

A young woman with vibrant red braids is smiling and framing her face with her hands. She is wearing a pink t-shirt with a white graphic and a small logo that says "Amplifying Girls' VOICES". The background is a rustic brick wall.

My Body. My Future. 2

**2022-2025 PROGRAMME REPORT AND
2025 ANNUAL REPORT**

My Body My Future 2

2025 Annual and Final Report

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Abbreviations

CAY	Children, adolescents, and youth
CBO	Community-based organization
CO	Country Office
CSE	Comprehensive sexuality education
CSO	Civil society organization
FGAE	Family Guidance Association in Ethiopia, a partner organisation in Ethiopia
GBV	Gender-based violence
HIV/STI	HIV and other sexually transmitted infections
LAMBDA	Associação LAMBDA, a partner organisation in Mozambique
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual, among other identities
MBMF	My Body. My Future.
MFA	Ministry for Foreign Affairs
M&E	Monitoring and Evaluation
MEAL	Monitoring, evaluation, accountability, and learning
NGO	Non-governmental organization
OPD	Organisation of persons with disabilities
PADet	Professional Alliance for Development, a partner organisation in Ethiopia
PVO	Private Voluntary Organisation
PWD	Person with disability
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SOGIESC	Sexual orientation, gender identity, gender expression and sex characteristics
ToC	Theory of Change
USAID	United States Agency for International Development
VSLA	Village Saving and Loan Association
YEE	Youth Economic Empowerment

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Summary

My Body. My Future. 2 (MBMF2) was a four-year programme (2022–2025) implemented by Plan International Finland together with country offices in Ethiopia, Laos, Mozambique, Myanmar, Uganda, and Zimbabwe, local partners, and a domestic component in Finland. The international programme implemented in six countries aimed to advance girls' rights and gender equality by improving sexual and reproductive health and rights (SRHR) for children, adolescents, and youth (CAY), particularly girls and other marginalised groups, with a focus on inclusion of CAY with disabilities and, in some contexts, LGBTQIA+ adolescents and youth. Through a gender transformative and inclusive approach, the programme sought to strengthen SRHR knowledge and agency, improve access to quality services, create more supportive environments, and influence policies and systems affecting young people.

The programme largely achieved its intended outcomes, validating its Theory of Change (ToC) and its integrated approach, which combined comprehensive sexuality education (CSE), strengthened SRH services, community engagement, civil society strengthening, and advocacy.

Significant progress was achieved in strengthening young people's SRHR knowledge, confidence, and decision-making. More than 56,900 CAY participated in CSE activities, contributing to substantial improvements in knowledge of key SRHR issues, the ability to challenge harmful social and gender norms, and confidence in making informed decisions about SRHR. The programme also strengthened young people's economic opportunities as a pathway to improved wellbeing and SRHR outcomes. More than 1,100 adolescents and youth developed vocational and entrepreneurship skills, while over 2,000 engaged in income-generating activities and savings groups.

The programme also improved access to quality, inclusive, and youth-friendly SRHR services. Support to health facilities and stronger links between communities and service providers contributed to increased service awareness and utilisation, reaching nearly 126,000 children and young people through outreach and referral mechanisms. Uptake of sexual and reproductive (SRH) services increased significantly among adolescents and youth, while young people became more actively engaged in monitoring service quality and youth-friendliness.

At the community level, MBMF2 contributed to more supportive environments for young people's SRHR by addressing harmful social and gender norms. More than 43,000 parents, caregivers, and community members were reached, improving knowledge, attitudes, and support for young people's SRHR. Engagement with community leaders and male allies helped normalise discussions around SRHR and gender equality, although resistance to issues such as safe abortion, adolescent autonomy, and sexuality remained. Livelihood and climate resilience interventions in Ethiopia, Uganda, and Zimbabwe also strengthened household resilience, helping sustain access to SRHR information and services during climate-related shocks.

The programme strengthened the capacity of civil society organisations, community-based organisations, organisations of persons with disabilities, and youth-led groups to advocate for inclusive SRHR policies and services. Advocacy efforts contributed to progress on issues including safe abortion, child marriage prevention, disability inclusion, and LGBTQIA+ inclusion. Across the programme period, 1,278 decision-makers were engaged, and almost 1,000 adolescents and youth participated directly in advocacy processes. Most youth participants reported meaningful participation and increased confidence to influence decisions affecting their lives.

A strong commitment to inclusion was embedded throughout the programme through both targeted support and mainstreaming approaches. This helped reduce barriers, improve access to services and information for marginalised CAY, and contributed to early shifts toward more inclusive community and institutional practices. Across all countries, collaborative decision-making contributed to stronger local ownership, contextual relevance, and shared accountability. Local partners actively shaped strategies, provided community insights, and participated in planning,

review, and monitoring, evaluation, accountability and learning (MEAL) processes, enabling adaptive management and continuous learning.

Despite substantial achievements, structural barriers limited the full realisation of the programme's outcomes. Deeply rooted social norms, stigma, and gender inequalities continued to restrict participation and access, particularly for marginalised groups. Political instability, uneven service quality, provider capacity gaps, and resource constraints further affected results. Although these structural barriers were anticipated in the ToC, their influence proved challenging in practice.

At the same time, key lessons emerged for future programming. Economic empowerment proved to be an important enabler of SRHR outcomes, particularly for marginalised young people, when closely linked to SRHR interventions. Stronger engagement with community leaders and men is needed to accelerate social norm change, while policy and systems-level change require sustained, long-term investment and collaboration across civil society actors. Learning from MBMF2 directly informed the design of the next programme phase, which builds on the programme's holistic and gender-transformative approach while strengthening localisation, advocacy, youth leadership, and the integration of economic empowerment as a pathway to improved SRHR outcomes.

In Finland, MBMF2 focused on communication, advocacy, and global citizenship education.

Strategic communications strengthened public awareness of development and humanitarian results, fostered informed public debate, and reinforced support for Finland's development policy objectives. Nearly 47,000 young people increased their knowledge of child rights, gender equality, sustainable development, and climate issues, while youth-led advocacy exceeded its targets and significantly expanded public outreach. The programme also strengthened educators' capacity to deliver high-quality global citizenship education, with most training participants reporting improved professional knowledge and tools. As a result, youth voices were increasingly reflected in civic dialogue and decision-making processes in Finland. More than 750 young people and volunteers contributed to advocacy efforts nationwide, while meaningful engagement with decision-makers helped advance discussions on girls' rights, gender equality, climate action, and sustainable development. Together, these results contributed to stronger active citizenship, greater awareness of global issues, and increased youth participation in Finnish society.

Despite ongoing structural challenges, MBMF2 successfully validated its ToC and demonstrated that sustained, inclusive, and locally led interventions can contribute to significant progress in advancing young people's SRHR and agency.

MBMF2: 2025 and the whole programme in numbers

Table 1 Reach of the MBMF2 in 2025 and during the whole programme.

International programme - SRHR projects	In 2025:	For the whole programme:
The total number of people reached by the SRHR projects:	73,274	268,996
Out of whom, children, adolescents and youths:	53,152	208,744
Out of whom, girls and young women:	32,868	130,652
Domestic programme - Communication, youth participation and global citizenship education	In 2025:	For the whole programme:
Total number of people reached in Finland:	76,263	231,617
Out of whom children and adolescents:	52,211	148,054
Out of whom girls:	38,288	99,855

1. Country and civil society context

1.1 Ethiopia

In 2025, Ethiopia's civil society faced shrinking civic space due to regressive legislative proposals, a more restrictive political environment, tighter limits on freedoms of association and expression, and shifting funding dynamics, particularly affecting rights-based and advocacy CSOs.

External donor engagement became more complex when USAID suspended support early in the year. In response, lawmakers proposed new domestic taxes to fund disaster response and debated additional levies on workers and companies to sustain humanitarian and development efforts, reflecting a shift toward domestic resource mobilisation amid declining foreign aid. While the 2019 Civil Societies Proclamation (No. 1113/2019) had expanded civic space, the 2025 draft Amendment threatened to reverse these gains by granting broad government powers to restrict NGOs, limit autonomy, and increase oversight.

These changes adversely affected partners such as FGAE and PADet, leading to project closures and staff reductions, while the MBMF2 "Yene-Yene 2" project remained largely unaffected and operational.

1.2 Laos

In 2025, shifts in global development funding significantly reduced financial support available to CSOs in Laos. USAID funding cuts led to the abrupt closure of several projects, including those implemented by GDA, an MBMF2 partner. At the same time, Laos is preparing to graduate from Least Developed Country (LDC) status in 2026, with a transition period extending to 2029, which is expected to further affect CSOs' access to funding in the coming years.

Institutional changes also took place, with oversight of CSOs transferred from the Ministry of Home Affairs to the Central Committee for Organisation and Personnel, Department of Public Administration Development. A revised CSO Decree required all organisations to re-register and extended the validity of work permits from one to three years. While the changes were not expected to reduce civic space, they created short-term adjustment challenges for CSOs. Additionally, a government-mandated 2025 increase in the Daily Subsistence Allowance required MBMF2 to revise its budget. Finally, in early 2026, following the National Congress and elections, government restructuring and leadership changes may further affect CSO operations and the implementation of new projects.

1.3 Mozambique

In Mozambique, the final project year began in a more restrictive civic space, as post-election sensitivities increased scrutiny of civil society organisations. Stakeholder engagement became more cautious, advocacy on sensitive SRHR issues faced greater constraints, and implementation delays required additional investment in relationship- and trust-building.

At the same time, the government continued to recognise the important role of civil society in development, particularly in education, health, gender equality, and the implementation of SRHR and youth policies. Alignment with national priorities facilitated collaboration and provided opportunities for participation in policy dialogue and public platforms. However, administrative and regulatory barriers persisted, including complex registration processes for LGBTQI+ organisations and demanding compliance requirements. In addition, the LGBTQI+ partner LAMBDA faced significant financial pressures due to broader economic challenges and U.S. funding cuts. In response, the project revised its budget to provide additional support and sustain advocacy for the rights of sexual and gender minorities.

1.4 Myanmar

Since the coup, Myanmar's civic space has remained highly constrained by political instability, conflict, and restrictive governance. Increased surveillance, security risks, and limitations on assembly and advocacy have particularly affected organisations working on SRHR, gender equality, LGBTQIA+ rights, and disability inclusion. Engagement with government remained minimal, while declining public funding and donor shifts toward humanitarian assistance reduced CSOs' capacity for longer-term development work.

In 2025, preparations for the elections heightened surveillance and the risk of politicisation, while the March 7.7-magnitude earthquake forced many CSOs to redirect resources to emergency response activities amid worsening access constraints and tighter controls. Together, these developments further underscored the fragility of civic space.

Despite these challenges, CSOs demonstrated considerable resilience by decentralising operations, strengthening informal networks, and adopting community-led approaches. Collaboration among youth, women-led, and LGBTQIA+ organisations continued, enabling sustained SRHR engagement and support at community level despite the limited formal space for civil society action.

1.5 Uganda

In 2025, Uganda's civic space remained mixed, characterised by both enabling policies and persistent restrictions. The Adolescent Health Policy supported non-discriminatory access to SRHR services and strengthened adolescent-friendly care. Climate policy frameworks, including the updates to the Nationally Determined Contributions, and a new Health National Adaptation Plan, created opportunities to integrate climate resilience and SRHR and to advocate for improved service quality and increased public investment.

However, significant constraints remained. The Anti-Homosexuality Act restricted the rights of LGBTQI+ individuals and limited the operating space for some CSOs, while SRHR actors continued to face scrutiny. Administrative requirements, including annual NGO registration, compliance certification, and local-level approvals, also created operational challenges. SRHR education in schools remained subject to Ministry approval; however, strong collaboration with government stakeholders enabled the continued implementation of CSE through the Model School Health Programme.

1.6 Zimbabwe

In 2025, the withdrawal of USAID funding in Zimbabwe caused significant disruptions across the health and SRHR sectors, weakening multi-sectoral support systems. Within MBMF, SRC was particularly affected, as the loss of service delivery and referral networks reduced its capacity to respond to growing demand, especially among vulnerable populations.

At the policy level, the Private Voluntary Organisations (PVO) Amendment Act, enacted in April 2025, introduced broad government powers over CSO registration and operations, increasing oversight and uncertainty for civil society organisations, including SRC as a Trust. At the same time, the approval of the National Gender Policy signalled continued commitment to advancing gender equality and strengthening gender mainstreaming across sectors. However, laws criminalising same-sex relations and persistent social stigma continued to constrain inclusive programming. Growing anti-LGBTIQ+ narratives, particularly in digital spaces, further heightened risks for organisations working to promote the rights and inclusion of sexual and gender minorities.

2. Programme results

2.1 International SRHR projects

MBMF2 generated impact across multiple, interconnected levels, contributing to global development goals, strengthening the agency and participation CAY, fostering more equitable social and gender norms, and reinforcing civil society and institutional systems. Through a gender transformative and inclusive approach, the programme prioritised marginalised groups, including girls, adolescents and youth with disabilities, and persons with diverse SOGIESC, contributing to the Leave No One Behind agenda.

2.1.1 Impact analysis

The programme contributed to several Sustainable Development Goals (SDGs), particularly SDG 3 (Good Health and Well-being), SDG 5 (Gender Equality), and SDG 4 (Quality Education). It supported progress towards SDG indicators related to family planning (3.7.1), adolescent pregnancy (3.7.2), child marriage (5.3.1), women's decision-making on reproductive health (5.6.1), and rights-based, inclusive education through CSE (4.7.1).

