STOCKHOLM EVALUATION UNIT

EVALUATION OF

ADOLESCENTS' SEXUAL AND REPRODUCTIVE HEALTH PROJECT IN MBARE, ZIMBABWE

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ACRONYMS

AC	Adolescent Corner
ART	Antiretroviral Therapy
AFSRH	Adolescent-Friendly Sexual and Reproductive Health
ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
AYP	Adolescents and Young People
CARGS	Community ART Refill Groups
CATS	Community Adolescent Treatment Supporter
CeSHHAR	Centre for Sexual Health and HIV/AIDS Research
CG	Consultation Group
CHW	Community Health Worker
CoH	City of Harare
CSE	Comprehensive Sexuality Education
EmONC	Emergency Obstetrics and Neo-natal Care
EO	Edith Opperman (maternity)
FP	Family Planning
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
ICT	Information & Communications Technology
IDI	In-depth Interview
IR	Inception Report
IUCD	IntraUterine Contraceptive Device
KP	Key Population
LARCs	Long-Acting Reversible Contraceptives
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex
MH	Mental Health
MHM	Menstrual Health Management

MVA	Manual Vacuum Aspiration
OI	Opportunistic Infections
OPD	Outpatients Department
PCC	Person-Centered Contraceptive Counselling
PE	Peer Educators
PEP	Post-Exposure Prophylaxis
PSI	Population Services International
PrEP	Pre-Exposure Prophylaxis
PSZ	Population Services Zimbabwe
RA	Research Assistant
SGBV	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
TOP	Termination of Pregnancy
ToR	Terms of Reference
VL	Viral Load
WHO	World Health Organization
YPSS	Young People Selling Sex
YRA	Youth Research Assistant

GLOSSARY OF TERMS

Adolescent-Friendly Services: Bring together the qualities that young people demand, with the high standards that have to be achieved in the best public services. Based on the WHO framework, these services are accessible, acceptable, equitable, appropriate, and effective for adolescents. The standards for ensuring quality in health services for adolescents include *Adolescents' health literacy, Community support, Appropriatepackage of services, Providers' competencies, Facility characteristics, Equity and non-discrimination, Data quality and adolescent participation.*

Post Abortion Care (PAC): consists of emergency treatment for complications related to spontaneous or induced abortions; family planning and birth spacing counselling, and provision of family planning methods for the prevention of further mistimed or unplanned pregnancies that may result in repeat induced abortions.[1]

Person-Centered Contraceptive Counselling: Person-centered contraceptive counselling (PCCC) places theperson seeking contraceptive information and/or services and their needs at the center of care. In PCCC, the person actively participates in the development of a care plan that is tailored to and aligned with their uniqueneeds, opinions, and priorities. Finally, PCCC seeks an understanding of not just the patient, but the whole person – their emotional needs and life circumstances.

Key populations and especially vulnerable groups: Populations that have a high epidemiological impact from AIDS, TB, and malaria, combined with reduced access to services and/or being criminalized or otherwise marginalised. In this report they include LGBTQI adolescents, adolescents living on the street, adolescents with disabilities, adolescents living with HIV, young people selling sex and young people using substances.

Contraceptive Care vs. Family Planning: Family planning focuses on the need to space apart children and limit family size: having children when you want to have children. This has not always been a relevant term or description for the unique needs and priorities of adolescents, like the ones in this study. That is to say, a girl aged 16 years may not necessarily be concerned about planning a family, but she does not want to get pregnant. Contraceptive care is the combination of contraceptive information and services that seek to ensure that adolescents can make free informed decisions about contraceptive use (prevent pregnancy) from a full range of methods. This report uses the appropriate 'contraceptive care' to refer to pregnancy prevention services and information for adolescents. However, the report also acknowledges contextual understanding and phrasing for communities in Zimbabwe who continue to refer to 'contraceptive care' more broadly as under the umbrella of 'family planning'. In that regard, certain wording in the report continues to use the term 'family planning' and this includes keeping the '3-pillar family planning strategy' named as such.

[1]Introduction to Post-Abortion Care: https://www.postabortioncare.org/sites/pac/files/CompendiumIntroPAC.pdf

EXECUTIVE SUMMARY

The World Health Organization (WHO) recommends that healthcare services should be equitable, accessible, and acceptable to adolescents (10-19 years old) who make up 16% of the global population. However, globally adolescents continue facing barriers to access much needed services because of social, cultural, religious, and political factors. Health systems are often designed to meet the needs of adults but are often poorly designed to meet adolescents' health needs, particularly those who belong to vulnerable and marginalised groups. Quality health services for adolescents should encompass adolescents' health literacy, community support, appropriate package of services, providers' competencies, facility characteristics, equity and non-discrimination, data quality and adolescent participation standards. Adolescents are at high risk of Sexually Transmitted Infections (STIs) and HIV, especially adolescent girls and those who belong to key populations. Adolescents have a right to safe and pleasurable experiences and should have access to comprehensive information and services for prevention, testing, and treatment of HIV and STIs without barriers such as third-party consent. These services should be responsive to their needs, confidential and with special provisions for vulnerable and at-risk groups.

This report is an evaluation of the Mbare Adolescent Sexual and Reproductive Health (ASRH) project in Zimbabwe which was developed in 2015 and is run by MSF. The project is as a pilot to test innovative models of providing HIV and Sexual and Reproductive Health (SRH) services for adolescents aged 10-19 (up to 24 years for some services) and aims to provide an adolescent-friendly comprehensive and integrated package of SRH services - including the HIV cascade, Mental Health (MH) and tuberculosis (TB) care for adolescents at community and facility level (an Adolescent Clinic, AC, and the Matapi Youth Hub) in Mbare. As part of its integrated model and intention to address the differentiated care needs of adolescent subgroups, the project collaborates with multiple key stakeholders who play a role in adolescent health and wellbeing. Youths (15-24 years old) make up 20% of the Zimbabwe population and Mbare is one of the oldest suburbs of Harare, the capital city of Zimbabwe. There are high poverty levels in Mbare, and the suburb is overcrowded. This environment is conducive to risky behaviour that fuels the spread of STIs and HIV and amplifies the vulnerability among adolescents.

This evaluation used the OECD/DAC evaluation criteria, combined with the Medical Research Council's Guidance on Process Evaluation framework, to identify and understand the implementation, mechanisms of change amongst beneficiaries and context of MSF's Adolescent-Friendly Sexual and Reproductive Health (AFSRH) project. The focus was on the appropriateness, effectiveness, coverage, and connectedness of the project, its stakeholders and beneficiaries using a mixed-methods approach. The evaluation used a mixed-methods approach incorporating both quantitative and qualitative research methods. This included a secondary data analysis of four project datasets from 2016-2020, eight non-participant observations, 66 in-depth interviews and nine focus group discussions with the project beneficiaries and key stakeholders. The evaluators followed all guidance outlined in the SEU Ethical Guidance to ensure respect for dignity and diversity, fair representation, confidentiality, avoidance of harm for MSF staff, evaluation stakeholders and clients. Verbal consent was obtained from all interview participants and, in addition, adolescents younger than 16 years old provided written guardian/parental consent. Key limitations of this evaluation were reliance on routinely collected data for the quantitative analysis which had several limitations such as the inability to track individual clients,

multiple changing datasets and variables, inconsistencies, and errors in data entry. Although the effects of COVID-19 did not have a significant impact on the evaluation, some interactions with the Mbare ASRH project were observed throughout including, but not limited to, changes in availability and uptake of some services such as community-based activities and service provision at the Matapi Youth Hub.

During the period from 2016-2020, the Mbare ASRH project has had 20,373 consultations (58% female) with adolescents and young people. Over 83% of these were at the AC and 67% were adolescents aged 16-19 years indicating low service uptake by younger adolescents. From 2016-2019 most adolescents consulted (59%) received HIV testing services and the uptake of contraceptive services by female clients increased from 6.4% in 2019 to 43% in 2020. Notably, contraceptive care was the only SRH service that had an increase in uptake in 2020. Condom uptake ranged from 0.5% - 7% over the 5-year period and overall, 42% of consultations with the project also received outpatient department (OPD) services. Services such as referrals to ANC, MH and psychosocial support have low uptake (<5%) consistently. Most referrals out of the project were for other hospital services (43%) followed by post-abortion care (31%) services. HIV prevalence among adolescents tested through the service was 2.3% while linkage to care was 62% and viral load suppression (<1000 copies/ml), among the subgroup that received a viral load test, was 80%.

Overall, the services at the AC and Matapi are considered appropriately youth friendly. There are areas for improvement which include, providing SRH services to unaccompanied minors; not having long waiting times during lunch hours; not having adolescents and the parents/guardians of accompanied minors wait in the same space; and as much as possible not having to refer or transfer clients from Matapi to the AC. Adolescents find their interactions with the peer educators to be appropriate and beneficial. The school health clubs and income generating activities are also considered highly appropriate. In the community peer educators are the face of the project. They sensitize the community on what the project offers. Although peer engagement with key population groups has been met with challenges, these may be addressed over time by the key population's strategies introduced towards the end of 2020.

The evaluation also found that the teen mom clubs have been effective in providing wellbeing support for pregnant adolescents. Contraceptive care in the project has been highly effective in increasing access and uptake of contraceptive care services, however, the operational focus on the 3-pillar strategy may be at the expense of other health services in the project such as HIV services, condom distribution, STI management and general health education. As such, it will be important for the project to clearly define if all services are centered around this strategy or if an integrated package of ASRH services, including family planning is being offered. Learnings from the successful implementation of the 3-pillar strategy (effective sensitization, knowledgeable peer educators, nurse-escort for referrals when needed) can also be transferred for other services and potentially increase their uptake.

The evaluation found major gaps in the projects monitoring and evaluation framework and tools to collect the data for evidence generation through the project. Despite the innovativeness of the project – its many components and growth over the years – there has not been a systematic collection of high-quality evidence to support the project. Quantitative data entry for the project is mostly paper-based which is time consuming for staff and leaves room for errors. Although several changes have been made over the years to improve data capture this report highlighted several areas where improvements could

be made. A key objective of the Mbare ASRH project is to test innovative models of providing HIV and SRH services for adolescents. As such robust and accurate data is essential. Creating systems that facilitate this will be useful for not only the monitoring and evaluation efforts of the project but future advocacy and policy work and may also improve service delivery by reducing the time spent managing paperwork by project staff and the data team. Costs and feasibility of implementing and electronic data capture system should be assessed. Furthermore, there was little to no evidence of advocacy efforts systematically occurring during the project's life course. Advocacy for ASRH is a critical component of this project. However, this evaluation noted that there is a need to strengthen advocacy efforts particularly through the early generation of evidence. This can be supported by robust data as noted above but also human resources to monitor and capture components relevant to current and future advocacy efforts of the study, and strengthening areas of the project that require close attention such as the HIV care cascade.

Due to the wide range of services provided to adolescents by the project this evaluation highlighted some areas where ASRH service provision to adolescents can be strengthened. Of note, integrating services to maximize on uptake of all components of the project will support in achieving project objectives. It may not be ideal for MSF to provide all adolescent health and wellbeing services as the frontline provider. Networking and collaborative strategic partnerships would support project objectives. However, the evaluation noted the referral-based components of the project which depend on effective strategic partnerships do not have consistent (recorded) follow-up for the continuum of care, for example ANC services to pregnant adolescents, and offer no guarantee of quality AFSRH services at referral partners.

The Mbare ASRH project is one of the few projects in Zimbabwe that focuses primarily on the provision of comprehensive integrated health services for adolescents and some young people. Most programs and projects provide partial health service, information and/or referrals. When assessing sustainability, it was noted that there is a need for MSF to identify and work with other partner organizations, who may be able to adopt and continue components of the project, as it is unlikely that the Government of Zimbabwe will be able to adopt such a complex intervention. In preparation for this handover in the future, it will be critical for MSF to begin conversation and planning for this well in advance to allow to a smoother transition for implementing organizations and more importantly the adolescents that this project serves.

In conclusion, this evaluation has demonstrated that the Mbare ASRH project is positively impacting the health and wellbeing of adolescents who encounter its components. This evaluation noted that over the 5-year period there has been a concerted effort by MSF to adapt and improve service provision for adolescents. Innovative strategies for adolescent care and support have been developed and as such this project has over the years been growing and evolving. Due to the wide range of services

provided to adolescents by the project this evaluation highlighted some areas where ASRH service provision to adolescents can be strengthened. As such, five key recommendations have been made:

Recommendations

1. Invest in strengthening the monitoring and evaluation framework. This is key to generating quality evidence that can be used for policy and practice.
2. Investments need to be made in a) efforts to create the necessary evidence to inform/substantiate advocacy goals; and to develop an advocacy strategy and activities aimed at influencing policy and practice.; and b) in more capacitated human resources.
3. Activate the Handover Committee meetings and ensure that the committee has adolescent representation to begin strategizing how, when, and to whom, which components of the Mbare ASRH project will be handed over to Harare City Council.
4. The support to Mbare Polyclinic for a PAC intervention should be added into the Mbare ASRH project. Considering the high acceptability of the AC adolescent-friendly model, it is possible that PAC uptake would be higher if at the polyclinic vs. by referral. This could contribute to reduced maternal-related adolescent morbidity and mortality.
5. A decision needs to be made about whether this project is a comprehensive integrated adolescent services project or whether it is a contraceptive-care focused, comprehensive integrated adolescent service.

INTRODUCTION

The World Health Organization (WHO) defines adolescents as individuals aged between 10-19 years (1). Adolescents make up 16% of the global population (2). Adolescence is a crucial transitional stage of development where young people go through physical, social, cognitive, and sexual changes and they start assuming more responsibilities in life (3). Adolescents are often excluded from health programming as it is assumed that they are healthy and have lower risk of ill-health, however, there has been increasing realisation of the need to include and prioritise adolescent needs. WHO recommends that healthcare services should be equitable, accessible, and acceptable to adolescents.1 These services should meet their expectations, be appropriate for their needs and effective enough for meaningful contribution to adolescent health including sexual and reproductive health (4). Adolescents should have access to comprehensive sexuality education, services to prevent, diagnose and manage HIV and sexually transmitted infections (STIs), comprehensive sexual and reproductive health services that includes contraceptive care counselling and resources, quality obstetric, neonatal, antenatal care, and postnatal care for girls and young women and empowerment to exercise their rights (5). However, globally, adolescents continue facing barriers to access much needed services because of social, cultural, religious, and political factors.

In 2019, 1.7 million adolescents were estimated to be living with HIV and accounted for 10% of new adult infections globally. Over 85% of all adolescents living with HIV reside in sub-Saharan Africa (6). Globally, there has been some progress on some adolescent sexual and reproductive health (ASRH) indicators. The global adolescent fertility rate fell from 126 per 1000 live births during the years of 2000–2005, to 103 during 2015-2020, marriages before the age of 18 years (child marriages) have declined and contraceptive use prevalence among single young women between 15 to 24 years has risen from 23% between 1996-2000 to 33% between 2011-2015 (7).

ADOLESCENT FRIENDLY HEALTH SERVICES

Sexual and Reproductive Health (SRH) is a state of physical, emotional, mental, and social wellbeing with regards to sexuality and reproduction and not just the absence of disease or infirmity (5). Despite some process in meeting adolescent needs, adolescents and young people continue to face barriers in accessing care due to social, economic, and religious factors. Health systems are often designed to meet the needs of adults and are often poorly designed to meet adolescents' health needs, particularly those who belong to vulnerable and marginalised groups. As such, health services should be accessible, acceptable, equitable, appropriate, and effective for all adolescents. Healthcare providers should treat adolescents equally with dignity and respect (8). Services should also be accessible for adolescents through differentiated models with convenient hours of operation and involvement of adolescents themselves in service provision. The services should be affordable with adolescents well informed about the range of services available to them and how to obtain them (8).

Quality health services for adolescents have *Adolescents' health literacy, Community support, Appropriate package of services, Providers' competencies, Facility characteristics, Equity and non-discrimination, Data quality* and *adolescent participation standards*. Participation of adolescents in key strategic processes like designing and assessment of the services is helpful in meeting their

expectations. Community support is essential in ensuring adolescents access the services that are provided. All the procedures and policies in place should guarantee privacy and confidentiality, with non-judgmental staff, short waiting times and services delivered in an appealing and clean environment with a variety delivery channels to contribute towards acceptability of services. Adolescent friendly services should also be appropriate and fulfil their needs and effective guided by evidence-based guidelines and protocols, competent staff, and well-resourced points of delivery (8).

ADOLESCENT SEXUAL & REPRODUCTIVE HEALTH NEEDS

Multiple factors contribute to adolescent sexual and reproductive health (ASRH) risks and vulnerability beyond individual behaviour. Therefore, interventions have to be targeted at addressing biological needs, positively influencing their interpersonal and social networks and strengthening their social ties. Interventions should also make their communities safer and supportive through reduction of harmful practices and addressing gender equality. Improved access to economic empowerment and academic opportunities has also been noted to reduction in risky sexual behaviour (9).

Economic empowerment and academic opportunities have mostly been implemented in HIV prevention, where there is integrated combination of effective biomedical, behavioural, and structural approaches to address the HIV prevention needs of adolescent and is of benefit in address other SRH challenges adolescents face (10). Adolescents are at high risk of STIs and HIV, especially adolescent girls and those who belong to key populations. In 2019, an estimated 170,000 adolescents globally were newly infected with HIV and sub-Saharan Africa was the most affected (6). While there is data on the prevalence of HIV and new HIV infections, there are data gaps in this age group with regard to the prevalence of STIs. STIs, if untreated, have short- and long-term reproductive complications with gonorrhoea and chlamydia causing infertility and the Human papillomavirus (HPV) responsible for cervical cancer (11). STIs also increase the risk of acquiring HIV. Adolescents have a right to safe and pleasurable experiences and should have access to comprehensive information and services for prevention, testing, and treatment of HIV and STIs without barriers such as third-party consent (12). These services should be responsive to their needs, confidential and with special provisions for vulnerable and at-risk groups.

Comprehensive Sexuality Education (CSE) contributes to behaviour change and prevention of HIV, STIs and unintended pregnancies. It has been shown to be effective in reducing risky behaviour and delaying sexual debut (13).

SRH services including menstrual health management (MHM) and contraception counselling and provision are also essential in ASRH. Knowledge and access to MHM services for adolescent girls is important for their personal development, access to education and life skills programs, self-confidence; their menstrual health needs must be met to achieve their full potential. They also have a right to choose if, when, and how, they want to have a child including the number of children. Access to contraception services, information and counselling help prevent early unintended pregnancies and their associated health and social consequences. Unsafe abortion contributes to 4.7%-13.2% of maternal mortality with an estimated 3.9 million older adolescent having unsafe abortions every year in developing countries (14). Access to sexual and reproductive health services and an enabling

environment is essential in upholding the adolescent rights to choose when they want to have a child and in reducing maternal mortality and morbidity associated with unsafe abortions.

Pregnant adolescents face stigma and barriers to accessing maternal health services and their pregnancies carry risks for maternal and neonatal mortality and morbidity (15). Pregnant adolescents may be also vulnerable and require access to adolescent responsive, affordable, and comprehensive SRH services including antenatal, Emergency Obstetrics and Neo-natal Care (EmONC) and postnatal care services at every stage guaranteeing privacy and confidentiality to reduce risk of poor outcomes (4).

Young girls are vulnerable to intimate partner, gender-based, and sexual violence. Gender inequalities and cultural values are some of the contributing factors. Intimate partner violence increases the risk of STIs, HIV, unintended pregnancies, and unsafe abortions (16). Interventions to prevent and respond appropriately in an adolescent friendly manner are key. Interventions should also address socio-economic and cultural factors that contribute to gender inequality and expose young women to abuse. Harmful traditional practices like female genital mutilation and child marriages also violate adolescents' rights to respect of body integrity, privacy, and personal autonomy (17). These practices expose the survivors to long-term health and social consequences. There is a need for multicomponent interventions that address the root causes of such harmful practices and also to protect the survivors.

Comprehensive ASRH should be holistic, multi-sectoral, adolescent friendly and able to meet specific age and developmental needs. It should also promote a safe and supportive environment fostering meaningful participation with necessary information, skills, and attitudes to uphold ASRH rights. All these services and interventions should be implemented in an effective and equitable manner that make them accessible, acceptable, and appropriate for all adolescents.

ZIMBABWE

Zimbabwe has a youthful population. Youths aged 15-24 years make up 20% of the population and 70% of young people aged 10-24 years live in rural communities (18). The legal age of the majority in Zimbabwe is 18 years and anyone below the age of 18 is regarded as a child (19). Approximately 14% of children below the age of 17 are orphans with half of them having lost a father and approximately 6% having lost both parents (18).

Zimbabwe has been facing economic challenges for the past two decades resulting in only 23% of people formally employed and the majority of the population has depended on informal employment. It is estimated that 38.5% of the country live in extreme poverty – below $1.90 a day – and rural communities are the most affected (20). The country has been recovering from the cyclone Idai, which affected the eastern provinces, and a severe drought, putting half of the entire population at risk of starvation. Recently, the COVID-19 pandemic resulted in the country adopting lockdown measures to curb the spread of the disease, however, this has had and unintended negative impact on the economy, exposing vulnerable young people to abuse and exploitation (21).

The health sector has not been spared from the economic crisis and is faced with frequent health professional strikes, shortage of essential resources and is heavily dependent on donor funding

especially for the HIV/AIDS program. The country's health sector financing is based on taxation though the government spending on health is below the recommended 15% from the Abuja agreement (22). Approximately 10% of the population has some medical cover with the rest relying on out-of-pocket expenditure. In 2015, 7.6 % of households incurred catastrophic health expenditure (23). It is important to note, however, that global funding for ASRH has increased. For example, the Global Fund Strategy for 2017-2022 includes a specific commitment to scale up programs that support adolescent girls and young women, including programs to advance sexual and reproductive health and rights with over five-fold increases in funding for these programs in priority to high burden countries including Zimbabwe. Furthermore, PEPFAR through the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) partnership across 15 countries, also including Zimbabwe, has provided over USD 7 million in funding for programming for adolescent girls and young women. The increased funding for adolescent health, and more specifically for ASRH, allows for strategic partnerships and a coordinated response leading the efficient maximization of impact. Adolescents are a diverse group of different ages, sex, ability, gender identity, religion, cultural and social classes, and all this informs their risks and protective factors. In Zimbabwe, 84% of population above the age of 15 identify as Christian (18). Adolescents with disabilities, orphans, living with HIV, girls, pregnant and adolescent mothers are considered to be vulnerable groups. Adolescents comprise 22% of the total Zimbabwean population. Among the many health challenges faced by this group, access to SRH services for adolescents in Zimbabwe is poor. According to the 2016 Zimbabwe population-based HIV impact assessment (ZIMPHIA), 4% of young people (aged 15-24 years) reported sexual activity before the age of 15 years, however, only 75% of young people knew that a person could reduce the risk of HIV by using a condom every time they have sex (24). Unprotected sexual intercourse among young people exposes them to the risk of unintended pregnancies, STIs, and HIV infection. According to the Zimbabwe Young Adult Survey conducted from 2001-2002, only 34% of young girls (15-19 years) sought treatment upon experiencing STI symptoms. In this survey adolescent girls (15-19 years) also had a higher percentage of unintended pregnancies (55%) when compared with older women aged 20-24 years (42%) and 25-29 years (37%) (24), (25).

Mbare is one of the oldest suburbs of Harare, the capital city of Zimbabwe. According to the 2012 Demographic Health Survey, Mbare is estimated to have a population of up to 142,195 with 60% of them aged between 10-24 years (26). There are high poverty levels, and the suburb is overcrowded. Therefore, the environment is conducive to risky behaviour that fuels the spread of STIs and HIV and also amplifies the vulnerability among adolescents.

It is against this background that the Mbare Adolescent Sexual and Reproductive Health (ASRH) project is being conducted.

PROJECT BACKGROUND

The Mbare ASRH project which was developed, and is run by MSF, began in 2015. Initially, the project was stated as an extension of the Sexual and Gender-Based Violence (SGBV) clinic that MSF had been running in Mbare since 2011. During its life course, the SGBV clinic served a lot of adolescents who were brought in by their parents as rape victims. However, some of them were identified as sexually active and in a relationship, revealing a gap in the provision of adapted ASRH services for such adolescents. MSF then began the Mbare ASRH project as a pilot to test innovative models of providing HIV and SRH services for adolescents aged 10-19 (up to 24 years for some services). Over the last six years, the project components and model have evolved.

The project is providing an adolescent-friendly comprehensive and integrated package of sexual and reproductive health services - including the HIV cascade, Mental Health (MH) and Tuberculosis (TB) care for adolescents at community and facility level in Mbare. For this project, staff articulated that MSF uses the WHO framework and definition of 'adolescent-friendliness' (see Glossary of Terms; and Annex 6).

At the project's inception in 2015, within the SRH services component, a 3-pillar strategy: Family Planning, Antenatal Care (ANC) and Post-Abortion Care (PAC), for improving high rates of teenage pregnancies and associated complications was created. In this strategy, 90% of eligible adolescent requesting family planning should be accessing it; 90% of eligible young women should receive antenatal care (this includes the 10% who do not get contraceptives and end up pregnant and keep these pregnancies); and lastly 90% of eligible adolescent women (unintended pregnancies and choose not to keep these pregnancies) should access PAC services. Eventually cohorts of adolescent women who receive ANC and PAC, should also access on contraceptives (Figure 1). Implementation of this strategy began in 2020.

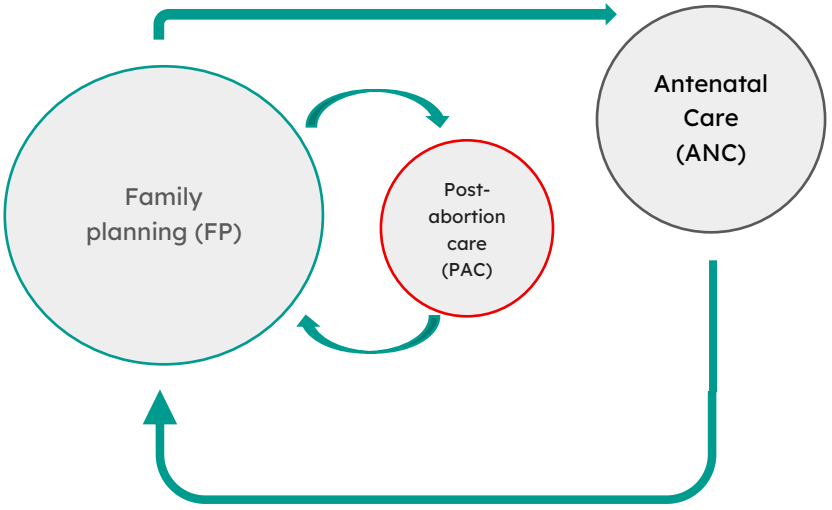

Figure 1. The 90-90-90 Three-pillar family planning strategy for improving high rates of teenage pregnancies in Mbare.

As part of its integrated model and intention to address the differentiated care needs of particular adolescent subgroups, the project collaborates with multiple key stakeholders who play a role in adolescent health and wellbeing.

There are **three main sites** from which the adolescent-friendly sexual and reproductive health (AFSRH) project activities occur, namely: **Mbare polyclinic** (Edith Opermann/ANC, OI), **Matapi Youth Hub** and the **community** (income generating activities, follow-up home visits, mobile and moonlight clinics, health promotion activities like peer-to-peer interactions, community mobilization, school health clubs, engagement with churches and digital health promotion). The lessons learnt from implementing models (which include the use of strategic partnerships) of providing access to 1) multidisciplinary and comprehensive AFSRH at Mbare Polyclinic, 2) less medicalized Matapi Youth Centre that offers opportunistic access to AFSRH such as 'drop-in' services, 3) referral-based health services, and 4) the light and non-medical approaches in the community, will be used to define the most acceptable and replicable AFSRH model.

