GET UP SPEAK OUT for youth rights

MIDTERM REPORT 2018

GET UP SPEAK OUT PROGRAMME

JULY 2018 / PROJECT NR 28432

INDEX

SUMMARY

The midterm evaluation of the GUSO programme shows that halfway through the programme, good progress is made towards the outcomes of the GUSO Theory of Change. Moreover, it shows promising results towards the long-term objective to empower young people to realise their SRHR. The assessment also points out that progress towards the goals of the programme varies between countries and that there is room for further enhancement of the Multi-component Approach. The coming year, [R0] the NL/UK Steering Committee and the in-country alliances will develop a post-2020 strategy that will include various scenarios for sustaining the work for young people's SRHR in the seven GUSO countries. In addition, country alliances will develop a plan for transitioning towards 2020. NL/UK will support the country alliances in developing these.

The midterm evaluation consisted of three components: (1) A qualitative approach to assess progress for outcomes 1, 2 and 5a (all countries) by collecting information from country alliances; NL/UK Consortium members, the MoFA and the embassies; (2) Quantitative Performance studies (Ethiopia, Ghana, Malawi, Indonesia, Pakistan) to assess progress on indicators for Outcome 3, 4 and 5b, by collecting information from end-beneficiaries;and (3) A qualitative assessment in Kenya and Uganda, to understand the contribution of the Multi-component Approach towards the empowerment of young people. After conducting the midterm, in-country Validation Workshops were planned (May-June 2018) to validate and discuss the draft results in-country. Recommendations from these workshops are incorporated in this midterm report.

The midterm evaluation shows that in most countries there is a stronger collaboration of organisations working as an alliance, indicating progress for Outcome 1. Although funding horizons for most alliances do not go beyond the duration of the programme, they all indicate the intention to continue working within the alliance after GUSO. [R1] It is recommended that country alliances should discuss their post-2020 ambitions, applying the principle of country ownerhship, with regard to continuation as an alliance. The midterm also points out that it is difficult to link the impact of MCA to the impact of alliance working. To be able to better understand and appreciate the contribution of alliance working towards the GUSO long-term objective, [R2] it is recommended to start an Operational Research (OR) track in 2019/2020 to gather evidence of success and learnings from alliance building. From the midterm and the in-country validation it becomes clear that alliances would welcome capacity strengthening support to increase visibility and develop allies and technical support, as well as advice to accelerate strengthening and sustainability. [R3] It is recommended that country alliances should include linking and learning in their 2019-2020 work plans.

Good progress is made under Outcome 2, especially for the overarching principle of Meaningful Youth Participation, and the strategies aimed at the capacity building of young people, and youth-led advocacy. However, the midterm showed that young people do not always feel trusted by adults, and are sometimes hesitant to ask adults questions. It was also highlighted that more can be done to ensure that youth engagement goes beyond implementation and advocacy, and to include (financial) planning and Monitoring & Evaluation. Based on the results so far, it is recommended to review the two strategies, [R4] youth-adult partnerships, taking into account the trust issue, and [R5] youth movement building, and decide if these need more attention in the remaining years of the GUSO programme. Furthermore, it is important to assess what the impact of the strategy is on investment in youth-led organisations and [R6] to find ways to ensure sustainability so that youth structures and meaningful participation of young people will not disappear after the GUSO program has ended.

All countries show good progress with respect to the uptake of and access to SRHR information and education (Outcome 3). The qualitative assessment shows that the GUSO programme is having a positive impact on young people's knowledge about sexual and reproductive health. Interaction with peer educators was referred to as very instrumental for gaining SRHR information and access to services. In many countries it remains difficult to *comprehensively* address sexuality education in-school and in out-of-school settings. The midterm shows that to some extent it is easier to address sensitive issues in out-of-school settings than in-school settings.

It is recommended for the second phase of the programme to strengthen strategies to improve [R7] the comprehensiveness of SRHR information and education, either in-school or in out-of-school settings and [R8] online by the use of social media.

The midterm evaluation shows a mixed pattern of progress for Outcome 4. It clearly illustrates the need to better link *demand* (Outcome 3) and *supply* (Outcome 4) under the Multi-component Approach. A positive change in access to services was observed for the African countries. Yet, current use of contraceptives remained low and was even lower than reported at baseline in most countries. Moreover, unmet need for contraceptives has increased compared to the baseline in many countries. The results call for [R9] an in-depth analysis of the reasons behind the gaps in access to services. This should guide the implementation of targeted strategies, which could include: strengthening referral systems; improving social accountability mechanisms; addressing the issue of stock-outs and/or non-availability of some commodities (contraceptives, HIV tests and treatment, etc.); training providers in supply chain management; advocating for sustainable and affordable youth-friendly services; and enhancing the collaboration with public and private health facilities. In Pakistan and Indonesia, [R10] a specific analysis should be carried out to understand how to increase access to contraception among unmarried young people. While discussing the affordability of services, it has become clear in a few countries that the economic empowerment component was missed in the GUSO programme. While this was a deliberate decision made at the beginning of the programme, [R11] it is recommended to assess if, at this stage of the programme, it is realistic and favourable to add economic empowerment components, besides what is already being implemented under the Flexibility Fund in Uganda.

A key challenge that several countries face in implementing the GUSO programme, is the shrinking space for civil society and the growing conservative climate regarding SRHR. The midterm evaluation shows that the SRHR Alliances in these countries employ different – often advocacy – related approaches to deal with this situation, which differs from country to country. It is clear that some progress is made with respect to the strategy "evidence-based advocacy" under Outcome 5, but more is needed. [R12] With regard to advocacy, embassies remarked that for the second part of the programme, they could be engaged more strategically, also for policy-level dialogue. Moreover, [R13] it is recommended to discuss how, and if GUSO with a district focus on advocacy, can align on advocacy with RHRN, but also with other programmes such as PITCH that work on national (and international) level advocacy. The midterm also shows that it is difficult to measure progress for this outcome area. To measure progress of advocacy efforts and to be able to attribute this to the GUSO programme and it's Multi-component Approach [R14], it is recommended to assess the use of a systematic methodology, such as Outcome Harvesting for future monitoring. While the countries face opposition at national level, the midterm shows some progress with respect to support at the local (implementation) level. In many countries, religious and community leaders are seen as both allies and opponents. [R15] It is recommended to increase the use of community champions. Additionally, promoting an enabling environment, linking support with demand and supply under the Multi-component Approach, requires youth participation. Youth participation improves self-esteem and confidence, increases young people's use of SRH services, and is also seen by young people to improve their position in their communities.

The reflection on the partnership working showed that midway the programme, all partners see an added value of working in this SRHR Partnership. Working in a partnership means creating synergies, learning from each other and building on each member's strengths. It also requires true understanding of each other and accepting different ways of working. The added value of the MoFA in this partnership is the joining of forces in countering the growing conservatism, keeping SRHR as a priority and leading by example to other governments on how civil society and government can collaborate. Moreover, the role of the embassies is highly valued and [R16] it is recommended to enhance further collaboration with the in-country alliances for the second phase of the GUSO programme.

It can be concluded that the GUSO programme so far has had a significant impact on the lives of respondents in the seven countries. Halfway the programme, young people reported to have improved knowledge, which led to a range of other positive outcomes for their sexual health, social relationships, and overall self-esteem and empowerment. Although the programme implementation can and will be strengthened in the coming two years, it can be concluded that the GUSO programme is already positively impacting the wellbeing of young people in a variety of ways.

List of recommendations

The following recommendations are formulated based on the results of the midterm evaluation studies, the in-country Validation Workshops (May-June 2018), and the validation with the NL/UK Programme Team and Steering Committee (7 June 2018). The recommendations were further discussed during the Strategic Learning Days (17-18 July) with the Chairs of the National Steering Committees (NSCs), the National Program Coordinators (NPCs), the Youth Country Coordinators (YCCs), the NL/UK Programme Team (PT), the NL/UK Steering Committee (SC) and the MoFA. Based on these discussions, R0 was added. In September 2018, the recommendations will be translated into actions, under the principle of country-ownership, during the in-country Planning and Review Meetings.

Outcome 1
[R0] It is recommended that the NL/UK Steering Committee together with the in-country alliances develop a post-2020 strategy that will include various scenarios for sustaining the work for young people's SRHR in the seven GUSO countries. In addition, country alliances will develop a plan for transitioning towards 2020. NL/UK will support the country alliances in developing these.
[R1] It is recommended that county alliances should discuss their post-2020 ambitions with regard to continuation as an alliance, and if yes, what kind of support do they need from the NL/UK or other parties for the last two years of GUSO? *-> Corresponding ToC strategy = Capacity building of Alliances and CSOs*
[R2] it is recommended to start an OR track in 2019/2020 to gather evidence of success/learnings from alliance building to be able to better understand the contribution of alliance working towards the GUSO LTO, *-> Corresponding ToC strategy = outcome level OA1*
[R3] It is recommended that country alliances should include linking and learning in their 2019-2020 plans. *-> Corresponding ToC strategy = Capacity building of Alliances and CSOs*
Outcome 2
[R4] It is recommended to review the strategy on youth-adult partnerships and decide if this strategy needs more attention in the remaining years of GUSO. *-> Corresponding ToC strategy = Build youth-adult partnerships*
[R5] It is recommended to review the strategy and definitions on youth movement building and decide if, based on the limited results so far, this strategy needs more attention in the remaining years of GUSO. *-> Corresponding ToC strategy = Networking and movement building*
[R6] it is important to find ways to ensure sustainability so that youth structures and the Meaningful Youth Participation of young people will not disappear after the GUSO programme has ended.
Outcome 3
[R7] It is recommended to assess if and how the (quality of) comprehensiveness of SRHR education and information can be improved. *-> Corresponding ToC strategy = Provision of SRHR Information and Education*
[R8] It is recommended to assess for each country if further strengthening the use of social media for SRHR information provision will increase the uptake of quality SRHR (including HIV) information. *-> Corresponding ToC strategy = Provision of SRHR Information and Education*
Outcome 4
[R9] It is recommended to conduct an in-depth analysis of the reasons behind the gaps in access to services. This should guide the implementation of targeted strategies. *-> Corresponding ToC strategies = Establishment of referral systems & social accountability mechanisms*
[R10] For Indonesia and Pakistan, it is recommended to carry out an analysis to understand how to increase the access to services for unmarried young people. *-> Corresponding ToC outcome level = increased use of services*
[R11] it is recommended to assess if, at this stage of the programme, it is realistic and favourable to add Economic Empowerment components, besides what is already being implemented under the Flexibility Fund.
Outcome 5
[R12] It is recommended for all countries to engage more strategically with the embassies in the coming years of the GUSO programme to enhance advocacy. *-> Corresponding ToC strategy = evidence based advocacy*
[R13] It is recommended to discuss how and if GUSO, with a district focus on advocacy, can align with RHRN, but also with other programmes (e.g. PITCH) that work on national (and international) level advocacy. *-> Corresponding ToC strategy = evidence based advocacy (OA5) & networking and movement building (OA2)*

[R14] To measure progress of advocacy efforts and to be able to attribute this to the GUSO programme it is recommended to assess the use of a systematic methodology in 2019/2020, such as Outcome Harvesting *-> Corresponding ToC strategy = Outcome level OA5*
[R15] It is recommended to increase the use of community champions for increasing support for SRHR *-> Corresponding ToC strategy = engage key-influencers as SRHR Ambassadors*
[R16] The role of the embassies is highly valued within GUSO: it is recommended to enhance further collaboration with the in-country alliances for the second phase of the programme.

INTRODUCTION

In this report, the midterm results of the Get Up Speak Out (GUSO) Programme are presented. GUSO is a five-year programme (2016-2020) implemented by a consortium consisting of Rutgers, Aidsfonds, CHOICE for Youth and Sexuality, dance4life, the International Planned Parenthood Federation and Simavi. The consortium and the in-country alliance partners aim to continue or consolidate what was started by the Unite for Body Rights (UFBR) and Access, Services, Knowledge (ASK) programmes with the overall ambition of creating country ownership for SRHR interventions under the lead of a country SRHR alliance that will be able to continue when the GUSO programme expires.
The GUSO programme has the following Long-Term Objective (LTO): All young people, especially girls and young women, are empowered to realise their SRHR in societies that are positive towards young people's sexuality. This midterm report aims to present the progress midway through the programme. The context of the programme, that runs in seven countries: Ethiopia, Ghana, Kenya, Indonesia, Malawi, Pakistan and Uganda, varies per country. Most countries face restricting conditions (of a different nature) that challenge the implementation of the GUSO programme and therefore may affect the progress towards the LTO. In this introduction, an overview of the programme context per country is presented. In Annex 2 a more detailed overview of the country alliances and intervention areas are included.

In Ethiopia, 64.7% of the population is below the age of 25 years. Twenty-nine percent (29%) of currently married women (15-49 years) and 57% of sexually active unmarried women (15-49 years) are using a method of contraception. Among younger women, contraceptive use is lower: 5% of all women aged 15-19 use any contraceptive method. The reason for this is that, amongst others, adolescents lack adequate access to sexual and reproductive health (SRH) services and information. Comprehensive knowledge of HIV/AIDS is low, especially amongst women: among young women (15-25 years), comprehensive knowledge of HIV/AIDS is 24%. In relation to gender equality, Ethiopia ranks low on the gender inequality index (129). The percentage of child marriage is among the highest of the world where 63% of girls are married before the age of 18 and the teenage pregnancy prevalence is 38%. In this context, the GUSO programme is implemented by the SRHR Alliance in three sub-cities of Addis Ababa. The implementation faced challenges because of the state of emergency declared in October 2016 after an uprising by different ethnic groups. This hampered the implementation since it prohibited mass sensitisation, and imposed restrictions on the freedom of speech and access to information including the temporary shutting down of the internet. In addition, the Alliance faces opposition regarding the delivery of CSE from different stakeholders, including the Ministry of Education that has prohibited the inclusion of CSE in the formal school curricula. A positive development though, was the new national Adolescent Youth Health Strategy (2016-2020) showing strong political backing for implementing GUSO. Yet, conservative values and norms existing in the community impede Sexual and Reproductive Health (SRH) issues being openly discussed. Also civil society organisations are barred from operating on rights and advocacy related issues.

Young people between the ages of 10 and 24 constitute 31% of Ghana's population. Regardless of their marital status, 99% of the women and men in Ghana have knowledge about at least one contraceptive method, which means that this knowledge is almost universal. Contraception use among unmarried sexually active girls (15-19 years old) is 43.7%, and when married, this percentage is much lower at 18.6%. Young women aged 15-19 have the highest unmet need for family planning (51%). Only 20% of young women (15-24 years old) have comprehensive knowledge about HIV/AIDS and the HIV prevalence among women aged 15-49 is 2.8%. The 14% teen pregnancy rate in Ghana is not amongst the highest in the world, but large regional differences are visible (36% in the Northern Region and 27% in the Upper East Region). The country ranks 127 on the Gender Inequality Index. In this context, the GUSO programme in Ghana is being implemented by the Ghana SRHR Alliance For Young People in five districts: three districts in the North and two in the upper East Region. The SRHR alliance can implement the programme in an enabling political setting. There has been a growing safe and flexible space for prioritising and promoting young people's SRHR issues.

The Adolescent Reproductive Health Policy was strengthened in 2017 to provide guidance to NGOs. Secondly, the Adolescent Health Service Policy and Strategy was launched and CSE eventually gained the desired national attention, resulting in the development of National Guidelines for CSE delivery in Ghana.

