"Teenage mothers can now go back to school"

Teenage pregnancy and child marriage in Traditional Authority Liwonde, Machinga district, Malawi

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Preface

The **YES I DO** programme (2016-2020) aims to contribute to enhancing young women´s decision-making space on whether, when and who to marry as well as on whether, when and with whom to have children. The programme, funded by the Dutch Ministry of Foreign Affairs, is implemented in seven countries, namely Ethiopia, Kenya, Malawi, Mozambique, Zambia, Indonesia and Pakistan until 2018. In Malawi, the programme is implemented in Traditional Authority Liwonde in Machinga district. The Yes I Do programme is implemented by an alliance consisting of Plan Netherlands, Amref, Rutgers, Choice for Youth and Sexuality and the Royal Tropical Institute (KIT). In Malawi, the Yes I Do alliance consists of Plan Malawi, Amref Health Africa, the Family Planning Association of Malawi (FPAM), the Centre for Youth Empowerment and Civic Education (CYESE) and the Centre for Human Rights and Rehabilitation (CHRR).

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LIST OF ACRONYMS

ADRA	Adventist Development and Relief Agency
CAMFED	Campaign for Female Education
CBDA	Community-Based Distribution Agent
CBO	Community-Based Organization
CHRR	Centre for Human Rights and Rehabilitation
CoC	Champions of Change
CYECE	Centre for Youth Empowerment and Civic Education
DSWO	District Social Welfare Office
EA	Enumeration Area
FGD	Focus Group Discussion
FPAM	Family Planning Association of Malawi
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
IDI	In-depth Interview
IUD	Intra Uterine Device
KII	Key Informant Interview
KIT	Royal Tropical Institute
MDHS	Malawi Demographic and Health Survey
NGO	Non-Governmental Organization
NSO	National Statistical Office
PSI	Population Services International
RA	Research Assistant
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TA	Traditional Authority
ToC	Theory of Change
VCT	Voluntary Counselling and Testing
VSL	Village Savings and Loans
YONECO	Youth Net and Counselling
YFHS	Youth-Friendly Health Services
YIDA	Yes I Do Alliance

KEY TERMS AND DEFINITIONS

Adolescents	Females and males aged 10 to 19 years
Child marriage	Legal or customary union involving a boy or girl below the age of 18
Participant	Focus group discussion or qualitative interview participant
Respondent	Survey participant
Teenage pregnancy	Pregnancy before the age of 20
Young people / youth	Females and males aged 15 to 24 years

Executive summary

INTRODUCTION

Child marriage and teenage pregnancy are challenges experienced by many young people in Malawi. In 2013/2014, Machinga was among the districts with the highest prevalence of child marriage and teenage pregnancy. The Yes I Do alliance chose to implement a package of interventions in this district, and Traditional Authority (TA) Liwonde in particular, aiming to reduce child marriage and teenage pregnancy. TA Chikwewo in Machinga was chosen as a control area.

This report contains the findings of the base-, mid- and end-line study of Yes I Do Malawi. The overall objective of the study was to provide insight into the (interrelated) causes and effects of child marriage and teenage pregnancy and the extent to which these causes and effects, and the two problems themselves, were present in TA Liwonde over the period of 2016-2020.

METHODOLOGY

This study employed a mixed-methods approach. At baseline, 1,595 and at end-line, 1,622 young men and women aged 15-24 years were surveyed in TA Liwonde and TA Chikwewo. The survey used a two-stage cluster sampling approach. At base-, mid- and end-line, qualitative data were collected using focus group discussions (FGDs) with young people and parents or guardians, in-depth interviews (IDIs) with young people, parents or guardians, elderly women, religious and traditional leaders, teachers, health and social workers and community-based organization (CBO) and youth organization staff. Key informant interviews were conducted with representatives of non-governmental organizations (NGOs) and district-level policy makers.

RESULTS

Characteristics of the study population: At both baseline and end-line, half of the survey respondents were single, while one out of three were monogamously married and 5% were polygamously married. Most respondents were Muslims and the major ethnic group was the Yao, who make up more than half of the population. Most people in TA Liwonde and Chikwewo do not own nor have access to piped water, television, motorized transport and electricity. Just over half of the respondents had phones with no internet and about a tenth had mobile phones with internet. The radio and internet were the main sources of media.

Community context: Boys and girls are socialised to perform certain tasks in society as they grow up. However, since 2016 with the implementation of the Yes I Do programme, many informants reported that tasks previously only prescribed for girls and women are now also done by boys and men, as observed at mid- and end-line. Some informants observed that some tasks, such as digging graves and pit-latrines, are still reserved for boys and men. While girls and boys shared tasks, a key informant observed that the girl child still does a lot of work compared to the boy child.

Roles of gatekeepers, youth engagement and empowerment: The Yes I Do alliance trained government, NGOs and other local structures such as traditional leaders to address sexual and reproductive health and rights (SRHR) and education among young people. These stakeholders were working together on creating awareness about child marriage and teenage pregnancies and promoting education. Other interventions included, amongst others: (i) The implementation of bylaws by traditional leaders, which outlawed child marriages; (ii) The implementation of youth-friendly health services (YFHS) including the provision of contraceptives by the Ministry of Health with assistance from NGOs. (iii) The payment of school fees and providing requisite school materials for girls; (iv) The investigation by the police and other stakeholders of child marriages, ensuring that such marriages are dissolved; (v) The settling of disputes about child marriage and teenage pregnancy by traditional leaders; and (vi) The orientation of teachers to enable them to comfortably teach life skills education and coordinate Champions of Change (CoCs) in the school programme. Most informants reported that while prior to 2016, these stakeholders also implemented interventions to reduce teenage pregnancies and child marriage, most have become more active in implementing such interventions after being sensitised by the Yes I Do alliance.

Just over a third (35%) of the respondents in TA Liwonde participated in the Yes I Do programme with a higher percentage of females (40%) than males (22%) participating in Yes I Do activities. These respondents mainly participated in youth clubs (65%) followed by the CoC intervention (26%) and community dialogues (21%). Most (54%) of those who did not participate said the reason for this was that they did not know enough about these activities. There was a decline in the intervention area in the percentage of respondents who reported that they found it easy to talk to their parents about sexuality and marriage from 50% at baseline to 38% at end-line. In the control area there was a larger decline, from 59% to 38%. Most of the intervention area respondents at end-line, more than 87%, said they can decide on their own whom to date.

How young people explore their sexuality and SRHR issues: A higher percentage of male respondents (76%) reported engaging in sexual activities or sexual intercourse than female respondents (63%) at end-line[1]. Boys engaged in sexual activities and intercourse when they were around 16 years, while for girls this was 17 years on average. At end-line, two out of three boys had ever had a girlfriend and around one in four girls ever had a boyfriend in TA Liwonde. The percentage of young people who ever received education about sexuality and sexual health was 77% for females and 74% for males at baseline. However, this percentage decreased over time by 15% in TA Liwonde and 28% in TA Chikwewo. Teachers were the common source of sexuality education, but the respondents' preferred source for such information was health centres at both base- and end-line.

Provision of sexual and reproductive health (SRH) services: The percentage of respondents in TA Liwonde who reported ever having used SRH services increased from 71% at baseline to 90% at end-line among the male respondents, while for females this remained at 86%. In TA Chikwewo, the use of SRH service among female respondents increased by 5% from 78% at baseline to 83% at end-line, while among males it increased from 69% to 88%. Voluntary counselling and testing and family planning services were the services that were most frequently used at end-line in both areas. The implementation of YFHS seems to have contributed to an increase in the use of SRH services among young men and women.

Contraception knowledge and use: In TA Liwonde, the percentage of female respondents who had knowledge of modern contraceptive methods increased from 76% at baseline to 82% at end-line, while it increased from 84% at baseline to 94% at end-line among male respondents. In TA Chikwewo, among females, it increased from 73% at baseline to 77% at end-line, while among males, it increased from 86% at baseline to 90% at end-line. In particular, more respondents knew about injectables (41% to 54%), the intra uterine device (IUD) (21% to 43%) and birth control pills (15% to 25%). At end-line, almost one in three respondents had ever used contraceptives[2]. In TA Liwonde, 39% of the males and 15% of the females reported currently using contraceptives at end-line. Most female respondents in TA Liwonde used injectables (64% of those currently using contraception) and most male respondents used male condoms (89%).

Child marriage: The percentage of women (18-24 years) who were married or in union before the age of 18 increased (but not significantly) in TA Liwonde, from 18% at baseline to 20% at end-line. In TA Chikwewo, the prevalence of child marriage among women (18-24 years) significantly increased from 23% to 29% over this period. There was almost no change in the percentage of girls and women aged 16-24 who were married before the age of 16 in TA Chikwewo, while in TA Liwonde this decreased from 6% to 3%.

Teenage pregnancy: At end-line, more than half of all female respondents had experienced a pregnancy, with no difference between TA Liwonde (54%) and TA Chikwewo (53%). The percentage of young women (20-24 years) who had their first child under the age of 20 increased from 63% at baseline to 70% at end-line in TA Liwonde, and significantly from 65% at baseline to 76% at end-line in TA Chikwewo. Among males (20-24 years), this declined from 9% at baseline to 7% at end-line in TA Liwonde, and from 12% to 5% in TA Chikwewo. In TA Liwonde, the percentage of female respondents who had children and reported wanting to become parents at that time increased from 43% at baseline to 55% at end-line, while it increased from 44% at baseline to 53% at end-line for male respondents. The average age at first pregnancy for males and females remained at 18 years and 20 years respectively, between base- and end-line in both areas.

1 & 2 This question was not asked at baseline.

Circumstances and consequences of child marriage and teenage pregnancy: The main reasons why boys and girls end up in child marriage included poverty, pregnancy, peer pressure, lack of education, the desire to become parents/grandparents, being out of school without any other purpose in life, experiencing abuse within the parental household, and the desire to follow widely accepted cultural norms. These reasons were similar to those that informants provided at baseline. At midline and end-line, informants reported that when girls get pregnant, they are not forced into marriage (anymore) but are advised to deliver their child and then return to school. In TA Chikwewo, 70% of the respondents reported that people intervene in cases of child marriage at end-line. Eighty-four percent (84%) of the respondents in TA Liwonde reported this at end-line and stated that these people are mainly community leaders (71%), NGO staff (47%), and parents (46%).

Decision-making dynamics around marriage: The percentage of girls and young women in TA Liwonde who agreed that their parents or relatives decide their future partners remained the same at base- and end-line at 15%. Among boys and young men in TA Liwonde, there was a 3% increase from 17% to 20%. Most married respondents at end-line in TA Liwonde (82%) stated that they had decided for themselves to get married and did not feel pressured into marriage (91%). These percentages increased from 66% and 88% at baseline, respectively. However, 60% of the married respondents in TA Liwonde also indicated that they did not feel it was the right time for them to get married at end-line. This implies that while young people do not feel they are placed under direct pressure to get married, in retrospect many may feel that marriage was not as they expected it to be. They might have aspired to get married due to peer pressure or a perception of marriage as a potential solution to their problems.

Education and economic empowerment: The percentage of girls (15-18 years) who reported attending secondary school dropped from 13% at baseline to 10% at end-line in TA Liwonde. There was no change in this percentage in TA Chikwewo: it remained at 4%. Five percent (5%) of female respondents in TA Liwonde at end-line had ever dropped out of school due to marriage, similar to the 6% who had done so at baseline. In TA Chikwewo, this increased from 6% to 10%. The percentage of female respondents who left school due to pregnancy did not change in TA Liwonde (15% at baseline, and 16% at end-line), while in TA Chikwewo this increased from 4% to 8%. Unlike in the past, participants reported that there is no gender discrimination with regard to schooling. However, some participants felt that girls are more encouraged and supported with bursaries and other school materials to go to school than boys. Since 2016, primary school enrolment of girls has been increasing with some of them being selected to secondary school.

TA Liwonde is a rural area and participants felt that there were no opportunities for employment due to the lack of businesses and enterprises in the community. Vacancies often do not reach young people in TA Liwonde. Despite this, half of the young people surveyed at end-line in this TA were employed. Most of these young people were self-employed and running small-scale businesses, and some travelled to South Africa in search of jobs. Survey data show that the percentage of young people who were employed increased from 38% at baseline to 49% at end-line in TA Liwonde, and more women reported being employed over time. In TA Chikwewo, employment also increased from 34% at baseline to 58% at end-line. COVID-19 and xenophobia reportedly made it more difficult for young men to travel to South Africa.

Key informants reported that organisations such as Plan Malawi, the Adventist Development and Relief Agency (ADRA), Campaign for Female Education (CAMFED) and CYECE offered training to young men and women in vocational skills such as tailoring, welding and mechanics and some were given starter packs such as a sewing machine. In addition to vocational training, the Yes I Do alliance also trained many young women who joined village savings and loans (VSLs) and were able to borrow money to boost their business.

Policy and legal issues: Key informants mentioned that the school readmission policy, which allows pregnant girls to return to school after birth, existed before 2016, but that the Yes I Do alliance and other stakeholders had sensitised the community about this policy. As a result, many girls who had withdrawn from school due to pregnancy re-enrolled into school. Another major change was the development and implementation of community bylaws, which outlawed child marriage and ensured that anyone who infringed these laws was fined by the chiefs. However, there were concerns that some stakeholders, especially chiefs and policemen, were corrupt and could not effectively implement the bylaws.

Tables 1 and 2 provide an overview of the key quantitative and qualitative indicators.

Table 1 **Summary of quantitative indicators tracked** 1/2

	Baseline		End-line	
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**
Child marriage and teenage pregnancy				
Girls and women (18-24 years) who were married or in a union before age 18 (i.e. child marriage)	78 (18.2)	89 (22.7)	80 (20.2)	115 (28.8)
Girls and women (16-24 years) who were married or in a union before age 16 (i.e. child marriage)	32 (5.8)	24 (4.7)	15 (2.9)	30 (5.8)
Girls below 18 years old who are currently married	15 (8.1)	6 (3.2)	6 (3.1)	9 (4.6)
Young women (20-24 years) who had their first child under the age of 20 (i.e. teenage pregnancy)	190 (63.1)	190 (65.7)	202 (69.9)	226 (75.6)
SRHR behaviour				
Girls and young women (15-24 years) who can decide for themselves whom to date and go out with	532 (86.5)	481 (83.1)	518 (87.4)	496 (83.1)
Boys and young men (15-24 years) who can decide for themselves whom to date and go out with	178 (89.0)	185 (92.0)	190 (87.6)	199 (92.6)
Girls and young women (15-24 years) that have ever utilized SRH services, including modern contraceptives	528 (85.9)	453 (78.2)	510 (86)	494 (82.7)
Boys and young men (15-24 years) that have ever utilized SRH services, including modern contraceptives	141 (70.5)	139 (69.1)	196 (90.3)	190 (88.8)
Girls and young women (15- 24 years) who have ever used contraceptives[3]	NA	NA	157 (26.5%)	128 (21.4%)
Young mothers (15-24 years) indicating using male condoms	12 (3.8)	9 (3.1)	2 (0.7)	4 (1.4)
Young fathers (15-24 years) indicating using male condoms	14 (38.9)	16 (44.4)	10 (25.0)	7 (24.1)

3 This question was added at end-line, therefore there are no baseline data available for comparison.

Table 1 **Summary of quantitative indicators tracked** 2/2				
	Baseline		End-line	
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**
SRHR knowledge				
Girls and young women (15-24 years) who know how to prevent pregnancy using modern contraceptives	470 (76.4)	422 (72.9)	488 (82.3)	462 (77.4)
Boys and young men (15-24 years) who know how to prevent pregnancy using modern contraceptives	167 (83.5)	173 (86.1)	204 (94.0)	194 (90.2)
Girls and young women (15-24 years) who disagree with the statement "It is not appropriate for a girl to propose to use a condom"	301 (48.9)	270 (46.6)	367 (61.9)	332 (55.6)
Boys and young men (15-24 years) who disagree with the statement "It is not appropriate for a girl to propose to use a condom"	117 (58.5)	131 (65.2)	155 (71.4)	141 (65.6)
Girls and young women (15-24 years) who feel confident to insist on condom use every time they have sex	496 (80.7)	453 (78.2)	481 (81.1)	423 (70.9)
Boys and young men (15-24 years) who feel confident to insist on condom use every time they have sex	188 (94.0)	184 (91.5)	185 (85.3)	187 (87.0)
Girls and young women (15-24 years) who ever received education about sexuality and sexual health	466 (75.8)	455 (78.6)	350 (59.0)	283 (47.4)
Boys and young men (15-24 years) who ever received education about sexuality and sexual health	141 (70.5)	156 (77.6)	131 (60.4)	127 (59.1)
Education and economic empowerment				
Girls below 18 years who dropped out of school	70 (37.6)	65 (34.8)	55 (27.9)	53 (27.2)
Girls below 18 years who left school due to marriage	3 (1.6)	1 (0.5)	0 (0.0)	3 (1.5)
Girls below 18 years who left school due to pregnancy	9 (4.8)	2 (1.1)	10 (5.1)	2 (1.0)
Girls (15-18 years) currently attending secondary school	21 (11.3)	8 (4.2)	17 (8.6)	7 (3.6)
Girls (15-18 years) who have a child and follow education	32 (12.6)	10 (4.2)	26 (10.5)	10 (4.2)
Young women (18-24 years) who are economically active outside of the household	177 (41.3)	129 (32.9)	209 (52.8)	260 (65.0)
Young women (18-24 years) who have received any income in the last six months	282 (65.7)	235 (59.9)	159 (40.2)	160 (40.0)

Table 2 **Summary of qualitative indicators tracked**
Knowledge of gatekeepers about harms of child marriage and teenage pregnancy
The majority of gatekeepers have knowledge about the harms of teenage pregnancy and child marriage.
Attitudes and actions of gate keepers to prevent child marriage and teenage pregnancy
Most gatekeepers have a positive attitude towards prevention of teenage pregnancy and child marriage, and some gatekeepers are involved in actively preventing teenage pregnancy and child marriage.
Youth who feel they can advocate for themselves
Girls and boys seem to have some capacity to advocate for themselves, especially through the Champions of Change programme and other youth clubs, they have been able to express themselves and learn about their rights. However, young people do not always feel free to discuss or express themselves especially on sensitive issues.
Current access to SRHR information by girls/ young women and boys/ young men (15 to 24 years)
The majority of young people aged 15 to 24 years report to have access to various SRHR information sources, however, access to SRHR education has dropped from base- to end-line.
Perceived autonomy of girls/ young women (15-24 years)
Most girls and young women (15-24 years) report to have autonomy in dating/ choosing a partner and there are several protection/support mechanisms when girls get pregnant or forced into child marriage. Within marriage, they have less to say and can face abuse, especially when the age gap is big.
Girls indicating safety in and out of school is a problem
Boys indicated that girls can experience unsafe situations when walking to school, and also at schools when teachers demand sexual favours. Sanitation at schools has improved and protection mechanisms (mother groups, youth clubs, matrons and patrons) in school facilitate more safety at school.
Number of new or adjusted national and local laws (incl. bylaws) and policies prohibiting child marriage
An increased number of laws and policies prohibiting child marriage are implemented. Bylaws have been developed in TA Liwonde to stop child marriage and teenage pregnancy and to get pregnant girls back to school. These bylaws are now also taken on in all other TAs.
Policy makers actively/openly supporting gender equality and girls' rights
More policy makers are actively /openly supporting gender equality and girls' rights; not only in speech but also through actions.
Active engagement of men and boys in strategies reducing child marriage and teenage pregnancy
Men and boys have been reached in activities to reduce teenage pregnancy and child marriages and improving gender equality, services, and information and education on SRHR and counselling sessions. Men in leadership roles like traditional leaders and chiefs are engaged.

CONCLUSIONS AND RECOMMENDATIONS

The results show that the goal of reducing child marriage and teenage pregnancy in TA Liwonde was not achieved over the four-year study period. A complex mix of factors contributing to teenage pregnancy and child marriage still prevail in TA Liwonde, and more time is needed to observe change at impact level. The following recommendations are made:

- Continue sensitising communities on the harmful effects of child marriage and teenage pregnancy.
- Continue mobilising resources for implementing interventions to reduce child marriage and teenage pregnancy.
- Build the capacity of youth organisations and clubs to interact with young people and create awareness about their rights.
- Identify local role models to motivate young people to complete (secondary) education.
- Engage and involve boys and men in the in the fight against child marriage and teenage pregnancy and promotion of gender equality and girls' rights.
- Promote the use of contraceptives among young people.
- Strengthen the delivery of YFHS.
- Support vulnerable boys and girls at risk of withdrawing from school, including girls who withdrew from school because they were pregnant.
- Continue to economically empower young men and women through offering of vocational skills programmes and entrepreneurship training programmes and start-up capital.
- Work with chiefs and other stakeholders to effectively implement prevailing bylaws in TA Liwonde and other TAs in Machinga.
- Continue creating awareness about existing national legislation on child marriage.

1. Introduction

Child marriage and teenage pregnancy constitute some of the most considerable challenges experienced by adolescents and young women and men. These challenges arise due to a number of factors including gender inequality and social norms, poverty, limited economic opportunities, and inadequate access to comprehensive sexuality education and sexual and reproductive health (SRH) services. The Yes I Do programme, funded by the Dutch Foreign Ministry, was conceptualised to address the issues of child marriage and teenage pregnancy in Malawi, Ethiopia, Indonesia, Kenya, Mozambique, Pakistan and Zambia. In Ethiopia, Kenya and Indonesia, interventions also aimed to reduce female genital mutilation/ cutting.

1.1 CHILD MARRIAGE

Child marriage is defined as any legal or customary union involving a boy or girl below the age of 18. Every year, 12 million girls marry before the age of 18. Child marriage occurs across the world and across cultures[4]. A number of studies conducted in Malawi have explored issues around child marriage. In Malawi, a 2018 national survey found that 9% of the female respondents aged 15-49 were married before the age of 15 in 2018, compared to 1% of the male respondents in the same age group. The percentage of female respondents who were married before the age of 18 was at 42%, which was higher than 6% among the male respondents. The northern region had the highest prevalence of child marriage among female respondents at 51%, compared to the southern region at 47% and the central region at 36%. On the other hand, the percentage of female respondents who were married before the age of 15 was highest in the southern region at 14% followed by the northern region at 8% and the central region at 5%. Among males, the percentage who married before the age of 18 was highest in the south at 8% and there was no difference between the north and the central, both at 5% (Makwemba et al., 2019). It is evident that child marriage is more prevalent among females than males.

Deep-rooted cultural practices and norms significantly contribute to child marriage among the different ethnic groups in Malawi. It has been reported that girls as young as 15 years old are married off to much older widowed men as a form of replacement of deceased wives (National Youth Council of Malawi, 2009). In the northern district of Karonga, *kupimbira* is practiced where girls as young as nine years are offered for marriage as a form of payment of debt incurred by parents (Malawi Human Rights Commission, 2006). In some parts of Malawi, especially in the northern region, a husband may be 'given' a younger sister or niece of his wife by his parents-in-laws as a form of appreciation for taking good care of their daughter (Malawi Human Rights Commission, 2006). Other factors which force young girls to get married include peer pressure, lack of information and the general lack of role models (Panos southern Africa, 2015). A 2018 survey on traditional practices found that among both females who were married before the age of 18 and those who were married at the age of 18 or above, the major reason for marriage was to start a family. Other reasons that were mentioned included poverty, pregnancy, the wish for independence and the desire to spend more time with their partners. This study also found that a significant proportion of respondents who were married before the age of 18 were more likely to mention poverty and pregnancy as reasons for their marriage compared to those who were married at 18 years or above (Makwemba et al., 2019).

In many settings, child marriage marks the beginning of frequent and unprotected sex that leads to a greater risk of sexual transmitted infections (STIs), HIV and early pregnancy. The 2015/16 Malawi Demographic and Health Survey (MDHS) found that among female respondents aged 15-24, the prevalence of HIV among those who were married (4.7%) was much higher compared to those who were never married and had never had sex (2.6%) (National Statistical Office, 2017). The high prevalence of child marriage and the prevalence of HIV among young women who have ever had sex is an urgent call for the effective promotion of safer sex among young people.

1.2 TEENAGE PREGNANCY

Teenage or adolescent pregnancy is defined as pregnancy before the age of 20. It is estimated that every year, 21 million girls aged 15-19 in the developing world become pregnant and approximately 12 million of them give birth (World Health Organisation, 2020). Complications from pregnancy and childbirth are among the leading causes of

4 www.girlsnotbrides.org/where-does-it-happen

death among girls aged 15-19 (Williamson, 2012). In Malawi, the percentage of girls aged 15-19 who reported having begun childbearing was 35% in 1992. This declined to 26% in 2010 and then increased again to 29% in 2015/2016. In 2015/2016, 22% reported they had had a live birth while 7% were pregnant with their first child (National Statistical Office, 2017). It is estimated that 14% of pregnancies among girls (15-19 years) end in abortion (Sedgh et. al., 2015). Poverty constitutes one of the major factors that drives teenage pregnancy. Transactional sexual relationships are common, for girls to obtain money and other material goods. Other factors that contribute to teenage pregnancy are non-use of contraceptives among young people, physical and sexual violence and cultural practices which for example encourage early sexual debut, hence, putting girls at risk of unplanned pregnancies (Kaphagawani, 2017).

1.3 THE YES I DO PROGRAMME

The Yes I Do programme aimed to contribute to a world in which adolescent girls can decide if, when and with whom to marry and have children. For this to be achieved, there was a need to design and implement innovative interventions which could effectively address child marriage and teenage pregnancy. Annex 1 presents the Yes I Do programme's Theory of Change (ToC) for Malawi. The programme had five strategic goals:

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

These five goals are related to five intervention strategies, illustrated by the interrelated boxes in Annex 1. The intervention strategies focus on: (i) forming a social movement to influence social norms in communities on child marriage and teenage pregnancy, (ii) empowering and meaningfully engaging young people in policy making and programming, (iii) improving access to high quality and affordable SRHR and child protection information and services, (iv) stimulating education and economic empowerment for girls, and (v) enhancing evidence-based lobby and advocacy for improved legal and policy frameworks.

The Yes I Do programme was implemented in Machinga district in southern Malawi. Machinga district has a population of 735,438: 47.7% are males while the rest (51.3%) are females. There are ten Traditional Authorities (TAs) in Machinga and these are TAs Liwonde, Sitola, Kawinga, Chamba, Mposa, Mlomba, Chikwewo, Ngokwe, Chiwalo and Nyambi. The interventions for the Yes I Do programme were implemented in TA Liwonde, an area which had a population of 89,424 in 2018. Most people in TA Liwonde are Yaos. While some of the people in Machinga are Christians, most of them are Muslims. This is a matrilineal society and at marriage, the husband moves from his natal village to stay in his wife's village and among her kin. The district has one of the highest rates of child marriage in the country, which is why the Yes I Do programme was implemented in Machinga. In 2013/14, 42.1% of the women aged 15-49 were currently married or in union. Seventeen percent (17%) of the women aged 15-49 were married before the age of 15 (National Statistical Office, 2015).

2. Aim and objectives of base-, mid- and end-line study

The Yes I Do programme was implemented between 2016 and 2020. A baseline study was conducted in July 2016, a midline in April 2018 and an end-line in March/ April 2020. This section describes the overall and specific objectives of base-, mid- and end-line study.

2.1 OVERALL GOAL

Broadly, the base-, mid- and end-line study aims to provide insight into the (interrelated) causes and effects of child marriage, teenage pregnancy and the extent to which these causes and effects, and the two problems themselves, are present in the intervention area of the Yes I Do programme, as compared to a non-intervention area, over a period of four years. In addition, the research aims to provide insight into different pathways of change, thereby testing the theory of change, and unravel why and how the Yes I Do intervention strategies do or do not contribute towards improved outcomes related to the five strategic goals, and ultimately a decrease in child marriage and teenage pregnancy.

2.2 SPECIFIC OBJECTIVES

The specific objectives of base-, mid- and end-line studies were as follows:

1. To explore attitudes of community members and gatekeepers[5] around child marriage and teenage pregnancy, whether and to what extent they take action to prevent child marriage and teenage pregnancy and which factors influence this and how.
2. To determine the level of meaningful engagement of adolescent girls and boys in community activities, programmes and policies – thereby claiming their rights – and which factors influence this and how.
3. To explore and analyse whether and to what extent adolescents take informed action on their sexual and reproductive health and which factors influence this and how.
4. To explore and analyse whether and to what extent education and economic empowerment of girls provide them with alternatives beyond child marriage and teenage pregnancy.
5. To provide insight into developed and implemented legislation and policies on child marriage and teenage pregnancy.
6. To contribute to the evidence on effective and context specific intervention strategies to eliminate child marriage and reduce teenage pregnancy.

5 Gatekeepers: caretakers; family members such as grandmothers, mothers in-law; health and social workers; teachers; traditional and religious leaders and peers, who influence girls' situations in relation to child marriage and teenage pregnancy.

3. Methodology

3.1 STUDY AREAS

In 2016, the Yes I Do alliance had consultations with the Machinga District Council after which a decision was made that the programme should be implemented in TA Liwonde. This decision was made because there were other non-governmental organization (NGOs) working on SRHR in other TAs in Machinga District. TA Chikwewo was chosen as a control area, because that there were no NGOs working in that area at that time.

3.2 STUDY METHODS, SAMPLING AND RECRUITMENT PROCEDURES

The study employed a mixed-method approach in order to assess whether the interventions that were implemented were effective in reducing child marriage and teenage pregnancy, but also to understand how, why and in which context these (possible) changes came about. While the base- and end-line involved a household survey and a qualitative component, the midline study was only qualitative in nature. The baseline was conducted in 2016, the midline in 2018 and the end-line data collection was conducted in March 2020, prior to the COVID-19 pandemic.

3.2.1 QUANTITATIVE COMPONENT

A questionnaire was administered at the household level among females and males aged 15-24 in TA Liwonde and TA Chikwewo at both base- and end-line. The questionnaire included questions on community norms, SRHR information and knowledge, young people's ability to claim SRHR, gender norms and attitudes and the situation of child marriage and teenage pregnancy. At both baseline and end-line, the National Statistical Office (NSO) was consulted, and it provided maps for TA Liwonde and TA Chikwewo showing the enumeration areas (EAs). Twenty-seven (27) EAs were randomly selected in each TA at both baseline and end-line. Thirty respondents (households) were sampled in each EA. The respondents were split into two: those aged 15-19 and those aged 20-24. Both age groups were intended to be equally represented in the sample. In each age group, 75% of the respondents were intended to be female while the rest (25%) were intended to be male. A sampling interval was calculated for each TA, starting from the centre of the EA and the research assistants (RAs) spreading towards the boundaries of the EA until the target number of 30 households was reached. Upon arrival at the household, respondents for the survey were randomly selected. If there were no eligible respondents, data collectors moved on to the next household. In case more than one eligible household member were available, one respondent was randomly selected by drawing lots.

Table 3 **Overview of quantitative component**

	Baseline			Endline		
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**Total n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**	**Total n (%)**
Young women (15-24 years)	615 (75.5)	579 (74.2)	1,194 (75.9)	593 (73.2)	597 (73.5)	1,190 (73.4)
Young men (15-24 years)	200 (24.5)	201 (25.8)	401 (25.1)	217 (26.8)	215 (26.5)	432 (26.6)
Total	815 (100.0)	780 (100.0)	1,595 (100.0)	810 (100.0)	812 (100.0)	1,622 (100.0)

A total of 1,600 questionnaires were intended to be administered at each stage as per the sample size calculation, but, as it will be demonstrated later, a total of 1,596 and 1,622 questionnaires were administered at baseline and end-line, respectively. The intended size of the sample was calculated so as to allow detection of the desired 10% reduction over the period of five years in the percentage of women aged 15-19 who have had a live birth or who are pregnant with their first child. The percentage of this indicator reported in the 2010 MDHS was 33.4% for Machinga. This indicated a required

sample size of 319 using a standard formula for calculating sample size. On top of this, 25% male respondents were added. Furthermore, taking into account possible design effects because of the clustered sampling, the required sample was multiplied by 1.5. Given these assumptions, we obtained a rough sample size of 800 per group (intervention and control). Table 3 shows the actual number of respondents who participated in the baseline and end-line surveys.

