YES I DO SYNTHESIS. REFLECTIONS ON THE MIDLINE STUDIES 2018

YES I DO.

Plan
Girls first

amref
flying doctors

Rutgers | For sexual and reproductive health and rights

KIT Royal Tropical Institute

CHOICE FOR YOUTH & SEXUALITY

by

John Kingsley Krugu
Maryse Kok
Anke van der Kwaak

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CONTENTS

ABBREVIATIONS

ARP	Alternative Rite of Passage
CCC	Community Coalition Committee
CoC	Champions of Change
CSE	Comprehensive Sexuality Education
DEO	District Education Officer
ELA	Empowerment and Livelihood for Adolescents
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
IDI	In-depth Interview
KII	Key Informant Interview
PTA	Parent-Teacher Association
NGO	Non-Governmental Organization
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SSI	Semi-Structured Interview
UNESCO	United Nations Educational, Scientific and Cultural Organization

EXECUTIVE SUMMARY

This synthesis report presents cross country reflections on the qualitative midline studies conducted in the seven countries where the Yes I Do programme is being implemented. The midline synthesis aims to provide an overview of how the programme implementation is progressing and how the participants are reacting to the various intervention strategies.

In general, the Yes I Do programme seems to have influenced positive change in attitudes among different stakeholders towards ending child marriage and preventing teenage pregnancy in all countries, and many stakeholders are in favour of ending female genital mutilation/ cutting (FGM/C) in the countries where ending FGM/C is a targeted outcome. However, changed attitudes still need to translate into sustained changes in behaviour in the form of preventative actions at all levels.

Although the midline reports point to a decrease in child marriage, teenage pregnancy is still reported to be highly prevalent in many settings. This implies that more efforts are needed to get all stakeholders to acknowledge youth sexuality, and to stimulate more open communication between youth and adults, as part of the interventions under pathway 1 and 2 of the programme theory of change. In addition, to prevent teenage pregnancy, more attention is needed to interventions that increase young people's access to skills- and rights-based comprehensive sexuality education and to contraceptives and youth friendly health services (pathway 3). Further efforts and innovative ways to stimulate youth economic empowerment, as an alternative beyond child marriage but in some settings also teenage pregnancy, are recommended under pathway 4. Under pathway 5, enforcement of (by)laws need continued attention. Strengthened men and boys engagement in all intervention components remains crucial to the success of the Yes I Do programme.

1. INTRODUCTION

The Yes I Do programme aims to contribute to enhancing adolescent girls' and boys' decision making space on whether, when and whom to marry as well as on whether, when and with whom to have children. In addition, it aims to contribute to the fight against female genital mutilation/ cutting (FGM/C). The programme is being implemented in seven countries: Ethiopia, Indonesia, Kenya, Pakistan, Malawi, Mozambique and Zambia. The programme 's theory of change has five strategic goals:

	Pathway 1	Community members, gatekeepers and other stakeholders have changed attitudes and take action to prevent child marriage, teenage pregnancy and (where applicable[1]) FGM/C;
	Pathway 2	Adolescent girls and boys and men are meaningfully engaged to claim their sexual and reproductive health and rights (SRHR);
	Pathway 3	Adolescent girls and boys and men take informed action on their sexual health;
	Pathway 4	Adolescent girls and boys have alternatives beyond child marriage, teenage pregnancy, and FGM/C through education and economic empowerment;
	Pathway 5	Policy makers and duty bearers harmonize, strengthen and implement laws and policies on child marriage, FGM/C and sexual and reproductive health (SRH).

In line with these five goals, the intervention strategies focus on forming a social movement at the community level, empowering and meaningfully engaging young people, improving access to information and services, stimulating education and economic empowerment for girls and adolescent girls and boys and enhancing evidence-based lobby and advocacy for improved legal and policy frameworks.

The research component of the Yes I Do programme involves a base-, mid- and end-line study in each of the programme countries. These studies aim to provide insight into the (interrelated) causes and effects of child marriage, teenage pregnancy and FGM/C[1] and the extent to which these causes and effects, and the three problems themselves, are present in the intervention areas of the Yes I Do programme over a period of four years. Also, the research aims to provide insight into the different pathways of change, thereby

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[1] In Ethiopia, Indonesia and Kenya.

testing the theory of change, and unravelling why and how the Yes I Do intervention strategies do or do not contribute towards improved outcomes related to the five strategic goals. The baseline study, involving both qualitative and quantitative methods, was conducted in 2016 in all countries before the start of the implementation.

This report presents the synthesis of the qualitative mid-line studies conducted in 2018.. The objectives of the midline study in all seven countries included:

1) To explore changes in attitudes of community members and gatekeepers around child marriage, teenage pregnancy and/or FGM/C and to what extent they take action to prevent the three problems and which factors influence this and how;

2) To determine changes in the level of meaningful engagement of adolescent girls and boys in community activities, programmes and policies – thereby claiming their rights – and which factors influence this and how;

3) To explore and analyse whether and to what extent adolescents take informed action on their sexual and reproductive health (SRH) and which factors influence this and how;

4) To explore and analyse whether and to what extent education and economic empowerment of adolescent girls and boys provide them with alternatives beyond child marriage and teenage pregnancy;

5) To provide insight into (changes in) developed and implemented laws and policies on child marriage, teenage pregnancy, and FGM/C; and

6) To contribute to the evidence on effective and context specific intervention strategies to eliminate child marriage and FGM/C, and reduce teenage pregnancy.

After an overview of the methodology of the midline studies (Chapter 2), this report presents the main findings for each of the programme countries per pathway (Chapter 3). Chapter 4 contains the discussion and recommendations and Chapter 5 presents the overall conclusion.

2. METHODOLOGY

The midline studies used qualitative methods to assess participants' experiences and perceptions about changes related to Yes I Do programme outcomes.

Data were collected by employing key informant interviews (KIIs), in-depth interviews (IDIs) and focus group discussions (FGDs) in Yes I Do implementation areas in all the seven countries[2]. The KIIs were conducted with district-level policy makers and representatives of non-governmental organizations (NGOs). The IDIs were conducted with (married and unmarried, male and female) young people aged 15-24 years. Other IDI participants included parents/caregivers, grand-mothers and senior women, religious and traditional leaders, teachers, health and social workers and representatives of youth or community-based organizations. The FGD participants included young people (15-24 years) and parents/caregivers (Table 1).

Table 1: Summary of the research areas and methods

Study country and areas	KIIs	IDIs	FGDs
Ethiopia, Abayatir Kebele in Qewet Woreda and Yigoma Huletu Kebele in Bahirdar Zuria Woreda, Amhara region	19	12	12
Indonesia, Lombot Barat, Sukabumi and Rembang districts	31	42	15
Kenya, Oltepesi and Toresei, Kajiado West, Kajiado County	5	19	60
Malawi, Traditional Authority Liwonde, Machinga district	8	20	10
Mozambique, Nametil, Mogovolas district, Nampula province	13	13	10
Pakistan, Sanghar and Umerkot districts, Sindh province	8	20	12
Zambia, Petauke district, Eastern province	8	20	10

Data processing and analysis were conducted per country based on a common coding framework and NVivo version 11.0 was used to assist in this process. This synthesis is based on an inter-county analysis of the data per pathway. In all countries, ethical approval was obtained for the midline studies.

