubs*	***Developing Radio Partners' youth journalist model*, as implemented during the Health Policy Plus programme**
Department of Social Development's *Out of school comprehensive sexuality education (CSE) programme including intergenerational dialogues*	***Safe Spaces model*, as implemented by Girls Empowerment Network (GENET) for the Spotlight Initiative**

3.3 Data collection

Primary data was collected in Malawi and South Africa over the period March to April 2023. Qualitative research methods were used, including semi-structured interviews (SSIs), which were conducted virtually and in-person, and focus group discussions (FGDs), which were all conducted in-person.

Study participants included national government officials, national and international civil society organisations (CSOs), United Nations (UN) agencies, and sector experts. One intervention site was selected per programme. Here, interviews were conducted with district government officials, programme management, implementation and financial staff, community health care workers, community leaders, parents/caregivers/guardians, and adolescent girls and young women (AGYW) and adolescent boys and young men (ABYM).

A purposive sampling method was used to select government, UN agency and CSO representatives, as well as community health care workers and community leaders; that is, these participants were selected based on their roles, participation in and knowledge of the selected programmes.

A non-probability convenience sampling method was used to select parents/caregivers/guardians, AGYW and ABYM. Here the following factors were considered:

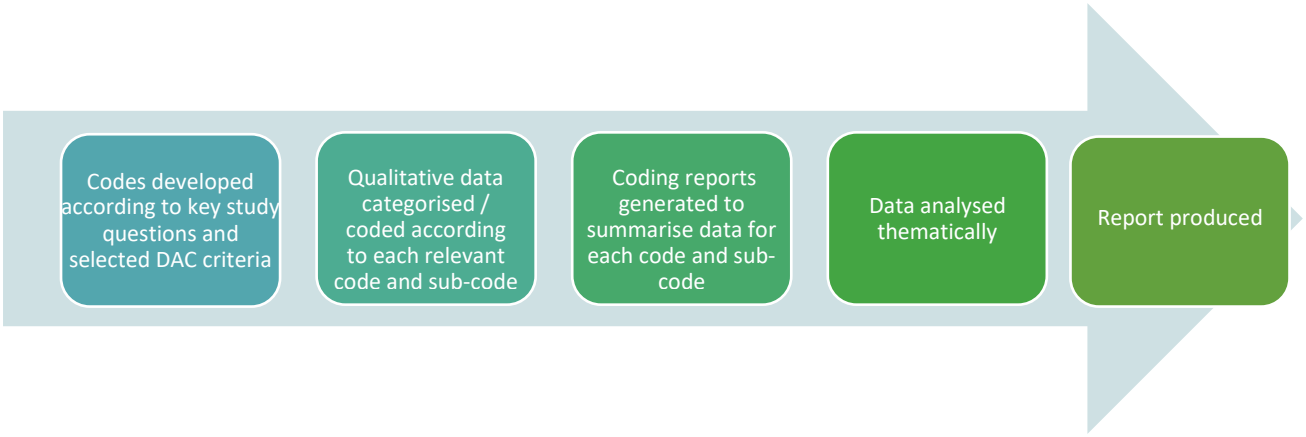
- gender balance,
- age,
- duration of time engaged in the programme.

The proposed sample was almost fully achieved, as indicated in **Annexure 4**. Sixty six SSIs and 16 FGDs were conducted in total.

3.4 Data analysis

The figure below summarises the data analysis process, which is elaborated on in the narrative below.

Figure 2 Thematic data analysis process



The research team categorised the raw data using the NVIVO 12 software programme. The process is as follows:

- As a starting point, the study team familiarised themselves with the data by doing a preliminary 'read through' of all transcripts/interview and focus group notes.
- A code sheet or data classification / coding framework was developed, based on the DAC criteria selected for the study (relevance, coherence, effectiveness, sustainability), as well as key research questions.
- This coding framework was entered into NVIVO 12, following which team members captured and categorised / grouped all primary data according to the relevant code or sub-code.
- Once all data had been collected, findings were compared across data sources to ensure consistency of findings. Where findings were inconsistent, this is highlighted in the findings.

3.5 Interpretation of study findings

The following considerations are noted in relation to this study.

- The study sample is small and only one implementation site was visited per programme. Therefore, it should be noted that the findings cannot be generalised across all programme sites. The data collected is, however, adequate for this study given that the purpose thereof was not to undertake a comprehensive evaluation of each programme. As outlined in the introduction to this report, the study aimed to gather information about programmes that address early, unintended pregnancy, for reflection and learning about what works, why it works, and what might be replicated and scaled going forward.
- While the report outlines findings regarding programme outcomes, these should be treated with caution as a) only one site was visited per programme, and b) some programmes only commenced full implementation in the post COVID-19 period; that is, from 2022 onwards.

4 Definition of terms

- The study focused on interventions that address **early, unintended pregnancy.** This is understood as a pregnancy that occurs to an adolescent girl between 10-19 years old who was not planning to have any (more) children, or was mistimed in that it occurred earlier than

desired, and regardless of whether the pregnancy is carried to term or not (termination, miscarriage, etc).

- By **prevention**, one means a deliberate undertaking aimed at stopping early, unintended pregnancy from happening. As such, the study did not consider interventions aimed at managing situations from the moment an adolescent girl has fallen pregnant.

5 Tentative Theory of Change for early, unintended pregnancy prevention interventions

The TOC captured in **Annexure 3** is based on the document and literature review. This review indicates that, in order to tackle the complexity of a problem such as early, unintended pregnancy, a holistic or "layered" approach, including a package of interventions, is required.

The **ultimate desired impact** noted in the TOC is *the prevention of early and unintended pregnancy amongst adolescent girls between 10-19 years*. There are **three pathways** to achieving this objective, which are based on a set of interventions representing a multi-sectoral approach. These pathways include:

- **Social behaviour change interventions** including CSE in school and co-curricular activities such as girls' and boys' clubs; CSE out of school; and family and community interventions.
- **Biomedical interventions** including sexual and reproduction health (SRH) services such as the provision of contraception and emergency contraception.
- **Structural interventions** including programmes that respond to the structural drivers of early, unintended pregnancy. These include social services, social security measures (grants), education, and economic empowerment programmes.

The **short-term outcomes** of these interventions for AGYM and ABYM are that they will have a comprehensive understanding of SRH issues as well as their rights in relation to SRH; improved access to adolescent and youth friendly services (AYFS); and access to psycho-social support services, cash grants, economic empowerment activities, and education. In addition, families and communities will have an increased awareness of AGYW and ABYM SRH rights and needs, and spaces for dialogue about SRH priorities and challenges (and how to address them) will be created. This will allow for improved support to adolescents and young people.

The outcomes above will, in turn, result in **longer term outcomes** or changes for AGYW and ABYM who will:

- Have improved self-belief and self-confidence, resilience, self-efficacy and social integration;
- Increase their uptake of SRH services, specifically contraception;
- Remain in school and complete their education; and
- Be economically active or have access to opportunities when they leave school.

The TOC further builds on the notion that the long-term impact is unlikely to be achieved unless a series of **system-level changes** take place. In other words, if there is insufficient government support, little collaboration and coordination among implementers and government departments, and a general lack of data and evidence to support learning and responsive programming, then it is unlikely that the outcomes will be achieved. The following system elements or foundational items thus need

to be in place to ensure that there are well-coordinated, well-resourced and evidence-informed programmes and services available:

- Alignment of programmes and services to international, regional and domestic legal frameworks
- Leadership support and buy-in
- Stakeholder coordination and collaboration
- Adequate financial resources
- Adequate and skilled human resources, including strong implementing partners
- Results-based monitoring and evaluation (M&E) and data management

Key assumptions underpinning the TOC

Detailed assumptions per intervention, as highlighted by the evaluation respondents, are captured in **Annexure 5**. The common assumptions across all of the programmes are:

- that community members and families must be well-informed about the programme goals and approach to facilitate and encourage their buy-in and programme support;
- that collaboration is a vital component of all SRH interventions and takes place with all key stakeholders;
- that youth-friendly spaces for discussion about SRH topics are available and accessible;
- that young people need to receive accurate and up-to-date information about available services to encourage uptake thereof;
- that resources, like contraceptives, are readily available and in keeping with demand; and
- that adequate budgets and trained personnel are available to support SRH interventions.

Overall, there was a high level of consensus amongst programme stakeholders regarding the need for sufficient funding, community buy-in, the adoption of a holistic approach, strong partnerships and collaboration, the creation of an enabling environment, and education about SRH and related services, being essential to address early, unintended pregnancy.

6 Findings on international and legal frameworks

International and national priorities for SRH rights (SRHR) in Malawi and South Africa are aligned, as evidenced by the ratification of international commitments and frameworks by both countries. While implementation on the ground remains a challenge, these commitments have provided a foundation for government lobbying and calls to recognize SRHR as human rights, and for civil society and international agencies to develop monitoring and accountability tools.

Some of the international commitments and frameworks that have been ratified include:

- The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW; 1979)[6]

[6] CEDAW, 1979. *Convention on the Elimination of All Forms of Discrimination Against Women*.

- United Nations Convention on the Rights of the Child (UNCRC; 1989)
- International Conference on Population and Development Programme of Action (1994)
- Sustainable Development Goals (SDGs; 2000), particularly SDG 3, 4 and 5
- The Maputo Plan of Action (MPoA) on the Continental Policy Framework Strategy on Sexual and Reproductive Health and Rights (2006)
- The Convention on the Rights of Persons with Disabilities (2006)
- The United Nations Special Assembly on HIV/AIDS (2001); which considers how to implement SRHR and services in Africa
- The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa[7]
- The Eastern and Southern Africa (ESA) Ministerial Commitment on sexuality education and sexual and reproductive health services for adolescents and young people (2013, renewed in 2021). The ESA Commitment aims to fast-track regional and country level actions to reduce early, unintended pregnancy among adolescents and young people aged 10-24 years by 40% by 2030.[8]

7 Presentation of findings for South Africa

7.1 Background and context

7.1.1 Prevalence of early, unintended pregnancy in South Africa

Globally, the staggering increase in unintended teenage pregnancy is considered a social and public health concern affecting approximately 12 million girls[9].The Guttmacher Institute reports that globally, 44% of all early pregnancies are unintended, with rates being highest in sub-Saharan Africa and South Asia[10].

South Africa located in sub-Saharan Africa has seen an increase in teenage pregnancy rates in the past few years. A national study by Barron et al shows that the rate of pregnancies among girls aged 10-14 had increased by 48.7% from 2017-2021[11].Similarly, the Department of Basic Education (DBE) also reported an annual increase in pregnancy rates for girls aged between 10-19 years, from 86,000 in

[7] Gerntholtz, et al., 2010; Bearinger, 2007; MIET; 2011. Rights of Women in Africa. *Protocol to the African Charter on Human and Peoples' Rights*.

[8] https://www.youngpeopletoday.org/_files/ugd/364f97_b99daa2ed6c846bda782eb5c443130ee.pdf)

[9] World Health Organization (WHO). (2020). Adolescent Pregnancy. Accessed October 2022 from https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

[10] Guttmacher Institute. (2021). Adolescent Pregnancy. https://www.guttmacher.org/fact-sheet/adolescent-pregnancy-united-states-and-worldwide .Accessed 04 May 2023.

[11] https://www.unfpa.org/press/nearly-half-all-pregnancies-are-unintended-global-crisis-says-new-unfpa-report accessed 25 November 2022

2017 to 136,000 in 2020.[12] A sharp increase in teenage pregnancy rates were recorded in 2020 and 2021 and have been attributed to the COVID-19 pandemic and associated lockdowns which limited access to contraceptives. Data from Statistics South Africa shows that 90 037 girls aged ten to 19 years gave birth from March 2021 to April 2022 in all nine provinces, of which 934 were aged under 14[13]. Studies on the risk and protective factors related to adolescent pregnancy in LMICs indicate that levels tend to be higher among those with less education or of low economic status[14]. Likewise, a report by the South African Medical Research Council found that teenage pregnancy rates in South Africa are higher among girls from poorer households, with rates as high as 135 per 1000 girls in some areas[15].

7.1.2 Factors contributing to early, unintended pregnancy

The table below summarises numerous factors related to early, unintended pregnancy in South Africa, categorised by health system, household, structural-behavioural, and individual levels[16] [17] [18].

Table 1 Factors contributing to early, unintended pregnancy in South Africa

Level	Factors
Health system	• Inadequate access to adolescent and youth friendly services • Stigma and discrimination against unmarried pregnant adolescents • Judgmental attitudes or shaming amongst health service providers • Lack of sexual and reproductive health care and information • Insufficient contraceptive knowledge, low levels of use of contraceptives correctly and consistently, limited availability of contraceptives (31% of girls aged 15 to 19 are reportedly not getting the contraceptives they need) as well as limited knowledge about fertility and conception[19].
Household	• Reluctance of parents to engage in discussions about sex and sexuality education and permit sexual education at schools • Low parental education and involvement • Low socio-economic status, poverty, large family size • lack of parental monitoring, guidance and supervision
Structural	• Limited education and employment opportunities

[12] https://www.dailymaverick.co.za/article/2021-09-07-schoolgirl-births-unacceptably-high-in-south-africa accessed 20 January 2023
[13] Save the Children, "Teen Pregnancies Increase During Covid -19", 14 October 2021, https://www.savethechildren.org.za/news-and-events/news/teen-pregnancies-increase-during-covid-19, Accessed 26/01/22
[14] Chung, W.H, Kim, ME., Lee, J. Comprehensive understanding of risk and protective factors related to adolescent pregnancy in low- and middle-income countries: A systematic review. Journal of Adolescence. 2018; 69: 180-188.
[15] South African Medical Research Council. (2016). Teenage pregnancy in South Africa - with a specific focus on school-going learners. https://www.mrc.ac.za/sites/default/files/attachments/2016-06-23/TeenagePregnancyReportFinal_13June2016.pdf. Accessed May 4, 2023
[16] Ruba, A. E., Al-Turki, H. A., Al-Mutairi, A. F., & AlRumaih, T. F. (2018). Factors Contributing to Unintended Pregnancy Among Adolescents: A Systematic Review of Peer-Reviewed Literature. *Journal of Pediatric and Adolescent Gynecology*, 31(4), 363-371. doi: 10.1016/j.jpag.2018.02.005.
[17] Singh, S., Darroch, J. E., & Ashford, L. S. (2014). *The Role of Education and Poverty in Early Adolescent Pregnancy and Childbearing*. New York: Guttmacher Institute.
[18] National Adolescent Sexual Reproductive Health and Rights Framework, South Africa.
[19] SAMRC.2021. *Herstory study*. https://www.samrc.ac.za/intramural-research-units/HealthSystems-HERStory.Accessed 15 November 2022

Level	Factors
	• Transactional sexual practice • Media influence and exposure • Poverty (poverty can lead to transactional relationships and age disparate relationships, leading to unequal power relations and lack of condom negotiation and usage) • Gender inequalities, leading to gendered expectations of how teenage boys and girls should act; sexual taboos (for girls) and sexual permissiveness (for boys)[20] • High levels of gender and sexual based violence • Harmful norms and stigma surrounding women controlling their own fertility and bodies
Behavioural	• Substance abuse • Lack of knowledge about sexual and reproductive health • Inconsistent contraceptive use, desire for pregnancy • Rape and coerced sex • limited decision-making power • Curiosity or experimentation
Individual	• Low educational achievement • Peer pressure • Lack of information / education related to safe sex practices • Early sexual debut, which was found to be high in males compared to females. For girls, this is prompted by high age differences between themselves and their partners[21]

7.1.3 Impact of early, unintended pregnancy

Health impact: Early, unintended pregnancy has several negative impacts on the health and well-being of adolescent girls and their families. In South Africa, complications during pregnancy and childbirth are the leading cause of death among adolescent girls aged 15-19 years because of complications during pregnancy such as preeclampsia, eclampsia, haemorrhage, and obstructed labour. If not, morbidity and mortality, they can lead to long-term disabilities, such as obstetric fistula[22].

Economic impact: Early, unintended pregnancies can also have significant economic consequences, both for the adolescent girl and her family, as well as for society as a whole. Adolescent girls who become pregnant are more likely to experience poor academic performance, drop out of school, which can limit their future educational and employment opportunities, and perpetuate the cycle of poverty[23]. Furthermore, the economic costs associated with teenage pregnancy can be substantial, including reduced productivity, increased health care costs, and reduced economic growth.

[20] Barron et al.2022. *Teenage births and pregnancies in South Africa, 2017 - 2021 – a reflection of a troubled country*: Analysis of public sector data. SAMJ.
[21] National Adolescent Sexual Reproductive Health and Rights Framework, South Africa.
[22] Chirwa, G. C., & Nkwalo, K. (2021). Exploring the factors contributing to teenage pregnancies in Malawi: A case study of Lilongwe District. Malawi Medical Journal, 32(3), 102-109 https://www.ajol.info/index.php/mmj/article/view/197098 Accessed on 5 May 2023.
[23] Masuku, A. 2021. *The psychosocial effects of teenage pregnancy on high school learners in the Vryheid district, KwaZulu-Natal*. https://openscholar.dut.ac.za/bitstream/10321/4045/3/Masuku_AS_2021_Redacted.pdf Accessed 07 May 2023.

Psychosocial and social impact; Results from different studies showed that the overall effect of early, unintended pregnancy on maternal anxiety and depression, shame, stigmatization and parenting stress was statistically significant[24]. Social consequences of teenage pregnancy include the following:

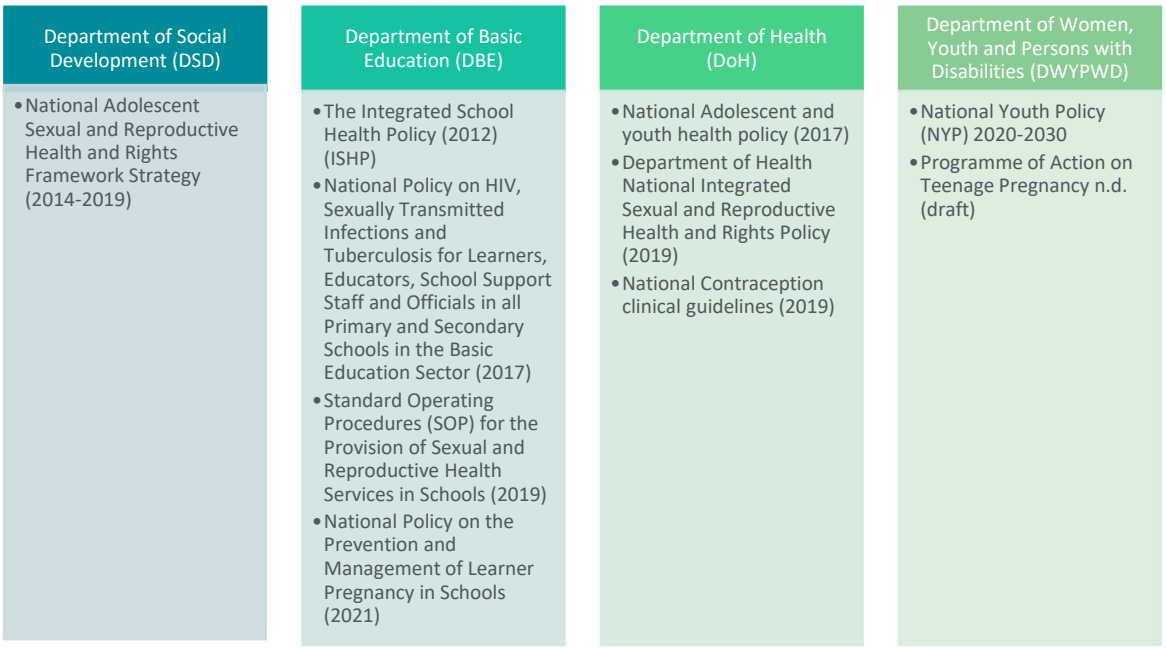
- Increased burden of parenting – a child raising a child and the stigma associated with it;
- A continued cycle of poverty
- Girls who become pregnant before the age of 18 years have been found to be more likely to experience violence within a marriage or partnership[25].

The burden is significant, and more should be done to tackle unintended pregnancy.

7.1.4 Domestic policies, plans and strategies

The document review identified a total of ten (10) policies, strategies, plans and standard operating procedures (SOPs) as *most relevant* for prevention of teenage pregnancy. These are summarised in the diagram below.

Figure 3 Reviewed policies, strategies and guideline documents (South Africa)



7.2 Overview of interventions

7.2.1 Key objectives, description of services, target group and reach

The table below provides an overview of the four interventions and is **based on a synthesis of information provided by respondents and review of documents**. This overview covers the key

[24] UNFPA. https://esaro.unfpa.org/en/topics/adolescent-pregnancy. Accessed 15 November 2022
[25] WHO. *Violence against women prevalence estimates-2018*. https://www.who.int/publications/i/item/9789240022256 Accessed 21 November 2022.

objectives, the description of services, target group and geographic reach. More detailed information is provided in the Annexure 6 attached.

Table 2 Overview of South African interventions selected for in-depth review

Name	Key Objectives	Description of Services	Target group	Implementation sites and reach
DSD CSE out of school programmes including intergenerational Dialogues	- To empower young people to be able to make the right decisions about their SRH to boost their confidence and make them knowledgeable about their SRHR	-Engaging in dialogues with young people on SRHR topics such as GBV, safe termination & contraceptives. -Organizing campaigns with local clinics to provide information and access to SRH & youth-friendly services. -Capacity building sessions, including life & economic empowerment to prevent substance abuse and unplanned pregnancies	-Out-of-school youths from the age of 14 to 25, community members, and healthcare workers	The training on intergenerational dialogues and facilitation of dialogues took place in 7 provinces of Free State, KwaZulu-Natal, Eastern Cape, Western Cape, Limpopo, Mpumalanga and Gauteng reaching more than 4000 youths and adults
LoveLife	-To improve the well-being of young people in South Africa by addressing issues related to sexual health, education, and mental and physical health.	-Providing youth friendly SRH services, including health talks, counselling, and referrals. -Offering economic opportunities through basic computer skills training, job readiness, and referrals. Conducting specific programs in/out of schools, and monthly health campaigns on SRH topics	-Young people aged 10-24 years old, -Community level; parents, healthcare workers, and elderly people	All 9 provinces in South Africa
Partners in Sexual Health Common Good Programme	-To increase youth economic and employment opportunities, train them on SRHR to decrease HIV incidence, teenage pregnancy and GBV in the targeted areas	-Providing on-the-job training in communication, leadership, mentoring, and job readiness. -Disseminating of SRHR educational materials and facilitating youth and intergenerational dialogues. -Referring people to relevant services and engaging in social media campaigns on GBV, teenage pregnancy, and HIV prevention.	-2000 unemployed youth -community members in targeted districts and provinces	-4 provinces- Eastern Cape, Northern Cape, Free State and Western Cape
Soul City	- To provide young people with access to quality SRHR services to prevent new HIV infections and teen pregnancy.	Rise women Clubs' build safe spaces and exposure to positive peer learning and information sharing on SRHR, HIV testing, condom use and GBV awareness. -Develops and enhances life skills and economic	-15-24-year-old in and out of school girls and boys	In all 9 provinces covering mostly informal settlements and rural areas

		opportunities through vocational training. -Strengthens advocacy and community engagements through campaigns, events, television and radio broadcasting, parental engagement programmes		

7.3 Relevance

This section assesses the relevance of the four selected interventions for addressing unintended early pregnancies in South Africa. It explores the needs of adolescent girls and young women in relation to the prevention of unintended early pregnancies, how programmes or services are addressing these needs, and the major gaps in the response of programmes and services.

7.3.1 Major problems or needs faced by adolescent girls and women

The study findings show that AGYW in South Africa face significant challenges when it comes to SRH. Access and utilisation of SRH services is largely limited by demand and supply side barriers. The diagram below provides a summary of these challenges, and these are further elaborated on below.

