REPORT NO./YEAR

EDUCATING GIRLS – REDUCING TEENAGE PREGNANCY IN MALAWI

Project evaluation 2014-2015

EVALUATION

Save the Children
Norway

WE ARE the world's leading independent organisation for children.

OUR VISION is a world in which every child attains the right to survival, protection, development and participation.

OUR MISSION is to inspire breakthroughs in the way the world treats children, and to achieve immediate and lasting change in their lives.

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LIST OF ACRONYMS

ADC	Area Development Committee
AIDS	Acquired Immunodeficiency Syndrome
ASRH	Adolescent Sexual and Reproductive Health
BLM	Banja La Mtsogolo
CADECOM	Catholic Development Commission
CBO	Community Based Organisations
CHAM	Christian Health Association of Malawi
CPC	Child Protection Committee
DHO	District Health Office (s)
DHMT	District Health Management Teams
DOT	Dedicated Outreach Teams
DRH	Directorate of Reproductive Health
DYO	District Youth Office
FAWEMA	Forum for African Educators – Malawi Chapter
FGD	Focus Group Discussion
GBV	Gender Based Violence
GVH	Group Village Headman
HIV	Human Immunodeficiency Virus
KAP	Knowledge Attitude and Practice Survey
KGIS	Keeping Girls in School
KII	Key Informant Interviews
MoEST	Ministry of Education Science and Technology
MG	Mother Group
MGCD&SW	Ministry of Gender, Children, Disability and Social Welfare
MoH	Ministry of Health
NYCoM	National Youth Council of Malawi
NOK	Norwegian Kroner
PADev	Participatory Development
PEA	Primary Education Advisor
PTA	Parent Teacher Association (s)
QLE	Quality Learning Assessment
RHU	Reproductive Health Unit
SC	Save the Children
SCM	Save the Children Malawi
SCN	Save the Children Norway
SHN	School Health and Nutrition
SMC	School Management Committee
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Disease (s)
QIT	Quality Inspection Team
QLE	Quality Learning Assessment
RTP	Reducing Teenage Pregnancies
TA	Traditional Authority
ToC	Theory of Change
UFE	Utilization Focused Evaluation
UNESCO	United Nations Education Scientific and Cultural organization
UNFPA	United national Fund for Population Administration
USAID	United States agency for International Development
VDC	Village Development Committee

VH	Village Headman
YCBDA	Youth Community Based Distribution Agent
YFHS	Youth Friendly Health Services
YFSRH	Youth Friendly Sexual and Reproductive

EXECUTIVE SUMMARY

Malawi's health and education sectors have limited resources and services are poor. This cupled with a myriad of contextual economic and social factors leads to a large number of school drop outs and to teenage pregnancies.

The program "More educated girls – Reducing teenage pregnancies in Malawi" (2014- 2016) (RTP) is a test and invest project financed by Save the Children Norway/Norad and implemented by Save the Children Malawi and partners. Through the program, SCN has supported multiple activities providing a diverse set of services and capacity development aiming to achieve a multiplier effect. The premise is that a multi-pronged approach is better suited to respond to the complexities experienced by young girls in Malawi. The effort therefore is trying to retain girls in schools, but simultaneously target a supposed key reason for drop out and exclusion from schools-pregnancy.

To this end the program has brought together the health and education sector and a multiplicity of government and civil society actors to work towards a set of strategic outcomes. These include:

- Improved learning environment and self-efficacy of adolescent girls
- Improved access to high quality sexual reproductive health services for youths
- Improved social environment to support adolescents' sexual reproductive health rights and educational achievement
- Improved operationalization of policies to support adolescents' sexual reproductive health rights and educational achievement.

Based on the intervention activities, the objectives relative to the 2014 baseline findings are as follows:

1) A 10% reduction in teenage pregnancies for girls aged 10-19 years in each of the 6 targeted districts from 21.3% in 2014;
2) A 5% reduction in school dropout rate for girls aged 10-19 years in each of the 6 districts from 21% in 2014 and lastly;
3) A 5% Increase in girls' re-entry to school from 15% in 2014[1][2].

MAIN FINDINGS
These have followed four main themes:

Relevance: Overall the relevance of the project is undisputed. The issues the program tackles are clearly important in Malawian at this time. However, it is worth noting that the success of the program is currently being measured based on indicators which do not adequately reflect the complexity and comprehensiveness of the program approach.

Progress towards achieving results: Comparing recorded results against stated indicators seems to indicate limited progress towards achieving the expected end outcomes even though the majority of activities have been implemented (see chapter 4 and annex 4). This disconnect between achieving expected outcomes and the conduct of activities is due to the use of indicators which only measure a limited range of potential successes and do not cover all the potential impact of the programme at output or outcome level... If one were to expand one's view and ask if the program activities have had, or have the potential to change the way education of girls on the one hand, and teenage pregnancy on the other, are regarded locally, then the answer may be very different. To this end the collection of activities conducted by the program appear to be jointly better suited to

[1] Save the Children (2014). Baseline survey report of Save the Children NORAD Project "More educated girls – Reducing teenage Pregnancies in Malawi. Pp. 4-6.
[2] Save the Children (2014). Goal hierarchy – Malawi proposal on "More educated girls – Reducing teenage pregnancies in Malawi" Pp. 1-2

achieve social change at broad levels and should be measured by qualitative indicators better suited to capture the actual achievements of the programme, and or by quantitative output indicators.

Although they do not specifically respond to the indicators listed above, the review team has identified the following notable positive results from the programme interventions,. They include:

- Working with mother groups to strengthen their abilities and skills in supporting girl retention rates was consistently noted by mother group FDG as an asset. This was particularly visible in the district of Mchinji where Mother Groups showed a self imposed drive to achieve positive and noticeable results. A potentially negative side effect here could be that when mother groups focus more exclusively on pregnant teens rather than teens more broadly including all out of school teens regardless of the reason for their drop-out status.
- Improved ability of teachers to provide pupils with information regarding SRH, and in promoting a safe environment for students.
- The most noted results, as claimed by matron and patrons interviewed,, visible amongst children members of school clubs was the Improved ability of Child Protection Committees to support a safe environment for children[3]
- Improved knowledge amongst youth members of youth clubs on SRH issues.
- Improved gender dynamics amongst member of youth clubs. This includes empowerment of females regarding their own sexuality. This was particularly highlighted by the nurse responsible for the Malukula youth club in Mangochi.

Additional positive outcomes that were highlighted during the field research include:

- More equal gender relations between girls and boys who regularly attend lectures as part of the youth clubs in health centers which focus on SRH.
- The improvement of skills amongst mother groups who work towards girl retention in school more generally.
- Improved knowledge about the impact of births on the body and the reduction of pregnancies close together.
- Reduction in sexually transmitted diseases.
- Increased awareness of the threats faced by girls in schools including for example propositions by male teachers.

If we limit ourselves to looking strictly at the three indicators set to measure programme achievements, however, many of the positive results of the programme are not captured. In summary, the following can be said about the achievements as measured by the set indicators (A thorough analysis of the achievements related to each indicator is given in the findings section):

Objective: A 10% reduction in teen age pregnancies for girls aged 10-19 years in each of the 6 targeted districts from 21.3% in 2014

Available data point to significant decreases in the number of girls that dropped out of school in 2014/15 calendar year across the project catchment area due to pregnancies, but the indicator, as is currently defined, appears difficult, if not impossible to meet during the project period.

Objective: A 5% reduction in school dropout rate for girls aged 10-19 years in each of the 6 districts from 21% in the 2013/2014 academic year

While the drop out rate for girls had improved beyond the 5% target between 2012/13 and 2014/15, the drop out rate for girls has generally remained constant since commencement of RTP program in 2014.

Objective: A 5% Increase in girls' re-entry to school from 15% in 2014

[3] It is worth noting however, that the practice of transferring teachers who engage in sexual activities with pupils was seen as a legitimate solution by CPC in Mangochi and Phalombe.

On average 28.5 % of adolescent girls (10-24 years) who fell pregnant in any of the following years; 2012, 2013, 2014, and 2015 have returned to school. Except for Mangochi district where the percentage of re entry in 2015 had exceeded the 5% increase called for based on the 2014 baseline (Baseline: 15%).

Partnership and child participation and role of civil society partners

The program works with an extensive number of partners at the government and civil society level, both at the national and local levels. Generally speaking the relationships are good and productive. It is important to note that the knowledge and expertise of different partners in their fields appears to be very extensive and that thus far the program has not been able to fully and systematically exploit this knowledge for the collective benefit of the program; second, that the government bodies are not currently particularly open to changing the way they work with the topics at hand. The latter means that considerable attention and effort will be required in order to secure the sustainability of the program.

Sustainability, Scalability and Replicability

Currently one of the key elements for sustainability and scalability, is the snowball effect. The premise is that people who are trained will go on to train others and so on and so forth. This appears not to have happened systematically. In other cases, where direct training of health workers, teachers etc. aiming to enable the trainee to improve its ability to work with adolescents did not presume a snow ball effect, but rather saw the training as an end in and of itself. Evidence collected through interviews conducted during the evaluation showed these trainings yielded positive results. These trainings are dependent on the continued support from SC. As it currently stands, if SC stopped funding, the trainings currently sponsored by SC would be halted immediately. Together this means that a different approach with increased focus on advocacy at the government level to ensure the government takes on responsibilities for the direct trainings may be beneficial for the sustainability of the project.

Context and community structures

It is undoubted that the context in Malawi is a major factor in the success or failure of the program interventions. Indeed this program is clearly positioning itself to achieve social change. Social change is not generated over night and therefore consistent long term efforts are required. SC has chosen to work with a series of entities and bodies that already exist (teachers, health care workers, mother groups etc.), still strong partnerships with Malawian government entities to ensure that activities carried out by the program are incorporated into government led initiatives is crucial in order to ensure the sustainability and longevity of the program.

Recommendations

Relevance:

- SC should consider using the program as a way to refine the content of curricula at multiple levels. For example: What should be included in Life Skills (or equivalent), what should be included in Teacher Training Packages regarding conducive teaching environments, what should be included in healthcare workers training regarding YFSRH services, etc.
- SC should consider how issues of gender relations, masculinity, and the role of men/boys in active sexual relationships and parenting should be included in relevant curricula.
- Currently the welfare of the newborn babies born from teenage mothers are not addressed in any way. Therefore, SC should consider how to address the needs of the new-born children to ensure that they do not suffer (reduced care or nutrition) when their mothers return to school.
- Currently how children with disabilities are cared for in relation to school retention and their SRH rights is not addressed. Therefore, SC should consider including elements into relevant curricula that addresses the challenges faced by disabled children.

Progress towards achieving results:

- SC should consider reducing the number of activities it undertakes to ensure that each activity can be adequately monitored/reflected upon.
- SC should consider enforcing a single rule regarding per diem/coverage of costs of trainings and meetings.
- The value of each activity relative to others is not possible to determine at this time, as not all activities had been implemented equally in the areas visited to enable reliable comparison by those interviews, or

by the evaluation team. Still it is important to note that generally it appeared that the first level of activities (direct trainings, monitoring, etc.) were most successful, as were the youth clubs at both health posts and schools. The activities that derived from these (sharing of information) seemed to be less successful because the snowball affected did not systematically yield as expected. Therefore SC should focus on prioritising activities that are not dependent on the snow ball effect multiplier element.

- SC should consider engaging in advocacy more systematically. This would serve to support the idea that program elements are incorporated as standard service package options by the government in the future (both health and education ministries)
- SC should consider developing qualitative indicators that are better suited to capture the achievements of the program through focusing on behavioural change. To this end SC could consider looking into options such as Knowledge Attitude and Practice (KAP) surveys or elements thereof. Another and complementary option would be to consider a more systematic use of case studies to supplement quantitative indicators.
- SC should consider identifying a series of quantitative indicators that focus on provision/delivery of services (output) rather than on outcomes. This data could, and should, be supplemented with qualitative data (see above recommendation)

Partnership and child participation and role of civil society partners

- If SC chooses to invest in the refinement of different curricula, SC should consider including children more actively as part of this process.
- In future SC should consider involving partners in a more active way in order to ensure that their knowledge is capitalized upon during both program design and implementation phases.
- In future SC should consider opportunities that may enable a more direct and continual relationship between program partners. For example, a partial joint office.

Sustainability, Scalability and Replicability

- The degree to which the operational model (collection of activities) used by RTP is best suited to achieve, maintain, scale up and replicate the strategic objectives of the program is unclear because both teenage pregnancy and school retention of girls are very complex. Hence SC can choose to:
  - a) Continue to implement the program activities as they are, but change the way it measures progress to ensure that it is able to better measure the social change character of the current program package. This approach would require that SC remain committed long term to the implementation of program activities to ensure sustainability.
  - b) Utilise the current activity package as a way to develop tools (curricula and protocols) that can be introduced into the standard service package implemented by the government in future (training of teachers, health care workers, mother group members etc.) and hence focus on the refinement of the tools used and on advocacy to have these adopted and implemented by the government in the future.

The main elements of these two options overlap, but the latter would focus on an eventual reduction of services, so that these can be included into a government plan, while the former would support a continuation of a widely varied and expansive service package delivery by SC (see recommendation 1 for relevance). Clearly these are not mutually exclusive, but quite complementary. In fact (a) can be a key element to informing (b)

Context and Community structures

- This program is not one which meets the expectations of all communities. Particularly communities with well developed aid dependency ideas. Therefore, SC should consider focusing on communities which believe in, accept the provision of knowledge as a valuable form of assistance.
- SC should consider engaging beneficiaries in agreements that require them/ make them accountable to share the knowledge gain.

CHAPTER 1 BACKGROUND AND DESCRIPTION

1..1 Country Context Background

From 1998 to 2008 Malawi's population has grown from 9.9 million to 13.1 million. This represents an increase of 32% and a population density increase from 105 to 139 persons per square kilometre[4]. About 20% of Malawi's population is made up of youth, with a mean age of 13 years[5]. The projected national population in 2014 was 15.8 million of which 8.1 million were females and 7.75 million were males[6].

It is estimated that 50.7% of the population lives in poverty, with 24.5% defined as poor, while 26.2% are defined as moderately poor. Issues that have a clear impact on poverty levels include climate and weather changes particularly for populations, which are highly dependent on rain fed agriculture. Other factors include economic shifts at the national and international levels; disease and particularly HIV/AIDS and population growth[7]. By and large poverty in Malawi manifests through high mortality rates, low life expectancy, malnutrition and low education levels[8].

Malawi comprises people of different ethnic and cultural backgrounds; the principal groups are the Chewa people who live in the central region, the Ngoni and Tumbuka peoples who inhabit the northern region and the Lowe, Yao, Sena and Mangánja peoples who inhabit the southern region. While the Chewa, Lomwe, Mang'anja and Yao are matrilineal, the Sena and Tumbuka[9] follow patrilineal practices. In Malawi like in most African societies, tradition and customs largely define ones identity, informs societal values and attitudes, and contributes to bringing cohesion to community life.

Some cultural practices and traditions inform and nurture perceptions that undermine women rights. Many such practices and traditions define women and girls as second class citizens and in the process contribute to a lack of self-esteem and reduced active involvement of women in decision making at both the community and the national level. Cultural practices in some regions also foster early marriage and early pregnancy; and do not value the education of girls. Further, cultural practices among some ethnic groups have tended to promote practices that facilitate the transmission of HIV/AIDS.[10]

In rural communities, kinship and family relations provide a sense of unity and are essential for survival. The role of traditional leaders often includes serving as guardians of the customs and traditions of the people. Traditional leaders are most often consulted before development activities planned for their areas are executed. Moreover, they can play an arbitration role on a variety of civil cases as well as a central role in mobilising community to development work. They also play a critical role in promoting immunisation campaigns, family planning and Sexual and Reproductive Health (SRH), school enrolment and active participation of the population in the political process. Likewise they can also play a key role supporting or advocating against school enrolment and the provision of SRH services to children and youth. Therefore, mobilising the support of community leaders is a vital element to ensuring the success of development and aid interventions.

Other structures through which communities participate (often on a voluntary basis) in development work include village and area development committees (ADC) (through which communities participate in the development of district development plans), village health committees, parent teacher associations and school management committees, various community based organisations and more recently mother groups.[11]

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[4] Source: National Statistical Office. (2010). *Report on the 2008 Population and Housing Census* at http.//www.nso.malawi.net/
[5] Source: National Statistical Office (2012): Population Data Sheet, p. 2.
[6] National Statistical Office (2015). Statistical yearbook. Zomba, p.8
[7] Ministry of Economic Planning and Development. (2012). Malawi National Social Support Programme, 2012/13 - 2015/16. Pp. 4-5
[8] National Statistical Office. (2007). Malawi Poverty and Vulnerability Assessment
[9] Ethnic groups in all the six districts of the northern region are patrilineal.
[10] Ministry of Economic Planning and development, op. cit

[11] Ibid

Rural communities are more vulnerable than urban communities. . This largely arises from limited access to basic services by the former. For instance, in 2012, 71% of live births in rural areas were delivered at health facilities compared to 86% in urban areas. The death rate of children under the age of five in rural areas is 130 per 100000 live births compared to 113 per 100000 live births in the urban areas[12]. Furthermore, about 21% of the women in rural areas have had no education compared to 9% of women in urban areas[13].

Some of the key findings from Reducing Teenage Pregnancy (RTP) project base line (2014)[14][15] outlined below align well with the general findings and knowledge described in the general literature on Malawi. These include:

a) While most Focus Group Discussion (FGD) participants supported the provision of SRH services to the youths (either through health facilities or in special locations), almost all the key informants – 11 out of 13 (most of them local chiefs) opposed the provision of SRH to adolescents arguing that it would encourage sexual activities among the youths. Most of the local chiefs were of the view that SRH service provision to the youths should be limited to provision of information.

b) Overall, 8.7% of the adolescents felt their communities were **very supportive** of girls accessing SRH services, 40.5% said that their communities were **supportive** and the rest either said their communities were **not supportive**.

c) There was a general consensus among participants interviewed in the community that the creation of conducive learning environments could promote school retention amongst adolescents. Examples of non-conducive learning environments, according to interviewees, included the practice by some teachers of engaging in illicit affairs with their female pupils, and/ or of using negative reinforcement as an approach to teaching.

d) The community also cited video shows, peer pressure, low parental influence levels, sexual relations and lack of food[16] in the homes as factors which distracts learners from schooling. The communities also noted teen mothers sometimes drop out because they are mocked by fellow students and/or teachers.

e) 67.5% of adolescents asked attributed school drop-outs among the pupils to pregnancies (amongst girls), 46.5% to poverty, 42.5% to lack of interest and 23.1% to early marriages (especially among girls) (n=672). Other factors cited were family responsibility and seeking employment (especially among the boys)[17].

f) 66.9 % of adolescents interviewed thought that parents had a positive attitude towards educating girls, 18.9% felt that parents had a negative view of educating girls, and 14.2 % were unsure (n=672).

g) Generally the findings of the baseline suggest that by and large the communities are in favor of teen mothers having a choice to return to school if they want to. Communities also acknowledged the important role played by Mothers Support Groups in encouraging teen mothers to return to school.

A more detailed contextual presentation of both the health and education sectors in Malawi, including the principal findings of the baseline study can be found in Annex 2.

1..2 Project Goals and Objectives

The program on “More educated girls – Reducing teenage pregnancies in Malawi” (2014- 2016) (RTP) is a ***test and invest***[18] program financed by Save the Children Norway (SCN)/Norad and implemented by Save the

[12] National Statistical Office (2012), Malawi Population Data sheet, p. 6
[13] National Statistical Office. (2010). *Report on the 2008 Population and Housing Census* at http.//www.nso.malawi.net/
[14] Save the Children (2014). Baseline report on save the Children Norad Project “More educated girls- reducing teen age Pregnancies in Malawi.
[15] Baseline sample comprised 759 adolescents of whom 480 were females (63.2%) and 279 males (36.8); 322 (42.4%) were aged 10-14 years and 437 (57.6%) aged 15-19 years.
[16] During this evaluation the poverty assessment conducted showed that the number of people who did not attend school because they feel into an extreme poverty category: lack of food, lack of basic means to buy school supplies, was less than 10% in any one village.
[17] It is assumed that multiple answers were possible given the data available in the report. Moreover, the data collected during this evaluation, however, suggests very strongly that the reasons are more complex and intertwined.
[18] A *test and invest* program within Save the Children refers to a program area where SCN decides to commit funds and resources to explore future involvement. Save the Children Norway. *Strategy: Investing in Children: 2014-2017*

Children Malawi (SCM). Through the program, SCN has tried to support multiple activities providing a diverse set of services and capacity development aiming to achieve a multiplier effect. The premise is that a multi-pronged approach is better suited to respond to the complexities experienced by young girls in Malawi. The effort therefore is trying to retain girls in schools, but simultaneously target a supposed key reason for drop out and exclusion from schools: teenage pregnancy.

The primary implementation partners (see figure 1) for this program are the Ministry of Health (MoH) and Ministry of Education Science and Technology (MoEST) at national and district levels. Other Ministries that the program is working with include the Ministry of Gender, Child Development and Social Welfare (MGCD &SW) and Ministry of Youth. At national level, SC coordinates with the Reproductive Health Directorate (RHD) formerly Reproductive Health Unit (RHU) of MoH and School and Health Nutrition Department at Ministry of Education. At the district level, program implementation is led by SC District Coordinator in collaboration with the District Health Office and the District Education Office (DEM).

The program has a national coordinating committee currently chaired by the Directorate of School Health and Nutrition (SHN) of the MoEST with membership from MoH, National Youth Council, and Forum for African Women Educators (FAWEMA), Banja La Mtsogolo (BLM), Ministry of Youth and Ministry of Gender, Children, Disability and Social Welfare (MGCD&SW). The Committee meets quarterly to review activity reports and to plan future activities. The work conducted is guided by a program Terms of Reference (ToR).

At activity implementation level, SCM implements project activities in partnership with FAWEMA Malawi Chapter[19] and BLM[20]. The work is governed by bi-lateral partnership agreements with each organization which were signed in 2014. Both BLM and FAWEMA were selected owing to their institutional experience and expertise, namely:

- BLM is a key player with vast experience in the area of SRH services; and
- FAWEMA has a proven track record lobbying and advocating for gender- sensitive education policies, and implementing and scaling up interventions to improve the outcomes of girls' education while working with students, teachers and parents in particular.

The RHD at the MoH is another key partner in the implementation of the RTP. The RHD has responsibility for providing policy and technical direction on all SRH interventions implemented in Malawi. The RTP program benefits from SRHR services and information SRHR supervision tools and other program implementation tools developed under the guidance of this RHD. Technical staff from RHD participates in the training of healthcare workers and in periodic supervisory visits to the field locations. Additionally the RHD chairs national level program reviews.

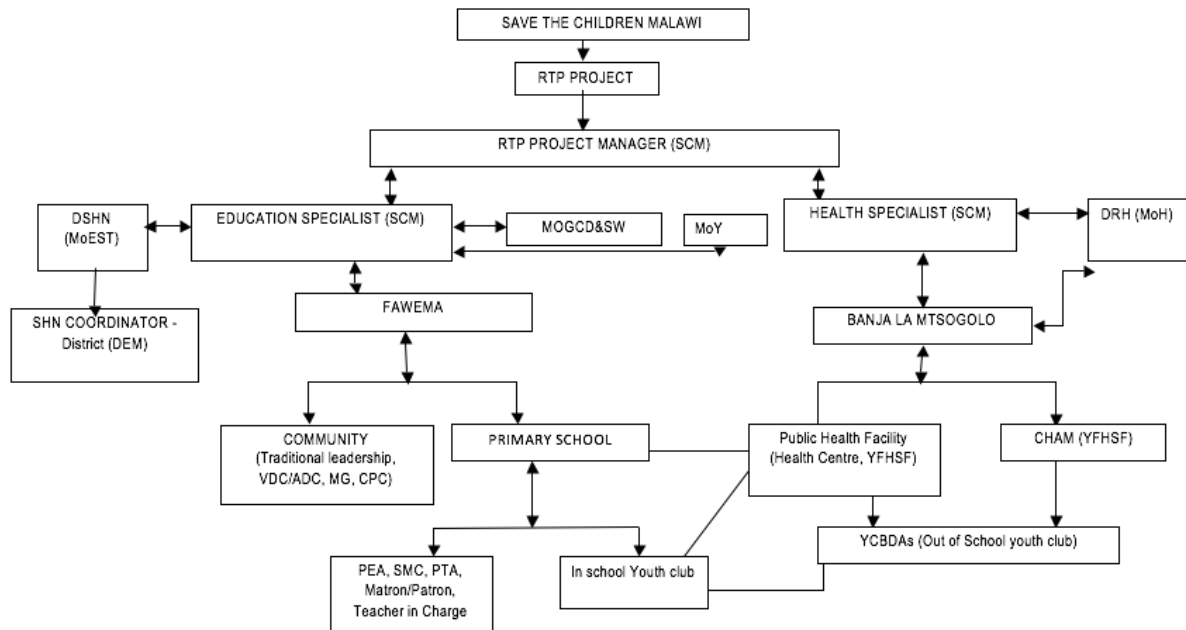
As regards education elements, the MoEST central office and its District Education Officers are involved in the implementation of the project especially through provision of policy direction. At the school level they work closely with FAWEMA. The SHN of the MoEST has a key role in championing the integration of SRH interventions into schools. The Teachers training manual is a key tool used to build capacity amongst teachers in support of female pupil retention. For its part the MGCD&SW is responsible for providing policy direction for

[19] Has been active in Malawi since 2001 as the national chapter of the Forum of African Women Educationalists. Its work focuses on lobbying and advocating for gender- sensitive education policies, and implementing and scaling up interventions to improve the outcomes of girl's education while working with students, teachers and parents in particular. FAWEMA has a network of 500 members, most of who are female teachers. It works in close partnership with MoEST and the MoGCD&SW and hence has been influential in the re-entry and re-admission policy for teen mother, the National Action Plan on Education for All, the establishment of a gender desk in the MoEST and the Education Sector Implementation Plan (2013-2016) and campaigned against early marriage. The Association is a leader in promoting mother groups in Malawi and in promoting gender equity in classroom. Since 2002, FAWEMA has established 1,500 mother groups across the country. This model has proven so successful that it has been adopted by development partners, international and local NGOS and is now an integral part of the MoEST National Education Sector Plan. FAWEMA is instrumental in implementing interventions under Outcome strategy 1 on learning and social environmental and girls' self- efficacy components

[20] The organization has a network of 31 health centers in 28 districts. It provides RH services free of charge to youth aged 24 and below at all health centers as well as outreach services to over 400 outreach service sites free of charge. Recently, BLM has trained 35 Youth Reproductive Health Agents to distribute injectable contraception at the community level. In addition, it operates a franchise network, the Blue Star Franchise, with 51 Blue Star clinics in operation. Five of the 31 health centers have youth drop in centers. BLM's work with schools is largely focused on HIV and AIDS. In RTP, BLM champions interventions under Outcome strategy 2 and other components leading to increasing of access to ASRH activities amongst adolescents.

various welfare schemes aimed at women and children and capacity building of structures which are supported by the RTP. The MGCD&SW is also well placed to facilitate Government ownership and support for the various economic and empowerment interventions proposed by the RTP program. Other government stakeholders include the Ministry of Youth Development and Sports, the National Youth Council of Malawi (NYCoM), District Councils, District Health Management Teams The Christian Health Association of Malawi (CHAM).