A key area of impact, measured by the project directly, was increased contraceptive use among adolescent girls and young women aged 15–24 (SDG indicator 3.7.1). The proportion using a modern contraceptive method increased from 29% at baseline to 34% at endline (+19%). This progress was driven primarily by adolescents aged 15–19, among whom contraceptive use increased from 18% to 29% (+57%). The result is particularly significant given the role of contraception in preventing unintended pregnancies, supporting girls' educational attainment, and strengthening their autonomy and decision-making. Contraceptive use among young women aged 20–24 remained relatively stable, increasing from 43% to 44%, suggesting different barriers or a possible plateau effect for this age group.

Results varied across countries. Strong improvements were recorded in Uganda (+75%), Mozambique (+66%), Ethiopia (+53%), and Laos (+30%), while Zimbabwe experienced a slight decline. In Myanmar, contraceptive use fell from 12% to 0%, reflecting severe health system disruptions resulting from the ongoing political crisis and restrictions on access to SRHR services.

Beyond contraceptive uptake, the programme contributed to intermediate outcomes associated with improved SRHR and reduced risk of unintended adolescent pregnancies. CSE strengthened SRHR knowledge, attitudes, agency, and decision-making among learners, while investments in health systems improved the accessibility, quality, confidentiality, and youth-friendliness of services. Although reductions in adolescent birth rates require longer timeframes to materialise, these results represent important progress towards sustained improvements in SRHR outcomes.

The programme also contributed to reducing drivers of child and early marriage through interventions targeting individuals, communities, and addressing structural factors. Improvements in SRHR knowledge, attitudes, confidence, and agency among CAY were complemented by community-level engagement, including intergenerational dialogue and collaboration with religious and traditional leaders, as well as male community members. These efforts helped challenge harmful norms related to adolescent sexuality, contraception, girls' autonomy, and early marriage. Increased acceptance of adolescents' access to SRHR information and services, alongside greater openness to discussing SRHR issues within families and communities, suggests progress towards declining expectations around early marriage.

More broadly, the programme generated early signs of normative change. Across countries, participants reported increasing acceptance of young people's rights to access SRHR information and services, as well as greater willingness to discuss previously taboo topics. While resistance remains on sensitive issues and progress has been uneven, these findings indicate movement towards environments in which adolescents and youth can exercise greater agency and make informed decisions regarding their sexual and reproductive health.

Economic empowerment provided an additional pathway to impact. Youth Economic Empowerment (YEE) activities improved young women's access to livelihoods, financial independence, and future opportunities, which are factors associated with delayed marriage, greater autonomy, and improved SRHR outcomes. At the same time, the programme promoted meaningful youth participation in community dialogue, advocacy, and accountability processes, enabling young people to influence decisions affecting their lives and communities.

At the systems level, MBMF2 strengthened the capacities of CSOs, OPDs, youth-led organisations, and community structures to advance SRHR and gender equality beyond the programme period. Through capacity strengthening, partnership development, and advocacy support, local actors enhanced their ability to deliver services, advocate for rights, promote accountability, and engage in policy dialogue, including in increasingly restrictive civic spaces. These investments strengthened local ownership and sustainability.

The programme also contributed to system resilience by supporting community-based and institutional mechanisms, including Disaster Risk Reduction (DRR) committees and the integration of SRHR considerations into health facility preparedness and planning. These efforts helped strengthen the capacity of communities and institutions to maintain SRHR services during crises and climate-related shocks.

Finally, MBMF2 contributed to incremental policy and institutional change through advocacy led by CSOs and young people. Across countries, engagement with government stakeholders advanced discussions on issues such as safe abortion, child marriage, disability inclusion, and LGBTQIA+ rights. While policy change remains gradual and highly context dependent, the programme strengthened awareness, accountability, coordination, and dialogue among key actors, helping create more enabling conditions for future progress in SRHR and gender equality.

Overall, MBMF2 achieved meaningful progress across behavioural, normative, institutional, and systems levels. While some impacts will require longer timeframes to fully materialise, the programme has established important foundations for sustained improvements in SRHR, gender equality, and the empowerment of CAY.

2.1.2 Analysis of Outcome 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

CAY in programme countries continue to face significant barriers to accessing accurate, age-appropriate, and inclusive SRHR information. Restrictive social norms, limited opportunities to discuss sensitive topics, and gaps in formal education often leave young people without the knowledge, confidence, and skills needed to make informed decisions about their SRHR. MBMF2 addressed these challenges through CSE delivered through both in- and out-of-school modalities, creating safe spaces for learning, reflection, and peer exchange on topics including gender, social norms, safety, puberty, relationships, sexuality, contraception, and STI/HIV prevention.

In line with the Theory of Change, CSE sought to strengthen young people's agency, knowledge, attitudes, and decision-making capacity. In total, 56,901 CAY (30,995 female, 24,649 male, and 113 with diverse gender identities) were reached through peer-led and facilitator-led approaches. Monitoring data show consistent improvements across three key dimensions of empowerment: SRHR knowledge, attitudes and ability to challenge harmful gender norms, and confidence in making SRHR-related decisions.

Table 2 Indicators measuring CAY's SRHR empowerment. Baseline and endline data, 2025 monitoring data, pre- and post-test.¹

Indicators to measure CAY's SRHR empowerment	Age group	Baseline (2022)	Endline (All years)	2025 data ²	
				Pretest	Post test
Correct knowledge of key SRHR issues	All	29 %	57 %	30 %	60 %
	Children	18 %	46 %	28 %	52 %
	Adolescents	30 %	55 %	25 %	53 %
	Youths	49 %	70 %	38 %	75 %
Positive attitudes in key SRHR issues and the ability to challenge harmful gender norms	All	24 %	61 %	27 %	64 %
	Children	26 %	63 %	36 %	65 %
	Adolescents	21 %	56 %	10 %	58 %
	Youths	28 %	66 %	47 %	69 %
Feeling of being able to make informed decisions over one's SRHR	All	42 %	63 %	33 %	67 %
	Children	29 %	57 %	32 %	63 %
	Adolescents	37 %	64 %	29 %	70 %
	Youths	59 %	78 %	47 %	88 %

Knowledge of key SRHR issues

CAY's SRHR knowledge increased significantly, with 57% demonstrating correct knowledge at endline (55% girls, 60% boys), up from 29% at baseline, although below the target of 69%. Monitoring data from 2025 showed similar results (60%), indicating sustained progress. For many participants, CSE provided first-time access to SRHR information, filling critical knowledge gaps. better school attendance, and increased confidence.

In Ethiopia, Myanmar, and Uganda, the MHH component was particularly strong, with correct knowledge increasing from 18% at baseline to 72% at endline. A Ugandan girl explained the impact: *"Before joining, I would skip school during my period... now I come to school with confidence."* Boys' understanding also improved, helping reduce stigma in schools and communities.

Improved knowledge translated into more informed choices and safer practices. As an adolescent girl in Uganda noted: *"I used to believe contraceptives were only pills. Now I understand condoms too, and we use them consistently to protect ourselves."* Similarly, a male adolescent in Mozambique highlighted greater shared responsibility: *"[With my girlfriend], everything we do now is mutually agreed upon... it's not just up to me or her to prevent STIs and pregnancy."*

Menstrual health and hygiene (MHH) knowledge also improved, contributing to reduced stigma, CAY also acted as peer educators, extending the programme's reach by sharing knowledge and challenging harmful norms within their communities. In Laos, a young adolescent explained: *"I can talk about sex with my friends, such as how to protect myself by using condoms."* Similarly, in Mozambique, a young man involved in out-of-school CSE clubs described his experience: *"Some young people who weren't part of the club still engage in certain practice[s]... but I actually talk to them and explain and discuss various topics I've learned here at the club"*

¹ Data distribution and variation are represented using colour scales, which serve as visual guides for comparing values. These scales use a gradient—ranging from red to indicate lower values to green for higher values—making it easy to spot patterns and differences briefly.

² Pre-tests were only collected in Ethiopia, Laos, Uganda and Zimbabwe, whilst post-test data also include Myanmar and Mozambique results.

Text box 1 CSE curriculum at school

Focus on Laos: CSE curriculum at school

The project has transformed teaching practices and attitudes towards sensitive topics across the districts of Paktha, Pakbeng, and Houn. Teachers are now more confident in integrating SRHR topics across subjects using interactive, student-centred approaches, creating safe spaces for dialogue on issues such as early marriage and contraception. This shift has also contributed to positive changes in teachers' own attitudes towards gender norms.

Teacher-led school clubs further strengthened students' confidence, leadership, and participation, while close collaboration with education authorities ensured mentoring, quality assurance and institutional support.

Text box 2 CAY and climate resilience throughout the programme

Close-up: CAY and climate resilience throughout the programme

Climate education was integrated into CSE through activity cards, visuals, and storytelling, helping CAY understand how climate-related shocks, such as droughts and floods, can affect access to SRHR services, increase the risk of gender-based violence (GBV), and contribute to early marriage and transactional sex. Across programme countries, CAY also learned practical actions to strengthen community resilience, including tree planting and the use of energy-efficient stoves to reduce reliance on firewood.

Evidence shows improved understanding of these links, particularly their gendered dimensions. As a girl in Zimbabwe explained: *"CAY will be unable to access sanitary pads, condoms and other SRH services due to heavy rain, floods... If they cannot access condoms, they may have unprotected sex and face STIs or unwanted pregnancy."*

This emerging area of work shows promising results and will be further strengthened in the next programme, with particular attention to reaching marginalised groups, especially rural CAY and adolescents and youth with disabilities

Some knowledge gaps persist, particularly among children and younger adolescents. While understanding of puberty and contraceptive use is high, more complex topics such as HIV, STIs, and consent remain less well understood. Strengthening CSE content and facilitator capacity, particularly on HIV and STI prevention, alongside more tailored knowledge assessments, will be important for addressing these gaps.

Attitudes towards and the ability to challenge gender stereotypes linked to SRHR

Over the programme period, 61% of CAY (60% girls and 62% boys) demonstrated an increased willingness and ability to challenge gender stereotypes at endline, up from 24% at baseline and exceeding the target of 54%. Monitoring data from 2025 showed similar results (64%). Improvements were observed across several key areas, including acceptance of CSE, recognition of SRHR rights (including the rights of girls and CAY with disabilities), and increased confidence to report or challenge abusive situations.

CSE played a critical role in shifting attitudes by creating safe spaces for CAY to question gender norms and discuss sensitive topics such as bodily autonomy, consent, and contraceptive use. Acceptance of contraceptive use among unmarried girls increased from 34% at baseline to 61% at endline (70% in 2025), while attitudes towards premarital sex remained more conservative. This suggests growing recognition of girls' rights and decision-making autonomy, even where broader

social norms around sexuality remain restrictive. Qualitative findings show that adolescents' support for contraceptive use among unmarried peers ranged from protective to rights-based perspectives, alongside greater openness to discussing these issues, pointing to a gradual normalisation of contraceptive use regardless of marital status.

These shifts reflect broader progress towards more positive and nuanced understandings of sexuality, empowering CAY to challenge gender stereotypes and harmful social norms. As one adolescent girl in Uganda noted: *"I used to believe sexual relations were negative... now I understand they are healthy and that I can make informed decisions, including refusing early marriage if pressured."*

However, progress remains uneven. Attitudes towards issues such as homosexuality and safe abortion remain more restrictive in some contexts, reflecting broader social and legal constraints. Variations also persist across sexes and countries. In Ethiopia, boys demonstrated more positive SRHR attitudes than girls (+31 percentage points and +21 percentage points, respectively, in 2025), while in Laos, out-of-school young women held more progressive attitudes than young men (+15 percentage points). These findings suggest that SRHR attitudes are shaped less by gender alone than by social norms, context, and lived experiences, highlighting how different groups face distinct opportunities and barriers in exercising their SRHR.

Table 3 Indicator: % of CAY with increased desire/ability to challenge gender stereotypes linked to SRHR. Monitoring data: detailed results per variable.

Attitudes and ability around key SRHR issues		Baseline (2022)	Endline (All years)	2025 data ³	
				Pre-tests	Post tests
Among children	Acceptance of sexuality education	66 %	90 %	78 %	89 %
	Acceptance of sex before marriage for girls	30 %	36 %	15 %	37 %
	Acceptance of homosexuality ⁴	37 %	53 %	20 %	50 %
	Recognition of CAY with disabilities' SRH rights	79 %	92 %	86 %	95 %
	Ability to report some abusive situations	85 %	96 %	91 %	98 %
Among adolescents and youth	Acceptance of contraceptive use among unmarried girls	34 %	61 %	23 %	70 %
	Acceptance of sex before marriage for girls	29 %	38 %	26 %	42 %
	Recognition of women's rights to say no to unwanted sex	70 %	87 %	65 %	87 %
	Recognition of safe abortion as an option for girls and women	52 %	71 %	46 %	73 %
	Acceptance of homosexuality	27 %	58 %	13 %	67 %
	Recognition of CAY with disabilities' SRH rights	82 %	90 %	78 %	92 %
	Acceptance of masturbation	22 %	63 %	17 %	72 %
	Ability to challenge some abusive behaviours among peers	47 %	63 %	39 %	66 %

³ Pre-tests were only collected in Ethiopia, Laos, Uganda and Zimbabwe, whilst post-test data also include Myanmar and Mozambique results.

⁴ Question around homosexuality was only included in Myanmar, Laos, Mozambique and Zimbabwe.

Ability to make informed SRHR decisions

Based on monitoring data, 63% of CAY (61% girls and approximately 65–68% boys) reported being able to make informed SRHR decisions at endline, up from 42% at baseline, although slightly below the target of 68%. Monitoring data from 2025 showed further improvement, with 67% reporting confidence in making informed SRHR decisions.