3.2.2 QUALITATIVE COMPONENT

The qualitative base-, mid- and end-line provided insights into a variety of issues related to the ToC. It was only conducted in TA Liwonde. It focused on participants' experiences, opinions and feelings about social and cultural norms and values, community and youth participation in decision-making, young people's SRHR, opportunities for schooling and economic empowerment and related policies and laws. The following methods of data collection were used:

1. Focus group discussions (FGDs) were conducted with groups of females and males aged 15-19 and 20-24 years, and groups of parents or caregivers. These FGDs provided information about shared or diverging views, community norms and values about SRHR, specifically on issues influencing child marriage and teenage pregnancy. At mid- and end-line, possible changes over time were explored.

2. Semi-structured, in-depth interviews (IDIs) were conducted with females aged 15-19 and 20-24 years; males aged 15-19 and 20-24 years; parents or caregivers; grandmothers or elderly women; religious and traditional leaders; teachers; health and social workers; and community-based organization (CBO) and youth organization staff. These IDIs were used to obtain in-depth information about the causes and consequences of child marriage and teenage pregnancy. During these discussions, possible changes in experiences, opinions and feelings over time were also discussed.

3. Key informant interviews (KIIs) were conducted with NGO staff and policy makers at district level and these allowed the research team to obtain the views and experiences of NGO staff and policy makers regarding the pathways of the ToC.

The research team purposefully selected study participants. Traditional leaders and health surveillance assistants (HSAs) helped in the recruitment of participants. The young people interviewed at mid- and end-line were direct or indirect beneficiaries of the Yes I Do programme and the aim was to achieve maximum variation sampling based on age, sex, and marital status. Regarding health personnel, HSAs working in the area and attached to the health facilities in TA Liwonde were recruited. Other study participants (religious and traditional leaders, teachers, social workers, representatives of youth associations and CBOs and policy makers at local and district levels) were selected based on their roles at different levels and were identified in consultation with local partners. Table 4 provides an overview of the qualitative data collection methods including the numbers of study participants.

Table 4 **An overview of qualitative data collection methods**			
Methods and participants	**Baseline**	**Midline**	**End-line**
Focus group discussions			
Girls (15-19 years)	17 (2 groups)	16 (2 groups)	12 (2 groups)
Young women (20-24 years)	17 (2 groups)	16 (2 groups)	13 (2 groups)
Boys (15-19 years)	14 (2 groups)	14 (2 groups)	13 (2 groups)
Young men (20-24 years)	16 (2 groups)	14 (2 groups)	15 (2 groups)
Parents or caregivers	19 (2 groups)	14 (2 groups)	14 (2 groups)
In-depth interviews			
Girls (15-19 years)	2	2	2
Young women (20-24 years)	2	2	2
Boys (15-19 years)	2	2	2
Young men (20-24 years)	2	2	2
Parents or caregivers	2	2	2
Elderly women/ initiators	2	2	1
Religious and traditional leaders	4	5	2
Teachers	2	1	1
Health and social workers	1	2	1
CBO and youth organization staff	1	2	2
Key informant interviews			
NGO staff	5	5	5
District-level policy makers/ officials	3	3	4

3.3 COMPETENCE OF RESEARCH STAFF AND TRAININGS

Ten, five and twelve RAs were recruited at baseline, midline and end-line respectively to participate in the data collection process. Most RAs had a degree-level qualification and previous experience in both qualitative and quantitative data collection methods. These RAs received five days of training at baseline, and then three days at mid-line and end-line. Each training was followed by a pilot conducted in TA Liwonde, after which the data collection tools were slightly adjusted. The issues covered during the training of RAs included: the information about the Yes I Do programme, objectives of the study, research ethics, methodology (administration of the survey questionnaire, FGDs, IDIs and KIIs), going through the questionnaire and interview guides, and checking the translations. RAs were trained on how to use tablets to collect survey data. Mock interviews were carried out by the RAs in each training.

3.4 DATA COLLECTION AND ANALYSIS PROCESS

The quantitative data were collected using tablets and sent to an online protected server at the end of each day of data collection. Data were downloaded and analysed using Stata and SPSS. Descriptive statistics were employed to describe demographic and behavioural data for both TA Liwonde and TA Chikwewo. Logistic regressions were conducted for all outcomes of interest i.e. on all relevant key indicators with a large enough sample size and variation. The key indicators are those that contribute to the monitoring and evaluation framework, which are outlined in the executive summary. Univariable and multivariable regressions were run with each outcome of interest as the dependent variable against time, population (meaning intervention or control area) and the interaction between time and population. These difference-in-difference analysis results are reported throughout the report and detailed in Annex 2. To allow for additional insights,

multivariate regression models were run on the impact indicators of child marriage and teenage pregnancy. Three models were run:

1. Individual characteristics: Age, dropout of school, income, employment, education
2. Individual characteristics + SRHR-related individual characteristics: ever married or had a child marriage (one model with each) and ever received sexuality education
3. Individual characteristics + SRHR-related individual characteristics + family-level characteristics: mother's education, father's education, household size

At base-, mid- and end-line, all the interviews and FGDs were conducted by a selected number of more experienced RAs and recorded and transcribed by someone who did not conduct the interviews/FGDs. Content analysis of the data was carried out using a comprehensive thematic matrix based on the topic guides, and emerging themes were added at each phase. NVivo 12 software was used to support the analysis of the qualitative data.

During the field work, regular team meetings were held to discuss data and address sampling issues. Both quantitative and qualitative data were jointly discussed with RAs during data analysis workshops. At end-line, the data analysis workshop was blended, with KIT researchers joining online while the research team based in Malawi met in-person.

3.5 DATA QUALITY

KIT developed a field protocol which described the study design and all study procedures. All RAs were comprehensively trained. The trainings were facilitated by KIT and the national researcher. In each phase, there was a supervisor who was responsible for the distribution of work to other RAs, checking the data on the tablets and going through some transcripts. The supervisor held daily de-briefing sessions each evening. When the progress of the data collection encountered problems, possible resolutions were discussed with the team. The national researcher was present in most of these meetings for quality assurance purposes. At base- and midline, community feedback and validation sessions were held. This was not possible at end-line, because of the COVID-19 pandemic. However, an online validation meeting with the Yes I Do partners was held in January 2021. The authors of the base-, mid- and end-line reports drafted sections of the reports and peer reviewed each other's work before consolidating and reviewing the final report.

3.6 ETHICAL CONSIDERATIONS

This study was approved by the ethical review committee of KIT in the Netherlands and by the National Health Sciences Research Committee, National Committee for Research in the Humanities and Social Sciences and then the University of Malawi Research Ethics Committee. In all phases of the studies, informed consent was obtained from all study participants before they participated in the survey, FGDs, IDIs or KIIs. For study participants who were aged less than 18 years, consent was obtained from their parents or guardians while assent was obtained from the children themselves. All study participants signed consent/ assent forms and were given copies of these forms for their records.

3. Results

4.1 CHARACTERISTICS OF THE STUDY POPULATION

For the quantitative component, 1,595 young people were sampled at baseline, while 1,622 were sampled at end-line. As per the sampling strategy, three out of four respondents were females. About one-third of all respondents reported to be in a monogamous marriage at base- and end-line and in both the intervention and control area. About half of the respondents reported to be single, with a slightly higher percentage in TA Liwonde (56%) as compared to TA Chikwewo (48%) at both base- and end-line. A few respondents (5%) reported being in a polygamous marriage, and 4% were divorced, at both base- and end-line (Table 5). Religious and ethnic composition did not change much over time. About two third of the sample identified as Muslim, while many of the remaining respondents identified as Christian (not shown). The dominant tribe was Yao (>50%), followed by the Chewa (25%) and Lomwe (17%) (not shown). Regarding education, a slightly higher percentage of respondents was in primary school over time (32% in the intervention and 34% in the control area at end-line), which was also the case for secondary level education (11% in the intervention and 8% in the control area at end-line). None of the respondents were currently in university except for one respondent at end-line (Table 5).

Table 5 **Demographic characteristics of survey respondents** 1/2

	Baseline			End-line		
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**Total n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**	**Total n (%)**
Gender						
Female	615 (75.5)	579(74.2)	1,194 (100.0)	593 (73.2)	597 (73.5)	1,190 (75.0)
Male	200 (24.5)	201 (25.8)	401 (100.0)	217 (26.8)	215 (26.5)	432 (25.0)
Total	815 (100.0)	780 (100.0)	1,595 (100.0)	810 (100.0)	812 (100.0)	1,622 (100.0)
Age						
15-17	246 (30.2)	243 (31.2)	489 (100.0)	257 (31.7)	257 (31.7)	514 (25.0)
18-24	569 (69.8)	537 (68.9)	1,106 (100.0)	553 (68.3)	555 (68.3)	1,108 (75.0)
Total	815 (100.0)	780 (100.0)	1,595 (100.0)	810 (100.0)	812 (100.0)	1,622 (100.0)
Relationship status						
Single	453 (55.6)	380 (48.7)	833 (52.2)	450 (55.6)	386 (47.5)	836 (51.5)
Monogamous marriage	254 (31.2)	261 (33.5)	515 (32.3)	246 (30.4)	259 (31.9)	505 (31.1)
Polygamous marriage	19 (2.3)	63 (8.1)	82 (5.1)	25 (3.1)	55 (6.8)	80 (4.9)
Divorced	33 (4.0)	27 (3.5)	60 (3.8)	32 (4.0)	28 (3.4)	60 (3.7)
Widowed	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.1)	1 (0.1)	2 (0.1)
Cohabiting	6 (0.7)	2 (0.3)	8 (0.5)	1 (0.1)	1 (0.1)	2 (0.1)
Separated	9 (1.1)	5 (0.6)	14 (0.9)	6 (0.7)	3 (0.4)	9 (0.6)
Boy/girl friend	41 (5.0)	38 (4.9)	79 (5.0)	46 (5.7)	70 (8.6)	116 (7.2)
Multiple boy/ girlfriends	0 (0.0)	4 (0.5)	4 (0.3)	3 (0.4)	9 (1.1)	12 (0.7)
Total	815 (100.0)	780 (100.0)	1,595 (100.0)	810 (100.0)	812 (100.0)	1,622 (100.0)

Table 5 **Demographic characteristics of survey respondents** 2/2						
	Baseline			End-line		
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**Total n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**	**Total n (%)**
Current level of education						
Primary school	234 (28.7)	227 (29.1)	461 (28.9)	248 (32.0)	265 (34.1)	513 (33.0)
Secondary school	73 (9.0)	38 (4.9)	111 (7.0)	87 (11.2)	62 (8.0)	149 (9.6)
Vocational training	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
University	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.1)	0 (0.1)	1 (0.1)
Completed	18 (2.2)	8 (1.0)	26 (1.6)	7 (0.9)	4 (0.5)	11 (0.7)
Not currently in school/ dropped out	470 (57.7)	457 (58.6)	927 (58.1)	431 (55.5)	445 (57.3)	876 (56.4)
Other	0 (0.0)	0 (0.0)	0 (0.0)	2 (0.3)	1 (0.1)	3 (0.2)
Missing	20 (2.5)	50 (6.4)	70 (4.4)	0 (0.0)	0 (0.0)	0 (0.0)
Total	795 (97.5)	730 (93.6)	1,525 (100.0)	776 (100.0)	777 (100.0)	1,553 (100.0)
School dropout						
Ever dropped out of school	556 (68.2)	541 (69.4)	1,097 (68.8)	459 (58.5)	485 (62.0)	944 (60.2)
Employment						
Not employed	504 (61.8)	515 (66.0)	1019 (63.9)	410 (50.6)	339 (41.7)	749 (46.2)
Employed	311 (38.2)	265 (34.0)	576 (36.1)	400 (49.4)	473 (58.3)	873 (53.0)
Total	815 (100.0)	780 (100.0)	1,595 (100.0)	810 (100.0)	812 (100.0)	1,622 (100.0)
Participation in the Yes I Do programme						
Yes	NA	NA	NA	141 (35.4)	NA	141 (35.4)
No	NA	NA	NA	257 (64.6)	NA	257 (64.6)
Total	NA	NA	NA	398 (100.0)	NA	398 (100.0)

About 68% of the respondents in TA Liwonde and 69% in TA Chikwewo indicated they had ever dropped out of school at baseline. This had changed at end-line. In TA Liwonde, the dropout rate reduced to 58.5%, while there was a smaller decrease in the control area to 62%. In general, females were more likely to drop out compared to males (Table 6).

Table 6 **Respondents who ever dropped out of school**						
	TA Liwonde			TA Chikwewo		
	Females	**Males**	**Total**	**Females**	**Males**	**Total**
Baseline	427 (69.4)	129 (64.5)	556 (68.2)	403 (69.6)	138 (68.7)	541 (69.4)
End-line	347 (59.6)	112 (55.2)	459 (58.5)	361 (63.2)	124 (58.8)	485 (62.0)

The primary reason for dropping out of school at both base- and end-line was a lack of fees or school materials; 35% of the respondents in the intervention area and 34% of the respondents in the control area reported that they had ever dropped out of school for this reason at baseline[6]. This was similar to end-line, when 36% of the respondents in the intervention area and 30% of the respondents in the control area stated this. Males were more likely to state this reason compared to females. At baseline, a higher percentage of females in the intervention area (15% of all female respondents) indicated that they had ever dropped out of school due to pregnancy/ birth of a child as compared to the percentage in the control area (4% of all female respondents). This percentage increased to 16% at end-line in the intervention area, while it doubled in the control area to 8%. Very few male respondents (1% or less) reported this at any study stage. Marriage as a reason for dropping out of school was not mentioned as often, with 5% and 8% (of all respondents, not just females) in intervention and control areas, respectively, reporting this at baseline. At end-line, this decreased slightly to 4% in the intervention area and 5% in the control area. Less than 1% of male respondents reported dropping out of school due to marriage in both areas across study stages.

The characteristics of parental education have changed over time. For both mothers and fathers, the percentage of those that were not educated fell over time in the intervention are (mothers: from 48% at baseline to 30% at end-line; fathers: from 27% at baseline to 15% at end-line) and control area (mothers: from 51% at baseline to 31% at end-line; fathers: from 30% at baseline to 18% at end-line. Over time, a higher percentage of mothers had received mainstream education (40% at baseline and 49% at end-line), while for fathers this stayed fairly steady at about 50%.

Looking at Table 5, at end-line, a higher percentage of respondents in TA Liwonde reported to be employed (49%) as compared to the baseline (38%). In TA Chikwewo, an increase in employment was observed as well. While respondents reported a variety of sources of income, the two most common types of work they were involved in were daily, casual labour and subsistence farming on both TAs. The overall percentage of respondents who reported these types of work increased from 27% to 38% and from 10% to 28%, for casual labour and subsistence farming, respectively. Males were more likely to be involved casual labour as compared to females. The percentage of females engaged in subsistence farming increased considerably over time, while for males the percentage decreased. On average, young people worked about four to five hours a day in both areas at both base- and end-line. Similarly, the two primary sources of income at the household level were agriculture and casual labour, and a small percentage included small business owners[7]. As confirmed by the qualitative data, in both TA Liwonde and TA Chikwewo, there are many people who have travel to South Africa to look for employment. Survey respondents in TA Liwonde, both male and female, shared that their household income included remittances, which grew from 3% as one of the sources of income to 7% as the main source of income. The primary sources of income mentioned by survey respondents correspond with what was mentioned during FGDs, IDIs and KIIs, namely agriculture, doing *ganyu*[8] and running small-scale businesses. The small-scale businesses or *ganyu*[8] that people mentioned included moulding and burning of bricks and then selling them.

Fathers (54%) or partners (25%) (mostly in the case of female respondents), were the primary income earners, showing that men were the main breadwinners. They were followed by the mother (14%) and the respondent himself/herself (12%). More male than female respondents mentioned the father as a primary earner in both TA Liwonde and TA Chikwewo. The main decision-maker regarding spending money in the household was the father, followed by the mother. Other respondents mentioned the partner or the sister, and most respondents who said this were women. In the intervention area, there was a higher percentage of respondents who mentioned mothers compared to the control area at both base- and end-line.

To get an indication of the households' socio-economic status, at end-line, respondents were asked if they have access to materials or utilities[9]. In general, female respondents reported having access to fewer utilities as compared to male respondents, including toilets and mobile phones. Overall, it is clear that the two areas are not well equipped with different utilities. Twenty-two percent (22%) of all respondents had access to solar energy. Very few respondents had access to electricity provided by Escom (national electricity supplier) (2%), piped running water for drinking (6%)

6 Percentages in this paragraph relate to all respondents (denominator), not those who reported to have ever dropped out of school. Respondents were able to provide multiple reasons why they had ever dropped out of school.

7 In this case it is difficult to make comparisons between base- and end-line, as at baseline multiple answer options were permitted while at end-line, only one answer was permitted.

8 Short-term labour, piecemeal work.

9 The list of utilities included: electricity (Escom), electricity (solar), none, mobile phone (not internet, only calls), mobile phone (internet including social media), radio, toilet facilities, motorised transport, non-motorised transport, television and piped running water.

and television (3%). A little less than half of the respondents at end-line had access to a mobile phone (only calls), compared to only 13% a phone with internet. In general, people had access to non-motorized transport and toilet facilities.

There were not many changes regarding the sources of media used by young people. The radio remained the most popular source for about half of the full sample, followed by the phone which saw an increase from 34% at baseline to 40% at end-line.

At the end of the survey, respondents were asked if they had participated in the Yes I Do programme. At end-line, 35% of the respondents reported to have participated in the programme in the intervention area i.e., TA Liwonde. Respondents from the control area were not asked this question (Table 5).

4.2 COMMUNITY CONTEXT AND MOBILISATION

4.2.1 GRADUAL CHANGE IN WHAT GIRLS AND BOYS ARE EXPECTED TO DO

Participants at base-, mid- and end-line shared similar views on roles and responsibilities in the household. The dominating gender norms in TA Liwonde are linked to certain tasks which are supposed to be performed by boys and others by girls. The following tasks were to be performed by boys and men: construction of houses, farming, taking care of livestock including constructing a kraal for them, moulding and burning bricks, burning charcoal, and digging of pit latrines. The following tasks were identified for girls and women: fetching water and firewood, cooking food for the household, taking care of the children, taking care of the inside of the house, including mopping. These fixed female tasks contribute to the household, but do not contribute to income generation. The only income generating activity or job mentioned for girls and women, was hairdresser. Many participants saw these roles as fixed.

> *"You cannot give a task to a woman that pertains to a man. Never…. You cannot send a boy to go to a maize mill. This is impossible unless if there is a [long] distance. Then you can send a boy to go by bicycle. If the distance is too long, then you send a boy to do on behalf of the girl. This is according to culture. Yeah."* (P7, FGD with male parents)

However, at mid- and end-line, some parents and other informants reported that what boys can do, girls can also do and the other way around. They mentioned this interchanging of tasks taking place at the household level but also in schools. For example, an informant indicated that previously teachers assigned domestic tasks to girls, but nowadays boys and girls mop the classrooms together.

> *"There is no difference between the roles of men and women in this community. For example, if you are living with your sister in the same house, a boy can be washing the dishes depending on what your sister is doing. She might also be doing other jobs. But if you take it that I am a boy and this is a girl job then it will not help anyone."* (P6, FGD with young men 20-24 years)

A specific reason given for the shifting of roles and responsibilities for boys and girls was the importance of becoming independent. Several examples were given where girls and boys learn the same skills. Often, boys do not know how to cook or fetch water. When they become independent, they will suffer when they are not able to do these kinds of tasks. One informant reported that previously, only boys were learning vocational skills but that in these days, both girls and boys are learning for instance skills like plumbing. An official working for an NGO also reported that in the Yes I Do alliance, one of the organisations teaches both boys and girls about baking, which was previously perceived as a task for women and girls. Despite some changes in gender roles, one key informant still felt that girls do most of the household chores as compared to boys.

> *"You see, most of the times a girl wakes up in the morning to go and fetch water, while some of the older boys do not go and fetch water, they just bath and start off to school while a girl still has more to do, other household chores, before she goes to school, sure."* (KII with a district official)

This observation is confirmed by results from the survey, where it was reported that girls and young women spend on average five to six hours a day on households chores at baseline, while young men spent about two hours. At end-line, this marginally dropped for females who spent about five hours.

In addition to the specific task division between males and females, other expressed cultural expectations were related to marriage. People expect that young people get married early, especially females. In some cases, parents were said to force their daughters to get married by giving them examples of their fellow youth who might be having a child. They tell their children that they are embarrassing them "mukutichititsa manyazi wakuti wakuti ali ndi mwana iwe ulibe chifukwa chani". Some informants also mentioned that some parents actually offer their daughters for marriage "kuwatomeletsa" to men that are going to South Africa, so that when they come back home, they get some blankets or bicycles. Their expectation is therefore that their children, especially girls, will get married early. Boys are expected to contribute to finances at home, as such, some of the youths (mainly boys) flock to Mozambique or South Africa to look for jobs so that they can help at home.

Not only there is a push from parents, but some young women also expressed, that some girls have internalised this cultural expectation of early marriage and are interested in getting married. They are not concentrating on education as they feel like education will not benefit them.

> *"People in this community they like to get married. They disregard education. They prefer to get married. They do not think of going to school. What they think is to get proposed; so they just wait to be proposed."* (P6, FGD with girls 15-19 years)

In terms of decision-making, most informants reported that men are the ones who make decisions at household as well as at community level.

> *"Men are more dominant when it comes to decision-making in the household as well as on development agendas in our community. They make sure that girls or women should listen and understand what they are saying."* (P1, FGD with young men 20-24 years)

The Yes I Do programme aimed at, among other things, addressing gender inequalities prevailing in TA Liwonde. While there has been great progress in addressing gender inequality in terms of more men and boys doing what previously was prescribed as tasks for women and girls, several participants acknowledged that it is not all that easy to change social and gender norms, as narrated by a key informant:

> *"Actually, the project was being done to address this gender balance, but you do know it's not easy to change the social norms. But now some few boys, men have realized that it is important to give women the responsibility but you know this is being done outside the homes but you find that inside the homes this is being found difficult…"* (KII with an NGO representative)

4.2.2 "GOOD BOYS AND GIRLS DO NOT HAVE SEX"

Study participants were asked about the characteristics of a good boy and a good girl. The expressed qualities were similar over time. People described good girls and boys as those who demonstrate respect, dress properly, are religious, do not involve themselves in sexual activities and work hard in school.

> *"When we talk of character of this child, you observe the time you send him to do something or some task. He leaves whatever he was doing and then follow your orders. By this, we know that this boy he is well mannered…"* (P7, FGD with girls 15-19 years)

Some informants specifically mentioned that a good boy respects girls, for example, he does not touch them on their body, he does not engage in sexual relationships, he is not promiscuous and he discourages other boys from engaging in sexual relationships with girls. One of the main issues raised by some study participants was that good girls or good boys dress themselves properly. By a girl dressing properly, participants meant that she should not put on tight

trousers but wear long dresses with a wrapper.

While study participants were able to provide a description of a good girl and a good boy, one elderly female informant expressed her concern that this generation does not listen to what parents and elderly persons generally tell them to do and that they do not obey.

> *"… This new generation is something else. Children are not obeying the elders. It's different with our time. In our age, we were advised by our parents to say; 'Do this and do that. Do not involve yourself in these things' we listened and obeyed them. We had nothing to attract us. Money was not much important than today. I was there in the 1949 country famine."* (IDI with an elderly woman)

It was only during an FGD with females aged 15-17 and one key informant interview at Machinga Boma, where participants mentioned that good boys and girls are supposed to be religious, not participate in bar activities but participate in youth clubs as well as church activities. Lastly, one key informant emphasised that a good boy or a good girl is one who understands his or her rights and responsibilities such that she/he does not infringe on the rights of another person.

4.2.3 THE ROLES OF GATEKEEPERS: MORE AWARENESS AND ACTION REGARDING CHILD MARRIAGE AND TEENAGE PREGNANCY

In this study, participants of FGDs, IDIs and KIIs were asked about the roles of different stakeholders, including NGOs/CBOs, mother groups, religious groups, the police, youth clubs, traditional leaders, health workers, the social welfare office, teachers and the private sector in preventing child marriage and teenage pregnancy. Over the period that the Yes I Do alliance has been implementing interventions, most of these stakeholders have become more active regarding these issues.

4.2.3.1 NON-GOVERNMENTAL ORGANIZATIONS

There are a number of NGOs working in TA Liwonde, especially since 2016 and these, according to study participants, are playing an important role in promoting access to SRH information and services. NGOs were not only teaching young people, but they were also targeting adults including people working in different government sectors. A Yes I Do alliance partner said that they have been involved in sensitizing teachers to not just teach SRHR issues for the sake of the examinations, but to transform young people's attitudes and behaviours around SRHR. A CBO representative reported that NGOs such as One Community have built the capacity of CBOs by conducting seminars. After having strengthened their capacity, they were able to create awareness among community members. A head teacher at one of the schools in TA Liwonde commended on the work being done by the Yes I Do programme:

> *"There is an organization called Yes I Do which looks at children's rights and also trains teachers who later on have a talk and advise the community never to force the children into marriages. There are also people from an organization called YONECO [Youth Net and Counselling] who come twice a month to have a talk with young boys and girls on the negative consequences of child marriages."* (IDI with a head teacher)

At end-line, many informants – young and old, male and female – reported that NGOs intervened when girls got pregnant, for them not to get married as a consequence. Those who were forced to get married could report to NGOs and traditional leaders, so that they could intervene by talking to guardians. Participants in an FGD with females (20-24 years) explained that people from YONECO gave them a phone number 116 to call when teenagers got pregnant or married. Once cases of child marriage were reported, NGOs, working with other stakeholders, intervened and ensured that marriages did not proceed or got cancelled. Participants reported that this did not happen before 2016 in TA Liwonde.

Plan Malawi, as narrated by most participants, also promoted girls' education: through the provision of school materials that the girls require, such as uniforms, notebooks and school bags. CYESE brought role models who motivated girls who dropped out of school to go back to school. The District Education Office and other study participants also

mentioned specific NGOs such as CAMFED and FHI360, which supported the youth with materials to retain them in school.

Furthermore, NGOs have contributed to the delivery of youth friendly health services (YFHS), as reported by a key informant in Machinga who is involved in the delivery of these services. He particularly mentioned Population Services International (PSI) as playing a critical role in supporting the provision of YFHS. He explained that the partners helped in the training of HSAs and other health workers in the delivery of YFHS.

> *"… If we are to do an assessment, it would be discovered that almost 20 facilities have been certified as youth friendly delivery points in Machinga. This was because of the different partners working in Machinga such as PSI and Goal Malawi. There was also a project called Pa Mawa, which was a PSI and Goal Malawi project, which had a great impact on the youth friendly services to be certified."* (KII with a health worker)

In some FGDs and interviews especially with young people, participants mentioned that NGOs like One Community also provide contraceptives such as injectables and pills to young people and that there are also NGOs who deliver circumcision services to boys. Lastly, many participants reported that NGOs also played an important role in facilitating the formulation of bylaws, which were designed by chiefs and people from TA Liwonde.

4.2.3.2 MOTHER GROUPS

Mother groups, initiated by the government and NGO, have been active in TA Liwonde since baseline. A key informant explained that mother groups were established to manage issues concerning children, especially girls. These groups report to the schools on girls who are pregnant or married. They discuss with teachers that pregnant girls should continue their education until they deliver. They also advise parents to get a new and bigger uniform for the girl so that she would not be embarrassed. Some study participants reported that when a girl gets pregnant, they would report this to the mother group for them to take action.

> *"If it happens like this. We do not just stay. If she is schooling, we also report to the mother group. 'My daughter is pregnant and yet she is schooling' then the mother group sits down with her together with the parents. They say that 'Go and watch over her until she delivers. After delivery she has to go back to school'; This is what happens."* (P5, FGD with female parents)

During an FGD with young men (20-24 years), it was reported that in case of child marriage, mother groups would threaten the children involved. They would tell them that NGOs will take them to task if they get married. If children are forced to get married, mother groups would help by discussing with parents to not force their daughter into marriage, as mentioned by a key informant. In most cases, parents accept this advice. The mother groups then visit the households periodically to monitor what is happening to the child. In addition to these roles of mother groups, key informants also explained that mother groups offer support to girls who have reached puberty, by making sure that they have sanitary pads and that there are changing rooms available in schools.

> *"Whilst at school they [mother groups] make sure that sanitation pads are available at the change rooms for the girls to use instead of them going back home. So they can just use these sanitation pads and continue learning with their fellow learners. In the past, girls would excuse themselves and go home each time they started the periods whilst at school."* (KII with an NGO representative)

4.2.3.3 RELIGIOUS GROUPS

Religious leaders have played an important role in terms of creating awareness about the disadvantages of child marriage and teenage pregnancy, ensuring that under-aged youth do not get married and providing counselling services to young people.

In some FGDs and interviews, informants reported that religious leaders advised young men and women to abstain from sexual intercourse until they get married. Religious leaders were also involved in creating awareness about the harms of child marriage among community members.

"I saw this other time that at our church a certain religious leader spoke about the same issues that YONECO was saying about child marriage. It is not like they have their own messages that they share to people." (P7, FGD with young men 20-24 years)

Some participants also explained that under aged young people who want to get married do not even go to the church, because they know that they will not be accepted to wed in church. In an FGD, participants also reported that persons who got married before the age of 18 were in some cases advised by the church or mosque not to continue with the marriage. If they did not agree, they were threatened to be excommunicated from the church: such couples had fears to have no church and hence they chose to end the marriage.

While most informants acknowledged the roles of the religious leaders, there were a few who had the view that religious leaders do not play any role regarding preventing child marriage and teenage pregnancy. For example, participants in an FGD with girls (15-19 years) reported that religious leaders did not take part in these issues because traditional leaders were not serious in enforcing the prevailing bylaws. They said that "Ngati eni akewo sakupangapo kanthu, ife titani", meaning if the 'owners' are not doing anything, what could we do as church leaders?

"No, they [religious leader] do not take any role in child marriages. They just leave it like that. They say 'we are religious leaders, nothing we can do with this. If they [the children] have accepted the marriage, then we will leave it like that'." (P6, FGD with girls 15-19 years)

Most of the people in TA Liwonde are Muslims. A female parent observed that most of the sheiks in her community are also chiefs, hence they are playing a role in managing child marriages and teenage pregnancy as they speak out on these issues in mosques and could disallow contraceptives. Some religious groups have doctrines that negatively impact on access to services. For example, Catholics do not allow people to use contraceptives or abortion. While this is the case, the Yes I Do partners have trained them to make sure that they disseminate accurate information about SRH services and that they should allow young people to access SRH services.

Lastly, some informants reported that religious leaders also offer counselling services to the general population, including to married young men and women.

"Another role that the religious sector can do is just to encourage the youth psychologically on how to stay in marriage and to engage in income generating activities since they have already entered into marriages." (IDI with a female health worker)

4.2.3.4 THE POLICE

Key informants reported that since the police have been oriented on child rights, they are aware that these matters should be treated with urgency. Within the police system, there is a victim support unit, whose responsibility is to hold parents or young men accountable in case of teenage pregnancy. Parents or other community members may report directly to the police about cases happening in their community. Caretakers of pregnant girls must come over to report the situation at the police and there is a chance that young men can be jailed, according to several study participants.

In addition, the youth clubs also helped identifying parents whose children are involved in child marriage. They were said to take the issue to the child protection committee, who would investigate if it is true and when confirmed, take the culprit to the police. Not only young men and parents have been arrested, but there was also an example of a chief. A key informant narrated a case in which a chief was arrested by the police, because he allowed a child marriage to take place in his village: he said that the chief received chabwalo, a form of payment, and he endorsed or accepted a marriage taking place in his village.

The police were also involved in sensitizing the communities about the disadvantages of child marriage and teenage pregnancy:

"The police usually go around the villages, they visit the schools. I have seen different fora where the police would come forward and teach the people on such issues." (IDI with a health worker)

At community level, a community policing forum has been introduced under the Malawi Police. They have been trained on how they can carry out their duties and take offenders to task. When child marriage cases are reported to the police, they would go into the community, investigate and arrest the person. One of the Yes I Do partners, however, added that in some cases, the police did not have transport, and this constrained their capacity to address issues at community level. Some key informants suggested that the police office in TA Liwonde should improve its mobility and hire more police officers. An innovative approach was taken, where mobile courts were established with police officers in the communities. This initiative was supported by Plan Malawi.