In Malawi, young people between 10-24 years of age comprise of around 65% of the population. The prevalence of child marriage and teenage pregnancy is high, 52.2% and 29% respectively. The country ranks 140 on the Gender Inequality Index. Although progress has been made regarding access to SRH services, there is still a need for improvement regarding the access of adolescents to youth friendly services and information. Only 31% have heard about these services and the utilisation of youth friendly health services is low (13%). In this context, the GUSO programme is being implemented by the SRHR Alliance in two areas, the Chikwawa district and the Mangochi district. Malawi faced a backlash on sensitive issues by the general public under the influence of the Catholic Church and the Blantyre Synod of Central African Presbyterian Churches. However, several positive changes occurred in the first two years of the programme with respect to SRHR-oriented work.

In Indonesia, young people (10-24 years) make up approximately 27% of the population. Among sexually active unmarried women and married women (15-49 years), 46% are using any form of contraception. In particular, younger women (15-19 years) are less likely to use any contraception (6%). Findings from the Indonesian Demographic Health Survey show that adolescents' knowledge on SRHR is not adequate. While Indonesia belongs to the top 5 countries of women aged 20-24 who gave birth by age 18 (in absolute numbers), the teenage pregnancy rate in Indonesia is 'only' 16%. Overall, Indonesia ranks fairly poorly on the Gender Inequality Index with a rank of 110. While the country ranks better on the Reproductive Rights Index, the high uptake of contraception by married women is overshadowed by the poor access and vulnerabilities faced by unmarried men and women. It is in this context, that 10 organisations from the Aliansi Satu Visi (ASV) implement the GUSO programme in five districts across the country: Lampung (Sumatra), Jakarta and Semarang (Java), Bali and Kupang (East Nusa Tenggara). In Indonesia, growing conservatism is being experienced at the national level, whereas at the local/district level the environment to implement is generally supportive. At the local level, the national political situation does have implications for the education sector where SRHR education is hindered because of reluctance among teachers to discuss sensitive topics (LGBTI, contraceptives for unmarried people, abortion). Although, a new school policy was launched that may open opportunities for CSE at schools.

In Pakistan, 55% of the population is below 25 years old. Among married Pakistani women, 26% use a modern form of contraception and 9% use traditional methods. Contraception use among married women age 15-19 is low, where only 10% use a form of contraception. Low access to SRH services and information for adolescents in Pakistan remains a challenge. However, according to the Demographic Health Survey, knowledge about contraceptives are high. Generally, women's participation in decision-making is low. In Pakistan, 39% of ever-married women aged 15-49 reported ever having experienced physical and/or emotional violence from their spouse. The prevalence of child marriage is high (35.2%) and a study performed in two districts showed that the mean age for girls married can be as low as 12 to 13 years. The teen pregnancy rate is not among the highest of the world: at 15.2%. Pakistan ranks 121 on the Gender Inequality Index. In this context, the GUSO programme is being implemented by six organisations from the Pakistan Parwan Alliance in three districts, Karachi, Lahore and Quetta. The overall political situation for SRHR in Pakistan has not improved since the start of the programme, SRHR is a sensitive topic to openly discuss. A nationwide debate led to some positive changes, such as the initiative to provide Life Skills Based Education (LSBE) to young people in public schools launched in the Sindh province. Moreover, the ongoing re-registration process of several international NGOs is a challenge that hinders programme roll-out.

In Kenya, young people aged 10-25 constitute 28% of the population and more recent figures show that 24% of the total population is aged between 10 and 19 years. Among married young women (15-19 years), only 40% use any form of contraception, when sexually active and unmarried this percentage is around 50%.

These percentages increase for young women aged 20-24, with 53.5% for married women and 70% for sexually active and unmarried women. STIs including HIV are common among young people. The prevalence of teenage pregnancy is high in Kenya. Among girls aged 15-19, it was found that 11.3% experienced sexual violence, for girls aged 20-24 this was 19.5%. Research has shown that access to and utilisation of SRH services is limited for both married and unmarried adolescents. In some cases, unmarried youth are excluded from services, even where policy is supportive. A recent report also stated that some of the main challenges to effective sexuality education in Kenya include a lack of comprehensiveness in SRHR related topics. In addition, a fear-based orientation is reported in teachings, as well as a negative light consistently being cast on adolescent sexuality are hindering CSE. In this context the GUSO programme is implemented by 9 organisations from the Kenya SRHR Alliance in six counties: Bungoma, Homa Bay, Kakamega, Kisumu, Nairobi and Siaya. In Kenya there were several limiting factors, such as the extended election process and strikes among health care workers that affected service provision and the supply of drugs and commodities. Moreover, the Ministry of Education barred NGOs from implementing CSE in schools prior to approval of Information, Education and Communication (IEC) materials. Overall growing conservatism further resulted in opposition from religious groups. However, a positive development was the Health Act that was signed in June 2017, resulting in a unified health system for aligning national and county government health systems.

Over half (55%) of the population in Uganda is below the age of 18 years and 35% of the population comprises of 10-24 year olds. Teenage pregnancy and childbearing are widespread in Uganda and are both causes and effects of poverty. The GUSO programme is being implemented by the SRHR Alliance in four districts in the Busoga Region: Iganga, Jinga, Bugiri and Mayuge. The sub-region of Busoga has some of the worst SRH indicators in the country. Current SRH indicators for women (15- 49 years) are as follows: modern contraceptive use is at 29%, compared to 47% at national level; unmet need for family planning is at 36.5%, compared to 28% at national level; sexual violence is at 26% (ever experienced) and 13% (experienced in the past one year), compared to 22% and 13% respectively at national level. Over the years, the environment for access to SRHR has been shrinking in Uganda. The continued "Ban on CSE" by the parliament affected timely implementation of in-school activities and resulted in a shift towards using the "Presidential Initiative on AIDS Strategy for Communication to Youth" (PIASCY) materials at schools as requested by the government. This has had a negative impact on the quality of content because PIASCY does not comprehensively cover rights and positive-based sexuality education. Secondly, the Ministry of Gender, Labour and Social Development went ahead in banning CSE for out-of-school youth, although this did not affect implementation of SE for those youth in the GUSO target districts where implementation of CSE with out-of-school youth is still supported. The debate will continue, with the new national framework for CSE launched in May 2018.

As presented above, there is clearly a need to implement the GUSO programme in these seven countries. The GUSO Theory of Change (Annex 1) describes five interrelated outcomes that will contribute towards the long-term objective. These interrelated outcomes are:

1 Strengthened and sustainable in-country SRHR alliances.
2 Empowered young people voice their rights.
3 Increased use of SRHR information and education.
4 Increased use of youth-friendly SRH services.
5 Improved socio-cultural, political and legal environment for SRHR.

In this report, progress is described towards the five outcomes areas of the GUSO programme. The midterm evaluation addresses the following specific objectives: 1) To evaluate (progress towards) programme outcomes and the long-term objective of the GUSO programme; 2) To understand what processes has led to these results, including enabling factors and barriers; and 3) To propose feasible recommendations to inform future programme design.

1 METHODOLOGY

The overall goal of the midterm evaluation is to assess progress of the programme towards the five outcome areas and the long-term objective. In this chapter a short summary of the methodology is presented. The full design is included in Annex 3.

The midterm evaluation consists of three components:

1. A qualitative approach for outcomes 1, 2 and 5a (all countries).

Information from in-country alliances was collected by means of adding additional questions to the regular GUSO M&E system for the Annual Report process in 2017. In addition, for Outcome 1 and 2 information was used from the surveys (and Focus Group Discussions (FGDs) for Outcome 2) and workshops that were conducted in 2017. For the partnership assessment, next to the regular M&E system, questions on collaboration within the partnership were addressed to the NL/UK consortium members, the MoFA and the embassies.

2. Performance studies (Ethiopia, Ghana, Malawi, Indonesia, Pakistan).

The performance studies, jointly conducted by the Royal Tropical Institute (KIT) and GUSO partners focus on measuring outcome indicators 3, 4 and 5b (see Table 1 Annex 3) at the level of end-beneficiaries. The sampling and methodology was similar to the baseline to be able to compare results. In every country in one or more implementation sites a sample of 350-500 young people aged 10-24 years were recruited.[1] Structured quantitative questionnaires were completed by young research assistants using a tablet.[2] Data was analysed by the KIT using Stata. Results were compared with the results from the baseline study conducted in all GUSO countries early 2017.

3. A qualitative assessment in Kenya and Uganda, to understand the contribution of the Multi-component Approach towards the empowerment of young people.

No external midline evaluation was planned for in Kenya and Uganda. The GUSO consortium took the initiative to conduct a qualitative assessment in both of these countries, to assess the progress of the GUSO programme towards the long-term objective. First, a systematic mapping was conducted, in both the intervention and the control area (see Annex 2), to thoroughly document which different stakeholders implement SRHR programmes in the intervention and in the control site. Subsequently, a qualitative assessment was conducted in the intervention area to assess progress towards the LTO. In Kenya, a Qualitative Impact Assessment (QUIP) was used in Siaya district, as a methodology that was designed to serve as a reality check as to whether the Multi-component Approach on intended beneficiaries is as expected, or whether it is having unintended consequences. The impact of the GUSO programme was evaluated by gathering end-beneficiaries perceptions of what has changed in their lives over the past two years across a series of domains (based on the GUSO ToC). The Bath University was contracted to conduct the QUIP. In Uganda, a qualitative content analysis study was used to explore and understand how young people within the GUSO program in Iganga experienced empowerment and its drivers. In addition to end-beneficiaries, different stakeholders were interviewed to explore how they experienced the implementation of the Multi-component Approach. Data was analysed using Qualitative Content Analysis (QCA). The Lund University was contracted to conduct this assessment.

Following the data collection, in all countries, a 2-3 day Validation Workshop was organised (May/June 2018) to validate and discuss the draft results of the midterm and to assess progress in light of the country specific ToCs. A report with a summary of the Validation Workshop discussions were provided to the GUSO Consortium Office and recommendations are integrated in the current midterm report. In addition, recommendations from the validation with the NL/UK PT and SC, that took place 7 June 2018, are integrated in this report.

1 In Indonesia and Malawi, an additional sample was recruited in a second implementation site (not covered by the baseline). The results are used in country for programme steering. However, they are not included in this report since no comparison could be made with the baseline.
2 In Pakistan, a paper version of the questionnaire was used.

2 RESULTS

2.1 Outcome 1 - Strengthened and sustainable alliances

A lot of work has been put into ensuring country alliances are strengthened and sustainable alliances that comprehensively address the SRHR of young people, including sensitive issues.

The diagram on the left shows the key activities that have taken place. In 2017, the seven countries held Outcome area 1 reflection workshops. The workshops resulted in each alliance selecting three areas to prioritise (from the framework, see Annex 4) until 2020. The action plans are serving as a roadmap to realising more sustainability on the part of the country alliances. This means that alliances aim to work towards a more defined governance structure, provide high quality SRHR, have a stronger position and a positive reputation in their respective countries.
Table 1 below shows the 3 priorities that were selected by each country alliance. Financial sustainability was selected by all 7 alliances as being crucial to their sustainability. Since the Outcome 1 workshops, action plans have been developed which are aimed at realising each priority and are at the centre of implementation for OA1 in 2018.

Table 1 Top three priorities for each country alliance

Ethiopia	Ghana	Indonesia	Kenya	Malawi	Pakistan	Uganda
Financial Sustainability	Financial Sustainability	Financial Sustainability	Financial sustainability	Financial sustainability	Financial Sustainability	Financial Sustainability
Ability to develop allies and partnerships	Shared ambition	Capable Organization	Capable Organisation	Visibility and favorable reputation	Capable Organisation	Shared ambition
Visibility and favorable reputation	Visibility and favorable reputation	Quality Content Delivery	Quality Content Delivery	Quality Content and Delivery	Open culture	Visibility and favorable reputation

Based on the selected priorities and discussion in the validation workshops we can summarise that:

1. Alliances expressed that they need financial sustainability for strong alliance after 2020.
2. Most alliances expressed that they need visibility and a good reputation for a strong alliance after 2020

We can observe that slowly, there is a stronger collaboration of organisations working as an alliance. The joint activities under OA1 provide the platform for alliance members to meet and collaborate regularly, discuss and make decisions on different programmatic issues. This helps to promote understanding and foster stronger collaborations. Overall we see that joint activities providing efficiency in execution of project objectives, and the opportunity to update and feedback to each other at alliance level.

Working as country alliances presents a more viable framework for resource mobilisation and in turn leads to better visibility in the political context through working as an alliance. We now see alliances having a bigger and louder voice and slowly becoming more influential. For example in Indonesia in 2017, through regular collaboration with the government for SRHR-related initiatives, the ASV (One Vison Alliance) was requested to provide input for the CSE module being developed by the Ministry of Health and Ministry of Education. The Malawi Alliance was invited to several SRHR meetings organised by the Ministry of Youth, and the National Youth Council of Malawi. In Ghana, the alliance attended a meeting with the Minister of Education to present the Guidelines for CSE and discuss the inclusion of the same guidelines into the educational curriculum. In Kenya, the Alliance continues to play and affirm its key role in SRHR and establishing of Youth Friendly Services (YFS) facilities in the counties and national level through the various strategies as envisaged in the ToC. In Uganda, GUSO partners have participated in review of the National Sexuality Education Framework, the Adolescent Health Policy Standards and Service Guidelines. In Ethiopia, the Alliance established a Program Advisory Committee at the Addis Ababa City Administration level, which comprises delegates from various government bureaus and the partner organisations.

The Ghana SRHR Alliance is now registered to increase its credibility and appeal to stakeholders. Alliances are moving more and more towards capable organisations. Kenya, Malawi, Indonesia and Uganda made positive steps towards formalisation and having structures and systems in place to guide their work as an alliance. In Kenya, the registration is expected to be completed in 2018. In Uganda, the Alliance more and more operates as one entity, but has not decided on registration. In Pakistan, Memoranda of Understanding (MOUs) have been signed by the country alliance with district local governments for most of the partners. The One Vision Alliance of Indonesia in 2017 managed to develop key documents to guide and inform alliance working, such as the Standard Operating Procedure Manual. In Malawi, the Alliance has a draft MOU to guide its operations in the absence of a constitution.

Ambitions shared by many alliances include: an increase in membership of other relevant NGOs to the alliance; increased visibility/recognition; better internal governance-structures; increased (influence of) advocacy-efforts; legal registration; and resource mobilisation. Some alliances aim to have an independent secretariat (currently, secretariats are based within one of the member organisations).

Financial sustainability through working as an alliance

Some country alliances have attracted funds from donors, but the core funding for most alliances is still from GUSO. As part of the Outcomes of OA1 the alliances should diversify their funding base, which is seemingly difficult to realise for most alliances. Alliances have prioritised financial sustainability and lined-up activities geared towards realising this, such as developing resource mobilisation strategies, stakeholder mapping, proposal writing trainings, but there is a clear capacity gap in this regard.

In 2019, a second survey will be conducted as a follow up to the baseline survey conducted in 2017. The results will inform the OA1 implementation until the end of the programme. Moreover, it is recommended to better understand and appreciate the contribution of alliance working towards impact on the long-term objective. An OR track should be initiated in 2019-2020 to collect evidence of success/learnings from alliance building.

