# *Prevention or Punishment?*

## Teenage pregnancy and child marriage in Chadiza and Petauke, Eastern Zambia

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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. In Zambia, the programme is implemented in Chadiza and Petauke districts. 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 Zambia, the Yes I Do alliance consists of Plan Zambia and Generations Alive.

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# Abbreviations

## LIST OF ACRONYMS

| | |
|---|---|
| **AU** | African Union |
| **CBO** | Community-Based Organization |
| **CHW** | Community Health Worker |
| **CSE** | Comprehensive Sexuality Education |
| **CoC** | Champions of Change |
| **FGD** | Focus Group Discussion |
| **GBV** | Gender-Based Violence |
| **IDI** | In-Depth Interview |
| **KII** | Key Informant Interview |
| **NGO** | Non-Governmental Organization |
| **SEA** | Standard Enumeration Area |
| **STI** | Sexually Transmitted Infection |
| **ZDHS** | Zambian Demographic Health Survey |
| **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

This report presents the results of the Yes I Do base-, mid- and end-line study in Chadiza and Petauke districts in Eastern Zambia. The study adopted a mixed-methods design. A household survey was administered among young women and men (15-24 years) at base- and end-line. Focus group discussions, semi-structured and in-depth interviews, and key informant interviews with various stakeholders were held at base-, (September 2016), mid-, (May 2018) and end-line (October 2020).

The Yes I do programme has played an important role in increasing knowledge of different stakeholders about the harms of child marriage and teenage pregnancy and triggering positive attitudes towards the prevention of child marriage and teenage pregnancy in the communities. This study reveals a small but significant decrease in the prevalence of child marriage among young women (18-24 years) in Petauke district over the past four years. In Chadiza, no change in child marriage prevalence is observed. It is unclear why there is a difference between the two districts and it is not possible to conclude whether the Yes I Do programme contributed to the changes observed. The teenage pregnancy rate significantly increased in both Chadiza and Petauke. While access to SRHR information and SRH services increased over the past four years, a positive change that could be attributed to the Yes I Do programme, a taboo on youth sexuality – supported by social and cultural norms – limits young people's confidence in accessing and consistently using contraceptives. The Yes I Do programme established more awareness about gender equality and young people's SRHR, but transformation of gender norms needs more time. Young people's agency and capacity to speak out seem improved, but they do not always get the space from other community members. Some traditional leaders, parents, teachers and health workers, have become more supportive to young people's SRHR, but others have not. More investments are needed to increase their support. The Yes I Do programme seems to have had a positive effect on the value of education among parents and adolescents. Young people's economic empowerment needs more attention. Future programmes should build upon the positive changes of the Yes I Do programme and equally involve all gatekeepers to trigger a social movement that promotes young people's SRHR and takes joint actions to prevent child marriage and teenage pregnancy.

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

Table 1 **Summary of quantitative indicators tracked**

| Category and indicator | **Overall baseline value** | **Overall end-line value** |
|---|---|---|
| **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) | 36 (12.8%) | 44 (11.2%)* |
| Girls and women (16-24 years) who were married or in a union before age 16 (i.e. child marriage) | 10 (2.2%) | 7 (1.3%)* |
| Girls below 18 years old who are currently married | 5 (2.1%) | 5 (2.3%) |
| Young women (20-24 years) who had their first child under the age of 20 (i.e. teenage pregnancy) | 73 (45.1%) | 177 (61.5%)** |
| **SRHR behaviour** | | |
| Girls and young women (15-24 years) who can decide for themselves whom to date and go out with | 461 (89.3%) | 440 (71.8%)*** |
| Boys and young men (15-24 years) who can decide for themselves whom to date and go out with | 167 (87%) | 162 (82.7%) |
| Girls and young women (15-24 years) that have ever utilized SRH services, including modern contraceptives | 299 (57.9%) | 517 (84.3%)*** |
| Boys and young men (15-24 years) that have ever utilized SRH services, including modern contraceptives | 76 (39.6%) | 148 (75.5%)*** |
| Girls and young women (15- 24 years) who have ever used contraceptives | 155 (30%) | 302 (49.3%)** |
| Young mothers (15-24 years) indicating using male condoms | 5 (3%) | 35 (11%)** |
| Young fathers (15-24 years) indicating using male condoms | 9 (36%) | 27 (62.8%)* |

| SRHR knowledge | | |
|---|---|---|
| Girls and young women (15-24 years) who know how to prevent pregnancy using modern contraceptives | 331 (64.1%) | 532 (86.8%)*** |
| Boys and young men (15-24 years) who know how to prevent pregnancy using modern contraceptives | 105 (54.7%) | 182 (92.9%)*** |
| 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" | 239 (46.3%) | 280 (45.7%) |
| 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 (60.9%) | 84 (42.9%)** |
| Girls and young women (15-24 years) who feel confident to insist on condom use every time they have sex | 333 (64.5%) | 391 (63.8%) |
| Boys and young men (15-24 years) who feel confident to insist on condom use every time they have sex | 160 (83.3%) | 131 (66.8%)** |
| Girls and young women (15-24 years) who ever received education about sexuality and sexual health | 356 (69%) | 424 (69.2%) |
| Boys and young men (15-24 years) who ever received education about sexuality and sexual health | 86 (44.8%) | 130 (66.3%)*** |
| **Education and economic empowerment** | | |
| Girls below 18 years who dropped out of school | 86 (36.6%) | 69 (31.4%)* |
| Girls below 18 years who left school due to marriage[1] | 3 (1.3%) | 1 (0.5%) |
| Girls below 18 years who left school due to pregnancy | 19 (8.1%) | 18 (8.2%)* |
| Girls (15-18 years) currently attending secondary school | 80 (26.4%) | 69 (25.5%) |
| Girls (15-18 years) who have a child and follow education | 15 (36.6%) | 10 (18.9%) |
| Young women (18-24 years) who are economically active outside of the household | 25 (8.9%) | 164 (41.7%)*** |
| Young women (18-24 years) who have received any income in the last six months | 76 (27%) | 27 (6.9%) |

Significant change between base- and end-line: * p-value<0.05, **p-value<0.001, *** p-value<0.001.
1. insufficient respondents for statistical modelling

## Table 2 **Summary of qualitative indicators tracked**

*Knowledge of gatekeepers about harms of child marriage and teenage pregnancy*
In line with base- and mid-line findings, gatekeepers were very much aware of the harms of child marriage and teenage pregnancy. Participants spoke about several problems in relation to teenage pregnancy, including sexually transmitted infections and HIV, child marriage, gender-based violence, (unsafe) abortion and economic hardship. Others spoke about how child marriage truncates girls education and future prospects.

*Attitudes and actions of gate keepers to prevent child marriage and teenage pregnancy*
Similar to the baseline, and in line with the midline findings, participants generally had positive attitudes towards the prevention of child marriage and teenage pregnancy, largely informed by gatekeepers' continued appreciation of the harmful effects of the two events on the life of young girls. Participants referred to various bylaws that have been instituted and are being enforced (more in Chadiza than in Petauke). The bylaws included punishments in relation to teenage pregnancy, e.g., moulding bricks for making a girl pregnant or having the parents paying a cow. Participants also spoke about how stakeholders were implementing various activities to prevent child marriage, including the social welfare department sponsoring girls to stay in school. Others, like religious leaders and teachers, preferred preaching abstinence as a solution to teenage pregnancy, which does not seem to work. However, the issues of church gatherings leading to teenage pregnancy and teacher-student sexual relationships did not come up strongly in the end-line interviews, compared to the baseline.

*Youth who feel they can advocate for themselves*
Relative to the baseline, it seems there are some observed changes to young people's agency and capacity to speak out. Some participants spoke about improvements in intergenerational communication, others said it was still difficult to discuss issues with adults. A conservative culture remains and young peoples' self-expression is mostly shaped by their outward appearance (mode of dressing, responding to greetings), and hardly by contributing in for example community meetings, which seems to limit self-expression and agency.

*Current access to SRHR information by girls/ young women and boys/ young men (15 to 24 years)*
Young peoples' access to information remains relatively high as it was at base- and mid-line. Teachers and health workers remain the main sources of SRHR information, but young participants also reported to have accessed information from churches, parents, grandparents and their friends in the community. Similar to the baseline, they reported that young people accessed information from elders who are more open to listen to them. With such elders, they were free and comfortable to ask them questions on SRHR. However, the quality and comprehensiveness of the information they get remain limited - more tilted towards moral and authoritative instructions. Regarding services, the end-line results show that girls, boys, women and men have more access to (youth friendly and free) SRH services at health facilities compared to baseline. Young people particularly mentioned to access voluntary counselling and testing, condoms and contraceptives. It was reported that nowadays, pregnant teenagers were more welcomed at health facilities and provided with services. However, some mission health facilities do not offer family planning services.

*Perceived autonomy of girls/ young women (15-24 years)*
Similar to base- and mid-line findings, perceived autonomy of girls did not come up strongly in the interviews and discussions at end-line. It seems social and gender norms continue to undermine girls' autonomy as also indicated by the quantitative findings. However, girls did report autonomy in dating, and selected (sexual) partners to be able to receive money or goods, similar to base- and midline.

*Girls indicating safety in and out of school is a problem*
Relative to base- and midline findings, school safety does not seem to a big issue - girls and boys reported to walk freely to and from school, largely due to a general improvement in school infrastructure, which goes beyond the scope of the Yes I Do programme. However, some participants indicated that teacher-students sexual relationships remain an issue. The issue of self-boarding leading to teenage pregnancy came up in a few interviews.

*Number of new or adjusted national and local laws (incl. bylaws) and policies prohibiting child marriage*
One bylaw. Similar to the baseline, participants spoke about bylaws and national laws and policies being enforced to prevent child marriage and reduce teenage pregnancy, but it is hard to put numbers to these laws and policies. However, in both districts, a bylaw was adopted, which took place after midline.

*Policy makers actively/openly supporting gender equality and girls rights*
Relative to the baseline, the end-line data show that the prevention of teenage has been promoted through the development and implementation of bylaws. These bylaws, which were more prominent in Chadiza than in Petauke, prescribed punishments for young girls who got pregnant, her parents and the man responsible for the pregnancy. Other participants spoke about child marriage cases now frequently being reported to the police. In particular, a parent in Petauke, referred to the national laws and the victim support unit of the police service that helps girls when they are forced to marry by their parents. Local policy makers thus do focus on child marriage and teenage pregnancy, but it is less obvious that they particularly focus on gender equality and girls' rights (root causes of child marriage and teenage pregnancy).

*Active engagement of men and boys in strategies reducing child marriage and teenage pregnancy*
Different from the baseline but similar to the midline, there was evidence of active engagement of men and boys in strategies to reduce teenage pregnancy and child marriage. In particular, the Champions of Change intervention seems to have positively engaged male youth who were advocating for girls' rights.

# 1. Introduction

## 1.1 BACKGROUND

### 1.1.1 CHILD MARRIAGE AND TEENAGE PREGNANCY IN ZAMBIA

Zambia practices a dual legal system—customary law that regulates customary law marriage and statutory law that regulates statutory law marriage. The customary norms vary among different ethnic groups, but there are some core conditions for a valid marriage, including girls' attainment of puberty, followed by the appropriate initiation ceremonies, parental or guardian consent, negotiations and exchange of lobola (bride-price or dowry) and an act of specific rituals symbolising marriage, e.g. a wedding (Munshya, 2017). In statutory law, marriage is regulated by the Marriage Act. To marry, one has to be at least 21 years. A person below 21 years needs parental consent to marry, but the law does not specify the threshold below 21 years at which consent from parents is not acceptable. The law also allows a high-court judge to consent that a child below the age of 16 can be married. There is a conflict in law where the statutory law prohibits sexual intercourse with a person below the age of 16 and classifies it as an offense called "defilement" (Section 138 of the Penal Code), and yet recognizes marriage below 16 years with consent from parents or a high-court judge. In addition, for customary law, age is irrelevant. In 2016, the government of Zambia adopted a national strategy on ending child marriage, accompanied by a costed national action plan, aiming to achieve a 40% reduction of child marriage by 2021. One of the objectives of this strategy is to develop end review policies and legislations to ensure consistent interpretation of child-related interventions (Government of Zambia – Ministry of gender, 2016).

Child marriage affects both young women and men although the practice is more prevalent among young women. According to the Zambian Demographic Health Survey (ZDHS) 2013-2014, marriage also includes living with partners in a consensual but informal union. The percentage of married women increases sharply from 17% among women aged 15-19 years to 79% among women aged 30-34 years. Among men, the percentage of those married also steeply increases from 22% at age 20-24 years to 91% at age 45-49 years (CSO, 2014). The ZDHS 2018 shows that one in seven (15%) female adolescents (15-19 years) are married (or in union) compared to only 1% of their male counterparts. The percentage of adolescents who have begun childbearing ranges from 6% among those aged 15 years to 53% among those aged 19 years. Furthermore, it shows that 21.5% of married girls (15-19 years) have an unmet need for family planning (Zambia Statistics Agency, 2019). Various factors have been cited for making children vulnerable to marriage in Zambia. These factors include age at first sex, region of residence, education level, family size and poverty (Mulenga et al., 2018).

Recent data also show a high rate of teenage pregnancy at 29%. The median age at first birth among women aged 20-49 years is 19.2 years and the percentage of women aged 15-19 years who have begun childbearing increases with age, from 6% among those aged 15 years to 53% among those aged 19 years. The teenage pregnancy rate is higher in rural areas (37%) than in urban areas (19%) (Zambia Statistics Agency, 2019).

According to the ZDHS 2018, injectables are the most common method of contraception at 26% among currently married women in Zambia, followed by implants and the pill (8% each) and male condoms (3%). However, only 40% of young people report regular condom use. The modern contraceptive prevalence rate is only 10% among adolescent girls (15-19 years), despite the rate having been estimated to have increased from 33% to 45% in the general population (Zambia Statistics Agency, 2019). This, therefore, puts adolescents at an increased risk of unintended pregnancies, HIV, and other sexually transmitted infections (STIs).

Both teenage pregnancy and child marriage are complexly interrelated and have common causes and drivers. Poverty, gender inequality, cultural customs and traditions, lack of education and economic opportunities, and lack of access to sexual reproductive health (SRH) information and services have been identified as contributing factors to the high prevalence of child marriage and teenage pregnancy (CSO, 2014).

### 1.1.2 SUMMARY OF YES I DO PROGRAMME AND ACTIVITIES

The Yes I Do programme aims to contribute to enhancing young women´s decision-making space on whether, when and whom to marry as well as on whether, when and with whom to have children. The programme's theory of change (Annex 1) has five strategic goals:

1. Community members, gatekeepers and other stakeholders have changed attitudes and take action to prevent child marriage and teenage pregnancy.
2. Young women and men are meaningfully engaged to claim their sexual and reproductive health and rights (SRHR).
3. Young women and men take informed action on their sexual health.
4. Young women 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.

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

Many activities (that cover the five intervention strategies) have taken place in selected wards in Chadiza and Petauke districts, the implementation districts in Zambia. These activities included community sensitisations, including a variety of gatekeepers[1], on negative effects of child marriage and teenage pregnancy, the facilitation of the development of bylaws at community level, supporting the government to make public health facilities youth friendly, establishment of youth peer groups or clubs, such as the Champions of Change focusing on gender equality, provision of SRHR information and education in and out of schools, and the establishment of village saving loan initiatives, amongst others.

### 1.2 AIM AND OBJECTIVES OF BASE-, MID- AND END-LINE STUDY

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 areas of the Yes I Do programme 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 interventions 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.
The specific study objectives were:

1. To explore (changes in) attitudes of community members and gate keepers 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; over a period of four years in Yes I Do intervention areas in Chadiza and Petauke.
2. To determine (changes in) the level of meaningful engagement of adolescent girls and boys in community activities, programmes and policies – thereby claiming their rights - and which factors influence this and how; over a period of four years in intervention areas in Chadiza and Petauke.
3. To explore the factors that influence adolescents in taking informed action on their sexual and reproductive health over a period of four years in intervention areas in Chadiza and Petauke.
4. To explore how education and economic empowerment of girls provide them with alternatives beyond child marriage and teenage pregnancy after five years in intervention areas in Chadiza and Petauke.
5. To provide insight into (changes in) developed and implemented laws and policies on child marriage and teenage pregnancy over a period of five years; and
6. To contribute to the evidence on effective and context specific intervention strategies to eliminate child marriage and reduce teenage pregnancy.

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

# 2. Methodology

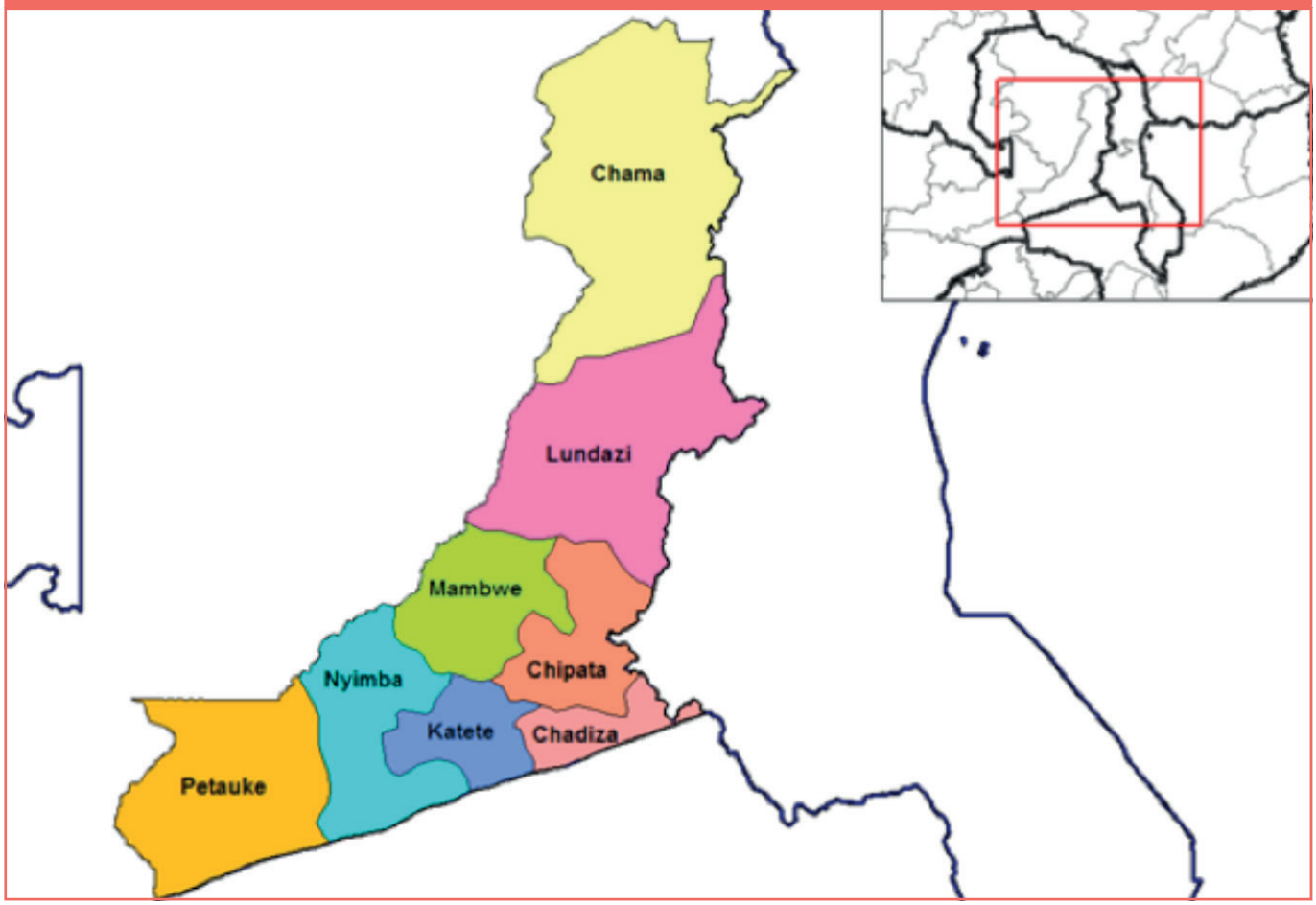
## 2.1 STUDY TYPE

The study adopted a mixed-methods design. A household survey was administered among young women and men (15-24 years) at base- and end-line. Focus group discussions (FGDs), semi-structured and in-depth interviews (IDIs), and key informant interviews (KIIs) with various stakeholders were held at base-, (September 2016), mid-, (May 2018) and end-line (October 2020).

## 2.2 STUDY AREAS

This study was conducted in the Eastern Province, more specifically in selected wards in Chadiza and Petauke districts (Figure 1), were the Yes I Do programme was implemented. At baseline, the research team visited randomly selected villages, while at end-line, data collection only took place in wards and villages where the programme had been implemented.

Figure 1 **Map of the Eastern province with the study districts Chadiza and Petauke**




## 2.3 STUDY METHODS, SAMPLING AND RECRUITMENT PROCEDURES

### 2.3.1 QUANTITATIVE COMPONENT

A total of 1,517 men and women between 15 and 24 years were included in the study, 708 at baseline and 809 at end-line (Table 3). The statistical justification for this sample size can be found in Annex 2, including a comparison of the

intended and achieved sample size. The study included more women (n=1,129) than men (n=388) as child marriage and teenage pregnancy primarily affect women. The sample was equally divided over Chadiza (n=758) and Petauke (n=759).

At baseline, a two-stage cluster sampling approach was used, which selected 32 standard enumeration areas (SEAs) with probability proportional to size, based on a list of SEAs that were going to be covered by the Yes I Do programme. In the second stage, 25 households were selected in each of the selected SEAs by applying a fixed interval based on the listing of households per SEA. At end-line, the two-stage cluster sampling approach was modified. The first stage consisted of drawing a random selection of 32 villages from a list of villages in the intervention districts, selection of villages was done proportional to village size. Within each village, 25 households were randomly selected by applying a fixed interval based on the number of households in the village.

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.

More female than male respondents were selected (75%-25%), which meant that in one out four households a young man was interviewed, and in three out of four, a young woman. If after three young women, the next selected household did not have a young man, the closest household with a young man available was identified. The data collection was conducted at a time that most young people were at home. The survey included questions on demographics, young people's SRHR (e.g., worries, desires, access to information and services), (teenage) pregnancy, child marriage, participation in decision-making and education and economic empowerment.

Table 3 **Overview of quantitative component**

| | Baseline | | | Endline | | |
|---|---|---|---|---|---|---|
| | **Chadiza** | **Petauke** | **Total** | **Chadiza** | **Petauke** | **Total** |
| Young women (15-24 years) | 272 (38.4%) | 244 (34.5%) | 516 (72.9%) | 301 (37.2%) | 312 (38.6%) | 613 (75.8%) |
| Young men (15-24 years) | 85 (12.0%) | 107 (15.1%) | 192 (27.1%) | 100 (12.4%) | 96 (11.9%) | 196 (24.2%) |
| Total | 357 (50.4%) | 351 (49.6%) | 708 (100%) | 401 (49.6%) | 408 (50.4%) | 809 (100%) |

### 2.3.2 QUALITATIVE COMPONENT

The qualitative part of the study included, besides young people (15-24 years), other population groups: parents and caregivers, grandmothers and elderly women, traditional and religious leaders, teachers, health and social or community development workers, community-based organization (CBO) staff, representatives from Plan Zambia and district-level policymakers (Table 4). All participants were selected with the assistance of community-level resource persons. Participants discussed their knowledge and perceptions on cultural norms and values, the causes and consequences of child marriage and teenage pregnancy, changes in experiences, feelings and opinions over time, and specific information on the effectiveness of interventions addressing child marriage and teenage pregnancy. The qualitative component was conducted at base-, mid- and end-line. At base- and end-line, it took place in Chadiza and Petauke, and at mid-line all FGDs and interviews took place in Petauke. The reason was that the operational research component focused on Chadiza (Zulu, Krugu and Kok, 2020).

| Table 4 **Overview of qualitative component** | | | |
|---|---|---|---|
| Methods and participants | Baseline | Midline | Endline |
| **Focus group discussions** | | | |
| 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 |
| | | | |
| | | | |
| **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 |
| Grandmothers or elderly women | 2 | 2 | 2 |
| Religious and traditional leaders | 2 | 2 | 4 |
| Teachers | 2 | 2 | 2 |
| Health and social workers | 2 | 2 | 2 |
| CBO and youth organization staff | 2 | 2 | 0 |
| **Key informant interviews** | | | |
| NGO staff | 2 | 5 | 1 |
| District-level policy makers | 2 | 2 | 1 |
| **Total number of interviews** | 34 | 37 | 31 |

## 2.4 DATA COLLECTION

For each of the data collection phases, data collection was carried out by a team of research assistants and two supervisors. Two research assistants solely focused on qualitative data collection. Field workers were recruited based on previous experience in similar research. They were trained for four days before each phase of data collection. The training covered both theory and practice of questionnaire design and administration by using a tablet, sampling, sources of bias, research ethics, interviewing techniques and general information about young people's SRHR, child marriage and teenage pregnancy. The overall purpose of the training was to familiarize the research assistants with the methodology and the research tools. The research workshops also included pretesting of the research tools in the field. All interviewers were instructed about the issue of sensitivity of questions during training and special emphasis was given on establishing reliable rapport and mutual trust before asking any sensitive questions.