The objectives of the Mbare ASRH project are:

- **General objective**: To reduce the morbidity and mortality for adolescents in Mbare and surrounding areas by improving access to an AFSRH package of care.
- **Specific objective**: To develop and implement innovative and replicable models of comprehensive and integrated ASRH care as a pilot in Mbare. These models are to be disseminated and lead to programmatic and policy changes in Zimbabwe, the region and other MSF projects.

As part of phase one of this evaluation, the evaluators developed a logic model to describe the Mbare ASRH project inputs, activities, outputs, outcomes and intended impact. It is described in detail in Annex 2: Logic Model.

EVALUATION SCOPE

This evaluation aims to identify and understand the implementation, mechanisms of change amongst beneficiaries and context of MSF's ASRH project in Mbare, Zimbabwe. The evaluation focuses on the appropriateness, effectiveness, coverage, and connectedness of the project, its stakeholders, and beneficiaries, and also relates these evaluation components to the project's outputs and intended outcomes. The findings are intended to guide in the adaptation of the intervention and inform the AFSRH priorities of MSF and other stakeholders involved in AFSRH within Mbare.

Specifically, the evaluation:

1. Established an AFSRH project profile, including intervention components (inputs, activities, outputs, outcomes, impact). It describes key measures such as: number of beneficiaries, age, gender, and service uptake.
2. Analysed implementation of the Mbare ASRH project (including HIV, mental health and TB prevention and care) and identified critical needs, major challenges, barriers, enablers, and facilitators to the project's engagement, intended outputs and outcomes.
3. Mapped current ASRH programmes (both donor-supported and governmental) in Mbare and Harare, in order to identify the main gaps, overlaps, and opportunities for MSF's project.
4. Analysed links between key elements, such as gender, education, economic and social development; and access to SRH, Mental Health, HIV and TB prevention and care, in the Mbare ASRH project.
5. Identified the main areas requiring concerted efforts and greater investment for the Mbare ASRH project and proposed priority actions, including implementation timelines, and timeframes for scale-up of the project components.

As part of the Inception phase of this evaluation the evaluators developed an evaluation framework based on the Medical Research Council's Guidance for the Process evaluation of complex public health interventions (27). The three process evaluation domains (Implementation, Mechanisms of Change and Context) and the components being investigated under each of the domains allowed the evaluation to describe and understand the processes of the ASRH project and whether these processes (or parts of these processes) are Appropriate, Effective, Connected, and Sustainable (Annex 1: Terms of Reference). Table 1 below defines each of the components of the mechanism of change and Figure 2 shows the domains of adolescent-friendliness that were used to explore the quality of the Mbare ASRH project. An Annex 6, has been included as part of this evaluation that compares the domains of adolescent-friendliness used in this evaluation, to the WHO framework on adolescent-friendliness. The annex continues to map the findings from this evaluation against the WHO framework.

Table 1. Definitions of mechanisms of change components

COMPONENT	DEFINITION
Access	Refers to geographic accessibility, which refers to how easily the client can physically reach the provider's location.
Acceptability	Captures the extent to which the adolescent client is comfortable with the more immutable characteristics of the health provider and vice versa. These characteristics include the age, sex, social class, and ethnicity of the provider (and of the client), as well as the diagnosis and type of service coverage of the client. This also captures the extent to which the health providers are comfortable with the intervention characteristics. The characteristics cold include work hours and load, intervention structures, community responses.
Availability	Is a measure of the extent to which the Mbare ASRH project has the requisite resources, such as personnel and technology, to meet the needs of the adolescent client?
Accommodativeness	Refers to the extent to which the Mbare ASRH project's operation is organized in ways that meet the constraints and preferences of the adolescent clients. For example, some concerns could be, hours of operation, or how client telephone communications are handled, and/or a client's ability to receive care without prior appointments.
Affordability	Refers to how the Mbare ASRH project's charges relate to the client's ability and willingness to pay for services.s

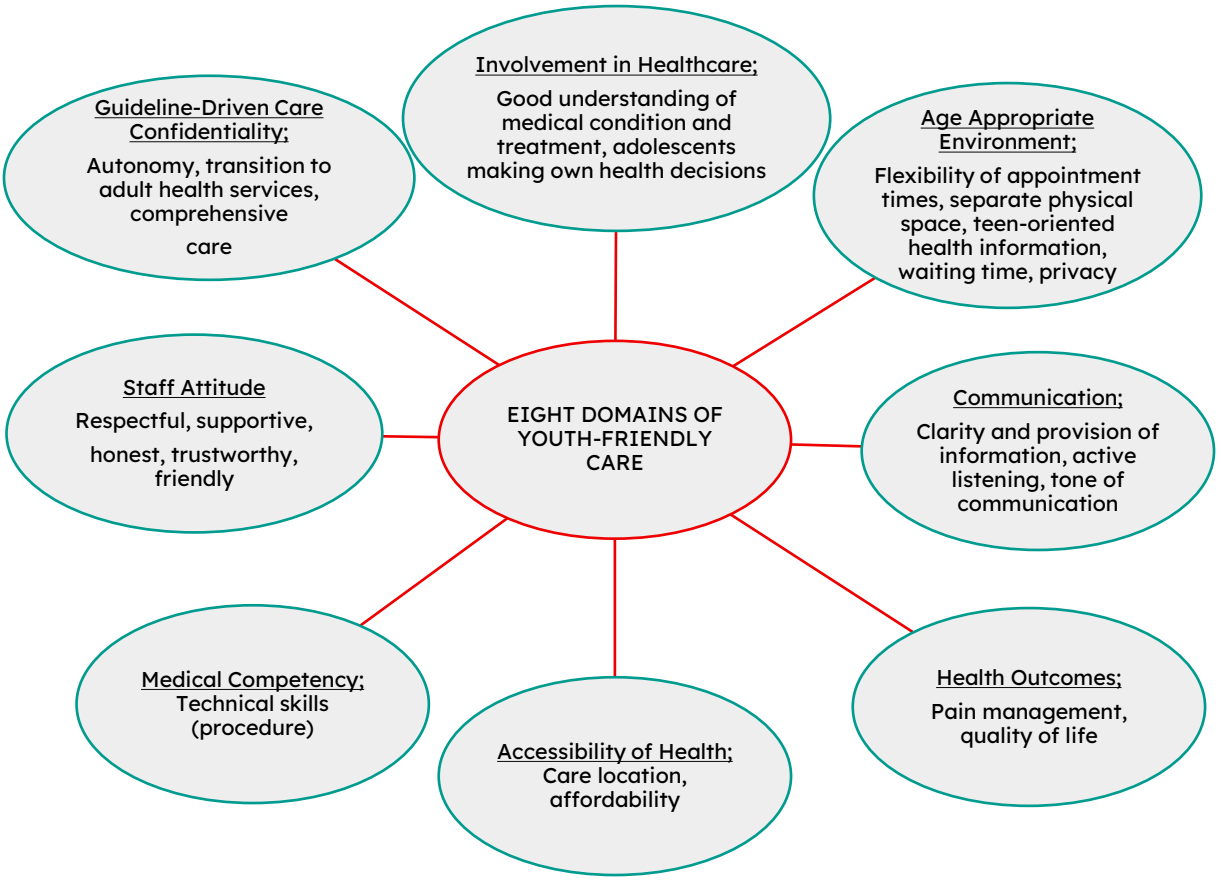

Figure 2. Domains of youth-friendly health care (adopted from Sangraula, M et. al. (6)

METHODOLOGY

The evaluation sought to measure results and experiences of MSF's Mbare ASRH project using a mixed-methods approach. The evaluators followed a flexible and innovative methodology to engage with the project implementors, stakeholders and beneficiaries to elicit their experiences using the following steps:

1. Review of project documents, and results framework
2. Conduct critical literature review
3. Conduct stakeholder mapping
4. Review of the project theory of change and reports
5. Context modelling and review
6. OECD-DAC Evaluation approach
7. Experiences evaluation approach addressing the ASRH project experience
8. Provide evaluation conclusions and recommendations

PREPARATORY PHASE

Between January and February 2021, the evaluators conducted an in-depth desk review and preparatory phase in order to understand the Mbare ASRH project and to inform the methodology required for the data collection phase of the evaluation.

As part of the preparatory phase the evaluators completed the following tasks:

1. Assessed the provided MSF Project Documentation,
2. Conducted a literature review on ASRH in Zimbabwe,
3. Completed stakeholder mapping of ASRH in Mbare, Harare and Zimbabwe,
4. Developed qualitative data collection tools,
5. Conducted a preliminary data analysis of the project data,
6. Interviewed the evaluation Consultation Group and Commissioner (Annex 4: Evaluation Participants), and
7. Recruited experienced Research Assistants (3) and Youth Researchers (2) to assist in the data collection and analysis phases.

Findings from the tasks above were used to inform the Inception report, refine the evaluation methodology described below. During this phase, the Mbare ASRH project and objectives were redefined as per section *Appropriateness* below and a logic model (Annex 2) was developed as a result of unclear/incomplete project documentation, and to have a clear working definition and description of what the Mbare ASRH is.

Research Assistant (RA) recruitment was aimed at ensuring that the evaluation would be able to elicit meaningful data that may not be accessible through traditional data-driven methods. As such youth-driven participatory research methodology was also utilized. Two male Youth Research Assistants (YRAs) that fell within the target age group and resided within Mbare were recruited to support the evaluators. These YRA were selected purposively to create a gender balance within the team, and they also have experience working with the evaluators on other youth-focused projects. Additionally, all the RAs

recruited to work on the project had done research with adolescents (including sub-groups) before and went through a two-day training conducted by the evaluators. The training included an overview of the Mbare ASRH project and the evaluation scope and methodology.

During this phase and throughout the evaluation the evaluators met weekly to discuss and synthesise findings from each of the evaluation components, describe any facilitators and challenges with the evaluation, confirm next steps for the evaluation and re-assess timelines.

MAIN DATA COLLECTION AND ANALYSIS PHASE

During March-April 2021 the evaluators conducted the main data collection and analysis phase which involved a secondary data analysis of Mbare ARSH data, conducting Focus Group Discussions (FGDs) and In-depth Interviews (IDIs) with Mbare ASRH staff, stakeholders, beneficiaries, and community members. This phase included a three-week field visit period where part of the evaluation team was based in Mbare. The evaluation methodology for quantitative and qualitative data collection and analysis is described in detail below.

QUANTITATIVE METHODOLOGY

OBJECTIVES

The primary outcome of the secondary data analysis was to describe the uptake of Mbare ASRH services defined as the total number of adolescents accessing ASRH services from Mbare Polyclinic, the Matapi Youth Hub and Community outreach programs stratified by age, sex, and year from 2016-2020.

The secondary objectives stratified by project site, age, sex, and year were:

1. Uptake of the specific ASRH services including HIV testing, menstrual hygiene, contraceptive care, STI treatment, antenatal care (ANC), health education, TS screening and MH.
2. Uptake of referrals to collaborating partners for services including FP/PAC, PrEP and PEP, Cervical cancer screening and contraceptive care (long-acting methods not available at Mbare Polyclinic and Matapi Youth Hub before 2019)
3. Proportion of adolescents who complete referrals to collaborating partners for services including FP/PAC, PrEP and PEP, VIAC and contraceptive care services (long-acting methods not available at Mbare Polyclinic and Matapi Youth Hub before 2019)
4. Proportion of HIV positive adolescents who are linked to HIV care, initiated on treatment and are virally suppressed.
5. Proportion of adolescents reached by community activities and events.

DATA ANALYSIS

Four anonymised datasets with quantitative data from the Mbare ASRH project were shared with the evaluators in Excel format. These datasets were:

1. Service uptake data from 2016-2019
2. Service uptake data for 2020
3. HIV cohort data
4. TB treatment data (2016-2019)

The four datasets could not be linked due to differing identifiers and were therefore analysed separately and combined for presentation where feasible. Analysis from Datasets 1 and 2 are presented together while those from datasets 3 and 4 are reported separately. Two data analysis were conducted. The preliminary analysis was conducted in Phase 1 of the evaluation (February 2021) and was used to inform the development of the Inception Report as well as components of the qualitative data collection. The findings from the preliminary data analysis were shared with the qualitative research assistants and evaluator prior to the commencement of FGDs and IDIs in order to elicit cross-cutting learning and provide context of service uptake and allow the use of qualitative methods to compliment and provide context to some of the quantitative findings.

The main data analysis was conducted in March 2021 and the findings are presented in this report. For analysis the data was extracted from Excel and all analysis were carried out using STATA v15-0 software (StataCorp, TX, USA). Demographic data from the datasets was used to create descriptive summaries of the clients accessing any of the Mbare ASRH project services and their uptake of the different available services. Continuous variables were summaries as medians (inter-quartile range: IQR) and categorical variables as counts (percentages). In addition to descriptive summaries, where possible, data was populated into tables and also presented as graphs.

In addition to the secondary data analysis, during the field visit the evaluators met with the Mbare ASRH Data Team Leader to review primary data collection tools and the data flow of the project. Particular attention was made to allocation of unique IDs for participants, where and how data are entered into registers and subsequently entered into the database, as well as data capturing procedures and linking of datasets for referral outcomes. This was aimed at understanding the flow of data for the Mbare ASRH project as well as ways through which this can be improved.

The evaluators also met at the end of the data collection phase and shared findings from the final analysis in order to sync the quantitative and qualitative findings of the evaluation.

QUALITATIVE METHODOLOGY

Qualitative data collection methods were used to explore the experiences of different stakeholders and beneficiaries who interact with the Mbare ASRH project. This evaluation also assessed how local contexts affect implementation and shaped project outcomes.

Qualitative methodologies included FGDs, in-depth interviews, and semi- structured field observations. Participants were recruited from a pre-defined list of stakeholders and beneficiaries. This list was compiled using project documents that articulated the beneficiaries and stakeholders of the Mbare ASRH project. The list was shared with MSF prior to the field visit, and amended after consultation with the project team, to ensure as much as possible maximum representation in the study sample. Guided by emerging data and field visits, additional participants were added as appropriate (Annex 4: Evaluation Participants). MSF was responsible for participant recruitment and participants represented the groups:

1. Implementing partners/collaborators
2. Adolescents including subgroups (HIV+, LGBTQI, substance users, Young People Selling Sex (YPSS, general)
3. Community members/care workers
4. Caregivers/Guardians
5. Teachers
6. Mbare ASRH project staff
7. Mbare Polyclinic staff and
8. Key informants including representatives from community organisations, community leaders, leadership from Harare City Health Department and Ministry of Health.

Data collection and analysis for this component of this evaluation was iterative so that emerging themes were explored during subsequent data collection. The aim of these interviews was to understand what social, cultural, political, and logistical factors impede or facilitate how the Mbare ASRH project components were implemented, and how beneficiaries were able to engage with and adopt aspects of the project. In addition, data collected from stakeholders was to ensure maximum understanding of factors expected to influence the effectiveness of the project.

SAMPLING AND RECRUITMENT

Purposive sampling was adopted to reflect issues emerging from other data sources or context. Purposive criteria may include age, ASRH access, sexual history, HIV status, type of contraceptive use, marital status, subgroup, and educational status. Both purposive and snowball sampling were used to recruit stigmatized subgroups (e.g., YPSS, substance users, LGBT). Demographic information was collected for all sampled adolescents. Adolescents and Young People (AYP) who stay in Mbare (or elsewhere) and did not interact with the Mbare ASRH project were not included in this evaluation. A list of interviewees for this evaluation is presented in Annex 4.

FOCUS GROUP DISCUSSIONS

Focus Group Discussions (FGDs) were conducted to elicit group level data on cultural norms and to generate a broad overview of issues of concern to the cultural groups or subgroups being represented. Participants were selected by the MSF team and research assistants. They were all invited in advance. FGDs were tape-recorded, and field notes were taken. Between March 1st and 31st, nine FGDs with a total of 75 individuals were conducted with the following subgroups: Adolescents & youth (n=6 focus groups), community members (n=1), peer educators (n=1), and caregivers/guardians (n=1) (see Annex 4). Each focus group had 6-10 participants and lasted between 55 to 120 minutes.

SEMI-STRUCTURED INTERVIEWS

Semi-structured interviews were used to collect individual histories, perspectives, and experiences – and were important when exploring potentially sensitive topics. IDI questions and topic guides were developed to guide data collection and were adapted for each sub-group of interviewees. IDIs were tape-recorded and translated interview summaries were written up. Between March 1st and 31st, sixty-six semi-structured interviews, were conducted with the following subgroups: Adolescents & youth (n=34), health providers (n=7), peer educators (n=7), caregivers of adolescents living with HIV (n=3), key

informants (n=3), and stakeholders/partners9n=7) (Annex 4). Each interview lasted between 20 and 120 minutes.

NON-PARTICIPANT OBSERVATIONS

Non-participant observations were used to provide a holistic understanding of the intervention. Observations were an opportunity to check non-vocal cues, see interactions between participants, and see how these interactions and activities occur. Eight semi-structured non-participant observations were conducted by the research assistants and youth researchers at the Adolescent Corner (AC) and Matapi Youth Hub. Observations included client flow into the spaces, as well as different types of interactions between adolescents and staff. The team took field notes that included an accounting of the session, participant behaviours and conversations, relationship dynamics present, the evaluator's subjective responses to what is going on; and any other details that would complete the observation story. Observations of situations that participants described in interviews allowed for data triangulation, and mitigated any distortions, misinterpretations or inaccuracies in descriptions that may have been provided during interviews.

QUALITATIVE DATA ANALYSIS

Thematic data analysis was used to identify key themes and concepts on implementation, mechanisms of change and context of the intervention; as they relate to the appropriateness, effectiveness, connectedness, and sustainability of the Mbare ASRH project. A key thread in the analysis was to describe the intervention as it is happening and being experienced by its beneficiaries. The domains of investigation acted as the initial deductive codes with careful attention being paid to emerging codes and themes. Using iterative thematic coding, emerging ideas were labelled and grouped into themes as patterns emerged. Attention was paid to understanding what and how intervention components were perceived to have occurred. There was also an analysis of how the AFSRH components were taken up, or not, in practice; as well as understanding the health system and contextual interactions with the intervention. The evaluation team conducted weekly meetings to share findings from the previous week and inform any recruitment for the following week or adaptations in data collection tools.

IMPACT MODELLING MEETING

After the two data collection phases, an impact modelling meeting was conducted on April 26, 2021, as part of the data collection and analysis phase. This meeting was meant to bring together 12 stakeholders and partners (Annex 4: *Evaluation Participants*) who had been interviewed during phases 1-2 of data collection, to share key findings and collaborate on how to make the Mbare ASRH project stronger based on the key findings. This meeting did not include any key MSF management staff in order to foster an environment where power hierarchies were reduced, and stakeholders could speak freely about the project. Of the 12 invitees representing 11 stakeholders/partners, 7 confirmed they would attend the impact modelling meeting. Only 4 out of 12 stakeholders showed up for the meeting and fortunately they represented key domains of the project and this evaluation (advocacy, community, family planning and vulnerable sub-groups). The evaluation team shared some key findings (both quantitative and qualitative) with the partners, especially they related to the partnerships/ connectedness and adolescents' experiences of these partnerships. Partners were also invited to bring

any of their own data or findings that they have been collecting on their partnership with the Mbare ASRH project. None of the attendees brought presentations of their own programs. The goal was to raise discussion, learning and recommendations. The attendees contributed to a lively discussion about what is working or not working for providing services and programs for adolescents. They articulated the parts of the Mbare ASRH project that are working well, challenges and opportunities that they face in their own work with adolescents and how that marries to the findings of the evaluation. Learnings from this meeting have been weaved as part of the analysis in this evaluation. Overall, the meeting did not change the emerging key findings and recommendations of the evaluation project but rather provided clarity, nuance, and context.

ETHICS

The evaluators signed the SEU Ethical Guidance prior to the commencement of this evaluation. In summary, the evaluators declare no conflicts of interest and have followed all guidance outlined in the SEU Ethical Guidance to ensure respect for dignity and diversity, fair representation, confidentiality, avoidance of harm for MSF staff, evaluation stakeholders and clients.

All participants who took part in this evaluation provided verbal consent prior to the interview. Adolescents younger than 16 years were required to provide written guardian/parental consent (Annex 3: Consent Forms). Where consent was not provided no data was collected from the participant in question. No participants withdrew consent. Additional considerations were made for any interviews with vulnerable population groups such as minors involved in commercial sex, minors with MH problems including substance use. For each of these sub-groups the evaluators made a case-by-case assessment to ensure participants are protected and able to independently provide consent. Two interviews with adolescents living with disability could not be conducted due to the nature of their disabilities (deaf; extreme mental illness) which limited the RAs' ability to interact with them.

LIMITATIONS

COVID-19 IMPACT

Due to the ongoing COVID-19 pandemic which has resulted in national lockdowns there were concerns that some components of this evaluation may be affected. It was not possible for the evaluators to conduct a field visit prior to the completion of the inception report and data collection was compressed to one prolonged period during March 2021. However, through support from MSF it was possible for the evaluation team to conduct all evaluation activities with no disturbances within the evaluation timeline.

QUANTITATIVE METHODOLOGY

The proposed methodology for the secondary data analysis relied on the use of routine data from the facilities in Mbare. Although full support of the MSF staff was received it was not possible for evaluators to assess the uptake of referrals as this data was not available from MSF. While the provided database captured where participants were referred there was no available dataset describing the outcome of the referrals. As such the evaluators have provided only summary data of referrals made.

Some indicators were not captured in the provided databases including the adolescent subgroups (YPSS, substance users and LGBTQI). The evaluation was therefore unable to present any data on uptake of services by vulnerable adolescent groups. Although MH and substance use are main areas of the Mbare ASRH project data on uptake was not consistently available for the 5-year period being evaluated. This may be due to changing datasets or inconsistent data capturing. Where available data has been presented as part of the quantitative findings.

Data entry errors were noted in the datasets including (but not limited to) provision of ANC services to males and birth dates inconsistent with entered age category. For age categories the evaluators preferentially used the date of birth when it was in conflict with the age category. Where ANC or family planning services were provided to males this data has been kept as is for purposes of this report. It is also important to note that although reported as a service taken up, ANC services are not provided directly by the Mbare ASRH project but an adolescent requesting these services is referred out of the project to the nearest clinic. For this report all quantitative data on ANC uptake (referrals) is reported as a service consistent with the provided datasets.

The evaluators noted that some indicators were added at different time points during the course of the project. Such denominators varied but it was not clear in the datasets when exactly indicators were added and why. The change in data collection points appears to have been ongoing throughout the duration of the Mbare ASRH project. As such this could not be mitigated, and where available data is presented as is to avoid multiple changes in denominators. Furthermore, in some instances data points were not captured consistently. Consequently, uptake figures did not tally with clients seen e.g., uptake of HIV testing and method of HIV testing. Again, this could not be mitigated, and data is presented as is but accompanied by explanatory footnotes in the tables. Provided datasets were anonymized and as

a result the consultants could not track individual clients and the services they have received, particularly in the 2021 dataset where there may have been duplications. All data reported is therefore based on contacts (consultations) with the Mbare ASRH project and not per individual. As such for this evaluation the number of repeat consultations per individual could not be ascertained. In order to mitigate against additional data duplication, the evaluation team shared all quantitative findings and met with the MSF data manager as part of the synthesis of this report to verify datapoints and the findings presented in this report. Where discrepancies were noted the evaluation team and the data manager worked backwards to reconcile the data.

Although it was reported that menstrual health products became available to clients in 2019, uptake of menstrual hygiene products was not recorded in the provided 2016-2019 database. A report provided from the MSF team dated 9 May 2019 states that 245 menstrual cups were distributed in 2019. This data has not been reported as part of the quantitative findings as it is not part of the databases included in the secondary analysis of this evaluation. Furthermore, some outreach data prior to 2021 was collected only on paper forms and as such not captured as part of this evaluation. As a result, the reach of outreach activities particularly health education may be underreported in this report.

Due to the nature of the provided datasets, it was not possible for the evaluators to link databases nor link individual clients to the services taken up, this would have been useful to track adolescents who test HIV positive and their HIV treatment and care records to ascertain individual outcomes and uptake of other ASRH services. So, for this evaluation the four provided datasets had to be analysed separately as it was not possible to link them. Where possible the evaluators have combined findings and present data together.

QUALITATIVE DATA COLLECTION RECRUITMENT

MSF staff led in the recruitment of FDG and IDI participants. While this is a standard practice and was in this case necessary to meet evaluation targets and timelines there is the possibility of recruitment bias. To try and mitigate this, the evaluation team also conducted some independent recruitment when they were at the Mbare ASRH sites: about a quarter of adolescent participants were independently recruited by the evaluation team. As such the participant sample was a mix of MSF and independent recruits.

The evaluation team faced some challenges with recruiting some key informants and adolescent sub-groups for interviews. For key informants, this was due to conflicts in scheduling and the short timeline for the evaluation. Where possible alternate stakeholders were recruited. Adolescent sub-groups that were difficult to recruit included those who were living with HIV as their contact details were incorrect; and some of them came to the AC but did not actually stay in Mbare. Yet still some adolescents worried about being stigmatised and did not want to be as associated with anything to do with their HIV status. To mitigate against leaving out this sub-group the evaluators re-scheduled interviews with adolescents living with HIV to their ART refill dates which were after the main data collection phase. The focus group for adolescents living with HIV was conducted on March 30th, 2021.

Mbare Polyclinic staff could not participate in an FGD because Harare City Council health providers were on strike during the evaluation period. Individual staff that were available were approached to participate in semi-structured interviews instead.

FINDINGS

QUANTITATIVE FINDINGS

This section provides a summary of the secondary data analysis and aims to provide an overview of the coverage of the Mbare ASRH project. Findings are stratified by sex, site, year, and age category where necessary. In order allow for contextual interpretation of the quantitative data both qualitative and quantitative findings are discussed as part of the qualitative findings (Section on *Appropriateness*, *Effectiveness* and *Connectedness & Sustainability* below). Within this section (on *Quantitative Findings*) only descriptive summaries of the quantitative data are presented.

KEY MESSAGES

- Service uptake for the Mbare ASRH project has increased gradually over the 5-year period of this evaluation and only dipped in 2020, likely due to COVID-19. This increase in uptake reflects a needfor the services provided by the project in Mbare.
- Uptake of services by younger adolescents is low. This may be as a result of barriers to accessing services such as the requirement for parental consent, lower need for OPD and SRH services or no knowledge of available services.
- Contraceptive care and OPD services were the only services with increased uptake in 2020. There may be missed opportunities for service comprehensive service provision among adolescentsattending the project.
- There is limited data available on the outcomes of referrals made from the project. This is a critical gap in data capture. Tracking outcomes for referrals made such as those for ANC should be considered by the project.
- The HIV cascade can be improved. Although high, HIV testing rates have declined over the last four years.
- Although there is attrition among adolescents who are in HIV care; most adolescents who are in stillin care and have received a viral load test are virally suppressed. This is very encouraging for a difficult age group which often has very poor treatment outcomes.

UPTAKE AND DEMOGRAPHIC DATA

During the period from 2016-2020 the Mbare ASRH project has made 20,373 service contacts with adolescents and young people. The majority of these contacts were served at the AC (17 003,83.5%) followed by Outreach activities (2,047, 10.0%). The year 2019 had the highest service uptake overall and there had been a gradual increase in service uptake from 2016-2019 (Figure 2). Consistently over the five-year period most of the clients served were females (11,894, 58.4%) and in the 16 - 19 years age category (13,614, 66.8%) followed by the 13-15 years age category (3,157, 15.5%) (Table 2). The median age of service users in 2020, where data was available was 17.7 years (IQR 15.8-19.1).