Figure 4 Demand and supply side barriers affecting access and utilisation of SRH services

Demand-side barriers

- Social norms underpinned by religious beliefs and patriachal norms about SRHR for younger girls (under 18 years old)
- Perceptions that the responsiblity of SRH lies solely with women
- AGYW fear of being stigmatised as being promiscuous if they want to use contraceptives or condoms.
- Beliefs that the use of contraceptives has long term effects on preventing pregnancy
- Unemployment and poverty

Supply-side barriers

- Stock outs and unavailalbity of certain services
- Fear of being stigmatised, judged and even denied services by healthcare workers
- Older service providers who are more conservative, and the lack of knowledge and skills to provide services to AGYW/ABYM
- Clinic operation hours are not conducive for young people at school
- Queues are often long
- Confidentiality is often compromised

Social norms were identified as a key determinant of many of the challenges faced by adolescent girls and young women in relation to preventing unintended early pregnancy. Beliefs about the inappropriateness of sex and sexual reproductive health rights (SRHR) for younger girls (under 18 years old), particularly subjects them to stigma and hinders access to services. Religious beliefs and patriarchal norms often underlie these social norms.

At the level of the **household**, these beliefs make conversations between caregivers and young people about sex and SRHR a taboo, making girls and young women reluctant to seek information about their SRHR or use contraceptives.

> *"We don't know how to talk to our young girls at home that when they sleep with a young boy or man without a condom, they will get pregnant because I think most parents in this community are still old school, so we feel like we are protecting our*

> *children from getting pregnant by not talking about condom and contraceptives, which is not true" (SSI_parents/guardians)*

Patriarchal beliefs are a major contributing factor to adolescent girls and women not asserting or accessing their SRHR. Girls and women find it difficult to negotiate safer sex within their relationships. They are furthermore subjected to gender-based violence, including sexual abuse and underage marriages. In South Africa specifically, the phenomenon of *Ukuthwala* puts girls and women in some communities at risk of being abducted and forced into arranged marriages. Furthermore, the responsibility of sexual reproductive health and rights is perceived as being with girls and women, thus exempting boys and men from taking the same level of responsibility for SRHR and preventing unintended early pregnancy.

> *"As parents, we only talk to our girl children about condoms and contraceptives and forget that we need to have the same talks with boys because they are ones who impregnate the girls. So, we only focus on the girls and forget about the boys which is a problem." (SSI_parents/guardians)*

Girls engage in risky behaviour such as unsafe sex, thus increasing their risk to early unintended pregnancy. **Unemployment, poverty and valuing material possessions** play a key role in girls and women engaging in intergenerational relationships (with "blessers") that bring economic relief to themselves and their families. The power dynamics that come with the age difference between older men and younger women, as well as the financial control held by men in this situation, makes it difficult to negotiate safer sex. In South Africa, **substance abuse** amongst young people is a key factor that is increasingly leading to risky sexual behaviour and unintended pregnancy. Intergenerational relationships, substance abuse and risky sex is also reportedly normalised amongst peers.

> *"Young people, especially young girls feel like they don't have power when it comes to sexual intercourse. They feel like they can't negotiate and their partners have the upper hand…. I used to operate a tavern…and I could see that a six pack of alcohol that a man buys for a woman can go a long way in terms of them having the authority over the young girls." (SSI_programme management staff)*

Due to their stage of development, adolescents are also more impulsive and therefore engage in risky sexual behaviour.

The **beliefs and attitudes of adolescents and young people** affect their uptake of services. Social norms make pregnancy acceptable (and sometimes even expected at a young age, e.g. 18 years) and therefore discourages the uptake of services. Girls and woman also fear being stigmatised as being promiscuous if they want to use contraceptives or condoms.

Within **healthcare facilities and schools**, nurses and educators play a key role in providing SRHR information and services. There are widespread reports of adolescent girls who access such services being stigmatised, judged and even denied services. Social norms, having older service providers who are more conservative, and the lack of knowledge and skills to provide services to this age group, are all factors that contribute to nurses and educators not providing youth friendly SRHR information and services. To ensure confidentiality, girls and women try to access SRHR services in communities where they are not located. However, this is not allowed within the public healthcare system.

> *"They treat young people coming to access SHR commodities and services in a way that discourage them to go back to the clinic. For example, some are told that they are too young to be using contraceptives and they should stay away from boys. Young people are scared that the nurses in community clinics might know their parents and because of that, the privacy and confidentiality …are compromised. There are some nurses… that ask young people inappropriate questions. For example they would say, "Where is youth mother, is she aware that you are here for contraceptives/ you are too young to be here" (SSI_district government official)*

Further challenges exist in relation to the **quality and access to SRH services**. In some instances, stock outs (especially contraceptives such as injections and emergency contraceptives) and the unavailability of certain services (such as termination of pregnancy, and access to sanitary pads) are reported. Participants report that often clinic operation hours are not conducive for young people at school, queues are often long, confidentiality is often compromised as young people are exposed for the services being used (e.g. certain colour cards provided for HIV testing, having to disclose the reason for visit to security or having nurses who are associated with particular kinds of services). This makes healthcare centres inaccessible for young people.

Misconceptions about the age of consent[26] for accessing SRH services also hinder access. There is the perception amongst adolescent girls and nurses that caregivers need to accompany minors when accessing services. Inaccurate beliefs about the negative effects of using contraceptives also hinder the use of such services. For example, some young people believe that the use of contraceptives has long term effects on preventing pregnancy. There is reportedly also still limited knowledge amongst girls and women about SRH and SRH services (particularly female condoms, PrEP, termination of pregnancy, and free access to services). These factors deter adolescent girls from using SRH services and in some instances, girls are denied services.

7.3.2 Programme response and relevance to these needs

The study sought to understand whether the sampled programmes are relevant to the needs of AGYW. The diagram below presents programme responses to the needs and challenges identified above, as well as the gaps in SRHR programmes and services that seek to prevent unintended early pregnancy. These reflections come from the views of key departments (DSD, DoH and DBE) programmes (loveLife's Groundbreakers Programme, PSH's Common Good Programme and Soul City's programme interventions including Rise Women's Clubs) targeted in this research.

The table below demonstrates that the sampled programmes address the socio-economic drivers of early unintended pregnancy. They improve access to youth friendly services through providing alternatives to access services outside of healthcare facilities and placing trained service providers who target young people. Awareness raising and education programmes around provided to young people and the community at large to increase knowledge about SRHR and SRH services available.

[26] Age of consent for accessing SRH services in South Africa is 12 years old.

Table 3 Programme response to AGYW needs

Problem or needs faced by AGYW	Programmes/services response
Social norms and patriarchal beliefs around sex and SRHR for young people	loveLife, DSD, DBE, and PSH report having programmes that address social norms. loveLife addresses issues around gender-based violence with young people, community leaders and parents/caregivers. They partner with the South African Police Services to do community campaigns. Their "Body Wise" programme targets parents/caregivers and young people to educate them about SRHR and enable them to talk about SRH at home. loveLife is currently initiating the "what about the boy" programme to focus on their responsibility around SRHR. PSH conducts interventions with parents/caregivers to support them to understand SRHR and their role in preventing early pregnancy. They also address GBV as a driver of early unintended pregnancy which is a key focus of the Common Good programme. The DSD Population Planning Unit conducts intergenerational community dialogues between parents/caregivers and young people around SRH services and SRHR. The Population Planning Unit develops the capacity of Social Auxiliary workers to enable them to tailor SRHR programmes to address with social/cultural drivers of early unintended pregnancy. The DBE, through their comprehensive sexuality education, addresses gender inequality in the curriculum. They have also conducted awareness raising with traditional leaders and parents/caregivers on gender-based violence.
Unemployment and poverty leading to and risky sexual behaviour (e.g. intergenerational relationships, transactional sex, unprotected sex)	DSD, Soul City and loveLife provide skills (e.g. entrepreneurial skills) to address unemployment and poverty which is integrated into their programming. Kitso Lesedi receives funding from DSD to develop the skills of young people to improve their employability. A key objective of the PSH Common Good programme is to provide employment for 2000 youth as Health Promoters to focus on three interventions: teenage pregnancy, GBV and HIV/AIDS. PSH, Soul City and loveLife, develop the capacity of youth (e.g. Groundbreakers) to implement their SRHR programmes and services and provide stipends to them. In this way, they also contribute to the economic strengthening and skills development of these young people, and improve their employability.
Risky behaviour (e.g. substance abuse and unprotected sex)	loveLife and Soul City provide sports and recreational activities to keep "youth off the street". loveLife and Soul City distribute condoms in taverns to minimize the risk of engaging in unprotected sex when under the influence of substances.
Knowledge, attitudes and skills of service providers (healthcare workers, educators and administrative/support staff) to provide SRHR services to young people	loveLife, Soul City and PSH, DoH and DSD respond to these challenges. loveLife (Groundbreakers) and Soul City (Social Mobilisers) place trained youth at healthcare facilities to provide youth friendly services. PSH, DSD and Soul City engages with DoH to advocate for youth friendly services. This is done through dialogues between young people and DOH to raise issues regarding accessing SRH services and webinars. The Soul City programme helps girls and women in clubs to organise and advocate around their needs and challenges in terms of accessing services. DSD has developed lesson scripts and provided training to assist educators to provide youth friendly lessons and messaging as part of CSE.

Problem or needs faced by AGYW	Programmes/services response
	DoH has youth friendly zones in healthcare facilities located in "hotspots" for teenage pregnancy.
Stock outs, limited access to range of SRHR services or products, clinic hours, long queues, confidentiality of services	CSOs play a key role in expanding access to services outside of healthcare facilities and schools. loveLife have a "vitality room" based at its Y Centre where young people can access youth friendly SRHR information and services (including contraceptives) and psychosocial support. Likewise, PSH also provides contraception and sanitary pads. Both loveLife and PSH provide door-to-door services distributing condoms and providing SRHR information to young people and the community. These provide an alternative to accessing services through nurses at healthcare facilities.
Misconceptions and knowledge of girls and women about their SRHR and services/ products	Soul City, loveLife and PSH provide SRHR information in community, including condom demonstrations, dialogues and community campaigns that address prevention and management of TB, HIV/AIDS, STIs, teenage pregnancy. Topics include: emergency contraceptives, condoms, safe termination of pregnancy, consequences of pregnancy, alternative care for babies. The DBE provides CSE as part of the curriculum and co-curricular activities.

The greatest **gaps** are insufficient good quality programmes addressing social norms and unemployment/poverty within communities, and that services and programmes are inadequate to meet the demand. The quality of youth friendly services provided by healthcare workers and CSE educators is not consistent. The effectiveness section below further describes the specific challenges in this regard.

7.4 Effectiveness

This section of the report looks at the extent to which programme activities have been achieved based on interview data and review of reports and documents where available, and strengths and challenges of implementation.

7.4.1 Extent to which programme activities have been achieved

During interviews, programme level respondents from PSH, loveLife and SCI stated that their programme activities are well on their way to being achieved and that their targets are close to being reached. However, for the DSD CSE out of school programme, programme staff noted that insufficient staff and budget has hampered effective achievement of all programme activities. The findings were validated **by the community health care workers and district government officials** that programme activities for all four organisations had been implemented in the sampled sites.

A review of documents confirms that the following number of beneficiaries have been reached for the Common Good (PSH), Rise Women's Club (SCI) and DSD CSE out of school.

Table 4 Reach for South African interventions under review

Organisation	Intervention	Target reached
SCI	Rise young women's clubs	61 136 young women reached
PSH	Common Good	2000 young people trained as Health Promoters 187,323 people reached with Sexual and Reproductive Health & Rights (SRHR) information, inclusive of gender-based violence, teenage pregnancy and HIV/AIDS) through different media platforms. 5422 young people actively participate in dialogues and 12798 reached through events.[27]
DSD	CSE out of school (Ezabasha dialogues)	100 training sessions reaching more than 4 000 adults; 74 dialogues were held with 3 317 individuals from 2014-2018[28]

Programme staff also reported on a wide range of complementary interventions being implemented by their organisations which allows for a 'layering' of services for AGYW and ABYM across the targeted districts (see **Annexure 6**).

During focus group discussions **ABYM and AGYW** confirmed that they had been **selected to participate** in programme activities through a variety of ways including: campaigns and flyers distributed communities and malls; school visits; word of mouth in the community; referrals by community workers; social media; and community activities such as sports tournaments

They further reported their participation in a variety of SRHR programme activities including club activities, life skills, awareness raising, community dialogues, AYFS, access to contraceptives and skills training; thus confirming the layering of services referred to by programme staff (see table below).

Table 5 Feedback from AGYW and ABYM on their engagement in programme activities

Organisation	Programme services / activities reported by AGYW and ABYM
Soul City	• Rise Clubs in schools and the community • Adolescent and youth friendly services (youth zones) offered in clinics and supported by Soul City • Condom distribution and demonstrations • Distribution of IEC materials (pamphlets on HIV, TB, STIs etc.)
loveLife	• *What about a boy* programme • Condom distribution • Coach for life • Sports activities • Access to youth friendly services including a nurse and counsellor • Radio broadcasting

[27] PSH SIP monthly progress report, January 2023

[28] See Presentation for SRHR Strategy Planning meeting NPU and PPUs (2020)

PSH	• Door to door awareness raising on HIV, teenage pregnancy, substance abuse • School and community outreach activities • Community dialogues • Media communication and joining youth networks (Siyakwazi network) • Provision of contraceptives • Training by PSH on SRHR, GBV, teenage pregnancy • Mentorship and leadership training and development
DSD CSE out of school	• Skills training: computer course, security course, career expos • Life skills training • GBV and teen pregnancy programmes including SRHR dialogues

When asked if there was **any cost involved for them to attend programme activities**, AGYW and ABYM from said that there are no travel costs because activities are based within their communities. No other costs were reported besides the DSD CSE out of school participants reporting that they have to print their own learning materials for the skills development courses they attend which is a challenge, because they are unemployed with no disposable income.

7.4.2 Strengths and challenges of implementation

The strengths and challenges for implementation were unique for each intervention and thus are presented per programme below.

DSD CSE out of school programme

The data collection for this study focused on Kitso Lesedi's youth skills development programme, which receives funding from DSD and provides an entry point or platform for DSD's CSE out of school programme which focuses largely on life skills and rolling out intergenerational dialogues in the community.

A programme strength is that DSD makes use of two **core documents** which guides the capacity building of a range of community level stakeholders on intergenerational communication SRHR[29] and helps to standardise implementation across sites.

DSD's approach of partnering up with youth targeted by skills development centres is a strength because it allows for sharing of resources (e.g. venues) and for easy access to the target group (out of school youth), however, **inadequate budget allocation and shortage of social workers** hampers effective roll out of activities.

During the focus groups AGYW and ABYM highlighted similar strengths of Kitso Lesedi's skills development courses, namely: courses are free of charge, practical and accredited; and participants receive a certificate of completion which supports their job search. The life skills course supports with preparing CVs and for job interviews and the career expose and free WIFI at the centre supports their job search. Challenges include: the limited number of people admitted to the courses

[29] *Intergenerational Communication on Adolescent Sexual and Reproductive Health and Rights, Participants Handbook*, (n.d.) Department of Social Development National Population Unit; *Adolescent Sexual and Reproductive Health and Rights Facilitator's Manual*, Department of Social Development National Population Unit, Sonke Gender Justice, UNFPA.

with the security course prioritising men over women; overcrowded classes and limited number of computers; delays in receiving certificates; shortage of learning materials and stationery; and loadshedding affecting planned lessons.

AGYW and AGYM said that the SRH programme (including GBV and teen pregnancy programme for AGYW) creates more awareness on issues affecting young people including teenage pregnancy, substance abuse and GBV, however, AGYW raised that the SRH programmes are **too focused on theory** with limited practical activities and they need to **address both genders** as they tend to focus only on AGYW:

> *"There is so much emphasis on how young girls should carry themselves so that they don't get pregnant as if we cause ourselves to be pregnant, but what about the boys?" (FGD_AGYW)*

The main challenge with intergenerational dialogues is the **ongoing resistance by parents and caregivers** to talk about SRH which is still deemed to be a 'taboo' topic for them:

> *"The challenge is that talking about SRH to parents is still a challenge because it's something new to them, so we need to have more intergeneration communication workshops with them so that we keep sensitising them", (SSI_programme management staff)*

During the focus groups young people also said that the inclusion of 'community elders' during intergenerational dialogues can **hamper free expression by young people** as the following young person explains:

> *"Sometimes there are elders in the dialogues and because of that, young people are not able to express themselves freely", (FGD_AGYW)*

They also said there are **insufficient SRH education programmes targeting parents**, with a call for more frequent intergenerational dialogues to be run in the community. Parents and guardians said that some of the materials distributed during the dialogues are in English and thus difficult to understand its content.

This finding was supported by UN agency interviewee who noted that dialogues **cannot just be once-off event** as it takes time to build rapport with the community on issues that are considered taboo:

> *"You are dealing with the core of how people define themselves so when you bring your dialogue you are talking to a father who has no engagement with his children except to ask for water…you need to gain their trust as an expert", (SSI_UN agency)*

It could thus create problems between young people and their parents if not tackled properly and it is important to 'tread carefully' with ongoing conversations. The suggestion here is to **put together a community task team** with representation from the traditional, religious and education sector and capacitate them to become the custodians of continuing the work to address conservative social norms in the community.

A final challenge is that, although DSD programmes are being developed at national level in partnership with DBE (both are participants of the inter-ministerial committee), this information and collaboration is not filtering down to lower tiers of government resulting in **poor provincial level collaboration**. For example, provincial DSD trained intern social workers in SRHR but were unable to

place them in schools because DBE felt it does not align with the Integrated School Health Programme. Poor collaboration was confirmed by other stakeholders:

> *"We are working in silos, it is not coordinated and we are doing bits and pieces here and there and there is no good way or coordinating interventions for impact and sustainability", (SSI_UN agency)*

As this quote suggests, a lot of work is being done but everyone is working in silos which minimizes impact. This is discussed further in section 7.5 below.

loveLife

The data collection site for this study took place at the loveLife Y Centre in Kwa-Nobuhle in the Eastern Cape.

Overall strengths of the loveLife programme are its use of **standard operating procedures (SOPs)** to standardise implementation across sites; its **good collaboration** with SAP, DSD, DOH and DOHA for referrals for health and social work services and grant applications; and community leaders involvement in the programme.

The most frequently mentioned strength is that the loveLife programmes at the Y Centre provide **youth-friendly services that are accessible to young people**, including door-to-door delivery of condoms, counselling and SHRR services by trained nurses and healthcare workers:

> *"The strength is that we have youth-friendly services in the centre that young people can freely access without being judged. Another strength is that loveLife services are free", (SSI_community leader)*

AGYW and ABYM in the focus groups confirmed that when they visit clinics with youth zones **services become easy to access** and promote a sense of feeling safe and prioritised:

> *"There are Ground breakers in the clinic youth zones that you can go straight to access SRH services which makes the patient feel safe and prioritized", (FGD_AGYW)*

It was raised that, although loveLife has a helpline, young people prefer face to face psychosocial support which is difficult for those who are too far to access the Y centre.

A further strength is that **programmes are driven by young people**. The Ground breakers, who are young people themselves and are trained in counselling skills, are able to relate well with other young people. The value of placing Ground breakers in clinics was highlighted by a National DOH official:

> *"The strength of youth zones is they are run by young people themselves – they are able to relate with young people very well. Right from the door you get greeted by young people and you will see one of the loveLife strengths is in health talks – our ground breakers are giving health talks to alleviate all the fears (of young people)", (SSI_national DoH)*

The main challenge, however, is that loveLife **loses Ground breakers to other organisations** and programmes due to different stipend amounts being paid.

The **nurses at HCFs have also been trained by loveLife in AYFS** which has reportedly led to an increase in young people visiting clinics and accessing SRH services.

Parental involvement is another strength as loveLife involves parents and guardians in its activities. Parents learn to have open conversations about SRH with their children:

> *"I have also learned to have open conversations about SRH with my children which is something that I didn't do in the past because it felt like I am encouraging them to be sexually active", (SSI_parent/guardian)*

A final strength is that loveLife **receives funding from organizations** such as Volkswagen and UNICEF to continue its programmes.

What did AGYW and ABYM say?

Strengths and challenges specific to each loveLife intervention was raised by AGYW and ABYM during the focus groups discussions. These are summarised in the table below.

Table 6 AGYW and ABYM perceptions of programme strengths and challenges

Intervention	Strengths	Challenges and recommendations
Radio broadcasting	Helps spread awareness about topics such as SRH, GBV, and teenage pregnancy.	The radio signal does not reach all communities and the fact that it is an online radio can limit access to those who cannot afford data. A recommendation is to make the radio station free for all.
Counsellor	Offers psychosocial support in a private and confidential setting	Although the services are considered good, the challenge is that they are not available on weekends, which is when young people who attend school are free. The recommendation is to hire an assistant counsellor who can offer services during weekends.
Nurse (based at the Y Centre)	Youth friendly and considered helpful in referring patients to the clinic and offering free access to contraceptives and condoms.	The nurse does not offer services such as Antiretroviral Treatment, PREP and long acting (3- or 5-year) contraceptives.
What about a boy Programme	praised for allowing young boys to share their challenges and for addressing issues related to SRH and the patriarchal system.	Insufficient focus on young boys in primary school. Recommendations include more marketing of the programme, more focus on primary school learners.
Condom distribution	Easy accessibility of condoms for young people	Poor access to female condoms and packaging issues of female condoms, shortages of condoms in clinics. Recommendations include more awareness of female condoms, making sure that condoms are always available for young people to access in the community and in clinics, and better and appealing packaging of female condoms.
Sports activities (e.g. netball and soccer)	Distract young people from unsafe behaviour and keep them physically and mentally healthy	The challenge is the lack of variety of sport activities and space in which to hold sports events. Recommendations include more choices on sports that will attract more young people in the community.
Coach for life programme	Considered beneficial in teaching young people how to be responsible citizens and addressing issues related to mental health	However, the programme is not well-marketed, and not everyone in the community knows about it. The recommendation is to market the programme more.

In summary, the loveLife program provides youth-friendly services that are accessible to young people, involves the community and parents in its activities and receives funding from organisations to continue its programmes.

PSH Common Good programme

Whilst a key strength of the programme is that it has been **successful at employing 2000 young people** as Health Promoters, **retaining employees is a challenge** due to the low stipend and the availability of better-paying jobs. However, a key intention of the programme is to help people get better jobs, which is seen as a positive outcome, but it also means that the programme needs to replace the Health Promoters frequently.

A further strength is the **structure of the programme** which strengthens the management of the programme and ensures adequate supervision, mentoring and support. The 2000 Health Promoters are supported by 200 well-trained mentors[30] who are in turn supported by Team Leaders and a Provincial Coordinator. During the focus group discussions, Health Promoters said that the Mentors support them with planning their daily programme, trouble shooting and problem solving, and that they feel safe to talk to them about their problems. However, it is challenging when Mentors arrive late and not everyone has cell phones, which hampers communication and organisation of the Health Promoters.

During the focus group discussions, Health Promoters gave positive feedback on the training they receive for the job including **knowledgeable facilitators, good training materials and remuneration** whilst attending the training. However, it was raised that **the duration of the training (3 days) is insufficient to cover all the topics** required to do their work and they recommend at least 10 days of training to be split across the 9 months of their contract.

A further challenge is the **logistical challenges** related to rolling out the Health Promoter training because of the large numbers of trainees, including transport costs and coordination.

The Health Promoters focus on three key problems faced by young people at community level – **teenage pregnancy, HIV/AIDS and GBV** and their interventions are implemented via **community outreach activities** including: door to door awareness raising, school outreach, community outreach and dialogues, referrals to services, media communication

A strength of **door-to-door outreach activities** is that community members are mostly open to listening and receiving information from Health Promoters and visiting homes after 10am is a good time to go into the community. However, some community members are not receptive to the information, are too busy to listen and older people are usually afraid of scammers, which makes it difficult for them to invite the young men into their houses. This indicates the need for better communication and cooperation between the community and health promoters.

A strength of **community dialogues** is that they are able to reach the target faster, are more efficient, and facilitate the exchange of information. However, a challenge is that it is difficult to keep some people engaged, especially groups of teenagers who get bored easily, and some people ask a lot of questions which Health Promoters are unable to answer. It is also challenging for male Health Promoters to gain the trust of people, especially older people and men who prefer to listen

[30] 10 Health Promoters are supported by one Mentor.

to females. In addition, people have expectations when they are invited to group discussions, and catering and transportation can be a challenge. Recommendations to overcome these challenges include teaming up with females, and being well-prepared to answer questions.