## 2.5 DATA ANALYSIS

### 2.5.1 QUANTITATIVE COMPONENT

The quantitative data analysis was performed using Stata version 15. Data were checked and cleaned for outliers or inconsistencies before data analysis. The base- and end-line data were compiled in a single database for comparative analysis. Descriptive statistics were computed, disaggregated by timing of the survey (base- and end-line) and gender for all survey questions. An overview of these descriptive statistics can be made available upon request.

Logistic regression analysis was performed to assess changes over time using a 5% significance level. All models were adjusted for school attendance and age of the respondent due to the considerable difference in school attendance between base- and end-line, and a slightly older population at end-line. A description of the models can be found in Annex 3, including the results of all models (univariable and multivariable) presented with odd ratios, confidence intervals and p-values.

### 2.5.2 QUALITATIVE COMPONENT

For qualitative data, interviews and FGDs were digitally recorded, transcribed and, where applicable, at the same time translated into English and independently checked by someone not involved in transcribing. During data collection, daily review meetings were held to identify emerging themes, completeness of work and inconsistencies coming out of the work. For the qualitative analysis, content analysis of the data was carried out using a comprehensive thematic matrix, based on the topic guides and the theory of change. End-line results were compared with qualitative results from the base- and mid-line (Menon et al., 2016; Menon et al., 2018b). The quotes presented in this report are only from the end-line. NVivo software was used to support the analysis of the data.

All results from the above-described components were further assessed by the authors of this report during an online data analysis workshop from the 16th to the 20th November, 2020. While at base- and end-line, this process took place in-county in presence of the full research teams (including research assistants), this was not possible at end-line in the light of the COVID-19 pandemic.

## 2.6 QUALITY ASSURANCE

The tools were translated and pre-tested before data collection started. The national researcher with the support from two supervisors monitored data quality during the whole research process. During field work, the research team met on a daily basis to discuss any difficulties arising during interviews which could have possibly affected the quality of the data collected. Regular quality assurance discussions were conducted to ensure that any issues were addressed as soon as possible. Clear standard operating procedures in the form of a field protocol, data management plan and statistical analysis plan were put in place to guide data collection, analysis and reporting. The end-line report underwent various rounds of peer-review. At base- and midline, data validation workshops were conducted. However, this was not done at end-line (at district and community level) because of the COVID-19 pandemic.

## 2.7 ETHICAL CONSIDERATIONS

Ethical clearance was obtained from the ethical review committee of KIT, the Netherlands, and the ERES Converge Institutional Review Board in Zambia. Further permission was obtained from the National Health Research Authority. Informed consent was obtained from participants, and voluntary participation and confidentiality were upheld. Informed consent was obtained from parents or caregivers when study participants were below the age of 16. The participants of the survey and qualitative interviews were compensated through refreshment allowance and the FGD participants were reimbursed with a transport allowance. At end-line, COVID-19 prevention measures such as social distancing, mask wearing and hand washing were taken into account when conducting interviews.

# 3. Results

## 3.1 CHARACTERISTICS OF STUDY POPULATION

A total of 708 respondents were surveyed at baseline and 809 at end-line. At district level, 357 respondents in Chadiza and 351 in Petauke were surveyed at baseline, while 401 respondents in Chadiza and 408 in Petauke were surveyed at end-line. As per the sampling design, approximately 75% of the survey respondents were females. In both districts, over 90% of the respondents at both base- and endline were Christians. The majority of the respondents in Chadiza belonged to the Chewa ethnic group (74% at baseline; 87% at end-line) and respondents in Petauke were mostly of the Nsenga ethic group (83% at baseline; 94% at end-line). Over the four years' time span, the percentage of respondents who were married saw a slight increase in both districts, and more people were married in Petauke as compared to Chadiza at base- and end-line. In both districts, the percentage of respondents who indicated to have a boy- or girlfriend was higher at end-line as compared to baseline. Thirty-seven percent (37%) of all end-line respondents ever participated in the Yes I Do programme, more so in Chadiza than in Petauke (Table 5).

In Chadiza, 79% of the respondents were in school at baseline, as compared to 40% at end-line2. In Petauke, the in-school population remained stable: 40% at baseline and 41% at end-line. At baseline, among those who were in school, the majority were in primary school (33.5%) followed by junior secondary school (12%) and senior secondary (10%). Except for junior secondary school, there were reductions in the percentage of respondents currently attending the other educational levels, with primary school and senior secondary school registering 22% and 3% at end-line respectively.

In both districts, school dropout rate remained relatively high, with more respondents in Chadiza indicating to have ever dropped out of school at end-line (59%) compared to baseline (47%). In Petauke, the dropout rate was already much higher at baseline (61%) dropping slightly to 58% at end-line. The most common reasons for dropping out of school were lack of fees (baseline: 44%, end-line: 48%) for male and female respondents. For girls, pregnancy was another common reason for dropping out of school (baseline: 26%, end-line: 37%) (not shown in the table).

According to the respondents, about one third of their mothers (33% at baseline and 32% at end-line) and one fourth of their fathers (21% at baseline and 26% at end-line) had not received any education and a similar percentage received primary education. However, many respondents were not aware of mother's (baseline: 23%, end-line: 16%) or father's (baseline: 36%, end-line: 23%) education (not shown in the table).

Most respondents were not employed at baseline (92%), which saw a reduction at end-line (57%) (Table 5). At baseline, employed respondents were mainly doing unpaid work (homemaker/housewife) or subsistence farming. At end-line, most people worked in subsistence farming or informal trading, as casual labourers, being self-employed or unpaid work (homemaker/housewife). More females indicated to be in employment at end-line than at baseline, and they mostly worked as informal traders or in unpaid work.

Among households in both districts, the primary source of income came from agriculture (74% at baseline; 79% at end-line), petty trading (13%) and small business ownership (9%). In almost half of the households the father was the primary earner (49% at baseline and 48% at end-line), followed by the mother (14% at baseline and 19% at end-line). Male respondents indicated themselves as the primary earner more frequently (14% at baseline and 15% at end-line), while female respondents indicated their husband as the primary earner more frequently (baseline: 16%, end-line: 18%). An almost identical pattern can be discerned for the main decision-maker about spending money.

Most households were well exposed to media. At end-line, 65% of the households owned a mobile phone with internet and 41% owned a radio. Nonetheless, almost none of the respondents used internet as a source of media on a regular basis (1% at baseline as compared to 3% at end-line). The most commonly used source of media was the radio (68% at baseline, 63% at end-line).

| Table 5 **Demographic characteristics of survey respondents** | | | | | | |
|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | |
| | **Chadiza** | **Petauke** | **Total** | **Chadiza** | **Petauke** | **Total** |
| **Gender** | | | | | | |
| Female | 272 (76.2%) | 244 (69.5%) | 516 (72.9%) | 301 (75.1%) | 312 (76.5%) | 613 (75.8%) |
| Male | 85 (23.8%) | 107 (30.5%) | 192 (27.1%) | 100 (24.9%) | 96 (23.5%) | 196 (24.2%) |
| **Age** | | | | | | |
| 15-19 years[2] | 255 (71.4%) | 202 (57.5%) | 457 (64.5%) | 202 (50.4%) | 222 (54.4%) | 424 (52.4%) |
| 20-24 years | 102 (28.6%) | 149 (42.5%) | 251 (35.5%) | 199 (49.6%) | 186 (45.6%) | 385 (47.6%) |
| **Marital status** | | | | | | |
| Married (monogamous) | 42 (11.8%) | 67 (19.1%) | 109 (15.4%) | 58 (14.5%) | 104 (25.5%) | 162 (20.0%) |
| Unmarried (single) | 262 (73.4%) | 204 (58.1%) | 466 (65.8%) | 244 (60.8%) | 191 (46.8%) | 435 (53.8%) |
| Boy/girlfriend | 47 (13.2%) | 57 (16.2%) | 104 (14.7%) | 87 (21.7%) | 102 (25.0%) | 189 (23.4%) |
| Other | 6 (1.6%) | 23 (6.6%) | 29 (4.1%) | 12 (3.0%) | 11 (2.7%) | 23 (2.8%) |
| **Education** | | | | | | |
| In school[2] | 282 (79.0%) | 140 (39.9%) | 422 (59.6%) | 160 (39.9%) | 168 (41.2%) | 328 (40.5%) |
| Out of school | 75 (21.0%) | 211 (60.1%) | 286 (40.4%) | 241 (60.1%) | 240 (58.8%) | 481 (59.5%) |
| **Current level of education** | | | | | | |
| Primary | 159 (44.5%) | 78 (22.2%) | 237 (33.5%) | 81 (20.2%) | 95 (23.3%) | 176 (21.8%) |
| Junior secondary | 45 (12.6%) | 38 (10.8%) | 83 (11.7%) | 68 (17.0%) | 59 (14.5%) | 127 (15.7%) |
| Senior secondary | 51 (14.3%) | 19 (5.4%) | 70 (9.9%) | 11 (2.7%) | 14 (3.4%) | 25 (3.1%) |
| University | 1 (0.3%) | 1 (0.3%) | 2 (0.3%) | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) |
| Completed | 9 (2.5%) | 27 (7.7%) | 36 (5.1%) | 30 (7.5%) | 9 (2.2%) | 39 (4.8%) |
| Other | 26 (7.3%) | 4 (1.1%) | 30 (4.2%) | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) |
| No education | 28 (7.8%) | 31 (8.8%) | 59 (8.3%) | 16 (4.0%) | 77 (18.9%) | 93 (11.5%) |
| Not currently in school (dropped out/ stopped) | 38 (10.6%) | 153 (43.6%) | 191 (26.0%) | 195 (48.6%) | 154 (37.7%) | 349 (43.1%) |
| **Employment status** | | | | | | |
| Employed | 27 (7.6%) | 29 (8.3%) | 56 (7.9%) | 158 (39.4%) | 193 (47.3%) | 351 (43.4%) |
| Not employed | 330 (92.4%) | 322 (91.7%) | 652 (92.1%) | 243 (60.6%) | 215 (52.7%) | 458 (56.6%) |
| **Ethnicity** | | | | | | |
| Chewa | 264 (73.9%) | 31 (8.8%) | 295 (41.7%) | 350 (87.3%) | 6 (1.5%) | 356 (44.0%) |
| Nsenga | 7 (2.0%) | 290 (82.6%) | 297 (41.9%) | 6 (1.5%) | 383 (93.9%) | 389 (48.1%) |
| Other | 86 (24.1%) | 30 (8.5%) | 116 (16.4%) | 45 (11.2%) | 19 (4.6% | 64 (7.9%) |
| **Religion** | | | | | | |
| Christianity | 337 (94.4%) | 320 (91.2%) | 657 (92.8%) | 369 (92.0%) | 370 (90.7%) | 739 (91.3%) |
| Other | 20 (5.6%) | 31 (8.8%) | 51 (7.2%) | 32 (8.0%) | 38 (9.3%) | 70 (8.7%) |

2 At baseline, respondents in Chadiza were much younger and school attendance was higher. Therefore, all statistical models are adjusted for school attendance and age due to the large differences in these population characteristics between base- and end-line in Chadiza.

| | | | | | | |
|---|---|---|---|---|---|---|
| **Knowledge of the Yes I Do programme** | | | | | | |
| Yes | NA | NA | NA | 319 (79.6%) | 141 (35.6%) | 460 (56.9%) |
| No | NA | NA | NA | 80 (20.0%) | 267 (65.4%) | 347 (42.9%) |
| **Ever participated in the Yes I Do programme** | | | | | | |
| Yes | NA | NA | NA | 216 (53.9%) | 83 (20.3%) | 299 (37.0%) |
| No | NA | NA | NA | 185 (46.1%) | 325 (79.7%) | 510 (63.0%) |
| **TOTAL** | 357 (100%) | 351 (100%) | 708 (100%) | 401 (100%) | 408 (100%) | 809 (100%) |

The main participants of the qualitative component comprised of girls and boys (15-19 years), young women and young men (20-24 years), and female and male parents or caregivers. The young people that we spoke to had a mix in education background and marital status; and part of them had children, others not. Some young women had experience with a teenage pregnancy, and some young men had experience with making a teenage girl pregnant. Community leaders including religious leaders and chiefs, teachers and health workers were also included in the study. Key stakeholders relevant to the study were policy makers in the decentralized sectors of health and education as well as non-governmental organizations (NGOs) working in the study areas (Table 4).

## 3.2 COMMUNITY CONTEXT AND MOBILISATION

### 3.2.1 SOCIAL, CULTURAL AND GENDER NORMS

The quantitative data indicate that household chores such as cooking, cleaning and childcare are largely performed by female household members. According to female respondents, most of the cooking, cleaning and childcare is done by themselves (baseline: 75%, end-line: 62%) or by their mothers (baseline: 33.5%, end-line: 30%). However, in both instances, the female respondents reported a reduction of household responsibilities by females. Similarly, most male respondents reported a reduction of female household responsibilities, indicating at baseline that their mother (67%) or sister (28%) were responsible for most of the cooking, cleaning and childcare at home as compared to 52% and 19% at end-line respectively. Male respondents' performance of household responsibilities recorded a slight change from 10% at baseline to 11% at end-line. When asked how many hours of cooking, cleaning and childcare they personally do per day on average, most female respondents indicated three hours at baseline (25%) as compared to two hours at end-line (26%), although a good number still did household chores for three hours (16%) at end-line. Together, the responses suggest a slight improvement in the sharing of household chores among males and females at end-line as compared to baseline. Regarding decision-making about household resources, the results also suggest a slight increase in women participation in decision-making about spending money, albeit it is still largely dominated by the men. Most respondents reported that decisions about spending money are made by fathers (females – baseline: 43%, end-line: 47.5% and males – baseline: 64%, end-line: 54%) or by their mothers (females - baseline: 17%, end-line: 21% and males – baseline: 13%, end-line: 20%).

The qualitative narratives show that social and gender norms surrounding the expectations towards girls and boys have not changed much compared to the baseline situation. In general, girls are expected to perform household chores and boys are expected to do work outside the house, respondents frequently referred to activities such as gardening or moulding of bricks. Meeting these gendered expectations defines one as a good boy or a good girl, which was also the case at baseline. In addition, there seem to be high expectations of discipline and respect that shape the relationship between young people and their important reference adults such as parents and teachers. This expectation of respect influences communication between young people and their elders, making it difficult to communicate sensitive issues including sexuality topics. Participants explained that boys and girls are required to demonstrate a respectful conduct through their mode of dressing and how they respond to greetings and advice from adults; underpinned by the norm to follow instructions from parents and elders. Like the baseline situation, it seems these social norms are still determining young people self-expressions and autonomy in decision-making.

> *"Ooh yes very much, a good boy needs to know men jobs such as thatching the house, moulding bricks, construction of houses, gardening and many other good men jobs... The same applies to a girl. She is supposed to sleep with a problem on how she will do her chores in the morning such as fetching water, washing plates and sweeping surroundings. These are the signs that she is a good girl and hard working."*
> (IDI with a headman, Chadiza)

However, when asked about any changes that they have observed and that can be attributed to the Yes I Do programme, some participants gave examples where household chores are increasingly becoming a shared responsibility of both boys and girls, which seems to confirm the small changes observed in the quantitative findings.

> *"Again, in terms of gender equality, nowadays boys and girls are sharing housework such as cooking, sweeping."* (IDI with a 20-year-old man, Chadiza)

> *"Aahh, sometime back you find that a boy can't go and fetch water, wash plates, cook but now boys we saw them cooking, fetching water, washing plates…"* (IDI with a church leader, Petauke)

At both base- and end-line, survey respondents were asked whether they agreed with the statement 'A wife should be subservient to her husband'. The level of agreement was high at baseline (79.5%) as well as at end-line (71%). The level of disagreement with this statement went up by 3%, from 16% at baseline to 19% at end-line. Other respondents indicated to be neutral or not to know what to answer. Survey respondents were also asked whether they agreed with the statement 'Men should be the heads of their household'. Most respondents agreed with this statement at baseline (96%), but the level of agreement went down at end-line: 74%. Although the majority of the young people agreed with the statement at end-line, the results could imply that more young people thought that men should not always be necessarily the head of their household at end-line, as compared to the baseline.

Similar to the baseline, most participants thought that both child marriage and teenage pregnancy have hardly any benefits. However, they were both existing in the community (especially teenage pregnancy), and the reasons for this are further outlined in Sections 3.5 and 3.6. Some participants believed that teenage pregnancy and child marriage were reducing, relative to the baseline situation, and one teacher cited Plan Zambia's contribution to the positive changes. A headman also spoke about positive changes in the incidence of gender-based violence (GBV), explaining that a traditional court system had led to a reduction in GBV cases in the community.

> *"Compared to the past, we have seen a change, especially with the coming of Plan International. They have held a lot of sensitization workshops with the community and even with the teachers… and we are beginning to see that girls are not marrying too early."* (IDI with a teacher, Chadiza)

> *"Since we started our traditional court sessions, we are very happy that the cases of gender-based violence are reducing because they are fearing the charges which we usually give to the man who is doing that."* (IDI with a headman, Petauke)

Other participants, on the other hand, indicated to have seen no changes. Participants explained that there are no changes regarding safe spaces for girls and boys to participate in discussions on issues affecting them. Other young women also spoke about how young men continue to engage in multiple sexual relationships, contributing to STIs. A young man in Petauke reported that community meetings to discuss about important issues were not frequently taking place:

> *"Aaaah but there is no change. There is no proper cooperation here in this village. So it is usually even very difficult to just hold a meeting. Very few boys would be there."* (IDI with a 22-year-old man, Petauke)

### 3.2.2 RELIGION

The narratives show a mixed perspective on the role of religious leaders. For some participants, religious leaders are doing enough to address teenage pregnancy and child marriage, relative to their role at baseline, partly because of their enhanced knowledge of the adverse effects of such events on the prospects of young people and partly in the interest of morality. Participants frequently referred to how religious leaders are sensitizing their members on child marriage, including teaching parents on how to advise their children.

*"Aahh, church leaders from different churches are also helping to stop early marriages, they teach parents to advise their children because parents are the ones that can decide what should be done to his or her child."*
(IDI with a 19-year-old woman, Chadiza)

On the other hand, some participants believed that the role of religious leaders in addressing child marriage and teenage pregnancy is as limited as it was at baseline. While some shared that religious leaders are only interested in moral teachings, others bemoaned the practice where church leaders allow under-aged marriages in their churches.

*"But on the part of the religious leaders I feel they are not doing enough. You may say they are trying to protect them but I also blame them. You will find that I will get a young girl and go with her to the church to wed her. But they cannot manage to ask you to go back home, instead they will wed that wedding. So for the church leaders it is not easy for them to defend certain things very well."*
(IDI with a 22-year-old man, Petauke)

Yet interviews with two religious leaders themselves gave a different picture at end-line. Not only did they say that they are actively campaigning against child marriage and teenage pregnancy, but one leader indicated that they will not allow under-age marriages in the church.

*"Aahh, we don't allowed to make a family under 18 years… because when they go to the hospital for delivery it becomes so difficult for her to deliver because she is young, as a result she must undergo an operation that as a church we say no to witness such issues."* (IDI with a church leader, Petauke)

Some study participants acknowledged that by engaging young people in various church activities, they take their minds off from delinquent activities. Others spoke about mission hospitals refusing to offer family planning services due to doctrinal reasons (see section 3.4.5).

### 3.2.3 ROLE OF GATEKEEPERS

From the qualitative narratives, Plan Zambia, also referred to as Plan International, was recognized as a strong player in the prevention of child marriage and teenage pregnancy and promoting girls' education in the study areas. It is obvious that relative to the baseline, the Yes I Do alliance partners, often collectively referred to as Plan Zambia or Plan International, had increased recognition and visibility. Plan Zambia was repeatedly mentioned in providing information to the community on the harmful consequences of child marriage and teenage pregnancy. Some participants were clear that there are positive changes regarding issues faced by young people because 'Plan International has helped the youth to know their rights and responsibilities'. Other participants also spoke about how Plan, through the formation of youth clubs, educated them to understand the impact of child marriage and teenage pregnancy on their future prospects. It seems the number of NGOs operating in the study areas are very limited and besides Plan, participants only mentioned Keep Girls in School, an NGO that seems to have in played a crucial role in helping teenage mothers return to school in Petauke.

*"Aahh in terms of understanding it is going just very well so I must thank Plan Zambia International because they really helping for sending their agents to us to give us awareness. So now there is really a change because when early marriages happen, girls are being flashed out and get back to schools."*
(IDI with a church leader, Petauke)

*"There is also the Keep Girls in School organization which is there to help the girls, those who got pregnant early but they still want to go to school and get educated, as sometimes their parents stop paying their school fees because of the pregnancy they had acquired."*
(FGD, boys 16-18 years, Petauke)

On the other hand, other participants spoke about how Plan Zambia was helpful to them in the past and gave the impression that Plan had stopped implementing projects in their communities. They bemoaned how Plan's departure can reverse progress made towards the prevention of teenage pregnancy and stopping child marriage. Others also

linked Plan's departure to the function of the chiefs, explaining that without the support of stakeholders like Plan, the chiefs are unable to perform their role in addressing the SRH issues affecting young people.

> *"… it is difficult for us in this area because Plan Zambia was the only organization which was working with youths in our area but now since it is no more here it is very difficult for us as youths."* (FGD young men 20-24 years, Chadiza)

> *"Ah like chiefs when Plan Zambia was still in, a lot was happening because chiefs and stakeholders where working hand in hand but now since there is no any stakeholders working with them, I think they are doing nothing…"* (FGD young men 20-24 years, Petauke)

The role of teachers has been extensively described in section 3.4.3, highlighting their delivery of sex education in schools and how they are more inclined to exhort young people to abstain from sex than to teach comprehensive knowledge and skills regarding the use of contraceptives. The role of traditional leaders (chiefs, headmen) has been described in different sections throughout the results chapter (see sections 3.5.3, 3.6.7 and 3.8.2). Most importantly, traditional leaders have taken various actions, including the development and implementation of bylaws to prevent teenage pregnancy and end child marriage. The bylaws, which seems to be more prominent in Chadiza than in Petauke, prescribe punishments for all actors involved in a teenage pregnancy – the young girl who got pregnant, her parents and the man responsible for the pregnancy. The narrative also shows that, compared to the baseline, health workers are more accommodative of young people seeking SRH services, which has led to more young people accessing services. However, long distances to health facilities and related costs remain barriers to accessing services (see section 3.4.5). Parents' roles also run through the results chapter, but in section 3.4.3 in particular, the role in parents in expanding access to SRHR information at home has been outlined. It seems that gradually, more parents and grandparents are standing up to the challenge of providing SRHR information to their children at home.

## 3.3 YOUTH ENGAGEMENT

### 3.3.1 YOUTH ENGAGEMENT AND EMPOWERMENT

The survey results indicate that 55.5% of the female and 61% of the male respondents were aware of the Yes I Do programme. Most females participated in community dialogues (71%), followed by Champions of Change (CoC) activities (23%) and youth club activities (12%). Similarly, most males participated in community dialogues (65%), CoC activities (47%) or youth clubs (36.5%). The majority of those who participated in the Yes I Do programme activities found community dialogues (females 72%, males 68%) and CoCs activities most beneficial (females 24%, males 49%). The survey respondents found 'prevention of pregnancy and contraception' (females and males 60%) and 'child marriage' (females 59%, males 62%) the most useful topics to learn about, with the least useful topics being 'entrepreneurship' and 'meaningful youth participation' (see also section 3.4.3).

Similar to the baseline, it seems that the social norm defining young people's respectful conduct imposes limitations on their participation in decision-making. However, many participants spoke about observed changes regarding decision-making and youth participation in communal activities. Some participants indicated that youth participation in decision-making, in particular, discussions with parents and elders has contributed to a reduction in child marriage.

> *"Ooh, yes, these days youths are actively involved in village programmes leadership and responsibility, a good number are now taking part in decision-making."* (IDI with a headman, Chadiza)

> *"Change is there because education has advanced. Because you could find that in 2016 or before there were a lot of early marriages. But because of continued discussions with parents and elders these cases in the recent years have reduced."* (FGD, young men 20-22 years, Petauke)

### 3.3.2 DISCUSSING SENSITIVE ISSUES AND INTER-GENERATIONAL COMMUNICATION

The quantitative data show that young people are generally more confident in discussing topics such as gender equality and girl's rights with people of their own age and gender. At end-line, females were more comfortable discussing gender equality and girl's rights with their female age mates (37%), followed by their male age mates (29.5%), adult women (26%) and adult men (15%). Males on the other hand, felt more confident discussing these topics with their male age mates (61%), followed by their female age mates (52%), adult men (33%) and adult women (25%). A considerable number of females did not feel confident at all discussing such topics with adult men (60%) or adult women (44%) or their male age mates (40%).

There is a statistically significant reduction in the percentage of youth who find it easy to discuss sexuality and marriage with their parents over time (OR=0.53, p-value<0.001). At baseline, 38% of all respondents found it easy to talk to their parents on the topic of sexuality, as compared to 24% at end-line. Females found it easier to talk to parents about sexuality than males. The percentage of respondents who found it easy to talk to their parents about marriage went slightly down, from 36% at baseline to 33% at end-line. Again, females found it easier to talk with parents about marriage than males (Table 6).

