Terms of Reference: Consultant services for End of Project Evaluation – The Youth for Health (Y4H) Project

The Youth for Health (Y4H) project is a three-year EU co-funded project being implemented in six countries in sub-Saharan Africa (Ethiopia, Ghana, Kenya, Sierra Leone, Tanzania and Zambia). The project started in July 2022 and ends in December 2025, with final reporting taking place in Q1 2026. It is managed by a consortium that is led by MSI Reproductive Choices, together with six MSI country programme teams, nine national partners and DSW as a global and regional partner.[1]

The Y4H consortium is seeking the services of consultant or team of consultants for the purpose of conducting a final evaluation of the Y4H project according to the terms of reference set out herein.

Published on:	30th September 2025
Proposals submission date:	12th October 2025
Supervisor:	MSI Reproductive Choices
Funder:	European Commission
Language:	English
Evaluation timeline	November 2025 – March 2026
Assignment title:	End of Project Evaluation: Youth for Health (Y4H) – Expanding Access to Life-Changing Adolescent Sexual and Reproductive Healthcare in Ethiopia, Ghana, Kenya, Sierra Leone, Tanzania, and Zambia
Budget:	€45,000

1. Background

The Y4H project aims to expand access to life-changing adolescent sexual and reproductive healthcare and rights (ASRHR), with a focus on reaching the poorest and most marginalised adolescent girls, including those with disabilities, in rural and hard-to-reach areas of Ethiopia, Ghana, Kenya, Sierra Leone, Tanzania, and Zambia. By unlocking demand and access and contributing towards changes in favour of supportive policies and funding environments, Y4H aims to increase and sustain access to ASRHR for girls and young women.

The project's three key objectives are to:

1. Increase demand for, and access to, high-quality and discrimination-free ASRHR information and services with a focus on reaching the poorest and most marginalised adolescents in rural and hard-to-reach areas

2. Increase public sector willingness and capacity to deliver and sustain high-quality ASRHR information and services for the poorest and most marginalised adolescents in rural and hard-to-reach areas

3. Improve the enabling policy and funding environment at regional, national and sub-national level, supporting the fulfilment of ASRHR

[1] Y4H partners include: the Youth Network for Sustainable Development and DSW in Ethiopia; Youth Advocates Ghana in Ghana, the Centre for the Study of Adolescence and Youth for a Sustainable World in Kenya, Health Alert Sierra Leone in Sierra Leone, Sikika and DSW in Tanzania and Restless Development Zambia in Zambia.

The project's indicators are listed below. The logframe with updated results to June 2025 is included in Annex One.

	Results chain	Indicator
Impact (Overall objective)	Enhanced adolescent sexual and reproductive health and rights (ASRHR) in Ethiopia, Ghana, Kenya, Sierra Leone, Tanzania, and Zambia.	Adolescent (<20) birth rate per 1,000 adolescents (15-19 years old)[2]
		Proportion of adolescent (<20) FP demand satisfied by modern methods
		Estimated % growth in unintended pregnancies averted (all clients and adolescent clients)
Outcome (s) (Specific objective(s))	**Outcome 1**: Increased demand for, and access to, high-quality, discrimination-free ASRHR information and services with a focus on reaching the poorest and most marginalised adolescents in rural and hard-to-reach areas.	% of FP/SA client visits made by those aged under 20 at public sector sites supported by the project.
		% of FP/SA client visits made by those living in severe multidimensional poverty at public sector sites supported by the project.
		% of FP/SA clients report some[3] difficulty in one or more domain of the Washington Group questions at public sector sites supported by the project.
		% FP/SA clients receiving comprehensive FP counselling according to FP2020 method information index criteria at public sector sites supported by the project.
	Outcome 2: Increased public sector willingness and capacity to deliver and sustain high-quality ASRHR information and services for the poorest and most marginalised adolescents in rural and hard-to-reach areas.	# of "active"[4] public sector sites
	Outcome 3: Improved enabling policy and funding environment at regional, national, and sub-national level supporting the fulfilment of ASRHR.	# of new and existing policies[5] with enhanced reference to SRHR – in particular on ASRHR and commodity security
		% increase of domestic budget allocated for SRHR – in particular ASRHR – in target countries at national and sub-national level
		# of supported countries with essential drugs lists reviewed and updated to include SRHR/FP commodities

2. Purpose and objectives

MSI is seeking a consultant or team of consultants to undertake an end-of-project evaluation of the outcomes and impact of the Y4H project.