Table 2. Uptake of services stratified by year.

INDICATOR		TOTAL	YEAR, N (%)				
			2016	2017	2018	2019	2020
Tot no (N): Adolescents		20373	1533 (7.5)	2688 (13.2)	4527 (22.2)	6430 (31.6)	5195 (25.5)
OPD services		8494 (41.7)	610 (39.8)	910 (33.9)	1504 (33.2)	2653 (41.3)	2817 (54.2)
Site	AC	17003 (83.5)	1272 (83.0)	2461 (54.4)	4360 (96.3)	5279 (82.1)	3631 (69.9)
	Outreach	2047 (10.0)	261 (17.0)	227 (5.0)	167 (3.7)	1151 (17.9)	241 (4.6)
	Matapi	1323 (6.5)	-	-	-	-	1323 (25.5)
Sex	Male	8479 (41.6)	727 (47.4)	1131 (42.1)	2091 (46.2)	2672 (41.6)	1858 (35.8)
	Female	11894 (58.4)	806 (52.6)	1557 (57.9)	2436 (53.8)	3758 (58.4)	3337 (64.2)
Age groups (years) *	<10	30 (0.1)	-	-	-	-	30 (0.6)
	10-12	1921 (9.4)	342 (22.3)	395 (14.7)	400 (8.8)	652 (10.1)	492 (9.5)
	13-15	3157 (15.5)	334 (21.8)	605 (22.5)	576 (12.7)	774 (12.0)	868 (16.7)
	16-19	13614 (66.8)	857 (55.9)	1688 (62.8)	3359 (74.2)	4364 (67.9)	3346 (64.4)
	20-24	1202 (5.9)	-	-	167 (3.7)	610 (9.5)	425 (8.2)
	25+	89 (0.4)	-	-	25 (0.6)	30 (0.5)	34 (0.7)
Services **	HIV testing	12072 (59.3)	1204 (78.5)	2263 (84.2)	3383 (74.7)	4266 (66.3)	956 (18.4)
	Condom uptake	524 (2.6)	41 (2.7)	62 (2.3)	22 (0.5)	34 (0.5)	365 (7.0)
	Menstrual hygiene***	224 (1.1)	-	-	-	-	224 (6.7)
	Family planning***	2014 (9.9)	24 (3.0)	138 (8.9)	166 (6.8)	239 (6.4)	1447 (43.4)
	STI treatment	1109 (5.4)	101 (6.6)	188 (7.0)	347 (7.7)	419 (6.5)	54 (1.0)
	Antenatal care	419 (2.1)	17 (1.1)	47 (1.7)	107 (2.4)	157 (2.4)	91 (1.8)
	Health education	7097 (34.8)	532 (34.7)	1373 (51.1)	2039 (45.0)	2623 (40.8)	530 (10.2)
	Mental health	228 (1.1)	-	-	53 (1.2)	11 (0.2)	164 (3.2)
	Psychosocial support	92 (0.5)	-	-	-	-	9 (1.9)
	Drug abuse	73 (0.4)	-	-	25 (0.6)	6 (0.1)	42 (0.8)

* 2020 Median Age (IQR) 17.7 (15.8 - 19.1). Not available for 2016-2019 as data was grouped into age categories and date of birth not available for all records.
** Total does not equal the total number of adolescents as individuals could get more than one service.
*** The denominator used is the total number of female clients attending in that year

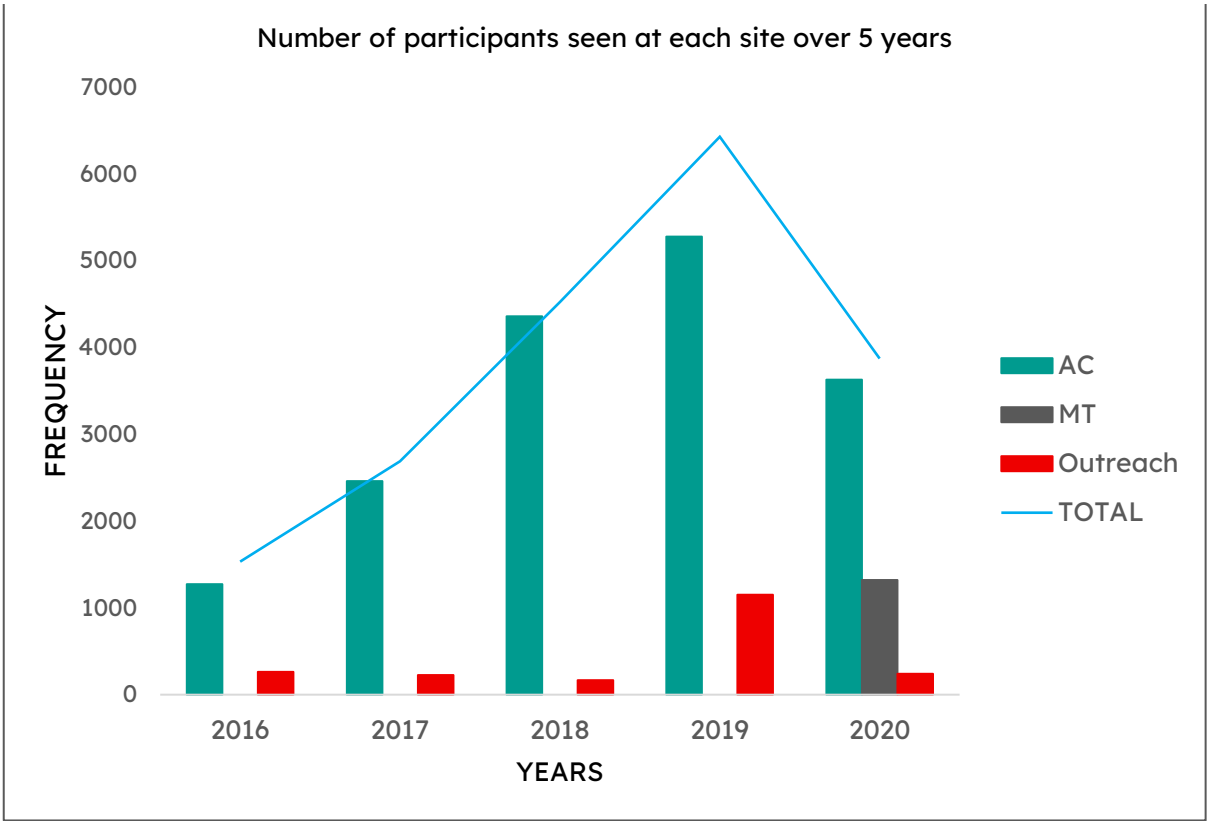

Figure 3. Number of participants seen each year by site.

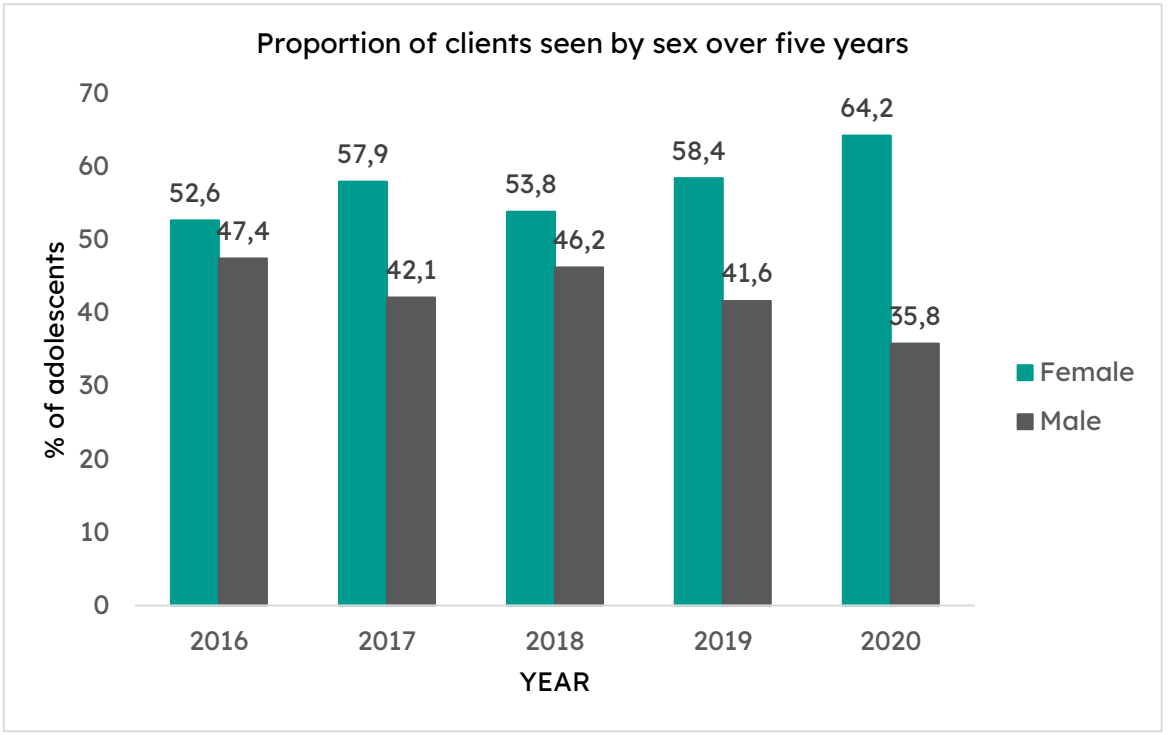

Figure 4. Proportion of clients seen by sex over five years.

Uptake of services by younger adolescent is very low. Possible reasons for this include: 1) requirements for consent which act as a barrier to service uptake, 2) they are unaware of ALL the Mbare ASRH services available to them, or 3) younger adolescents generally do not seek OPD and ASRH services when compared to older age groups. Some of these possible explanations for the low uptake of services by younger adolescents specifically, could not be confirmed by qualitative data collected through this evaluation.

From 2016 - 2019, the majority of clients contacts accessing any of the Mbare ASRH services took up HIV testing services and received health education (Table 2 and Figure 5). However, in 2020 there was a shift and the uptake of contraceptive services by female clients increased from 6.4% in 2019 to 43.4% in 2020. Contraceptive care was the only SRH service that had an increase in uptake in 2020. Prior to 2020 the uptake of contraceptive care among females had ranged from 3%-8.9% (Table 2). In 2020, the project began implementing a 3-pillar family planning care strategy; and the COVID-19 pandemic may have increased the need for family planning services via the Mbare ASRH project to protect against unintended pregnancies as other services may have been available and difficult to access due to COVID-19 lockdowns. These two events may be responsible for the sharp increase in family planning service uptake within the project. Health Education has the second highest uptake until 2019 as there was also a significant drop in health education uptake in 2020. Only 10.2% of client contacts with the project received health education in 2020.

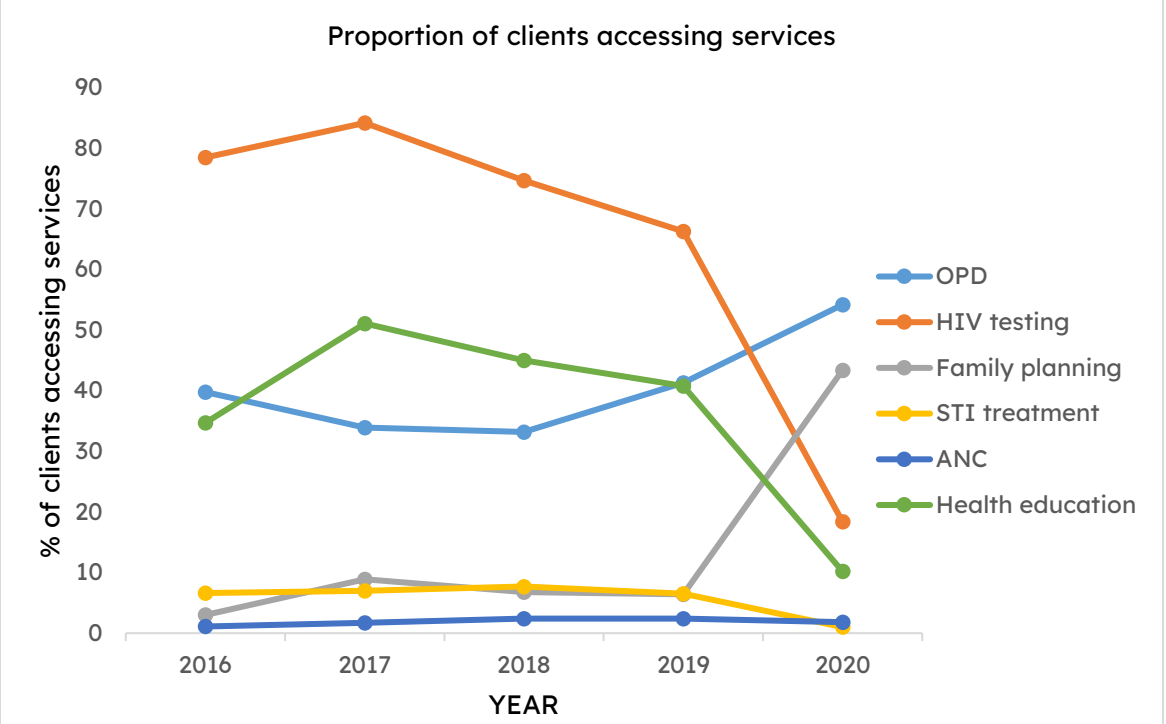

Figure 5.Proportion of adolescents accessing services*
*Note: Only services with available data for the 5-year period presented in this figure. Condom uptake excluded due to low uptake.

Generally, there is low uptake of condoms; over the 5-year period uptake has ranged from 0.5% to 7.0% (Table 2). Condom uptake of 7.0% was recorded in 2020 and was a significant increase from 0.5% uptake in 2018 and 2019. From 2016-2019, uptake of condoms was highest among females. In 2020, males had the highest uptake when compared to females (81.6% vs 18.4%). It is possible that this is due to males receiving condoms being mistakenly recorded as having received family planning services from 2016-2019 or inconsistent data capture of condom uptake (Table 7). No data on menstrual hygiene was available from 2016-2019, however uptake in 2020 was 7.0% among female clients. Services such as referrals to ANC, MH and psychosocial support have low uptake (<5%) consistently throughout the 5 years where data was available (Table 2). The proportion of consultations for STIs has ranged from 6.0%-7.4% of consultations seen (Table 2, Figure 5). The highest proportion of clients treated for STIs was reported in 2020 (7.4%). In 2020 94.4% of clients treated for STIs were females, although generally more females have been treated for STIs than males since 2017 the disparity was greatest in 2020.

Overall, 8 494 (41.7%) client contacts accessing Mbare ASRH services have received OPD services (Table 2). The proportion of consultations accessing OPD services has steadily increased since 2018 (Figure 5).

In 2020, 54.2% of client contacts attending any of the Mbare ASRH services accessed OPD services (Table 2). When assessing uptake of services by age, most client consultations in the younger age categories access OPD services (78.6%, 10-12 years and 60.8%, 13-15 years) whereas in the older age categories less than 35% of client consultations access OPD services (Annex 5: Table 8).

With the exception of HIV testing and health education, less than 2% of client consultations in the 10-12 years age group accessed any of the available SRH services (Table 8), however in the <10 years age group 4 clients (13.3%) required ANC services. Uptake of family planning services increases gradually with increase in age category from 1.4% in the 10–12-year age category to 21.1% in the 20-24 years age category (Table 8).

There is no data available on the uptake of services by vulnerable groups (LGBTQI, YPSS, young people living with disabilities, young people living on the streets) in the provided datasets. To understand the reach of the Mbare ASRH project to vulnerable groups, these data points should be added to the data collection tools.

REFERRALS

No data was provided for the outcome of referrals made from the project and entry of referral data in the provided datasets was inconsistent and difficult to track for this project. It was noted that referral outcome data was available for some services particularly FP/PAC however this was not provided to the evaluation team. Overall, 428 referrals were made out of the Mbare ASRH project (Table 3). Most referrals were for Hospital services (185 clients, 43.2%) followed by FP/PAC services (212 clients. 49.5%) with the highest number of FP/PAC referrals in one year occurring in 2020 (77 clients, 36.3%). Only 13 clients have been referred for voluntary medical male circumcision (VMMC). All VMMC referrals were made in 2018.

Table 3. Referrals outside the Mbare ASRH project.

UPTAKE OF REFERRALS	TOTAL	YEAR				
	N=428	2016	2017	2018	2019	2020
FP/PAC	212 (49.5)	-	16 (7.5)	71 (33.5)	48 (22.6)	77 (36.3)
PrEP	7 (5.2)	-	-	-	3 (42.8)	4 (57.1)
VMMC	13 (3.0)	-	-	13 (100)	-	-
SGBV	11 (2.6)	-	2 (18.2)	6 (54.5)	3 (27.3)	-
Hospital referrals	185 (43.2)	53 (28.6)	51 (27.6)	62 (33.5)	19 (10.4)	23 (12.4)

HIV CASCADE AND TB

Over the five-year period, 12,072 contact points (59.3%) were for HIV testing services. Overall HIV testing rates have declined over the same period with the steepest decline noted in 2020 (66.3% of clients tested in 2019 vs 18.4% of clients tested in 2020) (Figure 5). Over 98% of the clients seen via outreach activities in 2019 received an HIV test and in 2020 90% of clients seen via outreach were tested (Table 2). In 2017 and 2018, uptake of testing during outreach was 100%.

Where data is available (2018-2020) client uptake of HIV self-testing was preferred to rapid HIV testing in 2019 and 2020. Overall, there was missing data for HIV test method for 55.2% of HIV tests conducted. Among all HIV tests conducted 276 clients (2.3%) had confirmed HIV positive diagnosis and 171 (62.0%) were linked to care (Figure 5). HIV prevalence was highest in 2016 (3.7%) and lowest in 2019 (1.5%)(Table 4). Linkage to care was also highest in 2016 (33 out of the 44 clients who tested HIV positive (75%) were linked to care) and lowest in 2018 were only 55.8% of clients who tested HIV positive were linked to care (Table 4).

Table 4. Uptake of HIV testing services and HIV test outcomes.

INDICATOR		TOTAL	YEAR				
			2016	2017	2018	2019	2020
Total adolescents seen (N)		20373	1533	2688	4527	6430	5195
Adolescents tested		12072 (59.3)	1204 (78.5)	2263 (84.2)	3383 (74.7)	4266 (66.3)	956 (18.4)
Test method choice*	Rapid test	1842 (15.2)	4 (0.3)	-	1125 (33.3)	567 (13.3)	146 (15.3)
	Self-test	3572 (29.6)	-	-	652 (19.3)	2350 (55.1)	594 (62.1)
	Unknown	6659 (55.2)	1200 (99.7)	2263 (100.0)	1606 (47.5)	1349 (41.6)	216 (22.6)
Test results	Negative	11796 (97.7)	1160 (96.3)	2203 (97.3)	3297 (97.5)	4203 (98.5)	933 (97.6)
	Positive	276 (2.3)	44 (3.7)	60 (2.7)	86 (2.5)	63 (1.5)	23 (2.4)
Proportion of HIV positive adolescents linked to care (N=276)		171 (62.0)	33 (75.0)	36 (60.0)	48 (55.8)	40 (63.5)	14 (60.9)

*Not all tests have specification of the test method choice, so "n" does not equal the total number of tests.

Of the 659 adolescents who have been in HIV care in the project, the median age was 19 years (IQR 14-21) and their median duration on ART was 34 months (IQR 18-59). The majority of clients on ART are female (460, 69.8%) and the majority of adolescents were on first line adult ART either 1T3E (n=310, 48.9%) or 1T3O (n=133, 21.0%) regimens at last refill. Male adolescents are more likely to have ever had a viral load test 58.3% than female clients 42.0%. Most clients who had a viral load done (79.6%) were virally suppressed (<1000 copies/ml) at last viral load (Table 5). As of December 2020; 229 (34,7%) clients were no longer receiving care as part of the program. Among them 17 (7.4%) had passed on, 89 (38.9%) were lost to follow up and 123 (53.7%) had transferred out.

Overall, 12 adolescents have received TB treatment from Mbare Polyclinic from 2016-2019. Most of them were female (9) and the median age at diagnosis was 16 years (IQR 15-18.5).

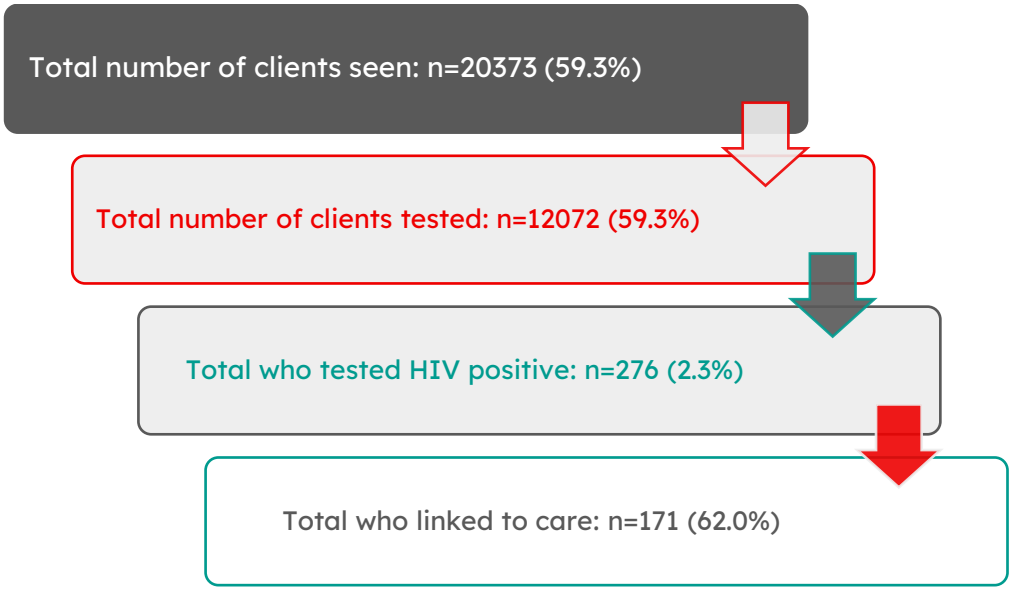

Figure 6. HIV testing and care cascade 2016-2020.

Table 5. Characteristics of adolescents living with HIV.

INDICATOR		TOTAL (N=659)	FEMALE (N=460)	MALE (N=199)
Birth age, median (IQR)		19 (14-21)	19 (16-21)	17 (9-20)
Age at ART initiation, median (IQR)		16 (12-18)	17 (13-17)	12 (6-19)
Method into ART, n (%)	New	548 (83.2)	395 (85.9)	153 (76.9)
	Transferred	86 (13.1)	52 (11.3)	34 (17.1)
	Missing	25 (3.8)	13 (2.8)	12 (6.0)
Duration of ART (months), median (IQR)		34 (18-59)	31 (17-52)	48 (24-80)
Performed viral load, n (%)	Yes	309 (46.9)	193 (42.0)	116 (58.3)
	No	350 (53.1)	267 (58.0)	83 (41.7)
Last viral load, n (%)	<1000 copies/ml	246 (79.6)	155 (80.3)	91 (78.5)
	≥1000 copies/ml	63 (20.4)	38 (19.7)	25 (21.6)

APPROPRIATENESS

This section presents the findings on how appropriate the Mbare ASRH project is in meeting the needs of adolescents and different subgroups of adolescents. Appropriateness addresses the accessibility, quality, implementation, and beneficiary experiences of the Mbare ASRH project (Research questions 2, 3, 4, 5, 6, 8, 9 in the evaluation matrix) and the extent to which MSF's strategy (and model of care) contributes to achieving project objectives (Research questions 11, 12, 13 in the evaluation matrix). Barriers and facilitators to accessing components of the project are also presented as they align to appropriateness. The Mbare ASRH project is either directly providing or facilitating the provision of family planning, ANC, PAC, HIV testing, linkage to care, ART treatment and adherence support, TB screening and diagnosis, and menstrual health services, OPD services, mental health services, STI treatment and symptom management services, underpinned by health education, promotion, and community engagement activities – Figure 6 gives a representative visual of the project components.

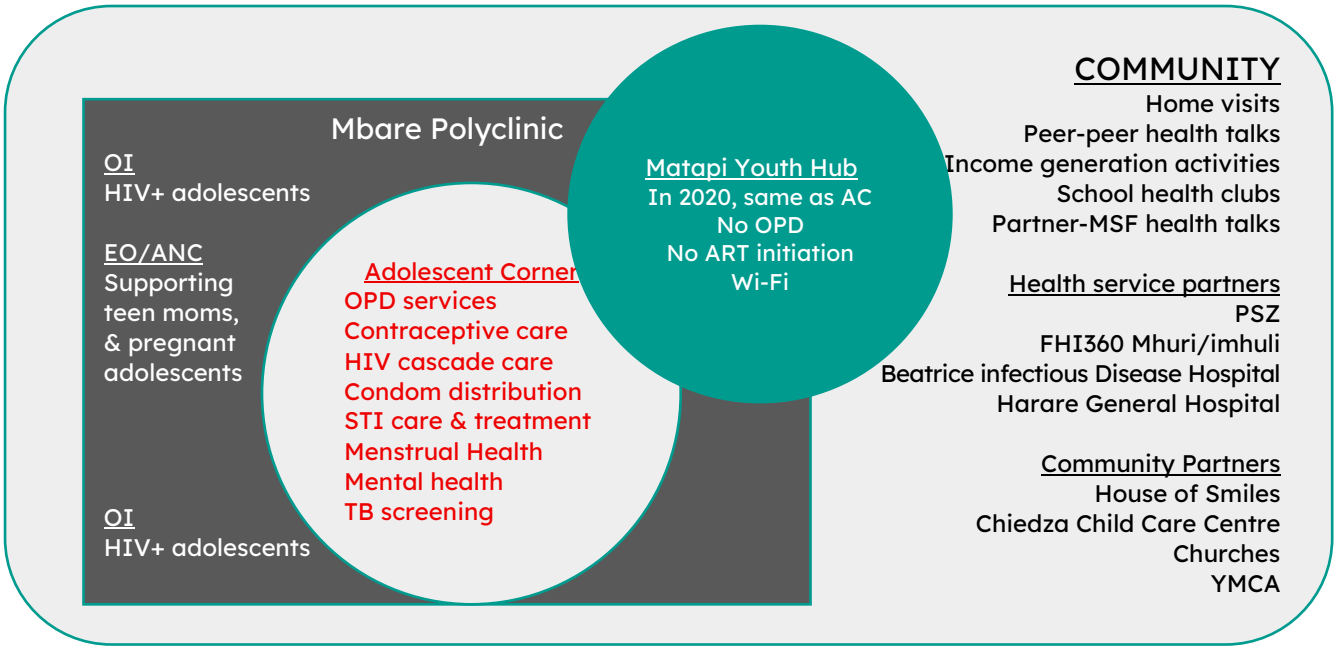

Figure 7. A visual representation of project components and how they interact with each other.