Figure 1 Relationship between different entities involved in the RTP



As noted above, the RTP program includes the involvement of a large number of stakeholders/partners (see Figure 1). While different actors/entities work independently, they are supposed to work on activities or efforts which are complementary to one another and which support the common objectives of the program. The program has focused on a multi-sectoral approach aiming to curb the challenges and threats that contribute to early pregnancy and to the early school drop out of girls.

In interviews with all partners the relationship between them and SCM was consistently noted as a positive one. Where expectations from each partner were generally met and collaboration was smooth. In this context it is important to note that while FAWEMA felt that there had been opportunities for them to contribute to the program design, BLM felt that their role was much more akin to a service provider. Moreover, we would remiss if we did not mention a number of unresolved challenges faced by the partnerships. The main ones include:

- An overreliance on SC RTP to provide financial support for routine project monitoring visits, annual and midyear partnership review and planning meeting, technical and steering committee meetings at national and district level thereby potentially compromising the sustainability of the RTP;
- Lack of liaison and coordination by the sub grantees on programmatic issues at operation level;
- Inadequate capacity within FAWEMA, one of the sub grantees, to effectively implement their assigned role resulting in the need to invest in the institutional capacity building of that organization;
- Discord between MoEST and MoH policy on provision of SRH services in schools, as well as differences on the interpretation of the definition of youth as found in the Youth Policy, the Child Protection and Welfare Act of the MGCD&SW and the Constitution.

Implementation of project activities started in May 2014, five months after the expected start date. This has been attributed to the following factors:

- It took a long time to reach partnership agreements with BLM and FAWEMA;
- Changes had to be made to the project document following release of the baseline study conducted in June 2014 (report was available in late August);

- Cancellations of initial training sessions due to misunderstandings between trainers and participants on how the government's full board policy versus the provision of per diem would be implemented;
- Some instances of late disbursement of project funds by SCN[21].

The program is funded by NORAD and targets 10-19 year old girls in six administrative districts where the incidence of teenage pregnancies is understood as highest. These are: Balaka, Machinga, Mangochi and Phalombe in the southern region; and Ntcheu and Mchinji in the central region. The project targeted schools in seven educational zones in the six districts expecting to benefit a total population of 830,000 adolescents aged (10-19 years old) and youth (19 to 24 years old)[22]. The distribution of the target population by district and age is depicted in Table 1 based estimates generated in 2014. The number of districts targeted was determined by the donor, but the coverage in each district was determined by SC.

Table 1 Profile of Primary Target Groups (2014 estimates)

District Name	Total population	10-14 years	15-19 years	Total 10-19 years
Balaka	383887	50298	42883	93181
Machinga	589709	82062	63107	145169
Mangochi	922058	134072	105212	239284
Mchinji	569086	71903	60837	132740
Ntcheu	557433	70165	60917	131082
Phalombe	564282	51639	38995	90594
Total:	**3646354**	**460139**	**371951**	**832050**

Extracted and adapted from: 2008 Population Projections; 2010 Malawi DHS[23].

The principal goal of the program has been to reduce teen-age pregnancies in Malawi, and thereby increase retention of girls and schools. The program was designed as a combined effort between the health and education programs and has been based on the tenets detailed in table 2[24]. This program was the first which combined health and education and was implemented by SCM with support of SCN. Although SCN does have previous experience with multi-sector programs and carrying out other test and invest interventions.

The initial program concept had six objectives, which were upon review were reduced to four. Following the outcome of the baseline data collected in June 2014, some changes were made to the program to address gaps identified through the baseline. These included the addition of a fifth objective focusing on improved coordination, monitoring and evaluation of project activities, revision of the project monitoring plan and the results framework and strengthening of the section on child protection. In addition, baseline figures of 15% and a target of 5% for the third objective on increasing school re-entry rate after pregnancy were added following a separate baseline study carried out in August 2014 to establish baseline for reentry rate post pregnancy/delivery.

Table 2 Causal Analysis Framework for the RTP

Casual Analysis	Underlying Hypothesis	Project Design
Lack of adolescent access to & utilization of SRH information and services	**IF:** adolescents' access SRH information & services are improved	**THEN:** Teenage pregnancies will be reduced
Lack of quality learning environment and girls self-	**IF:** quality of learning environment and self-	**THEN:** Dropout rates among girls

[21] BLM indicated, during the interview, that they received the first disbursement of funds in October 2014, although they started working earlier (May 2014) and were allowed to start working earlier. Earlier work was self financed until the first payment..This view was corroborated by the RTP Program Manager (SCM) who said that funds were disbursed starting in September 2014. However SCM maintains that the payment was made at the expected time. SCM notes that the first disbursement of funds was very small and hence they believe this was problematic for BLM. Subsequent payments were made on time.

[22] Save the Children International. (2014). More educated girls – Reducing teenage pregnancies in Malawi: A project proposal, p.10

[23] Cited in Save the Children International. (2014). More educated girls – Reducing teenage pregnancies in Malawi: A project proposal, p.10

[24] According to interviews and discussions with SCN Staff and Norad the program concept was discussed amply prior to finalization of the program document. However, there is a sense from both SCN and Norad that further discussion could have led to a more refined product. Norad specifically noted that they felt the activity package should have been simplified.

Casual Analysis	Underlying Hypothesis	Project Design
efficacy affects attainment of education for girl	efficacy is improved	will be reduced Retention rates will increase
Lack of community, and social support towards education of the girl child	**IF:** communities and social structures are empowered to support girl child at school	**THEN:** Girls will be motivated to remain in schools and teen mothers will be motivated to return to school

The hypotheses mentioned above are based on recognition that teenage pregnancy is an issue of concern, as is school drop out. Furthermore these hypothesis are based on an understanding that the community plays a key role in supporting, or not, the girl school attendance. As well as recognition that Youth Friendly Sexual and Reproductive Health Services (YFSRHS) are valuable and not readily available. The key issues here were validated by the baseline conducted for the program (see Section 1.1 and Annex 2). However as is discussed in more detail in chapter 7, and noted throughout this document, the dynamics leading to child pregnancy, school drop out, and benefits gained from YFSRHS are more complex and less linear than is suggested in table 2.

The program objectives relative to the 2014 baseline findings are as follows:

4) A 10% reduction in teen age pregnancies for girls aged 10-19 years in each of the 6 targeted districts from 21.3% as was identified in the 2014 baseline;
5) A 5% reduction in school dropout rate for girls aged 10-19 years in each of the 6 districts from 21% as was identified in the 2014 baseline; and lastly
6) A 5% Increase in girls' re-entry to school from 15% as was identified in the 2014 baseline [25][26].

These goals are pursued through a series of activities (between 6 and 10) that are carried out in support of four main strategic outcomes. Each strategic outcome and how it is supported is described next:

Improved learning environment and self-efficacy of adolescent girls: This strategic outcome is anchored on the belief that enhanced performance in education is directly linked to the quality of the education to which girls have access. A high quality education environment is understood as one that is safe, learner-centered, structured, personalized, inclusive and engaging. In addition the Quality Learning Environment (QLE) concept includes four main elements: Child-centered teaching and learner engagement, parent and community engagement, the protection of the well being of children and the catering (or meeting of) a learners emotional and psychological needs[27]. The expectation is that the existence of a conducive learning environment can lead girls to believe in better future opportunities and to work towards these while enacting self-determination. Enacting self determination includes control over their reproductive life. Therefore, while QLE does not focus on preventing teenage pregnancy per se the effort can lead to a reduction in teenage pregnancy as a positive *unintended impact.*

The following activities have been planned in an effort to achieve this strategic outcome:

- Conducting of quality learning environment assessments using QLE tools;
- Mapping exercises to identify areas where girls feel safe and unsafe within the school. These mappings and relevant recommendations are then shared with stakeholders in order to identify ways by which the threats can be minimized;
- Sensitization and capacity building of school governing structures on the RTP activities and objectives;
- Capacity building workshops to review and adapt project training tools as may be deemed necessary;

[25] Save the Children (2014). Baseline survey report of Save the Children NORAD Project "More educated girls – Reducing teenage Pregnancies in Malawi. Pp. 4-6.
[26] Save the Children (2014). Goal hierarchy – Malawi proposal on "More educated girls – Reducing teenage pregnancies in Malawi" Pp. 1-2
[27] Save the Children and Open University. n.d. *15 Measuring Results in Education (MEAL).* p.12

- Training of trainers (ToT) sessions designed to orient (teach or refresh) teachers on their knowledge of life skills, psychosocial support, child centered and gender sensitive pedagogy and mentoring, positive discipline, child protection including mappings and new sexual and reproductive health (SRH) services. The main focus groups for these activities are patrons and matrons (teachers who support the youth clubs)[28].
- Additional activities have included mentorship visits to trained teachers, reviewing their training tools and teaching aids and the conduct of refresher training after the initial training.

Improved access to high quality sexual reproductive health services for youths: This strategic objective is anchored on the view that ensuring that children and youth have access to high quality YFSRHS which are age sensitive (10-14 and 15-19 year olds), cater to the needs of adolescent girls, as well as cater to the needs of married adolescents and or parenting adolescents (married and unmarried), can have a substantive impact on early pregnancy and its reduction.

The following activities have been planned in an effort to achieve this strategic outcome:

- Capacity building (through training, orientation sessions and mentoring) on the provision of YFSRHS to health care providers from both Christian Health Association of Malawi (CHAM) and the public sector in the targeted areas; This includes the provision of support to 146 healthcare facilities.
- Capacity development and support of peer educators; Youth Community Based Distribution Agents (YCBDAs) both from within and outside of youth clubs with the aim to multiply the effect of training by supporting youths who then provide accurate information on SRH including the distribution of condoms to their peers;
- Support YFSRHS Coordinators and District Youth Offices (DYO) to enable them to better meet their responsibilities;
- Support to the Quality Inspection Team (QIT) members so that they are able to support the quality standards of both facility and outreach on YFSRHS;
- Supporting CHAM and public health care providers on forecasting and ensuring the adequate use of contraceptives through supervisory and support visits;
- Supporting District Health office (DHO), to set up outreach clinics with the support of BLM;
- Nurture relationships between schools and health facilities in an effort to revitalize school health services;
- Sensitizing out of school youth through outreach days;
- Supporting Community Based Organizations (CBOs) (one per Group Village Headman- GVH) to establish youth clubs; conduct of YFSRHS days at the community level to raise awareness amongst children and youth on key SRH issues; conduct biannual meetings with traditional and religious community leaders at the Traditional Authority (TA) to garner their support for YFSRHS.

Improved social environment to support adolescents' sexual reproductive health rights and educational achievement: this strategic outcome is based on the notion that a social environment that support adolescents' sexual reproductive health and educational rights is a fundamental element to ensure that girls access education, and do not have children early on. In an effort to achieve a more conducive environment, the program aims to engage community members, including community leaders, parents, and youth in dialogue, reflection, and action that can contribute to changes in behavioral and social norms.

The following activities have been planned in an effort to achieve this strategic outcome:

- Orientation on SRH to Area Development Committees (ADC) who then serves as supporters of the interventions and help secure the buy-in of village headmen, religious leaders and community leaders.
- Support the conduct of monthly community dialogues meeting that include community members, and school management committees, and focus on issues relevant to how to keep girls in school;
- Conducting zonal open days where SRH issues are shared;
- Supporting the revitalization of Child Protection Committees (CPS) by providing them capacity development support, engaging them on key ideas around SRHS and on how they can be actively involved in tracking teen mothers for readmission into school.

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[28] Teachers who are responsible for running/oversight of child clubs at the school

Improved operationalization of policies to support adolescents' sexual reproductive health rights and educational achievement. This strategic outcome aims to create an opportunity to harmonize the operationalization of MoH and MoEST policies respectively. The overall objective is to support the review of relevant policies, identify gaps in SRH issues, and in the provision of education on and dissemination of SRH services to girls.

The following activities have been planned in an effort to achieve this strategic outcome:

- Supporting the conduct of quarterly coordination committee meetings with both ministries to discuss the gaps and relevant conventions and policies and how they affect the delivery of services to, and education of, youth;
- Providing support to MoEST and MoH to summarize and translate SRH and education policies into local languages and to disseminate these during open days at the community level and at community meetings.

Improved coordination, monitoring and evaluation of project activities.
This strategic objective aims to ensure that the program is implemented in a manner that secures the high quality of the interventions, ensure that the activities are reported on at a high level, including the degree to which these support the achievement of the program objectives.

The following activities have been planned in an effort to achieve this strategic outcome:

- Conduct a project baseline
- Disseminate findings of aforementioned baseline
- Develop an electronic database
- Develop a data collection toolkit
- Conduct training in data management (M&E)
- Conduct quarterly district steering committee meetings to review progress and plan district activities
- Conduct quarterly project management meetings
- Document and disseminate best practices
- Conduct monitoring visits
- Conduct of annual review meeting
- Conduct Data Quality Assurance visits
- Support DEC meetings

As is evident from the different strategic objectives, and the manner by which these are to be achieved, the project includes a number of multi-sectoral activities that aim to be complementary and bring together policies, health care providers (national and local level), education providers (ministry and local level) and communities. This multi-level design is a key strategic feature of the RTP, and one that stands out in current development efforts. Integrating all these elements in one program is often considered as too complex for a single undertaking. According to program management the demands of the RTP easily exceed current capacity (man power). Being able to support the conduct of activities, and simultaneously be actively reflective about the activities undertaken requires man power, which is scarce at SCM. This was highlighted by the SCM staff. However, this should not be a concern in the future as according to the Section Director for Education at SCN the organization as a whole is putting in place mechanisms, as part of the implementation of the new strategy (2016-2018), that take into consideration the importance of learning from doing and therein of reflection. This once implemented at SCM will likely be an important element to ensure that programs such as the RTP become active learning tools for the institutions.

The RTP program has a 2014-2016 lifespan and a total budget of NOK 30,000,000. Based on expenditure and forecasts it is estimated that program activities account for 60% of the budget, program staff 25%, overheads 5.39% and SCN costs (technical support including monitoring) 3.9%. Overall, direct costs for the duration of the project amount to NOK 28,039,365 representing 93.46% of total budget. Budget allocations ware almost the same for each year with 2015 getting a slightly larger share. See table 3 below for a more detailed budget breakdown.

Table 3 RTP Revised budget 2014-2016 in NOK[29]

Activity/Cost item	Year			Total	% of total budget
	2014	2015	2016		
Direct costs					
Program staff	2280586	2391942	2508938	**7181466**	**25**
Program activities	5253790	6567217	6246649	**18067656**	**60**
Project overheads (non thematic)	552598	522409	541,486	**1616493**	**5.39**
SCN Costs	386000	343000	443,000	**1172000**	**3.9**
Total Direct costs	**8474904**	**9824568**	**9,739,893**	**28039365**	**93.46**
ICR (7%)	593103	687,739	681,793	**1962635**	**6.54**
Totals	**9066008**	**10,512,306**	**10,421,686**	**30,000,000**	**100**

Calculations based on SC Revised RTP Budget 2014 - Only key figures included

[29] Information on annual expenditure patterns was not available. The 2014 budget includes a note that overall project expenditure for 2014 was 65% of budgeted amount for the year.

CHAPTER 2 SCOPE AND PURPOSE OF THE EVALUATION

This evaluation has two principal goals: First to be **reflective** and second to be **forward looking**. Its reflective nature is to be summative in so far as it will examine what has been achieved and the lessons that can be learned from the efforts made, and its forward looking aspect must be formative in that it is expected that this document will contribute to improvements in program implementation for the remaining program period. To this end the team has worked closely with the SCN and SCM team to ensure that the focus of the report on the one hand responds to the evaluation questions and on the other is adapted to what is most useful and interesting in moving forward, given the findings.

The key questions that were the focus of this evaluation are:

The following set of evaluation questions should guide the evaluation team in further developing the evaluation design and questions:

1. *Relevance of integrated education and sexual reproductive health model*: It is important to ascertain the relevance of the model and project design including the specific interventions, objectives and activities. The following evaluation questions will be answered in this section:
   - To what extent are the outcome and objective areas of the program relevant to targeted beneficiaries, SC Malawi country priorities?
   - What measures were put in place to ensure that the program stakeholders were adequately informed of the program interventions and their roles in it?
   - Are the risks/assumptions identified during program design still valid? How are they being managed? Are there any new risks emerging?
   - To what extend Have the local health facilities gained knowledge and experience?

2. *Progress to achieving results:*
   - To what extent were the objectives achieved/are likely to be achieved;
   - Are program activities being implemented effectively to achieve maximum benefit within the context?
   - What are the factors that hindered/assisted the project to achieve its objectives?
   - To what extent is programming informed and influenced by situational and policy context, in relation to attainment of results?
   - What are the successes that need to be told? What are the lessons and good practices so far?
   - What do the youth themselves think of the successes? What is success for them? What have the youth learned from the project and how are the topics raised in class?

3. *Partnership, Child participation and the role of civil society partners*
   - Are the partnerships formed by the program effective in helping the program achieve its objectives? Why or why not? What are the lessons learnt on partnerships? How are the various partners selected? Are they the right ones?
   - How have the teachers worked and raised issues of SRH in class? What are the challenges with discussing these issues? Main messages? How are the teachers applying the activities in class? Linkage with the parents and home community - how?
   - To what extent have the children and youth participated in a youth friendly way in the project? What are the existing mechanisms available to listen to children and engage children during the project implementation?
   - How has the partnership with the government worked?
   - How has the BLM and FAWEMA delivered as per implementation plan?
   - Have the coordination mechanisms effectively supported the delivery of the program?

4. *Sustainability, scalability and replicability*
   - What are the sustainability measures and roles and responsibilities of various stakeholders in the process?

- Are there any potentials of scalability in other districts of Malawi? How could this happen? What are the prevailing evidences?
- How could the results influence at the national level and national policies?

5. *Context and community structures*
    - Which implications does the geographical variation and contextual differences in the targets areas have for the project? Is there any variation in project implementation among the various districts? Why?
    - Are there any other factors affecting such as incentives, payments and others in the project?
    - What is the communities' perception and attitudes towards the project?

In addition to responding to the questions in the ToR, which are included above, and in an effort to best address the forward looking element of the evaluation, the team has discussed preliminary findings with the client (SCN) and concluded that while a focus on achievements as planned is important, the evaluation should also harness and credit achievements made that are not well reflected in the indicators used by the program thus far.

CHAPTER 3 METHODOLOGY

This evaluation was carried out by a gender balanced team of three evaluators: a Team Leader, a Team Member and Country Specialist and a Quality Assurer and included a total of 50 person days. In order to best address the dual demand from the evaluation task (summative and formative), we have taken a **participatory rights based approach** throughout the assignment. This has been reflected in the tools (data collection methodology) we used, and also in the overall management of the task. To this end we have implemented a **Utilisation-Focused Evaluation**[30] **(UFE)** inspired approach. This means that the evaluation has been designed and conducted with the aim of maximising the utilisation of the evaluation findings, by ensuring the active participation of end users of this evaluation document throughout the assignment. The participatory efforts have included extensive discussion on the purpose and use of data tools during the inception period, a one day workshop with the program team in Malawi to examine and discuss the ToC, open and on-going discussions on preliminary findings, and frank and open discussions on possible recommendations and the implications thereof. The participation of a SCN staff member during the first week of meetings and interviews, and of a SCM staff member during field data collection has further facilitated the dialogue between the evaluation team and the client.

The objective of the initial one day workshop was to establish a common understanding of a ToC for the program. Following the ToC, the evaluation team utilized a contribution analysis approach to test and further developing a ToC. This process has served to identify key findings, lessons learned and recommendations, which go beyond the specific questions detailed in the ToR (see Annex 1).

In addition to the aforementioned workshop, and reviewing literature, the data was collected using individual key interviews, and group interview/FGD. Interviews used two complementary formats: case history, where respondents were asked to detail the program from the perspective of their role, and semi structured interviews which had more structured questions, guided by the questions in the ToR (see Annex 1). It is important that while case history interviews were used in many cases the line of question always ensured that all relevant issues in the ToR were covered. In cases where questions did not cover all issues in the ToR, the focus was shifted towards learning, sustainability, and replicability. Similarly with SCN and Norad, questions focused on the program experience (how it came about and how it developed) and on lessons learned which were considered relevant to future stages of the program or that could have value for other program opportunities. The tools used to guide questioning can be found in annex 6.

A total of 345 participants were involved either in KII or in FGD. Of these 9 were interviewed outside of Malawi. Of the remaining, 115 were interviewed in Mchinji (58 females, and 60 males); 108 were interviewed in Phalombe (69 females, and 40 males); 95 were interviewed in Mangochi (41 females and 51 males); and finally 18 were respondents representing key organisations/institutions in Lilongwe (7 females and 112 males). A full list of respondents by District, Membership Affiliation and Sex in Annex 5a and by District, Name, Sex and Membership Affiliation in Annex 5b.

In addition a poverty assessment tool based on the PADev[31] methodology was fielded in the majority of locations visited (all but the first school visited in Mchinchi). PADev is a highly participatory and inclusive methodology, which uses a variety of tools to collect specific sets of data. In this case the tool used is designed to more accurately define and map the wealth levels of the population at the community level. This tool allowed us to move away from generic responses such as ‘Children drop out of school due to poverty’ towards a richer data set that explained when financial poverty levels were the key to drop outs and when other factors, or aspects of poverty could/did play a role, and when factors –other than economic extreme poverty- such as cultural beliefs and practices played a more important role in drop out rates. This type of nuance is important particularly to context where the whole population can be broadly categorized as poor, or as living below the traditionally defined poverty line.

[30] Patton, Michael Quinn (2008), Utilization-Focused Evaluation (4th ed). Sage.
[31] http://www.padev.nl

Although there was an expectation that games as well as assessment tools would be used to identify how children and youth attending schools defined quality education and quality YFSRHS, the data collection conditions in the field made these tools largely irrelevant. In most cases youth groups were very small (only a few people) and composed of individuals who were no longer in school and hence exploring their perspective of factors that would support their desire to stay in school or the quality of the YFSRHS and how these complemented their schooling experience was not relevant. There was only one opportunity to interview girls who had had babies and returned to school, and this single opportunity afforded to us did not allow for the level of privacy required to secure the respondents rights. Hence the interview was short and limited in number of issues covered.

The review of documentation has covered the whole program, however the field visits was restricted to three districts and three schools in each districts as well as the corresponding health posts. The districts were selected purposively by SCM based on criteria discussed jointly. SCM chose the individual areas because they were accessible and because they felt that together they showed a diverse set of program experiences, and may enable the identification of markers of program success levels. These include:

Mchinji: This district has not shown major success relative to the measurable indicators. The local culture follows Ngoni tradition which is similar to Ntcheu.

Mangochi: this district has shown good progress relative to measurable indicators. The local culture largely follows Islamic tradition.

Phalombe: this district has had had mixed levels of progress relative to the measurable indicators. The local culture is lomwe.

Data was analyzed systematically, but using a qualitative data analysis tool such as Deedose proved not time effective for the type and quantity of the data available. Instead the interviews were analyzed by simply collating responses to specific questions. A few issues are worth noting, which will assist in understanding the use of data in this report, and the value of the data collected:

- The communities chosen for field visits were chosen purposively according to the criteria mentioned above. This type of sampling means that findings are not statistically representative of the program experience, but rather intended to demonstrate a variety of experiences. These experiences reflect the area visited and are believed to be indicative of other areas, but this cannot be ascertained with certainty.

- In order to speed up the process of data collection focus group discussions at schools often combined different groups with similar characteristics. For example: mother groups and child protection committees were involved in the same discussion. This is clearly visible in the interview lists provided in the annex. Although respondent groups were joined because they were believed to have similar experiences and views, and efforts were made to ensure that all individuals present participated in the discussion, it is possible that some views were not shared because individuals did not feel comfortable in doing so. Group interviews and FGD have the advantage that they collect information which is confirmed/agreed upon by the group (where there is consensus), but have the disadvantage that they may not reveal information which is contentious or problematic.