[2] This impact indicator is part of the EU Results Framework: Indicator 1.6.

[3] This is the above stricter definition of disability as advised by the Washington Group on Disability Statistics, designed to provide comparable data cross-nationally for populations living in a variety of cultures with varying economic resources.

[4] Defined as: providing services and adhering to MSI's quality of care assurance systems (having clinical quality internal audit (CQIA) every 12 months; and all relevant providers competency assessed every 12 months).

5 Defined as: laws, policies, national and local government approved work plans, strategies, regulation.

The Y4H project started on 01 July 2022 for a period of three years. A no-cost extension was granted in April 2025. Two countries (Sierra Leone and Tanzania) closed activities in June 2025 and four countries (Ethiopia, Ghana, Kenya and Zambia) will continue activities until December 2025. Final reporting is planned for January to March 2026. In accordance with the conditions of EU co-financing, a final evaluation has been planned to assess the extent to which the initial objectives have been achieved and to draw lessons for other ongoing or future projects within MSI Reproductive Choices and the Y4H consortium.

The proposed evaluation question is "To what extent has the Youth for Health (Y4H) project improved adolescents' access to, and utilization of, sexual and reproductive health services and rights in Ethiopia, Ghana, Kenya, Sierra Leone, Tanzania, and Zambia?"

The end of project evaluation has two key objectives:

1. Make an overall assessment of the project by analysing its results using the following criteria:

- Relevance: Determine the extent to which the Y4H project's design and interventions involved and were tailored to the specific needs and barriers faced by adolescents, people with disabilities, or those in rural or remote areas
- Coherence: Assess the extent to which the Y4H project is aligned with Government policies or strategies related to SRHR and what synergy exists between the project and other initiatives in the country and project regions
- Effectiveness: Determine the extent to which the Y4H project was able to achieve the objectives and outcomes outlined in the Theory of Change and the logical framework and what were its key successes and challenges in implementing the project's activities and reaching target groups
- Efficiency: Assess if any actions were taken to enhance efficiency during implementation and if the project has produced results in a cost-effective and timely manner
- Impact: Assess the overall impact of the Y4H project in enhancing adolescent access to SRHR and identify successful approaches and learnings
- Sustainability: Determine to what extent the project has engaged the Government, helped create buy-in and strengthened the Government to deliver services. Assess if the project has supported community structures to be able to continue to address / respond to adolescent needs after the project ends

2. Generate insights and learnings into what worked well and what challenges were encountered in expanding access to life-changing ASRHR during implementation in order to improve future programming

3. Scope of work

The consultant(s) is responsible for researching and delivering a global consolidated evaluation report and a PowerPoint presentation for dissemination to the EU and other audiences, as required. The consolidated report and PowerPoint will include an analysis of key findings from across the six implementation countries and at regional level, as well as findings and interlinkages between country, regional and global levels.

The consultant(s) will be responsible for all aspects of the study, including protocol development, designing data collection tools, obtaining ethical approvals, hiring and training data collectors as necessary, managing data collection, data entry/cleaning/transcription/translation, data analysis/validation, report writing and PowerPoint preparation.

The consultant(s) work closely with the MSI Global Support Office and consortium partners, who will support with data collection, including identifying stakeholders for qualitative data collection.

4. Existing information sources

The evaluation will use existing national data and studies on family planning, sexual and reproductive health and rights and adolescent sexual and reproductive health and rights, as well as project specific data including dashboards with data on the results as per the logframe (incl. service data, annual client surveys etc), annual reports, quarterly presentations, case studies and communications materials. The

consultant(s) will collect primary data, including qualitative data from focus groups discussions, key informant interviews, questionnaires etc.

