



MY BODY. MY FUTURE 2 2022-2025

ENDLINE PROGRAM EVALUATION



HUMANITARIAN
IMPACT INSTITUTE
Inclusive Learning



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The Humanitarian Impact Institute would like to thank the Plan International Finland, Uganda, Ethiopia, Mozambique, Zimbabwe, Myanmar, and Laos, along with Plan's local/national partners in each country for their professional engagement and support throughout this evaluation.

The photos used in this report have been provided by Plan International Finland.

Table of Contents

Executive Summary	3
Key Findings	3
Recommendations	3
Introduction.....	4
Context and Background	4
MBMF2 Programme	5
Methodology	8
Evaluation Purpose and Objectives	8
Approach	8
Methods	8
Findings	13
Relevance	13
Coherence	18
Effectiveness	21
Efficiency	36
Sustainability	42
Gender and Inclusion	46
Conclusion	52
Recommendations.....	52
Annex A: Evaluation Matrix	52
Annex B: Desk Review Documents.....	57





List of Acronyms and Abbreviations

ACTADE	African Centre for Trade and Development
AFHS	Adolescent-Friendly Health Services
AMODEFA	Associação Moçambicana para o Desenvolvimento da Família
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AYFS	Adolescent and Youth Friendly Spaces
BB	Building Bridges
BL	Baseline
CAY	Children, Adolescents, and Youth
CDSU	Community Development Shield Uganda
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
DAC	Development Assistance Committee (OECD-DAC criteria)
DREF	Dreams Rescue Foundation
ECDD	Ethiopian Center for Disability and Development
EL	Endline
FGAE	Family Guidance Association of Ethiopia
FGD	Focus Group Discussion
FoG	Friends of Goodwill
GDA	Gender Development Association
GBV	Gender-Based Violence
GCU	Growth Care Uganda
GDI	Gender and Development Initiative (referenced as partner)
GTA	Gender Transformative Approach
HCB	Hossana Community Bridge
HII	Humanitarian Impact Institute
HIV	Human Immunodeficiency Virus
IGA	Income Generating Activity
IDIs	In-Depth Interviews
IPTT	Indicator Performance Tracking Table
LAMBDA	Mozambican Association for the Defence of Sexual Minorities
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual
MAHLAHLE	Association for the Promotion and Development of Women
MBMF1 / MBMF2	My Body My Future (Programmes 1 and 2)
MEAL	Monitoring, Evaluation, Accountability and Learning
MoU	Memorandum of Understanding
NCDPZ	National Council of Disabled Persons of Zimbabwe
NYE	Nation Youth Empowerment
OPD	Organisation of Persons with Disabilities
PADAET	Professional Alliance for Development (Ethiopia)
PIF	Plan International Finland
PI	Plan International
PFHA	Promotion of Family Health Association (Laos)
SDG	Sustainable Development Goal
SGD	Small Group Discussion
SOGIESC	Sexual Orientation, Gender Identity and Expression, and Sex Characteristics
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRC	Sexual Rights Centre
STI	Sexually Transmitted Infection
SUF	Smart Up Factory
ToC	Theory of Change
UN	United Nations
UNFPA	United Nations Population Fund
VSLA	Village Savings and Loan Association
WWDA	Women with Disability Association



Executive Summary

My Body. My Future. 2 (MBMF2) is a four-year (2022–2025) multi-country Sexual and Reproductive Health (SRHR) programme led by Plan International Finland, implemented in Uganda, Ethiopia, Mozambique, Zimbabwe, Myanmar, and Laos. The programme aims to empower children, adolescents, and youth (CAY), in all their diversity, to exercise their bodily autonomy and SRHR in safe, supportive environments. The programme was designed around four programmatic outcomes:

1. CAY, in all their diversity, have the support and the confidence to make informed, responsible, positive, and healthy choices about their SRHR and future,
2. CAY, in all their diversity, have improved access to quality, inclusive, gender-responsive and adolescent- and youth-friendly SRHR services ,
3. CAY, in all their diversity, live in safe and supportive communities that transform gender roles, and challenge harmful stigma around SRHR as well as social and gender norms and stigma around SRHR,
4. CAY, in all their diversity, participate and benefit from a vibrant civil society that advocates for increased public investment and improved SRHR policy as well as promotes equality for and agency of girls.

The endline evaluation of MBMF2 was commissioned by Plan International Finland and conducted by the Humanitarian Impact Institute as an independent assessment covering the full programme cycle from 2022 to 2025. The evaluation was coordinated by Plan International Finland, with overall technical oversight, coordination, and quality assurance led by the MEAL Specialist.

The purpose of the evaluation was twofold: to determine the programme's relevance,

effectiveness, efficiency, coherence, and sustainability, and to generate actionable learning and recommendations to inform future SRHR programming. The evaluation faced limitations related to remote data collection and translation, which constrained probing, spontaneous insights, and may have introduced interpretation bias despite mitigation measures. Additionally, limited engagement with external stakeholders and the absence of field visits reduced opportunities to fully assess programme sustainability, contextual realities, and community-level perspectives.

The evaluation applied an explicitly gender-sensitive, participatory, and mixed-methods approach, integrating qualitative and quantitative evidence to assess outcomes and implementation experience across all six countries

Key Findings

Relevance

MBMF2 demonstrated a consistently high degree of relevance across all six countries by grounding its design and implementation in robust baseline analyses, social and gender norm diagnostics, and extensive consultations with adolescents, caregivers, CSOs and local authorities. This grounding allowed the programme to remain closely attuned to the changing needs and constraints affecting children, adolescents and youth. Relevance was further strengthened by the programme's deliberate adaptive management approach, which enabled teams to recalibrate interventions in response to political instability, civic-space restrictions and cultural sensitivities. For example, teams in Myanmar shifted to discreet, community-embedded modalities due to political risk, while teams in Uganda carefully adapted SRHR language to comply with restrictive legislation while still advancing adolescent rights.



Although MBMF2 made substantial advances in inclusion, particularly around disability, the programme's ability to fully address SOGIESC-related marginalisation differed by context. Legal and sociopolitical constraints limited the depth and safety of engagement with LGBTQIA+ adolescents and youth in countries.

Coherence

The programme functioned coherently within Plan International's broader portfolios and within national SRHR ecosystems, with MBMF2 models and tools influencing and being integrated into other programmes in several countries. For example, CSE and adolescent engagement models developed under MBMF1 and refined in MBMF2 were adopted by the education programme in Laos, demonstrating strong internal alignment and horizontal scale-up. Collaboration with government ministries, local authorities and UN agencies enhanced the programme's contribution to sector-wide SRHR strengthening, especially in Laos, Ethiopia and Mozambique where structured coordination mechanisms existed. CSO partnerships further reinforced coherence by complementing the programme's expertise on gender equality, climate resilience and inclusion.

However, coherence was impacted in Myanmar with political instability where government engagement was not possible, and in Ethiopia where project portfolios operated in separate geographic areas or under different donor mandates, limiting synergies. In some settings, the degree of coherence depended heavily on interpersonal relationships and local leadership rather than institutionalised coordination structures, which created challenges when the staff turnover occurred.

Effectiveness

MBMF2 met and exceeded many of its intended results. Adolescents reported large increases in SRHR knowledge, decision-making confidence and willingness to challenge harmful gender norms.

Community members became more supportive of adolescent SRHR needs, and parents showed marked improvements in communication about topics previously considered taboo. Service quality also improved significantly, with many health facilities offering more confidential, respectful and inclusive care – reflecting positive shifts in provider attitudes and practices. Youth economic empowerment and climate-resilience components further contributed to adolescents' autonomy and capacity to act on SRHR knowledge.

The programme did still experience limitations in translating improved attitudes and service availability into higher levels of service utilisation. Uptake remained below targets due to persistent stigma, fear of judgement, limited trust in service providers and, in some cases, a perception among young people that they had "no need" for SRH services unless experiencing illness or crisis. In Myanmar, the collapse of the health system and security restrictions severely constrained the programme's ability to influence service-seeking behaviours.

The programme's effectiveness was also shaped by partners' capacity and the degree to which components were layered. Where adolescents participated across several components, outcomes were stronger and more sustained.

Efficiency

The programme demonstrated strong efficiency by leveraging existing school structures, youth clubs, Village Savings and Loan Association (VSLAs) and health facilities, thereby reducing operational duplication and enabling wide reach at relatively low cost. Adaptive implementation helped teams redirect resources where safety risks or political barriers threatened activity delivery, preventing waste.

Coordinated planning with local authorities in countries such as Laos further enhanced efficiency by aligning schedules, co-hosting events and integrating government staff into implementation structures.



Administrative delays in some countries slowed programme start-up and partner contracting, while varying partner capacity sometimes required significant technical support and monitoring, which is an acceptable trade-off for meeting PIF's locally led goals.

Operating in restrictive and insecure environments significantly increased transaction costs, where staff safety, compliance requirements and logistical challenges necessitated more time and resources. However, these countries have high SRHR needs making these costs an unavoidable trade-off in return for access and reach.

Sustainability

The evaluation identifies promising signs of sustainability across several programme components. Government adoption of tools and curricula, such as the integration of CSE content into the education sector in Laos, reflects institutional uptake that may outlast the programme cycle. Health-facility improvements such as youth-friendly corners, disability-inclusive adaptations and strengthened referral mechanisms—show potential for long-term continuity, particularly where local health authorities were actively involved.

CSO partners enhanced their advocacy capacity, positioning them to sustain pressure for SRHR policy improvements and accountability. Emerging shifts in community norms, especially increased parental support for adolescent contraceptive use and reduced stigma around SRHR discussions, also suggest foundations for lasting change.

Sustainability is less assured in contexts where government engagement was limited or absent, and in areas where sociocultural resistance to sensitive SRHR topics persists.

Many youth livelihoods initiatives remain in early development stages and require continued support to survive and grow. Despite improved engagement, many

community leaders remain resistant to publicly supporting sensitive ASHR issues, particularly contraception for unmarried adolescents, resulting in cautious and protectionist approaches rather than active rights-based leadership.

Gender & Inclusion

MBMF2 made substantial progress in advancing gender equality and strengthening inclusion across diverse groups of adolescents. MBMF2 contributed to notable improvements in girls' and young women's SRHR knowledge, confidence and agency. Many reported an increased ability to communicate boundaries, negotiate safer sex and challenge restrictive gender norms. These shifts were reinforced by the programme's work on transforming masculinities, which helped engage boys and young men as allies and address the relational dynamics that shape girls' autonomy.

Disability inclusion was meaningful through adapted materials, improved provider attitudes, strengthened referral systems and support structures that enabled adolescents living with disabilities to participate more fully. These gains were supported by gender-transformative methodologies, community dialogues and sustained engagement with caregivers. However, deeply entrenched gender norms continued to limit autonomy for girls and adolescents with disabilities, and restrictive legal and sociopolitical environments significantly constrained safe engagement with LGBTQIA+ youth. In several settings, sensitivity around adolescent sexuality meant that support for contraceptive use often advanced more quickly than acceptance of adolescent sexual agency, creating a partial but incomplete shift in norms. The progress observed represents promising initial movement along a longer trajectory of norm change, laying important foundations for continued transformation beyond this programme period, recognising that deep normative shifts typically require sustained, multi-cycle investment.





Recommendations



Recommendation 1

Strengthen CSE Sustainability by Reducing Facilitator Dependency and Clarifying When to Use Whole-School or Targeted Approaches

Strengthen sustainability and ensure equitable access by tailoring CSE modalities to each context. Clearly define when whole-school, hybrid, or out-of-school models are appropriate and design sustainability strategies for each. Embed in-school CSE within teacher training systems, approved curricula, and district support structures. Anchor out-of-school CSE in existing community groups, youth clubs, safe spaces, and peer networks that can realistically continue beyond the programme. Reduce reliance on external facilitators by planning and implementing a structured handover to teachers, youth leaders, and community mentors equipped with inclusive and disability-sensitive facilitation skills. Require each country to develop a practical sustainability plan during inception that specifies who will continue CSE delivery, how ongoing support will be provided after project exit, and how safe access for marginalised CAY, including those with disabilities, will be maintained.

Recommendation 2

Continue Strengthening Disability and SOGIESC Inclusion Through Safe, Targeted and Contextually Adapted Approaches

Deepen and sustain progress by embedding social and gender norms diagnosis as a regular programme practice. Systematically analyse and respond to evolving social norms, power dynamics, and emerging behaviours that shape attitudes towards disability and SOGIESC inclusion. Maintain and expand adapted, safe, and context-sensitive approaches to disability and SOGIESC inclusion in partnership with representative organisations. Where contexts allow, particularly in countries working with both OPDs and SOGIESC organisations, prioritise support for social movement building and cross-movement collaboration to strengthen collective advocacy, solidarity, and locally led change processes. Undertake these



efforts with careful attention to safeguarding, risk mitigation, and context-specific social and political sensitivities to strengthen community acceptance and equitable participation. Systematically document these efforts and strengthen the use of qualitative and participatory methods to capture nuanced impacts, learning, and contributions to longer-term social change.

Recommendation 3

Make Layering a Core Programme Principle by Defining It Early and Embedding It in Planning and MEAL

Allocate dedicated inception-phase planning time to co-develop layering models with country offices and CSO partners. Establish a shared understanding of what layering entails and which combinations of interventions are feasible in each context, including clear agreements on coordination between Plan Country Programme Offices and CSOs. Improve the quality and depth of layering by reducing scale where necessary so that fewer CAY receive multiple, well-sequenced interventions rather than many receiving isolated activities. Intentionally layer interventions over time to clearly articulate pathways to sustainability, recognising that sustained exposure across SRHR, economic empowerment, and resilience components builds durable capabilities, reinforces behaviour change, and strengthens local systems beyond individual activities. Align MEAL frameworks to track CAY participation across components—not only by activity type—to assess how layered exposure contributes to SRHR, economic, and resilience outcomes.

Recommendation 4

Strengthen Local CSO Systems, Wellbeing and Long-Term Sustainability

Allocate resources specifically to strengthen CSO systems, including MEAL capacity, safeguarding mechanisms, and administrative structures. Integrate psychosocial support, such as professional supervision, into partnership frameworks to mitigate burnout and secondary trauma. Invest in CSOs' fundraising skills, governance structures, and strategic leadership to support long-term sustainability beyond the programme cycle. Establish clear role definitions between Plan and CSOs early in the inception period to enhance accountability, autonomy, and overall partnership quality.

Recommendation 5

Engage Men and Boys in Reflective Spaces to Address Patriarchal Norms Driving Both SRHR Inequities and Environmental Harm

Intentionally incorporate reflective masculinities work that examines how patriarchal norms contribute to environmental exploitation and gender inequality. Integrate this work into existing CoC curricula, intergenerational dialogues, VSLA groups, or climate resilience sessions to provide men and boys with structured opportunities to critically reflect on norms of masculinity—such as control, domination, extraction, risk-taking, competition, and power over others—and how these drive environmental degradation and SRHR inequities. Use the link between SRHR and climate through a masculinities lens as an entry point to shift harmful norms, strengthen gender-equitable behaviours, and promote more sustainable environmental practices. Co-design these reflective spaces during inception with country programme teams and CSOs, ensuring political feasibility, contextual adaptation, and facilitation by partners with expertise in gender-transformative approaches.



Recommendation 6

Increase SRHR Service Uptake Through CAY Informed Design and Delivery

Prioritise improving understanding of the dynamics shaping SRHR service uptake by placing CAY at the centre of analysis and design. Invest in methodologies that meaningfully engage CAY, including participatory monitoring, youth-led consultations, feedback mechanisms, and adolescent-led or adolescent-informed health facility assessments. Use these approaches to understand how perceptions of need, stigma, confidentiality, and service relevance vary by age, gender, and context. Apply the insights generated to design context-specific, youth-centred referral and service delivery pathways that link CSE, clubs, community groups, and VSLA structures to appropriate service points, including health facilities, mobile outreach, and pharmacy-based access.

Recommendation 7

Continue Strengthening In- and Cross-Country Learning to Improve Practice and Documentation

Ensure adequate GTA resourcing at community, country, and global levels, including support for analytical functions such as social and gender norms diagnosis, to sustain programme gains. Build on progress achieved in MBMF2 by strengthening integrated evidence-generation and learning systems. Systematically document promising approaches, enhance cross-country and in-country learning, and deepen shared understanding of how change happens to improve programme quality and replicability across diverse contexts.

Please refer to Annex C for country level action points in relation to above programmatic recommendations.



Introduction

Context and Background

Global progress on sexual and reproductive health and rights (SRHR) has slowed, and key indicators of autonomy and access remain deeply concerning. A 2025 report from UNFPA showed that, across 69 countries with available data, 11% of women cannot decide on contraception, 25% cannot make decisions about their own healthcare, and 24% cannot refuse sex, demonstrating persistent constraints on women's and girls' bodily autonomy.¹ Greater contraceptive access is associated with women's enhanced decision-making power, thereby linking method uptake not only to health but to broader gender equality and autonomy outcomes.² The progress on contraceptive prevalence is far from sufficient. Sustainable Development Goals (SDG) 3.7 tracking shows modest gains in contraceptive coverage for married women (15–49 years), increasing just 1.2 percentage points per decade, with national rates ranging from 58% to 87%.³ Limited access to contraception methods contributes to the 121 million unintended pregnancies that occur annually worldwide.⁴

These gaps in SRHR access and autonomy are shaped by broader political and social dynamics that undermine gender equality and progress on advancing gender equality and comprehensive, inclusive and rights-based SRHR for children, adolescents and youth. A growing global backlash against gender equality, SRHR, and LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual

(Aromantic/Agender), plus (+)) rights is accelerating, with 2025 evidence showing coordinated anti-gender movements and attempts to roll back legal protections for women, girls, and persons with diverse sexual orientations, gender identities and expressions, and sex characteristics (SOGIESC).⁵ At the same time, civic space is shrinking, with increasing restrictions on feminist, youth-led, and human-rights organisations that limit advocacy, participation, and access to SRHR services.⁶

Underlying drivers of unmet SRHR needs include restrictive laws, harmful gender and social norms, stigma surrounding adolescent sexuality, and significant gaps in comprehensive sexuality education (CSE) both in and out of school.⁷ In addition, fragmented service delivery (e.g., contraception, maternal health, HIV prevention, cervical cancer screening), essential sexual and reproductive health (SRH) supply stock sold-outs, inadequate health worker training and limited proactive outreach are the key gaps in service availability. Even if SRHR appears in policy commitments, it is not fully wired into the health systems, budgets, and processes that guarantee quality services, which results in gaps in availability, quality, and equity of SRH care.⁸

Climate change further impacts women and girls' ability to fully exercise their bodily

¹ United Nations Population Fund (UNFPA). *State of World Population 2025: The Real Fertility Crisis – The Pursuit of Reproductive Agency in a Changing World*. New York: UNFPA, 2025. [LINK](#)

² World Health Organization (2025, September 25). *Contraceptive use: a catalyst for women's health and socioeconomic empowerment*. [LINK](#)

³ World Health Organization. (2025). *World Health Statistics 2025: Monitoring health for the SDGs, Sustainable Development Goals* (ISBN 978-92-4-011049-6). Geneva: WHO. [LINK](#)

⁴ United Nations Population Fund. (2024). *Interwoven lives, threads of hope – State of World Population 2024: Ending inequalities in sexual and reproductive health and rights*. [LINK](#)

⁵ Equality Now. (2025). *Global backlash against women's and girls' rights: Words and deeds – Update 2025*. [LINK](#)

⁶ CIVICUS. (2025). *State of Civil Society Report 2025*. [LINK](#)

⁷ UNESCO. (2024). *Revised Global Education Monitoring Report: Gender Report*. Paris: UNESCO. [LINK](#)

⁸ Countdown 2030 Europe. (2025, May). *Integrating SRHR with UHC and HSS*. [LINK](#)



autonomy and achieve their SRH rights.⁹ A global dialogue of over 300 health and climate leaders concluded that climate change poses risk to accessing safe, quality, and affordable sexual, reproductive, maternal, newborn, child and adolescent healthcare services at both health system and societal levels.¹⁰

These challenges disproportionately affect groups facing intersectional marginalisation, including adolescent girls, young mothers, persons with disabilities, and LGBTQIA+ youths, whose access to quality, respectful, inclusive services remain limited.¹¹

All of these trends are occurring alongside a global funding cut on SRHR programmes. The Donors Delivering 2025 report¹² estimates that reductions in SRHR investment have translated into “12.5 million fewer women and couples receiving modern contraceptive care” and “3.9 million fewer unintended pregnancies averted” compared to what higher investment would have delivered. Therefore, they highlight the need for approaches that simultaneously strengthen demand for SRHR by empowering adolescents and marginalised groups with knowledge, agency and supportive social norms; reinforce supply by improving the quality, inclusiveness, and resilience of SRHR services; and expand an enabling environment grounded in rights, accountability, and meaningful youth participation.