KEY MESSAGES

- The community activities (mobile clinics, peer-to-peer engagement, home visits, partnerships with churches, school health clubs, and income generating activities) in the project appropriately sensitise the community and mobilises parts of the target populations (10-24 years old) to access SRH, mental health, TB and HIV services at Matapi and the Adolescent Corner (AC). The sensitisation and mobilisation of very young adolescents (10-15 years) may not be adequately appropriate as the project faces legal barriers that prevent independent (no caretaker) access to SRH services for minors.
- Peer educators are the cornerstone of community activities. Despite the age differences between peer educators and adolescent peers, adolescents find engaging with the PEs appropriate for improving their knowledge of what the Mbare ASRH project has to offer them.
- Key population adolescents find peer-to-peer engagement in the community to be challenging as this might result in unintentional disclosure. For them, a KP peer educator is likely disclosed and known in the community as KPs and a peer educator. If the adolescent is seen engaging with this KP-peer educator, then community may label and stigmatise the adolescent. The project needs to collaborate very closely with KP organization in Mbare and Zimbabwe to co-create a strategy that reaches key pops adolescents and allows them access to SRH without adding further risk and harm.
- The school health clubs are overall considered highly appropriate and needed by the school teachers and the adolescents who participate in them. Some school teachers do not find some of the content in the health clubs' curriculum to be appropriate (contraception). Sensitisation of and collaborating with teachers on the curriculum could improve acceptability and penetration of the school health clubs
- Income generating activities were found to be appropriate for improving the wellbeing of adolescents, particularly the teen mothers. There is room and scope to offer diverse income generating activities to ALL adolescents who are interested in income generating activities.
- COVID-19 pandemic provided an opportunity for the project's health promotion activities to become digital. The project can harness this opportunity, where with the availability of data, digital health promotion activities may potentially reach more adolescents in Mbare and beyond.
- Overarchingly, the services at the AC and Matapi are considered appropriately youth-friendly (Figure 2). There are areas for improvement which include, providing SRH services to unaccompanied minors; not having long waiting times during lunch hours; not having adolescents and the parents/guardians of accompanied minors wait in the same space; and as much as possible not having to refer or transfer clients from Matapi to the AC.

Cont'd. →

- There are age discrepancies between peer educator (18-22 years) and the peers they mostly engage with (10-19 years). This challenges the notion of 'peer educator' and peer-to-peer engagement as it is widely understood. However, the adolescents find their interactions with the peer educator to be appropriate and beneficial and they do know them as peer educators of MSF in the community. While it might be prudent to change the name of these peer educator to community health workers for example, it could create unintentional tension as the connotations of what a CHW is, differs from what a peer educator is. The project may want to define what a 'peer educator' is in the context of this project and disclaim this definition across project documents and presentations.
- There are existing hierarchies between the peer educators and other MSF staff which diminishes their contributions to program decision making. Meaningful adolescent/beneficiary involvement (not peer educators) in the decision making on project implementation, outcomes, improvements etc. is currently not adequately implemented in the project.
- The strategy for improving access to the Mbare ASRH project for key populations and other highly vulnerable groups has been under review since late 2020. The project is currently learning and implementing how to best serve with population cohort that encompasses diverse subgroups like young people selling sex, LGBTQI who have different needs. Key pops focal persons will need to be part of the project staff, to best serve this group.
- The success of the Mbare ASRH project is dependent on strategic partnerships. Staff considered these partnerships appropriate because partners can provide quality services in their niche areas. This can be challenging when/if other partners' agendas and strategies do not align with MSF-for example for other partners, youth friendliness is not a priority.

COMMUNITY ENGAGEMENT: SENSITIZATION AND MOBILIZATION FOR ACCESS TO COMPREHENSIVE HIV & SRH SERVICES

There is consensus that it is important to use community-based engagement activities to generate demand and community support for adolescent sexual and reproductive health services (28). The Mbare ASRH project aligns with this consensus by having a multicomponent community strategy that is linked to the facility-based programming (see section *Peer Educators: At The Intersection of Facility and Community Activities* in the chapter on *Appropriateness* below). The community activities (mobile clinics, peer to peer engagement, home visits, partnerships with churches, school health clubs, and income generating activities) in the project appropriately sensitise the community and mobilises parts of the target populations (10-24-years old) to access SRH, MH, TB and HIV services at Matapi and the Adolescent Corner (AC). The sensitisation and mobilization of very young adolescents (10-15 years) may not be adequately appropriate as evidenced by the uptake indicators outcomes (Table 2) and further discussed in section *Appropriately Accessing Health services at The AC* below.

The Peer Educators (PE) are the cornerstone of community engagement activities; and the acceptability of community activities varies in the different adolescent subgroups that are the target population. The general adolescent cohort finds the peer-to-peer engagement with the PE acceptable for informing

them about the services and/or commodities (menstrual products) that are available at the AC or Matapi. Most of the interviewed teen moms or pregnant adolescents, mentioned that they heard about the AC and free ANC services from PE who approached them in the community. The PE find it challenging to locate the adolescents living with HIV in the community. The HIV+ adolescents leave false contact details, as many of them have not disclosed their status to their guardians. This makes it difficult for PE to do follow up home visits. The key population (KP) adolescents, particularly YPSS and LGBTQI adolescents find engaging with PE in the community somewhat uncomfortable as it may result in unintentional disclosure. The PE-YPSS, and PE-KP may be recognisable in the community as YPSS and LGBTQI such that when they are seen talking to peers, it may become obvious that the peers are also YPSS and LBTQI. The engagement with peers is generally acceptable and triggers adolescents to visit the AC and Matapi. For especially vulnerable and high-risk subgroups of adolescents, this engagement may require more nuance, privacy, and confidentiality i.e., further adaptations to the models of adolescent care.

School health clubs have been known to contribute to improved knowledge and information of SRH (28). In the Mbare ASRH project, this community engagement activity that is well received by both scholars and teachers in the community. The school health clubs curriculum is disaggregated by age cohorts (10-15 years and 16-19 years) and the contents of the curriculum were developed using information needs from adolescents. MSF partners with schools to offer health information talks with students; and then sometimes also ferries students from the schools to the AC to access HIV testing services. The combination of PE and schoolteacher facilitators, and distribution of menstrual products at the schools increases uptake of the curriculum. The content of the curriculum may not be completely acceptable by some of the teachers. Adolescents who have attended these sessions mentioned that their teachers sometimes follow up the MSF health club sessions telling them to *"forget about the family planning component"* because they *"are still too young to know about this*." More collaborative work and sensitisation with the schoolteachers could increase acceptability and delivery of the curriculum. The school health clubs are currently not offering the income generating activities which are part of the curriculum.

Income generating activities in the Mbare ASRH project include training adolescents on how to make soap, shampoo, and dishwashing liquid that they can resell to get capital for additional income generating activities of their choice. The Mbare ASRH project has an internal focal person responsible for organising the trainings/activities. Invited facilitators come and provide the training to teen moms. These income generating activities were added to the MSF ASRH project in 2020, were just starting to gain traction, and have been a success with the teen mothers. The teen mothers appreciate having a source of income to help take care of their children. Because of the COVID-19 pandemic, the activities have had to stop.

Due to the COVID-19 pandemic, health promotion activities like home visits, in-person peer-to-peer health education, and engagement with stakeholders like churches in the community had stopped at the time of this evaluation. This could also explain the low uptake of health education in 2020 (Table 2). Participants (adolescents and community stakeholders) noted the significance of these activities in increasing knowledge and information about the Mbare ASRH project's health services, particularly for OPD services and teen mom (ANC) support.
Most of the participants only knew the components of the project that is based on their needs, and there was poor knowledge of the overall project and its many components that benefit adolescents. The project adapted to digital health promotion activities to engage with adolescents during the

COVID-19 pandemic. The pandemic has offered an opportunity to accelerate and innovate the implementation of digital health solutions, and the project is well placed to do this. The pre-conditions of adolescents' high use of WhatsApp and Facebook, when data is available, has favoured uptake of these health promotion activities.

APPROPRIATELY ACCESSING HEALTH SERVICES AT THE AC

Adolescents come to the Adolescent corner (AC) to access free OPD, HIV, and SRH services also including TB screening and mental health services. Upon arriving at Mbare Polyclinic adolescents do not have to wait in line at the gates with the adults seeking polyclinic services. They are screened at the gate and let through to the AC, which is secluded from the rest of the polyclinic. The adolescents then wait at the gazebo to enter the AC and access services. Screening and registration are done by a health promotion officer (who is a capacity-built/experienced/seasoned peer educator), who welcomes, screens for eligibility, and inquires/assesses what services the adolescent requires, as well as provides some services such as HIV testing, reusable menstrual pads/cups and condoms. This registration is manually done on paper registers, which leaves room for data collection errors and inconsistencies. After registration, the adolescents then wait in the gazebo, until it is their turn to enter the AC. During the waiting time, adolescents could play pool (pre-COVID), or listen to health education talks from the health promotion officers and/or peer educators. In the AC, the majority of the general adolescents found the providers to be non-judgemental, with no negative attitudes and friendly. There is no internet at the AC, which inconveniences staff who need WIFI to remain engaged with other non-AC components and responsibilities of the project.

The services offered at the AC are contraceptive care (oral contraceptives, Depo-Provera injectable, implants, IntraUterine Contraceptive Devices (IUCDs), HIV testing and linkage to Care, STI testing and treatment, TB screening, mental health care, menstrual health management (MHM) and Out-Patient-Department (OPD) services. The services referred for, from the AC are PAC to PSZ or Harare Central Hospital), TB treatment (Beatrice Infectious Diseases hospital), and Antenatal care (Mbare Polyclinic-EO). There are other services that are conjointly offered between the AC and other stakeholders. In conjoined services, adolescents receive layers of the same (or parts of the same) service from the project and other partners. These services include HIV care & treatment (OI department - Mbare Polyclinic), Adherence Support (Zvandiri CATS - Mbare Polyclinic), teen mom clubs (ANC Mbare Polyclinic).

According to the law, younger adolescents (10-15 years), should be escorted by their guardians/ caregivers to seek services, and should not access health service like contraceptive care and HIV testing without parental consent. There were varied responses from the health providers on how they navigate these legalities. Some AC health providers said they use 'best interest of the child' to provide health services for unaccompanied 10 to 15-year-olds. This was inconsistent with responses from partner/stakeholder health providers who alluded that the AC generally erred on the side of the law and did not provide SRH services to unaccompanied 10- to 15-year olds, whereas the partners/stakeholders usually offer SRH services to the minors- no questions asked. These SRH findings contrast to the SGBV data which showed a great need for SRH services amongst young adolescents. It is also possible that this younger cohort continues to present to the SGBV clinic (formerly run by MSF and still at Mbare Polyclinic) for SRH services and does not come to the AC for these services. Because the AC provides legally age appropriate SRH information and services, when interviewed about SRH services at the AC, participants in this 10-15 age cohort had little to say about SRH services for themselves at the AC.

Older adolescents (16-19 years) find it inappropriate that the parents of 10 to 15-year olds sit in the gazebo with them. The guardians/caregivers wait outside, while their 10 to 15-year-old goes into the AC to access the services they need (usually OPD services). A 16 to 19-year-old can then come for SRH services, and while waiting in the Gazebo meets with caregivers who may be neighbours or friends of their parents and may judge them or ask them questions about coming to access SRH services.

Lastly, adolescents who arrive at the polyclinic during lunch hour, are not able to access services at the AC. While the AC is open during lunch hours, the Mbare polyclinic reception desk is not – and every adolescent must pass through the reception to get the clinic card stamped before moving on to the AC. PEs encourage adolescents to go to the AC telling them of youth friendly, readily available free services. According to the PE, sometimes the adolescents then get to the clinic site, and are met with people who have attitudes in the gazebo or are made to wait during lunch until the reception reopens. This diminishes the youth friendliness and no waiting time that adolescent clients were expecting. The AC also closes at 5pm, but the polyclinic closes at 3pm. This means that AC clients who come in between 4-5pm may not get services due to lack of a stamped card. Sometimes the AC staff will borrow and stamp clinic cards from the SGBV clinic (which has cards there so that their clients who have sensitive issues do not need to go to the polyclinic), so they can serve clients who come in between 3-5 pm after the polyclinic has closed. Additionally, the AC is also closing around 4pm and not 5pm, to allow staff to get home on schedule, but also shrinking service provision times for adolescents.

APPROPRIATELY ACCESSING HEALTH SERVICES AT MATAPI YOUTH HUB

The Matapi Youth Hub has a slightly different set up from the AC. It is located where the Matapi satellite clinic is located, and right next to the Matapi flats – where most of the adolescents who come to the Youth Hub stay. Due to this set up, the nurses and peer educators at Matapi know their target community and population quite well and use this knowledge to strategically offer (or not) services. For example, there are some adolescents who are known for coming to access condoms so that they can resell them in the flats, so the providers know when to/when not to offer this commodity. There is a risk that the project may be denying access to adolescents who need condoms. Having adolescents who are selling condoms from the project does not nullify these clients' need or use of the commodities. It may be worthwhile for the project to absorb this risk and cost and provide condoms to all adolescents who request for some.

The satellite clinic has been closed since Q1 of 2020 due to COVID-19. However, the Matapi Youth Hub remains open. The client flow and tone of service provision is also less medicalised at Matapi, when compared to the AC. At Matapi, the Youth Hub has social spaces for adolescents to engage with each other, with health information and also to use Wi-Fi, whilst waiting to access mostly preventative health services (less medicalised). The AC on the other hand has a more clinical set up geared towards providing full range of health services (more medicalised). Adolescents who come to Matapi are screened for COVID-19 at the gate where there is no waiting line of adults, and then make their way to the Youth Hub, were they wait outside. Outside has different waiting areas (benches scattered in the yard); as well as a well-hidden smaller gazebo where young people who are conducting HIV self-tests can wait. The Youth Hub has internet, and adolescents are given 30min WIFI vouchers to use whilst they are waiting to access services. Similar to the AC, a health promotion officer (who is an experienced seasoned PE) screens and registers adolescents outside, and only four adolescents at a time can be inside the waiting area of the Youth Hub before going to be seen by a nurse provider for services. Clients

who want HIV tests are given self-test kits (and get peer counselling and support from the health promotion officer) to go and test themselves outside in a benched waiting area that is hidden from prying eyes. When adolescents come as a group and access HIV self-testing, there is a risk of unintentional disclosure when all of them are conducting the self-test together outside in the smaller gazebo.

In 2020, as a response to COVID-19 mobility restrictions, a decision was made that the Matapi Youth Hub would temporally offer the same range of services as the AC, within its non-medicalised setting. From non- participant observations and field notes, the nurse at Matapi seems to mainly be there to offer mainly contraceptive services and her presence at Matapi was intermittent. Other nurse-offered services like OPD services, STI, and mental health services are not being offered at Matapi. Clients continue to be referred to the AC for these services-which is far. Peer educator provides services like HIV testing and menstrual health commodities are offered at Matapi. Adolescents who test positive for pregnancy at Matapi, after counselling with the nurse at Matapi, are peer-escorted to Mbare polyclinic for ANC if they decide to carry the pregnancy. Those who test HIV positive, usually would be initiated at Matapi satellite clinic, which is in the same compound as the youth hub, but this is currently closed. They are currently being escorted to initiate ART at Mbare Polyclinic. Initiating ART at a facility that is far from where one stays could decrease retention in care and result in defaulting due to the inconvenience of having to travel.

PEER EDUCATORS: AT THE INTERSECTION OF FACILITY AND COMMUNITY ACTIVITIES

Peer-to-peer engagement has been established as one necessary ingredient in multicomponent approaches increasing demand and community support for adolescent-friendly health services (28). The peer educators in the Mbare ASRH project are between 18-22 years old, at which point they graduate out and are provided with transitioning support once they are no longer peer educators. The definition of peer educators is that they should look like and be the same age as the peers/adolescents (10-19 years old). This is not how the peer-to-peer set up in the Mbare ASRH project looks like. To diminish power hierarchies, peer educators are considered MSF staff. Legally in Zimbabwe one can only be employed when they are over 18 years old. This determines the earliest age of a peer educator. Even with these age discrepancies, the peer educators are trained and expected to be adolescent-friendly/youthful to allow for engagement with peers. Despite some challenges and these age discrepancies, the peer-to-peer interactions are appreciated by the adolescents in Mbare and supported by the parents and community. Since the advent of COVID-19, peer educators are no longer conducting home visits. They now walk in the communities and approach adolescents during these walks. They have a flyer with information about the Mbare ASRH project and use this to guide conversations. Each peer educator is supposed to refer 50 unique individuals to the AC or Matapi each month. PEs have a smartphone-based app that they are supposed to use in the field to collect demographic & service information of clients they recruit. Not every PE has a smartphone. According to project staff, the PEs now use phones provided by MSF to populate data, but they did not think it was mandatory to use this app. The PEs also do not know what happens to the data. This might explain data anomalies in services like "health education" (Table 2), that are spearheaded by the PE. This community level data collected by the PE's would aid in realising what services adolescents are seeking, disaggregate by age and sex; and then comparing this to the services offered and accessed at the AC and Matapi for quality improvement. It would be important to train PEs on the importance of this phase in their work.

The community health promotion officers (one at AC and one at Matapi) are also peer educators and administratively and operationally considered more MSF staff than the rest of the peer educators. In the hierarchy of PE, the rest of the PE fall beneath the community health promotion officers. The general PE noted that in the community, adolescents view them as both their friends and also as associated with MSF. Adolescents know that they can talk to the peer educators about their problems, whilst also being aware that the PE would bring these issues to MSF and/or refer the client to the AC or Matapi for services. The presence of both this peer-to-peer engagement and a strong linkage system to the AC or Matapi demonstrates quality components of community engagement that can result in increased uptake of services. The PE feel like they are reaching saturation. When they approach clients in the community, clients are now telling them *"We've already met with one of your colleagues. We will come when we are ready"*. The PEs' curriculum could be strategic and have more targeted community engagement for hard-to-reach areas of Mbare and hard to reach adolescents to ensure that no adolescent is left behind when trying to access HIV, SRH, mental health and TB services.

In line with the family planning Care 3-pillar strategy, the PE constantly and consistently talk about contraceptive care in their health talks and peer-to-peer engagement. PE have flipcharts about the different kinds of contraceptive commodities which they use as part of their conversations with adolescents who have a history of being sexually active. The PE do not have flipcharts or notes about the rest of the HIV and SRH including mental health and TB services that are offered as part of the Mbare ASRH project. This difference in the intensity of health education/knowledge provided by the peer educators for family planning versus other services can have biased implications on the outcomes of the project. If the project entails to have successful outcomes for all health service components- then efforts must be made to have similar levels of intensity and information resources.

For decision-making contributions, PE felt that they are provided with opportunities to make suggestions like the "*colour of their t-shirts*". They also write report-outs of the issues that adolescents in the community talk to them about and these report-outs are used to inform the health talk sessions that the Mbare ASRH program then puts together. For them, power hierarchies are very evident at the AC. The PE at the AC feel like they have less power and are considered "lesser than" other staff like the AC nurses. At Matapi the hierarchy feels more diluted and the PE there see themselves as one/ part/ equal to MSF staff there. Beyond the peer educators, it was not evident how the adolescents themselves, have been involved in the design, implementation and/or assessment of the project.

According to the peer educators, the Mbare ASRH project may be resulting in some unintended consequences. In the peer educators' opinions, the ready access of free services may be encouraging risky behaviours because young people know they will get free STI treatment and ANC support. The YPSS now have unprotected sex (more money) because they are on PrEP and know they will get free STI treatment from the AC.

KEY POPULATIONS (AND HIGHLY VULNERABLE GROUPS): A CURRENT FOCAL POINT FOR THE MBARE ASRH PROJECT

The strategy for key populations (key pops) adolescent began in 2015 at the inception of the project but has been undergoing review and updating since the end of 2020. The Mbare ASRH project is still putting together the updated strategy for appropriately and adequately supporting this subgroup of adolescents. The PE-key pops only started working in January 2021. The PE-key pops will be the main point of contact with key pops adolescents and their role will include collecting disaggregated

information for key pops (new variable). Potentially as a result of this newness, the LGBTQI adolescents feel excluded from the Mbare ASRH system. Many of them are hidden in the Mbare communities and have not come out as LGBTQI. They are also unlikely to come out until they have passed the adolescence stage and are young adults. They do not come out as LGBTQI for many reasons including, fear of being chased away from home when they are still dependents, fear of the law and stigma associated with being LGBTQI. In effect the Mbare ASRH project may be missing out on this key demographic who have unique SRH needs. The key populations strategy intends to offer services up to 24 years old for key pops. This messaging would need to be included in the community sensitisation messaging, so that key pops who are over the 10-19-years old range are aware they can access service. According to participants, there has also been a rise in men who have sex with men (MSM), who do not necessarily identify as LGBTQI, but due to economic hardships, and MSM *"that is where the money is"*.

According to YPSS, there are some peer educators at Matapi and the AC who are judgmental and have negative and discriminatory attitudes. Because of this, YPSS who are already extremely vulnerable, will not come and seek the services that they need. One YPSS noted that she will only come to seek services if a particular PE is working at Matapi because this particular PE is non-judgmental. If any other PE is working, she will turn back from Matapi and go back home with her concerns until the non-judgmental PE is back at work. The PE also experience judgement and negative attitudes from parents when they go into the communities. Derogatory name-calling like *"you are the ones who work with sex workers!"* or *"you work with gays!"* are used to refer to the peer educators, stigmatising them for interacting with key populations that are already sanctioned by society. Within the project, peer educators who identify as key pops are not revealed/known to the rest of the peer educators and this maintains their privacy and confidentiality until they decide otherwise.

Some key populations, have felt unsupported and frustrated with their experiences at the AC. One key pops participant developed piles from his anus and was frustrated with the way the AC staff treated him. He informed the AC provider that he had never had anal intercourse before, but the providers kept insisting that it was not possible for him to have this condition without having had anal sex. He did not understand why the providers wanted him to confirm something that he had not done yet – even though he is gay. He went away without getting treatment. He eventually came back because he did not really have a choice – the condition kept coming back and he did not have money to seek care elsewhere. The LGBTQI clients felt like the AC providers do not know what to do with them. They also would prefer to have their own AC day to access health services as they felt that their issues were unique and different. Their gazebo experiences with other adolescents were sometimes uncomfortable. One LGBTI participant mentioned how during health talks in the gazebo a PE could call them a "he" when they prefer to be called "she" or they could be asked to share a relationship story between opposite-sex when they have only been in same-sex relationships.

According to the YPSS, the AC hours and some activities are not friendly for them, because they can get called at any time by a client, so they do not have time for any group activities or health information talks. YPSS want a night clinic or 24hr mobile clinic so that they can go to the AC for services, at their convenience, as currently the AC hours are not conducive to the sex workers' schedule and their clients.

While there may be some challenges, the Mbare ASRH project has an appropriate system and structures for supporting adolescents with disabilities. The AC has a ramp around the building to

facilitate movement for adolescents with physical disabilities. For disabilities, there were no identifiable educational and counselling tools in the project. Peer educators noted that they are unable to support adolescents with certain disabilities such as those with hearing impairments. When deaf or dumb adolescents need services, the project brings a translator or refers them to Lennard Cheshire. This can delay their access to services. Ideally, the translator and referral partner should have educational and counselling tools for this group of adolescents. For extreme disabilities that the AC cannot manage, clients are referred to Harare Central Hospital.

For adolescents who are substance users and those with mental health issues, one of the nurses at the AC is a trained mental health nurse who supports these clients by conducting mental health and substance use assessments and making referrals for cases that she cannot support through enhanced counselling. The Mbare ASRH project also used to have a psychiatrist who would come once a week to support mental health cases but has since stopped because of COVID-19.

MSF'S STRATEGY: COLLABORATION FOR INTEGRATION AND DIFFERENTIATED CARE FOR ADOLESCENT HEALTH AND WELLBEING

Globally, there is a consensus that addressing adolescent health and wellbeing requires a comprehensive approach that encompasses the socio-behavioural ecosystem of this population cohort. In this regard, having community and facility-based programming as part of the Mbare ASRH project facilitates such a comprehensive approach. The Mbare ASRH project, has gaps in the interlinkages between facility and community programming, which dilute comprehensiveness. The facility-based programming (AC and Matapi being open) is consistent and specified to happen on certain days and times. The community programming is less systematic and operationalized to be more reactive than proactive. Partners where quite open about how they want and invite MSF at their outreach events because MSF has the resources (mobile van, transport to take people to and from the event), whereas they do not. The MSF resources help partners meet targets like those for LARC, where a mobile van set up is necessary to provide such services.

Evidence from this evaluation shows that right now the Mbare ASRH project has particular focus on the 3-pillar family planning strategy (family planning, ANC, and PAC), while the rest of the HIV, MH, TB and SRH services present as transversal and secondary services. This partly explains by the marked decline in HIV testing and Health Education and the increase in Family Planning uptake in 2020 (Table 2 and Figure 5) as contraceptives are offered in all three pillars of the family planning strategy. Mbare OI department noted that they sometimes get HIV+ adolescents who, after coming through the AC, want family planning services. They do not refer this client back to the AC, but instead refer them to FHI360's Mhuri/Imhuli program in the community, where they are given contraceptives. A participant articulated that the AC right now is particularly focused on the contraceptive care strategy and on pregnant teens and teen moms. According to her, an HIV+ client who wants contraception should not be missed by the AC (not enough counselling or conversation during the AC consult) only to be counselled and referred to a different program during the OI counselling sessions. In a separate data collection event, project staff noted that this was unlikely to happen between the AC and the OI, i.e. an HIV+ client who desired contraceptives would be sent back to the AC. The evaluation established that the AC is more likely to make decisions on the side of the law (see section *Appropriately Accessing Health Services at The AC* in the chapter on *Appropriateness*), and for HIV+ adolescents <15years old desiring family planning may end up at Mhuri/Imhuli where they provide these services-no questions asked.

The success of the Mbare ASRH project's health services strategy is also heavily dependent on partners' (PSI, PSZ, FHI360, Zvandiri etc) contributions. This strategy has some strengths and some weaknesses. A strength is that partners in this adolescent service provision consortium do not have to do everything to address the adolescent's ecosystem, but can instead focus on providing few high-quality services, and then refer the adolescent to partner organizations for other high- quality services. A weakness is that every organisation has their own outcomes, impact targets, and service delivery models, that may not necessarily be aligned or complimentary to MSF's strategy. For example, MSF's strategy and focus is on quality youth-friendly service-provision (Figure 1), whereas some of the partners clearly stated that adolescent youth-friendliness is not a focal point for them in their work. As such, youth friendliness may become diluted as the adolescent is referred from one partner to another which can have negative implications for retention in care and access.

All the established components of quality youth-friendly service provision (Figure 1) are present in the Mbare ASRH project. Some components (waiting times, adolescent only space), more than others, need strengthening. The recommendations below offer some suggestions.

Recommendations on Appropriateness

- In the training curriculum for Peer educators, have refresher trainings around health topics as needed, and supporting especially vulnerable and high-risk groups of adolescents.
- There is potential to train staff (including peer educators) in baseline communication (sign language for example) tools for deaf or dump adolescents.
- If the Youth Hub is to offer the same intensity of health service provision as the AC, then the hub should always have adequate commodity stocks and trained human resources to successfully do this.
- Consider having a separate waiting space/area for the guardians/caregivers of 10-15-year-olds.
- Internally, the MSF ASRH project needs to pick a side between erring on the side of the law or on the side of the 'best interest of the child' and then ensure that every provider and employee of the project is well versed and trained in how best to support unaccompanied minors who come are seeking care so that services are offered to ALL adolescents who need them.
- Collaborate and exchange data with the SGBV clinic. The ado project was born out of findings at the SGBV clinic, and there are likely some adolescents accessing the SGBV clinic who would require AC services and vice-versa. There is currently no obvious evidence of continued collaboration with the SGBV.

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- Collaborate with partners like Gays and Lesbian association on Zimbabwe (GALZ) to guide the strategy development for Key Pops in the Mbare ASRH project. Actively engage the key pops adolescents that they know now as part of the strategy formulation, activities, and plan. Consider having separate days, for key pops to access services. As part of the strategy for key pops: LGBTQI adolescents want a provider who is extremely aware and trained on their SRH issues. The adolescents in this subgroup should be informed/sensitised about the availability of this provider, knowing that when they mention certain things, the provider knows exactly what they are talking about and can support them.

- Services should be offered at all hours. Adolescents should be able to access services during lunch hours. MSF can work with the polyclinic to streamline adolescents' access during lunch break when the polyclinic's reception area is closed.