5. Methodology

The Y4H consortium proposes a mixed method approach collecting and analysing both quantitative and qualitative data through desk review, focus group discussions and key informant interviews. The consultant(s) is responsible for working with the MSI teams and Y4H consortium partners to finalise the research methodology during the inception period.

The consultant is expected to propose a methodology, which should include but is not limited to:

- An evaluation matrix outlining the sources of data for each of the evaluation questions
- The identification of project stakeholders, including adolescent and youth champions (aged over 18), community health workers, service providers, community leaders, Ministry of Health representatives, community health committee members etc, using an appropriate sampling methodology
- Criteria to identify for key informants and the creation, together with consortium partners, of a list of key informants
- Field activities include focus group discussions, in-depth interviews, and key informant interviews

The methodology should reflect the available budget and time to carry out the research, for example a case study approach with in-country qualitative data collection in a selection of the six Y4H countries could be considered.

6. Skills and qualifications

The consultant(s) must meet the following criteria and qualifications, which will be assessed using a scoring method during the selection process.

Essential

- Expertise in public health and/or sexual and reproductive health, including working with vulnerable population groups and/or gender equity
- Significant experience evaluating donor-funded projects, particularly multi-country end-of-project evaluations
- Proven experience in designing research and evaluation frameworks and methodologies and tools for data collection and analyses
- Similar work in the last three years (provide a sample copy of recent reports), particularly in the six Y4H implementing countries, with demonstrable experience:
    - conducting qualitative research
    - managing ethical approval processes
    - mobilising and contracting data collectors with strong qualitative research/evaluation skills in (a selection of) the Y4H countries.
    - organising successful validation workshops
- A demonstrated high professionalism and ability to work independently and in high-pressure situations under tight deadlines
- High proficiency in written and spoken English
- Strong collaborative ways of working and strong facilitation skills
- A commitment to MSI's mission and values

Desirable

- Demonstrable experience evaluating EU funded programmes
- Knowledge of working with DHIS-2 data and large datasets such as the DHS
- Previous experience working with MSI at global or country levels is an advantage

7. Logistics and procedures

Consultant(s) selected to conduct the Y4H end-of-project evaluation are responsible for implementing the evaluation and making sure all objectives are fully met. This responsibility includes the evaluation design, ensuring the recruitment of country consultants in close consultation with Y4H consortium members, training of country consultants, ensuring data collection, travel costs, supporting the data analysis, organising and implementing validation processes and ensuring high quality draft and final report are delivered integrating feedback provided by MSI and Y4H consortium partners.

8. Outputs/deliverables

The consultant(s) is expected to deliver:

- **Concept note:** outlining the approach and methodology for the evaluation
- **Inception report:** outlining the approach, methodology, draft protocols, timelines, workplan, budget and tools
- **Ethical approval certificates**: Approval letters from accredited IRB/IRC in Y4H countries and MSI's independent ethical review committee (ERC)
- **Final data analysis plan and data collection tools used.** This will include a set of cleaned quantitative and qualitative data
- **Draft evaluation report:** a draft report for review and approval
- **Validation workshop:** The consultant will arrange evaluation validation meetings in Y4H countries
- **Final Evaluation Report with concise Summary Brief.** The consultant will submit a final evaluation report of no more than 50 pages with a clear summary brief at the start outlining implications and recommendations from the evaluation
- **PowerPoint presentation:** which will summarise the findings from the evaluation report.

A proposed timeline for these deliverables is outlined below. It is expected that the evaluation will be conducted in phased manner and this timeline will be reviewed and finalised together with the selected consultant(s) during the inception phase.

