YES I DO SYNTHESIS

REFLECTIONS ON THE BASELINE 2016

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1. Introduction

1.1 The Yes I Do programme

The Yes I Do programme aims to contribute to a world in which adolescent girls can decide if, when and with whom to marry and have children, and are protected from female genital mutilation/ cutting (FGM/C). Child marriage and FGM/C are human rights violations and are, like teenage pregnancy, manifestations of deeply rooted gender inequality and social norms, poverty, inadequate access to sexual and reproductive health and rights (SRHR) information and services, and lack of voice amongst youth. Addressing these root causes desires a mix of innovative intervention strategies. The Yes I Do Alliance[1] will adapt intervention strategies to the specific contexts of Ethiopia, Kenya and Indonesia with regard to child marriage, teenage pregnancy and FGM/C; and Malawi, Mozambique, Zambia and Pakistan with regard to child marriage and teenage pregnancy. The Yes I Do intervention strategies intend to achieve the following strategic goals as presented in the programme's theory of change:

1. Community members and gate keepers have changed attitudes and take action to prevent child marriage, FGM/C and teenage pregnancy
2. Adolescent girls and boys are meaningfully engaged to claim their SRHR
3. Adolescent girls and boys take informed action on their sexual health
4. Girls have alternatives beyond child marriage, FGM/C and teenage pregnancy through education and economic empowerment
5. Policy makers and duty bearers develop and implement laws and policies on child marriage FGM/C

The intervention strategies focus on forming a social movement, empowering and meaningfully engaging young people, improving access to information and services, stimulating education and economic empowerment for girls and enhancing evidence-based lobbying and advocacy for improved legal and policy frameworks.

1.2 The Yes I Do baseline

The baseline is an integral part of the research component of Yes I Do. It gives insight into the current situation of child marriage, teenage pregnancy and FGM/C in the seven countries. The baseline studies were conducted in 2016. The findings are crucial for all Yes I Do Alliance partners, to be able to base interventions on context-specific evidence. This will facilitate the prevention and mitigation of child marriage, teenage pregnancies and FGM/C. It will also assist in reflecting on the assumptions of the Yes I Do theory of change. After having conducted an end-line in 2020, we will be able to reflect on the role and impact of Yes I Do.

This synthesis presents the major reflections on the outcomes of the baseline studies in the seven countries.

[1] The Yes I Do Alliance consists of Plan Nederland, Rutgers, AMREF Flying Doctors, Choice and KIT | Royal Tropical Institute.

2. Methodology of the baseline

The Yes I Do baseline used mixed methods to capture the inter-relationships between child marriage, teenage pregnancy and FGM/C. It comprised of a household survey targeted at young people between 15-24 years in intervention and control areas[2], combined with focus group discussions (FGDs), semi-structured interviews (SSIs) and key informant interviews (KIIs) in the intervention area.

2.1 Study areas

Four of the seven countries had an intervention and control area (see Table 1). The studies in Ethiopia and Indonesia did not include control areas, as there are multiple Yes I Do intervention areas in the countries. Therefore, the Alliance chose to include two intervention areas. In Pakistan, the intervention area was expanded over the course of the baseline study.

Table 1: Overview of the study areas

Country	Intervention area	Control area
Kenya	Kajiado County – Kajiado West – Iloodokilani and Ewaso Oo Nkidong'I wards	Kajiado County – Kajiado Central – Matapato and Purko North wards
Ethiopia	Bahir Dar woreda – Yelen, Sefeberet, Medina, Abbyatir kebeles and Qewet woreda – Robit, Chenta, Sosetu, Gombat kebeles	Not applicable
Malawi	Machinga district – TA Liwonde	Machinga district – TA Chikwewo
Zambia	Petauke and Chadiza districts	Katete district
Mozambique	Nampula – Mogovolas district	Nampula – Murrupula district
Indonesia	Lombok Barat district – Kediri and Lembar sub-districts; and Sukabumi district – Sukaraja and Cisolok sub-districts	Not applicable
Pakistan	Sanghar district – Sinjhoro and Sanghar; and Umerkot district – Kunri and Umerkot	Not applicable

2.2 Sample size and selection of participants

Adequate sample sizes for the survey were calculated for each country to ensure that changes in relevant indicators could be measured over time and that findings were representative to the areas presented in Table 1. The sample consisted of 75% females and 25% males and those between 15-17 and 18-24 were sampled with an equal proportion of 50%. FGDs and SSIs were conducted with males and females (15-24 years) and parents/caregivers. Other SSIs were conducted with health workers, teachers and traditional and religious leaders, while KIIs were conducted with non-governmental organizations and policy makers (Table 2).

[2] Where applicable.

Table 2: Overview of quantitative[3] and qualitative sample by country

Country	Quantitative	Qualitative		
	No. of respondent	No. of FGDs	No. of SSIs	No. of KIIs
Kenya	1368	13	17	5
Ethiopia	1166[4]	7	13	4
Malawi	1595	10	20	8
Zambia	1455	10	20	8
Mozambique	1482	12	28[5]	1
Indonesia	1534	16	35	12
Pakistan	1602	10	8	3

3. Findings

3.1 Demographics

Pakistan has the highest proportion of currently married respondents, followed by Malawi and Mozambique. The poor state of education amongst the sample in Pakistan stands in strong contrast to the rest of the countries. However, the proportion of the sample engaged in some form of labour is high in Pakistan, which comes second to Ethiopia. Indonesia has an educated sample with low drop-out rates, but engagement in work is low (Table 3).