- No control data was collected. This means that we do not know if places that received no support had vastly different experiences. The decision to exclude a control group was made knowingly because we felt that suggesting a control group presented multiple problems that we could not adequately address in order to make any control study valid. For example: we would not know what other interventions they may be implemented in a ‘control’ area. We would not know if any other factors, aside from possible interventions, may influence change. In short we could not know what had caused any *success* or *failure* or be able to explain it. Therefore our focus during the interviews was aimed at trying to make links between findings and program activities or not, in order to see the degree to which project activities could be regarded as influential in any way.

- At the community level by and large the targeted respondents can be divided into three categories: a) individuals who were staff at institutions that receive support, for example school principles or health care managers; b) individuals who received or expect to receive direct assistance, trainings for example, such as mother groups, teachers guiding clubs and health care workers; and c) direct beneficiaries such as children and youth part of clubs. Therefore our ability to measure the impact that interviewees can and do have on individuals who are not directly targeted by the project was limited. In short, how trained mother group member can/do affect the practice of untrained mother group members; or youth members of clubs affecting the behavior of non club members, was assessed based on the opinion of those interviewed only. This means, for example, that our conclusion on the difficulties in effectively implementing the snowball effect to disseminate knowledge is based on what individuals who had been trained told us they had the intention of doing or the capacity to do.

- Individuals were requested to speak openly and although names were taken to record/confirm participation their information was guaranteed as confidential, unless they represented an institution. Therefore we do not attribute statements to individuals.

- The views and perspectives of respondents were triangulated by ensuring that these were echoed by other respondent groups within the region/area.

CHAPTER 4 FINDINGS

In this chapter the principal findings of the evaluation are noted. These findings are based on both the review of documents and the interview of respondents. At the organizational level our focus was on the program experience. At the field level the focus was the challenges the respondent group experienced in relation to teenage pregnancy, school drop out, available health care services, educational facility conditions and the different experiences/engagement they had with the program. This varied from specific trainings to orientations, follow up etc. In some cases respondents had extensive program experience and were able to share these with us, while in others they had only recently been part of an event or were due to be part of an event, in which cases the focus of the interview also expanded into the speculative impact of the event/service.

4.1 Relevance

Assessing the **relevance** of this program can be done through multiple perspectives. On the one hand one can take a strict view and assess the degree to which the program as designed, can and does achieve, the program objectives (see Chapter 1). On the other hand one can take a far broader perspective and ask the degree to which the elements implemented as part of this program have value in relation to increasing school retention, primarily focusing on girls, and reducing teenage pregnancies.

First and foremost it is important to stress from the start that school retention and teenage pregnancy are real challenges in Malawi. Indeed, school retention is a challenge both for girls and boys. There are numerous program and projects that focus on addressing this problem. Promoting school retention of girls encounters cultural, as well as logistical challenges. These can be summarized as: a socio-economic and cultural context that often does not promote girl education; schools that lack basic sanitation facilities that can respond to the sanitary needs of pubescent girls (menstruation, in particular); education facilities that do not provide a nurturing safe environment.

Additionally, in many communities entrenched traditional and cultural beliefs and practices foster early pregnancy as an accepted part of a young girls life. Information from FGD with steering committee members and members of PTA/SCM in Mangochi for example pointed to the fact that girls are often expected by the community to have a baby after reaching puberty. Indeed both the young girl and the society/community find the pregnancy and birth as a great source of pride. Most FGD in all three areas revealed that girls often leave school and soon after marry and have children. Hence, while in some cases they drop out of school because they are pregnant, in many cases they drop out of school and soon after start a family. How many girls leave school and soon thereafter marry is not known, nor did we have access to data on how many of the marriages/relationships are stable or long term. If girls are not married at the time of their pregnancy, or if the marriage fails, they are left to care for the newborn alone or with the support of their own families

Girls becoming pregnant by teachers, or other adult males in the community as well as by a fellow pupil, face limited if any support from the father of the child. In schools such as Nkanda FP School in Traditional Authority Nkanda's area in Mchinji, and Nkope FP School in Mangochi, boys who make girls pregnant are *punished* by being made to leave school when the girl leaves, and remain suspended until the girl is able to return to school. In such cases, the boy and or his family are expected to help provide support to the girl and the baby. This means that the boy also looses out in his education. Although in some cases they are able to register in other schools. According to the Traditional Authority representative of Nkanda and Chairperson for ADC – Nkanda, Mchinji; and the FGD with PTA and SMC for Nkope FP School, Mangochi, when an adult male impregnates a girl, the man is expected to support the baby up to the time the baby is old enough for the girl mother to return to school. This scenario is what the MoEST Re Admission Policy requires, and the Child Protection Act provides for in terms of for child support. However, arrangements for enforcement of the latter are weak especially at community level.

The absence of clear by-laws and/or weak enforcement mechanism and weak penalties pose a challenge to deterring early pregnancies, and early marriages. Similarly mechanism to incentivize parents to value the education of their children, particularly girls, is also weak. For example, in Mchinji District, Nkanda FP School as

well as other schools in the Nkanda Traditional Authority area lack traditional by-laws to govern school attendance, early marriage and early pregnancy. Not all places face the same reality however. In Kawere FP School as well as other schools in the area of VH Mateyo which is under jurisdiction of GVH Kawere, chiefs responsible for the area resolved to refer parents that force their girls into early marriages, as well as girls that become pregnant while in school, to the Child Protection Unit of the Police for counseling. In Koche Model FP School and other schools in GVH Mchesi in Mangochi, the by-law stipulates payment of a fine of 2 chickens by parents or both male or female children who do not attend school. This is expected to be a punishment for being unable to discipline the child and ensure he/she attends school regularly. For Nkope FP School as well as other schools in the area of GVH Mchesi in Mangochi District, parents that force a girl into early marriages as well as those whose girls do not attend school are required pay a fine of K5000. It was reported that two parents have so far paid the fine. Hence how often the by-laws are implemented is questionable. Arguable this is because the fines are well beyond the means of many families. Still some respondents argued that it served as a deterrent[32]. In in Mchinji traditional leaders noted consistently that if an adult made a girl pregnant, without marrying her, the father of the child would have to pay the village leader a goat as punishment. However there appeared to be no link between the young mother's wellbeing and the payment of a goat. Still in other areas visited there were no by-laws governing child support or sanctions against adult men who impregnated teenage girls to begin with, and if these existed, there was limited if any follow up. Notably Malawian law establishes for child support the guidelines are often not applied.

While disciplinary measures are in place to sanction teachers who engage in sexual relationships with school girls including teachers that impregnate school girls, such measures can only be enforced by the MoEST headquarters. Due to bureaucratic challenges in the disciplinary process, it takes a very long time for a teacher to be punished. Meanwhile, most often teachers are transferred to new schools and in some cases, such teachers continue to abuse their power and engage in sexual relationships with their pupils in the new school. This was confirmed by multiple FGD with mother groups and CPC. In Malukula School, Mangochi, a FGD with the CPC and Mother group revealed that they had experienced this type of events themselves. Indeed a teacher had made a couple of girls pregnant and been transferred to another school at the request of the parents. It was known that at the new school the teacher had done the same, and again been transferred. While the MoEST representatives will highlight that transferring teachers is not the appropriate procedure, they do recognize that it does happen and that often the alternative, which would include a detailed investigation, is not favored at the village level because they feel it is a lengthy process that may be derailed or forgotten along the way.

The aforementioned shows that teenage pregnancy is a complex event in Malawi that is not automatically looked down upon by the community, and also that girls who become pregnant may not have the support they might need to return to school. In addition they may have fallen pregnant because they were in school in the first place (propositioned by teachers). The latter indicating that schools may not be safe for them in the first place.

Reducing teenage pregnancy and contributing to girl retention are two issues that are clear challenges faced in Malawi. From this perspective the project objectives **are clearly relevant**. Clearly the views on pregnancy as well as views on schooling, and the school environment itself must change, in order to facilitate the reduction of teenage pregnancy and the increase in girl retention. These are, broadly speaking, the target areas of the program.

Shifting our attention towards information exchange and collaboration between stakeholders, as is noted in Chapter one, there are mechanism that have been put in place and activated to ensure that program stakeholders, at the macro and micro level, are informed about the program. There is evidence to suggest that at the national (global level), sub grantee partners meet and share information on activities conducted, review progress and plan activities, but the degree to which this influences or informs changes is not known. Similar meetings, which include representatives from the MoH and MoEST meet at the district level. At community level, interviews with traditional leaders, SMC, PTA, Mother groups, members of ADC, MG across the project catchment areas generally point to the existence of mechanisms for the various community structures to jointly report on progress made relative to activities undertaken, as well as to discuss challenges.

[32] Sources: KII with GVH Mchesi, FGD with PTA and SMC for Nkope FP School, KII with GVH Chiwalo

Based on the interviews conducted the different partners in the different regions, there was evidence to suggest that there is an active working relationship and coordination between BLM, most of the health centers, and out of school youth clubs on one hand; and FAWEMA and the various school committees (SMC, PTA, MG, CPC, Mother Groups) and in school youth clubs (where they exist) on the other. However, collaboration between the education and health components of the program is, at the community level, limited to the work the YFHS facilitators and out of school Youth clubs do jointly. For example, when the YFHS facilitators from Kaigwazanga Health Centre in Mchinji and Malukula Health centre in Mangochi provide health education to surrounding schools. However, the same is not the case with YFHS facilitators from Nkanda Health Centre in Mchinji. Interviews with members of out of school youth clubs (open to in school youth aged 10 years old and above), indicates that members of Malukula Youth Club conducts health education talks at the nearby Malukuta FP School. In Kamphata and Nkanda out of school youth clubs in Mchinji; and Chiringa out of school Youth club in Phalombe do not. This means that this kind of collaboration is not a standard feature of the program throughout implementation zones. It appears that the lack of coordination between FAWEMA and BLM at the district level as well as the lack of a formal working relationship between health facilities and schools at community level limit the impact that support to individual groups has in relation to the wider community.

Additionally, there is little evidence of sharing of experiences across partners at the national, district and community level that may serve to improve the overall program. Rather each partner tends to stick to their area of domain. Basically health care practitioners focus on health related activities, and the same with education with little, if any cross over. So on the one hand everyone does know their individual role, but may have limited, if any idea, of what else is being done and how activities might build on each other. This makes an integrated design - as this program has intended to achieve – a highly relevant point of discussion for future planning of national programmatic efforts and strategies aimed at supporting adolescent girl. The views of multiple respondents corroborate this. For example the FGD with District Steering Committee, Phalombe noted that 'FAWEMA and BLM need to link their work to each other better through the District Steering Committee, which currently is not happening as each partner works on its own'. Like wise a Key Informant Interview with YFHS provider from a public health facility, Mchinji, noted that although BLM links their work to SCM in terms of service provision, there appears to be no link between YFHS provided by health facilities and the RTP program'. Moreover, BLM staff themselves noted that RTP implements a multitude of activities, but that these are not properly interlinked.

If we shift our attention towards ***risks and challenges*** as tied to the question of relevance we find that there are two specific areas that were not identified during program design. First, the degree to which the indicators would be able to measure progress made. As is evident later in this chapter, a strict evaluation of the indicators would suggest that the achievements of the program have been limited. The shortcomings of using girl pregnancy drop out rates as a key indicator are clear since numbers of girls who are known to drop out of school as a direct result of a pregnancy is limited in comparison to girls who drop out generally. This was illustrated by schools visited where the number of reduced enrollment of both girls and boys was drastic starting in grade 6th, but where the number of girls who left school due to pregnancy (reported cases) was limited to under 5 per year. Moreover, the reasons for why girls have children young are not only a result of lack of knowledge, that is to say lack of YFSRHS. Rather school drop outs and youth pregnancy are both a result of a complex set of factors which, as has been noted earlier, include community expectations, existence of role models, individual expectations etc.

The focus on numerical indicators to determine drop out rates, and more specifically, drop out due to pregnancy, completely overlooks that at its core this program aims to attain social change both in how sexual and reproductive health is understood and regarded, as well as relative to how education, particularly of girls, is valued. While many tangible activities can be undertaken to support these two areas, attaining notable social change cannot be expected over night. The innovative idea of bringing together two fields of work (health and education), and recognizing that they are complementary in efforts to support school retention require commendation. To this end the program does not only try to address very complex issues, but also tries to do so in a manner that is holistic.

Second, an important risk and challenge to the program is the relevance of how sustainability has been approached. These challenges are dealt with later in the document (see section 4.4).

4.2 Progress towards achieving results

In this section we introduce achievements of the program in accordance to the program plan.

4.2.1 Achievements per Outcome and Impact Indicator

Outcome: A 10% reduction in teen age pregnancies for girls aged 10-19 years in each of the 6 targeted districts from 21.3% in 2014

A total of 1855 adolescent girls dropped out of school in 2014 and 2015 due to pregnancies. The majority of them, 1,269, dropped out in 2014. The table presents substantial decreases in the number girls that dropped out of school in all RTP districts during the 2014 /2015 school calendar year. This could be attributed to the various interventions under RTP among other factors (see Table 4 below). However at the same time it is difficult to make such a clear attribution given that the number of drop outs in 2012 was so much lower than in 2015, and that there is a great degree of variance between years. The short time period under review also makes a trend difficult to establish, thus making a linear attribution to any one factor very difficult to determine.

Table 4 Girls who have dropped out of school due to pregnancy by district[33]

	2012	2013	2014	2015	Total
Balaka	22	99	157	106	384
Machinga	25	73	95	48	241
Mangochi	100	305	469	180	1054
Mchinji	75	179	271	72	597
Ntcheu	60	78	116	62	316
Phalombe	27	65	161	118	371
Total	**309**	**799**	**1269**	**586**	**2963**

Source: Save the Children 2015 Annual report on RTP Project

According to Table 5 below, the majority of girls that dropped out of school due to pregnancies between 2012-2015 were between 15-19 years of age, and were in senior classes of standard 6, 7, and 8. In addition, close to 10% of girls who dropped out of school due to pregnancy were attending standard 4. The table shows that the percentage of girls that dropped due to pregnancy increased in senior grades of standard 6 to 8 and that both the number and percentage of drop outs due to pregnancies was higher that the figure identified in the baseline (23.1% for girls in standard 6 and 7 at 23.3% and 25.3%, respectively) which suggests that either the data collected during the baseline was not accurate, or that the numbers of drop out due to pregnancy vary greatly from year to year, as was noted above[34].

Table 5 Proportion of girls that dropped out of each grade due to pregnancy (2012-2015)

Class	Number of learners that dropped out of school	Percentage
Standard 1	12	0.41
Standard 2	30	1.01
Standard 3	84	2.84
Standard 4	286	9.66
Standard 5	505	17.1

[33] We note that tables 4, 5 and 6 are reporting the same data in different ways. However the total figures, while similar are not identical. These discrepancies are replicated from SC documentation and was not generated by the consultants

[34] It is noteworthy that the reliability of data on school drop outs due to pregnancy is highly questionable, School principles and teachers in all schools visited noted that the drop out rate due to pregnancy at their schools fluctuates between 2-5 per year. Schools visited ranged in size from 4-600 pupils to 1200+

Standard 6	691	23.3
Standard 7	750	25.3
Standard 8	603	20.4
Total	**2961**	**100**

Source: Save the Children 2015 Annual report on RTP Project

Table 6 shows the age distribution of girls who dropped out due to pregnancy in the 2012-2015 time period. It is notable that while the percentage of 10-14 year olds that became pregnant increased by 2.9%, from 2014 to 2015, there was a 2.4% reduction in the percentage of 15-19 year olds that became pregnant within the same period. While interventions through RTP may have contributed to this improvement, a far more in-depth investigation is required to establish the contribution of RTP especially considering that the drop was not consistent, that areas have had different levels of support (i.e. trainings, sensitization meets etc.). Generally most respondents acknowledged the likely positive contribution of RTP in nurturing positive attitudes among community members, families and girls in particular on the value of education. Still it is difficult to know if this has led to a statistically relevant change in behavior.

Table 6 Proportion of adolescent girls who dropped out due to pregnancy by age category over the years (2012-2015)

Age	2012	2013	2014	2015	N
10-14 years	15.6%	24.9%	30.9%	33.8%	**833**
15-19 years	80.1%	73.7%	68.6%	65.8%	**2,081**
20-24 year	4.23%	1.38%	0.48%	0.34%	**32**
N	**307**	**798**	**1269**	**586**	**2946**

Source: Save the Children 2015 Annual report on RTP Project

Overall it is difficult to appreciate the magnitude of the problem relative to general school enrollment records considering that enrolment data for 10-19 year old girl in the project catchment areas is not presented in the 2015 project annual report. Such data could have provided a basis for comparing drop out rate against the baseline data collected for the project. From a very haphazard review of drop out rates generally at schools visited it appears that the majority of drop outs are not due to pregnancy at the time of drop out, although girls dropping out may very well become pregnant in the months that follow as was noted in chapter 1. Post drop-out pregnancy however is not recorded in any available statistic at this time. Similarly cases where girls may drop out so early in the pregnancy that it is not attributed to their condition are also not recorded.

Lastly, while Table 4 points to significant decreases in the number of girls that dropped out of school in 2014/15 calendar year across the project catchment area, Table 5 shows above baseline drop out rates due to pregnancy for girls in standard 6 and 7. Table 6 on the other hand, presents a progressive percentage increase in drop out rate due to pregnancy for 10-14 year olds from 2012-2015 while at the same time presenting a progressive percentage decrease in drop out rate due to pregnancy for 15-19 year olds. Based on the trend in percentage drop out for girls in grades 4-8 in Table 5 as well as for 10-14 year olds in Table 6, the strong focus on a 10% reduction in drop out rate of girls due to pregnancy by end of 2016 is an indicator that appears difficult, if not impossible to meet. The reasons for this can be multiple, not least calling attention to the complex nature of the dynamics that lead to early pregnancy in Malawi, which are not solely linked to lack of adequate sexual and reproductive healthcare or knowledge. This finding serves to illustrate that the ToC must be re-examined (see Chapter 7 and annex 3).

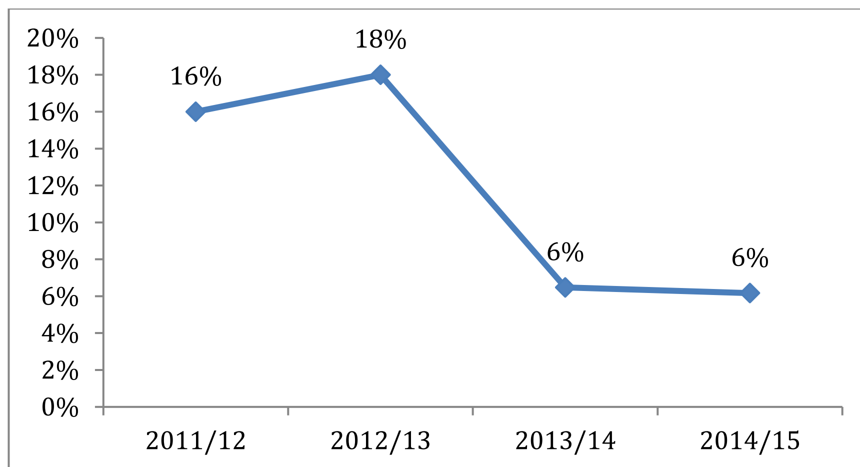
The short-comings of the indicators, however, does not mean that the program efforts are not achieving interesting results, or that they do not have potential to impact reduction in teenage pregnancy. Rather that the focus of the indicator is not sufficiently accurate and does not measure what is being achieved by the program. Interviews and FGD respondents, both at schools and health care facilities, consistently noted that they felt that

the activities done by the RTP were positive. This was particularly so in relation to children and youth who participate in health clubs, and mother groups who felt that the training they had received had made them better equipped to work with parents and pupils in their advocating for girls to return to school. Similarly health care workers interviewed consistently noted that their ability to provide YFSRHS was of value to their patients. However, how these efforts reflect on the indicator is impossible to ascertain, not least because the issues (school retention and teenage pregnancy) are so complex to begin with.

Outcome: A 5% reduction in school dropout rate for girls aged 10-19 years in each of the 6 districts from 21% in the 2013/2014 academic year

Dropout rates for adolescents in standard 5-8 significantly improved between 2012/13 and 2013/14 academic years throughout the project's catchment areas (decrease from 18% to 6%). However the drop out rate has remained constant at 6% during implementation of RTP program in 2013/14 and 2014/15 school years respectively[35] (see figure 2).

Figure 2 Drop out rates of adolescents in standard 5-8 in the impact areas

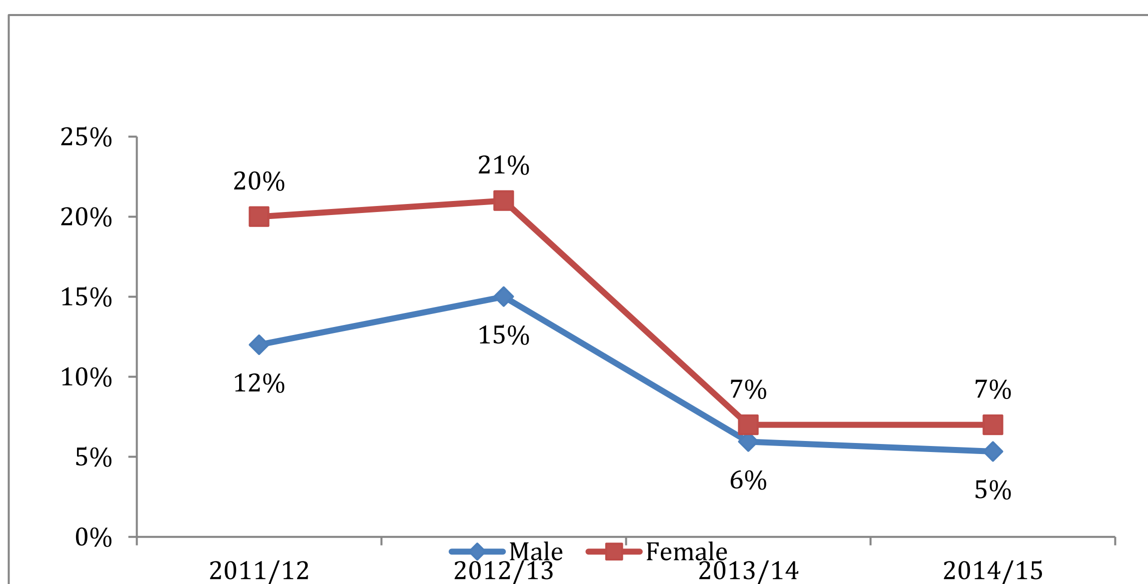


Source: Save the Children 2015 RTP report

Figure 2 above shows, the average drop out rates for adolescents (standard 5-8) decreased from 18% in 2012/13 to 6% in 2013/2014 school calendar. Figure 3 below shows that dropout rates for boys generally decreased from 21% to 7% and 15% to 6% for girls from 2012/2013 to 2013/2014 respectively. Overall, dropout rates for girls remained higher than for boys During the 2014/15 academic year, the drop out rate for boys improved by 1% from 6% in 2013/14 to 5% in 2014/15 while it remained constant at 6% for girls during the same period. Notably the drop out rate for girls had improved beyond the 5% program target between 2012/13 and 2014/15, however the drop out rate for the project catchment areas has not changed since the start of RTP program in 2014.

[35] Although implementation of RTP effectively commenced in May 2014, actual field work did not commence until December 2014

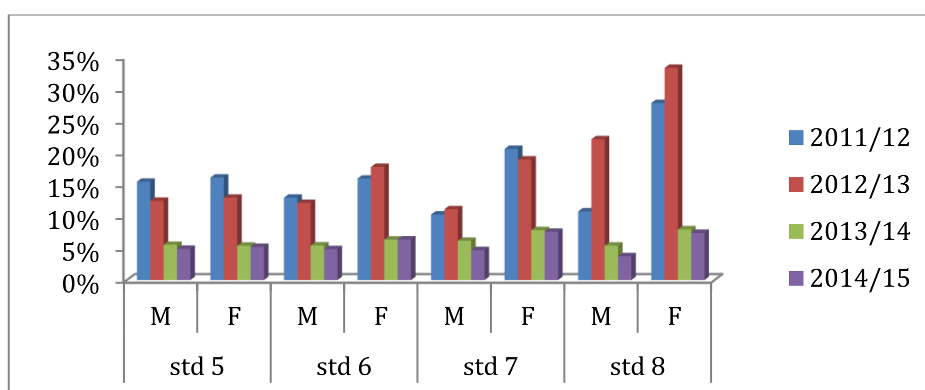
Figure 3 Boys and girls drop out rates in standard 5-8 in the program areas



Source: Save the Children 2015 RTP report

Drop out rate for both boys and girls increased in more senior classes (Standard 6, 7, and 8) with drop out rate for girls being notably higher than that of boys.

Figure 4 Trends in drop out rates for boys and girls from 2011-2012 to 2014-2015



Source: Save the Children 2015 RTP Project Report

While dropout rate for each of the districts followed the overall pattern seen, namely, the rate fell significantly for 2013/14 school year and remained constant between 2013/14 and 2014/15. Mangochi, Machinga and Mchinji districts had comparatively higher dropout rates for girls during the 2014/15 academic year (approximately 8%, 7% and 7.5% respectively). This was the case even though many of the locations covered by the RTP are targeted by other projects and programs that support school retention for girls. For example: Mangochi and Mchinji districts are targeted by DFID supported SC KGIS Project, and Machinga is targeted by the USAID ASPIRE Project. Balaka is targeted by USAID ASPIRE Project. This coupled with the drastic drop in drop out prior to the start of the RTP a more detailed study to determine the contributing factors may be required. It should be noted also that these reasons could include issues with data collection and management.