Activity	Responsible	Deadline
Publish ToR with request for proposals	Head of EU Programmes, MSI	30th September 2025
Deadline for submission of proposals	Head of EU Programmes, MSI	12th October 2025
Selection of evaluation consultant(s) (review of proposals and interviews with shortlisted candidates)	Head of EU Programmes and Evidence & Impact Advisor, MSI	17th October 2025
Contracting of international evaluation consultant(s)	Head of EU Programmes and HR team, MSI	24th October 2025
Kick off meeting with consultant(s)	Head of EU Programmes, MSI	29th October 2025
Draft concept note	Consultant(s)	7th November

Draft Inception report detailing approach, methodology, draft protocols, timelines, workplan, budget and tools	Consultant(s)	17th November 2025
Review of inception report	Head of EU Programmes and Evidence & Impact Advisor, MSI	24th November 2025
Finalisation of inception report	Consultant(s)	1st December 2025
Obtain ethical clearance at global level and all 6 Y4H countries	Consultant(s)	31st January 2026
Planning field work	Consultant leading, Y4H partners support in identification, mobilization and introduction of key informants	17th December 2025
Data collection	Consultant(s) and country data collectors	8th February 2026
Country validation workshops	Country consultants and partners	13th February 2026
1st draft report	Consultant	6th March 2026
Review of draft report by Y4H consortium	Head of EU Programmes and Evidence & Impact Advisor, MSI & Y4H partners	13th March 2026
Review of draft report by EU	EU team	20th March 2026
Validation and learning event for all countries, region and international team (online)	Consultants to facilitate, all partners to participate	25th March 2026
Final report incorporating feedback from the consortium and the EU	Consultant	30th March 2026
Review of final report by Y4H consortium	Head of EU Programmes and Evidence & Impact Advisor, MSI & Y4H partners	31st March 2026

9. Reporting and contractual arrangements

The evaluation will be managed by Susan Camara, the Head of EU Programmes, and Theodora Varelis Faisel, Evidence and Impact Advisor, at MSI Reproductive Choices. It will be supported by MSI Research, Monitoring and Evaluation Advisors in the six Youth for Health implementation countries, as well as selected Y4H consortium partners who will be identified during the inception period.

10. Remuneration

The budget for the end-of project evaluation is €45,000. The consultant(s) is responsible for paying for all aspects of the study from this budget, including but not limited to staff time, travel, recruitment and payment of data collectors, translation and transcription and validation workshops.

This contract payment scheme will be as follows:

- 30% on acceptance of the inception report
- 30% on review of the first draft of the report
- 40% on acceptance of the final report

11. Submission of proposals and selection process

Qualified consultants or consultancy firms are encouraged to submit a proposal to susan.camara@msichoices.org by **midnight on Sunday 12th October** including the following:

- **Technical proposal**: Includes a brief description of the consultant/agency, an outline of the recent experience that is most relevant to the assignment, understanding of the Terms of Reference, a description of proposed methodology and approach for undertaking the evaluation, work schedule and planning for deliverables, and CVs for main project staff
- **Financial Proposal**: Please include the level of effort for all consultants and data collectors, as well as daily fees and travel costs for all team members and costs of validation workshops. Please add a clear indication of how the total proposed amount has been calculated. The budget should cover all global and in-country costs.
- **Evidence of similar work done in the past**: Please include three recent reports written by the lead consultant for our review and two reference letters for similar work done
- **All necessary legal / registration documents**

All applicants must include in their proposal details of how they will ensure ethics and child protection in the data collection process. Specifically, the consultant(s) must explain how the appropriate, safe and non-discriminatory participation of all stakeholders will be ensured and how particular attention will be paid to the needs of adolescents and other vulnerable groups. The consultant(s) should also explain how the confidentiality and anonymity of participants will be ensured.

Proposals will be assessed and scored according to the following criteria:

Criteria		Points
Technical proposal (70%)		
i.	Understanding of the TOR	**10**
ii.	Specific experience of the Consultant(s)	**10**
iii.	Approach /Methodology	**30**
iv.	Team composition	**10**
v.	Time frame and work plan	**5**
vi.	Reputation and credibility	**5**
Budget (30%)		**30**
Total		**100**

