

POST-EVALUATION PREPARATIONS FOR THE PROJECT'S ROUNDTABLE  
IN JUNE 2024

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UNDERSTANDING THE IMPLEMENTATION, CONTEXT  
AND EFFECTS OF THE MBARE ASRH PROJECT IN  
ZIMBABWE

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This publication was produced at the request of Médecins Sans Frontières (MSF) – Operational Centre Brussels (OCB) under the management of the Stockholm Evaluation Unit (SEU).

This report is the culmination of a follow-up process initiated after the evaluation of the Mbare project completed in 2021. The evaluators, Constanica Mavodza and Chido Dziva Chikwari, returned to conduct a series of data collection activities and facilitated three working sessions, based upon which they contributed to planning the project's roundtable.

It was prepared independently by Constanica Mavodza and Chido Dziva Chikwari.

All evaluators contracted by the SEU must adhere to the SEU Ethical Guidelines for Evaluations.

DISCLAIMER

The authors' views expressed in this publication do not necessarily reflect the views of Médecins sans Frontières and the Stockholm Evaluation Unit.

## Contents

<b>INTRODUCTION</b> .....	2
<i>Context</i> .....	2
<i>Preparatory Phase</i> .....	2
<b>AIMS AND OBJECTIVES</b> .....	3
<b>METHODOLOGY</b> .....	3
<i>Participant Selection</i> .....	3
<i>Establishing a Working Group</i> .....	4
<i>Data Collection</i> .....	4
<i>Sense making and validation of findings</i> .....	7
<i>Ethical Considerations</i> .....	7
<b>QUANTITATIVE FINDINGS</b> .....	8
<i>Key messages</i> .....	8
<i>Overall uptake</i> .....	8
<i>Demographic Data</i> .....	9
<i>Service uptake</i> .....	9
<i>HIV Cascade</i> .....	12
<i>Peer educator community outreach</i> .....	14
<b>QUALITATIVE FINDINGS</b> .....	14
<i>A relevant and appropriate ASRH project</i> .....	14
<i>Acceptability of the ASRH project</i> .....	15
<i>Health Promotion and Peer educators</i> .....	15
<i>Key Populations: Access to services</i> .....	17
<i>Teen moms Support</i> .....	18
<i>Integrated Service Provision</i> .....	18
<i>Continuity and Sustainability</i> .....	20
<b>IMPLICATIONS FOR PRACTICE &amp; CONTINUITY</b> .....	21
<b>IMPLICATIONS FOR POLICY, AND SYSTEMS INFLUENCE</b> .....	21
<b>CONCLUSIONS</b> .....	22
<b>REFERENCES</b> .....	24
<b>ANNEX I: SECONDARY DATA ANALYSIS FIGURES</b> .....	26
<b>ANNEX II: SECONDARY DATA ANALYSIS TABLES</b> .....	32

## INTRODUCTION

Adolescents and young people (AYP) face multiple risks and vulnerabilities to their health and wellbeing<sup>1,2</sup>. Interventions aimed at improving AYP's health outcomes need to consider and engage with the complexities and temporality associated with them. Over the last decade, integrated combinations of biomedical, behavioural, and structural approaches to address the sexual and reproductive health (SRH) needs of AYP have gained traction. The Global Fund for example has committed to scaling up adolescent girls and young women (AGYW) programming that advances sexual and reproductive health and rights (SRHR) in high burden countries like Zimbabwe<sup>3</sup>. Additionally, PEPFAR's DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) partnership functions across 15 countries, including Zimbabwe and focuses on layering biomedical, behavioural, and structural interventions AGYW<sup>4-6</sup>. Such financing, and implementation enables strategic partnerships and a coordinated response to harness the impact on AYP's health and wellbeing.

### CONTEXT

In Mbare Zimbabwe, Médecins Sans Frontières (MSF) has been operating The Mbare ASRH project (*referred to as Mbare ASRH project or 'the ASRH project' in this document*) since 2015. Over almost ten years the ASRH project has evolved from being a Sexual and Gender-Based Violence (SGBV) clinic<sup>7</sup> to providing an adolescent-friendly<sup>8</sup> comprehensive and integrated package of SRH - including the HIV cascade, Mental Health (MH) and Tuberculosis (TB) care for adolescents at community and facility level in Mbare. While the Mbare ASRH project is anchored in the innovative provision of HIV and SRH services for AYP through an outpatient youth clinic, the program also supports wrap around biomedical, behavioral, and structural approaches that contribute to positive health and wellbeing<sup>8</sup>. As part of its integrated model and intention to address the differentiated care needs of adolescent subgroups, the project also collaborates with multiple key stakeholders who play a role in adolescent health and wellbeing.

2024 marks the 10<sup>th</sup> year of the initial SRH support project that MSF has been implementing in Mbare. More specifically, it's the 5<sup>th</sup> year of operating the ASRH project's strategy to implement innovative and replicable models of comprehensive and integrated ASRH care in Mbare, as an approach to reduce the morbidity and mortality for adolescents in the area. At this time juncture, MSF will conduct a roundtable discussion to assess the project's relevance, effectiveness and future in hindsight, current sight and with foresight. It is in the context of supporting this upcoming roundtable, that the post-evaluation exercise described in the rest of this document below will be operationalized.

### PREPARATORY PHASE

In November 2023, MSF's evaluation unit contacted the consultants who conducted the midterm evaluation of the project in 2022 to scope if they would be willing and able to engage with the evaluation and project to supporting the project team to prepare for the roundtable currently scheduled for June 2024. This support was requested by the MSF-Zimbabwe country team.

To better understand the situation, scope of the project and expectations of the roundtable, the consultants had some preliminary consultations with key personnel associated with the project who included the SEU medical referent, the HIV, AYP and SRH advisors, as well as the MSF-Zimbabwe project team who implement and operationalize the project. Using their knowledge and expertise of the AYP landscape in Zimbabwe, insights from consultations, and their understanding of the project as evaluators, the consultants propose the approach below to support the team’s roundtable preparations.

## AIMS AND OBJECTIVES

**AIM:** To conduct a post-evaluation exercise that provides technical support on AYP programming, policies, research, and implementation in Mbare and Zimbabwe as a mechanism to understand the effects and plausible impact of MSF’s Mbare ASRH project as part of preparations for the project’s upcoming Roundtable in late June 2024 and inform next steps for the project.

### OBJECTIVES:

1. To understand the implementation context of the ASRH project, and the effects and plausible impact of such implementation.
2. To identify and understand barriers and facilitators in the ASRH project that can inform current and future direction of the project.
3. To assess the relevance, appropriateness, and sustainability of the ASRH project in Mbare and its surrounding communities.
4. To map emerging strategic objectives; and focal/thematic areas for the ASRH project.

## METHODOLOGY

The exercise was an exploratory analysis of the Mbare ASRH project; and its intended and achieved outcomes. The study utilized a convergent non- sequential mixed-method design<sup>9,10</sup>. The qualitative and quantitative data were collected and analyzed separately, and then compared together to draw conclusions.

### PARTICIPANT SELECTION

Four groups of participants took part in the qualitative component of this study.

- MSF project staff who operationalize the project strategy, implement and monitor the project.
- MSF key informants including regional and global referents who are subject matter and thematic experts.
- Adolescents from Mbare and Epworth who are beneficiaries of the project.
- Stakeholders or partners who work with AYP in Mbare and Epworth and have directly engaged with the MSF Mbare ASRH project.

Participants were purposively sampled to represent the breadth and depth of activities, communities, individuals and system factors that interact with the project.

### ESTABLISHING A WORKING GROUP

As part of this assignment, a Working Group (WG) was established at inception. The WG consisted of members from the Mbare project, MSF referents, and thematic referents. The WG met every month during the data collection and analysis process to engage with and discuss emerging findings, as a strategy for sense making and validating the findings as well as beginning to curate the focal areas of the roundtable based on the evidence generated in this assignment.

### DATA COLLECTION

For this study, qualitative data was collected and analyzed. Quantitatively, secondary data analysis of the routine services uptake data collected as part of the project was conducted.

#### Qualitative data collection and analysis

A desk review of 161 project documents collated between 2015 to 2024, was conducted between February and April 2023. The documents included project guidelines and SOPs, meeting minutes and presentations, field visit, handover, monthly, and quarterly reports, work and implementation plans, as well as research outputs, project log frameworks, and MSF Medical Guidelines and protocols. This desk review was both complemented and supplemented by primary and grey literature reviews on adolescents and youth programming in Zimbabwe and in the region.

Qualitative data collection took place in March and April 2024 by trained and youthful research assistants, including two youth research assistants, led by the Consultancy team and supported by MSF staff in Mbare. Qualitative focus group discussions (n=13) and group interviews (n=3) were conducted with a total of 133 adolescents and peer educators (n=10) as well as staff (n=6) and KII (n=4) from MSF. The adolescent groups represented those aged 10-24, those living with HIV, living with disabilities, and living on the streets, as well as LGBTQI adolescents, those selling sex, and those using drugs. Additionally, stakeholder/partner interviews were conducted with individuals (n=17) representing organization (n=11) who engage with the ASRH project were also conducted.

The qualitative analysis sought to curate knowledge from the experiences, perceptions and beliefs of participants through the summarization and interpretation of empirical data<sup>11,12</sup>. Thematic analysis was manually conducted. All the interviews were transcribed into English by two research assistants. The research assistants met with the lead consultants to discuss emerging findings and consolidate a qualitative data summary after each data collection phase. The consultant and another research assistant then produced analytical memos in excel, extracting both deductive (identified from the research questions) and inductive (emerging) themes from the data, as well as the supportive quotes for these themes. These themes underpin the qualitative findings section in this report.

## Quantitative data collection, and analysis

The aim of the secondary data analysis conducted as part of the post evaluation exercise was to describe the uptake of the different components of the Mbare ASRH project from Mbare Polyclinic (MP), Matapi Youth Hub (MT), Epworth and Outreach activities from 2021 -2023.

Prior to commencing data analysis, the consultant met with the Mbare ASRH Project team to understand how and what data is currently being collected on the project and identify any changes made after the project evaluation in 2021. This meeting was also aimed at understanding the flow of data for the Mbare ASRH project as well as ways through which this can be improved.

Anonymized datasets for the secondary data analysis were then shared by the MSF project team in Excel format. All datasets were cleaned and exported to STATA v15.0 (StataCorp, TX, USA) for analysis by the consultants. Where feasible datasets were combined for analysis.

Demographic data from the datasets was used to create descriptive summaries of the adolescents accessing any of the Mbare ASRH project services and their uptake of the different available services stratified by age, sex, year and site. Continuous variables were summarized as medians (inter-quartile range: IQR) and categorical variables as counts (percentages). In addition to descriptive summaries, where possible, data was populated into tables as well as presented as graphs.

Two analyses were conducted during this exercise. The first analysis was conducted in March 2023 and preliminary findings were presented to the Working Group to demonstrate how data will be presented in this report. This presentation was followed by a validation meeting with the Mbare ASRH project team to discuss specific challenges faced by the consultant team, interpretations of the findings and identification of any missing data. Additional data was provided by the Mbare ASRH project team after this meeting and a second analysis was conducted in April 2023. The findings from the second analysis were reported in an Analytical Memo shared with the Working Group in April 2023 and presented during the Working Group Meeting in May 2023. These findings are presented in this report.

Throughout the secondary data analysis, the consultant team met to discuss emerging findings to explore possible synergies/areas of overlap with the ongoing qualitative data collection and analysis. Outcomes of these meetings included combined presentation of both quantitative and qualitative findings in working group meetings and additional analysis to explore specific components of the quantitative data. Within this report, quantitative and qualitative findings are presented separately while combined recommendations which draw from both elements of the exercise are provided.