The strength of **school outreach** is that some high schools in the community are **easily accessible,** and Health Promoters can then have formal dialogues with teenagers about sexual reproductive health, gender-based violence, and HIV in the classroom. This helps them work faster and teenagers listen better when they are at their schools. However, **school outreach** faces challenges such as teenagers not engaging much during the lessons and teachers are often uncomfortable discussing sensitive topics such as sexuality with children. It has also been difficult to gain access to some schools and the programme has thus had to develop relationships with schools to get access to children during free periods and Life Orientation classes.

A core activity of the Health Promoters is to **make referrals to SRH and other services** but they face challenges such as police not being responsive to community needs and judgemental and discriminatory attitudes from nurses. This can contribute to feelings of embarrassment and shame, and may discourage individuals from seeking healthcare services altogether.

> *"Going to the clinic has become very embarrassing because some nurses actually disclose your HIV status in front of other people in the clinic, it's embarrassing especially because we are in a township, the people who work there are the same people we live within the community with so there is not privacy or confidentiality", (FGD_ABYM)*

Health Promoters encourage people to listen to **PSH radio station** which airs a diversity of topics. However, radio communication faces challenges such as some radio stations being online and not accessible to people without data, and some people not having phones.

Soul City Institute (SCI)

A strength of the SCI programmes is that it reaches young people in different ways including CSE out of school, youth zones in clinics and the use of social media to reach out to more young people.

> *"The strength has been that Soul City reaches young people in different ways, thus at schools and at the clinic, and that way young people feel free because they can associate with the brand", (SSI_community leader)*

Additionally, it was noted by the parent/caregiver that the programme's "friendly and energetic approach" to educating young people is appreciated, noting that the programme has helped them understand sexual and reproductive health better.

One of the challenges highlighted by various interviewees is a lack of funding and resources to meet the needs in the community particularly for programmes targeting parents. This was confirmed by AGYW and ABYM during focus groups who recommended more programmes that capacitate and educate parents on SRH.

Another significant challenge is the shortage of Social Mobilizers, which means some schools are left behind.

One of the key findings is that condom distribution, which is combined with demonstrations, are seen as particularly effective in reducing the chances of early unintended pregnancy and sexually

transmitted infections. However, a challenge is the insufficient awareness raising and distribution of female condoms.

What did AGYW and ABYM say?

During the focus group discussions AGYW and ABYM highlighted a range of strengths and challenges with the Rise Clubs, AYFS in clinics and condom distribution and demonstration.

The Rise Club addresses issues around sexual and reproductive health such as teenage pregnancy, contraceptives, condoms, and pre-exposure prophylaxis (PrEP). The Rise Clubs also emphasizes the importance of education and encourages girls not to rely on their relationships for money. The participants noted that the programme places a lot of emphasis on capacity building, boosts AGYW's confidence and breaks stereotypes such as the idea that women belong in the kitchen.

> *"Rise Clubs emphasise emotional support to young girls especially on issues around sexual intercourse and sexuality – also when I lost my mother last year during my matric, they gave me counselling and also referred me to a psychologist that I could talk to, and they also followed up on how the sessions were going and if I was getting the help that I needed", (FGD_AGYW)*

However, there is a challenge related to the Rise Clubs gender bias, as it focuses more on girls than boys. This was confirmed by a community leader:

> *"Another challenge is that Rise Club in high school is only for young girls and excludes men, so it is not fully inclusive – it takes two to be pregnant so we need interventions that target boys as well", (SSI_community leader)*

There is thus a need for interventions that target boys, as they are often excluded from programme activities and some are afraid to participate due to social pressures or being judged by their peers.

> *"Boys are also afraid of being judged and peer pressure is long among them for example, if a boy decides to go and seek sexual advice, his friends might think that he is weak or he is not a man enough because boys think they know everything about sex." (FGD_AGYW)*

Regarding the youth-friendly services offered by Soul City members in clinics, participants appreciated the creation of a comfortable and judgment-free environment for young people to visit clinics without fear. Additionally, the participants noted that there are a range of contraceptives on offer and there has been an increased uptake of contraceptives among young people. In addition, the HIV and BMI testing for young people promoted healthy lifestyles.

However, a significant challenge was the lack of youth-friendly zones in *every clinic*, which makes it time-consuming for young people to access the services. The participants noted that they had to travel from different communities to access AYFS. Therefore, participants recommended that youth-friendly services be available in every public clinic to avoid the long distances that young people must travel.

Regarding information pamphlet distribution on HIV, TB, STIs, and so on, participants commended Soul City for creating awareness of SRH issues for both girls and boys. However, they noted that most of the information in the pamphlets is in English, which can be a barrier, especially in communities with elderly people. Therefore, participants recommended the use of South African

languages. They also recommended more podcasts for young people to engage on issues that affect them.

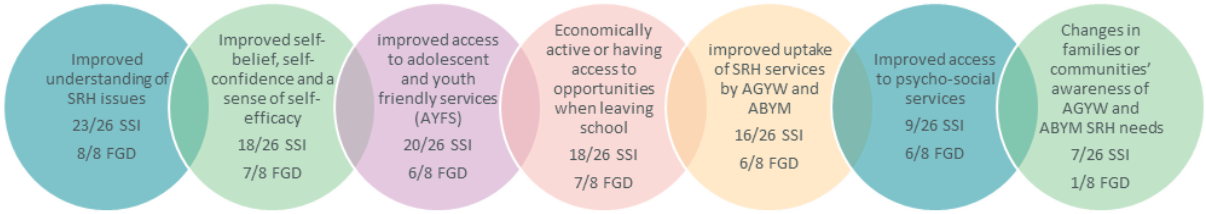
7.5 Emerging outcomes

The section below presents the findings on the extent to which the outcomes in the TOC for prevention of early, unintended pregnancy (see **Annexure 5**) had been achieved (or not) by the four interventions including the enablers and barriers for change. The main data source was the 26 interviews with programme staff, national and district government officials, community leaders, parents/guardians and eight FGDs with AGYW and ABYM, who are both target groups and beneficiaries across the four programme interventions.

7.5.1 Key changes / outcomes achieved

The diagram below captures the changes achieved by the programme.

Figure 5 Key changes achieved by the programme interventions



Changes at the individual level

The most frequently mentioned change in 23/26 interviews (SSIs) and 8/8 FGDs is the **improved understanding of SRHR issues** amongst all four programme target groups at the selected study sites. LoveLife Ground breakers, PSH Health Promoters and SCI Social Mobilisers mentioned improved understanding on a wide range of topics including: different types of contraceptives; difference between PrEP and PEP; how to care for yourself and someone who is HIV positive; importance of knowing your HIV status; GBV and its different forms.

> *"Knowledge about GBV…. before joining the programme I didn't know that there were different types of violence. We have also realised that there are serious consequences of GBV. We also learned that there is a connection between GBV and substance abuse….so being part of this opens your mind, you start seeing things from a different perspective", (FGD_ABYM)*

These findings were confirmed by programme staff members, parents/caregivers, community health workers and community leaders who shared changes observed amongst beneficiary groups:

> *"Young people ask a lot of questions on SRH and that on its own shows that they understand what they are being taught through the programmes," (SSI_parent/caregiver)*

AGYW targeted by the DSD CSE out of school intervention noted that they have not been exposed to sufficient life skills interventions and thus they experienced limited changes in their understanding of SRHR issues and this is even less so for ABYM who were less likely to attend the life skills

interventions. Members of two focus groups said they still have a **gap in knowledge about female condoms.**

The majority of interviewees (18/26 SSIs) and focus group respondents (7/8 FGDs) said that AGYW and AGYM targeted by the interventions (Ground breakers, Health Promoters, Social Mobilisers and recipients of Kitso Lesedi training courses) have shown **improved self-belief, self-confidence and a sense of self-efficacy.** The main enablers here are the knowledge and skills developed through their participation in the programme:

> *"My confidence also changed because even in my relationship, I know I have the power to say no and I know that my partner doesn't have power over me because he equally needs me as I need him – I know my worth", (FGD_AGYW)*

> *"My confidence also changed because they teach us about interview and presentation skills and now I can confidently speak in front of people and present on a particular topic – I no longer feel intimidated", (FGD_AGYW)*

Finally, it was confirmed by most interviewees (18/26 SSIs) and almost all focus group respondents (7/8 FGDs) that the programmes are contributing to AGYW and ABYM becoming **economically active or having access to opportunities when they leave school.** Ground Breakers, Social Mobilisers and Health Promoters are all paid a monthly stipend or wage to provide services in their respective communities:

> *"I was unemployed after completing my studies and I am grateful that LoveLife presented me with an opportunity to be a Groundbreaker", (FGD_AGYW)*

They are also capacitated with softer skills including facilitation, presentation and leadership skills and work experience which **strengthens their future employability**:

> *"We have seen a lot of Groundbreakers getting more economic opportunities after their contract end for example some of them were having an orientation week this week for new jobs where they will be school assistants – more than 80% of school assistants in schools around the Eastern Cape are from LoveLife", (SSI_programme staff)*

> *"Job experience – For some of us who have never been employed before, you get job experience that we can put on our CVs. The skills that we gain in this job are going to be useful in the future when we get the jobs especially when we it comes to dealing with people. We have also gained other skills such as time management and team work as well", (FGD_ABYM)*

They are able to contribute to their household income which gives them a **sense of dignity**. The recipients of Kitso Lesedi training courses receive accreditation and together with the CV and interviewing skills, this improves their chances of gaining employment.

Findings from process and outcome evaluation of Rise Women's programme

The process review of the Rise Women's programme and an outcome evaluation of the Raising Voices of young women project in 3 provinces found that participation in RISE is associated with: reduced odds of Teenage Pregnancy; high odds of high HIV Knowledge; and awareness of Thuthuzela

Care Centres as a support service in context of high GBV rates[31]. Furthermore, the evaluations demonstrated that RISE is meeting its objectives among YWGs and that exposure to the Rise program is associated with HIV testing, negotiating condom use, and awareness of GBV support services after controlling for age, province, education, exposure to other media and other programs[32]. It is worth noting that Rise clubs were implemented to include an economic strengthening component in 10 high HIV prevalent districts in South Africa between 2016 and 2019, with the aim to provide young women with socio-economic development support and opportunities to enable them to become economically active, and as a consequence, lower their vulnerability.

Changes at the community level

It was frequently mentioned (20/26 SSIs; 6/8 FGDs) that programme interventions have contributed to **improved access to adolescent and youth friendly services (AYFS)** in three out of the four targeted sites. As a result of the improved understanding and access, respondents in three out of the four sites (16/26 SSIs; 6/8 FGDs) said there is also an **improved uptake of SRH services** by young people in the area including the younger AGYW (13- and 14-year-olds)**.**

> *"Ever since the placement of groundbreakers in clinics I have noticed an increase in the number of young people coming to the clinic to access contraceptives and condoms – even young boys come to ask about PrEP," (SSI_district government official)*

As this quote suggests, the main **enablers** here are referrals being made to clinics (e.g. by PSH Health Promoters); the dedicated AYF nurse at the Y Centre; the existence of youth zones in clinics; and the inclusion of **Ground breakers or Social Mobilisers at clinics** because young people find it easier to relate to someone of a similar age.

> *"There has been a change because we have Groundbreakers stationed in clinics where they offer youth-friendly services and young people feel freer to visit the clinics unlike before when they were afraid to be judged", (FGD_AGYW)*

> *"We are no longer having any second thoughts when going to the clinic to get contraceptives because we know that we go straight to the youth zone, and no one will judge us there even if you want to terminate pregnancy…. you will meet a familiar face from Soul City that is welcoming, that is why young people are no longer afraid to access condoms at the clinic," (FGD_AGYW)*

This was confirmed by the community leader:

> *"There has been a big change because most young people prefer to access their SRH services in the LoveLife centre than the community clinic – the nurse and the counsellor are young and friendly to the young people", (SSI_community leader)*

A key theme emerging is that **more girls than boys are accessing SRH services** because of the belief that contraceptives are 'only for girls' and 'if girls test regularly there is no need for boys to test too.'

[31] PPT, *Progress in implementing an HIV prevention intervention that empowers young women: qualitative insights and lessons from the Rise clubs*. 2019. Soul City Institute.
[32] Soul City Institute for Social Justice (SCI). *Rise Young Women Clubs: programme highlights.* Johannesburg: 2020.

Where **no change in service access or uptake** was reported the **barriers** mentioned include: lack of AYFS at the clinics, negative attitudes of staff, lack of confidentiality, the age of the nursing staff (elderly nurses are described as being 'less relatable'), fear of being judged and children being turned away from the clinics because they are unaccompanied by their parents. Once the word spreads through the community about 'youth unfriendly services' young people are afraid of going to the clinic to seek contraceptives and other SRHR services:

> *"Most young people prefer to come to loveLife for youth-friendly services because the attitude that they get from the clinics is sometimes discouraging especially for those who are still going to school as older nurses might think they are still young – you would hardly find young people in clinics asking for condoms because they are afraid of the nurses there," (SSI_parent/guardian)*

A national government official noted that young people have **unequal access** to YFS because youth friendly zones have not been rolled out to all 4000 health care facilities across the country.

There is some evidence that the interventions are contributing to improved access to **psycho-social support services** where 9/26 SSI respondents and 6/8 FGDs said this because referrals are made to the dedicated counsellors at their organisation (SCI and loveLife) or to counselling services at local clinics. However, the **barrier** here is that this service is not widely available as the following healthcare worker explains:

> *"There hasn't been much change, especially in psychosocial support because it's only a few clinics offering such services and we can only accommodate a few people – young people are suffering from depressions and they need to be assisted", (SSI_community healthcare workers)*

This is a gap in AYFS and some respondents raised concerns about the absence of psycho-social support given the **high rates of suicide and depression** amongst young people, particularly post COVID pandemic. Only two (2/26) reported improved access to **cash grants** via referrals being made to the Department of Home Affairs.

Finally, the study sought to assess whether the programmes had contributed towards **creating spaces for dialogue** to enable the discussion of SRHR issues, improve support on SRHR interventions, and leading to **changes in families or communities' awareness of AGYW and ABYM SRH needs**.

Overall, changes in this regard are limited (7/26 SSI, 1/8 FGD), and working with families and communities was repeatedly mentioned as a **programme gap:**

> *"I would say there is still more work to be done here because for example parents who go to church are holding on to the belief that their children are not sexually active, so they don't want to have any sexual talk with them as it might encourage them to be sexually active", (SSI_district government official)*

As alluded to above, the biggest barrier here is the **conservative attitudes and cultural and religious beliefs of parents/caregivers** which make it difficult to talk to their children about their SRHR needs:

> *"There hasn't been much change here – that is why we need more programmes that will educate parents on SRH – there is still resistance because parents are in denial that their children are sexually active," (SSI_community leader)*

In the few instances where parents have participated in programme activities (e.g. in intergenerational dialogues or SCI's BodyWise programme) ABYM and AGYW were extremely positive about the changes experienced in their relationships with parents/caregivers:

> *"Before, I could not talk to my mother about anything involving sex, but ever since I started sharing with her what we learnt…she actually reminds me to always use a condom….she is now more open and it's becoming easier for me to have these conversations with her," (FGD_ABYM)*

> *"My relationship with my mother has changed – we are now able to talk about sex and contraceptives…she even set me down with my partner and told us that if we are not ready to have children, we must use contraceptives and practise safe sex which is something that we never discussed before", (FGD_AGYW)*

As one national government official noted, there is a very slow shift but there is **a need to include community members and especially religious leaders** to create a more enabling environment for young people to access SRH services without fear of judgement.

Evaluation of Intergenerational Dialogues training

An evaluation of the implementation of the Intergenerational Communication on ASRHR training course was conducted in 2018[33]. The findings revealed that 346 out of 347 participants perceived the training course as relevant to them. Participants developed awareness and knowledge that allowed them to be able to talk to people about SRHR issues. There was general consensus that the knowledge gained will be useful in the participants' personal lives and in their communities. Participants perceived that intergenerational communication between parents and their children is important to the alleviation of challenges such as teenage pregnancy, STIs and STDs, and gender-based violence. This is because intergenerational conversations can raise awareness and knowledge to promote sexual and reproductive health and rights amongst young people, and encourage responsible sexual behaviour.

An important outcome of the training course is that many of the participants shared that they would like to start their own organisations that will assist their own communities when it comes to intergenerational engagements about ASRHR. Some have started the process by developing proposals informed by the training course tool in the process of establishing their own initiatives. Ultimately, the training course left a lasting impression on the participants and the trainers. The evaluation revealed that there is a heightened interest for the training to take place on a continuous basis.

7.5.2 Impact on prevention of unintended, early pregnancy

The four organisations included in the study were unable provide data on the impact of their programmes on the prevention of unintended, early pregnancy despite it being a key objective. Although the DOH is collecting data via the DHIS on the number of births delivered by adolescents in a public health facility, the impact of programmes on prevention of unintended early pregnancy is

[33] Quest Research Services and the Department of Social development (2018) *Evaluation of the Implementation of the Training Course: Intergenerational Communication on Adolescent Sexual and Reproductive Health and Right.*

considered challenging to measure for a number of reasons. These include: 1) the complexity of the issue makes it difficult to measure the contribution of the programme to any changes in unintended early pregnancy; 2) it takes time for the impact of the intervention to be seen; and 3) it is difficult to collect data on unintended early pregnancy due to underreporting or stigma associated with reporting unintended, early pregnancy, thus affecting accuracy of the data.

7.6 Coherence

In this section we assess the extent to which programmes are addressing unintended early pregnancy are aligned to national priorities and policies, and whether these programmes collaborate with other role players in the sector to provide comprehensive services.

7.6.1 Programme alignment to national priorities and policies

All participants interviewed indicate that prevention programmes and services in relation to early unintended pregnancy are aligned to national priorities and policies. This includes the National Development Plan 2030, Integrated School Health Policy (2021) and Programme, the National Adolescent and Youth Health Policy (2017), National Integrated Sexual Reproductive Health and Rights Policy (2020), Domestic Violence Amendment Act and the National Policy on Prevention and Management of Teenage Pregnancy in Schools (2021) to mention a few.

7.6.2 Collaboration with other, similar programmes and services implemented by government or NGOs

The table in Annexure 7 provides a summary of how various organisations and departments collaborate with each other around the prevention of unintended early pregnancy. The key role players are CSOs, DoH, DBE, DSD, SAPS and other departments. The column of the left indicates who actively seeks out collaboration.

In total, two of the three CSOs sampled are collaborating with other CSOs as well as government departments. The other CSO is mostly collaborating with government, specifically DoH, DSD and DBE. The analysis shows that CSOs and DSD are most actively reaching out to collaborate with other government departments and CSOs. Other government departments are playing a role in providing access to spaces (e.g. healthcare facilities or schools). This may indicate that other departments do not see the prevention of unintended early pregnancy as a key priority under their mandate.

The strength in terms of collaboration is there seems to be no duplication of services. The challenge is that SRH services are not often well co-ordinated between service providers. Some of underlying causes of this were shared:

- Stakeholders do not plan together to ensure activities are complementary and efforts are maximised. As a result, activities are dispersed and ad hoc. As an example, some partners may provide interventions in school, and others out of school, but they are working in different communities. Or organisations may collaborate for certain events, but not consistently around ongoing interventions. There is a need for better planning and prioritising between Departments. In terms of programme design, two of the three sampled CSOs interviewed have included government in their planning processes.
- Most of the CSOs and government stakeholders interviewed have not meaningfully engaged community stakeholders in the planning of interventions. Rather community stakeholders (Ward Councillor, Deputy Ward Councillor and Community Leaders) are informed and consulted

around the implementation of the programme so that they can grant access to the communities. Soul City has included the community, former RISE participants and the DBE in the planning of their programmes.

- There are no clear priorities, strategies, roles and alignment between strategies and programmes offered by different stakeholders, which makes ownership and accountability a challenge. For example, there is confusion between the alignment of the Integrated School Health Programme, and other programmes offered through CSOs; this is a challenge for the implementation of programmes in schools.
- When opportunities for collaboration are raised, this is perceived as an indication that a particular department is not fulfilling their role. And so, suggestions for collaboration are often perceived as a threat.
- There is insufficient guidance and communication from national to provincial level government on how programmes are supposed to collaborate in line with national policies and priorities.
- While there is a national co-ordination structure that deals with SRHR for young people, these meetings are not prioritised by all departments. It is not clear what existing structures at a local level deal with prevention of unintended early pregnancy.

7.7 Efficiency: summary of findings from the costing exercise

The focus of the costing tools is on Soul City's Young Women's Rise Clubs and the PSH Common Good Programme.

For the costing tools to work optimally in a changing environment a few assumptions have been made that can be changed by the users. Three scenarios were costed in each tool, the first looking at the minimum or current service being provided (i.e. outputs based on current funding), the second shows the results of providing a service 50% larger than the current size, and the third looks at the changes in costs if the service were doubled in size (e.g. double the number of clubs active).

Young Women's Rise Clubs

This costing tool has three working sheets namely, Head office costs, Training, and Club activities. A distinction is made between once-off costs and ongoing costs. It should be noted that the costing tool does not separate costs related to the prevention of teenage pregnancy of the programme – as this is best regarded as an outcome of the Training and Club activities.

Based on the tool, if the programme were to double the number of clubs across the nine provinces, the cost per club would reduce to R32 760 from R37 328 per club, or to R1 310 per member from R1 490 per member.

A summary of the outcome of the costing assumptions are presented below.

Figure 6 Young Women's Rise Clubs overview of cost

	Costing scenarios		
	Scenario 1 100% Current	Scenario 2 150% Ideal	Scenario 3 200% Enhanced
Once off costs	**1 035 103**	**1 284 039**	**1 427 018**
Head office cost	607 551	750 530	893 509
Training	427 551	533 509	533 509
Club Actvities	-	-	-
Ongoing costs	**17 211 327**	**23 494 634**	**30 678 189**
Head office cost	6 833 633	7 334 705	7 835 776
Training	*6 763 318*	*10 236 616*	*14 272 661*
Club Actvities	*3 614 376*	*5 923 314*	*8 569 752*
Total cost	**18 246 430**	**24 778 674**	**32 105 207**
Number of provinces active	9	9	9
Number of active clubs	490	735	980
Average number of members per club	25	25	25
Cost per club	37 238	33 712	32 760
Cost per member	1 490	1 348	1 310
Cost per people reached per event	2 027	1 224	892

PSH Common Good Programme

There are no once-off costs identified in this programme. As discussed in the expenditure analysis, the programme has three main foci, however, the costing tool does not differentiate between these foci and shows costs for the entire programme and not just for the costs related to the prevention of pregnancy.

Figure 7 PSH Common Good overview of costs

	Costing scenarios		
	Scenario 1 100% Current	Scenario 2 150% Ideal	Scenario 3 200% Enhanced
Once off costs	-	-	-
Ongoing costs	**84 337 300**	**105 428 825**	**168 714 200**
Provincial staff cost	70 144 000	87 680 000	140 288 000
Training of health promoters	4 191 000	5 206 350	8 382 000
Training of mentors	498 300	662 475	1 036 200
Engagements	9 504 000	11 880 000	19 008 000
Total cost	**84 337 300**	**105 428 825**	**168 714 200**

The cost per health promoter across the three different scenarios remain similar at R38 335 per health promoter. The cost per person reached by the face-to-face engagements is R22 in all three scenarios. Note that the model costs are shown for a full year – this (and other differences highlighted in the costing report) should be considered when comparing the costs to the expenditure analysis (9 months only).