MSI REPRODUCTIVE CHOICES

Annexe One – Youth for Health Logframe

	Results chain	Indicator	Baseline (2021)	Target December 2025	Interim Report Year One June 2023	Current value Year Two June 2024	Current value Year Three June 2025	Source and mean of verification	Assumptions
Impact (Overall objective)	Enhanced adolescent sexual and reproductive health and rights (ASRHR) in Ethiopia, Ghana, Kenya, Sierra Leone, Tanzania, and Zambia.	Adolescent (<20) birth rate per 1,000 adolescents (15-19 years old)[6]	Ethiopia: 63 (2019) Ghana: 65 (2019) Kenya: 73 (2019) Sierra Leone:108 (2019) Tanzania:116 (2019) Zambia:117 (2019)	Ethiopia: TBC[7] Ghana: TBC Kenya: TBC Sierra Leone: TBC Tanzania: TBC Zambia: TBC	N/A	N/A	N/A	World Bank	N/A
		Proportion of adolescent (<20) FP demand satisfied by modern methods	Ethiopia: 70.9% (PMA 2018) Ghana: 28.9% (MICS 2018) Kenya: 58.2% (PMA 2019)1 Sierra Leone: 59.7% (DHS 2019) Tanzania: 40.6% (DHS 2016) Zambia: 48.0% (DHS 2018)	Ethiopia: TBC Ghana: TBC Kenya: TBC Sierra Leone: TBC Tanzania: TBC Zambia: TBC	N/A	N/A	N/A	Demographic and health surveys (DHS), Performance monitoring for action (PMA), Multiple indicator cluster surveys (MICS)	
		Estimated % growth in	0	All: 41%	N/A	N/A	N/A	Modelled in MSI's Impact	

6 This impact indicator is part of the EU Results Framework: Indicator 1.6.
7 These targets are taken from external sources, including demographic and health surveys, which will be updated during the project duration. As such the targets will be completed and reported against in the final year of the project.

	Results chain	Indicator	Baseline (2021)	Target December 2025	Interim Report Year One June 2023	Current value Year Two June 2024	Current value Year Three June 2025	Source and mean of verification	Assumptions
		unintended pregnancies averted (all clients and adolescent clients)		Adolescents: 60%				2.5 tool from routine service statistics.	
Outcome (s) (Specific objective(s))	**Outcome 1**: Increased demand for, and access to, high-quality, discrimination-free ASRHR information and services with a focus on reaching the poorest and most marginalised adolescents in rural and hard-to-reach areas.	% of FP/SA client visits made by those aged under 20 at public sector sites supported by the project.	0	15%	16%	16%	19%	National health management information systems (HMIS) or routine service data collection in ORION where this is not available.	No major disaster or political crisis strikes a target country resulting in national resources and priorities being diverted from SRH. The COVID-19 pandemic does not have a sustained resurgence in the target countries. Sufficient national supply of essential FP commodities maintained.
		% of FP/SA client visits made by those living in severe multidimensional poverty at public sector sites supported by the project.	Ethiopia: 29% Ghana: 27% Kenya: 20%	Achieve or maintain parity with the national benchmark among women of reproductive age[89]: Ethiopia: 28% Ghana: 6% Kenya: 4%	Ethiopia: 6% (CI: 4-10%) Ghana: 13% (CI: 9-18%) Kenya: 13% (CI: 9-18%)	Ethiopia: 29% (CI: 23-36%) Ghana: 6% (CI: 4-11%) Kenya: 5% (CI: 3-9%)	Ethiopia 25% (CI: 19-30%) Ghana 3% (CI: 1-5%) Kenya 2% (CI: 1-4%)	Annual client exit interviews (CEIs) from public sector service delivery channel. The results in the framework will be expressed with the confidence intervals and the target will be considered achieved if the	

[8] Demographic Health Surveys were completed in Ghana, Kenya and Tanzania in 2022 and national benchmark data has been updated to reflect this. Errors in the benchmark data for Ethiopia and Sierra Leone were also identified and have been corrected.