Table 3: (Quantitative) Sample demographics

Country	Currently married (%)	Ever followed education (%)	Ever dropped out (%)	Employed (%)
Kenya	22	94	24	18
Ethiopia	22	89	53	69
Malawi	37	96	71	35
Zambia	15	90	51	19
Mozambique	34	86	68	45
Indonesia	27	99.5	15	24
Pakistan	43	30.5	99[6]	65.5

3.2 Child marriage

The baseline investigated the prevalence, circumstances and attitudes towards child marriage. As evident in Figure 1, Ethiopia has the highest rate of child marriage in the Yes I Do sample sites, closely followed by Pakistan, while Zambia has the lowest rate[7].

[3] These numbers only include those who consented to take part in the study.
[4] Due to political unrest in Ethiopia, data was collected at a smaller scale for fewer respondents. However, this will be compensated for by a consequent study in 2017.
[5] This included seven community leaders and a community court judge.
[6] However, this is a grossly over-estimated figure as 55% did not give an answer.
[7] Kenya has a stark difference in the rate of child marriage between intervention and control area with 30% and 11% respectively.

Figure 1: Rate of child marriage (marriage below 18 years) amongst females (18-24 years) across all sample sites

Marriages take various forms including registered marriages, but a large proportion entails unregistered traditional marriages or religious ceremonies. The age difference between partners amongst all married respondents, ranges from three years in Zambia to nine years in Kenya.

The Child Marriage Acceptability Score, a tool developed by Plan International, was used to calculate a score of child marriage acceptability, with a score of 23 representing a low and 161 representing a high acceptability (Table 4)[8]. A glance at the score reveals that Indonesia and Pakistan have has the highest levels of acceptability, while the lowest are in Kenya. It should be noted that acceptability gives an indication of knowledge, not of behaviour and practice.

Table 4: Child Marriage Acceptability Scores across sample sites

	Kenya	Ethiopia	Mozambique	Malawi	Zambia	Indonesia	Pakistan
Mean Score	67	75	83	70	74	98	102[9]

While in some of the countries, child marriage is mostly a manifestation of socio-economic inequality, in others, it is intertwined with religious and social norms. Some of the major influencing factors highlighted by the baseline are outlined below.

Child marriage is seen as a mechanism to escape poverty. Resource constraints on the household, coupled with the burden of bride price and dowry, lead families to marry off their daughters at an early age. In such a situation, the marriage is often to an (older) man who can provide resources. Some girls choose for themselves to marry early as they see it as an opportunity for resources that they could not previously access, or they would like to relieve the burden that they perceive they place on their families.

[8] The Child Marriage Acceptability Score is a component of the Child Marriage Acceptability Index, a tool developed by Plan International. The score consists of 23 statements, on which the respondents can (dis)agree using a seven-point Likert scale.
[9] There was a high non-response rate in Pakistan.

"For example if the child is at school, nowadays money is hard to find so if the girl is in school and the parent fails to find money for her to go to school, they will advise her to just get married." (Girl, FGD 15-19 years, Petauke District, Zambia)

The lack of financial resources is also directly related to the ability of young people to continue education. It was cited as the most prominent reason for dropping out of school by respondents in Zambia, Malawi, Pakistan and Mozambique. Lack of secondary schooling facilities in contexts such as Mozambique and Ethiopia also play a role. Lower educational qualifications in turn are closely linked to the inability to access and qualify for jobs. However, the mere lack of (good quality) jobs is also a factor.

"There are other girls in the community when they see this situation [of no employment opportunities]*, they say, 'Why should we waste money from our parent to study and then end up working in the machamba* [field]*?' Thus, they prefer to leave school, to marry and work in the machamba.*" (Girl, SSI, Mozambique)

Poor education and employment opportunities, together, have direct implications on the probability of child marriage. The interaction of these factors differ depending on the country, where in some cases, getting married also implies having to drop out of school.

"Well, if you are married you don't go to school any longer. You drop out of school. Unless you go to college, you can get married while you are still in college. But if you are still in high school, for example, you should not expect to go to school again." (Female elder, SSI, Lembar Sub-District, Lombok Barat District, Indonesia)

From the baseline findings, it also emerged that (child) marriage acts as a solution to teenage pregnancy. This is evident in Kenya where approximately 75% of respondents agreed to the statement that child marriage occurs after teenage pregnancy. This also emerged in Malawi, Zambia and Mozambique, where the girl would be expected to marry the boy who impregnated her.

"This [pregnant] *girl will be married off to an older man as a second or third wife."* (Girl, FGD 15-17 years, Kenya)

Marriage is used as a protective or coping strategy and the girl is usually the primary subject in such a strategy. This takes form of protecting family honour against pre-marital sex or *zina* as evidenced in Indonesia and Pakistan, or teenage pregnancy as seen in Ethiopia, Kenya, Malawi and Indonesia, or to cope with financial hardships as seen in countries like Malawi, Zambia and Mozambique. An unmarried pregnant girl in Indonesia would fetch a lower bride price, while in Ethiopia there is a fear of not finding a husband once the woman is considered too old. In fact, of all married respondents in Ethiopia, 45% said they had been pressurized by family and friends. Cultural rites also facilitate child marriage, such as wife-in-trainings in Ethiopia or abduction marriages in Indonesia.