2.2 Outcome 2 - Empowered Young People Increasingly Voice Their Rights

Mainstreaming Meaningful Youth Participation (MYP) was identified as a key component to achieve GUSO objectives and was therefore selected as one of the core-principles of the programme. In addition, the GUSO ToC has four strategies to achieve OA2: 1). capacity building of young people; 2) building Youth-adult Partnerships; 3) networking and youth movement building; and 4) youth involvement in advocacy.

Meaningful Youth Participation

The MYP surveys and FDGs show that young people involved in GUSO in general perceive their participation as meaningful. However, while young people feel they have adequate amounts of information, freedom of choice and voice in the program, responsibility and decision-making power is often lagging behind. Young people reported to be involved in separate youth structures, and not so much in e.g. budgeting and M&E. In all GUSO countries, youth structures are established, e.g. the YCCs and youth advisory board. However, budget for these youth structures is reported to be an issue.

Capacity building of young people

In the first two years of GUSO, a lot has been achieved on capacity strengthening of young people, resulting in progress under the Outcome 2 strategy. Many trainings were organised, e.g. on SRHR, MYP, youth-led advocacy, leadership and PMEL. The research shows that young people often have an adult mentor or coach that provides guidance. In many of the GUSO countries, young people reported that they would like to understand the GUSO program better and get to know the other GUSO organisations.

Building youth-adult partnership

There is progress on this strategy, as can be seen from examples such as the YCC-NPC partnership in all countries. However, the research project shows that young people often feel that adults do not trust them, and that they miss a safe space in which they can have open discussions and dialogues with adults. Young people reported that communication between adults and young people could be more regular and more transparent.

Networking and youth-movement building

The midterm shows that the work on indicator 2b (collaborations between young people from different organisations/networks) is behind in four countries (Ethiopia, Ghana, Kenya and Uganda). While some successful examples can be found in countries, such as the organisation of exchange visits in Malawi and Pakistan, the organisation of the Youth Health Celebration in Indonesia and the Youth Camp in Kenya, not much progress can be reported under this strategy.

Involving young people in advocacy

In multiple countries, strong examples of youth-led advocacy were found. In Ethiopia, TaYA promoted meaningful youth engagement with the national youth policy amendment and revision of the Adolescent and Youth Health Strategy. In Kenya, the SRHR Alliance engaged and supported 30 youth champions who advocated for young people's SRH in their specific counties. 21 Youth Advocates from NAYA Kenya led community forums and participated in budget advocacy forums. In addition, a youth advocate from the Ambassador for Youth and Adolescent Reproductive Health Program (AYARHEP) was part of the committee on SRHR-related issues in the Kenya Coordinating Mechanism for the Global Fund. In Uganda, young people led community research on peers' SRHR experiences and discussed this with school administrators, sub-county and district officials. This led to commitments by both the district and school administrators to improve the SRHR environment. These examples show that progress is made and that youth-led advocacy is a promising strategy that should be strengthened.

2.3 The Multi-component Approach (OA3 & OA4 & OA5b)

The Multi-component Approach is the overarching strategy in the GUSO programme. The approach serves as a comprehensive framework for program delivery, targeting a broad range of actors and addressing factors responsible young people's SRHR vulnerabilities. By simultaneously improving access to SRHR information and education (Outcome 3), SRH services (Outcome 4), and creating an enabling environment for young people (Outcome 5), the program works at all levels to achieve lasting and effective change.

Table 2 shows the characteristics of the participants in the five quantitative performance studies (Ethiopia, Ghana, Malawi, Indonesia and Pakistan) and the overview of participants in the qualitative assessment in Kenya and Uganda. In Indonesia and Pakistan, the mean age of the participants was younger than in the African countries.

Table 2 Characteristics of participants, by country

	ETH	GHA	MAL	IND	PAK	KEN#	UG#
Number of participants	456	765	353	350	744	24 INT 4 FGDs	15 INT 2 FGDs
Age range (years)	13-24	15-24	15-24	11-24**	11-24**	15-24	18-24
N (%) Male	199 (45%)	312 (41%)	158 (45%)	175(50%)	315 (42%)	50%	62%
Single In a relationship (not married) Married	67% 21% 11% (F 18%)	58% 33% 9% (F10%)	35% 37% 26% (F 25%)	85% 15% 0%	99.7% 2 (F 0.2%)	63% 29% 8%	
% Out-of-school	46% (M78%)*	46% (M45%)	49% (M50%)	1% (M1%)	15% (M17%)	29%	60%
Ever dropped out (school)	23%*	32%	44%	1%	27%	NA	NA
Sexually active***	31% F28%, M36%	47% F50%, M43%	78% F69%, M89%	1% Fn=3, Mn=2	NA	NA	NA

*baseline ETH out-of-school 19% and ever dropped out 79%

**midline IND and PAK age distribution is younger (42% and 49% aged between 11-14 years) than in ETH, GHA, MAL

***It was asked whether the respondent had ever had sexual contact. This question was not asked during the baseline

qualitative assessment in Kenya and Uganda (only information from end-beneficiaries included here), NA=Not Available

2.4 Outcome 3 - Increased use of SRHR Information and Education

In general, the uptake of SRHR information and education has increased, compared to the baseline. The countries show progress with respect to all indicators under Outcome 3 (Table 3). In Malawi, the picture is slightly different. Although the proportions of young people that reported to have received information and education were high, they were lower than at baseline. There were several limitations with respect to the recruitment at baseline (young people interviewed in youth clubs were already active and informed in SRHR issues), which affects comparability at midline. Compared to the baseline, teachers and health workers (except for Indonesia and Pakistan) are more often reported by young people as the source of SRHR Education. The qualitative study in Kenya showed that the main positive primary outcome reported by respondents was improved knowledge about sexuality and sexual and reproductive health. This improved knowledge was linked to two main drivers. These included receiving training in life skills, sexual and reproductive health and relationships, and accessing guidance and counselling. This shows that the GUSO programme is having a positive impact on young people's knowledge about sexual and reproductive health (Figure 1). Moreover, in Uganda, participants mentioned a positive change in their access to SRHR information and services. Interaction with peer educators was referred to as very instrumental for gaining SRHR information and access to services (by provided referral notes) in Uganda as shown by the following quote:

"I approached the peer educator, they taught me how to prevent unwanted pregnancies, so we (my girlfriend and I) started using family planning methods" (Male – interviewee Uganda).

Table 3 Indicators for Outcome 3 Increased use of SRHR Information and Education

	ETH		GHA		MAL**		IND		PAK	
Number of young people interviewed Midterm - Baseline	456	532	765	737	353	503	350	500	744	677
OUTCOME 3	**MID**	**BAS**	**MID**	**BAS**	**MID**	**BAS****	**MID**	**BAS**	**MID**	**BAS**
• **% of young men and women who ever received information about SRHR**	**70%**	56%	**88%**	65%	**87%**	96%	**94%**	93%	**89%**	57%
• **% of young men and women who received SRHR information through GUSO (among those who received information)**	**59%**	3%	**91%**	2%	**82%**	60%	**89%**	1%	**89%**	67%
• **% of young men and women who ever received education about SRHR in school**	**64%***	69%	**85%**	60%	**68%**	91%	**97%**	93%	**75%**	52%
• **% of young people who perceive the SRHR information as beneficial to them.**	**97%**	92%	**100%**	95%	**100%**	91%	**100%**	96%	**100%**	86%

*ETH: lower in midline in 1 out of 3 areas

**MALAWI: baseline sampling was done at youth clubs were GUSO was already implemented, this affects comparability at midline.

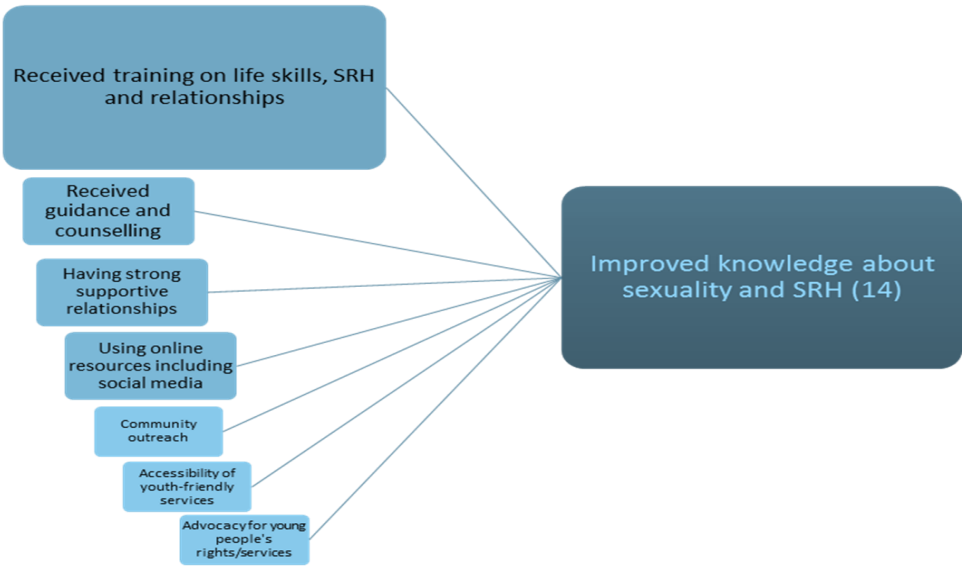


Figure 1 Drivers of Change associated with the "increased knowledge" outcome (Kenya)

In four out of five countries teachers were the most important source of information, except for Malawi where information provision is mainly being provided by youth clubs and no in-school SRHR education or information is included in the programme (Table 4). Peer educators were mentioned as an (increasing) source of SRHR information in the African countries, although the absolute proportions reported were rather low. It should be noted that peers often offer their services through youth clubs and NGOs, being separate categories to report on under this question. Health providers were mentioned more often as a source of information in Ethiopia and Ghana, whereas this proportion decreased in Malawi and Pakistan and has stayed low (12%) in Indonesia. Parents were often reported as an (increasing) source of information in Indonesia and Pakistan, whereas these proportions were lower in the African countries. Moreover, other family members and stakeholders such as traditional or religious leaders were often not reported to be a source of SRHR information.

Table 4 Source of SRHR Information (multiple sources could be indicated)

	ETH	GHA	MAL	IND	PAK
Teachers	65% (D)	90% (^)	17% (^)	87% (^)	58% (^)
Youth Club	24% (^)	13% (^)	68% (^)	2% (^)	5% (D)
Media (TV, radio, newspaper, magazine)	19% (D)	30% (D)	14% (D)	17% (^)	2% (D)
Social media and internet	10% (D)	7% (^)	1% (^)	37% (^)	0% (D)
Health providers	17% (^)	51% (^)	28% (D)	12% (=)	24% (D)
Peer educators/counsellors	16% (^)	12% (^)	18% (^)	0% (D)	38% (D)
Friends	14% (D)	4% (D)	19% (^)	38% (^)	12% (D)
Parents	12% (^)	4% (D)	11% (D)	52% (^)	27% (^)
Other family members	3% (D)	1% (D)	3% (D)	11% (^)	4% (D)
Traditional leaders	1% (D)	4% (^)	5% (^)	1% (=)	1% (D)
Religious leaders	1% (=)	1% (D)	2% (D)	9% (^)	1% (D)
NGOs	0%	0%	17% (^)	55% (^)	0%
Other	5% (^)	NA	21% (^)	1% (^)	0%

(^), (D), (=) = increase (^), decrease (D) or equal (=) in comparison to baseline

In the Midline Performance Survey a question was added about which topics were covered by sexuality education and information. Countries show different patterns in the topics that were covered (see Table 5) and variations between topics covered by SRHR education provided in school versus SRHR information provided in out-of-school settings. HIV/STI testing was reported quite often, whereas lower proportions were reported for the topics concerning SRH services and sexual harassment and abuse. However, a more diverse picture of topics covered is reported under SRHR information than education. The topic of family planning and contraceptives show a different picture for the African countries versus Indonesia and Pakistan.

Table 5 Topics covered by SRHR education in-schools & SRHR information

Topics (multiple topics could be indicated)	Ethiopia		Ghana		Malawi		Indonesia		Pakistan	
	EDU	INF	EDU	INF	EDU	INF	EDU	INF	EDU	INF
Where to access SRH services	20%	38%	65%	62%	52%	71%	17%	31%	84%	90%
Types of SRH services available	17%	31%	51%	54%	40%	58%	10%	15%	62%	65%
Different methods of family planning/contraceptives	47%	62%	68%	73%	62%	89%	5%	10%	0%	0%
HIV/STI testing	76%	73%	66%	67%	76%	85%	53%	55%	52%	42%
Information regarding puberty	46%	61%	76%	81%	68%	58%	70%	82%	37%	35%
Information regarding sexual relationships and love	23%	51%	78%	81%	57%	63%	65%	78%	38%	30%
Information regarding gender equality and rights	38%	56%	78%	84%	52%	65%	31%	36%	37%	24%
Information regarding sexual harassment/abuse	24%	45%	50%	53%	43%	54%	56%	63%	36%	26%
Other*	4%	11%	0%	0%	5%	1%	40%	45%	0%	0%

*e.g. Unwanted pregnancy and safe abortion, sexual orientation and identity, fertility

In Kenya, an interesting issue emerges on fear of using family planning (not related to the GUSO programme). In one FDG, myths and misconceptions about family planning were mentioned, and one individual respondent had heard negative things about using medical family planning methods, but used condoms instead:

"I don't use family planning due to the fear of side effects. This has not changed. I have accessed condom use, asit prevents me getting infections and unplanned pregnancy." (Female interviewee - Kenya).

In many countries social media was used as a tool for information. Social media appeals, in part, for young people, as they can seek information without shame or fear. However, the information available was sometimes problematic, as shown by this quote from a young woman in Kenya:

"Young people have a right to access health services, access information. This has changed as young people get information from the social media which is not healthy. I get information on love and relationships from articles, social media, trainings, friends and television. I get information on what to do when raped, types of relationships. This has changed as most relationship is getting worse due to distorted information." (Female interviewee - Kenya)

2.5 Outcome 4 Increased use of youth-friendly SRH services

In general, the knowledge on preventing pregnancy has remained high compared to the baseline results in the African countries. Moreover, in Indonesia this knowledge has increased substantially since baseline. For Pakistan no information is available on progress on Outcome 4 since these questions were discarded from the questionnaire because of sensitivity and security issues. The current use of contraceptives remained low. In Ethiopia it remains low at around 17%, in Ghana current contraceptive use decreased from 31% to 24%. In Malawi, the proportion decreased, but was the highest with about 60% reporting to use contraceptives. In Indonesia only one respondent indicated to use contraceptives (male condoms). Male condoms were the most reported method of contraceptives, followed by injections and the pill in Ethiopia and Ghana and implants in Malawi. The proportion of abstinence were low and decreased since baseline.