Participation in CSE significantly strengthened CAY's agency, communication, and decision-making skills. Among children, the proportion able to discuss relationships and SRHR with peers increased by 10 percentage points from baseline to endline (+23 percentage points in 2025 pre–post tests), highlighting the role of CSE groups in fostering safe peer dialogue. As one girl in Ethiopia noted: *"Before, we were shy to talk about reproductive health... now we speak openly."* Children's ability to seek advice and refuse unwanted sex also improved (+9 and +18 percentage points, respectively).

Similar gains were observed among adolescents and youth. At endline, 80% of adolescents and 93% of youth reported being able to seek advice (+13 and +18 percentage points, respectively), alongside greater openness to discussing sexuality with peers. In Laos, peers became important sources of support: *"Many female friends come to ask me questions about sexual health and contraception..."* In Uganda, changing norms around these discussions were reflected in one participant's experience: *"I engaged with some youths... and encouraged them to use condoms..."*, demonstrating both increased openness and more informed decision-making.

The ability to discuss feelings, relationships, and sexual preferences with a partner increased from 45% at baseline to 78% at endline. While this indicator initially showed a gender gap of up to 15 percentage points in favour of boys, the gap narrowed to just 3 percentage points in 2025, suggesting more equitable gender dynamics. Qualitative findings similarly point to increased confidence among girls to communicate their needs and boundaries: *"I now know how to talk to my partner about what I want and don't want..."* (Zimbabwe); *"I openly discuss my feelings... He understands and respects my decisions."* (Ethiopia).

Access to contraception also improved. Among adolescents, the proportion reporting confidence in obtaining contraceptives increased from 63% to 82%, while among youth it rose from 81% to 94%. Proxy indicators suggest these gains translated into increased service uptake, rising from 24% to 40% among adolescents and from 36% to 60% among youth. Modern contraceptive use also increased among adolescent girls (+50%) and young women (+23%).

These results were supported by strong investments in facilitator capacity. Across all countries, peer educators and teachers received training and ongoing support, often through regular review and learning meetings. In total, 730 teachers were trained, with 87% demonstrating adequate capacity to deliver inclusive CSE, up from 23% at baseline.

Overall, the findings show that CSE, combined with safe spaces and mentorship, effectively strengthened the knowledge, confidence, and skills needed for informed SRHR decision-making, while contributing to more equitable relationships and gradual shifts in gender norms. These gains also translated into tangible outcomes: in Zimbabwe, project schools recorded a teenage pregnancy rate of 1.2%, compared with 4.5% at the district level, underscoring the preventive potential of quality CSE.

Table 4 Indicator: % of CAY who feel able to make informed decisions about their SRHR. Monitoring data: detailed results per variable.

Ability to make informed decisions over one's SRHR		Baseline	Endline	Focus on 2025 data ⁵	
				Pretest	Post-test
Among children	Possibility to talk with friends about relationships and sex	64 %	74 %	52 %	75 %
	Possibility to ask about puberty, relationships or sex to a parent/caregiver	73 %	82 %	60 %	85 %
	Knowledge of where to get advice about contraception	69 %	79 %	50 %	87 %
	Confidence to say no to unwanted physical interaction	73 %	91 %	87 %	94 %
Among adolescents	Confidence to ask advice about sexual and reproductive health from a trusted friend, peer or older adult	67 %	80 %	58 %	82 %
	Ability to get contraception if needed	63 %	82 %	58 %	89 %
	Feeling able to talk to a partner about one's feelings and sexual activities enjoyed/not enjoyed	Not measured in the baseline	72 %	45 %	78 %
Among youths	Confidence to ask advice about sexual and reproductive health from a trusted friend, peer or older adult	78 %	93 %	66 %	96 %
	Ability to get contraception if needed	81 %	94 %	83 %	98 %
	Feeling able to talk to a partner about one's feelings and sexual activities enjoyed/not enjoyed	Not measured in the baseline	89 %	55 %	92 %

Youth Economic Empowerment (YEE)

The YEE component was implemented across Ethiopia, Laos, Myanmar, Uganda, and Zimbabwe to strengthen adolescents' and youths' economic opportunities, resilience, and SRHR outcomes. Guided by the programme's Theory of Change, it aimed to enhance vocational and entrepreneurial skills, financial literacy, and life skills, particularly among young women and the most marginalised groups, to increase economic independence and support informed decisions about their futures and SRHR.

A total of 1,155 AY (711 young women) were reached, including 242 participants in 2025, while a further 2,044 AY engaged in income-generating activities and Village Savings and Loan Associations (VSLAs). Training was adapted to local labour market opportunities and national systems, with a strong emphasis on inclusion, including persons with disabilities and LGBTQIA+ individuals in Zimbabwe.

⁵ Pre-tests were only collected in Ethiopia, Laos, Uganda and Zimbabwe, whilst post-test data also include Myanmar and Mozambique results.

Implementation models were tailored to country contexts while maintaining a focus on employability and SRHR integration. In Laos, training targeted young women with disabilities and other vulnerable groups, integrating CSE alongside vocational skills. In Zimbabwe, vocational and entrepreneurship training promoted opportunities in the green economy and targeted marginalised youth. In Ethiopia and Uganda, hub models (Smart Up Factory and Innovation Hubs) combined market-driven skills development with mentoring, internships, and peer-led training on life skills, SRHR, and climate resilience. In Myanmar, the Ready for Work programme emphasised life skills alongside tailored vocational training.

These approaches led to tangible economic outcomes. In Ethiopia, Uganda, and Zimbabwe, 72% of adolescents and youth had started a business, secured employment, or returned to education six months after completing training. In Uganda, participants established businesses or found employment in sectors such as blacksmithing, ICT, tailoring, and media. As one participant shared: *“Through this project, I learned hairdressing... I now work with diverse clients, earning a steady income.”* In Zimbabwe, improved financial literacy and entrepreneurship skills among young women strengthened economic independence and reduced vulnerability, including to gender-based violence.

The programme also contributed to increased confidence and agency. The proportion of adolescents and youth reporting confidence in their life skills increased from 32% at baseline to 70% at endline, alongside improvements in leadership, communication, and decision-making. As one participant noted: *“I now lead my peers and speak confidently in public.”*

Overall, YEE reinforced SRHR outcomes by strengthening agency, economic independence, and future opportunities. Strong synergies with CSE and climate resilience interventions further enhanced these results, particularly in Zimbabwe, where youth were linked to emerging green economy opportunities.

Inclusion approach and strategies

The programme adopted a dual approach to inclusion, combining targeted interventions with the systematic mainstreaming of disability and SOGIESC (whenever possible) across all SRHR activities. This approach sought to address structural barriers, power imbalances, and intersecting forms of discrimination that limit participation and access to services for marginalised CAY.

Disability inclusion was implemented through both dedicated interventions and integration across programme components. Targeted activities created safe and accessible spaces and tailored resources for CAY with disabilities, while mainstreaming helped ensure that inclusion became a standard feature of education, community engagement, and service delivery. For example, in Laos, a tailored CSE package was developed for girls with disabilities in vocational training; in Uganda, schools improved accessibility through disability-inclusive infrastructure; and in Ethiopia, “tea and coffee” sessions provided safe spaces for youth with disabilities to discuss social and health-related challenges.

Partnerships with Organisations of Persons with Disabilities (OPDs) were central to these efforts, helping ensure that programming reflected lived experiences while strengthening ownership and sustainability. Ongoing collaboration supported programme adaptation, problem-solving, advocacy, and learning, while also contributing to the documentation of good practices.

Inclusion of CAY with diverse SOGIESC was approached through both targeted support and broader efforts to promote non-discrimination and equal access to information and services. Across Laos, Myanmar, Zimbabwe, and Mozambique, CSE was adapted to be inclusive of diverse sexual orientations and gender identities, supporting safe and non-judgmental participation. Outreach activities in Zimbabwe and Mozambique further connected LGBTQIA+ youth with SRHR services, including HIV testing and STI care. Partnerships with SOGIESC-focused organisations also strengthened advocacy to address discriminatory norms and policies. In Mozambique, for example, engagement with government stakeholders helped strengthen institutional understanding of LGBTQIA+ inclusion.

Overall, the programme's inclusion strategy operated across individual, community, and systems levels, combining direct support with efforts to strengthen institutional responsiveness. This contributed to improved access to SRHR information and services for marginalised CAY, stronger referral pathways, and early signs of more inclusive attitudes and practices within communities and institutions.

2.1.3 Analysis of Outcome 2

CAY in all their diversity have improved access to quality, inclusive, gender-responsive, and adolescent- and youth-friendly SRHR services

Despite the existence of supportive SRHR policies in many programme countries, access to quality, inclusive, and age- and gender-responsive services remains constrained by limitations in resources, infrastructure, and service provider capacity. MBMF2 addressed these barriers through a comprehensive health systems strengthening approach, supporting 89 government health facilities across Ethiopia, Laos, Mozambique, Uganda, and Zimbabwe. Interventions included service provider training, infrastructure and equipment improvements, establishment of Youth Friendly Corners (YFCs), peer navigation systems, and measures to strengthen service continuity during crises. Together, these efforts sought to improve the quality, accessibility, and responsiveness of SRHR services for CAY while strengthening youth engagement in service planning, monitoring, and accountability.

Increased quality of SRH services

Investments in health systems strengthening contributed to substantial improvements in the quality of SRH services. Based on the programme's monitoring tool aligned with WHO standards, 76% of assessed facilities provided high-quality adolescent SRH services in 2025, compared to 29% at baseline, while the remaining facilities achieved medium quality levels. Improvements were observed across all assessed dimensions.

Health facilities strengthened their outreach and communication approaches, including youth discussions (99% vs. 74% at baseline), hotlines, and digital platforms. Community engagement also improved substantially, with 99% of facilities reporting supportive community environments facilitated through collaboration with community workers, parents, and local leaders.

Service delivery became increasingly responsive to adolescents' needs. A greater proportion of facilities offered a full range of contraceptive methods (90% vs. 70% at baseline), including long-acting methods, alongside more comprehensive counselling services. Referral systems strengthened significantly (95% vs. 64%), supported by peer educators, outreach mechanisms, and improved follow-up procedures. Youth-friendly outreach approaches, including mobile brigades, further expanded access for underserved populations.

Provider competencies and attitudes improved markedly. A total of 755 service providers were trained, with 81% demonstrating adequate capacity to deliver age-, gender-, and rights-based SRH services, compared to 46% at baseline. Qualitative findings across countries suggest a shift from judgmental attitudes towards unmarried adolescents seeking contraception to a more rights-based approach. In Uganda, one provider reflected: *"Before the project, I believed that unmarried adolescents should not access contraception, but now I support their choices."* Similarly, a service provider in Ethiopia explained: *"Previously, as professionals, we treated unmarried girls with discomfort when they sought SRH and counselling services. However, following participation in various trainings provided by this project, we now recognise that they have full rights to access all services."*

The programme also contributed to greater inclusion. Changes in attitudes towards CAY with disabilities were particularly notable, with providers reporting increased awareness and responsiveness to their SRHR needs. As one provider from Bahir Dar Zuria, Ethiopia, stated: *"Before, we reacted with disgust when a disabled girl sought SRHR services. Now we provide*

respectful, inclusive care.” More broadly, facilities increasingly recognised adolescents and youth as a distinct client group with specific needs, with 82% promoting themselves as youth-responsive and safe spaces, compared to 53% at baseline.

Despite this progress, inclusion remains uneven. While awareness of disability inclusion improved, physical accessibility and service adaptations continue to present challenges. Accessibility for clients with diverse sexual orientations and gender identities also remained limited, with only 66% of facilities reporting that they were easily accessible to these groups. Progress towards inclusive services therefore continues to be shaped by broader legal, policy, and sociocultural contexts.

Health facilities also reported improvements in the youth-friendliness of their services. More facilities adopted youth-friendly branding (54%, up from 23%), 92% offered subsidised and/or free services for young people, and privacy protections strengthened, with 88% providing consultation spaces away from public view and 98% securely storing client records. However, service convenience remained a challenge, with limited improvements in after-school and weekend opening hours and only 34% of facilities offering dedicated youth service hours.

Youth participation in service delivery and accountability also increased, although results remained below programme targets. In 2025, 34% of facilities demonstrated a high level of youth participation, compared to none at baseline. While this represented a decline from 61% in 2024, it nevertheless reflects important progress in institutionalising youth engagement. Most facilities now collect youth feedback, maintain feedback mechanisms, engage peer educators, and include young people in management or decision-making structures. For example, in Ethiopia, youth were trained in social accountability to monitor SRH services and engage with providers and government officials to address service gaps. In Uganda, adolescents and youth participated in quarterly advocacy processes to identify barriers, develop action plans, and follow up with local authorities on SRH access issues.

Improved perceptions of the youth-friendliness of SRH services among adolescents and young people

Adolescents’ perceptions largely confirm the improvements observed at the facility level. The proportion of CAY rating SRH services as highly responsive increased steadily from 48% in 2022 to 82% in 2025, exceeding the programme target. Positive changes were reported across key dimensions, including accessibility, respectful treatment, confidentiality, and overall service quality.

Findings across countries indicate that CAY experienced more responsive and youth-friendly services. In Uganda, one participant noted: *“Whenever I visit our local health facility, especially on designated youth days, the health workers attend to adolescents and young people promptly and respectfully, which makes us feel valued and motivates us to return whenever we need services.”*

Youth Friendly Corners (YFCs) played an important role in creating safe entry points to services, particularly for boys and young men, while also supporting peer engagement, information provision, and referrals. The programme strengthened YFCs across contexts: in Myanmar, they provided essential information and referrals through peer-led sessions; in Ethiopia, renovations improved privacy and accessibility; in Uganda, advocacy efforts contributed to the establishment of dedicated youth service hours; and in Mozambique, centres were equipped with trained staff and supplies to deliver youth-friendly services.