While parents and societal pressure play an important role in determining child marriage, it is worth noting that child marriage is not always forced. For example, of the married respondents in Indonesia, almost none of them reported to have been pressured into the marriage. Young people choose to marry young as they see a variety of benefits that they could gain, including a stable sexual and household partner (for boys), access to financial resources (for girls) and being considered an adult in their society.

"I married at the age of 14. No one pressured me to marry at the time. Due to the hot weather condition [having sexual desires]*, getting married is a golden opportunity for girls, whether they are students or not. After the age of 15, no girl refuses to marry."* (Female 22 years, SSI, Ethiopia)

The agency of young people manifests in different ways. In Zambia, Malawi and Mozambique, lack of alternatives play a larger role in choosing pregnancy or marriage as a 'next step' towards adulthood while in Indonesia, marriage allows young people to engage in sexual relationships.

"Nowadays if the child wants to get married, but is not allowed, they would do it [pre-marital sex]*, causing more shame. Thus it is better to marry them. Nowadays teenagers if not allowed by the parents, they would cross the line. That is our fear."* (Male parent, SSI, Sukaraja Sub-District, Sukabumi District, Indonesia)

Peer pressure plays a role in almost all settings. Divorce is also concluded by several couples, particularly in Mozambique.

3.3 Teenage pregnancy

Mozambique has the highest reported rate of teenage pregnancies amongst females followed by Malawi, while the lowest is found in Ethiopia (Figure 2). The average age of pregnancy[10] was reported to be the lowest in Mozambique at 16 years, while the highest was in Indonesia at 18.5 years.

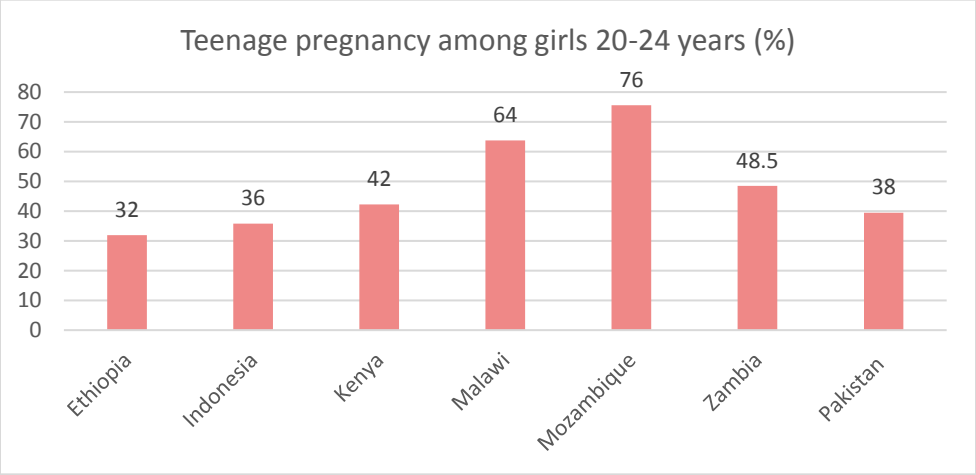

Figure 2: Rate of teenage pregnancy (pregnancy below 20 years) amongst females (20-24 years) across all sample sites

Teenage pregnancy occurs under different circumstances across the Yes I Do countries. The role of initiation rites[11] and transactional sex are influential factors in Mozambique, Malawi, Zambia and Kenya. Child marriage often precedes teenage pregnancy and in Ethiopia, Pakistan and Indonesia. Other influencing factors include the (systematic) lack of access to contraception and lack of safe transport; all these contributing factors interact with each other.

Young people go through initiation rites around the age of puberty, where they are given (mis)information regarding bodily changes and sexuality. These rites are led by counsellors and elders to ensure that women are aware of their sexuality and are taught how to please a man. They symbolize a transition to adulthood and give social endorsement to young people to begin engaging in sexual activity. This is often

[10] Including teenage and non-teenage pregnancies. Exclusion of non-teen pregnancies does not change the figures by a large margin.

[11] Throughout this document, we use the term 'initiation rites'. It must be acknowledged that these rites differ per context and that in Ethiopia and Kenya, they are called rites of passage, while in Malawi, Mozambique and Zambia they are referred to as initiation ceremonies.

unaccompanied with the use of contraception and exposes young people to the risk of unprotected sex and consequently unintended pregnancy.

[In reference to the initiation rite] *"…immediately after they are taught these things the young girls want to go and experiment what they are taught with a man."* (Boy, FDG 20-24 years, Chadiza District, Zambia)

In several cases, there is a lack of availability and access to contraception, or inability to negotiate contraceptive use. The lower rates of teenage pregnancy in Ethiopia could be attributed to higher use of contraception, however, further study is needed to explore contraceptive use among different age groups. In Indonesia, unmarried young people are systematically denied contraception by the government with the aim to discourage pre-marital sexual activity. The inability to negotiate contraceptive use is a reflection of the power dynamic between partners. In the uncertain socio-economic contexts of Malawi, Zambia, Kenya and Mozambique, transactional sex is a common occurrence and takes many forms. The baseline findings indicate that teachers are complicit in offering (economic) resources to their female students in exchange for a sexual encounter or relationship. This provider relationship with an older male adds a layer of vulnerability for young women and seems to take form of a 'power-over' relationship.