- There are particular parts of Mbare where YPSS operate from, having a mobile van available in these areas in the evenings would improve acceptability and accommodativeness of the project to YPSS.

- Restructure the HIV self-testing mechanism to allow for individual privacy and confidentiality during the HIV testing journey at Matapi: space out clients to various benches and waiting areas at Matapi

- Have regular consultations between peer educators and peers to debunk myths and misconceptions regarding behaviours that lead to risk.

- Adolescent participation in the design, assessment and implementation of the project goes beyond the peer educators' involvement. Active adolescent involvement should be considered.

- Community engagement also includes community participation and empowerment (including adolescents in the community).

- The project should continue income generating projects for teen mothers as this can be a preventative factor for selling sex.

EFFECTIVENESS

In this section, the effectiveness of different components of the ASRH project in meeting project objectives will be addressed, including plausible reasons for the achievement and underachievement of said project activities. By addressing the implementation, context and beneficiary experiences of these different components, inferences for making the program more effective will be made (Research questions 4,6, 9, 11, 12 in the evaluation matrix). How the monitoring and evaluation framework, data collection of the project is working/not will also be presented. Barriers and facilitators to accessing components of the project are also presented as they align to effectiveness.

KEY MESSAGES

- OPD care services are the most common and can be used to attract young people to access more sanctioned SRH services.
- The HIV cascade could be improved for the small cohort of adolescents living with HIV. There is high uptake of HIV testing, then linkage to care, retention and adherence in care as well as viral load monitoring in this cohort is a challenge. HIV+ adolescents face disclosure challenges and often provide false contact details which make retention, follow ups and tracing of these clients difficult. HIV+ adolescents find the structure around ART refills effective as they have a specific adolescent ART refill day that happened during the school holidays.
- SRH services in the Mbare-ASRH project is centered around a 3-pillar strategy (family planning, ANC, and PAC) that has been highly effective in increasing access and uptake of contraceptive care services. In some instances, the operational focus on the 3-pillar strategy is at the expense of other health services in the project. LARC are popular amongst teen mothers and additional training in person-centered contraceptive counselling as well as LARC is needed for the project staff.
- The teen mom clubs have been effective in providing wellbeing support for pregnant adolescents that include health information talks, income generating activities, and a small preparation hamper for the incoming babies. They currently end after one year. There is room to extend this period so that teen mothers continue to receive postnatal wellbeing and support for both them and their babies.
- Many clandestine abortions occur in the community and adolescents seem to see these community spaces as their only options given the legal status and potential socio-cultural stigma associated with unwanted pregnancies. Young people usually then present to the AC with an ongoing miscarriage in need of PAC. The project will need to expedite, if possible, the partnership with Mbare Polyclinic to provide PAC onsite versus as a referral to partners.

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- Menstrual Health service should be offered to all adolescents as part of regular service provision and not once-off events. Adolescents should be provided with options of MHM products to choose from and uptake data should be collected for each of the products.
- There is overall low uptake of mental health services. However, for those few clients who access mental health services, they find the services highly acceptable particularly the experience with the mental health nurse. The project has room and opportunity to train more project staff in mental health and innovate around mental health support (provide safe open spaces for dialogue and discussion amongst young people)
- Condom distribution, STI care and treatment and TB screening and diagnosis also have low uptake. There is a likelihood that part of this low uptake is due to inconsistent data entry and errors. For condoms, the project gives the public sector ones that have low acceptability with young people when compared to flavored and textured condoms.
- Advocacy efforts could be improved in the project as there was little to no evidence of these systematically occurring during the project's life course. Adolescents in Mbare can be trained to advocate for their SRHR; collaborations with advocacy partners can push the project' agenda forward on multiple platforms.

OPD CARE

In 2020, the out-patients department (OPD) care the highest uptake at the AC (Figure 5). The younger adolescents are mostly coming to the AC and Matapi for WIFI and OPD services (Annex 5: Table 7). Young men also come with an excuse of seeking OPD services, and then upon further inquiry during the consult, they open up about what the services they really need (condoms, STI treatment). In a community and health system that sanctions adolescent sexuality, OPD care services gives adolescents a general service to come and seek at the AC. Once they are there the adolescents can have a private and confidential consult with the health providers to access the SRH (if any) care that they need. This should be exploited to improve uptake of other services like HIV testing amongst young men.

THE HIV CASCADE

Achieving the 90-90-90 targets of the HIV cascade amongst adolescents has been a globally identified challenge (30). The Mbare ASRH project has also faced since its inception (Figure 5).

HIV Testing: An Entry Point into The Mbare ASRH Project

In line with national guidelines and global suggestions, the Mbare ASRH project uses oral HIV testing. In 2019, HIV testing had high uptake both in the AC and during community outreach (Annex 5: Table 6) and is usually the entry point for service provision for many of the adolescents. Ordinarily, peer educators actively push for this service when they are mobilising in the community, as well as conducting door to door testing, in schools, mobile clinics, and during hot spotting etc. In 2020 COVID-19 halted all the community activities, which resulted in a decline in the uptake of HIV testing when compared to previous years (Table 2 and Figure 5). According to the peer educators, when adolescents

and young people are being ferried from the community to the AC for testing, it is usually because there are some *"testing targets"* that have to be met. Transporting adolescents from the community to the AC is a needs-based strategy to increase testing uptake and have adolescents who live far from the AC get access. It is also not a sustainable strategy for improving access and engagement with the project is health services.

Linkage to Care and Treatment: Intersecting with The National System

The Zimbabwe national guidelines do not allow for HIV+ clients to be taken out of the national system. Therefore, the Mbare-ASH project has had to link the HIV+ cohort to Mbare polyclinic instead of linking and providing all HIV care from the AC. Adolescents who test positive at the AC are linked to ART care at the OI department at Mbare Polyclinic. Those who test positive at Matapi are ordinarily linked to ART care at the Matapi satellite clinic but since COVID-related closure of the satellite clinic they are linked to the OI at Mbare polyclinic as well. The Polyclinic's OI department is supported by MSF through the provision of a staff member who works specifically with HIV+ adolescents, together with the City of Harare (CoH) staff. Adolescents who test HIV+ and need to be linked to care generally are a small proportion of those who get tested. Linking these few cases to care is challenging. According to UNAIDS targets 95% of people living with HIV should be on ART, and overall, only 62% of adolescents diagnosed through the Mbare ASRH project have been linked to care (Figure 5). Some of the challenges with linkage to care are out of the project's control. For example, some adolescents are tested within the project but do not stay in Mbare or are living on the streets – these get lost to follow up almost immediately. Other adolescents come to be tested when they are already HIV+, and this is only discovered when now attempting to link them to care and they are found already existing in the national system.

HIV Care, Treatment and Adherence: Disclosure Challenges

HIV status disclosure is a challenge that negatively impacts adherence and retention in care for adolescents living with HIV. During interviews, some HIV+ adolescents denied their status (said they are HIV- during demographic history data collection), even though during, the interviews they acknowledged taking *"treatment daily"*. Some adolescents and young people have not disclosed to their guardians or the people they live with, for a variety of reasons which include a fear of being thrown out of the home when they have nowhere else to go. When given their three-month supply of ART, some choose to only take 1-month supply back home – because it is easier to hide than all 3-month supply. They also keep any treatment documentation at the clinic and will not take this home; and they would prefer for their ART pills to not be in bottles which make a noise when shaken in case they are found out. Young people are also not disclosing their status to their partners. One young person who is HIV positive, has not disclosed to his girlfriend he has unprotected sex with her. Before, she comes over, he sends his niece to Matapi to get emergency contraception, dissolves the pills in juice so that she drinks it. He believes the emergency contraception protects against both pregnancy and HIV. The latter case may be indicative of poor SRH knowledge and information, where debunking myths and misconceptions around SRH commodities can be a topic explored in an adherence support group session with young people living with HIV.

According to project staff who work with adolescents living with HIV, adherence and retention in care is quite difficult with this age group such that sometimes they have to monitor viral loads every three months to keep the HIV+ adolescents coming back to and also so that they can see how/if they are adhering. Viral load has only been captured from 46.9% of adolescents living with HIV (Table 5). If

possible, taking into consideration the lost to follow up challenges with this cohort, the gap in VL monitoring could be improved in order to monitor adherence to treatment for the HIV cohort- which is successful as those adolescents who are virally monitored are virally suppressed in the project.

HIV Care, Treatment and Adherence: The ART Refill System Works

Adolescents living with HIV like accessing ART at the AC because they only come for reviews during the holiday, on specific dates that the clinic would have given them, and they do not have to mix with the adults. These adolescents also appreciate being subdivided into groups, the younger ones then the older ones so the waiting time becomes short. The OI staff treat them well, and they are provided with refreshments which increases the likelihood of adolescents returning on ART refill days. Non-participant observations on ART refill days showed that adults were present on adolescents' ART refill day. One could not tell that it was specifically an adolescent ART refill day. The adolescent clients feel that if there are grownups who are coming to pick up drugs for their children, they should come on an adult day instead of the adolescent ART refill day. Project staff clarified that because of COVID-19, the school calendar has shifted but ART refill days are locked in (must happen every three months) even for adults such that at this point, there is an overlap between adult and adolescent days, and they expect the same to happen at the next ART refill day in about three months. Ordinarily, this would not be the case. Considering the disclosure challenges of this age group, the efforts at privacy and confidentiality afforded the adolescents by the Mbare ASRH project is valued.

There is a cohort of adolescents that are both living with HIV and selling sex. Some, in this group of young people is adhering to their ART regimens by sharing ART supplies. The YPSS articulated that getting sick would mean that they cannot work. Many conveniently take their ART at night and keep their drugs at their rooms where they service clients. Some clients will take the sex worker home and one sex worker said she usually discloses to her client that she needs to take her ART. In some cases, clients are also on ART and will ask the sex worker what her ART regimen is. If they are on the same regimen, the client will share his ART with her, and she spends the night or some days with that client and still does not default.

Adherence Support Could Be Stronger

The adherence support groups could be stronger. In trying to organise a FGD with an adherence support group, the evaluation team realised that the structures around these groups are limited, when compared to similar structures like Zvandiri (An Africaid run peer support structure for young people living with HIV). One model of support structure that has been running pre-COVID includes collaborative adherence clubs that are supported by the project, CoH, Zvandiri and Chiedza childcare centre. These adherence clubs are meant to be a les medicalized one stop shop that is psycho-socially inclined to provide both ART refills and support to adolescents and young people living with HIV. The project has not yet evaluated the impact of this model, and at the time of the evaluation this model was not operational. For the project cohort, a lot of younger adolescents on ART do not have phone numbers to keep regular contact with them. The support group sessions also happen on the ART refill day. Adolescents living with HIV are given a date to come back and get ART, which is also the support group meeting day and in-between those dates (which are usually 3-4 months apart) there is no communication with the adolescents. Meeting 3-4 times a year okay for the adolescents living with HIV. Based on observations, ART refill days and the activities associated with that are already long. Including a support group session on the same day makes the day exhausting and the session has limited impact and quality. Adolescents want the support groups to be on a weekend and not at the clinic and not on ART refill days. One stakeholder who had attended one such "support session" was

concerned about the adherence support that is given to the cohort in the Mbare ASRH project. In this stakeholder's program, adolescents living with HIV meet at least once a month, whereas the Mbare ASRH project meets only about 3-4 times a year and based on her experience of the one session she attended, was concerned about the comprehensiveness of the support sessions. The stakeholder's support program distributes food hampers of dry goods during Adherence support group sessions. This does not happen at the Mbare ASRH adherence support group.

This evaluation showed that the adolescents living with HIV are not adequately aware that there is an adherence support group that they are part of/or can be a part of. They are unaware/unclear that on the days that they come for ART refill, there is also adherence support group sessions that happen. The young people understand that there is an ART refill day that is just for them alone, and they are split into the younger adolescents, and the older adolescents and get their drugs with no adults present (ART refill groups). When asked about attending or being part of an actual adherence support group, where young people share peer- peer support and activities- they did not know, nor could they speak to this. The adolescents have not experienced the activities that are aligned with adherence support. Some said they have 'heard' that a group exists but have not participated in one. With the advent of COVID-19, the older adolescents have a WhatsApp group where people share information, and these adolescents seem to find the WhatsApp engagement effective. An interview with another stakeholder that is partnered with MSF to provide adherence support to young people in Mbare, noted that in-person support groups have not happened since April 2020 because of COVID-19. Support groups became virtual WhatsApp sessions that are quite popular with the 20-24-years old HIV+ cohort. This cohort was difficult to engage with for in-person sessions pre- COVID-19. It is likely and possible that the participants we managed to recruit and speak to, have only ever experienced the virtual adherence groups and never had the experience of in person meetings.

FAMILY PLANNING: 3-PILLAR STRATEGY

Unwanted teenage pregnancies rates are high in Mbare. This occurrence shaped MSF's 3-pillar strategy which was always a part of the project since 2015, but whose implementation began in 2020. Community members noted that the high rates of poverty in Mbare leave young girls particularly vulnerable to risky sexual behaviours. Parents reported that young girls (8-14 years old) are recruited by older males who take them to their friends to have sex with them. These young girls are not paid cash for this. In many instances, these recruiters target young girls who are hungry, living on the streets, struggling economically, and are willing to accept a meal as payment. The 3-pillar strategy is an attempt to address the high rates of unwanted teenage pregnancy and unsafe abortion care and any pregnancy-related consequences in the community. This strategy contributed to the surge in contraceptive uptake within the Mbare ASRH project between 2019- 2020 (Table 2 and Figure 5).

CONTRACEPTIVE CARE: A STORY ABOUT LARCS

Since the inception of the 3-pillars strategy in 2020, over 40% of females received family planning services (Table 2, figure 5). According to the project staff, in 2020, most of the adolescent women on family planning are teen mothers who after giving birth are, for the most part, put on long-acting contraceptives (LARCs). According to the teen mothers interviewed, they choose LARCs because they were likely to forget to take the pill. The quantitative data does not disaggregate the family planning data by subgroup (age and contraceptive care method). The Depo-Provera injectable i s a popular contraceptive because it is long term and not visible. According to the AC providers, adolescent women do not come back after three months for their next Depo shot, and the providers then see them when they become pregnant and need to register for free ANC through the AC. In the impact modelling

meeting, one family planning stakeholder questioned why MSF was offering Depo to adolescents who for the most part, have never had children or only have one child. According to the stakeholder, Depo-provera has been proven to have delayed- return-to-fertility and should not be offered to this age group (never had children/only have 1 child). The Mbare ASRH project does not make this distinction when offering contraceptives to adolescents, instead the AC staff provide all the information and side effects on the available contraceptives so that the adolescent can make an informed choice about what contraceptive they desire. If an adolescent chooses depo, after being informed of this delayed return to fertility effect, then the adolescent will be given Depo.

Contraceptive commodities, including Depo injectables are also sold in the tuckshops/on the streets. This may reduce uptake of contraceptive commodities at the AC, for adolescents who are not concerned about the cost, or are unwilling to make the trip to the AC. Commodities on the streets are exposed to the sun and sometimes expired. According to the health providers, some of the teen pregnancies who come and say that they got pregnant while they are on contraceptives bought these contraceptives from the streets, revealing a potential need to perhaps follow-up on Depo clients who need to return after three months.

Implant's insertions are visible on the which sometimes reduces their acceptability. One young woman came for an implant insertion. She returned the following day and asked for it to be removed because it was visible when she was serving food for her family and her mother would be able to see it. Another adolescent had the implant for a year and came back saying she wanted the implant to be removed because her boyfriend has promised to marry her- exposure to risk of unintended pregnancy. Adolescent women continue to face the risk of unwanted pregnancy due to physical, emotional, societal and structural risks. While the Mbare ASRH project many be providing a high-quality contraceptive care services, the challenges, and conditions that young people face are societal and happening in their communities- sometimes outside the project's control.

The LARCs training for the AC providers needs to be updated to prevent referrals out for LARCs. Four AC nurses were trained- three were trained in offering Depo- Provera and implants and only one was trained in IUCD insertions. Whenever the IUCD-trained nurse is not available, or has some kind of challenge in providing services, clients have to be taken to FHI360's Mhuri/Imhuli program for contraceptive care.

ANTENATAL CARE & TEEN MOM CLUBS

The Mbare ASRH is providing ANC service by referral to other partner(s) (Mbare Polyclinic), and this is one of the reasons by ANC data were not collected. Since these services are offered by referral, the project needs to strengthen data collection. There is need to monitor the outcome of ANC consultations and health status of pregnant teen mothers. Adolescents have higher risk of delivery complications and can deliver premature babies. The project needs to invest to assure that adolescent have access to safe delivery care, link to PNC care, support for breastfeeding and delivery outcomes monitored and collected.

The teen mothers' clubs is the component of the Mbare ASRH project that is thriving the most. It is highly effective and accepted by pregnant adolescents and teen mothers who are benefiting from it.

There are two main ways a pregnant or young mother joins the Mbare ASRH project ANC/teen mothers' component:

1. An AC client can get a positive pregnancy test at the AC, get support to register for free at the ANC and is encouraged to join the teen mothers club.
2. An ANC pregnant client hears about the teen mothers' clubs and joins them but has never actually been going to the AC until that teen mothers club moment.

The lifetime for a teen mothers club is about one year. Young women who are early in their pregnancy form one club; and then those who are later in their pregnancy form another club. The club continues until everyone is that club has given birth, and they all share experiences of childbirth to new motherhood as they each deliver their babies. During that year, the teen moms are exposed to all the activities that are part of the teen mothers club curriculum. After a year, the club is dissolved.

The teen moms find the clubs highly acceptable and effective at providing health information and socio-economic capacity-building. At these clubs, they get SRH information; are given a preparation hamper for their incoming baby; are put on contraceptives – usually they choose long-acting contraceptives post-partum. Teen mom participants noted that pull factors for attending the clubs include 1) the food they get at each session, 2) training in income-generating projects, and 3) the $10 reimbursement for coming to the training. For the income generating activities, teen moms are given raw materials to them make these at scale and sell them. If they do not understand they go back and get more lessons. According to the project staff, income -generating activities are availed to all key populations and vulnerable subgroups as well as PE and are done on regular basis for all. From the evaluation findings, teen mothers are the only adolescent subgroup that has had continuous training in income-generating activities; and have been given raw materials to make more soaps in bulk and sell. Other adolescents, like the PE, said they were introduced to the activities, but usually it was either a once-off and the training was not continued in successive sessions; or they did finish the training but did not get the additional raw material support to be able to sell in bulk and get some capital to keep the project going. YPSS in particular noted that if they had something else to do and generate income, they would not be selling sex. For some they are aging out of sex work as older adolescents since the YPSS are starting at younger ages. They need other opportunities like income-generating activities, and these opportunities could be better marketed to attract adolescents who would benefit from them.

CLANDESTINE ABORTIONS HAPPEN IN MBARE

The 1974 Termination of Pregnancy (ToP) Act does not allow for ToP on request – only in the cases of rape, incest, life endangerment of the mother and foetal deformity. Sociocultural and religious beliefs stigmatise and impose social sanctions and isolation for women who have unwanted pregnancies. This contributes to unsafe abortion practises, as young women feel that they cannot openly seek SRH information on and/or services. This evaluation found that clandestine abortions are happening in the community. Mothers help their daughters get abortions. Some young women get information from friends: pour washing powder in coca cola and drink that, to remove a pregnancy. Everyone in the block of flats usually knows who has aborted because people talk. Usually, adolescents will only visit a facility when there have been complications, and that is how they then present for PAC referrals. At the AC, the providers talk consult and counsel the clients and those who are eligible for PAC are referred to PSZ. The referral system loop is completed via- either verbal confirmation from the referral partners, or financial receipts of payment. This is not systematic, and the outcomes of the referrals are currently not being adequately collected.

MENSTRUAL HEALTH MANAGEMENT: GIVE ADOLESCENTS A CHOICE

At the time of the evaluation, menstrual health services were not being consistently offered as a service at the AC and Matapi, in the same way that other SRH services are offered. According to the project staff, MHM products were being piloted to better inform which ones, how and what the service would look like in the project. Such that, MHM services were dependent on availability of stock for the pilot. To access menstrual pads and cups, community mobilisation campaigns happen through peer educators when stock is available. Young women then come to Matapi and the AC for menstrual products. The adolescent young women are registered by the community health mobiliser and are given pads (10-15-years old) or menstrual cup (16-19 years). According to project staff, data on MHM was being collected manually and only became digital in 2021 (2021 data is not included in this evaluation. The piloting of this service, and potential errors in data entry may explain some of the low uptake numbers for MHM (Table 2). Because menstruation is expected among young women and its commodities expensive, MHM services can facilitate for the uptake of more sensitive and contentious SRH services. The project could offer MHM more consistently as part of the suite of SRH services available for young women and in the same principle as OPD care for young men, MHM can facilitate young women's access to services like contraceptive and STI care.

The 16-19-year-olds are given the menstrual cup; and the 10–15-year-olds are given the reusable pads. The age cohorts are not really given a choice in that regard. The project team noted that this demarcation was only because they were piloting products from suppliers before committing procurement. However, at the time of data collection this age-based product demarcation was still in existence. Participants believed that the menstrual cup can 'take away your virginity'. There is no evidence that suggests that the 16-19-year-olds prefer the cup over the reusable pads. The cups are just what is offered to them, and some said they did not even be using it and have resort to using clothes or other materials. Some give the cups away to their mothers to use.

MENTAL HEALTH CARE

According to the participants, this is an extremely strong component of the project. Uptake of mental health and psychosocial support is low (Table 2) but of those adolescents who have engaged with the mental health nurse in some capacity, they have been deeply satisfied with the support they received from the mental health nurse. Adolescents who use substances know the mental health nurse well, and appreciate her service provision and support, and keep returning for additional counselling sessions with her. The mental health of adolescents is increasingly becoming a global focus (31). The project could collate the training, capacity-building, personality traits of the mental health staff to illustrate a list of ingredients that are necessary for providers to effectively provide mental health support for adolescent. This collation can be used for both programmatic and policy development around mental health and adolescents.

CONDOM DISTRIBUTION

There is low stock of the flavoured condoms at the AC, which are the preferred condoms and are only intermittently offered by the AC. The public sector condoms, which were out of stock at the polyclinic, but in-stock at the AC are not popular with adolescents. Condom distribution is also not systematic as, there are sometimes stockouts/low supplies of the condoms. The AC limits the condoms that YPSS can access per visit. YPSS mentioned that they always need condoms for their work. They cannot keep coming back all the time to the AC just for condoms. When they run out of condoms, they end up having unprotected sex for more money vs. if they were given a large supply of condoms from the AC

then they would not have unprotected sex. The low uptake of condoms in this project is an area where improvement can be made (Table 2). Reasons for low uptake of condoms should be explored. Low use of condoms in this population group will likely lead to an increase in STIs, pregnancies, clandestine abortions and HIV which are all adverse to the project objectives.

HEALTH EDUCATION

The quantitative findings showed that the uptake of 'health education' service decreased in 2020 (Figure 5). This was inconsistent with how the providers and peer educators responded in the interviews. "Health education" is the one service consistently given to everyone who contacts the Mbare ASRH project. In effect, the reach of health education should be close to the number of clients that the project has contacted. This is not the case (Table 2). There could be discrepancies in how each provider defines "health education" and also how one then records "health education" as a service that has been taken up, within their registers etc, especially because there is health education being given at the AC, Matapi and in the Community – are all of these (or should all of these be) recorded as "health education" service provision. Health education should be appropriately provided to every client who access the Mbare ASRH project.

STI CARE AND TREATMENT

This did not come up much in the data we collected. According to interviews with the AC providers, the most common STI that adolescent girls come seeking care for genital warts. The project does not offer cauterization for this STI and refers to other partners for cauterization. The project does not offer any diagnostic STI testing, and often does not disaggregate routine STI service provision data by the type of STI a client is treated for. Adolescents are symptomatically assessed and offered triple antibiotic treatment. Providers worry that the triple antibiotic therapy will result in antibiotic resistance as they only send a client to for lab investigations when they suspect resistance. For the providers, being able to both symptomatically manage and test for STIs would provide more accurate diagnosis and treatment of STIs than the umbrella triple antibiotic therapy.

TB CARE AND TREATMENT

Prevalence of TB is very low amongst adolescents who have interacted with the Mbare ASRH project. In the quantitative data only 12 TB cases over the last five years of the project and qualitatively, this component did not provide any elaborate findings. TB screening is done at the AC, and sometimes a sputum sample is also collected. For care, and treatment adolescents are referred to Beatrice Infectious Diseases Hospital.

ADVOCACY EFFORTS

PE work with an advocacy organization (SAT Zim) that is stationed in Mbare whereby the PE attend SAT sessions at Stodart Community Hall in Mbare. The SAT partners intentionally invite the Mbare ASRH project peer educators to their events because they *"are extremely knowledgeable and well trained".* One key advocacy finding for this evaluation has been, the low effort in collaborative and direct advocacy activities during the course of the Mbare ASRH project. When the project's advocacy-based partner was interviewed, the organisation noted that they work with the Mbare ASRH project more around outreach service provision, than they do on a collaborative advocacy agenda. This organisation works specifically in SRHR advocacy, therefore collaborating with them in terms of 1) creating and delivering advocacy materials 2) empowering and training adolescents from Mbare to advocate for

their SRHR could be part of this collaborative agenda with measurable goals and outcomes. There are opportunities to infuse an advocacy lens in the digital health promotion activities as well as utilising the diverse adolescent population that the project reaches as advocacy champions.

MONITORING AND EVALUATION FRAMEWORK: GO DIGITAL

There are gaps in the data collection methods and systems for monitoring and evaluating outcomes of the Mbare ASRH project. There is a heavy reliance on manual data collection, which is then transferred from the registers into an excel spreadsheet. Every step of this process leaves room for errors and inadequate data collection. The current system does not collect data or disaggregate data for especially vulnerable and key populations. The project intends to serve this cohort of adolescents and identify innovative models of care for key pops. There is a need to collect routine and unique data for this group and use this to inform the project's strategies for providing care to these adolescent cohorts.

Most health services components of the project do not have a specified numerical outcome for coverage, reach, dose). It is unclear if the project began or at some point identified specified targets (how many adolescents does the project aim to reach in a defined time period; how frequently does the project aim to provide all components of its components in order to meet its target etc). This would aid in measuring progress and identifying challenges that hinder in the achievement of specified targets.

The current monitoring and evaluation framework has the data for the HIV cascade being collected in separate databases, makes accessing this data, combining it for analysis, and using it for quality improvement a challenge. An immediate response for this would be to use existing data collection tools. MSF has existing data collection systems that can prevent data errors and replace the existing excel databases. Another option would be to digitalise. Digitalising data collection processes, for service uptake could mitigate this challenge as it allows all the information to be collected in one place. The data entry of which HIV testing method was used, has not been collected consistently (Table 4), and needs to be entered consistently for all clients who access HIV testing. This has implications for real time quality improvement of the programme, as well as learnings for program practices and policy development. It makes it challenging to measure success of the project, without robust data.

The project documents note that there are focus group discussions that are conducted with beneficiaries of the project to improve the project. The findings from the FGDs and how they have been used to adapt the project were relevant, are not available and/or systematically recorded.

Monitoring of referral outcomes data is also not consistently done. The Mbare ASRH project is a referral-based project where MSF glues partners together to provide comprehensive care for each adolescent. Referral outcomes information is critical to understanding if this model works; if this model can be adapted for other adolescent programs and policy development for adolescent health. Referral outcomes data needs to be collected for adolescents whose entry point into care is the AC or Matapi, and the project should consider critical investment in this.

Overall, because one of the specific objectives of this project is to innovate and implement models of care that can potentially be transferred and used in different settings; and learning used to influence policy: it is critical to generate quality and robust evidence for these purposes. A thorough monitoring and evaluation framework and processes would contribute to this objective.