An important challenge expressed by participants was that in some cases communities tend to hide offenders. One Yes I Do partner reported that when community members know that a case is in the hands of police, they hide the culprit or hide the age of the child so that they would not be convicted. As a result, the police just drop the case. While the police are playing a vital role, in some cases they were said to be corrupt. For example, during an FGD with females aged 15-19, participants said that if a girl gets pregnant and the issue is in the hands of the police, the police will just demand money from the parents and then release them. Hence, most parents when going to the police they just take some money with them to settle the case.

4.2.3.5 YOUTH CLUBS

There are a number of youth clubs operating in TA Liwonde. These youth clubs are working closely with the Yes I Do alliance, other NGOs and government departments. Several key informants reported that youth clubs were created to provide a platform where youth themselves can sit down and discuss issues affecting them. Such clubs, therefore, provide space for dialogue and engagement among the youths and between youth and other members of the community.

Most informants in this study identified a wide range of issues that youth club members discussed and these included SRHR, child marriages, teenage pregnancies, dressing and education. They particularly played a role in encouraging young men and women who dropped out of school to go back to school.

R1: *"We [in the youth clubs] talk about how we can do things be it at home or at school protecting those in child marriages and those with teenage pregnancies and giving them advice and telling them that they shouldn't do that."*
R6: *"We talk about how the teenager that dropped out of school should go back to school."*
(FGD with boys 15-17 years)

In addition to discussing issues among themselves, the youth clubs also created awareness among the wider community on issues affecting young men and women using different fora including performing drama and conducting community meetings. Some youth clubs also provided contraceptives to young men and women. They worked with organisations such as Plan Malawi and Youth Net and Counselling (YONECO), and several key informants reported that the Yes I Do alliance has empowered youth clubs with knowledge and skills.

4.2.3.6 TRADITIONAL LEADERS

One of the major responsibilities of traditional leaders is that they settle disputes. Their response to teenage pregnancy and child marriage differed, as shown in the qualitative data. Some leaders were supporting the prevention of teenage pregnancy and eradication of child marriage, others tried to get some benefits out of certain situations.

As discussed above, several participants reported that cases of teenage pregnancy and child marriage are brought to traditional leaders for settlement.

"They go to the chiefs and report that 'my parents want me to get married and yet I do not want. I want to continue with my education.' She gets helped. The chiefs calls the parents to say 'leave her alone. If she wants to get married, she will [do so] at her own time'." (FGD with female parents)

If cases of child marriage or teenage pregnancy cannot get settled by the traditional leader, then they go to the police and courts for settlement. During an FGD with male parents, participants explained that before people get married, the chief needs to know and assent to the marriage. If the persons who want to get married are below the age of 18, and insist to get married, the case would be reported to YONECO for further intervention. Traditional leaders also create awareness about child marriage and teenage pregnancy through the available bylaws. It seems that the TA from Liwonde himself was a driver for this change. He threatened to dethrone village headmen who encouraged child marriage and teenage pregnancy.

"… The TA conducted a meeting with all his subordinates. He illustrated the impact of child marriages. You know that if the TA has spoken, no one can what, can oppose. The TA also said that and it's a caution 'if it happens that the village head has tolerated child marriage in his/her village and it comes to my knowledge, that person will no longer be the village head.' Because of these words, the village heads are in forefront denying child marriages." (KII with a district official)

Traditional leaders are responsible for implementing the bylaws. People who violate the bylaws are fined specific amounts of money. A female parent reported that if people fail to pay the fine, they are told to cultivate in the chief's garden and sweep the surroundings for a month. However, some informants said that they had never seen anyone being fined. They were concerned that traditional leaders are corrupt, which has a negative impact on prevention of teenage pregnancy and child marriage in TA Liwonde. This corruption was visible when chiefs were not prosecuting own family members, or when chiefs benefitted from the situation. For example, a female health worker reported that if the man or boy who made a girl pregnant is travelling to South Africa, the traditional leaders do nothing since they know that they will benefit blankets or money from him. In addition, the girl is even advised to lie that she is 18 years old in order to avoid prosecution. One key informant added that sometimes the community hides cases of child marriage and teenage pregnancy, by taking the child to another district where she will stay with a relative.

"Let's say the girl is impregnated and the boy who impregnated her has run away. The chief starts telling the parents that for him to solve this they [the parents] should give him something so that he should help them. And it happens that the parents search for the money and pay and even ending the story not to go on that's why am saying it brings corruption…" (IDI with a 21-year-old man)

Lastly, one key informant reported that in some cases, chiefs do not care about teenage pregnancy and child marriage cases: what matters to them is just registration of child marriages so that they receive more donations.

4.2.3.7 HEALTH WORKERS

Before 2016, health workers already conducted sensitisation meetings at community level. Key informants and other study participants however indicated that awareness campaigns have been intensified since the implementation Yes I Do programme started in TA Liwonde.

Many informants reported that health workers sensitize young people on the dangers of teenage pregnancy and consequences of child marriage. Some informants said that health workers encourage young people to use contraceptives and to go for antenatal clinics. A key informant reported that health workers in TA Liwonde were trained on SRHR issues, including how they can help girls to deliver. The information and services that health workers provided were not only given in the health facilities. The health workers also came to the villages for sensitisation sessions and to provide contraceptives to young people. Activities were executed in collaboration with schools or chiefs. Young people and adults in the community used to walk long distances to access contraceptives. The situation has now changed, because a vehicle goes to the community and people can access contraceptives from there.

"They [health workers] are doing a lot of things, every time we are having meetings or workshops, we make sure they are also present. We have some health workers that were trained to provide contraceptives to youths, or STIs or rape cases. We also have others that provide SRHR information such as how they [girls] can get pregnant unexpectedly, how they can avoid them, consequences of child marriages and also provide condoms to the youths." (KII with a Yes I Do partner)

In terms of service delivery, quite a number of informants expressed some concerns. While there are health facilities in TA Liwonde, health workers tell people that it is not safe for pregnant girls to deliver in TA Liwonde. They are advised to travel to Machinga District Hospital in Liwonde town.

"It's a problem these days, because if a girl gets pregnant, she is advised to go to Lilongwe Hospital, yet we have a hospital [health centre] right here in Mangamba. So, when you look at our financial status, we cannot manage." (IDI with a 22-year-old woman)

A participant in an FGD with females aged 20-24 explained that health workers argue that it is dangerous for girls to deliver at any health facility in TA Liwonde, as they require highly qualified staff to safely deliver. During an FGD with girls aged 15-19, participants said that one of the major challenges is that pregnant teenage girls are required to get a letter from the chief in order for them to start antenatal services. Some informants expressed challenges with regard to the services. First, often there were not enough materials including medicines. Second, poor attitudes of health workers towards young men and women and high workload made health workers not always interacting adequately with the youth.

"We have few health providers and also no medications most of the times. You go there and you spend the whole day. They say that you have malaria. Then they say 'we have no drugs for malaria, so go and buy' this is a challenge. No medications in our health facilities…The health workers are also few in number if we compare with the population here." (FGD with male parents)

4.2.3.8 SOCIAL WELFARE

One Yes I Do partner reported that the district social welfare office (DSWO) played a key role in addressing child marriage and teenage pregnancy, including annulment of child marriages. However, one key informant reported that in some cases, DSWO fails to address cases timely because of lack of transport.

Several key informants furthermore reported that DSWO sensitises people in the community about the child protection law. They facilitated the establishment of child protection structures at community level, such as child protection committees and community victim support units, and built the capacity of such structures to ensure that they are functioning. In addition, some key informants reported that this office provides counselling services. Community-based child protection workers help to identify children who are abused. Once reported, the DSWO in conjunction with other stakeholders, conduct investigations and make sure that the offenders are apprehended.

4.2.3.9 TEACHERS AND SCHOOLS

Most informants in this study reported that in general, teachers are the ones who teach children on a wide range of issues, including SRHR. Initially, according to some informants, teachers felt uncomfortable to teach life skills education. However, the Yes I Do programme trained them in comprehensive sexuality education including counselling and mentorship. After these trainings, teachers were able to effectively teach life skills education. One key informant emphasised that the Yes I Do programme sensitised teachers not just to teach life skills education for the sake of the exams, but to transform learners' attitudes and behaviours in terms of SRHR.

"Yes, they do. We are taught the life skills subject, but it is not like they teach us to go and have sex – no – but they teach us how we can prevent sexually transmitted diseases and pregnancies and other skills we can use in life." (P6, FGD with girls 15-19 years)

Plan Malawi also introduced the Champions of Change (CoC) intervention in schools and communities of TA Liwonde. At each school in TA Liwonde, there were teachers who have been trained and acted as matrons and patrons. They motivate learners to discuss a wide range of SRHR issues.

> *"There are other teachers who are acting as matrons and patrons in schools and they were trained to support the girls and boys in SRHR. So they would actually counsel them, create platforms for them to sit around and discuss issues relating to sexuality and as I said that they are in clubs and its either they do it at "Yes I Do" clubs or other clubs like Life Skills clubs where they discuss issues related to sexuality."*
> (KII with a Yes I Do partner)

Most informants had the view that it is the responsibility of teachers to provide guidance to pregnant girls. These girls were advised to withdraw from school and stay at home until they had delivered. They were advised not get married: they should return to school after delivery. Several cases were reported in which girls have been enrolled in school after delivery. A few informants reported that some teachers advise girls to use contraceptive or not to engage in sex while young.

> *"They [the teachers] advise girls that if they really want to sleep with someone, they should use contraceptives like injections so that their education should not be affected."*
> (IDI with a 22-year-old woman)

Teachers also linked up with health providers for the provision of SRHR information and contraceptives to boys and girls in school.

> *"The role they [teachers] take is that they do link up with the health providers. They call them and they do come here at school. Then the health providers give information related to girls. If you want to have any contraceptive measures, you are allowed to have it. If you want injections, they inject you right there."*
> (P1, FGD with girls 15-19 years)

Other teachers referred young people, with a referral letter, to the health centres, as explained by a female health worker:

> *"There is at least a little bit of openness between the youth and the teachers. For instance, here at the clinic, we receive young people who are seeking health services like family planning methods. They are given written permission/ referrals by their teachers. This just shows that they discuss such things with their teachers. Therefore, we can conclude that the youth and the teachers are open to discuss about such issues to each other unlike in the past."* (IDI with a female health worker)

Teachers also played a supportive role in reporting cases of abuse to the respective authorities. Several key informants gave examples of teachers reporting cases of child rape and defilement. One case was about a girl of 11 years old. Her teacher noticed something different about her. When she was asked by the teacher, it was found out that the girl was raped and her vagina was badly bruised. The DSWO took up this case.

4.2.3.10 PRIVATE SECTOR

In TA Liwonde, there are hardly any private sector companies. One company called African Packs was reported to provide support to young people in secondary schools. Another key informant commented that Plan Malawi has established over 20 village savings and loans (VSL) groups. This key informant recommended to link young people to financial service providers, as they cannot stay in these groups forever. He suggested that they need to migrate from VSLs and come up with cooperatives which can be able to access loans for investments.

4.3 YOUTH ENGAGEMENT AND EMPOWERMENT

4.3.1 ABOUT ONE THIRD OF THE YOUTH HAD PARTICIPATED IN THE YES I DO PROGRAMME

Almost one out of two respondents in TA Liwonde (49%) had heard about the Yes I do programme in the community. Thirty five percent (35%) of the respondents in TA Liwonde reported they had participated in the Yes I Do programme. A higher percentage of females (40%) than males (22%) reported participating in the programme. Table 7 shows the activities in which the respondents participated.

Table 7 **Yes I Do activities respondents participated in, TA Liwonde**

Type of activity[10]	Females n (%)	Males n (%)	Total n (%)
Youth club	82 (68.9)	9 (40.9)	91 (64.5)
Champions of change	29 (24.4)	8 (36.4)	37 (26.2)
Community dialogues	24 (20.2)	6 (27.3)	30 (21.3)
Medical camps	6 (5.0)	3 (13.6)	9 (6.4)
Other	11 (9.2)	1 (4.5)	12 (8.5)
Vocational training	6 (5.0)	0 (0.0)	6 (4.3)
Total respondents	117 (98.3)	22 (100.0)	139 (98.6)

Table 7 also shows that most respondents (64.5%) participated in youth clubs with a higher percentage of female respondents participating (69%) compared to male respondents (41%). The other two often mentioned activities in which respondents participated were CoC (26%) and community dialogues (21%). The percentages of male respondents participating in the CoC (36%) and community dialogues (27%) were higher than those of female respondents (24% and 20%, respectively). Six percent (6%) of the respondents participated in medical camps. Table 7 further shows that only females participated in vocational training programmes.

Respondents who participated in the Yes I Do programme were also asked which activities they found beneficial. Their answers mostly follow the activities that they were involved in as presented in Table 7. Respondents found youth clubs beneficial at 62% and this was followed by the CoC intervention (23%) and community dialogues (21%). The rest of the activities were mentioned by less than 10% of the respondents. There were again some variations by gender: a much higher percentage of female respondents (66%) reported youth clubs being beneficial compared to male respondents (36%). On the other hand, there were more male respondents who described the CoC intervention (41%) and community dialogues (36%) as beneficial compared to females at 20% and 19%, respectively.

Survey respondents who had indicated that they did not participate in Yes I Do programme activities were asked for the reasons why. More than half of the respondents (54%) reported that they did not know enough about these activities and nearly a tenth (9%) said that they did not find the activities relevant or important. Six percent (6%) of the respondents said that they did not participate because their friends were not participating while others (5%) were in school while activities were going on. Only one female respondent reported that her parents did not allow her to participate.

10 Reported by respondents who indicated to have participated in the Yes I Do programme.

4.3.2 YOUNG PEOPLE ARE MORE CONFIDENT TO DISCUSS GENDER EQUALITY AND GIRLS' RIGHTS, ESPECIALLY WITH PEERS

In this study, respondents were asked whether they felt confident (discussing gender equality and girls' rights with (i) girls their age, (ii) boys their age, (iii) adult women, and (iv) adult men.

The percentage of respondents in TA Liwonde who felt completely confident in discussing gender equality and girls' rights with girls of their age doubled from 17% at baseline to 34% at end-line. Among females, there was an increase from 21% to 41% while among males the increase was from 4% to 15%. In TA Chikwewo, the percentage of respondents who felt confident in discussing gender equality and girls' rights with girls of their age also increased from 16% at baseline to 33% at end-line and also here, females felt more confident to discuss with girls their age than males.

In TA Liwonde, the percentage of respondents who felt completely confident discussing gender equality and girls' rights with boys of their age strongly increased from 10% at baseline to 31% at end-line. For males, this percentage went from 12% at baseline to 47% at end-line and for females, it went from 10% at baseline to 25% at end-line. In TA Chikwewo, there was also a considerable increase in the percentage of respondents who felt confident to discuss these issues with boys of their age, from 13% at baseline to 27% at end-line. The percentage of males who felt confident discussing gender equality and girls' rights with boys of their age was considerably higher than the percentage of females at both baseline and end-line.

There was also a strong increase in the percentage of respondents who felt completely confident discussing gender equality and girls' rights with adult women: from 5% at baseline to 14% at end-line in TA Liwonde and from 5% at baseline to 13% at end-line in TA Chikwewo. There was a large increase in the percentage of females who felt completely confident from 7% to 17%, this was different for males (from 0% to 3%).

Lastly, the percentage of respondents who felt completely confident discussing gender equality and girls' rights with adult men increased from 2% at baseline to 6% at end-line in both TA Liwonde and TA Chikwewo. In TA Liwonde, the percentage of male respondents who felt completely confident increased from 1% at baseline to 24% at end-line, compared to 2% at baseline and 5% at end-line for female respondents. At end-line, the percentage of males who felt confident discussing these issues was much higher in TA Liwonde (24%) than in TA Chikwewo (6%).

It seems that respondents find it easier to discuss gender equality and girl's rights with people of their own gender and age, and that improvements in the confidence of discussing these issues has increased in both the intervention and control area.

4.3.3 MOST YOUNG PEOPLE FEEL THEY ARE ABLE TO DECIDE WHOM TO DATE AND MARRY

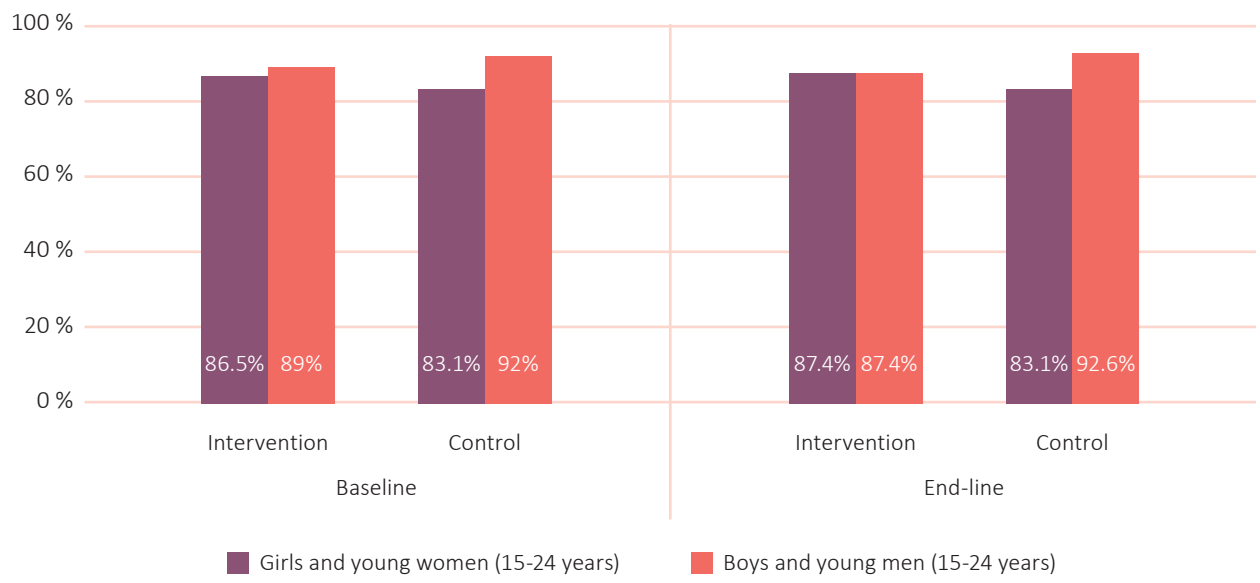
During the interviews and FGDs, young people gave a mixed picture about their decision-making power. Young women (15-19 years) indicated that they have little decision-making power and are not listened to. This was confirmed by young men, who mentioned that young women sometimes lack self-esteem to express themselves and men would take over their ideas. In an FGD with young women (20-24 years), it was mentioned that youth are listened to by educated elders, but that their views are hardly accepted by uneducated elders.

To provide an insight into changes in decision-making capacity, young people were asked if they could decide for themselves whom to date. The majority of the respondents, both females and males, indicated that they could do so. At baseline, it was clear that young men in the control area were more confident when it comes to decision-making around dating as compared to young women, while in the intervention area, it was more balanced between young women and men (Figure 1).

When zooming into the situation for young women, at baseline, the percentage who could decide for themselves whom to date was higher in the intervention area (87%) compared to that in the control area (83%). This difference at baseline, however, was not statistically significant (OR 1.3). It is clear from Figure 1 that for both areas, the trend is stable (the trends are not statistically significant, OR 1.0 for the control, and OR 1.1 for the intervention area). When

comparing changes in both areas over time, the increases in the perceived ability of females to decide for themselves who to date were similar across areas (OR 1.1), and the difference in trends was not significant. For young men, the percentage who felt they could decide for themselves whom to date was lower in the intervention area (89%) compared to the control area (92%) at baseline (OR 0.7). This difference is not statistically significant. There is a fairly stable trend in the control area (OR 1.1) and a decreasing trend in the intervention area (OR 0.9) over time; neither however are significant. The difference between the trends in both areas over time is not significant (OR 0.8)

Figure 1 **Young people who (strongly) agree that they can decide for themselves whom to date**



Young people's autonomy is also reflected in decisions relating to marriage. About eight in ten young people at baseline said that had a say on whom to marry, instead of parents or relatives deciding for them. However, at end-line, there was a drop in the percentage of male respondents (from 83% at baseline to 77% at end-line) in the intervention area who were able to decide from themselves whom to marry. Among female respondents in the intervention area there was no notable change from baseline (84%) to end-line (85%).

4.4 YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH KNOWLEDGE, BEHAVIOUR, INFORMATION ACCESS AND SERVICE UTILIZATION

4.4.1 YOUNG PEOPLE'S DESIRES, NEEDS AND WORRIES FOCUS ON EDUCATION, EMPLOYMENT, (FUTURE) MARRIAGE AND PREGNANCY

At base-, mid-, and end-line, young people's desires focused on marriage, having children, making money and the appeal of working in South Africa. Some young people expressed that they were influenced by their peers. They saw what others had and hence desired to have the same.

> *"Some youth they just marry due to peer pressure. Once they see that their friend has been married to a guy who works in South Africa, they also admire. They see their friend having a baby, having baby suit, has an umbrella, they also want to have the same. Since they admire much, they end up getting married also."*
> (FGD with girls 15-19 years)

Some boys also shared that they desired to marry so that they did not have to perform household chores anymore.

Parents and other elderly informants seemed not fully aware about young people's desires. Others disapproved young people's wishes, because they would not help them towards a better future.

> *"Young boys and girls rush into marriages because they feel like they are capable of supporting themselves compared to the support they get from their parents. They should realize that when they drop out of school and rush into marriages, they can end up getting themselves into problems and the girl should also realize that when she rushes into marriage the spouse can't provide her with everything she needs. When she successfully completes her education, she can have a job and become self-reliant."* (IDI with a teacher)

Key informants revealed that some parents lacked the responsibility to meet the needs of their children, and therefore their children resorted to marriage easily with the hope that their needs shall be fulfilled. However, they also explained that there had been some changes in the mind-set of community members, and that more parents were catering for the needs of their children, for instance, by paying for the school development funds.

> *"Our interaction with the youths now reveals that there's a change in the mind-set… So what we are seeing is that, for example, if we talk of schools, I think in the first and second years of our interventions we noted that parents were not ready to pay for school development funds even a small [amount of] money, about the examination fees parents were unable to pay. But the past two years up to last year we have seen that change."* (KII with a Yes I Do partner)

The survey explored young people's worries and hopes and whether they could express these. In the intervention and control area, about eight out of ten females at both base- and end-line indicated they had someone to talk to. Among males, there was a marginal increase from 79% at baseline to 82% at end-line in TA Liwonde, but a small decrease from 86% at baseline to 82% at end-line in TA Chikwewo. In particular, both young females and males, could most easily talk to their mothers. Boys and young men were more likely to talk to their brothers, while girls and young women were more likely to talk to their sisters. It is worth noting that in TA Liwonde, there was an increase in the percentage of male respondents who spoke to their father about their worries and hopes – from 10.5% at baseline to 15% at end-line. However, this was still limited to male (and not female) respondents.

Although young people had someone to talk to about their (general) worries and hopes, they were less likely to find it easy to talk to their parents about sexuality and marriage over time, with larger decreases in the control than in the intervention area (Table 8).

Table 8 **Respondents who find it easy to talk to their parents about sexuality and marriage**

	Baseline		End-line	
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**
Girls and young women (15-24 years)	345 (56.1)	362 (62.5)	247 (41.7)	246 (41.2)
Boys and young men (15-24 years)	60 (30.0)	101 (50.2)	61 (28.1)	66 (30.7)

The study also dived into specific worries that young people had (Table 9). Young women worried a bit more about becoming pregnant, becoming a bride, and being worth a bride price only as compared to young men. This percentage of female respondents who worried about becoming pregnant fell over time from 74% to 70.5% in the intervention areas and from 72% to 66% in the control area. Worries of young women and men about becoming a bride or groom early reduced over time, with the control area observing a larger decrease. However, many respondents worried about this at end-line: 65% of the respondents in the intervention area and 62% of the respondents in the control area. There were no major changes with regard to bride price worries in the intervention area, while in the control area, the percentage of females who worried about this decreased and the percentage of males who worried about this increased over time.

Not finishing school was another major worry for young people. In the control area, this was particularly high among young men at both study phases, but there was a decrease in the percentage of young men who worried about this from 86% at baseline to 73% at end-line. There were no major changes in the intervention area, where this continued to be an important worry (77% at baseline and 76% at end-line).

When asked if they worried about being denied access to contraceptives, it appears that female respondents worried more about this than male respondents. In the intervention area, there was a marginal increase over time among young women, from 43% to 48%. There were larger increases in worry about being denied access to contraceptives in the control area among both men and women (from 43% at baseline to 49% at end-line and from 31% at baseline to 40% at end-line, respectively).

Table 9 **Respondents' worries**

Worries	Baseline						End-line					
	TA Liwonde n (%)			**TA Chikwewo n (%)**			**TA Liwonde n (%)**			**TA Chikwewo n (%)**		
	Female n (%)	Male n (%)	Total n (%)	Female n (%)	Male n (%)	Total n (%)	Female n (%)	Male n (%)	Total n (%)	Female n (%)	Male n (%)	Total n (%)
To become/ make someone pregnant early	455 (74.0)	131 (65.5)	586 (71.9)	419 (72.4)	138 (68.7)	577 (71.4)	418 (70.5)	151 (69.6)	569 (70.2)	394 (66.0)	149 (69.3)	543 (66.9)
To become a bride/groom early	439 (71.4)	118 (59.0)	557 (68.3)	406 (70.1)	142 (70.1)	547 (70.1)	396 (66.8)	133 (61.3)	529 (65.3)	368 (61.6)	139 (64.7)	507 (62.4)
To not finish school	482 (78.4)	151 (75.5)	633 (77.7)	437 (75.5)	173 (86.1)	610 (78.2)	453 (76.4)	163 (75.1)	616 (76.0)	415 (69.5)	156 (72.6)	571 (70.3)
To be worth a bride price only	352 (57.2)	82 (41.0)	434 (53.3)	351 (60.6)	71 (35.3)	422 (54.1)	351 (59.4)	89 (41.0)	441 (54.4)	307 (51.4)	84 (39.1)	391 (48.2)
To not decide for myself who to date	296 (48.1)	68 (34.0)	364 (44.7)	241 (41.6)	65 (32.3)	306 (39.2)	308 (51.9)	84 (38.7)	391 (48.4)	302 (50.6)	77 (35.8)	379 (46.7)
To be denied access to contraceptives	266 (43.3)	71 (35.5)	337 (41.3)	248 (42.8)	63 (31.3)	311 (39.9)	282 (47.6)	72 (33.2)	354 (43.7)	290 (48.6)	86 (40.0)	376 (36.3)

When it came to worrying about not being able to decide who to date, Table 9 shows that this worry was more prominent among female respondents than among male respondents. In both the intervention and the control area, the percentage of respondents who worried about this increased over time: from 45% at baseline to 48% at end-line in the intervention area, and from 39% at baseline to 47% at end-line in the control area.

Respondents were asked which topics they had discussed with family members, and which they had discussed with friends. At end-line, overall, more respondents talked to their friends about relationships, marriage, sexuality, and hopes and fears than with their family members. Higher percentages of young women than young men spoke to their parents about all topics except two; the two exceptions were the implications of dropping out of school, and birth rights including property ownership. This pattern is reversed when respondents were asked about which topics they discussed with friends, as young men were more likely than young women to report discussing all topics, except for marriage.

4.4.2 YOUNG MEN ARE MORE SEXUALLY ACTIVE THAN YOUNG WOMEN

The survey explored sexual behaviour of young people at end-line. Table 10 shows that about two third of the respondents (67%) were engaged in sexual activity and sexual intercourse. However, this is clearly gendered with young men being more sexually active than young women. Male respondents seem to engage in sexual activity and intercourse at an average earlier age than female respondents. The average age of sexual intercourse for males was around 16 years, while for females this was 17 years (not shown in table).

Table 10 **Respondents who ever engaged in sexual activities/ sexual intercourse at end-line**

	TA Liwonde n (%)			TA Chikwewo n (%)			Total n (%)
	Female n (%)	Male n (%)	Total n (%)	Female n (%)	Male n (%)	Total n (%)	
Respondents (15-24 years) who have ever engaged in sexual activities (petting, kissing)	372 (62.7)	170 (78.3)	542 (66.9)	381 (63.8)	158 (73.5)	539 (66.4)	1081 (66.6)
Respondents (15-24 years) who have ever engaged in sexual intercourse	381 (64.2)	160 (73.7)	541 (66.8)	372 (62.3)	159 (74.0)	531 (65.4)	1072 (66.1)

Contrary to the survey findings, in the FGDs and IDIs, it was sometimes assumed that girls start sexual relations earlier than boys. This discrepancy between the survey and the qualitative findings could be explained by participants feeling more comfortable/ anonymous in a survey setting, or it could be that community members (in FGDs) report the most extreme cases and assume the average age of first sexual relations lower than it actually is.

> *"For girls they begin at 12 years old, I have also observed that this generation is starting to have their monthly periods at early ages… I have even seen girls very young giving birth at 13 or 14 years at this health centre. This shows that the girls start having sex from the age ranges of 12 to 13 years old unlike the boys that tend to begin sexual encounters at 15 or 16 years old."* (IDI with a female health worker)

Study participants mentioned many different reasons why young people engage in sexual activities. Young participants said that they felt peer pressure to do so, or they wanted to fulfil their sexual desires. Quite a number of participants referred to how the initiation ceremonies contributed to early sexual debut for both girls and boys. Sexual encounters were reported to happen at night after initiation ceremonies, during birthdays or other (night) parties and after the market closes.

> *"Alright I can say maybe because of cultural practices that are there. Like when they go to initiation camps, they are told that they should go and try sex. They claim that they stopped it but I am not sure how far true that is. Video shows also that they do watch. Sometimes they are shown this pornography and they are tempted to go and try. So yeah."* (KII with a Yes I Do partner)

Others mentioned that some young people have no job opportunities, have dropped out of school and therefore, having sex is a way to pass their time.

> *"The youth start to get engaged in sexual relationships because they lack job opportunities and some of the youth fail to go to school, trying to force them to go to school but they do not so they just get engaged in sexual relationships because they do not go to school. They do not have chores or jobs to do that can make them pass their time, nothing to keep them busy."*
> (FGD with young women 20-24 years)

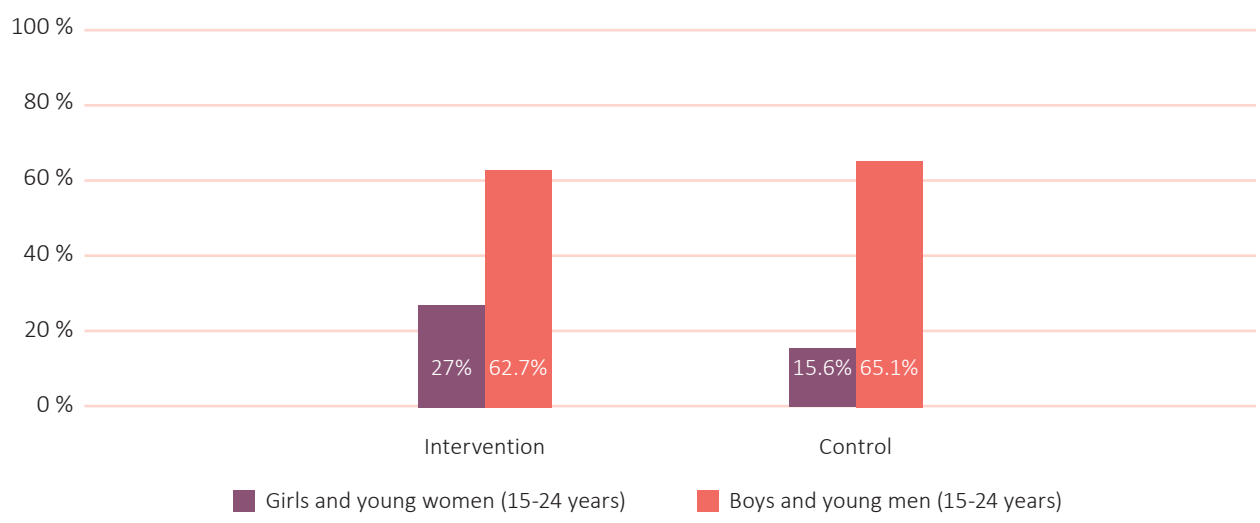
There were also girls and young women who entered into transactional sexual relationships because their families were unable to provide for them, or because they wanted to obtain products such as lotions or new dresses.