MBMF2 Programme

The four-year (2022-2025) My Body. My Future. 2 (MBMF2) programme, led by Plan International Finland (PIF), is designed to empower children, adolescents, and youth (CAY), in all their diversity, to have control over their bodies and futures in a healthy, safe, and supportive environment. Through the individual projects implemented in Uganda, Ethiopia, Mozambique, Zimbabwe, Myanmar, and Laos, the programme aims to lead changes in knowledge, attitudes, and practices of individuals, groups, and institutions in the hopes for improving the enabling environment for diverse CAY.

The programme particularly targets triggering changes in three interdependent and interconnected dimensions in the lives of the most marginalised CAY, including girls, young women, as well as those with disabilities and diverse SOGIESC, through the programme’s rights-based gender-transformative approach:

- influencing social norms—particularly harmful gender norms—and related attitudes and behaviours
- strengthening people’s personal, social, and economic assets as well as safety nets
- contributing to better policies, legislation, budgets, and government services at various levels that affect children’s and, particularly, girls’ lives.

⁹ United Nations Population Fund (2025). *2025 Global Symposium on Climate Justice & Impacted Populations*. [LINK](#)

¹⁰ Partnership for Maternal, Newborn & Child Health (PMNCH). (2025, March 3). *Addressing the impacts of climate change on maternal, newborn and child health and building climate-resilient societies*. [LINK](#)

¹¹ United Nations Population Fund. (2025). *State of world population 2025: The real fertility crisis – The pursuit of*

reproductive agency in a changing world.

<https://www.unfpa.org/swp2025>

¹² Deutsche Stiftung Weltbevölkerung (DSW). *Donors Delivering for SRHR 2025: Tracking OECD DAC Donor Support to Sexual and Reproductive Health and Rights*. DSW, 2025. Available at: <https://donorsdelivering.report/wp-content/uploads/2025/06/DDSRHR2025.pdf>



Table 1. MBMF 2 Programme Outcome and Output Table

Project Outcomes	Project Outputs
Outcome 1 Children, adolescents, and youth, in all their diversity, have the support and the confidence to make informed, responsible, positive, and healthy choices about their SRHR and future.	Output 1.1 Through receiving CSE, SRHR training, and youth-led awareness-raising actions on SRHR information and services, CAY have improved skills and knowledge on SRHR, healthy and positive sexuality, intimate relationships, and gender roles. Output 1.2 Thanks to the participation in pre- or in-service training of teachers or teacher education trainees and the support to in and out of school clubs and youth groups, CAY have a safe space for learning and sharing on SRHR issues. Output 1.3 Adolescents and young people, especially adolescent girls who are most at risk, have skills and increased links to pursue economic opportunities, including alternative livelihood opportunities and green solutions, by accessing vocational trainings, green skills trainings, village savings loan associations (VSLAs), and Income-Generating Activities (IGAs). Output 1.4 CAY understand what climate change is and how it affects them by receiving climate change-related information and having a space to reflect about it.
Outcome 2 Children, adolescents, and youth, in all their diversity, have improved access to quality, inclusive, gender-responsive and adolescent- and youth-friendly SRHR services.	Output 2.1 Service providers (including health workers, health centre staff, health authorities, and support staff) have enhanced capacities to provide adolescent-friendly, gender-responsive, and disability-inclusive SRH services, through pre- or in-service training on adolescent-friendly health services (AFHS) and disability inclusive services. Output 2.2 CAY have access to mobile outreach service provisions, enhanced referrals mechanisms, and helplines.
Outcome 3 Children, adolescents, and youth, in all their diversity, live in safe and supportive communities that transform gender roles, and challenge harmful stigma around SRHR as well as social and gender norms.	Output 3.1 Parents, community members, and leaders know how to create an enabling environment, how to challenge stigma and harmful norms as well as support adolescents' access to SRHR services through trainings/sessions provided. Output 3.2 Parents, caregivers, and communities have capacities and positive coping strategies to overcome shocks and stresses through attending VSLA groups being supported with IGAs, receiving information related to climate resilience.
Outcome 4 Children, adolescents, and youth, in all their diversity, participate and benefit from a vibrant civil society that advocates for increased public investment and improved SRHR policy as well as promotes equality for and agency of girls.	Output 4.1 Civil Society Organisations (CSOs) have improved their capacity to influence SRHR and gender equality for CAY, in all their diversity, and advocate for CAY's rights through strengthening capacity and through developing and implementing gender-transformative plans for joint and strategic influence on SRHR. Output 4.2 Policymakers and decision-makers at local and/or national level (government/ministries/local bureaus of education, health and social affairs) have improved understanding of CSE, adolescent and youth friendly spaces (AYFS), and adolescent sexual and reproductive health and rights (ASRHR) through advocacy initiatives promoting the adoption/implementation of laws and regulations that ensure availability of inclusive, non-discriminatory, and quality SRH services, national consultations, and dialogues on SRHR issues. Output 4.3 Adolescents and young people, especially young people with disabilities, most at risk or in vulnerable situations, have space and support for innovation and participation through their engaging in advocacy processes that promote improved SRHR policies, gender equality, and inclusion, climate resilience, and/or other related themes.



Methodology

Evaluation Purpose and Objectives

Plan International Finland (PIF) has commissioned Humanitarian Impact Institute (HII) to conduct an independent summative and formative endline evaluation of the MBMF2 programme. The evaluation assesses the programme's overall performance and its contribution to SRHR for CAY, particularly girls and young women and most marginalised groups, including its use of a gender-transformative, inclusive and intersectional approach. The evaluation covers the full programme cycle from 2022 to 2025, across all six implementation countries and focuses on four interlinked outcome areas by consolidating learning, documenting good practices, and generating insights to inform future SRHR programming within PIF.

The objectives of the evaluation are:

- Evaluate the relevance, effectiveness, efficiency, sustainability, and coherence of the MBMF2 programme with reference to OECD DAC criteria and its contribution to gender equality and inclusion.
- Identify key programmatic learning and formulate recommendations at country and programme level on how the continuation of the programme and SRHR programming, in general, can be improved.

Approach

The evaluation adopted a participatory, gender-sensitive and learning-oriented approach, offering insights to support future programming and ensure accountability to key stakeholders.

The technical approach compared baseline and endline data and supplemented it with insights from the qualitative evaluation questions. A core part of the evaluation

focused on analysis of inclusion, such as gender, disability, and age.

Two sets of primary data informed the evaluation. The first followed the programme's MEAL strategy and included annual quantitative data collected through surveys and assessments, as well as qualitative data gathered through focus group discussions (FGDs), outcome harvesting, and learning harvesting. For this component, HII provided technical backstopping to the Plan country programme teams, who led the data collection.

The second set of primary data was collected directly by HII and focused on stakeholder perspectives. This component was conducted online through small group discussions (SGDs) with CSOs and in-depth interviews (IDIs) with PIF team Finland and country programme teams, in Uganda, Ethiopia, Mozambique, Zimbabwe, Myanmar, and Laos. These online data collection activities took place between August 18 and September 18, 2025. See Annex A for the evaluation questions.

Methods

Desk Review

HII undertook a two-stage desk review of relevant programme documents: one in the inception phase to inform tool development and a second ongoing review to inform final analysis.

These reviews included MBMF2 programme document, organisational and strategy documents, thematic and technical guidance notes, annual reports, the mid-term review (MTR) report, final evaluation report of MBMF1 programme, country baseline and endline reports, country outcome harvesting and learning reports,



diagnostic analysis of social and gender norms, outcome analysis report, indicator performance tracking table (IPTT), and PowerBI Dashboard¹³. The desk review supported producing an evidence-based triangulated analysis to answer the evaluation questions.

See Annex B for the full list of documents reviewed.

In-Depth Interviews with PIF and Country Programme Teams

HII conducted 26 online IDIs with the PIF team (7 IDIs) and country teams (19 IDIs), equalling a total of 28 key programme team members. The interviews focused on

understanding perspectives on the implementation, challenges, and outcomes of the programme, which are nuanced, context-specific insights that could not be obtained through document review or monitoring data. The discussions explored relevance, effectiveness, efficiency, coherence, and sustainability as well as cross-cutting dimensions, such as gender and inclusion.

Out of the total number of IDIs conducted, four were conducted in Lao and Burmese and translated into English, with the interpretation support from Plan's Country Programme Offices in Laos and Myanmar, respectively.

Table 2. IDI Sampling for PIF and Country Programme Teams

Programme Teams	Positions	# of IDIs
PIF	Programme Managers	7
	Technical Specialists	
	Head of Programme	
Plan Office Myanmar	Gender Advisor	4
	Project Coordinator	
	Project Manager	
	SRHR Advisor	
Plan Office Laos	SRHR Coordinator	2
	Project Managers	
Plan Office Ethiopia	SRHR Thematic Sector Lead	5
	Project Manager	
	MEAL Manager	
	Economic Empowerment Coordinator	
	SRHR Coordinator	
Plan Office Zimbabwe	Gender and Inclusion Coordinator	3
	Project Manager	
	Economic Empowerment and Resilience	
	Building Facilitator	
Plan Office Mozambique	SRH Programme Facilitators	2
	Project Manager	
	SRHR Officer	
Plan Office Uganda	Inclusion Officer	3
	SRHR Coordinator	
	Gender and Inclusion Officer	
	Innovation & Digital Development Coordinator	
	Project Manager	

¹³ <https://app.powerbi.com/groups/me/reports/3437ad19-da99-4b36-aa3b-13086ef74816/ReportSectionea320d7447ccbc103e32?ctid>

[=96306d57-5eb7-4dc4-a5bd-22a0e5cc0aab&experience=power-bi](https://app.powerbi.com/groups/me/reports/96306d57-5eb7-4dc4-a5bd-22a0e5cc0aab&experience=power-bi)



Small Group Discussions

Ten online small group discussions (SGDs) were conducted with partner CSOs across six programme countries. In addition to focusing on evaluation criteria, the SGDs provide specific insights on collaboration, local ownership, and contextual realities.

Out of 10 SGDs conducted, two were conducted in Lao and Burmese and translated into English, with the interpretation support again from Plan's Country Programme Offices in Laos and Myanmar respectively.

Table 3: One SGD conducted in each country (5 in Uganda), comprising the following CSOs in each

Country	Country Project Names	CSOs Participating in Country SGDs
Myanmar	Me Me Kanda, Me Me Anagat Pa – My Body My Future	Kumudra Social Life Support Association
Laos	Anakhot Khong-Khoi – My Future	Promotion of Family Health Association (PFHA)
		Women with Disability Association (WWDA)
		Gender Development Association (GDA)
Ethiopia	Yene Raey – My Future	Professional Alliance for Development (PADET)
		Ethiopian Center for Disability and Development (ECDD)
		Family Guidance Association of Ethiopia (FGAE)
Zimbabwe	My Body My Future	Sexual Rights Centre (SRC)
		National Council of Disabled Persons of Zimbabwe (NCDPZ)
		Intwasa
Mozambique	Mandziku – My Future	Associação Moçambicana para o Desenvolvimento da Família (AMODEFA)
		Association for the Promotion and Development of Women (MAHLAHLE)
		Mozambican Association for the Defence of Sexual Minorities (LAMBDA)
Uganda	An Amoko Tama – I Decide	Growth Care Uganda (GCU)
		African Centre for Trade and Development (ACTADE)
		Change Lead Agency Social Support (CLASS)
		HCB (Hossana Community Bridge)
		Dreams Rescue Foundation (DREF)
		Nation Youth Empowerment (NYE)
		Community Development Shield Uganda (CDSU)
		AYUA en Accion Uganda
		Lango Youth Development Network (LAYDNET)
		Global Youth Foundation (GYF)
		Uganda Shelter for Community Transformation
		Global Support Development Initiative Uganda (GDI Uganda)
		SafeAid Uganda
		Friends of Goodwill Uganda (FoG)
		Lira District Union of Persons with Disabilities Uganda (LIDUPED)
		Reproductive Health Uganda (RHU)
		Communication for Development Foundation Uganda (CDFU)



Validation Workshops

As part of the participatory and learning-oriented approach, HII conducted two validation workshops: one with the country programme managers on September 29th (six participants) and PIF programme staff (nine participants) on October 3rd in the post-data collection phase. During the workshops, emerging findings of the evaluation were presented, and the interpretations of these findings were discussed with the participants. The workshops provided an opportunity to help nuance the analysis, a space for reflection, and to generate additional evidence to ensure the findings were accurate. Revisions were made as needed to ensure accuracy and contextual relevance.

HII also conducted a co-design workshop with the PIF and country programme managers on December 8th to ensure that the recommendations are tailored to PIF and Plan country programme teams. The workshop aimed to ensure the recommendations are addressing the key findings and tailored to PIF's organisational way of working.

HII also conducted a final dissemination workshop to share the key findings and recommendations with the CSOs on 17th December.

Data Analysis and Reporting

Following the primary data collection, the evaluation team systematically analysed the data against key questions outlined in the Evaluation Matrix. Triangulation across secondary documents, IDIs, SGDs, and two validation sessions with members strengthened the accuracy of the findings. A thematic analysis approach was applied to IDIs and SGD transcripts, enabling a structured examination of implementation dynamics. Transcripts were reviewed for accuracy, coded to identify recurring themes, and then organised under overarching topics.

Limitations

The following limitations were experienced.

Data collection limitations: Two IDIs and two SGDs were conducted via email responses due to participant unavailability or connectivity issues, limiting probing and spontaneous reflection and potentially affecting contextual interpretation. The evaluation team used detailed interview guides including follow-up questions to compensate for written responses. In addition, four IDIs and two SGDs required interpretation and translation, introducing risks of interpretation bias. Interpreters were briefed, translation was verbatim and meanings were validated.

Stakeholder engagement limitations: The evaluation relied mainly on CSOs and Plan teams and lack of external stakeholder perspectives might have reduced opportunities to assess programme sustainability and coherence, cross-validate findings, and mitigate institutional bias. The evaluation team triangulated the data across multiple internal stakeholders and desk review documents to reduce institutional bias and validate information from different data points. Intended validation sessions with CSOs were not conducted as some of the CSO contracts ended before the evaluation process ended, limiting their ability to confirm or challenge findings and reducing ownership and robustness of the evaluation. Instead, HII and PIF teams conducted a dissemination session to CSO partners, offering them the option to participate and discuss the findings and recommendations.

Methodological limitations: This evaluation was conducted entirely online, without field visits, which prevented visits for example to health facilities, innovation hubs or schools, and direct engagement with community-level stakeholders. The evaluation used the primary data collected from the affected communities by Plan country programme teams through endline survey, assessments and FGDs to validate reported results.





Findings

Relevance

SUMMARY

MBMF2 remains strongly aligned with the evolving needs of CAY and demonstrates a programme that is both well-conceived and consistently kept relevant. Through its adaptive management, the relevancy is maintained in response to changing and emerging political conditions. The programme's ability to translate learning into practical improvements reinforces its relevance and positions it as a model of adaptive programming.

Rather than operating with a static design, MBMF2 uses continuous feedback loops, flexible planning, and participatory diagnostics to adjust modalities, partnerships, and delivery platforms. The intentional adaptability maintains the programme's alignment with CAY priorities.

Although contextual constraints limit full implementation in some settings, the programme's flexible, locally grounded partnerships ensure continued value and responsiveness.

Q1. To what extent have the programme objectives and design responded to CAYs' needs and priorities, and have they continued to do so if/when circumstances have changed?

The programme's design and implementation strategies drew directly from the MBMF1 evaluation, CSO-level needs assessments, baselines, social- and gender-norms diagnostics and analysis and stakeholder consultations. This resulted in [objectives that reflected clearly articulated gaps](#) across the six countries:

- In Laos, early consultations with the community members and external stakeholders highlighted parental gatekeeping and discomfort with sexuality education, informing a design that prioritised school-based CSE, community engagement, and policy support.
- In Uganda, youth needed economic empowerment and safe spaces, with strong demand for vocational paths and integrated SRHR-livelihoods due to harmful norms. Programme response includes Smart Hubs, foundational training, and support to transition to TVET.

- In Mozambique, gender-norms diagnostics highlighted silence around premarital sex and child, early forced marriage, prompting early engagement of religious and community leaders to open space for dialogue and support CSE delivery.
- In Ethiopia, harmful norms and low communication restrict SRHR, especially for LGBTQI and persons with disabilities in rural areas. Programmes focus on social norms change, inclusion, community dialogue, and youth-friendly services.
- In Zimbabwe, social and gender norms, stigma, cost barriers, and disability inaccessibility limit SRHR, and adolescent pregnancy is high. Programmes add disability inclusion, mobile clinics, youth-friendly rooms, and young-mother support.
- In Myanmar, SRHR awareness is low with gender discrimination, early marriage, and safety concerns including LGBTQ privacy. Programmes conduct social



norms analysis, gender sensitisation, safer access, and visual learning.

Across countries, core components such as CSE, AFHS strengthening, social norms programming, youth economic empowerment (YEE), and inclusion responded to documented CAY needs.

Adaptive capacity was intentionally built into MBMF2's programme architecture through participatory norm diagnostics, flexible annual planning, and continuous feedback loops with CAY, CSOs, and local authorities. These mechanisms helped teams to revise delivery modalities, relocate activities, and adjust partnerships as political, socioeconomic, and environmental conditions shifted across countries.

In Myanmar, political instability required a shift to low-profile implementation, reliance on village elders for safe access, and streamlined IEC distribution as well as reduced the implementation focus on service provision and advocacy. In Uganda, discomfort with facility-based services prompted CSOs to adopt community outreach and mobile models, maintaining relevance amid changing youth preferences such as sports-based and peer-led engagement, safe and confidential learning spaces, and community-based outreach. Mozambique strengthened intergenerational dialogues through Building Bridges (BB) when early engagement revealed entrenched taboos in family communication. As MBMF2 enters its final phase, activities in Laos increasingly focus on integrating CSE into school systems and government monitoring, considering the restricted civil society space and relying on government approval processes

"Due to the political situation, armed conflicts frequently occur everywhere, so work must be done with a low profile. IEC materials must be distributed as quickly as possible. There are instances where ministries do not permit [...] Work must be done after informing and requesting

permission from the General Administration Department."

-SGD, Kumudra, Myanmar

"We noticed that youth were engaging weekly but without additional motivation. To make the sessions more enjoyable and sustainable, we introduced games and later organized football matches [...] This helped for a continued participation."

-SGD, GCU, Uganda

Over time, the programme strengthened its relevance by addressing differentiated needs across diverse CAY segments.