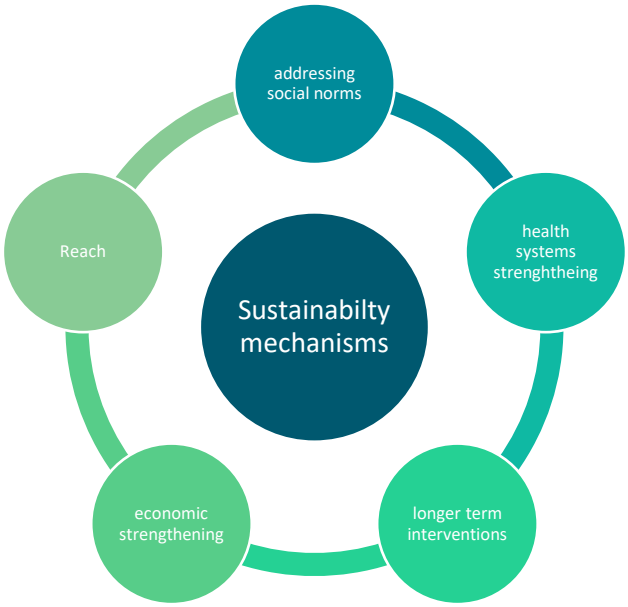
Figure 8 PSH Common Good per unit cost

	Number of units			Costing scenarios		
	Scenario 1 100% Current	Scenario 2 150% Ideal	Scenario 3 200% Enhanced	Scenario 1 100% Current	Scenario 2 150% Ideal	Scenario 3 200% Enhanced
Number of provinces active	4	5	8	*21 084 325*	*21 085 765*	*21 089 275*
Number of health promoters per province	550	550	550			
Total number of health promoters	2 200	2 750	4 400	*38 335*	*38 338*	*38 344*
Number of days worked a month per health promoter	8	8	8			
Number of days worked a year per health promoter	96	96	96			
Number of face to face engagements per health promoter per d	18	18	18			
Total number of face to face engagements	3 801 600	4 752 000	7 603 200	*22*	*22*	*22*

7.8 Sustainability

This section presents the mechanisms needed to strengthen the sustainability of outcomes related to the prevention of unintended early pregnancy. It covers the factors that have been reported to enable or hinder the sustainability in existing programmes sampled.

Figure 9 Sustainability mechanisms



Programmes that address social norms, particularly patriarchy, religious beliefs, cultural norms and practices, enable sustainability as they ensure that social beliefs and behaviours do not encourage unintended early pregnancy. Programmes that have focussed on intergenerational dialogues and targeting parents and communities have made a good start to addressing social norms. The challenge, however, is that boys and men, religious and traditional leaders have not sufficiently been included in programmes. This hinders the sustainability of programmes.

Programmes that strengthen health systems, particularly the capacity of government service providers to provide youth friendly services, leadership support, monitoring and evaluation data, and human and financial resources, enable sustainability.

It is critical that government drives and owns interventions. There are many challenges that point to the limited reach in terms of consistent strengthening of health systems. For example, youth zones are not consistently implemented, there are still barriers in terms of accessing schools, good quality SRHR services are still reliant on CSO support, and there are numerous challenges with the capacity of government service providers providing youth friendly services. Funding, human resources and capacity strengthening of service providers is not yet being consistently and practically prioritised within government. Furthermore, there is a need to provide evidence-based programmes to enable scaling of interventions within the resources of government.

Having longer term interventions are critical for behaviour change and health systems strengthening work. Interventions such as those offered through loveLife are longer term in nature and build generations of young people committed to social change. However, a barrier is that this longer-term work requires much funding which hinders sustainability, particularly within the context of government.

Economic strengthening support is important for addressing the poverty drivers of risky behaviour. Skills development interventions that offer a combination of theory of practice, as well as qualifications, are considered to be more sustainable as they offer opportunities for economic relief. However, the limited employment opportunities may threaten sustainability.

Generally, it was felt that the work on preventing unintended early pregnancy is not yet done, as the reach of programmes have been limited and inconsistently implemented. Continuous support is therefore still needed around preventing unintended early pregnancy.

7.9 Assessment of adequacy

The study sought to assess the adequacy of programme interventions. More specifically it sought to answer the following question: To what extent are the interventions, taken together, sufficient for the purpose of reducing the prevalence of unintended early pregnancy to a satisfactory level? The section below summarises the findings in this regard.

- While good models exist for addressing early unintended pregnancy (centre- and community-based services), these are **inadequate in meeting the demand for services**. Programmes run by loveLife, PSH and Soul City are not available in every facility/school and all clinics do not have youth friendly zones.
- While government departments have the capacity to take such programmes to scale, healthcare workers have not been sufficiently supported to implement youth friendly services. Healthcare workers are not only insufficiently trained to provide biomedical support (for example around IUDs and the Implant) but are also not sufficiently capacitated to provide youth friendly services. In addition, other healthcare facility staff (such as security guards) are not trained around providing youth friendly services. Challenges around stock outs, limited access to a range of contraception and service options and other challenges with access (e.g. times and spaces for young people to access services) remain a challenge. Again, the limited financial and human resources prevent these challenges from being addressed.
- The most frequently mentioned gap is that there are **insufficient good quality programmes addressing social norms** (patriarchy, cultural norms, religious beliefs) that lead to early unintended pregnancy in the community. This work requires deeper ongoing intervention with girls and women, parents/caregivers and the community at large. While some programmes target traditional leaders, none of the organisations sampled mention that they are targeting religious leaders. The limitations in programming addressing social norms are due to limited funding, human resources, and poor evidence-based planning. As a result, the social/cultural drivers are not being sufficiently addressed. This is a threat to the effectiveness and sustainability of programmes.
- The following groups are at increased risk but are **not sufficiently being targeted or reached** by programmes and services: boys and men, those abusing substances, those living in rural areas, LGBTIQ+ community, and persons with disabilities. And so, programmes are not adequately designed to reach these groups.
- While schools provide good entry points for accessing learners, there are challenges with the quality and dosage of **programmes targeting school learners**. CSOs sometimes have limited access to learners in school (due to backlash from parents and School Governing Bodies) and good CSE is not consistently implemented in schools. Programmes such as Soul Buddyz are not provided at high school. The age of consent is also a challenge for accessing services for school aged learners.
- There is insufficient messaging around the **consequences and implications of unprotected sex** and pregnancy for young people (e.g. psychosocial and economic effects). Furthermore,

psychosocial support for girls and women is a challenge, especially in the face of the mental health challenges faced by young people since COVID 19.

- Very few programmes are addressing issues around **unemployment and poverty** and substance abuse as drivers of risky sexual behaviour in communities.

7.10 Conclusion

Social norms play a fundament role in driving unintended early pregnancy. Patriarchal systems undermine the agency of girls and women around their SRHR. The result is gender-based violence, girls and women not being able negotiate safe sex, and girls/women alone carry the responsibility of preventing unintended early pregnancy. Furthermore, conversations around sex and sexuality for young people, particularly girls and women, is taboo. There are insufficient programmes that address social norms. Unemployment and poverty and substance abuse play a critical role in girls and women engaging in risky sexual behaviour in South Africa, and yet very few programmes provide interventions in relation to this. Access, quality and reach of services provided through healthcare facilities and schools are a challenge. While CSOs are trying to close the gap, they do not have the capacity to take such programmes to scale in a sustainable way. Insufficient support has been provided within healthcare facilities and schools to provide adequate, accessible, youth friendly services.

Assessment of programme effectiveness found that PSH, loveLife, and SCI organizations are close to achieving their planned activities, while insufficient staff and budget has hindered the effective implementation of programme activities for the DSD CSE out of school program. The community health care workers and district government officials validated the implementation of programme activities for all four organizations in the sampled sites. AGYW and ABYM confirmed their participation in a variety of SRHR program activities with no reported travel costs.

Overall, the four programmes face a variety of strengths and challenges that are specific to each intervention. However, common strengths across the four programmes include a focus on community involvement and collaboration with other organizations, as well as the use of standardized procedures to guide program implementation. Youth-friendly services that are accessible and free of charge are also highlighted as a strength across two of the four programmes. The LoveLife, Soul City and PSH Common Good interventions all include the active involvement of young people in their activities including the training and employment of youth to deliver YFS. All four programmes offer courses or interventions that improve employability of AGYW and ABYM and can support job searches (e.g. skills training, interviewing skills, CVs).

Retaining young people due to low stipends and better-paying jobs is a common challenge. Other challenges include the logistics related to rolling out training and gaining access to schools, insufficient focus on young boys and there is a need for more intergenerational dialogues, and youth-friendly zones in clinics.

The study sought to assess the extent to which the outcomes in the TOC for prevention of unintended, early pregnancy had been achieved by the four interventions. The findings reveal that the most frequently observed change in target groups was an improved understanding of sexual and reproductive health and rights (SRHR) issues, including GBV, HIV, and contraception. AGYW and AGYM, targeted by the interventions, also showed improved self-belief, self-confidence, and self-efficacy. Finally, the findings reveal that the interventions have also contributed to economic activity and improved employability of AGYW and ABYM, which in turn improved their household income

and contributed to their sense of dignity. At the community level, the interventions have led to an increase in access to adolescent and youth-friendly services and improved uptake of SRH services by young people in three out of the four sites. These findings highlight the importance of continued support for such programmes to achieve greater success in preventing unintended early pregnancy among adolescents and young people.

Findings on programme coherence found that CSOs and DSD are most actively reaching out to collaborate with other government departments and CSOs, suggesting that other departments do not view the prevention of unintended early pregnancy as a key priority under their mandate. Programmes that seek to prevent unintended early pregnancy are often not well co-ordinated. Stakeholders do not co-ordinate their planning, and collaborative activities are often unfocussed, dispersed, and ad hoc. There is insufficient guidance and communication from national to provincial level government on how programmes are supposed to collaborate. While co-ordination structures exist, it is unclear whether prevention of unintended, early pregnancy is a key priority for these structures.

Findings on sustainability reveal that programmes which address social norms and economic drivers, enable effective and sustainable outcomes related to preventing unintended early pregnancy. A threat to sustainability, however, is that boys and men, religious and traditional leaders have not sufficiently been included in programmes and there are limited employment opportunities.

Programmes that strengthen health systems, particularly the capacity of government service providers to provide youth friendly services, leadership support, monitoring and evaluation data, and human and financial resources, enable sustainability. There are many challenges that point to the limited reach in terms of consistent strengthening of health systems. Having longer term interventions are critical for behaviour change and health systems strengthening work.

Finally, the assessment of adequacy found that, whilst good models exist for addressing early unintended pregnancy such as those implemented by loveLife, PSH and Soul City, their reach is inadequate to meet the demand for services. The most frequently mentioned gap is that there are insufficient good quality programmes addressing social norms (patriarchy, cultural norms, religious beliefs) that lead to early unintended pregnancy in the community; very few programmes are addressing issues around unemployment and poverty and substance abuse as drivers of risky sexual behaviour in communities; and many groups remain hard to reach such as boys and men, those abusing substances, those living in rural areas, LGBTIQ+ community, and persons with disabilities.

Furthermore, while government departments have the capacity to take such programmes to scale, healthcare workers have not been sufficiently supported to implement youth friendly services. Challenges around stock outs, limited access to a range of contraception and service options and other challenges with access (e.g. times and spaces for young people to access services) remain a challenge.

It is thus concluded that interventions in South Africa are insufficient for the purpose of reducing the prevalence of unintended early pregnancy to a satisfactory level.

8 Presentation of findings for Malawi

8.1 Background and context

8.1.1 Prevalence of early, unintended pregnancy in Malawi

Early, unintended pregnancy is considered both a social and public health problem across the globe. The global estimated average adolescent birth rate was 44 births per 1000 girls aged 15 to 19 years in 2018[34]. However, Malawi had a significantly higher rate of 141 births per 1000[35]. The Malawi Demographic and Health Survey of 2015-2016 found that 29% of total pregnancies were among adolescent girls aged 15 to 19 years[36]. The same data source notes that almost two-thirds of women start sexual activity before the age of 18, and one in five has sex before age 15.

Globally, the COVID-19 pandemic contributed to an increase in teenage pregnancy rates and Malawi was no exception, with 13 000 cases of child marriage and over 40 000 cases of early unintended pregnancy reported in the period March to July 2020; an 11% increase in early pregnancies compared to the same period in 2019[37][38].

Malawi statistics

Nearly 1 in 3 adolescent girls aged 15–19 years have begun childbearing.

Of those, 46% gave birth before their 18th birthday.

More than 1 in 3 pregnancies among women and girls aged 15–24 years were mistimed.

Teenage fertility is higher in rural areas (31%) than urban areas (21%). (UNFPA, 2022)

8.1.2 Factors contributing to early, unintended pregnancy

The literature has reported various factors associated with early, unintended pregnancy in Malawi. These factors have been grouped into different categories including the health system, and household, structural-behavioural and individual levels. The table below provides a summary of these factors.

It is worth noting that although most of the factors contributing to early, unintended pregnancy are similar to those reported for South Africa, there are some Malawi-specific considerations, such as the high levels of child marriage in the country. According to UNICEF[39], poverty, and cultural and religious traditions, are the key drivers of child marriage.

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[39] [39]UNICEF, Child marriage Case study in Malawi. 2018 https://www.unicef.org/malawi/media/526/file/Child%20Marriage%20Factsheet%202018.pdf . Accessed 22 November 2022

Table 7 Factors contributing to early, unintended pregnancy in Malawi

Level	Factors
Health system	• Limited access to adolescent and youth friendly services (AYFS) • Limited number of health care workers who are trained to deliver AYFS • Negative and judgmental attitudes amongst health care workers regarding young people seeking SRH services • Limited information regarding SRH issues, including contraception utilisation and how to access services
Household	• Lack of parental guidance and role models • Reluctance of parents to engage in discussions about sex and sexuality education • Reluctance of parents to permit their children to be exposed to sexuality education or to seek SRH services
Structural	• Poverty, which contributes to transactional sex and age disparate relationships, unequal power relations and challenges related to condom negotiation and usage • Gender inequalities, leading to gendered expectations of how teenage boys and girls should act • Sexual and gender-based violence (SGBV) • Harmful traditional practices, as well as negative norms and stigma surrounding women controlling their own fertility and bodies • Child marriages
Behavioural	• Risky sexual behaviour, including multiple sexual partners • Curiosity or experimentation
Individual	• Low educational achievement • Peer pressure • Lack of information / education related to safe sex practices • Early sexual debut (for girls, this is often prompted by high age differences between themselves and their partners)

8.1.3 Impact of early, unintended pregnancy

The following section provides an overview of the health, economic and social impacts of early, unintended pregnancy.

Health impact:

- Early, unintended pregnancies can have serious, negative health consequences for both mothers and children. These consequences include an increased risk of maternal mortality, pre-term birth, low birth weight, maternal depression, neonatal mortality, obstetric fistula, and

anaemia; all of which can have long-lasting effects on the mother and child's physical, emotional and economic well-being[40] [41].

- Additionally, early, unintended pregnancies can lead to an increased demand for health care services, which can strain health care systems; especially in countries with limited resources[42].

Economic impact:

- Teenage mothers often face social and economic barriers that can prevent them from continuing their education and obtaining employment, thus perpetuating cycles of poverty and inequality[43].
- The economic costs associated with early, unintended pregnancy can be substantial, including reduced productivity and economic growth[44].

Social impact:

- Early, unintended pregnancy is often stigmatized and viewed as a moral failing rather than a public health issue. This results in discrimination and marginalization for young mothers and their children, which - in turn - leads to social isolation, mental health challenges and limited access to health care, education and employment opportunities[45].
- Stigma and discrimination can also prevent young people from seeking information and services related to reproductive health, perpetuating the cycle of unintended pregnancies[46].

8.1.4 Domestic policies, plans and strategies

A set of domestic policies, strategies and guideline documents related to the prevention of early, unintended pregnancy in Malawi were reviewed as part of the study's literature review. These are listed in the diagram below.

[40] Malawi: Msyamboza, K. P., Ngwira, B., Banda, R., Mkwanda, Z., & Sikwese, S. (2016) Prevalence and correlates of depression among adolescents in Malawi: Findings from a population based survey. *Child and Adolescent Psychiatry and Mental Health*, 10(1), 1-12.
[41] World Health Organization (2021) *Adolescent pregnancy*. https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy Accessed 05 May 2023.
[42] Ibid
[43] Manezeu, T., & Sebitosi, A. B. (2014). *The economic impact of adolescent pregnancy in Malawi*. International Journal of Scientific and Research Publications, 4(10), 1-7.
[44] Ibid
[45] Phiri, N., Ataguba, J. E., & Fonn, S. (2017). *A review of health leadership and management capacity in Malawi*. BMC health services research, 17(1), 1-9.
[46] Ibid

Figure 10 Reviewed policies, strategies and guideline documents (Malawi)[47]

Policies	Strategies/Action plans	Guidelines/Manuals
• National Youth Policy (2013) • National Sexual Reproductive Health and Rights Policy (2017-2022)	• National Strategy for Adolescent Girls and Young Women (2018-2022) • Health Sector Strategic Plan II (2017-2022) • National Youth Friendly Services Strategy (2015-2020) • National Plan of Action to Combat Gender-Based Violence in Malawi (2014-2020) • The School Health and Nutrition (SHN) Strategy 2009-2018	• National Reproductive Health Service Delivery Guidelines (2014-2019) • National Youth Friendly Health Services Training Manual (Revised November 2016)

8.2 Overview of interventions

8.2.1 Key objectives, description of services, target group and reach

The table below provides an overview of each of the four programmes selected for in-depth review including key objectives, target group/s, implementation sites and reach. The information was extracted from secondary data sources, including programme documents, as well as primary data. A more comprehensive overview is provided in **Annexure 2**.

[47] The information included in Figure 9 was sourced and reviewed for the literature review that was conducted as part of this study in 2022. As such, the policies and strategies cover the years up to 2022. A desktop search and requests for strategies and policies for the year 2023 onwards did not yield any results.

Table 8 Overview of Malawi models selected for in-depth review

Name of model/programme	Name of implementing organisation/s	Key objectives	Services	Target group/s	Implementation sites and reach
Ana Patsogolo Activity (APA) – DREAMS model	APA is led by the Bantwana Initiative of World Education Inc (WEI / Bantwana) and is currently implemented in partnership with the Government of Malawi and four Malawian NGOs; namely, the Diocese of Chikwawa; Global AIDS Interfaith Alliance (GAIA/M); Global Hope Mobilisation (GLOHOMO); Malawi AIDS Resource and Counselling Organisation (MACRO)	To prevent new HIV infections and reduce vulnerability to HIV among AGYW	An evidence-based intervention that is delivered through primary and secondary packages. These are provided via DREAMS clubs (20-30 girls per club), according to age bands 10-14 years; 15-19 years; and 20-24 years. Interventions are delivered according to age, school status and risk criteria to ensure that the package is tailored to the circumstances of each AGYW. Every AGYW completes the entire primary package while delivery of the secondary package is needs based. To complete DREAMS, an AGYW must complete the entire primary package plus at least one secondary service. **Primary package** includes: • HIV and GBV prevention information, condom and contraceptive information / family planning (FP) • DREAMS toolkit *My Dreams My Choice*[48] • Pre-exposure prophylaxis (PrEP) education / information[49] • Financial literacy[50]	Most at risk to HIV AGYW, aged 10-24 in DREAMS districts in Southern Malawi (both in and out of school)	Machinga, Blantyre, Zomba and Phalombe districts APA has enrolled 208,843 adolescent girls and young women in DREAMS, with 85,978 already completing the program, of which 99.98% remained HIV negative

[48] Content in the toolkit is tailored according to age band
[49] Not included in the 10-14 year old package
[50] APA offers a different financial literacy curriculum for each age band (Aflatoun/Aflateen/Aflayouth)

Name of model/programme	Name of implementing organisation/s	Key objectives	Services	Target group/s	Implementation sites and reach
			• Screening for HIV Testing Services (HTS) and referral; HIV Self Testing (HIVST) **Secondary package** (needs-based) includes: • Violence prevention (IMPower)[51] • Education support (primary and secondary bursaries; menstrual hygiene management)[52] • Dropout prevention and reintegration support[53] • Access to contraceptive services / FP / condoms • HTS / HIVST • Families Matter (parenting) programme[54] • Access to post-violence care services • Youth Village Savings and Loans Associations (VSLA)[55] • PrEP screening and uptake • Siyakha youth economic strengthening package[56]		

[51] Not delivered to 20-24 age band
[52] Not delivered to 20-24 age band
[53] Not delivered to 20-24 age band
[54] Not delivered to 20-24 age band
[55] Not delivered to 10-14 age band
[56] Not delivered to 10-14 age band

Name of model/programme	Name of implementing organisation/s	Key objectives	Services	Target group/s	Implementation sites and reach
			In addition to the above, APA implements the *SASA! And SASA! Faith for Community Mobilization and Norms Change* model. Male sexual partners of AGYW are targeted using trained Male Champions who deliver SASA and make referrals for men's health services, including distribution of HIV self-test kits. Other programme interventions include condom distribution and referrals for HIV prevention services (such as PrEP and post-exposure prophylaxis or PEP)		
Safe Spaces – implemented as part of the Spotlight Initiative	Girls Empowerment Network (GENET)	To empower women and girls to develop strategies and assertive skills to negotiate and challenge harmful practices that fuel sexual and gender-based violence (SGBV), child marriage and early, unintended pregnancy To provide a supportive and safe environment within	• Mentor training (5 days) • Weekly, 2 hour sessions for 25-30 mentees (structured according to age bands of 10-14 years, 15-19 years, 20-24 years) to provide SRH and rights education as well as education on small business operation and management • Small business support as well as access to village savings and loans associations (VSLA) • Community structure strengthening and outreach activities • Referrals for AGYW as survivors of SGBV and harmful traditional practices	Adolescent girls and young women (AGYW); aged 10 to 24	Dowa and Nkhata Bay (Spotlight Initiative); plus Lilongwe, Blantyre, Mulanje, Machinga and Chikwawa 68 960 AGYW accessed services through safe spaces, including SRH services, psychosocial support and counselling (this figure includes 23 640 girls and young women who attended the safe space mentoring programme)[57]

[57] UNFPA Malawi Annual Report 2021*; Accelerating the Three Zeros* (page 6)

Name of model/programme	Name of implementing organisation/s	Key objectives	Services	Target group/s	Implementation sites and reach
		communities to report and access quality, essential services			
Health Policy Plus programme	Developing Radio Partners (DRP)	To strengthen local media partners' (community radio stations) preparation and broadcasting of weekly programmes related to community priority issues To ensure that AGYW and ABYM have access to information, including SRH and their SRH rights, as well as access to adolescent and youth friendly services (AYF)	• Selection, training and mentoring of youth journalists • Establishment of radio listening clubs • Peer to peer education sessions • Establishment of father and mother groups • Community outreach and events for education and information-sharing on SRH, SRHR • Access to SRH services, including HIV testing; distribution of condoms; contraceptive information • Provision of technical assistance to radio stations to support the production of weekly radio programmes • Special productions, including television, radio and newspaper series on ending child marriage • Purchase - and replacement - of computers and recording devices	AGYW and ABYM aged 13-19 years Parents / guardians of AGYW and ABYM Community members in targeted districts	Mangochi, Nkhotakota, Nkhata Bay, Blantyre, Nsanje and Mchinji districts 30 youth journalists per radio station; 2 listening clubs per radio station – 10 ABYW; 10 ABYM Parents / guardians - approximately 10 female and 10 male, per community radio station, are targeted for the mothers and fathers groups In terms of radio listeners, it is estimated that each radio station has approximately 750 000 potential audience members. The total, potential reach across all sites is approximately 6,5 million.

Name of model/programme	Name of implementing organisation/s	Key objectives	Services	Target group/s	Implementation sites and reach
***Break Free!* programme**	Five year joint programme of Plan International, SRHR Africa Trust (SAT) and Forum for African Women Educationalists (FAWE)	To ensure that adolescents can make their own free and informed choices about their SRH in order to combat early, unintended pregnancy and child, early and forced marriage (CEFM)	The programme focuses on social movement and network building for social norms change. Activities including the following: • Capacity building of CSOs and youth hubs for lobbying and advocacy purposes • Research, learning and exchange • Support for lobbying and advocacy campaigns targeting decision makers and key stakeholders to increase budget allocations and implement/amend laws and policies addressing CEFM and early, unintended pregnancies • Community outreach activities, including community theatre, for information dissemination regarding SRHR • Radio programming regarding SRH issues and rights (Timveni Radio – *Timasuke pa zaumoyo wathu*) • *Champions of Change* model for youth groups for education and information dissemination on SRH and rights[58] • Community-based distribution agents to increase access to SRH information and services (condom distribution)	AGYW aged 10-24 years primarily, but programme includes ABYM of same age	Machinga and Lilongwe districts

[58] The Break Free! youth groups are organised according to age; that is, 10- 14 year olds; 15-19 year olds and 20-24 year olds. This ensures that the information shared is age appropriate and aligned to the needs of the different age groups.