[9] MSI measures poverty using the Global Multidimensional Poverty Index created by the Oxford Poverty & Human Development Initiative (OPHI). We are unable to measure the nutrition indicator, so on advice from OPHI we instead double weight the child mortality indicator. We benchmark accordingly against the most recent Global MPI % severe poverty (at the time of writing, Global MPI 2020), using OPHI's syntax to limit to women of reproductive age (our client base) and double weighting child mortality in place of nutrition.

	Results chain	Indicator	Baseline (2021)	Target December 2025	Interim Report Year One June 2023	Current value Year Two June 2024	Current value Year Three June 2025	Source and mean of verification	Assumptions
			Sierra Leone: 37% Tanzania: 28% Zambia: 15%	Sierra Leone: 21% Tanzania: 10% Zambia: 12%	Sierra Leone: 25% (CI : 19-29%) Tanzania: 11% (CI : 8-16%) Zambia: 13% (CI :10-19%)	Sierra Leone: 19% (CI : 14-25%) Tanzania: 17% (CI : 12-23%) Zambia: 16% (CI :10-22%)	Sierra Leone 27% (CI: 21-33%) Tanzania 18% (CI: 14-23%) Zambia 8% (CI: 4-12%)	upper bound of the CI is at the national benchmark. Monitoring of this indicator under other donor-funded programmes (e.g., WISH by FCDO) has validated this approach. The latest available data will be used in final reporting. One final round of CEI's is planned in Q4 2025.	
		% of FP/SA clients report some[10] difficulty in one or more domain of the Washington Group questions at public sector sites supported by the project.	3%	5%	2%	2%	2%	Annual client exit interviews (CEIs) from public sector service delivery channel. The latest available data will be used in final reporting.	
		% FP/SA clients receiving comprehensive FP	65%	70%	66%	61%	74%		

[10] This is the above stricter definition of disability as advised by the Washington Group on Disability Statistics, designed to provide comparable data cross-nationally for populations living in a variety of cultures with varying economic resources.

	Results chain	Indicator	Baseline (2021)	Target December 2025	Interim Report Year One June 2023	Current value Year Two June 2024	Current value Year Three June 2025	Source and mean of verification	Assumptions
		counselling according to FP2020 method information index criteria at public sector sites supported by the project.						One final round of CEI's is planned in Q4 2025.	
*Other Outcomes (*where relevant)*	**Outcome 2**: Increased public sector willingness and capacity to deliver and sustain high-quality ASRHR information and services for the poorest and most marginalised adolescents in rural and hard-to-reach areas.	# of "active" [11] public sector sites	0	150	109[12]	161	202	QTA reports, medical development team database reviews	Public sector sites are able to acquire the resources needed to address quality of care deficiencies. The majority of national governments are open to engagement and entry points for ASRHR policy review and reform are identified. The effect of COVID-19 will decrease and
	Outcome 3: Improved enabling policy and funding environment at regional, national, and sub-national	# of new and existing policies[13] with enhanced reference to SRHR – in particular on ASRHR and commodity security	0	10	2	3 Project to date: 5	4 Project to date: 9	Government policy documents, guidelines, curricula, and teaching and learning materials	

[11] Defined as: providing services and adhering to MSI's quality of care assurance systems (having clinical quality internal audit (CQIA) every 12 months; and all relevant providers competency assessed every 12 months).
[12] This figure has been revised from the previously reported figure of 128 in the Year One Interim Report. Data validation exercises carried out during the reporting period revealed that only 26 facilities in Kenya had carried out their CQIA and competency assessments rather than the reported figure of 45.
[13] Defined as: laws, policies, national and local government approved work plans, strategies, regulation.