"The teachers here abuse the girls a lot, we had a problem with a former school director who had to leave as he made four students pregnant…. but there are many teachers who 'make children in the area they work in', they come to work but then they marry the students." (KII, Kenya).

"They start at 12, because maybe she will want a sweet or something nice and doesn't have money; the boy will start buying the things she wants, when he asks to have sex with her she will fail to refuse. Some are very poor. They start sleeping around with men in exchange for money to help at home." (Girl 15-19 years, Petauke District, Zambia)

A common impregnator includes *boda boda* or motorcycle riders. This was most prominent in Kenya. Most of these encounters occur on the 'market day' when girls are on their way to school. This is also signals the lack of safe transport for girls as a factor exposing them to risks of rape and pregnancy.

"This is the biggest problem is the Saturday market we have here. Many girls come over to help their parents in these small businesses and end up having sexual affairs. This issue of motorbikes is a big issue." (Parents FGD, Kenya)

However, such transactional sex also sees young women exercising their own agency to gain access to resources that they otherwise would not possess.

The baseline findings show a trend that young women who fall pregnant in Pakistan, Indonesia and Ethiopia face different social consequences. Since teenage pregnancies occur under the aegis of child marriage, they enjoy the social sanction and protection of a regular marriage. This implies that young women do not face social stigma or shame which is the case in the other countries. However, it would be premature to assume that this also allows them to exercise autonomy regarding child-bearing decisions. Alongside, the negative health effects of an early pregnancy still remain. With the anticipated arrival of a new-born, married women in school are further prompted to drop-out to take on child-rearing responsibilities.

3.4 Female Genital Mutilation/Cutting

The Yes I Do baseline focused on FGM/C in Indonesia, Ethiopia and Kenya. Of these, the baseline found the highest reported FGM/C cases in Indonesia, followed by Ethiopia and Kenya (Figure 3)[12]. The age of circumcision starts as early as at birth in Indonesia and Ethiopia, while in Kenya it is carried about at 8-10 years of age. The act of circumcision is not homogenous across the countries. While in Indonesia, it often takes the form of 'nicking', in Ethiopia it is excision and clitoridectomy and in Kenya it is a mix of different forms of clitoridectomy.

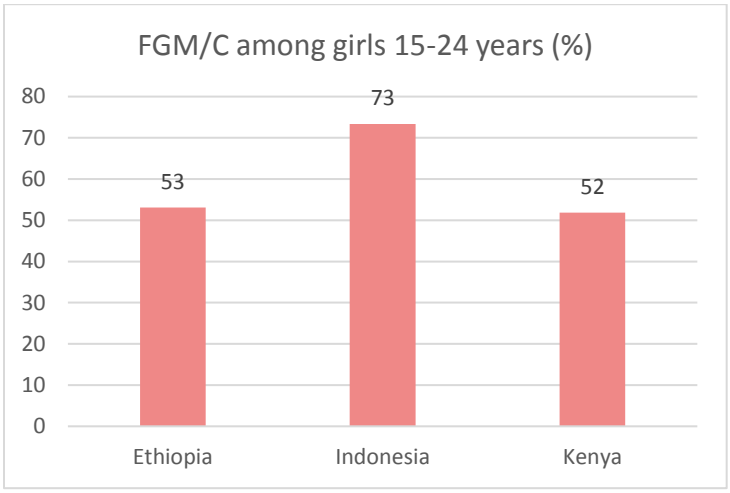

Figure 3: Rate of FGM/C amongst females across sample sites

FGM/C takes on an exclusive cultural significance in Ethiopia and Kenya in contrast to Indonesia where Islam and culture inter-mingle to advocate for the practice. FGM/C is seen as unlawful in both the African countries and young people indicate that they want to discontinue the practice. This is in contrast to findings from Indonesia. However, there are stark differences within Indonesia between Sukabumi and Lombok Barat districts. FGM/C rates in the latter are much lower and this can be attributed to a shift in social values and the role of health personnel who strongly prohibit the practice[13].

Traditional birth attendants and local circumcisers majorly carry out the circumcision across all countries. However, some medical personnel are complicit in the act, specifically in Kenya. It is worth noting that health workers also use their position to reduce the harmful impact of the strongly entrenched practice. In Indonesia, some health providers, on requests of circumcision, simply wipe the vagina with cotton as a 'symbolic' circumcision. In Kenya, it takes a different form.

"No medical practitioners do actively participate in cutting girls, but they train the traditional cutters to use anesthesia and scalpels and gloves."(Women 19-24 years, FGD, Kenya)

While these are the circumcisers, the pressure to perpetuate the act comes from older women in the family and the community; and the responsibility to carry out the tradition rests with them. Nevertheless, the role of men in this practice deserves attention as they are the final decision-makers in case of any refusal. More

[12] However, these figures are likely to be underreported as the practice is declared illegal in Kenya and strongly campaigned against in Ethiopia. The secretive nature of the act alongside the early age of circumcision are also other reasons for lack of knowledge amongst the respondents.