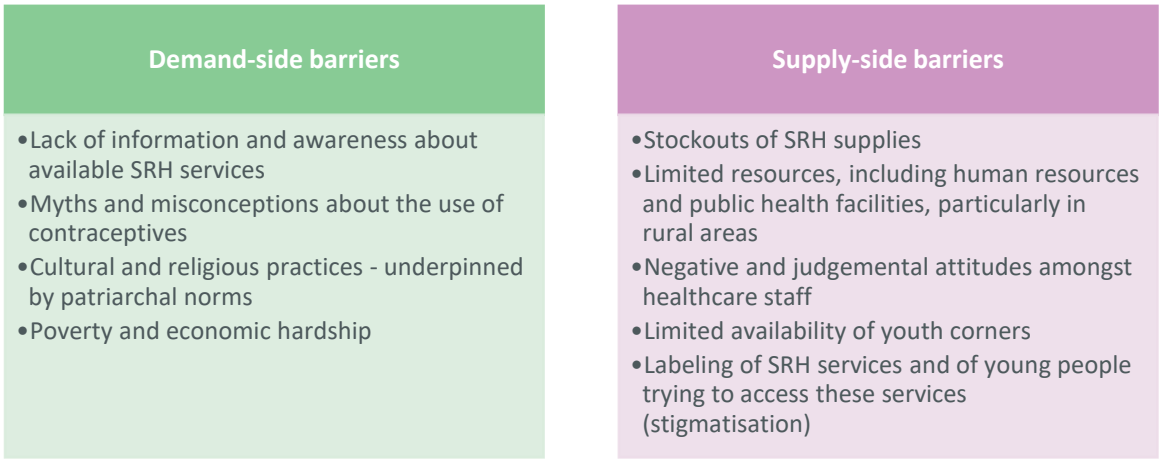
8.3 Relevance

This section of the report assesses the relevance of the four programmes selected for in-depth review. It begins with a discussion on the major problems or needs faced by adolescent girls and young women when it comes to accessing SRH services. It also covers how the different programmes are addressing these needs. The section ends with a brief discussion on the major gaps in the unintended, early pregnancy response programmes.

8.3.1 Major problems or needs faced by adolescent girls and young women

The study findings show that AGYW in Malawi face significant challenges when it comes to SRH. Access to and utilisation of SRH services is limited by demand and supply side barriers. The diagram below provides a summary of these challenges. These are further elaborated on below.

Figure 11 Demand and supply side barriers affecting access and utilisation of SRH services



Demand-side barriers

One major issue cited across all four programmes that were sampled is the **lack of information on SRH services**. Several respondents argued that many young people are unaware of the services available to them, and the term "family planning" can create misconceptions that these services are only for older, married individuals. Furthermore, some respondents noted that despite government SRHR services being provided for free, many people are not aware of the services provided by public healthcare facilities. This results in services being underutilised due to the lack of information about them.

> *"The biggest gap is the lack of information on available services. Many young people do not know about the services that are available at government facilities and so these services are not being used although they are free." (SSI_INGO Malawi)*

> *"I could have fallen pregnant because I was not aware of how I can protect myself from pregnancy. Thanks to this programme I am now aware." (FGD_AGYW)*

Cultural and religious norms and practices were also identified as a significant barrier to youth accessing SRH services. In Malawi, CEFM are still common practices which prevent young girls from accessing SRH services, as many of their decisions in relation to SRH are made on their behalf by their husbands and senior family members. There are also cultural practices which promote the

presentation of virgins to traditional chiefs as a way of publicly welcoming the young girls into adulthood. A key challenge with this process is that it publicises the transition of girls from childhood to womanhood, making them susceptible to abuse as they are no longer considered children. Such practices also perpetuate harmful gender stereotypes and contribute to many cases of GBV remaining unreported.

> *"In Machinga, there was a tendency of getting girls married at a younger age, this was seen as normal. It's starting to change now that communities are being sensitised and know that this could land them in jail." (FGD_AGYW)*

The study also shows that there is a stigma associated with accessing family planning by youths who are not married and are thus still perceived as "children" in society. Therefore, some parents refuse to allow their children to access family planning services, fearing that they will be labelled as prostitutes.

> *"In some areas AGYWs are stigmatised by people when they want to access SRH services. They are labelled by the community as prostitutes, and this discourages AGYWs to make further visits to health facilities." (SSI_district government official)*

Additionally, **myths and misconceptions about the use of contraceptives**, such as the belief that those who use contraceptives are not pleasurable in bed or become infertile, discourage young people from accessing these services. Unfortunately, young people often rely on such misinformation and myths when making decisions about their SRH.

> *"There are also misconceptions and myths that are associated with SRHR services which include that if one takes contraceptives, they will experience problems to have children in the future." (SSI_youth distributor)*

> *"Machinga district is one district where myths and misconceptions about contraception use are rife. Parents and adults believe that contraceptives are a ploy to make sure the girls become barren as a grand conspiracy for depopulation." (SSI_club facilitator)*

Lastly, the study findings show that poverty is also a key challenge faced by AGYW. This **increases economic pressure** on AGYW and increases the likelihood of them engaging in transactional sex or entering early marriage as a means of accessing financial support. This, in turn, increases their risk of early, unintended pregnancies and associated health risks.

> *''The main challenge when it comes to prevention of unintended early pregnancies in Machinga is that due to the level of poverty in district, most girls engage in relationships with older men. Girls who are doing this end up contracting STIs or even getting pregnant which later leads to early marriages." (SSI_district government official)*

Supply-side barriers

Limited resources and infrastructure, including stockouts of supplies, inadequate integration of services, and insufficient human resources, were also cited as major barriers to young people accessing SRH services. One of the biggest challenges is the stockouts of supplies and limited number of trained personnel at public health facilities. This is a challenge because public health facilities are often the only option available to young people, as a result of the high cost of private health care.

> *"We have challenges with stockouts of contraceptives and other supplies. Sometimes, we also have challenges with trained personnel, and there is a high turnover of those who were trained."(SSI_district government official)*

In addition, **long distances and the cost of transport** is a major barrier to accessing SRH services, especially for those living in hard-to-reach areas. For instance, young people in Machinga district, which is considered one of the hardest to reach areas in Malawi due to poor road conditions (particularly during the rainy season), and living in hilly terrain areas like Ngonkwe, Nyambi, and Mposa, have difficulty accessing SRH services.

> *"Another challenge is that YFHS are not available in most remote parts in the district. Those who want to access these services must travel long distances to the district hospital." (SSI_radio station manager)*

> *"AGYW have to walk long distances to access services in clinics. For example, some have to travel up to 40km just to access services." (SSI_district manager)*

Despite health policies encouraging the provision of YFHS, limited access to such services remains a significant barrier for adolescents. The YFHS policy requires health facilities to have a youth corner, where young people can access information and services relating to reproductive health. However, study findings show that **youth corners are not available in all public facilities** and in areas where they exist, overcrowding often occurs. This creates a situation where young people are mixed with adults when accessing SRH services. This discourages young people from accessing the services as they fear judgement.

> *"Another barrier is that SRH services are offered in unconducive and unfavourable environment for young people to be comfortable enough to seek these services. Some of our services are offered in a mixed environment where adults are mixed with youths." (SSI_community health care worker)*

> *"AGYW are facing a lot of challenges when they want to access YFHS, the first is overcrowding of young people at the youth corner. For example, the youth corner at Mchinji District hospital is not enough to assist everyone." (SSI_community leader)*

Limited access to YFHS is not the only barrier to accessing SRH services for adolescents. The labelling of SRH services at health care facilities can contribute to stigmatization of those who seek such services; that is, the labelling gives a negative connotation that young people who visit these facilities are either victims of rape or intend to or have been having unprotected sex. This stigma can be a significant deterrent for young people, leading them to be shy about entering areas designated as youth friendly zones. As a result, young people avoid accessing essential SRH services.

> *''Labelling at health facilities gives a gone conclusion and also stigmatises one entering and coming from such rooms as being a victim of rape or of having unprotected sex. It disadvantages girls seeking the services." (SSI_national government official)*

Finally, the study found that **negative and judgmental attitudes from health care staff**, particularly nurses, remain a significant obstacle for young people seeking SRH services. In some cases, health care providers breach confidentiality, leading young people to feel that they cannot trust them. This lack of trust leads to young people shying away from using these services.

"We did a survey which showed that a lot of young people either did not know about available services or had a bad experience there. These facilities are supposed to be youth friendly but young people found that they were not, as service providers were often judgemental and would not maintain confidential information. Therefore, youth found them to be non-credible and non-trustworthy." (SSI_programme staff)

8.3.2 Programme response and relevance to these needs

Overall, the study shows that all four programmes are responding to the needs of young people with regards to accessing SRH services and preventing early, unintended pregnancy. Key activities include providing education on sexual health and family planning, facilitating access to SRH services, as well as conducting community engagement with boys, parents and traditional leaders amongst others.

Furthermore, evidence from this study shows that all the programmes employ a holistic approach to address the multiple needs of AGYW. The programmes do not only provide information and access to services, but also seek to address the underlying socio-economic factors that lead to early, unintended pregnancy, such as reducing school dropouts and providing vocational skills training and financial support. Some of the programmes include an advocacy component whereby they equip young people with skills to advocate for change in their communities. This empowers them to have a voice in decisions that affect their health and wellbeing.

The specific strategies used by each programme are tailored to the needs of the communities that they serve, but they all share a focus on empowering young people and creating an enabling environment for them to access the services they need. The table below provides a summary of how each of the four selected programmes responds to the needs of AGYW and ABYM.

Table 9 Programme response to AGYW and ABYM needs

Problem	How the different programmes address the needs of AGYW and ABYM
Lack of information available on SRHR services & misconceptions about the use of contraceptives	• APA provides education on sexual health and family planning to young people. The programme uses a toolkit which includes sessions on sexual health and family planning. Health facility staff provide SRH information as well as services via the clubs, and referrals are made to health facilities for services that cannot be delivered via mobile clinics (e.g. PrEP). Information is also shared regarding the days and times that health facilities can be accessed and particular services on offer. Where required, the APA provides transportation to facilities providing specific services via a transport coupon system. • GENET facilitates safe spaces and mentorship programme activities which educate AGYW on how to handle issues of GBV and SRHR, as well as sensitise their peers on these issues. In addition, services are provided at the community level through mobile clinics where information regarding SRH services is disseminated, ensuring that youth can access services. • The *Break Free!* programme builds AGYW capacities to make safe and informed decisions, including the option to choose to use contraception or to say no if they are not ready for sex. Weekly outreach activities are conducted where programme staff interact with young people increasing their knowledge and building their capacities on SRH. In addition, the programme utilises theatre and a Champion of Change model to share information regarding SRH and rights with young people. • DRP uses radio programming to provide AGYW with easy access to relevant SRH information and involves them in the generation and presentation of SRH media content.

Problem	How the different programmes address the needs of AGYW and ABYM
Cultural and religious norms and practices	• APA focuses on educating and sensitizing parents and guardians on how they can interact with children; for example, how a parent can communicate with a child about SRH issues. An evidence-based parenting curriculum, the *Families Matter Programme*, is used to do this. • The *Break Free!* programme engages with parents and traditional leaders to educate them on issues related to early, unintended pregnancy and the consequences. The programme also undertakes advocacy interventions for improved implementation, and amendment – where required, of laws and policies that address child marriage and early pregnancy. • DRP created fathers' groups that educate boys on preventing early, unintended pregnancy, as well as gender equality and promoting respect for girls. The fathers' groups, and ABYM, also provide support with community level interventions related to the protection of the rights and dignity of AGYW. These include the construction of private toilet facilities and changing rooms for girls at school. ABYM, together with father's groups, are encouraged to act as gender equality champions and to support the SRHR of AGYW. The programme also engages with traditional leaders to spread anti-child marriage messages and interventions. • A key component of GENET is to strengthen community structures and engage the community in changing norms and practices that compromise the SRH and overall wellbeing of AGYW. The programme also sensitises young people on the effects of early marriage, the identification of GBV and where they can report cases.
Limited resources including stockouts of SRH supplies	• The *Break Free!* programme includes outreach interventions that respond to the needs of AGYW, such as linkages to services, including contraceptives, condoms; counselling services and referrals where needed. In addition, *Break Free!* engages with Central Medical stores, the Reproductive Health Directorate, and Logistics and Supply Chain management to address the issue of stockouts of commodities. Engagements target stakeholders at national level and at programme impact areas. • APA collaborates closely with clinical partners (HIV prevention and SRH) and the Ministry of Health to provide access to YFHS and other family planning services such as contraceptives. The programme also has a transport coupon system for AGYW to be able to access services at the nearest health facility. • DRP conducts community outreach activities where SRH services are provided. These events also include entertainment including music and poetry amongst others. • GENET facilitates the provision of SRH services at the community level through mobile clinics. The programme also works on strengthening referral pathways ensuring the timely delivery of services.
Poverty and socio-economic challenges resulting in transactional sex	• APA provides economic strengthening activities including age-appropriate financial literacy, participation in youth VSLAs and adult VSLAs for AGYW caregivers. It also provides a comprehensive, market-based workforce readiness programme (Siyakha Girls) that includes partnerships with vocational skills training centres and local artisans. In addition, the programme offers educational support, starter packs and scholarships to ensure that young people stay in school. • Through GENET, AGYWs are given skills to start and grow businesses as well as financial management skills. The aim is to provide AGYW with a form of income to reduce their level of financial dependency.

8.3.3 Programme gaps

A few gaps have been identified in terms of meeting the SRH needs of AGYWs and preventing early, unintended pregnancy.

- First, there is a need for comprehensive services in the community and not just in health facilities, particularly for hard-to-reach areas. Although all the four organisations support the provision of SRH services at community level, these services are not comprehensive enough to address all the needs of AGYW. This means that some girls may not have access to essential services such as a variety of family planning options. This limits their ability to make informed choices about their reproductive health.
- Second, there is still limited information about available SRH services, which means that many young people do not know about the services that are available at government facilities. This lack of awareness could be due to the negative attitudes of health care workers towards young people and their SRHR, resulting in a reluctance to share SRH information with young people. These attitudes can be a significant barrier to accessing services and contribute to the stigma and discrimination faced by young people seeking SRH services.
- Another challenge that was identified is the limited number of programmes that focus solely on addressing early, unintended pregnancy. For example, programmes may address early, unintended pregnancy but this is within the scope of other efforts such as HIV and SGBV prevention and response.
- There are indications that members of key populations; for example, youth with disabilities ,are not engaging in programme activities; as outlined in the quote below.

  "Young people with disabilities are not participating in the programme; mostly those who are just kept indoors by their parents. Also mobility is a challenge to go and access the activities and some of these youth are just shy and cannot work with their fellow youth." (FGD_AGYW)

- Lastly, some of the stakeholders that participated in this study emphasised the need for the government of Malawi to dedicate more resources to support and finance the provision of comprehensive SRH services to AGYW. A key concern here is the perception that most of the larger and better-resourced interventions that address early, unintended pregnancy are donor funded.

8.4 Effectiveness

This section of the report examines the extent to which planned programme activities have been implemented and key outputs achieved. The information provided is based on primary (interview) and secondary (programme reports and documents) data. The programme objectives, planned activities and target groups are presented in section 8.2 of the report.

8.4.1 Extent to which programme activities have been achieved

During interviews, staff from all four programmes reported that **planned activities were being implemented** or had been completed within the allocated programme time frames. Programme roll out of planned activities was confirmed during interviews with stakeholders at district and community level including government officials, parents / guardians, traditional leaders, and community health care workers.

Of note is that all four programmes implement a **range of activities** or provide a package of different services. This allows for a 'layering' of complementary services for AGYW. In addition to these programme-related activities, all of the interventions reported extensive engagement with local community leaders as well as collaboration with district government officials and community structures, both prior to and during programme implementation, to enable high levels of programme support and collaboration within targeted districts.

> Each of the AGYW participating in the **DREAMS** programme is assigned a unique identifier code (UIC). This allows the programme to track each AGYW to ensure their access to - and completion of - the full primary package plus at least one secondary package intervention, which is provided according to the individual needs of each AGYW.

All of the programmes reported the use of **standard operating procedures or programme guidelines,** which are aligned to national and district level strategies and action plans related to the provision of AYF SRH services, HIV / AIDS prevention and the rights of AGYW. Specifically noted were the National Sexual Reproductive Health and Rights Policy (2017-2022), the National Strategy for Adolescent Girls and Young Women (2018-2022) and the National Youth Friendly Services Strategy (2015-2020). DRP staff also reported the use of guidelines and journalist codes of conduct related to interviewee confidentiality, while GENET has prepared a manual and guidelines for its safe space mentors, and follows national guidelines on child protection and safeguarding.

During FGDs, **ABYM and AGYW** confirmed their participation in the programmes, with starting dates for the APA, GENET's Safe Spaces and *Break Free!* ranging between 2021 and 2022. DRP has been operating in Malawi since 2014. The focus group participants also noted the different activities that they had participated in, as outlined in the table below. This input confirms the comprehensive nature of service provision and / or support provided by all four programmes.

Table 10 Feedback from AGYW and ABYM on their engagement in programme activities

Programme	Programme services / activities reported by AGYW and ABYM
Ana Patsogolo Activity	• Information regarding SRH services (e.g. PrEP) and where these might be accessed • Referrals to local health facilities for SRH services • Information regarding HIV/AIDS – *"…how people can protect themselves from the virus, and, if they have the virus, what should they do to live a healthy life,"* (FGD_AGYW) • Information about GBV and where to access services should one experience any form of SGBV • Educational support, including school reintegration support • Access to post-school (vocational) training and VSLAs
Health Policy Plus	• Training and mentoring in journalism skills (including access to weekly tip sheets on topical themes; training on content development, interviewing skills, digital editing and broadcasting of weekly radio programmes) • Access to equipment for recording and editing of radio programmes • Youth clubs / youth corners for peer to peer engagement and information-sharing • Information on SRHR, AYFS, and the risks associated with child marriage, early pregnancies and substance abuse • Community events / variety shows and outreach activities • Intergenerational dialogues

Programme	Programme services / activities reported by AGYW and ABYM
Safe Spaces (Spotlight Programme)	• Training as safe space mentors • Information regarding gender equality, SRH services and rights, how to access SRH services, STIs and how to prevent them (including HIV / AIDS), risks and negative effects of child marriage and early, unintended pregnancy, SGBV, contraceptives, and PrEP • Information regarding budgeting, small business and financial management skills • VSLAs and "community banks"; micro loans • Referrals for survivors of SGBV • Sporting equipment and activities (chess, netball, soccer)
Break Free!	• Youth clubs for discussion and peer to peer engagement regarding SRH and rights • Information on SRH services and how they might be accessed, risks of early marriage and unintended early pregnancy, STIs, SGBV • HIV testing • Psycho-social support and counselling • Referrals for survivors of SGBV • Community-based distribution agents (provide SRH information and contraceptives, door to door) • Community drama groups (Theatre for Change) • *Champions of Change* intervention, with a focus on ABYM

AGYW and ABYM are **recruited to participate** in programme activities in a variety of ways. For example, youth are often accessed via existing youth clubs or networks and schools or via community outreach activities and sensitisation meetings. Where selection processes are in place; for example, to receive training as a safe spaces mentor under the GENET programme or as a youth journalist by DRP, the programmes reported similar sets of selection criteria. These include youth with an interest in community issues, prior engagement in community activities, self-confidence and the ability to speak in public, as well as some prior knowledge of SRH concepts and issues. The quote below refers to a method used by DRP as a means of identifying youth for training in radio journalism,

> *"In schools, students are requested to write essays on issues related to SRH and rights and also early marriage. Those who wrote the best essays are selected."(FGD_ABYM)*

The APA model targets AGYW most at risk of HIV. Programme implementers use an eligibility screening tool that is age-based; that is, different eligibility criteria are utilised for screening within different age bands[59]. GENET works closely with traditional authorities who assist in the identification, interviewing and selection of mentors, as outlined in the quote below.

> *"We were called by village headmen in our communities as a group. Once we were together, we started discussing issues that affect us as AGYW, mostly in terms of SRH, GBV and other issues related to HIV and AIDS. The types of questions were just general.*

[59] For example, the criteria "ever had sex" is considered a risk factor for the 10-14 age band, but not 15-19 and 20-24 age bands. History of pregnancy and out of school are considered risk factors for the 10-14 and 15-19 age bands, but not 20-24, while experience of violence, and alcohol and substance abuse, are considered risk factors across all age bands.

I remember I was asked if I was walking alone at night and I saw a boy and a girl chatting under a tree, what could I do. After a while GENET called those who were selected as mentors for a five day training; 30 girls were selected in the district." (FGD_AGYW)

8.4.2 Strengths of implementation

A number of similar themes emerged in study participant discussions regarding the strengths of implementation of the four programmes included in this review. These are outlined below.

- The most frequently mentioned strength across all four programmes is the **quality and relevance of the information and services provided**. Study participants noted that the information provided was age-appropriate, youth-friendly and relevant to the needs of the targeted youth. This may be linked to the use of specific age bands for education and information-sharing activities, as well as SRH service delivery and access to other support interventions, such as VSLAs, financial literacy and vocational training[60]. The majority of study participants also noted that the information provided was current / up-to-date and that it had contributed towards dispelling a number of myths and misperceptions regarding adolescent SRH.
- In line with the above, is the frequent reporting of the high level of **technical expertise of the programme management and implementation staff**. This too was reported as a key strength across all four programmes.
- Of particular interest were the frequent mentions of the **localisation of the programmes** or their "embedding" of skills and expertise within the local context; for example, via the appointment of local programme coordinators and implementers, and the recruitment and skilling of local youth as facilitators, journalists, distribution agents and mentors. These were all highlighted as good practice examples as they contribute to the building of a local skills base while also ensuring that those with the necessary level of local knowledge and insight are responsible for programme planning and implementation.
- Another frequently reported strength across all programmes was the use of a participatory and consultative approach coupled with high levels of **community engagement both prior to – and during – implementation**. Programme staff reported the use of stakeholder / community mapping activities, participatory needs assessments, as well situation analyses, and the inclusion of other, local CSOs, traditional authorities, religious leaders, parents / guardians, AGYW and ABYM, and district government officials and departments, in the planning and implementation of programme activities. An example of this is the abovementioned engagement of traditional leaders in the interviewing and selection of GENET safe space mentors. Programme staff also reported conducting initial information sessions in target communities where programme objectives and key activities were shared. These efforts have resulted in high levels of community buy in and support of programmes and good levels of collaboration between programme staff and local community structures. It has also been a key facilitator of programme sustainability.

[60] APA, GENET and *Break Free!* all reported the use of age bands as a means of structuring their delivery of content and services.

"The collaboration of the programme and community structures when implementing activities is one of the main strengths that the programme had. By involving the community structures during the implementation phase, the programme was welcomed and did not receive any resistance from the people in the district." (SSI_youth facilitator)

"The programme has many strengths but the main one is the engagement of all community structures, involving the community leaders, parents and guardians, and even the youth themselves. As a result, the programme was accepted in the community and implementation of the activities was easier because people know the objectives of the programme." (SSI_community leader)

- All of the programmes reported that they had **monitoring systems** in place for tracking their implementation and recording of outcomes, and that data is used for learning and programme strengthening. For example, DRP requests a monthly report from each of its community radio station partners detailing what has been done, any challenges experienced and outcome stories. Audio files of the prepared radio programmes and short public announcements are also shared by radio station partners with DRP's Programme Manager/Director. The APA Annual Reports include short change stories as a way of outlining key changes for programme participants, while the SAT staff confirmed the use of Outcome Trackers for capturing *Break Free!* programme-related outcomes. The APA also collects data from all DREAMS Club members upon entry and exit from the programme. This, together with the use of the UIC allows the programme to track the services provided to each AGYW enrolled in DREAMS.
- Another key strength, linked to the above point, was the high level of **collaboration and cooperation of the programmes** with local partners and structures. For example, *Break Free!* youth ambassadors and APA's DREAMS Clubs work closely with community health facilities to support referrals of those requiring SRH services; while health care workers utilise the club structures to share information about available services and ways to access them. Other examples include the use of government facilities, such as schools and health clinics, for programme activities as a means to minimise programme costs. DRP identifies and works closely with community radio stations who demonstrate a high level of interest in – and coverage of - local, priority issues; while its radio listening club members participate in peer to peer discussions and information-sharing in local health facility youth corners and schools. It was also reported that additional structures, to support collaboration and information-sharing, have been established in programme-targeted communities. For example, GENET supported the establishment of a chief's forum where *"…chiefs interact and share information about what they are doing in the community, challenges that they are facing and how to address them. This has also helped to harmonise any by-laws that they produce."* (SSI_district government)

  In addition to the above, mechanisms and systems are being implemented to support cooperation amongst community-level stakeholders as outlined in the quote that follows,

  "We all move along together in the implementation of the programmes. We have a monthly review meeting and all partners participate in this, together with our youth. This makes it easy for everyone to share information and to follow what is happening amongst the other parties." (SSI_programme staff)

- Study participants noted that a key strength of all four programmes is their adoption of a **youth-led and youth empowerment approach** as outlined in the quotes below.