Table 6 **Easiness of talking about sexuality and marriage with parents**

| **Youth (15-24 years) who find it easy to talk to their parents about sexuality and marriage** | Baseline | | | Endline | | |
|---|---|---|---|---|---|---|
| | **Females** | **Males** | **Total** | **Females** | **Males** | **Total** |
| **Sexuality** | 224 (43.4%) | 43 (22.4%) | 267 (37.7%) | 161 (26.3%) | 35 (17.9%) | 196 (24.2%) |
| **Marriage** | 220 (42.6%) | 36 (18.8%) | 256 (36.2%) | 209 (34.1%) | 60 (30.6%) | 269 (33.3%) |

Relative to the baseline and contrary to the survey findings, the end-line qualitative narratives suggest a mixed situation where some participants spoke about a more open space for communication between young people and their elders. Positive changes were informed by some young people's enhanced agency to speak to adults regarding sensitive issues and parents' renewed interest in their children education.

> *"So far the communication among adults and young people is great. Nowadays young people discuss a lot of issues with their parents, grandparents and even uncles and aunties."* (IDI with a parent, Petauke)

> *"Yes we are communicating with elderly, they teach us and advise about all kinds of stuff like sexual intercourse, staying away from beer drinking so that we can have a better future."*
> (FGD young men 20-24 years, Chadiza)

On the other hand, many young people did not feel they can talk to adults about sensitive issues. Some participants described situations similar to that of the baseline, where intergenerational communication is defined by respect for the elderly and moral, authoritative instruction towards young people remain the norm. They explained that young people are expected to show respect by not speaking out, even when they know that the adults are wrong.

> *"When an elderly person calls us we need to kneel down to show respect and we wait until what he or she wants to say. If what elders are saying is not good we keep quiet because when you answer you show disrespect."* (FGD, young women 20-24 years, Chadiza)

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

### 3.4.1 YOUNG PEOPLE'S DISCUSSIONS, WORRIES AND ISSUES FACED WITH REGARD TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

*Young people discussing about sexual and reproductive health and other issues in life*

Survey respondents were asked whether they have a person to talk to about feelings or worries. Those who answered 'yes' are presented in Table 7. The percentage of young people who said that they have a person to talk to has increased over time, and this increase was mainly because at end-line, more boys and young men indicated that they have a person to talk to as compared to baseline. Overall, there is a statistically significant increase in the odds of having someone to talk to over time among male respondents (OR=4.6, p-value<0.001), but no change is observed among female respondents (OR=1.1, p-value=0.583). At end-line, among the female respondents who indicated that they have someone to talk to about feelings or worries, mothers (31%) and sisters (29%) were mostly referred to, while among the male respondents, these were brothers (25%), grandfathers or grandmothers (19%) and fathers (16%).

Table 7 **Youth having someone at home to talk to about their feelings, hopes or worries**

| Youth who have someone at home with whom they can talk to about feelings, hopes or worries | Baseline | | | Endline | | |
|---|---|---|---|---|---|---|
| | **Chadiza** | **Petauke** | **Total** | **Chadiza** | **Petauke** | **Total** |
| Young women (15-24 years) | 202 (74.3%) | 146 (59.8%) | 348 (67.4%) | 226 (75.1%) | 197 (63.1%) | 423 (69.0%) |
| Young men (15-24 years) | 36 (42.4%) | 28 (26.2%) | 64 (33.3%) | 65 (65.0%) | 69 (71.9%) | 134 (68.4%) |
| Total | 238 (66.7%) | 174 (49.6%) | 412 (58.2%) | 291 (72.6%) | 266 (65.2%) | 557 (68.9%) |

Survey respondents were also asked whether they had ever discussed about certain topics with their family and friends. The topics were marriage, dating and relationships, how to prevent pregnancies, what it means to be circumcised (for boys only), what it means to be out of school, questions about sexuality and sexual health, and hopes and fears about the future. At end-line, looking at discussions with family, the topics that were most mentioned to be discussed were hopes and fears about the future (70%) and what it means to be out of school (70%). The percentage of males discussing these topics with their family was higher than the percentage of females. The topic that was least discussed with family was dating and relationships (29.5%; 29% for females and 32% for males). For all the topics, the percentages of respondents who talked about them with friends were higher than the percentages of respondents who talked about them with the family. The majority of the survey respondents indicated to talk with their friends about how to prevent pregnancy (78%), hopes and fears about the future (77%), what is means to be out of school (75%), questions about sexuality and sexual health (73%), dating and relationship (72%) and marriage (62%). Eighty-two percent (82%) of the male respondents said to talk with friends about circumcision. On the other topics, the percentages of male respondents talking with friends were higher than the percentages of females talking with friends.

*Young people's worries*

The survey also asked about young people's worries. The most important worry was becoming pregnant or early impregnation (42% at end-line, while this was 35% at baseline). Many respondents were also worried about dropping out of school. At baseline, 41% of the respondents were worried about this and at end-line, the percentage was 42%. Being worried about becoming an early bride or groom was mentioned by 32.5% of the respondents at baseline and 41% of the respondents at end-line. The increasing trends on being worried about both teenage pregnancy and child marriage, for both female and male respondents, could indicate a raise in awareness on these topics among youth people. In relation to marriage, 33% of the respondents at end-line indicated to be worried about being worth a bride

price/ dowry only, and this did not change much over time, as the baseline percentage was 36%. However, at baseline, more females were worried about this and at end-line, more males were worried about this, which is unexpected. The percentage of respondents who were worried about being unable to decide who to date went down from 55% at baseline to 37% at end-line. With regard to 'being denied access to contraceptives', the percentage of respondents with worries went up: from 28% at baseline to 38% at end-line. For the two latter issues of worry, again, at baseline more females were worried, while at end-line more males were worried. It might be that males became more aware about possible limitations relating to dating and accessing contraceptives.

*Sexual and reproductive health issues faced by young people*
Participants in the qualitative study component reported to face similar issues related to SRHR as compared to the baseline. The focus lied on early sexual relations, which resulted in several problems, such as teenage pregnancy, STIs and HIV, and related to these, child marriage, GBV, (unsafe) abortion and economic hardship. One married 21-year-old male participant in Chadiza summarized it as follows:

> *"Aah, well, young boys and girls are facing a lot of challenges when engaging themselves in sexual activities, mainly when they are not engaged in any economics and sports activities. Here boys form groups and start looking for girls in nearby villages and within some time, as a result of engaging themselves in sexual relationships, many boys and girls have ended up into early marriages, teenage pregnancies, poverty, ignorance and a lot of economics hardships. In other words, a good number of young people are poor. Some have even been infected with HIV/AIDS and STIs. Aah, apart from what I said, girls are also aborting early pregnancies which results into health problems among young girls; and also infant mortality rates are high in our communities as a result of young people engaging into early sexual activities."*

The consequences of teenage pregnancy were often mentioned by study participants, and mainly focus on economic hardship for the girl and her family, and not being able to provide for the baby. Problems with delivery were also often referred to. More information about this can be found in section 3.5.2.

A few participants mentioned abortion, which the girl would choose to do to avoid shame in the community and to avoid dropping out of school. One participant, in an FGD with young women (15-18 years) in Chadiza, reported that pregnant girls could go to a witch doctor for traditional medicines in the form of charms to remove the pregnancy.

### 3.4.2 SEXUAL BEHAVIOUR

Table 8 shows the numbers and percentages of female and male respondents who indicated that they ever engaged in sexual activity (such as petting, kissing) and sexual intercourse at end-line (this was not asked for at baseline). It can be seen that the majority of the respondents had experience with both, with males having more experience than females.

Table 8 **Engagement in sexual activity and intercourse at end-line**

| | Endline | |
|---|---|---|
| | **Sexual activity (petting, kissing etc.)** | **Sexual intercourse (penetrative)** |
| Young women (15-24 years) | 423 (69.0%) | 456 (75.9%) |
| Young men (15-24 years) | 177 (90.3%) | 182 (92.9%) |
| Total | 600 (74.2%) | 647 (80.0%) |

Table 9 further indicates that the average age of first sexuality activity was lower for males than females, i.e. they start earlier with petting, kissing. However, the average age of first sexual intercourse was higher for males than females. Females experienced penetrative sexual intercourse earlier in their lives than males, and it might be that this was less often accompanied with petting and kissing.

Table 9 **Average age of sexual activity and intercourse at end-line**

| | Endline | |
|---|---|---|
| | **Sexual activity** | **Sexual intercourse** |
| Young women (15-24 years) | 16.7 | 15.4 |
| Young men (15-24 years) | 15.4 | 16.8 |

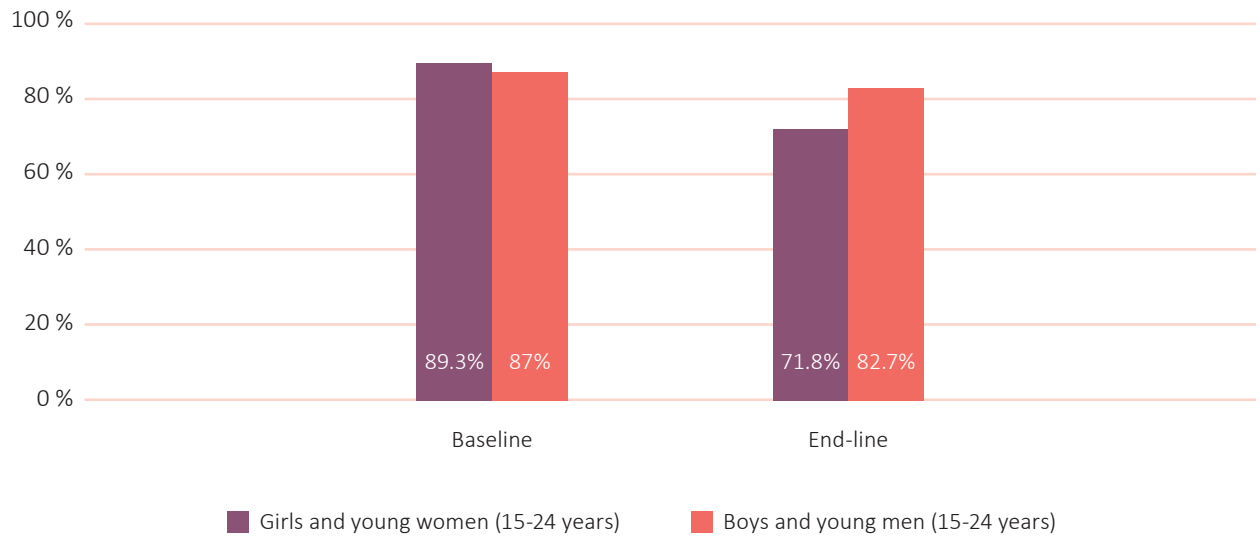
At end-line, unmarried survey respondents were also asked whether they ever had a girl- or boyfriend. Figure 2 shows that, as expected, most of the older youth (18-24 years) indeed had ever had a girl- or boyfriend.

Figure 2 **Unmarried youth who have ever had a girl/boyfriend at end-line**


Autonomy in dating was covered in the survey with the statement 'I can decide for myself whom to date and go out with'. The percentage of female respondents who agreed with this statement significantly decreased over time (OR=0.27, p-value<0.001). While a decrease can also be observed among male respondents, this is not as strong as among female respondent and not statistically significant (OR=0.80, p-value=0.457) (Figure 3)[3].

3 The percentage of respondents who were worried about being unable to decide who to date went down from 55% at baseline to 37% at end-line, as presented in section 3.4.1. Although less respondents, both females and males, seemed worried about not being able to decide whom to date, the percentage of females indicating that they decide for themselves whom to date when down from 89% to 72%. It should be noted that being worried about deciding whom to date and actually deciding whom to date are two different things. Quite a significant percentage (37%) was worried at end-line, but still a majority indicated to decide for themselves.

Figure 3 **Youth who can decide for themselves whom to date**




Sexual relationships between young people were often influenced by peers. Similar to the baseline, many participants, both young people and adults, reported that transactional sex was happening in the community. Girls would get into relationship with (older) young men, some of which were already married, to gather for their 'needs and wants' – partly because of their peers having money or certain items. This sometimes resulted in teenage pregnancy, and the pregnancy not being accepted by these men, partly because girls could have those relationships with multiple men.

> *"… because other girls want money to buy some stuffs like clothes and the boy will demand sexual intercourse for him to give out money. As a result of that, they have sex and the girl ends getting pregnancy because of money."* (IDI with a 18-year-old young man, Chadiza)

*Violence*

A 17-year-old boy in Petauke reported that when a girl receives money or goods from a (young) man, this could lead to violence, because of the man having to right to sex, even if she does not want it. In addition, violence was reported where girls had, or were perceived to have, more than one boyfriend.

Violence within marriage seems to have increased over the past four years. On the question whether a partner ever physically hurt or hit married respondents, 66% of the respondents at baseline responded 'never', while this was 55% at end-line. At end-line, responses to the other answer options were as follows: 1% 'all the time', 4% 'frequently', 15% 'sometimes' and 25% 'rarely'. Physical violence within marriage was more often reported to take place by female than by male respondents. However, for both females and males, the percentages of respondents who reported to have ever (meaning all the time/ frequently/ sometimes/ rarely) been hurt or hit by a partner increased over time: from 35% at baseline to 46% at end-line for females (OR=1.56, p-value=0.100) and from 11% at baseline to 33% at end-line for males (OR=5.33, p-value=0.077), but the results are not statistically significant. There were no major differences between Chadiza and Petauke.

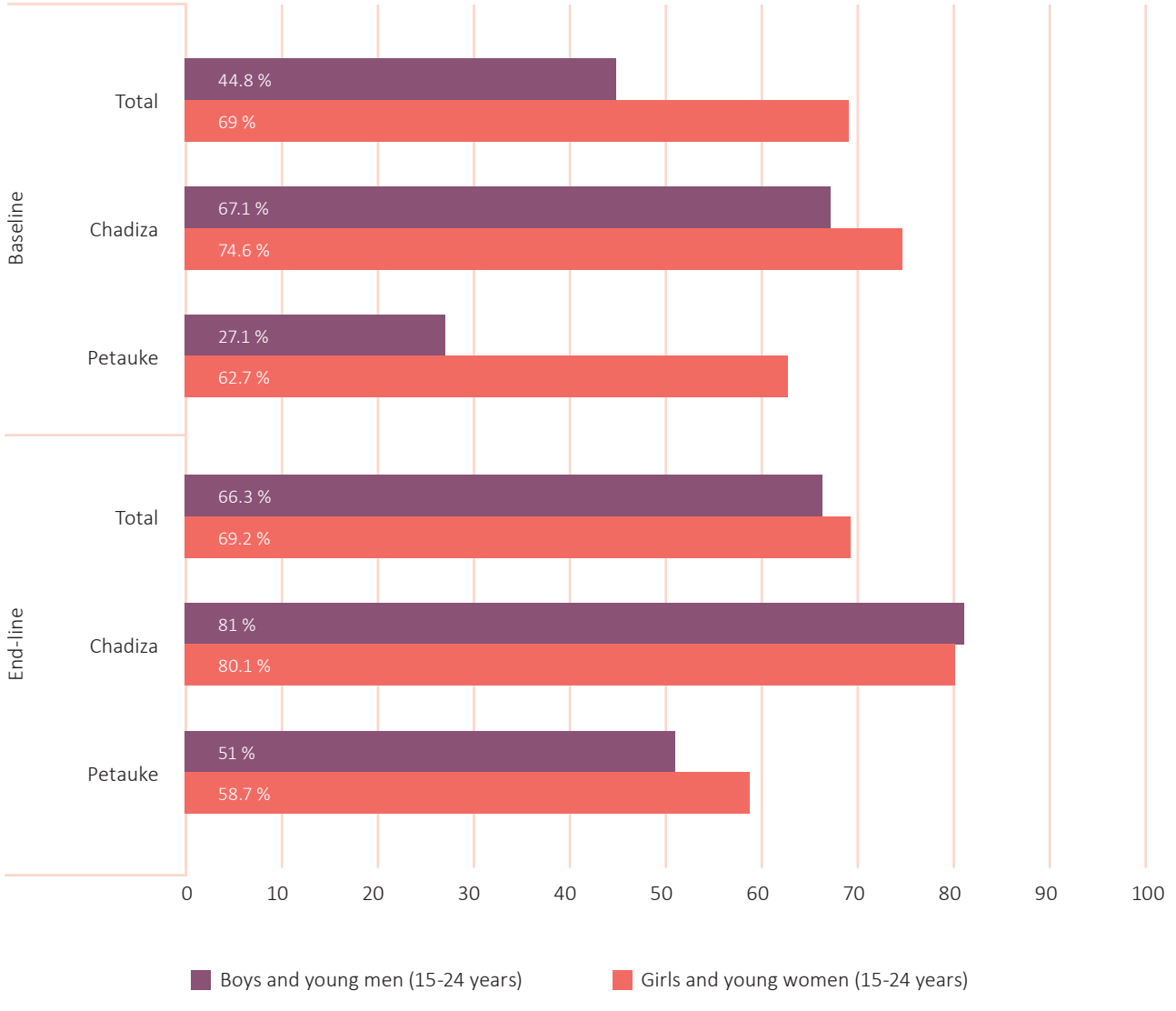
Experiences with sexual harassment also increased between base- and end-line. At baseline, 18% of all females respondents had ever experienced sexual harassment (either every day, once or twice a week, once or twice a month, or less than once a month), which significantly increased to 46% at end-line (OR=3.08, p-value<0.001). Similarly, 7% of all male respondents indicated that they had ever experienced sexual harassment at baseline which significantly increased at end-line (24%; OR=4.70, p-value<0.001) More respondents in Petauke reported experience with harassment than in Chadiza at both base- and end-line.

### 3.4.3 SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS INFORMATION AND EDUCATION

*Exposure to SRHR information*

Figure 4 shows that there was an increase in the percentage of young people who have ever received education about sexuality and sexual health. The percentage of boys and young men (15-24 years) who have ever received education about sexuality and sexual health in Chadiza increased from 67% at baseline to 81% at end-line. Similarly, the percentage of girls and women (15-24 years) who received education about sexuality and sexual health increased from 75% at baseline to 80% at end-line in the same district. Petauke also observed an increase in the percentage of male respondents (15-24 years) who received education about sexuality and sexual health from 27% at baseline to 51% at end-line. However, a decrease was observed for girls and young women, from 63% at baseline to 59% at end-line. Overall, there is a statistically significant increase in the odds of male respondents who have received education about sexuality and sexual health (OR=2.97, p-value<0.001), but not for female respondents (OR=1.07, p-value=0.626). Although our study, including the qualitative component, does not provide any potential reasons for this, the results of the regression analysis suggest that male and female respondents who are currently attending education and who are older are more likely to have ever received sexuality education than out-of-school and younger people.

Figure 4 **Young people who have ever received education about sexuality and sexual health**



Most of the participants in FGDs and interviews reported that more young people had now accessed information on sexuality and sexual health compared to previous years. The Yes I Do programme had enhanced the capacity of schools to deliver SRHR information through training of youth club facilitators in the schools and providing manuals for youth club facilitators. The Yes I Do programme had also contributed towards strengthening youth friendly corners through building the capacity of health workers in delivering SRHR information and also through providing sports materials in health facilities.

*Sources of SRHR information and education*

The survey respondents who had ever received SRHR information were asked about the current and preferred sources of information. Teachers/ schools and health providers/ health facilities were most mentioned as current and preferred sources among both males and females at base- and end-line (Table 10). Not shown in the table, parents were mentioned as current sources information by 19% of the females and 14% of the males at end-line, while 'home' was mentioned as preferred source of information by 22% of the females and 12% of the males at end-line. This shows that parents played less of a role in the provision of SRHR information than other people in the community, such as teachers and health providers.

Table 10 **Most common current sources and preferred sources of sexuality education**

| | | **Most common current sources of SRHR information** | **Most common preferred source of SRHR information** |
|---|---|---|---|
| Baseline | Girls and women (15-24 years) | 194 (54.5%) Teacher<br>125 (35.1%) Health provider | 229 (44.4%) Health facility<br>177 (34.3%) School |
| | Boys and young men (15-24 years) | 55 (64.0%) Teacher<br>27 (31.4%) Health provider | 66 (34.4%) School<br>61 (31.8%) Health facility |
| End-line | Girls and women (15-24 years) | 168 (39.6%) Teacher<br>144 (34.0%) Health provider | 240 (39.2%) Health facility<br>204 (33.3%) School |
| | Boys and young men (15-24 years) | 69 (53.1%) Health provider<br>54 (41.5%) Teacher | 110 (56.1%) Health facility<br>69 (35.2%) Radio |

Participants of the interviews and FGDs also mentioned schools and health facilities as the main sources of sexuality information and education. In the schools, information was provided through Yes I Do clubs and school subjects such as biology. A parent in an in-depth interview stated that the government also introduced comprehensive sexuality education (CSE) in schools.

> *"In school, we also have Yes I Do. So they choose people from different classes to go and do Yes I Do and in this program they teach us on a number of things like early pregnancies and early marriages."*
> (FGDs, females, 20-24 years, Chadiza)

Health workers at the health facility and in the community also provided SRHR information and education. Young women reported that they access information from the health facility when they receive maternal and child health services and from the youth friendly corners.

> *"We get this [SRHR] information from the clinic. If it is for the women for instance, they get this information from the under-5 sessions, that is where they get the information or learn more information from. But for us the male when we go to register with your partner for antenatal that is when we find such information."*
> (IDI with a female parent, Chadiza)

Peer educators or counsellors were not mentioned a lot, despite Plan Zambia reporting that they had trained peer educators and youth counsellors. As these people were attached to health facilities, it could be that the young people interviewed regarded them as (regular) health workers.

In the FGDs with young people and also in IDIs with parents, in addition to schools and health facilities, it was reported that young people also accessed SRHR information from churches, parents, grandparents and their friends in the community. Similar to the baseline, young people reported that they accessed information from elders who are open to listen to them. With such elders, they were free and comfortable to ask them questions on SRHR.

> *"Thank you, aah, young people, in most communities go to adults that they are free and comfortable with and ask questions on SRH issues that need good clarifications, apart from elderly people in the communities, young people (adolescents) acquire information and answers to various SRH questions from health workers at clinics. For example, parents usually advise girls who are pregnant to start accessing antenatal services to safe guard the life of the inborn baby and mother."* (IDI with a 22-year-old man, Chadiza)

Relative to the baseline, the qualitative narrative points to a high expectation on teachers' roles in teaching young people sexuality education and in the prevention of teenage pregnancies. Traditional leaders and parents were of the view that teachers are better positioned in terms of their knowledge of the issues faced by young people and because they spend more time with young people compared to other reference persons. Compared to baseline, it could be seen as a positive development that parents in particular are not opposed to their children being taught on sexuality education but rather see it as responsibility of teachers. During FGDs, adolescents aged 15-19 years shared their experiences in receiving sex education in school, including lessons on abstinence, condom use and family planning.

> *"Aah, I think teachers need to be open and teach boys and girls these issues since they spend most of the time with them. I think teachers need to discuss with boys and girls about the effects of teenage pregnancy and marriage so they have a huge responsibility in the community."* (IDI with a female parent, Chadiza)

> P2: *"Some teachers they teach topics on Yes I Do and when we meet they teach and others also join to learn."*
> P5: *"He introduces a topic, then he starts explaining that you have to abstain from sex or you should be using condoms when having sex or use family planning."* (FGDs boys 15-19 years, Petauke).

At end-line, young men mentioned the radio as their second preferred source of information (Table 10). In the qualitative interviews, only one parent mentioned the radio as a source of SRHR information. However, young people in the FGDs or IDIs did not commonly cite the radio as a current source of information, while provision of SRHR information through the radio could have potential, as 63% of the survey respondents (60% of the females and 72% of the males) mentioned the radio as most accessed media.

*Content of SRHR information and education*

Young people reported that in school, SRHR topics included life skills such as assertiveness, communication skills, rights and prevention of GBV. They also reported to learn about the causes, and effects of teenage pregnancy and child marriage, and how to prevent these. While the manuals that were used stressed different methods of preventing pregnancies, teachers and many young people reported that the emphasis was on abstinence.

> *"They teach us not to have sex with the boys. It is bad. They teach us that when a girl reaches at a certain age then she can get pregnant. They also tell us to get educated."*
> (FGD, young women 15-19 years, Petauke)

> *"I think about contraception it is one of the topics we are teaching them in our manual we are using. Where you talk about all the family planning methods and then you single out only abstinence as the only best method."* (IDI with a teacher, Petauke)

While schools mostly emphasized abstinence as the only best method for preventing pregnancy, this male teacher reported that this method does not work for some young people. The teacher suggested that there is the need for better collaboration between teachers and health workers in dealing with SRHR information to adequately address some of young people's SRHR needs that may not be met within the school setting.

*"More especially the grade 9s. Now you tell that boy to say abstinence is the best. If you feel something take a cold bath, go for jogging you come back you will be tired, spend some time playing games, watching movies… He would say I have done all that. But I don't know how my body is made up. So you would say there is nothing that we can do maybe the people from the health are the ones who are experienced and they may know what to do."* (IDI with a teacher, Petauke)

Compared to the schools, some health facilities were reported to promote the use of contraceptives, including condoms. The lessons also covered different STIs and how they can be prevented. Some health facilities that had youth friendly corners also provided entertainment and sports activities for young people. This provided an enabling environment for young people to interact and freely discuss issues which affect adolescents, such as teenage pregnancies.