[13] This was particular to Lembar sub-district where only 43.48% of the girls reported to have been circumcised.

importantly, particularly in Ethiopia, men refuse to marry those women who are '*chincha*' i.e. are uncircumcised. These ideas are driven by several shared and common myths which centre on the female body. These myths perpetuate this practice and are closely linked to notions of virginity and marriageability.

In Kenya, the cut symbolizes womanhood – after preservation of virginity, whereby girls are told and believe that they have 'graduated' to become women. This motivates them to engage in activities associated with adult women: sexual relationships, marriage and childbearing. Several young women choose to undergo circumcision due to these advantages that the rite endows. This includes the status of adulthood, and specifically womanhood, the sense of belonging, inclusion and shared experience both within the larger society but also between age-mates.

"Whether she is told or not, it is automatic the girl believes that she has graduated to a woman. This therefore comes along with behaviour change and all that women practice. You should also note that girls who are forced by parents and those who ask to be circumcised are of equal percentage. There is also a lot of peer pressure, where their friends in school stigmatize girls who are not circumcised. Pressure that they may not find husbands is also high. Thus the girls end up asking to be circumcised by all means. There is a name that is given to a girl who gives birth before going through the cut. The name sounds bad and hence no one would want to be named that." (Man 19-24 years, FGD, Kenya)

"…The other issue is no man wants to marry a girl who is uncircumcised, should she get pregnant before she is circumcised, the midwives refuse to assist her during childbirth. The community has formed myths to coerce girls into accepting to be circumcised. Another myth is that a girl who is not circumcised is not sexually appealing. The other myth is to make women faithful to their husband in marriage." (Man 19-24 years, FGD, Kenya)

The myth that FGM/C can suppress the high sexual drive of women is also widely held. This is evident in Indonesia where they aim to sanctify or clean the genitals and remove the 'unclean/dirty part'.

"If the girl is not circumcised, when she grows up, syahwatna ageng [she has a high sex drive]*. Once she has intercourse, she would want it continuously, due to her high sex drive."* (Female adult, SSI, Cisolok Sub-District, Sukabumi District, Indonesia)

This discourse of hygiene and regulation of sexual desire is also present in Ethiopia. Alongside, there exists a strong belief that FGM/C is a means of socialisation and a pre-requisite to become good wives who are obedient and unaggressive. Hence, FGM/C is strongly linked to these notions of marriageability.

3.5 Inter-relationship between teenage pregnancy, child marriage and FGM/C

The premise of the Yes I Do programme is based on the inter-relationship between teenage pregnancy, child marriage and FGM/C as they have common causes and social drivers. The baseline explored these inter-linkages.

Table 5[14]: Girls with both child marriage and teenage pregnancy: what comes first?

	Ethiopia	Indonesia	Kenya	Malawi	Mozambique	Zambia	Pakistan
Number of girls with child marriage and teenage pregnancy Who had…	87	133	132	171	287	76	206
Child marriage and then teenage pregnancy	86%	70%	48%	10.5%	43%	32%	83%
Teenage pregnancy and then child marriage	2%	2%	17%	33%	11%	9%	1.5%
Child marriage and teenage pregnancy, both in the same year	11.5%	28%	33%	56%	46%	59%	15.5%

In the context of the Yes I Do countries, it is clear that teenage pregnancy, child marriage and FGM/C are inter-related. A clear trend emerges when the age at first pregnancy is assessed against the age at first marriage amongst those who underwent both child marriage and teenage pregnancy (Table 5). Figures from Ethiopia, Pakistan and Indonesia clearly indicate that child marriage precedes teenage pregnancy. However, in Mozambique, Malawi and Zambia, the figures signal that both occurred in the span of the same year. In Kenya, while the largest proportion had a child marriage first, occurrence of both in the same year is also common. In Malawi, although most occur in the same year, teenage pregnancy preceding child marriage is common. The data does not allow to trace the exact sequence for those that had both in the same year[15]. However, it does give an indication of the interaction between child marriage and teenage pregnancy. From the qualitative data and the findings presented in 3.2 and 3.3, it seems that child marriage is a response to teenage pregnancy in Malawi, Mozambique and Zambia.

"The thing is, once they are pregnant, most of them get married, but it is not their intention to get married, the parents just say they should get married." (Boy 15-19 years, FGD, Malawi).

Initiation rites in Kenya, especially those which involve both male and female cutting, may expose young people to the risk of unprotected sex which can lead to teenage pregnancy and marriage. This is particular to Kenya. Although FGM/C is a pre-requisite to marry, one cannot conclude that it is a factor that directly causes child marriage. This is especially true in the case of Ethiopia. Both in Ethiopia and Indonesia, while FGM/C is closely linked to the regulation of female sexual desire, it cannot be attributed as a cause for child marriage or teenage pregnancy. The findings indicate that the link between FGM/C, teenage pregnancy and child marriage seems to be the strongest in Kenya.