  "A key strength for me is the engagement of the young people in the programme; they are the presenters and they articulate issues that matter to them at this age of their lives. I see young people that have gone through this programme and how they support each other. They also act as models to their peers." (SSI_community leader)

  "Putting the programme beneficiaries (AGYW) at the forefront of programme planning and implementation is another strength. AGYW have been taking the lead in programme interventions. For example, the mentors recently recruited the third cohort of mentees with little support from GENET. The mentors are standing out to be role models and supervisors of girls in their communities." (SSI_programme staff)

- Finally, although all four programmes noted a focus on AGYW, they also all reported efforts to **include ABYM and fathers** in programme interventions to support and strengthen their ability to act as champions of girls rights and participate in joint decision-making about SRH issues. An example of this was DRP's establishment of father's groups to work in collaboration with the many mother's groups that already existed in programme-targeted districts. The *Break Free!* programme includes ABYM in their *Champions of Change* intervention, while APA targets male sexual partners of AGYW using trained male champions who deliver SASA and make referrals for men's health services, including distribution of HIV self-test kits.

8.4.3 Challenges of implementation

A number of **contextual challenges** affecting implementation were reported by study participants in relation to all four programmes. These included the COVID-19 pandemic, extreme weather conditions[61] and resulting cholera outbreaks. The following challenges and constraints were noted in relation to the programmes specifically.

- Staff from all four programmes noted **capacity and resource constraints** as a challenge, particularly the limited amount of budget that can be allocated to cover programme overheads, such as staff salaries and transport. Budget constraints also limit the number and type of staff that can be hired for programme implementation.
- The community radio stations partnering with DRP, as well as the trained youth journalists, reported the lack of up-to-date **equipment** as a limitation, noting that the age and limited number of items, such as recorders and computers, is negatively affecting young people's ability to produce their weekly programmes. While DRP provides all partner radio stations with new equipment and replaces this when required, budget constraints limit the number and frequency of such purchases.
- Budget and capacity challenges are also impacting on **programme reach**. For example, the APA's needs-based secondary package of support, provided to girls graduating from primary package, was viewed as a key means of enabling access to further education and training, as

[61] In March 2023, Cyclone Freddy was the third destructive cyclone to hit Malawi within a year, after cyclones Ana and Gombe. See https://mg.co.za/africa/2023-03-21-cyclone-freddy-leaves-trail-of-destruction-in-malawi/ (accessed 11 May 2023)

well as financial independence. However, AGYW noted that this package was provided according to a selection process and was therefore not available to all those considered by programme participants to be in need. Similar observations were noted in relation to programmes providing education support. FGD participants had the perception that where such support is provided, it is insufficient in addressing the high levels of demand.

- When asked if any **personal costs** were incurred as a result of their participation in programme activities, AGYW and ABYM that participated in the FGDs noted that, at times, they had to cover airtime and data purchases as well as travel / transport and personal meal costs when participating in community outreach activities. This may hinder young people's participation in programme activities or serve as a deterrent to the recruitment of future cohorts. It was also reported that some of the youth community-based distribution agents had lost interest in conducting door-to-door outreach activities as a result of the lack of monthly allowances or incentives. This too, has had an impact on the delivery of much needed information and access to contraceptives.
- Another challenge was noted in relation to the youth clubs; a key component of all the programmes. FGD participants reported instances where discussions and personal details had been shared outside of these spaces with community members. This is reportedly resulting in young people leaving the clubs. It may also be hindering their full and open participation in these structures. FGD participants also highlighted that the **lack of confidentiality** is deterring other young people from joining the clubs.
- Lastly, while all programmes reported the implementation of **monitoring and evaluation (M&E)** systems for the tracking of programme implementation and documenting of outcomes, it appears as though the assessment of programme impact remains a challenge for some of the implementers, as outlined in the quote below,

  "The issue of documentation of success stories and impact remain a challenge. We deal with life and with people and outcomes are not immediate. When you are dealing with numbers of people reached or training conducted, you can easily tick the boxes. It has been challenging to document the type of success that we have achieved in the project timeframes. Capturing unintended results has also been challenging. It requires skill, more time…sometimes it can be frustrating to fail to capture changes that are evident and that we have witnessed in field." (SSI_programme management staff)

As noted above, under *Strengths*, programmes have attempted to address these challenges in a variety of ways. APA has formulated and implemented entry and exit level surveys for its club members, while GENET mentors are capturing and providing data from their communities; for example, on the number of early, unintended pregnancies and GBV cases. *Break Free!* youth ambassadors have been capacitated on the use of scorecards to assess outcomes in relation to advocacy initiatives. However, the limited level of research and data collection; for example, at health facility level, makes assessment of the level of programme impact on early pregnancy and child marriage within targeted districts difficult to ascertain.

8.5 Emerging outcomes

The section below presents the findings on the extent to which the outcomes in the tentative TOC for prevention of early, unintended pregnancy have been achieved by the four programmes selected for in-depth study. The discussion includes key enablers and barriers to change.

The findings are based on primary data, which was gathered through interviews with programme staff, district government officials, community leaders, and parents/guardians (24). Data gathered via focus group discussions (8) with AGYW and ABYM, who are both target groups and beneficiaries of the programmes, was also included.

8.5.1 Key changes / outcomes achieved

The diagram below captures the changes achieved by the programmes.

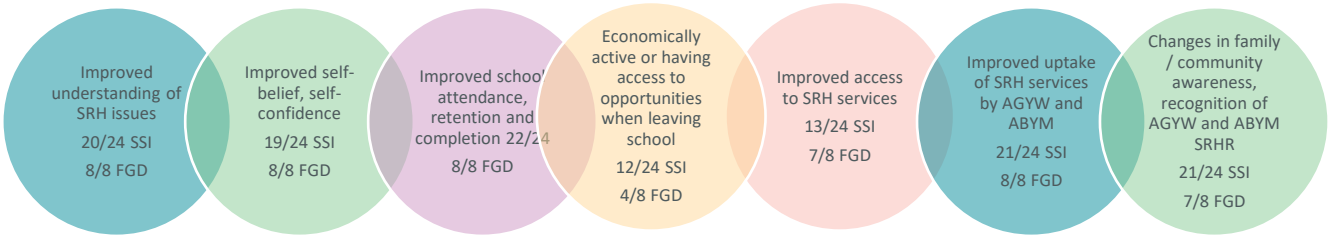


Figure 12 Key changes achieved by the programme interventions

Changes at the individual level

A frequently mentioned change in 20/24 interviews (SSIs) and across all 8 FGDs is **improved knowledge and understanding of SRH issues** amongst the youth targeted by the four programmes. These findings were confirmed by other study participants, including programme staff members, parents/guardians, community health care workers, district government officials, and community leaders who noted changes amongst the programmes' beneficiary groups, as well as their parents / guardians and caregivers.

> *"Before the Break Free! programme, ABYM and AGYW were behind and had no information on how to use condoms and other family planning services. They were engaging in bad behaviours like having unprotected sex. (FGD_ABYM)*

> *"Yes, as a community leader I could to say that I have noticed change in understanding of SRH services in my village. Through radio programming young people in my community has received comprehensive knowledge on issues of SRHR. Parents in my community are also more aware now that AGYW and ABYM have the right to access SRH services."(SSI_community leader)*

In addition to changes in knowledge, a high number of study participants; that is, 19/24 interviewees and focus group respondents in all eight workshops, said that young people targeted by the interventions demonstrate **higher levels of self-belief and self-confidence.** This is being facilitated via the knowledge and skills gained through their participation in the programme, as well as the opportunity to speak at public gatherings and, in the case of DRP's youth journalists, on air, about key issues related to ASRHR. The following quotes refer:

> *"Before the programme, we were very shy and did not have the courage to speak in public. Now we are confident and we are able to even speak with government officials. We are also able to have a voice on issues affecting us." (FGD_AGYW)*

> *"Targeted AGYW and ABYM have the confidence now to express their needs to duty bearers. The youth clubs are presenting opportunities to acquire skills and be resilient in their everyday undertakings."(SSI_community health care worker)*

Of note is that these changes in self-belief and self-confidence amongst young people are leading to higher levels of **youth participation and input** in community development and decision-making platforms. The quote below illustrates this.

> *"Young people in my area are speaking out on issues that concern them. I have appointed some of them to serve in area development committees and they are offering constructive ideas." (SSI_community leader)*

AGYW and ABYM's participation in programme activities has led to a number of other positive changes at individual level. FGD participants reported that their club activities keep them busy and provide them with interesting activities that support their own development.

> *"The programme was looking for young people who had just written their MSCE and had nothing to do; they were just staying idle. I was one of the girls at that time with nothing to do and I was enrolled in a club. Here we learnt a lot about family planning and SRHR. We also did a lot of activities like sensitising fellow youth on issues related to family planning and encouraging girls to stay in school. I have become very interested to learn and to help my fellow youth."(FGD_AGYW)*

The FGD participants also reported that those involved in the programmes were less inclined to engage in **risky behaviour**, including the use of alcohol and drugs, as outlined in the quote below.

> *"Some young people who were smoking marijuana are changed now. They engage with their fellow youth. We have also noted that the youth have been motivated and are working hard in school. The programme really helped the youth in this. They are also presenting themselves for voluntary work in the community."(FGD_ABYM)*

Young people as well as their parents / guardians also reported **better communication and improved intergenerational relationships** within the home, while the financial and psychosocial support provided via the programmes has led to **improved school attendance and retention rates** including those girls who return to school following the birth of a child or leaving an early marriage. The latter outcome was reported by 22/24 interviews and by participants in all eight FGDs.

Although less frequently reported, study participants did note that the programmes are contributing to AGYW and ABYM becoming **economically active or having access to opportunities when they leave school.**

> *"We were taught how to budget and set up our businesses. This has worked well because we are now able to sustain our businesses and make some money to support ourselves." (FGD_AGYW)*

This is linked to programme financial support; for example, mentees participating in GENET's safe spaces receive funds for the establishment of small or micro businesses via VSLAs and community banks. The APA links older girls (aged 18-24) to vocational training programmes and mentoring via the Siyakha youth economic strengthening intervention. Through this intervention, girls are able to gain skills in a number of sectors identified through a local labour market assessment. This includes skills sets that are traditionally associated with men, such as carpentry, tourism, electrical

installations, and welding. As outlined above, DRP capacitates youth reporters in the production and broadcasting of radio programmes. In addition, the programme provides capacity building on report and proposal writing, as well as the formulation of budgets[62]. Some of these reporters have gone on to become paid members of staff at community radio stations.

The economic empowerment components of the programmes are often extended to the parents / guardians of the AGYW and ABYM participating in the SRH-focused activities,

> *"We also host parenting sessions where we provide education on parenting skills and the girls are also linked to groups like village loans and savings groups. They engage in the programme with their parents / caregivers and are taught about financial literacy and other skills, also to set up group savings and loans schemes. At the end of the programme, they can use their savings as they see fit; that is, the girls but also their parents. If they choose bad options for their investments, then we will provide guidance, but generally we see these savings and loans groups working well. Girls participating in it have bought their own school materials and later go on to invest in small businesses or IGAs to support themselves." (SSI_programme staff)*

Changes at the community level

It was frequently mentioned that programme interventions have contributed towards improved **access to and uptake of SRH services**. This was linked to the following programme components:

- Increased knowledge amongst AGYW and ABYM regarding where and how to access SRH services, as well as their right to do so;
- The programmes' combination of community information dissemination and sensitisation events with access to services via mobile clinics and peer educators;
- Programme provision of certain services, for example condom distribution, via the established youth clubs;
- Programme-led advocacy initiatives to address barriers such as the lack of AYF service provision and facility closures; and
- Programme linkages and establishment of referral mechanisms with key service providers.

However, a number of **barriers to accessing SRH services** were noted in the course of primary data collection. These included the following:

- The limited number of health facilities, particularly in rural areas. As a result, young people are often required to travel long distances to access services and may not have the means to cover transport costs. The quote below refers,

  > *"The biggest challenge that remains is for those living in deep, rural areas where there is limited access to SRH services. We have tried to address this via mobile clinics but even so, there are areas that cannot be reached." (SSI_programme staff)*

[62] The youth reporters are required to prepare detailed proposals for all community outreach events. This includes providing information to DRP regarding the purpose of the event, the target population, the agenda and guest list – including panelists. In addition, a detailed budget for the event must be prepared and submitted.

- The continued challenge of negative attitudes amongst staff regarding ASRH and the subsequent lack of AYFS in some of the targeted sites; and
- Frequent stock-outs.

The study found that the programmes have made a significant contribution towards changes in family / community awareness and recognition of AGYW and ABYM SRHR, as outlined in the quote below.

> *"Parents and communities are understanding SRH issues and some encourage their children now to concentrate on education and to join and participate in youth club activities. Some parents are also discouraging early marriages and unintended pregnancies."(SSI_parent / guardian)*

A key enabler of this is the extensive amount of community engagement undertaken by the programmes and outlined in the section above on programme strengths. However, study participants highlighted that, in some areas, **conservative attitudes, harmful traditional practices, and religious beliefs** continue to hinder young people's access to and uptake of SRH services and information, as well as their participation in programme activities.

> *"Some of the parents and guardians are refusing to allow their children to join the clubs because they saw their children receiving condoms. They have a mindset that this is promoting prostitution amongst adolescent girls." (SSI_club facilitator)*

> *"Some AGYW are discouraged by their parents who don't want them to use SRH services. They think that SRH services are there to promote AGYW having sex or that it will make their daughters start prostitution." (SSI_district government official)*

The study indicates that, despite the economic empowerment interventions offered by the programmes, poverty remains a key driver of child marriage and early, unintended pregnancy.

8.5.2 Impact on prevention of unintended, early pregnancy

Data on the impact of the programmes on early, unintended pregnancy was not available.

- Study participants noted limitations in the collection of data on the number of *unintended* pregnancies due to under-reporting and the stigma that is often associated with early pregnancies, particularly amongst AGYW who are not married or who are not perceived as being in a "permanent" relationship.
- As noted in the report for South Africa, challenges related to the complexity of early, unintended pregnancy and the difficulty of measuring the contribution of specific programmes or programmatic elements to changes in prevalence, also affect the ability to report on impact.
- The short timeframes of project implementation for three of the programmes (APA, GENET and *Break Free!*) also means that it may take some time for the impact of these interventions to be realised.

APA's **DREAMS** model is implemented at scale until saturation is achieved in the targeted districts; that is, it provides intense support in specific areas (high burden HIV districts in Southern Malawi) and to specific AGYW (those who meet the programme's eligibility criteria). In addition, it coordinates efforts with the Global Fund, who delivers HIV prevention programming to AGYW in districts where DREAMS does not operate.

- Lastly, it was noted that health facilities experience staff and resource challenges, making regular monitoring and data collection on early, unintended pregnancy difficult. This affects the accuracy and regularity of data collection, analysis and dissemination.

8.6 Coherence

In this section we assess the extent to which sampled programmes are aligned to national priorities and policies, and whether these programmes collaborate with other stakeholders in the sector.

8.6.1 Programme alignment to national priorities and policies

An analysis of the study findings reveal that all four programmes have a significant level of alignment to national priorities and policies in relation to the prevention of unintended early pregnancy in Malawi.

The APA is strongly aligned with national and district level priorities and policies, and its strategies are designed around policies such as the National Youth Policy, the National Sexual and Reproductive Health and Rights Policy, and the AGYW National Strategy. Similarly, the *Break Free!* programme is also well aligned with national priorities and policies, and its interventions support priorities in the AGYW strategy, the Youth Friendly Services Policy, Gender Policy, Gender Equality Act, laws on child protection, and the Prevention of Domestic Violence Act. The programme also collaborates well with key line ministries such as Gender, Education, Youth, Health, and Justice.

> *"The programme is designed around the policy environment and government is one of our key implementing partners. I think we work in about 117 health facilities and almost all of them are government facilities. PEPFAR (donor) and the Malawi government have an agreement and therefore our programme is an extension to help government to achieve policy objectives." (SSI_programme staff)*

Developing Radio Partners' work is also aligned with national policies on SRH and YFHS, and its interventions are guided by the AGYW Strategy, child protection laws, and the National Sexual and Reproductive Health and Rights Policy. The safe spaces programme implemented by GENET is aligned with the same policies outlined above, as well as the Ending Child Marriage strategy.

8.6.2 Collaboration with other, similar programme and services implemented by government or NGOs

The study shows that all four programmes collaborate with various partners and stakeholders, including government actors, other CSOs and community structures. Community sensitization meetings, mobile clinics and capacity building sessions are some of the activities that the programmes collaborate on or conduct jointly with other stakeholders. Below are some of the stakeholders with whom the different programmes have collaborated.

Table 11 Summary of stakeholders with whom the programmes collaborate

Name of intervention	Government sectors/authorities/ officials	Civil society organisations/INGOs (CSOs)	Community structures/representatives
Ana Patsogolo Activity	• Public healthcare facilities	• Catholic Diocese of Chikwawa • Global Hope Mobilization (GLOHOMO)	• School Management Committees

Name of intervention	Government sectors/authorities/ officials	Civil society organisations/INGOs (CSOs)	Community structures/representatives
	• District technical working groups • District Council Sector of Health, Youth, Education, and Gender • Gender Office • Social welfare officers	• Malawi AIDS Counselling and Resource Organization (MACRO) • Youth Net and Counselling (YONECO) • Global AIDS Interfaith Alliance of Malawi (GAIA/M) • FHI360 under the EMPOWER Activity • Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) • JHPIEGO • Development Aid from People to People (DAPP • Pakachere IHDC • Baylor • Ujamaa	• Mothers' groups, parents and guardians • Community Victim Support Unit • Traditional leaders • Child protection workers • Mentors and teachers • Area Development Committees • Village Development Committees. • Police and Community Victim Support Units
Break Free!	• Government sectors including Youth, Gender, Education and Health • Parliamentarians and the committee on health • District Technical Working Group on Health • Police • Child protection workers	As part of the consortium approach: • Forum for African Women Educationalists Malawi (FAWEMA) • SAT Malawi • Plan Malawi Sub-grantees: • Youth Response for Social Change • GLOHOMO • Timveni Radio	• Village development committees • Parents and guardians • Traditional and Religious leaders • Champions of Change groups • Mother Groups • Child protection committees • Community Victim Support Unit and Committees
Developing Radio Partners	• Government sectors such as Education, Health, Youth, and Agriculture • District Executive Committee • District Health Office, • District Council • Child protection workers • District Education Office	• Youth Net and Counselling (YONECO) • Save the Children • International Organisation of Migration	• Traditional leaders • Community radio stations • Mother and father groups • Teachers and school committees • Religious leaders • Youth clubs/networks • Parents / guardians

Name of intervention	Government sectors/authorities/ officials	Civil society organisations/INGOs (CSOs)	Community structures/representatives
	• YFHS Coordinators • Police and Victim Support Units		
GENET	• Courts • Gender District Technical Working Groups (Dowa, Nkhata Bay and Lilongwe districts) • Child Protection Technical Working Groups	• Malawi Interfaith Aids Organisation (MIAA) • Malawi Girl Guides Association • Emmanuel Intervention • UNDP • UNFPA	• Village Development Committees • Police forum • Local chiefs

The findings show that all four programmes have partnerships with a range of stakeholders and conduct periodic reviews to ensure coordination and avoid duplication of services. For example, in Mchinji district, the stakeholders have periodic meetings where they review plans on AGYW programming. Government sectors and CSOs in the district are also members of a District Executive Committee, which meets monthly to discuss district interventions and events. Programme staff and district officials from the sampled programmes also reported conducting periodic reviews. These have played a key role in ensuring complementarity of efforts and reducing any possible duplication.

> *"As partners we are informed of progress in programme implementation. Through review meetings reports are presented and input and feedback solicited. This is helpful to check if we are achieving our plans. This also avoids duplication of interventions if new partners come to work in the district." (SSI_district official)*

A key strength of the collaboration methods and structures outlined above is that implementing partners are able to share responsibilities and clearly define roles. In some instances, formal arrangements have been put in place to ensure this. For example, the APA has set formal agreements in place with all of the health facilities that they work with. The programme also collaborates with clinical implementing partners that are managed by other local and international NGOs.

> *"The other strength of our collaboration is that we share responsibilities and who should do what. For example, we have APA and IMPOWER programmes that are both targeting youth and offering SRH services. Through collaboration we agreed as a district that APA will be mobilising the youth and giving information and IMPOWER will come in to offer the services and commodities. So, there is cordial relationship and sharing of responsibilities which is a result of collaboration." (SSI_community health care worker)*

Government stakeholders who participated in interviews raised a few concerns related to coordination of stakeholders. These include limited support of coordination initiatives, as well as a high level of reliance on government to initiate meetings.

> *"We also have some partners who show little interests to support periodic meetings that are conducted at district level and these constrain our small budgets as district council. In some cases, partners do not show up to meetings that we have invited them to attend, and this is a challenge in collaboration." (SSI _district government official)*

> *"Recently we did a re-assessment of partners with National AIDS Commission to find out how partners support collaboration activities. We observed that some partners are unwilling to support collaborations activities. They leave everything on part of government to organise and invite them to meetings. We feel partners are part of the collaboration and they also need to initiate meetings." (SSI_district government official)*

Lastly, another coordination challenge or concern was raised regarding provision of YHFS. One of the study participants argued that provision of YFHS is currently viewed as solely the responsibility of the Ministry of Health and this narrow approach overlooks the potential contributions of other sectors, such as the Ministry of Education and Youth. Therefore, it is important to recognise and actively involve these other sectors as this could create more opportunities for AGYW to access and engage with services beyond traditional health facilities.

8.7 Efficiency: summary of findings from the costing exercise

The focus of the costing tools is on Girls Empowerment Network and the Developing Radio Partners Programme.

For the costing tools to work optimally in a changing environment a few assumptions have been made that can be changed by the users. Three scenarios were costed in each tool, the first looking at the minimum or current service being provided (i.e. outputs based on current funding), the second shows the results of providing a service 50% larger than the current size, and the third looks at the changes in costs if the service were doubled in size (e.g. double the number of clubs active).

8.7.1.1 Girls Empowerment Network (GENET)

Most of the ongoing costs relate to the weekly mentorship sessions. There are no once-off costs identified in this programme. Based on the tool, if the programme were to double the number of active districts and mentors, the cost per mentor would reduce to MK665 658 from MK817 144 per mentor.[63]

Figure 13 GENET overview of cost

[63] These costing scenarios has not been validated with the programme implementer.

Total cost	Number of units			Costing scenarios			
	Scenario 1 100% Current	Scenario 2 150% Ideal	Scenario 3 200% Enhanced	Scenario 1 100% Current	Scenario 2 150% Ideal	Scenario 3 200% Enhanced	
Once-off costs				-	-	-	
Ongoing costs				**119 303 019**	**146 020 137**	**194 372 054**	
Mentorship Activities				103 661 416	122 632 732	163 238 848	
Demand creation activities				15 641 603	23 387 405	31 133 206	
Total cost				**119 303 019**	**146 020 137**	**194 372 054**	
Number of mentors per district	73	73	73				
Number of active districts	2	3	4				
Total number of mentors	146	219	292	*817 144*	*666 759*	*665 658*	*cost per mentor*

The largest cost item for the programme is for mentorship activities, which includes cost of personnel.[64] Mentors currently receive a stipend of MK30 000 per month for their mentorship activities. If the programme were to double in size (i.e., go from 146 mentors to 292 mentors), the proportion of the mentor stipend goes from 44% of total cost of the programme to 54% of the cost of the programme.

8.7.1.2 Developing Radio Partners

Costs for this programme are shown in MK and USD[65] for comparison with expenditure analysis. Most of the ongoing costs relate to staff costs. The once-off costs amount to USD15 800, for purchasing solar-powered radios, desktop computers and digital recorders. Based on the tool, if the programme were to grow by 50% (i.e., an additional 4 radio stations), the cost per station would go from USD36 499 to USD32 455.