Outcome: A 5% Increase in girls' re-entry to school from 15% in 2014

On average 28.5 % of adolescent girls (10-24 years) who fell pregnant in any of the following years; 2012, 2013, 2014, and 2015 have returned to school. Except for the experience had in Mangochi district, the percentage of re entry in 2015 exceeded the 5% increase expected by the project based on data collected during the 2014 baseline (Baseline estimated re-entry at 15%)(See Table 7 below).

Table 7 Proportion of teen mothers that returned to school after delivery

	2012	2013	2014	2015	All
Machinga	50.0%	41.5%	28.9%	26.2%	**36.6%**
Mchinji	53.1%	42.5%	32.0%	8.0%	**33.9%**
Phalombe	55.6%	48.4%	23.3%	4.3%	**32.9%**
Balaka	50.0%	30.0%	19.9%	6.9%	**26.7%**
Ntcheu	26.8%	27.4%	21.8%	9.8%	**21.5%**
Mangochi	31.2%	22.3%	19.8%	4.1%	**19.3%**
All	**44.4%**	**35.4%**	**24.3%**	**9.9%**	**28.5%**

Source: Source: Save the Children 2015 RTP Project Report

Available records seem to suggest that there is a likely positive correlation between teen mother follow-up rate and teen mother return rate to school. Districts where more teen mothers were individually followed up by members of mother groups, appear to show an increased number of them returned to school. For example Balaka experienced a reported teen mother follow up rate of 83.3% and a return rate of 36.6% while in Phalombe with a much lower follow up rate the return rate was reported at 19.3%[36]. Anecdotal evidence from FGD with Mother groups, CPC, PTAs, SMC, club matrons and patrons, members of youth clubs and in some cases youth themselves attest to this positive trend. For example, according to members of Kamphata Youth Club in Mchinji, 4 girls who had dropped out of Kamphata FP School due to pregnancy re enrolled in 2015 after giving birth. Similarly members of PTA and SMC for Nkanda and Kawolambumba FP Schools reported that a total of 12 girls re-enrolled at Nkanda and Kawolambumba FP School in 2015 respectively after delivering. In Mangochi according to members of PTA and the SMC, 4 girls re-enrolled at Nkope FP School in 2014 and a further 2 in 2015. A further 11 have reportedly re-enrolled at Koche Model FP School since 2014. In Phalombe, members of PTA and SMC at the respective schools reported that 25 girls, some who had been part of early marriages and others upon the delivery of their babies, re-enrolled at Malukuta FP School, 1 girl re-enrolled at Nkhulambe FP School after delivery and another divorced her husband and returned to school at Nambiti FP School. However, in the absence of raw official data on number of girls that dropped out each year, it is difficult to establish the magnitude of the problem that the project has had to address.

Although it is difficult to show statistically the impact of the program, there are areas where positive results are identifiable. These include:

- Working with mother groups to strengthen their abilities and skills in supporting girl retention rates was consistently noted by mother group FDG as an asset. This was particularly visible in Mchinji where Mother Groups showed a self imposed drive to achieve positive and noticeable results. A potentially negative side effect here can manifest when mother groups focus more exclusively on pregnant teens rather than tees more broadly including out of school teens.
- Improved ability of teachers to provide pupils information regarding SRH, and in promoting a safe environment for students. The most noted results, as claimed by matron and patrons interviewed, were visible amongst children members of school clubs.
- Improved ability of Child Protection Committees to support a safe environment for children[37]
- Improved knowledge amongst youth members of youth clubs on SRH issues.
- Improved gender dynamics amongst member of youth clubs. This includes empowerment of females regarding their own sexuality. This was particularly highlighted by the nurse responsible for the Malukula youth club in Mangochi.
- Bringing together the MoEST and MoH to discuss the issue of teenage pregnancy and drop out, alone, should also be considered as a gain made by the program thus far.

[36] Save the Children (2015). 2015 Report on RTP Project, p.70

[37] It is worth noting however, that the practice of transferring teachers who engage in sexual activities with pupils was seen as a legitimate solution by CPC in Mangochi and Parombe.

Areas where the program has not focused attention, and where possible efforts should be focused, include:

- Vouching for the care and wellbeing of the child of the teenage mother.
- Expanding attention to gender relationships and particularly the role of men/boys in pregnancy, fatherhood, etc.
- Addressing the special needs of children and youth with disabilities to ensure that they too are considered in ensuring adequate school environments and the provision of SRHS.

4.2.2 Individual activities and the degree to which these have been achieved in accordance to the program plan

In addition to implementation of preparatory project activities, Table 8 overleaf presents the extent to which planned activities especially at grassroots (operational level) had been achieved relative to the program plan for 2014-2015. The data reflects activities carried out until December 2015.

A review of annual work plans and reports for 2014 and 2015, vis a vis activities that FAWEMA is responsible for under Outcome strategy 1 on Improved learning environment and self-efficacy of adolescent girls and Outcome strategy 3 on Improved social environment to support adolescents' sexual reproductive health rights and educational achievement indicates that of the 25 activities planned 16 (64.%) were fully done with targets reached, 8 (32%) were partially done in that the targets were not reached while 1 (4%) of the activities were not done at all. An additional 2 activities that had not been planned for were fully done with no cost to the project. Reasons given for discrepancies between planned and executed activities include delays in funding allocation, inadequate time allocations to carry out the expected task, overestimation of the number of schools that had been identified for targeting, decision not to run a particular activity in all the targeted schools and some misunderstandings on the part of the community. Notably of the activities planned for implementation, none of them seem to put particularly focus on the issue of male champions (boys, uncles, and fathers) to protect girls from various risks they encounter, to support a reassessment of gender relations and the role of boys/men in pregnancy and child care, or to facilitate girl retention in school or re-entry after they give birth.

A review of annual work plans and reports for 2014 and 2015, vis a vis activities that BLM championed Outcome strategy 2 on Improved access to high quality sexual reproductive health services for youths indicates that out of a total of 13 activities that the organization led, 5 (38.41%) were fully done with targets achieved while 8 (61.53%) did not, to various degrees perform to full achievement of set targets. In addition one unplanned for activity was implemented. Reasons provided for failure to implement some activities fully include time constraints, scheduling challenges and delays in undertaking key orientation sessions.

Under strategic outcome 4 on Improved operationalization of policies to support adolescents' sexual reproductive health rights and educational achievement, the 2015 RTP Annual report indicates that only one of the 3 planned activities was fully carried out. This was the Quarterly Project Coordinating committee meetings with MoH and MoEST to discuss the gaps and relevant conversions and policies and how they affect service and education for adolescents. The other 2 activities, 3 of the 4 quarterly project coordinating committee meetings were held with MoH and MoEST to discuss policies and how they affect service and education for the youth. 1 policy (Admission Policy) of the 2 policies meant for dissemination was done, but only in one district, Machinga. Lastly under Strategic Outcome 5 on Improved coordination, monitoring and evaluation of project activities (added following baseline study) 11 of the 16 (68.75%) planned activities were fully done while (31.25%) were not carried out in full[38].

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[38] Annex 4 presents additional details on progress in the implementation of selected activities

Table 8: Progress in relation to implementation of activities per strategic outcome.

Implementer	Strategic Outcome	Activity Fully done (2014-2015)	Activities not fully done	Activities not done	Additional activities done at no cost to the project
FAWEMA	**1**	Training of Trainers involving SHN Coordinators, Head Teachers and PEAs) on Psychosocial Support, Child Centered and Gender Sensitive Pedagogy, Positive Discipline, Child Protection including Mapping, VAG, SRHR.	32 of the 42 planned follow-up observation and mentoring visits to assess knowledge transfer by teachers and provide them with further support were carried out. The activity was not fully accomplished in 2015 due to delayed implementation of activities.		
		Development of teacher training manual.	Support school-based interventions by youth clubs to strengthen knowledge acquisition and self-efficacy (quiz/essay competitions) – activities were carried out in 34 of the 42 clubs. It was not fully done in 2015 due to time delays.		
		Trainings of teachers on child-centered and gender-sensitive pedagogy, psychosocial support/mentoring positive discipline, child protection, and ASRH).	Of the 513 targeted schools, 478 replicated the mapping exercise to identify areas where girls feel safe and unsafe within the schools. The exercise was not done in Junior schools.		
		Teacher trainings – follow-up/review meetings with school authorities (i.e., club patrons, head teachers, and health center staff who will be visiting schools for health talks)			

		Conduct QLE assessments. and provision of support			
		Provide support to school clubs (girls camping and role-modeling).			
		Printing & distribution of the training material			
		Supervision of in-school clubs			
FAWEMA	**3**	Community sensitization meeting (zone-based).	1256 schools of the targeted 1448 schools benefitted from Training of community structures (MG, SMC, and PTA) in tracking and reporting of issues. The reason given for underachievement is that some zones have fewer schools than the estimated 15 schools per zone. For example Migowi in Phalombe have only 8 schools.	Conduct quarterly meetings with CPCs to monitor community engagement.	Talks at initiation camps for girls protection-MH.
		Community sensitization (school based).	40 of the targeted 52 clubs were sensitize in- and out-of-school clubs about SRHR services and service delivery points in Phalombe and Machinga (took place during youth attendance at outreach days).		Awareness open days on ending early marriages and child protection policies were done in Ntcheu.
		Conduct one-day orientation for school structures (mothers groups, SMCs) at zone level to assist and support teen mothers' to re-enter into schools, reporting systems for sexual violence, and additional encouragement for girls to remain	A total of 44 of the planned 46 ADC sensitization meetings were conducted in 6 targeted districts Two (2) meetings did not occur due to misunderstanding on election procedures.		

		in school.			
		Conduct one-day orientation of 443 CPC/TAs on adolescent SRHR and how to track teen mothers and re-admission (orientation training for CP Workers – had planned to continue in 2016.	A total of 32 of the 42 Zonal open days were conducted. The activity has not been done in Phalombe District.		Revitalize dormant CPCs.
		Orient school structures (mothers groups, SMCs) at zone level to assist and support teen mothers' re-entry into schools, reporting systems for sexual violence, and additional encouragement for girls to remain in school	58 of the 516 quarterly community dialogues on keeping girls in school and re-admission procedures were conducted. The activity was not done Phalombe due to delayed funding.		
		Orient CP Committees on teen mother tracking and re-admission to continue n 2016			
		Conduct VDC sensitization meetings.			
		Conduct Mapping exercises			
BLM	**2**	Source QIT standards and guidelines, print, and distribute to QIT.	169 out of 292 YFHS providers – 2 per facility (1 nurse/clinician and 1 HSA) were trained. However, since there are 76 health facilities in the project catchment area, the total figure for persons trained should have been 152[39]. Training was significantly delayed. It started late in 2014 due to disagreement between trainers (BLM) and participants from the health facilities on the application of the government policy on per diem.		Debriefing meetings with DHMTs on QIT /YFHS findings.

[39] However, a number of health that work with the youth in health facilities e.g. at Nkanda and Kaingagwaza Health Centre in Mchinji, Migowi Health Centre in Phalombe were not invited to the training. It is clear from their recommendation that they need to be trained to carry out their duties more effectively.

		Recruitment of the YCBDA.	245 out of 303 sessions were carried out to support to DHOs and partners for mobile YFHS (through public or private outreach services) in areas with identified service delivery gaps. The BLM DOT failed to complete all sessions due to time constraints and logistical challenges (e.g. unavailability of fuel). Training did take place in all 6 districts.		
		Conduct one-day orientation for 8 QIT members (per team) on QIT standards and guidelines	Only 30 of the targeted 443 YCBDAs were trained, all of them in Balaka.		
		Orient 6 district YFHS coordinators and DYO in their roles in monitoring and supervision.	102 of the 144 Health worker quarterly visits to schools and youth clubs and student visits to service delivery points were made. Activity not fully implemented due to scheduling challenges, weather etc.		
		Conduct one-day orientation for 8 QIT members (per team) on QIT standards and guidelines.	Support was provided for 6 out of the planned 12 monitoring visits by Quality Improvement team (QIT) team to health facilities in the districts. The teams could not cover 2 visits per district due to time constraints as their orientation was conducted late; No visits were conducted in Mchinji while only 2 visits were conducted in Machinga		
			6 of the 12 Quality Improvement team (QIT) monitoring visits in the districts at facility level were made. Other visits could not be made due to delays in orientation. No visits were conducted in Mchinji, while 2 visits were conducted in Machinga.		
			Support was provided to DHO and partners for YFHS for 7 of the 32 targeted health facilities within RTP		

			catchment areas. (Available data is for Machinga and Ntcheu only; only 1 facility reported).		
			102 out of 144 Health worker quarterly visits to schools and youth clubs and student visits to service delivery points were conducted. Some visits did not occur due to rains, exams, and health workers' schedules.		
SCM/Various	**4**	Quarterly Project Coordinating committee meetings with MoH and MoEST to discuss the gaps and relevant conversions and policies and how they affect service and education for adolescents	3 out of 4 quarterly project coordinating committee meetings were held with MoH and MoEST to discuss policies and how they affect service provision and education delivery for the youth.		
			1 policy (Admission Policy) of the 2 policies meant for dissemination was done and only on one district, Machinga.		
SCM	**5**	Conduct a Baseline study.	Conduct quarterly district steering committee meetings to review progress and plan district activities were carried out (17 out of 24 meetings conducted).		
		Disseminate Baseline study report.	Conduct quarterly project management meetings (3 out of 4 meetings conducted).		
		Develop an electronic database.	Conduct Data Quality Assurance visits (1 of 2 visits was done).		
		Develop a data collection tool kit.	Conduct DEC meetings (5 out of 6 districts –DEC meeting was not held in Ntcheu) - 2015		
		Conduct training in data management.	245 out of 303 sessions were carried out to support DHOs and partners for mobile YFHS (through public or private outreach services) in areas with identified service delivery gaps. The BLM DOT failed to complete all sessions due to time constraints and		

			logistical challenges (e.g. unavailability of fuel).		
		Document and disseminate best practices,			
		Conduct monitoring visits			
		conduct an annual review meeting			
		Review performance plan (2014)			
		Conduct DEC Meetings 2014			
		Develop reporting forms			

Based on analysis of the program's defined indicators, the program has not yet achieved its expected results. However, as noted earlier this evaluation found that the indicators were not particularly adept to the conditions on the ground. Based on the data collected for this evaluation, we found that consistently respondents highlighted the existence of a complex set of factors which include, in addition to the provision of adequate services in both health and education sectors respectively, socio-cultural and economic factors, which influence teenage pregnancy and school retention amongst girls. According to FGD and interviews with Mother Groups, teachers, CPC, and village headmen, factors adding to the complex nature of drop out and pregnancy dynamics include, but are not limited to: lack of role models that encourage education, lack of employment prospects after education, schools which lack minimum standards (classrooms, sanitation), support for early marriage by the community, ability to access disposable income by becoming the lover or wife of an older man, gender relations which do not empower women and hence they feel they must oblige when sexual favors are requested/demanded of them, to name but a few.

All of this strongly suggests that what the project intends to achieve in a short period of time is a tall order, and that the pregnancy drop out link is only one visible challenge. Girls may drop out and soon after become pregnant or marry, for example. Still, there was substantial anecdotal evidence from the interviews conducted in the different areas visited that suggested that the individual activities carried out by the program are beneficial and do support the overall objective of girl retention in school and a reduction of pregnancies. The program efforts also serve to support other changes/successes, which are not currently reflected in the project documents. These include, for example:

- More equal gender relations between girls and boys who regularly attend lectures as part of the youth clubs in health centers which focus on SRH.
- The improvement of skills amongst mother groups who work towards girl retention in school more generally.
- Improved knowledge about the impact of births on the body and the reduction of pregnancies close together.
- Reduction in sexually transmitted diseases.
- Increased awareness of the threats faced by girls in schools including for example propositions by male teachers.

More specifically in relation to activities conducted and the degree to which these have been or not achieved on schedule (see Table 8) some key issues/challenges are worth highlighting here:

- **The per diem or full board policy:** In Malawi, as in many other countries, there has been a long established culture of equating courses, workshops, meetings with per diem, which essentially means that attending any such event serves to generate additional income. In an effort to reduce the monetary incentive associated with trainings a new policy was passed at government level which encourages non governmental organization to not pay per diem, but rather cover all costs. This has had some budgetary implications for the project, but more importantly it halted training at the beginning because would be participants did not want to take part if they were not to receive a per diem. Currently SCM has a flexible position where sometimes they do pay full board and other times they pay a per diem.
- The phased approach taken to the conduct of activities has meant that many areas received training very recently indeed, some of the people interviewed had been trained just a week or two prior to the field visit. This makes any impact the activities might have speculative. Tied to the difficulty in measuring impact, it must also be noted that as table 8 delineates there have been an out right delay in the conduct of some activities also.

In relation to factors that have hindered or assisted the achievement of objectives, aside from those mentioned above, a few others can be highlighted.

- Interviews with all groups in Mchinji showed that there was a clear willingness to achieve the goals of the program. Mother groups, for example were very self driven and identified ways, for example, to raise funds to support their efforts to keep girls in schools. This was less evident in Mangochi and least evident in Phalombe. The same general trend in behavior was noted in health posts, where staff not

directly involved in program activities appeared not to be concerned at all with what it achieved, or intended to accomplish. In Phalombe FGD with all groups at the village level suggested that "controlling" youth was difficult, if not impossible. Similar views were highlighted in Mangochi, but less extreme. In both areas the capacity provided was seen as an asset, but there was a clear mention of the need fort material support. This was particularly the case in Phalombe. Overall there were clear indications that some communities/individuals especially in Mchinji and Mangochi welcomed capacity, saw its value and were willing to use it, while others especially in Phalombe felt that development should focus on material goods and hence were less interested in receiving training. There appeared to be a link between communities that have a long history of aid dependency and communities that did not. The level of material poverty did not seem to be the deciding factor.

- The current MoEST policy that does not accept the provision of services within school premises. This is a serious challenge to the program and drastically limits potential coverage considering that existing evidence point to the progressively increase in pregnancies among 10-14 year olds and above baseline rates among 15-19 year olds (see Table 5 & Table 6).
- The general hesitance thus far by ministries to engage in a discussion that would allow for curriculum changes for pre-service training of teachers and health care providers limits the sustainability of the project objectives. However this may change as according to SCM, UNESCO is currently working with the MoEST on changes to the curricula.
- The time frame of the program is limited while the type of achievements are ones that expect socio-cultural shifts and hence long periods of time are required before change will be achieved and evident.

From a policy perspective it is clear that the program has focused on providing support in areas where it is possible to provide support. That is to say it has not yet taken a clear and solid stance to challenge the current positions by the different ministries regarding in-service versus pre-service training, active collaboration between ministries, curriculum adaptations etc. In this sense the program has aligned itself to the conditions it must work in. Indeed according to program staff advocacy has not been a focus for the RTP thus far. There is, hence, a danger that there will be no changes at the policy level at any point in the future. Whether or not SC believes that a longer term strategy, to ensure the sustainability of the program interventions as part of the standard government objectives, should be had alongside the program intervention is something worth discussing internally.

From the perspective of youth themselves the program activities seem to provide much needed support. However it was clear that the benefit is extended primarily to individuals who actively participate in youth clubs, or who are targeted by mother groups. Aside from this there appeared to be limited benefit to the wider youth population, unless they themselves sought out a service. While it is not possible to know how much children and youth members of clubs discuss issues learned at the club with their peers, there was no indication that this happens systematically or that it has a clear and noticeable impact. It is hence important to note that the number of children and youth included in clubs are a small fraction of the number of children and youth to whom the services provided within the club are relevant.

4.3 Partnership and child participation and role of civil society partners

Partnerships in general: Generally speaking the partners selected at the different levels appear to be adequate and relevant. They are either implementing agencies with long and solid experience in their respective area of operations, or government or government established entities. From this perspective the institutions and entities are well chosen as the tasks that are being demanded of each are ones that fall well within their areas of expertise.

The coordination mechanism for delivery of the RTP follows the existing government structures from national to local assembly (district), to community level. By so doing the RTP benefits from strengths of government's coordination mechanism as much as it is affected by challenges inherent in the system. According to SCM respondents, sub grantees and member of the national RTP steering committee (especially government ministries interviewed) indicated that the setting up of a national steering committee for RTP has facilitated engagement and sharing of information especially on SRH and girls education among stakeholders. Similar sentiments were expressed by a member of RTP steering committees at the district level.

The role of government actors: Four government ministries seem to have been actively involved in the project, namely, MoH, MoEST MoY and MGCD&SW. From the key informant interviews with persons from MoH, MoEST and MGCD&S, government participated, after the project conception and design stage, hence the impression that government's role is to support the project as opposed to owning it. Of course there are challenges promoting ownership amongst partners who are confronted with limited resources, and policies which may restrict their ability to partake as widely as they may wish and a myriad of challenges only one of which is that addressed by the program. The MoEST, for example, although individuals in the Ministry are positive towards the program and the activities conducted by it, Ministerial policies restrict what type of activities it may endorse. This means that the ministry may be better able to participate more fully following the presentation of clear evidence that the program achieves results rather than leading the way with innovative approaches. That is to say that if there is clear evidence that that provision of goods in schools, for example, is effective, this may serve to sway the Ministry to change its current position.

Thus far in this program the government involvement has been largely partitioned. That is to say that each government office attends to their area of expertise and competence without engaging actively across sectors. The partnership with RTP has placed more responsibility on some government ministries than others. The MOH has probably made more investment in RTP than the other government ministries. This is so that RTP's area of focus is understood by many actors as relating more to health than to education, because pregnancy is understood as a health concern. Within the health component the collaboration between the MoH and the BLM has been productive. This is not least because there is a long standing relationship between the two organizations, thus emphasizing the importance and benefit of understanding the institutional landscape correctly.

In the case of MoEST, activities in RTP education component are implemented through existing structures. RTP interfaces with MoEST Headquarters through the Directorate of SHN, and at district level through DEM, PEA and the individual schools. The MoEST has worked closely with FAWEMA in the identification of school to benefit from the project, in mobilizing support for participation of teachers and their schools in the project, as well as participation of existing PTA and SMC. MoEST and other key ministries have also been involved in the development of the teachers' manual, in facilitating QLE assessment and the mapping of safe and unsafe areas through school exercises.

While there is consensus that partnership with government has helped to harmonize efforts of different government ministries into a single portfolio of an adolescent child, information from key informant interviews in government as well as project staff in SCM indicate that the partnership is constrained by a number of factors. Key among them is the two different policies governing the delivery of SRH: While MoH policy in this area is applicable to all levels of health institutions and promotes provision of contraceptives to persons that require them (including pupils at primary school level), the MoEST policy currently promotes abstinence and to this end only supports dissemination of information on SRH but does not allow provision of contraceptives to youth in primary school irrespective of their age.

Moreover there information provided to students in schools, as part of the current curricula, is quite limited. Indeed the data collected for this evaluation showed that although there are shortcomings to only providing information, without providing contraceptives, in schools, these activities still play an important role. Indeed the importance of youth clubs relative to Life Skills curriculums was highlighted by matrons and patrons interviewed. As it stands currently the Life Skills curriculum is not only shallow in terms of SRH but also that pupils learn it to pass exams and not necessarily to obtain knowledge and skills. As such, content of the Life Skills curriculum is largely memorized. Main messages in the Life skills curriculum include: Adolescence and development milestones, STIs including HIV, risks of early marriages and early pregnancies and possible sources of information on sex and sexuality. Pupils indicated that matrons and patrons were able to provide information as well as to counsel pupils even one on one basis. Pupils further indicated that such information was supplemented by information provided through heath education talks by visiting YFSRHS coordinators. It is also important to note that youth clubs are far more interactive and participatory than traditional classroom imported knowledge. Most teachers interviewed recommended review of the curriculum. Moreover, there was consensus among club matrons and patrons interviewed that issues of sexual reproductive health should be provided to the

majority of pupils through the normal curriculum rather than the creation of a club that only includes a fraction of students. However, many of the parents and members of community structures (PTA, SMC, and CPC) interviewed through FGD were supportive of the current curriculum content as they felt that pupils were too young to be exposed to the subject in depth.

Lastly, there is consensus among government partners that the project is inadequately monitored by the national steering committee. This is seen to be largely due to the inadequate allocation of resources for monitoring by SC as well as by time constraint arising from competing priorities on the part of government. Lastly, findings from SC point to high financial dependence on parts of government for financial resources; as well as a highly bureaucratic system within government. Some of these challenges may negatively impact the effectiveness of the partnership.

Child Participation: the field data collection revealed that, active participation for the children in the schools is largely limited to their involvement in school youth clubs. During the QLE assessment open days, during mapping of the school environment and for some, through membership of out of school youth clubs, children were included, but this too appears to have primarily targeted children from youth clubs. Pupils from junior primary schools in Mchinji were excluded from taking part in QLE related activities. In any event participation in events and quizzes targeted a limited number of pupils, according to data collected from matrons and patrons it most often included 50+- pupils per school. In a few instances, youth are actively involved as a target group in the development work of civil society organization. Data collected from youth clubs in all three areas visited, concluded that members of the Chiringa school youth club (also open to in school youth) and Nambiti FP School in Phalombe were the only youth clubs currently targeted by multiple civil society organizations as beneficiaries of development efforts. The civil society organizations include the Catholic Relief and Development Organization of Malawi (CARDCOM) which support the club on issues to do with agriculture and inclusive education and Action Aid which provides support on matters related to food security and the environment. However, based on the results from the mapping exercise, RTP lobbied for the support from CARDCOM which led to the eventual building of toilets in some of the schools[40].