## Quantitative Data Strengths

Since the evaluation in 2021 there has been digitalization for data collection for some components of the project. This has aided in the collation of data for the project and will likely make it easier for the project teams to access and the data routinely and reduce errors throughout. This has been a welcome step by the project teams who did not express any challenges with this shift.

Overall, the project team has a deep understanding of the community that they serve. This has aided in the interpretation of the data during the validation meetings. This intricate and historical knowledge of the community and the project by the Mbare team is a key strength of the project and a resource that

should be maintained. This team should be supported to ensure this remains and reduce observed gaps highlighted in the limitations below.

Despite the challenges with the Mbare ASRH project data, which resulted in significant delays with the analysis, the project team was supportive of the consultants and this exercise.

#### Quantitative Data Limitations

Several limitations were identified by the consultant team and are reflective of challenges reported from the evaluation in 2021.

Although the project has been able to migrate to electronic data collection for some components there is still some data that is collected manually. Specifically, the following data collection methods are used:

- Matapi youth hub: Paper forms later captured in Excel
- Mbare Polyclinic HIV cohort data: EPMS
- Mbare Polyclinic adolescent clinic: Paper forms later captured in Excel
- Epworth youth hub: Epi info
- Outreach data: Paper forms later captured in Excel
- Peer educators in the community: Kobo collect

This disjointed data collection creates challenges as the project currently has multiple data sets that cannot be linked. Manual data entry is prone to entry errors particularly when the project currently has one data clerk who is responsible for all data entry. This subsequently results in delays in data entry and poses a significant risk particularly in instances when this member of staff is on leave or absent from work due to personal or work-related issues. It was not immediately clear why different strategies are used for the different components of the project, however, streamlining of these data collection methods is needed in order to ease loads for any analysis of project data and allow for comprehensive interpretation of the project workload.

It was also observed that although the data clerk is familiar with the project and has been working in this role for several years support from the project epidemiologist has been low, possibly due to high turnover in this role or competing priorities for individuals who take up the role. The epidemiologist was not available to provide support during this exercise.

The above has cumulated to several errors and duplication observed within the analyzed dataset and an inability to combine some datasets to conduct one analysis e.g. HIV cohort and condom uptake data. It also results in limitations for the project team to analyze and use their data on an ongoing basis to inform any programmatic changes or activities.

As observed in 2021, the project at present is unable to track individual adolescents and as such presented data within this report is at the level of each visit i.e. there may be multiple visits by individual adolescents. This is due to the design of the datasets which collect data mainly on uptake of services and not long term follow up of cohorts or individuals.

There are also instances where some datasets had to be analyzed and reported separately specifically Peer Educator community data, condom data and HIV treatment data as these datasets could not be merged with the routine service uptake data.

Overall, the challenges above resulted in significant delays in the consultants accessing the project datasets for analysis and presentation to the Working Group for detailed discussions. Addressing the data collection challenges faced within the Mbare ASRH project should be a key priority in the next phase of the project with allocated funding dedicated to these components including the development of a data management strategy for the project with named implementers and timelines.

### SENSE MAKING AND VALIDATION OF FINDINGS

During the data collection and analysis process, sense making, and validation sessions were conducted with the WG for the project. Every month the WG and consultant team met for 90-minute online sessions to discuss emerging findings from the project. These meetings served a few purposes including:

- Providing further context and interpretation to the findings emerging from the assignment
- Validating the findings based on WG experiences and understanding of the project.
- Collectively, generating potential strategic objectives to be deliberated upon during the RT.

### ETHICAL CONSIDERATIONS

Prior to commencing this assignment, the consultants signed the SEU Ethical guidelines and have followed the guidance outlined in the guidelines to ensure respect for dignity and diversity, fair representation, confidentiality, avoidance of harm for MSF staff, evaluation stakeholders and clients. The consultants declare no conflict of interest.

All participants who took part in this evaluation provided verbal consent prior to the interview. Adolescents younger than 16 years had to provide guardian/parental consent in order to participate in this assignment. No participants withdrew consent. There were adolescent participants who used drugs and showed up to their interviews inebriated. The interviewers made a case-by case assessment of the situation to avoid harm and ensure that themselves and the participants were protected, but informed consent in this case could not be guaranteed. Some of these adolescents wanted to talk and be heard. The interviewers allowed them to speak and take the conversation in whichever direction they saw fit. The interviews from these adolescents were not included in the analysis.

Additional considerations were made for any discussions with vulnerable population groups such as minors involved in commercial sex, and those who identify as LGBTQI. For each of these sub-groups group discussions were conducted together with their peer educator who knew them well and added a sense of safety and confidentiality to their contributions in this assignment.



## QUANTITATIVE FINDINGS

This section provides a summary of the secondary data analysis and aims to provide an overview of the uptake of services within the Mbare ASRH project. Findings are stratified by sex, site, year, and age category where necessary.

Please note data is at the level of visits to the service rather than individual adolescents as this cannot be tracked using the available data within the project.

### KEY MESSAGES

1. Overall, there is an increase in the demand for the services provided by the project which demonstrates the need of services within Mbare and potentially surrounding communities due to the availability of the long-standing free services which are now well known.
2. There has been a notable increase in the proportion of visits where syndromic management of STIs is reported as well as adolescent pregnancy within the project. These increases are of concern and may be due to increased risky sexual behavior of adolescents. Considerations for additional risk reduction interventions within the project are warranted.
3. HIV positivity of tests conducted within the project has doubled since 2021. This may be due to increased HIV incidence in this population or the use of a risk screening tool within the project.
4. Uptake of drug abuse, psychosocial support and mental health services within the project has not increased since 2021. Qualitative evidence in this assignment (see Qualitative findings section) revealed that substance misuse is a challenge that adolescents are facing, and it has implications on their mental health. It is important to note, however, that substance misuse in the community may be affecting the subsequently higher proportion of STI visits, adolescent pregnancy and HIV positivity observed within the project. The lack of quantitative evidence within the service uptake data may be indicative of either data collection challenges for adolescents using substances, and/or needing mental health services; or could be revealing that most of these adolescents are not being reached by or taking up the project services specific for substance use and mental health.
5. The definition of the HIV cohort within the project relies on attendance to last HIV visit and may not be representative of the total cohort of adolescents living with HIV who should be accessing services within the project i.e. those who miss visits. The protocol for the HIV cohort definition should be clarified in text to support interpretation of the available data.
6. The cohort of adolescents living with HIV is now getting older and considerations for supporting transitions to adult care within the project need to be made.

### OVERALL UPTAKE

Overall, a total of 55 654 visits were made to the project between 2021 – 2023 (Table 1, Figure 1). The majority of the visits (35 709, 64.2%) were to Epworth followed by Mbare Polyclinic (MP) (16 770, 30.1%). Matapi youth hub had a total of 2419 visits across the three years (4.4% of total visits) and there were

only 756 outreach contacts (1.4% of total visits). It is noted, however, that the peer educator's data is captured and reported (see section 1.9 below) separately and therefore not included as part of the outreach data presented in this section.

There has been a steady decrease in the total number of visits each year across the three-year period under evaluation although an increase in OPD service uptake and visits to MP was observed (Table 1). The observed decrease is mainly due to the reduced number of visits to Epworth which has consistently had the highest number of visits for all three years and contributed over 64% of overall visits to the project. The project staff indicated that the decrease in visits to Epworth was attributed to a harsh political environment during the national election period in 2023.

The project staff noted that the observed increase in OPD and MP visits was attributed to community familiarity of the available free services at MP but also likely due to adolescents from other surrounding communities coming to Mbare to access the services. This is reflective of a need for the services provided by the project beyond Mbare.

## DEMOGRAPHIC DATA

The majority of visits (57.5%) to the project are by females (Table 1, Figure 2) although the Epworth site has consistently had more males than females in 2022 and 2023 (62.9% and 59.0%), which contrasts with the other sites (Table 3). It would be important for the project to assess which aspects of the service setup and provision in Epworth have made it attractive to males and if any of those aspects can be adapted and incorporated into the other sites. This is of importance particularly when decline in service visits was observed for females but not males.

The median age of attendees is 17 years for MP and adolescent who visit Epworth are slightly younger with a median age of 16 years and those seen for outreach are older at 19 years (Table 1). The biggest age category served is the 15–19-year-olds who constitute 52.5% of all visits across the three years evaluated followed by the 10 – 14-year-olds who make up 37.7% of visits (Figure 3). This has been consistent across all three years. Fewer adolescents aged >19 years were seen in 2023 (6.8% compared to 21.2% in 2021) likely due to the increased and intentional focus on targeted 10–19-year age group by the project.

## SERVICE UPTAKE

### Health Promotion and Counselling

Majority of adolescent visits to the project are for health promotion and counselling (61.1%) although there has been a steady decline since 2021 with only 48.8% of adolescent visits for this service in 2023 when compared to 70.1% of these visits in 2021. It was not immediately clear what the reason for this decline was, but it may be due to incomplete data entry across the project sites (Table 1).

### Family planning

The second most popular service within the project is the provision of family planning services with 18.5% of adolescent visits by females accessing family planning overall (Table 1). It is important to note, however,

that in 2022 there was a spike in family planning uptake (33.5%) which project staff attributed to an older age group having access to the service in Epworth. After noticing this spike, adjustments were then made to the age eligibility to ensure that only adolescents aged 10-19 had access to the service as per the projects criteria.

When assessing the specific family planning service taken up; the most popular method was Secure which was taken up in 2118 (6.8%) visits, followed by control which was taken up in 1742 visits (5.6%) and Depo which was taken up at 1295 visits (4.1%). Jadelle was taken up at 1% of visits (314). The IUCD was taken up at only 16 adolescent visits and implants at only 37 adolescent visits in the 3 years under evaluation despite nurses being capacitated to provide this service. These long-acting methods appear to be unpopular among this population group. (Table 8). It is important to note that these visits likely include repeat visits by adolescents which cannot be tracked by the current data collection tools. **It will be important for this to be assessed/evaluated to understand the continuity on contraception by adolescents as well as their outcomes e.g. pregnancy and subsequent access to ANC which is also a component available in the project.** At present this cannot be done due to the current limitations of the existing project data collection tools.

#### STI treatment

Over 2600 adolescent visits have been for STI treatment within the project (4.7%). Proportion of visits for STI management among adolescents has also increased steadily during the three-year period under evaluation from 4.1% in 2021 to 4.6% in 2022 and 5.5% in 2023. Majority of STIs are among female adolescents. The proportion of symptomatic STIs in this project is high when compared to adolescents in other settings within Zimbabwe<sup>13</sup>. The STICH trial conducted in Harare and Bulawayo saw only 1.3% of visits by adolescents and youth aged 16-24 years to the community site receiving treatment for an STI syndrome<sup>13</sup>.

The high and increasing STIs among adolescents in Mbare may be due to increases in risky sexual behavior fueled by drug and substance abuse in addition to risk associated with economic vulnerability. This project is uniquely placed to address this challenge as it provides a comprehensive service although considerations for additional risk reduction interventions may be warranted. No data on the uptake or provision of partner services for STIs is available within the project data. The provision of robust partner services is critical for comprehensive STI control, however, additional nuance that addresses the complexity of adolescent sexual relations is needed to ensure effectiveness of any partner services provided.

#### Antenatal care

Antenatal care services (ANC) have been provided at 1305 visits by adolescent girls (4.1%) and this has been increasing during the period under review from 2.4% in 2021 to 5.9% in 2022 to 9.0% in 2023. This alarming increase in the need for ANC service by adolescent girls could be indicative of several things:

- Broader challenges in terms of an increased unmet need for contraception in this setting.

- Increased awareness by adolescents of free ANC services that they can access at the polyclinic, facilitated by the Adolescent clinic

It is important to note that this increase is also within the context of a comprehensive sexual health service which also provides contraception for adolescents.