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[2] Please note that in this report, findings are presented while referring to the countries, and not the exact implementation areas within the countries.

3. RESULTS

3.1 Pathway one: Social movement is established to transform social and gender norms that perpetuate child marriage, teenage pregnancy and female genital mutilation/ cutting

In **Zambia**, the midline findings indicate that, after two years of implementation, more gatekeepers appear knowledgeable about the potential harm to young people when they get involved in child marriage and teenage pregnancy as compared to the baseline situation. It seems that the enhanced knowledge has influenced attitudinal changes. The midline study found that most gatekeepers have a positive attitude towards the prevention of teenage pregnancy and child marriage.

There is nothing good at all with these early marriages because it brings poverty in a home. You find that a 14-years-old girl has a baby and the husband is also young in that they cannot even manage to buy napkins for their baby because they are still under their parental care. (FGD, Married females 20-24 years, Petauke, Zambia)

In particular, traditional leaders were reported to be involved in prevention strategies and activities. However, the examples given by study participants were more reactive and authoritative (punishing perpetrators) through bylaws – which seem still unclear to many community members. Some study participants reported that bylaws related to teenage pregnancy are counter-productive, because of the fine to be paid by the (family) of the boy/ man to the family of the pregnant girl, which some families welcome. Religious leaders were said to be supportive, but study participants also reported that teenage pregnancy is sometimes resulting from sexual activities at church gatherings. Teachers and health workers were reported to play an important role in sensitizing the youth and the community at large about the negative consequences of teenage pregnancy and child marriage. The majority of the people in the community seem to favour the need to eliminate child marriage and reduce teenage pregnancy, but active involvement in prevention is mostly left to NGO-led groups.

In **Mozambique**, the midline study found that actions aiming at preventing child marriage and teenage pregnancy are mainly led by health providers and some teachers, and are focused on providing information (often through *palestras*) and increasing access to contraceptives. Some teachers encourage girls to continue to stay in school as a way to prevent child marriage and teenage pregnancy. Motivational actions by the Gender Office of the Education or Social Action Directorate to encourage retention in school include exemption from paying tuition fees and provision of study materials. A few stakeholders mentioned having proactively visited some families to stop specific cases of child marriage, these actions were largely successful. At the same time, the midline findings show that some teachers and community leaders do not take any actions, despite showing awareness and knowledge about child marriage and teenage pregnancy. In addition, there seems little attention for out-of-school pregnant or married adolescent girls and boys, most of whom are suffering various forms of marginalisations.

The midline study in **Malawi** showed most gatekeepers expressing a positive attitude towards taking actions to prevent teenage pregnancy and child marriage, a change from the situation at baseline that seemed to emanate from enhanced knowledge about the potential harm associated with teenage pregnancy and child marriage. The gatekeepers did not see any advantage of teenage pregnancy and child marriage, but rather recounted several disadvantages, including school drop-out leading to an increase in the poverty situation

and other health and emotional risks factors. Some traditional authorities and village headmen were seen to be active in the prevention of teenage pregnancy and child marriage (more regarding child marriage than teenage pregnancy).

> *I have said the chiefs – they do call for community meetings and say 'I have gathered you to discuss with you about child marriages. Our children are getting married while young. Therefore, if we can follow these steps, it will help us.' So the chief comes up with some bylaws to control this.* (FGD, Unmarried boys 15-19, Liwonde, Malawi)

Despite bylaws on prevention of teenage pregnancy and child marriage not being officially accepted by the District Council yet, they have been discussed between traditional leadership, community representatives and district officials and will become valid for the whole of Machinga district. Besides traditional leaders, teachers and health workers were frequently acknowledged for their active role in activities, resulting in progress made on returning adolescent girls and boys to school after delivery, although this is still not always taking place. Traditional and religious leaders and parents also frequently reported being aware of youth-led activities (such as the Champions of Change). However, their active support for such activities remains ambivalent.

In **Pakistan**, evidence from the baseline study shows that teenage pregnancy mostly occurs within the context of child marriage. Thus, efforts to prevent teenage pregnancy in Pakistan must start with the prevention of child marriage. Compared to the baseline situation, the midline study found that some gatekeepers have become aware of the need to prevent child marriage and have shown positive attitudes by actively getting involved in activities aimed at preventing child marriage. Similar to changes in other countries, several gatekeepers in Pakistan demonstrate enhanced knowledge about the harms of child marriage and teenage pregnancy. For teachers, this enhanced knowledge was said to be gained through participating in Yes I Do programme training activities, and they were said to be opening up more about giving SRH-related information to young people. Health workers also reported undertaking outreach activities in schools and communities, in addition to clinic-based initiatives. Personnel of the police service reported having become more active when child marriage cases are reported to them but are not yet proactively looking for and intervening in child marriage cases. Policy makers at the district level also reported being aware of the harms of child marriage and teenage pregnancy. Despite the reported positive changes in attitudes towards child marriage, some religious leaders were found to exhibit varying levels of knowledge and awareness resulting in differences in attitudes towards taking actions against child marriage. Religious leaders can play a crucial role by actively verifying ages of young couples before officiating a marriage. However, midline study participants who commented on the religious perspectives of child marriage gave divergent views; while some thought that child marriage was an unacceptable practice, others referred to religious texts supporting the practice.

Similar to the baseline situation, the midline findings in **Kenya** show that gatekeepers are aware of the potential harm that child marriage and teenage pregnancy could cause, with some specifically mentioning consequences for the yet developing body of the adolescent girl, young girls having their freedom curtailed in intergenerational marriages, and girls being frequently subjected to sexual and gender-based violence in such marriages. Except for the bride price paid to the girl's family, and the cultural value of having a larger family if reproduction can start early in a girl's life, most study participants did not see any advantages of child marriage. This observed enhanced knowledge and positive attitudinal changes among gatekeepers do not seem to translate into actions to prevent teenage pregnancy and child marriage. There is hardly any

dialogue among young people with their parents on sexuality. However, parents do take action once teenage pregnancy has occurred. It was also reported that some chiefs take action to get girls back to school through finding scholarships. As a result, some girls re-enter schools after giving birth and grandmothers take care of their babies, as was also found in other countries. Teachers were reported to prevent teenage pregnancy by providing SRH education in schools. They were also said to be the most likely gatekeepers to report on a case of child marriage to the appropriate authorities. In general, it was felt that it would have been better to train and involve a larger number of teachers. In some communities in Kajiado West, in particular, there are rescue centers operated by NGOs not involved in Yes I Do programme where girls who are considered to be at risk of child marriage or FGM/C can go for support. In some cases, girls are selected to receive scholarships to attend or stay in school.