Figure 14 Developing Radio Partners overview of cost

							Dollar to MK	1027,32	
	Number of units			Costing scenarios (MK)			Costing scenarios (USD)		
	Scenario 1 100% Current	Scenario 2 150% Ideal	Scenario 3 200% Enhanced	Scenario 1 100% Current	Scenario 2 150% Ideal	Scenario 3 200% Enhanced	Scenario 1 100% Current	Scenario 2 150% Ideal	Scenario 3 200% Enhanced
Once-off costs				**16 231 320**	**24 346 980**	**32 462 640**	**15 800**	**23 700**	**31 599**
In-country and International staff costs				-	-	-	-	-	-
Partnership fees and costs				-	-	-	-	-	-
Training of youth journalists				-	-	-	-	-	-
Training of mentors				-	-	-	-	-	-
In-country office expenses				-	-	-	-	-	-
Once-off costs				16 231 320	24 346 980	32 462 640	15 800	23 700	31 599
Ongoing costs				**246 243 891**	**325 743 676**	**492 487 782**	**239 695**	**317 081**	**479 391**
In-country and International staff costs				60 534 000	60 534 000	121 068 000	58 924	58 924	117 848
Partnership fees and costs				88 996 600	122 810 772	177 993 200	86 630	119 545	173 260
Training of youth journalists				21 938 398	32 907 596	43 876 795	21 355	32 032	42 710
Training of mentors				36 294 423	54 441 635	72 588 846	35 329	52 994	70 658
In-country office expenses				22 249 150	30 702 693	44 498 300	21 657	29 886	43 315
Once-off costs				16 231 320	24 346 980	32 462 640	15 800	23 700	31 599
Total cost				**262 475 211**	**350 090 656**	**524 950 422**	**255 495**	**340 781**	**510 990**
Number of stations active	7	11	14	*37 496 459*	*33 341 967*	*37 496 459*	*36 499*	*32 455*	*36 499*	*per station cost*
Number of youth journalist per station	10	10	10	*3 749 646*	*3 334 197*	*3 749 646*	*3 650*	*3 246*	*3 650*	*per youth journalist*
Number of radio listening clubs per station	20	20	20						

[64] NOTE – only mentor stipends were included in the costing tool due to conflicting data regarding staff composition provided during the interviews. Other staff costs were also not apparent in the budget documentation.
[65] The costing tool allows for the user to update the exchange rate.

8.8 Sustainability

This section presents the findings related to perceptions on sustainability of changes achieved as a result of implementation of the different programmes. It explores some of the enablers and barriers to these changes. The section ends with an outline of mechanisms that are required to strengthen the sustainability of outcomes related to the prevention of unintended early pregnancy.

8.8.1 Enablers to sustainability of changes achieved

The overall perception is that changes achieved through implementation of the sampled programmes are likely to be sustained. Study participants identified a number of key enablers that are critical in ensuring that the changes brought about by the four programmes and/or similar interventions are sustained. The diagram below provides a summary of these enablers, and a brief description is given below.

Figure 15 Sustainability mechanisms

Coordination and collaboration: This study has demonstrated the importance of strong coordination and collaboration amongst key actors (i.e., partners, government, and communities) for effective programme implementation and achievement of key objectives. Similarly, continued coordination and collaboration among actors that are implementing AGYW programmes is perceived as being essential to ensuring the sustainability of outcomes. Therefore, coordination structures at national down to district level need to be strengthened.

Use of and strengthening of community structures and leadership: It is important to ensure that implementing partners involve community structures such from the project design stage to ensure buy-in, community support and legitimacy. Well capacitated community leadership and structures that know their roles and responsibilities in supporting AGYW are also a key enabler for sustainability.

Ownership: Ownership of the interventions aimed at preventing united early teenage pregnancy should be established at both the government and community levels. These programmes do this by engaging community leaders, parents, and AGYW.

Community empowerment: The programmes have demonstrated the importance of empowering communities including target groups and beneficiaries of these programmes including mother groups, community healthcare workers, and youth groups or clubs to mention a few. Providing knowledge and information on issues related to SRHR, GBV, and the ills of forcing girls into marriage after they have fallen pregnant are a key component of the programme strategies. The programmes have played a key role in also ensuring that target communities are aware of and equipped to fulfil their SRHR roles and responsibilities. It is also important to focus on building stronger relationships with parents and caregivers and engaging them in discussions around safe sex and contraception. Once this is achieved, then communities and families can support the children accessing the services so then this is sustained.

Capacity building: Training mentors, peers, and volunteers who will remain in the communities and be a resource for the future when the programme comes to an end is a key enabler for sustainability. Building the capacities of community gatekeepers such as local chiefs is also important as they have both influence and mobilising power at the community level and therefore will continue spreading advocacy messages on SRHR.

Economic empowerment: The study shows that poverty remains a key driver of child marriage and early, unintended pregnancy. Therefore, it is important for aimed at preventing early, unintended pregnancy to incorporate an economic empowerment or strengthening component which will help build skills of AGYW, keep them in school, and empower them to be self-sufficient. Two of the sampled programmes are already doing this and resulting outcomes of such interventions are reported above.

At the programme implementation level, it necessary to diversify funding sources to ensure that programmes can continue even after donor support has ended.

Addressing socio-cultural norms: Addressing socio-cultural norms and harmful practices, such as child marriages and patriarchal systems, is a key enabler for the sustainability of interventions that seek to prevent unintended early pregnancy. This is because such norms and practices can perpetuate the cycle of early pregnancy and hinder the success of prevention efforts. By challenging and transforming these norms, interventions can help shift attitudes towards the value and agency of adolescent girls and young women, promoting their health and rights, and ultimately contributing to sustainable development. Additionally, engaging with and involving the community in addressing these harmful practices can help to ensure that the interventions are more likely to be adopted and sustained in the long term.

8.8.2 Barriers to sustainability of changes achieved

There are several challenges to sustainability that were identified in this study, and these include: limited engagement with parents and caregivers, heavy reliance on donor support, lack of resources to support SRHR programmes in the community, transportation challenges, and inactivity of some youth clubs at the community level. It is also unclear if the government can take over and implement bigger programmes such as DREAMS as these are resource-intensive and require the involvement of many stakeholders. Transitioning these programmes to a more fully government-led model may require significant planning and resources.

8.9 Assessment of adequacy

The study sought to assess the adequacy of the programme interventions aimed at addressing unintended early pregnancy. More specifically it sought to assess the extent to which the interventions, when taken together, are sufficient for the purpose of reducing the prevalence of early, unintended pregnancy. The section below summarises the findings in this regard.

- While the four programmes reviewed are making a considerable effort to offer a comprehensive and layered package of support, resource and capacity constraints are limiting programme reach. It was frequently noted that, while the programmes are highly relevant and much appreciated, current coverage is insufficient in the face of high levels of demand.
- Public SRH service provision is hindered by the limited number of facilities, particularly in rural areas, regular stock outs and insufficient capacity to provide AYFS. While programme

collaboration with government is addressing these challenges to some extent, the study indicates that here too, demand is still outstripping supply by some margin.

- The programmes have achieved a high level of success in encouraging programme support amongst parents / guardians, religious leaders and traditional authorities. However, as outlined in the sections above, child marriages remain prevalent and thus present a threat to the effectiveness of early, unintended prevention programmes, as do social and cultural norms and attitudes regarding ASRHR.
- All of the programmes have introduced mechanisms to target boys and men and there is some evidence that these practices are achieving good outcomes in terms of gender equality and the championing of girls rights. However, only one of the programmes included in this study reported addressing issues related to service access to young people with disabilities and none of the programmes referred to any specific interventions related to the LGBTIQ+ community.

8.10 Conclusion

AGYW in Malawi face a number of challenges in relation to SRH. Study participants noted the limited information available on SRH topics as well as available SRH services. Cultural and religious norms and practices present a significant barrier to SRH service access, compounded by myths and misconceptions regarding the use of contraceptives. Stockouts, capacity constraints, a lack of AYF services, and the limited number of health facilities, particularly in rural and hard-to-reach areas, also impact negatively on SRH service availability and access. All of these factors contribute to early, unintended pregnancy.

The study found that all four programmes included in this in-depth review are **relevant** to the SRH needs of young people. Each programme employs a different model or approach, or implements a different set of interventions, but all adopt a holistic approach in addressing the challenges outlined above. For example, the programmes provide information about SRH and rights, plus facilitate access to services through mobile service mechanisms, referrals and linkages with other SRH service providers and programmes. They also seek to address underlying socio-economic factors and structural drivers that contribute to early, unintended pregnancy, by enabling access to VSLAs, micro-business support, skills development and training, and school retention and reintegration interventions. All of the programmes implement community outreach and/or family / parenting programmes to contribute towards the creation of an enabling environment for AGYW to gain knowledge about – and access to – SRH services. In addition, all four programmes are implemented in areas with high levels of child marriage and early, unintended pregnancy thus making them well-aligned to target community challenges in relation to adolescent SRH.

The assessment of programme **effectiveness** found that all four programmes are being implemented according to plan. Programme design and planning and/or implementation is generally undertaken in collaboration with local structures and other development partners, as well as government and community stakeholders. This consultative and collaborative approach appears to have contributed considerably to community buy-in and support of the programmes, thus enabling programme effectiveness and sustainability, as well as expanding reach. Other key strengths noted across all four programmes reviewed for this study include the quality and relevance of the information and/or services provided, and the innovative use of monitoring tools and systems for learning and programme adaptation, as well as evidence generation on innovative practices. In addition, all of the programmes include youth-empowerment initiatives and, while all noted a focus on AGYW, they also reported the inclusion of interventions targeting ABYM and, in some cases, fathers or male

caregivers / guardians. This too indicates the adoption of a holistic response to addressing SRH needs amongst young people. The inclusion of exit strategies for those graduating from some of the programmes was also highlighted as a good practice.

The study sought to assess the extent to which the **outcomes** in the proposed TOC for prevention of unintended, early pregnancy had been achieved by the four selected programmes. The findings reveal that the programmes have contributed towards a number of changes at individual level. These include improved knowledge and understanding of SRH issues, including knowledge about risks associated with child marriage and early unintended pregnancy; menstrual health and hygiene; STIs (including HIV / AIDS), SGBV and SRH services. In addition, a high number of study participants noted that young people targeted by the programmes demonstrate higher levels of self-confidence and self-belief. Young people as well as their parents / guardians also reported better communication and improved intergenerational relationships, while the financial and psychosocial support provided via the programmes has reportedly led to improved school attendance and retention rates, as well as the reintegration of girls who left school after falling pregnant. Although less frequently reported, study participants also noted that the programmes are contributing towards economic empowerment of targeted AGYW and, in some cases, their family members. Lastly, it was reported that the programmes have contributed towards increased access to – and uptake of – SRH services across all four sites included in the study.

Despite these outcomes, there were reports that a number of **barriers** to SRH service access remain. These include the limited number of health facilities, particularly in rural and hard-to-reach areas; the continued challenge of negative attitudes amongst health facility staff regarding adolescent SRH; frequent stockouts; and the persistence of conservative attitudes and harmful traditional practices.

In terms of **coherence**, the study found that all four programmes are well-aligned to national priorities and policies in relation to the prevention of unintended, early pregnancy. In addition, the findings show that all four programmes have partnered with a variety of community and district level stakeholders and have set up structures and systems to facilitate coordination of efforts and avoid duplication. Examples here include the formulation of formal agreements and the scheduling of regular meetings to review progress and assign roles and responsibilities.

The abovementioned collaboration is a key enabler of the **sustainability** of programme-related outcomes. Other enablers include collaboration with – and strengthening of – community structures and leadership to enable and encourage their support of programme interventions; the inclusion of skills development and capacity strengthening initiatives for AGYW as a means of addressing the key drivers of early, unintended pregnancy; and the focus on addressing social and cultural norms and practices, including potentially negative attitudes towards adolescent SRH and harmful traditional practices. Areas to address going forward as means of supporting sustainable outcomes include higher levels of engagement with parents / guardians, traditional authorities and religious leaders, as well as the strengthening of economic empowerment interventions and support packages to allow AGYW to stay in or return to school.

Aligned to the above, the study found that, while all four programmes present comprehensive and holistic models for addressing SRH priority areas, including early unintended pregnancy, current interventions are not able to meet the high demand for services and support. Other areas noted in relation to **programme adequacy** include the need to strengthen and expand on interventions targeting ABYM as a means of addressing harmful social norms (often associated with patriarchy) related to AGYW's access to SRH services and rights. It also appears as though there are limited interventions at present addressing SRH issues amongst key populations including the LGBTIQ+

community and persons with disabilities. Furthermore, it was noted that healthcare workers have not been sufficiently supported to provide youth-friendly services. Challenges related to patient confidentiality were noted by study participants in all four sites. These same challenges were noted in relation to some of the youth clubs, thus indicating that this is an area that also requires further attention in the future.

It is thus concluded that, while a number of highly effective and holistic Malawi-based interventions that include components to prevent early, unintended pregnancy are in place, they are insufficient to reduce early, unintended pregnancy prevalence to a satisfactory level. Further support and funding is required to allow programmes demonstrating good practice to scale and expand their reach, while strengthening their ability to meet high levels of demand for SRH information and services, and protect the SRHR of young people.

9 Lessons learnt and recommendations for programme scaling and replication

The section below captures the **lessons or good practices** learnt from SRHR programmes and **recommendations** that can be applied to similar early and unintended pregnancy prevention interventions in the future. The recommendations include inputs made by stakeholders during the validation workshop held on 16 May 2023.

Lesson learnt on layered interventions: tackling early, unintended pregnancy requires a comprehensive approach or layering of interventions that tackle multiple factors that contribute to early, unintended pregnancy including social, cultural, behavioural and the structural drivers of the problem such as poverty and unemployment. This would include, for example, CSE in and out of school programmes coupled with adolescent and youth friendly services (e.g. youth zones) in clinics and economic empowerment programmes.

- Use a holistic approach. To effectively tackle early, unintended pregnancy, it is essential to use a comprehensive approach that involves multiple interventions. This could include CSE in and out of school programs, AYFS in clinics, economic empowerment programs, and other interventions that address the social, cultural, behavioural, and structural drivers of the problem.
- Improving access to youth friendly services that offer a range of service options and products, in a confidential, non-judgemental and accessible way for young people should be scaled up to all clinics but starting with those in areas that are hotspots for early, unintended pregnancy.
- There is a dire need to address the structural barriers that often lead to increased risk. There is a need for more programmes that link girls and women to economic strengthening opportunities (skills development, entrepreneurial skills, job opportunities).
- Behaviour change programmes that address social norms need to be expanded. The programmes should target the whole ecosystem of young people, i.e. girls and women, boys and men, parents/caregivers, traditional and religious leaders, and services providers.
- Information, education and communication around misconceptions, SRHR and services available is still needed.
- Psycho-social support and programmes that tackle substance abuse also needs to be more widely offered. SRHR and HIV services should be integrated into such programmes.

- Interventions for boys (see below), persons with disabilities, substance users, young people living with HIV and LGBTQI groups are needed and there needs to be differentiated interventions per age groups.
- Exit strategies or packages of support for those graduating from programmes are necessary for sustainable programme outcomes. These should focus on post-school education opportunities such as internships and further education opportunities or economic empowerment, and entrepreneurial opportunities etc.
- There is a need for evidence of sustainable and scalable solutions for youth friendly services and programmes that address early unintended pregnancy. These services and programmes need to be feasible within government resources, and need to be institutionalised and owned by government.

Lesson learnt on stakeholder engagement and coordination: a comprehensive approach requires the support of all stakeholders at all levels (provincial / district and community) to collaborate and tackle the multi-dimensional nature of early, unintended pregnancy. Thus initial stakeholder engagement is key to understand the needs and resources available. Ongoing, regular meetings need to be scheduled to give updates on progress and programme impact. The Nzululwazi model of intervention (see Annexure 7) is a good example of a collaborative approach.

- Engage all stakeholders at all levels. The support of all stakeholders at all levels is essential for the success of the programme. This includes engaging provincial, district, and community-level stakeholders, understanding their needs and available resources, and holding regular meetings to update them on progress and impact.
- Co-ordination between organisations and departments need to be more purposeful and planned. Technical support and funding need to be provided to strengthen co-ordination efforts around the prevention of unintended early pregnancy.
- Having national, provincial / district and local forums responsible for co-ordination will improve co-ordination efforts of programmes addressing prevention of early unintended pregnancy. These need to be led by key departments.
- CSOs play an important role in expanding and deepening SRHR programmes and services. The role of key departments and CSOs in relation to tackling early, unintended pregnancy needs to be clearly defined, both in terms of their own mandate and interaction with other departments and CSOs. Improved guidance for the collaboration between schools and CSE programmes offered by CSOs is needed to facilitate better access for CSOs to school going learners.
- Programme “localisation” and skills-sharing at community level are examples of good practice that should be included going forward.

Lesson learnt on youth participation and youth engagement: include young people from the community in both the programme design and implementation of pregnancy prevention programmes. This is an important consideration in terms of relevance, but also because young people relate better to their peers. Where possible, safe spaces must be created where young people can engage with one another and express their opinions without fear of information being shared beyond the safe space and without fear of censure and stigmatisation. Youth-friendly activities, or implementing a range of interventions that appeal to youth and encourage their participation, is a good practice.

- Involve young people. Youth need to be more meaningfully involved in the design of programmes to ensure that they are relevant to the challenges that they face. Including young

people from the community in the design and implementation of pregnancy prevention programmes is thus critical. Young people can generally be reached through existing networks and youth led organisations.

- Create safe spaces for young people to gather, share information and express themselves freely. As young people relate better to their peers, utilise peer-to-peer education and outreach strategies to promote responsible sexual behaviour and healthy relationships. Good practice examples are placing Groundbreakers in clinic youth zones with a dedicated space and time for young people; also the Rise Women's Clubs, DRP's listening clubs, the *Break Free!* programme's Champions of Change intervention, and GENET's Safe Spaces model.
- Youth-friendly events and infotainment activities provide a good means of expanding programme reach and AGYW and ABYM's access to SRH information and services; for example, the DRP-supported community music and drama events, which are coupled with mobile service provision and peer-to-peer outreach activities; and the *Break Free!* programme's use of community theatre and radio programming, for information dissemination regarding SRH.

Lesson learnt on inclusion of boys in programming: To reduce early, unintended pregnancy both boys and girls should be targeted equally. This helps to promote gender equality, empowers them to make informed decisions, and creates a culture that promotes responsible sexual behaviour and health relationships. Good practice examples include LoveLife's *What about Boys* programme and APA's trained Male Champions.

- Target both boys and girls: To reduce early, unintended pregnancy, it is important to target both boys and girls equally. This promotes gender equality, empowers young people to make informed decisions, and creates a culture that supports responsible sexual behaviour.
- Boys and young men need to be empowered with the skills and knowledge to make informed decisions about their sexual and reproductive health. This can include information about contraceptive methods, sexually transmitted infections, and healthy relationships.
- It is important to engage with boys and young men in a way that is inclusive, non-judgmental, and culturally sensitive. This can be achieved by creating safe spaces for boys and young men to ask questions and discuss sensitive topics.
- Harmful gender norms perpetuate negative attitudes towards sexual and reproductive health, and these must be addressed in interventions. Boys and young men need to understand the importance of consent, mutual respect, and equality in relationships.
- Father's groups and the recruitment of ABYM as champions of change works well in addressing gender inequality and power relations, patriarchal norms and gendered responses to decision-making around the use (or not) of contraceptives.

Lesson learnt on inclusion of parents/caregivers: Involving parents and caregivers in sexual and reproductive health programmes equips them with the knowledge and skills to provide accurate and age-appropriate information to their children; improves communication; and creates a supportive environment at home that helps to promote healthy decision-making for young people. Good practice examples include the intergenerational dialogues run by DSD's CSE out of school programme and the *Families Matter* parenting curriculum implemented by APA.

- Involve parents and caregivers: Involving parents and caregivers in sexual and reproductive health programmes is essential. This equips them with the knowledge and skills to provide accurate and age-appropriate information to their children, improves communication, and

creates a supportive environment at home that promotes healthy decision-making for young people.

Lesson learnt on inclusion of traditional and religious leaders: traditional and religious leaders play an important role in tackling early, unintended pregnancy because they hold significant influence within communities and their involvement can help mobilise the communities and promote acceptance and support for pregnancy prevention initiatives. They can also help with identifying barriers to prevention such as stigma and cultural beliefs.

- Involve traditional and religious leaders: Traditional and religious leaders play an important role in promoting pregnancy prevention initiatives. They can help mobilize communities, promote acceptance and support, challenge cultural norms and identify barriers to prevention. It is important to be sensitive to cultural and generational differences and power dynamics in the group and create a safe space where all voices can be heard and respected.
- Where possible, programmes should support the establishment of community structures to facilitate engagement with – as well as information-sharing and feedback between – community leaders. A good example of this is the Chief's Forum in Malawi.

Lesson learnt on intergenerational dialogues can be a valuable tool for getting parents/caregivers and community members involved in tackling early, unintended pregnancy and creating an enabling environment for young people to make healthy decisions. However, they need to be ongoing and not just once-off events. It is also important to tread carefully when running dialogues so that they are sensitive to cultural and generational differences and power dynamics in the group. The creation of an inclusive space where all voices can be heard and respected is key.

- Expand roll out of ongoing intergenerational dialogues as a tool for engaging parents/caregivers and community members on SRHR.
- Be mindful of cultural and generational differences as well as power dynamics within the group, and create inclusive spaces where all voices are heard and respected.
- To ensure sustainability of the intervention, form community task teams with representation from the traditional, religious and education sector - and capacitate them to become the custodians of continuing the work to address conservative social norms in the community.

Lesson learnt on training and mentoring: regular and follow up training and mentoring of SRHR service providers ensures they are in a good position to share correct and up to date SRHR information and services.

- Provide regular training and mentoring. More efforts to develop the capacity of government to deliver on programmes that seek to prevent unintended early pregnancy is required.
- Regular training and mentoring of SRHR service providers including youth implementers (e.g. Groundbreakers, Social Mobilisers, Community-based Distribution Agents) ensures they can share correct and up-to-date SRHR information and services.

Lesson learnt on monitoring and evaluation: a good system to collect disaggregated data, analyse, report and learn about pregnancy prevention interventions generates evidence about 'what works' to strengthen the implementation and impact of such interventions.

- Monitor and evaluate: Establishing a good system to collect disaggregated data, analyse, report, and learn about pregnancy prevention interventions generates evidence about what works to strengthen the implementation and impact of such interventions. This will help refine and improve programmes to ensure they are effective and impactful. Good practice examples here

include APA's use of UICs to track service delivery and ensure that each AGYW enrolled in the DREAMS programme is receiving the full package of services.

- Share evidence of what works across all sectors to promote learning and collaboration.