There is a possibility that adolescents are only presenting to the facility when pregnant or accessing this facility for ANC services from surrounding communities outside Mbare. Without comprehensive tracking of adolescents throughout the SRH care cascade (See family planning above) it is difficult to assess if these are adolescent girls who have been in contact with the service before or only presenting when pregnant.

Reaching adolescent girls prior to major events such as pregnancy is paramount to the improvement of their sexual health outcomes. A possible avenue for reaching them is through community outreach which is already a component with the project and could be further targeted to adolescent girls. For example, through enhanced condom and contraception delivery in the community as well as risk reduction counselling. Further understanding and targeting of the sexual partners of these adolescent girls as well as the wider community who might be accepting of adolescent pregnancy is an additional avenue for exploration within the project.

#### Drug abuse, Psychosocial support and Mental Health

Uptake of drug abuse, psychosocial support and mental health services within the project was 3.2%, 3.1% and 3.4% respectively. This has largely remained consistent in terms of total numbers of adolescent visits for these services across the three years analyzed for this exercise despite expectations that this would increase based on qualitative evidence and community reports. The project has also invested in a mental health nurse and specific support for adolescents who abuse substances, and **it is unclear why service uptake for these services has not increased overall**. It is possible that the available services are not acceptable nor appropriate to the increasing number of adolescents in the community who are facing these challenges. Defining these existing interventions and documenting their completion/success among youth who take them up will be important in understanding their acceptability and effectiveness among those who take them up.

Although there is qualitative evidence available through the project; there is a need to generate evidence for the increased need of these services within the project (reflected by uptake as presented here) and in Mbare to justify the resource allocation and needs and to also explore further what services are needed to mitigate these challenges as well as their negative impact on SRH outcomes which are the focus of the project. Potential avenues may be to consider additional community-based interventions for drug abuse, psychosocial support and mental health to improve utilization. Co-creation of these interventions with youth to ensure they appropriately address their needs and are acceptable will be important.

#### Menstrual health management

There has been a steady increase in the uptake of menstrual hygiene products on the project from 3.1% in 2021 and 7.8% in 2022 to 13.0% in 2023. This increase is commendable as there has been documented evidence<sup>14</sup> of the menstrual health needs of adolescent girls particularly in areas where economic

vulnerability makes it difficult for them to buy these products. It is important to note that the availability of these products can act as a hook for girls to access to service and subsequently take up other services such as HIV testing.

### Condoms

Condom uptake data was analyzed as a separate dataset for the purposes of this evaluation. This was mainly because it was not completely captured in all the existing data collection tools but entered mainly as tally sheets when handed out by providers.

Within the project facilities condoms are in discreet locations where adolescents can collect them without speaking to a provider. **As such condom uptake data reported here is likely lower than true uptake of condoms.** It is also important to note that condom uptake reported here is also not a measure of correct and consistent condom use by adolescents who access the Mbare ASRH services although condoms remain a key tool for the prevention of HIV, STIs and pregnancy.

Overall, there have been 19025 recorded visits where adolescents took up condoms (Table 10). Majority of condoms were taken up in 2022 and condom uptake is highest in the community (12 924, 66.9%) although there is variation of this by site and year (Figure 7).

Given the high STI visits observed and increasing adolescent pregnancies there is a need for enhanced condom programming across all project sites to reduce risk.

### Referrals

A total of 3453 referrals were made from the project during the period under review (Table 6). Majority of the referrals (1023, 40.4%) were Hospital Referrals for care not available at primary care and this was followed by referrals for GBV (977, 38.6%) and PEP (239, 9.4%). The project has also continued to make referrals out for family planning (135) likely from Epworth where non-medicalized services are available. **Considerations for the provision of some medicalized services at Epworth where the project is referring adolescents out is warranted** specifically those considered to be provided with in the project at MP and those closely aligned with the project aims such as FP, PEP and PrEP.

Unfortunately assessing the outcomes for all referrals (if adolescents received the service they were referred for) from the project was not feasible for this evaluation and remains a key limitation in available data from the project.

## HIV CASCADE

### HIV testing

Overall uptake of HIV testing on the project is 9.4% and this has fluctuated in the 3-year period under evaluation from 6.8% in 2022 – 11.0% in 2021 (Table 1). This testing reflects all tests including HIV self-test and provider tests. Majority of tests (89%) conducted in the project are self-tests (Table 5). As it not possible to track individuals within the project this test uptake is inclusive of repeat tests among

individuals and does not incorporate additional factors such as eligibility for HIV testing e.g. some visits are by youth who are not eligible for an HIV test.

While at least 20%-78% of adolescent visits to MP, MT and reached via outreach are tested for HIV, there is low uptake of testing in Epworth consistently below 5% throughout the 3-year period under evaluation (Table 2). **The project should consider increasing the availability of HIV testing services in Epworth.** Majority of HIV testing is currently being conducted for adolescents >15 years, with only 1.8% of adolescent visits in the 10-14 years age group receiving a test within the project (Table 4). Although there is increased risk for horizontally transmitted HIV infection among adolescents >15 years there is still a risk for undiagnosed vertically transmitted HIV infection among adolescents aged 10-14 years and testing services for them should also be prioritized.

Majority of tests conducted on the project are HIV self-tests. Only one blood-based test was recorded in 2023 and 17 in 2022.

Among adolescent tests HIV positivity was 2.8% overall, however this has doubled in the 3-year period under evaluation from 1.9% in 2021 to 3.6% in 2022 to 4.0% in 2023 (Table 5). This increased positivity may be attributed to the use of a risk screening tool within the project and targeted testing strategies which may have subsequently led to adolescents with highest risk receiving a test although this is not reflected in the absolute numbers of tests conducted going down. The use of the screening tool was introduced in the second quarter of 2022 which coincides with the increased positivity.

It is important to note that the oral HIV self-test used within the project is only a screening test and subsequent confirmatory testing is required. However, it was not possible to deduce subsequent confirmatory testing and results for these tests with the provided datasets for the project during this exercise.

#### HIV treatment and care

Among the 160 adolescents diagnosed with HIV within the project 127 (79.4%) were successfully linked to care (Table 5). Although the proportion linked to care is suboptimal, project staff noted that there are some adolescents with a known HIV positive status who continue to retest. These adolescents are subsequently not linked to care as they abscond or are sometimes already linked to care. This is a challenge that may potentially be mitigated by **incorporating unique identifiers for adolescents who access the project and allowing the project to longitudinally track adolescents.**

Overall, the project has a cohort of 248 adolescents living with HIV in care (60.5% Female) (Table 7). The median age of adolescents on ART is 19 years. The median age at ART initiation is 10 years although this older for females (11 years) when compared to males (9 years). Majority of adolescents on ART at MP were diagnosed there (75.4%). **These findings demonstrate that the project has had a longstanding cohort of adolescents living with HIV who are now likely in need for support to transition to adult care. This is something that should be considered for the project.**

Overall viral load coverage was 80.7%. Among them 93.0% were virally suppressed (viral load <1000copies/ml) (Table 7). There is a need for the project to prioritize the provision of HIV viral load tests for adolescents living with HIV and on care.

During this post evaluation exercise, it was observed that definition of the HIV cohort is based on attendance to the clinic during a prespecified period. The use of such a definition leaves risk for exclusion of adolescents living with HIV who have missed HIV treatment visits and need adherence support. As such, the consultants **recommend a re-evaluation and clarification of this HIV cohort definition to ensure comprehensive inclusivity of adolescents living with HIV who should be accessing care within the project. This definition should be provided in writing to ensure smooth analysis of cohort data in future and may be included in the proposed project data management strategy.**

#### PEER EDUCATOR COMMUNITY OUTREACH

Peer educators have made over 49000 contacts with adolescents in the community since 2021 (Table 9). Majority of these contacts have been with females (57.6%) in the 14 -19-year age category (65.9%). **There were much higher numbers of adolescents seen in Epworth in 2023 when compared to Mbare (12546 vs 6880).** This was despite similar numbers seen in 2022. The main topics discussed with adolescents were HIV (37.1%) and Family Planning (30.4%) followed by Menstrual Health (25.9%), COVID-19 (15.8%) and STIs (10.4%).

With the provided data it is not immediately clear what services have been provided in the community by the peer educators. Reflected above is the topics discussed. The project has over time increased the available service components in the community and it would be important for this to also be recorded and included in the reporting for the project.

## QUALITATIVE FINDINGS

#### A RELEVANT AND APPROPRIATE ASRH PROJECT

The Mbare ASRH project is a peer-led community driven model that was found to be highly relevant and appropriate. Having peer educators aged 18-24 years, representing different kinds of adolescents (selling sex, living with HIV, team moms, those with disabilities) be the ones to conduct community engagement, mobilization and sensitization was found to be a driver of demand generation, and linkage between the community and the facility/medicalized services.

The project is one of the few, if not the only one, in Zimbabwe that has both a facility service provision component and a community engagement and outreach component in the same program and providing services instead of referring or linking to other providers - unless necessary. The project has a comprehensive approach to adolescent health and wellbeing.

In the service provision component of the project, the health services offered are primary health care (PHC) services. These services are also highly tailored/customized to the service gaps in Mbare and Epworth; as well as to the needs of adolescents and young people themselves. For example, the PHC services include mental health/substance misuse to address the substance misuse challenge in these communities and reduce harm; as well as STI testing, care and management addressing the rising prevalence and incidence of STIs among adolescents and young people.

Moreover, while the project is ordinarily domiciled in Mbare, with softer components being provided in Epworth, it is servicing more communities than just these two. Adolescents from other communities like Hopley come to access services at the adolescent clinic, because these services are free and are adolescent friendly. The adolescents from communities further away would rather look for transport money to get to Mbare and access services, which for them is a lesser cost than accessing non-free services that may not be adolescent-friendly within their home communities.

As part of responsive adaptations, at the time of this post-evaluation exercise, the ASRH project had new or adapted activities beginning to be implemented. For example, an advocacy strategy had been developed in 2023, and a new Advocacy Manager was incoming whose responsibility would be to execute this strategy. Additionally, there are plans in place to open a new hub/site at Stottgart hall in response to adolescents in the community's requests.

In Zimbabwe, adolescents and young people continue to face barriers in accessing services that range from supply side issues such as unfriendly providers, provider negative attitudes, as well as restrictive policy and legal environments and demand side issues such as poor knowledge or information about health services and constrained sociocultural environments<sup>15,16</sup>. In such a setting, adolescents have limited voice, agency, and access. This project's approach attempts to shift these imbalances. Additionally, the ASRH project is essential because it provides MSF with evidence-based models and learning for uptake and acceptability of (health and non -health) services by AYP, particularly in MSF's humanitarian medical response. The project also aligns with MSF's mandates as it addresses the needs of an often-neglected population like adolescents.

### ACCEPTABILITY OF THE ASRH PROJECT

Overall, the project was found to be highly acceptable by its main constituents- the adolescents and young people. Adolescents particularly appreciated having the adolescent-only spaces at Matapi and the adolescent corner. Having the adolescent/youth delivered interface through the peer educators in the community as well as the peer educators being the first contact with adolescents seeking services was highly acceptable.

Adolescents noted that, dominantly the providers and project are invested in understanding adolescents' lives and needs- which often are beyond just understanding their health concerns. This creates an environment that motivates them to continue returning for care or informing their peers about the care and services available at the project.

### HEALTH PROMOTION AND PEER EDUCATORS

At the time that this post-evaluation exercise was conducted, the peer-educator strategy had been revamped; and a new peer educator handbook had been developed. Executing this new strategy had also just begun and included reducing the peer educators from 40 peers to 25 peers. The reduced and restructured number of peer educators has improved their ability to be integrated into the greater MSF staff setting, and in turn improved the support for them. These peer educators have been trained on monitoring and evaluation, adolescent-friendly services and microplanning for key populations. These



trainings were layered onto the standardized onboarding and peer educator trainings that MSF conducts with the peer educators. The microplanning training and anticipated implementation is meant to support demand generation, engagement, and access to services for adolescent key populations, including contributing to understanding the gaps and needs of this adolescent population cohort.