- In Ethiopia, CSOs broadened disability inclusion through adapted CSE materials, sign-language training, and home-based support.
- In Zimbabwe, the teams introduced safe spaces and tailored modules for LGBTQIA+ youth and key populations where context permitted, addressing long-standing exclusion.
- Uganda integrated VSLA and skills components in response to economic vulnerabilities and concerns about transactional sex among adolescents and established Disability Inclusion Facilitators (DIFs) within health facilities to improve access to SRHR for adolescents and youth with disabilities and support sustainable inclusion.
- In Laos, building on the school-based activities and student clubs established under MBMF1, MBMF2 expanded work to community-based youth clubs, including activities for out-of-school youth. This also introduced opportunities for adolescents from different backgrounds to participate together.

We took advantage of various platforms to get feedback from communities and used this feedback to strategize some of the activities. We decided to train mobilizers for a targeted mobilization, so sex workers and LGBTQI for example; we trained them on SOGIESC.

-SGD, SRC, Zimbabwe



Q2. To what extent have lessons learnt been used to improve and adjust programme and projects implementation, including the recommendations from the Mid-Term Review?

The transition from MBMF1 to MBMF2 demonstrates [intentional learning from the earlier phase](#). MBMF1's final review identified loose integration across thematic areas (SRHR, YEE, climate resilience), inconsistent inclusion practices, and limited social-norms work. MBMF2 addressed these gaps by further operationalising a gender-transformative approach (GTA) by introducing structured-norms diagnostics, strengthening the inclusion of adolescents with disabilities and diverse SOGIESC, engaging men and boys and integrating YEE and climate resilience with SRHR from the outset. Climate resilience and YEE had previously been treated as separate add-ons.

A major example of this learning is the [evolution of MEAL systems](#). Drawing on the final review of MBMF1 and other internal reviews, tools to measure indicators were developed for the baseline and then applied annually in 2023, 2024, and 2025. Activity tracking and learning-harvesting workshops began in 2023, and outcome harvesting was conducted for both the mid-term review and the endline. These exercises proved valuable in turning findings into programme adjustments. After the MBMF2 MTR, MEAL tools were refined to detect early signs of norms change. The second programme-level diagnosis conducted in 2025 focused largely on identifying early signs of normative change.

The MTR emphasised the importance of ["layering"](#), ensuring adolescents participate in multiple components (CSE, YEE, climate resilience) to realise the full Theory of Change (ToC). Most Country Programme Offices applied this recommendation:

→ Zimbabwe piloted one of the most structured integration models by linking CSE/CoC clubs directly with green-skills training and climate-resilient value chains. This created a clearer sequence from SRHR learning to practical

livelihood opportunities, although most enterprises are still in early stages and require continued support.

- Uganda strengthened mentorship and follow-up within YEE to ensure skills translate into real livelihood gains and greater SRHR autonomy. This linked income opportunities with reductions in early marriage and pregnancy and operationalised the YEE-SRHR theory of change more clearly.
- Laos integrated CSE and climate education school structures, which enabled consistent exposure to both themes through institutional platforms.
- In Myanmar, a clear sequencing approach was used to move young people from CSE participation to skills and work-readiness. CSE club members were intentionally linked to the "Ready for Work" curriculum and then to vocational training opportunities. This created a stepwise pathway that aimed to connect SRHR knowledge with practical livelihood opportunities despite restrictive operating conditions. The Myanmar team described this as a way for adolescents "to apply SRHR skills to future livelihoods," even under political constraints.
- In Ethiopia, Champions of Change (CoC) and BB participants were encouraged to join VSLAs, creating a progression from social norm change to confidence building and savings and livelihoods opportunities. Ethiopia repeatedly emphasised that CoC facilitators knowing the language and community needs helped sustain engagement as young people transitioned into VSLAs.
- In Mozambique, layering was attempted through linking CSE participation with



YEE¹⁴, particularly through the youth-led labour market assessment and subsequent skills training. Adolescents first engaged in SRHR and soft-skills sessions, and those who later entered YEE were supported to choose livelihood pathways based on market demand and personal interest.

Inclusion also improved significantly from MBMF1 and in response to MTR findings. Laos developed disability-adapted CSE packages; Uganda institutionalised inclusive SRHR in Model School Health Clubs and developed community structures such as Disability Inclusion Facilitators and Peer Navigators to expand inclusive outreach. SOGIESC inclusion was mostly carried out in out-of-school contexts, given the sensitivity of integrating such content into formal school curricula. As a result, the inclusion tended to occur in more informal ways, including in Zimbabwe and Laos, as well as in Myanmar through the Kumudra partner.

Partnership practice continued to evolve. The MTR noted uneven partner involvement and limited localisation. In response, Country Programme Offices increased joint planning, co-created annual plans, expanded partner participation in learning events, and supported greater ownership of gender and social norms diagnostics tools including uptake of the norms diagnosis package developed under MBMF2, facilitating both horizontal scale-up across additional projects and vertical scale-up reported by partners. Governments and

partners in Laos and Uganda, respectively, used MBMF resources to expand SRHR work beyond the programme. Nonetheless, systemic challenges, such as administrative delays, limited resources for consortia, and variable partner capacity, persist.

Social-norms work, central to both phases, was significantly strengthened. Social-norms work, central to both phases, was significantly strengthened. Early in MBMF2, Country Programme Offices implemented participatory social and gender norm diagnostics, and in 2025 this was expanded through programme-level work and a second round of diagnosis to identify early signs of norm change and strengthen understanding of programme impact. After the MTR, they deepened process quality, expanded value-clarification work with staff and partners, and embedded behavioural insights across CSE and community engagement.

Approaches varied:

- including reframing SRHR in development language by shifting away from explicitly use of SRHR language to socially acceptable development themes such as presenting contraception and SRHR as health services (Uganda, Mozambique),
- Embedding SRHR in school systems or official manuals (Laos), softening terminology in conservative contexts (Ethiopia), and
- Shifting activities to remote or small-group formats during crises (Myanmar).

¹⁴ It is important to note that YEE in Mozambique was a very small scale and was not part of the initial design.



Q3. To what extent have the programme and projects been implemented through a holistic approach (i.e., by engaging different stakeholders at all levels in a coordinated and strategic way)?

From its inception, MBMF2 was designed as a **layered system of engagement** that positions adolescents and youth at the centre, supported by coordinated roles across families, communities, service providers, and government structures. Across all countries excluding Myanmar, implementation involves parents, teachers, community leaders, health workers, district authorities, and relevant ministries, with responsibilities tailored to local systems. The stakeholder participation is embedded structurally and is a defining feature of how the programme operates. Examples show multi-level engagement.

- In Uganda, youth mentors, village councils, religious leaders and district health officers jointly implement and/or review activities through institutionalised quarterly visits.
- In Laos, national engagement is formalised through an MoU with the Ministry of Education. Under this framework, district steering committees, chaired by Deputy Governor of district and involving other government entities, jointly plan and co-develop the monthly implementation calendars with Plan,
- Ethiopia, the Children and Women Affairs department mainly participates in monitoring rather than joint planning; they review proposed plans and join selected activities alongside implementing partners, but they do not co-design programme plans.
- In Zimbabwe, district officials participate directly in activities and meetings, largely to ensure programme sessions do not address LGBTIQ+ topics, meaning their presence functions more as content oversight and political safeguarding than as collaborative planning.

Internationally, PIF's collaboration with UN agencies and the involvement of youth delegates in global spaces extends the

programme's reach beyond country contexts.

"Every time we conduct an activity, whether at a school, village, or community level, we have the participation of representatives from Ministry of Education, Ministry of Health, Lao Youth Union, and Lao Women's Union, village administrative office, the village head, or village volunteers."

-IDI, Plan Country Programme
Office, Laos

The programme complements broad **engagement with a set of formal mechanisms** that organise responsibilities and ensure alignment with government systems. These include MoUs with line ministries, district steering committees and direct engagement with national working groups, and routine joint planning and monitoring forums. The programme has also engaged in international platforms and peer-learning spaces, enabling cross-country exchange of good practices with global partners.

- In Ethiopia, district health, social affairs, and education offices conduct quarterly joint monitoring that produces shared action plans aligned with government priorities.
- Laos provides a strong cascade model; country team trains government coordinators, who train teachers and facilitators, who then implement school-level sessions which creates a coherent delivery chain anchored within government systems.
- In Mozambique, coordination with district and provincial structures determines outreach schedules, mobile team deployment and integration of health-facility reporting. These mechanisms reduce duplication, standardise processes, and support smoother collaboration across multiple stakeholders.



Strategic partnerships provide specialised expertise that enhances thematic depth and service quality. MBMF2 works closely with Sonke Gender Justice to advance gender-transformative SRHR, particularly through engaging men and boys and strengthening positive masculinities components across programme countries. Engaging with the private sector was an important development approach to mobilize expertise and resources for SRHR and youth economic empowerment. For example, in Uganda Lunette¹⁵'s donation of menstrual cups represents a valuable in-kind contribution that strengthens our SRHR work, although this collaboration does not currently include a youth economic empowerment component.

Additionally, CSO partners, including ACTADE, CLASS, FoG, and GDI, contribute complementary expertise in gender norms, advocacy, and climate adaptation. For instance, in Uganda, ACTADE contributes expertise in climate policy, which has enabled youth-led advocacy on climate-finance.

However, political instability, restrictive laws, and security risks have prevented MBMF2 from fully operationalising its multi-actor design and have limited engagement with government actors at local, district, and national levels. In such environments, progressing work safely requires more than technical adjustments—it calls for specialised expertise, political sensitivity, and strong, trusted partnerships. Collaborating closely with specialist organisations, strengthening staff capacity, and grounding all decisions in do-no-harm and safeguarding principles have been essential to advancing gender equality and inclusion without placing people at risk.

→ In Myanmar, instability and military oversight after 2021 coup¹⁶ have eliminated opportunities for district or

national-level engagement, forcing reliance on village leaders and health service providers without formal government collaboration. Most activities were delivered through peer-based interventions and CSOs.

In Uganda, the combination of restrictive legislation such as the Anti-Homosexuality Act, bans on CSE, and heightened scrutiny of civil society actors has created a genuinely high-risk environment. For CSOs and Plan teams, integrating themes related to diversity is not simply technically complex, it is a safeguarding concern in its own right. Staff, young people, and community partners can face real personal and organisational risks if issues are framed in ways perceived as contravening the law. As a result, teams have had to adapt terminology carefully, remove explicit references to LGBTQIA+ issues, work strictly within legally permitted SRHR language, and prioritise the safety of those involved above all else.

- In Zimbabwe, for example, CSOs have retained substance while adjusting framing, using broader concepts such as “key populations” to maintain inclusive practice without triggering political backlash. This has been possible in part because of the programme’s partnership model, which brings in specialised rights-based organisations that understand the landscape, know which doors can be opened safely, and can advise on the boundaries of what is workable.
- Conflict in Ethiopia’s Amhara region has disrupted planned engagement with schools and required a shift to village-level sessions delivered by trusted local facilitators.
- Mozambique’s post-election unrest after October 2024 temporarily halted group-based community activities to avoid perceptions of political mobilisation.

¹⁵ Lunette is a brand of menstrual cup made from medical-grade silicone, which is reusable, environmentally friendly, and used as an alternative to pads and tampons.

¹⁶ In Myanmar, direct collaboration with the de facto government was deliberately excluded after the 2021 military

coup, as the civic space became closed and engagement posed operational and safeguarding risks. Consequently, MBMF2 relied on local CSOs and community-based alternatives rather than formal government partnerships.



These constraints limit the programme's ability to fully operationalise its multi-level engagement model in affected areas.

Youth leadership is one of the programme's strong examples of young people shaping decisions at community, district, national, and global levels. Across Uganda, Ethiopia, and Mozambique, youth groups are moving beyond participation to active leadership, driving local advocacy, supporting school re-enrolment, influencing district SRHR budget allocations, and improving community infrastructure, such as water points and youth-friendly corners in health facilities.

Uganda's climate initiative demonstrates the transformative potential of this leadership. Youth-developed climate finance recommendations advanced from district dialogues to international arenas, ultimately contributing to Plan's global delegation at COP. At the global level, youth participation, such as representation in Plan International's global events and delegations, elevate young people's voices beyond national boundaries. Although participation varies by Country Programme Office nomination practices, these opportunities highlight a clear pathway to institutionalising global youth engagement more consistently.



Coherence

SUMMARY



MBMF2 has evolved into a well-integrated programme that consistently reinforces and is reinforced by the wider ecosystem of Plan International's interventions and national SRHR and gender-equality efforts. Strong internal synergies—such as the replication of MBMF2's CSE and adolescent-engagement models in Laos and Zimbabwe—show that the programme is generating approaches with value far beyond its own boundaries.

Collaboration with governments, UN agencies, and civil-society networks further positions MBMF2 as a constructive actor that contributes to harmonised sector practices rather than isolated SRHR delivery.

Where coordination was less systematic, the evidence suggests that stronger institutionalisation, rather than new strategies, is the main opportunity for deepening coherence.

Q4. To what extent did the project leverage synergies with other interventions by Plan International, partners and/or other stakeholders, including governments and international organisations?

MBMF2 demonstrated intentional synergy with other Plan International (PI) programmes and with the broader ecosystem of SRHR, gender equality, climate change, and youth empowerment actors. The strength of this coherence varied across countries and was shaped by the maturity of pre-existing Plan portfolios. Where long-term programming or sponsorship structures were already embedded, MBMF2 plugged in quickly; where institutional architecture was thinner, coordination tended to rely more on interpersonal relationships than on systematised processes. In all countries with established Plan presence, the programme benefitted from pre-existing relationships, shared platforms, and aligned thematic frameworks, creating a strong basis for joint planning, shared resource use, and mutual reinforcement of approaches. For example, in Myanmar, the project was implemented directly within established sponsorship areas, which provided a trusted entry point with communities and created a favourable environment for delivering more sensitive components of MBMF2.

One example is in Zimbabwe for a high-functioning synergy within a crowded programme landscape. Here, MBMF2 complemented long-standing SRHR and education initiatives providing school-fee support and CSE. The programme also drew heavily on safeguarding and child-protection expertise from the “Ending Child Marriage” project in Kwekwe. In turn, MBMF2's SRHR technical expertise and its Champions of Change (CoC) curriculum informed the practices of neighbouring projects. Teams described “a lot of cross-learning” and frequent collaboration with Population Services Zimbabwe and other development actors, with joint participation in coordination forums and sector networks. Mozambique similarly showed strong operational integration, which shared transport with sponsorship-funded activities, used sponsorship groups to disseminate SRHR and GBV prevention messages, and co-organised public events, such as International Day of the Girl and Menstrual Hygiene Day.

“MBMF2 operates in two of our five programme areas, alongside other SRHR, protection, and education projects. One



SRHR-education project supports girls with school fees, uniforms, and CSE so they can stay in school. We collaborate closely with them, especially in cases of sexual violence or when adolescent pregnancy threatens school retention. Because girls travel long distances to school and to collect water or firewood, these interventions also serve as important protection measures."

-IDI, Plan Country Programme Office,
Zimbabwe

In Ethiopia, MBMF2 aligned with other SRHR and gender-equality interventions of Plan focusing on teenage pregnancy and girls' empowerment. Teams collaborated through structures, such as the Youth and Adolescent Health Council, joint advocacy work, and periodic learning exchanges. Social-norms work, which is central to MBMF2's ToC, was shared across CSOs, government actors and peer organisations. Social-norms work, which is central to MBMF2's ToC. For example, CDFU's norm-diagnosis informed the design of interventions in Parents' VSLA groups and intergenerational dialogues. However, staff acknowledged coordination gaps where projects operated in different locations (kebeles¹⁷) in Ethiopia for example, or under different donor frameworks, noting that *"we need to work more on integration."*

In several countries, MBMF2 sat alongside other Plan International programmes such as education, child protection, or YEE, which created natural points of connection. Plan Laos, for example, provided the most tangible example of internal alignment. The Education Programme of Plan Laos has now adopted the CSE manual and student-club model developed originally under MBMF1. The Laos Country Programme Office also linked CEFM-related funding to the same adolescent structures, with Plan Laos deliberately reviewing new grants to ensure they sit within the wider country programme.

"Currently, the Education programme team is conducting sex education activities similar

to ours. They receive funding from Japan and have been implementing activities using the model developed by our organization and team. This shows that our work is being replicated and that there is interest in our activity model."

-IDI, Plan Country Programme
Office, Laos

Joint advocacy and shared understanding of social-norm barriers were common.

- In Mozambique, the CSOs jointly engaged in advocacy through provincial and district SRHR networks, AIDS councils, and human-rights platforms.
- In Ethiopia, joint advocacy was carried out with other SRHR and gender-equality projects, including support to government Youth and Adolescent Health Councils to address teenage pregnancy and child marriage.
- Advocacy on CEFM, adolescent SRHR and safeguarding was undertaken through coordination forums, including engagement with the International AIDS Council in Zimbabwe.
- In Laos, advocacy took the form of coordinated awareness events such as IDG Day, ERAW and Contraception Day which were implemented together with UNFPA, UNICEF and government authorities.
- In Uganda, advocacy was less formalised, but implementing partners collaborated on issue-focused efforts—for example with RHU on SRHR service access, with ACTADE on climate-change messaging and with LIDUPED on disability inclusion.

Government ministries and local authorities were central partners in every country, excluding Myanmar. In Laos, MBMF2 worked closely with the Ministries of Education and Sports and of Health, as well as the Lao Women's and Youth Unions. Plan Laos contributed learning to the development of

¹⁷ This refers to the smallest administrative unit of local government in Ethiopia.



national CSE materials, led by UNFPA, and supported national events, such as the International Day of the Girl under the Government's Noi framework¹⁸. In Mozambique, the project secured buy-in from district and provincial authorities at start-up and trained government staff on disability and LGBTQAI+ inclusion, SRHR, and safeguarding. Government bodies also collaborated on disaster-risk assessments in schools and communities. In Ethiopia, teams worked with health offices to improve youth-friendly and disability-inclusive services and jointly strengthened structures, such as adolescent health platforms.

UN agencies and coordination platforms played selective but meaningful roles. For example, coordination with UNFPA was important in the development by Plan Laos of the CSE manuals. In other settings, MBMF2 staff participated in humanitarian clusters and working groups, linking programme learning to broader sector discussions (e.g., GBV, Education, Health, Gender in Humanitarian Action, Cash & Voucher Assistance). However, some countries—including Mozambique—reported limited engagement with UN agencies at provincial level despite being part of NGO networks.

¹⁸ The "Laos Noi Network" is the broader network and ecosystem built around the Noi 2030 Framework, which uses the character "Noi" (a 10-year-old girl) to represent all adolescent girls in Laos.

https://lao.unfpa.org/sites/default/files/pub-pdf/noi_2030_framework_eng.pdf



Effectiveness

SUMMARY



The programme's multicomponent approach, combining demand generation, service strengthening, and enabling-environment interventions, achieved substantial progress in SRHR knowledge, agency, gender norm change, and quality of services across the six participating countries. Most outcomes and outputs met or exceeded endline targets, showing that the overall theory of change was sound and well implemented.

However, behavioural uptake of SRH services increased only modestly despite significant supply-side advances, with meaningful improvements in Ethiopia and Mozambique where youth-friendly corners and referral systems were stronger, very limited uptake in Myanmar due to the political and health-system crisis, and slower progress in highly restrictive environments such as Uganda and Zimbabwe where confidentiality concerns and stigma continued to deter service-seeking and low uptake in Laos, where entrenched sociocultural norms, shyness around discussing sexual health, and limited adolescent-responsive service models continued to constrain demand.

The programme achieved change, especially in parent–child communication and acceptance of contraceptive use among unmarried girls. The evaluation identified emerging shifts where communities increasingly prioritise AY's contraception even when premarital sex remains disapproved.

Economic empowerment substantially improved AY's ability to act on SRHR knowledge by increasing income, mobility, and independence from partners or caregivers. Community resilience activities also strengthened parental support and reduced economic pressures linked to early marriage or transactional sex. Gaps remained where YEE coverage was limited or where youth, especially those with disabilities, faced mobility and resource barriers.