Civil Society Partners: Moving our attention towards the implementation of activities, BLM is responsible for the implementation of activities under objective 2 on improved access to high quality sexual reproductive health services for youths. A review of work plans and annual reports for 2014 and 2015 indicates that out of a total of 12 activities that the organization conducted, only 4 were fully completed and targets achieved. Other activities were only partially achieved. One activity not predicted was added to the list of activities carried out. The reasons provided included time constraints, scheduling challenges and delays in undertaking some orientation sessions (for details see table 8).

FAWEMA unlike BLM was more involved in RTP from project concept and design, development of the project including planning, budgeting and review including in reflections and re-planning meetings. Their extensive experience was therefore an asset to the program. FAWEMA has been responsible for the implementation of activities under objective 1 on Improved learning environment as well as some activities under objective 3 on Improved social environment to support adolescents' sexual reproductive health rights and educational achievement. A review of annual work plans and reports for 2014 and 2015, indicate that of the 24 activities that FAWEMA was responsible for, 14 were fully done with targets reached, 8 were partially done and targets were not reached while 2 of the activities were not done at all. An additional 2 activities were fully done with no cost to the project. Reasons given for activities that were not fully done include delayed funding, inadequate time, overestimation of the number of schools that had been earmarked for targeting, decision not to run a particular activity in all the targeted schools and some misunderstandings on the part of the community (for details see table 8).

[40] This information was reported by SCM after the draft report, hence not corroborated through interviews.

4.4Sustainability, Scalability and Replicability

The RTP faces challenges in relation to sustainability, scalability and replicability. First the project uses existing government bodies and supports existing structures and bodies, and this suggests it has a solid potential for sustainability. However all the activities carried out are largely dependent on SC generated funding.

YFHS facilitators and providers in public and CHAM health facilities are established cadres that could continue to provide YFRHS; YCBDAs as a voluntary cadre could continue interfacing with the youth through out of school youth clubs; activities of SMC, CPC, PTA, MGs, PTAs, PEAs could continue based on commitment of the cadres to promote retention of girls in School; Steering committees at district level could monitor youth clubs and integrate RTP in education and health sector plans at that level and finally the Steering committee at national level could continue to priorities issues of ASRP through the line ministries of education and health as well as through involvement of other development partners, the project's sustainability equally depends on sustainable funding. For sustainability, stakeholders need to be systematically strengthened by making training of health personnel in both public and CHAM facilities, training of more YCBDAs, community cadres (MG, CPC, PTA, SMC), tailor made training of families and traditional leaders, strengthening and regular monitoring of youth clubs, sustained community sensitization and implementation mechanism that would target male pupils and male adults as gate keepers. In addition, refresher training of all cadres would be a requirement. All these activities would necessitate funding in the short to medium term. In the absence of said funding most of the activities would progressively scale down and eventually (possibly) stop.

Secondly, the sustainability of the program is in part based on a basic notion of multiplier effect. This means that there is an expectation that the training of a limited number of people would lead to the many people gaining an adequate level of baseline knowledge through orientations provided by those trained. However consistently the data collected in the field, through focus groups discussions and KII, showed that this had not happened and that the chances that it will happen in the future (for people recently trained) was limited at best. That is to say that in cases where people were trained, they had not made any effort to orient others; and in cases where the training had recently happened, those trained mentioned they had no plans of orienting others. This means for example, that a trained mother group member may pass on some of her knowledge, or not, but this will not be done systematically. Moreover that once the mother group membership is changed the new members will have no knowledge or skills that were gained through the program intervention. Importantly, in cases where some level of snow balling effect was intended and planned for, as when youth clubs visited neighboring areas to disseminate information, we were consistently told by youth club members at health posts that they lacked the resources and hence that the number of events was minimal. For example, once per year. Club members noted that they gained substantial information and support from participating in the club. At Malukula both Health Center in Mangochi and Migowi Health Centre in Phalombe where youth clubs were active, YFHS providers noted that the continuity of the club, the weekly meetings, were an important element to transferring knowledge and getting children and youth to explore issues about sexuality, gender, etc. This would suggest that there is a clear value in repetition, which is not currently exercised in relation to the outreach activities done by the trained youth. Moreover we consistently found that while the information gained by health care workers who are trained in YDFS is valuable, it does not lead to knowledge extended to the health facility as a whole, but remains with the key individual trained. Therefore if transferred the knowledge goes with him/her.

This is not a challenge that is new or specific to this program, but rather a challenge experienced often across the development sector. Still, since the type of knowledge imparted is needed all over the country transfers of staff do not necessarily lead to a net loss of knowledge, but rather to the reduction of the ability of the program to achieve objectives directly. Overall the knowledge provided is relevant all over the country and that remains. This suggests that supporting efforts that make YFHS provision a standard component of the service package available throughout the country is important.

Third, in some cases snowballing is not expected as a result of activities. For example, teachers and health care works that are provided training directly whereby the support they receive is intended to assist them individually in the execution of their job. In these cases there is no expectation that the training will lead to the generation of a wider knowledge base. Still the sustainability of these efforts is currently dependent on the funding provided by

SC. Indeed if SC stops supporting the training, these efforts will, in the absence of other external support, cease.

A solution to the two aforementioned challenges could be to focus attention on making the government responsible for the program and working closely with government to ensure that all relevant training curriculums are integrated into the appropriate sustainable mechanism (i.e., training of teachers, health care workers, students and support bodies such as mother groups). This approach however is one that requires a solid advocacy component to gain, over time, the commitment of relevant government entities.

Another challenge faced by SC is that the project has a very high number of activities, and these are not individually followed up because there is not enough staff and in some cases the knowledge base to provide the required follow up. Indeed a number of stakeholders raised the issue of inadequate supervision as challenge. This is illustrated by the FGD with SMC/PTA, Nkhulambe FP School, Phalombe where it was noted that inadequate supervision has lead to weak coordination among various committees. A similar view was voiced by members of the Nkanda Youth Club, Mchinji.

One aspect that is not addressed in this evaluation, is the role played by other projects and programs on the question of the sustainability of RTP. At this time SC has three other projects working in the same field[41] in Malawi. These are listed below. These projects while complementary in theme may not be complementary in approach. In fact in some cases they could counter each other's general efforts, by for example having different policies towards using cash incentives, providing per diems for training participation, generating expectation of cash incentives to promote school retention of girls etc.

- DFIDs Keeping Girls in School (KGIS) which provides incentives for girls to continue their schooling. Apart from providing incentives to girls in standard 7 and those that proceed to standard 8, the project also focuses on providing training to female teachers. KGIS project is implemented in 8 districts 3 of which Mchinji, Ntcheu and Mangochi) also benefit from RTP.
- USAID ASPIRE Empowering Girls through Education and Health work. The project is operational in Balaka and Machinga, both of which are also targeted by the RTP project. They work with the same structures as does the RTP, such as Mother Groups, SMCs and PTAs, which means in some cases the target group benefits from both projects simultaneously.
- European Commission/ Save the Children Italy Comprehensive Sexuality Education and Family Planning for Protection and Empowerment of Adolescent and Women Project. The project shares one of its objectives, to reduce pregnancies and early motherhood among adolescents, with the RTP's. While none of RTP's targeted districts are targeted by this project, the two efforts share BLM as a key partner. Both projects have adopted the same outreach strategies, use dedicated outreach teams (DOTS) to provide access to SRHR to inaccessible areas and linked up during development of YFHS strategy.

How any one of these programs has affected the implementation of RTP activities has not been explored and hence knowing with more certainty what would be successful where in the absence of the other programs is hard to know.

4.5 Context and community structures

As noted in chapter 1 there are many contextual issues that affect early pregnancy and school drop out amongst girls. These include cultural, and economic factors, as well as the availability of services. Cultural challenges include, for example, the belief that young girls should marry and have children soon after puberty. Additionally cultural and economic combined factors include, for example, the view that education for girls leads to limited opportunities, while learning how to tend to the families needs is both important and is not learned at school. Economic aspects include for example, young girls who want to be able to access goods (buy things) which they

[41] SC. (2014). 2014 RTP Annual report

cannot afford. Hence they engage in relationships with older men who have the economic capacity to provide them purchasing power. These type of relationships were reported, by FGD respondents, in both Phalombe and Mangochi, as difficult to counter and not conducive ensuring school retention.

Aside from the broad issues mentioned above there are key contextual factors found at three different levels (National, District and Local) which are worth mentioning:

National level: The national level includes how the central government reacts to program interventions (national structures), as well as factors that affect the program implementation nation wide. AT the national level the MoH is very positive to the support provided by the RTP. RTP funded training uses the curricula and material developed by the MoH. This is regarded as highly positive. However, the focus on YFHRS as *in-service* rather *pre-service* training presents some challenges. While health care practitioners interviewed, as well as MoH representatives, at all levels stressed that *in-service* training was important because practitioners forgot material taught in *pre-service* training, we do not see this as a mutually exclusive choice. Given that the majority of Malawian population can be described as youth[42], and that there is a high level of birth rate amongst teenage and young adult women, not to mention a high incidence of HIV-AIDS, and so on, would suggest that having YFHRS widely available is imperative. Hence while refresher courses may be warranted, a strong argument could be made for the importance of including this subject as a standard component of all health care practitioner's training. It is important to note that while the MoH states that all practitioners receive a basic training in YFSRHS, those interviewed noted that they had received no such training during their pre-service tenure.

The MoEST is, as noted earlier, working with UNESCO to explore opportunities for curriculum development, however there is no indication at this time, about whether or not any such modification will include considerations into how sexual education (or Life Skills) is imparted. Additionally, the fact that the MoEST does not allow the provision of services or delivery of goods, such as condoms, within school premises is also a challenge. Enabling health care workers to provide sessions on SRH at schools is clearly a positive step and the RTP must be commended for this achievement, but this is still a long way away from ensuring that school children generally are able to access the knowledge they need to ensure that they treat their sexual and reproductive life responsibly.

Regarding issues which affect the program nation wide, the issue of incentives for trainings is key. Although the Malawian government has passed a policy inviting non-governmental organizations and donors to no longer provide per diem for attending workshops, courses or meeting, and rather provide full board, many state employee are accustomed to the former way of doing things (I.e., receiving per diem which essentially meant a stipend) and are less willing to participate in trainings that do not offer said incentive. This has been a key challenge faced during the implementation of training and orientation sessions carried out under the RTP program. Having said this, the general regard for the program activities is positive, although in some areas it functioned far better than in others. The variability in success is mainly due to local commitment to the issues that the program is aiming to address and to the ability of the community to do something vs. the wish to get compensated for doing something.

A final issue of importance at the national level is the question of advocacy. According to program staff the RTP has not had a clearly defined advocacy strategy. The mechanism for implementing an advocacy strategy are currently weak. Indeed the advocacy carried out thus far is tied to the support to carry out program activities, on

[42] A total of 2.8 million (20.3%) of the population is under-five years, about 6.0 million (43.47%) are aged 18 years or more, and 4% are aged 65 years or older. The median age of the population in Malawi is 17 years reflecting a predominantly young population (Source: Source: NSO (2010). *Malawi Demographic and Health Survey*, p. xxiii at http://www.nso.malawi.net/)

the one hand; and on the other as supported by the Ministry of Gender which works towards policy harmonization.

District level: At the district level the structures at national level are replicated. The district steering committee reports to the district executive committee. The district executive committee is a joint committee which is responsible for programing and budgeting at the district level. This is important because it means that issues raised in connection with experiences from the RTP program may be integrated at the district service level.

One example of how changes can be done at the district level, as well as of how the RTP has influenced district level activities, was recorded in Mchinji where the District took it upon itself to secure funds and create activities which were aimed at resolving issues noted in the baseline. These were activities which were identified and funded individually and not in any way part of the RTP activities.

Community level: At the community level there are numerous factors that con contribute to teen-age pregnancy and school retention amongst girls. Hence, unsurprisingly, communities, as was noted by SCM staff during the start up workshop for this evaluation, plays a key role in the success or failure of the interventions.

We also found that there was a stark difference between communities such as Mchinji where there is less experience with cyclical delivery of material aid and Phalombe where cyclical delivery of aid is common place. It seemed apparent that communities which are accustomed to receiving aid view aid and development as material value and hence were less inclined to reap the benefit from capacity development efforts. Institutions such as mother groups and child protection committees were more sluggish in their approach, and in using skills gained, than communities where there was no expectation of material goods. Interestingly this also meant that the least economically wealthy areas (Mchinji) appeared to benefit more from RTP activities than wealthier areas (Phalombe).

At the community level there are subgroups of children which appear largely invisible. For example, children with disabilities. Disability among children is estimated at 2.4%[43], children with disability exist in all communities and constitute some of the most marginalized persons. Evidence abounds on the various forms of discrimination that children with disabilities face within their families and communities. For instance, they are discriminated against in relation to their education because school infrastructure[44] is often inaccessible. For example, water and sanitation facilities within the school. Children with disabilities also suffer because teachers lack of technical capacity to adapt the curriculum and teaching methodologies that work for the disabled child. Lack of peer support within the classroom and in the school and the existence of negative attitudes towards the disabled are also a challenge. These issues result in significant number of disabled children dropping out of school. In addition, adolescents with disability are often denied access to RHS as they are considered not be sexually active although there is considerable data to show that the sexual abuse of female youth with disabilities is not so rare[45].

[43] National Statistical Office (2010). Population and Housing Census 2010.

[44] Of all the school visited during data collection, only Nambiti FP School in Mulanje has provided for some ramps to ease mobility for pupils with mobility challenges

[45] Department of Disability and Elderly Affairs (2016). The National Disability mainstreaming strategy and Implementation plan (draft)

CHAPTER 5 CONCLUSIONS

Here we present some of the key conclusions derived from this evaluation:

Relevance: Clearly child school retention and teenage pregnancy are two important and problematic issues in Malawi today. Overall the project shows solid potential towards supporting changes in the way the education of girls is understood and perceived locally and in providing children and youth with better SRH services. The program efforts to strengthen existing bodies such as mother groups, child protection committees, teacher matrons and patrons, as well as enriching the ability of health care providers to better perform their duties as relative to youth appears to be generally successful. In short the support provided to these bodies can support them in their efforts to maintain children in school support their re-enrollment and support their ability to become better aware of SRH issues.

Progress towards achieving results: The project document takes a narrow view of how teenage pregnancy and girl drop our rates can be assessed, and progress measured. Arguably one can focus on the importance of schools being safe environments and of the provision of YFSRHS, and indeed on the provision of SRH services within the school environment, as important to Malawian society without expecting any efforts in these areas to show a direct result in teenage pregnancy or drop out rates. As it stands the program has not simply focused on ensuring the delivery of certain services, but on a wide range of activities which together hope to achieve social change. However, measuring social change statistically as represented in drop out rates and teenage pregnancy reductions is very difficult, as is clearly noted in chapter 4. Hence, although it is hard to demonstrate that the program has made strides towards statistically relevant changes in drop our rates or teenage pregnancy, a number of activities show positive results. These were introduced earlier, but warrant mention here too:

- Working with mother groups to strengthen their abilities and skills in supporting girl retention rates. A potentially negative side effect here can manifest when mother groups focus more exclusively on pregnant teens rather than tees more broadly including out of school teens.
- Improved ability of teachers to provide pupils information regarding SRH, and in promoting a safe environment for students.
- Improved ability of Child Protection Committees to support a safe environment for children.
- Improved knowledge amongst youth members of youth clubs on SRH issues.
- Improved gender dynamics amongst member of youth clubs. This includes empowerment of females regarding their own sexuality.

Areas where the program has not focused attention, and where possible efforts should be focused, include:

- Vouching for the care and wellbeing of the child of the teenage mother.
- Expanding attention to gender relationships and particularly the role of men/boys in pregnancy, fatherhood, etc.
- Addressing the special needs of children and youth with disabilities to ensure that they too are considered in ensuring adequate school environments and the provision of SRHS.

A review of the ToC (see chapter 1) and changes that could be made to it (see Annex 3) further illustrates the complexities of the issue being addressed. To this end we have found that the program could shift its objectives towards achieving social change as regards how education, early pregnancy, sexuality, and gender relations are regarded. In doing this an intended consequence could be re-enrollment of teenage mothers, reduction of teenage pregnancy and school retention. However the main goal would be a general shift in perspective. Towards this end, indicators would be more oriented towards measuring behavioral change among various targeted entities. While this shift would be harder to measure it would more accurately reflect what the RTP is actually doing. An alternative would be to simplify the program activities and focus on macro level interventions that work towards changes in curricula (i.e. what is taught in school regarding SRH); changes in procedures to ensure a more conducive learning environment (i.e. how teachers who abuse their power are dealt with – sexual relationships with student, physical punishment); improved educational facilities/resources (i.e. availability of school classrooms, sanitation facilities, etc.); changes to the standard service package at health care facilities (i.e., to include YFSRHS). Clearly these efforts are not mutually exclusive. What is true of both, however, is that it would be difficult to measure progress with the current indicators. The first option would require studies on

behavioral changes over time, while the latter would require a statistical assessment of what services, infrastructure and materials are available where and when.

In relation to the joining of health and education, the effort is undoubtedly relevant, however thus far the activities of each field have been largely implemented separately and hence there has been limited benefit from the joint nature of the project. This was confirmed by the different implementing partners (FAWEMA and BLM), and highlighted by the representatives of heath care and education at the national, district and local level. Indeed there was very little, and in some cases no evidence, of active joint work. The single exception was of cases where health care practitioners visit the school to provide SRH sessions, but this was ad hoc at best and reliant on individual relationships, it seemed. This is not to say that health and education sector/activity representatives did not meet, but rather that planning is done separately and that they themselves regard their activities as parallel rather than interlinked. This however should not obscure that there are key opportunities for a more joint and united approach. Still for two fields to work together in a joint program is no simple feat and that in itself would require considerable commendation as it may lead to new ways of working in future.

Lastly it is important to highlight that at this time it is not possible to know which activity has been more or less successful in relation to which other activity. This is so due to three issues, first that the program life cycle is very short and hence attributing success is difficult given the complex nature of the achievements expected; second, because some activities have been conducted earlier than others, it would be unreasonable to compare the success of each between them. Lastly, some activities may yield results faster than others, but this does not mean the result is more sustainable.

Partnership and child participation and role of civil society partners*:* It is clear that the program counts with a multitude of partners. This on the one hand is good as it serves to highlight the holistic nature of the issues being addressed. However this approach also presents a challenge, mainly that there is little ability to provide clear and consistent follow up.

Another key issue on partnerships that should be mentioned is that by and large the knowledge of different partners was not exploited for the collective good. Rather individual partners tended to focus on their own area of expertise and largely ignore other interventions. For example, FAWEMA and BLM could have explored the possibility of conducting a joint assessment of knowledge retention on issues of RHS among teachers (especially matrons and patrons) as well as gender and age sensitive methodologies for disseminating information on RHS through in school youth clubs. Additionally, BLM mentioned that they have considerable experience from all over the country on the delivery of health related information and services, and that much of this knowledge can be of value to other fields beyond health. FAWEMA too has ample contextual experience. BLM felt that their expertise was not used in the design of either health or education related interventions, this appears to have been a missed opportunity.

As pertains to child participation, the program does not avail children and youth of many clear opportunities to participate. Indeed children and youth participation are mainly linked to youth clubs, as efforts to work in communities to disseminate information are limited. According to a health care worker responsible for a youth club in Mangochi, results from active child and youth participation included, for example, new ways of interacting between boys and girls. This was alluded to by other health care practitioners in Mangochi, and Phalombe, and also by youth club members themselves in Mchinji. Although not all youth club members or coordinators highlighted this issue, those who did made a strong case for it.

Sustainability, Scalability and Replicability: Mainly the program as it currently stands is not sustainable as the snow ball effect expected from the trainings provided has not materialized. Moreover the training activities will only take place so long as SC funds them. Therefore the program will only function in so far as SC or someone else continues to pay for the conduct of the program activities.

However, there are clear opportunities to support sustainability, scalability and replicability. These would depend on a much stronger government ownership and willingness by the government to include program efforts as part of their own activities long term, through, for example, the inclusion of materials into the curricula of teachers, health educators and students. As well as solid work towards ensuring that YFSRHS become part of the

standard service delivery package of health care facilities, and supporting a process that works towards improving school environments.

Context and community structures: There is evidence that the program can achieve change at the community level through efforts to the build capacity of, and work with, local entities such as mother groups, CPC, matrons and patrons, youth clubs and so on. However this only works when these entities are active and make ample use of the knowledge gained and where there is strong commitment by policy makers, law enforcement agents and traditional/cultural leadership to act decisively in support of measures that promote retention of boys and girls in school; and prevent teenage pregnancy. When these bodies are not active, then the gain from the capacity built is limited. There was a strong indication that in areas which were more aid dependent, these bodies were less active and less willing to make use of knowledge gained because their expectation of support was material.

CHAPTER 6 RECOMMENDATIONS

In the following pages the main recommendations are introduced. These are presented according to the main areas of inquiry that guided this report.

Relevance:

- SC should consider using the program as a way to refine the content of curricula at multiple levels. For example: What should be included in Life Skills (or equivalent), what should be included in Teacher Training Packages regarding conducive teaching environments, what should be included in healthcare workers training regarding YFSRH services, etc.
- SC should consider how issues of gender relations, masculinity, and the role of men/boys in active sexual relationships and parenting should be included in relevant curricula.
- Currently the welfare of the newborn babies born from teenage mothers are not addressed in any way. Therefore, SC should consider how to address the needs of the new-born children to ensure that they do not suffer (reduced care or nutrition) when their mothers return to school.
- Currently how children with disabilities are cared for in relation to school retention and their SRH rights is not addressed. Therefore, SC should consider including elements into relevant curricula that addresses the challenges faced by disabled children.

Progress towards achieving results:

- SC should consider reducing the number of activities it undertakes to ensure that each activity can be adequately monitored/reflected upon.
- SC should consider enforcing a single rule regarding per diem/coverage of costs of trainings and meetings.
- The value of each activity relative to others is not possible to determine at this time, as not all activities had been implemented equally in the areas visited to enable reliable comparison by those interviews, or by the evaluation team. Still it is important to note that generally it appeared that the first level of activities (direct trainings, monitoring, etc.) were most successful, as were the youth clubs at both health posts and schools. The activities that derived from these (sharing of information) seemed to be less successful because the snowball affected did not systematically yield as expected. Therefore SC should focus on prioritising activities that are not dependent on the snow ball effect multiplier element.
- SC should consider engaging in advocacy more systematically. This would serve to support the idea that program elements are incorporated as standard service package options by the government in the future (both health and education ministries)
- SC should consider developing qualitative indicators that are better suited to capture the achievements of the program through focusing on behavioural change. To this end SC could consider looking into options such as KAP surveys or elements thereof. Another and complementary option would be to consider a more systematic use of case studies to supplement quantitative indicators.
- SC should consider identifying a series of quantitative indicators that focus on provision/delivery of services (output) rather than on outcomes. This data could, and should, be supplemented with qualitative data (see above recommendation)

Partnership and child participation and role of civil society partners

- If SC chooses to invest in the refinement of different curricula, SC should consider including children more actively as part of this process.
- In future SC should consider involving partners in a more active way in order to ensure that their knowledge is capitalized upon during both program design and implementation phases.
- In future SC should consider opportunities that may enable a more direct and continual relationship between program partners. For example, a partial joint office.

Sustainability, Scalability and Replicability

- The degree to which the operational model (collection of activities) used by RTP is best suited to achieve, maintain, scale up and replicate the strategic objectives of the program is unclear because both teenage pregnancy and school retention of girls are very complex. Hence SC can choose to:

- a) Continue to implement the program activities as they are, but change the way it measures progress to ensure that it is able to better measure the social change character of the current program package. This approach would require that SC remain committed long term to the implementation of program activities to ensure sustainability.
- b) Utilise the current activity package as a way to develop tools (curricula and protocols) that can be introduced into the standard service package implemented by the government in future (training of teachers, health care workers, mother group members etc.) and hence focus on the refinement of the tools used and on advocacy to have these adopted and implemented by the government in the future.

The main elements of these two options overlap, but the latter would focus on an eventual reduction of services, so that these can be included into a government plan, while the former would support a continuation of a widely varied and expansive service package delivery by SC (see recommendation 1 for relevance). Clearly these are not mutually exclusive, but quite complementary. In fact (a) can be a key element to informing (b)

Context and Community structures

- This program is not one which meets the expectations of all communities. Particularly communities with well developed aid dependency ideas. Therefore, SC should consider focusing on communities which believe in, accept the provision of knowledge as a valuable form of assistance.
- SC should consider engaging beneficiaries in agreements that require them/ make them accountable to share the knowledge gain.

CHAPTER 7 LESSONS LEARNED

Here we focus on lessons learned from the program implementation, which were identified during the evaluation process.

Program Planning: First there is a discord between what the program has achieved and the ToC that underpins the program. Hence lets explore the ToC. The RTP ToC is anchored on the principal of attribution based on a causal analysis which attributes increased enrolment and retention of adolescents in schools on an interplay between the different outcomes (see Table 2). However, discussion at the start of the evaluation process identified a number of key **"if"** factors that are not clearly reflected in the program hypothesis and which lead to key challenges in both achieving results and in fairly measuring the program accomplishments.