> *"Most youths think that when they sleep with someone, they will be given a little something to buy food. If there is no food in the house, they will just get the MK 500 and will buy mandasi at the market and eat, they will not even take the money home. They get used to that, thinking that every time I want money, I will just sleep with someone and he will give me some money."* (FGD with young men 20-24 years)

4.4.3 SEXUALLY ACTIVE BUT NOT IN A RELATIONSHIP

It is clear that the majority of the young women and men were sexually active. However, this does not necessarily mean that they, mainly the young women, were in a relationship. Figure 2 shows that there is a big difference between male and female respondents who reported to have ever had a boy/ girlfriend. Two out of three males ever had a girlfriend and around one out of four females reported that they had ever had a boyfriend in TA Liwonde. In TA Chikwewo, the percentages were lower.

Figure 2 **Young people who have ever had a girl/ boyfriend at end-line**



Transactional sex or forced sex may perhaps be reasons why more girls and young women were sexually active outside a relationship. Transactional and forced sex were frequently mentioned in the FGDs with young men (20-24 years) and in the IDIs with health and social workers. Young men shared that older men may 'prey on younger women and lure them'. Upon seeing (or having made use of) the wealth of the older man, a girl may not ask for help in case he has touched her inappropriately or slept with her, because she needs to allow him in return. It is also possible that some female respondents did not want to report that they ever had a boy or girls friend, because of existing social norms.

4.4.4 SEXUAL HARASSMENT MORE COMMON THAN PHYSICAL VIOLENCE

Looking at physical violence, at baseline, about 10% of the married respondents in the intervention area reported that they had been physically hurt by their partner. There were no differences between women and men. In contrast, in the control area, married young women (12%) reported this, while no men did so. Over time, these percentages dropped to 8% in both areas. In the interviews, violence was said to be caused by age difference in marriage, and the neglect of girls and young women in marriage.

Sexual harassment seems to be more common than physical violence. In TA Chikwewo, male respondents, irrespective of marital status, more often reported to be sexually harassed than female respondents (Table 11)[11]. This increased from 22% at baseline to 35.5% at end-line among unmarried males, and from 15% at baseline to 44% at end-line among married males. As for young women, there was a decrease over time in the incidence of sexual harassment in the intervention and in the control area. This was particularly large among married respondents compared to unmarried respondents over time in the intervention area.

> *"When they go and get married, maybe to an elder person, and she is doing her childish behaviour, she will always be getting the beating in the house, sure, and even when giving birth she will have so many children… So there is violence in the communities because the child has married an older person, they are doing different things and she will be exposed to abuse."* (IDI with a religious leader)

Table 11 **Youth who reported to have ever experienced sexual harassment[12]**

	Baseline		End-line	
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**
Unmarried females (15-24 years)	95 (28.8)	71 (27.1)	85 (26.2)	69 (24.4)
Unmarried males (15-24 years)	38 (22.4)	36 (22.2)	45 (25.7)	65 (35.5)
Total unmarried youth (15-24 years)	133 (26.6)	107 (25.2)	130 (26)	134 (28.8)
Married females (15-24 years)	56 (19.6)	73 (23)	28 (10.4)	58 (18.5)
Married males (15-24 years)	4 (13.3)	6 (15.4)	6 (14)	14 (43.8)
Total married youth (15-24 years)	60 (19)	79 (22.2)	34 (11)	72 (20.8)

4.4.5 SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS INFORMATION AND EDUCATION

4.4.5.1 EXPOSURE TO EDUCATION ABOUT SEXUALITY AND SEXUAL HEALTH HAS DECREASED

The percentage of young people who had ever received education about sexuality and sexual health has decreased considerably between base- and end-line in both TA Liwonde and TA Chikwewo. At baseline, three out of four female respondents had ever received education about sexuality and sexual health. At end-line, among female respondents, this significantly dropped by 17% in TA Liwonde (OR 0.5) and by 32% in TA Chikwewo (OR 0.25) (Figure 3). The difference between these two trends is statistically significant (OR 1.9).

For male respondents, the trends were different (Figure 4). At baseline, the percentage of male respondents who had ever received sexuality education was lower in the intervention area (70.5%) compared to the control area (78%) (OR 0.7). This difference was not statistically significant. In the intervention area, there is a significant decreasing trend over time from 70.5% to 59% (OR 0.6), and in the control area, a significant decreasing trend is also observed (OR 0.4). Although the decrease in the intervention area was less strong than in the control area over time (OR 1.5), this is not significant.

11 Those who stated that they experienced harassment with any level of frequency (every day, once or twice a week, once or twice a month) apart from 'never' were considered to have ever been sexually harassed.

12 During baseline, this was asked to all single respondents, while during end-line, those who said they were cohabiting were also included. However, there are no major differences due to this.

Figure 3 **Girls and young women (15-24 years) who ever received education about sexuality and sexual health**

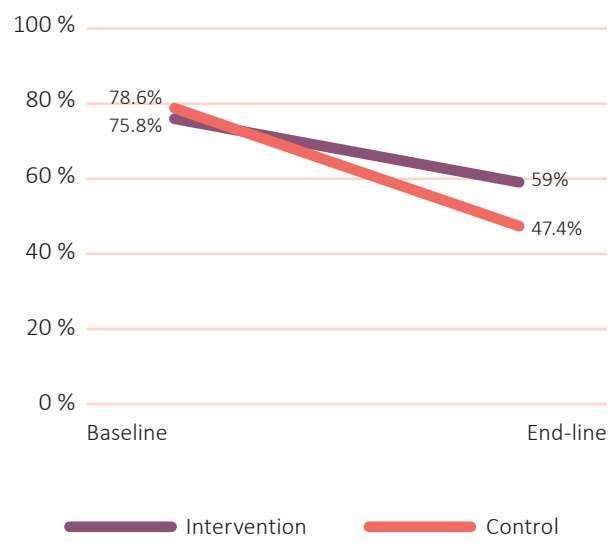
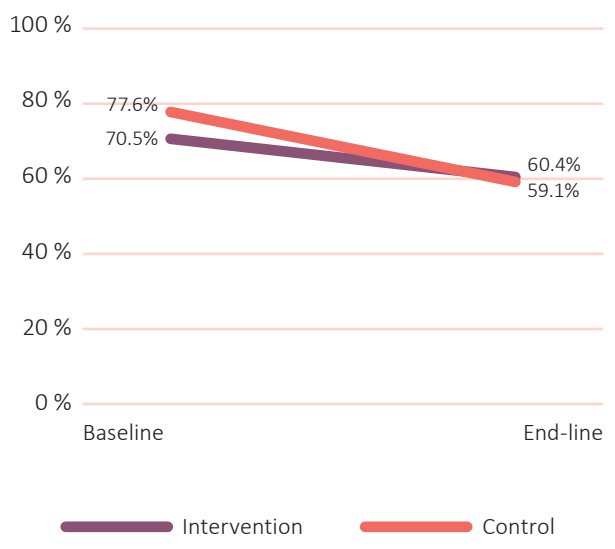


Figure 4 **Boys and young men (15-24 years) who ever received education about sexuality and sexual health**



4.4.5.2 LACK OF AGE APPROPRIATE EDUCATION ABOUT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

It seems that the young people in schools receive SRHR education as part of the curriculum. However, it also appears that information is too little and often does not correspond with their grade and their age, since many young people do not reach secondary education. From the qualitative data, the are no clear explanations for the above mentioned quantitative results.

> *"They are getting it in youth clubs, even in schools. In schools they will just touch a little bit you know our curriculum in primary schools. The way the curriculum was made was set that the youth will get this information at secondary school unfortunately most of the ages that are in primary school should be in secondary school so there is wrong messaging."* (KII with a Yes I Do partner)

4.4.5.3 MORE YOUTH CLUBS PROVIDING INFORMATION ABOUT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Besides teachers and schools, many participants mentioned a variety of other sources of sexuality education and information, which were also available for out-of-school youth. These were youth clubs, mother groups, health providers, hospitals, YFHS, grandmothers, peers, parents and sometimes the elderly, village [health] committees, chiefs, initiation camps and the radio. NGOs such as One Community, FPAM and YONECO were also mentioned to provide information and rights education.

> *"The youth clubs talk about issues of growing up and changing, what changes in the male and female bodies when they are growing up. They also talk about the development of sexual feelings in their bodies and how to control those sexual feelings in order to protect themselves from contracting sexually transmitted infections. What to do when they contract sexually transmitted diseases. These are the issues that the youth discuss. They are also encouraged to open up to their health providers if they have any problems in order to receive proper treatment."* (IDI with a female health worker)

Young people also received information through the Champions of Change intervention, which has been part of the Yes I Do programme. This intervention had also been inviting parents to engage in the sexuality education of young people.

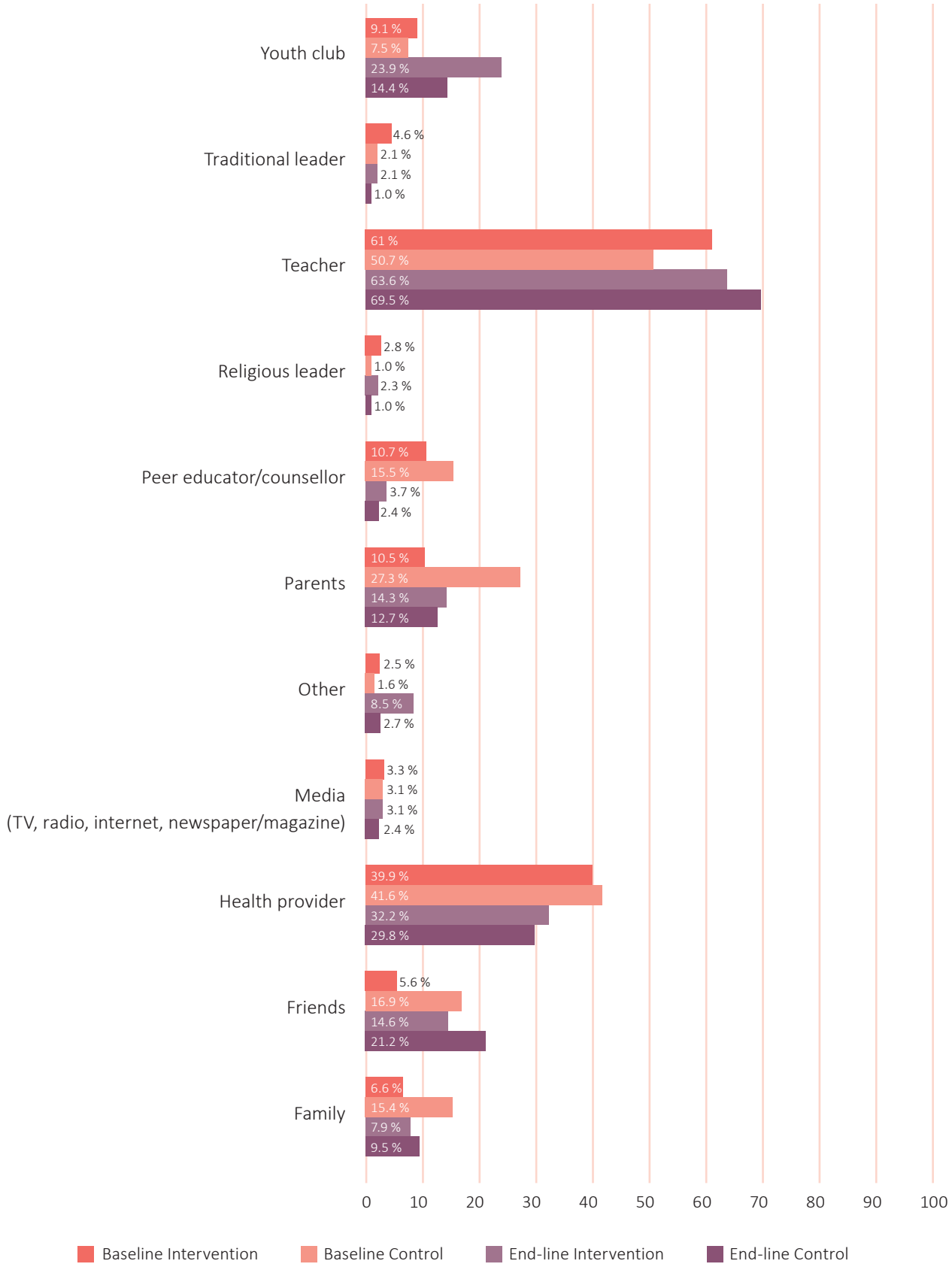
"They are other teachers that are acting as matrons and patrons in schools and they are trained to support the girls and boys in SRH… As I said that they are in clubs and it's either they do it at a "Yes I Do" club or other clubs like life skills clubs, where they discuss issues related to sexuality… once they have challenges, they would refer the issue to the mother group and they would even invite parents to discuss issues related to sexual violence related to girls and boys in schools." (KII with a Yes I Do partner)

4.4.5.4 TEACHERS ARE THE MOST COMMON SOURCE OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS INFORMATION AND EDUCATION

Figure 5 shows that according to survey respondents, teachers and health providers were the most common sources of SRHR information. Although youth clubs were not the most common source cited at base- and end-line, there was a considerable increase in youth clubs as a source of information over time. In the intervention area, the percentage of respondents who mentioned youth clubs as a source of SRHR information increased from 9% at baseline to 24% at end-line. In the control area, it increased from 7.5% at baseline to 14% at end-line. A decrease was seen in the percentage of respondents who received information from peer educators and counsellors; this decreased from 11% at baseline to 4% at end-line in the intervention area. A similar and even more pronounced decrease was observed in the control area. Friends became an increasingly common SRHR information source over time in both the intervention and control area.

As indicated, the majority of the respondents reported that the most common source of sexuality education was teachers. There was a small increase from 61% at baseline to 64% at end-line in TA Liwonde and a larger increase in TA Chikwewo, from 51% at baseline to 69.5% at end-line. However, from responses to another question, it was found that the preferred source of SRHR information was health centres both at base- and end-line and in both study areas. Despite the preference for health centers, the percentage of respondents indicating health providers as their current source of SRHR information decreased over time in both areas. In TA Liwonde, it decreased from 40% at baseline to 32% at end-line and in TA Chikwewo, it dropped from 42% at baseline to 30% at end-line (Figure 5).

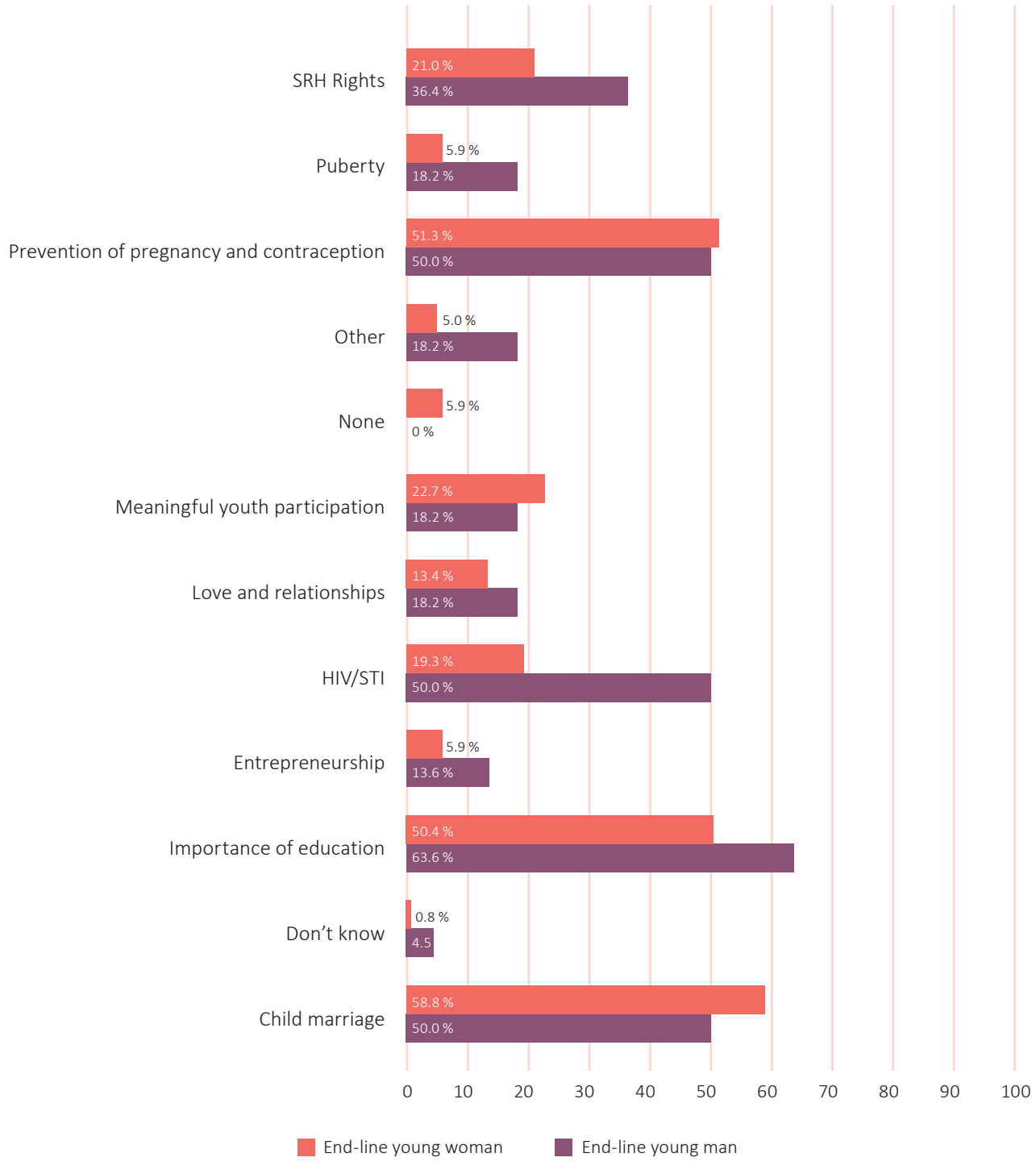
Figure 5 **Sources of SRHR information**



4.4.5.5 THE CONTENT OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS INFORMATION AND EDUCATION VARIES

The content of the SRHR information and education that young people were exposed to was very diverse, depending on the interest, values and religious/ traditional background of the information provider. Messages and information

Figure 6 **Topics addressed in Yes I Do activities that young people (aged 15-24) found beneficial at end-line, TA Liwonde**



could be focused on abstinence, fearing men (for girls and young women), sexual pleasure for males or females, the experience of bodily changes, rights and protection, menstrual hygiene, and the use of male condoms and other contraceptives to prevent teenage pregnancies. Participants also mentioned pornographic videos as sources of information.

At end-line, young people in TA Liwonde who participated in the Yes I Do programme activities (n=141) were asked which topics they found beneficial. Girls and young women found the topics of child marriage, prevention of teenage pregnancy and meaningful youth participation most beneficial. Boys and young men found the importance of education, prevention of pregnancy, child marriage and HIV/STI the most beneficial topics discussed, as can be seen in Figure 6. An equal percentage of young men and women found the topic of pregnancy prevention beneficial.

Figure 7 **Girls and young women (15-24) that have ever utilised SRH services, including modern contraceptives**

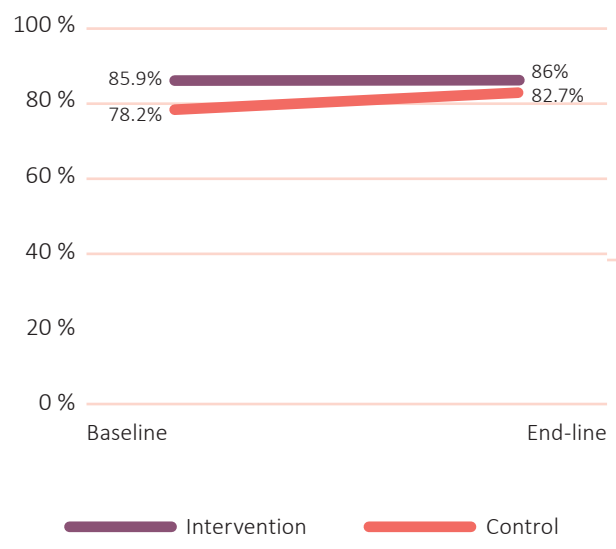
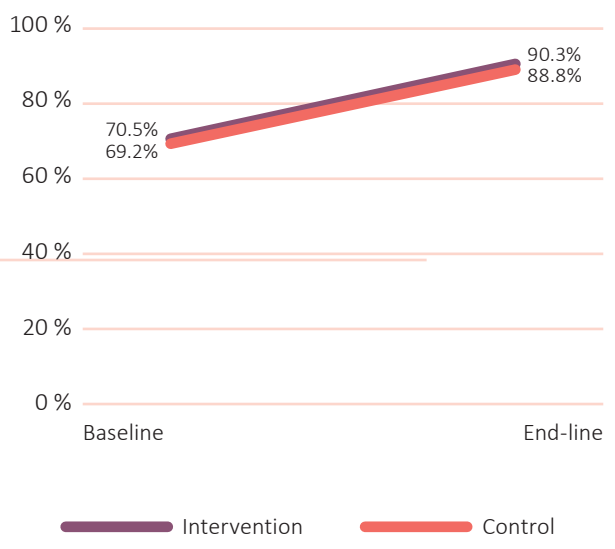


Figure 8 **Boys and young men (15-24 years) that have ever utilised SRH services, including modern contraceptives**



4.4.6 SEXUAL AND REPRODUCTIVE HEALTH SERVICE PROVISION AND UTILIZATION

4.4.6.1 UPTAKE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES INCREASED AMONG YOUNG MEN, AND REMAINED STABLE AMONG YOUNG WOMEN IN TA LIWONDE

Figures 7 and 8 show the percentage of young people who ever used SRH services, including modern contraception[13]. In general we see an increase over time, with the exception of young women in the intervention area.

At baseline, the percentage of females who reported having ever used SRH services was higher in the intervention (86%) than in the control area (78%). This difference was statistically significant (OR 1.7). In the intervention area, there was no statistically significant change over time (OR 1.0). However, in the control area, there was a slight increase from 78% at baseline to 83% at end-line, but this was not statistically significant (OR 1.3). When comparing the changes in both areas and over time, we see that the difference in trends is not statistically significant (OR 0.8) (Figure 7).

At baseline, boys and young men in the intervention area (70.5%) were almost as likely to have ever used SRH services compared to those in the control area (69%) (OR 1.10). The difference was not statistically significant. There is a strong and statistically significant increasing trend in the intervention area over time (OR 3.9) from 70.5% at baseline to 90% at end-line, and the same in the control area (OR 3.5) from 69% to 89%. SRH service use increased slightly more among men in the intervention area than in the control area over time (OR 1.1) but this difference between areas is not statistically significant.

At end-line, those who did not use any SRH services were asked why this was. About six out of ten respondents reported that they had never thought about it, while 17% shared that they did not have the need to go – this was mostly said by female respondents. Some respondents expressed reasons related to barriers in accessing services. These included 5% of the respondents (who had never used SRH services) in the intervention area who said that their parents disapproved, and 17% shared that they did not know about these services, most of whom were male respondents. In particular, four out of ten male respondents said they did not know about such services. In the control area, there were similar patterns.

13 At baseline, the answer option list that was read out did not include 'never'. All such responses were put in the 'other' option. At end-line, this option was part of the answer list.

4.4.6.2 VOLUNTARY COUNSELLING AND TESTING THE MOST COMMON SERVICE USED

Figure 9 shows which types of services were used by the survey respondents at base- and end-line in the intervention area. Voluntary counselling and testing (VCT) remained the most common service used by both male and female respondents and this increased over time (particularly among males, from 62% at baseline to 83% at end-line).

Antenatal care services were most popular among female participants, which also saw an increase over time by 10%. While there was a small increase in the use of family planning, the percentage of males who used this service increased majorly over time (from 12.5% at baseline to 60% at end-line). Life skills and sexuality counselling was mentioned by a third of the girls and young women at baseline, but this dropped at end-line. This trend was the opposite for boys and young men. At end-line, for both female and male respondents, almost three out of ten had accessed sexual violence counselling (while at baseline, none of the respondents mentioned this). It could mean that more awareness has been created around sexual harassment, which could have led to a higher demand and supply of sexual violence services.

At end-line, STI treatment, STI testing and HIV prevention were added as extra answer options. At end-line, four out of ten female respondents and five out of ten male respondents used STI testing and HIV prevention. The rate of using STI treatment was less high (9%). The types of services that were used in the control area were similar to those used in the intervention area (not shown in the figure).

The qualitative data also offers insight into the increased use of STI services:

> *"At first, we used to record few cases of STIs and we thought the cases were rare in the villages, but we did not know that this was because we were not active in making the people access the services. We did not know that this was a case of customer service so the coming in of the youth friendly services has helped us in terms of customer services. Hence, most of the youth are accessing the services because they are receiving good treatment due to the component of youth friendly services."*
> (KII with a youth friendly health service co-ordinator)

4.4.6.3 MEDICAL STAFF PROVIDE SEXUAL AND REPRODUCTIVE HEALTH SERVICES

The majority of the respondents shared that the health facility/medical staff had provided the SRH service that they had used (79% in both areas), followed by the community health worker (16% in the intervention and 12% in the control area). This cadre was mostly mentioned by males, as were the outreach services. Lastly, about 14% of the respondents across both areas said it was the school that provided them with SRH services. No baseline data are available, as this question was not asked at baseline.

4.4.6.4 APPRECIATION FOR THE QUALITY OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

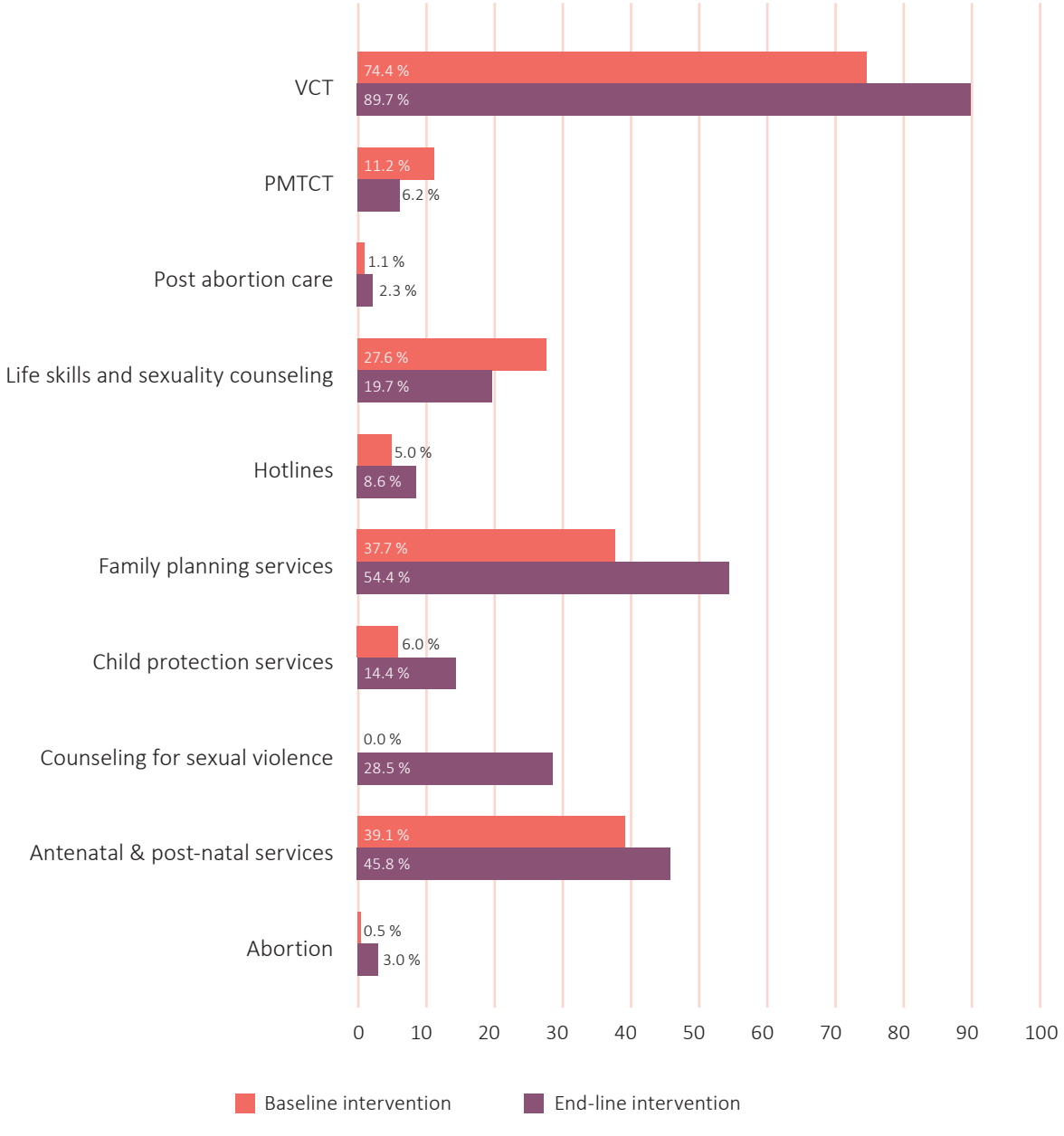
At end-line, the respondents who had ever made use of SRH services were positive about the quality of these services: 91% of the respondents rated the quality of the SRH services as good to excellent in TA Liwonde. In TA Chikwewo, 85% of the respondents rated the quality of the services as good to excellent. Overall, female respondents (91%) were more content with the services provided than male respondents (68%). About a fifth of the male respondents (19%) rated the quality as average. Some participants emphasized the (good) attitude of the health providers and that they provided the information needed.

> *"When we go to health centre seeking medical care or information, these health providers do not hide anything from us. They do tell us everything regarding to our needs."* (FGDs with girls 15-19 years)

4.4.6.5 ACCESSING YOUTH FRIENDLY HEALTH SERVICES

At baseline, it was observed that young people experienced challenges in accessing health services. To address this, the Yes I Do programme introduced YFHS. An official from Amref reported that the project trained service providers in the delivery of YFHS. At end-line another key informant observed that youth friendly corners were established in the health facilities. Still, some of the teenagers were not comfortable going to health facilities, due to the risk of being seen by and having to interact with adults. In addition to this, the Yes I Do programme, according to a key informant, also trained community-based distribution agents (CBDAs) to distribute various SRH commodities. The CBDAs are young people who have been capacitated with information and they work hand in hand with the HSAs in the catchment areas of different health centres. In addition to engaging CBDAs, the YFHS coordinator reported that HSAs were also targeted by the programme with a training in YFHS. He explained that at each health centre, six HSAs,

Figure 9 **Types of SRH services used (among those who ever used them) in the intervention area**



one medical assistant and one nurse trained the HSAs. These HSAs provide information as well as actual services in the community, thereby working together with CBDAs.

A change reported by the youth friendly health service co-ordinator was that girls and young women have less difficulty visiting health facilities for SRH services to prevent pregnancies or to receive antenatal care. This could explain the increase in use of these services as well as their general satisfaction about the quality of these services.

> *"Yes, there is that impact; there is a good relationship between the health sector and the youth. Firstly, even if a girl gets pregnant, they are not shy to visit the health centres, they can always come. We have antenatal services for girls on Saturdays and the girls are able to come. Secondly, most of the girls are able to access services [now including family planning], at first family planning methods were only accessed by elder people… This is different from what was happening four years ago. In addition, most of the girls have information, even in group discussions, you could see that they really do have information compared to how it was a while ago."* (KII with a youth friendly health service co-ordinator)

4.4.7 CONTRACEPTION KNOWLEDGE AND USE

4.4.7.1 MORE KNOWLEDGE ABOUT CONTRACEPTIVES

Figures 10 and 11 show that in the intervention area, there was an increase over time among both female and male respondents who knew (at least one) modern contraceptive method.