The Kenya midline findings show that most gatekeepers are well informed about the legal implications of performing FGM/C. At the same time, some community members are still not convinced about the negative health consequences of FGM/C, because especially (young) men have not seen these direct consequences. Their limited knowledge is largely informed by hearsays in the community, which are shaped by cultural and traditional beliefs towards FGM/C. Some male study participants reported being against FGM/C and blamed their wives for the circumcision of their daughters.

Participants in the midline study in Kenya also outlined several strategies to address FGM/C. Video screening was considered an effective strategy to engage young people, but should not only show the circumcision itself but the effects such as bleeding, infections, fistula or difficulties in delivery, possibly in the local languages. In particular, video materials in the 'Maasai' language were recommended. Teachers, education officers, and traditional leaders were reported to be the most vocal advocates against FGM/C, whilst parents were seen to be more silent about FGM/C, partly because many were still in favour of the practice – to fit into the society and to get girls married, especially among non-literate families.

Participants also suggested that the selection of alternative rites of passage (ARP) ceremonies should be improved, because it appears that both uncircumcised and circumcised girls join ARP activities. Some chiefs take action, but others also keep a blind eye to FGM/C and leave it to families, because they fear losing popularity in the community.

In **Ethiopia**, the midline study found that some gatekeepers such as parents and community elders show positive changes in attitudes towards child marriage and teenage pregnancy and were more receptive to young peoples' choices regarding marriage. Study participants mentioned new actions such as age estimation introduced at the Woreda (district) level to identify and take steps to prevent child marriage and punishment of parents for arranging marriages for underage girls. Despite these measures, some participants narrated that most people still accept teenage pregnancy as a normal practice within marriage. Teenage pregnancy outside marriage is mostly unacceptable, although some participants indicated that some parents have changed their views, due to the fear that girls will commit suicide or run away after becoming pregnant out of wedlock. Some parents help their daughters who became pregnant by allowing them to re-join school after giving birth.

Another highlight of the midline findings in Ethiopia was the establishments of community coalition committees (CCCs) as evidence of the awareness and preparedness of communities to take action to reduce child marriage. Some additional actions are taken in schools; students are oriented to use suggestion boxes to inform the school about proposed child marriages likely to affect any pupil. Through these school initiatives, it was reported that some schools, in collaboration with Kebele (village)

administration and the police, could trace the potential cases of child marriages and take the necessary preventive actions. It was also reported that the Yes I Do programme used in- and out-of-school existing structures such as youth associations and school clubs to engage young people on strategies to prevent teenage pregnancy and child marriage.

Regarding FGM/C, most gatekeepers seem to know about the negative health consequences of FGM/C, although some still believe it is beneficial for girls. Some study participants mentioned the health consequences of FGM/C to include excessive bleeding, fistula, and sexually transmitted diseases. Participants narrated that although FGM/C was considered a norm for girls in the past, its negative consequences are now recognized. Formerly FGM/C was practiced with the assumption that it eases sex and delivery. FGM/C is now seen to have negative consequences mainly while giving birth, and the practice was reported to decline at a faster rate compared to child marriage. The study also found that due to extensive training of FGM/C practitioners and health workers by the Yes I Do programme, it has become difficult to find circumcisers, because those who used to perform have abandoned the practice. It was also reported that compared to the baseline situation, FGM/C is more often not a key criterion for marriage.

In **Indonesia**, most parents and religious leaders reported positive attitudes towards the prevention of teenage pregnancy and child marriage compared to the baseline situation. However, only a few religious and traditional leaders were reported to be directly involved in actions to prevent the two. Similarly, teachers who had received training as part of Yes I Do programme activities reported being favourable towards efforts to prevent child marriage and teenage pregnancy, but only a few of them reported that they talk about prevention strategies in schools. Community members, especially women, seem to be more knowledgeable about the harmful effects of child marriage and teenage pregnancy, yet many still see child marriage as a way to avoid *Zina* (sex before marriage, considered as sin) and as a way to restore family honour in the case of premarital pregnancy. Across the gender divide, some men in Sukabumi were reported to have more negative attitudes towards the prevention of child marriage and teenage pregnancy, using Islamic teachings as justification.

Regarding FGM/C, many gatekeepers in Indonesia consider the practice as mandatory in Islam. Traditional birth attendants were reported to be no longer allowed to perform FGM/C, and most parents only go to midwives to perform a semblance of FGM/C as a symbolic gesture to their religious belief. Yet it was reported that in communities, there are still some traditional birth attendants who practice FGM/C and some ARP activities involve actual cutting in disguise. The midline study found that communities are beginning to have broadened discussions about the harmful effects of FGM/C and some study participants felt the need to take advantage of the on-going discussions to inform parents, using health workers and religious leaders as facilitators.

3.2 Pathway two: Adolescent girls and boys and men are meaningfully engaged to claim their sexual and reproductive health rights

In **Zambia**, the midline study found that some girls and boys have acquired an enhanced capacity to advocate for themselves, especially those who are directly involved in the Champions of Change (CoC) component and other youth clubs. Facilitators of CoCs and other peer educators have been undertaking advocacy activities on youth rights at the community level, and some early results are beginning to show up. However, during community meetings in general, young people still have limited voice and space to air their views, because speaking up towards adults is considered disrespectful. Some study participants

suggested the need to increase intergenerational dialogues to address communication barriers and challenges.

In **Malawi**, the CoC and other peer education activities also got to a good start and seem to be the rallying activities for advocacy for youth rights at the community level. Through these initiatives, some girls and boys have enhanced capacity to advocate for themselves, especially those directly involved in the CoC project. However, as in Zambia, the voice of youth in general community meetings was still described as limited.

In **Mozambique**, girls and boys seem to have little capacity to advocate for themselves. Youth engagement is limited as young people are rarely invited to community activities organized by adults and intergenerational communication is generally poor. However, there are some active youth activists who conduct awareness-raising activities such as lectures in the Services Amigos Dos Adolescentes e Jovens, also known as SAAJ (Youth-friendly services) and school or theatre places. There were more of these activists in the past in Nametil. Under Yes I Do programme, only a small number of such activities continued to happen. Further, the midline study found that most young people prefer to discuss their concerns and SRH issues among peers, which was also found in other countries, and a few others referred to the youth activists and youth/school clubs as safe spaces to participate and communicate on these matters. Parents and grandparents said that young people avoid addressing sensitive topics with adults partly due to discomfort and partly because of prejudging adults' advice as obsolete. On the other hand, young people emphasized that respect for elders is considered very important and that talking about sexuality issues with an adult is perceived as a sign of lacking respect.

The midline study in **Pakistan** reported similar findings regarding young people's agency. Some girls and boys seem to have an enhanced ability to advocate for themselves, especially those who are directly involved in the Yes I Do activities. However and similar to midline findings in other countries, the youth in Pakistan still face difficulties being heard by adults. Again, similar strong cultural norms regarding respect for elders contribute to a large communication gap between generations.