Key challenges include:

1) The importance of a community environment which welcomes non material support as a central element of development efforts. While the program assessment understands that communities must be open to the idea of changing views referent to SRH and girl education, they must also be open to support which is not monetary or material.
2) The importance of adequate infrastructure and of meeting basic needs. While quality education entails a wide array of factors, at a minimum school facilities must be available. That is to say that places where classrooms and/or sanitations do not exist, severely truncate efforts to support school retention. Indeed in some cases schools are closed down all together in the rainy season due to lack of classrooms. Similarly we found that while the proportion of families who are financially unable to cover the costs for basic school materials, and school uniform are limited (less than 10% based on the FGD poverty assessment conducted during this evaluation), there are individual children who fall within this category and hence this issue must be addressed. Notably the poverty assessment conducted also highlighted that families with the least financial means often had the largest number of children.
3) While schools visited showed that the number of children dropping out because they were pregnant was relatively low, in all schools visited except for 1 it was between 1-3 girls per year, the number of drop out of girls was a high multiple of the number of pregnant girls. Moreover there is no data on how many girls become pregnant within the first 18 months after dropping out of school. Furthermore, sexual education in schools is limited at best and access to health care facilities and SRH services limited. Hence while it is hard to establish a direct relationship between the provision of YFSRH services and school retention it is clear that both school retention and access to SRH services are challenges that need attention. Focusing the measurement of success on the intersection of these issues limits the ability of the project to highlight all its achievements (collect data that better reflects these achievements).

Given the aforementioned we would suggest that a more accurate reflection of the program is reflected in annex 3. Overall what we have found is that the activities carried out as part of this program achieve progress in multiple areas and these are not all reflected in the indicators or outcomes for the program as has been mentioned previously in this report.

A second key lesson learned is that this type of program requires considerable time and attention at the design level. There needs to be a clear investment into considering the components carefully, but also the role of each player and the knowledge they bring to the table. In this case considerable knowledge by some of the partners, such as BLM, was not properly used as an asset to the program because they were not engaged in the design process.

A third key lesson learned is that programs such as the RTP, that focus on social change, do not respond well to numerical indicators and therefore an effort to focus on other ways of measuring impact should be made. Case study based assessment is one example.

Implementation, Replication and Sustainability: Programs that focus considerable attention on building capacity can experience difficulties when replication does not happen. That is to say the sustainability of the program, even while funded, is very precarious. One health post visited had, for example, lost their YFHS trained health care provider. Therefore the youth club no longer got any training; they only met once in a while to use the sport assets. In doing this the actual value of the youth club was lost as relevant to the SRH issues. Of course there are opportunities for the knowledge to be kept and maintain, but this requires that they be promoted by the government as central components to capacity development.

Health and Education as a joint sector: Clearly both sectors have an influence on both teenage pregnancy and school retention. However the capitalization of joint efforts has not actively materialized thus far. Hence it is hard to know the advantages of joint work. It can be suspected that if SRH was included in the school curricula or solid partnerships between health centers and schools were built more synergies would become self-evident.

Unintended consequences and oversights: The number of unintended consequences associated with this program is few, but still they require attention. First, the care of the newborn child. At the moment the main focus is on ensuring that teenage mothers return to school, but there is no attention paid to what this will mean to the newborn. Do the mothers have sufficient knowledge of child nutrition, bonding and so on to know when they should return to school.

Second, the strong focus on re-enrollment of teenage mothers may unduly focus mother groups on teenage mothers at the exclusion of girls who have dropped out, but don not have children. This means that the skills given to mother groups could have a more limited, rather than broader, impact.

Third, the program pays no attention to the special needs of children and youth with disabilities and how their conditions can affect both early pregnancy and drop out rates. It can be assumed that children and youth who are disabled might very well be more vulnerable.

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Annex 1: ToR

Save the Children Norway (SCN)

Evaluation of "More Educated Girls - Reducing Teenage Pregnancies in Malawi" Project 2014-2015

1. Background

Save the Children (SC) is the world's leading independent organisation for children. Our vision is a world in which every child attains the right to survival, protection, development and participation. Our mission is to inspire breakthroughs in the way the world treats children, and to achieve immediate and lasting change in their lives. Accountability, ambition, collaboration, creativity and integrity are our shared values. SC's theory of change describes how we work to create immediate and lasting results for children: we will be the voice, we will achieve results at scale, we will be the innovator and we will build partnerships.

With the support of the Norwegian Agency for Development- NORAD, through Save the Children Norway, the 'More Educated Girls-Reducing Teenage Pregnancies in Malawi" project has three main strategic objectives of (1) increasing use of key sexual and reproductive health practices and services, (2) reducing girls' school dropout rate, and (3) increasing school re-entry rate after delivery. The project builds on synergies between our health and education programming, and addresses a growing constituency of adolescent health. The baseline results showed that overall 30.8% of the adolescents (28.3% females and 35.1% males) reported to have had sex by 18 years. The median age at first sex was 15 years against a national median age of 18years. The lowest mean age at first sex was found in Mchinji at 14 years while the highest mean age was in Ntcheu at 16 years. The project baseline further indicated that about 42.8% of adolescent had access to sexual reproductive health services and information while 21.3% of girls drop out of school due to pregnancies.

In order for the project to demonstrate that it has achieved its goal of reducing teenage pregnancies by 10% from the current 21% [Baseline 2014] the following strategic Outcomes(1)were proposed:

1. Improved learning environment and self-efficacy of adolescent girls.
2. Improved access to high quality Sexual Reproductive Health services for youths.
3. Improved social environment to support adolescents' Sexual Reproductive Health Rights and educational achievement.
4. Improved operationalization of policies to support adolescents' Sexual Reproductive Health Rights and educational achievement.

The project is working in six administrative districts namely Balaka, Machinga, Mangochi and Phalombe in the southern region and Mchinji and Ntcheu in the Central region. It has covered 18 educational zones and 76 Health centres in the reporting period. The project implemented its

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[1] The original proposal to NORAD had 6 strategic Outcomes. To make the project smart and achievable the strategic Outcomes were adjusted to these four.

activities in partnership with the Forum for African Women Educators – Malawi Chapter – FAWEMA who were instrumental in implementing learning and social environmental and girls' self- efficacy components; and Banja La Mtsogolo –BLM- who supported components leading to increasing of access to ASRH activities amongst adolescents. Some of the major activities conducted include: baseline survey , project launch both at national and district levels; mapping of education zones, schools, health facilities and health providers within the project impact zones; recruitment of Youth Community Based Distribution Agents – [YCBDAs]; provision of outreach services to increase access to ASRH; orientation and training of primary school teachers; and community structures to promote buy in; mapping of safe and unsafe areas in schools; and development of monitoring and evaluation framework for the project. As part of the baseline, the project also conducted quality learning environment [QLE] assessment[2] and dissemination of the baseline findings at national level.

In addition, a number of networking and coordination activities where undertaken during the period. The project facilitated Project Coordinating Committee meetings with Ministries of Education, Health, Gender and Youth and other stakeholders at national level. The project was an active member in the review of the Youth Friendly Health Services [YFHS] evaluation process and later in the development of the YFHS strategy for 2016-2020. It also facilitated District Executive Committee meetings, District Steering Committee meetings and district project launches at district levels.

2. Purpose of the evaluation

The overall purpose of the Evaluation is to assess progress towards achieving project outputs, outcomes and goal, and to consider the validity of assumptions made in the project design. The Evaluation will be a reflective and forward-looking exercise. It will reflect on what results have been achieved through the project implementation and will analyse the lessons learned. The recommendations of the exercise will then inform decisions on the parameters for changes in the activities and programme implementation strategies for the remaining period of the project as well as its continuity. Specifically, the objectives of the evaluation will be the following:

- Assess the **relevance** of integrated education and sexual reproductive health programme to the overall objectives of SC Malawi as well as its contribution to the Malawi national education and health strategies.
- Evaluate progress towards achieving the results, lessons learnt, success stories and challenges of the project.
- Assess whether the partnership has been working as per the agreed standards and to the level of expectations.
- Provide adequate evidences on the scalability, replicability and sustainability measures of this particular project.
- Assess how the various community structures are supporting or influencing the project. Meanwhile explore community's perceptions and attitudes towards the project.

This Evaluation will aim at responding to key questions relating to achieved results, relevance, progress towards meeting objectives and partnership aspects of the project. The Evaluation will validate and further explore findings from the baseline surveys, monitoring visits and project

[2] QLE is a global monitoring tool for measuring quality in learning environments developed by Save the Children

reports. Additionally, it will provide insight and increased focus on evidence based programming and potential forward-looking guidance to the effective and efficient implementation of the project.

4. Key questions

The following set of evaluation questions should guide the evaluation team in further developing the evaluation design and questions:

1. *Relevance of integrated education and sexual reproductive health model*: It is important to ascertain the relevance of the model and project design including the specific interventions, objectives and activities. The following evaluation questions will be answered in this section:
    - To what extent are the outcome and objective areas of the programme relevant to targeted beneficiaries, SC Malawi country priorities?
    - What measures were put in place to ensure that the programme stakeholders were adequately informed of the programme interventions and their roles in it?
    - Are the risks/assumptions identified during programme design still valid? How are they being managed? Are there any new risks emerging?
    - To what extend Have the local health facilities gained knowledge and experience?

2. *Progress to achieving results:*
    - To what extent were the objectives achieved/are likely to be achieved;
    - Are programme activities being implemented effectively to achieve maximum benefit within the context?
    - What are the factors that hindered/assisted the project to achieve its objectives?
    - To what extent is programming informed and influenced by situational and policy context, in relation to attainment of results?
    - What are the successes that need to be told? What are the lessons and good practices so far?
    - What do the youth themselves think of the successes? What is success for them? What have the youth learned from the project and how are the topics raised in class?

6. *Partnership, Child participation and the role of civil society partners*
    - Are the partnerships formed by the programme effective in helping the programme achieve its objectives? Why or why not? What are the lessons learnt on partnerships? How are the various partners selected? Are they the right ones?
    - How have the teachers worked and raised issues of SRH in class? What are the challenges with discussing these issues? Main messages? How are the teachers applying the activities in class? Linkage with the parents and home community - how?
    - To what extent have the children and youth participated in a youth friendly way in the project? What are the existing mechanisms available to listen to children and engage children during the project implementation?
    - How has the partnership with the government worked?
    - How has the BLM and FAWEMA delivered as per implementation plan?
    - Have the coordination mechanisms effectively supported the delivery of the programme?

7. *Sustainability, scalability and replicability*
    - What are the sustainability measures and roles and responsibilities of various stakeholders in the process?
    - Are there any potentials of scalability in other districts of Malawi? How could this happen? What are the prevailing evidences?
    - How could the results influence at the national level and national policies?

8. *Context and community structures*
    - Which implications does the geographical variation and contextual differences in the targets areas have for the project? Is there any variation in project implementation among the various districts? Why?
    - Are there any other factors affecting such as incentives, payments and others in the project?
    - What is the communities' perception and attitudes towards the project?

4. Scope of the evaluation

The evaluation will be covered by SCN/Norad in Malawi as explained in the background section. The scope will not cover other similar programmes that have been implemented by other SC members in Malawi. SC Malawi will propose areas that are suitable for the field visit.

5. Design and methodology

The evaluation team will use multiple data methods that are both quantitative and qualitative. *The evaluation will involve cost efficient survey in order to assess whether the project has been achieving its intended objectives. In these regard, the consultant will propose the most efficient quantitative survey methods in the technical proposal and later in the inception report. The rest of the evaluation aspect will be addressed by deploying qualitative methods*. This will be used as a key criterion while evaluating technical proposals submitted by the consultants. The evaluation team will also consider data collection instruments and methods to be used. The methodology should include but is not limited to the following:

- An evaluation design that builds on the above detailed objectives, scope and evaluation questions, including an evaluation matrix.
- Instruments and tools to be used for gathering relevant information and data, including identification of different key informants to be interviewed;
- The approaches for the analysis and the interpretation of data (e.g. types of data analysis used, data collection instruments, the level of precision, sampling approaches);
- Plans of dissemination of results
- A detailed work plan indicating timing of activities, responsibilities, and use of resources

The consultant should present a detailed statement of proposed evaluation methods in the technical proposal. The evaluator has to take into account the guiding principles mentioned in the Save the Children International Evaluation Handbook.[3]

6. Organisation, roles and responsibilities

The entire evaluation process will be led by an external consultant. SCN will select the potential candidate based on the technical and financial proposals submitted in consultation with SC

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[3] O'Neill, K. (2012). *Evaluation Handbook.* Retrieved from: http://resourcecentre.savethechildren.se/library/evaluation-handbook

Malawi. The lead consultant will be responsible of identifying potential researchers to assist him/her (potentially from Malawi). The consultant will also be responsible for developing a sound research methodology, planning and conducting a consultative evaluation and managing the data collection, as well as writing up the reports and presenting the findings and recommendations.

SCN will in collaboration with SC Malawi be responsible for facilitating the evaluation process through availing relevant documents and give feedback to the consultant. SC Malawi will facilitate in country visits and field data collection processes. A small evaluation project group will be established to manage the evaluation. The group, consisting of SCN staff from the Strategy and Analysis Section, the Education Section, and the Health Section, as well at the RTP core team in SC Malawi will review and validate the inception, the draft and the final report, and will also be engaged in discussing how the findings will be followed up. SCN will be responsible of covering the entire evaluation cost.

7. Desired competencies and skills of the consultant

- Advanced university degree in social sciences or equivalent with good understanding of SRH and education programmes
- Extensive and proven international experience in designing and conducting independent evaluations, desk studies and/or research of development programmes
- Good communication, analytical and drafting skills;
- Identify with Save the Children's values and principles;
- Good knowledge and understanding of Malawi and/or Southern Africa region
- Familiarity with a rights-based approach is an asset.

8. Deliverables

The following deliverables are expected from the evaluation exercise:

- **Deliverable** 1: An inception report which contains evaluation objectives and scope, description of evaluation methodology/methodological approach, data collection tools, data analysis methods, key informants/agencies, evaluation questions, performance criteria, issues to be studied, work plan and reporting requirements. It should include a clear evaluation matrix relating all these aspects and a desk review with a list of the documents consulted. It should be 7 to 10 pages excluding the annex, references, table of contents and cover page.
- **Deliverable 2**: Power point presentation (10 slides max) of preliminary findings to SCN and SC Malawi and then to the key stakeholders. The comments made by key stakeholders should inform the draft report.
- **Deliverable 3:** Draft evaluation report (30 pages max with unlimited number of pages for the annex) which should be delivered with adequate time to allow stakeholder discussion of the findings and formulation of recommendations.
- **Deliverable 4**: Final evaluation report (50 pages max with unlimited number of pages for the annex) which should be structured as per the reporting template provided.
- **Deliverable 5**: Disseminate results through a meeting organized by SCN. SC Malawi should be attending the dissemination meeting.

9. Timeline (Tentative)

The evaluation process will take the maximum of 45-50 days. Activities and tentative dates for the consultancy work are:

Task	Proposed date	Responsibility
Receive proposals from consultants	Jan 29 2016	SCN
Finalize the recruitment process of the consultant	Feb 19 2016	SCN
Initial briefings and provision of key documentation	Feb 23 2016	SCN
Submission of inception report	Feb 28 2016	Consultant
Finalize the inception report	March 4 2016	Consultant
Travel to Malawi	Tent. March 4 2016	Consultant
In country data collection	March 5-15 2016	Consultant + SC Malawi*
Submission of presentation slides (presentation to SCN, SCM and stakeholders)	March 18 2016	Consultant
Submission of draft report	April 1 2016	Consultant
Receive comments from SCN and SC Malawi	April 6 2016	Consultant
Submission of final report	April 10 2016	Consultant
In house dissemination of report (Oslo)	April/May 2016	Consultant

*SC Malawi will make a timeline together with consultant on the work in Malawi

10. Budget / Resources

Save the Children Norway will fund the evaluation by covering consultancy fees.

11. Plan for dissemination and learning

The evaluation report will be published on the SC web. The report will be used to extract briefing documents, lessons learned documents, communication materials, and presentation at workshops/conferences, and to make the best of results for the rest of the programme period.

12. Contract and payments

Save the Children Norway will sign a consultancy contract with the consultant. Thirty percent of the total amount will be paid upon signing the contract and the remaining amount upon submission and approval of the final report and all deliverables.

13. Contact information

For further information, please contact any of the following:
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Annex 2 :Health and Education Contex

Education Context

Malawi follows a British 3 tier system of education. The official primary school age in Malawi is 6-13 years. Most of the children enrol at primary school at age 6 and study at that level for 8 years before being able to progress to secondary school. Secondary school lasts four years. Students are awarded an equivalent of a General School Certificate of Education (GCSE) upon successful completion of secondary school. Tertiary education consists of public and private universities and technical colleges the respective numbers for which are 4, 7 and 7.

Latest statistics (2014) indicate that in 2014, 83.2% of persons aged 15-24 years were literate. Of these 80.5% are males and 64% are females[46]. Enrolment at primary school is 4.67 million. Enrolment by grade decreases with increasing grade from 1.1 million in Standard (Grade) 1 to 0.51 million in Started 5, 0.32 million in Standard 7 and 0.25 million in Standard 8. The pupil teacher ratio is at an average of 1:70 at primary school and 1:26 at secondary school. Pass rate at Primary School Leaving Certificate Examination level is 62.2% primary school[47] while the dropout rate is at 14% for boys and 16 % for girls in Standard one increasing to 16% for boys and 20% for girls in Standard 8[48].

In relation to sex education, the Education Act of 2013 Act is anchored on the principles of access, quality, relevance, efficiency, equality, equity, liberalisation, partnership, decentralisation, transparency and accountability as promulgated by the Republican Constitution. It, promotes equal access to education for all people in Malawi irrespective of race, ethnicity, gender, religion, disability and other characteristics. Comprehensive sexuality education designed and implemented in coordination with sexual and reproductive health services has been identified as one of best practice to preventing early pregnancy[49]. Life Skills Education was introduced in schools in 2002 basically to support the delivery of information about HIV and AIDS.

A review of school based sexuality education curricula in ten countries including Malawi in 2010 by UNESCO and UNFPA highlighted a number of gaps including absence of coverage of topics on sexuality and sexual behavior. Following the review, in 2015, Malawi introduced a more comprehensive sexuality education curricular for secondary school to address identified gaps. The new curricular include information on contraception, prevention of sexually transmitted diseases, the value of abstinence and how students could make sound sexual decisions[50]. At primary school level, however, very limited efforts have been made to introduce pupils to sex education through the Life skills curriculum. Compounding the problem, the provision of birth control and safer sex services at school premises in either primary or school level is not permitted. Overall, sexual education remains inadequate at both primary and secondary school level largely due to inadequate availability and access to youth friendly reproductive health services[51] [52]. This is believed to contribute to early marriages and childbearing, high rate of school attrition and reduced independence for young girls.

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[46] National Statistical Office (2015), Statistical Yearbook. Zomba, p.24
[47] Ibid. p.36
[48] Ibid. p.30
[49] World Health Organization(2011). The Sexual and Reproductive Health of Younger Adolescents: Research Issues in Developing Countries. Geneva
[50] Nyasa Times, July 9, 2015
[51] Ministry of Health. (2015). National Youth Friendly Health Services Strategy, 2015-2020.
[52] Youth friendly health services are defined as "High-quality services that are relevant, accessible, attractive, affordable, appropriate and acceptable to the young people. The services are provided in line with the minimum health

Key RTP base line findings specifically relevant to education indicate that:

a) Overall 78.4% of the adolescents were in school of whom 77.5% were females and 79.9% males
b) 88.5% of adolescent boys and girls knew of a girl that had dropped out of school
c) Pregnancy was cited by 21.3% (23/108) of the female school dropouts as reason for dropping out of school but was not regarded as a reason for male drop out[53].
d) Average school dropout rate in 2012/13 was 18%, 15% among the boys and 21% among the girls.
e) Of the 672 adolescents that were asked if girls that got pregnant returned to school, 59% answered in the affirmative (60.9 females and 55.7 males)
f) Poverty was cited as the reason for dropping out of school by 57.3% of respondents (n= 164) (54.6% among the female and 62.5 among the males).
g) Findings from data extracted from school records showed that school retention was at 81.1%; slightly higher among the boys at 82.0% than among the girls (80.3%).
f) 10% of the female adolescents reported having been propositioned by a teacher. Most of them (37.8%) reported to their headmasters; 35.1% told their parents; 13.5% told their friends; 8.1% reported to another teacher.
g) 55.3% of adolescents reported to have heard of a girl being sexually abused by a teacher (s) (60.4% of female adolescents and 46.6% of male adolescents).
h) Generally, 72% of the male adolescents knew that touching the breasts, forced hugging and kissing, touching the buttocks and hips, forcing sex on and inciting or seducing their female school mates are forms of sexual harassment.
i) On views and perceptions towards the teaching and learning environment, 82.2% of the adolescents felt their teachers come to school on time and attend classes, 73.3% said all their teachers listen to student' s questions and answer properly and 66.2% said their teachers were willing to teach and supportive of girls in class.
j) 86.2%, 97.8% of teachers reported being knowledgeable about SRH and life skills, respectively
k)Slightly over 28.3% of the teachers of 493 that provided responses indicated that they had acquired knowledge on SRH but through training that had focused STI management conducted in the last five years through an NGO , namely, Theater for a Change (TFAC) while 35.5% of the teachers reported to have been trained in life skills. Of the 493 teachers, 95.9% expressed willingness to teach SRH and 98.3% to teach life skills.
m) Generally, school performance in achieving the 4 Guiding principles of QLE was poor: Only 51.4% of the 30 participating schools achieved all the guiding principles in QLE assessment; 38.2% achieved Guiding Principle 1 which seeks to assess whether or not the education programmes meet the emotional and psychological needs of learners; 58.5% achieved the guiding principle 2 which assesses whether or not education programmes are protective of children's physical wellbeing; 66.3% achieved Guiding principle 3 which assesses whether or not teachers use active and child friendly teaching and learning techniques; whether or not teachers promote participation of learners in their education. Finally, the results show that 59.6% achieved guiding principle 4 which assesses whether or not basic education (or

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package and aims to increase acceptability and use of health services by young people (National Standards – YFHS, 2007).

[53] This is interesting because the Malawian law indicates that if a boy makes a school girl pregnant he too must leave school until she is able to return. According to the general perception of those interviewed during this evaluation, however, most often girls are impregnated by adult men who no longer attend school.

rather primary schools) involves parents, families and communities in planning, decision making and monitoring.

Health sector context

Malawi's Ministry of Health is responsible for healthcare in Malawi providing 60% of health services while 40% are provided by the CHAM. In addition, the latter provides up to 9 % percent of modern methods of contraception[54]

The Malawi public health system has a three service provision system, namely, primary, secondary and tertiary levels of care. Each tier is connected by a patient referral system. The primary health care level (consisting of community-based outreach clinics, health posts, dispensaries, urban health centers and rural/community hospitals) attends to and treats the largest number of patients both in semi urban and rural communities. Patients whose condition is considered critical are referred to the Secondary level health care provided by district hospitals located in each of Malawi's 28 districts. These hospitals provide the same basic services as the primary care facilities in addition to other services such as: x-ray, ambulance, operating theatre and laboratories. Lastly, the top tier of health care is provided by the central hospitals located in the 4 major urban areas and cities. This third tier provides various specialized services in addition to primary and secondary health care.

Malawi has increased its health expenditures from 2002 to 2011 per capita government expenditure from $16.4 to $56.5.This improvement notwithstanding, the health care system in Malawi is plagued by a critical shortage of physician and nurses (2 physicians per 10,000 population and 3.4 nurses and midwives per 10,000 populations in 2013). This is due to a low number of graduates from medical training institutions, poor retention of staff and morbidity. Other challenges include long distance to nearest health facilities with only 46% of the population living within 5 km of a health facility; shortage of drugs and basic equipment. Further, although most public health services are free, there are costs associated with transportation to and from a facility. Such costs deter many individuals especially in rural area from accessing health care[55]. Services offered include prenatal and post natal, family planning and reproductive health services, maternity, treatment of various diseases, public health as well as other services.

Malaria is the number one killer in Malawi with 31% of the population treated for malaria in public or CHAM health facilities in 2014[56]. HIV/AIDS is another healthcare challenge with a current infection rate of 8% among persons aged 15-24 (data from 2014)[57].

In terms of maternal and child health Malawi's unadjusted Crude Birth Rate (CBR)[58] per 2012 estimates is 40.42 births per 1,000 population rate while the death rate stands at 12.44 per 1000 live births[59]. The rate is higher in rural areas (40.4) compared to urban areas (34.6); unadjusted Total Fertility Rate (TFR) [60]stands at 5.2

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54 National Statistical Office and ICF Macro (2010) cited in Save the Children International. (2014). More educated girls – Reducing teenage pregnancies in Malawi: A project proposal, p.29

55 https://en.wikipedia.org/wiki/Healthcare_in_Malawi

56 Ministry of Health (2014) cited in National Statistical Office (2015), Statistical Yearbook. Zomba, p.14

57 National Statistical Office (2015), Statistical Yearbook. Zomba, p.16

58 Crude Birth Rate (CBR) is defined as number of births that occurred in a particular year per 1,000 population.

59 http://www.geographic.org/world_fact_book_2013/malawi/malawi_people.html

60 Total Fertility Rate (TFR) is defined as the number of births a woman would have if she survived to the end of her childbearing age, which ranges from 15-49 years, and experienced

children per woman, while Crude Death Rate (CDR) [61] at 10 deaths per 1000 population. CDR is comparatively higher in rural areas at 11 death compared to urban areas at 9 deaths. Average infant mortality rate estimates stood at 72.91 death per 1000 live births in 2013[62].