The post-evaluation exercise found that the peer educators enjoyed their work and saw the relevance of the work that they did. For them, their engagement with adolescents coupled with the provision of edutainment at Matapi for example, reinforced the health messages that they provide in the community and complemented service provision at the health sites.

Due to the prevalence of drug and alcohol misuse in the communities where the peer educators work, their job had elevated risks for experiencing violence or harassment from adolescents who were drunk or under the influence of drugs.

The peer-pair model where two peer educators work together was found to be highly acceptable and effective by the peer educators. They noted that they can leverage on each other's strengths and could support each other in the instances of violence or harassment.

One of the peer educators' key roles is to collect data/information about the beneficiaries that they engage with in the community. This data includes demographic information of the adolescent as well as the services, information and/or referrals or linkages provided by the peer educators. The peer educators expressed a desire to collect this data as the training and capacity strengthening for data collection was an upskilling for them. However, some of them expressed that the data collection efforts had increased in recent months- especially related to mental health screening, where many of the questions they were now responsible for asking were previously done by the nurses at the adolescent clinic. **To mitigate for this concern, it might be beneficial to provide adequate mental health (provision) training and support for the peer educators in the communities.**

In addition, the data collection process is predominantly paper based, but the target tracking is digital- the peer educators must enter their data using a mobile-based App. There are a few mobile devices available to do this, compared to the number of peer educators who need to use them; and they can only use them at the service sites (Matapi or AC); and not in real time within the communities. These limitations create a tension for meeting targets as peer educators struggle to balance the multitude of paper-based data collection tools; with entering this data on time to meet their monthly targets.

Peer educators also noted that their relationships with adolescents was being compromised because of MSF logistical challenges. The peer educators spend significant time building trust and rapport with especially hard to reach adolescents in the community. The project is meant to provide transport to escort eligible adolescents from the community to the adolescent clinic for services. Peer educators noted that this transport has not been consistently provided and has resulted in their recruited adolescents feeling frustrated and untrusting of the peer educators, and in some cases the peer educators using their personal finances to transport adolescents to service sites. It is likely that transport is not always available due to competing priorities or limited resources. In these instances, **it is important to communicate this unavailability to the peer educators so that they do not inform adolescents that they will be provided with transport when this is not guaranteed.**

Additionally, the peer educators expressed dissatisfied with some components of their jobs, even in the presence of incentives like a \$200 salary-allowance, scholarship and capacity-strengthening efforts. The dissatisfaction stemmed from the peer educators feeling and perceiving to be undervalued within the organization and the project itself. This undervaluation manifested in various forms that they noted to include:

- Feeling threatened or fear being installed by their superiors.
- Not having a space to safely air their concerns or grievances.
- Their voices, considerations or concerns not being heard or addressed within the organization.

It was observed when engaging with the peer educators that they feared to speak or engage with the study team as they anticipated backlash for the responses or concerns that they may raise during this post-evaluation exercise. This finding came up in 2021 during the midterm evaluation <sup>8</sup>. There seems to be a disconnect or misalignment between peer educator expectations and experiences of the project, and project staff's intentions or interpretations of these experiences. The peer educators are also adolescents, and young people. The manner, strategies, communication channels and mechanisms in with the project structures, and staff engage with them necessitates the consideration of them being AYP. The same principles of adolescent-friendliness that are afforded to beneficiaries of the project, are likely relevant to the peer educators themselves.

Overall, targeted and more resourcing could be provided towards edutainment at the AC to occupy waiting adolescents; more mobile phones or tablets for quicker data capturing to track targets by peer educators; commitment to providing transport for critical adolescents; and those being referred from Matapi when there is no nurse or for the STI study.

#### KEY POPULATIONS: ACCESS TO SERVICES

The adolescent key populations (KP) were challenging to recruit for this assignment. These adolescents noted that they continue to experience social sanctioning and stigmatisation which makes them reluctant to both openly identify as and talk about their experiences as key populations.

To improve their engagement with health services adolescents who identify as LGBTQI, and those living on the streets noted that their peer educators should emphasize that the services are free as this is not always clear. They expressed that peer educators should also try to not approach an adolescent KP as a group as this would likely reduce the adolescent's engagement with the peer educators.

For the KPs, the edutainment at Matapi Youth Hub has been supportive of their mental wellbeing; and they prefer to access services there, compared to going to the AC where the wait time can sometimes be prolonged; and there is no edutainment.

The KPs expressed that while the services in the project are friendly and free- these services are not necessarily targeting LGTBQI needs. The project balances providing overall youth-friendly services, with needing to also target for specific cohorts of the adolescent population and provide person-centred care. This might mean that sometimes the person-centred care or care for specific cohorts of the adolescent population may not always be optimal. **Adolescents living with disabilities** noted that the project is

meeting their needs, but they would like to see more peer educators representing diverse disabilities. It may not be feasible to ensure representation of every key and vulnerable adolescent group but **capacitating the existing peer educators and project staff to support and engage with diverse groups of adolescents may be an avenue to explore.**

The key population adolescents also noted that they desire to have safe spaces modelled similar to the teen mom clubs, skills training and access to or support for shelter for those who are kicked out of their homes because they identify as KPs.

### TEEN MOMS SUPPORT

The project has been providing support to teen moms who consist of pregnant adolescents and those that have just given birth. The teen moms who are support by the project found the counselling and support that they receive during their pregnancies and post-natal stage to be highly acceptable. They desired more skills training- which they were informed was a part of their club activities and objectives, but this component has not been happening.

While there is a teen mom clubs that are supported by the project, the teen moms themselves must receive their ANC care from the polyclinic which is run by the Harare City Council. The teen moms raised concerns about the nurses at the ANC clinic having negative attitudes, and sometimes intensifying their distress. There may be **an opportunity to transfer the learnings or capacity building on adolescent-friendliness form the AC, to the ANC so that adolescents who must move their care between the AC and other parts of the polyclinic, continue to receive quality care.**

### INTEGRATED SERVICE PROVISION

Integrated service provision encompassing health promotion, HIV, SRH, mental and other non-health services like teen mom clubs has positively influenced both the adolescent clinic and the clients/beneficiaries themselves. There are not many/any programs that offer a comprehensive medical package as a one stop shop for adolescents and young people in Zimbabwe.

There have been a few challenges that have hampered the effectiveness of the integration model. In Zimbabwe, the government' new statutory instrument that disallows the imported procurement of medical drugs and technologies that are produced in Zimbabwe has posed a challenge. Some of the Zimbabwe indigenous medications are not yet approved by the WHO, and MSF can only procure and provide WHO approved medications. This has posed challenges in providing such medications to adolescents who need them.

Additionally, the Mbare medical package is a primary health care package. When an adolescent is deemed to need secondary or tertiary care support- this is not offered in the adolescent clinic, and this is one of the instances when referrals and/or linkages to secondary or tertiary care facilities happens. These non-PHC services are not free, and often adolescents begin to incur time and financial costs to access this care, resulting in them not receiving it.

### HIV prevention services

In terms of adolescent-friendliness- the project is dominantly this. There were some concerns around privacy and confidentiality during HIV self-testing outside the AC or Matapi. Adolescents are self-testing in an open area with no privacy, which risks the confidentiality of their results, and likely diminishes adolescent friendliness.

### HIV care and treatment services

Overall, the quality of HIV care and treatment services has progressed and improved since the last evaluation. Adolescents living with HIV now receive their care and support directly from the adolescent clinic and not for the OI clinic. This has resulted in better support for the HIV cohort. According to these adolescents, the project is reinforcing their adherence and meeting their needs beyond HIV care. Specifically, the adolescents appreciate the psychosocial and mental health support they have been receiving within the project.

Adolescents living with HIV had mixed reactions on the consistency of the friendliness surrounding service provision within the project. They noted that service provision was dominantly friendly, but not always as the staff sometimes had negative attitudes when the adolescents sought care at the AC.

### The intersection of Mental Health, Substance misuse and SRH

The ASRH project has been offering mental health and wellbeing services to young people since its inception, iteratively adapting to accommodate gaps and needs in mental health care over time. The project identified this need in Mbare and responded by providing mental health care at the adolescent clinic. In the more recent years, substance misuse by adolescence has become prevalent in the Mbare and Epworth communities that are serviced by the project. The project has increased its capacity to support these adolescents by providing mental health specific human resources and support.

In the case of the project's adolescent beneficiaries, there have been some intersections between substance misuse and SRH issues. Qualitatively, according to project staff, peer educators and some adolescents, adolescent girls who are using drugs are at higher risk of unprotected sex and the subsequent vulnerabilities to STI and HIV infections as well as unintended pregnancies. The project staff qualitatively reported on several instances where **AYP who were using drugs also came in with advanced STI infections needing services in addition to the mental health support that is provided for substance misusers**. Quantitatively increase in the uptake of mental health and substance use service had not changed in the last three years, as already mentioned, but visits for STI syndromic management and reported adolescent pregnancies have increased. The integrated service provision model of the AC clinic enables all these services to be provided immediately as needed, which may be important for supporting these kinds of adolescents.

MSF had a previous "Harare Psychiatry Project" (HPP) that also had a community-level psychiatry model between 2012 and 2017, which was then handed over to the University of Zimbabwe when MSF ended. This project focused primarily on identifying, treating, and supporting the management of psychiatric

disorders. In future iterations of the ASRH project, **it will be important understand how the mental health support being provided for adolescents, can be improved based on learnings from the prior HPP project.**

### CONTINUITY AND SUSTAINABILITY

The project has good working relationships with other partners and stakeholders. In the areas where MSF is lacking resources or expertise, the project has been able to collaborate with other stakeholders to ensure services are provided.

Across all the participants in this study, there is consensus that the project should continue as it is providing free and needed services to populations in need. Stakeholders and beneficiaries in Epworth expressed a desire and need for the medical package to be introduced in this community to meet the health and wellbeing needs of adolescents there more directly.

The project has ongoing stakeholder collaboration and engagement, which is part of an effort towards capacity building of community, and staff, as well as identification of partners who could possibly take over components of the project. Some stakeholders like school teachers in this assignment noted that, integration of program activities like health education/information into their school settings has worked well and resulted in improved adolescent outcomes (both health and education). However, integrating this project's model into government clinics is currently not possible due to limited capacity.

A key factor that could support understanding the continuity and sustainability of this project would be **an assessment of the financing model for the project (cost-effectiveness)**, and how else it can be funded, in addition to mapping out the stakeholders who could continue to implement the project or its components.

Additionally, a detailed exit strategy will need to be developed and implemented to support the transition from MSF to other partners/stakeholders. This strategy should consider maintaining the role of peer educators in the implementation of adolescent friendly services.

## IMPLICATIONS FOR PRACTICE & CONTINUITY

One of the areas for reflection is that between when the midterm evaluation was conducted in 2021, and this post-evaluation exercise in 2024, some challenges have persisted/ continued but different areas for reflection and engagement has also arisen.

- Data collection, analysis and management systems continue to be siloed and disjointed. The current systems also do not enable cohort analysis. Data is collected based on adolescent visits for services, and not the individual adolescent, such that subsequently capturing health outcomes of adolescents is not possible. Linked to this, while understanding the cost-effectiveness of a project like this one is important to assess feasibility of continuation, the lack of individual level data makes it challenging to conduct such an analysis. All of these have implications for not only evidence generation, knowledge management and sharing, but for sustainability of the project.
- Peer educators feeling undervalued within the MSF system.