In **Kenya**, girls and boys admitted having limited space to advocate for their issues, especially sensitive issues that are perceived to be against the culture or religious beliefs. However, girls and boys with higher education seem to be more respected and can participate in community-wide engagements. Within the household, boys were reported to be able to speak directly with their fathers and girls mainly communicate with their mothers, although the father is the decision-maker in the household. It was also reported that boys and girls feel safer to discuss sensitive issues with their teachers or at church and less so in the family setting. Again, the midline found that young people are not organized enough to join forces to advocate for their issues in a collective voice.

About FGM/C and in comparison to the baseline study, although some study participants indicated that girls were also taking part in deciding to avail themselves for FGM/C, many young participants of the study indicated that their parents decide for them to go through FGM/C. When girls indeed decide to go through FGM/C by themselves, they were reported to do so because of stigmatisation for not being circumcised, often resulting from peer pressure by circumcised girls, and the fear of not being considered suitable for marriage.

In **Ethiopia** too, although most young people find it difficult to talk about sexuality-related topics with their parents or elders, some girls appeared to have increased access to income-generating activities which enable them to postpone marriage and negotiate with whom and when to marry. However, it was also

reported that girls' access to economic opportunities comes with other corresponding vulnerabilities and risks, including those related to health, access to education, exploitation and sexual abuse.

The midline study in **Indonesia** shows a more positive situation regarding young people's agency as compared to the other six countries. Girls and boys reported increased capacities to advocate for themselves (and others) about the prevention of child marriage and girls seem to be more active than boys.

I just feel happy, many friends, many new people, many new experiences … Yes, I can help others. It is just fun. (IDI Unmarried girl, 22 years old, Sukaraja, Sukabumi)

In Sukabumi and West Lombok, the actions of girls and boys are driven by their future aspirations, but in Rembang, less young people seem to have such aspirations for the future. In Rembang, it was said that there are not so many organisations and not so many advocacy activities by the youth. In addition, young girls who got married or pregnant at a young age do not feel confident to participate in community activities. The midline study found that although there are many youth organisations in Sukabumi, only a few of them interface with the Yes I Do programme. In West Lombok, the Yes I Do programme was said to have opened up spaces for young people to participate and advocate on issues about the prevention of child marriage.

3.3 Pathway three: Adolescent girls and boys and men take informed action on their sexual and reproductive health rights

In **Zambia**, the majority of young people aged 15 to 24 years reported increased access to sexual and reproductive health and rights (SRHR) information as compared to the baseline situation. They frequently receive SRHR information from NGO staff, teachers, youth clubs, peers, grandparents, health providers, social media and also at initiation ceremonies. However, similar to the baseline situation, the midline findings also show that not all information sources provide balanced and comprehensive information. In Zambia, sexuality education has been introduced in schools, but it is not clear whether this is taken up well, and the Yes I Do programme seems not to have specific attention for it in their implementation areas. Some young people reported that health providers do not approach them in a nice way when they seek SRH-related services. Also, the midline study revealed that many youth and adults still have misconceptions about contraceptives.

These misconceptions were also prominent in **Mozambique**, although most young people reported increased access to SRHR information, mainly through health centres, youth-friendly services, SMS via mobile phones, and community youth activists. Some stakeholders were of the view that many youths do not use this information. The programme 'Geração Biz' was frequently mentioned by most young people in Nametil as a key source of SRHR information. At the school level, access to SRHR information seems to be more limited as only some teachers were reported to discuss SRHR topics in class and much of this was within the natural sciences subjects areas.

The midline findings in **Malawi** are quite similar to those of Zambia and Mozambique: the majority of young people aged 15 to 24 years reported to have increased access to various SRHR information, which was mostly obtained from NGOs, teachers, youth clubs, youth peers, grandparents, health providers, video sex rooms and initiation ceremonies. Not all information sources provided balanced and comprehensive information and health workers' attitude towards young people seeking SRH services remained unfriendly,

as reported by some study participants. Therefore, like in other countries, young people are still constrained in taking informed action on their SRHR.

The midline study in **Pakistan** found that some young people (especially those in school) had increased access to SRHR information as a result of the Yes I Do programme activities.

Many NGOs are working here, as SAFWCO was working here, they gather teams of boy and girls named as "Kiran Plus" they explained every single thing, and then the girls knew how to defend themselves, as if boy and girl are combined in class, then how to speak to them. This everything was explained by NGOs, and now women have more confidence than in the past. Now at least they can speak out openly about adolescence and related matters. (IDI, Health worker, Umerkot, Pakistan)

Teachers are more likely to talk about SRHR topics openly and provide SRHR-related education in schools. The midline study found that print and electronic media are not used as widely due to low literacy levels and that the most common sources of information for young people are their peers or friends. Adolescent girls and boys were reported to be more comfortable to approach their mothers and female family members especially if they were married or out of school. However, information from family members seems to focus on the negative effects of child marriage, birth spacing (after marriage) and puberty-related issues like menstruation and is hardly empowering. While, as reported under pathway one, SRH services including outreach are available, it was found that very few young people use these services.

In **Kenya**, one of the main sources of SRHR information for young people are teachers, partly because the SRHR curriculum was introduced in 2017 as an integrated topic within biology, religious education, guiding and counselling subjects. The content in the curriculum was made examinable and cannot be skipped by teachers. The curriculum covers several SRHR topics, including pregnancy, life skills, HIV and AIDS, contraceptives and assertiveness and the level of comprehensiveness increases progressively from primary to secondary levels. Young study participants also reported to have received information from churches, but as expected, such information was limited to abstinence-only messages. The midline study found that boys and girls reported not to have received any SRHR information from health facilities. Youth participation and empowerment seem to be mostly happening within schools and churches. Out-of-school youth seem to be hardly reached by Yes I Do programme activities.

In **Ethiopia**, young people shared experiences of increased access to SRH information and services through various channels, including youth clubs, community conversations, youth-friendly health services, in-school information, mobile phones and on the radio – as a result of Yes I Do programme interventions. The midline study found that the Yes I Do alliance in Ethiopia is supporting both in- and out-of-school young people. Comprehensive sexuality education in schools or through school mini-media were considered as growing sources of SRHR information for young people. Although the initial stages of youth friendly services commenced by the Yes I Do programme in health centres were characterized by low patronage, the number of young people visiting such centres gradually increases.

The midline study in **Indonesia** found that through efforts by the local government and NGOs, there are many sources of SRHR information made available to young people. The child marriage education curriculum has been accepted in schools. Young people reported being able to access SRHR information from teachers, health providers, peers, the internet and community organizers in the village. However, many preferred to seek information from health workers, parents, teachers, and religious leaders. The midline study also found that although not all information sources are providing balanced information, the

majority of young people aged 15 to 24 years reported increased access to various SRHR information and services.