	Results chain	Indicator	Baseline (2021)	Target December 2025	Interim Report Year One June 2023	Current value Year Two June 2024	Current value Year Three June 2025	Source and mean of verification	Assumptions
	level supporting the fulfilment of ASRHR.	% increase of domestic budget allocated for SRHR – in particular ASRHR – in target countries at national and sub-national level	Budget studies in Y1 can serve as baseline.	6% *(3% per year starting in Y2)*	0	National data[14]: Ethiopia: SRHR: 50% ASRHR: 50% Kenya: SRHR: 36% ASRHR: 36% Tanzania: SRHR: 68% ASRHR: 68%	National data[15]: Ethiopia: SRHR: 125% ASRHR: 125% Kenya: SRHR: 62% ASRHR: 62% Tanzania[16]: SRHR: N/A ASRHR: N/A	Government budgets (tracking of public allocations to SRHR – in particular ASRHR) DSW budget studies	thus health spending on the pandemic will not continue to be prioritised at the same scale. The registration of essential SRH products results in wider and safer choice for women and girls.
		# of supported countries with essential drugs lists reviewed and updated to include SRHR/FP commodities[17]	0	1	0	1	Project to date: 1	National essential drugs lists	
Outputs	**Output 1.1:** Context-specific gender and social norm change interventions delivered in all six countries, promoting access to youth	% clients report being referred or recommended by a CBM or CHW prior to their visit	16%	20%	21%	14%	20%	Annual client exit interviews (CEIs) from MSI's public sector service delivery channel.	Communication campaigns are not affected by eexternal factors such as elections, strikes, natural disasters or the COVID-19 pandemic.
		# engagements (calls and social media) through the	40,200 (2020)	135,000	9,343	41,129 Project to date: 50,472	106,970 Project to date: 157,441	Routine data from C3, MSI's contact centre solution.	

[14] Please see the details reported under Outcome 3 and the attached budget studies for more detailed analysis, including subnational results

[15] Ibid

[16] As detailed above, the national budget study in Tanzania was delayed and will be completed in Q3 2025

[17] Outcome and output indicators which are part of the results framework of the ACP Programme to strengthen health systems for universal health coverage are underlined in our logical framework.

	Results chain	Indicator	Baseline (2021)	Target December 2025	Interim Report Year One June 2023	Current value Year Two June 2024	Current value Year Three June 2025	Source and mean of verification	Assumptions
	friendly service points.	contact centre from adolescents (<20)							
	Output 1.2: Comprehensive sexuality education (CSE) and/or health education interventions pilot-tested and adopted in three countries.	# of CSE/RHE pilots successfully conducted to inform subsequent scale-up	0	2	0	1	Project to date: 1	Project reports, evidence briefs	The political and societal environment allows for testing of TLMs in a contested area like CSE. National decision makers utilise learnings and insights from pilot activities.
		# of learnings from pilots incorporated into national/subnational guidelines to support CSE provision	0	2	0	0	0	Government guidelines, teaching and learning materials	
	Output 2.1: Tailored public sector strengthening interventions delivered in all six countries, supporting adoption of adolescent- and disability-inclusive best practices in the public sector to reach the poorest and most marginalised adolescents in	# of public sector sites whose staff have completed adolescent VCAT and training on youth friendly services	0	150	101	106 Project to date: 207	0 Project to date: 207	Training reports, competency assessments.	Trained public sector staff remain committed for the entire project duration and ToT capacity built to address staff turnover.
		# of public sector sites which have carried out disability audits and developed action plans	0	100	0	78[18]	35 Project to date: 113	Disability audit reports and action plans.	

[18] Result revised from 76 to 78 following data verification exercise during the reporting period

	Results chain	Indicator	Baseline (2021)	Target December 2025	Interim Report Year One June 2023	Current value Year Two June 2024	Current value Year Three June 2025	Source and mean of verification	Assumptions
	rural and hard-to-reach areas.								
	Output 3.1: Targeted advocacy actions for domestic resource mobilisation (DRM) delivered by trained adolescent champions in four countries, supporting increased domestic resource allocations for ASRHR at sub-national level.	# of occasions where asks advocating for DRM are presented by adolescent champions at sub-national level	0	72	15[19]	51 Project to date : 66	45 Project to date : 111	Project documentation (i.e. memos, official statements etc.)	
		# of occasions where asks presented by adolescent champions advocating for DRM are taken up[20] by target stakeholders at sub-national level	0	27	8[21]	23 Project to date: 31	26 Project to date: 57	Advocacy asks; Uptake tracking tool	
		# of supported countries which routinely monitor and review the progress of SRHR in their national health plans	0	4	4	5	6	TWG meeting minutes; progress reports	
	Output 3.2: Tailored data quality interventions delivered in all six countries, supporting	# of public sector sites supported to strengthen quantification, planning, requisition and reporting of	0	150	142	142	207	Project documentation Dependent upon country context support may be given at district or	Trained public sector staff remain committed for the entire project duration.