Climate change resilience integration into SRHR was effectively piloted which contributed to awareness and local coping strategies, although technical capacity varied. The programme made promising progress embedding SRHR into preparedness, green skills, and livelihoods initiatives. Further strengthening of technical guidance presents opportunities for the developed model for future scaling.

Where layering was planned, the programme achieved more consistent and sustainable results. The value of this integrated approach is particularly evident in Ethiopia, Uganda, and Mozambique. Where layering was less consistent, young people received only partial components which limited potential impact. Strengthened coordination and clearly defined entry points in the inception phase represent practical opportunities for future programming.

Q5. To what extent and how has the programme's SRHR multicomponent, demand, supply, and enabling environment, approach achieved its intended outcome and output results, including any differential results across CAY and



various modalities of implementation used in the six countries? **Q6.** Considering CAY, what significant and/or unexpected outcomes (positive or negative) emerged during implementation, and how did the programme contribute to these changes, respond to challenges, and leverage opportunities to enhance results?

Table 4: Impact, Outcome and Output Targets

Result	Indicator	Baseline Value	Endline Target	Endline Result	% ↑↓	% Progress Rate
Impact	Id % of sexually active young women aged 15-24 who are currently using a modern method of contraception (SRHI1.1.1)	29%	N/A	34%	17%	N/A
Outcome 1	1a. % of CAY who feel able to make informed decisions about their sexual and reproductive health (SRHO1.2.1)	42%	68%	63%	50%	93%
	1b. % of CAY with increased awareness and desire/ability to challenge gender stereotypes linked to SRHR	24%	54%	61%	154%	113%
	1c % of young people who started a business, became employed or resumed education	N/A	73%	75%	N/A	108%
Output 1.1	1.1a # of CAY receiving comprehensive sexuality education (donor aggregate indicator adjusted)	0	40080	56901	N/A	142%
	1.1c. % of CAY with correct knowledge about SRHR core topics (SRHO1.1.1)	28%	69%	57%	97%	80%
Output 1.2	1.2a. # of teachers and teacher education students who participated in pre- or in-service training (donor aggregate indicator)	0	6820 - decrease d to 720	730	N/A	101%
	1.2c. # of in and out of school clubs and youth groups supported and functional	0	1329	1965	N/A	148%
Output 1.3	1.3a # of adolescents and youths who have access to vocational training (donor aggregate indicator adjusted)	0	1010	1144	N/A	113%
	1.3b% of adolescents and youths who report at the end of the training feeling confident about their life skills (SOYO1.1.1)	N/A	69%	70%	N/A	101%
Output 1.4	1.4a Degree to which CAY can identify how their (SRH) rights are affected during and after a shock or a stress	Low to Medium	Medium to High	Medium	N/A	Medium



Result	Indicator	Baseline Value	Endline Target	Endline Result	% ↑↓	% Progress Rate
Outcome 2	2a. % of adolescents and young people who consider services to be adolescent- and gender-responsive, at the time asked (SRHO6.2.1)	48%	74%	83%	73%	112%
	2b % of CAY who have used an SRH service in the past 12 months (SRHO1.4.2)	28%	41%	34%	21%	83%
	2.c Degree to which government facilities involve input from CAY in SRHR service planning, delivery, and monitoring	High degree: 0% Medium degree: 20% Low degree: 80%	High degree: 77% Medium degree: 23% Low degree: 0%	High degree: 34% Medium degree: 30% Low degree: 36%	N/A	44%
Output 2.1	2.1a. # of health workers, health centre staff and health authorities who participated in pre- or in-service training on AFHS and disability inclusive services	0	815	786	N/A	96%
	2.1b. % of trained healthcare service providers with adequate attitudes and skills on adolescent and gender-responsive and inclusive SRH service provision	54%	78%	81%	50%	104%
Output 2.2	2.2a % of CAY including those with disabilities who know where and how to access SRHR services	78%	87%	89%	14%	102%
	2.2b # (%) of health facilities providing quality SRH services	High degree: 30% Medium degree: 67% Low degree: 3%	High degree: 82% Medium degree: 18% Low degree: 0%	High degree: 76% Medium degree: 24% Low degree: 0%	N/A	93%
Outcome e3	3a. % of adolescents and youths who feel that community leaders speak out and support their SRHR (SRHO3.2.3 - adapted)	41%	63%	70%	71%	110%



Result	Indicator	Baseline Value	Endline Target	Endline Result	% ↑↓	% Progress Rate
	3b. % of community members who believe that adolescent girls and boys with disabilities should have equitable SRHR services	14%	50%	27%	93%	54%
	3.c % of community members who implement strategies in their households to reduce vulnerabilities to climate change impacts and shocks and stresses	62%	77%	78%	26%	101%
	3.1a. # of parents, caregivers and community members participating in ASRHR dialogues, sessions and trainings	0	36955	402611	N/A	109%
Output 3.1	3.1b % of community members and community leaders with knowledge about SRHR core topics	46%	70%	70%	52%	100%
	3.1c. # of community leaders involved in advancing ASRHR, positive gender norms and gender equality	0	1165	1523	N/A	131%
Output 3.2	3.2a Degree to which parents, caregivers and community members understand how SRHR can be impacted by climate change and can identify positive coping mechanisms to overcome shocks and stresses	Low to Medium	Medium to High	High	N/A	N/A
	3.2b. # of parents, caregivers and adult community members who have benefitted from income generating activities, savings groups and alike	0	6180	3928	N/A	99%
Outcome 4	4a. Degree to which CSOs engage and support adolescents and young people, particularly girls and young women, in accountability processes for CAY SRHR (SRHO4.1.3)	High degree: 22% Medium degree: 52% Low degree: 26%	High degree: 80% Medium degree: 20% Low degree: 0%	High degree: 62% Medium degree: 29% Low degree: 9%	N/A	78%
	4b. Levels of readiness among CSO staff on the importance of SRHR, and the rationale for investing in and supporting SRHR programmes and policies for CAY (SRHO4.1.1)	High degree: 67% Medium degree: 33%	High degree: 90% Medium degree: 10%	High degree: 86% Medium degree: 14%	N/A	96%





Result	Indicator	Baseline Value	Endline Target	Endline Result	% ↑↓	% Progress Rate
		Low degree: 0%	Low degree: 0%	Low degree: 0%		
	4.c % of adolescents and youths engaged in advocacy processes who feel their participation has been meaningful	N/A	73%	86%	N/A	118%
Output 4.1	4.1a. # of CSOs with improved capacity to influence ASRHR and gender equality (donor aggregate indicator adjusted)	High degree: 21% Medium degree: 51% Low degree: 28%	High degree: 70% Medium degree: 30% Low degree: 0	High degree: 67% Medium degree: 31% Low degree: 3%	N/A	96%
	4.1b. # of gender transformative plans for joint and strategic influencing on SRHR developed and implemented	0	6	8	N/A	133%
Output 4.2	4.2a. # of decision makers reached with initiatives to promote adoption/implementation of laws and regulations that ensure availability of inclusive, non-discriminatory and quality sexual and reproductive health services (donor aggregate indicator)	0	449	1278	N/A	285%
	4.2b. # of national consultations and dialogues on SRHR issues with participation by the organizations of persons with disabilities (donor aggregate indicator adjusted)	0	13	17	N/A	131%
Output 4.3	4.3a. # of adolescents and youths who participate in advocacy processes promoting improved SRHR policies, gender equality and inclusion, climate resilience, or other related thematic	0	1356	807	N/A	60%

The programme achieved modest and meaningful improvements at the impact level, particularly in modern contraceptive use among sexually active young women aged 15-24, aligning well with the targeted behaviours of MBMF2 norm-diagnosis, as also indicated in social and gender norms

diagnostic analysis in 2025. Contraceptive use rose from 29% to 37%, representing a 28% relative increase. The most significant gains occurred among adolescent girls aged 15-19, whose modern contraceptive use increased from 18% to 27%. This 50% relative improvement reflects the



programme's effectiveness in addressing the unique barriers faced by younger adolescents—particularly misinformation, fear of stigma, and norms that frame contraceptive use as inappropriate for unmarried girls. Adolescents also

demonstrated marked increases in their ability to access contraception if needed and in their willingness to discuss SRHR topics with peers and partners, signalling a shift in both knowledge and self-efficacy.

Table 5: % of sexually active young women aged 15-24 who are currently using a modern method of contraception

Age	Programme		ETH		LAO		MMR		MOZ		UGA		ZIM	
	BL ¹⁹	EL ²⁰	BL	EL	BL	EL	BL	EL	BL	EL	BL	EL	BL	EL
15-24	29%	34%	17%	26%	40%	52%	12%	0%	53%	60%	24%	42%	26%	23%
15-19	18%	27%	8%	18%	33%	44%	5%	0%	35%	58%	13%	24%	16%	18%
20-24	43%	42%	26%	35%	55%	72%	24%	0%	70%	N/A	43%	64%	41%	41%

Data from the programme shows that modern contraceptive uptake among sexually active adolescent girls and young women in Myanmar is extremely low recorded at 0% at endline across all age groups. Unlike other programme countries, Myanmar experienced a severe collapse in SRH service availability due to escalating conflict, weakened health systems, disrupted contraceptive supply chains, and widespread mobility restrictions. These conditions significantly limited CAY's ability to safely access health facilities, resulting in extremely low uptake of all SRH services—reflected in only 4% access at baseline and a modest increase to 11% even after project-supported referral mechanisms were introduced. Despite evidence of meaningful improvements in SRHR knowledge, community attitudes, and early shifts in gender and social norms, adolescents particularly unmarried girls continued to face strong stigma, fear of judgment, and concerns about confidentiality, which were further intensified by insecurity and shrinking civic space.

The Myanmar social norms brief shows that the programme has achieved meaningful gender-transformative change by strengthening SRHR knowledge, improving parent-child communication, and shifting community attitudes that previously

restricted adolescent contraceptive use. Through CSE trainings, peer leaders, and awareness sessions, the programme helped normalize conversations about contraception, reduce judgment, and promote more supportive behaviour from parents and community leaders—changes linked to reduced unwanted pregnancies and declining early marriage in some areas. However, harmful social and gender norms continue to constrain adolescents, especially girls, who still face stigma, gossip, and moral scrutiny when seeking contraception. Misinformation through social media and the collapse of public health services following the coup further limited equitable access.

"It's become easier to get birth control now. Before, I didn't know how to use contraceptive, but I've learned. We can buy it at pharmacies. But I still think there's discrimination when it comes to who's buying it. If a boy goes to buy condoms, no one says anything. But if a girl goes to get emergency contraceptive pills, they start gossiping about her. Sometimes, they even tell her parents."

-FGD, 19-24 year old girl, Myanmar

Evidence across countries shows that attitudes toward adolescent sexuality are not shifting in a linear or uniform way, but instead reveal conflicting and sometimes

¹⁹ Baseline

²⁰ Endline



contradictory beliefs among adolescents, parents, and community members. While premarital sex for girls remains largely disapproved, acceptance of contraceptive use by unmarried girls has clearly increased, indicating the emergence of a pragmatic recognition of girls' SRHR needs even in contexts where sexual activity is still normatively discouraged. For example, endline data show that acceptance of sex before marriage for girls remains relatively low (25–42% depending on age and year), while acceptance of contraceptive use among unmarried girls reached up to 70% among adolescents in 2025 post-tests, compared to 34% at baseline.

The contrasting positions such as disapproval of girls' sexual activity on one hand, and growing acceptance that girls should protect themselves on the other indicate the presence of normative cracks, where social norms are being challenged in practice, even before they are openly accepted in discourse.

Outcome 1 Children, adolescents, and youth, in all their diversity, have the support and the confidence to make informed, responsible, positive, and healthy choices about their SRHR and future.

Outcome 1 shows strong and consistent progress in strengthening the knowledge, confidence, and agency of CAY to make informed SRHR decisions. CAY demonstrated substantial increases in correct SRHR knowledge (from 29% at baseline to 57% at endline), improved attitudes towards gender equality, and an enhanced ability to challenge harmful norms—exceeding the target with 61% expressing increased desire or ability to question stereotypes. CSE played a central role: it provided safe, interactive spaces for CAY to learn about puberty, contraception, consent, relationships, and gender norms, while encouraging open peer dialogue that helped reduce stigma, normalize SRHR discussions, and build critical thinking. FGDs

with the CAY such as girls in Ethiopia learning about menstruation for the first time or adolescents in Mozambique shifting from unprotected sex to condom use show how knowledge translated into healthier practices and more equitable relationships.

"Since started participating in the project, I learned where to go and whom I may consult in case of SRH services and they show us the room where SRH services are given for adolescents and youths. I also learned SRH services like contraceptives, STI screening and abortion services are given for free"

-FGD, 19-24 year old girl, Ethiopia

"With the arrival of the project, I adopted a contraceptive method so that I can study and finish school without problems."

-FGD, 15-19 year old girl, Mozambique

CSE supported CAY to develop communication, negotiation, and decision-making skills in their intimate lives. Endline data show that 63% felt able to make informed SRHR decisions (up from 42%) with gains in confidence to access contraception, seek advice, and communicate boundaries with intimate partner. These changes were reinforced by improved peer networks, the role of trained facilitators and teachers, and youth-safe learning environments. Older adolescents and youth engaging in YEE also demonstrated strengthened life skills (e.g., problem solving, leadership, and communication), contributing to greater autonomy in both economic and personal decision-making, including SRHR.

"I now know it's my right to consent or reject any advances from any boy if she doesn't want to. And I also know that it's my right to refuse anything if my boyfriend is not complying with what I want."

-FGD, 16-21 year old girl, Uganda

Girls often reported lower confidence than boys in communicating preferences or negotiating safer sex, and acceptance of sensitive issues such as homosexuality or



abortion varied sharply by country. Still, the programme enabled meaningful shifts: in Uganda, adolescents challenged the belief that contraceptives are only for married women; in Zimbabwe, youth questioned gendered expectations surrounding consent and early marriage; and in Ethiopia, intentions to practice FGM/C on future daughters decreased slightly²¹.

"My grandmother loved saying 'you will be beaten by your husband in marriage because of your stubbornness (to her I'm stubborn because I feel like I need to share the chores between me and my male siblings) and I would say no they won't beat me and who said marriage is all I want' [...] Now she has changed instead of being marriage centric and focusing on a negative way of motivating us, she encourages us to work hard and be able to do things on our own."

-FGD, 15-19 year old girl, Zimbabwe

Outcome 2 Children, adolescents, and youth, in all their diversity, have improved access to quality, inclusive, gender-responsive and adolescent- and youth-friendly SRHR services.

Health facilities showed substantial progress over the programme period. The proportion of facilities providing high-quality services increased from 29% at baseline to 76% at endline. This reflects major investments in provider training, the establishment of Youth-Friendly Corners, improved privacy and confidentiality practices, expanded SRHR information channels, and stronger community-facility linkages. Service providers reported shifts away from judgmental and restrictive attitudes toward a more rights-based approach, particularly when working with adolescents, unmarried girls, and CAY with disabilities. These changes suggest meaningful attitudinal

shifts and early signs of normative change within service settings.

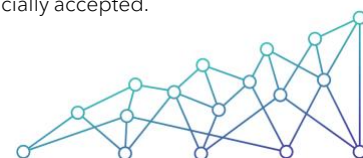
Facilities increasingly offered comprehensive contraceptive counselling, more respectful and confidential care, and broader SRHR information, ranging from contraception to consent and healthy relationships. These supply-side improvements align closely with quantitative findings showing that 83% of adolescents and youth now perceive services as responsive and respectful, up from 48% at baseline.

Despite these gains, progress in service uptake was more modest. Endline results show that only 34% of CAY used an SRH service in the previous 12 months, falling short of the 41% target and only slightly improving from the 28% baseline. Uptake among children remained very low (14-16%), increased more clearly among adolescents (around 38-40%), and was highest among youth (60-80%, depending on country). While uptake remained extremely low in Myanmar due to restricted service availability linked to the political crisis, countries such as Ethiopia and Mozambique showed more noticeable improvements, associated with strengthened referral systems, youth-friendly corners, and outreach strategies.

Persistent social and normative barriers continue to shape demand, including fear of stigma, privacy concerns, limited autonomy, and cultural expectations around premarital sexuality. However, the gap between improved service quality and modest uptake cannot be explained by social norms alone. Qualitative findings point to several practical and inclusion-related barriers that limit use even when services are available. These include limited perceived relevance of services for different groups of young people, weak or inconsistent referral

²¹ the share of adolescent girls and young women who do not intend to have their future daughters undergo FGM/C rose from 80% in 2022 to 89% in 2024 (and remained high at 86% in 2025), which shows a reduction in intended FGM/C. While

the intention to practice FGM/C on future daughters has decreased overall among adolescent girls and young women in Ethiopia, in some areas, such as Kersa/Jimma, FGM/C remains more commonly practiced or socially accepted.



pathways from CSE to clinics, youth-unfriendly opening hours, hidden costs of accessing care, and uneven levels of trust in providers. Adolescents—particularly girls, LGBTQIA+ youth, and those with disabilities—remain cautious if they fear judgement, poor treatment, or breaches of confidentiality. In contexts affected by political instability or insecurity, these barriers are further intensified.

A key driver of low uptake across age groups is the widespread perception among CAY that they do not need SRH services. Many CAY associate clinic visits with illness rather than preventive or protective care. Girls often reported that they would only attend if they suspected pregnancy, while others showed limited awareness of the broader purpose of SRH services. Importantly, this does not necessarily indicate non-use of contraception. Some adolescents rely on pharmacies, peers, or community outreach workers—forms of access that are not captured as SRH service use in facility-based surveys.

Among children, the perception on SRH services are not need is particularly pronounced. Around 75% at both baseline and endline reported having “no need” for SRH services. While this partly reflects their stage of development, it also masks unmet need. Approximately one-quarter could have benefited from services but were hindered by barriers such as not knowing where to go (9%), fear or worry about attending (5%), or other unreported concerns. Stigma and shame also influence behaviour, as reflected in qualitative findings from Zimbabwe and Laos, where adolescents reported avoiding local clinics due to fears of confidentiality breaches or community judgement, even when services were technically available and of higher quality.

As one adolescent girl in Zimbabwe explained:

“Pharmacies and clinics have developed but I don’t go to the nearest clinics because information isn’t as private since they will be knowing our parents and hence no confidentiality.”

—FGD, girl aged 15–24, Zimbabwe

Outcome 3 Children, adolescents, and youth, in all their diversity, live in safe and supportive communities that transform gender roles, and challenge harmful stigma around SRHR as well as social and gender norms.

Endline data indicate that community leaders have become more supportive of SRHR, with 70% of adolescents and youths reporting such support, exceeding the target and reflecting the impact of multi-year community dialogues, norm-reflection sessions, and capacity-building with parents, caregivers, and leaders.

At the community level, acceptance of equitable SRHR access for adolescents with disabilities rose sharply from 14% at baseline to 27%, though still below the 50% target. Communities in Laos, Ethiopia, and Mozambique demonstrated stronger shifts in attitudes where disability-inclusive dialogues, leaders’ participation, and contextualised messaging were more sustained than those in Zimbabwe or Uganda, showed more resistance around sensitive issues such as sexuality, safe abortion and autonomous access to SRH services for adolescents with disabilities. However, the most controversial issue across countries concerned whether adolescents with disabilities should access SRH services without parental approval, a debate closely linked to ideas of protection, safety, and perceived levels of autonomy depending on the type of disability. Although most community members increasingly agree that adolescents with disabilities should receive SRH information and contraception, many still conditions access on parental consent, reflecting persistent paternalistic norms. Nonetheless, the programme’s dual approach, mainstreaming inclusion across all activities while also implementing



targeted interventions, has contributed to a growing recognition of the SRHR rights of CAY with disabilities and diverse SOGIESC.