3.4 Pathway four: Adolescent girls and boys have alternatives beyond child marriage and teenage pregnancy through education and economic empowerment

In **Zambia**, the midline study found that young people reported becoming more autonomous in making dating decisions, however, because of poverty-related factors, the autonomy in decision-making was in some cases associated with young females engaging in transactional sex to gain money or other necessities. It was also noted that the perceived autonomy by girls is often experienced during the initial stages of entering into sexual relationships, but the autonomy of girls seems to dwindle when (sexual) relationships have started. It was found that there are limited economic opportunities for youth, and a few saving groups were started, targeting adult women. The study also found that schooling was believed not necessarily to result in enhanced chances on the labour market. While schools were considered a safe environment for young people, various study participants recounted instances when teachers are involved in sexual intercourse with girls, in several cases leading to teenage pregnancy. Besides the intergenerational sexual activities involving teachers, a concept known as 'self-boarding' (boys and girls occupying houses close to secondary schools to reduce distances from actual homes) was reported to be putting many girls at risk of teenage pregnancy.

In **Mozambique**, the majority of stakeholders reported that young people, both girls and boys, can decide for themselves whether or not to get married and/or start having sexual relationships. Some young unmarried women who were interviewed confirmed that they could decide for themselves regarding whom to date and to marry.

My expectations, my dreams in relation to marriage are to finish my studies, to get a job and then to get married and have my children because, without a job I cannot have children, I will not be able to support them. (IDI, unmarried young woman, 15-18 years, Mogovolas, Mozambique)

At the same time, other adolescent girls and boys indicated that their parents determine when and with whom to marry and that such a decision depends on the economic situation of the family and/or pregnancy status. Young people felt they have very little income and employment opportunities. General security in and outside of school is not seen as a problem in Nametil. However, stigma and discrimination towards teenage mothers were considered issues that require more attention. Also, some study participants referred to instances where teachers sexually abuse girls.

The midline study in **Malawi** found that most adolescent girls and boys between 15-24 years old reported having autonomy in dating/choosing a partner, however, transactional sex was also reported to take place, and adolescent girls and boys still have a limited voice in negotiating safer sex, a situation that continues to perpetuate teenage pregnancies and early marriages. In Malawi, it was also reported that although schools are considered as safe spaces for girls, some teachers are involved in sexual intercourse with girls, leading to teenage pregnancy. The study found that teachers often lure girls into sexual intercourse by promising to ensure a pass in examinations, amongst other material gifts. As was reported in the Zambian study, the issue of self-boarding of boys and girls who are in day secondary schools was seen as a contributing factor to teenage pregnancy. Regarding economic empowerment, the midline study in Malawi found that because of limited presence of companies operating in the intervention areas, economic empowerment activities

focused on skills development, setting up of small businesses and the establishment of village saving loan associations. For example, it was reported that Plan Malawi was in the process of starting a girl's vocational training programme and Save the Children already had a similar programme running.

In **Pakistan**, the Yes I Do programme engages young people as Kirans or Kirans+, and this has led to some level of (perceived) autonomy among young people between 15-24 years old. Nonetheless, young people who participated in the midline study expressed a desire to have more decision-making power, as mentioned under pathway 2. All participants of the midline study considered schools as safe places for young people. However, schools were said to be hostile towards married adolescent girls and boys; they are bullied and harassed by peers due to their marital status. Some study participants mentioned that girls and adolescent girls and boys face sexual and verbal harassment on their way to school. It was also reported that due to an upsurge of incidence of rape and sexual harassment, parents are worried about the safety of their daughters and many parents indicated having to pick up and drop their children in school to ensure their safety. In Pakistan, the midline findings also indicate that skill development opportunities such as stitching and handicrafts have been established for adolescent girls, but these skills still subscribe to traditionally female jobs. While opportunities for economic empowerment are relatively higher in Sanghar, they are almost absent in Umerkot due to widespread poverty.

The **Kenya** midline study found that most of the girls at the primary school level seem not able to make their own decisions regarding FGM/C or child marriage; such decisions are preserved for their parents and girls are simply required to oblige. Adolescent girls and boys who are in post-primary schools are less restricted and can decide more independently, including having a voice in marriage decision-making. The midline study also found that some girls can report FGM/C or child marriage cases to a rescue centre, their teachers or a chief for support – a remarkable improvement compared to the baseline situation. Some rescue centres provided by other NGOs not involved in the Yes I Do programme also gave scholarships to girls to retain them in school and secure them against the risks of child marriage.

The midline study in Kenya also found that some teachers engage in sexual abuse of girls, with some resulting in teenage pregnancies, and these are mostly young untrained teachers. Not surprisingly, the enrolment of girls at secondary schools was reported to be lower than boys due to teenage pregnancy and child marriage. The study also found that many parents send their daughters to boarding schools, because of the perception that girls are more protected in boarding schools. It was further reported that keeping girls in boarding schools (sometimes, including holidays) was seen as a solution to child marriage and teenage pregnancy. In Kenya, very few employment opportunities were made available as a result of the Yes I do programme in Kajiado area, and if there were economic activities, they were mainly accessible for young males.

The midline study in **Ethiopia** found that recognition of girls' rights is increasing. The increase in access to SRHR information seemed to have enhanced girls' decision-making on who and when to marry. Participants recounted cases of girls who were able to decline marriage offers and report potential cases of child marriage to the police, teachers or officials of the Women and Children affairs department. Compared to the baseline situation, the study did not find sufficient evidence of improvements in terms of safety and security of girls. Rather, multiple forms of violence including sexual violence and rape in different settings such as in flower farms, while walking to school and within the construction environment were reported. The study found that long walking distance to and from school is a risk factor for girls regarding sexual harassment. The income-generating activities that were frequently mentioned included working in flower farms (in Bahir Dar), cutting khats, construction and migration (in Qewet). The midline study also found

that Plan international (in Ethiopia) has established restrooms and provided sanitary pads to girls, which has helped many girls to manage menstruation more comfortably. The establishment of the sanitary rooms was considered an important intervention to retain girls in school.

In **Indonesia**, the midline study found that most girls between 15 and 24 years old reported having enhanced autonomy in making dating decisions or choosing a partner and in determining their future goals. However, the study also found that some girls are still denied a voice in decisions that affect them, including whom to marry and in the event of teenage pregnancy, whether or not to continue studies before or after childbirth. The study also found that most girls considered schools to be safe, but some girls mentioned instances where teachers or other male students were harassing female students. Also, it was found that schools do not have any mechanisms to prevent or address sexual harassment. Students who got married or became pregnant are stigmatized, and such events are considered the end of the road for girls' education. Although the study areas in Indonesia generally had more available job opportunities, such as factory work, the economic empowerment component of the Yes I Do programme needs to reach more (older) youth at the village level. The activities of the programme seem not enough to support young people to start their business.

3.5 Pathway five: Policymakers and duty bearers harmonize, strengthen and implement laws and policies on child marriage and SRH

As reported under pathway one, in **Zambia**, the midline study found that although bylaws on child marriage and teenage pregnancies were mentioned, it seems that there is limited ownership of these bylaws by traditional leaders as well as the community at large. The midline study highlights confusion about who developed the bylaws, with some study participants referring to Plan Zambia as author of the bylaws. At the national level, the Yes I Do programme has established good connections with key stakeholders, but there were no new laws or policies established as a result of advocacy actions.