*"What we usually do when they [young people] come for youth friendly corner, we have lessons to do with teenage pregnancies, for example. Last time we were given games, like ball games, the chess board (by Plan Zambia). We interact and talk with them talking about issues that deal with the same teenagers… Nowadays, changes among young people (boys and girls) are gradually showing up. This is because Plan International through the Yes I Do programme really helped us in knowing our rights and responsibilities. Again, in our communities, we have youth friendly corners at the hospital where we access information about our health. Community health workers also provide condoms to us and other counselling lessons… For example, last week one of the health workers had a meeting with us young boys on the importance of male circumcision and also how we can protect ourselves from STIs such as syphilis. Even young girls nowadays are slowly understanding the dangers of teenage pregnancies."*
(IDI with a 21-year-old man, Chadiza)

However, other participants in FGDs reported that also health workers stresses abstinence for young people:

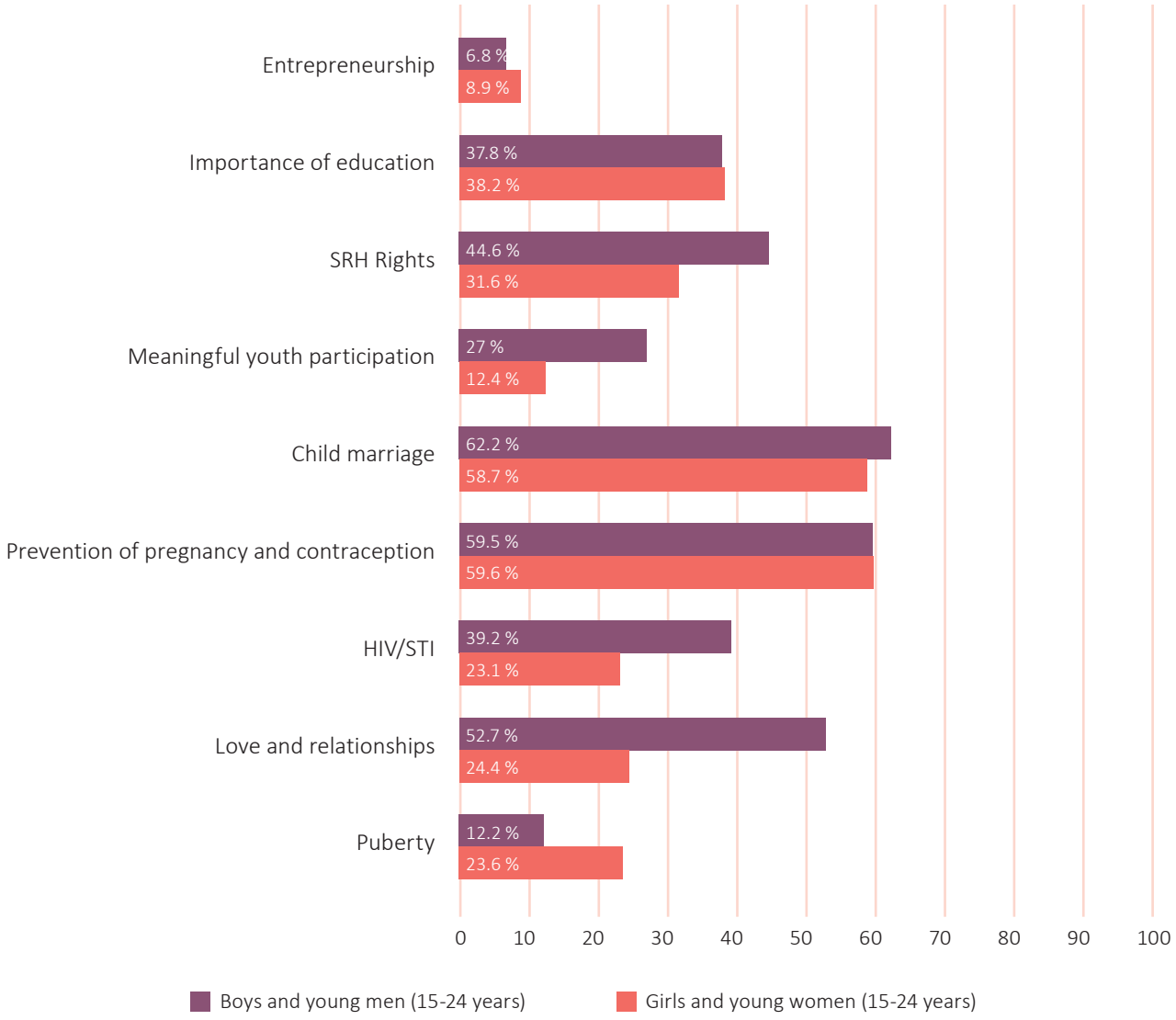
*"The health people teach us that if we want to avoid any disease, the best way to do is to abstain. That is what they teach us."* (FGD, young women 20-24 years, Chadiza)

Some participants referred to the CoC intervention implemented by the Yes I Do alliance, indicating that the CoC activities were useful to them. However, in one FGD where the details of what was being taught at the CoCs was discussed, it suggest that the content of the CoC lessons was predominantly moral instructions and fell short of providing evidenced-informed knowledge and skills to equip young people to prevent teenage pregnancy. The narratives show that young people were instructed not to have sex, not to become pregnant or marry, without providing them with the requisite skills to prevent those adverse outcomes.

P3: *"It was in 2019 and us who are at school are the ones in champions of change. Moreover, we are just countable [only a few of us]."*
P5: *"They teach us not to have sex with the boys. It is bad."* (FGD, girls 15-19 years, Petauke)

Survey respondents at end-line who had indicated to have participated in the Yes I Do programme, were asked which topics they found beneficial. The topics that were highly appreciated (with at least 50% percentage) were child marriage, prevention of pregnancy and contraception, and love and relationships. Sixty-two percent (62%) of the male and 59% of female respondents stated the topic child marriage. There were 59.5% males and 60% females who found the topic prevention of pregnancy and contraception beneficial. Finally, 53% males and 24% females reported that love and relationships was a beneficial topic for them (Figure 5). It seems the topics most mentioned to be beneficial were also the topics that were most stressed by the Yes I Do Alliance in Zambia.

## Figure 5 **Topics addressed in Yes I Do activities that youth find beneficial at end-line**




## Figure 6 **Knowledge of prevention of pregnancy (modern contraceptives)**

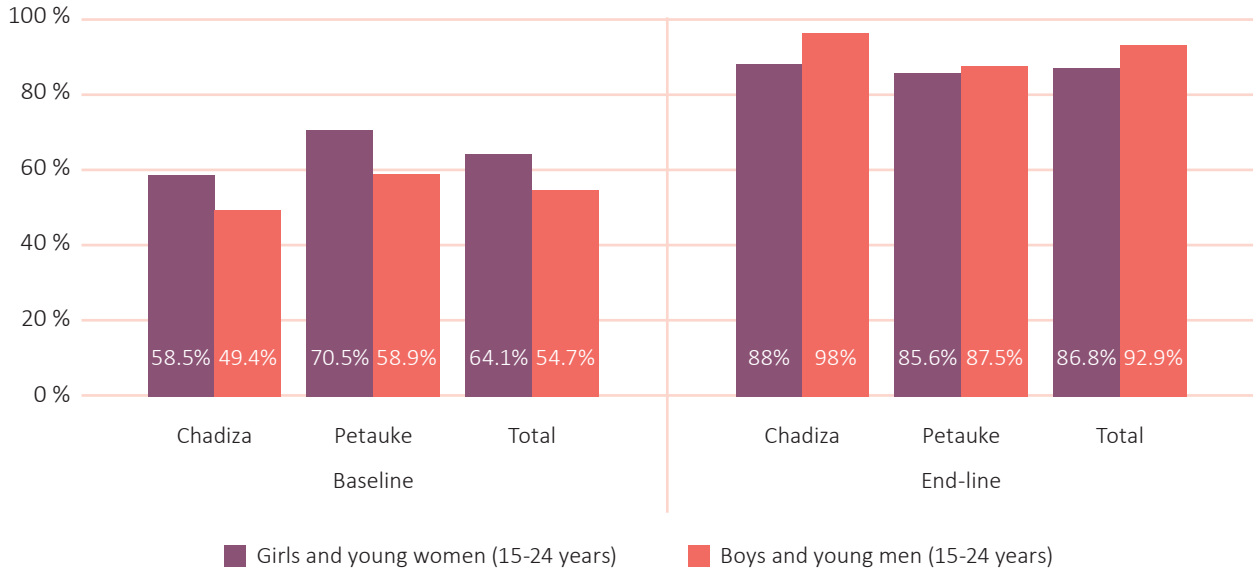
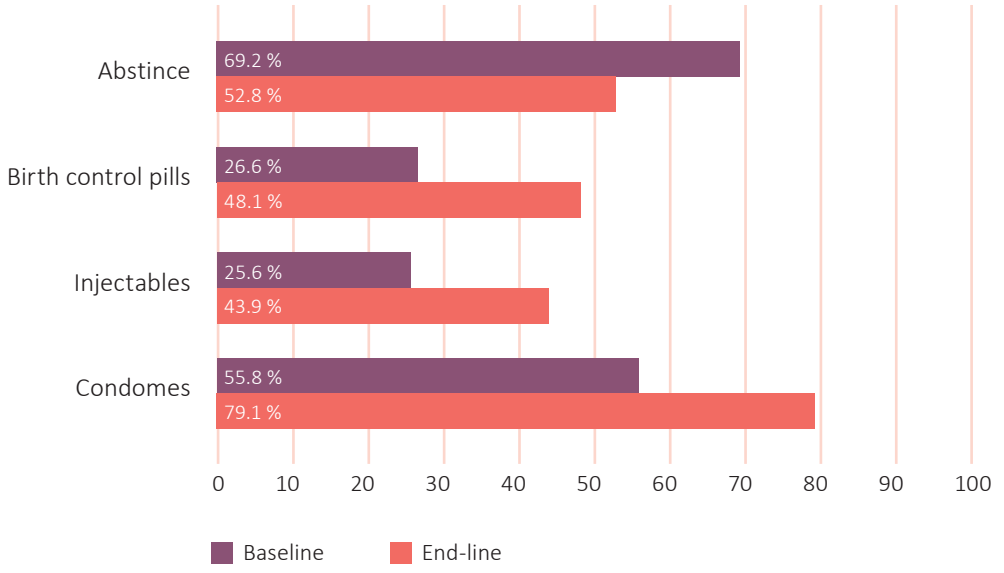


Figure 7 **Knowledge of types of contraceptive methods**




### 3.4.4 CONTRACEPTION KNOWLEDGE, ACCESS AND USE

*Contraceptive knowledge*

Knowledge on modern contraceptive methods (reported as methods to prevent pregnancy) significantly increased from base- to end-line among female (OR=3.23, p-value<0.001) and male respondents (OR=13.95, p-value<0.001), as shown in Figure 6.

Figure 7 provides more insight into the most popular known types of contraceptive methods (including non-modern ones) that were mentioned by the survey respondents. Multiple answers were possible for this question. At end-line, condoms were mentioned most often (79%) and then abstinence (53%), birth control pills (48%) and injectables (44%). Knowledge on the modern methods increased, while less respondents mentioned abstinence at end-line as compared to baseline. Periodic abstinence was mentioned by 8% of the respondents at end-line (not shown in the figure). The IUD, emergency pill and withdrawal were mentioned by less than 5% of the respondents (also not shown in the figure).

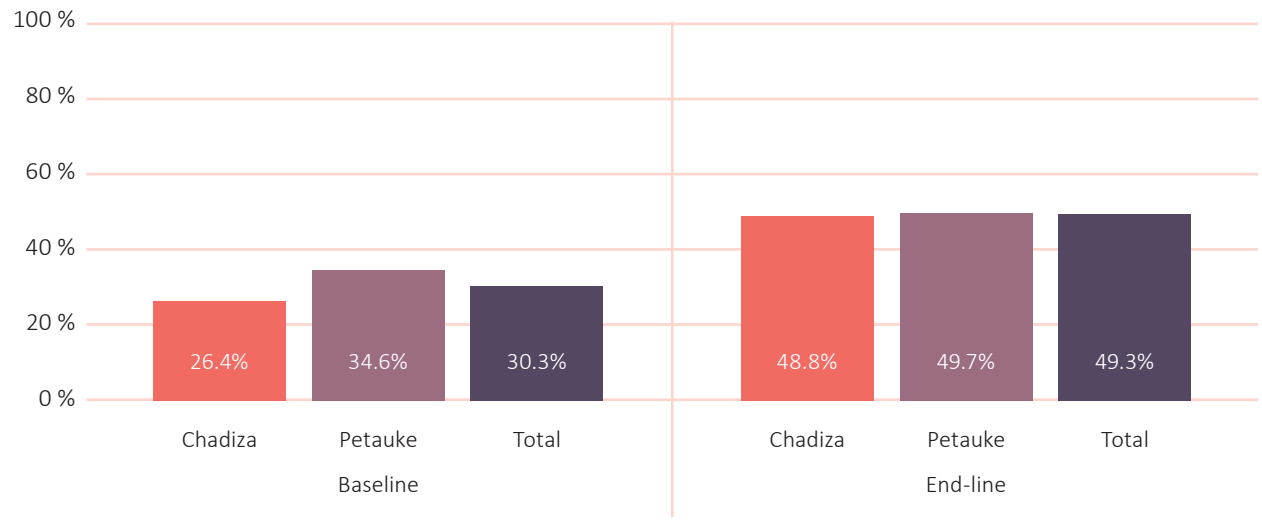
*Accessibility of contraceptives*

We also specifically asked which types of contraceptive were available in the community (Table 11): the available contraceptive methods that were mentioned by more than 5% of the respondents are shown. Over time, the availability of the various methods increased, as reported by the respondents, with an exception of male condoms.

Table 11 **Availability of contraceptive methods as reported by survey respondents who ever had a child**

| Availability of contraceptive methods | Baseline | End-line |
|---|---|---|
| Birth control pill | 125 (65.1%) | 225 (70.4%) |
| Female condom | 23 (12.0%) | 46 (12.7%) |
| Implant | 11 (5.7%) | 112 (30.9%) |
| Injection | 155 (80.7%) | 307 (84.8%) |
| IUD | 0 (0%) | 19 (5.2%) |
| Male condom | 124 (64.6%) | 207 (57.2%) |
| Natural family planning | 24 (12.5%) | 31 (8.6%) |

Figure 8 **Percentage of girls and young women (15-24 years) who ever used contraceptives**




We asked the survey respondents to agree or disagree with the statement 'It is difficult to access contraceptives for young people'. Among the female respondents (15-24 years), 39.5% agreed that it is difficult at baseline, and 58% agreed at end-line (59% in Chadiza and 57% in Petauke). Among male respondents (15-24 years), 45% agreed that it is difficult at baseline, and 42% agreed at end-line. It seems that females found it increasingly difficult to access contraceptives over time (OR=1.97, p-value<0.01), while for males there was hardly a change observed. On the question in what circumstances a person can access a modern form of contraception (any form of contraception except natural family planning), at baseline, 42% of all respondents reacted with 'always' at baseline, and this was 13% at end-line. The percentage of young people answering 'either after having children' or 'after being married' increased with 6% over time (from 55% at baseline to 61% at end-line), and the percentage of young people answering 'at the age of puberty' also increased: from 2% at baseline to 17% at end-line. These results correspond with the results regarding the level of agreement with the statement 'It is easy to access contraceptives if you are a married young person', which was 59% at baseline and 66% at end-line.

*Contraceptive use*

At baseline, 30% of the female respondents said to have ever used contraceptives. At end-line, this percentage increased to 49%. This increase is observed in both Chadiza and Petauke (Figure 8).

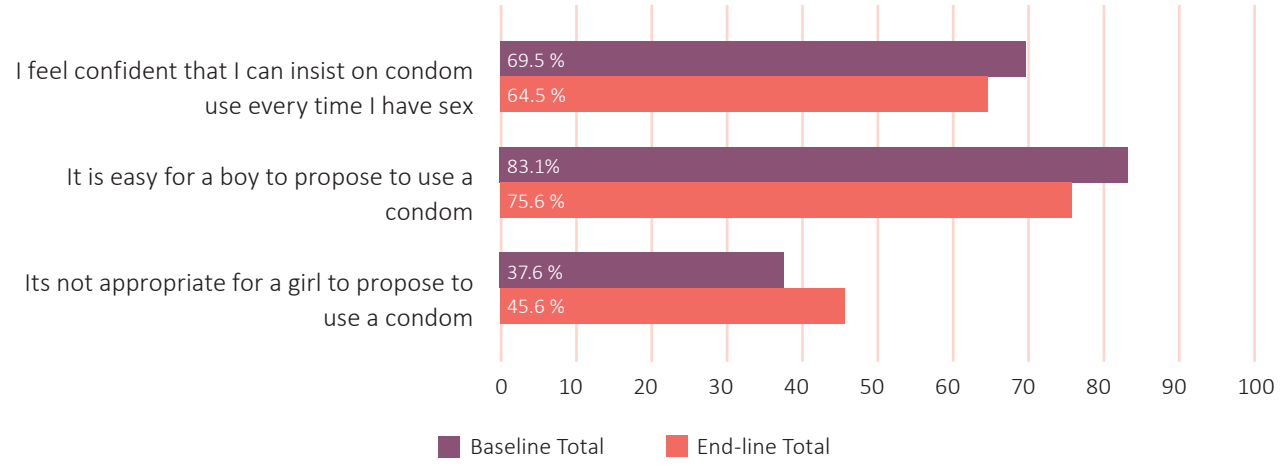
The percentage of women (15-24 years) who currently used (any type of) contraceptives (at the time of the survey) significantly increased from 21% at baseline to 37% at end-line (OR=1.66, p-value<0.01), with no difference between the two districts. The percentage of male respondents (15-24 years) who currently used a modern form of contraceptives was 54% at end-line, and the percentage was higher in Chadiza (61%) than in Petauke (46%) (this was only asked at end-line).

The percentage of women who ever had a child and currently use a modern form of contraception increased slightly from 51% at baseline to 58% at end-line but this was not statistically significant (OR=1.25, p-value=0.259). Similarly, utilization of modern contraceptives among fathers increased from 64% to 72% but was also not statistically significant (OR=1.34, p-value=0.612). Use of (modern) contraceptives appears to be higher among respondents who ever had a child. It is possible that young people who had a child were more aware of the importance on contraceptive use.

Among the respondents who used contraceptives, 49% used condoms, 40% used injections, 16% used the contraceptive pill and 10.5% the implant. The percentage of all sampled young men (15-24 years) who currently used condoms at end-line was 51.5%. This percentage was 10% for young women (15-24 years). There was a significant increase in the utilization of condoms by male (OR=3.53, p-value<0.05) and female respondents (OR=4.00, p-value<0.01) who ever had a child between base- and end-line.

At end-line, most of the survey respondents who used contraceptives got them from the health facility or medical staff (92%). Fourteen percent (14%) received them from a CHW, 8% got them from pharmacies/ shops, 3% from outreach

Figure 9 **Attitudes about contraception**




services, 3% from peer educators, 2% from the youth club, 1% from school (n=3) and only 0.6% from a private clinic (n=2). Plan Zambia reported to have trained community-based distributors, who fall in the category of CHWs.

At end-line, respondents who did not use contraceptives were asked for the reasons why. Thirty-four percent (34%) indicated to have never thought about it, 16% said they were worried about side effects, 15% said they were not sexually active and 12.5% indicated to want more children. Furthermore, 8% said that their partner disapproves the use of contraceptives (six females and one male respondent), 7% said there was no method available at that time and 3% (three females) said they did not agree with contraception. Two female respondents said that they were refused to obtain contraceptives by health workers and only one female respondent said she could not access contraceptives due to COVID-19 restrictions. None of the respondents gave reduction of sexual satisfaction as a reason not to use contraceptives.

Several participants in the qualitative study component reported that young people were increasingly using contraceptives, which is corresponding with the survey results presented above. One married 21-year-old male participant in Chadiza reported the following:

> *"Boys and girls who are willing to get pregnant protective measures such as condoms, pills, and contraceptives are given by health workers at the clinic and by community health workers around our villages. But there are some young people (boys and girls) and parents that have negative thoughts about contraceptives. Some believe if young people get pills or injections, they will not have children in the near future, at the same time some believe it's a way of promoting young people to be engaged in sexual activities while young."*

This reference to misconceptions about contraceptives was also found at midline. A health worker in Chadiza mentioned that women do not like to use condoms, they prefer pills and injections, because of perceptions of reduced pleasure when using a condom. This could explain the low percentage of current condom use among female survey respondents.

*Attitudes about contraception*

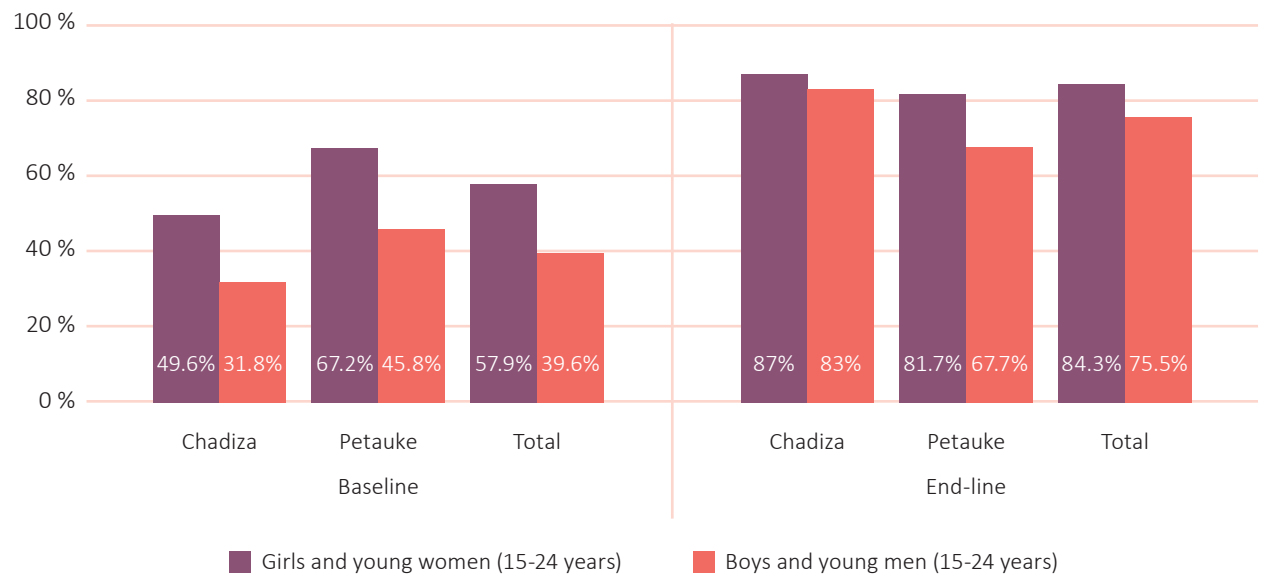
Figure 9 summarizes some attitudes around contraception. The confidence with regard to insisting on condom use slightly decreased over time; this trend was especially evident among the male respondents (gender aggregation is not shown in the figure). Among males, the confidence to insist condom use went from 83% at baseline to 67% at end-line, which was statistically significant (OR=0.41, p-value<0.01). The percentage of females (15-24 years) who felt confident to insist on condom remained stable: 64.5% at baseline to 64% at end-line (OR=0.97, p-value=0.821).

Young people at end-line thought less often that it is easy for a boy to propose condom use, however, the majority still thought so. At end-line, more respondents agreed with the statement 'It is not appropriate for a girl to propose to use a condom' (46%) than at baseline (38%). However, this increase was mainly seen among male respondents (from 29% at baseline to 51% at end-line, not shown in the figure) and was statistically significant (OR=2.08, p-value<0.01), while no change over time was observed among female respondents (OR=1.07, p-value=0.554).

### 3.4.5 SEXUAL AND REPRODUCTIVE HEALTH SERVICE PROVISION AND UTILIZATION

There was a significant increase in the percentage of young women between 15 and 24 years who had ever utilized SRH services, from 58% at baseline to 84% at end-line (OR = 3.94, p-value<0.001). The percentage of young men (15-24 years) who had ever utilized SRH services also significantly increased from 40% at baseline to 75.5% at end-line (OR=6.51, p-value<0.001). These increases in SRH service utilization over time were observed in both Chadiza and Petauke (Figure 10).