However, perceptions of service quality varied across countries, highlighting areas for further improvement. While overall trends were positive, challenges remained regarding affordability, access to a preferred provider, and inclusion of LGBTQIA+ youth, particularly in restrictive contexts such as Uganda. Confidentiality also remained a concern despite generally high ratings, with qualitative evidence suggesting that fears of privacy breaches continued to discourage some young people from seeking services. For example, adolescents in Zimbabwe and Laos reported discomfort accessing services in close-knit communities.

Table 5 Indicator: % of AY who assess SRH services as age- and gender-responsive at the time asked, for 2022, 2023, 2024, and 2025. Monitoring data: detailed results per variable.

Variables	2022 ⁶	2023	2024	2025
Convenient opening hours for youths	75 %	77 %	81 %	90 %
Easy accessibility of the location	78 %	83 %	85 %	94 %
Affordable fees	63 %	67 %	69 %	81 %
Appropriate duration of the attentions	73 %	86 %	85 %	91 %
Respectful treatment regardless of disabilities	68 %	81 %	82 %	89 %
Confidentiality	77 %	84 %	84 %	91 %
Respectful treatment regardless of age	75 %	82 %	83 %	91 %
Respectful treatment regardless of diverse SOGIESC ⁷	33 %	58 %	57 %	48 %
Respectful treatment regardless of marital status	74 %	83 %	83 %	92 %
Safety of the location for both male and female clients	80 %	87 %	88 %	95 %
Access to practitioner of one's own sex	59 %	67 %	70 %	81 %
Access to a wide range of contraceptives	77 %	87 %	86 %	89 %

Improved access to SRH service outreach

Increasing CAY's access to and uptake of SRH services was a central pillar of MBMF2's SRH service strategy. Across programme countries, more than 125,000 SRH services were accessed through a combination of facility-based service delivery and mobile outreach provided by partner organisations. Services included HIV/STI testing and counselling, contraception and family planning (including short- and long-term methods), antenatal and postnatal care, safe abortion and post-abortion care, and referrals to specialised services. Strengthened partnerships between community actors and health facilities also led to more effective referral pathways, enhancing continuity of care and trust in youth-friendly services.

Outreach approaches were particularly important in reaching CAY, who faced barriers to accessing formal health facilities. In Myanmar, mobile clinics expanded access in a highly constrained context by providing referrals and covering the costs of essential services. In Ethiopia, outreach services extended into insecure and hard-to-reach areas, helping ensure that vulnerable groups, including youth with disabilities, were not left behind. In Zimbabwe, outreach created safe and non-judgemental entry points for marginalised groups, including LGBTQIA+ youth and young women selling sex, linking them to both public and private providers. Together, these experiences demonstrate the value of flexible, community-based service delivery models in expanding access to SRHR services, particularly for underserved populations.

⁶ Data from Myanmar was excluded because we could not rely on the collected data (almost none of respondents had accessed SRH services in the past year, and the quality of SRH services was assessed as exceptionally good).

⁷ Data was not collected in Ethiopia, because of the restrictive context and legislation regarding diverse SOGIESC.

Uptake of SRH services among CSE participants

Knowledge of available SRH services increased significantly among CSE participants. At endline, 89% of CAY reported knowing where to access at least three SRH services, up from 79% at baseline. Combined with more youth-friendly services and outreach efforts, this contributed to increased utilisation: 34% of CAY reported using SRH services in the past 12 months, compared to 28% at baseline. Uptake was highest among older age groups, reaching 40% among adolescents and 60% among youth, while 2025 monitoring data confirmed continued gains, particularly among adolescents and youth, reflecting the combined effect of CSE and outreach.

These trends are also reflected in contraceptive use. The proportion of adolescent girls and young women using modern contraceptive methods increased from 29% at baseline to 34% at endline. Gains were strongest among adolescents aged 15–19 (18% to 27%), while use among young women aged 20–24 remained relatively stable, suggesting greater unmet need among younger adolescents. Finding that aligns with programme priorities and social and gender norms analysis.

Qualitative findings further illustrate these shifts. In Zimbabwe, one participant noted: *“I now know the clinic, the nurse and even what to say. Before, I didn’t even know these services existed.”* In Uganda, another explained: *“It is easy now to access SRH services because under Champions of Change, there is a referral form... to seek free SRH services.”* These examples highlight the role of CSE in improving awareness, confidence, and use of referral mechanisms.

Despite these gains, barriers remain. Low perceived need continues to be the main reason for non-use, as many young people still associate SRH services with illness or pregnancy rather than prevention. Social norms, stigma, and confidentiality concerns also continue to limit uptake, particularly in close-knit communities. Among youth, male respondents reported higher unmet need but were less likely to perceive services as relevant, pointing to persistent gender-related barriers.

Results varied across countries. Uptake remained low in Myanmar due to service disruptions linked to the ongoing crisis, although strengthened referral systems helped mitigate some challenges. In Ethiopia and Mozambique, increased demand was linked to greater awareness and more youth-friendly services. As one provider in Ethiopia noted: *“Before, youth came only when sick... now they seek counselling, testing, and preventive care.”* In Laos, however, utilisation remained low despite the availability of services, reflecting barriers such as stigma, shyness, migration, language barriers, and a preference for private pharmacies and resulting in services being used primarily by married adults rather than unmarried youth.

Overall, the programme’s integrated approach, combining CSE, outreach, strengthened service delivery, and community engagement, has contributed to improved knowledge and uptake of SRH services. At the same time, findings highlight the need for continued efforts to address persistent barriers related to prevention awareness, stigma, and equitable access, particularly for the most marginalised groups.

2.1.4 Analysis of Outcome 3

CAY in all their diversity live in safe and supportive communities that transform gender roles and challenge harmful social and gender norms and stigma around SRHR

Harmful social and gender norms continue to constrain CAY’s SRHR across programme countries, limiting access to information and services, reinforcing gender inequalities, and restricting young people’s ability to exercise their rights and make informed decisions. These norms are often reinforced by family members, community leaders, and broader social expectations, making community-level engagement critical for sustainable change. MBMF2 addressed these barriers by working with parents, caregivers, community members, religious and traditional leaders, and male allies to strengthen SRHR knowledge, promote gender-equitable attitudes, and foster more supportive environments for CAY.

Through dialogues, positive parenting sessions, CSE for parents, male engagement activities, and community mobilisation efforts, the programme engaged 43,621 parents, caregivers, and community members (25,385 men, 18,235 women, and 1 identifying as other). Locally adapted approaches helped address cultural sensitivities and encourage discussion of often taboo topics. Findings indicate improvements in SRHR knowledge, attitudes, and support for CAY's access to information and services, although progress remained uneven across topics and contexts.

Table 6 Indicators measuring community members' views on CAY's SRHR. Baseline and endline.

Main indicators to measure community members' views around CAY's SRHR	Baseline	Endline
Correct knowledge of key SRHR issues	48 %	70 %
Equal support to CAY with disabilities' SRHR	14 %	27 %
Positive attitudes towards CAY's SRHR	30 %	55 %

Knowledge of core SRHR issues

Knowledge of core SRHR issues among community members improved substantially over the programme period. At endline, 70% of community members, including caregivers and community leaders, demonstrated correct knowledge of key SRHR topics, compared to 48% at baseline, with similar improvements observed among both women and men. Results varied across countries, ranging from 51% in Ethiopia and 64% in Zimbabwe to around 70% in Myanmar and Mozambique, and close to 80% in Laos and Uganda.

Training and community dialogue helped address common misconceptions related to HIV, STIs, pregnancy, and contraception. For example, participants in Uganda reported improved understanding that HIV cannot be transmitted through casual contact. The programme also strengthened parents' and caregivers' capacity to communicate with children and adolescents on SRHR-related issues through positive parenting approaches. Many participants reported improved communication and more supportive relationships with CAY as a result.

In Laos, Myanmar, Mozambique and Zimbabwe⁸, SRHR messaging incorporated positive, sexual wellbeing-based approaches, including on sexual pleasure. It challenged traditional risk-focused SRHR messaging, promoting skills important for relationships, self-esteem and positive SRHR attitudes. Although topics such as sexual pleasure remained sensitive in many contexts, the programme contributed to expanding dialogue on issues that are often constrained by prevailing social norms and stigma.

Positive attitudes towards CAY's SRHR

In 2025, 55% of community members demonstrated positive attitudes towards CAY's SRHR (56% of women and 53% of men), up from 30% at baseline. Improvements were observed across key areas, including support for contraceptive use, comprehensive sexuality education, and girls' continued education during menstruation, although issues such as homosexuality, masturbation, and safe abortion remained more sensitive.

A key area of change concerned community attitudes towards adolescents' access to contraception and SRH services. These attitudes are closely linked to social norms around sexuality, which have traditionally condemned premarital sex, particularly for girls. Monitoring data indicate gradual but meaningful shifts in these norms. At endline, 37% of community members reported no expectation that girls should remain virgins until marriage, compared to 16% at

⁸ These thematics were not included in Ethiopia and Uganda's SRHR messaging because they were too culturally sensitive.

baseline. While a majority (56%) still perceived virginity until marriage as a community expectation, this represents a substantial decline from 79% at baseline.

Perceptions of community reality shifted in a similar direction. The proportion of respondents who believed that most women and girls remain virgins until marriage decreased from 54% at baseline to 38% at endline. Together, these findings suggest a gradual weakening of traditional norms and increasing recognition of diverse adolescent experiences and behaviours. Such changes are important, as shifts in perceived norms often precede broader changes in attitudes and behaviour.

Qualitative findings further illustrate evolving attitudes towards adolescent sexuality, contraceptive use, and girls' bodily autonomy. In Ethiopia, one participant reflected: *"There are some attitudinal and belief changes regarding women's bodily autonomy. Women have the right to decide on their body autonomously and we are accepting that right."* Similarly, a female community member in Uganda noted: *"I can allow my adolescent child to use contraception because they have desires just like everyone else and it would prevent early pregnancy due to the training I have received."*

Table 7 Attitudes towards CAY's SRHR. Baseline and endline.

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 ⁹	43 %	59 %
Support for safe abortion options	44 %	60 %
Acceptance of homosexuality ¹⁰	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 %

These changes translated into greater support for adolescents' access to contraception. By endline, 80–84% of community members reported that they would support their daughters and sons in accessing contraceptives, up from around 60% at baseline. Support for access at younger ages also increased: the proportion willing to support contraceptive access among children aged 10–14 rose from 13% to 24% for girls and from 8% to 20% for boys. At the same time, the proportion of respondents who believed support should only be provided at age 20 or above declined substantially, from 23% to 9% for daughters and from 29% to 16% for sons.

⁹ This variable is only measured in Myanmar, Laos, Mozambique and Zimbabwe.

¹⁰ This value corresponds to the pretest value, measured in 2024, because this variable was not included in the baseline. This variable is only measured in Myanmar, Laos, Mozambique and Zimbabwe.

Table 8 Support for CAY's contraceptive use from community members. Baseline and annual monitoring data.

Variables		2022 (Baseline)	2023	2024	2025 (Endline)
% of community members who would support their daughters accessing contraceptives		61 %	73 %	86 %	84 %
Minimum age their daughters would have to be to receive their support	Between 10 and 14 years	13 %	21 %	22 %	24 %
	Between 15 and 19 years	64 %	63 %	61 %	67 %
	From 15 to 17years	27%	27%	27%	32%
	18 and 19 years	37 %	36 %	34 %	35 %
	Between 20 and 24yo	23 %	16 %	18 %	9 %
% of community members who would support their sons accessing contraceptives		55 %	75 %	84 %	80 %
Minimum age their sons would have to be to receive their support	Minimum age from 10 to 14 years	8 %	15 %	18 %	20 %
	Minimum age from 15 to 19 years	63 %	60 %	59 %	66 %
	From 15 to 17 years	22%	24%	24%	31%
	18 and 19 years	41 %	36 %	35 %	35 %
	Minimum age from 20 to 24yo	29 %	24 %	23 %	16 %

Despite this progress, concerns remain regarding younger adolescents. Around half of community members still believe that access to contraceptives should begin only at age 18 or above. This highlights the need for continued engagement with parents and communities to address beliefs that restrict younger adolescents' access to SRHR information and services, while further challenging age- and gender-based double standards and fostering stigma-free environments that support informed decision-making.

Positive shifts were also observed in other areas. In Myanmar, community-level engagement on menstrual health and hygiene helped dispel myths and misconceptions, contributing to a substantial increase in positive perceptions, from 63% at baseline to 100% at endline. Participants reported greater openness in discussing menstruation, full support for girls' school attendance during menstruation, and the disappearance of several harmful beliefs, reflecting a more supportive environment for adolescent girls.

Overall, improvements in knowledge and attitudes appear to be translating into more supportive interactions between community members and CAY on SRHR issues. However, important variations persist across countries and between women and men. Women reported more positive attitudes in Myanmar and Mozambique (+14 and +13 percentage points, respectively), while men reported more positive attitudes in Ethiopia (+18 percentage points). Attitudes were most supportive in Mozambique (81%), Laos (71%), and Ethiopia (66%), compared to Myanmar (55%), Uganda (38%), and Zimbabwe (17%). Sensitivities also varied by context, including homosexuality and sexual pleasure in Zimbabwe, and safe abortion and sexual harassment in Uganda.

Consistent with findings among CAY, these variations demonstrate that SRHR attitudes are shaped by local social and cultural contexts rather than gender alone. They highlight the complexity of social norm change and the importance of context-specific approaches to promoting gender equality and young people's SRHR.