At household level, resilience activities for parents and caregivers, through BBs, intergenerational dialogues and VSLA engagement—shifted communication patterns and increased support for adolescents' SRHR needs. Caregivers who had never discussed menstruation, contraception or bodily changes began initiating conversations at home. In Laos and Zimbabwe, parents who previously feared stigma or judged clinic attendance became

more accepting of adolescents accessing SRHR services; some even reported guiding daughters through safe-abortion pathways or supporting educational continuation after pregnancy.

Currently, 55% of community members have now positive attitudes towards CAY's SRHR (56% for female respondents and 53% for male respondents), compared to 30% in the baseline. These attitudes were assessed through opinions on a range of SRHR issues, showing a general positive trend.

Table 6: Attitudes Towards CAY's SRHR

Attitudes towards CAY's SRHR	Baseline 2022	Endline 2025
Parental support for daughters using contraception	61%	84 %
Parental support for sons using contraception	59 %	80 %
Recognition of women's right to refuse unwanted sex	77 %	81 %
Acceptance of masturbation[1]	43 %	59 %
Support for safe abortion options	44 %	60 %
Acceptance of homosexuality[2]	21%	47 %
Support for sexuality education for CAY	83 %	94 %
Support for girls attending school during menstruation	84 %	94 %
Recognition of shared responsibility in contraception for men and women	52 %	57 %
Acceptance of sex before marriage for girls	16 %	37 %
Condemnation of sexual harassment, regardless of clothing	36 %	53 %

A key programme change is the shift in community attitudes toward adolescents' contraceptive use and access to SRH services. These attitudes are tied to longstanding norms condemning premarital sex, especially for girls. Monitoring data show clear movement: acceptance of premarital sex increased from 16% to 37%, and the belief that most girls remain virgins until marriage fell from 54% to 38%. Although 56% still expect virginity before marriage, this represents a major drop from 79% at baseline, indicating early normative change and reduced—though uneven—stigma across countries.

Across settings, links emerged between changing views on premarital sexuality,

increased support for adolescent contraceptive use, and growing recognition of girls' bodily autonomy. In Ethiopia, participants reported fewer negative reactions to girls engaging in premarital sex and greater acceptance of women's right to make autonomous decisions. In Uganda, one woman noted she now allows her adolescent child to use contraception to prevent early pregnancy, reflecting the influence of programme training.

Community support for adolescent contraceptive use has increased substantially, rising from about 60% at baseline to 80-84% at endline for both daughters and sons. More community members are now willing to support



adolescents at younger ages (10-14), with support for daughters increasing from 13% to 24% and for sons from 8% to 20%, while support only from age 20+ has declined for both genders. In Myanmar, significant progress was made in reducing menstrual stigma, with all girls and young women at endline reporting positive changes in community attitudes, increased openness, and the disappearance of myths such as menstrual cloths being dangerous; communities now encourage girls to attend school during menstruation. These shifts in knowledge and attitudes have influenced how adults communicate with and support CAY regarding SRHR. Gender differences persist, with women more supportive in Myanmar and Mozambique, while men show greater support in Ethiopia. Attitudes also vary across countries, with the most positive environments in Mozambique, Laos, and Ethiopia, and more conservative views in Myanmar, Uganda, and especially Zimbabwe, where issues like homosexuality and sexual pleasure remain particularly sensitive.

Climate change awareness also improved significantly, with 77% of community members, who were part of VSLA and climate smart livelihood component in Uganda, Ethiopia and Zimbabwe adopting positive coping strategies, where economic-resilience activities were implemented. This result mainly reflects stronger integration in Uganda, Ethiopia and Zimbabwe, where VSLA participation and climate-smart livelihoods directly supported those coping mechanisms. Communities increasingly understand how shocks such as floods, droughts, or heatwaves affect adolescents' access to SRH services and heighten risks of early marriage, transactional sex, and gender-based violence.

"If floods destroy crops and there is hunger at home, a pregnant woman may become weak, increasing the risk of giving birth to an underweight baby or even experiencing a miscarriage."

-FGD, 17-24 year old girl, Uganda

The programme has contributed to substantial changes in community attitudes regarding adolescents' contraceptive use, with many more parents and caregivers now willing to support both daughters and sons in accessing modern methods and at increasingly younger ages compared to baseline. These shifts represent early signs of changing social and gender norms linked to adolescents' sexual agency, although resistance remains particularly strong regarding unmarried girls. In addition, male engagement has been central to transforming household and community dynamics: targeted outreach and dialogue encouraged men and boys to discuss SRHR, share care responsibilities, and challenge harmful gender expectations, leading to more open communication and greater support for young people's SRHR.

Across the five countries, community leaders increasingly took active roles in shifting norms and supporting adolescent SRHR. In Zimbabwe, village leaders began openly discussing SRHR in public assemblies, helped reintegrate adolescent mothers into school, and promoted positive parenting and intergenerational dialogue to reduce stigma. In Myanmar, leaders partnered with peer leaders to run parent awareness sessions and collaborated with SRHR committees to develop broader community action plans, reinforcing local ownership of SRHR initiatives. In Mozambique, religious and community leaders moved from discouraging modern contraception to leading educational sessions that frame SRHR and contraceptive use as human rights issues, facilitating open discussion in families and churches. In Laos, village authorities supported and participated in project activities, demonstrating shifts in attitudes toward sensitive topics like sexuality and gender roles while encouraging joint decision-making among couples. In Uganda, male religious leaders were engaged to hold SRHR dialogues during sermons, and through training they became more confident discussing adolescent SRHR openly, transforming their understanding of



their role and becoming trusted sources of information for youth.

Discussions with Plan Offices and CSOs show that although conversations have become more open, leaders still influence marriage decisions and norms governing girls' behaviour, and often remain cautious in publicly supporting SRHR, particularly in restrictive environments like Uganda and Ethiopia, where some SRHR themes are politically or socially sensitive.

For instance, community leaders noted that discussing contraception is viewed as encouraging sexual activity and may be interpreted as violating moral and family norms, creating hesitancy to publicly advocate for adolescents' rights. Additionally, while leaders' knowledge and attitudes have improved, evaluation points out that this support sometimes still reflects protectionist rather than rights-based approaches which is limiting their willingness to champion sensitive topics such as contraceptive access for unmarried youth

"Many parents would react negatively. They associate contraceptive use with being sexually active, which is considered inappropriate for someone under 18. For them, it's less about health and more about morality and family image."

-FGD, an adult male community leader, Uganda

Outcome 4 Children, adolescents, and youth, in all their diversity, participate and benefit from a vibrant civil society that advocates for increased public investment and improved SRHR policy as well as promotes equality for and agency of girls.

CSOs significantly strengthened their readiness and ability to influence SRHR policies and accountability processes, with 67% achieving a high level of readiness. The programme's emphasis on inclusive, rights-based capacity development contributed to stronger CSO engagement with adolescents and youth, particularly girls, young women,

CAY with disabilities, and those with diverse SOGIESC. CSOs increasingly adopted participatory methodologies, integrated disability and gender perspectives into their advocacy, and expanded their partnerships with organisations of persons with disabilities (OPDs). Meaningful youth participation in advocacy processes increased, with 86% of youth participants feeling their engagement was meaningful, exceeding the 77% target. Qualitative data shows that young people increasingly view themselves as advocates, leaders, and agents of accountability.

"We were trained as champions on SRHR and our rights as persons with disabilities. After the training, we went into communities to teach others with disabilities—and their parents—about their right to access SRHR services and practise safe relationships. In short, we are champions empowering other people with disabilities to know their rights and push for an HIV-free generation."

-FGD, 15-17 year old boy living with disability, Zimbabwe

At policy level, influencing efforts engaged 1268 decision-makers and 17 national consultations on SRHR issues with participation of OPDs reached. CSOs successfully positioned themselves and youth stakeholders within national dialogues, strengthening platforms for long-term systemic change. Qualitative data indicate that CSOs are now more credible, coordinated, and strategically aligned in pushing for adolescent-responsive SRHR service delivery, improved legal protections, and more inclusive programming.

"We carried out strong advocacy efforts through media engagement, youth-focused initiatives, and community engagement at the facility level. As a result of these efforts, we have seen significant progress. A regional youth council has now been established, along with youth councils at the facility level. These council members are actively and meaningfully participating in improving health services. We also



organized youth conferences to voice SRHR issues affecting young people, and various government institutions have taken

responsibility in responding to these concerns."

-SGD, FGAE, Ethiopia

Q7. To what extent, and how, have the complementary strategies of economic empowerment with CAY and economic resilience with community members been contributing to CAY's SRHR outcomes and to community resilience?

Economic empowerment and community-resilience activities consistently strengthened the link between livelihoods and adolescents' ability to exercise SRHR choice. Across countries, youth who completed vocational training, Innovation Hub skilling in Ethiopia and Uganda or private-sector placements gained income that enabled them to cover transport to facilities, purchase contraceptives and sanitary pads, and reduce reliance on parents or partners. This shift directly increased their autonomy and service-seeking confidence, with several youth describing being able to return for follow-up visits, select preferred contraceptives or access care without negotiating with resource-controlling adults. Programme staff in Uganda noted that more than 80% of Innovation Hub graduates in one site secured employment or launched businesses within six months, positioning them to make independent SRHR decisions.

"The economic empowerment really helps young people access services more quickly. Young men, in particular, can use the funds to obtain the services they need, which improves their ability to choose the contraceptives they prefer and encourages them to return to the health facilities."

-IDI, Plan Country Programme Office, Uganda

The economic gains had critical SRHR implications for young women and girls, particularly those previously vulnerable to transactional sex or partner-controlled fertility decisions. Interviews with young mothers and out-of-school girls show that

combining CSE with YEE created space to negotiate contraceptive use, question norms around marriage and childbearing, and avoid economically driven sexual relationships. For youth with disabilities, the integrated vocational and SRHR curriculum filled gaps in knowledge about bodies, consent and contraception while simultaneously building employability. Participants reported being better able to choose partners, avoid exploitative situations and act on SRHR knowledge because they no longer felt economically or socially dependent. Young women and youth with disabilities experienced particularly meaningful shifts in confidence and independence, but gender norms, disability-related stigma, age-related constraints, and country-specific factors shaped the degree and depth of these shifts. For instance, stronger disability inclusion in Ethiopia and robust economic pathways in Zimbabwe helped accelerate gains for the most marginalised, whereas political instability in Myanmar and language or mobility barriers in Laos limited access and slowed progress.

Parents' and youth VSLAs provided financial cushions for health-related expenses, reducing service inaccessibility caused by transport costs or user fees. In multiple sites, parents used VSLA earnings to purchase sanitary pads for daughters and access their own SRHR care. Community groups that layered CSE, YEE and climate-resilient livelihoods observed increased solidarity, reduced stigma and a rise in youth-led SRHR mobilisation. Even in settings with minimal



economic-empowerment activities²² small economic inputs maintained cohesive youth groups that continued SRHR peer education, reportedly contributing to reduced CEFM and improved service demand. This suggests that economic activities can serve as an entry point that strengthens young people's engagement in SRHR peer education and may contribute to reduced CEFM and increased service demand.

The integrated, sequential layering of CSE, youth skilling and economic resilience via

VSLA emerged as central to observed changes. Implementers emphasised that CAY first completed CSE, then joined YEE, while parents simultaneously received sessions to build SRHR acceptance. This design helped prevent tensions around youth earnings, ensured parental support for SRHR choices and addressed financial barriers that previously restricted service uptake. Although restrictive legal and social contexts, particularly in Uganda and Myanmar, posed challenges, community acceptance improved over time.

Q8. To what extent and how effectively was the climate-change-resilience cross-cutting issue mainstreamed across components and countries, at individual, community, and institutional levels, including with health facilities? What strategies were used by the COs to mainstream this cross-cutting issue?

Across countries, Plan country programme offices and CSOs used a variety of strategies to mainstream climate resilience such as curriculum and manual integration, green skills/YEE, and DRR/institutional advocacy, although coverage and depth varied. Climate Resilience-SRHR handbooks and green/CC activity cards were systematically embedded in youth and parent groups, school clubs and Smart/Innovation Hubs (Ethiopia, Laos, Uganda, Zimbabwe), and the climate resilience content was also incorporated into CSE, BB and CoC curricula through green cards and dedicated sessions. As a result, CAY and parents can now better define and identify how climate change is impacting their SRHR and what actions to take, and many of those participating in YEE activities have begun adopting concrete coping strategies linked to YEE, developing "climate-friendly" business plans (e.g., recycling, organic agriculture, renewable-energy baking, tree nurseries), making energy-saving stoves to reduce unsafe firewood collection,

practicing climate-smart horticulture and kitchen gardening to secure food and income for transport and SRH costs, and joining VSLAs as safety nets during shocks.

At institutional level, mainstreaming was strongest where DRR and health systems were explicitly adapted to protect SRHR during climate shocks, but this remains concentrated in a few contexts. In Zimbabwe and Mozambique, local disaster and civil protection committees were re-established and trained on SRHR and climate resilience; district contingency plans were revised to include SRHR, including pre-positioning contraceptives, maintaining service continuity during floods/cyclones. Health facilities in Ethiopia and Mozambique introduced waste segregation systems and greening of compounds (AMODEFA), while youth in Uganda successfully advocated for road repairs and borehole fixing to secure physical access to services. CSOs reported that participants of YEE used income to buy pads or pay transport to clinics, and parent

²² The Mandziku example refers to community where very few or minimal economic-empowerment activities were

implemented, yet SRHR outcomes still improved because of strong youth-group cohesion and peer-led mobilisation.



participants of VSLA improved their economic security, which reduced pressure toward early/transactional sex.

At the same time, several CSOs (PFHA, LAMBDA, WWDA, Intwasa, NCDPZ and SRC) stressed they engage only lightly or indirectly on climate. CSOs in Zimbabwe, Mozambique and Laos noted that climate resilience and disaster risk reduction were not part of their core mandate and that they lacked the technical skills, specialists and resources to engage beyond basic awareness-raising. While ACTADE in Uganda had a strong background in climate change and provided capacity-building and technical leadership to CSOs in Uganda, the support was limited the extent to which other partners could deepen their practice. In addition, country programme offices and PIF staff repeatedly describe climate-SRHR integration as “*still a work in progress*” with strong practice in Uganda, Ethiopia, Mozambique and Zimbabwe but no fully standardised model yet. Country teams also pointed out limited budgets for climate resilience component, which often required additional adaptation, translation and simplification of training materials.

Multiple CSOs (Intwasa, GDA, WWDA) reported that many young people struggled to make the link between climate change and SRHR, even after training. Trainers noted that youth often saw climate change as a natural phenomenon unrelated to health or rights, and that significant time had to be

spent explaining basic connections such as between water scarcity, menstrual hygiene and infection risk. In Laos, climate content in the manual proved too technical, with terminology that had “no equivalent in local languages,” leading to comprehension gaps and reliance on extra visuals/videos.

While resources were considered limited for climate resilience integration, some CSOs were able to tap into external expertise, public programmes and local funding streams to advance climate-SRHR objectives. In Zimbabwe and Mozambique, for example, local disaster and civil protection committees were revitalised and district contingency planning was undertaken jointly with government, which enabled SRHR considerations to enter existing preparedness processes without requiring separate project budgets. CSOs in Uganda reported advocating with sub-county authorities to secure road repairs and borehole maintenance, while youth groups mobilised community members in tree-planting and waste-management initiatives, often drawing on local government contributions or existing environmental programmes. In Mozambique, youth accessed national or district-level platforms on climate action through collaboration with government units such as civil protection, and in several countries Plan International’s partnerships enabled youth to participate in green skills expos, Smart/Innovation Hubs or government-supported vocational initiatives.

Q9. How was the layering of activities at the individual, household, and community levels conducted across countries and components? To what extent did layering achieve better outcomes regarding CAY?

Across programme countries, the layering of activities across individual, household, and community levels broadly reflected a socioecological approach. In Uganda and Mozambique, for example, layering intentional layering has good examples.

Adolescents participated in CoC or school-based CSE, their parents simultaneously joined BB, and communities engaged in male-champion groups and social norms dialogues led by MAHLAHLE in Mozambique and CDFU in Uganda.



Layering consistently started with CoC or CSE as the foundational platform, onto which life skills, green/innovation skills, and service-linkage activities were added. This approach proved particularly effective in Ethiopia, where youth participating in CoC or SmartUp training were also supported through IGAs and systematically referred to youth corners in health facilities. Similarly, in Uganda, peer navigators mobilised CoC participants and linked them to mobile outreaches and adolescent-friendly services, leading to increased confidence among youth to seek SRHR care. In Mozambique, the use of safe spaces, combined with dialogue sessions and health fairs, provided adolescents with multiple points of entry for SRHR information and support.

At the same time activities were held with households and communities of the same Cay participants. In Mozambique, MAHLAHLE's community dialogue groups and intergenerational sessions created safe opportunities for parents, youth, and leaders to discuss sensitive SRHR issues—challenging long-standing taboos. In Uganda, local councils actively mobilised communities for SRHR outreaches, leading to improved turnout and stronger ownership of project activities. Meanwhile, partners in Ethiopia integrated community dialogues with referral mechanisms, enabling CoC graduates, parents, and youth with disabilities to access SRHR services collectively.

Evidence from Ethiopia, Uganda, and Mozambique shows that layering SRHR with YEE and skills development produced stronger and more sustainable outcomes. In Ethiopia, SmartUp trainees who completed soft skills and vocational training later received IGAs, reducing their economic dependence and enabling them to make more autonomous SRHR decisions. In Uganda, innovation hubs provided green and digital skills to CoC graduates, aligning livelihoods with climate resilience and strengthening agency. COs noted that, when AYs gained economic independence, they

were better able to avoid transactional sex and to negotiate safer sexual behaviours. VSLA integration also improved economic security for parents and caregivers, reducing pressures that fuel early marriage or school dropout.

While layering strengthened outcomes for most adolescents, some groups remained systematically less served. LGBTQIA+ youth were the least reached across several countries, particularly in conservative or legally restrictive contexts, such as Mozambique and Zimbabwe. Partners noted that many LGBTQIA+ youth avoided participating openly due to stigma, fear of disclosure, or limited specialised services. Similarly, although disability inclusion improved where OPDs, like LIDUPED in Uganda, NCDPZ in Zimbabwe or WWDA in Laos, were involved, youth with disabilities in remote or resource-poor settings still faced limited mobility, transportation barriers, and uneven outreach coverage. In some countries, layering “came late” or the turnover of community mentors interrupted continuity of programming. These gaps indicate that, while layering improved outcomes, its reach and equity varied depending on partner capacity, sociopolitical context, and resource allocation.

In Zimbabwe, during the inception phase, the consortium did not develop a shared understanding of what layering meant or how entry points should function. CSOs selected community members independently and implemented their components in parallel, which created missed opportunities for holistic support. As a result, some adolescents benefitted from only a single intervention instead of the intended multilayered package. Over time, the team recognised these gaps and began re-establishing entry points and strengthening coordination, but the initial lack of clarity around layering remained a key challenge affecting integration, planning, and resource allocation.



Efficiency

SUMMARY



The programme generally used resources efficiently by leveraging existing government systems and highly specialised CSO infrastructures, enabling wider reach and more tailored SRHR services, especially for key populations and young people with disabilities. However, challenges emerged where public systems were insufficient or could not be used, as in Myanmar that required alternative delivery models such as mobile outreach. Similar alternative models were used in other countries—for example, mobile brigades in Mozambique—to ensure services reached remote communities.

Human-resource constraints for CSOs including low salaries, high staff turnover, and sometimes unclear roles between Plan and CSO staff reduced capacity retention and created operational delays. MEAL capacity was insufficient at CSO level in several countries, which led to challenges in ensuring data quality, delays, and heavy manual reporting burdens.

Budget delays further reduced cost-effectiveness and affected the layering strategy.