Table 6 Methods of contraceptive use (multiple sources could be indicated)

	ETH (n=77)	GHA (n=186)	MAL (n=207)	IND (n=1)
Male condoms	51% (D)	62% (^)	63% (=)	n=1
Injections	17% (^)	38% (D)	25% (^)	0%
Pills	12% (=)	17% (^)	4% (D)	0%
Implants	10% (D)	3% (^)	21% (^)	0%
Morning After Pills (MAP)	8% (^)	0%	0% (=)	0%
Abstinence	4% (D)	12% (D)	3% (D)	0%
Intrauterine Contraceptive Devices (UID)	3% (D)	1% (^)	1% (^)	0%
Female Condoms	3% (D)	9% (^)	5% (D)	0%
SDSs (observing safe days)	1% (D)	3% (D)	1% (^)	0%
Sterilization	0% (D)	1% (^)	0% (=)	0%
Withdrawal	0% (=)	7% (^)	0% (=)	0%
Other	0% (D)	0% (D)	0% (=)	0%

(^), (D), (=) = increase (^), decrease (D) or equal (=) in comparison to baseline

The most important reason not to use contraceptives was that young people stated to never have had sex, or were not currently sexually active (Table 7). Another large proportion never considered it. In Ghana, 13% reported to be worried about the side effect as a reason for not using contraceptives and low proportions stated that they disagreed with contraception as a reason for not taking it.

Unmet need for contraceptives (% of men and women who would prefer to use contraceptives, but currently do not use them) has increased in comparison to the baseline results in the African countries, whereas in Indonesia this proportion decreased. The proportion of young people who never used a SRH service has decreased in Ethiopia and Ghana and slightly increased in Malawi and Indonesia. In Ethiopia and Ghana the proportion that were referred to a service has increased since the start of the programme. However, in Malawi and Indonesia this proportion has decreased. The source of referral varies per country (Table 9). Friends were the main source of referrals to services in Ethiopia, followed by peer educators. In Ghana, NGOs, teachers and health workers were most often reported as the source of referral, whereas in Malawi young people were most often referred by health workers and friends.

From the low number of young people that were referred to a service in Indonesia, parents were the most important source of referrals, followed by teachers.

Table 7 Reasons for not using contraceptives

	ETH (n=367)	GHA (n=579)	MAL (n=142)	IND (n=349)
I never had sex	62% (D)	60% (^)	37% (^)	48% (^)
I never thought of it	22% (^)	38% (D)	15% (D)	35% (D)
I am not currently sexually active	13% (D)	16% (^)	34% (^)	14% (^)
I am worried about the side effects	1%	13% (^)	4% (D)	1% (=)
I do not agree with contraception	1%	6%	1% (=)	0% (D)
It reduces satisfaction	1%	5% (D)	1% (^)	0% (=)
My spouse/partner disapproves	1%	2% (^)	2% (D)	0% (=)
Refused by health care providers	0% (D)	1%	1% (^)	0% (=)
Does not know where to get contraceptives	0%	3%	0% (D)	1% (^)
Does not know about contraceptives	0%	2%	1% (D)	18% (D)
Other*	14%	14%	5% (D)	3% (D)

(^), (D), (=) = increase (^), decrease (D) or equal (=) in comparison to baseline

Around 75% of respondents who had used services stated that the SRH services were of good or excellent quality. In comparison to the baseline this was an improvement in Malawi (see Figure 2) and Ghana (in Ethiopia and Indonesia no comparison was made). In Malawi and Ghana, young people at midterm felt relatively confident to use SRH services, get tested for HIV and STIs and get condoms. In Ethiopia, there was a mixed sentiment expressed by young women, where they did not feel confident to get condoms from a pharmacy, health clinic or shop. This was also the case for Indonesia, where about half of the respondents did not feel confident to get condoms.

Table 8 Indicators for Outcome 4 Increased use of youth-friendly SRHR services

	ETH		GHA		MAL		IND	
	MID	BAS	MID	BAS	MID	BAS	MID	BAS
% of young men and women who know at least one way to prevent pregnancy	97%	97%	99%	98%	98%	98%	87%	64%
% of young men and women who report currently using any contraception	17%	16%	24%	31%	59%	70%	0.3% (n=1)	1.6%
% of young men and women who would prefer to use contraception (among those who currently do not use it)	75%	60%	73%	62%	91%	67%	39%	48%
% who used condoms at last sexual intercourse (among those who had sex)	14%	15%	35%	*	68%	*	20% (1/5)	
% of young women who have ever been pregnant (% of pregnancies that were planned)	19% (83%)	5% (88%)	22% (29%)	29% (25%)	41% (53%)	46% (56%)	0%	5%
% of young people who never used SRH services	47%	54%	56%	61%	9%	6%	81%	71%
% of young people who were referred to access SRH services	38%	24%	76%	54%	45%	74%	57%	60%

*this % was not specifically stated in the baseline reports

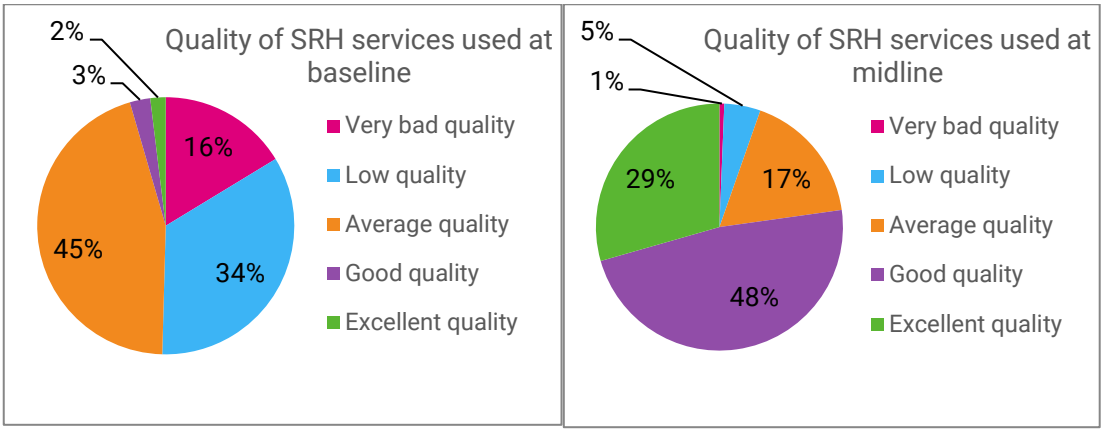


Figure 2: Quality of SRH services at baseline and midterm in Malawi (n=466 baseline; n=316 midterm)

Table 9 Source of referral at last SRH service used

	ETH (n=77)	GHA (n=275)	MAL (n=109)	IND (n=16)
School counsellor / nurse	0%	0% (D)	0% (D)	0%
Teacher	9% (D)	36% (^)	5% (D)	25%
Peer educator	14%	1% (D)	6% (D)	0%
Youth Club	NA	NA	NA	0%
NGO	9%	38% (^)	7% (^)	0%
Health Worker	11%	22% (D)	28% (^)	0%
Online / Mobile platform	0%	0% (=)	0% (D)	0%
Friends	34%	3% (D)	27% (D)	0%
Parents	6% (D)	0% (D)	13% (^)	56%
Other	13%	0%	13%%* (^)	19%

*6% in Malawi was referred by a Community Based Distribution Agent (CBDA), an increase in comparison with the baseline (^), (D), (=) = increase (^), decrease (D) or equal (=) in comparison to baseline

In Uganda, participants mentioned a positive change in their access to services:

"We now get to be tested, free condoms, several contraception methods, ARVs, training for youths who don't want to take ARV" (Male Interviewee - Uganda).

This change led to increased critical consciousness when making decisions in relation to one's sexual health.

"If you are not accessing such information you can be reluctant on what decisions to make but now that you are accessing information like warnings about HIV, you can wake up and understand that HIV is real" (Male FGD - Uganda).

The identified drivers of increased access to services in Uganda were: having services brought down to the community; acquiring information and education from several sources; and welcoming service providers.

Young people involved in delivering SRH services equipped them with the skills, confidence and knowledge to speak out about sexuality and related issues to peers, and even when not involved in service delivery, they felt it made talking about sexuality less daunting:

"Young people are treated friendly, but it also depend on the attitude of the service providers. This has changed, as there are young service providers who understand them. Young people are influencing the services designed for them by advising other young people to access them. This has changed, as young people are now more open." (Female interviewee - Kenya)

The main challenge facing the GUSO programme and its partners is ensuring that services such as, guidance and counselling are accessible, affordable and available to those who need them most. It became apparent that stock outs (availability of contraceptives and other commodities) were a major problem.

2.6 Outcome 5b - Improved socio-cultural, political and legal environment

With respect to increasing support from stakeholders, Ghana, Indonesia and Pakistan presented a positive picture in comparison to the baseline (Table 10). In Ethiopia, no major changes were observed. In Malawi, when it came to stakeholders that support young people in the realm of SRHR, health workers, young people's partners and peers were considered easy, understanding and supportive. Although traditional/community chiefs, (local) political and religious leaders were not found to be very easy to talk to, understanding or supportive, they were found easier to interact with at midterm compared to baseline, particularly local (political) leaders and traditional/community chiefs. In Pakistan, there is an improvement on ease in talking about LSBE, Youth Friendly Health Services, and relationships with their parents, spouse/partner and other family members. Moreover, young people in Pakistan reported that health workers/providers were one of the most difficult groups of people to speak to, followed by traditional/community chiefs. In Indonesia, respondents indicated, in general, to have less difficulty in talking about SRH with the stakeholders at midline, in comparison to the baseline.

With respect to personal attitudes there were no major shifts seen since the start of the programme in Ethiopia. In Ghana, some improvements were reported. Young people agreed that they were able to participate in the decision-making for their own healthcare, as well as decision-making on whether they wanted to have sex or not. In Malawi, a shift is visible from the results in attitudes of young people on SRHR. Fewer respondents felt guilty when they had sexual feelings and respondents also felt they could participate in decision-making for their healthcare. However, more felt afraid of changes in puberty at midterm compared to the results from the baseline study. In addition, attitudes on same sex relationships remained conservative. In Indonesia, progress was reported with respect to personal attitudes similar to Pakistan, where some changes in attitudes were noted.

In Uganda, local leaders, community members and religious leaders were seen as both allies and opponents, as illustrated in the following quotes:

"Others say you promoting bad behaviours when they give out condoms they are promoting immorality and others say they are preventing them from HIV, so some are positively supporting it yet others are negative about sexual health" (Male FGD – Uganda). Although some community stakeholders still oppose SRHR, participants acknowledged that there has been is a change since program implementation and that some of the opponents have now become allies: "They now ask if you use condoms and contraceptives. If you say yes, they say family planning is good" (Female interviewee – Uganda).

Promoting an enabling environment requires youth participation. Youth participation improves self-esteem and confidence, increases young people's use of SRH services, and is also seen by young people to improve their positioning in their communities. In Kenya, many respondents reported being seen more positively by older people over the past two years because they are active in community work. Whilst support for young people's rights should not be contingent on their behaviour, positive relations between young people and those who have power and influence in society may help in generating support for youth-friendly policies.

Table 10 Proportion of young men and women that agreed or strongly agreed to feel supported by various stakeholders in accessing sexuality education and SRH services

	ETH		GHA		MAL**		IND		PAK	
Number of young people interviewed Midterm - Baseline	456	532	765	737	353	503	350	500	744	677
	MID	BAS	MID	BAS	MID	BAS**	MID	BAS	MID	BAS
Religious leaders	26%	46%	57%	12%	23%	28%	64%	36%	49%	37%
Teachers	70%	79%	88%	59%	59%	59%	88%	67%	74%	26%
Peers	79%	82%	96%	77%	78%	70%	55%	43%	66%	39%
Parents	65%	69%	92%	47%	56%	53%	87%	83%	95%	39%
Other family members	46%	54%	92%	40%	59%	59%	54%	50%	83%	35%
Girlfriends/boyfriends/spouses/partners	61%	74%	99%	80%	80%	72%	29%	23%	73%	53%
Traditional / community chiefs	17%	34%	88%	21%	35%	32%	35%	17%	30%	42%
(Local) political leaders	17%	30%	92%	29%	26%	28%	23%	8%	29%	39%
Medical personnel	88%	NA	99%	NA	95%	NA	90%	82%	55%	NA

2.7 Long Term Objective – All young people are empowered to realise their SRHR

Progress towards the long-term objective was promising in Kenya and Uganda (see Annex % for visuals of the results). Due to the nature of the study no information on progress towards the LTO can be deducted from the performance studies in the other five GUSO countries. In Kenya, respondents reported overwhelmingly positive changes in nearly all areas of their lives, many of which are directly linked to the GUSO programme and the partner organisations responsible for its implementation.

In Uganda, study participants expressed an increase in voice, both within the private and public domain. Within the public domain, participants reported taking part in community discussions or having fellow young people represent them in different decision-making structures where they lobbied for their SRHR.

"Because I now know I am a citizen and am meant to get the services so if am not getting them I have to ask for them" (Female- interviewee).

At community level, focus was placed on the environment/space in which young people live and work, and the support provided by other people within this space. Participants mentioned local leaders, community members and religious leaders as key stakeholders that could potentially influence young people's SRHR.

Receiving training on life skills, sexuality and relationships led to young people in Kenya having improved knowledge, and a range of further outcomes. These outcomes are significant because they speak to a variety of improvements in the quality of life for young people in areas which reach beyond sexual and reproductive health. Feeling that one's attitude to sex and relationships had improved led to improvements in the quality of friendships. Feeling more empowered as a result of better knowledge also helped young people to navigate friendships and to avoid peer pressure. Attending training sessions and having improved knowledge also meant that young people felt overall more competent and that they had grown as people, which led to them feeling more able to access youth-friendly services.

However, some challenges also became apparent from this assessment. These challenges include: school-health facility linkages are strained by distance; transport to services was a problem experienced by young people; drug addiction was mentioned as a major problem that was not addressed within the programme; community members were said to be fed-up at times with peer educators who "just talk", but never provide services; young people faced financial barriers to accessing contraceptives and public facilities face stock-outs; religious leaders were referred to as contributors, but also as negative drivers of change; and partner involvement, especially for young women living with HIV, remains a major problem.

Prior to the qualitative assessment in Kenya and Uganda, a systematic mapping was conducted in both the intervention and the control area of the GUSO programme. In both countries, other SRHR programmes are being implemented in the GUSO intervention area. This will have consequences for the impact measurement of the GUSO programme at endline. The consequence can be positive if these SRHR programmes reinforce the GUSO message, or negative if conflicting messages are targeted at end-beneficiaries. Moreover, the mapping provides opportunities for the GUSO organisations to initiate or strengthen collaboration and alignment with other organisations and programmes in the intervention area. The mapping exercise showed that, in both countries, in the control area less SRHR programmes were enrolled compared to the intervention area. However, the few SRHR programmes that are being implemented in the control area may impact the study population. The direction of this impact (positive or negative) for the end-line study is difficult to predict.

A few questions on empowerment were added to the performance questionnaire in the midterm. When asked about empowerment, young people in Ghana stated that overall they felt empowered in different realms of making SRHR decisions and they also felt confident to resist or seek help when someone forced them to do something against their will. However in Ethiopia, Indonesia, Malawi, Pakistan, around 80%-90% of respondents stated that they wished they had more respect for themselves. The gradual changes in the attitudes of young people indicate progress, but also indicate that there is more to be done by the GUSO programme.

2.8 Outcome 5a Improved socio-cultural, political and legal environment

One of the main purposes of the alliances is to promote and push for a gender sensitive and youth friendly SRHR environment. The GUSO partner organisations have been involved in advocacy in the previous programs (ASK and UFBR), and in some countries an advocacy strategy already existed at the start of the programme. During GUSO, the country alliances are supported to formulate an advocacy strategy and to bring the advocacy to a higher and more strategic level. The better the alliance prepares itself for advocacy, the more chance they have of reaching their goals. Table 11 illustrates the advocacy themes per country that are prioritised under the GUSO programme.