The findings from this post evaluation assignment have shown that the project should continue because:

- There continues to be a large unmet need for adolescent support and services, such that discontinuation may result in negative effects. For example, over 38% of referrals in the project were for GBV services; and the recent gender assessment in Zimbabwe from the World Bank showed that GBV continues to pervasively persist in Zimbabwe<sup>17</sup>. This project historically, and presently contributes to accessing GBV services
- It is not yet time to handover to the Harare City Council who do not have the capacity to execute this project. If handed over, services will no longer be free, adolescents will experience long wait times to access services, and these services will no longer be adolescent focused.
- There is an opportunity to collect target cohort-based data that can be analyzed and contribute to understanding adolescent needs, services and how interventions can address these needs.

## IMPLICATIONS FOR POLICY, AND SYSTEMS INFLUENCE

The Mbare ASRH project is probably the only one in Zimbabwe that has a static one stop shop integrated service delivery model for adolescents and combines community and medical interventions as mechanisms for reaching and supporting adolescents. Addressing the evidence generation challenges in this project would provide the requisite evidence to enhance evidence-informed policy design for adolescent health and well-being in Zimbabwe. Learnings from this project could be used to contribute to policies that affect adolescents; as well as to health systems strengthening efforts so that they can better the adolescent and youth population.

## CONCLUSIONS

### FUTURE DIRECTIONS & ROUNDTABLE RECOMMENDATIONS

For the program to continue outside of MSF, stakeholder mapping, engagement and capacity is required for them to take over the activities of the program. There is strong evidence to show a need for the SRHR services provided by the project for the Mbare community. This is reflected by the higher numbers of STIs treated, HIV positivity, adolescent pregnancy and increase in uptake of services overall for all the sites except for Epworth when service delivery was significantly impacted by national election activities in 2023. If the ASRH project should continue, it could consider the following focal areas:

1. **Harm reduction in Mbare and surrounding communities.** Adolescents are using drugs, and abusing alcohol, which has implications for their mental health and increases their risk behaviours and vulnerability to sexually transmitted infections among other challenges. The project needs to assess and understand adolescent pathways to utilising drugs and alcohol and select where to intervene as part of harm reduction efforts overall.
2. **Enhanced quality clinical care.** The project's quantitative analysis showed increased visits for STI syndromic management, and adolescent pregnancies- as well a definition of the HIV positive cohort, that may be constraining the understanding and measurement of viral load suppression of adolescents living with HIV in Mbare. As part of understanding, and enhancing quality clinical care, the project could enhance pregnancy and STI prevention interventions and consider a different definition and subsequent interventions of the HIV positive cohort.
3. **Integrated, adolescent friendly service provision.** The ASRH project is the only intervention in Zimbabwe that has both a community and facility/medical package providing one-stop-shop, primary health care based and integrated services for adolescents and young people aiming to address their health and wellbeing. Globally, and in Zimbabwe efforts to meet the diverse needs of adolescents and young people have not always been successful. The ASRH project has a model that other programs and interventions could learn from. Investing in quality evidence generation that can be utilized to inform other programs and interventions; and then creating the space (stewarding) to convene and facilitate the absorption of this evidence should be prioritized.
4. **Evidence generation and knowledge management:** A lot of useful and impactful work in being done in the project. However, this is not necessarily being documented well, and there have been challenges associated with data collection systems; as well as the use of the generated evidence to inform programming. It is paramount for MSF to make resources available for the improvement of routine data collection within the project. This process should be aided by the development of a clear data management strategy for the Mbare ASRH project which should outline actions and responsible persons in relation to the following key elements:
  - The intended uses of collected data to inform what data to collect. A cohort analysis should be seriously considered.
  - A dedicated electronic data collection platform for the project with requisite ongoing checks to ensure completeness and accuracy

- Human resources to support data management and analysis as routinely analyzed data can also inform programmatic adaptations for the project.
- Cost-effectiveness data collection and analysis.

The project has a unique opportunity to enhance its data collection, and management systems not only to progress evidence informed programming in the project and within broader MSF, but to also generate evidence for policy and practice changes across adolescent programs in Zimbabwe, the region and even globally.

5. **Scaling 'up'** (laws and policy); **Scaling 'deep'** (relationships/ values/ beliefs) and/or **scaling 'out'** (greater numbers). Informed by the evidence generated during implementation, the ASRH project needs to consider what impact means for the project- operationalizing what the project intends/means by "improving adolescent mortality and morbidity" in Mbare and surrounding communities. The project could interrogate how it has or can scale up, scale deep and/or scale out adolescent health and wellbeing as a measure of its impact in Zimbabwe, MSF and beyond.
6. **The "what" in Adolescent health and wellbeing:** Compared to other interventions for adolescents, the Mbare project is one of the most comprehensive in terms of health and non-health needs that it tries to meet for adolescents. The project has an opportunity to either go deeper and better support/intervene for the needs it already addresses; or it can continue to be a responsive program and increase its breadth to address more and/or emerging adolescent needs. For example, playing a larger role in pregnant adolescents' wellbeing and supporting them during their postnatal phase.
7. **The role of peer educators:** The project needs to reflect and act on what it means to have a 'peer-led' model when the peer educators seem to be the most disadvantaged in the project ecosystem. The project should reflect and decide on what it means to have peer educators as beneficiaries (young people) and as co-implementors/colleagues. Clarifying the role of peer educators and supporting this role will be critical for how the project moves forward.



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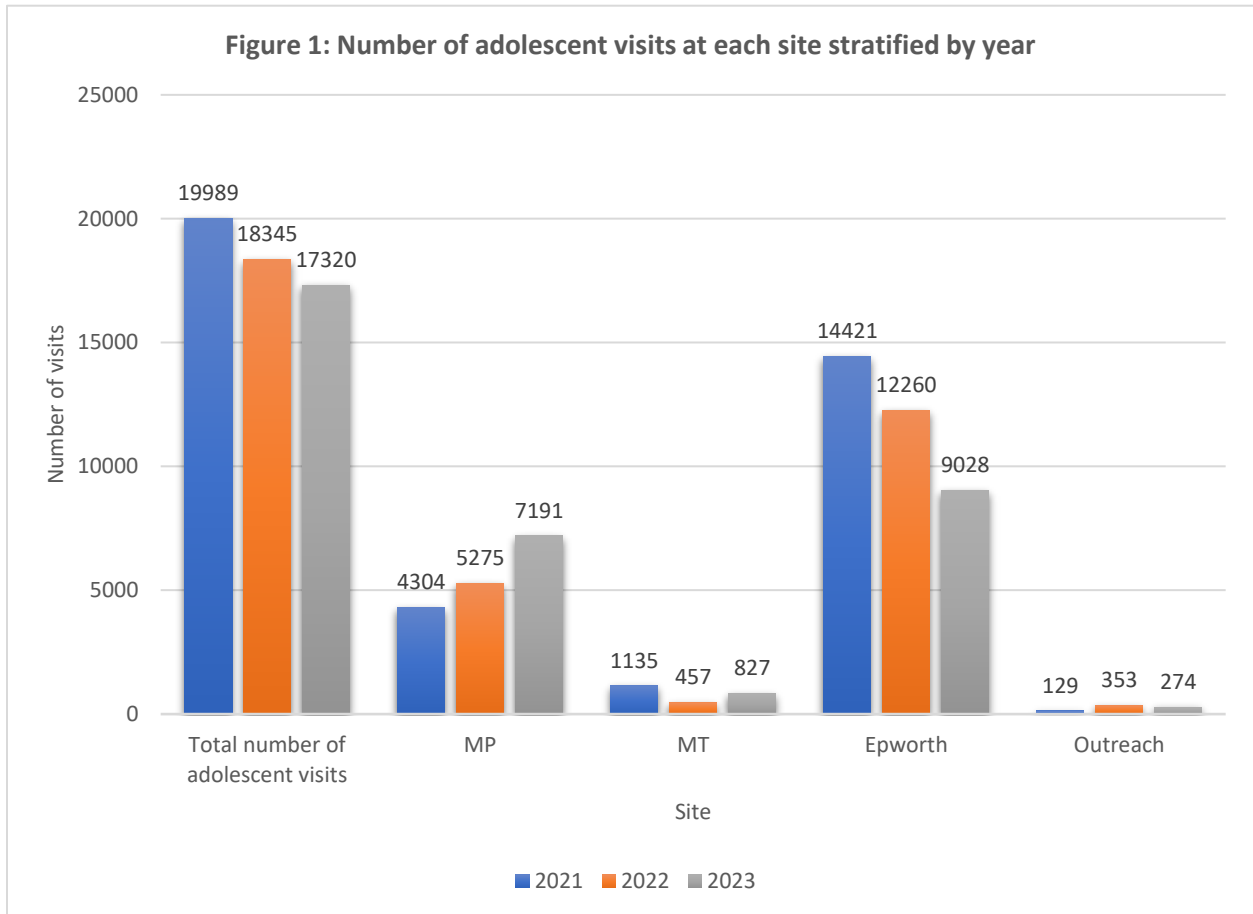
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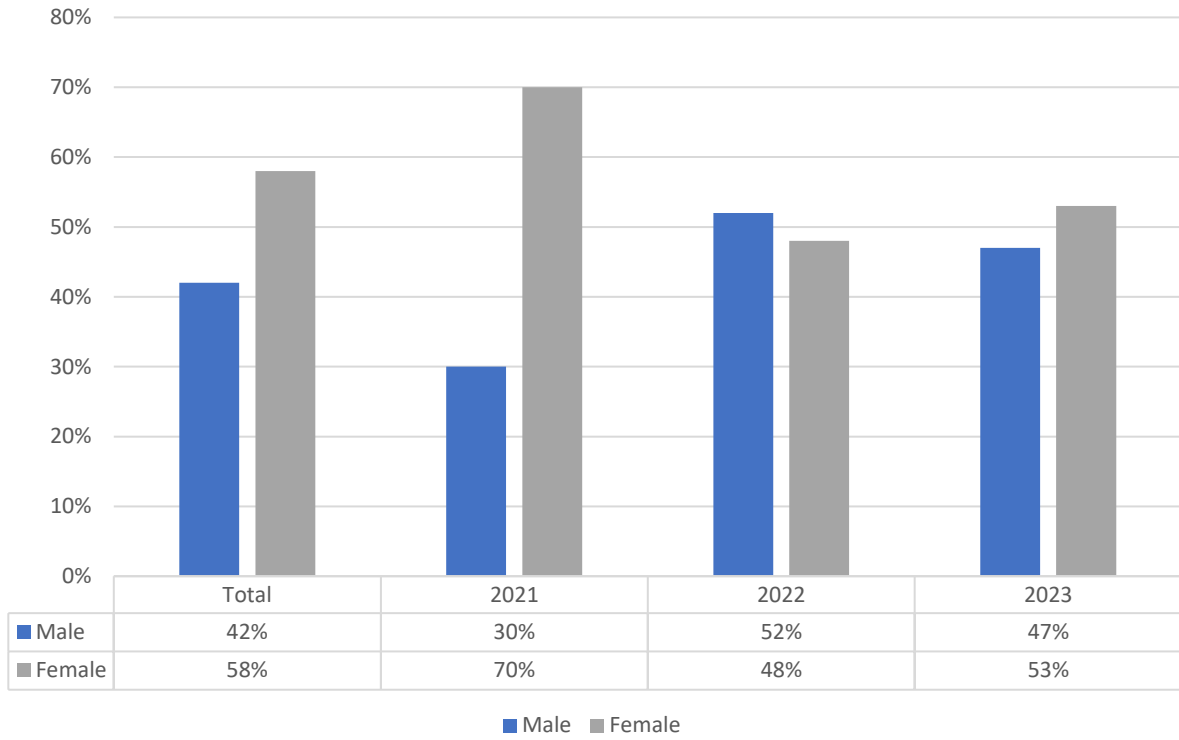
## ANNEX I: SECONDARY DATA ANALYSIS FIGURES