PIF's technical support was a major strength, though gaps in communication, limited in-country specialists, and constrained country budgets reduced its impact.

Risk management and safeguarding systems were strong. Overall efficiency would improve with stronger MEAL investment, clearer country programme office–CSO coordination, and more consistent application of programme strategies such as layering SRHR with livelihoods, using government structures, or applying standard CSE models.

Q10. How strategically have financial, human, and technical resources been allocated, and how efficient were the programme's strategies and modalities in delivering high-quality, timely, and cost-effective results? Which strategies should be considered for scaling-up, at country and programme level, and how?

Across contexts, the programme sought to build on existing systems and **strategic use of existing government structures**. While government teachers, health workers, district platforms and health facilities were engaged wherever possible, a considerable share of service delivery relied on specialised CSO partners whose structures were already active in SRHR, community mobilisation, disability inclusion, and working with key populations. In practice, the CSO delivery systems were filling gaps that government services could not meet, particularly given shrinking public financing and variable government capacity across settings. They were already recognised service providers in

their own right, operating health services, community outreach, disability-inclusive programming or SRHR support prior to the programme. The programme therefore leveraged and strengthened these CSO service infrastructures and enabled a greater reach and more specialised provision, including work with key populations and young people with disabilities. In addition, working with government structures also helped with the efficiency and reducing the costs.

"We are working with FGAE who are very unique in terms of accessing SRH components and they are very experienced,



there was no gap with them. The project built on existing services that they were already providing."

-IDI, Plan Country Programme Office,
Ethiopia

"We maximized efficiency by integrating project activities within existing structures, such as SMARTUP centers, which were used free of charge to train participants. Trainers were qualified government stakeholders and university lecturers, whose engagement proved cost-effective compared to external trainers."

-SGD, PADET, Ethiopia

However, in Myanmar, the programme did not work through government health service delivery to the same extent as in other contexts, both due to the very constrained health sector environment and because the implementing partner was not a full service provider with its own clinics. Instead, SRHR service delivery relied largely on mobile outreach, drawing on existing HIV and key population structures—and on strengthening referral pathways rather than direct provision. The project therefore placed greater emphasis on building partner capacity to independently deliver training, while simultaneously navigating frequent turnover among government health staff and the limited availability of youth-friendly services within public facilities. Translating MBMF2 ambitions to the Myanmar context became a central learning process, and the planned next phase seeks to expand service partnerships and integrate SRHR and GBV services more systematically, including through additional local partners.

"For the service delivery, we added more practical approaches, for example we provide SRHR services through mobile teams, through community-based health workers and community leaders. The feedback from the people shows a growing

demand for service delivery in addition to capacity strengthening."

-IDI, Plan Country Programme Office,
Myanmar

High staff turnover was a recurrent problem across Uganda, Ethiopia, and Laos, with several CSOs reporting that inadequate remuneration led staff to leave after receiving training, causing knowledge loss and increasing onboarding costs. CSOs in Uganda described that receive salaries²³ that are too low to meet basic costs and they are also expected to cover small operational expenses (e.g., transport, phone credit, or printing). Because these costs are not fully reimbursed, staff sometimes use their personal income to keep activities running. This creates financial strain and demotivation, which contributes to staff leaving shortly after receiving training and results in continuous capacity loss and higher onboarding requirements.

"We were not able to recruit, maintain and retain. People take the job, and they find other opportunities. This has been a big challenge for us in retaining the staff. The salaries are below average. You even spend your own salary for the project."

-SGD, GDI, Uganda

Zimbabwe also noted that uneven titles and career pathways across CSOs (e.g., Plan "facilitators" vs. partners' "project coordinators") produced inefficiencies and ambiguities in roles and expectations between Plan country programme teams and CSOs. Plan teams noted that similar roles carried different titles across Plan teams and CSOs (e.g., Plan "facilitators" versus CSO "project coordinators"), which created confusion over who was responsible for leading activities and making decisions, resulting in coordination delays and unclear expectations between Plan teams and CSOs. This appears to stem from limited planning for layering during inception and weak

²³ It should be noted that the programme does not define salary levels. Salaries are based on the policies and salary scales of the respective CSOs.



coordination between Plan facilitators and CSO teams.

A recurring operational gap across Uganda and to some extent Zimbabwe was the **limited availability in MEAL capacity** at CSO level. In Uganda, 14 Community-Based Organizations (CBOs) with less organizational capacity were operating on the ground, and they reported the need for a dedicated MEAL Officer for CSOs, as the current MEAL capacity at the Plan Office was not effectively supporting all the CSOs. They reported that their implementing staff assume monitoring tasks in addition to their implementation roles, which resulted in overstretched teams, inconsistencies in MEAL activities, delays in data submission and also adding on the fatigue and burnout. While quarterly MEAL visits from Plan were considered supportive, CSOs stressed the need for continuous, locally embedded MEAL advice.

"It was very hard for us to implement the project without a MEAL Officer attached to CSOs. Tracking the project progress has been taking long."

-SGD, FoG, Uganda

Limited budgets for transport, communication, and data collection further hindered MEAL functions. Most CSOs and Plan Country programme staff in Uganda and Zimbabwe reported operating on extremely low quarterly transport allocations insufficient to conduct routine monitoring across dispersed communities. They noted lacking resources for venues or digital tools needed for timely reporting. As a result, monitoring often depended on retrospective reporting, incomplete activity logs, or paper-based records that had to be manually entered later, reducing data reliability and timeliness.

"It is not allowed for mentors to use their own gadgets due to data privacy and security, so they have to write the report on paper and bring it to the office. Most of our time is capturing the data. We have too

many indicators within the project. We make the database on paper and then we input it online, why can't we make it digital directly?

-IDI, Plan Country Programme Office,
Zimbabwe

Across countries, implementation timelines were affected by inconsistent and delayed fund flows from Plan Country Programme Offices to CSOs particularly in Uganda, Ethiopia and Myanmar, though the severity varied. In Uganda, this challenge was most acute. Several CSOs, such as CLASS, ACTADE, and Hossana, experienced repeated delays in quarterly disbursements, forcing them to depend on suppliers willing to provide goods and services on credit to prevent activity stoppages. In Laos, late approval of the MoU led to a reduced first-year budget, requiring partners to deliver the full activity package with fewer resources. Some mitigation measures emerged over time; for example, ACTADE in Uganda shifted from quarterly to biannual transfers to stabilise implementation, while Zimbabwe received annual supplementary budgets that helped cover gaps.

"Activities and needs should drive the budget, rather than allowing the budget to define the scale of what can be achieved on the ground. While the budget naturally influences planning, it must be informed by actual needs to ensure they are effectively met. Budget forecasts were especially useful for advocating for additional funding from Finland, as they provided a realistic picture of what could be accomplished."

-IDI, Plan Country Programme Office,
Zimbabwe

IDIs with Plan staff from Ethiopia, Zimbabwe and Mozambique highlighted that the resources provided for youth economic activities were often too limited to generate sustainable income, especially in contexts affected by inflation and rising living costs. Plan staff reported that, YEE reached only a fraction of the CSE target population (e.g., 361 adolescents and youth compared to over 20,000 children, adolescents and youth



participating in CSE), which created a challenge for implementation, as the programme's SRHR focus could not always

respond to livelihood pressures and limited the expected synergistic effect between the two areas.

Q11. To what extent did programme teams have the skills, expertise, and support to deliver results efficiently, and which capacity-building methods were most effective? **Q12.** How effectively did management structures at PIF, Country Programme Office, and partner levels support efficient implementation, learning, risk management, and safeguarding; and in what ways could collaboration between Country Programme Offices and partners be strengthened?

Across all countries, programme teams consistently reported that PIF's technical support model substantially strengthened their ability to deliver results efficiently. Country programme office teams and CSOs highlighted that regular technical guidance, especially from SRHR, gender and disability inclusion specialists built their confidence and helped them avoid implementation errors.

- In Uganda for example, teams noted that advisers "*walked us through each step*" of the social norms analysis and endline evaluation, ensuring activities were designed correctly.
- Country programme office in Ethiopia praised the breadth of technical specialists available from PIF, describing the support as "*comprehensive and diverse*" and critical for results-based management.

The most effective capacity-building methods were those that *embedded practice, reflection, and a relationship-based approach*. Monthly catch-up calls, thematic online meetings, and field accompaniment were universally appreciated, where they enabled joint troubleshooting and real-time feedback. In Myanmar, Country Programme Office teams emphasised the value of webinar-based training that accompanied new approaches. Meanwhile, in Ethiopia and Laos, cross-country learning platforms helped teams contextualise lessons from diverse settings.

Although PIF's technical support was highly appreciated, evaluation identified several gaps. Examples include:

- In Myanmar, the field team reported that the *division of responsibilities between the Plan Country Programme Office specialists and the field team* was not clearly communicated or consistently followed. Staff reported being unsure who in the country programme office was responsible for providing technical inputs on gender, disability inclusion, and safeguarding, and when the field team should expect feedback or approvals. They also noted that communication related to donor expectations, reporting feedback, and technical guidance from PIF is often delayed or incomplete, with information such as comments or new templates sometimes not shared with the field team or only communicated shortly before deadlines.
- The Zimbabwe team explained that they regularly learn valuable practices from Uganda and other countries such as using budget lines to support volunteers, allocating funds for field monitoring, and equipping officers with organisational phones for follow-up with young people. However, Plan staff from Zimbabwe reported that they cannot implement these practices due to *budget limitations*.



- While virtual exchanges have been regular and helpful, teams from Ethiopia, Uganda, Mozambique, and Zimbabwe stressed that they lack opportunities for **in-person cross-country visits**. They specifically requested joint exposure visits to observe how peers conduct social norms sessions, how youth engagement structures operate in different contexts, and how SRHR activities are integrated with schools and community systems.
- Teams in Ethiopia, Myanmar, and Zimbabwe highlighted need for more **in-country specialists** for several cross-cutting areas such as disability inclusion, climate change, gender-transformative programming, and safeguarding. This means that when field teams need technical inputs—for example, on adapting climate-related activities, reviewing disability screening tools, or strengthening safeguarding protocols—they must rely entirely on PIF advisers who are supporting multiple countries, along with large Country Programme

Office portfolios and limited in-country expertise, coordination becomes more difficult. Because these topics are numerous and require regular follow-up, the lack of in-country focal points slows adaptation and reduces how quickly teams can implement PIF's technical recommendations. This has implications for management, resource allocation and clarity of roles at the project level. Being explicit about who covers which technical area is especially important when resources are limited, as this helps teams use existing expertise more efficiently and prioritise support.

Respondents across Finland, Uganda, Zimbabwe, and Ethiopia consistently emphasised that risk management, fraud prevention, and safeguarding systems were strong at programme management levels. Annual risk matrices, safeguarding compliance monitoring, and fraud oversight by programme managers were routine and well-integrated into PIF and country programme office management cycles.



Sustainability

SUMMARY



The programme generated the most durable impact at individual and community levels, where CAY gained sustained SRHR knowledge, confidence, and leadership that continued beyond project activities.

Community structures such as VSLAs, parenting groups, and CoC youth groups have become self-sustaining platforms that blend social, economic, and SRHR functions and continue to operate with limited external support. Institutional sustainability is evident where SRHR and CSE have been embedded in formal health and education systems, youth-friendly services, and national guidelines.

CSOs gained multisectoral skills (SRHR, disability inclusion, climate-linked SRHR), improved governance and planning systems, and developed durable tools and curricula that institutionalise knowledge. Several expanded their role in district committees and government coordination platforms, demonstrating increased legitimacy and advocacy reach. Still most reported lacking predictable financing and remain dependent on external resources for community-level work.

Some CSOs now influence district planning, operate youth-friendly corners, or participate in national policy spaces, showing progress toward local ownership and system integration. However, community-level sustainability remains fragile, often dependent on voluntary champions and small operational inputs.

Q13. What evidence exists of sustained benefits for target groups and lasting positive changes in institutions, frameworks, and policies following the end of the programme, and which programme strategies were most effective in contributing to these sustainable outcomes? **Q14.** What evidence exists of local ownership and of efforts to build partnerships and strengthen local capacities for partner CSOs?

Across the MBMF2 countries, the programme's most durable results are found at the individual level, where CAY gained significant, often transformative, knowledge and confidence related to SRHR. These changes stem from **sustained, intensive participation** in CSE, CoC, and Innovation Hub/Smart Up Factory processes.

- In Mozambique, for example, graduates of the CoC curriculum formed their own youth association to continue advocacy and peer education without Plan supervision.
- In Laos, youth who received intensive CSE and leadership training are already advising younger peers, and Country Programme Office staff describe how this

learning is now embedded into everyday communication at home and school.

- In Uganda and Zimbabwe, youth leaders trained under MBMF2 have moved into recognised leadership roles in their communities, influencing peers' access to contraception and modelling more gender-equitable behaviour.

Community structures established or strengthened by MBMF2 demonstrate high potential for long-term sustainability. VSLA groups, parenting groups, and CoC youth networks have become embedded **community mechanisms that combine financial, social, and SRHR-related functions**. This is an important factor in community-led continuity.



- In Ethiopia and Uganda, VSLA groups continue savings cycles and dialogue sessions independently, with trained “agents of change”, who keep SRHR discussions alive.
- In Mozambique, parents trained through VSLA groups now organise community dialogues without project oversight, and district officials recognise these groups as legitimate actors.
- In Uganda, registered CoC youth groups are now linked to sub-county governments, allowing them to access public development funds.

“We have CoC youth groups that have begun engaging directly with the sub-county. To receive support from the government, you must be organised as a group, and now the sub-county knows these groups by name, where they come from, and who their leaders are. When government projects come through the sub-county, funds are allocated to registered groups, and the youth must account for the money together.”

-SGD, LAYDNET, Uganda

Recent shifts in health sector financing in 2025 have placed additional pressure on public systems in several countries, increasing governments’ need for external support and, in some cases, reducing their ability to expand or sustain health services independently. While MBMF2 has not yet been severely affected, the broader funding constraints show the importance of continued investments that reinforce national systems and mitigate long-term sustainability risks. Investments in SRHR have achieved a degree of institutionalisation that increases the likelihood of sustained service quality. Below are some of the examples:

- Sustainability has been strengthened by embedding SRHR and CSE within formal education and health systems, where

curricula, workplans and national guidelines now include relevant content and are supported by government-owned reference materials.

- Health services have adopted youth-friendly approaches as part of routine delivery, with dedicated spaces, inclusive infrastructure and trained personnel becoming regular components of public health provision.
- Capacity building has equipped teachers, health workers and peer supporters with skills that remain within institutions and communities, enabling them to continue providing information and guidance independently. Anchoring adolescent SRHR service delivery in specialised SRH partners—not only government systems—has been a key sustainability strategy in MBMF2, successfully maintaining service availability beyond the project and validating the strategic shift from MBMF1.
- Local ownership has been reinforced by engaging community structures that already exist such as parents, leaders and organised AY groups so that SRHR discussion, outreach and referrals continue as part of everyday community activity.
- Policy involvement has ensured that project lessons inform national plans and legislative processes, including attention to disability, inclusion and emerging issues such as climate-related SRHR concerns.²⁴
- Communication and knowledge transfer are maintained through materials and media products that were formally handed over for continued use, including ongoing dissemination through community and digital platforms.
- Long-term access has been supported by establishing permanent service points

²⁴ Plan worked with government to embed project lessons in national frameworks in Zimbabwe, including contributing to the Adolescent Health Implementation Plan and integrating climate-related SRHR issues. They also engaged parliamentarians and senators to support longer-term

legislative change through the Disability Inclusion Bill, which seeks to address discriminatory attitudes, infrastructure barriers and transportation challenges faced by adolescents with disabilities in accessing SRHR services.



and referral pathways that reduce practical and attitudinal barriers for adolescents to access SRH services, ensuring continued use after external funding ends.

The programme invested substantially in strengthening the capacity of local CSOs and embedding ownership at community level across all countries. Local partners received targeted training in SRHR delivery, gender-transformative approaches, disability inclusion, youth-friendly service provision, climate-linked SRHR, and innovation and soft skills.

CSOs consistently noted that, while MBMF2 strengthened their technical ability to deliver adolescent SRHR, a lack of long-term and predictable funding remains the biggest threat to sustaining and scaling results. They indicated that the programme could have gone further in supporting organisational sustainability particularly by helping them access funding, link to new donors or government funding windows, and secure operational resources for youth groups, hubs and continued outreach. The recommendations therefore point to a need for future programmes to invest not only in technical capacity but also in resource mobilisation and organisational financing so that CSOs can continue delivering services beyond project cycles.

Several CSOs reported that working within government systems and community structures improved their coordination, networking, and integration capacities. For example, CDSU in Uganda described how collaboration with government programs such as climate change, agriculture, and youth development initiatives enhanced their ability to embed SRHR within broader district systems.

CSOs also strengthened their **technical capacity** in SRHR, disability inclusion, youth-friendly services, and community mobilization. Some examples are as follows:

- In Zimbabwe, CSOs reported that the project improved their expertise in disability-inclusive SRHR, including the development of sign-language IEC materials and accessible health facility modifications.
- In Uganda, it was noted that training peer navigators and facility focal persons resulted not only in stronger community referral networks but also the partner CSO providing SRH services - RHU's internal capacity to train and supervise community-based cadres.
- CSOs in Mozambique indicated that participating in district health system strengthening, including advocating for staffing of newly established clinics, increased their competence in health systems engagement and policy influence.
- One CSO in Ethiopia indicated that linking SRHR education with economic empowerment initiatives (Smart up Factory, VSLA and income-generating activities) expanded their technical experience in designing multisectoral interventions that strengthen both SRHR outcomes and youth economic empowerment.
- The CSO in Myanmar mentioned that implementing SRHR for diverse SOGIESC groups in a highly restrictive political context strengthened their organisational capacity in risk management and low-profile community engagement, through negotiating access with village elders and adapting activities in response to security threats.
- One CSO in Laos reported that developing peer-to-peer education models and village-level coordinators strengthened its capacity to foster community ownership and multi-actor collaboration for SRHR and early-marriage prevention.

Another area of capacity enhancement was **content development, communication, and media production**.



- In Zimbabwe, Intwasa gained substantial capacity in creating high-quality educational content, partnering with national broadcasters, and managing a digital platform that now reaches tens of thousands. Their experience producing audio and video content, combined with the solar media kits, strengthened their technical skills in digital SRHR communication.
- In Mozambique, PFHA also expanded its capacity to develop audio clips, mini-plays, and visual materials tailored for village-level dissemination.

CSO capacity was further enhanced through **improved tools, materials, and institutional resources**. CSOs developed and distributed durable training materials, game cards, and manuals that strengthened their capacity to deliver school-based interventions independently of project funding. CSOs now possess structured curricula, facilitation guides, and documented approaches that solidify their institutional knowledge and make their SRHR programming more standardized and replicable. Several CSOs such as CLASS, AYUA, and GCU in Uganda diversified their activities by integrating vocational training, IGAs, and innovation hubs, which not only supported community livelihoods but also improved the CSOs' ability to manage multifaceted, cross-thematic programs. Others, like AMODEFA in Mozambique and GDA in Laos, enhanced their capacity to influence district planning, integrate SRHR messages into government routines, and maintain strong relationships with public sector actors.

However, CSOs, a recurrent concern is that many activities especially community dialogues, CSE outreach, and youth group facilitation are unlikely to continue without external financial support. CSOs highlighted gaps in government budgets. Even when there is policy alignment, there is no visible government budget allocation and funding support remains essential. For instance, village structures lack the minimal tools needed to continue CSE, SRHR awareness,

or youth group facilitation. While district and school-level systems appear more stable, village actors often depend on small but essential items such as posters, markers, IEC materials, or simple teaching aids to run sessions. When these materials are depleted or damaged, community groups struggle to maintain momentum.