Figure 10 **Girls and young women (15-24 years) who know how to prevent pregnancy using modern contraceptives**

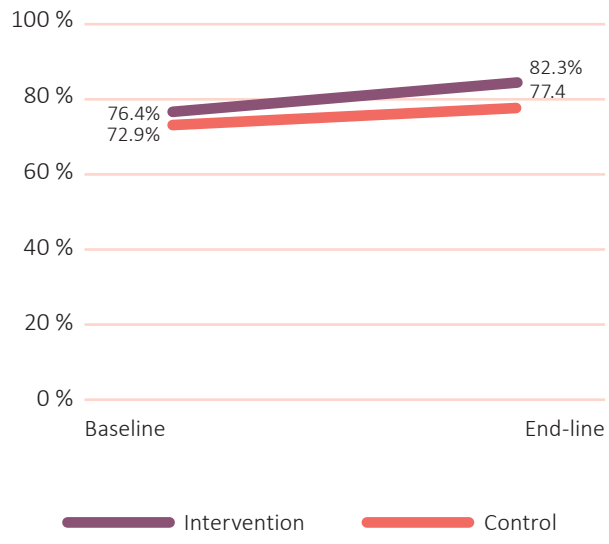


Figure 11 **Boys and young men (15-24 years) who know how to prevent pregnancy using modern contraceptives**

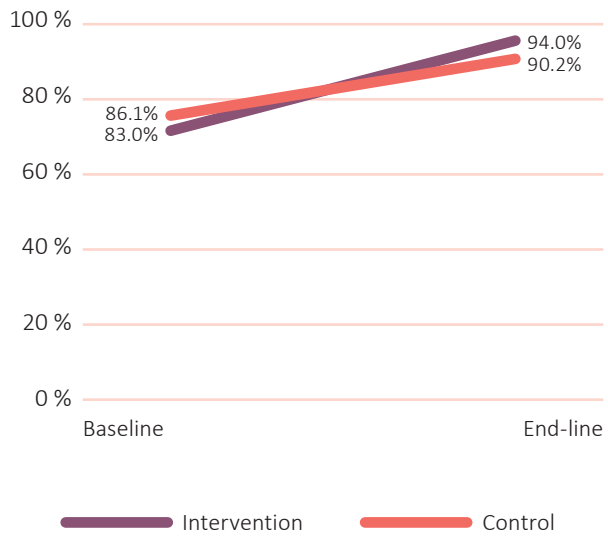
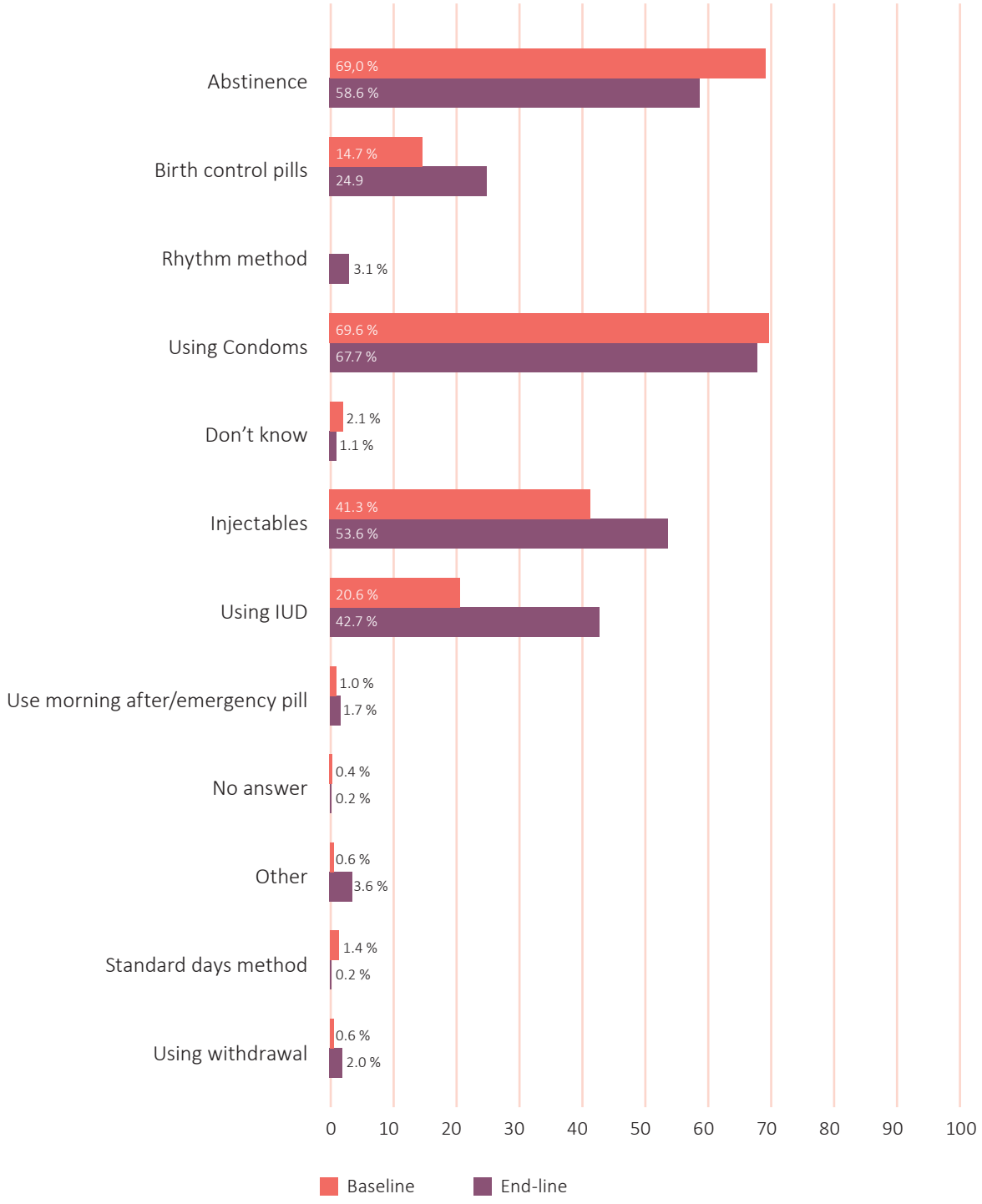


Figure 12 **Respondents' knowledge of types of pregnancy prevention methods in the intervention area**



At baseline, the percentage of female respondents who had knowledge about how to prevent pregnancy using modern contraceptives (76%) was marginally higher compared to the percentage (73%) in the control area. This difference was not statistically significant (OR 1.3). Over time, there was an increase in both areas, neither of which was statistically significant (OR 1.3 for the intervention and control area). When comparing between areas and over time, we see a similar but slightly steeper increase in the intervention area, but the difference in trends is also not statistically significant (OR 1.0). For boys and young men, the picture is a bit different. At baseline, the percentage of male respondents who had this knowledge (83%) was lower in the intervention area as compared to the percentage (86%) in the control area (OR 0.7). This difference was not statistically significant. In both areas, there is an increasing trend over time which is considerably larger and statistically significant in the intervention area, but not the control area (intervention area OR 3.9; control area OR 1.4). The increase in the percentage of boys and young men who

know how to prevent pregnancy using modern contraceptives between base- and end-line is 2.8 times higher in the intervention area compared to the control area. The difference in these rates of increase is statistically significant.

Figure 12 shows the different pregnancy prevention methods mentioned by survey respondents (multiple responses were possible). This also includes traditional methods of contraception. The most commonly mentioned method of contraception was male condoms (mentioned by almost three out of four respondents) followed by abstinence, injectables and the IUD. While abstinence was less commonly mentioned at end-line compared to baseline, injectables and the IUD were mentioned by more respondents over time.

4.4.7.2 CONTRACEPTIVES SEEM MORE ACCESSIBLE TO YOUNG PEOPLE

Survey respondents were asked which types of contraception were available in the areas in which they lived. All different options seem to be available in TA Liwonde and TA Chikwewo. At end-line, injectables were mentioned by the majority of respondents: 75% of the respondents in TA Liwonde and 79% of the respondents in TA Chikwewo referred to injectables. This was followed by male condoms (60.5%) implants (54%), contraceptive pills (45%) and the diaphragm (loop) (32% in TA Liwonde. In TA Chikwewo, the percentage of respondents who mentioned implants was 58% and followed by contraceptive pills (45%), male condoms (43%) and the loop (19%). The least commonly mentioned contraceptive method was the emergency contraceptive pill. No respondents in the control area mentioned the availability of emergency contraceptives and only five respondents mentioned it in the intervention area.

At baseline, 48% of the youth in intervention area agreed with the statement "it is difficult to access contraceptives for young people", which slightly reduced to 39.5% at end-line. This indicates an increase in ease over time. On the other hand, in the control area, there was an increase in the percentage of youth who agreed with this statement (from 40% at baseline to 49% at end-line). Moreover, 81.5% of the youth in the intervention area agreed with the statement "it is easy to access contraceptives as a married young person" at baseline and this decreased slightly to 79.5% at end-line. In the control area, there was a decrease in the percentage of those who agreed that it is easy to access contraceptives as a married young person from 85% at baseline to 79% at end-line.

From the qualitative data, it also seems that contraceptives have become more accessible for young people in TA Liwonde. Several participants explained that young people can access contraceptives within their communities, rather than needing to go to health facilities. In addition, if girls get pregnant, they are advised by health workers to make use of long-term family planning methods after delivery, so they can go back to school.

> *"They do access the contraceptives even in schools and public places. We have PSI. They come here and stay for a week. They come with tents here. They provide the contraceptives this time. If they [young men and women] are shy to come and take it from here, the health providers go to schools and they give contraceptives to these young girls in schools. Contraceptives are enough."* (FGD with male parents)

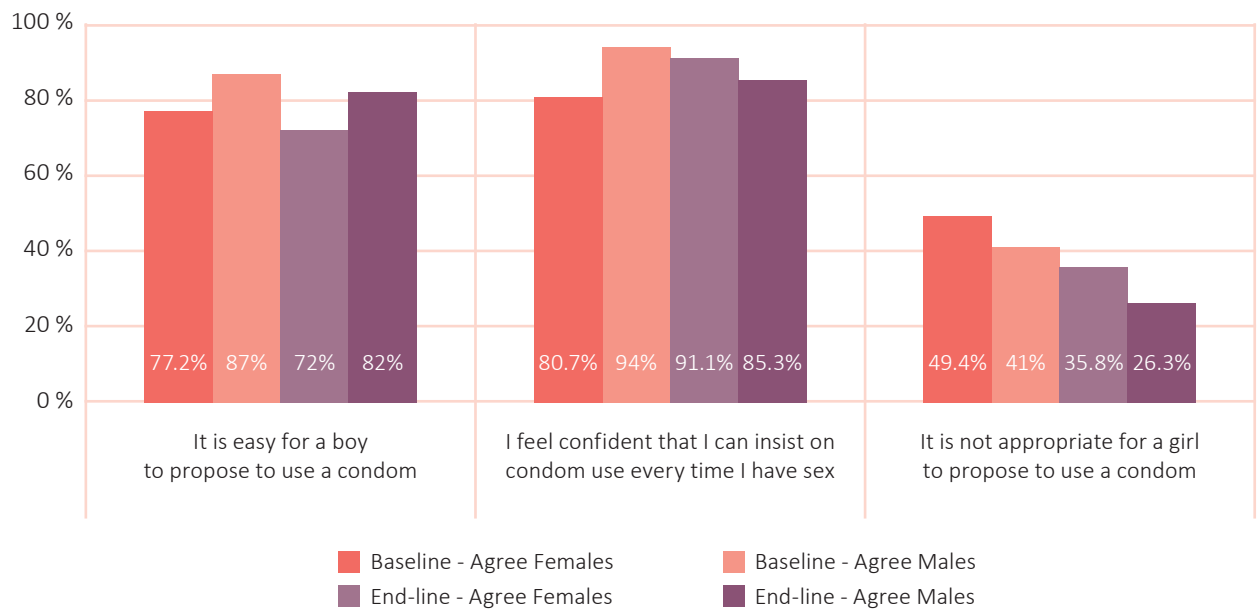
4.4.7.3 HIGHER CONTRACEPTIVE USE AMONG YOUNG MEN THAN AMONG YOUNG WOMEN

At base- and end-line, young people who ever had a child were asked about their contraceptive use. Table 12 shows that there is a decrease in the percentage of young mothers and fathers using male condoms in both areas. However, the sample is too small to conduct any regression analyses and draw conclusions.

Table 12 **Young people who ever had a child indicating using male condoms**

	Baseline		End-line	
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**
Young mothers (15-24 years)	13 (3.7)	9 (3)	2 (0.6)	4 (1.3)
Young fathers (15-24 years)	14 (38.8)	16 (44.4)	10 (15)	7 (24)

Figure 13 **Respondents' attitudes towards contraception in the intervention area**



While at baseline, only young people who had ever had a child were asked about contraceptive use, at end-line, this question was asked to all respondents. At end-line, one in three respondents had ever used contraceptives (34%) in the intervention area. A higher percentage of males (53%) than females (26.5%) indicated that they had ever used contraceptives in the intervention area. These young people (157 females and 115 young males) were also asked about their current use of contraceptives[14]. The pattern was similar: 39% of the male respondents reported currently using a contraceptive method, compared to 15% of the female respondents in TA Liwonde. In TA Chikwewo, contraceptive use (29%) was similar to that in TA Liwonde among females (16%) and lower among males (29%). Among those who currently used contraceptives, 90% of the males mostly used condoms, while females mostly used injectables (64%) and implants (7%) in TA Liwonde. In TA Chikwewo, the usage patterns were similar. Sixty-seven percent (67%) of the females using contraception at the time of the survey used injectables , followed by implants (17%), while 82% of the males used condoms. As girls and young women made use of different types of contraceptives than boys and young men, the providers were also different. Girls and young women mainly used health facilities and outreach centres. Boys and young men accessed condoms through pharmacists and community health workers.

At end-line, the main reasons (in both areas) why young people were currently not using contraceptives were because they were not engaging in sex at that time or had never done so (55%), they wanted (more) children (18%), they had never thought about it (9%), or disagreed with the use (7%). There were no large differences between areas in reasons for non-use of contraception.

Young people who did not use contraception were asked if they would like to in the future (at end-line). Overall, 20% of the female respondents and 16% of the male respondents indicated to like to use contraception in the future. These figures do not represent an unmet need for contraception, as they include respondents who do not use contraceptives for reasons such as sexual inactivity or wanting to have (more) children.

4.4.7.4 MORE YOUNG WOMEN AGREE THEY CAN PROPOSE CONDOM USE

Figure 13 presents the percentage of young women and men who agreed or strongly agreed with certain statements which reflected their attitudes around contraception in the intervention area. With regard to the first statement "It is easy for a boy to propose to use a condom", there was a slight decrease in the percentage of youth (both females and males) who agreed over time. A difference-in-difference analysis was conducted on the second and third statements "It is not appropriate for a girl to propose condom use" and "I feel confident that I can insist on condom use every time I have sex".

14 Three male respondents reported using natural contraceptive methods. These respondents were included.

At baseline, there was very little difference between the percentages of females who disagreed that it is not appropriate for a girl to propose condom use in the intervention (49%) and control area (47%). This difference was not statistically significant (OR 1.1). In both areas, the percentage of females who disagreed with this statement (or by implication, agreed that it is okay for a girl to propose condom use) significantly increased over time from 49% to 62% in the intervention area, and from 47% to 56% in the control area (OR 1.7: intervention area; OR 1.4: control area). Comparing the changes in the two areas over time, although there is a stronger increasing trend in the intervention area compared to the control area (OR 1.2), the difference between these two trends is not statistically significant.

At baseline, the percentage of males who disagreed that it is not appropriate (who by implication, agreed that it is appropriate) for a girl to propose condom use was higher in the control area (65%) than in the intervention area (58.5%). This difference was not statistically significant. While there was a non-significant increase in the intervention area over time from 58.5% at baseline to 71% at end-line, the trend in the control area was stable (OR 1.8: intervention area; OR 1.0: control area). When comparing the changes in both areas over time, although there was an increase in the intervention which was not seen in the control area, there was no statistically significant difference between the trends in both areas over time (OR 1.7).

The percentage of female respondents who reported that they were confident insisting on condom use each time they had sex was similar in both areas at baseline (81% in the intervention and 78% in the control area). The difference was not statistically significant (OR 1.2). There was a marginal non-significant change in the intervention area (80.6% to 81.1%, OR 1.0). In the control area, there was a significant decrease over time from 78% to 71% (OR 0.7). When comparing the changes in both areas over time, the difference between the marginal increasing trend in the intervention area and the decreasing trend in the control area is significant (OR 1.5).

Among male respondents, at baseline, a larger percentage in the intervention area (94%) than in the control area (91.5%) reported that they were confident insisting on condom use each time they had sex. However, this difference was not significant. Over time, there was a statistically significant decrease in this percentage in the intervention area to 85% (OR 0.7), and a non-significant decrease in the control area to 87% (OR 0.6). The difference in the trends over time was not significant (OR 0.6).

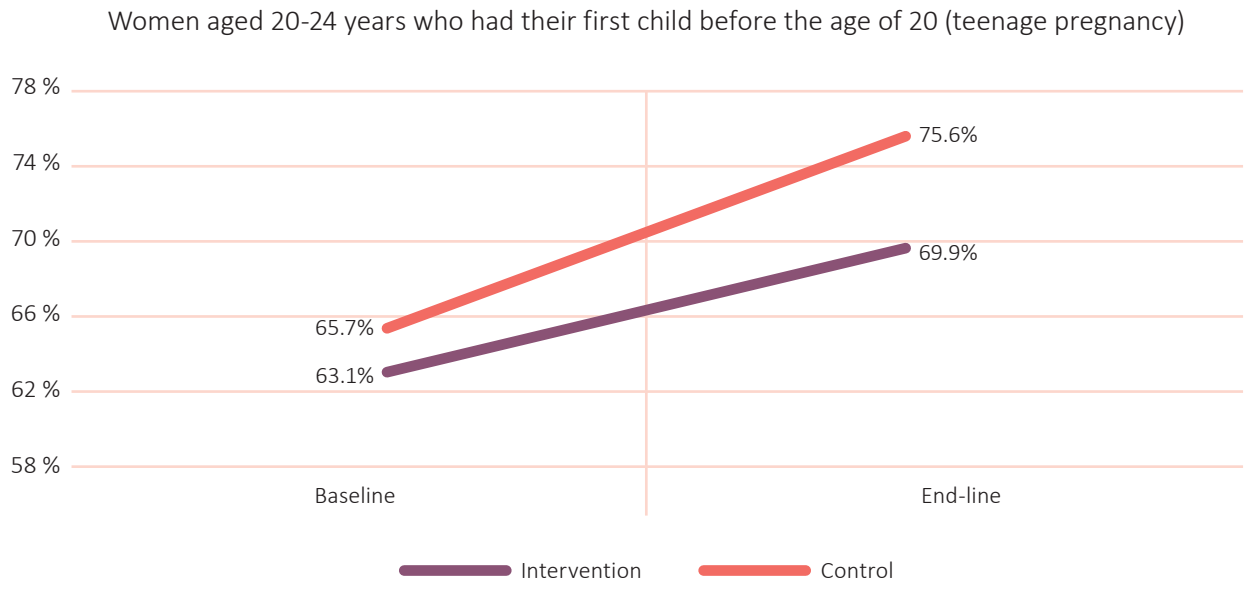
4.5 TEENAGE PREGNANCY

4.5.1 SIGNIFICANT INCREASE OF TEENAGE PREGNANCY IN TA CHIKWEWO, BUT NOT IN TA LIWONDE

At baseline, there was no statistical significant difference between TA Liwonde and TA Chikwewo in the rates of teenage pregnancy, which were 63% and 65% respectively (OR 0.9). In TA Liwonde, the teenage pregnancy rate increased to 70%, and in TA Chikwewo to 76% at end-line. This increase is only significant in the control area (OR 1.3: intervention area; OR 1.6: control area). When comparing the trends in both areas over time, the increase in the control area is steeper though not significantly different from that in the intervention area (OR 0.8) (Figure 14 and Table 13).

When including individual demographic characteristics in the regression models, it is apparent that teenage pregnancy was significantly more likely to occur among respondents who were employed, not educated and ever have dropped out of school. When adding the individual SRHR-related characteristic ‘ever having received sexuality education’, the associations with education and employment lose their significance. School dropout continued to be significant. Those who had experienced a teenage pregnancy were significantly less likely to have received sexuality education. The most prominent relationship is that between teenage pregnancy and child marriage. Respondents who had experienced a teenage pregnancy were significantly more likely to have experienced child marriage (OR 17). The regression analysis does not provide us the direction of this relationship i.e. the causality, but triangulation with the other data reveal that child marriage often follows a teenage pregnancy (see Section 4.6.6). When adding household or family-level characteristics into the model, having ever dropped out of school still remains significantly associated with teenage pregnancy (OR increases to 4). The child marriage variable continues to be significant as well (OR 13), while household size becomes more important. Those who lived in households with one or two members, or seven

Figure 14 **Trends in teenage pregnancy over time**



or more members, were less likely than those living in households with three to four members to have experienced a teenage pregnancy. However, it should be noted that the household size asked for was the current one and may not necessarily be the household that respondents grew up in. Hence, these findings must be taken with caution. Lastly, it is worth noting that having received an income in the preceding six months did not play a role in any model.

Some participants in the qualitative study component felt that there is an increase of teenage pregnancy because organizations look more actively for cases. Others were of the opinion that there are less teenage pregnancies because girls have more access to long term family planning methods and are supported by parents to take modern contraceptives.

> *"Many girls are able to come for family planning methods and even the parents are coming forward to help their daughters who are going to school to access the family planning methods… So I can say that changes are there."* (IDI with a female health worker)

Most of the survey respondents knew one to five girls who had children before the age of 20 and this decreased from 48% at baseline to 42.5% at end-line in TA Liwonde. In TA Chikwewo, this percentage remained stable. At baseline, 40.5% of the respondents indicated to know one to five girls who had had a teenage pregnancy and this was 41% at end-line. The percentage of respondents who knew more than five girls who had children below the age of 20 years increased between base- and end-line from 37% to 51% in TA Liwonde. In TA Chikwewo, a strong increase was noticeable as well: from 31% at baseline to 44% at end-line. The percentage of respondents who did not know any girl aged less than 20 years who had a child decreased from 15.5% at baseline to 7% at end-line in TA Liwonde. In TA Chikwewo, the percentage of respondents that did not know any girl with a child below 20 decreased with half from 28 % to 14.5%.

In the intervention area, the percentage of young women aged 20-24 who wished to become parents at the time they did increased by 14% (Table 13), meaning that more pregnancies were desired. Among young men aged 20-24 this also increased by 6% from 48.5% at baseline to 54% at end-line. The average ages of pregnancy among young women and parenthood among young men aged 20-24 did not change notably from base- to end-line. The largest change was in the control area, where the average age at first pregnancy among women aged 20-24 who ever had a child reduced from 18.4 years at baseline to 18.0 years at end-line.

Among the girls and young women who had ever been pregnant, over half had one child at end-line (58.5%) in the intervention area. The percentage of girls and young women with two or three children slightly dropped from baseline (43%) to end-line (41%) in TA Liwonde. The percentage who had more than three children decreased from 3% at baseline to 1% at end-line in TA Liwonde. In the control area at baseline, 36% of the girls and young women who had ever been pregnant had one child. At end-line, 55% had one child and 45% had two to three children.

Table 13 **Pregnancy and parenthood**				
	Baseline		End-line	
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**
Young women (20-24 years)				
Who had their first child under the age of 20 (teenage pregnancy rate)	190 (63.1)	190 (65.7)	202 (69.9)	226 (75.6)
Who reported having ever been pregnant	NA	NA	250 (86.5)	271 (90.6)
Who wanted to become parents at that time (of those who ever had a child)	116 (46.6)	174 (70.2)	147 (61.0)	198 (77.3)
Average age at first pregnancy (years)	18.4	18.4	18.2	18.0
Young men (20-24 years)				
Who had their first child under the age of 20	9 (9.0)	12 (12.3)	8 (7.3)	5 (4.8)
Who wanted to become parents at that time (of those who ever had a child)	16 (48.5)	26 (76.5)	20 (54.1)	18 (69.2)
Average age at first child (years)	20.6	20.3	20.7	20.4

If an unmarried girl fell pregnant, at baseline, 79% of the respondents in TA Liwonde indicated that they would turn to their family members/ relatives and this was 89% in TA Chikwewo. At end-line, this percentage dropped to 66% in the intervention area and 63% in the control area. Thirty-five percent (35%) of the respondents said that she would turn to their partner or boyfriend/ girlfriend or partner at end-line, while this was 23% at baseline in TA Liwonde. In TA Chikwewo, there was a slight increase in the percentage of respondents who indicated that she would turn to her partner or boy/girlfriend from 28% at baseline to 29% at end-line. At end-line, a higher percentage of respondents also said she would reach out to others in TA Liwonde (from 17% to 33%) and in TA Chikwewo (from 8.5% to 33%). At end-line, this increase of reaching out to others could be explained by more girls reaching out to other structures such as mother groups and other child protection mechanisms that had been strengthened by the Yes I Do programme in TA Liwonde. However, a similar increase was observed in the control area.

4.5.2 CAUSES AND CONSEQUENCES OF TEENAGE PREGNANCY

4.5.2.1 CAUSES OF TEENAGE PREGNANCY ARE MULTIPLE

The causes of teenage pregnancy were similar to those emphasized at baseline. Several key informants and young women in FGDs indicated that teenage pregnancies are mainly caused by initiation ceremonies, where girls are told to 'take off the dust' (kusasa fumbi): this is a rite in which young people engage in sexual intercourse after graduating from initiation ceremonies. It seems that the initiation ceremonies happen at an earlier age (from six or seven years) than before, which could lead to (unprotected) sexual debut/ activity at an earlier age. Some participants said that parents' desire to become grandparents was a cause of teenage pregnancy. Another reason mentioned was the lack of parents' engagement in their children's education.

According to some young male participants in an FGD, parents do not bother when a girl is out late at night. They do not ask the girl questions or do not discipline their children. Some other participants indicated that children are copying the behaviour of parents, who they hear (having sex) in their own bedrooms. Other issues that contributed to teenage pregnancy were transactional sex, caused by poverty and girls' desires for certain products, which led them to try finding a partner who works in South Africa. Another cause of teenage pregnancy was that girls are sometimes forced to have sex. This was mentioned several times in the FGDs and KIIs.

> *"The difference is that the girls are mostly forced into a relationship that they don't want. Because we forced them, we end up impregnating them as such their education is doomed."*
> (FGD with young men 20-24 years)

4.5.2.2 TEENAGE PREGNANCY BRINGS DISTRESS

As compared to the baseline, midline and end-line study participants seemed to be better aware of consequences of teenage pregnancy. Some participants indicated that when girls get pregnant, they have to get married, in particular when the man who made her pregnant is older. They end up having an intergenerational marriage, in which the girl has responsibility for the (many) children, while the girl herself is still a child. Combined with economic distress, they can end up in violent and abusive relationships, as mentioned by a district social worker.

> *"When to go and get married, maybe to an elder person, and she is doing her childish behaviour, she will always be getting the beating in the house."* (KII with a district official)

The notion that teenage pregnancy most often led into child or early marriage, which enhances a cycle of poverty, was mentioned by the majority of participants. At end-line, more participants in comparison to base- and midline were able to mention many different health consequences of teenage pregnancy. Some participants referred to the risks a girl may have because her body is not matured enough for the pregnancy, which can even lead to her death. Several participants reported cases where pregnant girls underwent caesarean section, or girls developing fistula and being stigmatized for the rest of their lives. It was also mentioned that girls give birth to malnourished babies. Some informants reported that some pregnant girls end up with an abortion, often conducted in an unsafe manner, which brings risks to their lives.

When girls return to school after their pregnancy, several female participants indicated that the girls are being mocked for example by being called mother. Some participants also reported that health providers in some cases shout at pregnant girls when they visit the health facilities.

> I: *"You have said they go to antenatal clinics, are the teenage pregnant girls properly assisted when they go there?"*
> R: *"No, they are shouted at. Even if it is doing things there, we are embarrassed, even parents are embarrassed."* (IDI with a 22-year-old young woman)

However, there was also a positive change noticeable: some participants indicated that pregnant girls have access to counselling and antenatal care services and that they are respected by health providers. Unmarried girls receive a letter from the chiefs and are sent for antenatal care at Machinga District Hospital, because, as stated by participants, they are young and run major risks being pregnant and therefore cannot deliver at local health facilities in TA Liwonde.

> *"We know for sure that if the health centre has referred the girls to Liwonde [Machinga District Hospital], it means that she is young. She cannot deliver in a normal way due to her age. She is young. She will be operated. Once operated she has a disability for their entire life."* (FGD with male parents)

4.5.2.3 YOUNG MEN CAN GET ARRESTED FOR TEENAGE PREGNANCY

Several participants indicated that young men who made girls pregnant have been arrested. They were taken to the police, and got into jail or their family needed to pay a fine. These fines were enforced when girls were minors or still in school. Several participants indicated that in case of teenage pregnancy, the boy and girl were temporarily expelled from school and when the baby is born, they could both return back to school. Boys were expected to take care of the pregnant girl, and if they did not, families would go to the village chiefs or to YONECO.

> *"We do investigations and find out where she [the pregnant girl] lives and we ask the mother who is responsible for the pregnancy. When we are told who the responsible man or boy is, we take the matter to the village head, then we take the boy or man to the police."* (IDI with an elder woman)

During an FGD with boys, some indicated that several boys escape from their responsibilities and find another school to continue their schooling. Child marriage among boys does not happen a lot. This is different for girls, especially when they are out of school. When out-of-school girls get pregnant, they are expected to get married.

4.5.3 MORE KNOWLEDGE HOW TO PREVENT TEENAGE PREGNANCY

Youth receive more information than before on preventing pregnancy through the youth clubs. Furthermore, youth are counselled, and community gatherings are organized with chiefs to discuss issues around teenage pregnancies, among other issues. Some NGOs such as YONECO and One Community provided information, made contraceptives available and took action in case of defilement of girls. Despite the preference of elders to prevent pregnancies by messages that focus on abstinence, several participants indicated that contraceptives are available and encouraged when youth cannot abstain, especially condoms and contraceptives such as the pill and injectables.

> *"Once they [NGO] come in the community, they do have a tent where you go and access these contraceptives. They do ask you; 'what kind of contraceptives do you want? Pills or injections or what? Norplant', then you make a choice."* (FGD with girls 15-19 years)

Teachers also seem more open to provide SRHR information beyond messages to abstain, as mentioned by several participants.

> *"They [teachers] advise girls that if they really want to sleep with someone they should use contraceptives like injections so that their education should not be affected."* (IDI with a 22-year-old woman)

Many participants reported that bylaws have contributed to the fact that girls who were pregnant and delivered have actually gone back to school. It shows that bylaws may not prevent a first pregnancy, but can contribute to a reduction of a second or third (teenage) pregnancy, when girls go back to school instead of getting married after their first pregnancy. Furthermore, the bylaws operated as a warning system to prevent pregnancy, as they made parents and young people more cautious to avoid risking fines.

> *"So I just found a paper [document] about that [bylaws] that said if who impregnates who, firstly they should be kicked out of school, go look after the pregnancy and pay a fine at the village head and go back to school. Also, it talked about that if one is found entering the home of a girl or boy, if caught he/ she should pay a fine. These are just the laws set in place to help prevent these things [child marriages and teenage pregnancies]."* (IDI with a 19-year-old young man)

4.5.4 MORE SUPPORT FOR TEENAGE MOTHERS

The change that teenage mothers experienced from base- to end-line was related to the support they received in the community. During the interviews, the mother groups were frequently mentioned as effective support mechanisms for pregnant girls as mentioned in Section 4.2.3.2. The mother groups reach out to the girl, they talked to her parents, and make sure that pregnant girls get tested and go for antenatal care. They also try to convince parents to not get pregnant girls into marriage, but to let them return to school after they have delivered. The mother groups collaborate with child protection committees and local chiefs.