Table 11 Advocacy Themes per country

Country	Theme(s)	Focus
Ethiopia	Youth Friendly Services	Quality implementation of YFS in health facilities
Ghana	Youth Friendly Services	Quality implementation of YFS in public health facilities
Indonesia	• Comprehensive Sexuality Education • Youth Friendly Services • Comprehensive Sexuality Protection	• Support implementation of CSE by 2020. • Implementation of revised guideline for YFS to improve the quality. • Adapt legislation Law on Elimination of Sexual Violence and adjust draft Penal Code to not criminalize rape victims and health care providers.
Kenya	1. 1.Finance and SRHR 2. Youth Friendly Services 3. Meaningful Youth Participation	1 Increased finance and human resources for SRHR. 2 Improved access to quality and comprehensive SRH information services. 3 Increased meaningful youth participation in decision making.
Malawi	1) Youth Friendly Services 2) Safe Abortion 3) Sexual Gender Based Violence	o Youth access to YFS in rural communities o Access to safe abortion o Sexual Gender Based Violence
Pakistan	Artikel I. Youth policy Artikel II. Life Skills Based Education	– Implementation of Youth Policy at provincial level – Integration of Life Skills Based Education in school curriculum at provincial level.
Uganda	a Information and Education b Youth Friendly Services	Focus on district and national level, amongst others, on resource allocation for youth friendly services at district level.

A key challenge in several countries regarding implementation of the GUSO programme is the shrinking space for civil society and the growing conservative climate concerning SRHR and topics such as CSE. The SRHR Alliances in these countries employed different – often advocacy related – approaches to deal with this situation, which differ from country to country. Some of the commonalities include: advocacy towards policy and decision-makers, civil society collaboration (both within the alliance and other civil society organisations) and different ways to seek public support for the advocacy agenda. For example working with allies/champions amongst policy-and decision-makers, cultural and religious leaders, and using the media.

2.9 Approaches used by the SRHR Alliances in the countries of implementation

Ethiopia

The Alliance faces challenges and oppositions with regards to delivery of SRH information and education from different stakeholders including Government Ministries, such as the Ministry of Education that has prohibited the inclusion of CSE in the formal school curriculums. Alliance members have therefore been *engaging with Alliance member FGAE, which is in the technical team that has been working for the integration of comprehensive sexuality education in the Ethiopian school curriculum*. The team is comprised of influential partners such as the Consortium of Reproductive Health Associations and UNESCO. Another approach being used by one of the Alliance members –DEC- was *contextualisation of the CSE manual*. Finally, an opportunity for the GUSO program to build on is the Ministry of Health's new National Adolescent and Youth Health strategy (2016-2020), which was finalised in 2017 and which uses CSE as major approach to address young people's SRH problems. Besides, there is a Charities and Societies Law banning civil society organisations to operate on rights and advocacy related issues. Despite this situation, organisations in the alliance -like Talent Youth Association- have managed to *collaborate with other stakeholders* such as the Consortium of Christian Relief & Development Associations for the amendment of this law so the alliance would be able to have a mandate to work on these issues.

Ghana

To a large extent the SRHR context in Ghana has remained progressive over the years. In 2017 some more improvements in the political, policy and regulatory environments were realised. For instance: the Adolescent Reproductive Health Policy was strengthened to provide guidance and a framework for contributions by CSOs to the policy objectives; the Adolescent Health Service Policy and Strategy was launched to provide a framework within which health provision and other related interventions for adolescents and young people would be coordinated and implemented; CSE eventually gained the desired national attention and culminated in the development of National Guidelines for CSE delivery in Ghana. Opposition largely came from the majority of the elderly in the communities (chiefs, elders, religious leaders, parents/guardians) who use cultural values and norms as basis for not allowing young people to access SRHR information and services for fear of promiscuity, which might lead to unwanted pregnancies and STIs. Opposition was also experienced from some health service providers who mostly imposed their religion or values on young people and intimidated them from subsequent visits for SRH services. The key strategy employed to deal with these oppositions was the *avoidance of confrontation while being more engaging with evidence and facts*. Alliance members also *created avenues for participatory planning, transparency and openness with key stakeholders* such as the District Health Management Teams and health service providers at facility level and the Ghana education service and teachers. This approach was helpful in securing their buy-in.

Indonesia

Opposition in Indonesia has the following characteristics: fundamentalist religious groups, building support and creating hatred on social media, mass mobilization, as well as lobby and advocacy in the parliament and constitutional court. One of the developments at national level was that in December 2017, Indonesia's constitutional court rejected a petition by a conservative group, Family Love Alliance (AILA), to make extramarital sex, including same-sex, a crime. Although this is a victory in the SRHR advocacy, it received a counter-reaction from the conservative groups as well as the public. This public pressure has prompted the Parliament to incorporate the issues to the draft of the Penal Code which is expected to be passed in early 2018. The draft of the Penal Code will also further limit information on contraception and contraceptive sales. In addition, abortion services cannot be given to rape victims, which is against the Health Law.

To deal with opposition, the alliance and their members tend to *work with other alliances/networks or organisations with intersectional issues,* such as human rights, women's rights, labour rights, children rights, and environment. These include advocacy networks such as Right Here Right Now (RHRN), GerakBersama, Aliansi Reformasi KUHP, and JKP3. Furthermore, Alliance members also collaborate with the Commission of Human Rights, and the Commission on Violence Against women for very sensitive issues, especially LGBTQI. These collaborations create more support for the alliance advocacy works and create greater force for the government to act. At the same time, the alliance is also more secure because it is not directly targeted by the opposition. In Kupang, the main issue seems to be the lack of understanding of SRHR among communities that lead to myths, stigma and discrimination. Nevertheless, as in many other parts in Indonesia, *religious leaders play a significant role in creating public opinion*. Therefore, Alliance member IHAP has been working with the Christian church Synod GMIT for the past year resulting in two agreements; (1) The Youth Network TeBe will facilitate a monthly discussion with the church youth community, and (2) IHAP to provide technical assistance to the church in developing their SRHR module for young people.

Kenya

The main opposition in Kenya has been reluctance and different priorities from the key stakeholders and policy makers like legislators. Most of the elected leaders prioritise political issues, thus ignoring the very important social problems such as SRHR. One of the key strategies of the Kenya SRHR alliance was therefore to *create allies –called champions- amongst religious leaders as well as political leaders*, such as the Members of County Assemblies in GUSO counties of implementation. An example of the latter: In 2017, a number of Alliance members collaborated in advocacy -like ADS Nyanza, KMET and CSA with NAYA taking lead- to advocate for SRHR issues and resource allocation. They worked closely with Reproductive Health stakeholders and County Assembly SRH Champions. In doing so, NAYA employed the inside out strategy: working with supportive Members of County Assemblies to reach out to those that were not in support. An example of a positive change: Siaya and Kisumu Counties increased stipend for community health volunteer's from 2500 to 3000 Kenyan Shilling (KES) including payment of National Hospital Insurance Fund in the financial year 2017/2018 and allocating 500,000 KES to HIV and Aids programs. This health budget advocacy was slowed down in 2017, as elections took place, after which several existing champions were not voted back. Therefore Alliance members had to create awareness, sensitize and train the new Members of County Assemblies in 2017.

The Alliance also *collaborated with other civil society organisations/ networks*: In Nov 2017 the SRHR Alliance was for example elected as a co-convener in the CSO CSE Advocacy Caucus, a network of CSO organisation advocating for CSE in the country. Besides, the Alliance and partners implementing Comprehensive Sexuality Education (CSE) participated in an Expert learning meeting in July, 2017 in Nairobi, on preventing and addressing backlash and opposition regarding Sexual and Reproductive Health and Rights (SRHR) that was jointly organized by Rutgers and IPPF AR. The meeting was an opportunity to share experience and knowledge and gain insights in useful strategies for addressing backlash and opposition regarding SRHR and/or CSE.

Malawi

There were a number of positive changes and new developments in Malawi relating to the policy and political context of Sexual and Reproductive Health and Rights. These included: the revising of the Post Exposure Prophylaxis (PED) guideline, which now recognises and prioritises LGBTI; Youth Friendly Health Service Corners have been scaled up from thirty two to sixty nine in all three regions in Malawi; increased budget allocation for a specific component on Family Planning under FP 2020 initiative in the 2017 budget; a revised CSE manual for out of school youth which is comprehensive and now covers LGBTIQ issues. On the other hand there was still a backlash on SRHR issues which are considered sensitive in Malawi, including LGBTI, Family Planning and Safe Abortion. The Catholic Church for example discouraged through pastoral letters condom use among the church members and the youth and instead promoted natural family planning methods.

One of the strategies that the Malawi SRHR alliance prioritised in 2017 at community level was to *win parents' support for youth access to SRHR and family planning methods*. Another strategy concerned *working with the concerned groups themselves -such as LGBT, young people living with HIV/ AIDS, and young girls - in advocating for* improved access to services in health centres and calling for community leader's recognition. This has been helpful as the decision makers prefer getting calls and appeals from the affected and concerned individuals. One of the SRHR Alliance members -COWLHA- for example deliberately extended invitations to youth leaders living with HIV/AIDS in some strategic awareness meetings so that they could make appeals to community leaders to include them in development agendas and reduce discrimination.

Pakistan

SRHR is a sensitive topic to openly discuss and talk about. The term Life Skills Based Education (LSBE) is more appropriate and acceptable, but it also demands careful selection of words to communicate without affecting the essence topic. A strategy to deal with this situation is to *engage like-minded people*. Meetings with religious and community leaders, and government officials are part of a successful strategy that resulted in smooth implementation of project activities in the targeted areas. Besides, an *LSBE taskforce* established by GUSO is working in close coordination and all member organisations provide support to each other in different regions. Recently, the LSBE taskforce and RHRN alliance have started to work together for inclusion of LSBE in the mainstream curriculum. During a recent meeting both platforms invited all the partners to join hands and come up with a collective LSBE teacher manual. This collective manual will be helpful in further advocacy efforts.

Uganda

The political situation in Uganda remained relatively stable in 2017 but highly restrictive for SRHR oriented work, as can be illustrated by the following developments: The temporal ban on Comprehensive Sexuality Education (CSE) by the Parliament of Uganda; the Ministry of Gender, Labor and Social development banned comprehensive sexuality education for out of school youth; the Ministry of Health recalled the Services and Standards guidelines for SRHR, in part because of their progressive nature to recognise and provide SRHR services including contraceptive services for young people below the age of 18 years.

One approach that was employed by the Alliance members towards a supportive policy environment for the delivery of rights based sexuality education programmes and youth responsive SRHR services, consisted of *organising key policy level activities*, in collaboration with other likeminded organisations. Considerable progress was for example made towards passing of the National Sexuality Education Framework, as the final draft was validated by end of 2017. It is anticipated that this will raise urgency and momentum to work towards a National Sexuality Education curriculum, a process that Alliance partners are lobbying for with the aim to fast track its development and passing.

Use of radio and TV to appeal to policy-and decision makers on SRH related policies and regulations was another approach used by Alliance members - RHU, CEHURD, STF and RAHU- to prevent and deal with opposition. Experience has showed that policy makers listen in and indeed engage with TV and radio. For example CEHURD, held a show in 2017 about the Ministry's failure to launch the SRHR guidelines. The Ministry responded by a press conference in parliament speaking to reasons for its failure to launch.

In using these media for promoting SRHR and Sexuality Education, an approach that was applied by one of the Alliance members, was to *include local government representatives*: RHU delivered radio talk shows together with district local government officials on various SRHR/Sexuality Education themes. Key departmental representatives from health, education, gender, and community development were engaged for instance in discussing rational sexuality education for young people, disabling factors for accessing Youth Friendly Services, modalities for accelerating parent involvement in promotion of access to services and information among others. This approach helped the project to neutralise opposition against sexuality education as well as strengthen access to key SRHR services for young people especially those in-school

2.10 Assessment of the collaboration within the partnership

GUSO is executed in a strategic SRHR Partnership with the Dutch Ministry of Foreign Affairs (MoFA). As the order states, the SRHR partnership is more than just a relationship between grant provider and grant recipient. Both partners aim to achieve a shared long-term goal together in the field of SRHR, to create impact. That is why MoFA funds the partnership as a donor, and why MoFA engages as a partner. MoFA acknowledges that balancing these roles can be challenging for all parties involved, and as a ministry, it continues assessing how to best operationalise the position as both donor and partner. The open and constructive meetings with consortium members are being perceived positively. Other positive impressions and experiences were that the GUSO partnership is well organised, has a good overview and is responsive. Working in a partnership, as partners, but also working in and with (local) alliances can be further assessed and improved according to MoFA.

Midway the programme, all NL/UK consortium partners see an added value of working in this SRHR Partnership. Working in a partnership means creating synergies, learning from each other and building on each member's strengths. Each consortium member brings different knowledge and expertise to the table. Moreover, every consortium member has a different network of collaborating partners at country level, which creates a bigger SRHR network. Because of the diversity in expertise between NL/UK members and local partners, a multicomponent approach can be implemented, where education, services and community interventions target young people from various angles, making the impact of our work stronger and more sustainable. Together the different components are more effective than as single actors. The added value of MoFA in this partnership is the joining of forces in countering the growing conservatism in some countries, keeping SRHR as a priority of Dutch development cooperation and leading by example to other governments on how civil society and government can collaborate together, especially in times of increased opposition. Working in a partnership can also be challenging at times. Collaboration takes time. Aligning the six members, MoFA, and 50 local organisations is time-consuming and requires significant financial and human resources. The heavy governance structure in this partnership is being perceived as a challenge and it is recommended to evaluate it. With so many partners involved in NL/UK and seven implementing countries, communicating about plans and decisions made is key for all staff to be on the same page.

Building a strong partnership requires true understanding of each other's strengths and accepting differences in ways of working. One of the challenges members face is that although all work on SRHR, this does not automatically imply that there is a common language. Continuous dialogue and unpacking of key concepts remains a challenge. Maintaining trust in the partnership is another challenge. All organisations in the partnership have to balance between their organisational stakes and the aims of the programme, and this can create distrust when there is a lack of openness. Moreover, some members have overlapping areas of expertise and interests. We have to continuously be sensitive to the level of trust in order to maintain good working relations. This not only applies to the NL/UK consortium but also to the countries, where power dynamics in country alliances are also present.

All members in the partnership (MoFA, NL/UK consortium members and in-country alliances) highly value the role of the embassies within this partnership. Through this partnership, the links with the embassies have been strengthened but more importantly, the country alliances and the partners are in closer contact with the embassies. Several embassies invest a lot of time and energy in aligning/coordinating and harmonising partnerships at country level. This has opened doors for advocacy in-country. With regard to advocacy, embassies remarked that for the second part of the programme, they could be engaged more strategically, also for policy-level dialogue. They have an added value in bilateral communication with the national governments on specific advocacy topics. In the coming years, this role (silent advocacy) may be further strengthened. Therefore, embassies need to be updated regularly by in-country partners on the progress of the programme, as well as by the NL/UK consortium members when they visit the country.