Mbare and Epworth ASRH Data (2021-2023)

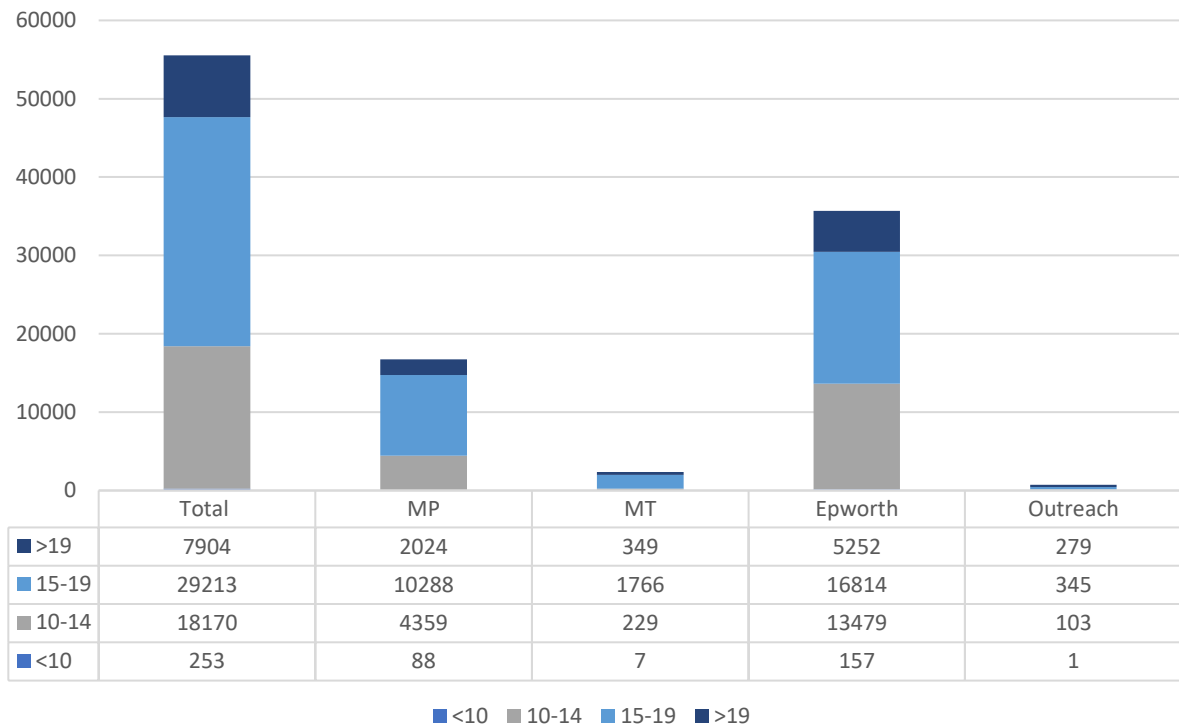
### FIGURES



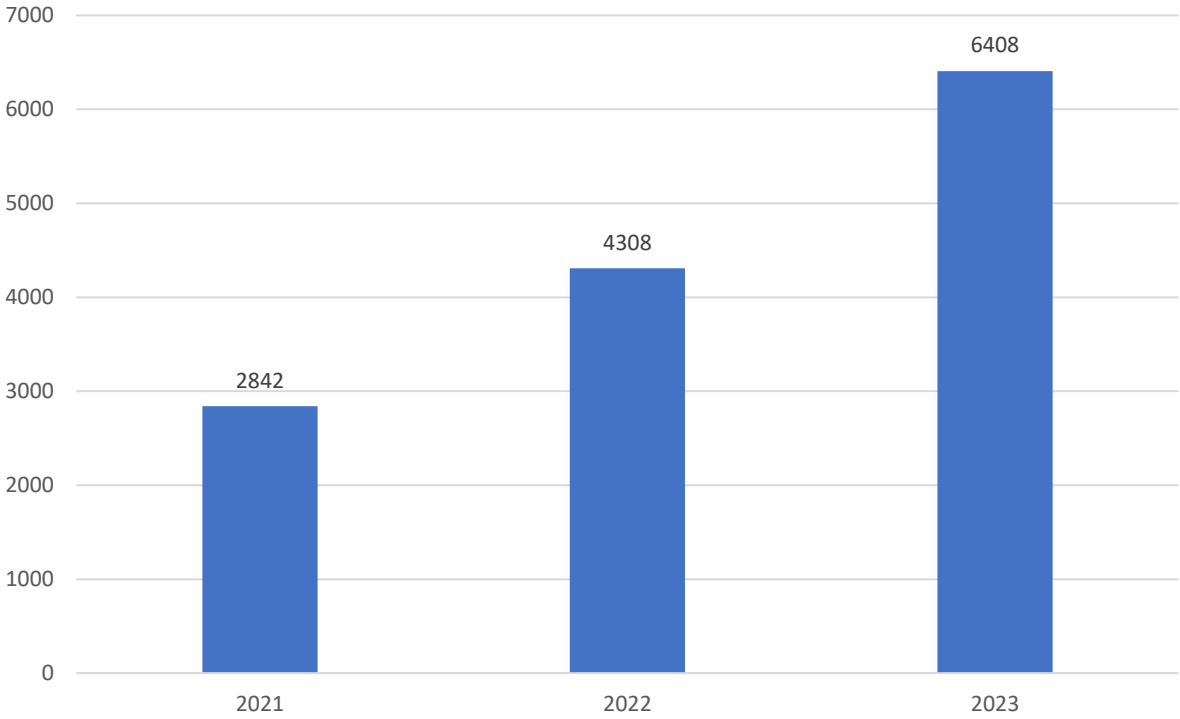
**Figure 2: Proportion of adolescent visits each year stratified by sex**



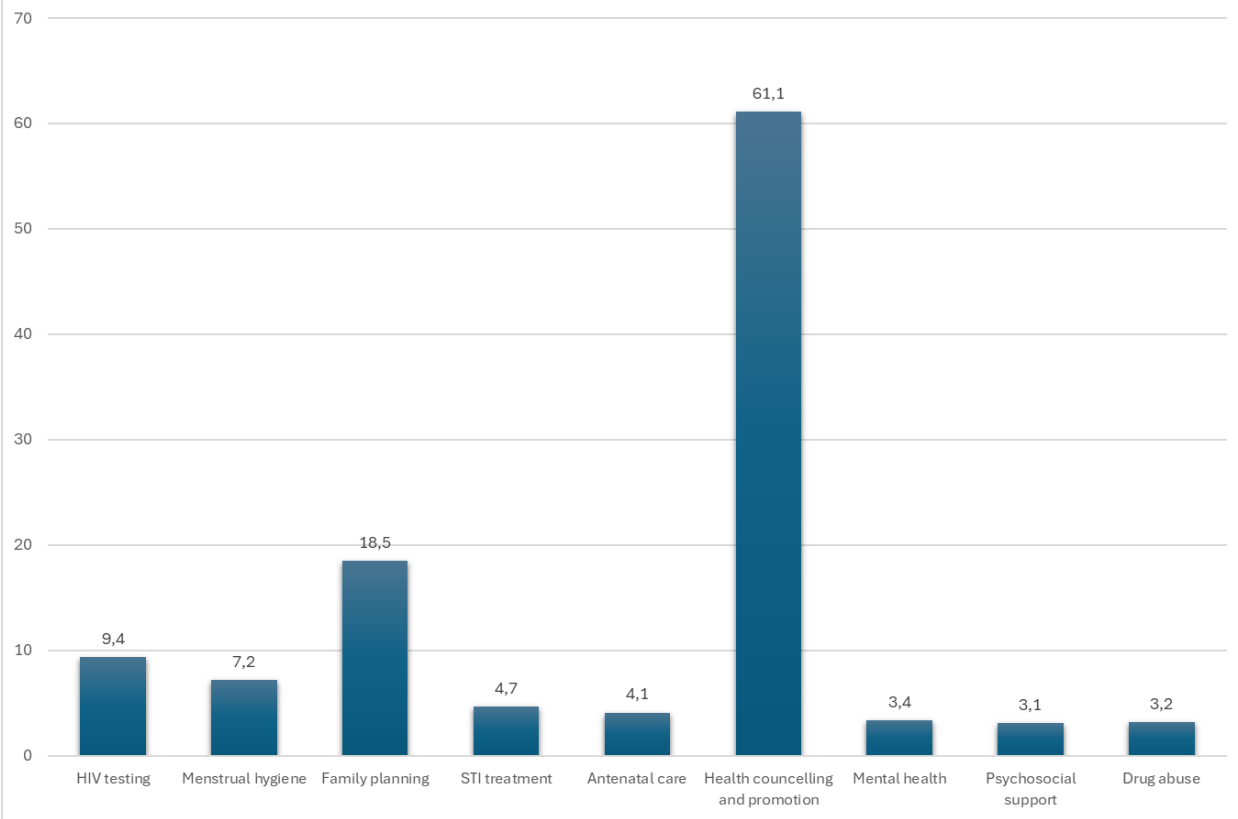
**Figure 3: Adolescent visits by age group stratified by site**



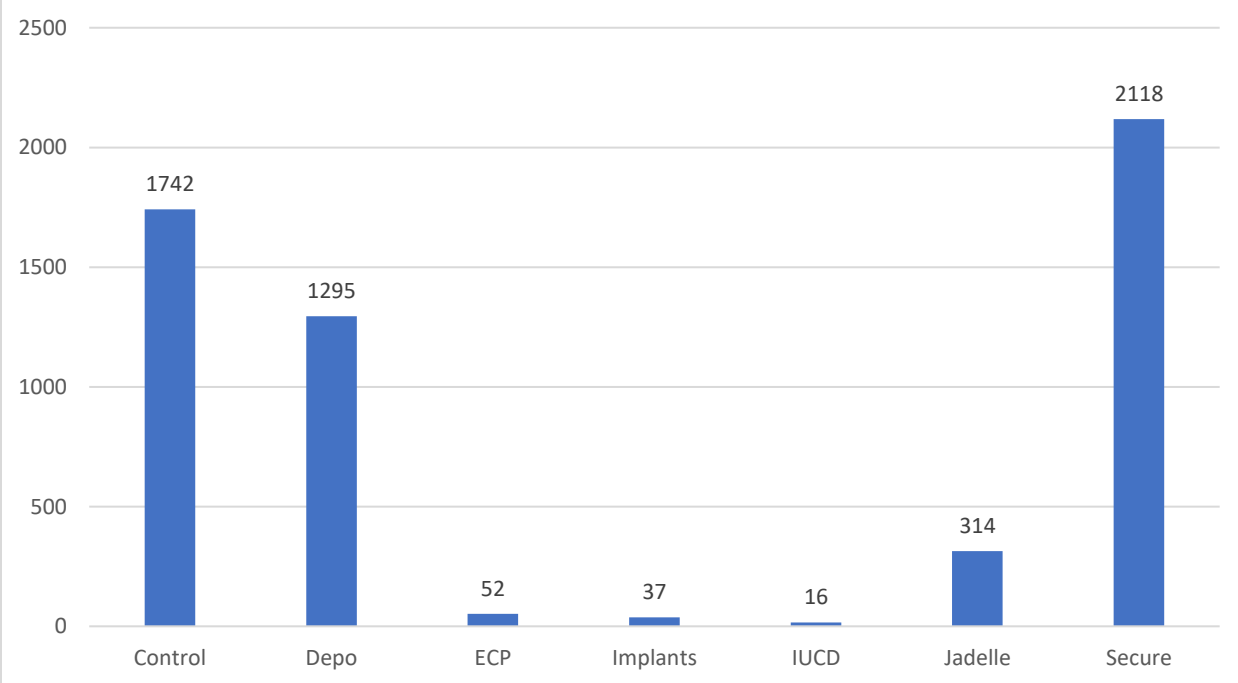
**Figure 4: Number of OPD visits stratified by year**