Figure 10 **Young people who have ever used SRH services**

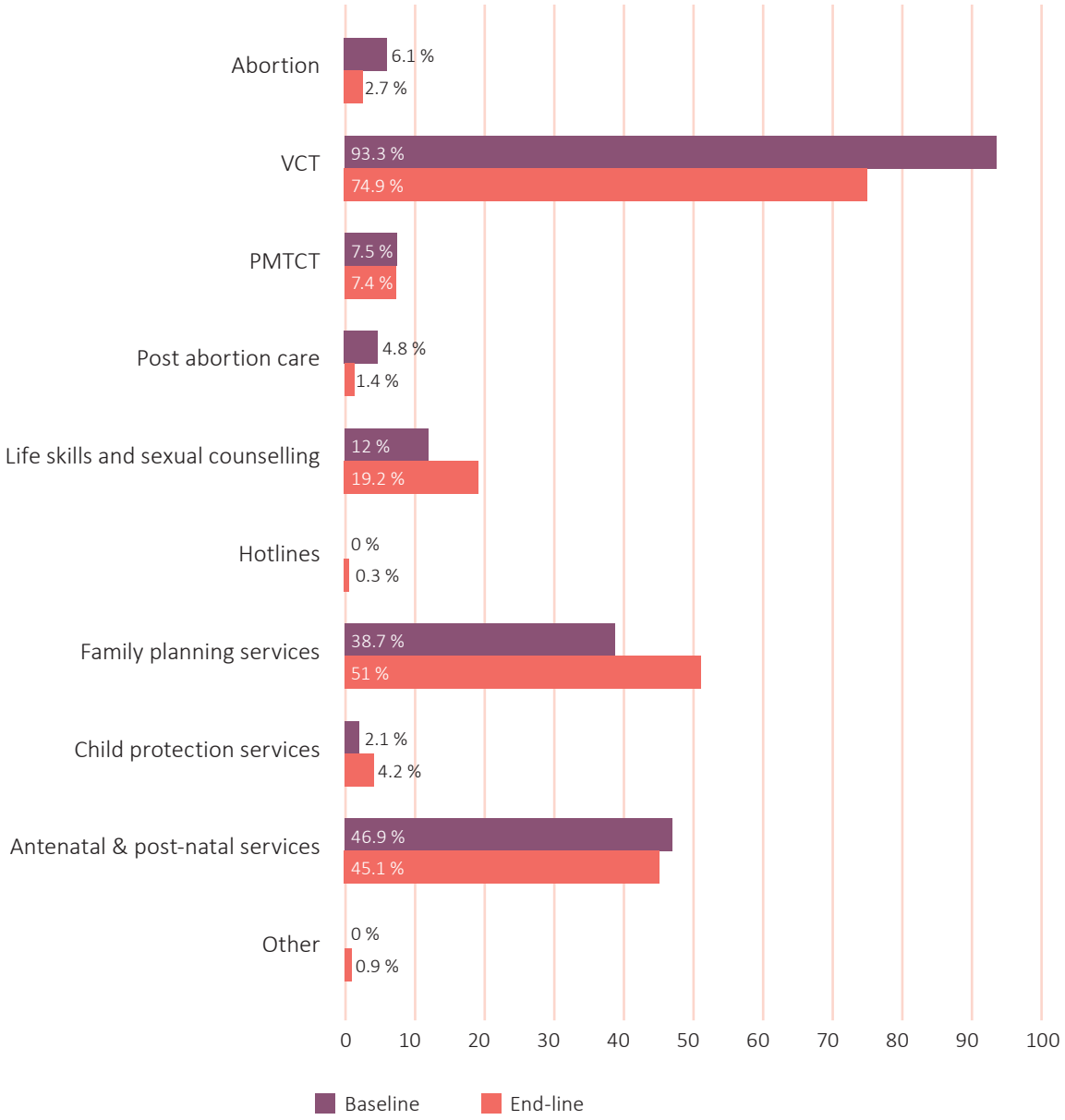



The respondents who indicated to ever have used SRH services were asked which specific services they had used (multiple answers were possible). At end-line, VCT (93%), family planning services (51%) and antenatal and postnatal services (45%) were most used. However, there was a decrease in the utilization of VCT services from 93% at baseline to 75% at end-line. Utilization of family planning services increased from 39% at base- to 51% at end-line. The percentage of respondents who used life skills and sexuality counselling also increased, from 12% at base- to 19% at end-line. Only a small percentage of respondents who used SRH services indicated to use child protection services (from 2% at base- to 4% (n=28) at end-line). There was a decrease in the percentage of respondents who used abortion or post abortion care services from 6% and 5% at baseline to 3% and 1% at end-line respectively (Figure 11).

Among the respondents who ever used SRH service, 92% received those services from a health facility, (from medical staff). Community health workers were mentioned by 14% of the respondents. Ten percent (10%) of the respondents mentioned school, 6% peer educators, 4.5% outreach services, 4% pharmacies or shops, 3% youth clubs and only two respondents mentioned a private clinic (multiple answers were possible).

In line with the quantitative results, qualitative findings at end-line show that girls, boys, women and men had more access to (free) SRH services at health facilities than before. Young people particularly mentioned to access voluntary HIV counselling and testing, condoms and contraceptives. It was reported that nowadays, pregnant teenagers were welcomed and provided with services at the health facility.

Figure 11 **Types of SRH services used (by those who ever used them)**




*"Mmm, health workers are providing various health services to boys and girls. For example, they give counselling, HIV and AIDS test, provision of condoms and pills to young people who are willing. In addition, they are also helping young ones (girls) to have a good delivery when they are pregnant."*
(IDI with a female parent, Chadiza)

*"Aaaah [light laughter], since the services are free for all and also looking at the way they [young people] are handled by the personnel here at the clinic it gives them confidence and we do interact with them. Most of them do come to youth friendly corner."* (IDI with a health worker, Chadiza)

Plan Zambia reported to have supported youth friendly corners in four health facilities in each district. They trained health workers in the provision of youth friendly health services, they provided furniture and they also provided teaching materials and drama kits for peer educators.

At end-line, 66% of the survey respondents who had ever used SRH services rated their quality as good, 26% said they were of excellent quality, and 5% said they were of average quality. Three percent (3%, n=22) indicated to find the SRH services of bad quality and one respondent said they were of very bad quality. Young women in a FGD in Chadiza thought that health workers maintained confidentiality:

*"They [young people] are welcomed… They [health workers] maintain confidentiality. No way they would go round and start telling people what kind of problem does someone have. They are welcomed with peace and given treatment. "* (FGD, young women 20-24 years, Chadiza)

At end-line, out of the 141 respondents who indicated to never have used SRH services, 43% said they never thought about it, 28% said they never had the need to go and 18% (n=25) said that they did not know about such services. Nine respondents said that they were too shy to go (seven women and two men), three respondents said that SRH services were not available in their community, three respondents were afraid to be scolded at the health facility, and one female respondents said that her parents disapproved. In the qualitative study component, young people from both Chadiza and Petauke said that long distance to health facilities, and related to this high transport costs, was a main barrier to accessing SRH services.

*"We need a health facility nearby here. At the moment there have to travel to Chadiza town to access services which is difficult to some who do not have bicycles and money to pay transport costs."*
(IDI with a headman, Chadiza)

In Minga Zone in Petauke, it was reported that the mission hospital does not provide family planning services. A female community health worker (CHW) reported that SRHR information and family planning services are only available from CHWs in this area. The CHW complained of being overwhelmed with work, explaining that the area is too vast for the CHWs to reach all the people. She also stated that family planning supplies were not always available to the CHWs.

*"Ahh like in that hospital there is no such because it is a mission hospital. Even family planning is not done from that side all those programmes they are done outside Minga hospital so those who want family planning they follow me here."* (IDI with a CHW, Petauke)

In an FGD in Chadiza, young people reported that the COVID-19 pandemic had also affected access to SRH services. It was reported that lock down measures had restricted the possibility of going to health facilities to access condoms and contraceptives. Furthermore, fear of contracting COVID-19 made people not go to health facilities.

*"Ooh, yes, COVID-19 has really affected boys and girls in our communities in such a way that they are saying we should stay one meter apart and staying in houses, which made life difficult for young people to share SRH services such as condoms, pills, infections and many others. In order to follow health guidelines of staying home, many young girls did not access contraceptives, as they were not allowed to move around, so COVID-19 really affected us in one way and other."* (IDI with a 21-year-old man, Chadiza)

*"Well, aah, so far no person was found with the virus called COVID-19 in our area and Chadiza as a whole, but young ones and adults were affected in such a way that movements from one place to another was difficult, so to access health services at some point was a challenge because we feared being sick of COVID-19. We were told that it's a deadly disease so we stayed at home, no movements."*
(IDI with a female parent, Chadiza)

## 3.5 TEENAGE PREGNANCY

### 3.5.1 PREVALENCE OF TEENAGE PREGNANCY

To assess the prevalence of teenage pregnancy and parenthood, we asked the survey respondents several questions. The first question was on what age they had had their first child. This question was asked to all participants (male and females) at base- and end-line. Overall, the percentage of female respondents (20-24 years) who had their first child under the age of 20 years (teenage pregnancy rate) significantly increased from 45% at base- to 61.5% at end-line (OR=2.56. p-value<0.05). This increase was seen in both Chadiza and Petauke (Table 12). At end-line, the percentage of young women (20-24 years) who reported to have ever been pregnant was assessed. Eighty-three percent (83%) reported to have ever been pregnant before. A third question that was asked at both base-and end-line assessed

the percentage of young women (20-24 years) who wanted to be pregnant at that time, and this slightly increased from 36% at baseline to 38% at end-line, but this is not statistically significant (OR=0.99, p-value=0.979). This increase was particularly observed in Petauke. At end-line, the average age at first pregnancy was 17.9 years for the female respondents (20-24 years) and 20.5 years for the male respondents (20-24 years) (Table 12).

Table 12 **Pregnancy and parenthood**

| | Baseline | | | Endline | | |
|---|---|---|---|---|---|---|
| | **Chadiza** | **Petauke** | **Total** | **Chadiza** | **Petauke** | **Total** |
| **Young women (20-24 years)** | | | | | | |
| Who had their first child under the age of 20 | 34 (45.3%) | 39 (44.8%) | 73 (45.1%) | 92 (61.3%) | 85 (61.6%) | 177 (61.5%) |
| Who reported to have ever been pregnant | NA | NA | NA | 124 (82.7%) | 116 (84.1) | 240 (83.3%) |
| Who wanted to become parents at that time | 9 (26.5%) | 17 (43.6%) | 26 (35.6%) | 23 (25.8%) | 43 (51.2%) | 66 (38.2%) |
| Average age at first pregnancy | 17.4 | 17.8 | 17.6 | 18.0 | 17.8 | 17.9 |
| **Young men (20-24 years)** | | | | | | |
| Who had their first child under the age of 20 | 1 (3.3%) | 2 (3.1%) | 3 (3.2%) | 8 (16.3%) | 2 (4.2%) | 10 (10.3%) |
| Who wanted to become parent at that time | 1 (100.0%) | 2 (100.0%) | 3 (100.0%) | 4 (50.0%) | 0 (0.0%) | 4 (40.0%) |
| Average age at first child | 20.1 | 20.8 | 20.7 | 19.9 | 21.1 | 20.5 |

At both base- and end-line, we asked all male and female respondents how many girls they knew who had had children before the age of 20. The gender-segregated data show that the average number of girls who experienced a teenage pregnancy that females reported to know reduced from 8.7 at base- to 6.4 at end-line. The reported number of known teenage pregnancies among male respondents was 6.3 at base- and 6.2 at end-line.

At end-line, 55% of all female respondents aged 15-24 years indicated to have ever been pregnant. When we asked female respondents who had ever been pregnant about the number of pregnancies they have had, 71% said one, 24.5% said two, 8% said three and 25 (n=5) indicated that they had had four pregnancies. There was a considerable increase observed in the percentage of female respondents who said they have had only one pregnancy: from 54.5% at baseline to 71% at end-line. The percentage of female respondents reporting to have had more than one pregnancy decreased over time. This implies that the frequency of pregnancy among women (15-24 years) went down from base- to end-line.

Survey respondents were asked the question 'if a girl falls pregnant here, whom can she turn to for support?' The majority of the respondents, both at base- and end-line, said that a girl can turn to a health provider, the percentage of respondents indicating this went from 53% at baseline to 72% at end-line. The second most mentioned was the family: 47% at baseline and 43% at end-line. There was a slight decrease in the percentage of respondents who said when a girl falls pregnant, she can turn to her partner/boyfriend/friends, from 15% at baseline to 12% at end-line. Other people that a girl could turn to as mentioned by the respondents included religious leaders, teachers and youth advocates, but these were not popular among the respondents at both base- and end-line.

### 3.5.2 CAUSES AND CONSEQUENCES OF TEENAGE PREGNANCY

*Causes of teenage pregnancy*
The causes of teenage pregnancy that were reported at end-line were very similar to those that were identified at base- and midline. Early and unprotected sexual intercourse, economic pressure, low education levels, and cultural factors such as initiation ceremonies were reported to lead to teenage pregnancy.

Young people reported that unprotected sexual intercourse was high in the communities. In FGDs with boys and girls as well as young women and men, it was reported that many young people do not use protection because they do not feel comfortable to ask for condoms at the health facility. In some cases, condoms and contraceptives were not readily available. One teacher in Petauke suggested that the promotion of contraceptive use among young people had contributed to early pregnancies. He thought that making young people aware about condoms makes some people to involve more in sexual activities.

> *"Mainly I will talk about early sex and the use of contraception. Because like for last year we had about 20 pregnancies… Then those that were not confirmed were also about 20 of them, those who just left school with such rumours. So I think early sex has a lot of problems. Then in the other year,… we had some relatively older girls… they were lodging within here the two of them, they had boyfriends who were truck drivers. Those girls they stopped school… And it was noticed… that the reason why they were… sleeping with every man in the community is that they had a 5-year family planning contraceptive."* (IDI with a teacher, Petauke)

Economic factors also contributed to high teenage pregnancy. In both the IDIs and FGDs, some participants mentioned that the exchange of sex for money or goods was common in the communities. Due to widespread poverty in the community, young people engaged in sexual relationships to lessen the economic pressure such inadequate food within their household. Others exchanged sex for money to buy or obtain goods such as clothing and shoes, which they admired from their friends.

> *"Aah, in most cases, young girls get pregnant at the age of fifteen simply because she needs good things which her parents cannot afford to buy for her. For if her friend has nice and expensive clothes, sometimes smartphones, many girls prefer to be going out with a sugar dad for them to be bought expensive things so that she can be of the same level with her friends."* (IDI with a 21-year-old man, Chadiza)

Low education levels and school dropout were also reported as additional factors that contributed to teenage pregnancy. Young people that had dropped out of school were said to have free time to experiment and engage in sexual activities. Young people who were not in school were also believed to more likely desire marriage and thus be involved in sexual relationships resulting in teenage pregnancy. Little or no education was also reported to contribute to teenage pregnancy, as such young people were likely to have limited knowledge about safe sexual practices or had 'nothing to do'.

Some participants stated that initiation ceremonies also contributed to teenage pregnancies. It was reported that the ceremonies gave young people information about sex, and, as a result, motivated young people to engage in sexual relationships when the ceremony was done. Compared to the baseline, interviews at end-line suggest that there have been some changes in way the ceremonies were handled. It was reported it was not allowed to hold ceremonies for young girls and during school days. However, changes in the content were not reported.

> *"But also to comment about one of the causes of increased teenage pregnancies, the initiation ceremonies which young girls are meant to go through also expose them to certain things which are not for their age. Also when the girl comes from there, most of the boys are always anxious to go and see what the girl learnt during her ceremony. Hence the increase in teenage pregnancies."* (FGD young men 20-24 years, Petauke)

*Consequences of teenage pregnancy: for girls*
Child or early marriage, health risks and school drop-out were the main consequences of teenage pregnancy that were mentioned at base-, mid- and end-line. Additional consequences that were mentioned at end-line only included stress/ pressure among family members.

Child or early marriage was widely reported as the automatic response to teenage pregnancy. Pregnant girls often ended getting married to avoid stigmatization or attracting shame to themselves and their family, as well as raising a child without a father. A few people said that perceived economic benefits of a marriage also contributed to young women getting pregnant with hope of getting married later.

> *"In some cases, when the boy who comes from a family which is financially stable makes a girl who comes from a family which is poor pregnant, the parents will mostly encourage the girl to make the relationship (marriage) work."* (FGD, boys 15-19 years, Petauke)

Almost all participants were aware that teenage pregnancy has health risks, particularly delivery complications, as the reproductive system of the girl may not have fully developed. Some girls experienced health complications when they tried to abort the pregnancy.

While school dropout can contribute to teenage pregnancy, the interviews also suggested that poor school performance and school dropout was a common consequence of teenage pregnancy. Pregnant young women dropped out of school because of the shame attached to a teenage pregnancy and ridicule from friends at the school. Childcare responsibilities, economic limitations including the pressure of providing food and clothes for the baby and household workload also contributed to poor performance at school or dropout.

> *"Aaah, the girl will not be free to interact with other girls, because she will be feeling shy, because she has pregnancy at wrong stage and time."* (IDI with a 23-year-old woman, Chadiza)

Compared to the baseline, some participants in the FGDs in both Petauke and Chadiza reported that there has been some changes in the community regarding school dropout, as some parents take the children back to school after delivering.

> *"It [teenage pregnancy] is a very painful thing for us the parents. We usually take our children [back] to school so that they can help the family and live a better life in future. But it is not fair and good for us parents as we are usually troubled, though there is nothing we can do about it."*
> (FGD with male parents, Petauke)

This quote and other qualitative interviews show that teenage pregnancy may cause tension between the girl and parents. This tension was due to parents having to take additional responsibilities of caring for the baby. It was reported that it is usually stressful for both the girl and her parents to find food, clothes and soap for the child, especially when the man refuses to support the girl. However, one father in the same FGD reported that some parents willingly accept the pregnancy, as they are happy that they will soon have a grandchild and son-in-law.

*Consequences of teenage pregnancy: for young men*

The main consequences of teenage pregnancy for young men were increased financial and social responsibilities. Many participants reported that young men have to compensate the girl's family in the form of money or cattle. Further, they need to provide for the child whether they decided to marry or not. Sometimes, the girl is brought to the young man's parents' house, so that they take care of her until delivery. As earlier mentioned, teenage pregnancy often automatically results into marriage, which may subsequently result in school dropout for young men as well.

> *"Aah, what happens when such girls get pregnant, a lot of parents usually charge the boy's family responsible for that pregnancy a certain amount for disturbing their daughter's life. In addition to that, a lot of parents meet and discuss so that the boy responsible for that pregnancy should marry the pregnant girl. So many people are getting married at teenage age."* (IDI with a 21-year-old man, Chadiza)

For both girls and boys (and their families), new bylaws have introduced new punitive consequences of teenage pregnancy. These are described further in the next section.

### 3.5.3 PREVENTION OF TEENAGE PREGNANCY

Qualitative and quantitative results show that activities aiming to prevent teenage pregnancy increased in both Chadiza and Petauke between base- and end-line. Through the Yes I do interventions, schools, health facilities, and communities implemented several SRHR education/ information sharing activities (see section 3.4.3). Churches promoted prevention of pregnancy by encouraging girls and boys to take a better moral standing in society by not engaging in sexual activity before marriage.

Although there has been an increase over time in terms of access to SRHR information, access to contraceptives, including condoms, was still a challenge, as outlined in section 3.4.4. The challenges to accessing the services at the health facility included irregular / non-availability of such services. Furthermore, the national school policy does not allow distributing of condoms and other contraceptives in schools. In addition, schools stressed abstinence as the best (if not only) option for preventing pregnancy (see section 3.3.4).

Prevention of pregnancy has also been promoted through the development and implementation of bylaws. These bylaws, which were more prominent in Chadiza than in Petauke, prescribed punishments for young girls who got pregnant, her parents and the man responsible for the pregnancy (see also sections 3.6.7 and 3.8.2).

> *"So even for girls with pregnancy while at school we (the community) also came up with penalties of moulding bricks for whatever project in the community… of course we agreed on the number of bricks. For the boy that has impregnated the girl, he will be given a penalty of moulding bricks either for the clinic or school or whatever project is about to take place in that kingdom. For the parents, I think the penalty was much higher in terms of paying a number of cows from both the family of the girl and the boy."*
> (IDI with a community development officer)

While community-level participants did not report any changes in initiation ceremonies (section 3.5.2), a representative of Plan Zambia reported that the curriculum used in initiation ceremonies for girls had been modified to support the prevention of teenage pregnancy. It was reported that the Ministry of Health and initiators participated in revising the curriculum. The Plan Zambia representative mentioned that age inappropriate information, such as teaching girls how to sexually satisfy a man had been removed and replaced with SRHR information on puberty and maintaining hygiene. Plan Zambia had trained two initiators per zone on how to use the curriculum.

### 3.5.4 THE LIVES OF TEENAGE MOTHERS

The Yes I Do programme helped to improve the welfare of young mothers through promoting education and economic empowerment. The programme sensitized the community on the rights and responsibilities of young people, such as the importance of taking girls who are pregnant back to school after delivering. A teacher suggested that such information had provided an opportunity to young women to continue with school.

> *"Yaa. For example, we have got the Yes I do programme, we have a patron and a matron. And we have a committee which was put in place. So these have been trained during workshops on the girls' and boys' rights and on their responsibilities. So the sensitization that has been going on, the peer teaching that has been going on has helped a lot [in bringing young mothers back to school]."* (IDI with a teacher, Chadiza)

Providing economic support was another way through which the programme supported teenage mothers. As further elaborated on in section 3.7.3, the programme encouraged young women to form saving groups or village banks. These groups were said to encourage young people to save some resources and have access to loans for their own business projects. This was partly meant help young people to refrain from engaging in sex for money and also to meet household and educational costs. However, not all young women had been economically empowered and business projects have experienced many challenges including those linked to COVID-19.

*"That is why we encourage them [young people] to join clubs, so that they are opened up and realize to start doing something that is self-employment, it could be selling of talk time, some they sell fried chicken (cut into pieces). Because of the savings that they make, it gives something creative, some they sell sugar canes. When they meet as a club, they even share ideas on how to keep the money, at least they would not just sit but they have something to do. Others do even delivery from one place to the other, they charge money and people pay the owner of the bicycle. They open up several ideas to one another."*
(IDI with a religious leader, Chadiza)

## 3.6 CHILD MARRIAGE

### 3.6.1 PREVALENCE OF CHILD MARRIAGE

The prevalence of child marriage among women aged 18-24 years decreased marginally from 13% at baseline to 11% at end-line. While this is not statistically significant in the univariable analysis (OR = 0.86, p-value>0.01), when adjusted for age and school attendance we observe a statistically significant decrease in the odds of child marriage between base- and end-line (OR = 0.61, p-value<0.05). The decrease in child marriage is only observed in Petauke – from 19% to 16%, while a slight increase is observed in Chadiza from 6.5% at baseline to 7% at end-line (Table 13).

The percentage of girls aged 16 to 24 years who were married or in union before the age of 16 reduced from 2% at baseline to 1% at end-line. Adjusted for age and school attendance of the respondent, a statistically significant decrease between base- and end-line can be observed (OR = 0.36, p-value<0.05). A similar trend can be observed for both Chadiza and Petauke (Table 13).

Despite the observed decreases in child marriage under 18 and 16 years, there was no significant change in the percentage of girls below 18 who are currently married (OR = 1.03, p-value=0.967). There were no girls below 18 in a marriage recorded in Chadiza, and only five at both base- and end-line in Petauke (Table 13).

Table 13 **Child marriage**

| | Baseline | | | Endline | | |
|---|---|---|---|---|---|---|
| | **Chadiza** | **Petauke** | **Total** | **Chadiza** | **Petauke** | **Total** |
| **Young women (20-24 years)** | | | | | | |
| Young women (18-24 years) who were married or in a union before age 18 (i.e. child marriage) | 9 (6.5%) | 27 (19.0%) | 36 (12.8%) | 14 (7.0%) | 30 (15.6%) | 44 (11.2%) |
| Girls and young women (16-24 years) who were married or in a union before age 16 (i.e. child marriage) | 5 (2.0%) | 5 (2.4%) | 10 (2.2%) | 3 (1.1%) | 4 (1.5%) | 7 (1.3%) |
| Girls below 18 years old who are currently married | 0 (0.0%) | 5 (4.9%) | 5 (2.1%) | 0 (0.0%) | 5 (4.2%) | 5 (2.3%) |
| Married girls and young women (15-24 years), who perceive that it was their choice to get married | 20 (58.8%) | 44 (71.0%) | 64 (66.7%) | 37 (75.5%) | 67 (71.3%) | 104 (72.7%) |
| (Married) young women (18-24 years) who were child brides, and who were married to an adult man | 9 (100.0%) | 24 (88.9%) | 33 (91.7%) | 14 (100.0%) | 25 (83.3%) | 39 (88.6%) |
| Young men (18-24 years) who were married or in a union before age 18 (i.e. child marriage) | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) | 1 (1.3%) | 1 (1.6%) | 2 (1.5%) |

There was no significant change over time in the percentage of child brides who were married to an adult man (OR = 0.68, p-value=0.617), which remained high at baseline (92%) and end-line (89%). There was also no significant change in the percentage of married girls and young women (15-24 years) who perceived that it was their choice to get married (OR = 1.3, p-value=0.378). However, a considerable increase in the percentage of women who perceived it was their choice to get married can be observed in Chadiza from 59% at baseline to 75.5% at end-line, whereas in Petauke the percentage remained stable at 71% (Table 13).

### 3.6.2 KNOWLEDGE OF THE MINIMUM, IDEAL AND MAXIMUM AGE OF MARRIAGE

Respondents were asked what they believed to be the ideal age for girls or boys to get married. The average ideal age for boys was higher than for girls at both base- and end-line. The average ideal age for girls was 20 years at baseline and 21 years at end-line, and 23 years for boys at both base- and end-line. There was little variation in the responses of male and female respondents. The lowest acceptable age of marriage for girls was 18 years on average, according to male and female respondents at end-line (the question was not asked at baseline). However, more than one third of the respondents believed that this age lies below 18. The lowest acceptable age of marriage for boys was higher, both male and female respondents reported an average age of 20 years and only 12% reported an age below 18.