Support for the SRHR of CAY with disabilities

Dialogue sessions across countries helped challenge misconceptions about disability and promote inclusive access to CSE and SRHR services, including through intergenerational exchanges that enabled adolescents with disabilities to voice their needs directly.

As a result, community support for the SRHR of adolescents with disabilities increased. At endline, 94% of community members agreed that adolescents with disabilities should have access to condoms (+17 percentage points) and sexuality education (+4 percentage points).

However, support for autonomous access to SRHR services remained more limited. Around 70% of respondents opposed adolescents with disabilities accessing SRH services without caregiver approval, reflecting persistent paternalistic attitudes. Evidence from Uganda and Zimbabwe suggests that acceptance of SRHR rights is often conditional: while adolescents with disabilities are generally supported to access contraception and services, this support is frequently tied to parental consent, indicating continued constraints on their autonomy and decision-making.

In Zimbabwe, qualitative findings suggest greater acceptance of independent access among older adolescents (16+), particularly those perceived as sufficiently mature, while resistance remains stronger for younger adolescents, partly influenced by policy and regulatory constraints. Across both Uganda and Zimbabwe, concerns about safety and abuse continued to shape attitudes, with parental involvement generally preferred and independent access viewed as a last resort.

Encouragingly, shifts towards greater support for autonomy are emerging. In Ethiopia, where community-level disability inclusion efforts were particularly strong, support for adolescents with disabilities accessing SRH services without parental approval increased from 23% at baseline to 61% at endline. This is reflected in community perspectives. As one participant from Kersa district noted: *“There is a big change in the community’s attitudes and beliefs regarding SRHR for CAY with disabilities. Now the community, the government and NGOs are supporting them to come out and learn about their SRHR. Previously many families were hiding their CAY with disability but now they are bringing them out [...] SRH services are given for all individuals who need it.”*

Gender differences persisted across contexts. In Ethiopia, men expressed higher levels of support than women (70% versus 55%), while in Mozambique women reported more supportive attitudes. These findings highlight the importance of gender-responsive and context-specific strategies to further strengthen inclusive community support for the SRHR of CAY with disabilities.

Male engagement for gender equality and SRHR

The programme promoted SRHR and gender equality by engaging men and boys as allies and encouraging more equitable attitudes, behaviours, and relationships. Through tailored outreach, peer education, and community dialogue, participants strengthened their capacity to support women’s rights, promote respectful relationships, and challenge harmful norms. This led to increased participation in discussions on caregiving, violence prevention, and positive masculinity.

To challenge restrictive gender norms, the programme created safe spaces for reflection and promoted men’s involvement in care work and household responsibilities, adapting approaches to local contexts. Technical support from Sonke Gender Justice strengthened implementation across countries.

In Uganda, male engagement sessions delivered through existing community groups and facilitated by trained male champions successfully reached men in positions of influence. Male parents represented 63% of all engaged community members, contributing to greater openness around discussions of adolescent and youth SRHR. As one community leader reflected: *“I used to think these were topics for women... now I encourage fellow male leaders and fathers to take part in educating our youth.”*

Evidence suggests that these shifts extended beyond awareness to changes in household dynamics. Participants reported improved communication within families, stronger relationships, and more equitable decision-making. In Ethiopia, one participant shared: *“Before this project, I was far from my wife and children... now we discuss openly and support them.”* Another noted that the programme *“helped me... to have shared decision making with my wife and to share domestic labour and child-care.”*

Overall, findings indicate that male engagement contributed to more supportive attitudes towards SRHR and gender equality, as well as greater involvement of men in family life and caregiving.

However, progress remains gradual and uneven, with changes concentrated among those directly reached by programme activities. As findings are largely based on self-reported experiences, continued efforts are needed to expand engagement beyond early adopters and to strengthen evidence on longer-term changes in gender norms and behaviours.

Engagement of community leaders in advancing CAY's SRHR

Community leaders play a critical role as gatekeepers of social norms, influencing attitudes and behaviours at both household and community levels. Recognising this, MBMF2 intentionally engaged religious, traditional, and community leaders as key actors in creating more supportive environments for CAY's SRHR.

By the end of the programme, 1,274 community leaders were actively promoting SRHR through personal support, community dialogue, social mobilisation, and public advocacy. While their engagement was sometimes framed by protective rather than fully rights-based perspectives on adolescent sexuality, leaders increasingly contributed to safer and more supportive environments through safeguarding efforts, school reintegration initiatives, community mediation, and awareness-raising.

Evidence across countries indicates growing leadership support for SRHR. In Zimbabwe, leaders increasingly spoke publicly about topics that had previously been considered taboo. As one village head noted: *"We couldn't easily talk about SRHR issues... but now it is a norm."* Leaders supported school reintegration for adolescent mothers, facilitated parenting and intergenerational dialogue, and encouraged communication between parents and children. In Myanmar, community leaders worked with peer educators to facilitate parent sessions and address harmful social norms. They later collaborated with community SRHR committees to develop action plans integrating climate change, disability inclusion, and referral systems, strengthening local ownership. In Mozambique, leaders reported shifts in their own views, moving from promoting traditional contraceptive methods to supporting modern contraception and framing access as a rights issue. As one leader explained: *"In the past, we avoided talking about contraception... today, we know it's a human rights issue."*

Leaders' involvement also strengthened community ownership. In Laos, village authorities encouraged participation and increasingly challenged traditional norms after gaining knowledge on SRHR and gender equality. In Uganda, religious leaders, primarily men, began discussing SRHR during sermons and community meetings. One participant reflected: *"Now, I speak more confidently... It has changed how I see my role as a leader."*

These shifts are reflected in rising youth perceptions of leader support for SRHR, which increased from 41% at baseline to 70% in 2025 (65% among girls and 74% among boys), surpassing the target of 63%. Although support for adolescent contraceptive use among some religious leaders in Ethiopia remained limited, especially for unmarried girls, the overall trajectory points towards a more enabling environment for CAY. As one young woman from Kersa explained: *"Community leaders at different levels are supporting adolescents and young people's SRH services. For example, health centre administrators built and gave us a room for SRH services. Government and non-governmental bodies are supporting adolescents and young people to access and use SRH services."*

Overall, findings suggest that leader engagement was an important driver of community-level change, contributing to increased acceptance of SRHR and stronger support for young people. However, progress remained uneven and sensitive to local contexts. In Uganda, perceived support declined from 75% in 2023 to 53% in 2024 due to leadership conflicts, while in Myanmar, insecurity and movement restrictions during 2024–2025 limited both leader engagement and programme reach.

Early signs of social and gender norm change

MBMF2 explicitly sought to influence harmful social and gender norms affecting CAY's SRHR, particularly those related to adolescent sexuality and contraceptive use, including among

unmarried girls. This work was informed by the programme's 2022 social norms diagnosis and reassessed in 2025.

Quantitative findings indicate increasing social acceptance of positive SRHR behaviours. Perceived acceptance of adolescents' and youths' access to SRH services increased to 86% among adolescents and youth and 91% among community members, up from 66% and 71%, respectively. Similarly, 87% of young people reported that discussing SRH issues with a partner is common (up from 63% at baseline), while 78% perceived community approval of modern contraceptive use among young couples, compared to 55% at baseline. Although these findings do not fully capture attitudes towards younger adolescents, they suggest growing openness towards young people's SRHR.

The programme also contributed to shifts in other harmful norms. Across countries, perceptions of child, early, and forced marriage and unions (CEFMU) increasingly moved from acceptance towards rejection. In Laos, perceived pressure for girls to marry early declined substantially, with negative reactions towards girls who remained unmarried after age 18 falling from 22% to 7%. In Uganda, changing parental attitudes illustrate this shift: *"Through the training... adolescents and youth now know that early marriage can lead to poverty and abuse... Before... we could see early marriage as success, but now... we know it's not good."* This reflects a gradual move away from norms linking marriage with protection and social status towards greater recognition of its risks and consequences. In Ethiopia, perceived community approval of FGM/C declined from 45% to 24%, indicating important shifts in social expectations, although not yet full abandonment of the practice.

Findings from the norms analysis also point to emerging behavioural change. Adolescents increasingly reported exercising agency in matters related to their SRHR. In Zimbabwe, girls continued to navigate restrictive norms through discreet strategies, while in Ethiopia and Laos, adolescents were increasingly initiating SRHR discussions more openly. At the same time, supportive influencers, including parents, teachers, health workers, and progressive religious leaders, became more visible across Uganda, Mozambique, Ethiopia, and Laos, helping to normalise SRHR discussions and reframe contraceptive use as supportive of education, health, and future opportunities.

The findings also highlight that norm change remains contested and uneven. In countries such as Zimbabwe and Uganda, conservative and progressive views continue to coexist, creating space for dialogue, negotiation, and gradual transformation rather than rapid change.

Overall, MBMF2 contributed to both increased adolescent agency and gradual shifts in the normative environment surrounding CAY's SRHR. While progress remains uneven, the evidence points to an emerging, though still fragile, process of social and gender norm transformation.

Strengthened community resilience

Another component of Outcome 3 focused on strengthening economic resilience and climate adaptation as enabling factors for CAY's SRHR and continued access to services during shocks and crises.

Climate-related risks and their links to SRHR were integrated into education activities through materials such as the *Bridging the Future* illustrations, helping raise awareness of how climate shocks can affect young people's wellbeing and access to services.

VSLAs and income-generating activities engaged 3,928 participants (2,676 women and 1,252 men) across Ethiopia, Uganda, and Zimbabwe. Climate resilience education was incorporated into VSLA activities, enabling participants to strengthen household preparedness and develop coping strategies. Monitoring data show consistent improvements across multiple resilience measures, including greater use of early warning information (62% to 80%), improved food storage (53% to 69%), increased savings (52% to 71%), and better continuity of essential services such as healthcare (74% to 81%) and education (73% to 85%). Overall, the proportion of households implementing at least five resilience strategies increased from 62% at baseline to 78% at endline.

Qualitative findings from Ethiopia further illustrate these changes. Community members reported improved environmental practices and greater financial preparedness. One participant from Kersa noted: *"The training... helped us to protect our environment; now we are planting trees... and saving money because we do not know what tomorrow will bring."* Another participant from Bahir Dar Zuria described adopting conservation and livelihood diversification measures, including composting, vegetable production, and flood-control practices.

In Zimbabwe, the programme also supported the integration of SRHR into local Disaster Risk Reduction (DRR) plans. This resulted in functional ward-level committees, stronger coordination with local authorities, and increased capacity to develop and implement contingency and preparedness plans, while ensuring the participation of persons with disabilities in decision-making processes.

Overall, these results suggest that strengthening household and community resilience can support more stable access to SRHR information and services during periods of economic, climate-related, and other shocks, while contributing to more supportive environments for CAY.

2.1.5 Analysis of Outcome 4

CAY in all their diversity participate and benefit from a vibrant civil society that advocates for increased public investment and improved SRHR policy and promotes equality for and agency of girls

Across programme countries, CSOs operate in challenging and, in many cases, increasingly restrictive environments that constrain advocacy, civic participation, and engagement in policy processes. According to the CIVICUS Monitor (2024–2025), civic space ranges from "obstructed" in Zimbabwe and Mozambique to "repressed" in Uganda and Ethiopia, while Laos and Myanmar are classified as "closed", reflecting severe restrictions on independent civil society activity. These constraints can limit opportunities to influence policy, promote accountability, and advocate for the rights of adolescents and young people, particularly marginalised groups.

MBMF2 sought to address these challenges by strengthening the capacities of CSOs, CBOs, OPDs, youth-led groups, and young advocates to engage in evidence-based advocacy, policy dialogue, and accountability processes related to SRHR. Through capacity strengthening, partnership development, networking, and support for youth participation, the programme worked to increase the influence of civil society actors and amplify the voices of adolescents and youth in decision-making processes.

A key success of MBMF2 was its ability to continue supporting local civil society and advancing a rights-based SRHR agenda despite increasingly restrictive operating environments. In several contexts, the programme's sustained presence helped preserve essential services, dialogue, advocacy spaces, and protection mechanisms for vulnerable groups, particularly adolescents, girls, and marginalised populations. This was made possible through careful navigation of civic space restrictions, adaptive implementation approaches, and strong partnerships with trusted local actors, ensuring that programming remained both effective and grounded in rights-based principles.

Strengthened capacity of local partners

Capacity strengthening of local CSO partners was implemented progressively based on identified needs and jointly agreed capacity development plans. Across all countries, partners were supported to lead inclusive SRHR programming through targeted technical assistance, training, and mentoring, with a focus on gender transformative approaches, disability inclusion, youth-friendly services, safeguarding, and MEAL. This enabled partners to increasingly design, implement, and monitor quality interventions with reduced reliance on external support.

Capacity strengthening combined regional and country-specific approaches. At regional level, teams from Ethiopia, Uganda, Mozambique, and Zimbabwe strengthened their capacity on disability inclusion and male engagement. At country level, support was tailored to local needs. In

Uganda, CBOs strengthened youth mobilisation and advocacy, contributing to the establishment of the Lango Humanitarian Platform, while partners replicated the Social Norms Diagnosis in new regions. In Myanmar, the local partner and youth-led groups received training and small grants to implement gender-transformative SRHR initiatives. In Ethiopia, partners strengthened organisational systems related to project management, MEAL, finance, safeguarding, and PSEA. In Laos, support focused on safeguarding and advanced CSE facilitation, particularly with an OPD partner, while in Mozambique, partners enhanced their advocacy capacity to drive local change.

Endline findings demonstrate substantial progress in organisational capacity. The proportion of CSOs demonstrating high readiness on SRHR increased from 67% at baseline to 86% at endline. Institutional systems were strengthened, with most organisations establishing or improving gender, inclusion, and safeguarding policies, alongside increased staff awareness and application of these frameworks. Capacity to integrate gender equality also improved, with nearly all CSOs conducting gender analyses, providing staff training, and strengthening their ability to anticipate and manage backlash.