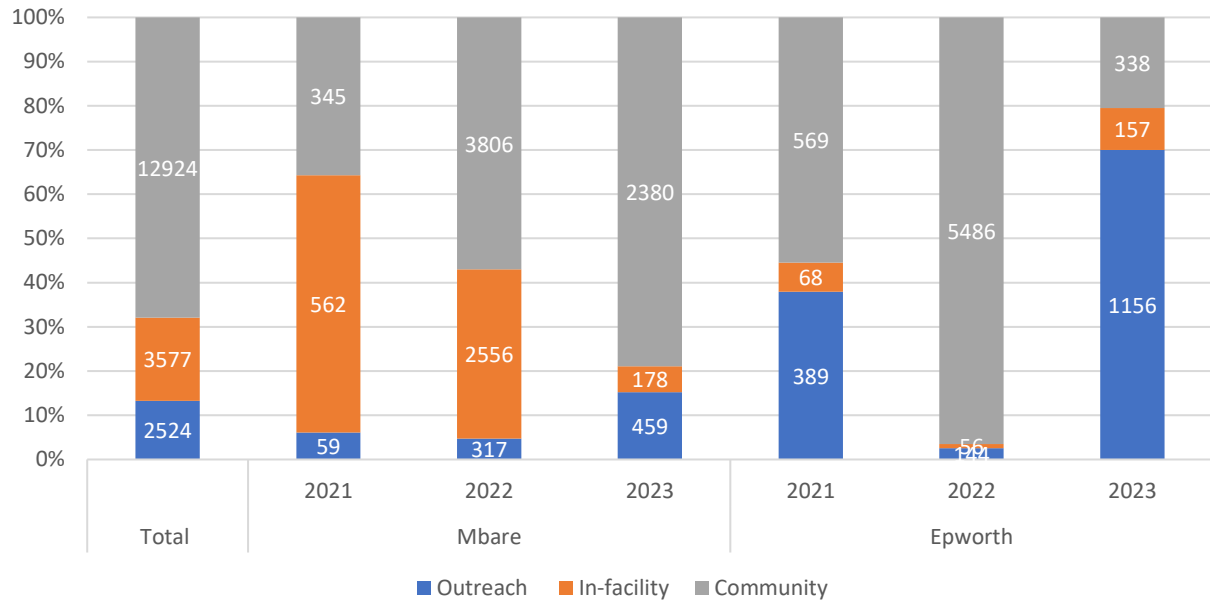
**Figure 5. Proportion of health services uptake for adolescent vists (2021-2023)**



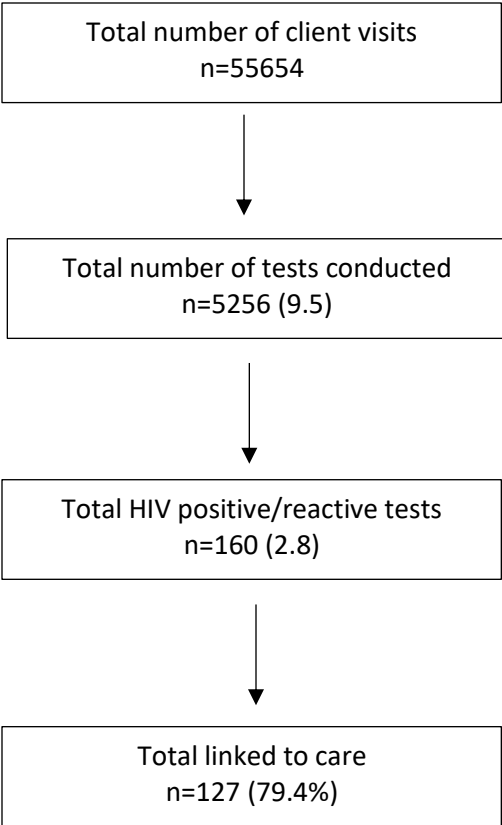
**Figure 6: Uptake of family planning options (2021-2023)**



**Figure 7: Condom Uptake**



**Figure 8: HIV testing and care cascade 2021-2023**





## ANNEX II: SECONDARY DATA ANALYSIS TABLES

Mbare and Epworth ASRH Data (2021-2023)

### TABLES

**Table 1: Uptake of services stratified by year**

Indicator	Total	Year, n (%)		
		2021	2022	2023
Total number of adolescent visits (N)	55654	19989	18345	17320
Site				
MP	16770 (30.1)	4304 (21.5)	5275 (28.8)	7191 (41.5)
MT	2419 (4.4)	1135 (5.7)	457 (2.5)	827 (4.8)
Epworth	35709 (64.2)	14421 (72.1)	12260 (66.8)	9028 (52.1)
Outreach	756 (1.4)	129 (0.7)	353 (1.9)	274 (1.6)
Sex				
Male	23621 (42.4)	6027 (30.2)	9478 (51.7)	8116 (46.9)
Female	31996 (57.5)	13951 (69.8)	8866 (48.3)	9179 (53.0)
<b>Missing</b>	37	11	1	25
Age, median (IQR)				
MP	17.1 [14.4-18.9]	16.2 [14.0-18.3]	17.8 [15.2-19.2]	17.5 [14.2-19.0]
MT	17.3 [16.7-19.1]	17.1 [16.7-18.9]	18.2 [16.6-19.5]	18.0 [15.9-19.3]
Epworth	16.1 [13.2-18.8]	15.5 [12.3-18.5]	17.0 [14.3-19.5]	15.9 [13.5-18.2]
Outreach	19 [17-22]	21 [17-23]	19 [17-22]	17 [14-19]
Age groups (years) <sup>a</sup>				
<10	253 (0.5)	79 (0.4)	63 (0.3)	111 (0.6)
10-14	18170 (32.7)	7795 (39.0)	4791 (26.1)	5584 (32.2)
15-19	29213 (52.5)	9261 (46.3)	9576 (52.2)	10376 (59.9)
>19	7904 (14.2)	2852 (14.3)	3881 (21.2)	1171 (6.8)
<b>Missing</b>	114	2	34	78
Services <sup>b</sup>				
OPD Services	7063 (12.7)	2842 (14.2)	4308 (23.5)	7191 (41.5)
HIV testing	5256 (9.4)	2203 (11.0)	1196 (6.5)	1857 (10.7)
Menstrual hygiene <sup>c</sup>	2316 (7.2)	432 (3.1)	692 (7.8)	1192 (13.0)
Family planning <sup>c</sup>	5905 (18.5)	1577 (11.3)	2971 (33.5)	1357 (14.8)
STI treatment	2623 (4.7)	813 (4.1)	848 (4.6)	962 (5.5)
Antenatal care <sup>c</sup>	1305 (4.1)	330 (2.4)	528 (5.9)	830 (9.0)
HCP	34027 (61.1)	14008 (70.1)	11569 (63.1)	8450 (48.8)
Mental health	1884 (3.4)	797 (4.0)	541 (2.9)	546 (3.1)
Psychosocial support	1740 (3.1)	611 (3.1)	565 (3.1)	550 (3.2)
Drug abuse	1758 (3.2)	637 (3.2)	569 (3.1)	552 (3.2)

<sup>b</sup> Total does not equal the total number of adolescents as individuals could get more than one service.

<sup>c</sup> The denominator used is the total number of female clients attending in that year

**Table 2: Uptake of services stratified by site and year**

Indicator	Year, n (%)											
	2021				2022				2023			
	MP	MT	Epworth	Outreach	MP	MT	Epworth	Outreach	MP	MT	Epworth	Outreach
Total number of adolescent visits (N)	4304	1135	14421	129	5275	457	12260	353	7191	827	9028	274
Sex												
Male	1371 (31.9)	449 (39.6)	4159 (28.8)	81 (62.8)	1545 (29.3)	122 (26.7)	7718 (62.9)	93 (26.4)	2434 (33.8)	283 (34.2)	5324 (59.0)	75 (27.4)
Female	2933 (68.1)	686 (60.4)	10251 (71.1)	48 (37.2)	3729 (70.3)	335 (73.3)	4541 (27.1)	260 (73.6)	4738 (65.9)	544 (65.8)	3698 (40.9)	199 (72.6)
Missing	-	-	11 (0.1)	-	1 (0.02)	-	1 (0.01)	-	19 (0.3)	-	6 (0.1)	-
Age groups												
<10	5 (0.1)	0	74 (0.5)	0	16 (0.3)	1 (0.2)	46 (0.4)	0	67 (0.9)	6 (0.7)	37 (0.4)	1 (0.4)
10-14	1267 (29.4)	16 (1.4)	6510 (45.1)	2 (1.5)	1069 (20.3)	62 (13.6)	3635 (29.6)	25(7.7)	2023 (28.1)	151 (18.3)	3331 (38.5)	76 (27.7)
15-19	2652 (61.6)	969 (85.4)	5591 (38.8)	49 (38.0)	3129 (59.3)	274 (60.0)	6021 (49.1)	151 (46.5)	4506 (62.7)	523 (63.2)	4845 (56.0)	145 (52.9)
>19	380 (8.8)	150 (13.2)	2244 (15.6)	78 (60.5)	1056 (20.0)	119 (26.0)	2558 (20.9)	149 (45.8)	589 (8.2)	80 (9.7)	427 (4.9)	52 (19.0)
Missing	-	-	2 (0.01)	-	5 (0.1)	1 (0.2)	-	28 (7.9)	6 (0.1)	67	5 (0.1)	-
Services												
OPD services	2721 (63.2)	121 (10.7)	-	10 (14.0)	3925 (74.4)	296 (64.8)	-	87 (24.6)	5686 (79.1)	492 (59.5)	-	230 (83.9)
HIV testing	1060 (24.6)	889 (78.3)	153 (1.1)	101 (78.3)	446 (8.4)	93 (20.3)	391 (3.2)	266 (75.3)	1077 (15.0)	273 (33.0)	430 (4.7)	77 (28.1)
Menstrual hygiene	-	-	432 (4.2)	-	0	0	692 (15.2)	-	0	0	1192 (32.2)	-
Family planning	687 (23.4)	182 (26.5)	678 (6.6)	30 (62.5)	884 (23.7)	136 (40.6)	1896 (41.7)	55 (21.2)	478 (10.1)	94 (17.3)	737 (19.9)	48 (24.1)
STI treatment	447 (10.4)	24 (2.1)	325 (2.2)	17 (13.2)	521 (9.9)	41 (9.0)	273 (2.2)	13 (3.7)	602 (8.4)	30 (3.6)	298 (3.3)	32 (11.7)
Antenatal care	178 (6.1)	0	151 (1.5)	1 (2.1)	213 (5.7)	5 (1.5)	303 (6.7)	7 (2.7)	189 (4.0)	0	1013 (17.0)	11 (5.0)
HCP	33 (0.8)	5 (0.4)	13970 (96.9)	-	4 (0.1)	0	11565 (94.3)	-	4 (0.01)	0	8444 (93.5)	2 (0.9)
Mental health	261 (6.1)	0	536 (3.7)	-	348 (6.6)	16 (3.5)	177 (1.4)	-	265 (3.7)	36 (4.3)	245 (2.7)	-
Psychosocial Sup	199 (4.6)	1 (0.1)	411 (2.8)	-	299 (5.7)	1 (0.2)	251 (2.0)	14 (4.0)	269 (3.7)	0	271 (3.0)	10 (4.0)
Drug abuse	-	-	637 (4.4)	-	-	-	569 (4.6)	-	0	0	552 (6.1)	-