Recommendations on Effectiveness

- Younger adolescents are still at risk of perinatal HIV infection. HIV testing services should also be offered to this group which frequently encounters the Mbare ASRH project for OPD services but does not access HIV testing services as much as other adolescent groups.

- AC should continue, with additional effort being placed in creating a system for the HIV cascade: another staff member to coordinate the HIV+ adolescence, coordination with Zvandiri CATS, CHIEDZA childcare centre, and Caritas for example, to ensure adherence and attendance to Support groups. WhatsApp groups facilitated by a peer educator to continue to engage with HIV+ young people in between ART refill and Adherence Support group sessions.

- Data entry errors can be reduced by use of electronic data entry systems. The Mbare ASRH project has been relying on paper-based data entry. This data is subsequently entered into an Excel database with no double entry checks. This system is time consuming for staff and prone to result in multiple data capture and entry errors. The project can use MSF existing data collection systems as this can prevent data errors and replace the existing excel databases. An electronic system would streamline data collection and ensure that no data points are missed. Have the community health promoters use tablets to enter screening and registration information from adolescents directly into a system like ODK. Potentially digitalize the M&E tools, hire additional staff whose focus is on intersecting the quantitative and qualitative data for the quality improvement of the project in real time.

- Provide contraceptive care information and knowledge to every eligible adolescent the project comes into contact with- including the downfalls of procuring their contraceptives on the black market. Since the 3-pillar strategy is core to the Mbare ASRH project, having a follow up system- call/text adolescents- for women who need to refill contraceptives would improve outcomes and also consider providing longer refills for contraceptives that allow it.

- The project's health provider should continue to receive training in person centered contraceptive counselling (PCCC) that allows adolescents to make informed decisions about their contraceptive care with the support of a trained health provider.

- Strengthen income generating activities. The income generating activities are successful with teen moms- who are a particular vulnerable group. There are many sub-groups of adolescents who are vulnerable and whose socio-economic status leaves them vulnerable to sexual high-risk behaviors. Introducing diverse income generating activities for different sub-groups could work. Young people out of school can/should be given income generating projects.

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- Continue the teen mom club curriculum and identify which other cohorts/subgroups of adolescents (LGBTQI) could benefit from this 'club + session' approach.

- PAC interventions that MSF desires to implement with Mbare Polyclinic should include a collaborative community-facility strategy so that the community is aware of the availability of this service.

- The menstrual hygiene component could be improved: give adolescents a choice of products to pick from; and the ability to switch products as they are comfortable with. Procure MHM products corresponding to demand- if more adolescents prefer reusable pads, then purchase more reusable pads than menstrual cups.

- Offer MHM products as part of AC services, consistently (a young person should be able to come to the AC and meet with a health provider and ask for FP together with reusable pads) vs. offering them as once-off events. Also consider offering different sizes of the menstrual cup and menstrual panties.

- Counselling effort and support into helping adolescents disclose their status to their support systems as this will enable adherence.

- Consider giving adolescents who identify as YPSS, more condoms.

- To improve advocacy engagement, incorporate adolescents who interact with the project to become advocates for/of their own health and wellbeing. The project can have partnerships to train these adolescents to strategically share learnings and experiences of the Mbare-ASRH project across local, national, and global platforms facilitated by MSF.

- The approach taken to increase uptake of contraceptive care services should be adapted for the other ASRH services provided. All client contact points are opportunities to provide any/all ASRH services.

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- Although there were over 5000 contacts with the Mbare ASRH project in 2020, less than 1000 HIV tests were conducted. While COVID-19 may have limited provision of some services, HIV testing is still an adolescent health priority and all contact points with health services must be exploited to increase uptake of HIV testing. This is also replicable for condom provision and MHM services. Use the CARGs model to structure ART refills/pick-ups by Matapi health providers, for Matapi adolescents living with HIV so that they do not always have to go to Mbare Polyclinic but can pick up their refills from the Matapi Youth hub.

- Outreach activities are effective in reaching clients for HIV testing, and this should be exploited. As part of community-based mobilization, certain groups of adolescents (from certain parts of Mbare, from schools, from community partners) are transported from the community, to the AC/Matapi to access services. This is not likely to be a sustainable strategy for increasing and maintaining uptake of AC/Matapi services in the long-term.

- Consider innovate and participatory ways (theatre, art, music, dance) of increasing SRH knowledge amongst adolescents and young people.

- Maximize viral load monitoring to improved quality HIV care.

- The project has many options to improve access to contraceptive care services which could include offering free, readily available self-care models of contraceptive care. In this age group (10-19years old), piloting the acceptability of self-care methods would be paramount to improving access as AYP people sometimes prefer the expertise and presence of an AYP-friendly provider.

- For mental health services, more staff could be trained in both the technical and soft skills for providing mental health support. Also consider having safe spaces/group settings were adolescents can come to just talk about issues important and concerning them, facilitated by trained HR, as part of mental health support for adolescents.

- During teen mom clubs' sessions, there is a lot of potential to introduce other information on other health topics as breastfeeding, how to prepare for birth, importance of postnatal care and vaccination, malnutrition of young infants etc. can be considered to include as recommendation.

- Clearly defined what content and/or activities fall under health education- especially if this is going to be measured as an indicator. Having a clear definition would enable staff to know when and how to record this, as at the presentation of the key findings, staff were quick to point out that more health education had occurred than what the data showed.

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CONNECTEDNESS & SUSTAINABILITY

This section presents the extent to which the Mbare ASRH project functions in partnership and collaborations with already existing organisations and entities, for the improvement of adolescent health and wellbeing. By addressing this partner-based implementation strategy, suggestions for the adaptability, transferability and/or sustainability of this project are also presented (Research questions 4,6,7,9, 11, 12,13 in the evaluation matrix). Some components of this section have already been addressed in section 1 on Appropriateness of MSF's strategy.

KEY MESSAGES

- A significant portion of the health service provision components in the Mbare ASRH project are referral based and depend on effective strategic partnerships to serve all the needs of the adolescent clients. Challenges with such a system is that there is inadequate and consistent follow up of referral outcomes and no guarantee of quality AFSRH services at referral partners. While resource intensive having peer navigators could improve linkage to care, and referrals outcomes.
- There is room for the project to have more strategic community-based partnerships to serve all the needs of the adolescent. This can include intentional collaborative and co-created strategies with organisations that specialize in income-generating activities, with social work departments and organisations that work with key populations and highly vulnerable groups of adolescents.
- The Mbare ASRH projects is a complex intervention with multiple components working at the same time to improve the health and wellbeing of adolescents. The government of Zimbabwe will not be able to adopt the whole project as is. MSF needs to identify and work with other partner organizations like itself, who may be able to adopt and continue components of the project.

A REFERRAL-BASED SYSTEM OF CONNECTEDNESS TO HEALTH SERVICES

The health services component of the Mbare ASRH project is referral-based and dependent on partner organisations contributing toward the health care of adolescents. The project staff clearly stated that they are dependent on these partnerships and collaborations for adolescent continuum of care.

There are challenges in the referral system. There is no adequate and consistent follow up of referred clients, who are given a referral letter from the AC/Matapi to other partners for additional care. There was no quantitative data for referral outcomes (were available the outcomes are entered as a comment in a comments section in the excel database). Depending on the referral system to complete the comprehensive and integrated care that a client needs is challenging. There is no guarantee that the clients will receive quality AFSRH care with the partners. Since clients are generally not escorted to the partner organisations for their referrals, there is a higher likelihood of clients never showing up to the referral partners for additional care. Having peer navigators to strengthen linkage, referrals and follow ups could reduce some of these challenges. However, it is expensive and resource consuming to have to follow up every client who has been referred to every partner.

A potential strength of the referral system may be that any entry point into care- that is adolescent friendly, could be the trigger to get young people to access care, even if the rest if the care cascade (including referrals) may not be of high quality. This approach may work for general adolescents, but the high risk, especially vulnerable (key pops, HIV+) could get lost/not retained in this referral-based care cascade that is currently in place.

COMMUNITY PARTNERSHIPS OF CONNECTEDNESS TO ADDRESS THE ADOLESCENT'S ECOSYSTEM

Beyond the health services-based partnerships, the Mbare ASRH project also partners with community- based organisations to better address the socio-economic and cultural factors that influence the health and well -being of adolescents. Findings from this evaluation show that some of these community-partnerships are more one-way leaning in favour of MSF agenda/outcomes, instead of a balanced collaboration to benefit both partners. One organisation that provides catering courses to adolescents and young people described that MSF comes to their site to give health talks and recruit adolescents for HIV testing. The Mbare ASRH project could partner with said organisation to offer catering courses to adolescents as an income-generating activity. Another organisation, that works with adolescents and children living on the street mentioned that they only have a loose relationship with MSF, and they would like an MoU to solidify the partnership. Considering the challenges this evaluation faced in accessing young people who live on the street, partnering with organisations who already have relationships and access to these adolescents would better support this subgroup.

The FGDs with parents/guardians and with community members revealed an overall understanding of the project and how it is helping the young people in Mbare. One of the areas that would benefit from increased advocacy and community engagement efforts would be to help community members understand the benefits of young adolescents obtaining the health services they need and for the community members to support this provision.

OVERARCHING AND OVERLAPPING PARTNERSHIPS IN THE PROVISION OF HEALTH SERVICES FOR ADOLESCENTS

There are stakeholders who work in Mbare providing a range of services for the same target population as the Mbare ASRH project. For partner stakeholders, some partnerships, for example PSZ, work seamless with the MSF project providing its services and then referring to PSZ for PAC – a service that the project is currently not offering. Other partnerships voiced contention and repetition of services and activities, for example Adherence Support Groups (see section *Adherence Support Could Be Stronger* in the *Effectiveness* chapter). Partners involved in supporting adolescents with HIV voiced that sometimes there have been clashes between MSF's strategy for Adherence Support and the adherence support structures that already exist amongst stakeholders. One suggestion to mitigate this could be for the project to consider where structures for adolescents are already in place, to support existing structures and systems instead of creating new and parallel structures.

The Mbare ASRH project now has a family planning focused strategy and the Mbare community has PSZ and FHI360's Mhuri/Imhuli programs – both are stakeholders that are well known in the community to be focused on consistently providing comprehensive contraceptive care service provision. Both stakeholder programs do not have an 'adolescent friendly' focus but do successfully provide contraceptive care to adolescents they come into contact with. As part of collating evidence

on the effectiveness of the Mbare ASRH project, the project staff could ask adolescents who come to the AC for contraceptive care where else they have accessed contraceptive care before coming to the AC. More significantly, the adolescent-friendly aspect of the Mbare ASRH project could become a blueprint or learning point for organisations like PSZ and FHI360 to improve the quality of care that they provide to adolescents.

Another component where the Mbare ASRH project has an opportunity to shrink gaps is in quality key pops- friendly service provision. Some partner organisations, that are not key pops focused, articulated that they did not distinguish nor treat differently key populations that came to access services from them. The Mbare ASRH project is currently curating a strategy to best support key populations who are accessing services from a non-key pops specific project like MSF's. Learning from operationalising and implementing this strategy could also be used to stimulate learning and engagement with other partners whose projects are not key pops specific but do come into contact with key pops.

FEASIBILITY OF CONTINUITY, REPLICATION, AND SCALABILITY: WHICH PARTS CAN WORK?

The eventual goal is to hand over the Mbare ASRH project to the CoH Health Services Department, so that the adolescents in Mbare can continue to be supported after MSF leaves. This evaluation has shown the Mbare ASRH project is an ambitious and complex intervention; and not all of it would be successfully implemented by CoH due to a number of factors. When interviewed, the health providers from Mbare polyclinic, were not aware of the AC and what services are offered there. CoH tends to rotate out it nurses frequently, such that there are always new nurses operating at facilities. This is detrimental to the penetration of the Mbare ASRH project at the polyclinic. The only nurse who was aware of the AC and its services is the ANC nurse because she goes for locums at the AC. Partner organisations in Adherence Support for adolescents living with HIV noted that there are potential disconnects between how MSF does Adherence Support (quarterly) vs. the way that Mbare Polyclinic and other partner structures do it (monthly, games, music, food/material hampers). However, because MSF is a 'big and influential' organisation, partners felt that MSF's way of doing things usually takes over, which is worrying for sustainability and continuity once MSF leaves and systems have to go on functioning. Additionally, there are other non-facility based (community) components of the Mbare ASRH project that the CoH is unlikely to continue implementing, without additional resource support: income generating activities, home visits, peer-to-peer engagement etc.

There are components of the Mbare ASRH project that are more easily replicable, and scalable by CoH and to other AFSRH projects, and these include:

- Having peer educators at the polyclinic to specifically support adolescents who are seeking care. This is especially important for key populations and vulnerable, high risk adolescents.
- Not having adolescents wait in registration lines with adults when they get to the polyclinic.
- Continuing to have health services for adolescents being offered by youth-friendly trained health providers at the AC and Matapi.

Evidence from other MSF projects has shown that it is challenging to successfully transition projects to governments for scaling-up, in part because governments do not always have the time, financial and human resources to effectively implement programs with the same breadth and depth that international organisations can. The free, readily available, accommodative, and accessible health

service components of the Mbare ASRH project may be difficult to consistently scale up via government. These can be scaled-up or replicated by other international NGOs running adolescent and youth focused programs in Zimbabwe and beyond- using learnings from the Mbare ASRH project. A comparative analysis of the Mbare ASRH project to the public sector adolescent-friendly health services has been placed in Annex 6.

Recommendations on Connectedness and Sustainability

- In order to correctly and consistently capture referral data, clear referral pathways, outcome measures, data entry records and follow up mechanisms need to be created. This should be done in collaboration with partners where referrals are made. For example, A coded text message system and partners can text the referral outcome of an adolescent using a unique identifier written on the referral slip. Adapt the text-based system that was used by MSF -Khayelitsha in 2015-2016, when clients were using SMS to report their HIVST results. This could be a gateway for improving communication channels amongst partners and stakeholders.

- Identify what more services can be offered inhouse and not referred out. For example, YPSS requested for PreP to be offered inhouse instead of referring them out.

- Because the key populations strategy for the Mbare ASRH project is currently in development, starting to involve CoH and relevant partners now during the strategy development, would ease the way for this transition.

- Additional stakeholders within Mbare and Harare have been identified as part of the stakeholder mapping conducted for this evaluation and these partners can also be explored.

- The Mbare ASRH project should look for a community equivalent of CoH Health Services Department (Social Welfare?); as well as other partners and NGOs to handover the community components of the project and have them be part of the Handover committee. This would enable a collaborative partnership between all possible stakeholder to take up the project when MSF leaves.

- MSF could facilitate or be the glue for partners to come together and create a robust referral system. This includes having enhanced collaboration with other departments at Mbare Polyclinic (ANC, maternity, SGBV, OI) where adolescents are referred to. This ensures maximum quality care and provision for the adolescent.

- MSF is considered a highly influential organization, and other partners feel that even if they think the strategy MSF is employing won't work, they don't really push back because the power of MSF is bigger than them. Go into partnerships with a willingness to learn, or support/ complement what is already going on, instead of going in and suggesting a different way of doing things.

CONCLUSIONS

This report has provided a summary of the services provided by the Mbare ASRH project by paying close attention to the appropriateness, effectiveness, connectedness, and sustainability. Using mixed method this evaluation has demonstrated that the Mbare ASRH project is positively impacting the health and wellbeing of adolescents who come into contact with its components. For the most part, the facility-based components providing quality adolescent-friendly health services that are appropriate and effective, as many general adolescents were satisfied with the care they received once they got to the AC or Matapi. It is key is to note where quality gaps for key population groups and very young adolescents.

This evaluation noted that over the 5-year period there has been a conceited effort by MSF to adapt and improve service provision for adolescents. Innovative strategies for adolescent care and support have been developed and as such this project has over the years been growing and evolving. Very successful elements have been introduced over the last two years including the teen mothers' clubs, the introduction of peer educators representing the LGBTQI community and efforts to increase family planning uptake. Most of these have been well received by adolescents and staff; and the findings illuminated gaps in reception of the project by key populations but the key pops strategy is currently under review and expected to improve in 2021.

Due to the wide range of services provided to adolescents by the project this evaluation highlighted some areas where ASRH service provision to adolescents can be strengthened. Of note, integrating services to maximize on uptake of all components of the project will support in achieving project objectives. It may not be ideal for MSF to provide all adolescent health and wellbeing services as the frontline provider. Networking and collaborative strategic partnerships would support project objectives. For example, comprehensive integration includes strengthening the collaborative relationships between the project and strategic partners like Mbare polyclinic (ANC, SGBV clinic, OI), Zvandiri for adherence support, and social work partners to improve overall wellbeing of the adolescents. The evaluation noted that the strong focus on contraceptive care through the 3-pillar strategy has been effective in increasing its uptake, however, it will be important for the project to clearly define if all services are centred around this strategy or if an integrated package of ASRH services, including family planning is being offered. Learnings from the successful implementation of the 3-pillar strategy (effective sensitization, knowledgeable peer educators, nurse-escort for referrals when needed) can also be transferred for other services and potentially increase their uptake.

Key among the findings were limitations related to the quality of data that is being collected (or not) in the project. Despite the innovativeness of the project, its many components and growth over the years- there has not been a systematic collection of high-quality evidence to support the project. Quantitative data entry for the project is mostly paper based which is time consuming for staff and leaves room for errors. Although several changes have been made over the years to improve data capture this report highlighted several areas where improvements could be made. A key objective of the Mbare ASRH project is to test innovative models of providing HIV and SRH services for adolescents. As such robust and accurate data is essential.

Creating systems that facilitate this will be useful for not only the monitoring and evaluation efforts of the project but future advocacy and policy work and may also improve service delivery by reducing the time spent managing paperwork by project staff and the data team. Costs and feasibility of implementing and electronic data capture system should be assessed.

Advocacy for ASRH is a critical component of this project. However, this evaluation noted that there is a need to strengthen advocacy efforts particularly through the early generation of evidence. This can be supported by robust data as noted above but also human resources to monitor and capture components relevant to current and future advocacy efforts of the study and strengthening areas of the project that require close attention such as the HIV care cascade.

When considering the sustainability of the project it was noted that the Mbare ASRH project is an ambitious and complex intervention for improving the health and wellbeing of adolescents. The Mbare ASRH project is one of the few projects in Zimbabwe that focuses primarily on the provision of comprehensive integrated health services for adolescents and some young people. Most programs and projects provide partial health service, information and/or referrals. The successful implementation of this project is dependent on successful cross- sectoral partnerships and collaborations. Its appropriateness and acceptability are dependent on how the project components meet the needs of adolescents in the Mbare community, and is also closely interlinked to the contextual socio-economic, cultural, and political landscape in which the project exists. Some components of the project are more easily transferable to Harare City Council than others; and the findings highlight that the project should focus on harnessing and strengthening those components of the project as well as consider hand over to other service providers within Mbare. For the project to be successful and transferable to City of Health and other settings, the referral-based system needs to be strengthened to allow for measurable outcomes and impact. In preparation for this handover in future it will be critical for MSF to begin conversation and planning for this well in advance to allow to a smoother transition for the CoH, partner organizations and most importantly the adolescents that this project serves.

RECOMMENDATIONS

⇒ **Recommendation 1: Invest in strengthening the monitoring and evaluation framework. This is key to generating quality evidence that can be used for policy and practice.**

- Improve the data collection system (types of data being collected, the tools, the collection and analysisprocesses, and data management) and how the data is used to improve the project. MSF has existingdata collection tools (non-digital) that are not being used or not known at project level. The project should explore how to incorporate these tools since they already take into consideration the constantchanges in priority indicators -which is the case for Mbare.
- Another option could be to digitalize the data collection and monitoring and evaluation tools were feasible, as this can reduce manual data entry errors. For example, the health providers and health promotion officers could enter demographic and service uptake data directly onto a tablet based ODK system; and these could be synced into the main database by the data team at the end of each day.
- Not only can the project better collect already existing data, but there is opportunity to collect new kinds of data. Examples of these new data includes capturing all the ANC data for pregnant adolescents identified through the AC. ANC is one of the important activities, however the link to delivery, postnatal care (breastfeeding, vaccination) is missed or could be improved. This data is referral data as the ANC is run by Harare City Council at Mbare Polyclinic. This includes data frequency of ANC visits, breastfeeding, vaccination, malaria, nutrition status, PMTCT data/outcomes for HIV+ pregnant adolescents etc. For ANC, adolescents can stay in ANC for 5 years and may nevercome back to the AC. Additional examples of (new) data that could be captured by the project includes data on key populations, mental health, TB screening, PAC referrals, community and adolescent engagement with the project, frequency and content of staff trainings, Collating all this data would contribute to decision-making on how the Mbare ASRH project is run and can improve for overall adolescent health and wellbeing.
- There is a need to strengthen advocacy efforts through systematic evidence generation; and then usingthis evidence to advocate for adolescent health and wellbeing. Robust data collection and the humanresources necessary to do this will be needed to monitor and capture data/evidence components relevant to current and future advocacy efforts. Evidence-informed advocacy could strengthen critical project areas like the HIV care cascade.

Recommendation 2-5 (of 5) cont'd à

⇒ **Recommendation 2:** Investments need to be made in 1) efforts to create the necessary evidence to inform/substantiate advocacy goals; and to develop an advocacy strategy and activities aimed at influencing policy and practice.; and 2) in more capacitated human resources.

- Capacitated HR is needed, among other things to support the HIV cascade care, collect and collate qualitative/social evidence as part of M&E, evidence generation, advocacy efforts and quality improvement efforts in real time.
- Part of the investments in advocacy include 1) co-creating an advocacy strategy with a partner organisation like SAT, 2) recruiting, training, capacitating, and supporting adolescent advocates from the Mbare-ASRH project. These adolescent advocates should be included in the design, implementation, and assessments of the advocacy strategy a whole.
- For years, the project has been running without a specialist in SRH/ASRH care. Project staff need training and support from an expert (national and/or expat) in ASRH to fully capacitate them to provide AFSRH services. This kind of support and training was planned before, but due to COVID-19 has been delayed. COVID-19 permitting it should continue happen.

⇒ **Recommendation 3:** Activate the Handover Committee meetings and ensure that the committee has adolescent representation to begin strategizing how, when, and to whom which components of the Mbare-ASRH project will be handed over to Harare City Council.

- The Handover strategy has been in place for a few years now. The strategy includes having a stakeholder committee that meets regularly to discuss what, when and how the Mbare-ASRH project will be handed over to City of Harare (CoH) Council in a few years. It will be important for these meetings to begin sooner rather than later. Adolescent representation in this high-level committee should be strongly considered. For successful continuity, MSF could also consider including and/or handing over some components or learnings from the project to capacitated partner organisations instead of the government/CoH.

Recommendation 4-5 (of 5) cont'd →

⇒ Recommendation 4: Activate and streamline the PAC intervention that the Mbare-ASRH project has been working on with Mbare Polyclinic. This intervention would allow PAC services to be provided at Mbare polyclinic.

- Considering the high acceptability of the AC adolescent-friendly model, it is possible that PAC uptake at Mbare polyclinic would be high if offered within the project vs. through referral.
- This intervention should have a carefully curated community-based component. Community involvement will be necessary for sensitisation of the PAC intervention. The community/target population would need to be informed about the availability of PAC at the polyclinic.
- Overall in all this, it will be critical for the project to create a safe environment for the beneficiaries and mitigate any eventual risk associated with receiving unsafe abortion and post-abortion services.

⇒ Recommendation 5: A decision needs to be made about whether this project is a comprehensive integrated adolescent services project; or whether it is a contraceptive-care focused, comprehensive integrated adolescent service.

- The former could mean every health service, and community component needs to have measurable objectives and outcomes and equal efforts should be put across the components.
- The latter could mean focusing on the family planning 3 pillar strategy 90-90-90 objectives and outcomes, and how the rest of the services and components contribute to improving these outcomes.
- This also includes clearly defining what adolescent-friendly means for the project.

Once all this clarity is internally established, the measurable and priority goals, activities, outputs and inputs of the project can be more easily defined (back to recommendation 1).

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ANNEXES

ANNEX 1. TERMS OF REFERENCE

Doctors without Borders/Médecins Sans *Frontières* ***(MSF)*** *is an international medical humanitarian organization determined to bring quality medical care to people in crises around the world, when and where they need regardless of religion, ethnical background, or political view. Our fundamental principles are neutrality, impartiality, independence, medical ethics, bearing witness and accountability.*

The Stockholm Evaluation Unit (SEU), based in Sweden, is one of three MSF units tasked to manage and guide evaluations of MSF's operational projects. For more information see: evaluation.msf.org.

Subject/Mission:	Evaluation of Adolescents' Sexual and Reproductive Health Project in Mbare, Zimbabwe
Starting date:	December 2020
Duration:	Final report to be submitted *by latest* May 1st, 2021
Applications includes:	Interested applicants should submit: 1) A proposal describing how to carry out this evaluation (including budget in a separate file), 2) a CV, and 3) a written sample from previous work
Deadline to apply:	December 2nd, 2020
Send application to:	evaluations@stockholm.msf.org

MEDICAL HUMANITARIAN CONTEXT

Adolescents (10-19 years old) comprise 23.3% of the total Zimbabwean population[2]. Among the many health challenges faced by this group, Sexual and Reproductive Health (SRH), and more concretely teenage pregnancy, is of great concern. The Demographic and Health Survey conducted by Zimbabwe National Statistics Agency in 2015 found that 21.6% of girls between 15-19 years old had begun childbearing in Zimbabwe, and 12.2% in Harare[3]. About 36% of the overall pregnancies among adolescents in Zimbabwe were reported as unplanned; being of concern that in most cases these pregnancies resulted in induced abortions generally performed under unsafe conditions[4]. In fact, about 10% of all pregnancies to Zimbabwean teenage girls end up in unsafe abortions (UNFPA, 2016). The

[2] Inter-censal Demographic Survey, 2017. Zimbabwe National Statistics Agency and UNFPA. http://www.zimstat.co.zw/wp-content/uploads/publications/Population/population/ICDS_2017.pdf

[3] Demographic and Health Survey, 2015. Zimbabwe National Statistics Agency https://dhsprogram.com/pubs/pdf/FR322/FR322.pdf

[4] Idem

existing legal frame at country level (i.e., legal age of consent is 16 years; contraceptive education and access are not allowed in schools) seems to play, together with other factors, an important role in terms of barriers to SRH care for young people in Zimbabwe. Vulnerable young people are often disadvantaged from many health programs.

Mbare is the oldest and one of the most densely populated suburbs of Harare. It was established in 1907 as a dormitory suburb for the working community during colonial era of Zimbabwe. The suburb is highly accessible from most parts of the country and has a hive of activities. The context gives the population unique characteristics that include high mobility, overcrowding and poor socioeconomic status leading to risky behaviours and higher vulnerabilities for adolescents and young people. According to the 2012 Demographic Health Survey, Mbare is estimated to have a population of between 84,168 and 142,195 with 60% of them aged between 10-24 years.

As specific SRH needs for adolescents were identified during a gender-based sexual violence project run by MSF in Mbare, the organization decided in 2015 to initiate another project specifically targeting adolescents[5]. Its general objective is to reduce the morbidity and mortality for adolescents in Mbare and surrounding areas by improving access to an adolescent-friendly SRH package of care. Its specific objective aims at piloting innovative and replicable models of SRH, HIV and TB prevention and care for adolescents, which could lead to policy changes.