3 DISCUSSION AND RECOMMENDATIONS

The midterm evaluation of the GUSO programme shows that halfway through the programme, good progress is made towards the outcomes of the GUSO Theory of Change. Moreover, it shows promising results towards the empowerment of young people to realise their SRHR. The evaluation also points out that progress varies between countries and that the Multi-component Approach can be strengthened in every GUSO country, by investing more in linking between information (demand), services (supply), and environment (support), and by meaningfully involving young people in the programme. Moreover, it highlights the need for enhancement of alliance building and the importance of (youth-led) advocacy to join efforts to improve SRHR for young people in times of growing conservatism. In the coming year, the NL/UK Steering Committee and the in-country alliances will develop a post-2020 strategy [R0] that will include various scenarios for sustaining the work for young people's SRHR in the seven GUSO countries. In addition, country alliances will develop a plan for transitioning towards 2020. NL/UK will support the country alliances in developing these.

3.1 Outcome 1

The midterm evaluation shows that steadily, there is a stronger collaboration of organisations working as an alliance in most of the countries, showing that progress is made on Outcome 1. Although funding and planning horizons for most alliances do not go beyond the duration of the GUSO programme, they all indicate the intention to continue with alliance working after GUSO. From the midterm and the in-country validation it becomes clear that alliances would welcome capacity strengthening support to increase visibility and develop allies and technical support and advice to accelerate strengthening and sustainability of their alliances. There should be a deliberate effort to make sure the NSC/NGB is in the lead/takes a more accountable role in strengthening and sustaining the alliance. Alliances need to address issues of shared ambition and agree on the urgency of becoming a more capable organisation, delivering high quality SRHR products, as well as developing allies and making new partnerships to diversify their resource base. [R1]

It is recommended that country alliances should discuss their post 2020 ambitions with regard to continuation as an alliance. If the answer is yes then it should become clear what kind of support they need from NL/UK or other parties for the last years of the GUSO programme. Consequently, alliance strengthening should then take a more central role in the coming two years to ensure that alliances at the end of the programme are stronger and more sustainable. The midterm also points out that it is difficult to measure impact of alliance working. To be able to better understand and appreciate the contribution of alliance working towards the GUSO long term objective, [R2] it is recommended to start an OR track in 2019/2020 to gather evidence of successful/learnings from alliance building.

There should be a clear distinction between joint activities and alliance strengthening. Joint activities feed into strengthening the alliances by providing a collaborative platform for alliance working, but should not be mistaken to be enough for alliance strengthening. In 2019-2020 there should be a deliberate plan for more sharing and learning by alliances. What is lacking is a more coordinated structure, and a platform for more south-to-south and north-to-south sharing and learning. The action plans should be seen as a good exit strategy designed for alliances to be in a stronger position post 2020. [R3] It is recommended that country alliances should include linking and learning as a strategy in their 2019-2020 plans.

3.2 Outcome 2

Good progress is made under Outcome 2, especially for the overarching principle of Meaningful Youth Participation, capacity building of young people, and youth-led advocacy. However, the midterm showed that young people do not always feel trusted by adults, and are sometimes hesitant to ask questions to adults. It was also highlighted that more can be done to ensure that youth engagement goes beyond implementation and advocacy, to include (financial) planning and Monitoring & Evaluation. Based on the results so far, it is recommended to review the two strategies, [R4] Youth-adult Partnerships, taking into account the trust issue, and [R5] youth movement building and decide if these need more attention in the remaining years of the GUSO programme. Moreover, the OR track that is planned in 2018 on the Youth-adult Partnership between the NPCs and YCCs, and on youth-movement building is expected to provide us with more insights in these two relevant strategie. Furthermore, it is important to assess the impact of investments in youth-led organisations throughout the years of GUSO and preceding programmes. Finally, it is recommended to [R6] find ways to ensure sustainability, so that youth structures will not disappear after the GUSO program has ended.

3.3 Outcome 3

Midway GUSO, the uptake of SRHR information and education has increased, compared to the baseline. All countries show progress with respect to Outcome 3. The qualitative assessment showed that the GUSO programme is having a positive impact on young people's knowledge about sexual and reproductive health. Moreover, participants mentioned a positive change in their access to SRHR information and services. Interaction with peer educators was referred to as very instrumental for gaining SRHR information and access to services. This study shows that support from peers is a key driver of the full realisation of young people's SRHR. If more young people are exposed to the positive ideals of the GUSO programme they can provide further reinforcement of these messages.

In many countries it remains difficult to *comprehensively* address sexuality education in-school and in out-of-school settings. Sensitive topics like sexual reproductive rights, sexual diversity, safe abortion, contraception and pleasure are much debated topics. Moreover, access to information on HIV remains a problem in some countries. The midterm shows that to some extent it is easier to address sensitive issues in out-of-school settings than in-school settings. These results raise questions as to what extent the intermediate ToC outcome, "Access to *quality* SRHR Information and Education, through diverse channels" is being met.

Moreover, the midterm shows that most countries face opposition from the government to implement SE *comprehensively*. Resistance may not only comes from governments, but as discussed in the validation workshops, it may also come from teachers who are sometimes unwilling to cover certain topics in class, or from other educators and health care workers due to political and normative dynamics. [R7] It is recommended to assess if and how the (quality of) comprehensiveness of SRHR Information and Education can be improved for the second phase of the programme and whether to adopt or strengthen strategies to cope with these limitations. For example, awareness campaigns and sensitisation sessions in and out of schools help to get teachers, parents and community members on board. Moreover, the learned-centred participatory approach can be explored, as was suggested in the validation workshops, to help educators to address sensitive issues.

Additionally, [R8] it is recommended to assess for each country context if strengthening the use of social media will increase the uptake of SRHR (including HIV) information provision. Social media, with part of its appeal for young people being the ability to seek information without shame or fear; yet the midterm shows that the information available was sometimes conflicting. Having several sources of inconsistency in information may create a predicament when making sexuality related decisions. Moreover, inconsistency in SRH information received from the several sources may lead to uncertainty and intrapersonal struggles on what information to act upon. Although not covered in the current research, consistency is a crucial point that the GUSO programme needs to take into consideration given that the program is implemented by various stakeholders, which could run the risk of differences in messages delivered to the target population. Sexual rights are young people's rights; caution is needed to ensure this message is not diluted.

3.4 Outcome 4

The midterm evaluation shows a mixed pattern of progress for Outcome 4. It clearly illustrates the need to better link *demand* (Outcome 3) and *supply* (Outcome 4) under the Multi-component Approach. The qualitative studies shows a positive change in access to services. Yet, the current use of contraceptives remained low and was even lower than reported at baseline in most countries.

Moreover, unmet need for contraceptives has increased since baseline in the African countries. In Ethiopia and Ghana the proportion that was referred to a service has increased since baseline, however decreased in Malawi and Indonesia. The midterm shows that young people's involvement in providing services and giving feedback which they see is acted upon makes a difference in various ways which support the GUSO Theory of Change. The quality of services provided generally increased since baseline, showing progress in the ToC strategy of "capacity building of service providers and health institutions".

The main challenge facing the GUSO programme and its partners is ensuring that services are accessible, affordable and available to those who need them most. The results call for [R9] an in-depth analysis of the reasons behind the gaps in access to services. This should guide the implementation of targeted strategies, which could include: strengthening referral systems; improving social accountability mechanisms; addressing the issue of stock-outs and/or non-availability of some commodities (contraceptives, condoms, HIV tests and treatment, etc.); training providers in supply chain management; advocating for sustainable and affordable youth-friendly services; and enhancing the collaboration with public and private health facilities.

In Pakistan and Indonesia, [R10] a specific analysis should be carried out to understand how to increase access to contraception among unmarried young people. While discussing the affordability of services, it has become clear in a few countries that the economic empowerment component was missing in the GUSO programme. While this was a deliberate decision made at the beginning of the programme, [R11] it is recommended to assess if, at this stage of the programme, it is realistic and favourable to add Economic Empowerment components, besides what is already being implemented under the Flexibility Fund in Uganda.

3.5 Outcome 5

A key challenge that several countries face in implementing the GUSO programme, is the shrinking space for civil society and the growing conservative climate regarding SRHR. The midterm evaluation shows that the SRHR Alliances in these countries employ different – often advocacy related – approaches to deal with this situation, which differ from country to country. Some of the commonalities include: advocacy towards policy and decision makers, civil society collaboration (both within the Alliance as with other civil society organisations) and different ways to seek public support for the advocacy agenda, for example by working with allies/champions amongst policy and decision makers, cultural and religious leaders and using the media.

It is clear that some progress is made with respect to the strategy "evidence-based advocacy", but more is needed. [R12] with regard to advocacy. Embassies remarked that for the second part of the programme, they could be engaged more strategically, also for policy level dialogue. In the coming years, this role (silent advocacy) may be further strengthened. Therefore, embassies need to be updated regularly by in-country partners on the progress of the programme, as well as by the NL/UK consortium members when they visit the country. Moreover, [R13] it is recommended to discuss how and if GUSO with a district focus on advocacy can align on advocacy with RHRN, but also with other programmes such as PITCH that work on national (and international) level advocacy. The midterm also shows that it is difficult to measure progress for this outcome area. To measure progress of advocacy efforts and to be able to attribute this to the GUSO programme [R14]. It is recommended to assess the use of a systematic methodology in 2019/2020, such as Outcome Harvesting, to document evidence. Outcome Harvesting collects ("harvests") evidence of what has changed ("outcomes") and, then, working backwards, determines whether and how an intervention has contributed to these changes.

While the countries at national level in the programmes face opposition, the midterm shows some progress with respect to support at local (implementation) level. Perceived support from various stakeholders has increased in comparison to the baseline under the intermediate outcome, "communities and key gatekeepers support youth SRHR". In many countries, religious and community leaders are seen as both allies and opponents. [R15] It is recommended to increase the use of community champions under the strategy, "engage key-influencers as SRHR Ambassadors". Moreover, promoting an enabling environment requires youth participation. Youth participation improves self-esteem and confidence, increases young people's use of SRH services, and is also seen by young people to improve their positioning in their communities.

The reflection on the partnership working showed that midway through the programme, all partners see an added value of working in this SRHR Partnership. Working in a partnership means creating synergies, learning from each other and building on each member's strengths. It also requires true understanding of each other and accepting different ways of working. The added value of the MoFA in this partnership is the joining of forces in countering growing conservatism, keeping SRHR as a priority and leading by example to other governments on how civil society and government can collaborate. Moreover, the role of the embassies are highly valued and [R16] it is recommended to enhance further collaboration with the in-country alliances for the second phase of the GUSO programme.

3.6 Limitations

The midterm evaluation faced several limitations that may affect the interpretation of the findings. We were not able to use a uniform approach for Outcome 3, 4 and 5 over the countries and therefore progress in Kenya and Uganda is difficult to compare with the other countries. Selection bias might have been present with respect to the sampling of the respondents. In addition, it is important to realise that the midterm in most countries is only conducted in one of the intervention areas. Results should be interpreted with caution for the other intervention sites. With regard to the quantitative data collection instruments, the data derived from the survey might not be able to prove significant differences for all of the relevant indicators, for example as a result of other interventions that are simultaneously being implemented in the implementation areas.

As this is a programme performance study, the findings cannot be generalised to the larger community or national context. Since study participants are the primary beneficiaries of the GUSO programme, there could be a tendency to give socially desirable answers, which could confound the results. The absence of a control group also limits the extent to which certain outcomes can be attributed solely to the GUSO interventions.

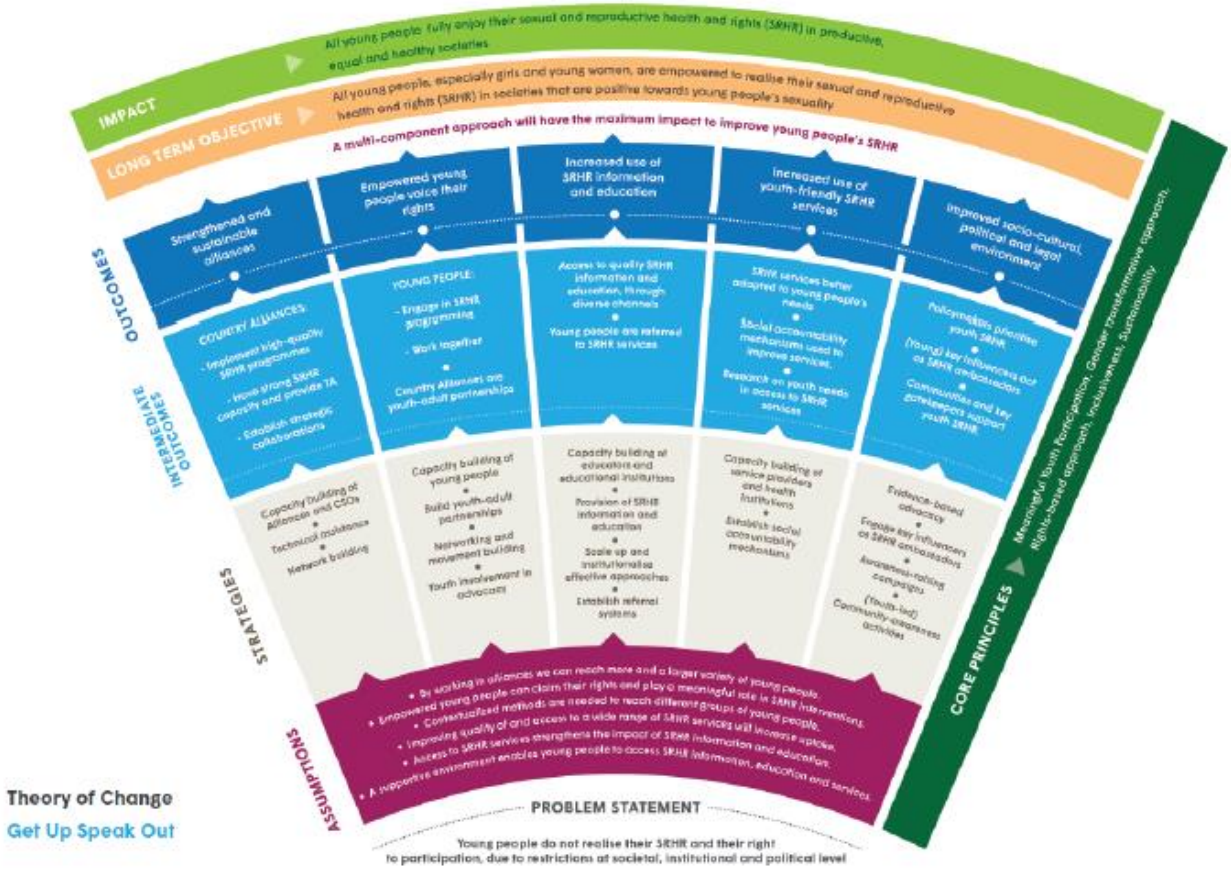
In addition, the qualitative assessment samples are not statistically representative of the wider population. Findings cannot be extrapolated out across wider project target areas, nor is that the intention. Lastly, there were contextual challenges that were not related to the GUSO programme, but that may have affected the responses, such as other programmes being implemented in the same areas with potentially conflicting messages.

For Pakistan, unfortunately no information on progress can be reported since information on Outcome 4 was not included in the study design, due to sensitivity and security issues. This is a major limitation, since progress on Outcome 4 cannot be measured. Moreover, Pakistan faced difficulties with the time line and the quality of the enumerators, affecting the quality of the results. In consultation with the NPC, the NSC of the Pakistan GUSO programme will propose an alternative way to measure progress for this aspect of the programme.