Across the programme, CSOs have not only delivered community-based SRHR and CSE initiatives but have also strengthened their organisational and systems capacities in ways that are likely to generate longer-term change. In several cases, CSOs reported increased ability to engage with local authorities, participate in district-level planning processes, and influence service provision. Some CSOs are now integrated into district committees, lead youth-friendly corners in health facilities, or contribute to government-led dissemination and counselling services. Others have developed strong digital communication capacity, expanded youth-led platforms, or created training resources that continue to circulate through government and community networks.

"In terms of the coordination and the partnerships, we were part of the committees of the districts we worked with. We were coordinating with SRHR organisations. We did partner with like-minded organisations and other Plan interventions. As a sustainability strategy, we worked with local clinics to be able to work with the young people, we moved away from private clinics to local authority service providers."

-SGD, SRC, Zimbabwe

Civil society strengthening was visible across several dimensions. Beyond technical SRHR knowledge, partners described improved governance arrangements, better planning and financial systems, and enhanced advocacy and policy engagement. CSOs also gained tools and materials that extend their reach—ranging from disability inclusion modules and climate change integration, to



community-level content creation, counselling rooms and youth-friendly spaces. These shifts have expanded CSOs' ability to work with government systems, while also reinforcing their legitimacy as actors in SRHR and youth development. Importantly, many organisations noted growing voice and agency in decision-making spaces, including participation in provincial or district councils, and engagement in national-level networks on SRHR, HIV, and inclusion.

"Counselling rooms were repaired at each of the health centers in our target areas. Now, they have counselling rooms available... this work is directly connected with the public sector because they have already been providing SRHR counselling services. Our contribution goes a bit further by focusing on youth and offering friendly and confidential counselling to them. Even after our project ends... they said that they will integrate our approaches into their regular activities because the health department already conducts dissemination, many activities, and vaccination campaigns."

-SGD, AMODEFA, Mozambique

A notable area of progress relates to collaboration and collective action. Most CSOs described strong coordination with government departments, health facilities, schools, women's unions, disability organisations and other SRHR actors. In several contexts the programme helped revitalise networks—such as sexual and reproductive health rights coalitions, men-for-change networks, or disability inclusion

partnerships—reducing fragmentation and creating more coherent district responses. These relationships also represent early forms of movement building, strengthening visibility and joint advocacy around youth SRHR.

There are differences across organisations. Larger national CSOs tend to engage more fully in policy or network spaces and are more frequently embedded within government systems, while community-based organisations mainly sustain impact through youth groups, VSLA structures or referral relationships. OPDs have contributed specialist skills and inclusion models, while service-delivery organisations have focused on youth-friendly services and referral pathways. These distinctions help explain variation in sustainability: district-level and institutionalised interventions are often better secured, while village-level facilitation, youth groups and community dialogues remain more dependent on resource, particularly when materials and small operational inputs are not available.

At community-level, continuity is also highly dependent on individual champions rather than institutionalized systems. CSOs repeatedly emphasized that sustainability rests on youth leaders and peer navigators who act voluntarily, warning that village-level continuation would occur in some areas, though perhaps not everywhere, and that while groups are active now, their work is *"happening without monitoring"*, making long-term continuity uncertain.



Gender and Inclusion

SUMMARY



MBMF2 has achieved significant gender-transformative progress, evidenced by improved SRHR knowledge, rising adolescent agency, and early signs of shifts in social and gender norms across all six countries. The programme's systematic gender and norms-diagnostics approach, along with strengthened engagement of men and boys, has helped dismantle harmful masculinities and legitimise positive behaviours.

Inclusion of persons with disabilities and youth with diverse SOGIESC has expanded meaningfully and revealed the importance of working through CSOs to challenge stigma and invisibility. MBMF2 is not only shifting individual attitudes and behaviours but also influencing organisational practice, community structures, and emerging national policy uptake, suggesting movement toward systemic transformation.

At the same time, the variability in inclusion, particularly in restrictive environments, highlights persistent structural, legal, and accessibility barriers that the programme should continue to navigate through adaptive, context-specific strategies.

Evidence of improved service quality and increased participation of marginalised youth shows that investments in capacity-building, technical accompaniment, and inclusive design are yielding high returns.

MBMF2 has laid strong foundations for gender-transformative change, but sustaining and scaling these gains will require continued work on GTA principles, and continued support for local partners' leadership.

Q15. What achievements has the programme made in terms of gender transformative change addressing the root causes of inequality, including harmful social and gender norms, attitudes and policies?

At the outset of MBMF2, PIF and country programme teams recognised that previous efforts to address harmful norms, particularly those affecting adolescents' access to contraception, had been inconsistent and/or not addressed systematically. In response, MBMF2 introduced a structured, organisation-wide norms approach, beginning with a comprehensive 2022 diagnosis and followed by a second round in 2025 to capture early signs of change. Importantly, this diagnostic work was conducted by country programme offices and CSOs themselves, rather than external consultants, allowing teams to develop mastery of the tools, build a shared language on norms, and internalise behaviour-change

thinking.

This approach has led to significant shifts. Across countries, the proportion of CAY with correct knowledge of SRHR doubled (29% to 57%), and those able to challenge gender stereotypes increased from 24% to 61%. In Zimbabwe and Uganda, for example, youth described becoming confident to question long-held beliefs, such as the idea that girls who use contraception are "*promiscuous*", while in Laos and Myanmar, youth have openly critiqued expectations around the topic of early marriage.

Across all six countries, community and household attitudes have become more supportive of adolescent SRHR and gender



equality, with measurable behavioural changes. Parents who once opposed adolescent contraception increasingly support their children's access, and in several settings, such as Laos, Ethiopia, and Mozambique, parents now accompany adolescents to health facilities or permit them to go unaccompanied, a substantial shift from baseline.

Importantly, the analysis from the second round of the norm diagnosis in 2025 indicates that these changes are emerging alongside growing adolescent agency, with young people more confidently negotiating their reproductive choices and initiating conversations with parents and community members. At the same time, positive influencers, including teachers, progressive religious leaders, and health workers, are becoming more visible in public dialogue, helping to legitimise contraceptive use and reduce stigma. Such changes show cracks in previously rigid normative frameworks, where long-standing restrictions around adolescent sexuality are being questioned and re-negotiated.

Practical changes in gender roles are also emerging. In Laos, for instance, husbands are now sharing household tasks traditionally labelled as "women's work," and women are participating more actively in village meetings. Youth testimonies highlight that LGBTQIA+ participants, girls, and young women now take leadership roles in mixed groups, with cis man peers demonstrating acceptance and respect for their authority. These shifts also highlight broader changes in discourse, where discussions on contraception use of AY are being negotiated within prevailing cultural and moral values, which is supporting more informed and autonomous decisions.

MBMF2 strengthened work on transforming masculinities work by strategically engaging men and boys as active partners in promoting gender equality in its efforts to shift attitudes and behaviours rather than positioning them as barriers to be addressed. With Sonke Gender Justice

providing technical advice and multi-country capacity-building, the programme refined its focus on how men and boys relate to SRHR as individuals, as partners, and as influencers in their communities. In Uganda and Ethiopia, teams learned to meet men "where they are," conducting dialogues in local bars and social spaces where male attendance was highest, resulting in increased participation and shifting attitudes on caregiving and decision-making. In Uganda, boys in innovation hubs who initially rejected SRHR topics are now champions for menstrual health and girls' access to services. Evidence from men's groups shows growing involvement in domestic labour, purchasing sanitary pads for daughters, and supporting partners' SRHR decisions.

A major gender-transformative achievement of MBMF2 has been its deliberate transition from generic "vulnerable groups" approaches towards partnerships with representative organisations; OPDs and LGBTQIA+/SOGIESC groups. These partnerships have challenged deeply embedded norms that deny youth with disabilities and LGBTQIA+ youth their sexuality, rights, and place in communities. In Zimbabwe, partner OPD NCDPZ guided work on disability inclusion, contributing models, such as the "Five As," that are now being documented as good practice. In Laos and Myanmar, LGBTQIA+ youth report decreased bullying, greater confidence in expressing their identities, and improved acceptance from teachers and community leaders. In Mozambique, engagement with LGBTQIA+ activists opened unprecedented dialogue with politicians, helping to normalise LGBTQIA+ issues within SRHR discussions. By elevating partner expertise and creating safe spaces for minority youth, MBMF2 has addressed stigma and invisibility, two powerful root causes of inequality rarely tackled at scale in SRHR programmes.

YEE interventions across five countries contributed significantly to structural aspects of gender-transformative change by improving young women's economic



autonomy, an essential determinant of their SRHR decision-making. Training in vocational and entrepreneurial skills, coupled with life skills and climate-resilience modules, increased youth confidence from and reduced gender gaps in self-efficacy. In Ethiopia and Uganda, follow-up data show that many female participants have started microbusinesses or secured employment within six months, enhancing their independence. In Laos, vocational training was provided to young women with disabilities and other marginalised groups, and although participation numbers were relatively small, several of the trained women have since secured employment, established small businesses, or continued with further training. In Zimbabwe, young women report that having their own income has reduced household tensions and lowered exposure to violence: Women no longer need to request money from male partners – often a trigger for conflict – and several participants stated that they were able to leave exploitative or transactional sexual relationships once they gained financial stability.

By 2025, 76% of assessed health facilities met the WHO standard for “high-quality” adolescent SRH services²⁵, compared to only 29% at baseline. Providers are now more willing to offer all contraceptive methods to adolescents, including long-acting reversible methods, and health workers increasingly discuss sensitive topics, such as consent, sexual pleasure, sexual orientation, and gender identity. In Uganda, peer navigators and disability-inclusion facilitators ensure that youth with disabilities can access information without judgement. In Mozambique, mobile brigades reach

adolescents in remote communities with accurate SRH information and counselling.

Across countries, teams noted that access to PIF specialists, particularly in gender, inclusion, SRHR, and climate, was critical to delivering activities efficiently and maintaining quality. Step-by-step coaching and continuous accompaniment helped avoid costly mistakes in norms measurement, results-based management, and CSE design. Ethiopia reported that this support enabled them to institutionalise the six GTA elements across all components, improving coherence without major additional cost. However, several countries noted that these gains were sometimes constrained by limited in-country technical staffing.

MBMF2 has contributed to organisational and policy shifts that address inequality at systemic levels. Notably, the programme provided the conceptual foundation, country learning, and partner engagement that enabled PI to develop and adopt its first global SOGIESC position paper in 2024, an outcome directly attributed to MBMF2 by PIF staff and partners. At national levels, evidence and tools from the norms diagnosis have been requested by government actors in Laos, Ethiopia, and Uganda, indicating emerging policy uptake. In Mozambique, training government officials on SOGIESC inclusion has begun to shift institutional attitudes. These developments demonstrate that MBMF2’s gender-transformative influence is not confined to community groups; it is shaping organisational culture, strategic direction, and national policy conversations, addressing root causes by altering the systems that reproduce exclusion.

²⁵ World Health Organization. (2015). Global standards for quality health-care services for adolescents: A guide to implement a standards-driven approach to improve the

quality of health care services for adolescents. Geneva: WHO.
<https://www.who.int/publications/i/item/9789241549332>



Q16. How have the key elements of the GTA, with a specific focus on boys and men's engagement to transform masculinities and increase their involvement in promoting gender equality, been successfully integrated and what have been the key practical and enabling factors?

Across the programme, partners have integrated the GTA, particularly the engagement of boys and men, through existing structures rather than through isolated interventions. In countries such as Laos and Mozambique, student and youth clubs became central mechanisms for normalising joint participation of boys, girls, and LGBTQIA+ youth, with students reporting that mixed-gender collaboration in leadership tasks, homework, cleanliness activities, and even sports had become routine. In Zimbabwe, male engagement structures such as male ring leaders, CoC sessions, and intergenerational dialogues enabled young men to openly discuss harmful norms and to demonstrate shifts in everyday behaviours, such as supporting their sisters' menstrual hygiene needs.

CSOs across the programme adopted peer-led, arts-based and dialogic approaches as practical mechanisms for engaging boys and men in transformative discussions on masculinity and gender equality. In Laos, student clubs used drama shows to highlight the consequences of harmful behaviour and model healthier alternatives for wider school communities. Mozambique's consortium partners, including AMODEFA and LAMBDA, relied on serial albums, theatre, and audio-visual content to engage young men who were otherwise reluctant to join conventional training sessions, allowing sensitive topics, such as sexual pleasure, consent, and discrimination to be addressed creatively. The CoC "dialoguing gender" module proved particularly influential in Uganda and Mozambique, where structured reflection sessions helped boys and men question harmful masculinities and the relationships between social privilege, power and GBV. Qualitative data across Ethiopia, Uganda, Mozambique and Laos show men began communicating about sexuality with partners and children,

challenging traditional masculinities and reducing taboos.

The programme's success in integrating GTA was strongly supported by the engagement of influential male leaders and the deliberate creation of male champions. In Uganda, religious and cultural leaders who were initially barriers to SRHR discussions became advocates after targeted sensitisation, using their authority to encourage male participation and dispel myths. Zimbabwe also benefitted from male ringleaders trained to cascade gender-equality messages in their communities, leading to tangible changes, such as men purchasing menstrual pads and supporting contraception. These champions created pathways to engage men who might otherwise resist gender discussions, demonstrating that the involvement of respected figures is an enabling factor for norm-shifting work and accelerates collective acceptance of GTA principles.

Efficiency in integrating GTA principles was greatly enhanced where partners leveraged existing structures and community routines. In Ethiopia and Uganda, VSLA groups became natural spaces for extending gender discussions beyond formal sessions, with parents continuing reflections during savings meetings. Partners, such as PFHA in Laos, incorporated gender-equality messaging into routine health outreach and village meetings, ensuring male participation by coordinating with village heads and offering small but meaningful incentives (e.g., condoms for men, sanitary pads for women). In Mozambique, quarterly reflection meetings linked CoC boys' groups to men's community dialogue groups, reinforcing consistent messaging without creating parallel structures. Childcare arrangements, such as toys and designated babysitters, introduced by GDA in Laos



addressed structural barriers that limited joint participation of fathers and mothers.

Across countries, CSOs and Country Programme Offices observed concrete shifts in boys' and men's behaviours, demonstrating the effectiveness of integrated GTA work. In Laos, boys who previously avoided playing football with girls now willingly participate in mixed teams, and club members report a notable reduction in bullying of LGBTQIA+ peers. In Mozambique, men engaged through CoC and community dialogues described supporting daughters' menstrual hygiene, talking about contraception openly, and sharing domestic responsibilities—behaviours previously seen as taboo. In Zimbabwe, men expressed that the programme allowed them to “come out and share their problems,” challenging harmful norms around emotional suppression and isolation.

While the programme has not yet generated direct evidence linking masculine ideals to environmental exploitation, the data do demonstrate that dominant gender norms shape climate-related vulnerabilities and responses, particularly for girls. Across countries, adolescents described how droughts and floods increase early marriage, transactional sex, and reduced access to SRH services—highlighting how gendered power relations determine who bears the greatest risk during climate shocks. Building on this experience, future programming could explore how the same patriarchal norms that position men as decision-makers and controllers of resources within households and communities also influence environmental decision-making and resource use, especially in contexts where climate stresses intensify gendered SRHR risks.

Q17. To what extent has the programme effectively included persons with disabilities and other marginalised groups—such as people with diverse SOGIESC (particularly in Myanmar, Laos, Zimbabwe, and Mozambique)—in the planning, implementation, and monitoring of activities, and supported their SRHR and meaningful participation across all countries?

CSOs and Plan country programme offices entered MBMF2 with markedly different levels of experience in disability-inclusive SRHR programming. Some Country Programme Offices, such as Laos, Mozambique, and Zimbabwe, already had established relationships with OPDs. In these contexts, OPDs were engaged not only as implementers but also as co-designers, with Laos' WWDA contributing to tailored CSE packages for girls with disabilities and Mozambique's FAMOD leading community-based approaches with trained disability focal points providing rehabilitation support and referrals. In contrast, other settings, such as in Uganda and Ethiopia, initially had more

limited mechanisms for inclusion, particularly for youth with sensory and intellectual disabilities. CSOs there often relied on influential community figures or informal guides due to the absence of formal sign-language interpretation or assistive technologies.

The programme's inclusion of people with diverse SOGIESC reflects a spectrum of possibilities shaped primarily by national legal and political constraints rather than by CSO commitment. For example, LAMBDA in Mozambique played an instrumental role in designing and implementing SOGIESC-inclusive SRHR outreach, provider training,



and community theatre interventions. Kumudra in Myanmar had to work low-profile, rely on village-level permissions, and use peer-based approaches rather than formal systems. Despite these constraints, partnerships such as with Kumudra enabled the creation of safe entry points for LGBTQIA+ youth through tailored SRHR activities, peer networks, and youth-friendly spaces. In Laos, although Proud To Be Us Laos could not be a formal partner due to registration constraints, they influenced programme design and youth club content, resulting in visibly increased confidence and reduced bullying among LGBTQIA+ youth in schools. SRC from Zimbabwe, although long-established as an LGBTQIA+ organisation, was a new partner to Plan and to other organisations in the project. Because direct discussion of LGBTQIA+ issues is not permitted by authorities due to its criminalisation, SRC used the programme's platform to work on these issues indirectly, for example by engaging under the language of key populations within SRHR, which provided a more acceptable entry point for authorities and partners. At the other end of the spectrum, Uganda and Ethiopia made a strategic decision not to formally engage SOGIESC groups due to heightened legal and personal security risks. CSO there acknowledged the importance of the issue but affirmed that visible inclusion would compromise both staff safety and programme viability.

Across all countries, partners also consistently demonstrated the capacity to include marginalised groups, especially youth with disabilities and LGBTQIA+ youth—in day-to-day implementation. In Laos, youth clubs and evening-learning sessions intentionally integrated young people with disabilities and SOGIESC youth, providing safe spaces supported by bilingual facilitators, sign-language helpers, and child-friendly arrangements, such as on-site babysitting to ensure that parents could attend. In Mozambique, peer educators from LAMBDA and community facilitators from OPDs co-delivered CSE and SRHR outreach,

while Zimbabwe's male engagement and intergenerational dialogue approaches created unexpected safe spaces for queer youth to participate alongside their families. ECDD strengthened disability inclusion across all project outcomes by training partners and health providers, supporting OPDs and improving service accessibility, for CAY with disabilities. However, CSOs across countries cited difficulty meaningfully including youth with hearing impairments, due to the absence of formal sign language, limited accessible transport, and youth reluctance to self-identify as disabled or LGBTQIA+ for safety reasons.

A clear programme achievement is the growing leadership of marginalised youth in advocacy, peer education, youth clubs, and community mobilisation. In Zimbabwe and Mozambique, LGBTQIA+ youth joined public forums and community dialogues—often for the first time—supported by club mentors and partner organisations. In Myanmar, youth governance structures, led by Kumudra, provided discreet but meaningful avenues for LGBTQIA+ youth to shape local SRHR messaging. Youth with disabilities in Ethiopia, Zimbabwe, and Uganda served as peer educators, advocates for accessible services, and co-facilitators of dialogue sessions with parents and religious leaders. Programme monitoring confirms the depth of participation: Large majorities of youth—including those with disabilities—reported feeling heard, respected, and able to influence programme decisions. However, this participation is less consistent in formal planning and MEAL processes, where marginalised youth and their representative organisations are not always present in indicator design, data-use discussions, or annual reviews. Participation of AY with disabilities and LGBTQIA+ AY in formal planning and MEAL processes is limited mainly due to structural and legal restrictions, communication and accessibility barriers, lack of organisational capacity or resources, and youth reluctance to self-



identify in politically or socially sensitive environments.