The project targets three subgroups of adolescents: teenagers from poor socio-economic context, adolescents at higher risk (adolescents from key populations[6], homeless adolescents and adolescents with disabilities), and adolescents living with HIV. SRH services of the project cover three areas: contraceptive care, antenatal care and post-abortion care[7] in addition to STI screening and treatment. HIV services include prevention, Provider-Initiated Counseling and Testing (PICT), self-testing, antiretroviral treatment (including differentiated service delivery models) and management of Opportunistic Infections (OI). In addition, other medical services were offered such as: Primary Health Care (PHC), Mental Health (MH) care, and psychosocial support in an adolescent friendly environment.

In terms of project activities, MSF is involved in the direct provision of sexual and reproductive care to adolescents in Mbare PolyClinic. In addition, MSF rehabilitated parts of Matapi satellite clinic. It is also currently running there a non-medicalized youth hub offering health education, contraceptive care and income generation activities in partnership with other organizations. At community level, MSF activities include Adolescent Sexual and Reproductive Health (ASRH) health promotion and education initiatives (i.e., School Health Clubs), and strategies to link and retain in care adolescents living with HIV and young people (i.e., mobile clinics to hotspots). Some of these activities are conducted with the involvement of peer educators. MSF also conducts capacity building activities for health staff of the City of Harare.

Since January 2016, a total of 16,500 adolescent beneficiaries received medical care in the facilities supported by MSF in Mbare. From January 2019 to the end of September 2020, 102 adolescents

[5] Care requirements for clients who present for rape and clients who present for consensual sex as a minor at a clinic in Harare, Zimbabwe, from 2011 to 2014. MSF study

[6] They group adolescents who sell sex, adolescents who use drugs, adolescents from LGBTI communities. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5956528/

received post-abortion care. 6,344 adolescents were sensitized through community peer-to-peer interventions. In addition, two SRH digital health promotion campaigns were carried out, reaching 630,020 persons. A roundtable with key MSF stakeholders is planned for the second trimester of 2021, to discuss the main project orientations for the next years.

REASON FOR EVALUATION / RATIONALE

While adolescents represent a part of patients' cohorts in MSF projects, the MSF experience in targeting them exclusively is quite limited. This project represents a unique opportunity for MSF to reflect and learn about the specific enabling factors and challenges of adolescents' health interventions.

The project strategy relies strongly on partnerships and collaborations with other actors including the delivery of health services. This component of its strategy represents an additional element of interest, to be assessed and reflected.

OVERALL OBJECTIVE AND INTENDED USE

OVERALL OBJECTIVE is to assess the appropriateness, effectiveness, coverage, and connectedness of the MSF adolescent SRH intervention in Mbare and to identify the necessary adaptations for the next years.

INTENDED USE of this evaluation is aimed primarily at informing MSF Operational Centre Brussels (OCB) discussions (to take place during the second quarter of 2021) about the project's main orientations for the next years, including potential necessary adaptations. It may also be used by MSF and other actors potentially interested in reflecting on how to adequately address adolescents' health in similar projects.

SPECIFIC OBJECTIVES

APPROPRIATENESS

- Are the health interventions (SRH, HIV, TB, PHC, MH) appropriate according to the target population (globally as well as more specifically to each subgroup)?
- Are the non-medical interventions (i.e., incoming generating activities) appropriate according to the target population (globally as well as more specifically to each subgroup)?
- Is MSF's overall strategy appropriate to achieve the project's objectives?

EFFECTIVENESS

- To what extent are the agreed objectives being achieved?
- What were the main reasons for achievement or under-achievement of objectives?
- What can be done to make the intervention more effective?
- How is the existing monitoring and evaluation framework aligned with the project objectives?

COVERAGE

- To which extent do the medical activities reach the target population (globally as well as more specifically to each subgroup)?
- Are there any factors that hinder project ability to reach the target populations and those most in need?
- To what extent do beneficiaries have access to medical services provided by this project? What are the main enabling factors to facilitate this access? Is any targeted group excluded from the services provided by this project?

CONNECTEDNESS

- What local capacities and resources have been identified? How does the project connect with these?
- Are there important gaps or overlaps regarding the services offered to adolescents in the project area, considering other actors and service providers?
- To what extent is MSF's current approach effective in attracting and working with different partners as a mean to achieve objectives and ensure continuity after MSF leaves?
- What problems can be identified for the continuity of the medical interventions, and how have they been taken into consideration?

EXPECTED DELIVERABLES

1. **Inception Report -** as per SEU standards, after conducting initial document review and preliminary interviews. It will include a detailed evaluation proposal, including methodology.
2. **Draft Evaluation Report -** as per SEU standards.
3. **Working Session -** with the attendance of commissioner and consultation group members. As part of the report writing process, the evaluator will present the findings, collect attendances' feedbacks and will facilitate discussion on lessons learned.
4. **Final Evaluation Report -** after addressing feedbacks received during the working session and written inputs.
5. **Other dissemination deliverables -** may include, among others, the presentation of evaluation findings to the main partners of the projects and the submission of one-page summary of main evaluation findings. A more detailed proposal will be defined as part of the Inception Report.

TOOLS AND METHODOLOGY PROPOSED

In addition to the initial evaluation proposal submitted as a part of the application, a detailed evaluation protocol should be prepared by the evaluators during the inception phase. It will include a detailed explanation of proposed methods and its justification based on validated theory/-ies. It will be reviewed and validated as a part of the inception phase in coordination with SEU.

The evaluation should ensure diverse perspectives and make explicit the experiences and values of the different stakeholders, not least those affected by the intervention and the partners.

RECOMMENDED DOCUMENTATION

- Project documents (project proposals, logical frameworks, situational reports, annual reports, field visit reports),
- MSF project-related documents (e.g.: Knowledge Attitude and Practice survey with adolescents in Mbare 2014),
- National and regional documentation (e.g. Zimbabwe SRH and adolescents health national policies, Zimbabwe reports)
- External literature and documentation of similar experiences (e.g. Zvandiri, CesHHAR, Pangea, Gals, PATA, Frontline AIDS READY+ etc.)

PRACTICAL IMPLEMENTATION OF THE EVALUATION

Number of evaluators	TBD
Timing of the evaluation	December 2020 – May 2021

PROFILE/REQUIREMENTS FOR EVALUATOR(S)

Requirements:

- Proven evaluation competencies (minimum 5 years)
- Experience in adolescent health interventions (minimum 5 years)
- Experience in Sexual and Reproductive Health programming (5 years), including HIV
- Language requirements: English (Fluent)

Assets:

- Experience in health-seeking behavior and community engagement
- Understanding of Southern African and Zimbabwean context

ANNEX 2. LOGIC MODEL

The Mbare ASRH project Model

Developed by: Constancia Mavodza, Chido Dziva Chikwari and Tinashe Goronga

The Mbare ASRH project is providing an adolescent-friendly comprehensive and integrated package of sexual and reproductive health (SRH) services- including the HIV cascade, Mental Health (MH) and TB care for adolescents at community and facility level. Since 2020, within the sexual and reproductive health services, there has been a particular focus on increasing access to family planning using a 3-pillar strategy (Family Planning (FP), Antenatal Care (ANC) and Post-Abortion Care (PAC)). As part of its integration model and addressing the differentiated care needs of particular adolescent subgroups, the program collaborates with multiple key stakeholders who play a role in adolescent health and wellbeing.

Adolescents 10-19 years old of age, and for some services, up to 24 years can access the project's services. For contraceptive care services, the nurse providers are government trained for long- acting reversible contraceptives (LARCs) to be able to offer both short term and LARC at Mbare Polyclinic, Matapi Youth Hub, and in the community. SRH, HIV, TB and MH services are integrated at planning and implementation level. All adolescents (including LGBTQI, disability, living with HIV, young people who sell sex; young people living and working on the street, substance users) who enter the Mbare ASRH project for care, in addition to the service that triggers their entry, they are offered all the services available. These services are offered for free, and according to national guidelines. MSF also covers the cost of all referrals to services that are offered by partner organisations or higher level of care.

Outside of the Mbare Polyclinic, and the Matapi Youth Hub, information on the available services and light- medicalised services are also offered in the community. This includes mobilization and sensitization efforts which include one-on-one interactions between potential clients, community members and peer educators, mobile and moonlight clinics, and engagement with schools and churches.

Logic Model (Figure 1) Description

INPUTS:

Financial resources are adequately available to run the project; set up logistical systems and pay staff. Adequately trained staff are available to offer information on and provide SRH, HIV, TB and MH services to adolescents (and young people). Stakeholder partnerships are established to streamline the delivery of an integrated and comprehensive package. The MSF-Zimbabwe, coordinating and management team is available to provide project guidance and support ensuring that the integrity of the project is observed, and data is adequately collected.

ACTIVITIES:

Community and facility implementation activities interact as this is an integrated health services package. The implementation team received full training so that they are able to offer correct information to clients. Only the nurses receive MoHCC delivered training on how to deliver both short-

term and LARC FP methods. A peer educators protocol exists and is implemented to enable young people's engagement and participation in the project.

Mobilisation and awareness activities include going into the intervention communities to engage with members, and adolescents, about what the Mbare ASRH project is, and the services being offered at the polyclinic, Matapi Youth Hub and the community. These activities also include the peer educators. Vulnerable and especially at-risk adolescents are supported by various stakeholders and partners in the Mbare community, therefore relationships with partner stakeholders are developed to ensure the project is meeting the SRH needs of all adolescents.

OUTPUTS:

Proper coordination across the comprehensive, integrated service delivery chain. Non-judgmental service provision, counselling and information. Full spectrum of contraceptive choice, the whole HIV cascade, follow-up and appropriate referral (as needed) is provided to all adolescents who need it. Supervision, monitoring and evaluation, and a functional logistics system is up and running. Advocacy engagement and dissemination activities around SRH issues are occurring systematically to exponentially improve impact

OUTCOMES:

All of the inputs, activities and outputs should, result in improved differentiated and integrated service provision for adolescents; improved SRH, HIV, MH, and TB outcomes and behavioural changes; and progressive impact on policy and other adolescent focused SRH programs

Overall, the Mbare ASRH project involves: comprehensive integrated services delivery; training of service providers to deliver high quality services; monitoring and evaluation; stakeholder engagements in the community; and advocacy and dissemination efforts. Successful implementation of this project requires the streamlined coordination of inputs, activities and, outputs which would lead to anticipated outcomes and impact.

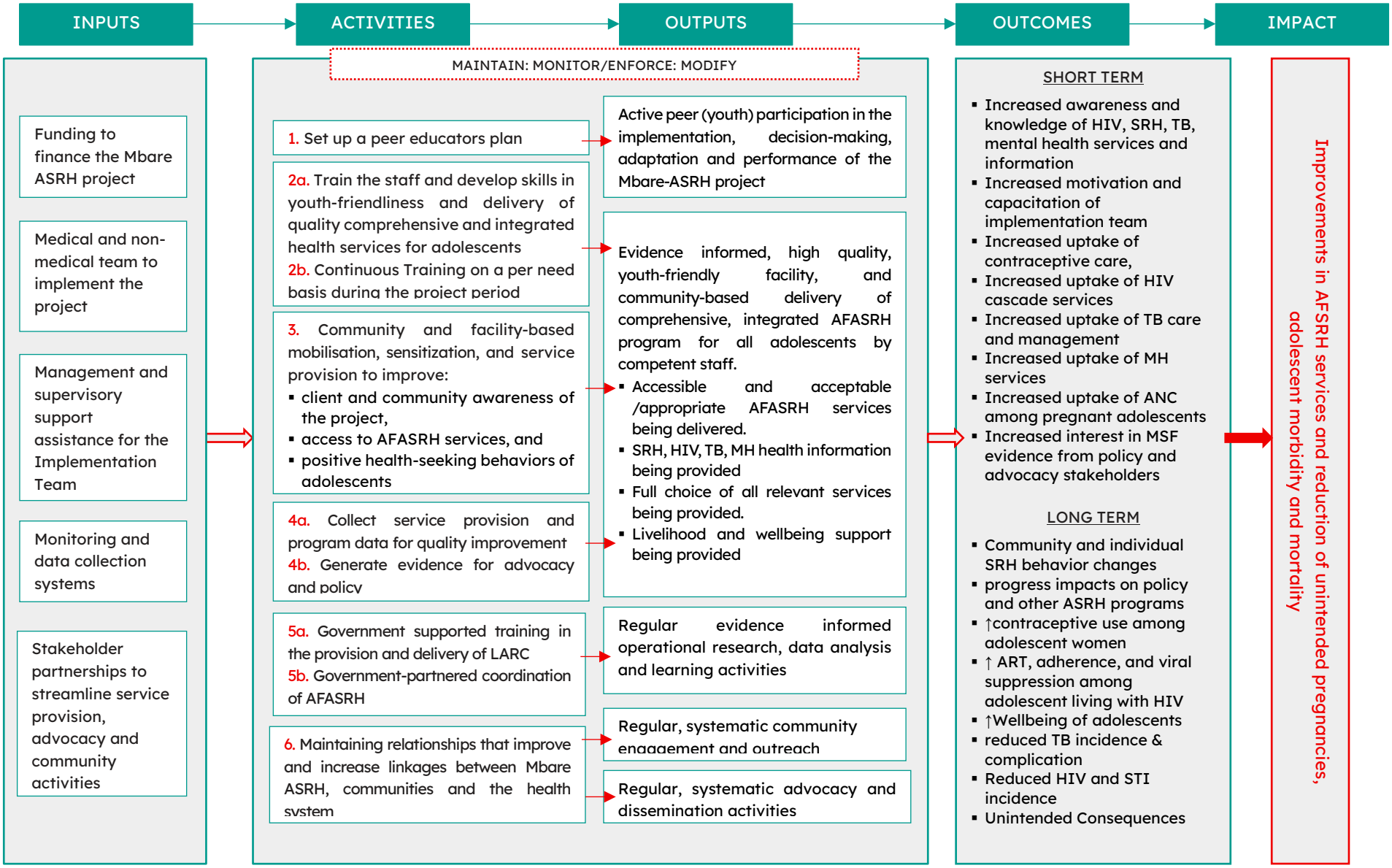

Figure A6. Implementation Model of the Mbare ASRH project as intended, Outcomes and Impact.

ANNEX 3. CONSENT FORMS

MBADO Evaluation - Evaluating the MSF Mbare ASRH project

Contact Team: Constancia Mavodza, Sarudzayi Kufandirori
Phone: +26 / +26

What you should know about this evaluation:

- We give you this consent so that you may read about the purpose, risks, and benefits of this evaluation.
- We cannot promise that this evaluation will benefit your child. The main goal here is to gain knowledge that may improve the Mbare- ASRH project.
- You have the right to refuse to allow your child to take part, or agree for your child to take part now and change your mind later.
- Whatever you decide will not affect your child's care.
- Please review this consent form carefully. Ask any questions before you make a decision.
- Your choice to allow your child to participate is voluntary.

PURPOSE:

We are conducting an evaluation to find out if the Mbare ASRH project is providing adequate and appropriate health services for adolescents and young people aged 10-24 years. This is because we want to improve the Mbare ASRH project, and we believe that the adolescents and young people who have received services can help us to do that. Your child was selected as a possible participant in this evaluation because he/she is aged between 10-15 years and is attending or has attended one of the Mbare ASRH projects' sites (either at the Mbare Polyclinic, Matapi Youth Hub or in the community). We are asking for consent for your child to participate in this evaluation.

PROCEDURES AND DURATION:

If you allow your child to participate in this evaluation, a member of the recruitment team will explain the study to you and your child, and you may choose whether to allow your child to participate in this study. If you and your child agree, we will ask some questions about your child's age, gender and health. Your child will then be asked some questions about what they think about the Mbare ASRH project and the services they received. These questions will be asked either in a group setting or a one-on-one interview with a trained member of the evaluation team. This will happen at a venue in Mbare; and will take approximately 30- 45mins.

We may also ask you (as the guardian) to participate in a brief interview on your thoughts and experience of the Mbare ASRH project and supporting your child in receiving health assistance through the Mbare ARSH project. You have the right to decline to participate in this interview, even if you agree for your child to participate. All the information you share will not have your name or personal information and will remain confidential to the evaluation team.

RISKS AND DISCOMFORTS:

Talking to your child about their experiences and thoughts on the Mbare ASRH project should not pose any risks to your child. Nevertheless, some questions may cause anxiety, and the trained evaluation

team member who will be interviewing the child will thoroughly explain the evaluation and inform your child, they are allowed to not answer any questions that may make them anxious or uncomfortable.

BENEFITS AND/OR COMPENSATION:
Taking part in this evaluation will not cost you anything. We cannot and do not guarantee or promise that your child will receive any benefits from taking part. Your child and other children could benefit in the future from the findings of this evaluation. A small snack will be provided at the end of each interview.

CONFIDENTIALITY:
If you indicate your willingness for your child to participate in this evaluation by signing this document, all information obtained will be for evaluation purposes only, and will be held securely and stored on paper and password protected computer files. No one outside of the evaluation team will have access to any of the information that you give us.

VOLUNTARY PARTICIPATION:
Participation in this study is voluntary. If you decide not to allow your child to participate in this study, your decision will not affect you or your child's future relations with the staff and service in the Mbare-ASRH project. If you decide to allow your child to participate, you and your child are free to withdraw your consent and assent and discontinue participation at any time without penalty.

Evaluating the MSF Mbare ASRH project

OFFER TO ANSWER QUESTION
Before you sign this form, please ask any questions on any aspect of this evaluation that is unclear to you. You may take as much time as necessary to think it over.

AUTHORIZATION
YOU ARE MAKING A DECISION WHETHER OR NOT TO ALLOW YOUR CHILD TO PARTICIPATEIN THIS EVALUATION. YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION PROVIDED ABOVE, HAVE HAD ALL YOUR QUESTIONS ANSWERED, AND HAVE DECIDED TO ALLOW YOUR CHILD TO PARTICIPATE.

- I have read the information sheet concerning this evaluation [or have understood the verbal explanation] and I understand what will be required of my child and what will happen to him/her if he/she takes part in it.
- I understand that my child will be asked questions about their thoughts or experiences of the Mbare ASRH project.
- I understand that at any time my child may withdraw from this study without giving a reason and without affecting his/her normal care and support.

I agree that my child may take part in this evaluation.
YES/NO

I (the guardian) agree to take part in a discussion about the Mbare ASRH project
YES/NO

I agree for this discussion to be audio recorded
YES/NO

Consent from parent/guardian/legally authorized representative:

Name of Guardian (Print):_____
Date:_____
Signature:_____
Relationship to Participant:_____

Participant Assent (Children 10-15 years only):
My participation in this evaluation is voluntary. I have read [or been explained] and understood the information. All my questions have been answered and I agree to take part in this evaluation.

Name of Participant (Print) :_____
Date: _____
Signature of Participant:_____
Name of Evaluation Staff:_____
Signature of Evaluation Staff:_____
Date:_____

If participant gave verbal assent, enter name of the person who witnessed the assent, and signature.
Witness Name:_____
Witness Signature:

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP
If you have any or more questions concerning this evaluation or consent form, including questions about the research, your rights as a research subject or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team , please feel free to contact MSF-Mbare on telephone +26

ANNEX 4. EVALUATION PARTICIPANTS

Participant ID	subgroup	Age	Gender (M/F)	Marital Status	Residential Status	HIV Status	In a relationship	Sexually Active (Y/N)	If Yes to H, # of partners	Education level
AC client	AYP	17	M	Single	With parents	Negative	N	N	0	Secondary
AC client	Living on the streets	17	F	Unmarried living with partner	With partner	Positive	Y	Y	1	Secondary
AC client	Substance user	19	F	Single	With parents	Negative	N	Y	4	Secondary
Matapi client	General	14	M	Single	With parents	Negative	N	N	0	Primary
AC client	Teen mom	18	F	Single	With parents	Negative	N	Y	1	Secondary
Matapi client	YPSS	21	F	Single	With parents	Negative	Y	Y	20+	Secondary
AC	YPSS	18	F	Single	On own	Positive	Y	Y	7-8 daily	Secondary
AC	ANC1	19	F	Single	With parents	Negative	N	Y	1	Secondary
AC	Teen mom using LARCs	18	F	Single	With parents	Negative	N	Y	1	Secondary
Matapi client	LGBTQI	28	M	Single	On own	Negative	Y	y	3	Secondary
AC	General (16-19)	19	M	Single	With parents	Negative	N	Y	1	Secondary
AC	ANC	19	F	Single	With parents	Negative	N	Y	1	Secondary
AC	General (16-19)	17	F	Single	With parents	Negative	N	N	0	Secondary
AC	HIV+ client	17	F	Single	With parents	Positive	N	Y	0	Secondary
AC	General	17	F	Married	With partner	Negative	Y	Y	2	Secondary
Matapi client	General	15	F	Single	With parents	Unknown	N	N	0	Primary
AC client	HIV+ client	16	M	Single	With parents	Positive	N	N	0	Primary
AC client	HIV+ client	21	F	Single	With parents	Positive	Y	Y	1	Secondary
AC client	HIV+ client	18	F	Single	With parents	Positive	Y	N	0	Primary
AC client	HIV+ client	21	M	Single	With parents	Positive	N	Y	2	Secondary

AC client	FP-OCP User	18	F	Single	With parents	Negative	Y	Y	1	Primary
AC	HIV+ client (16-19)	18	M	Single	With parents	Positive	N	N	0	Secondary
AC	Adolescent using LARCs	17	F	Single	With parents	Negative	Y	Y	1	Secondary
AC	Adolescent using oral contraceptives	17	F	Single	With partner	Negative	N	Y	1	Secondary
Matapi client	Living on the streets	19	F	Single	On own	Negative	Y	Y	6	Primary
Matapi client	General	16	M	Single	With parents	Negative	N	N	0	Primary
Matapi client	General	15	M	Single	With parents	Negative	N	Y	2	Primary
AC	Substance user	20	M	Single	With parents	Negative	N	N	0	Secondary
AC	LGBTQI	19	F	Single	With parents	Decline to answer	Decline to answer	N	0	Secondary
Matapi client	General	17	M	Single	With parents	Negative	N	N	0	Primary
Matapi client	General	15	F	Single	With parents	Unknown	N	N	0	Secondary
AC	General (10-15)	15	F	Single	With parents	Negative	N	N	0	Secondary
AC	OI client	12	F	Single	With parents	Unknown	N	N	0	Primary
AC	OI client	11	M	Single	With parents	Negative	N	N	0	Primary

Adolescents and Young People Focus Group Discussions (7 focus Group discussions with 57 adolescents and young people)

Participant ID	subgroup	Age	Gender (M/F)	Marital Status	Residential Status	HIV Status	In a relationship	Sexually Active (Y/N)	If Yes to previous, # of partners	Education level

AC&Matapi clients	General (16-19)	18	M	Single	With parents	Negative	Y	Y	3	Secondary
AC & Matapi clients	General (16-19)	17	M	Single	With parents	Negative	Y	Y	2	Secondary
AC & Matapi clients	General (16-19)	16	M	Single	With parents	Negative	N	N	0	Primary
AC & Matapi clients	General (16-19)	17	M	Single	With parents	Negative	y	y	2	Secondary
AC & Matapi clients	General (16-19)	16	M	Single	With parents	Negative	y	N	0	Primary
AC & Matapi clients	General (16-19)	17	M	Single	With parents	Negative	Y	Y	2	Secondary
AC & Matapi clients	General (16-19)	19	M	Single	With parents	Negative	N	Y	2	Secondary
AC clients	Teen mom	14	F	Single	With parents	Negative	N	Y	1	Primary
AC clients	Teen mom	19	F	Single	With parents	Negative	Y	Y	1	Secondary
AC clients	Teen mom	20	F	Single	With parents	Negative	Y	N	2	Secondary
AC clients	Teen mom	17	F	Single	With parents	Negative	N	Y	2	Secondary
AC clients	Teen mom	18	F	Single	With parents	Negative	N	Y	2	Secondary
AC clients	Teen mom	19	F	Single	With parents	Negative	N	Y	1	Secondary
AC clients	Teen mom	18	F	Single	With parents	Negative	N	Y	2	Secondary
AC clients	Teen mom	18	F	Single	With parents	Negative	N	Y	2	Secondary
AC clients	Teen mom	17	F	Single	With parents	Negative	N	Y	1	Secondary
AC clients	Teen mom	18	F	Single	With parents	Negative	Y	Y	3	Secondary
AC clients	Teen mom	17	F	Single	With parents	Negative	N	Y	3	Primary
AC & Matapi clients	HIV+ client	15	M	Single	With parents	Unknown	N	N	0	Primary

AC & Matapi clients	HIV+ client	13	F	Single	With parents	Positive	N	N	0	Primary
AC & Matapi clients	HIV+ client	21	F	Single	With parents	Positive	N	N	0	Secondary
AC & Matapi clients	HIV+ client	20	M	Single	With parents	Positive	N	N	0	Secondary
AC & Matapi clients	HIV+ client	19	F	Single	With parents	Positive	N	N	0	Secondary
AC & Matapi clients	HIV+ client	18	F	Single	With parents	Positive	N	N	0	Secondary
AC & Matapi clients	HIV+ client	18	F	Single	With parents	Positive	N	N	0	Secondary
AC & Matapi clients	General (16-19)	16	F	Single	With parents	Negative	N	N	0	Primary
AC & Matapi clients	General (16-19)	16	F	Single	With parents	Negative	N	N	0	Primary
AC & Matapi clients	General (16-19)	16	F	Single	With parents	Negative	N	N	0	Primary
AC & Matapi clients	General (16-19)	17	F	Single	With parents	Negative	Y	Y	1	Primary
AC & Matapi clients	General (16-19)	18	F	Single	With parents	Negative	Y	N	0	Primary
AC & Matapi clients	General (16-19)	16	F	Single	With parents	Negative	N	N	0	Primary
AC & Matapi clients	General (16-19)	16	F	Single	With parents	Negative	N	N	0	Primary
AC & Matapi clients	General (16-19)	18	F	Single	With parents	Negative	Y	N	0	Primary

Matapi	General	14	F	Single	With parents	Negative	N	N	0	Secondary
Matapi	General	14	F	Single	With parents	Negative	N	N	0	Secondary
Matapi	General	17	F	Single	With parents	Negative	N	N	0	Secondary
Matapi	General	16	F	Single	With parents	Negative	N	N	0	Secondary
Matapi	General	15	F	Single	With parents	Decline to answer	N	N	0	Secondary
Matapi	General	17	F	Single	With parents	Negative	N	N	0	Secondary
Matapi	General	15	F	Single	With parents	Negative	N	N	0	Secondary
AC	OI client	18	F	Single	With parents	Positive	Y	N	0	University college
AC	OI client	17	F	Single	With parents	Positive	N	N	0	Secondary
AC	OI client	16	M	Single	With parents	Decline to answer	N	N	0	Secondary
AC	OI client	19	M	Single	With parents	Positive	Y	Y	0	Secondary
AC	OI client	16	F	Single	With parents	Positive	N	N	0	Secondary
AC	OI client	17	M	Single	With parents	Decline to answer	N	Decline to answer	N/A	Secondary
AC	OI client	17	M	Single	With parents	Positive	Y	N	0	Secondary
AC	OI client	16	F	Single	With parents	Positive	N	N	0	Secondary
AC	OI client	19	F	Single	With parents	Positive	N	N	0	Primary
AC	OI client	16	F	Single	With parents	Positive	N	N	0	Secondary
AC	Peer Educator (3 months)	21	M	Single	On own	Negative	N	Decline to answer	N/A	Secondary
Matapi	Peer Educator (4 years)	22	F	Single	On own	Negative	Y	Y	1	Secondary

AC	Peer Educator (2 years)	20	M	Single	With parents	Negative	Y	N	0	Secondary
AC	Peer Educator (3 months)	18	F	Single	With parents	Negative	N	N	0	Secondary
Matapi	Peer Educator (3 months)	20	F	Single	With parents	Negative	N	Y	2	Secondary
AC	Peer Educator (3 months)	21	F	Single	With parents	Negative	N	N	0	Secondary
Matapi	Peer Educator (3years)	20	F	Single	On own	Negative	Y	Y	1	Secondary