3.7 Future

The midterm evaluation of the GUSO programme shows promising progress towards its long-term objective: all young people, especially girls and young women, are empowered to realise their SRHR in societies that are positive towards young people's sexuality. Hopeful results are presented with respect to increasing empowerment of young people, despite the fact that the programme countries face (growing) opposition in various ways. With the Global Gag Rule in place, limiting the space for SRHR and hampering the work of civil society organisations, it becomes even more imperative for the Dutch government to continue its leadership role and investments in the SRHR sector after 2020. Successes achieved during previous programmes (ASK/UFBR) and the GUSO programme should be sustained after the programme will come to an end. The midterm provides important input for further shaping the policy framework of the Ministry of Foreign Affairs when it comes to young people's SRHR.

ANNEX 1 GUSO THEORY OF CHANGE



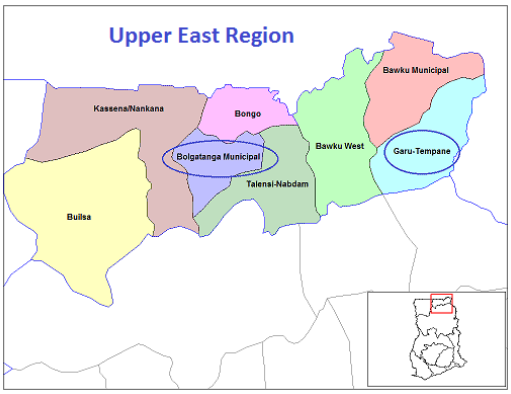
Theory of Change
Get Up Speak Out

ANNEX 2 STUDY SITES

SRHR Alliance = Ethiopia GUSO alliance, 4 organisations

Implementing GUSO partner organisations (4): Development expertise centre (DEC), Family guidance association of Ethiopia (FGAE), Talent Youth Association (TAYA) and Youth network for sustainable development (YNSD).

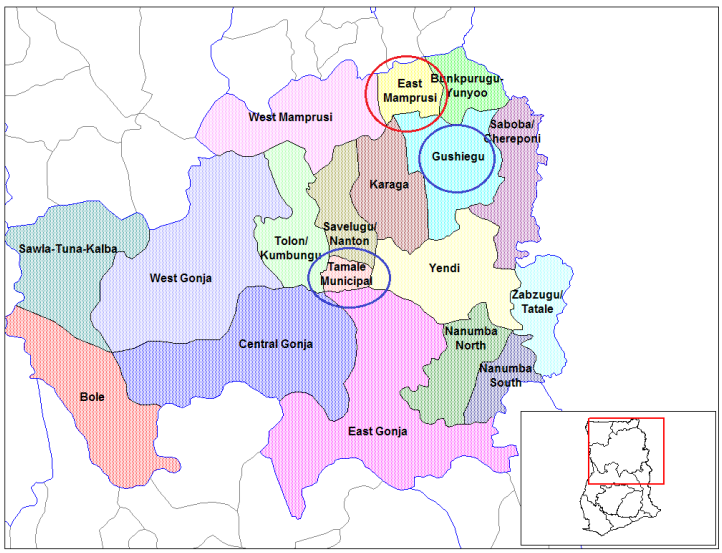
The GUSO programme is being implemented in three districts within the city of Addis Ababa, Ethiopia. The midterm was conducted in all three districts.



SRHR Alliance = Ghana SRHR Alliance, 6 organisations

Implementing GUSO partner organisations (6): Planned Parenthood Association of Ghana (PPAG), Curious Minds, Hope or Future Generations, NORSAAC, Presbyterian Health Services – North, Savana Signatures.

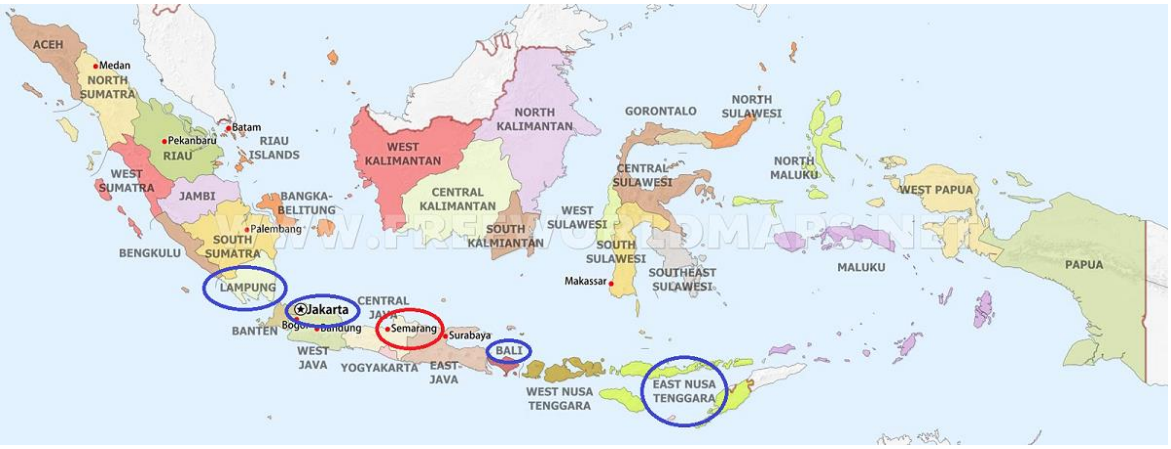
The GUSO programme is being implemented in five districts: two in North-Ghana and three in Upper-East-Ghana. The midterm was conducted in one of the districts in North-Ghana (East Mamprusi).



SRHR Alliance = Aliansi Satu Visi (ASV), 22 organisations

Implementing GUSO partner organisations (10 organisations): PKBI Lampung; PKBI Jakarta; PKBI Central Java; PKBI Bali; Rutgers WPF; ARI; IHAP; YPI; Red Cross West Jakarta (PMI); Ardhanary Institute

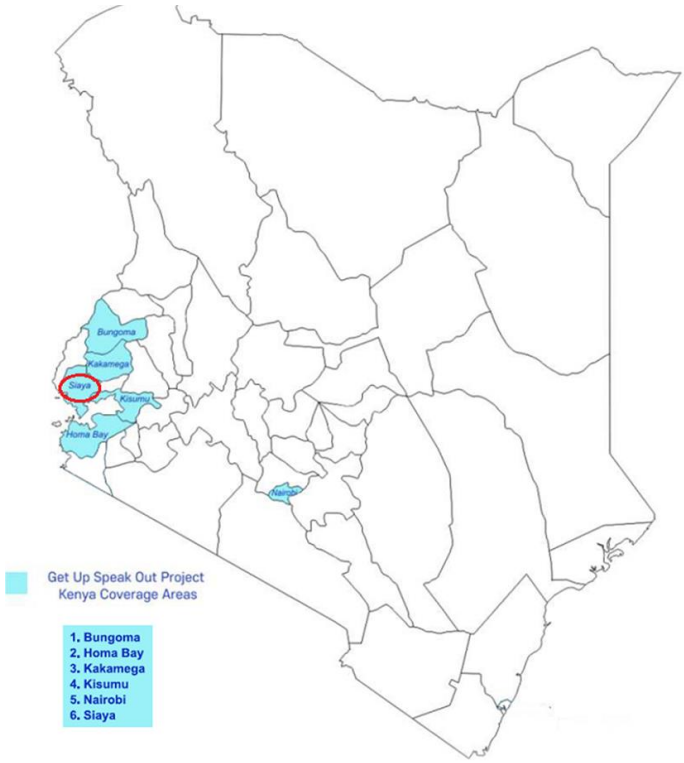
The GUSO programme is being implemented in five regions : Jakarta, Lampung, Bali, Semargang and East-Nusa Tengara. The midterm was conducted in Semarang.



SRHR Alliance = Kenya SRHR Alliance, 17 organisations

Implementing GUSO partner organisations (9 organisations): ADS NyanzA, Centre for the study of Adolescence (CSA); Family Health Options Kenya (FHOK); Great Lakes University of Kisumu (GLUK); Kisumu Medical Trust (KMET); NAIROBITS TRUST; NAYA; Ambassador for Youth and Adolescent Reproductive Health Program (AYARHEP); Women Fighting AIDS in Kenya (WOFAK).

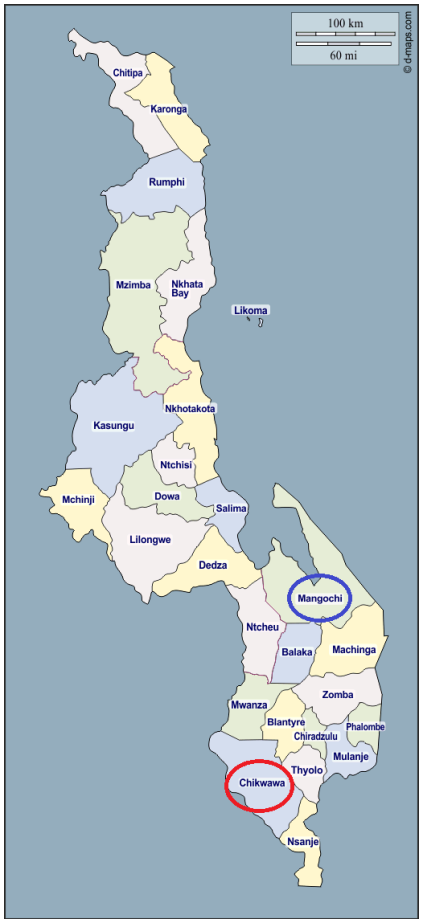
The GUSO programme is being implemented in six counties in Kenya: Bungoma, Homa Bay, Kakamega, Kisumu, Nairobi and Siaya. The Midterm is situated in Siaya county, this is also the intervention area selected for the external base- and endline.



SRHR Alliance = Malawi SRHR Alliance, 6 organisations

Implementing GUSO partner organisations (6 organisations): Centre for Alternatives for Victimized Women and Children (CAVWOC), Centre for Human Rights and Rehabilitation (CHRR), Centre for Youth Empowerment and Civic Education (CYECE), Family Planning Association of Malawi (FPAM), Youth Net and Counselling (YONECO), Coalition of Women Living with HIV and AIDS (COLWHA)

The GUSO programme is being implemented in two districts: Chikwawa and Mangochi. The midterm was conducted in Chikwawa. An additional sample was taken in Mangochi (not included in this report).



SRHR Alliance = Pakistan Parwan Alliance, 17 organisations

Implementing GUSO partner organisations (6 organisations):Rutgers Pakistan, Family Planning Association of Pakistan (FPAP), Idara-e-Taleem-o-Agahi (ITA), Blessings Welfare Association (BWA), Participatory Integrated Development Society (PIDS), Visionary Foundation Pakistan (VFP).

The GUSO programme is being implemented in three regions: Quetta, Karachi and Lahore. The midterm was conducted in Karachi.

SRHR Alliance = SRHR Alliance Uganda, 10 organisations

Implementing GUSO partner organisations (8 organisations): Straight Talk Foundation, Restless Development, Reach A Hand Uganda, Reproductive Health Uganda, Family Life Education Program (FLEP), UNYPA, NAFOPHANU, Center for Health, Human rights and Development (CEHURD).

The GUSO programme is being implemented in 4 regions: Jinja, Iganga, Bugin, and Mayuge. The midterm was conducted in Iganga.

ANNEX 3 METHODOLOGY MIDTERM

The objective of the overall GUSO evaluation is: to assess to what extent the GUSO programme has led to the empowerment of young people to realise their SRHR in societies that have a positive attitude towards young people's sexuality; and evaluate which interventions, strategies and processes have reached and affected young people the most.

The evaluation will address the following specific objectives:
1 To evaluate (progress towards) programme outcomes and the long-term objective of the GUSO programme.
2 To understand what processes have led to these results, including enabling factors and barriers
3 To propose feasible recommendations to inform future programme design.

Researching the programme impact and conducting the evaluation involves two major components:
A Base, midterm and end-line performance studies in five countries
B Comparative studies (base and end-line) in two countries (Kenya and Uganda).

The performance studies, jointly conducted by KIT and GUSO partners focus on measuring outcome indicators 3, 4 and 5b (see Table 1). These studies can be seen as programme performance evaluations of the countries Ghana, Malawi, Indonesia, Ethiopia and Pakistan. The comparative studies in Kenya and Uganda, conducted by KIT only during base- and end-line, make it possible to additionally measure long-term change in a way that it can be attributed to the GUSO programme (objectives 1 and 2). The GUSO consortium is responsible for the design, data collection and analysis and for producing the qualitative baseline, midline and end-line reports in the GUSO countries in relation to the remaining joined indicators, Outcome 1, Outcome 2 and Outcome 5a.

The Royal Tropical Institute (KIT) is a Dutch international knowledge and expertise centre committed to improving health, ensuring equitable social-economic development and promoting intercultural cooperation worldwide. KIT is responsible for researching and evaluating the programme to reveal the impact of the GUSO programme and the processes leading to this impact. Strong collaboration with the GUSO consortium and partners will take place as with national research teams. Furthermore, young people will play a crucial role in all different stages of the research and evaluation.

In table 1, the Joint indicator framework shows which indicators are used to measure progress for the five outcome areas and the LTO.

Table 1 Joint indicator framework GUSO (red indicators are measured by the KIT)

LONG-TERM OBJECTIVE: All young people are empowered to realise their SRHR in societies that have a positive attitude towards young people's sexuality
Indicators: • **Positive change in sexual health; gender attitudes, empowerment, and self-esteem among young people in the programme areas** ➔ ***For the Midterm: Some of these indicators(change in sexual health and empowerment) are measured through the qualitative assessment in Uganda and Kenya***
OUTCOME 1 STRONG AND SUSTAINABLE ALLIANCES
Outcome indicator: • **Country alliance is strengthened and more sustainable.** ➔ ***This indicator will be measured through the Alliance Capacity Assessment Tool (2017 and 2019) and reflection workshops*** ➔ ***For the Midterm: A qualitative assessment of current status of country alliances, priorities for alliance strengthening***
OUTCOME 2 YOUNG PEOPLE INCREASINGLY VOICE THEIR RIGHTS
Outcome indicators: • **Young people increasingly feel supported by adults in their organisations/the country alliance/partner organisations.** • **Young people increasingly feel empowered to contribute to changes for the target group and in the socio-political environment.** ➔ ***These indicators will be measured through an online survey and FGDs with young people, in 2017 and 2019*** ➔ ***For the Midterm: Assessment of current status of the strategies under Outcome 2 and the priorities for MYP***
OUTCOME 3 INCREASED UTILISATION OF COMPREHENSIVE SRHR INFORMATION AND EDUCATION BY ALL PEOPLE

Outcome indicators: • **Increased % of young people who are reached with SRHR information and education from the GUSO programme.** • **Increased % of young people who perceive the SRHR information and education as beneficial to them.** ➔ ***For the Midterm: indicators measured by KIT***	
OUTCOME 4 INCREASED UTILISATION OF HIGH-QUALITY SRH SERVICES THAT RESPOND TO THE NEEDS AND RIGHTS OF ALL YOUNG PEOPLE	
Outcome indicators: • **Increased % of young people (from the catchment area) who access high-quality SRH services, including modern contraception and safe abortion for young people.** • **Increased % of young people who use the referral system to access SRH services.** • **Decreased % of young people with an unmet need for SRH services.** ➔ ***For the Midterm: indicators measured by KIT***	
OUTCOME 5 IMPROVED SOCIO-CULTURAL, POLITICAL AND LEGAL ENVIRONMENT FOR YOUNG PEOPLE'S SRHR	
5A	Outcome indicator: • Progress towards high-quality implementation of (country-specific) SRHR policies and legislation. ➔ *For the Midterm*: *A qualitative assessment was done on the advocacy strategies of the country alliances.*
5B	Outcome indicator: • Young people experience increased support from important stakeholders and gatekeepers in accessing and using SRHR information and services. ➔ *For the Midterm: indicator measured by KIT*

The midterm evaluation consists of three components:

1. A qualitative approach for outcomes 1, 2 and 5a (all countries). In addition to this an assessment of the partnership was carried out among the NL/UK consortium, MoFA and the Embassies.
2. A quantitative approach (referred to as the "performance studies", coordinated by KIT) was used to assess the midterm for outcome indicators 3 and 4 and 5b (ETH, GHA, MAL, IND and PAK).
3. A qualitative assessment in Kenya and Uganda, to understand the contribution of the Multi-component Approach towards the empowerment of young people.