Monitoring systems have become increasingly sensitive to disability, with countries, like Uganda and Ethiopia, improving the visibility of youth with disabilities through targeted outreach, needs assessments, and service audits. Community surveys across multiple countries now measure changes in attitudes towards the SRHR of youth with disabilities, and accessibility audits, sometimes conducted jointly with OPDs, inform annual planning. However, disability data still undercounts participation because many

youths do not self-identify or fear stigma, a challenge explicitly reported in Laos and Mozambique. For instance, disability awareness in the Laos project areas remains limited, with community members typically recognising only visible impairments and lacking understanding of the broader range of disabilities, which constrains accurate identification and inclusive participation. SOGIESC monitoring remains far more limited. In Uganda and Ethiopia, political risks make SOGIESC monitoring impossible. Programme monitoring captures significant inclusion efforts but does not yet fully reflect the scope or depth of participation by all marginalised groups.



Conclusion

The endline evaluation of MBMF2 shows that the programme has achieved significant progress across its four outcome areas despite operating within an increasingly volatile and resource-constrained global SRHR environment.

Over the 2022–2025 period, SRHR financing contracted globally, development assistance became more unpredictable, and anti-gender movements intensified. These external pressures have limited government budgets, reduced donor investment, and introduced political and social barriers that directly affect adolescents' ability to access comprehensive, rights-based SRHR information and services. Against this backdrop, the scale and consistency of MBMF2's achievements are significant.

The programme has delivered meaningful and measurable progress for CAY across six diverse and often challenging contexts. The programme's relevance remained strong throughout its implementation period, driven by continuous learning, adaptive management, and a multicomponent approach that intentionally addressed demand, supply, and enabling-environment barriers to SRHR. The evaluation confirms substantial gains in SRHR knowledge, confidence, gender-equitable attitudes, community awareness, and the quality and inclusiveness of services.

Many outcomes exceeded their targets, and several promising signs of early normative change particularly around contraceptive acceptance indicate that MBMF2 has contributed to shifts that extend beyond individual behaviour to the broader social fabric surrounding young people.

At the same time, the evaluation identifies areas where change has been more modest or uneven. Service uptake among CAY increased only slightly despite clear improvements in service quality, reflecting persistent stigma, limited perceived need for

preventive SRH care, confidentiality concerns, and structural barriers such as mobility constraints, restrictive legislation, and political instability.

Inclusion efforts were advanced, yet social norms surrounding disability, LGBTQIA+ identities, and unmarried adolescents' sexuality continued to limit full participation and autonomy.

Progress on economic empowerment for VSLAs and climate resilience showed strong potential but reached smaller groups than intended, suggesting a need for more systematic layering to ensure that all adolescents benefit from reinforcing interventions across the programme's pillars. Additionally, the level of engagement from community leaders—while improving and achieving its target—remains limited to anchor sustained, rights-affirming SRHR environments in all settings.

Despite these challenges, MBMF2 has laid a solid foundation for future programming. The programme's gender-transformative, inclusive, and intersectional approach has been proven as relevant and effective in catalysing positive shifts that are beginning to take root at household, community, and institutional levels. The strengthened capacities of CSOs, service providers, teachers, and government partners suggest that many programme gains are likely to continue beyond the current funding cycle, particularly where structures such as youth groups, teacher networks, disability-inclusion mechanisms, and community dialogues have become embedded in existing systems. Moreover, the programme's investments in social- and gender-norm diagnostics, and iterative learning have generated rich evidence base and a set of adaptable models that Plan International Finland and its partners can scale and refine.



For the MBMF programme's future, the most important findings highlight three key implications. First, deepened integration—across SRHR, YEE, climate resilience, and inclusion—is essential to maximise impact and ensure that gains in agency translate into real opportunities and sustained behavioural outcomes. Second, strengthening the link between improved services and increased use will require tackling both practical barriers and the persistent normative stigma surrounding adolescent sexuality, especially for girls and for those facing intersectional marginalisation. Third, continued investment in localisation, capacity-sharing, and multi-level partnerships will be vital to institutionalising the programme's approaches, expanding their reach, and ensuring resilience in restrictive or fragile contexts.

MBMF2 has made significant contributions toward safer, more supportive, and more equitable environments for adolescents and youth to exercise their SRHR. While gaps remain, particularly in service uptake and the full realisation of inclusive norms change, the programme enters its next phase with strong momentum, proven strategies, and valuable lessons that position it to deepen, scale, and sustain its impact in the years ahead.



Recommendations

Recommendation 1

Strengthen CSE Sustainability by Reducing Facilitator Dependency and Clarifying When to Use Whole-School or Targeted Approaches

CSE is consistently one of the strongest-performing components of MBMF2, generating marked improvements in adolescents' SRHR knowledge, communication skills, confidence, and gender-norm resistance across all countries. The evaluation also shows that both in-school and out-of-school modalities play essential and complementary roles, especially in reaching diverse groups of adolescents, including those out of school, in rural areas, young mothers, adolescents with disabilities, and those facing high stigma or safety risks. Most CSE delivery continues to rely heavily on external facilitators, youth volunteers, or CSO staff. This creates challenges for continuity, institutionalisation, and long-term quality, particularly in countries where political environments restrict CSE framing. In addition, disability inclusion is stronger when intentionally integrated into CSE design (e.g., adapted materials, DIFs, peer navigators), yet those adaptations often depend on project-funded roles that may not continue after programme exit.

To strengthen sustainability and ensure equitable access, future programming should tailor CSE modalities to each context by clarifying when whole-school, hybrid, or out-of-school models are appropriate and designing sustainability strategies for both. In-school CSE should be embedded into teacher training systems, approved curricula, and district support structures, while out-of-school CSE should be anchored in existing community groups, youth clubs, safe spaces, and peer networks that can realistically continue beyond the programme. Reducing reliance on external facilitators requires a planned handover to teachers, youth leaders, and community mentors equipped with inclusive and disability-sensitive facilitation skills. Each country should develop a practical sustainability plan during inception that identifies who will continue CSE delivery, how they will be supported after project exit and how safe access for marginalised CAY including CAY with disabilities will be maintained.

Recommendation 2

Continue Strengthening Disability and SOGIESC Inclusion Through Safe, Targeted and Contextually Adapted Approaches

The programme achieved meaningful advances in disability inclusion, particularly in Ethiopia, Uganda and Laos, where adapted materials, sign-language capacity and disability inclusion facilitators improved access and participation. SOGIESC inclusion also progressed in contexts where CSOs had strong rights-based expertise, such as Zimbabwe, Mozambique and Myanmar. Despite these gains, inclusion is uneven across components, and political and social constraints remain significant barriers, especially in Uganda, Ethiopia and Myanmar. Community attitudes towards SRHR access for adolescents with disabilities improved only modestly, rising from 14% to 27%, mainly in relation to unacceptance of SRH access without parental approval, showing persistent gender norms and concerns about safety and autonomy.

To deepen and sustain progress, the programme should continue embedding social and gender norms diagnosis as a regular practice to ensure that evolving social norms, power dynamics, and emerging behaviours shaping attitudes towards disability and SOGIESC inclusion are systematically analysed and responded to. Future programming should maintain and expand adapted, safe, and context-sensitive approaches to disability and



SOGIESC inclusion, advancing this work in partnership with representative organisations. Where contexts allow, particularly in countries where the programme works with both OPDs and SOGIESC organisations, greater emphasis should be placed on supporting social movement building and cross-movement collaboration, strengthening collective advocacy, solidarity, and locally led change processes. These efforts should be undertaken with careful attention to safeguarding, risk mitigation, and the specific social and political sensitivities in each context, with the aim of strengthening community acceptance and equitable participation. The programme should continue to document these efforts systematically and strengthen the use of qualitative and participatory methods to capture nuanced impacts, learning, and contributions to longer-term social change.

Recommendation 3

Make Layering a Core Programme Principle by Defining It Early and Embedding It in Planning and MEAL

The evaluation demonstrates that layering—supporting CAY through multiple components such as CSE, economic empowerment and climate resilience produced the strongest and most sustainable results. Countries that layered intentionally, achieved higher autonomy, more resilient livelihood outcomes and greater SRHR agency. However, the concept was not fully understood or applied consistently. Without clarity on definitions, sequencing or expected combinations, layering depended largely on the initiative of individual teams.

The next programme phase should allocate dedicated inception-phase planning time to co-develop layering models with country offices and CSO partners, ensuring a shared understanding of what layering entails and what combinations of interventions are feasible in each context. This also entails a thorough discussion between Plan Country Programme Offices and CSOs on coordination. To improve quality and depth of layering, the programme should reduce scale where necessary so that fewer CAY receive multiple, well-sequenced interventions rather than many CAY receiving isolated activities. By intentionally layering interventions over time, the programme can more clearly articulate pathways to sustainability, as sustained exposure across SRHR, economic empowerment, and resilience components is more likely to build durable capabilities, reinforce behaviour change, and strengthen local systems beyond the life of individual activities. MEAL frameworks should be aligned to track CAY participation across components, not only by activity type, allowing the programme to assess how layered exposure contributes to SRHR, economic, and resilience outcomes.

Recommendation 4

Strengthen Local CSO Systems, Wellbeing and Long-Term Sustainability

CSOs played a central role in delivering CSE, facilitating community dialogues, advancing inclusion and leading climate and YEE activities in local communities and remote areas. The evaluation shows that local ownership greatly improved compared to MBMF1. However, CSOs continue to lack core funding for MEAL, safeguarding, administration and staff support systems, limiting their institutional resilience. Psychosocial strain and burnout emerged as increasing concerns. Without addressing organisational sustainability and staff wellbeing, programme quality and continuity are at risk.

Future programming should allocate resources specifically for strengthening CSO systems, including MEAL capacity, safeguarding mechanisms and administrative structures.



Psychosocial support (such as professional supervision) should be integrated into partnership frameworks to mitigate burnout and secondary trauma. Investing in CSOs' fundraising skills, governance structures and strategic leadership will support long-term sustainability beyond the programme cycle. Clear role definitions between Plan and CSOs, established early in the inception period, will also enhance accountability, autonomy and partnership quality.

Recommendation 5

Engage Men and Boys in Reflective Spaces to Address Patriarchal Norms Driving Both SRHR Inequities and Environmental Harm

The evaluation found that gender-transformative approaches, including work with men and boys, contributed to important shifts in community attitudes, parent-child communication, and support for adolescent SRHR. However, masculinities work has still room for growth, and there is a continued effort to link it to power, domination, and social norms that shape both gender inequality and environmental vulnerability. At the same time, the programme demonstrated promising results where SRHR and climate resilience were linked, and youth in multiple countries increasingly recognised how environmental shocks exacerbate risks such as early marriage, unintended pregnancy, and GBV. Patriarchal norms that valorise control, extraction, and dominance simultaneously drive harmful gender relations and destructive environmental behaviours. These connections were not fully explored in MBMF2 but represent a strategic opportunity for deepening gender-transformative and climate-integrated programming in the next phase. Given that men and boys hold significant influence over environmental resource use, decision-making, and household power structures, reflective spaces that interrogate these patterns could generate both social and ecological benefits.

The next programme could intentionally incorporate reflective masculinities work that explores how patriarchal norms contribute to environmental exploitation and gender inequality. This could be integrated into existing CoC curricula, intergenerational dialogues, VSLA groups, or climate resilience sessions, providing men and boys with structured opportunities to examine how norms around masculinity—such as control, domination, extraction, risk-taking, competition, and power over others—drive both environmental degradation and SRHR inequities. Linking SRHR and climate through the lens of masculinities offers a meaningful entry point for shifting harmful norms, strengthening gender-equitable behaviours, and promoting more sustainable environmental practices. Country programme teams and CSOs should co-design these reflective spaces during inception, ensuring they are politically feasible, contextually adapted, and facilitated by partners with expertise in gender-transformative approaches.

Recommendation 6

Increase SRHR Service Uptake Through CAY Informed Design and Delivery

While service quality improved substantially—reflected by a rise in high-quality facilities from 30% to 76% and improved provider attitudes from 54% to 81%—SRHR service uptake remained relatively low at 34%, with only modest increases from baseline. Qualitative data indicate several barriers: many adolescents, particularly younger ones, perceive “no need” for SRH services; girls fear judgement or lack trust in confidentiality; and distance, cost and safety concerns limit access in countries like Zimbabwe, Mozambique and Uganda. In



Myanmar, political instability and health system collapse rendered services largely inaccessible.

To address this, programmes should prioritise improving understanding of the dynamics shaping SRHR service uptake, placing CAY themselves at the centre of analysis and design. Country teams should invest in methodologies that meaningfully engage CAY such as participatory monitoring, youth-led consultations, feedback mechanisms and adolescent-led or adolescent-informed health facility assessments. This would help better understand how perceptions of need, stigma, confidentiality and service relevance vary by age, gender and context. Insights generated through these mechanisms should inform the design of context-specific, youth-centred referral and delivery pathways that link CSE, clubs, community groups and VSLA structures to appropriate service points, including health facilities, mobile outreach and pharmacy-based access.

Recommendation 7

Continue Strengthening In- and Cross-Country Learning to Improve Practice and Documentation

Across MBMF2, the programme invested in a range of evidence-generation and learning processes including monitoring and evaluation systems, in-house social norms diagnosis, outcome-harvesting exercises, joint planning sessions, and documentation efforts. These mechanisms significantly informed implementation by helping teams understand what was working, why, and under which conditions. They also facilitated adaptation of GTA and supported greater cohesion across intervention areas such as CSE, gender and social norms change, inclusion, youth economic empowerment, and climate-SRHR integration. Stakeholders across countries consistently expressed that these processes were valuable but required further consolidation and resourcing to fully meet their potential. In particular, teams requested more structured opportunities for peer learning, deeper sharing of tools and evidence, and stronger documentation practices to capture emerging insights. Ensuring adequate GTA resourcing at community, country, and global levels including for analytical functions like norms diagnosis remains essential for sustaining these gains.

Building on the progress achieved in MBMF2, the programme should continue strengthening its integrated evidence-generation and learning systems. Doing so will support more consistent documentation of promising approaches, enhance cross-country and in-country learning, and deepen shared understanding of “how change happens,” ultimately improving programme quality and replicability across diverse contexts.

Please refer to Annex C for country level action points in relation to above programmatic recommendations.

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Annexes





Annex A: Evaluation Matrix

DAC Criteria	Evaluation Questions	Desk Review	IDIs	SCDs	Reflection Workshops	Case Studies
Relevance	Q1. To what extent have the programme objectives and design responded to CAYs' needs and priorities, and have they continued to do so if/when circumstances have changed? (How did each CO define diversity in each context and how did they ensure that this was addressed in design, implementation, and measurement?)	✓	✓	✓	✓	✓
	Q2. To what extent have lessons learnt been used to improve and adjust programme and projects implementation, including the recommendations from the Mid-Term Review?	✓	✓			
	Q3. To what extent have the programme and projects been implemented through a holistic approach (i.e., by engaging different stakeholders at all levels in a coordinated and strategic way)?	✓	✓	✓	✓	
Effectiveness	Q4. To what extent and how has the programme's SRHR multicomponent–demand, supply, and enabling environment–approach been achieved its intended outcome and output results, including any differential results across CAY and various modalities of implementation used in the six countries?	✓	✓	✓	✓	✓
	Q5. To what extent and how have the complementary strategies of economic empowerment with CAY and economic resilience with community members been contributing to CAY's SRHR outcomes and to community resilience?	✓	✓	✓	✓	✓
	Q6. To what extent and how effectively was the climate change resilience cross-cutting issue mainstreamed across components and countries, at individual, community, and institutional levels, including with health facilities? What strategies were used by the COs to mainstream this cross-cutting issue?	✓	✓	✓	✓	✓





	Q7. How was the layering of activities at individual, household, community levels conducted across countries and components? To what extent did layering achieve better outcomes regarding CAY?	✓	✓	✓	✓	✓
	Q8. What significant and/or unexpected outcomes—positive or negative—emerged during implementation considering CAY, and how did the programme contribute to these changes, respond to challenges, and leverage opportunities to enhance results?	✓	✓	✓	✓	
Efficiency	Q9. How strategically have financial, human, and technical resources been allocated, and how efficient were the programme's strategies and modalities in delivering high-quality, timely, and cost-effective results? Which strategies should be considered for scaling-up, at country and programme level, and how?	✓	✓	✓	✓	
	Q10. How effectively did management structures at PIF, COs, and partner levels support efficient implementation, learning, risk management, and safeguarding—and in what ways could collaboration between COs and partners be strengthened?	✓	✓			
	Q11. To what extent did programme teams have the skills, expertise and support to deliver results efficiently, and which capacity-building methods were most effective?	✓	✓			
Sustainability	Q12. What evidence exists of sustained benefits for target groups and lasting positive changes in institutions, frameworks, and policies following the end of the programme, and which programme strategies were most effective in contributing to these sustainable outcomes?	✓	✓	✓		
	Q13. What evidence exists of local ownership and of efforts to build partnerships and strengthen local capacities for partner CSOs?	✓	✓	✓		
Coherence	Q14. To what extent did the project leverage synergies with other interventions by PI, partners, and/or other stakeholders, including governments and international organisations?	✓	✓	✓		





Gender and Inclusion	Q15. What achievements has the programme made in terms of gender transformative change addressing the root causes of inequality, including harmful social and gender norms, attitudes and policies?	✓	✓	✓	✓	✓
	Q16. How have the key elements of the GTA, with a specific focus on boys and men's engagement to transform masculinities and increase their involvement in promoting gender equality, been successfully integrated and what have been the key practical and enabling factors?	✓	✓	✓	✓	✓
	Q17. To what extent has the programme effectively included persons with disabilities and other marginalised groups—such as people with diverse SOGIESC (particularly in Myanmar, Laos, Zimbabwe, and Mozambique)—in the planning, implementation and monitoring of activities, and supported their SRHR and meaningful participation across all countries?	✓	✓	✓	✓	✓



Annex B: Desk Review Documents

Desk Review Documents
Annual Report 2022
Annual Report 2023
Annual Report 2024 (pending)
Baseline FGD Guides
GLO_Pathways to Resilience Leaflet
GLO_Annex 11_Resilience Framework_ToC
Baseline Report_Ethiopia
Baseline Report_Laos
Baseline Report_Mozambique
Baseline Report_Myanmar
Baseline Report_Uganda
Baseline Report_Zimbabwe
IPPF_SRHR and Climate Report
MBMF2_Indicators and Scoring Matrix
MBMF1 Final evaluation report
MBMF Final evaluation PPT
MBMF Final evaluation_6-pages
MBMF Final evaluation_6-pages
MBMF_MTR_FinalReport 1
MBMF2 MTR - all documents
MBMF2 Programme Document (Ohjelma-asiakirja)
Accountability strategy
MBMF Final evaluation_6-pages
Monitoring 2024
GLO-Partnerships-Building_Better_Partnerships_Guiding_Principles-Final-ENG-Apr18
Partnering with Organizations of Persons with Disabilities_Inspirational Guidance_MBMF2 (1)
20230315_MBMF2_RF and M&E plan
Quantitative tools
GLO-Safeguarding_Children_and_Young_People_Global_Policy-IO-Eng-ammended June 2019.docx
MBMF2 Learning Days_Social and Gender Norms Diagnosis and Analysis Round 1
Process Description_Round 1_Social and Gender Norms Diagnosis and Analysis Baseline
Process Description_Round 2_Social and Gender Norms Diagnosis and Analysis_MBMF2
SOYEE (2 presentations)
SRHR - Outcome 3 Analysis
Document 2_Peer-based Interventions_Guidance_Final
Strategies for SRHR influencing in restrictive contexts - Eng
GLO-Tackling_Exclusion_Framework-IO-ENG-FINAL-March24 (2)
MBMF2 Organigram
Statement of Core Values and Approaches by Plan International Finland_FINAL_2022
IPTT
PowerBI (LINK)



FGD data and reporting

Endline quantitative data and reporting

Outcome harvesting and learning workshops

Myanmar Social norms brief 2nd round_clean

Early Signs of Norm Change_MBMF2 Impact_Plan International Finland





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