Quantitative data reveal a disparity between perceived and actual knowledge with regard to the legal minimum age according to the statutory law. Perceived knowledge on the legal age of marriage significantly increased among females aged 15-24 years (OR = 3.69, p-value<0.001) from 39% at baseline to 77% at end-line (Table 14). Actual knowledge of the legal age of marriage (i.e. female respondents who knew the legal age of marriage is 21) significantly increased (OR=3.49, p-value<0.001), however it remained very low: 8.5% at end-line. Similar results are observed for male respondents. Seventy-seven percent (77%) of the male respondents had perceived knowledge of the legal age of marriage at end-line, a considerable and significant increase from the baseline result of 33% (OR = 8.27, p-value<0.001). However, this did not correspond with young men's actual knowledge of the legal minimum age of marriage (OR = 4.66, p-value = 0.018), which was 8% at end-line (Table 14).

Both male and female respondents with perceived knowledge of the legal minimum age of marriage reported an average legal minimum age for girls of 19 at baseline and 20 at end-line. The average reported legal minimum age for boys was 21 at baseline and 23 at end-line.

Table 14 **Perceptions and knowledge on age of marriage**

| | Baseline | | | Endline | | |
|---|---|---|---|---|---|---|
| | **Chadiza** | **Petauke** | **Total** | **Chadiza** | **Petauke** | **Total** |
| Young women (15-24 years) who perceive to have knowledge of legal minimum age of marriage according to statutory law | 112 (41.2%) | 89 (36.5%) | 201 (39.0%) | 230 (76.4%) | 190 (60.9%) | 420 (68.5%) |
| Young men (15-24 years) who perceive to have knowledge of legal minimum age of marriage according to statutory law | 26 (30.6%) | 37 (34.6%) | 63 (32.8%) | 88 (88.0%) | 63 (65.6%) | 151 (77.0%) |
| Young women (15-24 years) who have actual knowledge of legal minimum age of marriage for girls according to statutory law | 11 (4.0%) | 3 (1.2%) | 14 (2.7%) | 38 (12.6%) | 14 (4.5%) | 52 (8.5%) |
| Young men (15-24 years) who have actual knowledge of legal minimum age of marriage for girls according to statutory law | 0 (0.0%) | 3 (2.8%) | 3 (1.6%) | 14 (14.0%) | 1 (1.0%) | 15 (7.7%) |

Respondents were asked how often children get married under the legal minimum age (whatever they thought the minimum legal age was). At baseline, respondents said 'all the time' (17%), 'frequently' (21%) and 'sometimes' (27%). The percentages of respondents who selected these responses decreased at end-line: all the time, 5%; frequently, 10.5% and sometimes (23.5%). The percentage of respondents who said 'rarely' increased from 16% at baseline to 24% at end-line. Likewise, there was an increase from 18% at baseline to 37% at end-line for respondents who said children 'never' get married under the legal age, especially among female respondents (16% at baseline versus 42% at end-line).

When asked whether there is a minimum age for marriage for girls according to the respondent's religion, the percentage of respondents who said they did not know reduced from 68% at baseline to 37% at end-line. This reduction was seen among both male and female respondents. The percentage of respondents who said 'age of puberty' increased from 0% at baseline to 9% at end-line and the percentage of respondents who said 'no minimum age' increased from 5% at baseline to 14% at end-line. Finally, the percentage of respondents who reported an exact age increased from 26% at baseline to 40% at end-line. At baseline, the reported average minimum age for marriage for girls was 20.6 years among the female and 20 years among the male respondents. This did not change much at end-line: it was 20.7 years among the female and 20.3 years among the male respondents.

With regard to the minimum age for marriage for boys according to the respondent's religion, the percentage of respondents who said 'I don't know' also decreased from 67% at baseline to 40% at end-line. The percentage of respondents who said 'age of puberty' increased from 0% at baseline to 7% at end-line while the percentage of respondents who said 'no minimum age' increased from 5% at baseline to 15% at end-line. At baseline, 27% of the respondents mentioned a specific age, versus 38% at end-line. This increase was seen among both male and female respondents. At baseline, the reported average minimum age for marriage for boys was 23.9 years among the female and 21 years among the male respondents. At end-line, it was 22.7 years among the female respondents and 22.3 years among the male respondents.

When single people were asked at what age they want to marry, the percentage of respondents who reported that they had 'no definite age' reduced considerably from 24% at baseline to 8% at end-line. Only very few respondents never wanted to marry at baseline (3.5%) and no respondents said so at end-line (0%). The remaining respondents provided a specific age at which they wanted to be married. The average age decreased from 24 years at baseline to 23 years at end-line among single girls and from 27 to 24 years among single boys.

### 3.6.3 CIRCUMSTANCES OF AND REASONS FOR CHILD MARRIAGE

At baseline, we found that teenage pregnancy, limited future perspectives due to lack of education and job opportunities and gender inequality were mentioned to be the main drivers of child marriage. Many participants mentioned that child marriage was often related to economic hardship. When a girl was pregnant, marriage would push her upkeep to the boy and his family. In addition, the practice of bride price encouraged girls to marry. Religion and tradition were not identified to be connected to child marriage, although initiation ceremonies were reported to symbolize the transition into adulthood and readiness to marry. At end-line, these main reasons for child marriage were all mentioned as well. A parent in Petauke reported how teenage pregnancy and economic hardship were related to child marriage:

> *"Nowadays, a lot of young people, girls and parents, understand that a girl should continue learning until when she is about to deliver, but for some it's opposite. The moment a girl gets pregnant, that's the end of higher education and she will be married. They will charge cattle or money to the boys' family and push them into marriage. It's very rare that such cases are reported to relevant authorities such as the victim support unit and human rights; they are dealt with in the village to be honest with you."*

The survey respondents were asked whether someone intervenes when children are married or about to be married under the legal age. At baseline, 54.5% of all respondents said that this was the case, and this remained 54% at end-line. However, the percentage of respondents who said that nobody intervenes dropped from 29% at baseline to 13% at end-line. This was because at baseline, more respondents reacted with 'don't know'. The respondents who

indicated that someone usually intervenes indicated that this was mostly done by community leaders (41% at baseline and 65% at end-line), NGO staff (19% at baseline and 36% at end-line), law enforcement agents (4% at baseline and 22% at end-line) or the police (40% at baseline and 29% at end-line) (multiple answers were possible). The frequency of intervening in child marriage also went up over time, as can be seen in Table 15.

Table 15 **Frequency of intervention in child marriage**

| Frequency of intervention in child marriage | Baseline | End-line |
|---|---|---|
| All the time | 8 (5.6%) | 99 (22.6%) |
| Frequently | 42 (29.2%) | 182 (41.5%) |
| Sometimes | 64 (44.4%) | 131 (29.8%) |
| Rarely | 27 (18.8%) | 18 (4.1%) |
| Never | 3 (2.1%) | 5 (1.1%) |

### 3.6.4 ATTITUDES AROUND CHILD MARRIAGE

When asked about potential benefits of child marriage, all FGD and interview participants said that there are no benefits. However, some of them pointed to certain (short-term) benefits for specific people or in specific circumstances. For example, orphans were said to be sometimes better of when married. Short-term economic benefits for the girl's family often turned into longer-term economic hardship for the married child. The majority of the participants said that child marriage resulted in a lack of money/ economic opportunities (also because education was stopped) and not being able to care for one's family. Many also said that young brides do not know how to care for children and young grooms cannot take their responsibility to provide for the family. One parent, in an FGD in Petauke, mentioned that young people who marry young often divorce. A 22-year-old male participant from Petauke and a participant in an FGD (15-19 years) in Petauke referred to violence within marriage as a result of marrying too young. The participant of the same FGD mentioned that once a girl is married, all freedom is gone, because *"It is a must that a man will be bigger than you… any simple mistake you make then you are beaten."*

In line with the above, in the survey, on the statement 'There are advantages to marriage under 18 years for girls', 85% of all respondents disagreed at both base- and end-line. With regard to the statement 'A girl should never be forced or compelled into marriage', 95% of the respondents agreed at baseline, and 81% of the respondents agreed at end-line. Disagreement with this statement went up from 5% at baseline to 15% at end-line, where more females than males disagreed. Table 16 provides an overview of the level of disagreement with some statements around child marriage acceptability at end-line. This table shows that the although limited education, job opportunities and financial aspects were mentioned to contribute to child marriage (in the qualitative component), they were not regarded as acceptable reasons for child marriage by many of the survey respondents.

Table 16 **(Un)acceptability of child marriage at end-line**

| It is acceptable for a girl to marry under 18… | Level of disagreement at end-line |
|---|---|
| Because there is a lack of education opportunities | 705 (87.1%) |
| Because there are no job opportunities for her to work | 689 (85.2%) |
| To solve financial problems of the family | 699 (86.4%) |
| To give her financial security | 712 (88.0%) |
| To reduce the poverty of her family | 712 (88.0%) |

At end-line, 77% of all respondents agreed that if a girl marries under the age of 18, her family should pay a fine or be arrested. Ninety percent (90%) of the respondents at baseline recognized that a child marriage often occurs after a teenage pregnancy, but the majority (67%) also believed that child marriage is not a solution if a girl gets pregnant. At end-line, the percentage of respondents who believed that a child marriage often occurs after a teenage pregnancy decreased considerably to 42%, and 75% of the respondents believed that it is not a solution to pregnancy.

### 3.6.5 INTER-LINKAGES BETWEEN MARRIAGE AND PREGNANCY

Table 17 provides an overview of what came first: pregnancy or marriage, or if pregnancy and marriage happened in the same year, for different age groups. Both at base- and end-line, the female respondents who had both experienced pregnancy and marriage most often indicated that they happened in the same year. The percentage of females who indicated that they first became pregnant and then got married significantly increased over time, from 23% at baseline to 40% at end-line (OR=2.10, p-value<0.05). It is probable that this percentage is higher. First, because if pregnancy and marriage happened in the same year, the dataset does not provide for the exact order. Second, because of underreporting as a result of the taboo on sexual activity before marriage (80% of all respondents disagreed with the statement 'It is acceptable for girls to have sex before marriage' and 76% of all respondents disagreed with the statement 'It is acceptable for boys to have sex before marriage' at end-line). In addition, participants in the qualitative interviews and FGDs often mentioned that marriage was a consequence of teenage pregnancy.

Table 17 **Inter-linkages between marriage and pregnancy**

| | Baseline | | | End-line | | |
|---|---|---|---|---|---|---|
| | **Chadiza** | **Petauke** | **Total** | **Chadiza** | **Petauke** | **Total** |
| Number of (ever) married teenage mothers (15-19 years)[1] | 2 | 11 | 13 | 6 | 14 | 20 |
| Number of (ever) married teenage mothers (15-19 years) who first experienced a child marriage followed by a teenage pregnancy | 0 | 3 | 3 | 1 | 1 | 2 |
| Number of (ever) married teenage mothers (15-19 years) who first experienced a teenage pregnancy followed by a child marriage | 0 | 1 | 1 | 0 | 1 | 1 |
| Number of (ever) married teenage mothers (15-19 years) who experienced a teenage pregnancy and a child marriage in the same year | 2 | 5 | 7 | 1 | 4 | 5 |
| (Ever) married mothers (15-24) who were first married and then became pregnant | 7 (20.6%) | 24 (39.3%) | 31 (32.6%) | 9 (18.4%) | 11 (12.0%) | 20 (14.2%) |
| Married mothers (15-24) who first became pregnant and were then married | 6 (17.6%) | 16 (26.2%) | 22 (23.2%) | 21 (42.9%) | 35 (38.0%) | 56 (39.7%) |
| Married mothers (15-24) who married and became pregnant in the same year | 21 (61.8%) | 21 (34.4%) | 42 (44.2%) | 19 (38.8%) | 46 (50.0%) | 65 (46.1%) |

1 The total number of (ever) married teenage mothers (15-19 years) includes women who had a teenage pregnancy but not a child marriage.

### 3.6.6 DECISION-MAKING DYNAMICS IN RELATION TO MARRIAGE

To assess the decision-making capacity regarding marriage of both young women and men, a number of questions were asked. Overall, there is no statistically significant change in the percentage of female respondents (OR=0.94, p-value=0.685) or male respondents (OR=1.11, p-value=0.746) who agreed that their parents or relatives decide their future partner. The percentage of girls and young women (15-24 years) who agreed that their parents or relatives

decide their future partner reduced from 22% at baseline to 14% at end-line in Chadiza. On the contrary, in Petauke, there was an increase in the percentage of girls and young women (15-24 years) who agreed that their parents or relatives decide on their future partners, from 16% at baseline to 22% at end-line. In Chadiza, the percentage of boys and young men (15-24 years) who agreed that their parents or relatives decide their future partner increased from 8% at baseline to 19% at end-line, while a decrease from 15% at baseline to 9% at end-line was observed in Petauke (Table 18).

Table 18 **Decision-making regarding marriage**

| | Baseline | | | Endline | | |
|---|---|---|---|---|---|---|
| | **Chadiza** | **Petauke** | **Total** | **Chadiza** | **Petauke** | **Total** |
| Girls and young women (15-24 years) who agree that their parents or relatives decide their future partner | 61 (22.4%) | 39 (16.0%) | 100 (19.4%) | 41 (13.6%) | 69 (22.1%) | 110 (17.9%) |
| Boys and young men (15-24 years) who agree that their parents or relatives decide their future partner | 7 (8.2%) | 16 (15.0%) | 23 (12.0%) | 19 (19.0%) | 9 (9.4%) | 28 (14.3%) |

At both baseline and end-line, we asked (married) females and male respondents additional statements about whether it was the right time to get married, their choice to get married and whether they were given pressure by individuals to get married. Overall, the respondents who said it was the right time to enter into marriage decreased from 59.5% at baseline to 42.5% at end-line. The decrease was observed largely among female respondents (from 58% to 40%). When asked whether it was their choice to get married, there is an increase in the percentage of females who said 'yes' from 66% at baseline to 72% at end-line, but this is not statistically significant (OR=1.30, p-value=0.387). Among males, there was a slight decrease from 89.5% at baseline to 86% at end-line. Regarding whether they were pressured to enter into marriage by other persons, overall, the percentage of respondents who said 'yes' decreased from 32% at baseline to 17% at end-line.

The qualitative data show a mixed picture regarding decision-making around marriage. Different views were expressed across all interviews regarding who makes decisions regarding marriage. While some study participants said that parents were the main decision-makers, others were of the view that the situation has changed over time. They were of the opinion that decisions to marry are now mainly made by the girls and boys themselves. Those who said that some parents still make marriage decisions for their children cited financial constraints, educational concerns as well as social obligations as reasons. Similar to the baseline, participants noted that parents may force young people to get married because of teenage pregnancy, poor school performance, not wanting to continue caring for the girl, poverty and the perceived financial benefits that may come with marriage.

> *"Some parents force girls to marry so that they can bring wealth to the family such as cattle and money … so in fearing them getting diseases and unwanted pregnancies some parents prefer their boys and girls marry though young."* (IDI with a parent, Petauke)

Those who stated that these days more young people make independent decisions regarding marriage explained that children cannot be forced into marriage as they are aware of their rights. It was reported that in a few cases children decide to marry even when parents advise against it. It was reported that in very few cases children threaten to commit suicide if they are not allowed to marry the person they love.

> *"Sometimes the children themselves are the ones who actually insist that they should marry. This results in some of the parents to just let them on their own."* (FGD, boys 16-18 years, Petauke)

In-depth interviews with a headman and parents as well as FGDs with young people showed that it was not easy for parents to force children into marriage because there are bylaws that do not allow this, according to the national law. The presence of community structures such as the paralegal and community leaders who enforce these laws seem to have made many community members to stop forcing young people into marriage.

> *"Mmmm, such situations here are not common. And we don't allow parents forcing a child to marry yes… it will never happen as long as I am alive and remain a village headman."* (IDI with a headman, Chadiza)

It was also suggested that the Yes I Do alliance's continued effort and sensitisation on the importance of education and the negative consequences of early marriage made some parents to stop making marriage decisions on behalf of the children.

> *"… because of the education given to them, the (children) express themselves to say I'm being forced."* (IDI with a religious leader, Chadiza)

### 3.6.7 PREVENTION OF CHILD MARRIAGE

Participants of the qualitative interviews and FGDs were asked what is done to prevent child marriage. As compared to baseline when little was being done, several participants mentioned Plan Zambia's efforts in awareness raising initiatives on the negative consequences of child marriage and teenage pregnancy. A few participants mentioned that young people accessed information about preventing pregnancy from youth friendly corners and community health workers. In addition, similar to what was said at midline, several participants referred to chiefs and headmen having the authority to cancel child marriage and the establishment and implementation of bylaws. Participants also explained that when a schoolgirl becomes pregnant, the male partner (boy) is also sent home (from school) until the girl delivers. The new approach, along with other punishments such as paying cattle to the chief or moulding bricks, served as a deterrent to boys as well, and had a preventive effect on child marriage (and teenage pregnancy).

> *"… chiefs and the district commissioner met some years ago and agreed that whoever allows boys and girls below the age of 20 to marry will be charged to pay a fine of cattle to the chief. Also, parents are to mould bricks for the school where the children are learning and if not in school, they would mould for their traditional chief."* (IDI with a 21-year-old man, Chadiza)

Other participants spoke about child marriage cases now frequently being reported to the police. In particular, a parent in Petauke, referred to the national laws and the victim support unit of the police service that helps young women when they are forced to marry by their parents. Young women (15-19 years) in an FGD also referred to the police. Again, it was said that the police handling of such cases has made many parents afraid to marry off their daughters, thus serving as a preventive measure.

Some key informants spoke about how other stakeholders were implementing various activities to prevent child marriage, including the social welfare department sponsoring girls to stay in school; and adaptations of the curriculum for initiation ceremonies for girls. However, some participants were not convinced that child marriage incidence had reduced compared to the baseline situation. In particular, most participants from Petauke spoke of nothing being done to prevent child marriage and hardly referred to bylaws related to child marriage, except in one FGD with young men (20-24 years), where participants were not in agreement with each other on whether bylaws were there.

## 3.7 EDUCATION AND ECONOMIC EMPOWERMENT

### 3.7.1 ACCESS TO (HIGHER) EDUCATION AND ECONOMIC OPPORTUNITIES

Overall, there was no observed change in the percentage of girls aged 15 to 18 years who currently attended secondary school (OR=1.00, p-value=0.982). In Chadiza, 30% of the girls were currently attending secondary school at baseline compared to 28% at end-line, while in Petauke, the percentage of girls attending secondary school slightly increased

from 21.5% at baseline to 23% at end-line. A statistically significant decrease in the percentage of girls below 18 years who dropped out of school was observed (OR=0.58, p-value<0.05). Among the girls aged below 18 years surveyed at baseline, 29% in Chadiza and 47% in Patauke had dropped out of school. At end-line, the dropout rate decreased slightly in Chadiza (27%) but more considerably in Petauke (35%) (Table 19).

Table 19 **Education and economic empowerment**

| | Baseline | | | Endline | | |
|---|---|---|---|---|---|---|
| | **Chadiza** | **Petauke** | **Total** | **Chadiza** | **Petauke** | **Total** |
| **Education** | | | | | | |
| Girls aged 15-18 currently attending secondary school | 52 (30.1%) | 28 (21.5%) | 80 (26.4%) | 35 (28.0%) | 34 (23.3%) | 69 (25.5%) |
| Girls aged below 18 years who dropped out of school | 38 (28.6%) | 48 (47.1%) | 86 (36.6%) | 27 (27.0%) | 42 (35.0%) | 69 (31.4%) |
| Girls below 18 years who left school due to marriage | 0 (0.0%) | 3 (2.9%) | 3 (1.3%) | 1 (1.0%) | 0 (0.0%) | 1 (0.5%) |
| Girls below 18 years who left school due to pregnancy | 12 (9.0%) | 7 (6.9%) | 19 (8.1%) | 9 (9.0%) | 9 (7.5%) | 18 (8.2%) |
| Girls aged 20-24 years who left school due to pregnancy | 27 (36.0%) | 9 (10.3%) | 36 (22.2%) | 55 (36.7%) | 33 (23.9%) | 88 (30.6%) |
| Girls (15-18 years) who have a child and follow education | 14 (63.6%) | 1 (5.3%) | 15 (36.6%) | 7 (24.1%) | 3 (12.5%) | 10 (18.9%) |
| Boys below 18 years who left school due to marriage | 0 (0.0%) | 0 (0.0%) | 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 | 11 (7.9%) | 14 (9.9%) | 25 (8.9%) | 80 (39.8%) | 84 (43.8%) | 164 (41.7%) |
| Young women (18-24 years) who have received any income in the last six months | 24 (17.3%) | 52 (36.6%) | 76 (27.0%) | 10 (5.0%) | 17 (8.9%) | 27 (6.9%) |

In line with the high prevalence of teenage pregnancy reported in Section 3.5.1, and a moderately high school drop-out (Table 19), there is a slight yet statistically significant increase in the percentage of young women (20-24 years) who dropped out of school due to pregnancy (OR=1.69, p-value<0.05). This is not the case for the percentage of girls below 18 years who dropped out of school due to pregnancy (OR=0.75, p-value=0.450), which did not change over time in Chadiza and only slightly increased in Petauke (baseline 7%, end-line 7.5%). There is also no observed change over time in the percentage of girls below 18 years who left school due to marriage. This remained low at both base- and end-line, as no girl dropped out of school due to marriage in Chadiza at baseline and only one at end-line, while Petauke recorded a decrease from three girls at baseline to none end-line (Table 19). No boys aged below 18 years left school because of marriage (not shown in the table).

In Petauke, there was a higher percentage of girls (15-18 years) who had a child and followed education at the end-line (12.5%) compared to baseline (5%), while in Chadiza, there was a decrease: from 63% at baseline to 24% at end-line. Qualitative data suggest that the COVID-19 had contributed to increased school dropout and also to early marriage, because schools had been closed for a long time. The conversation in an FGD with girls (15-19 years) in Petauke provides more information on the effects of COVID-19:

I: *"How disturbed are we with this COVID-19 in terms of education apart from what our friends have mentioned?"*
P4: *"A lot of people have stopped school."*
I: *"Why have they stopped school?"*
P4: *"They feel lazy to start afresh."*
I: *"Okay, P3 you want to say something?"*
P3: "*Yes, some thought that schools will never be opened and as a result, a lot of children got married."*
I: *"Now within the small period of time they managed to find marriages?"*
P6: *"Yes, we stayed at home for almost seven months. The period was quite long."*

A significantly higher percentage (42%) of young women (18-24 years) indicated to be economically active outside the household at end-line (OR=6.98 p-value<0.001) as compared to baseline (9%). The increase over time was equal in Chadiza (from 8% at baseline to 40% at end-line) and Petauke (from 10% at baseline to 44% at end-line). Despite a higher percentage of young women reporting to be economically active, the percentage of young women (18-24 years) who had received any income in the last six months significantly decreased (OR=0.17, p-value<0.001) over time (in Chadiza, from 17% at baseline to 5% at end-line and in Petauke from 37% at baseline to 9% at end-line) (Table 19).

Similar to their female peers, there was an increase in the percentage of young men (18-24 years) who said they were economically active outside of the household in both Chadiza and Petauke. In Chadiza, this went from 24% at baseline to 47% at end-line and in Petauke, from 14% at baseline to 73%) at end-line. In Chadiza, the percentage of young men who received any income in the last six months decreased from 34.5% at baseline to 11% at end-line, while in Petauke, an increase was seen from 8% at baseline to 13% at end-line. In the qualitative interviews, it was suggested that failure to effectively do business or work due to the COVID-19 could have contributed to loss of income.

*"COVID-19 made people stop working in the past months and some were not even getting paid."*
(FGD girls 15-18 years, Chadiza)

### 3.7.2 SAFETY IN AND AROUND SCHOOLS

At baseline, not much was said about school safety and how safety issues affect girls' education in the two districts. At end-line, participants emphasized how a general improvement in school infrastructure had led to increased enrolment and retention in schools. Participants explained that the improvement in school infrastructure has shortened the distances to schools, invariably enhancing access and safety for girls in particular.

*"Yes there is a change, because many boys and girls are willing to attend school, because of the new secondary school that has been built in this area and also there are some dormitories for those that come from far distances."* (FGD, boys 15-19 years, Chadiza)

*"Aah, so far schools are accessible starting this year for young ones. We have a school that was built this year within our village so children are now walking a few meters from home to school, compared to previous years where they had to a long way to access education, which was not good for girls."*
(IDI with a female parent, Chadiza)

### 3.7.3 ACCESS TO ECONOMIC EMPOWERMENT OPPORTUNITIES

Similar to the baseline situation, socio-economic factors continue to determine the SRH outcomes of young people in the Yes I Do intervention areas. Many participants spoke about teenage pregnancy and child marriage deepening the economic fortunes of families and expressed their desire to see an end to child marriage and teenage pregnancies.