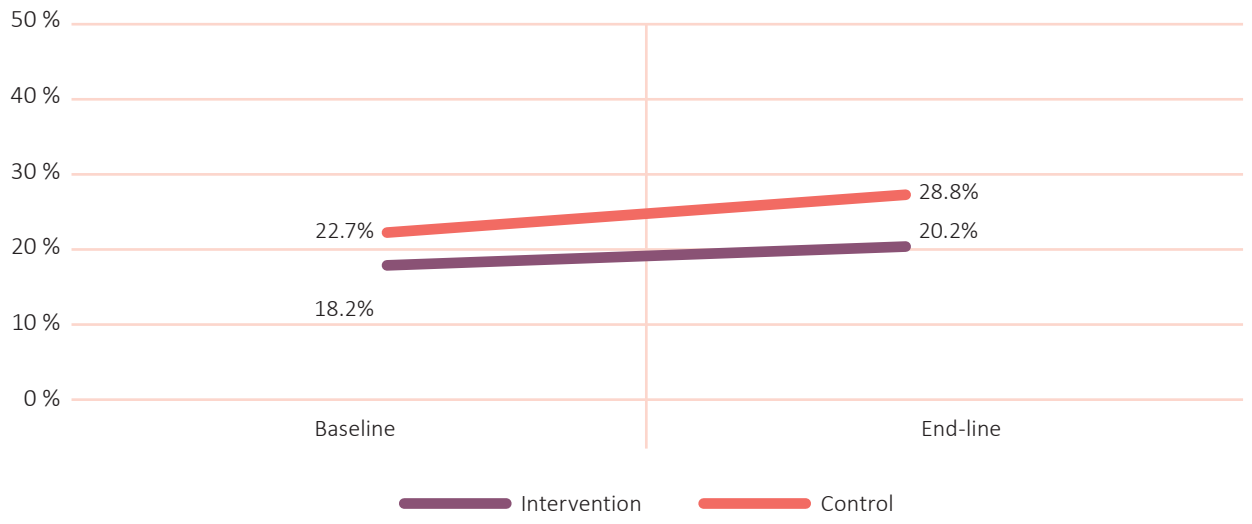
Collaboration between schools, mother groups, health workers, NGOs and chiefs seem to have strengthened the support of pregnant teenage girls. Despite that some pregnant girls are still treated badly, there are also positive changes in the attitudes of health workers, when girls are sent to them by community chiefs or teachers.

4.6 CHILD MARRIAGE

4.6.1 CHILD MARRIAGE BELOW 16 YEARS DECREASED IN TA LIWONDE

At baseline, the child marriage rate among young women aged 18-24 was 18% in the intervention and 23% in the control area, which was not a significant difference (OR 0.8). The percentage of young women aged 18-24 years who were married or in union before the age of 18 increased from 18% at baseline to 20% at end-line in TA Liwonde (OR: 1.1). In TA Chikwewo, child marriage increased as well from 23% at baseline to 29% at end-line (OR: 1.4)

Figure 15 **Trends over time in the prevalence of child marriage among young women (18-24 years)**



(Figure 15 and Table 14). The change over time is statistically significant in the control area, but not in the intervention area. The difference between the trend in the intervention and control area is not significant (OR 0.8).

Child marriage before the age of 16 slightly decreased over time by 3% in TA Liwonde among young women aged 16-24, from 6% to 3%. This was not the case in TA Chikwewo, where there was a 1% increase (from 5% to 6%) in the percentage of girls and young women (16-24 years) who were married before the age of 16 (Table 14). The difference in these trends over time was statistically significant (OR 0.4).

When including individual level demographic characteristics in the regression models, it is seen that child brides were significantly more likely to have dropped out of school and were more likely to be earning an income. When including SRHR characteristics, the likelihood of child brides also having a teenage pregnancy is high and significant. When adding in family-level characteristics, child brides were likely to be from bigger households (eight or more), compared to those with three to four members. However, it should again be noted that the household size asked was the current size and may not necessarily be the household they grew up in. In neither model sexuality education plays a role.

Female respondents of all ages who had ever married were asked if they felt it was their choice to get married at the time they did. There was an increase in the percentage of girls and young women who said that it was their choice to get married from 66% at baseline to 83% at end-line in TA Liwonde (Table 14).

Table 14 shows that girls who got married under the age of 18 years often got married to adult men (18 years and above). The percentage was 94% at baseline and 87.5% at end-line in TA Liwonde. Table 14 also shows that child marriage among male respondents remained low.

The discussed changes with regard to child marriage among participants in the FGDs and IDIs provide a varied picture. Whereas some informants stated that child marriage has increased a lot, others said it has reduced. Explanations given for the increase were the problems faced in the communities due to poverty, the bribing of police and chiefs, and down scaling of the work of NGOs. According to some informants, however, the bylaws helped in the prevention of child marriage because of the fear of parents to be arrested. Other said that the work of NGOs in educating people about preventing teenage pregnancy and child marriage, the information provided through youth clubs and the provision of economic support have helped to reduce child marriage.

Table 14 **Child marriage**				
	Baseline		End-line	
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**
Young women (18-24 years) who were married or in a union before age 18 (i.e. child marriage)	78 (18.2)	89 (22.7)	80 (20.2)	115 (28.75)
Girls and women (16-24 years) who were married or in a union before age 16 (i.e. child marriage)	32 (5.8)	24 (4.7)	15 (2.9)	30 (5.8)
Girls below 18 years old who are currently married	15 (8.1)	6 (3.2)	6 (3.0)	9 (4.6)
Married girls and young women (15-24 years), who perceive that it was their choice to get married	189 (66.3)	249 (78.6)	223 (83.2)	280 (89.2)
(Married) young women (18-24 years) who were child brides, and who were married to an adult man	73 (93.6)	85 (95.5)	70 (87.5)	110 (95.6)
Young men (18-24 years) who were married or in a union before age 18 (i.e. child marriage)	3 (2.1)	3 (2.1)	3 (1.9)	3 (1.9)

> *"Yes, there is a change. There were more cases of child marriages back then unlike now. Now organizations have provided us with counselling lessons, we have created some groups which are moving up and down teaching and encouraging fellow youths."* (FGD with young men 20-24 years)

In the survey, nine out of ten (92%) of the respondents at end-line did not see any benefits to child marriage. None of the informants from the interviews and FGDs saw any benefits of child marriage. Child marriage was believed to worsen the economic, financial and health situation of the people involved. Informants did come up with potential benefits of child marriage. Some thought that people think that it makes the men to be more in control when marrying a girl, and some thought that grandparents would like it to have grandchildren early.

> *"There are no benefits there. Problems and challenges in life. If 25 or 26 [years old], married men are hardly surviving. What about with this age group? 16 and 17. They cannot stand [the responsibilities to cater for the household]. Most of the times, such marriages end after two years."* (IDI with a social worker)

4.6.2 KNOWLEDGE ABOUT LEGAL AGE OF MARRIAGE FOR GIRLS REMAINED THE SAME

Informants from the interviews and FGDs indicated that the lowest age at which girls get married is from 11 years old, and that despite the law and bylaws, some girls and boys get married at the age of 15, 16 and 17. A key informant explained that these marriages happen in secret, because parents and young people fear to be jailed:

> *"It was somewhere 15 or 14 [year old] girls were getting married… Boys 17 or 18 years old. They were marrying at this age… But I think now with the project maybe they are happening but they are happening underground. They do not do this publicly because of the interventions. The police are involved and everything. They fear of being jailed."* (KII with an NGO representative)

From the quantitative data, at end-line, the average lowest acceptable age for girls to get married was rated at 18 years and for boys 19 years in both areas. When looking at the ideal age to get married, the average ideal age to get married for females was 20 years at baseline in both areas. At end-line, it dropped to 19 years in the control area and remained 20 years in TA Liwonde. The average ideal age to get married for males was 22 years in both areas at base- and end-line. Despite that the average ideal age to get married was 19 to 20 years for females and 22 years for males, the majority of the single respondents indicated that they personally want to get married between the age of 20 and 25. This age range of 20 to 25 years seems to also be promoted through the interventions of NGOs, as indicated by mothers in an FGD.

R: *"Lots of girls they got married at 18 or 17 before the interventions of some NGOs we have in the community. Since the coming in of the NGO interventions, the age range has changed."*
I: *"To what range?"*
R: *"To 25 years old. They get married at this age because of school. If they were schooling they end up getting married at this age."* (FGD with female parents)

Table 15 shows that the perceived knowledge about the legal minimum age to get married for females (according to statutory law) went up in both TA Liwonde and TA Chikwewo, among females as well as male respondents.

At end-line, 60% of the female respondents in TA Liwonde actually knew that the legal minimum age to get married is 18 years for females. In TA Chikwewo, a slightly higher percentage of the female respondents (63%) knew about the legal minimum age to get married for females. Table 15 shows that this knowledge did not increase over time in TA Liwonde, while in TA Chikwewo, it increased with 3%. On average, in both areas, 8% of the female respondents thought the legal minimum age to get married for females was at the age of 19, and 20% of the female respondents thought it was at the age of 20 at end-line.

Table 15 shows that among male respondents, the actual knowledge of the legal minimum age decreased from 64% at baseline to 60.5% at end-line in TA Liwonde, and from 72% at baseline to 63% at end-line in TA Chikwewo.

Table 15 **Perceptions and knowledge on age of marriage**

	Baseline		End-line	
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**
Young women (15-24 years) who believe that they have knowledge of the legal minimum age of marriage according to statutory law	470 (76.4)	187 (65.8)	482 (81.3)	429 (71.9)
Young men (15-24 years) who believe that they have knowledge of the legal minimum age of marriage according to statutory law	124 (62.0)	143 (71.1)	172 (79.3)	171 (79.5)
Young women (15-24 years) who have actual knowledge of the legal minimum age of marriage for girls according to statutory law	282 (60.0)	231 (60.6)	291 (60.4)	272 (63.4)
Young men (15-24 years) who have actual knowledge of the legal minimum age of marriage for girls according to statutory law	79 (63.7)	103 (72.0)	104 (60.5)	108 (63.2)

There was a lack of knowledge among respondents about the legal minimum age of marriage for males at both base- and end-line. Almost one out of three respondents at end-line (32% in TA Liwonde and 28% in TA Chikwewo) thought that the legal age of marriage for males is 20 years. Only 12% of the respondents in TA Liwonde mentioned 18 as the legal age of marriage for males and 10.5% of the respondents mentioned this in the control area. No changes are observed between base- and end-line.

When asked if children do get married under the legal age (whatever respondents thought this legal age is), 34% of the respondents in the intervention area and 30% of the respondents in the control area answered 'frequently' at end-line. Furthermore, 21% of the respondents in the intervention area and 19.5% of the respondents in the control area responded 'sometimes'. The indicated frequency of child marriage was higher at baseline, where 44% of the respondents in TA Liwonde and 48% of the respondents in TA Chikwewo indicated that children get married below the age of 18 frequently.

With regard to the religious laws and the minimum age of marriage, one out of five respondents (20%) in the intervention area and almost one out of three respondents (30%) in the control area mentioned that there is no minimum age to get married at end-line. Sixty-two percent (62%) of female and male respondents indicated that there is a legal minimal age to marry also within the religious law. One out of two respondents (50% in TA Liwonde and 52% in TA Chikwewo) indicated that this age for females is at 18 and 26% of the respondents in both areas said the age of 20 at end-line. The majority, namely three out of four respondents, indicated that the minimum age for males to marry according to religious laws was between 20 and 25 years. This was slightly less when comparing to the baseline, where on average 79% of the respondents indicated this age category.

4.6.3 REASONS FOR CHILD MARRIAGE REMAIN THE SAME, INTERVENING IN CHILD MARRIAGE MORE COMMON

Study participants gave many different reasons why girls and some boys end up in child marriage. Poverty, financial circumstances, pregnancy and a lack of education were the main cited reasons for child marriage. Some young people are forced by their parents to get married due to financial reasons or them receiving benefits from the marriage like a bride price. As mentioned earlier, some participants mentioned child marriage to happen due to parents' desire to become grandparents. The reasons expressed why young people themselves choose for marriage were pregnancy, a desire to have kids, love and the fear of losing it, being out of school without any other purpose in life, experiencing abuse within the parental household, and the pressure to get married after having gone through initiation ceremonies. Other reasons were to follow the norm of what is expected of young people from their culture and tradition, peer pressure by other young people and idealising the establishment of your own family, as indicated by young males and females in some FGDs.

> *"It is what we have said that a lot of [young people] are getting married because of the poverty and abuse, the people that are raising us, [the] way we stay in others' households and the way we imagine ourselves in marriage. So when we move out of our guardians' household and go to stay in our own household, we see the difference, we will be independent, the abuse that we face in the households that are raising us is what makes most of us to get engaged in marriage."* (FGD with young women 20-24 years)

All these reasons were similar to those that informants expressed at baseline. However, more participants at end-line than at baseline hardly saw any benefits of child marriage. Another change that has occurred is that when girls get pregnant, they are not automatically forced into marriage anymore, especially for the girls that are in school. Instead, the girl and her parents are encouraged that the girl should stay with the parents and return to school after delivering.

Most of the survey respondents were aware of the negative consequences of child marriage. Nine out of ten respondents (90% in TA Liwonde and 89% In TA Chikwewo) indicated that child marriage does not have any advantages at end-line. Participants in the FGDs and IDIs also indicated many negative consequences of child marriage, for example about the health situation of the girl and her children, worsened poverty and financial situation, responsibilities that they cannot carry yet, and the stigmatisation in the community that they can experience. These consequences were summed up by a key informant:

> *"They [negative consequences] are many despite the fact that it cannot happen to every girl who has a child, but they range from contracting STIs including HIV/AIDS, they drop out of school early, they start early parenting, they don't have the basis of bringing up a child, they don't have a job, they don't have anything to do economically to support the family and you know in the society, they are segregated because they do not accept them, because of these bylaws they are not accepted in the society and it becomes a big problem. So, you see, there are a lot of problems and then, as I said, in the future when they get married, when they have a daughter, the husband will be going for the girl and creating a lot of problems in the marriage."*
> (KII with a Yes I Do partner)

In TA Liwonde, more support was provided within the community to intervene when a child marriage occurred than in TA Chikwewo. In TA Liwonde, 84% of the respondents indicated that people intervene, while this was 70% in TA Chikwewo at end-line. Community leaders, NGO staff and parents are the people who usually intervene, as can be seen in Table 16.

Table 16 **Who usually intervened in child marriage**				
	Baseline		End-line	
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**
Community leaders	274 (62.1)	189 (55.1)	388 (70.7)	224 (53.3)
Law enforcement	37 (8.4)	26 (7.6)	59 (10.7)	24 (5.7)
NGO staff	153 (34.7)	176 (51.3)	259 (47.2)	170 (40.5)
Others	54 (12.2)	17 (5.0)	80 (14.6)	52 (12.4)
Parents	150 (34.0)	112 (32.7)	255 (46.4)	202 (48.1)
Police	85 (19.3)	20 (5.8)	203 (37.0)	78 (18.6)

Interventions to prevent child marriage, especially those from community leaders, law enforcement and NGO staff, were less occurring in TA Chikwewo than in TA Liwonde, as can be seen in Table 16. All mentioned stakeholders were more engaged from base to end-line in TA Liwonde. This was different in the control area, where most stakeholders were less engaged except for parents and the police at end-line. The frequency of intervention in cases of child marriage increased over time in both areas. The percentage of youth who indicated that someone intervened 'all the time' increased from 34% at baseline to 45.5% at end-line in the intervention area and from 27% at baseline to 41% at end-line in the control area.

4.6.4 STRONG SUPPORT TO PREVENT CHILD MARRIAGE

At end-line, collaboration was reported between community members, chiefs, the police, teachers, youth clubs and NGOs to address child marriage.

> *"It is helping much because if the chief is taking a role, the community is taking a role, the parents are taking a role the teachers are taking a role. The girl child has nowhere to go. These things are helping much. We combine forces and she ends up going back to school."* (IDI with a social worker)

Several participants in the qualitative study component explained that community leaders have an important role to play. As explained in Section 4.2.3.6, they have roles in intervening and warning people through the bylaws and fining or threatening to fine parents if they let their child be married before 18 years.

> *"The community members know very well and were advised not to force any of the children into marriage. We work together with community leaders to have a talk on such issues and it's impossible and very rare to find parents forcing their children into marriage. We also advise the children to report to the community leaders and their teachers as well as the police whenever someone forces them to get married."*
> (IDI with a head teacher)

According to informants, the bylaws had a strong influence to prevent child marriage, but these bylaws need to be enforced by several institutions together. Others mentioned that efforts taken to prevent child marriage included economic support through cash transfers, the provision of bursaries and transport money – all to keep girls in schools, by the government and NGOs. Because pregnancy is an important reason for child marriage, other ways of preventing child marriage that were mentioned were related to the prevention of teenage pregnancy, through SRHR education and the provision of contraceptives, as mentioned in the previous section. In an FGD with young men, abortion was mentioned:

> *"There have been changes. Before the laws were being implemented here, people were getting pregnant and marrying at a young age anyhow. But now, people are afraid, after the NGOs came and conducted community meetings, they know that we even have police right here in our community. They know that the moment the police unit gets hold of this information then we are toast! So these cases have so far reduced. That is why they rush to saying the girl should abort."* (FGD with young men 20-24 years)

Table 17 **(Un)acceptability of child marriage at end-line**		
It is acceptable for a girl to marry under 18…	Level of disagreement at end-line	
	TA Liwonde n (%)	**TA Chikwewo n (%)**
Because there is a lack of education opportunities	722 (89.1)	710 (87.4)
Because there are no job opportunities for her to work	733(90.5)	711 (87.6)
To solve financial problems of the family	726 (89.6)	710 (87.4)
To give her financial security	731 (90.2)	717 (88.3)
To reduce the poverty of her family	735 (90.7)	724 (89.2)

4.6.5 ATTITUDES AROUND CHILD MARRIAGE

As mentioned in Section 4.6.3, 90% of the respondents in TA Liwonde and 89% of the respondents in TA Chikwewo indicated that child marriage does not have any advantages at end-line. Similarly, 93% of the respondents at baseline in TA Liwonde and 98% in TA Chikwewo agreed that "a girl should never be forced or compelled to marry" at baseline. This stayed steady in TA Liwonde and reduced to 94% in TA Chikwewo. Moreover, at end-line, 79% of the respondents in both TAs agreed that "a girl should have a say when she marries".

Table 17 provides an overview of the level of disagreement with some statements around child marriage acceptability at end-line in the intervention and control area. This table shows that reasons related to limited educational and job opportunities or adverse economic conditions were not regarded as acceptable reasons for child marriage by many of the survey respondents in both areas. Lastly, 79% of all respondents in TA Liwonde and 73% in TA Chikwewo agreed to some extent that "if a girl marries under the age of 18, her family should pay a fine or be arrested".

4.6.6 THE INTERLINKAGE BETWEEN (CHILD) MARRIAGE AND (TEENAGE) PREGNANCY

There is a strong link between marriage and pregnancy. Table 18 provides information about the sequence of child marriage and teenage pregnancy among young women (15-19 years). In TA Liwonde, a small decrease occurred over time in the percentage of young women who first experienced a child marriage and then a teenage pregnancy, from 34% at baseline to 32% at end-line. This decrease was larger in TA Chikwewo, where the percentage halved over time. The percentage who first got pregnant (under 20 years) and then married (as a child) increased marginally between base- and end-line in TA Liwonde, but decreased in TA Chikwewo. The percentage of young women (15-19 years) who had a teenage pregnancy and a child marriage in the same year decreased marginally over time in TA Liwonde but increased in TA Chikwewo.

Table 18 **Inter-linkages between child marriage and teenage pregnancy in the intervention area**				
	Baseline		End-line	
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**
Number of teenage mothers aged 15-19 years who were married before age 18 (child marriage)	n=38	n=28	n=25	n=24
Teenage mothers (15-19 years) married before age 18 who first experienced a child marriage followed by a teenage pregnancy	13 (34.2)	10 (35.7)	8 (32.0)	4 (16.7)
Teenage mothers (15-19 years) married before age 18 who first experienced a teenage pregnancy followed by a child marriage	4 (10.5)	3 (10.7)	3 (12.0)	2 (8.3)
Teenage mothers (15-19 years) married before age 18 who experienced a teenage pregnancy and a child marriage in the same year	21 (55.3)	15 (53.6)	14 (56.0)	18 (75.0)

It is possible that the percentage of teenage mothers who first experienced a teenage pregnancy followed by a child marriage is higher in reality. First, because if teenage pregnancy and child marriage happened in the same year the data does not capture the order of these events. Second, because of underreporting as a result of the taboo around sexual activity before marriage (at end-line in the intervention area, 88% of the respondents disagreed with the statement 'It is acceptable for girls to have sex before marriage' while 85% disagreed with the statement 'It is acceptable for boys to have sex before marriage'). In addition, participants in the qualitative interviews and FGDs often mentioned that marriage was a consequence of teenage pregnancy.

When looking at the order of marriages and pregnancies in general, the pattern remained almost the same over time in TA Liwonde and TA Chikwewo (Table 19).

Table 19 **Inter-linkages between marriage and pregnancy in the intervention area**

	Baseline		End-line	
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**
Number of (ever) married mothers aged 15-24 years	n=254	n=242	n=242	n=271
Married mothers (15-24 years) who were first married and then became pregnant	62 (24.6)	88 (31.7)	62 (25.6)	68 (25.1)
Married mothers (15-24 years) who first became pregnant and were then married	45 (17.9)	52 (18.7)	40 (16.5)	26 (9.6)
Married mothers (15-24 years) who married and became pregnant in the same year	145 (57.5)	132 (47.5)	140 (57.8)	176 (64.9)

More respondents at end-line disagreed with the statement that child marriage often occurs after teenage pregnancy (an increase of 23.5%; from 12.5% at baseline to 36% at end-line in TA Liwonde). A similar pattern of increased disagreement (21%) was noticeable in TA Chikwewo where 19% of the respondents at baseline disagreed with this statement compared to 40% at end-line. In addition, there was a change in respondents' views about marriage as a solution for girls who get pregnant. At baseline, 63% of the respondents disagreed with girls marrying as a solution for pregnancy. At end-line, the disagreement increased with more than 18.% to 81%. In TA Chikwewo, a similar increase was observed from 66.5% at baseline to 82% at end-line.

4.6.7 DECISION-MAKING DYNAMICS IN RELATION TO MARRIAGE

The percentage of girls and young women who agreed that their parents or relatives decide their future partner remained similar between base- and end-line in the intervention area (at 14.5%). For boys and young men in TA Liwonde, there was an increase of 4% in the percentage who agreed that their parents or relatives decide their future partner (Table 20). In the control area, a higher percentage of young women and young men reported that their parents and relatives decide their future partner over time.

In the IDIs and FGDs with young people, it was said that mostly parents decide about marriage, while elder people more often mentioned that it is the young people who decide for themselves.

> *"Sometimes it is your own choice, sometimes it is the parents' choice for them to get married just because of the problems they are facing at their homes. Sometimes they think this is a solution to some of the problems at home."* (IDI with a 18-year-old girl)

Table 20 **Decision-making regarding marriage**				
	Baseline		End-line	
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**
Girls and young women (15-24 years) who agree that their parents or relatives decide their future partner	91 (14.8)	46 (7.9)	86 (14.5)	66 (11.1)
Boys and young men (15-24 years) who agree that their parents or relatives decide their future partner	33 (16.5)	26 (12.9)	44 (20.3)	42 (19.5)

Participants gave the impression that better support mechanisms for girls refusing child marriage were in place. These girls could ask support from teachers, NGOs, the police, the chief, and the mother groups, who have together enforced the bylaws. These gatekeepers would start dialogues with parents to stop the marriage and in some cases fines were given.

> *"If you are pregnant, the teachers take the issue to either the police or the NGOs so if you are being forced to marry then you go to the teachers and explain to them that I'm pregnant and my parents are forcing me to get married but I don't want so please help me and they do help."* (FGD with girls 15-19 years)

Despite that 82% of the married respondents in TA Liwonde and 88% of the married respondents in TA Chikwewo decided themselves to get married at end-line and did not feel pressured into marriage (91% in the intervention and 92% in the control area), 60% of the married respondents in TA Liwonde and 51% of the married respondents in TA Chikwewo indicated that they did not feel it was the right time for them to get married. This shows that some young people might feel the urge or aspiration to get married early due to peer pressure or due to having a too positive image of marriage as a solution to their problems. In an FGD with young males, participants said that some young men thought that they are ready for marriage when they have some money:

> *"Most of the youth rush into marriage when they have had a piece work and gained some money, sometimes when they just own a little land or harvest well on their piece of land they start thinking that they are ready to have a family. They do not want to enjoy that good harvest with their families. They do not realize that there are more problems in marriage. Just because they have some maize they start thinking they can handle the responsibility."* (FGD with young men 20-24 years)

4.7 EDUCATION AND ECONOMIC EMPOWERMENT

4.7.1 ACCESS TO SECONDARY EDUCATION AND ECONOMIC OPPORTUNITIES ARE LIMITED

Table 21 shows that the percentage of girls (15-18 years) who attended secondary school was low at base- and end-line, but higher in TA Liwonde than in TA Chikwewo. There was a slight (insignificant) decrease in the percentage of girls aged 15-18 who reported attending secondary school from 13% at baseline to 10% at end-line in the intervention area (OR 0.8). There was no change in this percentage in TA Chikwewo as it remained at 4% (OR 1.0). There was a larger decrease in TA Liwonde (of 10.5%) as compared to TA Chikwewo (7%) with regard to the percentage of girls below 18 years who dropped out of school.

The lack of fees was the biggest barrier for young people to continuing schooling, both at base- and end-line in TA Liwonde and TA Chikwewo. In TA Liwonde, many young people indicated that they had dropped out due to this reason (35% of all young people at baseline and 36% at end-line). Following that, young women also shared that becoming pregnant or having a child was a reason to drop out of school in TA Liwonde (12% at both base- and end-line). In TA Chikwewo, not many young people reported having dropped out of school due to a pregnancy or child. However, the percentage did increase over time (from 3.5% at baseline to 6% at end-line). In TA Chikwewo, more young people said that they did not like school (8.5% at baseline, and 12% at end-line). At end-line, there were 29 respondents (4%) in TA Liwonde who had left school due to marriage, all of whom were young women (15-24 years).

Table 21 **Education and economic empowerment**				
	Baseline		End-line	
	TA Liwonde n (%)	**TA Chikwewo n (%)**	**TA Liwonde n (%)**	**TA Chikwewo n (%)**
Education				
Girls aged 15-18 currently attending secondary school	32 (12.6)	10 (4.2)	26 (10.4)	10 (4.1)
Girls aged below 18 years who dropped out of school	70 (37.6)	65 (34.7)	53 (27.1)	108 (27.5)
Girls below 18 years who left school due to marriage	3 (1.6)	1 (0.5)	0 (0.0)	3 (1.5)
Girls below 18 years who left school due to pregnancy	9 (4.8)	2 (1)	10 (5.1)	2 (1)
Girls (15-18 years) who have a child and follow education	4 (10)	0 (0.0)	0 (0.0)	0 (0.0)
Boys below 18 years who left school due to marriage	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Economic empowerment				
Young women (18-24 years) who are economically active outside of the household	177 (41.2)	129 (32.9)	209 (52.7)	260 (65)
Young women (18-24 years) who have received any income in the preceding six months	282 (65.7)	235 (59.9)	159 (40.1)	160 (40)
Young men (18-24 years) who are economically active outside of the household	65 (46.4)	66 (45.2)	98 (62.4)	96 (61.9)
Young men (18-24 years) who have received any income in the preceding six months	116 (82.8)	76 (52.4)	113 (71.9)	112 (72.2)

According to the qualitative data, while girls were often said to drop out of school due to marriage or motherhood, boys often dropped out as they had started a business or a job, or in some cases also due to marriage, pregnancy, or as one participant mentioned – fear of being jailed as they made a girl pregnant. These reasons make it harder to follow up boys who drop out, as explained by a key informant. On the other hand, some participants also alluded positively to the government policy that girls were able to go to school after giving birth. Young mothers who returned were also counselled by mother groups, according to one key informant, as young mothers often felt they were 'equal' to the teachers, due to their new motherhood status.

In terms of economic empowerment, at baseline, the percentage of young women (18-24 years) who were economically active outside the household was significantly higher in the intervention area (41%) than in the control area (33%) (OR 1.4). The percentage of female respondents aged 18-24 years who were economically active outside the household increased considerably in both TA Liwonde (to 53%; OR 3.7) and TA Chikwewo (to 65%; OR 1.5) between base- and end-line. TA Chikwewo had a larger increase as compared to TA Liwonde (OR 0.42) (Figure 16).

There was also a considerable increase in the percentage of male respondents who were economically active outside the household in both TA Liwonde and TA Chikwewo (Table 21). In both areas, the percentage of males who were active outside the household was higher than the percentage of females who were active outside the household at both base- and end-line.

Table 21 also shows that the percentage of males who received an income (in the preceding six months) was higher than the percentage of females who received an income in TA Liwonde at both base- and end-line. In TA Chikwewo, more females reported having an income than males at baseline, but this reversed at end-line. Zooming into young

Figure 16 **Young women (18-24 years) who were economically active outside the household**

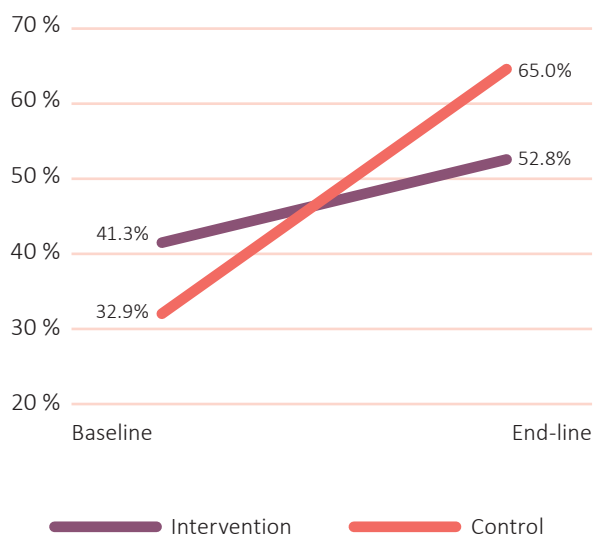
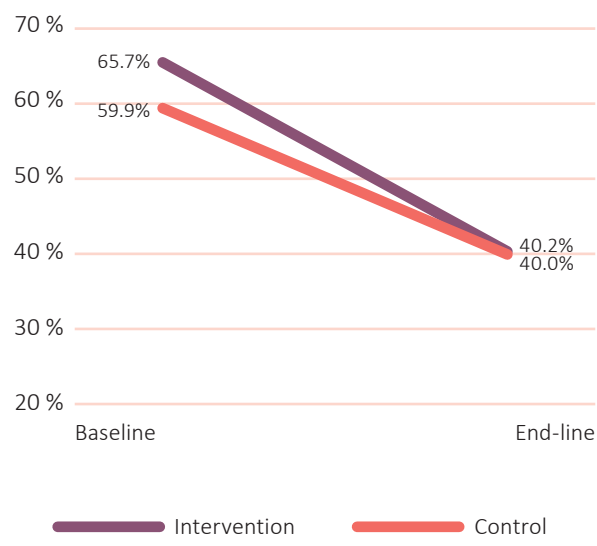


Figure 17 **Young women (18-24 years) who have received any income in the preceding six months**



women (18-24 years), at baseline, a higher percentage reported receiving an income in the preceding six months in the intervention area (66%) as compared to the control area (60%). This difference was statistically significant (OR 1.5). In both areas, there was a significant decrease to 40% at end-line in both the intervention and control area (OR 0.3 for the intervention area; OR 0.5 for the control area). There is a stronger decrease in the intervention area as compared to the control are over time, and this difference in trends is statistically significant (OR 0.65) (Figure 17).