3.6 Community context and youth engagement

The beliefs, desires and actions of young people are shaped by the social norms and values of the community around them. In the context of Yes I Do, although there are overall patterns between the countries, each area is distinct and has its own unique structures and characteristics. This is illustrated for instance by the starkly different attitude towards FGM/C between the districts in Indonesia. Hence, the baseline reaffirms that the 'community context' is not homogenous and differs between and within countries. Consequently, this has implications for strategies used by the programme to engage with the 'community' and the gatekeepers unique to each community. Migration seems to play a significant role in

[14] The highlighted cells in pink indicate the majority in each country.

[15] Since it is hard to obtain data on the exact date of first pregnancy, we have used age at first pregnancy.

the search of better economic opportunities. In Ethiopia, young girls see early marriage and/or migration to Arab countries as a next step, especially when they fail their examinations. In Malawi, young males travel to Mozambique or South Africa for work to escape poverty and this constitutes a reason to leave school. Consequently, the men who leave are considered preferred partners for women by parents and the girls themselves, as they expect to get a stable income. These factors influence the socio-economic context of young people, and in turn influence the likelihood of teenage pregnancy and child marriage.

Social norms also differ per country. The fear of engaging in pre-marital sex is strong enough for young people in Indonesia to choose to get married (early). The belief that a girl is a 'burden' and that she is valued less, combined with the poor socio-economic circumstances in some of the Yes I Do contexts also play a major role in contributing to teenage pregnancy and child marriage. This is evident in Pakistan and to some extent Indonesia and Kenya, where the girl embodies familial honour. It is conclusive that in Malawi, Zambia and Mozambique, the lack of economic opportunities and the poverty rates are key drivers for teenage pregnancy and consequently child marriage. In this case, the gender norm that boys and men are supposed to provide for girls/wives plays a role. It is important to pay attention to this expectation towards boys. These norms are shaped by ideas of what societies consider 'good girls' and 'good boys'.

Overall, the baseline found that girls do not feel confident discussing issues of gender equality with male peers or adult men, and boys also do not feel confident discussing with the opposite sex. The quote below illustrates perceptions on gender in Indonesia:

"For me, women do not need a high school education, so they do not to have to work and can take care of the household." (22 years old male, unmarried, SSI, Sukaraja Sub-District, Sukabumi District, Indonesia)

Although parents and family seem to be the primary support system for most young people across the countries, there is clear lack of inter-generational dialogue between elders and young people. This also includes dialogue with traditional and religious leaders, relatives and teachers. Young people, particularly in Pakistan and Mozambique, highlight the stronghold of elders in determining their life-course. In Pakistan, under the guise of respecting elders, young people are forced to be obedient, irrespective of their opinion or whether the decision is appropriate. This was attributed to the low levels of literacy amongst the older generation. There seems to be a complete absence of autonomy for young people.

"....When I start to talk with adults to discuss something that is bothering me, they tell me that I do not have the age to discuss this with them." (Man 19- 24 years, FGD, Manlahipa, Mozambique)

"Thanks to the culture, we youth are not allowed to talk in any way in front of adults, especially to the family chiefs [uncles and "régulos" – traditional kings]*."* (Boy 15 – 19 years, FGD, Meluli B, Mozambique)

This lack of communication indicates that parents either do not understand the concerns of young people, do not feel capacitated, and/or feel ashamed to address them. Young people in Ethiopia also highlighted that parents fail to express love and are unwilling to help out with educational materials. Parents on the other hand, expect youth to help on the farm and believe that they do not respect them enough. In all countries, parents find it difficult to talk to their children about sensitive subjects.

"As a father, I am embarrassed to talk about this… We cannot lie about illnesses and not getting pregnant. But about contraceptives I don't talk... My parents had this [embarrassment]*. With our children we have this embarrassment. This is very impossible* [to be talked about]*. This is our culture. Fathers can't talk about*

this… (Is that something that can change?) Yes, that is possible (How?) To sensitize parents. To help them understand this better." (Father, SSI, Nametil, Mozambique)

It seems that parental aspirations to raise children according to the social norms of the community often conflict with young people's desires. This tension causes the inter-generational gap to grow and does not provide an environment that is conducive for young people to discuss topics of sexuality, marriage and their aspirations. These desires of young people are also shaped by social structures around them. In Indonesia, technology is playing a major role. Social media and the internet have had an overwhelming influence in increasing interactions between young people, but consequently reducing interaction between the young and old.

"They mostly meet through facebook, handphone. From handphone, they get to talk to each other. They play facebook, meet, then get married." (Parents FGD, Lembar Sub-District, Lombok Barat District, Indonesia)

Girls find it easier to communicate with mothers while boys find it easier to speak to their fathers. This has implications, since fathers are the final decision-making authority for girls in most settings. Lack of parental supervision was cited frequently in Kenya as a driver of teenage pregnancies, signalling that there is a need for increased open dialogues between parents and children.