As compared to the baseline, more participants at end-line spoke about economic empowerment interventions that seem to have addressed the basic needs of families and contributed to increased access to education by girls. Participants spoke about how village saving groups and the rearing of chickens and goats provided by Plan Zambia were helping them to meet their basic needs, including paying school fees. The narratives suggest that the economic empowerment interventions were implemented more towards the end of the Yes I Do programme.

*"Aah, well, like this organization Plan International really helped, if I remember young people we were given goats to rear and through rearing we used to pay school fees after selling goats."*
(IDI with a 21-year-old man, Chadiza)

*"It was this year when they started when they went for training. At the end of it they gave them chance to choose what they want. They have goats, chickens and then if you want this alone it means they will provide you with everything so it is up to you to choose what you want."* (IDI with a 20-year-old woman, Petauke)

Nonetheless, the percentage of female respondents who believed that economic empowerment is a solution against child marriage decreased considerably from 81% at baseline to 34% at end-line, and from 95% to 51% among male respondents.

## 3.8 POLICY AND LEGAL ISSUES

### 3.8.1 KNOWLEDGE AND AWARENESS OF LAWS

Section 3.6.2 covers the knowledge and awareness of laws related to child marriage. It was found that while young people perceived that they have adequate knowledge of legal minimum age for girls according to statutory law, their actual knowledge was limited. Nevertheless, looking at young people's responses to survey questions and their and others' responses in interviews and FGDs, it is clear that people are aware that marrying young is illegal.

Married survey respondents were asked whether their (first) marriage was registered. At baseline, 89% of all married respondents indicated that their marriage was not registered, and at end-line, this was 84%. Religious registration was mentioned by 11% of the married respondents at baseline and by 22% of the married respondents at end-line. At baseline, two respondents indicated that their marriage was registered by the government, at end-line, none of the married respondents had an official government registration of their marriage. Furthermore, at baseline, seven married respondents reported to have a marriage certificate, against 16 at end-line.

### 3.8.2 LOCAL LAWS AND POLICIES

In section 3.6.7, it is reported that bylaws have been established to prevent child marriage and teenage pregnancy, mainly through punishing measures for parents and children who are involved in child marriage or teenage pregnancy. The findings indicate that the awareness on the existence of these bylaws was higher in Chadiza than in Petauke. The enforcement of bylaws seems also better in Chadiza than in Petauke. In Chadiza, many participants referred to the various punishments happening (they provided examples around this), while in Petauke, although in (only) one FGD it became clear that bylaws were established in 2017, one young man (20-22 years) in this FGD said they are not enforced:

*"These [bylaws] for me I have not seen them changing, like for instance moulding bricks or paying fines to the chief [is not happening], but only the issue of paying the girl who has been impregnated [is happening]. I have never seen people moulding bricks for such a reason."*

At midline, we found that there was limited ownership of bylaws by traditional leaders as well as the community at large. There was also confusion around who developed the bylaws (community members thought they were developed by Plan Zambia). At end-line, ownership seems to have increased, and confusion at community level seems to have decreased in Chadiza, while some confusion remained Petauke. A key informant from Plan Zambia reported that the bylaws were approved by the Ministry of Local Government through the district councils. The chiefs, who are part of the councils, have adopted the bylaws in both districts.

At end-line, there was no mention of national level policy makers being involved in community awareness meetings around preventing teenage pregnancy and child marriage, including issues on gender equality and girls' rights. This was particularly reported by participants at midline.

# 4. DISCUSSION

In this section, we discuss the key findings of the base-, mid- and end-line study. The study aimed 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 issues themselves, are present in the intervention areas of the Yes I Do programme in Zambia over a period of four years. In addition, the end-line study aimed to provide insight into the different pathways of change, thereby testing the theory of change, and unravelling why and how the Yes I Do interventions 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 in the intervention areas. The results of the study are discussed according to the five pathways of change and the cross-cutting strategies (meaningful youth engagement, male involvement, gender transformative programming and girls' empowerment). However, we first summarize the findings on the two main impact indicators of the Yes I Do programme: child marriage and teenage pregnancy.

## 4.1 CHILD MARRIAGE AND TEENAGE PREGNANCY: PERSISTENT PROBLEMS IN CHADIZA AND PETAUKE

The results show that the prevalence of child marriage among women aged 18-24 years decreased marginally from 13% at baseline to 11% at end-line, which is statistically significant when adjusted for age and school attendance. The decrease in child marriage is only observed in Petauke, while a slight increase is observed in Chadiza. The factors perpetuating child marriage have remained the same over time: teenage pregnancy, limited future perspectives due to lack of education and job opportunities, gender inequality, economic hardship and traditional practices such as initiation ceremonies. While this study shows a marginal reduction in child marriage over the period of 2016 to 2020, teenage pregnancy, which can be both a cause and an effect of child marriage, remains high in both Yes I Do intervention districts. The percentage of female respondents (20-24 years) who had their first child under the age of 20 years significantly increased from 45% at base- to 61.5% at end-line. The increase was similar in Chadiza and Petauke. This study is inconclusive on why teenage pregnancy raised to such an extent (and, for example, did not remain stable) over time. Unsurprisingly, the causes of teenage pregnancy were similar to those influencing child marriage: early and unprotected sexual intercourse, economic pressure, low education levels, and cultural factors such as initiation ceremonies (Menon et al., 2018c).

Compared to teenage pregnancy, child marriage seems a 'low hanging fruit', which is amendable to change due to high political commitment and a conducive policy environment towards ending the practice across Africa. At the continental level, the African Union (AU) launched the first-ever Campaign to End Child Marriage in Africa in 2014 (AU, 2014a), which was followed by the appointment of an AU Special Rapporteur and a Goodwill Ambassador with a mandate exclusively focused on child marriage (AU, 2014b). The need to end child marriage is also embedded in the Agenda 2063, the AU's 50-year vision for the development of the continent, including a commitment to "mobilize a concerted drive towards immediately ending child marriage, female genital mutilation and other harmful cultural practises that discriminate against women". These high-level, continent-wide political commitments have spurred governments across Africa to institute national measures aimed at ending child marriage. In 2014, the Government of Zambia launched a national campaign to end child marriage and in 2016, a National Strategy on Ending Child Marriage was developed to guide the campaign (Government of Zambia – Ministry of gender, 2016). Accordingly, it seems that NGOs like Plan Zambia are more comfortable implementing activities to address child marriage compared to other issues such as teenage pregnancy. This may explain why the Yes I Do programme had a more positive effect on child marriage than on teenage pregnancy. The findings suggest that since both child marriage and teenage pregnancy share similar causes and effects on girls, both the AU and national governments need to pay the same political attention to addressing teenage pregnancy.

## 4.2 PATHWAY 1

### COMMUNITY MEMBERS, GATEKEEPERS AND OTHER STAKEHOLDERS HAVE CHANGED ATTITUDES AND TAKE ACTION TO PREVENT CHILD MARRIAGE AND TEENAGE PREGNANCY

The study findings point to a limited progress towards forming a social movement to challenge gender and social norms restricting girls' rights and suggest that more needs to be done for such a movement to be fully established.

Although most community stakeholders are much aware of the negative consequences of child marriage and teenage pregnancy, and some take actions in preventing – and particularly, reacting to – child marriage and teenage pregnancy, actions to change underlying gender and social norms were less prominent. Addressing gender norms is instrumental for prevention of child marriage and teenage pregnancy in sub Saharan Africa (Sedgh et al. 2015).

The qualitative narrative shows that young people, in particular those involved in the CoC intervention, are reaching out to peers and (although less often) to other community members to discuss topics on gender, gender equality, girls' rights, the harmful effects of child marriage and teenage pregnancy, and the importance of education. In fact, young people themselves seem to be one of the most important change agents in this regard (Assumption 3 of the theory of change). In some communities, traditional and community leaders seem to support young people in conducting these activities, and also publicly champion gender equality and girls' rights through awareness raising in community meetings or through the enforcement of bylaws. At end-line, many participants referred to the establishment (and in Chadiza, the reinforcement) of bylaws. This shows the communities' awareness about the need to decrease cases of child marriage and teenage pregnancy, however, it remains to be seen if the punitive nature of these laws can also contribute to prevention.

The implementation of the CoC intervention seems to have triggered some positive changes in gender roles. Some young men said to be involved in tasks and chores that are traditionally defined as tasks and chores for women, and vice versa (Zulu, Krugu and Kok, 2020). Although the percentages of young people agreeing that men should have the decision-making power in the household and that women should be subservient to men decreased over time, still, the majority of young people agreed with these kinds of statements, representing persisting gender unequal attitudes. Quantitative data further show that physical violence against women and sexual harassment increased from base- to end-line. This could be a result of increased awareness about the importance of reporting such violence. Qualitative narratives confirm that verbal abuse and emotional violence are prevalent in the community. These findings are in line with what is reported in the ZDHS 2018, indicating that 36% of the women in Zambia had experienced physical violence at least once since they turned 15 years, of whom 18% had experienced it within the previous 12 months (Zambia Statistics Agency, 2019). This calls for more attention towards programming on ending GBV, which requires a transformation in gender norms as well.

It is difficult to transform social and gender norms. It requires involvement of all community gatekeepers. This study reveals that not all gatekeepers were equally addressed by the Yes I Do interventions. As a consequence, not all gatekeepers have actively taken action towards promoting gender equality and girls' rights. Religious leaders were considered active, but they mainly promoted abstinence and morality. It is unclear whether religious leaders were actively engaged in the Yes I Do activities. While health workers and teachers were engaged, their role in promoting SRHR was not so visible and teachers, and even some health workers, seemed to toe the line of religious leaders – stressing that abstinence is best for young people. Further, the Yes I Do alliance seems to have targeted parents in a limited manner, which has implications for intergenerational communication on matters related to gender and SRHR. One of the assumptions underlying the theory of change was that 'through participating in intergenerational dialogues, men and boys become allies in changing social norms'. Intergenerational dialogues have been organized by Yes I Do in both districts, but have not resulted in more sustained intergenerational communication. Study results indicate that in some households, it significantly improved – particularly if children took part in the CoC intervention – and in others not at all. The taboo on youth sexuality is large and supported by all these community gatekeepers. This makes it more difficult for young people to speak out and enjoy their SRHR. A qualitative study conducted in the Southern province of Zambia also showed that injunctive norms made parents to oppose to the idea that their girls use contraception to avoid unintended pregnancies, and that talking about contraception and condoms was viewed as encouraging girls to 'experiment' or to become 'prostitutes' (Svanemyr, 2019). Initiation ceremonies for girls happen in both districts. There were mixed views on whether the content of the ceremonies changed in terms of more gender equal information and education or prevention of teenage pregnancy. An earlier study under the Yes I Programme revealed that there were gradual changes in initiation ceremonies in Chadiza, but that information on how to have sexual intercourse and how to please a man in that regard was still part of the curriculum for very young girls (Menon et al. 2018a). This curriculum has now been changed, with involvement of the Yes I Do programme and this might yield positive results in the coming years. The absence of other NGOs in both districts, besides those involved in Yes I Do, did not help in strengthening collective action towards promoting gender equality and girls'

rights, and preventing child marriage and teenage pregnancy.

Evidence indicates that stakeholder influence on social and gender norms originates in the collective action of these stakeholders. Collective action binds individuals together, assists in the formation of a common identity and interests, and provides the means for stakeholder strategic action (King, 2008). Despite that pathway 1 of the Yes I Do theory of change intended to do so, it is important for future programmes to focus more on the *collective action* necessary for stakeholder influence. This will help to gain a better understanding of how negotiation processes might unfold between different stakeholders on sensitive matters such as adolescent SRHR. Collective action can be stimulated 'from outside', but needs to be established 'from inside', if a social movement is to sustain. The qualitative narratives from this study show that some participants, including community leaders, spoke of Plan Zambia in the past, suggesting that the presence of Yes I Do in the community might have been limited in the recent months (in 2020). While this was influenced by COVID-19, it is clear that the Yes I Do programme has not been able to reach all corners of the intervention areas, in particular in Petauke. In addition, the continuous reference to Plan Zambia's presence (or not) gives the impression that the implementation of activities is still much dependent on Plan. For example, a participant indicated that since Plan left, traditional leaders were not so active anymore in their actions around child marriage and the reinforcement of bylaws. This raises questions about ownership and thus sustainability of the various interventions of the programme.

Table 20 **Recommendations – Pathway 1**

| **Programme** |
| --- |
| The establishment of a social movement to respond to child marriage and teenage pregnancy requires the collective action of different stakeholders. It is important for future programmes to focus more on the collective action necessary for stakeholder influence. |
| **Research** |
| Bylaws seem to take a punitive approach to addressing teenage pregnancy, which can contribute to criminalization of adolescent sexual conduct. It is unclear whether such bylaws can reduce teenage pregnancy and protect adolescents, especially girls, from harms of sexual conduct. Future studies should explore the impact of bylaws on adolescent's sexual agency, prevention of teenage pregnancy and protection from exploitative sexual conduct. |

## 4.3 PATHWAY 2 AND 3

### PATHWAY 2 – 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 of the Yes I Do theory of change aimed to improve the level of meaningful engagement of adolescent girls and boys in community activities, programmes and policies – thereby claiming their SRHR. In relation to that, pathway 3 aimed to enhance adolescents' informed action on their SRH.

This study shows that some progress has been made towards engaging young people on their SRHR. Household-level discussion of sensitive topics such as SRHR improved for some, and not for other young people. Participation in community discussions and activities increased for some Champions of Change, however, the CoC evaluation also shows that the opportunity to speak out, in particular for young women, is still limited (Zulu, Krugu and Kok, 2020). The end-line study reveals that the Yes I Do programme activities, and in particular the CoC intervention, made young people more aware of their SRHR. The assumption in the Yes I Do theory of change on adolescent girls and boys who have improved knowledge concerning their rights wanting to organize themselves to influence others is indeed, at least partly, met. Young people were more comfortable talking about SRHR and gender equality with their peers

(of the same gender) as compared to talking to other age groups. This points to the added value of peer-to-peer engagement and the need to maintain meaningful youth participation and youth-led activities to take advantage of their 'comfort zone' conversations to enhance programme reach and effectiveness.

The study found that young people's decision-making in dating and marriage stayed generally stable over time. Most young people felt that they have autonomy in dating and deciding whom to marry. However, among females, the percentage who said that they can decide themselves whom to date significantly decreased over time. In Chadiza, the percentage of young people (both females and males) who agreed that their parents or relatives decide their future partner went down, while in Petauke, it went up. At base-, mid- and end-line, it was clear that young people's voice in marriage decisions was limited when a girl was pregnant.

Most end-line survey respondents indicated to have ever received SRHR information or education. In addition, more respondents had used contraceptives and SRH services at end-line as compared to baseline. Despite these improvements in information and service use, we still observe a significant increase in the teenage pregnancy rate in both Chadiza and Petauke.

When we look further into the quantitative end-line data, it can be observed that female respondents with pregnancy experience used SRH services, in particular family planning, the most. Girls and young women who had never been pregnant used family planning services less often than those who had ever been pregnant. The probability of contraceptive use, as such, increased after having experienced a pregnancy before. This corresponds to another finding that at end-line, there was a reduction in repeated pregnancies as compared to the baseline. Evidence has shown that having begun early childbearing, adolescent mothers are at increased risk of experiencing a rapid repeat pregnancy (Norton et al., 2017). It is therefore positive to see that young mothers more often seek and use SRH services leading to a reduction in repeated pregnancies. Other positive observations are that although women who ever had a child use contraceptives and SRH services more than women who never had a child, the latter group showed a significant increase over time in having ever used contraceptives, current use of contraceptives and the use of SRH services.

About one in three females and about one in two males reported to currently use contraceptives at end-line. While this was an increase compared to the baseline, it means that many young people actually do not use contraceptives, while 80% is sexually active. Evidence suggests that ineffective contraception — defined as non-use, inconsistent use or use of methods with high failure rates — is a strong predictor of an unplanned pregnancy (Coles et al., 2011). The increase in the teenage pregnancy rate, albeit increasing use of SRH services, raises questions about consistent use of contraceptives. The end-line data show that half of the respondents who used contraceptives indicated that they used male condoms as a contraceptive (female condoms are hardly used). The data also show that among males, attitudes on appropriateness for girls to propose condom use, and their own confidence to insist on condom use, went down over time. About two third of the female and male respondents felt confident to insist on condom use every time they have sex. This leaves quite some space for inconsistent condom use and consequently (teenage) pregnancy, despite that young people indicate to use contraceptives. The contraceptive pill, which was the third most used contraceptive among young women at end-line (after injections and condoms), also needs consistent use to prevent (teenage) pregnancy.

There is a need to consider promoting the importance of consistent use of all pregnancy prevention methods, including condoms. The lack of full involvement of stakeholders in promoting SRHR and the stressing of abstinence as the only best method for preventing pregnancy by many parents, teachers and some health workers, could have affected the adoption and use of other pregnancy prevention methods. More attention should also be given to value clarification among teachers involved in implementing activities. It could be considered to provide opportunities for teachers who are not comfortable teaching skills-based sexuality education to opt out. This is necessary because abstinence-only messages are not effective in preventing teenage pregnancy (Kohler et al., 2007). An increasing percentage of all respondents (38% at end-line) indicated to be worried about being denied access to contraceptives. Furthermore, the percentage of female respondents (15-24 years) who agreed with the statement 'It is difficult to access contraceptives for young people' increased over time to 58% at end-line. Forty-two percent (42%) of all male respondents thought the same. In addition, at end-line, about two out of three respondents indicated that people

can only access contraceptives after having children, or after being married. This shows that there remains a problem in young people's access to modern contraceptives in Chadiza and Petauke. The use of modern contraceptives seems not widely accepted and thus not actively promoted. At end-line, one community in Petauke did not have adequate SRH services as it is serviced by a mission hospital which does not provide family planning services for adults and youth. In other areas, access to family planning appeared dependent upon NGOs. In addition, in all areas, schools officially do not promote access to contraceptives for youth due to conservative norms towards adolescent sexuality.

Another study from Zambia reports, besides the lack of policies facilitating contraceptive provision in schools, health systems barriers to accessing SRH services, including long distances to healthcare facilities, stock-outs of preferred methods, and undesirable provider attitudes (Silumbwe et al., 2018). While generally, young people regarded the quality of SRH as good, our study does not provide clarity on whether all (government) health facilities in Chadiza and Petauke are truly youth friendly. It made clear, however, that mobility restrictions as a result of COVID-19 increased barriers to SRH service (including contraceptive) use. It is difficult to estimate the effects of the COVID-19 lockdown measures on young people's SRH outcomes, due to unavailability of meta-data on SRH needs of the young unmarried population, an invisibility largely on account of stigma around pre-marital sexual activity. The absence of adolescent SRH services from "essential" health services during COVID-19 amplifies this undocumented need (Nanda, Tandon & Khanna, 2020). These findings call for further investigations on the impact of COVID-19 measures on young people's access to SRH services and the best strategies to expand access to SRH services in resource poor settings like rural Zambia.

The radio was cited as the preferred source of SRHR information, similar to a study in Tanzania which shows that the leading sources of SRHR information for young people were peer educators and the radio (Ngilangwa et al., 2016). Radio was not one of the prominent information dissemination channels of the Yes I Do programme in Zambia. This finding suggests the need for a diversified approach for reaching specific groups of young people depending on their needs and circumstances. The radio is often the only source of information and entertainment in rural settings, and it can guarantee anonymity when asking questions. It can also provide another platform for meaningful youth engagement to increase access and uptake of quality SRH services and information and enhance informed action of young people on their SRH (Assumption 7 and 8 of the theory of change).

Table 21 **Recommendations – Pathways 2 and 3**

| **Programme** |
| --- |
| Inconsistent use of contraceptives leaves girls at risk of unintended pregnancy. Future programmes should consider promoting the dual protection approach to contraception, which gives the best protection against pregnancy and STIs. This study also shows that meaningful youth participation and youth-led activities should be maintained to enhance programme reach and effectiveness, and that using the radio can be considered as one of the SRHR information sources and platforms for youth. The 2018 UNESCO's characteristics of effective CSE programming include the need to provide educators with sensitization, values clarification, quality pre- and on-the-job training and continuous professional development opportunities. Future programmes should consider these aspects to prevent that teachers will provide moralistic authoritative instructions which are less effective in preventing teenage pregnancy. |
| **Research** |
| Our results show that adolescents' access to SRH services was already restricted by several factors before the onset of COVID-19. Further investigation on the impact of COVID-19 measures on young people's access to SRH services and the best strategies to expand access in resource poor settings like rural Zambia is recommended. |

## 4.4 PATHWAY 4

### ADOLESCENT AND YOUNG WOMEN HAVE ALTERNATIVES BEYOND CHILD MARRIAGE AND TEENAGE PREGNANCY THROUGH EDUCATION AND SOCIO-ECONOMIC EMPOWERMENT

While alternatives for girls and young women beyond child marriage and teenage pregnancy (through education and socio-economic empowerment) do exist, such opportunities are limited in both Chadiza and Petauke. Pathway 4 of the Yes I Do programme theory of change focused on promoting education and economic empowerment for adolescent girls, boys and young adults.

Qualitative data show that there is increased interest among boys, girls and their parents regarding education. This increased interest in education is partly a result of Yes I Do's advocacy efforts on the importance of education. The general improvement in school infrastructure and school safety also contributed to this positive finding. There were also more girls going back to school after delivery, because of the sensitization on the back-to-school policy by the programme. As documented in the literature (Chung, Kim & Lee, 2018), the study also showed that girls in school were less likely to be pregnant, a finding that supports the need for continued investment in girls' education. It is important to note that some participants feared that the COVID-19 situation might have resulted in increased school dropout and teenage pregnancies. This study cannot draw any conclusions on this, because these effects of COVID-19 can only be measured in 2021.

Regarding economic empowerment, in both districts, there are little employment opportunities. There are almost no private sector driven employment opportunities in both Chadiza and Petauke (which makes Assumption 10 on engaged private sector actors being willing to provide traineeships and jobs for girls not met). As was recommended in the mid-line study (Menon et al., 2018b), the Yes I Do alliance in Zambia intensified efforts in economic empowerment of young people following the mid-term reflections on the programme. At end-line, study participants frequently made reference to economic empowerment interventions such as rearing chickens or goats and participation in savings groups. While these economic empowerment activities were appreciated by most of the participants, the sustainability of the interventions remains questionable. The coverage of these interventions was little, which limits the potential impact on reducing child marriage and teenage pregnancy. Furthermore, gaps in transformation of gender norms could limit young women's control over and benefits from the outcomes of household resources such as chicken and goats. Limited control of resources by women may further attenuate the social, cultural and economic differences between males and females which interact on multiple and often simultaneous levels to contribute to systemic gender inequality (Bates et al., 2009; Nash, 2008).

The study shows that more young people (18-24 years) were economically active outside their households over time, which is a positive finding. However, less of them reported to have received an income at end-line as compared to the baseline. COVID-19 could have influenced this, but we asked respondents to think back before the pandemic. This shows that although education was more valued and economic activity went up, young people's economic empowerment is still limited. Empowerment does not (automatically) increase in rural, hard-to-reach and constrained settings like many areas in Chadiza and Petauke (Assumption 5 of the theory of change).

| Table 22 **Recommendations – Pathway 4** |
|---|
| **Programme** |
| Schooling serves as a protection for girls against both child marriage and teenage pregnancy. With a general improvement in school infrastructure as observed in this study, future programmes should leverage on the renewed parental interest in educating children and promote the girl-child education as a strategy to preventing teenage pregnancy and ending child marriage. Economic empowerment activities need expansion and their sustainability needs to be considered. |
| **Research** |
| Economic empowerment of young women remains critical to building their agency and autonomy in making informed decisions regarding their SRH. Yet, in poor rural settings such as the study areas, limited private sector activities makes it difficult for economic empowerment interventions to thrive, which stretched the Yes I Do programme into providing animals to beneficiaries as economic empowerment intervention. Efforts to investigate the impact and sustainability of such interventions in contributing to gender equality is recommended. |

## 4.5 PATHWAY 5

### POLICY MAKERS AND DUTY BEARERS DEVELOP, REFORM AND IMPLEMENT POLICIES AS WELL AS ENFORCE LAWS ON CHILD MARRIAGE AND TEENAGE PREGNANCY

As reported under pathway 1, the establishment and reinforcement of bylaws was the main policy intervention for preventing child marriage and teenage pregnancy as mentioned by the participants of this study. The finding represents a positive development compared to the situation at baseline. The bylaws, which are integrated within the traditional leadership system and adopted by the chiefs, prescribe punitive action in case of child marriage and teenage pregnancy. Although the bylaws seem to yield some positive results regarding people's awareness on the matters, it is unclear whether they can contribute to reduce the prevalence of both child marriage and teenage pregnancy in the future. The punitive measures could be stigmatizing for pregnant girls, their partners and parents. There is therefore a need for an assessment on the social and psychological impact of the laws including community perceptions of the laws.