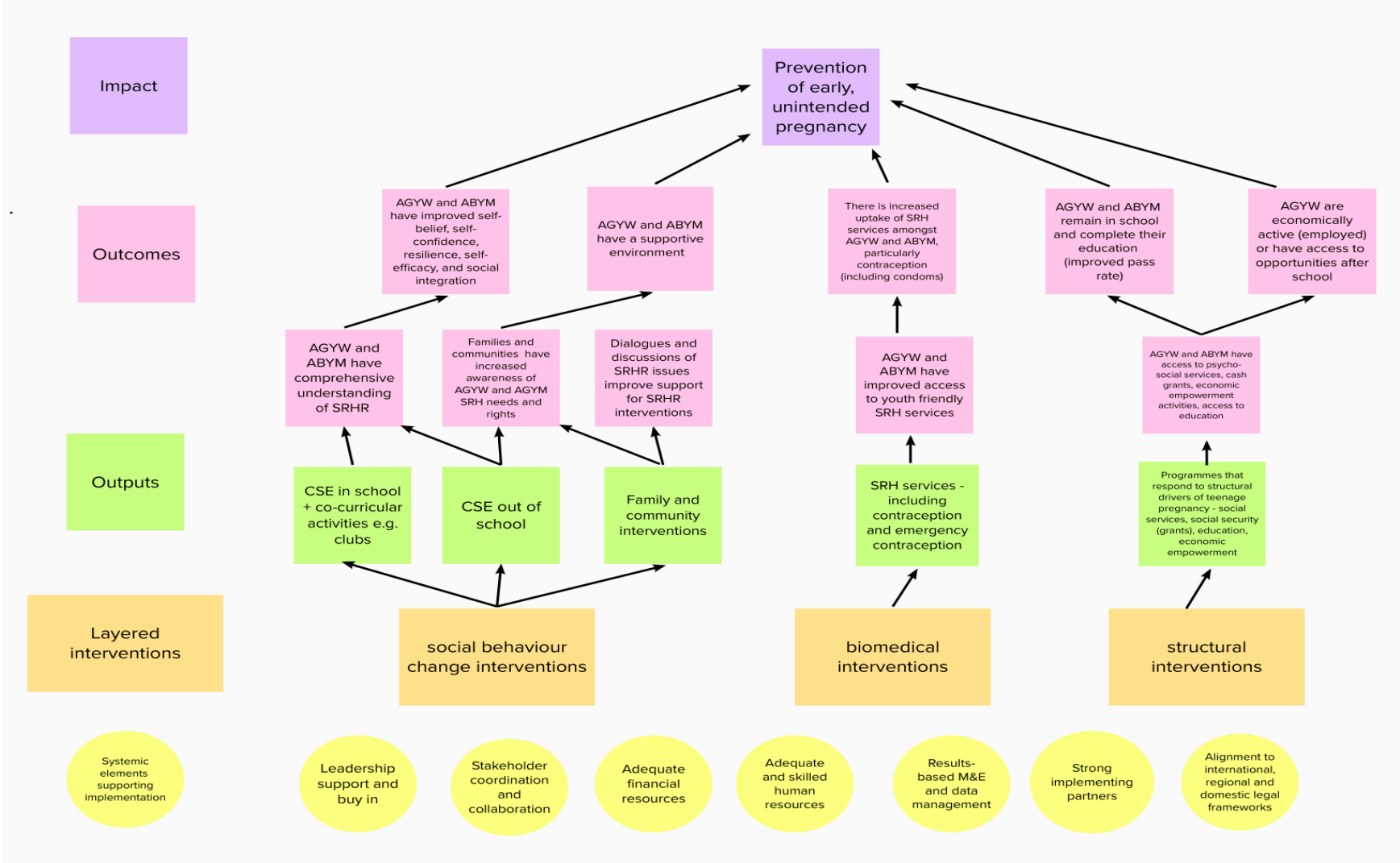
Annexure 1: Ethical clearance letters

See separate PDF documents attached

Annexure 2: Literature review

Separate PDF attached

Annexure 3: Theory of change for prevention of early, unintended pregnancy



Annexure 4: Sample of study participants

Summary sample

Level of implementation	Key stakeholders	Method	Planned data collection	Actual data collection
National level	Government, local CSOs, international NGOs, multilaterals and bilateral, academia	Mapping workshop	2	2 workshops were conducted
	Government officials (education, health, and social development/welfare)	Semi-structured interviews (SSIs)	8 (4 per country)	7 SSI were conducted
	National CSOs and NGOs	SSIs	8 (4 per country)	7 SSIs were conducted
	International NGOs, UN agencies and sector experts	SSIs	4 (2 per country)	3 SSIs were conducted
Selected programmes	Programme management and implementation staff	SSI	8 (1 per model	11 SSIs were conducted
	Financial staff	SSI	8 (1 per model)	7 SSIs were conducted
	Target group (including health care workers, youth club leaders, community distribution agents, etc)	SSI	16 (2 per model)	18 SSIs were conducted
	Adolescent girls and boys	Focus group discussions (FGDs)	16 (2 per model – 1 with ABYM and 1 with AGYW)	16 FGDs were conducted (participant numbers ranged from 5-12 participants)
	Parents / caregivers	SSIs	8 (1 per model)	7 SSIs were conducted
	Government official (provincial / district level)	SSIs	8 (1 per model)	8 SSIs were conducted
	Community leaders	SSIs	8 (1 per model)	8 SSIs were conducted
Total: 2 mapping workshops, 16 FGDs and 76 SSIs				

Detailed sample

Level of implementation	Key stakeholders	Method	Planned	Actual		Comments
				Malawi	SA	
Government, local CSOs, international NGOs, multilaterals and bilateral, academia		Mapping workshops	2	1	1	2 workshops were conducted (number of participants ranged from 7-12)
National Level	Government officials (education, health, and social development/welfare)	Semi-structured interviews (SSIs)	8	4	3	7 SSIs (Departments of Education, Health, Social Development – SA; Ministries: Youth, Sport, Gender and Health - Malawi)
	National CSOs and NGOs	SSIs	8	4	3	7 SSIs
	International NGOs, UN agencies and donors	SSIs	4	2	1	3 SSIs (UNFPA Country Focal Point, Programme Analyst: Adolescent & Youth Development, and SRH/HIV Specialist)
8 Models (4 in SA and 4 in Malawi)						
In depth interventions	Programme management and implementation staff	SSI	8	7	4	11 SSIs (3 additional SSIs were conducted with implementation staff in Malawi)
	Financial management staff	SSI	8	3	4	7 SSIs (APA declined the interview with their financial management staff member)
	Target group (including health care workers, youth club leaders, community distribution agents, etc)	SSI	16	9	9	18 SSIs, additional interviews conducted for APA (Malawi) & loveLife (South Africa)
	Adolescent girls and boys	Focus group discussions (FGDs)	8	8	8	16 FGDs (number of participants ranged from 5-12)

Level of implement ation	Key stakeholders	Method	Planned	Actual		Comments
	Parents / caregivers	SSIs	8	4	3	7 SSIs
				Malawi	**SA**	
	District / provincial government officials	SSIs	8	4	4	8 SSIs
	Community leaders	SSIs	8	4	4	8 SSIs
Total: 2 mapping workshops, 16 FGDs and 76 SSIs						

Annexure 5: TOC assumptions

Table 12 Key assumptions underpinning the TOC in the South African Context

Model	Key Assumptions
LoveLife programmes	• The information is shared in a youth friendly way • Community members and families are well aware of the programme and its goals so that they don't think its promoting sex
DSD CSE out of school - Intergenerational Dialogues	• Spaces where SRH topics are shared is safe and young people are receptive • Capacitating influential people in the community helps the intervention to be acceptable and supported by the whole community • Contraceptives are available and accessible when needed • Information young people receive matches the services available at the clinic
PSH Common Good Programme	• We are welcomed in the communities we are implementing in • There is collaboration with other stakeholders within the different communities
Soul City programmes	• Young people are confident and are aware of SRHR and can access these services • All clinics are equipped with the youth zones where young people can access them • Buy in from the various families and are supportive of the programme • Strong partnership on the ground to support with community buy in and referrals • Sufficient funding

Table 13 Key assumptions underpinning the TOC in the Malawi context

Model	Key Assumptions
APA	• Local actors trusted by the community implement the intervention • A favourable policy environment is crucial, and the Malawi government is willing to make services more youth-friendly • Collaboration with clinic teams, health teams, local leaders, and partners is necessary, and lead organizations should set the tone for this approach • The best approach is a holistic one, offering a comprehensive package of integrated services accessible in one place • Involving the communities and beneficiaries in planning, program design, implementation, and evaluation is key to the success of the intervention, and chiefs and caregivers are included here.
DRP	• Different stakeholders are able to coordinate and link young people to referral pathways where resources are available for uptake of these services; that is, demand for contraceptives is matched by supply. • Awareness-raising and community outreach events can be conducted by youth, and professionals, youth artists, mentors, and ambassadors can be engaged to participate in these events.
GENET	• Empowering girls with knowledge, skills and information will increase demand for SRH services and improve uptake. • Clearing myths and misconceptions associated with SRH and SRHR services at the community level is important.

	• Linkage between beneficiaries and community structures is crucial for successful implementation. • Intensive sensitization and strengthening of community structures is necessary to end gender-based violence. • Communities need to have access to information on SRH services to demand and access them.
Break Free!	• Laws and policies must be in place and well-implemented to address the needs of AGYWs. • Adequate budgets and resources must be available to support the education and other needs of AGYWs. • Trained personnel with the necessary skills and knowledge must be available to engage and educate young people. • Economic empowerment, social behaviour change, and community-level dissemination of information are necessary components of successful interventions addressing teenage pregnancies and child marriages.

Annexure 6: Detailed overview of interventions

Table 14 South Africa interventions

Name	Key Objectives	Description of Service	Target Group	Geographical Reach
LoveLife	To improve the well-being of young people in South Africa by addressing issues related to sexual health, education, and mental and physical health. It aims to do this by promoting healthy lifestyles, preventing substance abuse, encouraging them to stay in school and complete their studies, reducing the rate of teenage pregnancy through education, encouraging access to contraceptives and SRH services, and improving the physical and mental health of young people by providing counselling services and HIV testing.	Conducting health talks with the young people where they address clinic issues and encourage access to clinic services Equipped Vitality room with youth-friendly services (SRH, counseling, referral, campaigns, health talks) A nurse who provides youth friendly SRH services (contraceptives, condoms, referrals). Groundbreakers aid young people with schoolwork, referrals to counselling services and information about SRHR, GBV. Provision of economic opportunities where they teach them basic computer skills and job readiness. Conducting specific programs in/out of schools which include Living my Life, Body Wise, What About the Boys, Sport for Change, Coach for Life, and Born-Free Dialogue. Condoms and contraceptives drive in the community. Counselor and social worker for referrals and psychosocial support Running monthly health themed campaigns where they include in-school and out-of-school youth e.g STIs and condoms. Use of social media to link young people to economic opportunities. There is sports, culture and recreational activities that keep the youth busy and away from unhealthy behaviours	It targets young people aged 10-24 years old, but also includes parents, healthcare workers, and elderly people in the community. The program works with groundbreakers who are trained to work with young people, and there is no age restriction for the SRH services provided in the center.	It covers different parts of the Eastern Cape and South Africa. Groundbreakers are present in most clinics, schools, and communities in the Eastern Cape.
DSD CSE out of	To empower young people to be able to make the right decisions when it comes to their SRH to boost their confidence	Dialogues with young people on GBV, safe termination of pregnancies and contraceptives.	It targets out-of-school youths from	The training on intergenerational dialogues and

school programme	and make them knowledgeable about their SRHR.	Campaigns where local clinics are invited to provide information about SRHR and access to SRH and youth-friendly services Ooffering of psychosocial support to the youth who need it and also do referrals if there is a need to do so Debates for young people around annual themes for example HIV/AIDS Capacity building sessions- on life skills programme, Career expos, computer skills ,CV compilation and security training for job security and prevention of substance abuse/unplanned pregnancies	the age of 14 to 25, community members, and healthcare workers so that young people are not afraid to go to the clinics for services.	facilitation of dialogues took place in 7 provinces of Free State, KwaZulu-Natal, Eastern Cape, Western Cape, Limpopo, Mpumalanga and Gauteng reaching more than 4000 youths and adults.
Soul City	To provide young people with access to quality SRHR services to prevent new HIV infections and teen pregnancy. Support their education and link them up with available economic opportunities. Assist the Department of Health (DOH) in ensuring the availability of youth zones through the AYFS program. Advocacy at clinic and community level	Face to face engagement at Clubs around school. Sharing of information and discussing SRHR issues, as well as personal development and goals, undertaking community projects and intervention. Addressing structural issues such as substance abuse and GBV while creating an environment of positive peer learning and peer pressure. Inter-club events that focus on building life skills, or events where other organisations (DoH) provide information sessions to the participants. RISE Young Women's Clubs magazine (an edutainment magazine), which covers the curriculum, as well as articles that promote the development of life and leadership skills. Advocacy campaigns were they advocate for young girls to freely access SRH services in health facilities. Hosting webinars where they invite the government and healthcare workers, and young girls get to share their experiences. Media engagements, television and radio broadcasting through information sharing about SRRH	Our target is 15-24 in and out of schoolgirls, but some clubs have boys.	In all 9 provinces Covering mostly townships

		Youth zones in clinics where social mobilisers offer youth-friendly services to young people School and clinic engagement with young people on teenage prevention Resource mobilisation for youth looking for employment Parental engagement programme around sexuality. Social mobilisers who are trained in how to facilitate a session on contraceptives, meet weekly and engage with club members on PEP, body changes. Linking out of school youth to economic opportunities such as how to start business or apply for scholarship.		
PSH Common Good	To employ 2000 unemployment young people and train them in SRRH and leadership and mentorship Increase youth economic and employment opportunities through skills capacity building To decrease HIV incidence, teenage pregnancy and GBV in the targeted areas	On the job training in communication, facilitation, leadership mentoring and social media marketing. Job readiness training which includes CV writing, networking, interview preparation, and entrepreneurship. Training on HIV/AIDS prevention, teenage pregnancy prevention and GBV In turn, health promoters provide accurate SRHR information to the public through door-to-door visitations and street interactions. Dissemination of SRHR educational materials during presentations in schools, events/conferences and churches. Organising and facilitating youth and intergenerational dialogues. Referring people to relevant services when they need assistance e.g reporting GBV cases and accessing contraceptives. Social media engagement on GBV, teenage pregnancy and HIV prevention and encouraging people to listen to PSH radio as well as to join the Siyakwazi Youth Network.	2000 youth not in employment, education or training (NEET), and community members.	4 provinces- Eastern Cape, Northern Cape, Free State and Western Cape

Table 15 Malawi interventions

Name of model/programme	Name of implementing organisation/s	Key objectives	Services	Target group/s	Implementation sites and reach
Ana Patsogolo Activity (APA) – DREAMS model	APA is led by the Bantwana Initiative of World Education Inc (WEI / Bantwana) and implemented in partnership with the Government of Malawi and five Malawian NGOs: the Diocese of Chikwawa; Global AIDS Interfaith Alliance (GAIA/M); Global Hope Mobilisation (GLOHOMO); Malawi AIDS Resource and Counselling Organisation (MACRO); and Youth Net and Counselling (YONECO[66])	To prevent new HIV infections and reduce vulnerability to HIV among AGYW	An evidence-based intervention that is delivered through primary and secondary packages. These are provided via DREAMS clubs (20-30 girls per club), according to age bands 10-14 years; 15-19 years; and 20-24 years. Interventions are delivered according to age, school status and risk criteria to ensure that the package is tailored to the circumstances of each AGYW. Every AGYW completes the entire primary package while delivery of the secondary package is needs based. To complete DREAMS, an AGYW must complete the entire primary package plus at least one secondary service. **Primary package** includes: • HIV and GBV prevention information, condom and contraceptive information / family planning (FP) • DREAMS toolkit *My Dreams My Choice*[67] • PrEP education / information[68] • Financial literacy[69] • Screening for HIV Testing Services (HTS) and referral; HIV Self Testing (HIVST)	Most at risk to HIV adolescent girls and young women (AGYW), aged 10-24 in DREAMS districts in Southern Malawi (both in and out of school)	Machinga, Blantyre and Zomba and Phalombe districts APA has enrolled 208,843 adolescent girls and young women in DREAMS, with 85,978 already completing the program, of which 99.98% remained HIV negative

[66] The sub-award to YONECO was terminated in May 2022
[67] Content in the toolkit is tailored according to age band
[68] Not included in the 10-14 year old package
[69] APA offers a different financial literacy curriculum for each age band (Aflatoun/Aflateen/Aflayouth)

Name of model/programme	Name of implementing organisation/s	Key objectives	Services	Target group/s	Implementation sites and reach
			Secondary package (needs-based) includes: • Violence prevention (IMPower)[70] • Education support (primary and secondary bursaries; menstrual hygiene management)[71] • Dropout prevention and reintegration support[72] • Access to contraceptive services / FP / condoms • HTS / HIVST • Families Matter (parenting) programme[73] • Access to post-violence care services • Youth Village Savings and Loans Associations[74] • PrEP screening and uptake • Siyakha youth economic strengthening package[75] In addition to the above, APA implements the *SASA! And SASA! Faith for Community Mobilization and Norms Change* model. Male sexual partners of AGYW are targeted using trained Male Champions who deliver SASA and make referrals for men's health services, including distribution of HIV self-test kits. Other programme interventions include condom distribution and		

[70] Not delivered to 20-24 age band
[71] Not delivered to 20-24 age band
[72] Not delivered to 20-24 age band
[73] Not delivered to 20-24 age band
[74] Not delivered to 10-14 age band
[75] Not delivered to 10-14 age band

Name of model/programme	Name of implementing organisation/s	Key objectives	Services	Target group/s	Implementation sites and reach
			referrals for HIV prevention services (such as PrEP and PEP.		
Safe Spaces – implemented as part of the Spotlight Initiative	Girls Empowerment Network (GENET)	To empower women and girls to develop strategies and assertive skills to negotiate and challenge harmful practices that fuel sexual and gender-based violence (SGBV), child marriage and early, unintended pregnancy To provide a supportive and safe environment within communities to report and access quality, essential services	• Mentor training (5 days) • Weekly, 2 hour sessions for 25-30 mentees (structured according to age bands of 10-14 years, 15-19 years, 20-24 years) to provide SRH and rights education as well as education on small business operation and management • Small business support as well as access to village savings and loans associations (VSLA) • Community structure strengthening and outreach activities • Referrals for AGYW as survivors of SGBV and harmful traditional practices	Adolescent girls and young women (AGYW); aged 10 to 24	However, the Safe Spaces model is implemented in an additional five districts; namely, Lilongwe, Blantyre, Mulanje, Machinga and Chikwawa. 68 960 AGYW accessed services through safe spaces, including SRH services, psychosocial support and counselling (this figure includes 23 640 girls and young women who attended the safe space mentoring programme)[76]
Health Policy Plus programme	Developing Radio Partners (DRP)	To strengthen local media partners' (community radio stations) preparation and broadcasting of weekly programmes related to community priority issues	• Selection, training and mentoring of youth journalists • Establishment of radio listening clubs • Peer to peer education sessions • Establishment of father and mother groups • Community outreach and events for education and information-sharing on SRH, SRHR	AGYW and ABYM aged 13-19 years Parents / guardians of AGYW and ABYM	Mangochi, Nkhotakota, Nkhata Bay, Blantyre, Nsanje and Mchinji districts 30 youth journalists per radio station; 2 listening clubs per radio station – 10 ABYW; 10 ABYM

[76] UNFPA Malawi Annual Report 2021*; Accelerating the Three Zeros* (page 6)

Name of model/programme	Name of implementing organisation/s	Key objectives	Services	Target group/s	Implementation sites and reach
		To ensure that AGYW and adolescent boys and young men (ABYM) have access to information, including SRH and their SRH rights, as well as access to adolescent and youth friendly services (AYF)	• Access to SRH services, including HIV testing; distribution of condoms; contraceptive information • Provision of technical assistance to radio stations to support the production of weekly radio programmes • Special productions, including television, radio and newspaper series on ending child marriage • Purchase - and replacement - of computers and recording devices	Community members in targeted districts	Parents / guardians - approximately 10 female and 10 male, per community radio station, are targeted for the mothers and fathers groups In terms of radio listeners, it is estimated that each radio station has approximately 750 000 potential audience members. The total, potential reach across all sites is approximately 6,5 million.
***Break Free!* programme**	Five year joint programme of Plan International, SRHR Africa Trust (SAT) and Forum for African Women Educationalists (FAWE)	To ensure that adolescents can make their own free and informed choices about their SRH in order to combat early, unintended pregnancy and child, early and forced marriage (CEFM)	The programme focuses on social movement and network building for social norms change. Activities including the following: • Capacity building of CSOs and youth hubs for lobbying and advocacy purposes • Research, learning and exchange • Support for lobbying and advocacy campaigns targeting decision makers and key stakeholders to increase budget allocations and implement/amend laws and policies addressing CEFM and early, unintended pregnancies • Community outreach activities, including community theatre, for information dissemination regarding SRHR • Radio programming regarding SRH issues and rights (Timveni Radio – *Timasuke pa zaumoyo wathu*)	AGYW aged 10-24 years primarily, but programme includes ABYM of same age	Machinga and Lilongwe districts

Name of model/programme	Name of implementing organisation/s	Key objectives	Services	Target group/s	Implementation sites and reach
			• *Champions of Change* model for youth groups for education and information dissemination on SRH and rights[77] • Community-based distribution agents to increase access to SRH information and services (condom distribution)		

[77] The Break Free! youth groups are organised according to age; that is, 10- 14 year olds; 15-19 year olds and 20-24 year olds. This ensures that the information shared is age appropriate and aligned to the needs of the different age groups.

Annexure 7: Nzululwazi Model

The Nzululwazi Model

Based on qualitative research with 28 key informant respondents and 12 focus group discussions with peer educators, other learners and parents, a research report was produced on the **Nzuluwazi model** implemented at the Nzuluwazi Secondary School[78]. The main outcomes for the **adolescents** were that they felt empowered on ASRH and HIV prevention; they gained confidence; they have a comprehensive understanding of ASRH issues; they have an improved access to adolescent friendly SRH services, and supportive ASRH environment.

The main outcomes at **school level** were the creation and strengthening of a supportive environment for ASRH; the creation of a critical dialogue space for government, learners, teachers and community; increased consciousness about ASRH at the entire school, resulting in the school getting an indirect benefit of **high pass rate** due to ISHP interventions, and the school indirectly benefiting on capacitating teachers on CSE integration in curriculum as well as policy implementation.

The main outcomes at **community level** were an increased awareness of adolescents and youth needs, and improved support to the school on ASRHR interventions. The main outcomes at **government level** were effective government support, increased efforts to support ISHP policy implementation, innovative approaches in addressing ISHP blockages, and provision of ASRH services.

The Nzuluwazi model was also replicated at the **UMkhanyakude District** and saw achievements such as the introduction of youth friendly hours at the Msiyane Clinic and the reduction of teenage pregnancy at Msiyane High School and the Ubombo Circuit. The programme made an indirect impact in Matric pass rate of 2018/19 where the district took third position in the province.

Annexure 8: Collaboration between CSOs and Government in South Africa

Who collaborates	CSOs	DoH	DBE	DSD	SAPS and community police forum	Other government entities
CSOs collaborate with …	Other CSOs to: - gain access to groups of young people (e.g. LGBTQI+, boys/ men,	CSOs supplement DOH services through placing additional resources (e.g. ground	CSOs collaborate with DBE to access to learners in schools	CSO refers to DSD for psychosocial support	CSOs partner with SAPS or community police forums to provide information on GBV,	LoveLife partners with SASSA to facilitate access to social grants and identity documents.

[78] Adolescents and Youth Sexual and Reproductive Health and HIV prevention operational research of the Safe Guard Young People Programme intervention in Nzululwazi and surrounding community in Alfred Nzo District, Eastern Cape.

Who collaborates	CSOs	DoH	DBE	DSD	SAPS and community police forum	Other government entities
	young people in religious institutions) - gain easier access to school - raise awareness and education efforts CSOs collaborate on providing SRH services at events and health care facilities To provide psychosocial support	breakers) to provide youth friendly services in facilities CSOs partner with DOH to provide information session in schools CSOs refer to DoH for services such as PrEP, TOP and antidepressants. LoveLife trained healthcare workers on providing youth friendly services			crime and substance abuse.	Partner with Department of Sports, Arts and Culture to provide sporting and recreational activities after school One CSO is working with Co-operative Governance and Traditional Affairs) around targeting boys and young men
DoH collaborates with …			DoH provides information / education sessions on SRH services, SRHR and substance abuse in schools DoH provides screening services in schools	DoH refers to DSD for psychosocial support		
DBE collaborates with…						
DSD collaborates with…	DSD provides training to CSO to facilitate	DSD advocates for DoH to provide youth	DSD collaborating with schools around social		DSD partner with SAPS to provide information	DSD partners with National Youth

Who collaborates	CSOs	DoH	DBE	DSD	SAPS and community police forum	Other government entities
	dialogues on SRHR for youth in communities Collaborating with CSOs (e.g. Teddy Bear and Child Line) to provide psychosocial support DSD collaborates with CSOs to facilitate community dialogues around social norms. DSD collaborates with organisations that can provide logistical support.	friendly SRHR services DSD partners with DoH to provide information sessions in schools and the community	workers role in providing psychosocial support		sessions in schools	Development Agency to provide assistance with economic strengthening through job preparation activities
SAPS collaborates with…						
Other government entities (SASSA and Department of Sports, Arts, Culture, COGTA) collaborates with…						