Peer Educator Interviews (n=7)

Participant ID	Sub- Group represented	Time active as PE (years)	Age	Gender (M/F)	Marital Status	Residential Status	HIV Status	In a relationship	Sexually Active (Y/N)	If Yes to previous, # of partners	Education level
PE	Digital health Promotion	3	21	M	Single	On own	Negative	Yes	Yes	4	Secondary
PE	General	1	19	M	Single	With parents	Negative	N	N	0	Secondary
PE	General	1	19	F	Single	With parents	Negative	Y	Y	1	Secondary
PE	HIV+ client	3months	20	F	Single	With parents	Positive	Y	Y	3	Secondary
PE	LGBTQI	3months	20	F	Single	With parents	Negative	Y	Y	2	Secondary
PE	Substance abuse	-	22	M	Single	With parents	Decline to answer	N	N	0	Secondary
PE	Living with Disability	3	24	F	Single	With parents	Negative	Y	N	0	Secondary

PE	Community Health Mobilizer	-	21	F	Single	With parents	Negative	Y	Y	1	Secondary

Stakeholders and Partners Interviews (n=12)

Name of organization	Role at work	Age	Gender (M/F)	# of years in role	Education level achieved
YWCA	Hotel and catering teacher	34	F	3	University/College
Greenlight College	Principal and Health Club Leader	32	F	5	University/College
Ministry of Education (Primary)	Teacher & school health leader	50	F	23	University/College
MSF	Health Promotions Supervisor	36	M	9	University/College
PSZ	Nurse provider-Team leader	42	F	3	University/College
CESVI	Coordinator	67	M	9	University/College
AFRICAID-ZVANDIRI	Head of Programmes	36	F	1.5	University/College
AFRICAID-ZVANDIRI	Zvandiri mentor: Mbare Polyclinic	40	F	2.5	University/College
SAT	SRHR Youth Officer responsible for all SRHR youth programmes	29	M	4	University/College
CeSHHAR	Site Manager	38	F	2	University/College
FHI360/IMULI	Family Planning Nurse	34	F	3	University/College
CHIEDZA Child Care Centre	Project Officer for SRHR	31	F	3	University/College

Health Providers Interviews (n=7)

Workstation	Role at work	Age	Gender (M/F)	Years as health provider	Education level
AC	Doctor	45	F	20	University/College
Mbare Poly	FHS SIC	56	F	15	University/College
AC	Nursing Team Supervisor/ Mental Health Nurse	44	F	19	University/College
Mbare Poly	ANC Nurse/Midwife	48	M	13	University/College
Mbare Poly	OI Nurse/ Focal Person	51	F	29	University/College

AC/OI	Primary Counsellor	36	M	12	University/College
AC	Social Worker	38	F	10	University/College

Community FGDs (2 focus groups with n= 18 participants)

Participant ID	Age	Gender (M/F)	Marital Status	Education level	Place of work
Community stakeholder 1	45	M	Divorced	Secondary	MSF Facilitator
Community stakeholder 2	35	M	Married	Secondary	Community Member
Community stakeholder 3	16	F	Single	Secondary	SAIC Safety Programs
Community stakeholder 4	53	M	Widowed	Secondary	CCW-Social Welfare, Zim Widow, Widower and Orphan Association National Vice Chairperson
Community stakeholder 5	54	F	Single	Primary	MSF Water Point Chair
Community stakeholder 6	22	F	Single	Secondary	SAIC facilitator
Community stakeholder 7	32	F	Married	Secondary	Aqua Healing and Caritas Community based facilitator
Community stakeholder 8	28	F	Single	University/College	SAIC Safety programs, Rainbow Hockey club
Parent/Caregiver 1	48	F	Divorced	Secondary	Mbare waste transit
Parent/Caregiver 2	45	F	Married	Secondary	Water point
Parent/Caregiver 3	30	F	Married	Secondary	Vendor
Parent/Caregiver 4	39	F	Single	Secondary	Mbare waste transit

Parent/Caregiver 5	58	F	Married	Secondary	Self-employed
Parent/Caregiver 6	42	F	Single	Secondary	Self-employed
Parent/Caregiver 7	43	M	Married	Secondary	Water point
Parent/Caregiver 8	59	F	Married	Secondary	Mbare waste transit
Parent/Caregiver 9	47	F	Married	Secondary	Self-employed
Parent/Caregiver 10	54	M	Married	Secondary	Water point

Key Informants Interviews (n=3)

Name of organization	**Role at work**	**Age**	**Gender**	**# of years in role**	**Education level**
ZNFPC	Acting Assistant Director-service delivery and trading	55	F	3 months	University/college
ZNFPC	National ASRH Program Officer	48	F	12 years	University/college
ZNFPC	ASRH Program Assistant	27	F	6 months	University/college

ANNEX 5. OTHER TABLES AND FIGURES

Table A6: Uptake of services stratified by site and year.

INDICATOR		YEAR, N (%)										
		2016		2017		2018		2019		2020		
		AC	Outreach	AC	Outreach	AC	Outreach	AC	Outreach	AC	Matapi	Outreach
Total number of adolescents (N)		1272	261	2461	227	4360	167	5279	1151	3631	1323	241
OPD services		610 (48.0)	-	903 (36.7)	7 (3.1)	1503 (34.4)	1 (0.6)	2643 (50.1)	10 (0.9)	2391 (65.8)	407 (30.8)	19 (7.9)
Sex	Male	571 (44.9)	156 (59.8)	1051 (42.7)	80 (35.2)	1995 (45.8)	96 (57.5)	2116 (40.1)	556 (48.3)	1194 (32.9)	577 (43.6)	87 (36.1)
	Female	701 (55.1)	105 (40.2)	1410 (57.3)	147 (64.8)	2365 (54.2)	71 (42.5)	3163 (59.9)	595 (51.7)	2437 (67.1)	746 (56.4)	154 (63.9)
Age groups	<10	-	-	-	-	-	-	-	-	25 (0.7)	5 (0.4)	-
	10-12	282 (22.2)	60 (23.0)	377 (15.3)	18 (7.9)	398 (9.1)	2 (1.2)	609 (11.5)	43 (3.7)	401 (11.0)	88 (6.7)	2 (0.8)
	13-15	282 (22.2)	52 (19.9)	553 (22.5)	52 (22.9)	572 (13.1)	4 (2.4)	725 (13.7)	49 (4.3)	590 (16.3)	252 (19.0)	26 (10.8)
	16-19	708 (55.7)	149 (57.1)	1531 (62.2)	157 (69.2)	3303 (75.8)	56 (33.5)	3785 (71.7)	579 (50.3)	2412 (66.4)	853 (64.5)	82 (34.0)
	20-24	-	-	-	-	87 (2.0)	80 (47.9)	150 (2.8)	460 (40.0)	179 (4.9)	115 (8.7)	131 (54.4)
	25+	-	-	-	-	-	25 (15.0)	10 (0.2)	20 (1.7)	24 (0.7)	10 (0.8)	-
ASRH services	HIV testing	1084 (85.2)	120 (46.0)	2036 (82.7)	227 (100)	3216 (73.8)	167 (100)	3130 (59.3)	1136 (98.7)	641 (1.8)	98 (74.2)	217 (90.0)
	Condom uptake	41 (3.2)	-	62 (2.5)	-	22 (0.5)	-	33 (0.6)	1 (0.1)	55 (1.5)	247 (18.7)	63 (26.1)

INDICATOR		YEAR, N (%)										
		2016		2017		2018		2019		2020		
		AC	Outreach	AC	Outreach	AC	Outreach	AC	Outreach	AC	Matapi	Outreach
	Menstrual hygiene	-	-	-	-	-	-	-	-	53 (1.5)	171 (12.9)	-
	Family planning	24 (1.9)	0	138 (5.6)	-	165 (37.7)	1 (0.6)	206 (3.9)	33 (2.9)	782 (21.5)	558 (42.2)	107 (44.4)
	STI treatment	101 (7.9)	0	185 (7.5)	3 (1.3)	271 (6.2)	76 (45.5)	402 (7.6)	17 (1.5)	43 (1.2)	-	11 (4.6)
	Antenatal care	16 (1.3)	1 (0.4)	47 (1.9)	0	107 (2.5)	0	155 (2.9)	2 (0.2)	69 (1.9)	14 (1.1)	8 (3.3)
	Health education	272 (21.4)	260 (99.6)	1156 (47.0)	217 (95.6)	1950 (44.7)	89 (53.3)	1645 (31.2)	978 (85.0)	172 (47.4)	357 (27.0)	0
	Mental health	-	-	-	-	53 (1.2)	-	11 (0.2)	-	161 (4.4)	3 (0.2)	-
	Psychosocial support	-	-	-	-	-	-	-	-	85 (2.3)	7 (0.5)	-
	Drug abuse					25 (0.6)	-	6 (0.1)	-	42 (1.2)	-	-

Table A7: Uptake of services stratified by sex and year

INDICATOR		YEAR, N (%)									
		2016		2017		2018		2019		2020	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Tot no of adolescents (N)		727	806	1131	1557	2091	2436	2672	3758	1856	3337
OPD services		304 (49.9)	305 (50.1)	433 (47.6)	477 (52.4)	708 (47.1)	796 (52.9)	1126 (42.4	1527 (57.6)	1040 (36.9)	1777 (63.1)
Site	AC	571 (44.9)	701 (55.1)	1051 (42.7)	1410 (57.3)	1995 (45.8)	2365 (54.2)	2116 (40.1)	3163 (59.9)	1769 (35.7)	3183 (64.3)
	Matapi	-	-	-	-	-	-	-	-	-	-
	Outreach	156 (59.8)	105 (40.2)	80 (35.2)	147 (64.8)	96 (57.5)	71 (42.5)	556 (48.3)	595 (51.7)	87 (36.1)	154 (63.9)
Age groups	<10	-	-	-	-	-	-	-	-	11 (36.7)	19 (63.3)
	10-12	199 (58.2)	143 (41.8)	184 (46.6)	211 (53.4)	204 (51)	196 (39.1)	305 (46.8)	347 (53.2)	204 (41.5)	288 (58.5)
	13-15	155 (46.4)	179 (53.6)	274 (45.3)	331 (54.7)	234 (40.6)	342 (59.4)	319 (41.2)	455 (58.8)	360 (41.5)	508 (58.5)
	16-19	373 (43.5)	484 (56.4)	673 (39.9)	1015 (60.1)	1550 (46.1)	1809 (53.9)	1760 (40.3)	2609 (59.7)	1090 (32.6)	2253 (67.4)
	20-24	-	-	-	-	50 (39.1)	78 (60.9)	279 (45.7)	331 (54.3)	171 (40.2)	254 (59.8)
	25+	-	-	-	-	14 (56)	11 (44)	9 (30)	21 (70)	19 (55.9)	15 (44.1)
ASRH services	HIV testing	571 (47.4)	633 (52.6)	970 (42.8)	1294 (57.2)	1516 (47.1)	1705 (52.9)	1293 (41.2)	1847 (58.8)	396 (41.4)	560 (58.6)
	Condom uptake	17 (41.5)	24 (58.5)	22 (35.5)	40 (64.5)	9 (40.9)	13 (59.1)	14 (41.2)	20 (58.8)	298 (81.6)	67 (18.4)
	Menstrual hygiene	-	-	-	-	-	-	-	-	1 (0.4)	223 (99.6)
	Family planning*	17 (19.1)	72 (80.9)	27 (13.8)	169 (86.2)	13 (3.4)	372 (96.6)	163 (18.2)	733 (81.8)	298 (20.6)	1149 (79.4)
	STI treatment	51 (50.5)	50 (49.5)	72 (38.9)	113 (61.1)	123 (45.4)	148 (54.6)	138 (33.7)	271 (66.3)	3 (5.6)	51 (94.4)
	Antenatal care**	-	73 (100)	-	228 (100)	-	391 (100)	16 (3.7)	416 (96.3)	6 (6.6)	85 (93.4)
	Health education	260 (48.9)	272 (51.1)	593 (43.1)	783 (56.9)	1014 (52)	936 (48)	765 (46.5)	880 (53.5)	265 (50)	265 (50)
	Mental health	-	-	-	-	11 (20.8)	42 (79.2)	4 (36.4)	7 (63.6)	45 (27.4)	119 (72.6)
	Psychosocial support	-	-	-	-	-	-	-	-	17 (18.5)	75 (81.5)
	Drug abuse	-	-	-	-	14 (56.0)	11 (44.0)	4 (66.7)	2 (33.3)	12 (28.6)	30 (71.4)

* Males recorded as having received family planning services, for some records there are recorded as condoms

** Males recorded as having received ANC services., there are likely data entry errors

Table A8: Uptake of services stratified by age category

INDICATOR		Age-groups n (%)					
		<10	10-12	13-15	16-19	20-24	25+
Total number of adolescents (N)		30	2281	3157	13614	1202	89
OPD services		24 (80.0)	1794 (78.6)	1920 (60.8)	4468 (32.8)	259 (21.5)	31 (31.1)
Sex	Male	11 (36.7)	1096 (48.0)	1342 (42.5)	5446 (40.0)	539 (44.8)	42 (42.4)
	Female	19 (63.3)	1185 (52.0)	1815 (57.5)	8165 (60.0)	663 (55.1)	47 (47.5)
Site	AC	25 (83.3)	2067 (90.6)	2722 (86.2)	11739 (86.2)	416 (34.6)	34 (34.3)
	Matapi	-	88 (3.9)	252 (8.0)	853 (6.3)	115 (9.6)	10 (10.1)
	Outreach	5 (16.7)	125 (5.5)	183 (5.8)	1023 (7.5)	671 (55.8)	45 (45.5)
ASRH services	HIV testing	2 (6.7)	849 (37.2)	1266 (40.1)	8989 (66.0)	806 (67.1)	53 (53.5)
	Condom uptake	-	1 (0.04)	40 (1.3)	373 (2.7)	110 (9.2)	-
	Family planning	-	33 (1.4)	338 (10.7)	2394 (17.6)	254 (21.1)	10 (10.1)
	STI treatment	-	11 (0.5)	45 (1.4)	899 (6.6)	138 (11.5)	5 (5.1)
	Antenatal care	4 (13.3)	11 (0.5)	116 (3.7)	791 (5.8)	36 (3.0)	-
	Health education	1 (3.3)	379 (16.6)	788 (25.0)	5438 (39.9)	466 (38.8)	19 (19.2)
	Mental health	-	13 (0.6)	43 (1.4)	89 (0.7)	4 (0.3)	-
	Psychosocial support	1 (3.3)	11 (0.05)	29 (0.9)	48 (0.4)	3 (0.2)	-
	Drug abuse	1 (3.3)	2 (0.9)	11 (0.3)	52 (0.4)	7 (0.6)	-

ANNEX 6. COMPARATIVE ANALYSIS OF QUALITY OF CARE:
EVALUATION FRAMEWORK VS. WHO FRAMEWORK

Quality of Care Evaluation framework used (a)	**WHO 'quality of care' frameworks b)**	**Comparison of the twoframeworks**	**Is the MSF ASRH project providing quality ASRH care?**
Guideline-Driven Care: Confidentiality, autonomy,transition to adult health services, comprehensive care **Involvement in Healthcare:** Good understanding of medicalcondition and treatment, adolescents making own health decisions **Age Appropriate Environment:** Flexibility ofappointment times, separate physical space, teen-orientedhealth information, waiting time, privacy **Communication:** Clarity and provision of information, active listening,tone of communication **Staff Attitude:** Respectful,supportive, honest, trustworthy, friendly	**Accessible;** Adolescents are able to obtain thehealth services that are available. - Policies and procedures are in place that ensure that health services are either free oraffordable to adolescents - Point of service delivery has convenientworking hours - Adolescents are well informed about therange of reproductive health services available and how to obtain them. - Community members understand the benefits that adolescents will gain by obtaining the health services they need, and support their provision - Some health services and health-related commodities are provided to adolescents in the community by selected community members, outreach workers and adolescents themselves **Acceptable:** Adolescents are willing to obtainthe health services that are available. - Policies and procedures are in place thatguarantee client confidentiality. - Point of service delivery ensures privacy. - Health care providers are non-judgmental,considerate, and easy to relate to. - Point of service delivery ensures consultations occur in a short waiting time, with or without an appointment, and (where necessary) swift referral. - Point of service delivery has an	The evaluation team useda Domains of youth-friendly care framework (a) adapted from Sangruela et al. These domains are adopted from the WHO guidelines and framed/ presented differently andin summary format. The evaluators chose this framework for its ease ofuse, comprehensive and ease of understanding, and used these domains are reference point for analysis. Additionally, when the mechanisms of change components in cooperated in the evaluation (access, acceptability, affordability, availability, accommodativeness0 are combined with the presented domains of youth-friendly care- they both encooperate the components of the	**Accessibility** The project offer free health services to adolescents who need them, including covering the service provision costs for necessary referral health services. However, adolescents do potentially incur transport coststo some of the referral health facilities The working hours of the project have been convenient. Before COVID-19, the AC used to open on weekends as well, but this stopped with COVID-19.One challenge is inaccessibility during lunch hours as the clinic reception where young people must enter through closes for luncheven though the AC remains open Adolescents are well informed about the AC, and know that it provides services for them. However, there is limited knowledge on the range of all health services available to adolescents. Most of the adolescents onlyknew about the health service they received or needed and could not speak to the range of services they can access. Community members acknowledged the presence of MSF, and the importance of and relief at having the AC to serve adolescents and someyoung people. However, there seems to be a limited appreciation, understanding and sensitisation on the importance of very young adolescents (VYA), also being able to independently access SRH services Before COVID-19, community outreach activities were a crucial and active part of the project. Peer educators (who are older adolescents andyoung people) spearhead most of these activities, and were able to distribute condoms, and HIV self-testing kits during these outreach activities. Additionally the mobile clinic was also active and also provided contraceptives on its route. **Acceptability**

Medical Competency: Technical skills (procedure) **Accessibility of Health Care**: location,affordability	appealingand clean environment - Point of service delivery provides information and education through a varietyof channels	WHO quality of care framework (b).	The AC is located within the Mbare Polyclinic yard, but the AC buildingis behind the clinic buildings and cannot be easily seen. This ensures privacy for adolescents who come to access service there. Once the adolescents are present at the AC, privacy and confidentiality is
Health Outcomes: Pain management, quality of life	- Adolescents are actively involved in designing, assessing and providing health services. **Equitable:** All adolescents, not just selected groups, are able to obtain the health servicesthat are available. - Policies and procedures are in place that donot restrict the provision of health services - Health care providers treat all adolescentclients with equal care and respect, regardless of status. - Support staff treat all adolescent clients with equal care and respect, regardless ofstatus. **Appropriate;** The right health services (i.e. theones they need) are provided to them - The required package of health care is provided to fulfil the needs of all adolescents either at the point of service delivery or through referral linkages.		compromised in the gazebo waiting area where both adolescents and theguardians/ parents of VYA wait together in the same area. At Matapi, privacy and confidentiality is compromised as the young people conductHIVST in an open space together. Overarchingly, the general adolescents find the health providers at the AC and Matapi to be non-judgemental, considerate and easy to relate to.However, the key pops and some highly vulnerable groups have faced some challenges with either health providers or peer educators which include 1)not being easy to relate to/discomfort and 2) feeling judged orreduced by peer educators Adolescents have to wait in the gazebo (AC) or outside (Matapi). Whilewaiting times can become long, they are occupied waiting times. Health talks with peer educators, playing pool, using internet as some activities that happen during waiting times. Adolescents can show up any time during work hours and referrals are made as needed Matapi is less medicalised/more social environment. The AC is cleanand set up as a health facility. Health information is provided via IEC material, access to the internet,health talks with peer educators and with COVID-19 this

	Effective: The right health services are providedin the right way and make a positive contribution to their health. - Health care providers have the required competencies to work with adolescents andto provide them with the required health services - Health care providers use evidenced-basedprotocols and guidelines to provide health services. - Health care providers are able to dedicate sufficient time to deal effectively with theiradolescent clients. - The point of service delivery has the required equipment, supplies, and basic services necessary to deliver the required health services.		expanded to WhatsApp and Facebook as well. Peer educators are somewhat involved in the designing, assessing andprovision of health services. Regular adolescent do not seem to be as involved. Involving both could be improved. **Equitability** Accessing health services by VYA is compromised by the legal status which only allows>16years to independently access SRH services withno questions asked. Overarchingly, the general adolescents find the health providers at the AC and Matapi to be non-judgemental, considerate and easy to relate to.However, the key pops and some highly vulnerable groups have faced some challenges with either health providers or peer educators which include 1)not being easy to relate to/discomfort and 2) feeling judged orreduced by peer educators

			Appropriateness The health care package of HIV and SRH services including TB screening and diagnosis and mental health care is provided by or referredfor by the project. Some YPSS want PreP to be offered in-house, so that they can have a complete one stop shop. Other adolescents would prefer the flavoured and textured condoms to be provided vs. the non-flavoureduntextured options **Effective:** The training for provision of LARC is conducted by government/parastatal and does not happen systematically. Of the four nurses available, only 1 is trained in inserting IUCDs. There is only 1 mental health nurse. All staff receive training in adolescent-friendliness.The frequency and content of these trainings was not assessed in this evaluation The project uses WHO and national guidelines to provide health services. This can compromise access for VYA because these guidelineshave conditions for VYA to access SRH services unaccompanied Health providers' abilities to dedicate sufficient time to serve adolescentsis mixed. For the mental health services, this seems to be happening. Some HIV+ clients who want contraceptive care are missed by the project and this need later identified in the OI during HIV care and treatment, suggesting that providers may not have enough time to dedicate to the HV+ clients and discover their contraceptive care needs.The HIV+ clients seem to be quickly referred to the OI department **The AC** has the required equipment, supplies, and basic services necessary to deliver the required health services. Matapi was meant to temporally (because of COVI-19) provide all the services at the AC, butnever became fully equipped to accomplish this.
Overall, the project is providing quality adolescent-friendly services, and certain components of the project could benefit from improvements and quality checks.			

Assessment of public-sector youth-friendliness service provision vs. Mbare ASRH project

	PUBLIC SECTOR EVALUATION OF ADOLESCENT/YOUTH FRIENDLY SERVICE PROVISION[1]	MBARE ASRH PROJECT EVALUATION
Service Delivery	**Health facility based approach** ***Youth-friendly corners**:* aimed at impoving access to SRH informaton, clinical and counselling services - Weak referral systems from lower level facilities - Affordability a challenge for young people= low utilisation - Services accessed most by those geographically close to facility - Availability compromised by inadequate staffing,, staff attitudes not AYP friendly, shortage of FP commodities and STI supplies For YFCs to be effective, the whole health facility has to be youth-friendly. Capacity building needs to be facility wide YFCs found to be ineffective and costly	**Health facility based approach** ***Adolescent corner**:* aimed at impoving access to SRH informaton, clinical and counselling services - Weak feedback mechasnisms in the referral systems to strategic partners - Services are free and affordable - Uses peer educators within the facility approach - Easy access for those who live close by, those who live further away are sometimes transported to the AC, which is not a sustainable solution - The AC has adequate staff, commodities and supplies - Not all of Mbare polyclinic is adolescent friendly. This can have negative implications for the transferability of the project to the city of Harare health department - Cost effectiveness of the project has not yet been assessed
	Community based approach ***Community Youth Centres:*** the approach had linkages to private pharmacies. ASRH drop-in clubs aimed to inculcate knowledge and skills on ASRH-R and enhance leadership within culturally diverse communties. Youth centres offered clinical services and use of peer educators - Despite being a popular stratgey, youth centres were found to not be cost-effective for increasing uptake of SRH services in adolescents. - Services used mostly by a small proportion of adolescent who live close by and mostly male - Mainly frequented for recreational purposes, and limited girls seeking sensitive information or services - Cost per beneficiary was high	**Community based approach** ***Matapi Youth Hub:*** ASRH drop-in hub aimed to inculcate knowledge and skills on ASRH-R and provide a social and engagement space for adolescents. Also offeres preventative clinical services and use of peer educators - Services used mostly by a small proportion of adolescent who live close by (Matapi flats) and mostly male - Mainly frequented for recreational purposes (access to the internet), and may limit access for girls seeking sensitive information or services - Data is expensive to be providing as an enabler to attract adolescents to come and access services.
	Peer education - Popular strategy but effectiveness undermined by limited resources, support, weak linkages between peer education and other community cadres, and limited access by young people including key populations and specially vulnerable groups. - Approach ineffective at improving SRH outcomes (poor data on effectives of such services overall) - Cost per benefiaciary was high	**Peer education** - Popular amongst the adolescents and is support by resources and support for the peer educators to execute their tasks. The links/referral between peer educators in the community and the AC/Matapi are strong. The links between peer educators and other community-based cadres/organizatons/processes are not visible. - Peer education for key pops and highly vulnerable groups of adolescents could be stronger.
	School-based approach	**School-based approach**

[1] Zimbabwe. (2016). National adolescent and youth sexual and reproductive health (ASRH) strategy II: 2016-2020 : stepping up for good sexual and reproductive health outcomes for adolescents and youth in Zimbabwe.

	Life skills education: carried out in schools were the youth create HIV clubs,guidance and counselling clubc, and implemented peer educaton. Clubs weresupplies with resources from ZNFPC. - The Life Skills, Sexuality and HIV and AIDS Education strategic plan waslaunched. Limited evidence on it's effectiveness as it was not fully implemented. - Innovative approaches with ITC also explored	***School health clubs:*** carried out in schools were the adolescents create health clubs and implement health talks facilitated by msf peer educationand the school teachers. - Limited evidence on the effectiveness of the school health clubs, butthey are hgly acceptable amongst adolescents who attend them; and some teachers have reservations about some of the content
Social and behavioral change communication (SBCC)	**SBCC were peer led prevention approaches that emphasized abstinence, faithfullness and engaging parents.** The approach assumed effective health systems for increased access and utiliastion and livelihoods and life skills training - Peer education approach was undermined by limited resources. Communityawareness excluded parents. PCC strategy was developed but not implemented. Duty bearers and rights holders often lacked information to effectively support ASRH programmes. - No standardise approach to BCC. IEC materal had been developed but lackedtarget segmentation. Media effectiveness and reach not assessed - Specally vulnerable adolescents were left out of the strategy compromisingreach of these underserved populations ***Life skills and livelihoods:*** aimed at building capacity and mobilising demand and required teachers to have up to ate information on SRH to better support young people- especially those in difficult situations. Integration of livelihood skill has lagged behind and the development of the The Life Skills, Sexuality andHIV and AIDS Education strategic plan was meant to improve this ***ICT platforms like WhatsApp and Facebook*** were seen as promising innovationsin programming for adolescent and young people. Access was limited by limited resources (no data or smartphones etc)	**Community engagement approach to mobilise and sensitise for access toservices.** This approach includes community participation and empowerment and also assumes an effective linked AC and Matapi system. - Peer educators spearhead community awareness events and definetelyengage with adolescents. The project's egnagement with duty beares, gatekeepers, parents/guadians, other community members was felt in interviews with these cadres. - Community participation and empowerment as part of the ASRH project is not as obvious as with other MSF projects in Mbare (Wash projects) and is an area that the project could improve on. Commiteesexist that intersect MSF with community members, but the level of engagement in these committees and whether that constitutes participation and empowerment has not been assessed. - The project has been quite intentinal is reviewing the key pops strategyand planning to ensure that key pops are included in the design, assessment and implementation of this stategy. - Income generatng activities are part of the project mandate, but these could be diversified and also offered to all adolescent who want/needthem - COVID-19 reulted in digital health promotion activities. The project hasan opportunity to harness mobile and digital health as part of its activities if wifii/data is accessible.

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Médecins Sans Frontières

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