At the same time, partners consolidated their position as SRHR actors. More organisations reported having dedicated SRHR strategies, participating in relevant networks, and contributing expertise to SRHR-related discussions and initiatives. Technical capacity also expanded across most SRHR areas, although more sensitive topics, including sexual wellbeing, safe abortion, and LGBTQIA+ inclusion, remained comparatively less developed, reflecting both their complexity and the constraints of the operating environment.

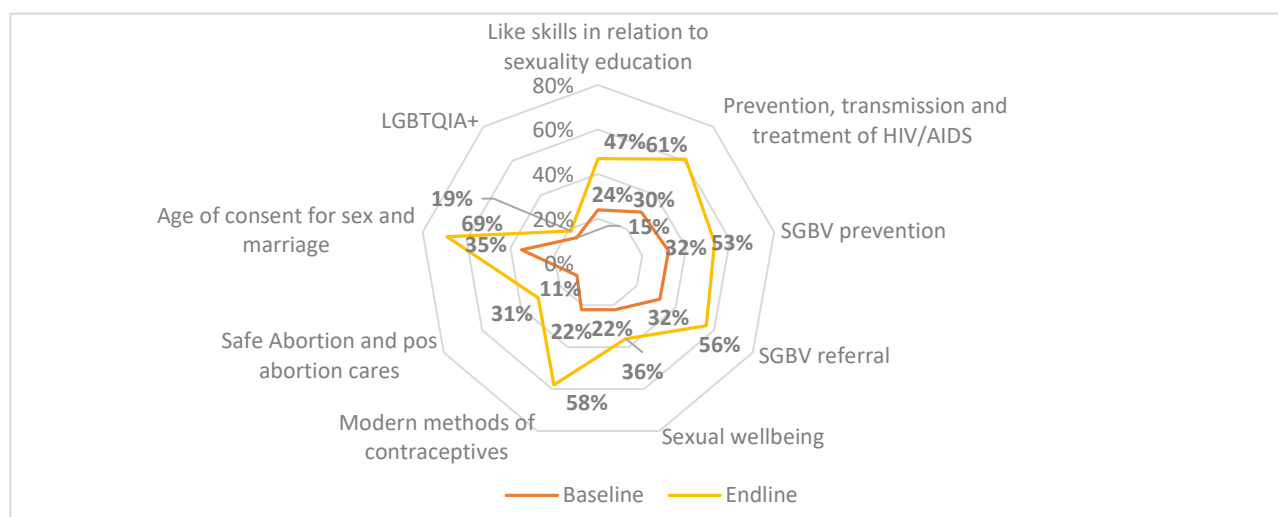


Figure 1 Percentage of CSOs rating their expertise at the highest level (5 out of 5), by topic. Comparison between baseline and endline data

Overall, the findings suggest that MBMF2 strengthened the organisational, technical, and advocacy capacities of local partners, increasing their ability to deliver inclusive SRHR programming and engage in policy and systems change processes beyond the life of the programme.

Advocacy influencing capacities and initiatives

Advocacy capacity strengthening was implemented across all programme countries. Through the MBMF2 MEAL system, CSOs' capacity to influence adolescent SRHR and gender equality was assessed at baseline and endline, showing substantial progress: the proportion of CSOs demonstrating high advocacy capacity increased from 21% to 67%, while those at low capacity decreased from 28% to 3%.

This progress was evident across multiple dimensions. By endline, 83% of CSOs had an SRHR advocacy strategy (up from 59%), and 81% were recognised by stakeholders as SRHR actors (62% at baseline). Integration of gender equality also strengthened, with 61% able to clearly articulate how gender considerations were incorporated into their advocacy strategies.

Collaboration remained strong, with 83% actively working with other organisations and all CSOs participating in coordination with peers.

Engagement with decision-makers increased significantly. By endline, 83% of CSOs reported regular dialogue with policymakers (+15 percentage points), while 89% had experience advocating for increased public investment in SRHR (up from 65%). Capacity to advocate on sensitive issues also improved, including safe abortion (38% to 56%) and LGBTQIA+ rights (33% to 44%). Communication and campaigning capacities strengthened in parallel, with 89% of CSOs leading advocacy campaigns and 81% routinely using social media for advocacy purposes.

These gains translated into concrete action. At endline, 61% of CSOs could demonstrate at least one successful advocacy initiative, compared to 22% at baseline, while the proportion reporting no advocacy achievements declined from 43% to 11%. Advocacy efforts were guided by priorities defined in 2024 with national stakeholders and adapted to local contexts, supporting more strategic and coordinated engagement.

As a result, 1,278 decision-makers were engaged over the programme period, including 533 in 2025 alone, through initiatives promoting inclusive, non-discriminatory, and high-quality SRHR policies and services. Key advocacy achievements included:

- **Ethiopia:** Advocacy on safe abortion and youth-friendly SRHR services informed dialogue with government stakeholders, contributing to commitments to strengthen service quality, accountability, and adolescent- and youth-responsive services.
- **Laos:** Advocacy on child, early, and forced marriage and unions (CEFMU) increased awareness of underlying drivers, including harmful social norms and economic pressures, helping build momentum for more coordinated responses.
- **Mozambique:** Advocacy efforts advanced LGBTQIA+ inclusion, securing commitments from local authorities to strengthen institutional responses, expand SOGIESC training, and promote community dialogue to address stigma and discrimination.
- **Zimbabwe:** Advocacy supported implementation of the Education Amendment Act through collaboration with the Ministry of Education, strengthening monitoring systems and promoting school retention and re-enrolment for vulnerable learners.

Overall, findings suggest that MBMF2 significantly strengthened the advocacy capacity and influence of local civil society actors, enabling more strategic engagement with decision-makers and contributing to incremental policy and systems change on key SRHR issues.

Text box 3 Disability inclusion and advocacy

Close-up: Disability inclusion advocacy

In 2025, disability inclusion advocacy focused on consolidating and institutionalising gains achieved throughout the programme. **In Ethiopia**, collaboration between OPDs and government actors became more embedded within local health systems, with joint review processes strengthening accountability and supporting more consistent implementation of disability inclusion measures, particularly in outreach services and the use of disability-disaggregated data. **In Zimbabwe**, youth-led advocacy contributed to tangible policy and service-level improvements. Adolescents with disabilities participated in the review of the Persons with Disabilities Act, helping influence provisions related to equitable access to SRHR services and accessible information. Advocacy also contributed to accessibility audits and the training of staff in 34 health facilities on disability-inclusive services and sign language. These efforts strengthened local authorities' commitment to making SRHR services more accessible and responsive to the needs of persons with disabilities.

Strengthening youth advocacy and participation

Strengthening youth advocacy was a core pillar of the programme, enhancing adolescents' and young people's participation in advocacy and accountability processes with support from CSOs. By endline, 58% of CSOs demonstrated a high level of engagement in enabling youth participation, up from 30% at baseline. This was accompanied by the expanded use of structured participation mechanisms, including consultative dialogues, feedback systems, and advocacy platforms. Across countries, 942 adolescents and youth (461 female, 481 male) engaged directly in advocacy on SRHR, gender equality, and inclusion.

These efforts translated into strong participation outcomes. On average, 86% of youth reported their engagement as meaningful, with high levels of satisfaction, relevance, and inclusivity. Most felt heard (73%) and able to contribute to decision-making (74%), reflecting increased confidence, skills, and recognition of their role in advocacy processes. As one participant noted: *"Before I could not speak in public... the youth dialogues helped me to be confident. I had the opportunity to represent other youths and advocate for their SRH rights."* While slightly lower levels of involvement in programme and advocacy design (78%) indicate room for further strengthening youth influence upstream, findings overall suggest a shift from participation as attendance towards more active and meaningful engagement.

These strengthened capacities translated into tangible results. **In Zimbabwe**, youth engagement in parliamentary committees and local dialogues contributed to the establishment of a Youth Policy Consultative Forum, institutionalising youth participation and creating opportunities for sustained influence on local decision-making. **In Uganda**, youth advocacy helped secure district-level commitments to expand youth-friendly SRHR services through additional outreach, dedicated service days, and infrastructure improvements, including the rehabilitation of a 12 km road to improve access to health services. Young people also successfully raised broader development priorities, including health facility expansion and climate resilience interventions, contributing to their inclusion in local planning processes.

Overall, the programme significantly strengthened both the scale and quality of youth-led advocacy, contributing to tangible policy and service improvements while advancing more meaningful participation of adolescents and young people in decision-making processes.

2.2 Results of the domestic component

The domestic component of the MBMF2 focused on communication, advocacy, and global citizenship education. MBMF2 strengthened CAY's knowledge, skills, and agency as active global citizens, enhanced educators' capacity to deliver high-quality global citizenship education, and supported youth-led advocacy, facilitating dialogue between young people and decision-makers in Finland.

In 2025, Plan International Finland's communications strengthened public understanding of gender equality, girls' rights and their importance for achieving the SDGs. Through results-focused, multi-channel communications aligned with MFA priorities, Plan communicated the impact of both development cooperation and humanitarian work. Content-gathering trips to Zimbabwe and Uganda produced high-quality stories and evidence of results in areas such as SRHR, education, protection, livelihoods and youth participation. These materials were widely used across digital channels, media engagement, marketing, and donor communications and shared within the global Plan International network, increasing awareness of Finland's contribution to advancing gender equality and strengthening accountability for results.

Media engagement remained a key pillar of communications. In 2025, Plan Finland contributed actively to public discussion through expert commentary, press materials and interviews, achieving a potential media reach of 41 million people. Social media channels reached 2.2 million people, while two issues of *Plan Magazine* communicated programme results to supporters and stakeholders.

Across 2022–2025, Plan International Finland’s communications delivered measurable results by adapting to changing operating environments and consistently strengthening strategic media work, research-based messaging and multi-channel outreach. This

positioned Plan International Finland as a credible actor in public discussion on gender equality, SRHR and humanitarian response, contributing to increased awareness, informed debate and sustained support for Finland’s development and humanitarian objectives.

In global citizenship education, the programme strengthened CAY’s knowledge, skills, and motivation to engage with global issues and active citizenship through the *Child Rights Ambassadors* network.

During the programme period, 46,080 CAY participated in workshops on child rights, Agenda 2030, global gender equality, and climate issues. These efforts increased awareness of global challenges and strengthened young people’s capacity and motivation to participate in society as active and informed citizens. Youth participation in civil society organisations and knowledge of sustainable development remained relatively high in Finland, with the programme likely contributing to these positive trends.

The programme also strengthened educators’ professional practice through training and the development of educational resources to support the delivery of high-quality, curriculum-aligned global citizenship education. Resources such as the *Child Rights 10* teacher guide provided new methods and research-based insights. According to training feedback, 76% of participants reported gaining new professional perspectives and practical tools.

During the programme period, teachers were provided with free educational resources that helped integrate global issues into everyday teaching. Resources such as the *Equality Makers* card game, together with 75 training sessions on global gender equality and sustainable development, strengthened Plan’s position as a trusted expert within the school and youth sector in Finland, thereby amplifying the programme’s broader contribution to global citizenship education and awareness of global issues. Youth voices were systematically integrated through their involvement in developing educational materials. To support reach, sustainability, and complementarity, the programme maintained the educational website *globaalikoulu.net*, promoted resources through relevant events and online channels, and actively participated in global citizenship education and child rights networks.

The programme exceeded its targets for youth activism and advocacy, demonstrating strong demand for youth-led engagement on global gender equality, climate justice, sustainable development, and human rights in Finland. Public outreach through youth-led campaigning grew significantly, with campaign reach increasing by 80% between 2024 and 2025. Campaigning increasingly connected global challenges to young people’s everyday realities, promoting peer learning, inclusive dialogue, and informed civic participation among young people and local communities. In 2025, a stronger focus on key campaign moments, including *Equality Day* (*#GirlsTakeover*), *Menstrual Day*, and the *International Day of the Girl Child*, contributed to an 80% increase in campaign reach compared to 2024.

The programme also strengthened youth leadership and long-term engagement in advocacy. More than 750 young people and volunteers participated as advocates and multipliers, planning and implementing over 1,000 advocacy activities across Finland. Redesign of the *#GirlsTakeover* and youth-led engagement models, including thematic advocacy groups and the Menstruation Day march led by the Children’s Board, expanded opportunities for participation and influence. The sustained involvement of trained volunteers across multiple years and the continued growth in outreach demonstrate strengthened youth leadership and active global citizenship. Collectively, these results contributed to embedding global responsibility, equality, and civic engagement within local action and public dialogue.

Under the Advocacy component in 2025, the programme contributed to strengthening dialogue between decision-makers, civil society, and young people on global gender equality, human rights, and climate action. This took place during a period marked by

geopolitical tensions and economic pressures. Our advocacy work also contributed to Finland's continued position of promoting the rights of girls and women as a priority within its development policy, including through engagement related to the OSCE Chairpersonship Conference on Gender Equality.

The programme facilitated engagement between policymakers and advocates on girls' rights and international development, reaching 156 decision-makers in 2025 and 977 during the entire programme period. It also supported direct dialogue between young people and decision-makers. Notably, in 2025, 100% of participating young people reported that they felt heard in these decision-making processes. Together, these results helped strengthen youth participation, raise the visibility of global issues, and promote informed policy dialogue on gender equality, human rights, and sustainable development.