4.7.2 GIRLS' EDUCATION IS ENCOURAGED, SAFETY CAN BE A PROBLEM WHEN TRAVELLING TO AND FROM SCHOOL

Key informants as well as informants at community level reported that previously, educating girls was not a priority, but that this situation has changed with the coming in of the Yes I Do programme. For example, a key informant at Machinga Boma reported that CAMFED is assisting girls with school fees, so that they are able to finish school. At community level, most informants acknowledged that it is mostly girls who are helped by NGOs to access education by purchasing items such as clothes, school uniforms, textbooks, pens and bags for them.

Some participants indicated that girls are more encouraged than boys. This is because girls were considered to drop out of school more often, and therefore more bursaries and opportunities were offered to them. According to participants, in the past years, school enrolment rates of girls have increased. This observation was confirmed by a social worker as well as well another key informant from a civil society organization.

> *"There is a change over the past four years, because learners have [the] opportunity to continue with their studies and most of the parents now realize that it's very imperative to send their children to school be it a girl child or boy child."* (IDI with a head teacher)

Another key informant explained that the value placed on girls' education has increased over time, and this was also evident in the emphasis placed on this topic during community gatherings.

> *"... you know [name] school, when we were starting the project, this is the school at the far end, when we were starting the project, I remember in 2015, in 2015/2016 this was the school calendar year, there was literally no girl in standard 8, it was like only boys. But over the years we have seen the number increasing and it was interesting to know that some of the girls were selected to secondary school."*
> (KII with an NGO representative)

According to a female health worker, however, a higher value was placed on Islamic religious education for girls due to

the dominance of Muslims in the community. According to her, boys also put much more effort in regular education. However, she did recognize that a few married girls who were now divorced returned to school because of the efforts of some organizations. Most participants explained that the culture encouraged equal opportunities for education for boys and girls. However, according to some young participants, girls did not work hard on their education and often dropped out and got married or due to the culture, they did not show interest in school.

The qualitative data indicate that secondary schools in TA Liwonde are far from where young people live and that they need to walk long distances (including crossing a river) to access them. Primary schools, on the other hand, are not very far. A big obstacle mentioned by different participants was flooding, which prohibited many young people from reaching school while crossing the river. One female parent reported that some young people going to secondary schools were given bicycles by an NGO or the government.

A key informant also highlighted the importance of having a female teacher in schools, as this supports female students as well. The informant went on to emphasize the importance of motivating teachers, pointing out that the housing structures for teachers are dilapidated. According to a head teacher, the school learning facilities are not in line with the number of students. There is a shortage of books, desks and infrastructure, with many conducting classes in open spaces. This was reiterated by another key informant. Most young people also confirmed the lack of books, desks and classrooms.

Participants also spoke about sanitation facilities for girls. According to girls (15-19 years) in one of the FGDs, their school built a room that can be used by female students when they have their period. A key informant also indicated that some NGOs have supported the improvement of sanitary facilities, which are usually a challenge.

While some participants mentioned that the schools were of good quality, some of them also mentioned that due to the lack of resources, learning for students was hindered. When probed, they further outlined these challenges. According to a health worker, there was only one school offering good quality education. The health worker explained that other schools often do not teach all subjects, which results in students failing the examinations. However, a young men indicated that they are able to learn nine subjects, which was not the case before.

When asked about safety, many participants indicated they were safe at school. Young men, a female parent and a religious leader emphasized the lack of safety on the way to and from school (especially for primary school learners and students in non-boarding secondary schools). It was said that young men in the community wait for girls along the road and harass them or attempt to rape them. Moreover, school girls may be involved in transactional sex with kabaza (bicycle taxi) riders, who offer them lifts for free in exchange for sex. This was mentioned by one key informant.

> *"… the boys in this community sometimes wait for these girls along the roads and harass them or try to rape them. So the girl child would choose to stay home [rather] than to go to school and experience something like that."* (FGD with young men 20-24 years)

Other safety related challenges also came up. Due to the proximity of some communities near the game reserve, there was a fear of encountering elephants on the way to school.

At end-line, as at baseline, some participants referred to safety in schools and mainly referred to teachers defiling girls. A young man in an FGD elaborated on this:

> *"It is very easy for girls to be pressured into having sex even by the teachers. They would just tell them, sweep around this area then later they grab her or coerce her to sleep with them."*
> (FDG with young men 20-24 years)

However, according to a key informant, previously, there were some reports of a few teachers who tried to have relationships with young girls. In the latter stages of the implementation of the Yes I Do programme, there were no or very few of such cases. This was because of the efforts of the mother groups, the child protection committees and the empowerment of girls to report. At the same time, a key informant mentioned that teachers also cover up

for each other in case they have been involved in this. On the same topic, another key informant indicated that they lacked a reporting mechanism to understand the role of teachers better.

> *"…a few months ago we have placed these suggestion boxes in schools, because we want to also appreciate that question you have asked and see how safe our children are in the schools, and also create a conducive environment for the learner. I hope in a few months, we will be able to confess and get reports from the suggestion box that children will be able to cast in their suggestions. But as of today we haven't had cases, serious cases that teachers are involved in sexual relationships with learners, we have not had very serious cases."* (KII with an NGO representative)

Some teachers had also been trained as CoCs and understood their role in protecting their learners better. However, a challenge was the transfer rate of CoC patrons and matrons as schools. It seemed that three quarters of the matrons and patrons had moved to other schools.

There was also an effort to treat sick learners at school, instead of sending them home. As explained by a key informant, this was done in partnership with another organization that distributed learners' treatment kits to schools. However, it is unclear if SRH-related treatment was included in these learners' kits. This would be important to investigate as this is planned to be scaled up in all districts of Malawi.

4.7.3 LACK OF JOB OPPORTUNITIES

There were mixed responses from community members on the question whether employment opportunities had improved since the past four to five years. While some felt that this was not the case and things have remained the same (jobs are still scarce), others felt that things had improved to some extent.

More young people were motivated to complete Form 4 and get the Malawi School Certificate of Education, needed as a minimal qualification for many jobs in Malawi. Some who had the Form 4 certificate continued on to pursuing a college education, which gave them more job opportunities. According to male parents in an FGD, government jobs were scarce and often hard to get due to corruption. With a Form 4 certificate, it was still difficult. According to a key informant, in the past, it was challenging to recruit young people for jobs, as there were no young people who had completed Form 4. At the time of the end-line, there were enough young people who have the Malawi School Certificate of Education and who could potentially be recruited. However, others in the community also mentioned that despite having a Form 4 education, getting a job was difficult.

Due to the rural nature of the community, it is difficult for young people to travel to cities like Blantyre to access job opportunities, as mentioned by a young man. Moreover, young men (20-24 years) also mentioned that there were no companies set up in their community and that vacancies that are advertised often do not reach young people in TA Liwonde. According to a male parent (in an FGD), some would try to go for the police training, or to become HSA, and if not, remain jobless. A few young people mentioned the possibility of becoming a teacher, medical personnel or doctor in the community.

Given the lack of (formal) job opportunities, most young people were self-employed – running small-scale businesses, or traveling to South Africa. Most people relied on farming on their own farm or on others' farms doing piecework. These were also the most common sources of income in the community.

> *"They live on so many things, some businesses, some agriculture [a lot]; young people depend on migration, moving from here to South Africa, that is what young people depend on a lot."*
> (IDI with a 19-year-old young man)

Survey respondents who said to be economically active were mostly doing casual labour, informal trading and were self-employed, and many reported to be practicing subsistence farming at end-line, with a large percentage of female respondents reporting this.

As referred to before, many participants talked about how young men would travel to South Africa, and at times Mozambique, for work. According to boys (15-19 years) in an FGD, the number of boys going to South Africa was increasing. It was lucrative as they could send money back home and were perceived positively by the community. However, according to a key informant, due to COVID-19, it had become harder to travel. Moreover, one key informant also mentioned that xenophobia and strict border controls were concerns and young men were using unchartered routes to get to South Africa. The key informant also mentioned an example where a mother group got a boy who wanted to cross the border (with Mozambique) to come back to school, as they were concerned he had not yet developed his decision-making abilities and that he may be unsafe. If not South Africa or Mozambique, young men would travel to cities such as Blantyre or Lilongwe for work.

> *"… Unfortunately, in TA Liwonde a lot of youth go to South Africa. They go there three months they are back in the community with MK 100,000 and people will look at them as heroes."* (KII with a Yes I Do partner)

While many young men were traveling outside, no participant mentioned young women doing the same. Only one participant mentioned that women could travel to the city to work as a household helps. However, in general, many participants (including young people) shared that young women and young men often did the same work, including farming. One young men shared that young women from the community had gone to Zomba to learn how to fix cars. According to a young woman, women were favoured in community development tasks and NGOs would assign maize to women and not to men. She said that this was because men did not bring money home and used it for their personal purposes. Moreover, organizations trained young women in welding and other vocational skills. Lastly, adult women were also pooling in money to support each other. While during the midline, there was quite some resistance by young men regarding the focus of these kinds of interventions on girls, this was not evident at end-line.

4.7.4. VOCATIONAL TRAINING AND SKILL DEVELOPMENT

A variety of vocations were offered in trainings by organizations such as ADRA, Plan Malawi, CAMFED, CYECE and another local Islamic organization. According to an interview with a NGO representative, more than 50 young people had been trained in vocational skills such as tailoring, welding, baking, cooking and mechanics. Some were given starters kits such as a sewing machine for tailoring and designing – which seemed to depend on their skill level. They also linked some youth to those who already had more experience in a certain vocational skill. This was echoed by another NGO key informant, who also reported that some young women were taught how to sew (re-usable) sanitary pads. A key informant mentioned that Plan Malawi was training members of youth clubs in different entrepreneurial skills, but some youth were failing to catch up. The Plan Malawi representative explained how they were delayed in providing start-up materials, which had hindered young people to start their businesses. However, they expected this to happen soon since they had recently distributed the materials. This could explain the challenge that young people mentioned: that they were unable to continue with what they had learnt once they returned home, as they did not have the materials or capital to do so. At midline, the issue of needing more capital was already raised. It could also be possible that not all young people who did the training received any/enough capital to start up a business themselves.

A parent also explained that Plan Malawi was providing support on baking and farming, with demonstration plots that had cassava and sweet potatoes. Moreover, ADRA was giving support in baking, also with baking machines. She also explained that those who are given sewing machines were now tailoring while those who were given money, were doing business, but were not making profits as they should be. An FGD with young males (20-24 years) revealed that youth clubs were also teaching young people how to be independent and self-employed, for instance by doing businesses and encouraging youth to study further. According to an NGO representative, there had been a change as many have been trained and joined the VSLs and were able to borrow money to boost their business.

It is worth noting that one young woman, when asked about the role of NGOs in economic empowerment, shared that some youth are in fact afraid of NGOs. However, a few participants such as a school headmaster and a young man said that NGOs were also considered future employers. Parents flagged that economic empowerment initiatives of NGOs did not always match the community needs. For instance, Plan Malawi had an intervention in which swales were digged, but male parents heavily criticized this because young people were not being paid well enough or were paid late – either with maize or money.

During the midline, participants expressed that there was a need for more role models for young people. At end-line, this seems to still be the case. When young people were asked if they knew of people in their community who had a job after studying, there were very few people mentioned.

4.8 POLICY AND LEGAL ISSUES

4.8.1 INCREASED MARRIAGE REGISTRATION

Marriage registration (of first marriage) increased over time in both the intervention and control area. At baseline, less than 1% of all respondents had government/ legal marriage registration and about 26% had religious registration. Government registration went up to 4% in TA Liwonde, while there was no change in TA Chikwewo. Religious registration went up in both areas (to 34% in TA Liwonde and 39% in TA Chikwewo). For those who had a registered marriage, the percentage who had a marriage certificate increased over time in both areas (from 6% at baseline to 10% at end-line in TA Liwonde and from 8% at baseline to 11% at end-line in TA Chikwewo).

4.8.2 LOCAL LAWS AND POLICIES

4.8.2.1 NEED FOR HARMONISATION OF LAWS AND POLICIES IN DIFFERENT SECTORS

The key informants interviewed for this study were the major sources of information regarding changes in laws and policies over the past four years. A few key informants gave an overview of different policy mechanisms available, such as those related to childcare, orphans and vulnerable children, adoption, and the marriage age law and divorce act. Although some key informants were unable to remember specific sections and penalties of the different laws, they acknowledged their existence. One key informant explained that there was lack of awareness regarding the laws at the community level.

A point highlighted by a few key informants was the need for harmonization between different laws and sectors, such as the education and health sector. A district official and an NGO representative explained the challenge of delivering SRH services through schools. According to them, SRH services are only allowed to be delivered at a certain distance from the school and the education sector believes that providing information is enough.

4.8.2.2 POLICY AND BYLAWS TO PREVENT SCHOOL DROPOUT ARE AVAILABLE

The policy of allowing pregnant girls to return to school after birth exists and is better used now than before. As per a key informant, this policy of the Ministry of Education helps girls to avoid marriage or another pregnancy. A district official emphasized that age was not a barrier when returning to school. While it is mandatory for the schools to welcome back young mothers, it is not mandatory for all young mothers to do so. Furthermore, caretaking for the child while the mother is in school can be a challenge. There were legal consequences if a teenage pregnancy occurred, both according to the national law (in some cases) and according to the bylaws. It is legally an offence for an adult to have a sexual relationship with a child, and adults are being jailed for this.

When a girl drops out of school due to pregnancy, according to a social worker, the parents should pay MK 12,000. It was said that this encouraged people to hide it when it occurred. A social worker explained that bylaws were made before the national law. The bylaws were made in 2016 in response to the problems that the communities in TA Liwonde were facing. If a child was found pregnant, the parents must pay one or two goats, and the girl is not allowed to marry (even if the parents have paid the fine).

4.8.2.3 POLITICAL WILL SEEMS THERE, BUT IS IT ENOUGH?

There were mixed responses by key informants on whether political will existed. A key informant at district level indicated that there has been some political will as some amendments and changes in laws and policies had taken place (including on child marriage), and this needed the buy-in of politicians. Chiefs were willing to give advice related

to child marriage and teenage pregnancy, and some even encouraged parents to let their children access YFHS, as mentioned by an NGO representative. The government was also invested in One Stop Centres (that take care of cases of sexual violence), as mentioned by a district officer. According to another key informant, there was a member of parliament who was interested in supporting the YFHS space and build a room.

However, there is still more work to be done, as acknowledged by a district officer who stated that some politicians remain ignorant. Financial resources are scarce, and TA Liwonde is big and it is difficult to reach everyone. Hence, an NGO representative suggested that organizations should focus on smaller areas and have more concentrated efforts. Government offices, such as the district social welfare office, were reported to be underfunded.

According to an NGO representative, there was more political will at the national level, but not at the district level. There was potential for the district-level political leaders to be influential as the community looked up to them. They could take on the role of sustaining the work of NGOs once they leave. Lastly, a lack of implementation of the law and mixed messages from the law enforcement authority were also issues.

> *"… it's like the government is saying this but in terms of action they are doing another thing so… political will is there but it lacks energy to actually put what they say into action. If the government was acting in accordance to what they advocate for, the environment could be different. It's the government's responsibility through police to bring people to court when they have done something against the law but the same government is saying this and you see the police acting differently so it's like what the government advocates for, in practice, it's not what people see on the ground."* (KII with an NGO representative)

One key informant explained that the lack of political will was evident in how some politicians did not recognize why the age bill had to be revised. Moreover, a key informant went on to explain that some politicians were 'fuelling child marriages, teenage pregnancy and prostitution among youth', and that more harmonization was needed between the work done in different TAs. For instance, despite having bylaws and an advocacy strategy which had been integrated in the district development plan, there had been no movement from the government on how they were monitoring those developments across TAs.

Some other study participants were more optimistic. One informant spoke about the politicians at the village level who were encouraging the formation of youth clubs and endorsing community-based child care centres. Moreover, each Member of Parliament has a constituency development fund, in which they were given MK 3 million to get to the community and to support vulnerable children. They also mentioned the importance of cash transfer systems.

5. DISCUSSION

5.1 CHILD MARRIAGE AND TEENAGE PREGNANCY HAVE PERSISTED

The Yes I Do programme was developed to reduce the prevalence of child marriage and teenage pregnancy in TA Liwonde in Machinga district. Between 2016 and 2020, the programme developed and implemented a series of context specific interventions aimed at reducing child marriage and teenage pregnancy. The midline study found that informants were of the view that the prevalence of teenage pregnancy was increasing but the prevalence of child marriage was decreasing. Following the bylaws, if girls got pregnant, they were not allowed to get married (Munthali & Kok, 2018). This end-line study found that the percentage of young women aged 18-24 who were married or in union before the age of 18 years increased from 18% at baseline to 20% at end-line in TA Liwonde. In TA Chikwewo, the control area, the child marriage rate also increased from 23% to 28%. While the increase in the prevalence of child marriage in the control area was more than in the intervention area, in both areas, the trends over time were not statistically significant. Therefore, it can be concluded that the child marriage rate did not significantly change over time. The percentage of young women (20-24 years) who had their first child under the age of 20 increased from 63% at baseline to 70% at end-line In TA Liwonde, while in the control area, it increased from 65% at baseline to 76% at end-line (this latter increase over time was statistically significant, but the difference in trends over time was not). The percentage of males who had their first child under the age of 20 decreased from nine male respondents at baseline to eight at end-line.

The midline and end-line studies demonstrate that the Yes I Do programme recorded significant achievements, such as improving knowledge about pregnancy prevention among young women and men, improving access to SRH services with the introduction of YFHS, improved access to contraceptives, increased access to education for girls and the development and implementation of bylaws which outlawed child marriages. The programme also worked with traditional leaders to modify initiation ceremonies including making use of health workers to conduct circumcision (Munthali et al., 2018) and promoted gender equality and girls' rights through the CoC intervention (Munthali et al., 2020). Individual decision-making with regard to whom to date and marry was high among both males and females at base- and end-line. Various stakeholders including the government, NGOs, traditional leaders and other structures were oriented and collaboratively worked with young men and women to reduce child marriage and teenage pregnancy. Despite recording such achievements, survey respondents at end-line reported to be less exposed to education about sexuality and sexual health than at baseline. The decrease in the percentage of respondents who ever had received education about sexuality and sexual health was significant in both TA Liwonde and TA Chikwewo, although the trend in TA Liwonde was significantly less negative. Furthermore, the improvements in knowledge and access to SRH services including contraceptives did not translate into a reduction in the prevalence of teenage pregnancies and child marriage.

Child marriage and teenage pregnancy have persisted in Machinga: in 2015/2016, two out of three married girls and young women were in union before the age of 18 (Republic of Malawi, 2019). A 2018 study found that at national level, the prevalence of child marriage among females aged 15-49 in Malawi was at 42%, with the prevalence being higher in rural (42%) than urban areas at 37% (Makwemba et al, 2019). The data collection for the end-line study was carried out in March 2020, just before the closure of schools due to the COVID-19 pandemic. An assessment conducted between March and July 2020 found that the number of cases of teenage pregnancies had increased from 20,276 in 2019 to 44,178 in 2020. In 2020, the number of child marriages nationally was at 20,109. The increase in the number of child marriage and teenage pregnancy was attributed to, among other factors, the lack of recreation facilities and the lack of economic and social alternatives mainly due to COVID-19 restrictions (Ministry of Gender, Social Welfare and Community Development, 2020). Therefore, the prevalence of teenage pregnancy and child marriage as found in this study could already be higher at the moment of publication of this report (January 2021).

It is clear that many factors that cause teenage pregnancy and (consequently) child marriage are still largely prevalent in TA Liwonde. These factors include the high levels of poverty (evidenced by, among other things, the increase in the percentage of respondents who dropped out of school due to a lack of fees/ school materials) and the persisting prevailing community expectation that girls are supposed to be married. Other factors are that many youth are sexually active (67%), but do not all use contraceptives. The percentage of respondents who reported using contraceptives was 34% at end-line, with twice as high contraceptive use among male respondents as compared to female respondents. It could be that young women who are engaged in transactional sex before marriage have less

power to negotiate use of contraceptives, which can lead to unsafe sex and teenage pregnancy. Sixteen percent (16%) of the female respondents indicated that they did not use contraceptive because they want (more) children in TA Liwonde. These factors that influence teenage pregnancy are confirmed by other studies in Malawi (Chirwa et al. 2019).

5.2 PATHWAY 1

COMMUNITY MEMBERS AND GATEKEEPERS HAVE CHANGED ATTITUDES AND TAKE ACTION TO PREVENT CHILD MARRIAGE AND TEENAGE PREGNANCY

For gatekeepers to act against child marriage and teenage pregnancy, it is needed that local structures, including government ministries, traditional leaders, mother groups, youth clubs, but also health facilities and schools, work together in changing prevailing norms. As boys and girls grow up, they are socialised to perform certain tasks in their communities: at baseline tasks such as construction of houses, moulding and burning of bricks, burning of charcoal and digging of pit latrines and graves were meant for boys and men, while fetching water and firewood, cooking and childcare were meant for girls and women. Vocational jobs were also only meant for boys and men. At midline, some tasks which were initially prescribed for girls and women started being performed by boys and men and the other way around. Most informants reported that parents, guardians and teachers stopped using sex as a determining factor for assigning chores to boys and girls. Other studies have also found that while traditional gender roles place a lot of responsibility for childcare, household work and food on women, there are changes taking place in rural central Malawi and men are increasingly taking on the responsibilities for house and care work, mainly as a result of implementation of bylaws (Mkandawire, 2019). While this is the case, changing of gender norms in the society goes gradually and this needs more time. The evaluation study of the CoC intervention concluded that in TA Liwonde, young people and adults do have gender unequal attitudes in relation to what females and males are supposed to do (or not), including the importance of being obedient for young women and having most decision-making power for men (Munthali et al. 2020).

Prior to 2016, pregnant girls dropped out of school and got married. The community expectation was that girls would get married while boys continued with school. At midline and end-line, girls who got pregnant would not get married as child marriage was outlawed and perpetrators were fined based on the bylaws. This change has been facilitated by the sensitisation campaigns and other interventions such as the CoC implemented by the Yes I Do alliance. The alliance trained different stakeholders, such as people working for the Ministry of Gender, Social Welfare and Community Development, the Ministry of Local Government and Rural Development, the Ministry of Health, the Ministry of Education and the Police in Machinga district as well as in TA Liwonde on the need to prevent child marriage, reduce teenage pregnancy and change gender norms. While before 2016, these stakeholders implemented interventions, it was mainly during the period 2016-2020 that they were brought together to jointly work on gender equality and girls' rights.

5.3 PATHWAYS 2 AND 3

ADOLESCENT GIRLS AND BOYS ARE MEANINGFULLY ENGAGED TO CLAIM THEIR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND PATHWAY 3 – ADOLESCENT GIRLS AND BOYS TAKE INFORMED ACTION ON THEIR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Pathway 2 was about adolescent girls and boys being meaningfully engaged to claim their SRHR. To achieve this, various government departments, NGOs, CBOs and local structures such as youth clubs, mother groups, schools and teachers were capacitated to effectively engage young men and women to improve access to SRHR information and quality and affordable YFHS. Both at midline and end-line, key informants, young women and men and their parents and guardians acknowledged that there has been an improvement in the delivery of health services to young women and men. Many informants talked about the introduction and implementation of YFHS. With regard to the percentage of young people who accessed SRH services, for females this remained at 86% while for males it increased

from 71% to 90%. Other studies have also found that the introduction of YFHS has contributed to an increase in the uptake of SRH services in Malawi (Barden-O'Fallon, 2020).

Quality of the SRH services was rated good to excellent in TA Liwonde, with more female respondents rating these services as excellent compared to male respondents. It became evident that the way young women and men were treated when they visited health facilities has improved. Nowadays, unlike in the past, health workers tell them everything they want to know. However, there is a need to improve access to education about sexuality and sexual health. It might be that young people have become more aware of their right to receive comprehensive SRHR information, and therefore reported less often to have received age-appropriate education on sexuality and sexual health. While the percentage of young people who reported to have ever received education about sexuality and sexual health decreased over time, the end-line study found that knowledge about how pregnancy can be prevented increased by 10% in TA Liwonde and 4% in TA Chikwewo, especially with respect to the use of condoms.

Young people are supposed to make decisions on their own on whom to date, get married to and with whom to have children. Although there was a decrease between base- and end-line, the majority of respondents – both females and males – reported that they can decide for themselves whom to date. The majority of young women and men also said that they have a say on deciding their future partners, instead of parents or relatives deciding for them.

Although youth were actively engaged in the programme and were able to reach fellow youth on SRHR and related issues, the scope of the programme has not been able to reach all youth in the TA. The end-line study found that 35% of the respondents in TA Liwonde participated in the Yes I Do activities and that youth clubs were the most popular, followed by the CoC intervention and community dialogues. The youth clubs supported young people to get more information on preventing pregnancy, and girls received information as well on menstrual hygiene. Young people were encouraged to be a role model in the communities by taking care of their environment. However, there seemed less emphasis on empowerment of young people in claiming their SHR rights in these fora. There was limited space for young people to address their concerns and plea for changes amongst influential elders. However, through pathway 1, more stakeholders have been supportive towards young people by re-enrolment in school after pregnancy, improvements in access to SRH services and actions in the community to prevent child marriage. The role and voice of youth however could be further strengthened in these processes.

This study also found that pregnant teenage girls are required (through a bylaw) to get a letter from the chief in order for them to start antenatal services. Many pregnant teenage girls do not have partners. Other studies found the same, that if a woman attends an antenatal care clinic without a partner, she is either served last or not provided with services until she returns with a partner. In case the woman is abandoned (by the partner), the chief writes a letter that the woman should be excused from the obligation of attending antenatal care with a partner (Mkandawire, 2018 & Manda-Taylor, 2017). Unmarried pregnant women are therefore marginalised by such bylaws.

5.4 PATHWAY 4

GIRLS HAVE ALTERNATIVES BEYOND CHILD MARRIAGE AND TEENAGE PREGNANCY THROUGH EDUCATION AND ECONOMIC EMPOWERMENT

Before 2016, there was an impression of girls being less interested in school in TA Liwonde. Study participants at base- and midline provided examples of primary schools where there were no girls in standard 8. The situation has changed from midline, as both girls and boys now have better opportunities of continuing with education. Unlike in the past, there is currently a lot of support being given to girls for them to continue with their education: NGOs are providing fees, school uniforms, notebooks and pens to girls to keep them in school. The other change is that while previously girls who got pregnant were not given an opportunity to return to school, these days, most of them temporarily stop school, deliver and return to school. Many examples were given where girls who had withdrawn due to child marriage or pregnancy were re-enrolled into school, in line with Malawi's school admission policy. While this is a welcome development, implementation does face a challenge as also found in other studies: some students do not re-enrol due to stigma of being school age mothers (Robertson et al., 2017).

The percentage of female respondents (15-24 years) who dropped out of school due to pregnancy or having a child remained fairly stable, albeit seeing a small increase from 15% at baseline to 16% at end-line in TA Liwonde. The influence of mother groups, teachers, chiefs and health workers on parents of pregnant girls, combined with the stronger enforcement of the bylaws, seem to have resulted in a reduction of school dropout due to pregnancy. There was also a significant reduction in the percentage of respondents who ever dropped out of school from 69% at baseline to 60% at end-line. Key informants reported that enrolment of girls increased over the years during the implementation of the Yes I Do programme. In a mixed method study conducted in Zambia, the re-enrolment of pregnant girls was studied (Zuilkowski et al., 2019). They found that girls who were knowledgeable about the re-enrolment policy, were less likely to be forced out of school while pregnant and perceived less stigma after delivery.

In terms of economic empowerment, the percentage of female respondents aged 18-24 who were economically active outside the household significantly increased in both TA Liwonde and TA Chikwewo: in TA Liwonde this increased from 41% to 53% while in TA Chikwewo it increased from 53% to 65%. There was also an increase in the percentage of males who were economically active between baseline and end-line. It might be that generally, the economic circumstances were better in Machinga district in 2020 as compared to 2016.

In terms of job opportunities, many participants indicated that there were no companies to offer jobs in the community as the area is rural. Most young people were self-employed, running small-scale businesses, or traveling to South Africa for work (for males). The offering of vocational training programmes for young women created an opportunity for them to be self-employed.

5.5 PATHWAY 5

POLICY MAKERS AND DUTY BEARERS HARMONIZE, STRENGTHEN AND IMPLEMENT LAWS AND POLICIES ON CHILD MARRIAGE AND SEXUAL AND REPRODUCTIVE HEALTH

Between 2016 and 2020, a number of interventions have been implemented to improve the policy and legislative environment for addressing SRHR issues including child marriage and teenage pregnancy. Earlier in 2015, the Government of Malawi passed the Marriage, Divorce and Family Relations Act which outlawed child marriage. Community members in TA Liwonde had a lack of knowledge about this legislation. The Yes I Do alliance, with support from various stakeholders, created awareness among community members including traditional leaders and young women and men about existing legislation in Malawi which prohibits child marriage. Traditional leaders, with support from NGOs, developed bylaws which banned child marriage, and recommended that schoolgirls who fall pregnant should not be married off but stay at their parents' home, deliver and after that return to school. At midline, informants reported that the number of child marriages had declined. This was because, even if the number of teenage pregnancies had increased, pregnant girls could not get married as it was contravening the prevailing bylaws set up by the community. Traditional leaders are currently working with NGOs and other government offices including the police on annulling child marriages, which was not the case before 2016. Despite this, there is a major challenge in the effective implementation of the bylaws. In some areas in TA Liwonde, they are not consistently reinforced by the traditional leadership. Other studies have shown that bylaws can have positive effects. For example in Ntcheu district in Malawi, traditional authorities established bylaws that prevented women from giving birth outside the facility. This contributed to an increase in the number of facility deliveries in the district (Mkandawire and Hendricks, 2018). It remains to be seen if current bylaws in Machinga district will contribute to a reduction in child marriage in general, and also in teenage pregnancy.

Lastly, before 2016, the school re-admission policy was not well known in TA Liwonde. The Yes I Do alliance created awareness about this policy. At end-line, many cases were cited during FGDs, KIIs and IDIs of girls who had re-enrolled after they had delivered.

5.6 CROSS-CUTTING STRATEGIES

Pathway 2 deals with meaningful youth engagement. The Yes I Do programme capacitated organisations, including government agencies and community level structures, to effectively work with young people. Youth organisations themselves, including youth clubs, were also capacitated to work with fellow youth. This end-line study found that youth clubs constituted one of the Yes I Do activities in which many young people participated, and they were explicitly appreciated by female respondents.

The Yes I Do alliance implemented several interventions to promote gender equality and girls' rights in TA Liwonde. As a result, things are gradually changing, as observed at mid- and end-line. Boys and men perform tasks which were initially prescribed for girls and women only and vice versa. In addition to this, prior to 2016, most girls dropped out of school once they got pregnant. As mentioned earlier, some girls had more interest in getting married than being educated. The Yes I Do programme promoted girls' education by providing financial and material support and encouraged out-of-school girls to return to school. There are some issues that affect the implementation of the school re-admission policy: in some cases, parents and guardians are not prepared to take care of the girl's child while she is at school. There were other reports that the girls are sometimes stigmatised by teachers and fellow learners when they return to school. While the support that the Yes I Do programme provided to girls was appreciated by communities in TA Liwonde, one major concern that was mainly expressed at midline, was that the programme did not provide equal support to boys.

Another way of empowering girls was through the implementation of the vocational skills training programme. Girls who attended vocational training were also given capital to start their businesses and examples were given of girls who were self-employed and were able to get an income. This was a new thing in TA Liwonde. Lastly, the CoC intervention promoted gender equality and girls' rights through the provision of information to girls, boys and other members of the community. Approaches to meaningfully engage young men were particularly included in the CoC intervention. Less focus was given on boys regarding education and economic empowerment activities. Despite them having more economic opportunities than young women in this resource constrained setting, young men should neither be forgotten in these kinds of activities.

5.7 STRENGTHS AND LIMITATIONS OF THE STUDY

This study used a comprehensive approach to collect data. Besides a random, two-stage cluster household survey among young people at base- and end-line in the intervention area and in a control area, at all three study stages, FGDs were conducted with young men and women of different age groups, IDIs were conducted with young men and women and various gatekeepers and KIIs were conducted with district level policy makers, officials and NGOs in the intervention area. At mid- and end-line, it was observed that there were other NGOs that were working in TA Liwonde. The NGOs that were mentioned during the interviews and FGDs included Save the Children, One Community, PSI and YONECO. At end-line, an interview was only conducted with YONECO at Machinga Boma.