In **Mozambique**, no new or adjusted national or local laws or policies on child marriage or teenage pregnancy were reported in the midline study. Rather, study participants shared worries that child marriage is still not attracting any punitive measures and that a legal framework to spell out some consequences for the act as a deterrent remains unavailable. The midline study also found that young men were more likely to know about the existence of the legal minimum age for marriage being 18 years than adolescent girls. It was also found that policymakers in local administrations in Nametil did not make explicit reference to the concept of gender equality. However, many of them shared openly about initiatives focusing on the protection and support of adolescent girls and boys, especially regarding education.

The midline study in **Malawi** found that at the national level, the constitution was amended in 2017 to include a definition of children as those under 18 years and thereby, child marriage was officially made illegal. There is evidence that some Yes I Do programme partners played a role in the constitutional amendments as well as to the National Strategy to End Child Marriage.

Last year in February the marriage age was revised from 16 to 18. The amendment was made to the Family Relations Act of which we as organizations we regarded this as a step ahead on ending child marriage and teenage pregnancies... government is also taking interest and action on ensuring that child marriages are not happening and also that teenage pregnancies are being reduced. (KII, Malawi)

As reported under pathway one, under the traditional authority of Liwonde in Machinga district, bylaws have been established through the efforts of the Yes I Do programme and implementation of the bylaws has begun. The bylaws include provisions requiring the dissolution of all reported child marriages and fines imposed on the participating families. Also, the bylaws include regulations supporting the prevention of teenage pregnancy, school drop-out, and sexual violence. The bylaws are expected to be ratified by the District Council, after which they will apply to the entire district and not only to the Yes I Do programme areas. Lastly, the midline study found that district-level policy makers are frequently involved in community awareness meetings around preventing teenage pregnancy and child marriage, including issues on gender equality and girls' rights.

In **Pakistan**, following the Sindh Hindu Marriages Act of 2016, the Hindu Marriage bill was passed in 2017 to regulate marriages of Hindus. Rules of business for the Sindh Child Marriage Restraint Act of 2013 were also specified. Further, the midline study found that a Sindh Youth Policy was launched in 2018 to empower youth in the political, educational and employment sectors. There seems to be a high awareness among young people and other stakeholders about the Sindh Child Marriage Restraint Act 2013. It was also reported that policymakers are aware of the laws concerning child marriage, child protection as well as gender-based discrimination faced by girls and adolescent girls and boys, however, it was unclear whether actions are undertaken to support gender equality and girls' rights. The passing of new laws and allowing local NGOs to work in these areas did indicate that policymakers are supportive, but the overall space for international NGOs has shrunk deep in Pakistan.

In **Kenya**, the situation regarding laws and policies is not different from the picture at baseline. Study participants seem not to know about any bylaws aiming to prevent FGM/C, child marriage and teenage pregnancy. However, a coalition of NGOs is currently working to contextualise the existing laws on FGM/C at the community level in Kajiado. The midline study also found that gender equality as a concept appears to be poorly understood and some policymakers do not consider issues such as child marriage, teenage pregnancy and FGM/C to be related to gender inequality in the society. Rather, frequently it is the girl (involved in pregnancy) who is blamed and expected to carry the burden and consequences of the pregnancy. In the case of school dropout, many policymakers and implementers are aware of the importance to prevent it, but none remembered taking specific actions. Rather, such matters are left to the parents to decide.

In **Ethiopia**, the midline study did find officers (police and Children Affairs Department officials) who knew about the child rights convention, land law and family laws. However, no evidence was found regarding new or amended national or local (including bylaws) legislation and policies prohibiting child marriage and FGM/C.

The midline study in **Indonesia** found new regulations and bylaws to protect children and prevent child marriage. In Sukabumi for example, one local regulation on child protection was instituted in 2016, and a village head decree to implement the regulation was passed in March 2018. In West Lombok, a circulating letter of the regent on Anti-Child Marriage Movement was cited, and in Rembang, a local regulation on child protection was instituted. The implementation of the regulations is yet to be effected. The study also found that many programmes continue to support gender equality and girls' rights, despite some policymakers still holding gender-biased views towards girls who encounter premarital pregnancy.

3.6 One of the cross-cutting themes highlighted: men and boys engagement

In **Zambia** and **Malawi**, engagement of men and boys in the Yes I Do programme activities were reported to be taking place at the community level. However, there are no specific established networks involving men. The CoC programme has an explicit component for boys and young males. Nonetheless, the topics covering education and economic empowerment were perceived as more focused on girls, which was considered to be a problem by many community members (males feel left out).

In **Mozambique**, the midline study found little information on active male involvement in Nametil, but SRH outreach activities were said to be directed at both girls and boys. Also, youth activists are both male and female.

The **Pakistan** study found that although boys and young men are engaged in the programme to some extent, engagement of older men, particularly fathers, was considered to be low. Young men expressed the need to get training from lady health workers, like adolescent girls do, and to have more employment opportunities, like their female counterparts have. There was some mention of the pressure that young men face when married, which needs to be further explored to understand how child marriage and teenage pregnancy adversely affect young men.

In **Kenya**, some study participants expressed concerns that in general, young men do not have a voice in matters affecting their lives; it is mainly older men who have a say regarding sex and sexuality. Although there is evidence that some Yes I Do programme partners have worked with young men, the applied method was considered not actively engaging young males. Some young male participants felt they were not listened to and that communication was more like a one-way information provision. The midline study in Kenya also points out that some young men play a role in curbing FGM/C practices targeting their siblings, by having dialogues with their parents against the practice.

In **Ethiopia**, young men were reported to be engaged in strategies towards reducing child marriage, teenage pregnancy and FGM/C in different ways, including increasingly using contraception, participating in discussions in school clubs, reporting cases of child marriage to teachers and showing preference to not have their daughters circumcised in the future. The participation of both females and males in school clubs enables young men to appreciate the negative consequences of child marriage, teenage pregnancy, and FGM/C. Young males also reported having taken part in parent-teacher association meetings where the adverse consequences of child marriage on adolescent girls and boys were discussed.

In **Indonesia**, the midline study found that active engagement of fathers and young males in strategies towards reducing child marriage and teenage pregnancy was evident but not so with the prevention of FGM/C. Rather, men appeared to harbour negative attitudes towards the prevention of FGM/C.

4 DISCUSSION AND RECOMMENDATIONS

4.1 Pathway one

Pathway one of the Yes I Do programme is focused on the establishment of a social movement to transform social and gender norms that perpetuate child marriage and teenage pregnancy. In all the seven programme countries, the midline findings show that gatekeepers and young people were more knowledgeable about child marriage, teenage pregnancy and FGM/C as compared to the baseline situation. Also, across countries, there seemed to be positive attitudinal changes towards taking action, especially related to child marriage. While the establishment of bylaws in Zambia and Malawi, and the age estimation and establishment of CCCs in Ethiopia are positive developments, there is limited evidence that the seemingly positive changes in knowledge and attitudes (already) translate into taking preventive actions at both the community and institutional levels. Many of the actions taken by communities were reported to be reactionary in nature. For example: punishment of parents for arranging marriages for under aged girls (Ethiopia); punishing perpetrators through bylaws (Zambia) and returning adolescent girls and boys to school after delivery (Malawi).