19 Result revised from 12 to 15 following data verification exercise during the reporting period
20 Advocacy ask uptake (could be e.g. policy draft, new policy, official strategy paper, change in legislation, budgetary commitments, implementation of commitments) by decision makers, which can be only measured after some time.
21 Result revised from 7 to 8 following data verification exercise during the reporting period

	Results chain	Indicator	Baseline (2021)	Target December 2025	Interim Report Year One June 2023	Current value Year Two June 2024	Current value Year Three June 2025	Source and mean of verification	Assumptions
	improved SRH commodity quantification and evidence-based commodity security advocacy.	SRHR commodities.						site (facility) level. Where quantification happens at district level the # sites will be the # supported by that district	
	Output 3.3: Joint advocacy strategies developed and implemented in all six countries, contributing to policy changes in support of ASRHR.	# of joint advocacy strategies developed	0	6	3	3 Project to date: 6	2 Project to date: 8	Review of strategies, meeting minutes, joint statements etc	Operating environment in project countries remains stable for CSOs. Engaged networks and organisations are able to influence public opinion.
		# of active national and sub-national level coalitions strengthened by the project effectively influencing ASRHR policy by end of project	0	28 (6 national/22 subnational)	9	21 Project to date: 30	8 Project to date: 38	Capacity audits, review of action plans	
	Output 3.4: Social accountability sessions and campaigns delivered in four countries, contributing to increased support for ASRHR at the community,	# of action points from community scorecards reflected in sub-national budgets and plans	0	42	5[22]	37 Project to date: 42	11 Project to date: 53	Project documentation, Scorecards	External factors such as elections, strikes, natural disasters or pandemics do not hinder target communities from engaging in social

[22] Result revised from 12 to 15 following data verification exercise during the reporting period

	Results chain	Indicator	Baseline (2021)	Target December 2025	Interim Report Year One June 2023	Current value Year Two June 2024	Current value Year Three June 2025	Source and mean of verification	Assumptions
	sub-national and national level.								accountability initiatives. Governments in project countries do not maintain or introduce restrictions of publishing accountability reports or running ASRHR campaigns.
	Output 3.5: Evidence-based innovations and models shared within and across participating country teams in all six countries to increase adolescents' choice and access to ASRHR.	# of innovations, models and good practices shared within and across participating teams	0	32 (Quarterly for the entire project period)	6	21 Project to date: 27	18 Project to date: 45	Toolbox on ASRHR Evidence briefs Meeting documents Good practice examples	The political and societal environment in a majority of project countries allows for innovations and testing of new models in a contested sector like ASRHR
	Output 3.6: Development and implementation of regional policies on ASRHR	# of adaptations made in regional policies focusing on ASRHR	0	6 *(1 annually per regional entity)*	1	2 Project to date: 3	2 Project to date: 5	Policy documents/ drafts (i.e. EAC SRH Policy, Maputo Plan of Action, AU Roadmap on	Regional decision makers utilise technical inputs and advocacy asks submitted.
		# of actions taken by target regional	0	7	2	2	1		

	Results chain	Indicator	Baseline (2021)	Target December 2025	Interim Report Year One June 2023	Current value Year Two June 2024	Current value Year Three June 2025	Source and mean of verification	Assumptions
	strengthened at the regional level.	bodies to promote ASRHR		*(1 annually per regional entity)*		Project to date: 4	Project to date: 5	Harnessing the Demographic Dividend through Investments in the Youth, AU Strategy for Gender Equality and Women's Empowerment)	Ongoing policy processes relevant to ASRHR are not discontinued or massively delayed, e.g. due to COVID 19. The political environment allows regional bodies to promote ASRHR.