The inter-generational gap is not limited to merely parents but is also present between young people and gatekeepers such as traditional and religious leaders, teachers and other family members. These gatekeepers also differ depending on the context, and certain gatekeepers play a more prominent role than others. Gatekeepers are not limited to elders but also include the influence of peers. Teachers exercise strong influence on the lives of young people. As highlighted in 3.3, male teachers are involved in transactional sex with their female students. This, not always, but often decreases the bargaining position of the girls. This is a fairly common occurrence in Kenya, Malawi, Zambia and Mozambique. Traditional leaders are considered the final authority in these countries and have the ability to influence major decisions. While they advocate for the discontinuation of child marriage, teenage pregnancy and FGM/C, the baseline reported several instances of their involvement in perpetuating these practices. Furthermore, nepotism also influences who is able to get away with partaking in these acts. This is in contrast to Pakistan where major gatekeepers are parents and religious leaders. The latter seem to play an important role across all countries due to their large realm of influence, but their role is ambiguous.

"I will also talk about the headmen they are the ones in the forefront of impregnating the young girls and they advise these girls to go and sleep with younger boys so that they have someone to point at when time comes to say who is responsible for the pregnancy." (Man 20-24 years, FGD, Chadiza District, Zambia)

Therefore, considering the important role that elders play, it is apparent that young people's voice is limited. Youth exercise their autonomy in different ways depending on the circumstances. In Indonesia and to a lesser extent in Ethiopia, young people are able to exercise their choice more frequently.

"I want to get education, and only then get married, it is worse if the marriage is rushed because there is more domestic work after marriage, also it is difficult to think about the economy." (15 years old unmarried female, SSI, Kediri Sub-District, Lombok Barat District, Indonesia)

In Indonesia in particular, some young people choose to have an early marriage despite parents wanting them to finish school. Parents disapprove of *zina* or pre-marital sex and hence, young people conform to this and are unable to engage in sex before marriage. Similarly in Ethiopia, most marriages are love marriages but unlike Indonesia, young people have high levels of knowledge of and access to modern methods of contraception. Nevertheless, parents are still the final decision-makers. There seems to be a gap between the autonomy that young people perceive for themselves versus the autonomy they can actually exercise. This could also explain why most respondents indicate that marriage was their choice in Indonesia. Hence, young people do exercise choice but it is rather constrained with the strict scrutiny of parents and society. The notion of choice is also problematic. When young girls choose to undergo child marriage or FGM/C, as seen in 3.2 and 3.3, they exercise this choice under the constraints that they are in. The strong role of social norms in shaping one's worldviews presents its dangers.

"The elders have been telling us so many positive effects regarding child marriages since our childhood that we have started believing in what they said. But now that we have gained education and read the relative literature and seen some harmful effects of child marriages, we have started thinking otherwise." (Young female, SSI, Pakistan)

3.7 SRHR information, education and services

The baseline also explored the current level of awareness of young people around SRHR information, education and their use of services (Table 6). A mixed picture emerged. Only 24% of the respondents in Pakistan had ever received sexuality education, followed by Mozambique (41%).

Table 6: SRHR education and awareness of preventing pregnancy

	Ethiopia	Indonesia	Kenya	Malawi	Mozambique	Zambia	Pakistan
Ever received SRHR education	76%	74%	59%	76%	41%	66%	24%
Know a method of pregnancy prevention[16]	94%	78%	88%[17]	97%	60.5%	93%[18]	45%

While the role of the teacher is most prominent in delivering sexuality education in most of the countries, parents were the most popular source in Mozambique and Pakistan. This is understandable in light of the high drop-out rates in both countries. The two countries also lag behind when it comes to knowledge about pregnancy prevention methods. It is also worth noting that in Kenya, Mozambique and Zambia, abstinence was mentioned most as a method to prevent pregnancy. This is a clear indication that young people do not have sufficient information regarding contraception; and it gives an indication of how sexuality is conceptualized in these countries. The large role of initiation rites in both Kenya and Mozambique, which indirectly serve to promote sexual activity, is contradictory to this finding. Participants of the baseline across the seven countries are not homogenous. Girls in Mozambique receive sex education from parents, but the boys receive it from health providers.

Although exposure to SRHR education is high in most countries, it is unlikely that the information provided is comprehensive. The qualitative findings in Zambia show that young people prefer to get information from their grandparents, and this information might be outdated. This is also true of information received

[16] Those who stated that they did not know or did not give answer are coded as no.
[17] This includes those who stated 'abstinence'. If you exclude these, it drops to 63%.
[18] This includes those who stated 'abstinence'. If you exclude these, it drops to 71%.

through initiation rites. Schools relay this information mainly through the biological perspective, while parents seem to only highlight the dangers of sexual activity and discuss it in a directive way. The timing of the education is also important and it should reach young people before their sexual debut. Young people across all countries believe that health providers have an important role to play in promoting SRHR. The role of the internet is highlighted in Indonesia where it features as the preferred source of information.

Although the picture seems grim when it comes to education and information in Mozambique and Pakistan, the uptake of services is much higher with antenatal care (ANC) being the most popular (Table 7). This aligns with the high incidence of teenage pregnancies, particularly in Mozambique.