In the areas of adolescent sexual and reproductive health (ASRHS), Malawi has a number of policies that in various ways address and promote such issues. The policies include the National Youth Policy, National Population Policy, National Gender Policy, Reproductive Health Policy, National Family Planning Policy, National Sexual and Reproductive Health and Rights Policy and the National HIV/AIDS Policy. These are supported by the National Youth Friendly Health Services Strategy (2015-2010), Contraceptive Guidelines and a National Plan of Action for Scaling up SRH and HIV Prevention Initiatives for Young People (2008-2012). In addition, a number of specific programs address adolescent sexual and reproductive health including life skills as part of the curriculum in schools and Edzi Toto ("AIDS is not for me"), Why Wait Education Program and the National Reproductive Health program[63]. In terms of enabling legislation, the Bill of Rights (Chap IV) of the Republican Constitution in Section 20 (1) guarantees equal and effective protection for all persons and prohibits discrimination on any basis including on the basis of gender. Similarly, principle of the national policy in Section 13 calls upon the State to progressively develop policies and legislation towards achieving the goals of gender equality, health, education, economic empowerment, children and persons with disabilities. Further, the Constitution in Section 30-(1) provides for the right to development and enjoyment of economic, social, cultural and political development for its citizenry and calls on state organs to put measures in place to ensure that marginalised persons such as women, children and the disabled are supported to realise this right. In addition, Section 30 (2, 3) prescribes measures that need to be undertaken to ensure, *"equality of opportunity for all in their access to basic resources, education, health services, food, shelter, employment and infrastructure*". A number of child specific legislation exists to enforce existing policy provisions. These include the Child Care, Protection and Justice Act of 2010, the Disability Act of 2012, the Gender Equality Act of 2013 and the Marriage Divorce and Family Relation Act of 2015.

The above provisions and services notwithstanding, Teenage pregnancy is a major health concern in Malawi because of its association with higher morbidity and mortality for both the mother and child. The 2010 Malawi Demographic and Health Survey (MDHS) indicates that 60% of youth aged 18-24 had sexual intercourse before age 18 and that 26% of adolescents aged 15-19 years begun childbearing, 20% have a live birth and 6% are pregnant with their first child. Early child bearing has a number of consequences for the mother and the baby including high health risks during pregnancy, delivery and post natal[64]. Nearly 50% of women attempting to access post abortion care are under the age of 25. This demonstrates existence of a huge gap between demand and supply for family planning services[65]. Access to contraceptives among adolescents is constrained by limited information and

the current observed age-specific fertility rates.

[61] Crude Death Rate (CDR) is defined as the number of deaths that occurred in a given calendar year per 1,000 population

[62] http://www.geographic.org/world_fact_book_2013/malawi/malawi_people.html

[63] Munthali, AC, Chimbiri A and Zulu E. (2004). Adolescent, sexual and reproductive health in Malawi: A synthesis of research evidence. Occasional report. New York: The Allan Guttmacher Institute, No 5, pp. 5, 33-36

[64] National Statistical Office, ICF Macro (2011) Malawi Demographic and Health Survey (2011) cited in Save the Children International. (2014). More educated girls – Reducing teenage pregnancies in Malawi: A project proposal

[65] Cited in Save the Children International – Malawi. (2013). Situation analysis on sexual and reproductive health interventions for young people in Malawi. Pp. 1-7

access to information on sexual and reproductive health services [66] [67], limited availability of contraceptives, unfriendly service providers and opposition from sexual partners[68].

In an effort to address the problems accessing YFHS, the Government of Malawi through the Ministry of Health developed a National Youth Friendly Health Service (NYHS) Strategy for 2015–2020. The Strategy, through collaborative efforts with relevant stakeholders, "seek to create an enabling environment for YFHS delivery, guarantee strict adherence to YFHS standards, strengthen synergies between and across sectors, increase youth and community participation, and identify opportunities for funding for creating a generation free of all chronic conditions"[69]. Implementation of the Strategy is through 3 priority areas of: Access to information through health promotional activities, social and behavioral change messages, and formal learning; delivery of services mainly through static and outreach sites; and referrals to social services, district and central hospitals, community structures, and/or police[70].

Information from RTP baseline report on health indicates that:
a)Most adolescents (75.8%) had knowledge of SRH services in their areas (72.3% of the females and 81.7% of the males). However only a limited number were currently accessing SRH services (42.8% (41.5 % girls and 45.2% boys)
b) Access to SRH access was higher among the older adolescents aged 15-19 years (61.3%) than among the younger adolescents aged 10-14 years (17.7%).
c) Schools and health facilities as opposed to the family were cited by 52.3% and 44.7% of the adolescents, respectively while the mass media (including radios) was mentioned by 29.25% of the adolescents as key sources on SRH.
d) Girls (and boys) initiated sex at a very early age: The median age at first sex was 15 years (against a national median age of 17.3 years and 18.6 years for females and males, respectively) while the mean age was 14.9 years (15.1 years among the females and 14.6 years among the males).
e) Overall 30.8% of the adolescents (28.3% females and 35.1% males) reported to have ever had sex.
f) Peer pressure was mentioned as the key push factor by 60.1% of the adolescents as a push factor for girls to start sex, followed by poverty or economic pressure (52.4%) and hormonal changes due to adolescence (45.3%).
g) Abstinence was mentioned by 75.6% of the survey participants as the effective way to avoid pregnancy followed by use of condoms (36.0%) and use of contraceptives (9.0%).
h) Adolescents had sufficient knowledge of the consequences of early sex: Of the adolescents (n. 572) asked 78.2% cited unplanned pregnancies, 69.1 cited contracting STI/HIV, 36.1% cited lost virginity while 25.3% cited dropping out of school.
i) Condoms are the main contraceptive method used by the majority of the adolescents (75.2%): 75.2% of adolescents (76.1% females and 73.2% males) reported to have used a condom. A quarter (25.7%) of the female adolescents having used some form of contraceptives other than condoms.
j) 86.2% of them reported to have used a condom in the last sexual encounter they have has with a casual partner

[66] Munthali, AC, Chimbiri A and Zulu E. (2004). Adolescent, sexual and reproductive health in Malawi: A synthesis of research evidence. Occasional report. New York: The Allan Guttmacher Institute, No 5. pp. 4-5
[67] Wittenberg J, Munthali A, Moore A, Zulu E, Madise N, Mkandawire M, Limbani F, Darabi L and Konyani S. (2007). Protecting the next generation in Malawi: New evidence on adolescent sexual reproductive health needs. Occasional report, New York: The Allan Guttmacher Institute, p. 4
Munthali, AC, Chimbiri A and Zulu E. (2004). Adolescent, sexual and reproductive health in Malawi: A synthesis of research evidence. Occasional report. New York: The Allan Guttmacher Institute, No 5 p. 5
[69] Ministry of Health. (2015). National Youth Friendly Health Services Strategy, 2015-2020. page 2
[70] Ministry of Health. (2015). National Youth Friendly Health Services Strategy, 2015-2020

k) Only 10.5% of the adolescents reported to have visited a health facility for other services other than seeking contraceptives

m) Overall, 21.7% of female adolescents and 63.4% of the male adolescents with stable sexual partners reported to have refused sex after a steady sexual partner suggested it.

l)75.2% of the adolescents with steady sexual partners (76.1% females and 73.2% males) reported to have used a condom while 45.6% of the adolescents with steady sexual partners reported that they use condoms all the time they have sex.

m) A small proportion of adolescents (27.5%) comprising (9.6% girls and 24.0% boys were able to make informed decisions on SRH issues.

Annex 3: Revised Program Hypothesis Matrix

Casual Analysis	Underlying Hypothesis	Project Design
Lack of adolescent access to & utilization of SRH information and services	IF: adolescents' access SRH information & services are improved ***IF: services are extended to also include the provision of information to groups (youth clubs, for example, as is done currently as part of the project)***	**THEN:** Pregnancies will be reduced (including Teenage, number of pregnancies, age of first pregnancy) *Sexually transmitted diseases will be reduced* *Girls will gain a stronger sense of self determination by being able to control their reproductive lives* *Boys may gain a better understanding of their roles and responsibilities in child bearing*
Lack of quality learning environment and girls self-efficacy affects attainment of education for girl	IF: quality of learning environment and self-efficacy is improved *IF: facilities meet minimum requirements for teaching (classrooms) and sanitation (toilets and areas for girls to wash)* *IF: Poorest families (the extreme poor only) are provided with basic material goods to enable school attendance*	**THEN:** Dropout rates among girls will be reduced Retention rates will increase
Lack of community, and social support towards education of the girl child	IF: communities and social structures are empowered to support girl child at school *IF: communities are committed to working towards school retention regardless of the support provided* *IF: communities welcome SRH services and information provision* *IF: there is an adequate care provision for the new born child*	**THEN:** Girls will be motivated to remain in schools and teen mothers will be motivated to return to school

Annex 4 Achievements per key outputs for each of the Key Outcome Strategy for selected activities

Objective 1: Improved learning environment and self-efficacy of adolescent girls			
Planned Activity	**Target**	**Achieved**	**Deviation/Comment**
Training of Trainers involving SHN Coordinators, Head Teachers and PEAs) on Psychosocial Support, Child Centered and Gender Sensitive Pedagogy, Positive Discipline, Child Protection including Mapping, VAG, SRHR	32 people SHN (6) PEAs (6) Head Teachers (6) SCI DCs (6) SCI CFs (6) FAWEMA (1) BLM 1	32	Fully done; one output was development of a training manual
Workshop to develop the teachers training manual	1	1	Experts from government, NGOs, sub grantees and SCI staff drafted user manual in 2015
Printing & distribution of the training material	3000	342	No indication from the 2015 report that the manual was piloted, finalized and distributed.

Trainings of teachers on child-centered and gender-sensitive pedagogy, psychosocial support/mentoring positive discipline, child protection, and ASRH).	1088 (949 males, 406 females)	1355	Target exceeded because it included teachers who could not be trained in 2014 due to logistical challenges
Teacher trainings – follow-up/review meetings with school authorities (i.e., club patrons, head teachers, and health center staff who will be visiting schools for health talks)	26 meetings	1239 total teachers 715 males, 524 females	Targeted number of teachers not indicated.
Follow-up observation and mentoring visits to assess knowledge transfer by teachers and provide them with further support.	42 visits	34 visits 40000 males; 50000 females	Activity not fully accomplished in 2015 due to delayed implementation of activities.
Refresher training for teachers, community structures, and school club patrons (no cost activity).			Target and achievement columns not completed. Most likely not done.
Conduct QLE assessments.	30 schools	61 schools; 30 girls from each school participated	Reason not provided for the deviation , most likely had budget implications as well as put pressure on time initially allocated to other activities
Replicate mapping exercise in remaining schools to identify areas where girls feel safe and unsafe within the schools.	513 schools	478 schools	Activity not fully done in 2015 per plan. Junior schools did not carry out the exercise. It was done in full primary schools. Junior schools should have been assisted to complete the

			mapping considering that the exercise was equally important for pupils in junior primary schools as well to promote participation and self-efficacy
Support school-based interventions by youth clubs to strengthen knowledge acquisition and self-efficacy (quiz/essay competitions).	42 clubs	34 clubs 95000 (40000 females)	Activity not fully done in 2015 due to time factor.
Provide support to school clubs (girls camping and role-modeling).	6 camps- 50 girls	6 camps 259 girls	Planned target number of girls not indicated
Objective 2: Improved access to high quality sexual reproductive health services for youths			
Recruitment and training of YFHS providers – 2 per facility (1 nurse/clinician and 1 HSA).	292 YFHS providers	169 YFHS providers, 56 females	76 health facilities exist in project catchment area – total target should have been a maximum of 152. However, a number of health that work with the youth in health facilities e.g. at Nkanda and Kaingagwaza Health Centre in Mchinji, Migowi Health Centre in Phalombe were not invited to the training. It is clear from their recommendation that they need to be trained to carry out their duties more effectively; Training was significantly delayed, started late in 2015 due to disagreement between

			trainers (BLM) and participants from health facilities on application of government policy on per diem and
Recruitment of YCBDAs.	178 YCBDAs	178 YCBDAs , 94 females	264 YCBDAS were recruited in 2014. In Total the project has 443 YCBDAs.
Training of YCBDAs.	443 YCBDAs	30 YCBDAs, 14 females	All the 30 were from one district (Balaka) From filed interviews, it appears that some members of out of school youth clubs that have not been trained are distributing contraceptives e.g. some members of Nkanda out of School Youth Organization in Mchinji
Support to DHO and partners for mobile YFHS (through public or private outreach services) in areas with identified service delivery gaps.	303 sessions	245 sessions, 40857 of which 20062 were females	The BLM DOT failed to complete all sessions due to *time constraints and logistical challenges e.g. unavailability of fuel.* Training took place in all 6 of 7 districts.
Support Quality Improvement team (QIT) monitoring visits in the districts at facility level.	12 visits	6 visits (72 facilities	Could not cover 2 visits per district due to time constraints; orientation done late; No visits conducted in Mchinji; Machinga conducted 2 visits

			(Total 6?)
Source QIT standards and guidelines, print, and distribute to QIT.	71	71	All trained YFHS providers were provided with YF standards and guidelines.
Conduct one-day orientation for 8 QIT members (per team) on QIT standards and guidelines.	6 QIT sessions (48 members	6 QIT sessions (44 members	Some DHMTs failed to attend. . Names of districts that did not send representation not indicated
Health worker visits to schools and youth clubs and student visits to service delivery points (quarterly).	144 visits	102 visits, 3214 persons ; 3346 of whom 2666 were females	Activity not fully implemented due to scheduling challenges, weather etc.; Achievement list has two figures, namely 3214 and 3346 – not sure which is which
Objective 3: Improved social environment to support adolescents' sexual reproductive health rights and educational achievement			
Community sensitization meeting (zone-based).	24 meetings (768 Teachers)	24 meetings (644 teachers of whom 185 were females	
Community sensitization meetings (school-based).	578 meetings	575 meetings 19,503, of which 8571 were males	Activity fully conducted save for one school due to in availability of a school governing group
Conduct one-day orientation for school structures (mothers groups, SMCs) at zone level to assist and support teen mothers' re-entry into schools, reporting systems for	33 mother groups	33 Mother group,	

sexual violence, and additional encouragement for girls to remain in school.	and SMCs	433 of which 226 were males	
Training of community structures (MG, SMC, and PTA) in tracking and reporting of issues.	1448	1256 including 452 females	Under achievement due to some zones have fewer schools than the estimated 15 schools per zone. For example Migowi in Phalombe has 8 schools
Conduct zonal open days and hold discussions on edutainment activities	42	32	Not yet done in Phalombe
Conduct ADC sensitization meetings (443 GVH, 53 TAs, 106 ADCs, and 53 religious leaders).	46	44	Conducted in 6 targeted districts, turn out low at some meetings and 2 meetings did not occur due to misunderstanding on election procedures.
Conduct quarterly community dialogues on keeping girls in school and re-admission procedures.	216	58	Not done in Phalombe due to delayed funding
Conduct one-day orientation of 443 CPC/TAs on adolescent SRHR and how to track teen mothers and re-admission (orientation training for CP Workers	6 sessions	6 sessions	The purpose was to orient CPWs to the manual used during CPC trainings.
Orientation of CP Committees on teen mother tracking and re-admission.	333	266	To continue in 2016
Objective 4: Improved operationalization of policies to support adolescents' sexual reproductive health rights and educational achievement			
Conduct quarterly (4	4	4	Some meetings in the 6 targeted

Project Coordinating committee meetings MoH and MoEST to discuss the gaps and relevant conversions and policies and how they affect service and education for adolescents			districts not conducted due to commitment by other stakeholders
Conduct quarterly project coordinating committee meetings with MoH and MoEST to discuss policies and how they affect service and education for the youth.	4	3	In Machinga, RTP, ASPIRE, and the DEM office distributed the re-admission policy to all schools in the district.
Disseminate policies/guidelines at different forums like open days, community meetings (distribution of	2 policies	1 policy	In Machinga, RTP, ASPIRE, and the DEM office distributed the re-admission policy to all schools in the district.
Strategic outcome 5: Improved coordination, monitoring and evaluation of project activities			
Conduct project baseline and	1	1	
disseminate findings	1 national level dissemination	72 participants including 25 females	The baseline dissemination drew participants from Government sector, NGOs and

			Research institutions, among others
Develop data collection toolkit	1	1	The tools were developed to capture reliable and consistent data
Conduct a training in data management	1	1, 16 participants including 6 females	Targeted project and Staff from key partners
Conduct quarterly district steering committee meetings to review progress and plan district activities	27	17	Not done in all districts due to other commitments by some stakeholders
Conduct quarterly project management meetings.	4	3	

Annex 5a List of Respondents by District, Membership affiliation and Sex

DISTRICT	MEMBERSHIP	MALE	FEMALE	TOTAL
	Members of Mother Groups	1	17	18
	CPC Members	6	7	13
	Youth	8	25	33
Phalombe	Matron/Patron	2	2	4
	PTA Members	5	7	12
	SMC Members	10	7	17
	Traditional Leaders			0
	District RTP Steering Committee Members	4	2	6
	YFHS Coordinators/Providers including CBDAs	3	2	5
	VDC ADC Members			
	Totals	**39**	**69**	**108**
	Members of Mother Groups	1	17	18
	CPC Members	7	6	13
	Youth	13	7	20
Mchinji	Matron/Patron	3	3	6
	PTA Members	4	9	13
	SMC Members	6	8	14
	Traditional Leaders	8		8
	District RTP Steering Committee Members	6	2	8
	YFHS Coordinators/Providers including CBDAs	5	2	7
	VDC ADC Members	4	2	6
	Teen Mothers		2	2
	Totals	**57**	**58**	**115**
	Members of Mother Groups	1	14	15
	CPC Members	5	4	9
	Youth	21	13	34
Mangochi	Matron/Patron	3	3	6
	PTA Members	5	2	7
	SMC Members	7	1	8
	Traditional Leaders	2		2
	District RTP Steering Committee Members	6	2	8
	YFHS Coordinators/Providers including	4	1	5

	CBDAs							
	VDC ADC Members							
	Teen Mothers							
	Primary Education Advisors						1	1
	Totals					**54**	**41**	**95**
	Save the Children Country Office					4	2	6
	FAWEMA					1	2	3
	BLM					3	1	4
Lilongwe	Ministry of Gender					1		1
	Ministry of Education					1	1	2
	Ministry of Health					1	1	2
	Totals					**11**	**7**	**18**
Overall breakdown for persons/groups interviewed in the 4 districts								
					M	**F**	**T**	
Members of Mother Groups					3	48	51	
CPC Members					18	17	35	
Youth					42	45	87	
Matron/Patron					8	8	16	
PTA Members					14	18	32	
SMC Members					23	16	39	
Traditional Leaders					10	0	10	
District RTP Steering Committee Members					16	6	22	
YFHS Coordinators/Providers including CBDAs					12	5	17	
VDC ADC Members					4	2	6	
Teen Mothers						2	2	
Primary Education Advisors						1	1	
Save the Children Country Office					4	**2**	6	
FAWEMA				1	2	3		
BLM				3	1	4		
Ministry of Gender					1	0	1	
Ministry of Education					1	1	2	
Ministry of Health					1	1	2	
				161	**175**	**336**		

Annex 5b List of Respondents by District, Name, Sex and Affiliation

List of participants

Phalombe District			
No.	**Name**	**Sex**	**Affiliation**
1.	Rose Gowa	F	Mother Group, Nkhulambe FP School
2.	Fanny Chimtengo	F	Mother Group, Nkhulambe FP School
3.	Rose Sumbuleta	F	Mother Group, Nkhulambe FP School
4.	Mary Thukuta	F	Child Proteection Committee, Nkhulambe FP School
5.	Ellen Mvito	F	Child Proteection Committee, Nkhulambe FP School
6.	Fannu Ekhaya	F	Child Proteection Committee, Nkhulambe FP School
7.	Amos Nulwe	M	Child Proteection Committee, Nkhulambe FP School
8.	Wyson Mizimu	M	Child Proteection Committee, Nkhulambe FP School
9.	Amos Seluweke	M	Child Proteection Committee, Nkhulambe FP School
10.	Bwanali Msisi	M	Child Proteection Committee, Nkhulambe FP School
11.	Bruno Toneki	M	Child Proteection Committee, Nkhulambe FP School
12.	Catherine Makasu	F	Child Proteection Committee, Nkhulambe FP School
13.	Vera Nazomba	F	Child Proteection Committee, Nkhulambe FP School
14.	Betrice Kupya	F	Child Proteection Committee, Nkhulambe FP School
15.	Mary Charles	F	Child Proteection Committee, Nkhulambe FP School
16.	Esnat Malizani	F	Migowi Youth Club
17.	John Botomani Kachingwe	M	Migowi Youth Club
18.	Lastone Matope	M	Migowi Youth Club
19.	Alinafe Nyalugwe	F	Migowi Youth Club
20.	Fyson Macheso	M	Migowi Youth Club
21.	Falida Amos	F	Tithandizane Save the Children Club, Nkhulambe FP School
22.	Susan Seremani	F	Tithandizane Save the Children Club, Nkhulambe FP School
23.	Benadetta Chiwaya	F	Tithandizane Save the Children Club, Nkhulambe FP School
24.	Alinane Daudi	F	Tithandizane Save the Children Club, Nkhulambe FP School
25.	Pilirani Mkhwiyo	F	Tithandizane Save the Children Club, Nkhulambe FP School
26.	Stella Paulos	F	Tithandizane Save the Children Club, Nkhulambe FP School
27.	Morgan Mandawala	M	Tithandizane Save the Children Club, Nkhulambe FP School
28.	James Malaulo	M	Tithandizane Save the Children Club, Nkhulambe

			FP School
29.	Emula Nyamucheka	F	Tithandizane Save the Children Club, Nkhulambe FP School
30.	Ruth Masewo	F	Matron, Nkhulambe FP School
31.	Lotson Sanjani	M	Patron, Nkhulambe FP School
32.	Dyton Magombo	M	Member, CPC, Nambiti FP School
33.	Patricial Materechela	F	Vice Chairperson, Mother Group, Nambiti FP School
34.	Dorothy Magambi	F	Secretary , Mother Group, Nambiti FP School
35.	Luisa Mulalika	F	Chairperson, Mother Group, Nambiti FP School
36.	Enelesi Simon	F	Vice Secretary, Mother Group, Nambiti FP School
37.	Margaret Mitochi	F	Vice Chairperson, Mother Group, Nambiti FP School
38.	Lizzie Maluwasa	F	Member, Mother Group, Nambiti FP School
39.	Grace David	F	Mother Group, Nambiti FP School
40.	Oliver Chamanga	F	Mother Group, Nambiti FP School
41.	Maria Chief	F	Mother Group, Nambiti FP School
42.	Chrissy Dodoma	F	Member, Mother Group, Namatapa FP School
43.	Edina William	F	Member, Mother Group, Namatapa FP School
44.	Esnat Juburg	F	Member, Mother Group, Namatapa FP School
45.	Afalesi Mulepa	F	Member, Mother Group, Namatapa FP School
46.	Enelesi Tolani	F	Chairperson, Mother Group, Namatapa FP School
47.	Chisomo Masande	M	Patron, Ufatse Fun Club, Namatapa FP School
48.	Hassan Liston	M	Member, Mother Group, Namatapa FP School
49.	Funny Mafuli	F	Treasurer, PTA, Nkhulambe FP School
50.	Hastings Muleso	M	Chairperson, PTA, Nkhulambe FP School
51.	Mercy Kuntaje	F	Member, PTA, Nkhulambe FP School
52.	Catherine Nasiyaya	F	Secretary, SMC, Nkhulambe FP School
53.	Joseph Chiromo	M	Chairperson, SMC, Nkhulambe FP School
54.	Sydney Nkata	M	Community Development, Member, District RTP Steering Committee
55.	Simon Braham	M	Youth representative, Member, District RTP Steering Committee
56.	Richard Juao	M	Department of Youth, Member, District RTP Steering Committee
57.	Chimwemwe Kalolo	F	Coordinator, YFHS, Member, District RTP Steering Committee
58.	Rachel Matemba	M	District Youth Network, Member, District RTP Steering Committee
59.	Rachel Matemba	F	District Youth Network, Member, District RTP Steering Committee
60.	Prisca Mitenbo	F	Vice Chairperson, PTA, Namatapa FP School
61.	Agness Ndendende	F	Member, PTA, Namatapa FP School
62.	Zinenani James	F	Member, PTA, Namatapa FP School
63.	Simplex David	M	Treasurer, PTA, Namatapa FP School
64.	Enock Banda	M	Secretary, PTA, Namatapa FP School
65.	Patricia Majanga	F	Member, PTA, Namatapa FP School
66.	Elaton Jackson	M	Vice Chairperson, SMC, Namatapa FP School
67.	Nastazious	M	Member, SMC, Namatapa FP School