These findings are not surprising; it has been long established that knowledge can change following any educational intervention, albeit by itself, is not sufficient to change behaviour (Gallant & Maticka-Tyndale, 2004). Also, changing attitudes is often considered a difficult behavioural task (Petty, Brino & DeMarree, 2007). It is therefore refreshing to see that after two years of implementing the Yes I Do programme, there is a generally positive change in attitudes among different stakeholders towards ending child marriage and preventing teenage pregnancy in all countries, and that many (but not all) stakeholders are in favour of ending FGM/C in Ethiopia, Indonesia, and Kenya. However, an important question remains: why do many various stakeholders not take *proactive* preventive actions and wait until events occur before they react? The answer could be that the programme activities have run for only two years and that more time is needed for bahavioural change, or that the programme activities still too much follow the long-held conventional wisdom that giving people information could change their behaviour and thereby solve health and social problems, with not enough focus on evidence-based methods for changing social influence, skills, capability, self-efficacy, and methods to overcome barriers to action.

Recommendation: intervention strategies that aim to increase knowledge should continue, and should expand to focus on social influence; skills, including communication between generations; capability and self-efficacy with regard to SRH and sexuality, and methods to overcome barriers to action.

4.2 Pathway two

Pathway two is focused on empowering and meaningfully engaging young people to claim their SRHR and take responsibility for their actions. The midline study found that particularly in Indonesia, young people who participated in programme activities were able to advocate for their rights. In the other countries, there seems to be little change in capacity to speak against harmful traditional practices, in particular for girls, which can be related to the programme's inability to facilitate and maintain intergenerational dialogues between young people and their most important reference persons in the social environment. In this case, the methods to change self-efficacy, skills and overcome barriers are crucial for the remaining life of the programme. Young people face various cultural, traditional and religious barriers to accessing information and services and for communicating with adults in a manner that can be considered acceptable

and respectful. What they need to overcome these barriers is not just information but crucially, skills and the feeling of capability (Tsang et al., 2012).

In general, intergenerational communication in settings where traditional and religious beliefs are strongly held is difficult, especially when it involves sensitive topics like sexuality. Several factors have been reported to hinder effective communication between adults and adolescents. A systematic review of studies on communication about reproductive health issues in sub-Sahara Africa reported that discussions between young people and adults tend to be authoritarian and unidirectional, characterized by vague warnings rather than direct, open discussion (Bastien et al., 2011). This was also found in many Yes I Do settings. Barriers to having open discussions regarding SRH issues are attributed to lack of age-appropriate respectful vocabulary and skills, and, cultural norms and taboos. Then there is also a perception that children are too young and discussions on SRH matters may promote premarital sex (Motsomi et al., 2016; Noar et al., 2006).

Recommendation: barriers to parent-child sexuality communication should be increasingly addressed in programme activities, not only from the side of the child, but also of the parent: programmatic efforts need to target not only parental knowledge but their self-efficacy and comfort to communicate with their children about sexuality.

Skills-based programmes which incorporate role plays may be one way to improve parental communication skills. Also, since several studies found that communication tends to be negative towards sexuality, role plays may assist parents in efforts to engage their children in a more dialogical, positive approach. The midline findings demonstrate that efforts need to be multi-level and also directed at the community level, to increase awareness of the importance of parent-child sexuality communication. This is needed to address the high prevalence of teenage pregnancy, which, in many settings, was reported not to decline as was the case for child marriage. Regarding teenage pregnancy, working with other stakeholders to expand boys' and girls' access to contraceptive remains crucial in the rest of the life of the programme.

4.3 Pathway three

Pathway three is about improving access to information and services for informed decision-making regarding SRHR. The midline study found that in all countries young people seem to have experienced enhanced access to SRHR information (mostly from teachers) and SRH services. However, similar to the baseline situation, not all sources provide balanced and comprehensive information, and in some settings, health providers exhibit a negative attitude towards young people seeking services. With the exception of Indonesia, Ethiopia and Kenya, where the programme took advantage of existing school-based sex education curricula to expose participants to comprehensive information on SRHR, the absence of comprehensive sexuality education (CSE) as a *core component* of the Yes I Do programme might have made the programme implementers to pay less attention to CSE. While CSE is just one component of a multifaceted approach necessary to address the SRH needs of young people, it provides a structured opportunity for adolescents to gain knowledge and skills, to explore their attitudes and values, and to practice decision-making and other life skills necessary for making healthy informed choices about their sexual lives and avoid adverse health outcomes (UNESCO, 2018). It is important to pay attention to the needs of out-of-school youth since the midline findings show that they are the least reached so far in most of the countries.

Recommendation: the Yes I Do programme should increase programme activities that include CSE for in-school as well as out-of-school youth.

Availability of SRH services expanded mainly in Ethiopia and Indonesia. In Indonesia, midwives are the main service providers for young females and in Ethiopia, there is a clear plan to roll out youth-friendly services in more areas. Besides the availability of SRH services, acceptability (among youth, but also adults) and quality of services need further attention, because young people's service use, including their use of contraceptives, is not yet optimal in many settings.

Recommendation: availability, acceptability and quality of SRH services, inclusing the provision of contraceptives, need more attention in the Yes I Do programme.

4.4 Pathway four

Pathway four is concerned with efforts to stimulate education and economic empowerment for adolescent girls and boys and young men and women as a way of providing them with alternatives beyond child marriage and teenage pregnancy. The midline study found that in all countries, most young people, including females, reported autonomy in decision-making regarding sexual choices, sexual relationships and in some settings, who and when to marry. However in Zambia and Malawi, adolescent girls' and boys' autonomy came at a price: autonomy in decision-making resulted in some young females engaging in transactional sex to gain money to meet necessities, thereby exposing themselves to other sex-related risks. The behaviour of the adolescent girls and boys points to what has been established in the literature – just providing information to adolescent girls and boys without empowering them economically exposes them to what Stoebenau et al. (2016) referred to as 'sex for basic needs'. The finding reaffirms the good intentions of the Yes I Do programme to incorporate economic empowerment components as part of promoting safe sex practices among young men and women. Unfortunately, the midline findings show that so far, the economic empowerment component of the programme remains weak. Except for Ethiopia where some youth, including adolescent girls and boys, could earn income through working on flower farms and a yet to be implemented vocational skills training for young women in Malawi and Zambia, in all seven countries, programme implementers continue to struggle to find viable economic activities for young people. In this regard, the Yes I Do alliance can draw lessons from the experiences of Bandiera et al.'s (2016) evaluation of the Empowerment and Livelihood for Adolescents (ELA) programme in Uganda. In the ELA intervention, a combination of sexual risk reduction and economic empowerment activities resulted in positive outcomes, although the approach requires more financial resources than what is available to the Yes I Do alliance. The ELA intervention included a broad range of income generating activities, including hairdressing, tailoring, computing, agriculture, poultry rearing, and small trades operation, which are all implementable in other developing country settings.