Table 7: Uptake of sexual and reproductive health services

	Ethiopia	Indonesia	Kenya	Malawi	Mozambique	Zambia	Pakistan
Ever used SRH service	69%	31%	66%	79%	55%	56%	49%
Type of SRH services used (excluding those who did not use)[19]	VCT (48%)	Family Planning (70%)[20]	VCT (77%)	VCT (86%)	ANC (65.5%)	VCT (86%)	ANC (31%)

The low uptake of sexual and reproductive health services in Indonesia could be explained by the conditionality that only married citizens can access contraception. Voluntary counselling and testing (VCT) is the most common service used by respondents across the rest of the countries, also indicating that awareness regarding HIV/AIDS is present. The baseline found that uptake of sexual and reproductive health services is directly affected by the attitude of health workers, the existence and distance to health facilities and the availability of contraception at the facilities.

"....*there is almost no health service here, there is only a community health worker and that is not enough to cover all the population needs, because many times the means to provide first aid are not available."* (Man 20 – 24 years, FGD, Manlahipa, Mozambique)

"The treatment is there, but the nurses they shout at them. The midwives shout at you even as a parent at the ward, because of underage of your daughter. Sometimes they just leave her. 'I was not there the time you were taking this pregnancy. You opted for this'. The midwife just calls: 'the mother to this girl should come' so you enter in the labour ward to assist her because you did not advise her." (FGD with parents, Malawi).

The baseline also found that amongst those women who had a history of pregnancies, a majority of them in Pakistan, Kenya and Mozambique were not using contraception at the time of the survey. These are also the countries that report the lowest exposure to SRHR education. Negotiating condom use is also difficult, majorly for women but also for men. The baseline also found that the use of sterilization as contraception was most prevalent in Ethiopia.

3.8 Policies and laws

Overall, there seems to be a low awareness of the statutory law that dictates minimum legal age, with the exception of Malawi and Ethiopia (Table 8). Amongst those who are aware, most place the minimum age

[19] This is calculated by including respondents who mentioned this service as ONE of the types of service used.
[20] Of these only three were unmarried.

of girls at 18. In fact in Indonesia, the majority thought the age to be 20. For boys, most respondents put the age at 20. This has implications with regard to what is considered a child marriage and local understandings may differ. As expressed by a religious leader in Indonesia, the age is not significant, maturity is. It was reported that several early marriages are not religiously sanctioned as the couple is not thought to be 'ready'. Instances of intervening in child marriages were reported to be frequent, mostly by community leaders or the police. In Ethiopia, teachers also played a role in preventing child marriage. The frequency of someone intervening is lowest in Indonesia, Mozambique and Pakistan.

"...My mother was married at 16 years old... had 11 children...no problems with reproductive health...the children were healthy...educated...not one was neglected...all of them turned out good. We shouldn't follow the western culture…fussing on the minimum age of marriage...there is a cultural context that we have to consider as well..." (Male adult, SSI, Tuan Guru, Lombok Barat District, Indonesia)

Table 8: Marriage law

	Ethiopia	Indonesia	Kenya	Malawi	Mozambique	Zambia	Pakistan
Knowledge of legal minimum age according to law	79%	39%	27%	70%	41%	39%	27% [21]
Intervention in case of a child marriage (Yes)	61%	27%	67%	70%	41%	58%	8%
Who intervenes?	Police[22]	Community leader	Community leader	Community leader & NGO	Community leader	Police	N/A

Concerns in implementation of laws and policies plague each setting. These include nepotism by traditional leaders, complicit roles of religious leaders and religious laws and the lack of accountability and coordination amongst different actors.

"Local leaders apply this laws with partiality i.e. they will be lenient with their friends, but will go ahead and arrest other parents when they marry off their daughters." (Man 19-24 years, FGD, Kenya)

Instances of manipulating the legal age of a young person (due to lack of birth certificates) highlights one of the ways that people use to circumvent the law. An institutional vacuum is present in a context like Ethiopia where no one institution has the complete official responsibility for eliminating these practices. Although the child protection law is being violated in Indonesia in the case of a child marriage, it is possible for the marriage to occur (recorded) under the provision of the Marriage Law no.1/1974 as long as they have the consent of parents and Religious Court (dispensation of marriage). Hence, any discrepancy between religious laws and the statutory law leave a window of opportunity for people to exploit.

4. Conclusions

The Yes I Do baseline study highlights the complex and dynamic relationship between teenage pregnancy, child marriage and FGM/C and gives a nuanced insight into the various factors that contribute and reinforce these harmful practices. The synthesis documents certain trends that are common across countries, but

[21] Includes a high no response rate
[22] A high proportion also mentioned teachers.

also highlights that these practices and the actors involved are not homogenous. While the findings reaffirm some of the assumptions of the theory of change, knowledge gaps are still there, which will be further explored in the operational research and mid and end-line study.

Child marriage and teenage pregnancy are intertwined across all countries and have different consequences, depending on the sequence. The link between child marriage and FGM/C is strongest in Kenya. The growing gap between young people and older generations has an impact on how young people express their sexuality, desires and exercise their autonomy. Young people are further influenced by the social and gender norms that govern their community and socio-economic structures around them. Overall, the baseline affirms that multiple interventions are needed at all levels, to drive a social movement that can eliminate child marriage and FGM/C and reduce teenage pregnancy. The Yes I do programme can play a crucial role in facilitating this, through its five pathways of change. Meaningful youth participation is instrumental here. The Alliance will use the presented findings to mobilize the appropriate stakeholders to jointly address the leading causes of child marriage, teenage pregnancy and FGM/C.