Overall, the domestic component successfully strengthened young people's knowledge, agency, and participation, while enhancing educators' capacity and creating meaningful opportunities for youth to influence public dialogue and decision-making on global issues in Finland. At the same time, Plan International Finland's communications increased public awareness of girls' rights and development results linked to development and humanitarian projects, while strengthening the organisation's role as a credible voice in public debate on gender equality, SRHR and humanitarian response.

3. Programme management

The programme's effectiveness was supported by deliberate investments in localisation, sustainability, learning, risk management, and financial oversight. Across countries, MBMF2 strengthened local ownership and capacities, promoted evidence-based decision-making, and adapted to complex operating environments. Together, these efforts strengthened accountability, programme quality, and the sustainability of results beyond the funding period.

3.1 Localisation and ownership

A core principle of MBMF2 was strengthening local ownership and participation. Through collaborative partnerships, engagement with local institutions, and meaningful involvement of young people, the programme promoted more contextually relevant, sustainable, and locally led approaches to SRHR programming. Overall, findings show increased partner ownership, stronger local systems, and active youth engagement across programme countries.

Strengthened partner ownership and decision-making

Across all countries, collaborative decision-making strengthened local ownership, contextual relevance, and shared accountability. Local partners actively shaped strategies, provided community insights, and participated in planning, review, and MEAL processes, enabling adaptive management and continuous learning. While this inclusive approach strengthened alignment with partner priorities and supported capacity development, the depth of engagement varied across contexts, depending on partner capacity and operating constraints. In Uganda, partners increasingly took the lead in delivering SRHR interventions, supported by targeted capacity strengthening and decentralised implementation. This was associated with more locally driven decisions, stronger alignment with community priorities, and faster adaptation interventions. However, sustaining this shift toward locally led delivery will depend on maintaining partner capacity and consistent resource flows.

Strengthened local institutions and systems

The programme also reinforced sustainability by working through existing local institutions and systems. In Zimbabwe, activities were embedded within schools, health facilities, and local governance structures, with teachers, health workers, and community facilitators playing central roles in delivery and follow-up. Youth and community members contributed to priority-setting, monitoring, and programme adaptation, strengthening ownership and accountability. Similar

approaches across countries helped anchor interventions within local systems, although sustainability will depend on continued institutional support, resources, and staff retention.

Meaningful youth participation and leadership

Youth engagement was a defining feature across contexts, with CAY contributing to design, implementation, monitoring, and advocacy. In Uganda, young people regularly identified and updated advocacy priorities through structured consultations and, by 2025, led evidence-based engagement with sub-county leaders on SRHR service access and broader development needs. In Zimbabwe, youth, including adolescents with disabilities, contributed to advocacy, service, and policy discussions, while youth champions led peer education, digital content creation, and community outreach beyond project sites.

In Laos, student and youth clubs played an active role in facilitating peer education sessions on SRHR and gender equality, while also contributing to basic data collection, activity tracking, and feedback mechanisms that informed programme adjustments. In Myanmar, youth engagement was embedded through peer leadership and community-based structures, with young people supporting planning, implementation, and feedback processes despite operating in a highly constrained environment, contributing to more context-adapted and inclusive interventions.

Across countries, youth participation moved beyond consultation towards more active roles in implementation and advocacy, strengthening programme relevance and responsiveness. However, influence over decision-making and programme design remained uneven, highlighting opportunities to further strengthen youth leadership and meaningful participation across contexts.

3.2 Sustainability

The MBMF2 programme demonstrates a multi-layered approach to sustainability across Ethiopia, Mozambique, Uganda, Zimbabwe, and Laos, based on the progressive integration of interventions into government, community, and civil society systems, alongside capacity strengthening and locally owned structures. However, sustainability remains constrained by limited financial resources, incomplete policy integration, and capacity gaps, particularly due to staff turnover. Weak data systems, uneven stakeholder engagement, and broader structural factors, including poverty and limited economic opportunities, further affect long-term viability. In Myanmar, due to contextual constraints, collaboration with government structures has been limited, reducing institutional sustainability.

A central feature of sustainability is the extent to which interventions are embedded within existing systems. In Mozambique and Ethiopia, community and school-based groups are anchored in established social structures, while in Laos and Zimbabwe, school and youth platforms support continuity through locally led activities. In Ethiopia, activities are closely linked to WCSA structures, health systems, and OPDs through formal handover and alignment with local governance. In Mozambique, Zimbabwe, and Laos, CSE has been integrated into education systems through teacher training and coordination with authorities, while in Uganda, interventions are increasingly aligned with district health systems and community platforms. This integration increasingly shifts implementation responsibility to local actors, strengthening continuity, although effectiveness may still be affected by staff turnover, facilitator attrition, and youth mobility.

Community-based and peer-supported approaches further reinforce sustainability by embedding outcomes in everyday practices. Mechanisms such as youth groups, Champions of Change models, VSLA platforms, and community facilitators sustain SRHR knowledge, social norms change, and support networks. For example, in Uganda, VSLA groups linked to the Building Bridges model enable sustained engagement with parents and communities, connecting SRHR with livelihoods and local development structures.

The sustainability of SRHR service delivery shows progress but remains conditional. Across Uganda, Zimbabwe, and Ethiopia, the programme strengthened health worker capacity, supported

community-based cadres, and reinforced referral systems between communities and facilities. In Uganda, referral systems have increasingly been integrated within existing structures, reflecting a broader trend across programme countries. However, sustainability continues to depend on public resources and institutional support, with constraints including staff shortages, limited infrastructure, weak incentives for community actors, and gaps in inclusive service provision.

Economic empowerment has emerged as a key cross-cutting enabler. In Zimbabwe, Ethiopia, and Uganda, linking SRHR with livelihoods, vocational training, and financial inclusion addresses underlying drivers such as poverty and migration. In Uganda, VSLA linkages with local development programmes strengthen sustainability, while in Zimbabwe, more advanced models, including private sector partnerships and youth entrepreneurship, create additional pathways. These approaches strengthen both individual resilience and the sustainability of community structures.

Sustainability is also reinforced through growing community ownership and shifting social norms. Engagement with parents, leaders, and influencers has supported the integration of SRHR discussions into existing community spaces, including schools, group platforms, and local forums. In Uganda, intergenerational dialogue within VSLA groups supports continued engagement, with similar dynamics in Mozambique, Ethiopia, and Zimbabwe through community mobilisation and leadership involvement.

Finally, the programme strengthened the role of local organisations, OPDs, and youth-led structures in sustaining activities and advocacy. In Uganda and Ethiopia, these actors increasingly support service linkages and community engagement, while in Mozambique and Zimbabwe, youth groups and CSOs are building advocacy and mobilisation capacity. However, sustaining these gains will require continued investment in organisational capacity, strategic advocacy, and the effective use of evidence and data for decision-making and influence.

3.3 Monitoring, evaluation, accountability and learning

Monitoring

Over the programme period, robust M&E systems were established to track both participation and outcomes. Activity monitoring relied on standardized attendance tools linked to Kobo Toolbox, enabling consistent data collection across Plan and partner teams and accurate tracking of participation, completion, and drop-out rates.

Outcome measurement was based on a suite of surveys covering CAY, community members, teachers, and service providers, with data collected digitally (CommCare, Kobo) on an annual basis, and visualized in Power BI. Qualitative data, including annual focus group discussions, complemented quantitative analysis. In total, nearly **27,000 surveys/assessments** were conducted, including around 7,000 entry points at baseline, and other 20,000 over the annual data collection rounds. Samples were designed to be representative, with random selection applied where feasible. Data collection was primarily conducted by trained enumerators; however, in some contexts, security and operational constraints required adapted approaches, such as in Ethiopia, where conflict in Amhara necessitated data collection through community facilitators. Some pre-tests were also conducted in selected contexts.

Endline data included **14,766 data points**, including **9,129 CAY**, **1,510 community members (2025)**, and **472 service providers**, providing a strong evidence base. In addition, FGDs and outcome harvesting workshops were conducted in 2025 to complement analysis.

Some limitations remained. Samples were not always fully comparable across countries or with baseline. In addition, **statistical power was sometimes insufficient for subgroup analysis**, particularly for intersectional groups (e.g. persons with disabilities) and finer age/sex disaggregation.

Monitoring data was regularly used to support evidence-based decision-making, including annual planning, programme adaptation, and performance reviews. In several countries, data validation and reflection workshops led by Country Office MERL coordinators supported joint interpretation of findings by Plan and partner teams, strengthening learning and evidence use. It was also used to refine interventions where results were below expectations. For example, in Zimbabwe, CSE delivery was adjusted by reducing the number of groups while strengthening facilitator support and peer-led approaches, improving the quality of exposure and outcomes.

Tools were sometimes complex and resource-intensive, limiting full use by partners and occasionally being applied more for compliance than learning. Going forward, maintaining standardized tools while simplifying them, and further strengthening partner engagement, will be key to enable deeper analysis, reinforce ownership, and better support the use of evidence for actionable programme improvements.

Evaluation

A Mid-Term Review (MTR) was conducted in 2023–2024, led by an external consultant team, providing a structured space for joint reflection, learning, and decision-making across six countries. A key regional workshop in Zimbabwe brought together Plan International staff and partners to review the gender-transformative Theory of Change and core values, assess strategic learnings, and strengthen partnerships. These findings informed management response plans at both programme and country levels, with a similar process undertaken for the domestic component.

In 2025, a final external evaluation was carried out using a mixed-methods approach, including a desk review, interviews with Plan International Finland and Country Offices, CSO discussions, and validation workshops. The evaluation assessed the programme's relevance, effectiveness, efficiency, coherence, and sustainability, while generating actionable learning for future SRHR programming.

Overall, the programme was found to be **highly relevant, effective, and efficient**, with strong results in adolescents' SRHR knowledge, agency, service quality, and community attitudes. However, it also highlighted **persistent gaps in service uptake** and **uneven sustainability**, particularly in constrained contexts.

The evaluation produced **seven key recommendations**, focusing on strengthening CSE sustainability, deepening inclusion (disability and SOGIESC), improving programme layering, reinforcing CSO systems and localisation, engaging men and boys, increasing SRHR service uptake, and strengthening learning and evidence systems.

Accountability and learning

Each country facilitated structured feedback processes involving children, adolescents, youth, and community members to gather insights on programme strengths, gaps, and areas for improvement. Mechanisms such as quarterly feedback sessions and After-Action Reviews, often conducted in age- and sex-disaggregated groups, supported continuous learning and programme adaptation.

The learning strategy combined structured reflection, documentation, and use of lessons learned across three levels: programme-wide learning sessions, Learning Harvesting Workshops, and ongoing reflective tools such as Activity Reporting Templates. These workshops brought together Plan and partner teams to review progress, identify challenges, and plan next steps, with outputs captured in Lessons Learnt Briefs and Action Trackers to inform programme decisions. The MEAL Community of Practice further strengthened continuous learning through regular exchanges.

In addition, feedback and accountability mechanisms, such as suggestion boxes and quarterly review meetings, enabled participants and community members to raise concerns, provide suggestions, and inform programme improvements throughout implementation.

Cross-country learning was reinforced through partner-led knowledge-sharing spaces, including thematic sessions on LGBTQIA+ inclusion, disability inclusion, and other priority areas. These

platforms enabled the exchange of practical approaches and challenges across contexts, strengthening collective capacity and supporting the replication of effective practices.

Key programme strategies, including the CSE approach and engagement with communities and leaders, were documented and disseminated through knowledge products, including a programme magazine.

Lessons learned contributing to the design of the BRAVE Programme

The programme's monitoring, evaluation and learning processes generated several important lessons regarding both the Theory of Change and programme implementation.

First, economic empowerment emerged as an important pathway to improved SRHR outcomes. Findings suggest that livelihoods, financial inclusion, and skills development can strengthen young people's agency and decision-making; however, in an increasingly constrained funding environment, such investments should be strategically targeted to the most marginalised groups and closely integrated with complementary SRHR interventions.

Second, the programme highlighted the value of making intersectionality more explicit within the Theory of Change. While disability inclusion, gender equality, age, and other forms of marginalisation were addressed throughout implementation, a clearer articulation of how different groups experience barriers and benefit from programme interventions would strengthen both programme design and results measurement.

Third, the findings reinforced the importance of engaging community leaders, parents, caregivers, and male community members as key influencers of social and gender norms. Changes in attitudes and behaviours were most evident where community-level engagement complemented individual-level empowerment approaches, demonstrating the need for sustained investments in social norm change.

Fourth, experience across all programme countries confirmed that policy and systems-level change requires long-term engagement and strong collaboration among civil society actors. Advocacy outcomes were often incremental and dependent on broader political and civic space dynamics, highlighting the importance of coordinated approaches, strategic partnerships, and realistic timeframes for achieving institutional change.

These lessons directly informed the design of the BRAVE - Breaking Barriers Building Equality Programme (2026-2029). While maintaining the holistic, multisectoral, and gender-transformative approach to SRHR, the new programme strengthens engagement with men and community leaders, introduces clearer country-level Theories of Change, and more explicitly articulates the pathways through which different programme strategies contribute to outcomes for specific stakeholder groups. Youth economic empowerment has been positioned more clearly as a pathway towards improved SRHR outcomes, while the programme design process itself was highly participatory, strengthening localisation and ownership through partner engagement. Learning from MBMF2 also informed the earlier development of country-level advocacy strategies and the introduction of more structured support for youth-led monitoring and accountability of SRH services.

3.4 Risk management

During 2025, risks and mitigation measures were regularly reviewed by country offices, implementing partners, and Plan International Finland. Risk matrices guided the analysis and were reviewed and updated twice during the year as part of the annual reporting and planning processes. Despite several contextual and operational risks materialising, including conflict, political instability, shrinking civic space, and staff turnover, the programme was able to adapt implementation and largely maintain planned results.