Recommendation: The Yes I Do Programme needs to enhance its attention to economic empowerment interventions, in which young women and men gain vocational skills and are involved in income generating activities which are feasible in the particular context.

A disturbing finding under pathway four was the reports that in all countries, adolescent girls and boys faced various levels of sexual violence in schools. Study participants recounted how some teachers were involved in sexual intercourse with adolescent girls, even leading to teenage pregnancy. With little or only moral and authoritative sex communication at home, the sexually abusive conduct of teachers in school

leaves adolescent girls with limited avenues to discuss questions regarding their sexuality. Previous studies in Zimbabwe, Ghana and Malawi concluded that in Africa, schools are a breeding ground for potentially damaging gendered practices, the influence of which can stay with young girls into adult life (Leach et at., 2003). Sexual aggression goes largely unpunished, dominant male behaviour by both pupils and teachers is not questioned, and pupils are strongly encouraged to conform to the gender roles and norms of interaction which they observe around them. This sends messages to boys and girls about what can be tolerated and therefore 'normalises' abusive behaviour.

Recommendation: the remaining life of the Yes I Do programme provides an opportunity to pay attention to the safety of girls in schools, through interventions aiming at preventing sexual violence against school girls.

Tackling the issue of abuse and gender violence in schools, as is the intention of the Yes I Do programme, requires a holistic approach which should involve a range of stakeholders, including teachers, parents, pupils, officials from various ministries and at all levels, and civil society. Without this, there is the risk of one-off interventions, without support systems to protect children where cases of abuse are reported.

The in-country Yes I Do alliances can take advantage of pathway five to engage the relevant ministries and State departments to ensure the effective enforcement of regulations about teacher misconduct. Such engagements should include efforts to ensure wide dissemination of national policies on sexual harassment and abuse, the review and strengthening of procedures where appropriate, and prompt action to prosecute those accused of sexual relations with pupils. A further step is to ensure that clear guidelines are provided to schools, school committees and parent and teachers associations (PTAs), detailing the appropriate action to take in cases of abuse. Members of school committees such as PTAs should be provided with training in how to handle such cases. At the district level, linkages between district education offices (DEOs), school committees and PTAs (and through them, parents and communities) need to be strengthened, with improved coordination and communication. Engagements at this level should also demand prompt action to be taken by DEOs to suspend teachers and investigate cases thoroughly, referring them to the courts where necessary. DEOs may need training in how to handle accusations of teacher misconduct.

4.5 Pathway five

Pathway five focuses on enhancing evidence-based lobby and advocacy for an improved legal and policy framework around teenage pregnancy, child marriage, FGM/C and SRHR in general. The midline studies report that the Yes I Do programme activities have contributed to the enactment of various laws, policies, and bylaws, including the amendment of the Malawian Constitution in 2017 to include a definition of children as those under 18 years, thereby making child marriage illegal, and the passing of the Hindu Marriage bill in 2017 to regulate marriages of Hindus in Pakistan. However, the awareness of these laws and regulations among community members was reported limited in some settings, and duty bearers' commitment to enforce the laws remains questionable.

Recommendation: awareness raising on existing laws and regulations, including bylaws, needs continuous attention and programme activities should focus on holding duty bearers accountable to enforce the laws and regulations.

In Kenya, where many boys do not want to get married to uncircumcised girls, and the value and respect for womanhood are strongly connected to marital status, community members continue to support the circumcision of girls. Under such situations, laws by themselves are not enough. Fear-based information about the consequences of the law to prevent FGM/C is not so effective if community members are not informed about the negative consequences of FGM/C itself from a health and rights perspective. In the present alternative rites of passage, the Maasai community in Kenya is informed and at the same time takes a shared-dicision not to circumcise their girls. Some participants in the midline studies in Ethiopia, Indonesia and Kenya seemed, however, to have been well informed about FGM/C and could mention the consequences, but appeared not to have internalized it and sometimes questioned the interlinkages between the practice and health-related outcomes.

Recommendation: community members need to receive more information about the consequences of FGM/C, related to teenage pregnancy, maternal health-related outcomes, infections and childbirth consequences for young couples.

4.6 Men and boys engagement

The midline study also found that engagement of boys and men can be a game changer across all the five pathways and can make a significant contribution to preventing teenage pregnancy, child marriage, and FGM/C. Evidence shows that engaging boys and men and the wider community to transform gender and other social norms is a promising strategy in promoting adolescent SRHR (Svanemyr et al., 2015). However, the midline results also show that the engagement of boys and men remains weak in some countries. Boys in Malawi and Zambia expressed a feeling of 'being left behind', because the programme activities are perceived to be skewed towards girls. One useful resource for the Yes I Do alliance is Muralidharan et al.'s (2015) report on 'Transforming Gender Norms, Roles, and Power Dynamics for Better Health: Evidence from a Systematic Review of Gender-integrated Health Programmes in Low- and Middle-Income Countries'. The report presents several suggestions and strategies to effectively engage boys and men to improve the SRHR of adolescents and can be a good reference to support the Yes I Do alliance's increased attention for gender transformative action aimed at involving young males in different ways.

Recommendation: men and boys engagement should gain more attention in all Yes I Do activities, as part of gender transformative programming.

5. CONCLUSIONS AND RECOMMENDATIONS

Over two years, the Yes I Do programme has implemented various intervention strategies across seven countries, with various degrees of success. There is a generally positive change in knowledge and attitudes among different stakeholders towards ending child marriage and preventing teenage pregnancy in all countries, and many (but not all) stakeholders are in favour of ending FGM/C in Ethiopia, Indonesia, and Kenya. However, changed attitudes still need to turn into sustained changes in behaviour in the form of preventative actions at all levels.

While child marriage seems to decrease, teenage pregnancy is still reported to be highly prevalent in many settings. Strengthening intergenerational communication, acknowledging (female and male) youth sexuality and men and boys engagement are important points of attention for the final year of the programme. Efforts towards getting all stakeholders to acknowledge youth sexuality should incorporate strategies to expand boys' and girls' access to contraceptives.

While SRHR information seems widely available, the comprehensiveness of the information and education provided needs to be assessed, also for the sources of information as part of the Yes I Do programme. In the same vein, in some of the countries, evidence shows that the availability of SRH services for youth has increased over the past years, but the programme needs to enhance their acceptability and quality.

Interventions in the area of economic empowerment need expansion in almost every country. With regard to education, prevention of sexual violence in schools, which is currently not part of the Yes I Do theory of change, does need attention. Furthermore, advocacy activities should continue, at the community, district and national level, to stimulate the enforcement of (by)laws.

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