One observation when looking at the quantitative data is that in a few cases, TA Chikwewo performed equally or better than TA Liwonde. It was mentioned during the course of collecting data for the end-line study that there are a few NGOs in TA Chikwewo, but they seem not to particularly focus on reducing child marriage and teenage pregnancy. However, it would have been good to interview some of these NGOs working in TA Chikwewo. It should be noted that other contextual factors, such as changes in the general economy or having a good (or bad) rainy season could also influence some of the outcomes measured in this study.

The Yes I Do programme supported girls who fell pregnant, withdrew from school and re-enrolled after delivery. A number of young women and men attended vocational trainings supported by the programme. The traditional leaders, social welfare officers and Yes I Do partners participated in the annulment of child marriage. There were also quite a number of females who participated in VSL activities. The mid- and end-line studies would have been enriched if interviews were also conducted with young people who had been particularly involved in these issues.

6. CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSION

6.1.1 ACTIONS TAKEN TO STOP CHILD MARRIAGE AND TO GET PREGNANT GIRLS BACK TO SCHOOL

The Yes I Do programme aimed at contributing to a decrease in the prevalence of child marriage and teenage pregnancy in TA Liwonde. This report shows that this overall aim has not been achieved. In TA Liwonde, the prevalence of child marriage and teenage pregnancy increased, but not significantly. Both child marriage and teenage pregnancy did significantly increase in TA Chikwewo between base- and end-line. Despite this, we cannot conclude that the differences in these trends (between TA Liwonde and TA Chikwewo) are a result of the Yes I Do programme, because they were not statistically significant.

However, the Yes I Do programme did create more awareness among traditional leadership, young people, and other community members and gatekeepers about the disadvantages of child marriage and teenage pregnancy and the need for girls to go to school. This is why the community in TA Liwonde accepted and appreciated the Yes I Do programme, and developed bylaws on child marriage and teenage pregnancy. The teenage pregnancy rate increased, hence, in addition to increasing awareness, there is a need to promote the use of contraceptives among young women and men through, among other things, the strengthening of YFHS.

Some of the programme's successes were achieved because it actively involved young women and men in its implementation: these young people were capacitated, and were better able to claim their rights and prevent child marriage. For example, cases were cited in which girls who were not ready to get married reported their parents to relevant authorities to intervene and most of them made their own decisions on whom to date and when to get married. The empowerment of girls and young women has increased, also through their participation in education and economic activities.

6.1.2 SUSTAINABILITY OF THE YES I DO PROGRAMME: HAS BEEN WORKED ON, BUT SUSTAINED SUPPORT FROM PARTNERS IS NEEDED

The Yes I Do alliance did not implement the interventions on its own, but worked together with the Machinga District Council. In particular, they worked with the District Commissioner, the DSWO, District Police Station, District Education Office, District Health Office, District Youth Office and community level structures such as the traditional and religious leaders, mother groups, youth organisations and youth clubs and the wider community. The implementation of the Yes I Do interventions could therefore be sustained, as existing structures have been capacitated. However, there is a need to properly hand over project activities to the Machinga District Council, especially to the District Social Welfare Office, where child marriage and teenage pregnancy issues are coordinated. In addition, there is a need for sustained support of partners, because financial resources are scarce in the district.

6.2 RECOMMENDATIONS

Based on the end-line findings, the following recommendations are made for future programmes.

Pathway 1

- The sensitisation of the community on the harms of child marriage and teenage pregnancy should be an on-going activity and the underlying gender norms need to be addressed. While the Yes I Do alliance played a role during the implementation of the programme, existing government structures such as the Machinga District Council including the DSWO, the police, traditional leaders, religious leaders and mother groups should continue working on these issues, together with development partners.

Pathways 2 and 3

- Only 35% of the young respondents participated in the Yes I Do programme. The DSWO and the District Youth Office should work with new and existing youth organisations, including youth clubs, to build their capacity to interact with fellow youth and create awareness about their rights.
- Machinga District Council should identify local role models who can motivate youth to look at their long-term perspectives and finish (secondary or higher) education.
- Machinga District Council should encourage the engagement of boys and men in the fight against child marriage and teenage pregnancy and promotion of gender equality and girls' rights.
- The District Health Office should work with various partners including NGOs to keep on strengthening the delivery of YFHS, including access to contraceptives for young people in order to prevent teenage pregnancy.

Pathway 4

- The Machinga District Council should mobilise resources to financially support vulnerable boys and girls at risk of withdrawing from school, including girls who withdrew from school because they were pregnant.
- The Machinga District Council and the NGOs in Machinga should economically empower young women and men through offering of vocational skills programmes and entrepreneurship training programmes and start-up capital.
- The Machinga District Council should keep on creating awareness among community members on the school re-admission policy and the advantages of educating girls.
- There is need to continue empowering and educating communities to ensure that people understand the rights of children and ensure their protection.

Pathway 5

- While the bylaws on issues such as child marriage, teenage pregnancy and education were developed and implemented, there was a lack of effective implementation of these bylaws at community level. The Machinga District Council should work collaboratively with other government offices, NGOs and traditional and religious leaders and continue creating awareness about the existing legislation at national level, including the bylaws.
- There were reports of a number of traditional leaders who did not follow the bylaws. TA Liwonde had said that any traditional leader who would not follow the bylaws would be dethroned. The TA should therefore ensure that all the group village heads effectively implement the bylaws. Any traditional leader who does not obey the bylaws including those who are corrupt should be dethroned.

Recommendations for further research are:

- Investigate the retention and experiences of girls who were enrolled into school after they delivered.
- Explore the effectiveness of community bylaws, and their potential (negative) effects on teenage pregnant girls.
- Study migration of young men to South Africa: trends and impacts.
- Study the content of SRHR information provided in schools and in community interventions.

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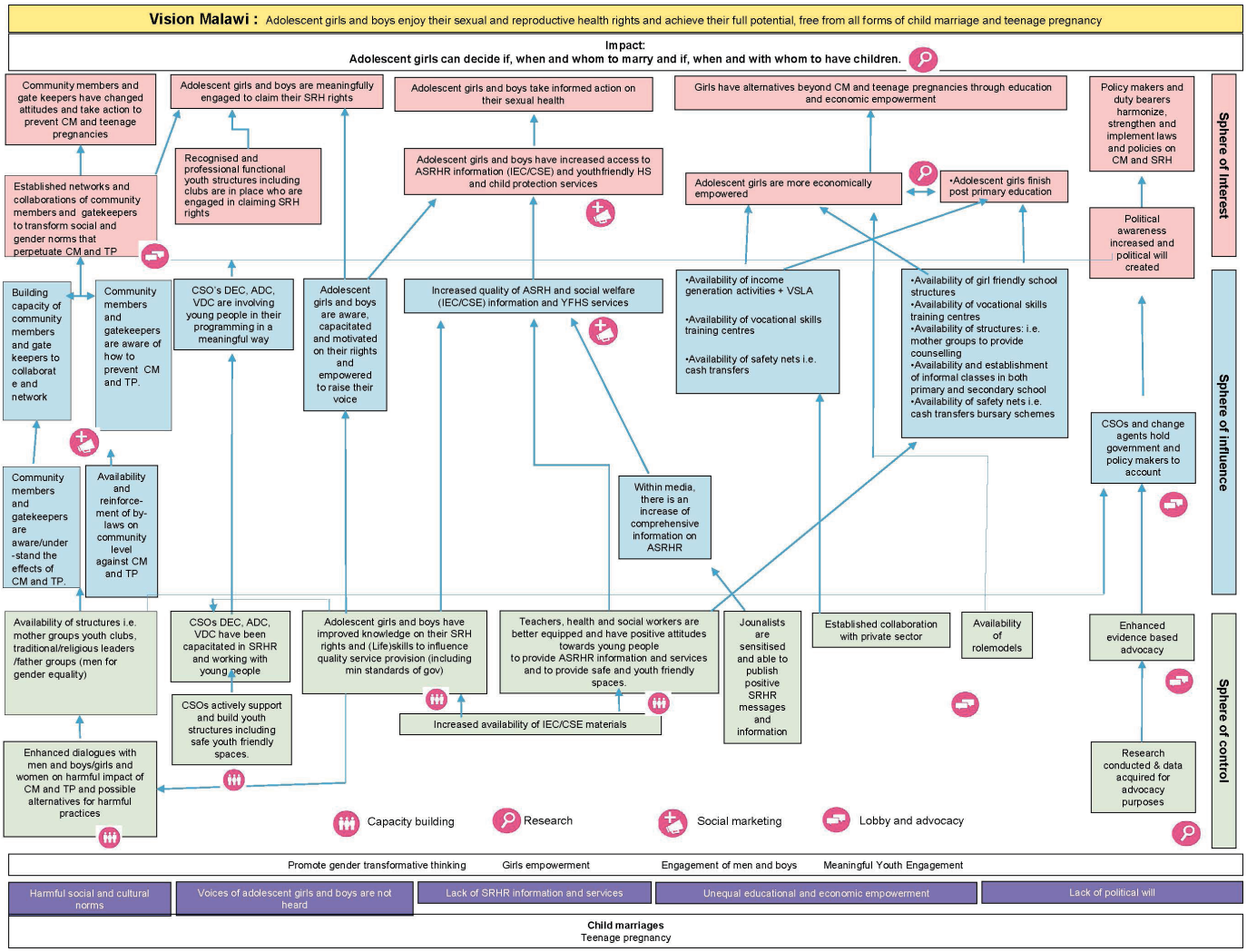
7. ANNEXES

ANNEX 1: THE YES I DO THEORY OF CHANGE IN MALAWI



ANNEX 2: DIFFERENCE-IN-DIFFERENCE MODELS

Overview and description of models

Univariable and Multivariable regression model

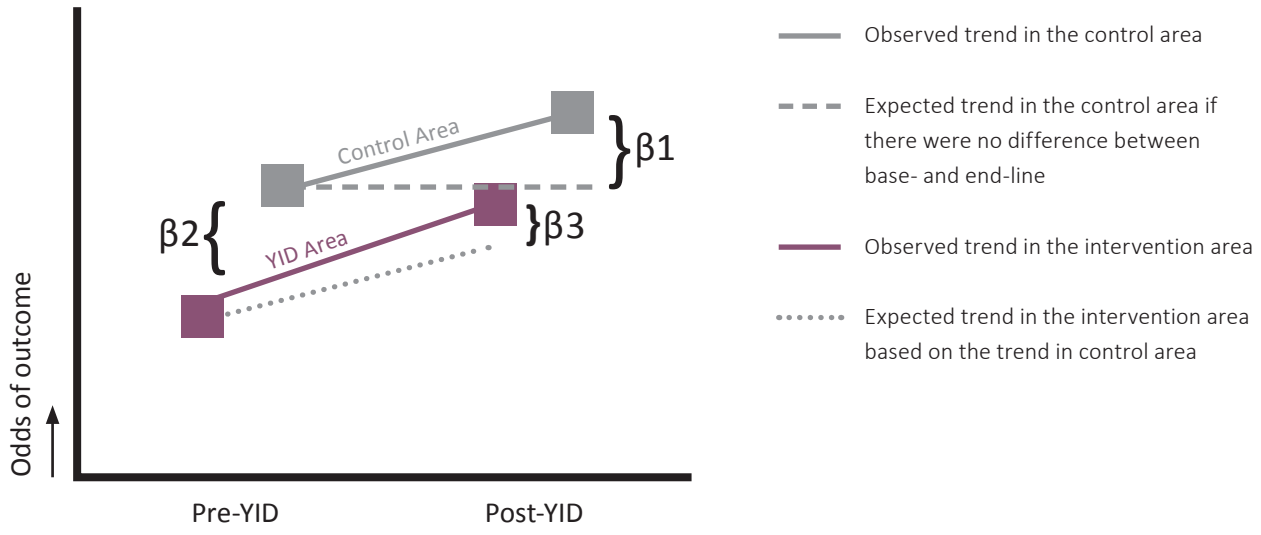
The models presented below aim to assess the trend over time in the intervention against the trend over time in the control area. All models are logistic regression models as the outcome variables are all **binary**. This means that the parameters estimated and provided in the tables below are **odds ratios (OR)**. An odds ratio below 1 indicates and **inverse association**, e.g. an **increase** in 'x' is associated with a decrease in 'y'. An odds ratio of more than one indicates a **positive** association, e.g. an **increase** in `x' is associated with an **increase** in 'y'. An odds ratio of 1, means that the odds in both groups are the same.

Note: an odds ratio can be >1 or <1 but as long as it is not statistically significant we assume no association.

The overview below describes the model in more detail.

Malawi model overview

$$\text{logit}(P(y=1)= \beta 0+ \beta 1*[\text{Time}]+ \beta 2*[\text{YID}]+\beta 3*[\text{Time*YID}]$$



y: The binary outcome variable (different for each model)
β0: Baseline odds of outcome variable at baseline in the control area
β1: quantifies the trend over time in the control area. I.e. the odds in the control area at baseline vs endline. In the tables it is referred to as 'Time'.
β2: quantifies the difference between the intervention and control area at baseline. I.e. the odds in the control area at baseline vs the odds in the intervention area at baseline. In the tables it is referred to as 'YID intervention'.
β3: quantifies the difference between the expected trend in the intervention area if it would follow *the same trend* as the control area and the observed trend. In the tables it is referred to as 'YID : Time'. If this variable is significant, it means that the trend in the intervention area is statistically significantly different from the trend in the control area.

UNIVARIABLE REGRESSIONS OVER TIME

The following outcome variables were modelled[15]:

Outcomes	
Theme	**Outcome variable**
Child marriage	Girls and women aged 18-24 who were married or in a union before age 18
	Girls and women aged 16-24 who were married or in a union before age 16
Teenage pregnancy	Girls and women aged 20-24 years who had their first child under the age of 20
Education	Girls aged below 18 years who dropped out of school
	Girls aged 15-18 currently attending secondary school
Employment	Girls between 18 and 24 years old who are economically active outside of the household
	Girls between 18 and 24 years old who have received any income in the last six months
SRHR behaviour	Girls aged 15-24 who can decide for themselves whom to date and go out with
	Boys aged 15-24 who can decide for themselves whom to date and go out with
	Girls between 15 and 24 that have ever utilized SRHR services
	Boys between 15 and 24 that have ever utilized SRHR services
	Girls aged 15-24 who ever received education about sexuality and sexual health
	Boys aged 15-24 who ever received education about sexuality and sexual health
	Girls aged 15-24 who know how to prevent pregnancy using modern contraceptives
	Boys aged 15-24 who know how to prevent pregnancy using modern contraceptives
	Girls aged 15-24 who disagree with the statement "It is not appropriate for a girl to propose to use a condom"
	Boys aged 15-24 who disagree with the statement "It is not appropriate for a girl to propose to use a condom"
	Girls aged 15-24 who feel confident to insist on condom use every time they have sex
	Boys aged 15-24 who feel confident to insist on condom use every time they have sex

15 Some M & E indicators that were not modelled had too small a sample size or not enough variation in the data.

MULTIVARIABLE REGRESSIONS OVER TIME

These are also logistic regressions, which denotes that the outcomes are binary. Multivariate difference-in-difference regressions are conducted on the two impact indicators: prevalence of child marriage, and prevalence of teenage pregnancy. The same set of independent variables are used in the regression model.

The three main models that are run for each outcome are presented below:

Malawi model overview

$$logit(P(\gamma=1)= \beta 0+ \beta 1*[time]+ \beta 2* [YID] + \beta 3*[YID*time]+ \beta 4*[covariate1]...+\beta x*[covariateX]+ \varepsilon$$

γ: The binary outcome variable (different for each model)
β0: Baseline odds of outcome variable at baseline in the control area
β1: quantifies the trend over time in the intervention area. I.e. the odds in the intervention area over time. In the tables it is referred to as 'Time'.
β2: quantifies the difference between the intervention and control area at baseline. I.e. the odds in the control area at baseline vs the odds in the intervention area at baseline. In the tables it is referred to as 'YID intervention'.
β3: quantifies the difference between the expected trend in the intervention area if it would follow *the same trend* as the control area and the observed trend. In the tables it is referred to as 'YID : Time'. If this variable is significant, it means that the trend in the intervention area is statistically significantly different from the trend in the control area.
ε: Random error term
There are three different types of covariates:
Individual demographic characteristics: Age, Education, School-dropout, Employment, Income
Individual SRHR-related characteristics: Teenage pregnancy OR ever had a child and Sex education
Family-level/Household characteristics: Mother's education, Father's education and Household size

Child marriage								
	Univariable regressions				Multivariable regressions			
		95%CI				95%CI		
	B	Lower bound	Upper bound	P-value	B	Lower bound	Upper bound	P-value
Outcome variable: Young women 18 – 24 years old who are married before 18 years of age								
Constant					0.29	0.23	0.37	0.00
Time (time)**	1.27	1.01	1.61	0.05	1.37	1.00	1.89	0.05
YID intervention (pop)	0.68	0.54	0.86	0.00	0.76	0.54	1.06	0.11
YID : Time (poptime)	0.84	0.64	1.11	0.23	0.83	0.52	1.33	0.44
Outcome variable: Young women 16 – 24 years old who were married before 16 years of age								
Constant					0.05	0.03	0.07	0.00
Time (time)	0.83	0.55	1.24	0.35	1.27	0.73	2.20	0.40
YID intervention (pop)	0.83	0.56	1.25	0.38	1.26	0.73	2.17	0.41
YID : Time (poptime)	0.52	0.30	0.92	0.02	0.39	0.17	0.89	0.03

Teenage pregnancy								
	Univariable regressions				Multivariable regressions			
		95%CI				95%CI		
	B	Lower bound	Upper bound	P-value	B	Lower bound	Upper bound	P-value
Outcome variable: Young women aged 20 - 24 who had their first child <20								
Constant					1.92	1.51	2.45	0.00
Time (time)**	1.48	1.15	1.89	0.00	1.61	1.13	2.31	0.01
YID intervention (pop)	0.82	0.64	1.05	0.11	0.89	0.64	1.25	0.51
YID : Time (poptime)	1.08	0.81	1.45	0.58	0.84	0.51	1.38	0.49

Education								
	Univariable regressions				Multivariable regressions			
		95%CI				95%CI		
	B	Lower bound	Upper bound	P-value	B	Lower bound	Upper bound	P-value
Outcome variable: Young women 15 – 17 years old who dropped out of school before 18 years of age								
Constant					0.53	0.39	0.72	0.00
Time (time)	0.67	0.16	-2.56	0.01	0.70	0.45	1.08	0.11
YID intervention (pop)	1.08	0.16	0.52	0.60	1.13	0.74	1.73	0.56
YID : Time (poptime)	0.78	0.18	-1.34	0.18	0.92	0.50	1.69	0.78
Outcome variable: Young women 15 – 24 years old who are currently attending secondary school								
Constant					0.04	0.02	0.08	0.00
Time (time)**	0.85	0.53	1.35	0.49	0.98	0.40	2.41	0.97
YID intervention (pop)	3.00	1.77	5.07	0.00	3.29	1.58	6.85	0.00
YID : Time (poptime)	1.53	0.93	2.51	0.09	0.82	0.29	2.35	0.72

Employment								
	Univariable regressions				Multivariable regressions			
		95%CI				95%CI		
	B	Lower bound	Upper bound	P-value	B	Lower bound	Upper bound	P-value
Outcome variable: Young women 15 – 24 years old who received income in the last six months								
Constant					0.76	0.64	0.90	0.00
Time (time)**	0.39	0.32	0.48	0.00	0.46	0.36	0.60	0.00
YID intervention (pop)	1.15	0.95	1.40	0.15	1.53	1.20	1.95	0.00
YID : Time (poptime)	0.54	0.43	0.68	0.00	0.65	0.46	0.93	0.02
Outcome variable: Young women 15 – 24 years old who are economically active outside the household								
Constant					0.49	0.40	0.61	0.00
Time (time)**	2.41	1.98	2.95	0.00	3.79	2.82	5.08	0.00
YID intervention (pop)	0.91	0.75	1.11	0.35	1.43	1.08	1.90	0.01
YID : Time (poptime)	1.29	1.03	1.62	0.03	0.42	0.28	0.63	0.00

SRHR behaviour								
	Univariable regressions				Multivariable regressions			
		95%CI				95%CI		
	B	Lower bound	Upper bound	P-value	B	Lower bound	Upper bound	P-value
Outcome variable: Young women aged 15 - 24 who can decide for themselves who to date								
Constant					4.91	3.95	6.10	0.00
Time (time)**	1.03	0.82	1.29	0.80	1.00	0.74	1.36	1.00
YID intervention (pop)	1.35	1.08	1.70	0.01	1.31	0.95	1.79	0.10
YID : Time (poptime)	1.29	0.98	1.70	0.07	1.08	0.68	1.69	0.75
Outcome variable: Young men aged 15 - 24 who can decide for themselves who to date								
Constant					11.56	6.94	19.27	0.00
Time (time)**	0.95	0.60	1.50	0.82	1.08	0.52	2.21	0.84
YID intervention (pop)	0.63	0.39	1.00	0.05	0.70	0.36	1.38	0.30
YID : Time (poptime)	0.68	0.41	1.10	0.12	0.81	0.32	2.06	0.66
Outcome variable: Young women aged 15 - 24 who ever used SRH/R services								
Constant					3.60	2.95	4.38	0.00
Time (time)**	1.17	0.94	1.45	0.15	1.33	1.00	1.78	0.05
YID intervention (pop)	1.48	1.19	1.83	0.00	1.69	1.25	2.28	0.00
YID : Time (poptime)	1.32	1.01	1.71	0.04	0.76	0.49	1.17	0.21
Outcome variable: Young men aged 15 - 24 who ever used SRH/R services								
Constant					2.24	1.66	3.02	0.00
Time (time)**	3.71	2.55	5.39	0.00	3.53	2.10	5.94	0.00
YID intervention (pop)	1.10	0.78	1.55	0.58	1.07	0.70	1.63	0.77
YID : Time (poptime)	2.88	1.77	4.69	0.00	1.11	0.52	2.34	0.79
Outcome variable: Young women 15 – 24 years old who received sex education								
Constant					3.67	3.01	4.48	0.00
Time (time)**	0.34	0.28	0.40	0.00	0.25	0.19	0.32	0.00
YID intervention (pop)	1.24	1.04	1.46	0.01	0.85	0.65	1.12	0.25
YID : Time (poptime)	0.70	0.58	0.85	0.00	1.87	1.31	2.67	0.00
Outcome variable: Young men 15 – 24 years old who received sex education								
Constant					3.47	2.49	4.83	0.00
Time (time)**	0.52	0.39	0.70	0.00	0.42	0.27	0.64	0.00
YID intervention (pop)	0.88	0.66	1.18	0.39	0.69	0.44	1.08	0.11
YID : Time (poptime)	0.69	0.50	0.95	0.02	1.53	0.85	2.77	0.16

SRHR behaviour								
	Univariable regressions				Multivariable regressions			
		95%CI				95%CI		
	B	Lower bound	Upper bound	P-value	B	Lower bound	Upper bound	P-value
Outcome variable: Young women 15 – 24 years old who know how to prevent pregnancy using modern contraceptives								
Constant					2.93	2.43	3.54	0.00
Time (time)**	1.28	1.05	1.57	0.01	1.28	0.97	1.69	0.08
YID intervention (pop)	1.27	1.04	1.56	0.02	1.27	0.97	1.67	0.08
YID : Time (poptime)	1.40	1.10	1.79	0.01	1.01	0.68	1.51	0.96
Outcome variable: Young men 15 – 24 years old who know how to prevent pregnancy using modern contraceptives								
Constant					0.75	0.43	1.32	0.32
Time (time)**	2.23	1.40	3.55	0.00	1.40	0.75	2.61	0.29
YID intervention (pop)	1.08	0.69	1.68	0.73	0.75	0.43	1.32	0.32
YID : Time (poptime)	2.95	1.50	5.81	0.00	2.81	1.07	7.37	0.04
Outcome variable: Young women aged 15 - 24 who think it is appropriate for a girl to propose condoms use								
Constant					0.87	0.74	1.03	0.11
Time (time)**	1.55	1.32	1.83	0.00	1.43	1.14	1.80	0.00
YID intervention (pop)	1.18	1.00	1.39	0.04	1.10	0.87	1.38	0.42
YID : Time (poptime)	1.60	1.32	1.93	0.00	1.18	0.85	1.63	0.31
Outcome variable: Young men aged 15 - 24 who think it is appropriate for a girl to propose condoms use								
Constant					1.87	1.40	2.50	0.00
Time (time)**	1.34	1.01	1.79	0.04	1.02	0.68	1.53	0.93
YID intervention (pop)	0.99	0.75	1.32	0.96	0.75	0.50	1.13	0.17
YID : Time (poptime)	1.46	1.04	2.04	0.03	1.74	0.98	3.09	0.06
Outcome variable: Young women 15 – 24 years who feel confident to insist on condom use every time they have sex.								
Constant					3.60	2.95	4.38	0.00
Time (time)**	0.82	0.67	0.99	0.04	0.68	0.52	0.88	0.00
YID intervention (pop)	1.45	1.19	1.76	0.00	1.16	0.88	1.54	0.30
YID : Time (poptime)	1.31	1.04	1.66	0.02	1.52	1.03	2.25	0.03
Outcome variable: Young men 15 – 24 years who feel confident to insist on condom use every time they have sex.								
Constant					10.82	6.59	17.79	0.00
Time (time)**	0.48	0.30	0.77	0.00	0.62	0.33	1.17	0.14
YID intervention (pop)	1.03	0.66	1.60	0.90	1.45	0.67	3.12	0.34
YID : Time (poptime)	0.59	0.37	0.94	0.03	0.60	0.23	1.53	0.28

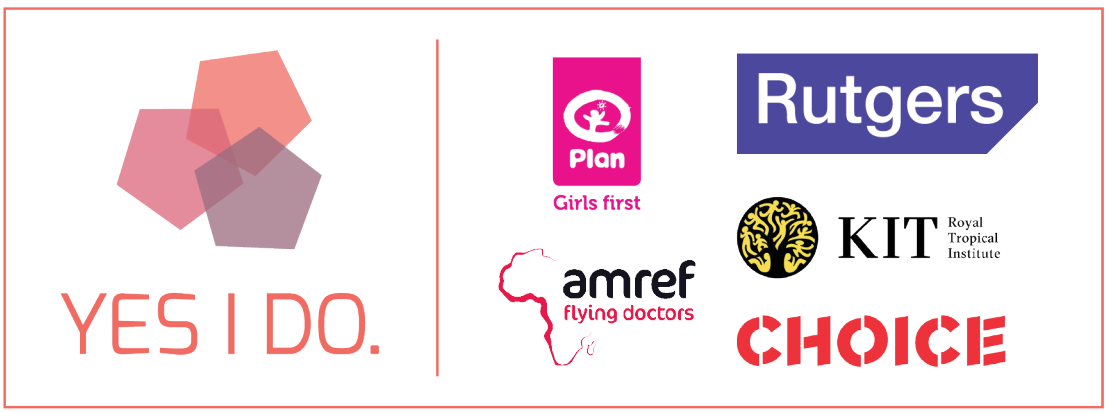
OUTPUT: MULTIPLE REGRESSION ANALYSIS

Factors influencing teenage pregnancy					
		Child marriage or not		Ever married or not	
	(1) odds ratio	(2) odds ratio	(3) odds ratio	(4) odds ratio	(5) odds ratio
Teenage pregnancy (females-20-24)					
YID Intervention	0.957	1.014	0.997	1.146	1.014
	(0.173)	(0.194)	(0.220)	(0.218)	(0.218)
Time	1.729***	1.338	1.434	1.418	1.559*
	(0.352)	(0.297)	(0.370)	(0.308)	(0.393)
YID Intervention*Time	0.866	0.952	1.098	0.903	1.068
	(0.231)	(0.268)	(0.370)	(0.251)	(0.357)
Age	0.987	0.978	0.916	0.902**	0.846***
	(0.0440)	(0.0461)	(0.0523)	(0.0437)	(0.0511)
Educated or not	0.260***	0.376*	0.190**	0.335**	0.152***
	(0.131)	(0.197)	(0.158)	(0.156)	(0.107)
Employed or not	1.336**	1.300*	1.343*	1.366**	1.429*
	(0.192)	(0.195)	(0.239)	(0.203)	(0.253)
Income	0.970	0.908	0.785	0.968	0.819
	(0.136)	(0.135)	(0.140)	(0.143)	(0.150)
School dropout	3.947***	3.206***	4.142***	2.728***	3.788***
	(0.776)	(0.661)	(1.067)	(0.541)	(0.939)
Received sex education		0.706**	0.742	0.629***	0.675**
		(0.114)	(0.145)	(0.104)	(0.135)
Child marriage		17.51***	13.67***		
		(6.466)	(5.997)		
Ever married				4.598***	4.021***
				(0.821)	(0.990)
Mother's education			0.940		0.908
			(0.177)		(0.170)
Father's education			0.875		0.916
			(0.180)		(0.189)
Household size (1-2 members)			0.354***		0.283***
			(0.0934)		(0.0753)
Household size (5-7 members)			0.831		1.153
			(0.187)		(0.262)
Household size (8 or more members)			0.297***		0.454***
			(0.0704)		(0.121)
Constant	2.359	2.449	24.24***	7.141*	71.18***
	(2.535)	(2.811)	(34.82)	(7.971)	(98.57)
Observations	1,145	1,145	836	1,145	836
Robust see form in parentheses					

* p<0.1, ** p<0.05, *** p<0.01

Factors influencing child marriage					
		Teenage pregnancy		Ever had a child	
	(1) odds ratio	(2) odds ratio	(3) odds ratio	(4) odds ratio	(5) odds ratio
Child marriage (females-18-24)					
YID Intervention	0.763	0.734	0.737	0.712*	0.692
	(0.137)	(0.144)	(0.172)	(0.133)	(0.155)
Time	1.519*	1.259	1.294	1.403*	1.388
	(0.280)	(0.265)	(0.324)	(0.283)	(0.333)
YID Intervention*time	0.940	0.897	0.795	0.891	0.761
	(0.237)	(0.245)	(0.260)	(0.237)	(0.242)
Age	0.946	0.885***	0.869***	0.801***	0.779***
	(0.0328)	(0.0334)	(0.0409)	(0.0310)	(0.0373)
Educated or not	0.499*	0.726	0.375*	0.648	0.369*
	(0.210)	(0.303)	(0.191)	(0.266)	(0.188)
Employed or not	1.234	1.146	1.040	1.164	1.043
	(0.165)	(0.164)	(0.179)	(0.161)	(0.174)
Income	1.642***	1.742***	1.596***	1.665***	1.550***
	(0.222)	(0.254)	(0.278)	(0.238)	(0.261)
School drop out	4.384***	1.693**	1.935**	1.855**	2.021**
	(1.013)	(0.434)	(0.638)	(0.472)	(0.655)
Ever had a child				15.47***	11.97***
				(4.391)	(4.377)
Teenage pregnancy		16.79***	12.42***		
		(4.398)	(3.763)		
Received sex education		0.830	0.824	0.783*	0.777
		(0.123)	(0.153)	(0.113)	(0.140)
Mother's education			1.156		1.149
			(0.218)		(0.207)
Father's education			1.232		1.190
			(0.255)		(0.239)
Household size (1-2 member)			0.837		1.122
			(0.267)		(0.342)
Household size (5-7 members)			0.943		1.113
			(0.188)		(0.220)
Household size (8 or more members)			0.237***		0.286***
			(0.0885)		(0.102)
Constant	0.320	0.286	0.0465***	2.293	0.0398***
	(0.261)	(0.263)	(0.0281)	(2.067)	(0.0255)
Observations	1,581	1,574	1,155	1,581	1,162
Robust see form in parentheses					

* p<0.1, ** p<0.05, *** p<0.01


YES I DO.
Plan
Girls first
amref
flying doctors
Rutgers
KIT
Royal
Tropical
Institute
CHOICE