Contextual risks

Based on the risk analysis for the year 2025, the programme team continued close monitoring of the situation in Ethiopia, Myanmar, and Mozambique, where the political situation remained fragile or prone to acute conflicts. Tensions in Amhara, Ethiopia, continued in 2025, and the programme implementation was adapted to the situation during annual planning with emphasis on activities that did not require high mobility and community gatherings. Project implementation continued throughout the year as the local partners were able to access communities.

In Myanmar, security risks were high, and the project implemented robust security measures throughout the implementation. The experience demonstrated the importance of flexible implementation arrangements and trusted local partnerships in maintaining continuity in highly volatile contexts. In August, the project experienced a sudden phase-out and had to make operational adjustments, including relocating activities to Mandalay due to security concerns. The existing coordination mechanisms supported the relocation process, and the reprogramming arrangement was effectively implemented through the existing partnership with a local partner during the final quarter of the programme.

The risk analysis for 2025 took into account the prolonged security challenges after the elections in Mozambique at the end of 2024. Mitigation measures were in place, and large community gatherings were avoided. The situation calmed down during the first months of the year and did not affect project implementation.

Conflict risk also materialised in Laos, where a conflict erupted between Lao military forces and heavily armed militant groups allegedly tied to transnational drug syndicates in some project areas along the border of Laos and Thailand. The conflict caused delays in some project activities but did not affect the project's overall results.

The risk matrix recognises restrictive policies and shrinking of civil society space as risks that cause backlash on young people's and/or gender activists' civic engagement and activism. As explained in Chapter 1.6, the PVO Amendment Act in Zimbabwe created uncertainty for the partner organisation SRC. Increased government oversight also increased the human rights risks to the LGBTIQ+ community and advocates. The mitigation measures in the project included contextualised messaging, active information sharing, and communication with authorities on planned activities. In Myanmar, on the other hand, the project's engagement with young people was restricted by the authorities during the election period. Security measures were followed, and in order not to compromise the safety of the project participants and staff, the project was relocated as explained above.

Inflation remained a key risk throughout the programme period, particularly in Zimbabwe. While macroeconomic conditions improved in 2025, broader funding uncertainty increased following major shifts in global development financing. Although programme implementation was not directly affected, several partner organisations experienced significant funding reductions and organisational restructuring.

Programmatic risks

Although sensitive SRHR content remained a recognised programme risk, mitigation measures established throughout the programme period helped minimise disruption. Due to the strengthening anti-gender movement and increasing restrictions on the rights of gender and sexual minorities, the risk of resistance to SRHR messaging, particularly on LGBTQIA+ issues, remained significant throughout 2025. This risk was especially pronounced in Zimbabwe, where legislative changes further constrained civic space and advocacy on these issues. Context-sensitive approaches, tailored messaging, and close engagement with communities and local stakeholders helped maintain acceptance and participation across programme contexts.

Institutional risks

Staff turnover and transfer of government staff have been identified as risks to the project quality. During the period under review, the Ministry of Social Welfare in Zimbabwe enrolled new

Community Case Workers (CCWs), replacing the old ones who had been part of the project since its inception, disrupting earlier progress. To address this and promote sustainability, the project conducted additional training for the newly appointed CCWs, equipping them with knowledge and skills on disability-inclusive service delivery.

On-going remote technical support was also given to country teams throughout the year by Plan Finland, to support quality and to ensure that the project and financial management meet the MFA compliance requirements and adhere to Plan's global approach and guidelines, including child protection and safeguarding, prevention of sexual harassment, and the general principles of good governance. The support included monitoring and technical support visits to all the projects during 2025. No incidents conflicting with Plan International's rules and regulations on financial management and safeguarding were found in 2025. These measures contributed to maintaining programme quality, compliance, and safeguarding standards throughout the final year of implementation.

Overall, the risk matrix proved effective in identifying key contextual and operational risks, including conflict, shrinking civic space, and staff turnover. However, the scale of global development funding reductions following USAID cuts and broader geopolitical shifts was underestimated. These developments highlighted the need for stronger consideration of donor concentration and global funding trends in future risk analyses.

3.5 Financial management

Total MFA grants for the programme period amounted to €23.4 million (€6 million annually in 2022–2024 and €5.4 million in 2025). Total programme expenditure reached €27.3 million, of which MFA funding covered 85% and self-financing 15%. Total MFA expenditure amounted to €23.2 million, with a carryover of €172,469 to 2026.

Key economic factors influencing the financial management during the programme period consisted of global inflation and exchange rate fluctuations. At the beginning of the programme period the euro depreciated against the US dollar resulting in loss of purchasing power across programme countries. At the same time global inflation, driven by the war in Ukraine and energy price shocks, increased the cost of food, fuel, salaries, and supplies across all programme countries.

To address these challenges, Plan Finland introduced a monthly forecasting model in 2022 requiring detailed consumption projections from all projects, paired with a mechanism allowing declared unspent funds to be carried forward. Projects facing funding shortfalls received reallocated resources from projects that underspent.

Annual expenditure rates improved steadily from 93% in both 2022 and 2023 to 95% in 2024 and 97% in 2025. The final year achieved the programme's highest expenditure rate, reflecting strengthened financial management systems, improved implementation performance, and partial stabilisation of the economic environment.

4. Financial reports

Financial report 2025

		Budget	Expenditure	Expenditure vs. budget %	MFA costs	Self-funding	Self-funding %
Mozambique	Mandziku - My Future (259PL149)	730 250	730 189	100	620 661	109 528	15 %
Uganda	An amokotama - I Decide (285PL150)	983 135	942 773	96	801 357	141 416	15 %
Ethiopia	Yene Raey - My Future (238PL151)	867 301	867 197	100	737 118	130 080	15 %
Zimbabwe	My Body My Future (266PL153)	698 341	696 320	100	591 872	104 448	15 %
	East and Southern Africa Total	3 279 027	3 236 479	99	2 751 007	485 472	15 %
Laos	Anakhot khong-khoi - My Future (745PL224)	900 000	900 000	100	765 000	135 000	15 %
Myanmar	Me Me Kanda, Me Me Anagat Pa - My Body My Future (635PL225)	271 881	259 489	95	220 566	38 923	15 %
	Asia Total	1 171 881	1 159 489	99	985 566	173 923	15 %
Global	Gender and SRHR (998PL515)	40 000	42 333	106	35 983	6 350	15 %
Global	Disability inclusion (998PL517)	16 750	9 487	57	8 064	1 423	15 %
Global	Climate resilience (998PL512)	7 000	5 859	84	4 980	879	15 %
Finland	Global citizenship education (998PL501)	343 000	327 478	95	278 356	49 122	15 %
Finland	Policy advocacy in Finland (998PL501)	170 000	154 843	91	131 617	23 226	15 %
	Global thematic Total	576 750	540 000	94	459 000	81 000	15 %
	GRAND TOTAL	5 027 658	4 935 969	98	4 195 573	740 395	15 %

FINANCIAL SUMMARY				Expenditure vs. budget %			
	Total budget						
Programme activities	5 027 658	4 935 969		83	4 195 573	740 395	15 %
Plan Finland							
MEAL and Quality assurance (998PL406)	95 085	91 788		97	78 020	13 768	15 %
Communications in Finland (998PL516)	320 000	310 606		97	264 015	46 591	15 %
Administration (998PL01)	669 445	649 154		97	551 781	97 373	15 %
Plan Finland programme salaries: Programme management, thematic and MEAL support to the international programmes (998PL518)	582 258	504 024		87	428 420	75 604	15 %
Total Plan Finland	1 666 788	1 555 572		93	1 322 236	233 336	15 %
PROGRAMME S TOTAL 2025	6 694 446	6 491 540		97	5 517 809	973 731	15 %
Max 10% unallocated							
Grant total	6 694 446	6 491 540		97	5 517 809	973 731	15 %

MFA Financing	€
Transferred from 2024	290 278
Funds 2025	5 400 000
MFA funds available	5 690 278
Expenditure 2025	- 5 517 809

Carry over to 2026	172 469
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Summary of Plan Finland costs 2025

Quality Assurance

Planning, monitoring, technical support and programme development	91 788,00	91 788,00
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Global Citizenship Education and Policy advocacy

Global Citizenship Education	327 478,00	
Policy advocacy in Finland	154 843,00	
	482 321,00	482 321,00

Communications in Finland

Programme communications	310 605,61	310 605,61
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Administration

Programme related direct administrative staff	172 542,99	
Share of administration cost of programme teams	138 079,01	
Fundraising activities	210 935,01	
Share of		
Premises	67 886,31	
IT	55 730,54	
Administration cost of management, premises and HR	119 448,77	
Misc.: Organization communication, donor education public, audits	37 896,07	
	280 961,70	

Administration costs total	802 518,71	
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MFA approved administration costs 10%	649 154,02	649 154,02
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Administration costs exceeding the 10% limit (not charged to the donor)	153 364,69	
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PLAN FINLAND COSTS TOTAL		1 533 868,63
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Self-funding 2025

1. Project specific self-funding

Donations

Mozambique - Mandziku - My Future (259PL149)	109 528,35
Ethiopia - Yene Raey - My Future (238PL151)	65 039,78
Zimbabwe - My Body My Future (265PL153)	104 448,01
Laos - Anakhot khong-khoi - My Future (745PL224)	135 000,00
Myanmar - Me Me Kanda, Me Me Anagat Pa - My Body My Future (635PL225)	38 923,40
Gender and SRHR (998PL515)	6 349,95
Disability inclusion (998PL517)	1 423,05
Climate resilience (998PL512)	878,85
PROJECT SPECIFIC SELF-FUNDING TOTAL	461 591,40

2. Project specific sponsorship funding

Uganda - An amoko tama - I Decide (285PL150)	141 415,95
Ethiopia - Yene Raey - My Future (238PL151)	65 039,78
PROJECT SPECIFIC SPONSORSHIP FUNDING TOTAL	206 455,73

PROJECT SPECIFIC TOTAL

668 047,13

3. Plan Finland self-funding

MEAL and Quality assurance (998PL406)	13 768,20
Communications in Finland (998PL516)	46 590,84
Plan Finland administration (998PL01)	97 373,10
Global citizenship education (998PL501)	49 121,70
Policy advocacy in Finland (998PL501)	23 226,45
Plan Finland programme salaries (998PL518)	75 603,60
PLAN FINLAND TOTAL	305 683,89

SELF-FUNDING TOTAL

973 731,03

Financial report 2022-2025

Country	Program me	Total Budget 2022-2025	Total Expenditure	MFA costs	Self- funding	MFA %	Self- funding %
Mozambique	Mandziku - My Future (259PL149)	3 153 790	3 153 729	2 619 139	534 590	83,0 %	17,0 %
Uganda	An amoko tama - I Decide (285PL150)	4 275 140	4 234 778	3 611 349	623 429	85,3 %	14,7 %
Ethiopia	Yene Raey - My Future (238PL151)	3 589 745	3 589 641	3 059 967	529 674	85,2 %	14,8 %
Zimbabwe	My Body My Future (265PL153)	2 802 581	2 800 560	2 387 854	412 706	85,3 %	14,7 %
	East and Southern Africa Total	13 821 256	13 778 708	11 678 309	2 100 399	84,8 %	15,2 %
Laos	Anakhot khong-khoi - My Future (745PL224)	3 225 316	3 225 316	2 748 706	476 610	85,2 %	14,8 %
Myanmar	Me Me Kanda, Me Me Anagat Pa (635PL225)	1 087 849	1 075 457	916 662	158 795	85,2 %	14,8 %
	Asia Total	4 313 165	4 300 773	3 665 368	635 405	85,2 %	14,8 %
Global	Gender and SRHR (998PL515)	386 637	388 970	332 002	56 968	85,4 %	14,6 %
Global	Disability inclusion (998PL517)	174 820	167 557	143 166	24 391	85,4 %	14,6 %
Global	Climate resilience (998PL512)	88 345	87 204	74 508	12 696	85,4 %	14,6 %
Finland	Global citizenship education (998PL501)	1 309 203	1 293 681	1 102 749	190 932	85,2 %	14,8 %
Finland	Policy advocacy in Finland (998PL501)	703 549	688 392	586 894	101 498	85,3 %	14,7 %
	Global thematic Total	2 662 554	2 625 804	2 239 319	386 485	85,3 %	14,7 %
	GRAND TOTAL	20 796 975	20 705 285	17 582 996	3 122 289	84,9 %	15,1 %
	FINANCIAL SUMMARY	Total Budget	Total Expenditure			MFA %	
	Programme activities	20 796 975	20 705 285	17 582 996	3 122 289	84,9 %	15,1 %
	Plan Finland						
	MEAL and Quality assurance (998PL406)	373 153	369 856	315 398	54 458	85,3 %	14,7 %
	Communications in Finland (998PL516)	1 372 825	1 363 431	1 162 394	201 036	85,3 %	14,7 %
	Administration (998PL01)	2 752 917	2 732 626	2 329 716	402 910	85,3 %	14,7 %
	Plan Finland programme salaries (998PL518)	2 233 299	2 155 065	1 837 027	318 038	85,2 %	14,8 %
	Total Plan Finland	6 732 194	6 620 978	5 644 535	976 442	85,3 %	14,7 %
	PROGRAMMES TOTAL 2022-2025	27 529 169	27 326 263	23 227 531	4 098 731	85,0 %	15,0 %
	MFA FINANCING	€					
	MFA grant 2022	6 000 000					
	MFA grant 2023	6 000 000					
	MFA grant 2024	6 000 000					
	MFA grant 2025	5 400 000					
	Total MFA grants 2022-2025	23 400 000					
	Total MFA expenditure 2022-2025	-23 227 531					
	Carry over to 2026	172 469					