	Sebastian		
68.	Lyson Katoma	M	Member (Deputy Head Teacher), SMC, Namatapa FP School
69.	Patricia Fadwick	F	Member, SMC, Namatapa FP School
70.	Margaret Mihire	F	Member, SMC, Namatapa FP School
71.	Bestone Mmangeni	M	Member, SMC, Namatapa FP School
72.	Bright Likoswe	M	Treasurer, SMC, Namatapa FP School
73.	Justine Chiwaya	M	Secretary, SMC, Namatapa FP School
74.	Teleza Mayawu	F	Member, In school Girls Youth Club, Namatapa FP School
75.	Madalitso Kachingwe	F	Member, In school Girls Youth Club, Namatapa FP School
76.	Mary Francis	F	Member, In school Girls Youth Club, Namatapa FP School
77.	Mary Francis	F	Member, In school Girls Youth Club, Namatapa FP School
78.	Catherine Banda	F	Member, In school Girls Youth Club, Namatapa FP School
79.	Agnes Katoma -(has a speech challenge)	F	Member, In school Girls Youth Club, Namatapa FP School
80.	Regina Luka	F	Member, In school Girls Youth Club, Namatapa FP School
81.	Afera Khumulika	F	Member, In school Girls Youth Club, Namatapa FP School
82.	Afera Khumulika	F	Member, In school Girls Youth Club, Namatapa FP School
83.	Rita Benitto	F	Member, In school Girls Youth Club, Namatapa FP School
84.	Eliza Liston	F	Member, In school Girls Youth Club, Namatapa FP School
85.	Luzana Enock	F	Member, In school Girls Youth Club, Namatapa FP School
86.	Christina Kachingwe	F	Member, In school Girls Youth Club, Namatapa FP School
87.	Veronica Jackson	F	Member, In school Girls Youth Club, Namatapa FP School
88.	Chrisy Elias	F	Member, In school Girls Youth Club, Namatapa FP School
89.	Judith Pilingu	F	Health Surveillance Assistant, Migowi Health Centre
90.	Hannech Masuku	M	Health Surveillance Assistant, Migowi Health Centre
91.	Enock Sambira	M	Health Surveillance Assistant, Migowi Health Centre
92.	Angela Magwira	F	Community Mid wife, Migowi Health Centre
93.	Charleston Namalamba	M	Health Surveillance Assistant, Migowi Health Centre
94.	Joseph Pensulo	M	Vice Chairperson, SMC, Nambiti FP School
95.	Patrick Kaseyama	M	Member, SMC, Nambiti FP School
96.	Fyson Mulanje	M	Secretary, SMC, Nambiti FP School
97.	Ellen Mopiwa	F	Vice Secretary, SMC, Nambiti FP School

98.	Konda Masanjala	F	Treasurer, SMC, Nambiti FP School
99.	Anne Musaiwa	F	Member, SMC, Nambiti FP School
100.	Jenny Kongonera	F	Member, SMC, Nambiti FP School
101.	Westone Matere	M	Member, PTA, Nambiti FP School
102.	Alesi Chikomoni	F	Member, PTA, Nambiti FP School
103.	Goliati Gomani	M	Chairperson, PTA, Nambiti FP School
104.	John Mhasuwa	M	Member, Chiringa Youth Club, Nambiti
105	Stanford Benson	M	Member, Chiringa Youth Club, Nambiti
106	Peter Nawani	M	Member, Chiringa Youth Club, Nambiti
107.	Femiya Mankhwala	F	Member, Chiringa Youth Club, Nambiti
108.	Judiith Kalimula	F	Member, Chiringa Youth Club, Nambiti
Total for Phalombe 108 (39 Males, 69 Females)			
Mchinji District			
109.	Samuel Chanika	M	Member, PTA, Kawere FP School
110.	Judith Sosten	F	Member, PTA, Kawere FP School
111.	Florence Sosten	F	Member, PTA, Kawere FP School
112.	Emily Biziwick	F	Member, PTA, Kawere FP School
113.	Doreen Reuben	F	Chairperson, Mother Group, Kawere FP School
114.	Florence Petro	F	Secretary, Member, PTA, Kawere FP School
115.	Dorice Tembo	F	Treasurer, Member, PTA, Kawere FP School
116.	Falesi Kadeka	F	Member, Member, PTA, Kawere FP School
117.	Maria Mathews	F	Member, Member, PTA, Kawere FP School
118.	Yacob Chikuse	M	CBDA, Kawere
119.	Petro Chilunga	M	Vice Chairperson, Kawere Youth Club
120.	Molecious Phwanda Phwanda	M	YFHS Coordinator, Kawere
121.	Moffat James	M	Member, Kawere Youth Club
122.	Moreen Laston	F	Member, Kawere Youth Club
123.	Zione Mbewe	F	Chairperson, Member, Kawere Youth Club
124.	Annes Daud	F	Teen mother , Kawere FP School
125.	Lea Nafitale	F	Teen mother, Kawere FP School
126.	Golden Bwanali	M	Patron, Kawere FP School
127.	Chikaiko Chidazi	F	Matron , Kawere FP School
128.	Lekeleni Kamanga	F	Head teacher, Matron, Kawere FP School
129.	Astina Mikelani	F	Member, CPC, Kawolambumba FP School
130.	Levison Light	M	Secretary, CPC, Kawere FP School
131.	Mulitani Milliward	M	Treasurer, CPC, Kawere FP School
132.	Oliva Rodwell	F	Member , Mother Group, Kawolambumba FP School
133.	Timvane Josasi	F	Vice Secretary, Mother Group, Kawolambumba FP School
134.	Filesi Chilombo	F	Member, Mother Group, Kawolambumba FP School
135.	Pollina Dambo	F	Member, Mother Group, Kawolambumba FP School
136.	Funny Moses	F	Secretary, Mother Group, Kawolambumba FP School
137.	Joana Chifundo	F	Treasurer, Mother Group, Kawolambumba FP School
138.	Falesi Damalekani	F	Chairperson, Mother Group, Kawolambumba FP School

139.	Felix L Nyirenda	M	Chairperson, PTA, Kawolambumba FP School
140.	Marita Chapuma	F	Member PTA, Kawolambumba FP School
141.	Regina Chikankheni	F	Secretary PTA, Kawolambumba FP School
142.	Adess Facksson	F	Vice Chair SMC, Kawolambumba FP School
143.	Benjamin Chapuma	M	Member SMC, Kawolambumba FP School
144.	Issac Sikelo	M	Secretary SMC, Kawolambumba FP School
145.	Rodgers Kunkhandze	M	Chairperson, SMC, Nkanda FP School
146.	Maseko Kaponda	M	Representing Head teacher, Member, Nkanda FP School
147.	Christabel Nyirenda	F	Vice Secretary, SMC, Nkanda FP School
148.	Dorothy Dickson	F	Treasurer, SMC, Nkanda FP School
149.	Joyce Nyerere	F	Vice Chairperson, SMC, Nkanda FP School
150.	Lesia K Galleta	F	Treasurer, PTA, Nkanda FP School
151.	Kanock Jonasi	M	Member, PTA, Nkanda FP School
152.	Gereson Milioti Matheza	M	Vice Chairperson, PTA, Nkanda FP School
153.	Naomi Selemani	F	Youth Representative, Malawi Care, District RTP Steering Committee
154.	Vitumbiko Mhango	F	YFHS Coordinator and School Health Nutrition (SHN)Program Coordinator, Member, District RTP Steering Committee
155.	Sub Inspector Peter Chinkango	M	Coordinator, Community Police, Member, District RTP Steering Committee
156.	Blessings Chinkhadze	M	Desk Officer/Coordinator of Primary Education Advisors, Member, District RTP Steering Committee
157.	Precious Madengu	M	District Supervisor (Child Protection), District Social Welfare, Member, District RTP Steering Committee
158.	Rodrick Dziko	M	Community Facility RTP
159.	Alick Mbewe	M	District Coordinator, RTP, Member, District RTP Steering Committee
160.	Irene Goleta	F	Child Protection Worker – Dept. of Social Welfare, Member CPC, Kawere FP School
161.	Susan Banda	F	Member, CPC, Kawere FP School
162.	Angelina Kerempino	F	Member, CPC, Kawere FP School
163.	Jane Jamusi	F	Member, CPC, Kawere FP School
164.	Yenala Kachenje	F	Member, CPC, Kawere FP School
165.	VH Mateyo Kawere	M	Village Headman, Kawere Village
166.	VH Chiwama,	M	Village Headman, also representing Group Village Headman Kawama
167.	VH Dress	M	Village Headman
168.	VH Kapangwa	M	Village Headman
169.	VH Kawama	M	Village Headman
170.	VH Levison	M	Village Headman
171.	VH Faindani	M	Village Headman
172.	Joseph Jackson	M	Vice Chairperson, Kazgyozgyo Youth Club

173.	Wezzie Mwanza	F	Chairperson, Kazgyozgyo Youth Club
174.	Gideon Banda	M	Vice Chairperson, Kazgyozgyo Youth Club
175.	Brian Chanza	M	Chairman, Kazgyozgyo Youth Club
176.	Khumbo Kachikho	M	Treasurer, Kazgyozgyo Youth Club
177.	Mariet Mvuta	F	Chairperson, Mother Group, Mkanda FP School
178.	Judie Chinsato	F	Member, Mother Group, Mkanda FP School
179.	Christina Kanyama	F	Member, Mother Group, Mkanda FP School
180.	Martha Banda	F	Member, Mother Group, Mkanda FP School
181.	Magret Shapala	F	Vice Chairperson, Mother Group, Mkanda FP School
182.	Joseph Chalemera	M	Member, CPC, Nkanda FP School
183.	Amos Khoza	M	Member, CPC, Nkanda FP School
184.	Chielo Banda	M	Child Protection Worker, Member, CPC, Kamphata FP School
185.	Vincet Tsitsi	M	Secretary , CPC, Kamphata FP School
186.	Mathias Kalumba	M	Chairperson, CPC, Nkanda FP School
187.	Eric Banda	F	Secretary, CPC, Nkanda FP School
188.	Felista Jonas	F	Member, Mother Group, Kamphata FP School
189.	Rose Mwale,	F	Secretary, Mother Group, Kamphata FP School
190.	Kilinesi Elemondi	F	Chairlady, Mother Group, Kamphata FP School
191.	John Masilikali	M	Village Headman, Member, Mother Group, Kamphata FP School
192.	Binosi Ganizani	F	Member, Mother Group, Kamphata FP School
193.	Frank Chitedze	M	Chairperson, Nkanda Area Development Committee
194.	Jilesi Phiri	M	Representative of Traditional Authority Nkanda
195.	VH Waya	M	Village Headman under GVH Kamphata, TA Nkanda
196.	Ekonia Manota	M	Patron, Edzi Toto Club, Kamphata FP School
197.	Dorica Chitukula	F	Matron, Girl Guide, Sister to Sister Club, Kamphata FP School
198.	Jacob Jickson	M	Chairperson, Kamphata Youth Club
199.	Alick Banda	M	Vice Secretary, Kamphata Youth Club
200.	Pirirani Fedson	M	Treasurer, Kamphata Youth Club
201.	Grace Kaliwa	F	Secretary, Kamphata Youth Club
202.	Mphatso Kaliwa	F	Treasurer, Kamphata Youth Club
203.	Lezina Saizi	F	Member, Kamphata Youth Club
204.	Chimwemwe Gama	M	Member, Nkanda out of School Youth Club
205.	Chimwemwe Samala	M	Member, Nkanda out of School Youth Club
206.	Joseph Benson	M	Secretary, Nkanda out of School Youth Club
207.	Judith Phiri	F	Acting Chairperson, Nkanda out of School Youth Club
208.	Hawa Kassim	M	Member, Nkanda out of School Youth Club
209.	Postan Mchenga	M	Chairperson, SMC, Kawere FP School
210.	Elube Textford	F	Committee member, SMC, Kawere FP School
211.	Elube Textford	F	Committee member, SMC, Kawere FP School
212.	Ellias Banda	F	Vice Chairperson, SMC, Kawere FP School
213.	Rosemary Joseph	F	Treasurer, SMC, Kawere FP School
214.	Harry Saidi	M	Secretary, SMC, Kawere FP School
215.	Zakeyo Kachingwe	M	Chairperson, Village Development Committee, Kawere

216.	Bakshoni Chikuse	M	Member, Village Development Committee, Kawere
217.	Mwazanji Chisale	F	Chairperson, Village Development Committee, Kawere
218.	Patricia Kanchiputo	F	Member, Village Development Committee, Kawere
219.	Moses Kalimo	M	Member, Village Development Committee, Kawere
220.	Chancy Chinokola	M	Nurse Midwife Technician Coordinator, YFHS, Kayigwazanga Health Centre
221.	Lucy Kachere	F	Nurse Midwife Technician, Kayigwazanga Health Centre
222.	Frederick Katole	M	Health Surveillance Assistant (HSA) Supervisor, YFHS Provider, Nkanda Health Centre
223.	Grafield Gama	M	Health Surveillance Assistant, Nkanda Health Centre
Total for Mchinji: 115 (57 Males, 58 Females)			
Mangochi District			
224.	Benedicto Chingoli	M	YFHS Coordinator, Malukula Health Centre, Patron, Malukula Youth Club
225.	James Phiri	M	HSA, Malukula Health Centre
226.	Ida Stuart	F	Nurse, Malukula Health Centre
227.	Chrispin Sombo	M	Member, Malukula Youth Network
228.	Saidi Makwinja	M	Member, Malukula Youth Club
229.	Alabi Yusufu	M	Member, Malukula Youth Club
230.	Lukiya Mdala	F	Member, Malukula Youth Club
231.	Gift Atatu	M	Member, Malukula Youth Club
232.	Gift Umar	M	Member, Malukula Youth Club
233.	Chifundo Macholowe	M	Member, Malukula Youth Club
234.	Sayiti Anafi	M	Member, Malukula Youth Club
235.	Wirison Lajab	M	Member, Malukula Youth Club
236.	James Ndagoma	M	Member, Malukula Youth Club
237.	Dinar Matola	F	Member, Malukula Youth Club
238.	Lima Yasini	F	Member, Malukula Youth Club
239.	Gerald Hassan	M	Member, Malukula Youth Club
240.	Charles Limbani	M	Member, Malukula Youth Club
241.	Asiyatu Sani	F	Member, Malukula Youth Club
242.	Davie Basikolo	M	Member, Malukula Youth Club
243.	Fatima Saiti	F	Member, Malukula Youth Club
244.	Jonathan Makusula	M	Member, Malukula Youth Club
245.	Homida Alabi	F	Member, Malukula Youth Club
246.	Alinafe Chingoli	F	Member, Malukula Youth Club
247.	Isaac Banda	M	Member, Malukula Youth Club
248.	Mariam Rasheed	F	Member, Malukula Youth Club
249.	Everesi Ayam	F	Member, Malukula Youth Club
250	Humble George	M	Member, Malukula Youth Club
251.	William Bwanali	M	Member, Malukula Youth Club
252.	Evance Kalonga	M	Member, Malukula Youth Club
253.	Shanil Morris	F	Member, Malukula Youth Club
254.	Zainabu Witiness	F	Member, Malukula Youth Club
255.	Margaret Bwanali	F	Member, Malukula Youth Club
256.	Dija Mustafa	F	Member, Malukula Youth Club

257.	Muhammad Jafuli	M	Member, Malukula Youth Club
258.	Yusufu Jangiya	M	Member, Malukula Youth Club
259.	Tabiya Mtonyo	F	Member, Malukula Youth Club
260.	Mussa Kazembe	M	Member, Malukula Youth Club
261.	Patuma Mkwanda	F	Member, Malukula Youth Club
262.	Bedda Kazembe	F	Member, Malukula Youth Club
263.	Jackson Makwinja	M	Member, Malukula Youth Club
264.	James Banda	M	Project Officer, Malukula Youth Club
265.	Kimu Mangani	M	Chairperson, PTA, Malukula FP School
266.	Kiati Ali	F	Vice Chairperson, PTA, Malukula FP School
267.	Militoni Tumamu	M	Treasurer, PTA, Malukula FP School
268.	Karim Daudi	M	Chairperson, SMC, Malukula FP School
269.	Makowa Swale	M	Member, SMC, Malukula FP School
270.	Iddrissa Ngaula	M	Vice Chairperson, SMC, Malukula FP School
271.	Ellina Ajida	F	Member, Mother Group, Malukuta FP School
272.	Hajira Hardin	F	Vice Secretary, Mother Group, Malukula FP School
273.	Mary Hassan	F	Chairperson, Mother Group, Malukula FP School
274.	Aisha Assma	F	Secretary, Mother Group, Malukula FP School
275.	Chida Kuseli	M	Chairperson, CPC, Malukula FP School
276.	Allattaji Yunus	M	Member, CPC, Malukula FP School
277.	Francis Tembo	M	Patron, Malukula FP School
278.	Zione Alice Binali	F	Matron, Malukula FP School
279.	GVH Michesi	M	Group Village Headman Michesi
280.	Mrs Dzidzi	F	Chairperson, PTA, Koche Model FP School
281.	Fahad Zuze	M	Member, PTA, Koche Model FP School
282.	Charles Kwembe	M	Secretary, SMC, Koche Model FP School
283.	Richard Banda	M	Chairperson, SMC, Koche Model FP School
284.	Steven Mbalu	M	Patron, RTP, Koche Model FP School
285.	Juliet Masanje	F	Matron, RTP, Koche Model FP School
286.	Biton Mbwana	M	Chairperson, CPC, Koche Model FP School
287.	Barbra Mtepuka	F	Primary Education Advisor, Koche Zone
288.	Lyson Assani	M	Member, CPC, Koche Model FP School
289.	Joyce Davie	F	Member, Mother Group, Koche Model FP School
290.	Florence Magalasi	F	Member, Mother Group, Koche Model FP School
291	Mary Nkhoma	F	Treasurer, Mother Group, Koche Model FP School
292.	Gloria Manyefeza	F	Vice Chairperson, Mother Group, Koche Model FP School
293.	Juma James	M	Community Based Distribution Agent, Koche
294.	Lekeleni Molo	M	Community Based Distribution Agent, Koche
294.	Steven Botomani	M	Chairperson, PTA, Nkope FP School
296.	Kester Masina	M	Deputy Head, Member, Member, PTA, Nkope FP School
297.	Idan Chadzuka	M	Member, SMC, Nkope FP School
298.	Joyce Mnelemba	F	Chairperson, SMC, Nkope FP School
299.	Ali Ngalande	M	Member, SMC, Nkope FP School
300.	Zeeb Kanjala	M	Patron, Nkope FP School
301.	Florence Muhama	F	Matron, Nkope FP School
302.	Mellina Chibisa	F	Teacher, Member, Mother Group, Nkope FP School

303.	Elida Kamwendo	F	Member, Mother Group, Nkope FP School
304.	Maggie Jali	F	Chairperson, Mother Group, Nkope FP School
305.	Chifundo Majawa	F	Member, Mother Group, Nkope FP School
306.	Gladys Mkawa	F	Member, Mother Group, Nkope FP School
307.	Mary Kalako	F	Member, CPC, Nkope FP Scholl
308.	Noria Bwanamdogo	F	Member, CPC, Nkope FP School
309.	Nelson Mkawa	M	Chairperson, CPC, Nkope FP School
310.	Antony Zimba	M	District Community Development Officer, Member, District RTP Steering Committee
311.	Aggrey Mfune	M	Chairperson, Civil Society Network, Member, District RTP Steering Committee, Member, District RTP Steering Committee
312.	Joyce Chautsa	F	Family Planning Coordinator, Ministry of Health, Member, District RTP Steering Committee
313.	Noel Nzunga	M	Senior School Health and Nutrition Coordinator, District Education Manager's Office, Member, District RTP Steering Committee
314.	Andrew Matendeu	M	District Education Manager's Office, Member, District RTP Steering Committee
315.	Gloria Khauke	F	Primary Education Advisor, Member, District RTP Steering Committee
316.	Kumbukani Manda	M	Youth Department, Member, District RTP Steering Committee
317.	Ernest Kadzokonya	M	Local Assembly, Member, District RTP Steering Committee
318.	Group Village Headman (GHV) Chiwalo	M	Group Village Headman, Nkope
Total for Mangochi: 95 (54 Males, 41 Females)			
Lilongwe District			
319.	Maggie Kambalame	F	Health Specialist, Save the Children Malawi
320.	Abel Kavuta	M	MEAL Coordinator, Save the Children Malawi
321.	David Melody	M	Head of Health, Save the Children Malawi
322.	Frank Mwafulirwa	M	NORAD RTP Project Manager, Save the Children Malawi
323.	David Onunda	M	Head of Education, Save the Children Malawi
324.	Ruth Kawale	F	Inclusive Education Project Manager, Save the Children Malawi
325.	Sanjay Singh	M	Director of Programs, Banja La Mtsogolo
326.	Donald Makwakwa	M	Senior Program Manager, Banja La Mtsogolo
327.	Joyce Chikhoswe	F	Clinical Trainer, Banja La Mtsogolo
328.	Davis Kapenga	M	Outreach Coordinator, Banja La Mtsogolo
329	Wesley Chabwera	M	Programme Manager, FAWEMA
330.	Hendrina Givah	F	Executive Director, FAWEMA
331.	Thokozani Phiri	F	Project Officer- RTP, FAWEMA
332.	Dominic Misomali	M	Principal Social Welfare Officer (Family and Child Welfare)/ Principal Investigations Officer, Family and Child Welfare, Ministry of Gender, Children, Disability and Social Welfare

333.	Hans Katengeza	M	Reproductive Health Officer/National Coordinator for Adolescent Health and Youth, Ministry of Health
334.	Modester Kasawala	F	Principal Reproductive Health Officer responsible for Family planning, Ministry of Health
335.	Virginia Kachigunda	F	Director, School Health and Nutrition (SHN)& Chair, RTP National Coordinating Committee, Ministry of Education
336.	Pickmore Moswira	M	Principal Programs Officer, School Health and Nutrition, Ministry of Education
Total for Lilongwe: 18 (11 Males, 7 Females)			
Overall Total: 336: (161 Males, 175 Females)			

Interviews outside Malawi

337	Ann Stewart Pedersen	F	Head of Norad and NMFA partnerships, SCN
338	Anne Pedersen	F	Area director for central and southern Africa, SCN.
339	Marte Bøe Wensaas	F	Head of Health Programming-Senior Advisor Health, SCN
340	Veslemoy Ask	F	Senior Advisor Strategy and Analysis
341	Sidsel Foalkvam	F	Associate Professor, University of Oslo
342	Ronit Cohen	F	Education Advisor, SCN
343	Sebastiam Blomli	M	Education Advisor, SCN
344	Nora Ingdal	F	Section Director- Education
345	Austen Peter Davis	M	Senior advisor, Department for Global Health, Education and Research Global Health Section

Annex 6 – Data Collection tools overview

The table blow shows the tools that were intended to use for this assignment in the data collection process, as well as the main targets for KI, FGD and .

	KI	FGD	Case history	Literature	Main Respondents
Relevance: ascertain the relevance of the model and project design including the specific interventions, objectives and activities. The following evaluation questions will be answered in this section:					
To what extent are the outcome and objective areas of the programme relevant to targeted beneficiaries, SC Malawi country priorities?	XX	XX	XX	XX	All
What measures were put in place to ensure that the programme stakeholders were adequately informed of the programme interventions and their roles in it?	XX	XX		XX	All
Are the risks/assumptions identified during programme design still valid? How are they being managed? Are there any new risks emerging?	XX	XX		XX	SC, All program partners
To what extend Have the local health facilities gained knowledge and experience?	XX	XX		XX	SC, MoH, BLM, Health care facilities,
Progress to achieving results: To what extent were the objectives achieved/are likely to be achieved					
Are programme activities being implemented effectively to achieve maximum benefit within the context?	XX	XX	XX	XX	All
What are the factors that hindered/assisted the project to achieve its objectives?	XX	XX	XX	XX	All
To what extent is programming informed and influenced by situational and policy context, in relation to attainment of results?	XX	XX		XX	SC, All partners
What are the successes that need to be told? What are the lessons and good practices so far?	XX	XX		XX	All

What do the youth themselves think of the successes? What is success for them? What have the youth learned from the project and how are the topics raised in class?		XX		XX	All (focus on youth groups)
Partnership, Child participation and the role of civil society partners					
Are the partnerships formed by the programme effective in helping the programme achieve its objectives? Why or why not? What are the lessons learnt on partnerships? How are the various partners selected? Are they the right ones?	XX	XX		XX	SC and all partners
How have the teachers worked and raised issues of SRH in class? What are the challenges with discussing these issues? Main messages? How are the teachers applying the activities in class? Linkage with the parents and home community - how?	XX	XX		XX	Matrons, patrons, school principals, SC, Fawema
To what extent have the children and youth participated in a youth friendly way in the project? What are the existing mechanisms available to listen to children and engage children during the project implementation?	XX	XX	XX	XX	Partners, youth, teachers
How has the partnership with the government worked?	XX			XX	SC and all partners
How has the BLM and FAWEMA delivered as per implementation plan?	XX			XX	SC and partners
Have the coordination mechanisms effectively supported the delivery of the programme?	XX	XX		XX	Sc and all partners
Sustainability, scalability and replicability					
What are the sustainability measures and roles and responsibilities of various stakeholders in the	XX	XX	XX	XX	all

process?					
Are there any potentials of scalability in other districts of Malawi? How could this happen? What are the prevailing evidences?	XX	XX		XX	all
How could the results influence at the national level and national policies?	XX			XX	SC, all partners
Context and community structures					
Which implications does the geographical variation and contextual differences in the targets areas have for the project? Is there any variation in project implementation among the various districts? Why?	XX	XX	XX	XX	All
Are there any other factors affecting such as incentives, payments and others in the project?	XX	XX	XX	XX	All
What is the communities' perception and attitudes towards the project?	XX	XX	XX	XX	All (focus on community)

Poverty assessment tool was implemented using PADev parameters. The tool was used with Mother Groups and CPC to determine wealth levels locally

<table>
<tr><td>How do you define extreme poverty</td><td rowspan="5">Describe here how wealth is defined and the proportion of the local population that falls into each category</td><td rowspan="5">Identify key questions related to wealth that link to access to health and education as indicators. Refined during ToC. Defined during the FGD</td></tr>
<tr><td>How do you define poor</td></tr>
<tr><td>How do you define average wealth</td></tr>
<tr><td>How do you define above average wealth</td></tr>
<tr><td>How do you define extreme wealth</td></tr>
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