**Table 3: Uptake of services stratified by sex and year**

Indicator	Year, n (%)					
	2021		2022		2023	
	Male	Female	Male	Female	Male	Female
Total number of adolescent visits (N)	6027	13951	9478	8866	8116	9179
Site						
MP	1371 (31.9)	2933 (68.1)	1545 (29.3)	3730 (70.7)	2434 (33.9)	4738 (66.1)
MT	449 (39.6)	686 (60.4)	122 (26.7)	335 (73.3)	283 (34.2)	544 (65.8)
Epworth	4159 (28.9)	10251 (71.1)	7718 (63.0)	4541 (37.0)	5324 (59.0)	3698 (41.0)
Outreach	48 (37.2)	81 (62.8)	93 (26.3)	260 (73.7)	75 (27.4)	199 (72.6)
Age groups						
<10	20 (25.3)	59 (74.6)	34 (53.9)	29 (46.1)	64 (57.7)	47 (42.3)
10-14	1929 (24.7)	5879 (75.3)	3356 (70.1)	1435 (29.9)	3175 (57.0)	2399 (43.0)
15-19	3033 (32.7)	6238 (67.3)	4890 (51.1)	4685 (48.9)	4309 (41.6)	6056 (58.4)
>19	1044 (37.0)	1775 (63.0)	1177 (30.3)	2704 (69.7)	527 (45.1)	642 (54.9)
<b>Missing</b>	1	0	21	12	41	35
Services						
OPD services						4023 (43.8)
HIV testing						1191 (64.1)
Menstrual hygiene						1157 (97.2)
Family planning						1254 (89.8)
STI treatment						542(57.6)
Antenatal care						810 (98.9)
HPC						3162 (37.5)
MH						321 (58.8)
PSS						349 (63.6)
Drug abuse						235 (42.6)

<sup>a</sup> Males recorded as having received family planning services, for some records there are recorded as condoms

<sup>b</sup> Males recorded as having received ANC services., there are likely data entry errors

**Table 4: Uptake of services stratified by age (2021-2023)**

Indicator		Age-groups N (%)			
		<10	10-14	15-19	>19
Total number of adolescent visits (N)		253	18170	29213	7904
Sex	Male	118 (46.6)	8460 (46.6)	12234 (41.9)	2758 (34.9)
	Female	135 (53.4)	9710 (53.4)	16979 (58.1)	5146 (65.1)
Site	MP	88 (34.8)	4359 (24.0)	10288 (35.2)	2024 (25.6)
	MT	7 (2.8)	229 (1.3)	1766 (6.1)	349 (4.4)
	Epworth	157 (62.1)	13479 (74.2)	16814 (57.6)	5252 (66.5)
	Outreach	1 (0.4)	103 (0.6)	345 (1.2)	279 (3.5)
Services	OPD services	75 (29.6)	4184 (23.0)	7742 (26.5)	1567 (19.8)
	HIV testing	7 (2.8)	320 (1.8)	3825 (13.1)	1008 (12.7)
	Family planning	4 (3.0)	320 (3.3)	3554 (20.9)	2272 (44.2)
	STI treatment	1 (0.4)	438 (2.4)	1143 (3.9)	829 (10.5)
	Antenatal care	0	78 (0.8)	1226 (7.2)	383 (7.4)
	HCP	156 (61.7)	13283 (73.1)	15916 (54.5)	4661 (59.0)
	Mental health	7 (2.8)	522 (2.9)	996 (3.4)	359 (4.5)
	Psychosocial support	13 (5.2)	557 (3.1)	913 (3.1)	180 (2.3)
	Drug abuse	5 (2.0)	609 (3.4)	897 (3.1)	247 (3.1)

**Table 5: Uptake of HIV testing services and HIV test outcomes**

Indicator	Total	Year		
		2021	2022	2023
Total adolescents seen (N)	55654	19989	18345	17320
Adolescents tested	5256 (9.4)	2203 (11.0)	1196 (6.5)	1857 (10.7)
Test method choice*				
Rapid test	34 (0.9)	16 (0.8)	17 (1.4)	1 (0.3)
Self-test	3317 (89.0)	2034 (96.8)	917 (76.9)	366 (99.7)
Unknown	-	-	-	-
Test results				
Negative	4630 (97.2)	2109 (95.7)	891 (95.4)	1630 (95.8)
Positive	160 (2.8)	42 (1.9)	43 (3.6)	75 (4.0)
Proportion of HIV positive adolescents linked to care (N=127)	127 (79.4)	31 (73.8)	40 (93.0)	56 (74.7)

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

**Table 6: Referrals outside the Mbare ASRH program**

Services where referrals are made to	Total N=2532	Year		
		2021	2022	2023
PrEP	36	5	16	15
PEP	239	62	87	90
VIAC	4	-	4	-
FP	135	13	46	76
GBV	977	459	306	212
Hospital referrals	1023	313	466	244

**Table 7: Characteristics of children and adolescents living with HIV<sup>a</sup>**

Indicator	Total (n=248)	Female (n=150)	Male (n=98)
Birth age, median (IQR)	19 (14-22)	19 (14-22)	18.5 (14-21)
Age at ART initiation, median (IQR)	10 (4.5-16)	11 (6-16)	9 (3-14)
Method into ART, n (%)			
New	187 (75.4)	118 (78.7)	69 (70.4)
Transferred	61 (24.6)	32 (21.3)	29 (29.6)
Duration of ART (years), median (IQR)	7.3 (3.8-10.1)	6.4 (2.8-12.1)	8.1 (5.9-11.2)
Baseline CD4 performed, n (%)			
Yes	47 (18.9)	26 (17.3)	21 (21.4)
No	201 (81.1)	124 (82.7)	77 (78.6)
Baseline CD4 count, median (IQR)	200 (28-384)	288.5 (136-395)	110 (17-285)
Viral load coverage, n (%)			
Yes	200 (80.7)	120 (80.0)	80 (81.6)
No	48 (19.3)	30 (20.0)	18 (18.4)
Viral load suppression <sup>c</sup> (n=200), n (%)			
Yes	186 (93.0)	110 (91.7)	76 (95.0)
No	14 (7.0)	10 (8.3)	4 (5.0)

<sup>a</sup> This is cohort level data as defined by the project

<sup>c</sup> Viral load suppression defined as < 1000copies/ML

**Table 8: Uptake of Family planning services among female clients stratified by site and year**

Indicator	Year, n (%)												
	Total	2021				2022				2023			
		MP	MT	Epworth	Outreach	MP	MT	Epworth	Outreach	MP	MT	Epworth	Outreach
Total number of female adolescent visits (N)	31301	2917	686	10251	48	3578	335	4541	260	4627	544	3315	199
<b>Family planning options</b>													
Control	1742 (5.6)	179 (6.1)	30 (4.4)	304 (3.0)	10 (20.8)	105 (2.9)	17 (5.1)	868 (19.1)	21 (8.1)	30 (0.6)	14 (2.6)	164 (4.9)	0
Depo	1295 (4.1)	230 (7.9)	72 (10.5)	0	7 (14.6)	423 (11.8)	54 (16.1)	0	10 (3.8)	411 (8.9)	62 (11.4)	0	26 (13.1)
ECP	52 (0.2)	12 (0.4)	3 (0.4)	0	2 (4.2)	6 (0.2)	4 (1.2)	1 (0.02)	1 (0.4)	9 (0.2)	0	14 (0.4)	0
Implants	37 (0.1)	6 (0.2)	2 (0.3)	0	0	20 (0.6)	4 (1.2)	0	2 (0.8)	3 (0.06)	0	0	0
IUCD	16 (0.05)	6 (0.2)	0	0	0	7 (0.2)	0	0	2 (0.8)	1 (0.02)	0	0	0
Jadelle	314 (1.0)	73 (2.5)	15 (2.2)	0	8 (16.7)	102 (2.9)	9 (2.7)	0	9 (3.5)	85 (1.8)	11 (2.0)	0	2 (1.0)
Secure	2118 (6.8)	8 (0.3)	5 (0.7)	444 (4.3)	3 (6.3)	4 (0.1)	0	1164 (25.6)	6 (2.3)	6 (0.1)	0	473 (14.3)	5 (2.5)

**Table 9: Peer educator community data by year and site**

Indicator	Year, n (%)						
	Total	2021		2022		2023	
		Mbare	Epworth	Mbare	Epworth	Mbare	Epworth
<b>Total number of adolescent contacts (N)</b>	49054	8257		10496	10875	6880	12546
<b>Sex, n (%)</b>							
Female	28243 (57.6)	5322 (64.5)		6305 (60.1)	6799 (62.5)	3800 (55.2)	6017 (47.9)
Male	20750 (42.3)	2935 (35.5)		4164 (39.7)	4076 (37.5)	3046 (44.3)	6529 (52.1)
Other	61 (0.1)	-		27 (0.3)	-	34 (0.5)	-
<b>Age group (years), n (%)</b>							
<10	297 (0.6)	38 (0.5)		34 (0.3)	21 (0.2)	89 (1.3)	115 (0.9)
10-14	5247(10.7)	907 (11.0)		537 (5.1)	843 (7.8)	601 (8.7)	2359 (18.8)
14-19	32329 (65.9)	6323 (76.6)		8014 (76.4)	3953 (36.3)	5162 (75.0)	8877 (70.8)
20-24	10145 (20.7)	951 (11.5)		1829 (17.4)	5191 (47.7)	997 (14.5)	1177 (9.4)
>24	1036 (2.1)	38 (0.5)		82 (0.8)	867 (8.0)	31 (0.4)	18 (0.1)
<b>Topics discussed</b>							
ANC	3300 (6.7)	969 (11.7)		1147 (10.9)	221 (2.0)	576 (8.4)	387 (3.1)
Family planning	14906 (30.4)	2843 (34.4)		3851 (36.7)	2611 (24.0)	2042 (29.7)	3559 (28.4)
COVID-19	7770 (15.8)	4184 (50.7)		2311 (22.0)	530 (4.9)	290 (4.2)	455 (3.6)
HIV & AIDS	18216 (37.1)	3933 (47.6)		4386 (41.8)	4043 (37.2)	2618 (38.1)	3236 (25.8)
Mental health	3668 (7.5)	1261 (15.3)		856 (8.2)	380 (3.5)	692 (10.1)	479 (3.8)
Menstrual health	12710 (25.9)	2831 (34.3)		2448 (23.3)	3752 (34.5)	632 (9.2)	3047 (24.3)
Sex and sexuality	1203 (2.4)	790 (9.6)		359 (3.4)	22 (0.2)	23 (0.3)	9 (0.1)
SGBV	818 (1.7)	396 (4.8)		242 (2.3)	93 (0.9)	37 (0.5)	50 (0.4)
STIs	5113 (10.4)	827 (10.0)		1143 (10.9)	919 (8.4)	1005 (14.6)	1219 (9.7)
TB	335 (0.7)	122 (1.5)		86 (0.8)	69 (0.6)	23 (0.3)	35 (0.3)
Water and Sanitation	1057 (2.1)	109 (1.3)		121 (1.1)	167 (1.5)	60 (0.9)	600 (4.8)
<b>Type of visit</b>							
New	42710 (87.1)	6554 (79.4)		8420 (80.2)	10149 (93.3)	6018 (87.5)	11569 (92.2)
Follow-up	6344 (12.9)	1703 (20.6)		2076 (19.8)	726 (6.7)	862 (12.5)	977 (7.8)

**Table 10: Condom uptake data**

	Total	Mbare			Epworth		
		2021	2022	2023	2021	2022	2023
Outreach	2524	59	317	459	389	144	1156
In-facility	3577	562	2556	178	68	56	157
Community	12924	345	3806	2380	569	5486	338
Total	19025	2987	8701	5040	3047	7708	3674