In all countries, a 2-3 days Validation Workshop was organised in May or June 2018 to validate and discuss the draft results of the midterm and to assess progress in the light of the strategies of the Country Specific ToCs. A report with a summary of the Validation workshop discussions was provided to the GUSO Consortium Office and recommendations are integrated in the current Midterm Report.

Ad 1). Methodology Qualitative approach OA1 – OA2 – OA5a – partnership assessment (all countries)

Information on progress was collected by means of the regular M&E system, meaning that questions were added to the process of information collected for the annual report 2017. Moreover, for progress under Outcome 1, information was used from the 2017 survey on alliance strengthening and the Outcome 1 workshops conducted in country. During the in-country Validation Workshops (May-June 2018) information on progress of Outcome 1 Action Plans was assessed as was the progress towards the strategies under Outcome 1 in the ToC. For Outcome 2, the survey and focus group discussions on Meaningful Youth Participation (MYP), conducted in 2017 by the YCCs and NL/UK PMEL advisors, provided useful input to assess progress. Moreover, during the Validation Workshops, progress towards the 4 strategies under Outcome 2 was assessed with the in-country alliances. For Outcome 5a questions on the Advocacy Strategy and dealing with opposition were asked in the reporting over 2017. Again, during the Validation Workshop, progress was discussed and reported. For the assessment of the partnership questions were asked in the Annual Report process to the seven country alliances, to the NL/UK Consortium members, to the policy advisor from MoFA and to the Embassies of six countries (excluding Malawi, since they do not have an EKN).

Ad 2). Quantitative performance studies (ETH, GHA, MAL, IND and PAK)

An quantitative performance study, coordinated by KIT, was used to assess the midterm for outcome indicators 3 and 4 and 5b, the outcome areas that measure results on the level of the target group, conducted in five countries. The selection and methodology is similar to the baseline study in order to compare the results. The questionnaire included questions related to the generic indicators mentioned in Table 1. Youth form the core of the performance study - both in terms of the target group and study participants but also as research assistants that conducted the survey. This unique position has not only increased their involvement in the organisation of the research process but has enabled them to secure information on sensitive issues related to SRHR in an easy manner.

For the midterm, the sample size is more or less similar to the baseline performance studies, around 500 young persons within each country. However, the midterm is an independent sample from the baseline survey. Because the project is targeting girls and boys between 10 and 24 years of age, gender and age of those surveyed was also balanced. Country specific details are discussed with country alliances and partners. Data are collected in a youth friendly manner, suitable to the context. Young people are interviewed by young research assistants appointed by the in-country GUSO alliance, who have undergone an (online) training on the programme performance evaluation; and appropriate ways of data collection. Interviews took place one-on-one in safe environments, either at the household level or at specific places such as schools or health centres. For quality assurance purposes, tablets are used for data collection. Inclusion of research assistants (close) from the study areas ensured to overcome barriers related to literacy and local languages.

A generic questionnaire, based on the baseline questionnaire (developed by KIT), was assessed by the PMEL WG. This generic questionnaire was shared with the in-country alliances in February 2018 and was subsequently adapted according to different country contexts with the input of the GUSO country teams and any other relevant actors. The assistance of the GUSO alliance was needed in translation of the country-specific questionnaires to the appropriate language. The questions included issues about girls' and boys' knowledge on SRHR, their level of access to SRHR information and services, whether they find the information and services beneficial and appropriate or not, contraception access and use, referral systems and the level of support received from relevant stakeholders. In Pakistan, all questions regarding services and contraceptives (Outcome 4), were excluded from the questionnaire. After data collection, filled questionnaires were extracted from the server and quantitative analyses was done by the KIT, coordinating closely with the alliances through the process for input. Midterm results are compared to the Baseline results. Data was analysed using Stata.

Due to the sensitive nature of SRHR issues in several of the GUSO country contexts, information obtained from the study participants was kept confidential. For this purpose, research assistants were trained on ethical issues to ensure that guidance on ethical conduct is clearly understood and implemented. This was part of the online training that was facilitated by KIT. In addition, research assistants were trained on the meaning and process of obtaining oral consent before data collection. For children under the age of 18 or 16, depending upon the country, it was necessary to obtain the informed consent of a parent or caregiver (foster parent) regarding participation of the girl/ boy. Hence, consent was sought as appropriate in the country or region, based on national ethical guidance. Lastly, in each country/ study area, (child/ youth) counsellors and referral opportunities to appropriate care were put in place and this was mentioned in the consent form.

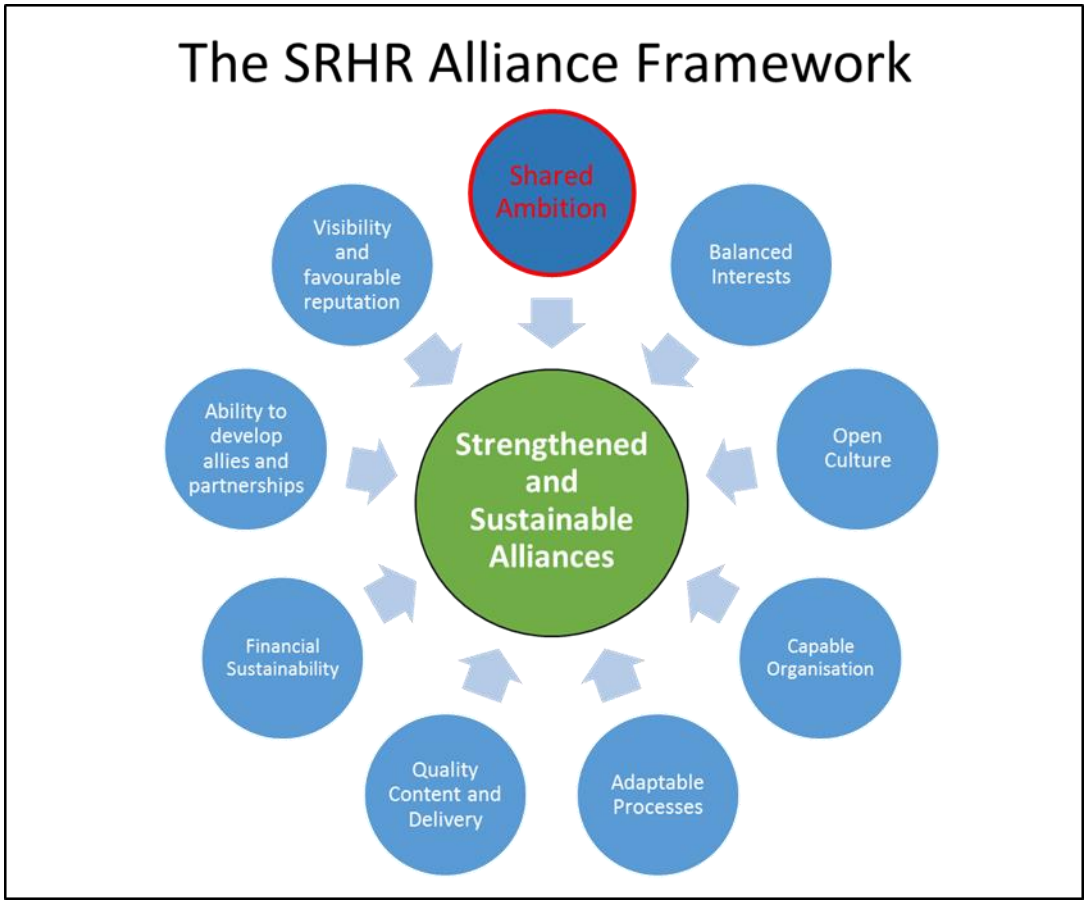
Ad 3). Qualitative assessment of the Multi-component Approach (Kenya and Uganda)

At the start of the programme, no external midline evaluation was planned for in Kenya and Uganda. The GUSO consortium took the initiative to conduct a qualitative assessment in both of these countries, to assess the progress of the GUSO programme towards the LTO "All young people are empowered to realise their SRHR in societies that have a positive attitude towards young people's sexuality". First, a systematic mapping was conducted, in both the intervention and the control area (see Annex 1 for geographical information of the study sites), to thoroughly document which different stakeholders implement SRHR programmes at what frequency in the intervention site and in the control site. Subsequently, a qualitative assessment was conducted in the intervention area to assess progress towards the LTO.

In Kenya, a Qualitative Impact Assessment (QUIP) was used in Siaya district, as a qualitative evaluation methodology that is designed to serve as a reality check on whether the Multi-component Approach of the GUSO programme on intended beneficiaries is as expected, or whether it is having unintended consequences. The impact of the GUSO programme was evaluated by gathering end-beneficiaries perceptions of what has changed in their lives over the past two years across a series of domains (based on the GUSO ToC). The Bath University was contracted to conduct the QUIP. In May 2018, 24 end-beneficiaries (young people aged 15-24 years) were interviewed. In addition to the individual interviews, four focus groups were also carried out across the communities. These were organised according to age and sex, with separate groups for: older men (18-24), older women (18-24), younger men (15-17) and younger women (15-17). Each consisted between six to eight people. Analysis of respondent interviews begins with systematic coding of responses. Only statements related to changes that the individual or focus group experienced are coded. A system of triple coding has been developed whereby the analyst allocates a driver, an outcome and an attribution code to statements of change (for more information see Country Report Kenya).

In Uganda, a qualitative content analysis study was used to explore and understand how young people within the GUSO program in Iganga experienced empowerment and its drivers. Semi-structured individual interviews and focus group discussions were the primary data collection methods adopted for the study. Purposive sampling was used. In March 2018, 15 interviews were conducted (6 female, 9 males) and two FDGs. For purposes of addressing change (empowerment) at group level, by understanding the norms and attitudes, and to clarify (triangulation) information obtained from individual interviews, two FGDs each consisting of 5 and 6 young people respectively were conducted after the interviews. In addition to end-beneficiaries, different stakeholders were interviewed (May 2018) to explore how they experienced the implementation of the Multi-component Approach. The stakeholders (both male and female) were directly involved in the implementation of MCA within the GUSO program. These included peer educators both in school (2) and out of school (5), program officers from implementing organisations (8), health workers (2), district officials (2), and teachers (2). With the aim of capturing variations in experiences/perspectives, the study employed the purposeful sampling strategy. Participation in the study was on a voluntary basis and anonymous, all informants provided informed consent. Ethical approval was obtained from St. Francis Hospital Nsambya Institutional Review Board. Additionally, verbal permission was sought from the relevant district and sub- county authorities. Data was analysed using qualitative content analysis (QCA) guided by Graneheim and Lundman (2004).

ANNEX 4 FRAMEWORK SUSTAINABLE ALLIANCE



ANNEX 5 VISUALS QUALITATIVE ASSESSMENT KENYA AND UGANDA

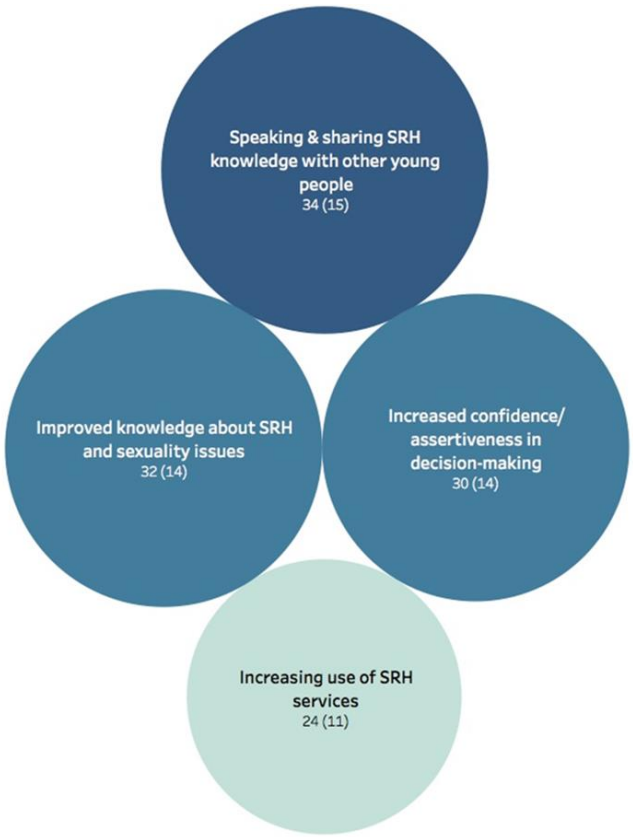


Figure 5.1 Main positive changes, attributed to the GUSO programme (Kenya)

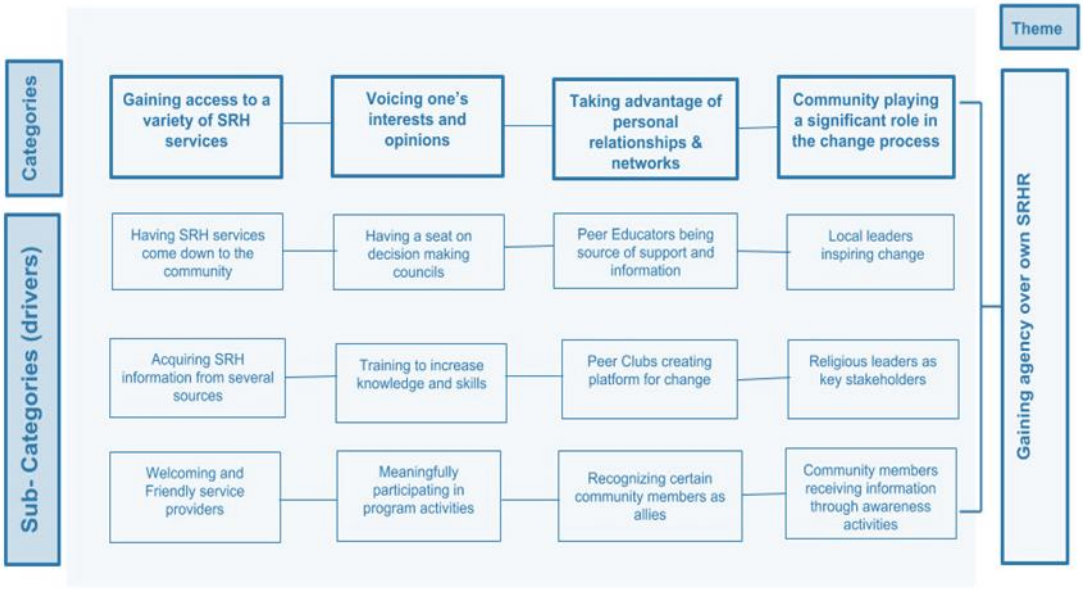


Figure 5.2 Analytical model qualitative assessment Uganda