While many study participants and survey respondents indicated to receive SRHR information in school, study results show that the comprehensiveness of the information was limited. Some teachers were against family planning topics, a finding which is similar to those of a qualitative study on the implementation of CSE in Zambia which showed that teachers used their discretion to decide when, what and how to teach CSE (Zulu et el. 2019). Currently, there is massive resistance against implementing CSE in schools in Zambia. It is therefore important for Plan Zambia to advocate for implementation of CSE at national and provincial level. Value clarification within NGOs such as Plan Zambia is important to be able to effectively advocate for CSE in schools. Given the growing stigma associated with in-school CSE, which is often linked to concerns about indoctrinating young people with ideas on homosexuality, future programmes should consider placing an emphasis on promoting CSE outside the school curriculum. Out-of-school CSE is recommended to substitute or complement in-school CSE for in-school youth and to reach out-of-school youth with tailored information to their specific needs, particularly in contexts such as Zambia (UNFPA, 2020).

| Table 23 **Recommendations – Pathway 5** |
|---|
| **Programme** |
| Zambia is one of the few countries in Africa implementing CSE as part of the school curriculum. However, the programme is facing a growing resistance. Sustained advocacy by civil society is needed to secure the implementation of CSE at national and provincial level and to ensure that it is comprehensive enough to support skills development for young people. |
| **Research** |
| Punitive measures against teenage pregnancy in the form of bylaws could be stigmatizing for pregnant girls, their partners and parents. It will be a useful exercise to conduct an assessment on the social and psychological impact, and community perceptions of the bylaws. |

## 4.6 CROSS-CUTTING STRATEGIES

### (MEANINGFUL YOUTH ENGAGEMENT, MALE INVOLVEMENT, GENDER TRANSFORMATIVE PROGRAMMING, AND GIRLS' EMPOWERMENT)

Positive changes regarding meaningful youth engagement were observed, mainly through training the youth as peer educators (Champions of Change) in schools. Through the CoC intervention, young people were able to increase their voice and promote their rights, although their participation in decision-making is still limited at the community level. Male involvement in promoting gender equality and girls' rights also improved through involvement of male CoCs. Headmen also reported to have been actively involved in supporting gender equality by talking about these issues in meetings or through hosting meetings for CoCs. As indicated earlier, there have been efforts towards economic empowerment of women through building their capacity to manage savings clubs and also keeping (small scale) animals. Whether these efforts will lead to increased economic empowerment remains to be seen. Girls are not fully empowered, as their position and ability to make decisions were still limited when compared to that of boys and young men. Gender unequal attitudes persist in the communities in both Chadiza and Petauke.

## 4.7 STRENGTHS AND LIMITATIONS OF THE STUDY

While at baseline, a random selection of SEAs based on the wards that were going to be targeted by the Yes I Do programme was conducted, at end-line, there was a need to change this approach[4] to a random selection of villages out of a list of intervention villages provided by Plan Zambia. Both at base- and end-line, the selection of households was conducted in a similar way by applying a fixed interval based on the number of households in the SEA or village. The change in the selection of study clusters between base- and end-line makes the results of the survey only applicable to the population of the included villages at end-line, and not to the ward or district population level. In addition, this study did not include a control area. Therefore, potential differences between Yes I Do intervention areas and non-intervention areas could not be assessed. At end-line, the study team faced difficulties in meeting key informants that were listed to be interviewed, potentially as a result of the COVID-19 pandemic. This could have resulted in less detailed information on some of the study issues.

The strength of this study is that it used both qualitative and quantitative methods over a period of four years, involving a wide range of different stakeholders. This enabled the research team to triangulate study findings and analyse changes in perceptions, behaviours and experiences over time. The research team is confident that this end-line report presents a good picture of the outcomes of the Yes I do programme.

4 The approach was changed because the Yes I Do interventions did not have enough coverage at ward level.

# 5. CONCLUSIONS AND RECOMMENDATIONS

## 5.1 CONCLUSION

The Yes I do programme has played an important role in increasing knowledge of different stakeholders about the harms of child marriage and teenage pregnancy and triggering positive attitudes towards the prevention of child marriage and teenage pregnancy in the communities. This study reveals a small but significant decrease in the prevalence of child marriage among young women (18-24 years) in Petauke district over the past four years. In Chadiza, no change in child marriage prevalence is observed. It is unclear why there is a difference between the two districts and it is not possible to conclude whether the Yes I Do programme contributed to the changes observed. The teenage pregnancy rate significantly increased in both Chadiza and Petauke. While access to SRHR information and SRH services increased over the past four years, a positive change that could be attributed to the Yes I Do programme, a taboo on youth sexuality – supported by social and cultural norms – limits young people's confidence in accessing and consistently using contraceptives. The Yes I Do programme established more awareness about gender equality and young people's SRHR, but transformation of gender norms needs more time. Young people's agency and capacity to speak out seem improved, but they do not always get the space from other community members. Some traditional leaders, parents, teachers and health workers, have become more supportive to young people's SRHR, but others have not. More investments are needed to increase their support. The Yes I Do programme seems to have had a positive effect on the value of education among parents and adolescents. Young people's economic empowerment needs more attention. Future programmes should build upon the positive changes of the Yes I Do programme and equally involve all gatekeepers to trigger a social movement that promotes young people's SRHR and takes joint actions to prevent child marriage and teenage pregnancy.

## 5.2 RECOMMENDATIONS FOR FUTURE PROGRAMMES

1. It is important for future programmes to focus more on promoting collective action through increased involvement of gatekeepers, especially parents, teachers, health workers and traditional and religious leaders, in initiatives to prevent teenage pregnancy. This would help to build common identity and interests, and provide the means for stakeholder strategic action in preventing teenage pregnancy.
2. Continued efforts are needed to expand the reach of youth friendly services. There is also need to develop sustainability plans for youth clubs, including the Champions of Change. This may help in maintaining meaningful youth participation and youth-led activities which have proven to be valuable in the Yes I Do programme.
3. There is a need to promote the consistent use of (all possible) pregnancy prevention methods. Furthermore, increased attention should be given to value clarification among teachers, health workers and others involved in implementing SRHR interventions.
4. Saving groups and income generating activities should be continued and were possible expanded, as these activities were useful in meeting some of young people's given the limited economic opportunities in rural Zambia
5. Future programmes should leverage on the renewed parental interest in educating children and promote the girl-child education as a strategy to preventing teenage pregnancy and ending child marriage
6. Findings of this study should be disseminated to government stakeholders at district and provincial levels to solicit their support in developing policies and activities that promote gender equality and young peoples' SRHR, especially activities that promote effective delivery of CSE to both in- and out-of-school boys and girls.

## 5.3 RECOMMENDATIONS FOR FURTHER RESEARCH

1. There is a need for further research to explore the impact of bylaws on adolescent's sexual agency, prevention of teenage pregnancy and protection from exploitative sexual conduct. This research should include the possible social and psychological impact of bylaws on the people involved in cases of teenage pregnancy and child marriage, and community perceptions of the bylaws.
2. Further investigation on the impact of COVID-19 measures on young people's access to SRH services and the best strategies to expand access in resource poor settings like rural Zambia is recommended.
3. It would be valuable to investigate the impact and sustainability of economic empowerment interventions in contributing to gender equality and young people's SRHR.

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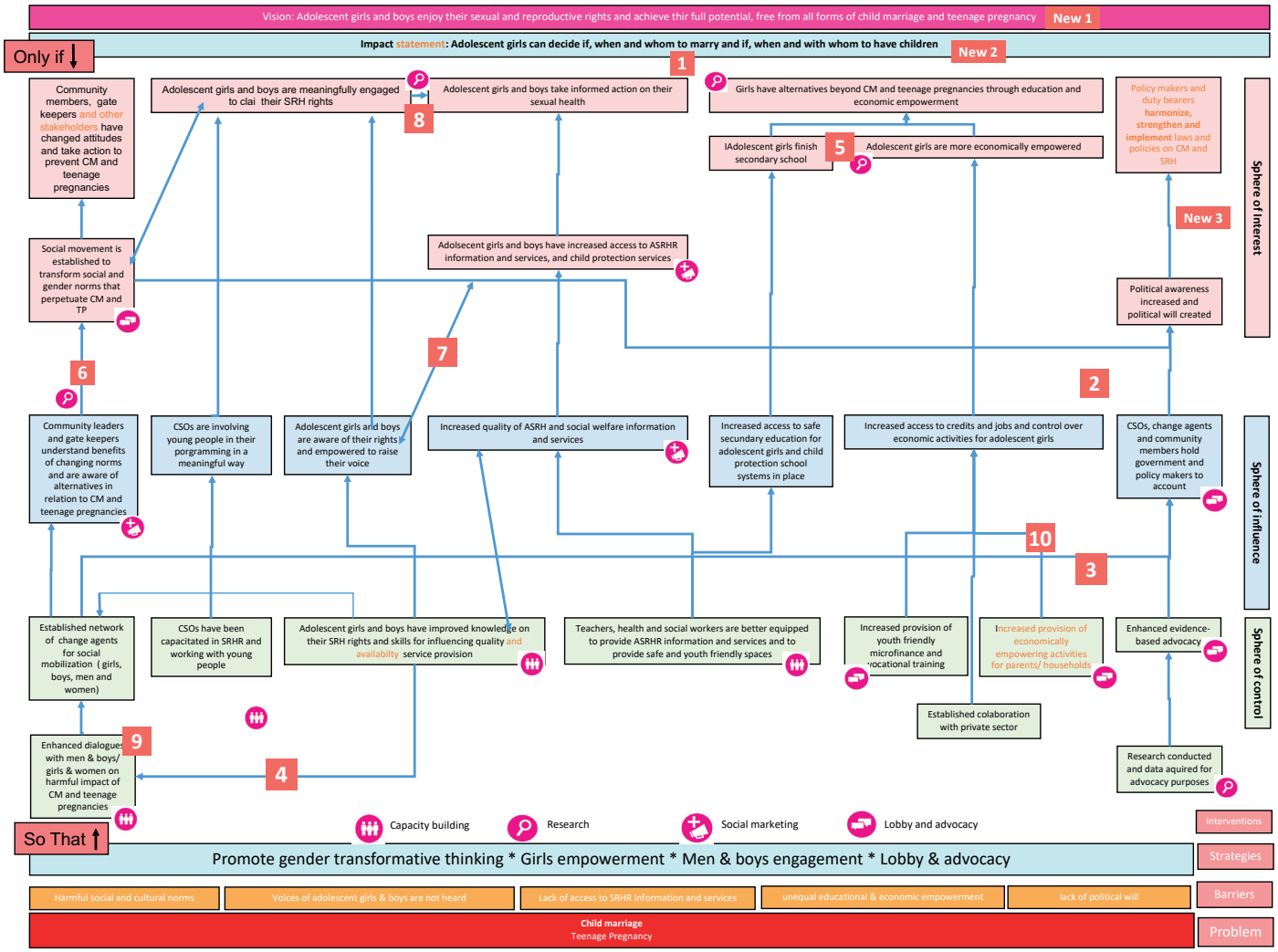
# 7. ANNEXES

## 1. COUNTRY-SPECIFIC THEORY OF CHANGE




### ASSUMPTIONS

1. Only a combined approach of strategies will reduce CM, FGM/C and TP[1].
2. Policy makers are as much influenced by social norms, as people in communities[2].
3. Change agents are willing to organize themselves to influence community members and to hold duty bearers accountable[3].
4. When adolescent girls and boys have improved knowledge concerning their rights, they want to organize themselves to influence others[4].
5. When adolescent girls finish post-primary education, they have more chances to be economically empowered[5].
6. Through rights awareness and alternatives, people will take action to change their social environment[6].
7. Meaningful youth engagement is required for increased access and uptake of quality ASRHR services and information[7].
8. When girls and boys are meaningfully engaged to claim their SRHR they will take informed action on their SRH[8,9].
9. Through participating in intergenerational dialogues, men and boys become allies in changing social norms[10,11].
10. Engaged private sector actors are willing to provide traineeships and jobs for girls.

1 Solutions to end child marriage, ICRW, 2011
2 Ending child marriage in a generation, Ford Foundation, 2014 (p13-14,17)
3 Report of the External end Evaluation of the Youth Incentives Programme 2009-2010, Rutgers, 2010
4 Meaningful Youth Participation: an Operations Research, ASK Projects, 2014
5 Girls' Education, The World bank, 2014
6 Outcome Measurement 2013, SRHR Alliance, 2013
7 Report on Operations Research on Meaningful Youth Participation, ASK Project, 2014
8 Participate: the voice of young people in programmes and policies, IPPF, 2008
9 Provide: Strengthening Youth Friendly Services, IPPF, 2008
10 Engaging men and boys to end child marriage, 2015
11 Engaging men and boys in changing gender-based inequity in health: evidence from programme interventions, 2007

## 2. SAMPLE SIZE CALCULATIONS

| Sample size calculations | | | | | |
|---|---|---|---|---|---|
| Indicator | Prevalence | | Sample size per group | | |
| | **Baseline** | **Endline** | **Women**[1] | **Men** | **Total** |
| Child marriage | 53% | 43% | 588 | 192 | 780 |

1. α = 0.05, β = 0.8, AR: 0.2, DEFT = 1.5

**Effect size:** A 10 percentage point change between base- and end-line was chosen.

**α:** The precision (or 'level of significance') was set at 5%, which is standard in most studies.

**β:** The power of the study (i.e. the probability of the study to detect an association or change if one exist) is set at 80%, which is standard in most studies.

**AR:** The attrition rate accounts for potential non response and is set on a conservative 20% due to the sensitive nature of the survey.

**DEFT:** The design effect accounts for the clustered sampling approach used to select the participants of this study and was estimated at 1.5.

**Baseline prevalence:** the assumptions above are applied to the baseline prevalence of child marriage in Nyimba district, a district close to Petauke and Chadiza, of 53%.

| Sample size calculations | | | | |
|---|---|---|---|---|
| | Baseline | | End-line | |
| | **Intended** | **Achieved** | **Intended** | **Achieved** |
| Males | 179 | 192 (107%) | 192 | 196 (102%) |
| Females | 534 | 516 (97%) | 588 | 613 (104%) |
| Total | 717[1] | 708 (99%) | 780 | 809 (104%) |

1. Sample size calculations were slightly different at baseline, and were refined at end-line. Therefore, the estimated sample size was slightly lower at baseline.

## 3. LOGISTIC REGRESSION MODELS

**Overview and description of models**

The models presented below aim to assess the trend over time in the intervention 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 an **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.**

These models cannot be used to attribute change to the Yes I Do intervention as they lack a counterfactual.

All logistic regression models were adjusted for school attendance (yes/no) and age in years. Teenage pregnancy among women aged 20 to 24 and 15 to 24 was modelled with additional covariates to further explore associations with teenage pregnancy over time. The following outcome variables were modelled:

| Outcomes | |
|---|---|
| **Theme** | **Outcome variable** |
| **SRHR knowledge** | Young women aged 15 - 24 years old who perceive to have knowledge of legal minimum age according to statutory law |
| | Young women aged 15 - 24 years old who have actual knowledge of legal minimum age according to statutory law |
| | Young men aged 15 - 24 years old who perceive to have knowledge of legal minimum age according to statutory law |
| | Young men aged 15 - 24 years old who have actual knowledge of legal minimum age according to statutory law |
| | 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 |

| | |
|---|---|
| **SRHR behavior** | Boys aged 15-24 who feel confident to insist on condom use every time they have sex |
| | Young women between 18 - 24 years old who have ever experienced sexual harassment |
| | Girls and women aged 15 - 24 years old who ever had children and use a modern form of contraceptive |
| | Girls and women aged 15 - 24 years old who currently use any form of contraception |
| | Married girls and young women between 15 - 24 years old who have ever been physically hurt by their partner |
| | Young men between 18 - 24 years old who have ever experienced sexual harassment |
| | Boys and young men aged 15 - 24 years old who ever had children and use a modern form of contraceptive |
| | 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 |
| | Young mothers aged 15-24 years indicating using MALE condoms |
| | Young fathers aged 15-24 years indicating using MALE condoms |
| | Girls between 15 and 24 that have ever utilized SRHR services |
| | Boys between 15 and 24 that have ever utilized SRHR services |
| **SRHR support** | Girls and young women (15-24 years) who find it difficult to access contraceptives as a young person |
| | Girls and young women between 15 - 24 years old who agree that their parents or relatives decide their future partner |
| | Girls and young women who have someone at home with whom they can talk about feelings/hopes or worries |
| | Boys and young men between 15 - 24 years old who agree that their parents or relatives decide their future partner |
| | Boys and young men who have someone at home with whom they can talk about feelings/hopes or worries |
| | Young women and men between 15 - 24 years old who find it easy to talk to their parents about sexuality and marriage |
| **Teenage Pregnancy** | Young women (20-24 years) who wanted to become parents at that time |
| | Girls and women aged 20-24 years who had their first child under the age of 20 |
| | Girls and women aged 15-24 years who had their first child under the age of 20 |
| **Pregnancy and Marriage** | Ever married mothers aged 15 - 24 years old who were first married and then became pregnant |
| | Ever married mothers aged 15 - 24 years old who became pregnant and were then married |
| | Ever married mothers aged 15 - 24 years old who became pregnant and were married in the same year |
| **Child Marriage** | Married girls and young women (15-24 years), who perceive that it was their choice to get married |
| | 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 |
| | Girls and women aged 18-24 who were child brides and were married to an adult man |

| | |
|---|---|
| **Education** | Girls below 18 years who left school due to pregnancy |
| | Girls below 18 years who left school due to marriage |
| | 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 knowledge | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Univariable | | | | Multivariable | | | |
| | | 95%CI | | | | 95%CI | | |
| | B | Lower bound | Upper bound | P-value | B | Lower bound | Upper bound | P-value |
| **Outcome variable: Girls aged 15-24 who know how to prevent pregnancy using modern contraceptives** | | | | | | | | |
| Constant | | | | | 0.03 | 0.01 | 0.10 | 0.000 |
| Time | 3.67 | 2.73 | 4.93 | 0.000 | 3.23 | 2.37 | 4.39 | 0.000 |
| Age (in years) | 1.32 | 1.24 | 1.40 | 0.000 | 1.28 | 1.19 | 1.37 | 0.000 |
| School attendance | 0.38 | 0.29 | 0.51 | 0.000 | 0.75 | 0.54 | 1.05 | 0.095 |
| **Outcome variable: Boys aged 15-24 who know how to prevent pregnancy using modern contraceptives** | | | | | | | | |
| Constant | | | | | 0.01 | 0.00 | 0.08 | 0.000 |
| Time | 10.77 | 5.83 | 19.89 | 0.000 | 13.95 | 7.22 | 26.95 | 0.000 |
| Age (in years) | 1.20 | 1.11 | 1.31 | 0.000 | 1.28 | 1.16 | 1.42 | 0.000 |
| School attendance | 0.46 | 0.29 | 0.73 | 0.001 | 1.06 | 0.60 | 1.90 | 0.833 |
| **Outcome variable: Girls aged 15-24 who disagree with the statement "It is not appropriate for a girl to propose to use a condom"** | | | | | | | | |
| Constant | | | | | 0.86 | 0.33 | 2.21 | 0.746 |
| Time | 0.97 | 0.77 | 1.23 | 0.830 | 0.93 | 0.73 | 1.18 | 0.554 |
| Age (in years) | 1.02 | 0.98 | 1.06 | 0.353 | 1.01 | 0.96 | 1.05 | 0.775 |
| School attendance | 0.84 | 0.67 | 1.07 | 0.158 | 0.84 | 0.64 | 1.09 | 0.189 |
| **Outcome variable: Boys aged 15-24 who disagree with the statement "It is not appropriate for a girl to propose to use a condom"** | | | | | | | | |
| Constant | | | | | 1.39 | 0.28 | 6.92 | 0.686 |
| Time | 0.48 | 0.32 | 0.72 | 0.000 | 0.48 | 0.32 | 0.73 | 0.001 |
| Age (in years) | 1.02 | 0.95 | 1.09 | 0.592 | 1.01 | 0.94 | 1.09 | 0.832 |
| School attendance | 1.01 | 0.67 | 1.50 | 0.980 | 0.90 | 0.58 | 1.41 | 0.643 |
| **Outcome variable: Girls aged 15-24 who feel confident to insist on condom use every time they have sex** | | | | | | | | |
| Constant | | | | | 0.19 | 0.07 | 0.53 | 0.001 |
| Time | 0.97 | 0.76 | 1.24 | 0.793 | 0.97 | 0.76 | 1.25 | 0.821 |
| Age (in years) | 1.07 | 1.03 | 1.12 | 0.001 | 1.11 | 1.06 | 1.17 | 0.000 |
| School attendance | 1.17 | 0.91 | 1.49 | 0.216 | 1.54 | 1.16 | 2.05 | 0.003 |
| **Outcome variable: Boys aged 15-24 who feel confident to insist on condom use every time they have sex** | | | | | | | | |
| Constant | | | | | 1.08 | 0.17 | 7.04 | 0.935 |
| Time | 0.40 | 0.25 | 0.65 | 0.000 | 0.41 | 0.25 | 0.68 | 0.001 |
| Age (in years) | 1.08 | 1.00 | 1.17 | 0.061 | 1.08 | 0.99 | 1.18 | 0.088 |
| School attendance | 1.04 | 0.66 | 1.65 | 0.860 | 1.04 | 0.62 | 1.75 | 0.871 |

| SRHR knowledge | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Univariable | | | | Multivariable | | | |
| | | 95%CI | | | | 95%CI | | |
| | B | Lower bound | Upper bound | P-value | B | Lower bound | Upper bound | P-value |
| **Outcome variable: Girls aged 15-24 who ever received education about sexuality and sexual health** | | | | | | | | |
| Constant | | | | | 0.18 | 0.06 | 0.51 | 0.001 |
| Time | 1.01 | 0.78 | 1.30 | 0.949 | 1.07 | 0.82 | 1.39 | 0.626 |
| Age (in years) | 1.05 | 1.00 | 1.10 | 0.032 | 1.12 | 1.06 | 1.18 | 0.000 |
| School attendance | 1.62 | 1.26 | 2.10 | 0.000 | 2.21 | 1.64 | 2.97 | 0.000 |
| **Outcome variable: Boys aged 15-24 who ever received education about sexuality and sexual health** | | | | | | | | |
| Constant | | | | | 0.08 | 0.01 | 0.43 | 0.003 |
| Time | 2.43 | 1.61 | 3.66 | 0.000 | 2.97 | 1.91 | 4.61 | 0.000 |
| Age (in years) | 1.03 | 0.96 | 1.11 | 0.345 | 1.10 | 1.02 | 1.19 | 0.019 |
| School attendance | 1.52 | 1.01 | 2.27 | 0.043 | 2.32 | 1.44 | 3.73 | 0.001 |
| **Outcome variable: Young women aged 15 - 24 years old who perceive to have knowledge of legal minimum age according to statutory law** | | | | | | | | |
| Constant | | | | | 0.05 | 0.02 | 0.13 | 0.000 |
| Time | 3.41 | 2.67 | 4.36 | 0.000 | 3.69 | 2.85 | 4.78 | 0.000 |
| Age (in years) | 1.09 | 1.04 | 1.13 | 0.000 | 1.13 | 1.07 | 1.19 | 0.000 |
| School attendance | 1.16 | 0.92 | 1.47 | 0.217 | 2.10 | 1.57 | 2.82 | 0.000 |
| **Outcome variable: Young women aged 15 - 24 years old who have actual knowledge of legal minimum age according to statutory law** | | | | | | | | |
| Constant | | | | | 0.00 | 0.00 | 0.03 | 0.000 |
| Time | 3.32 | 1.82 | 6.07 | 0.000 | 3.49 | 1.89 | 6.44 | 0.000 |
| Age (in years) | 1.07 | 0.99 | 1.17 | 0.102 | 1.10 | 1.00 | 1.21 | 0.050 |
| School attendance | 1.14 | 0.70 | 1.88 | 0.597 | 1.86 | 1.04 | 3.32 | 0.036 |
| **Outcome variable: Young men aged 15 - 24 years old who perceive to have knowledge of legal minimum age according to statutory law** | | | | | | | | |
| Constant | | | | | 0.02 | 0.00 | 0.14 | 0.000 |
| Time | 6.87 | 4.39 | 10.76 | 0.000 | 8.27 | 5.08 | 13.47 | 0.000 |
| Age (in years) | 1.08 | 1.01 | 1.16 | 0.028 | 1.16 | 1.06 | 1.26 | 0.001 |
| School attendance | 0.84 | 0.56 | 1.26 | 0.398 | 1.68 | 1.01 | 2.78 | 0.044 |
| **Outcome variable: Young men aged 15 - 24 years old who have actual knowledge of legal minimum age according to statutory law** | | | | | | | | |
| Constant | | | | | 0.05 | 0.00 | 2.39 | 0.128 |
| Time | 5.22 | 1.49 | 18.34 | 0.010 | 4.66 | 1.30 | 16.68 | 0.018 |
| Age (in years) | 0.98 | 0.83 | 1.15 | 0.809 | 0.96 | 0.80 | 1.15 | 0.646 |
| School attendance | 0.52 | 0.19 | 1.42 | 0.203 | 0.61 | 0.20 | 1.81 | 0.373 |

| SRHR behaviour | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Univariable | | | | Multivariable | | | |
| | | 95%CI | | | | 95%CI | | |
| | B | Lower bound | Upper bound | P-value | B | Lower bound | Upper bound | P-value |
| **Outcome variable: Girls aged 15-24 who can decide for themselves whom to date and go out with** | | | | | | | | |
| Constant | | | | | 2.21 | 0.64 | 7.67 | 0.212 |
| Time | 0.30 | 0.22 | 0.42 | 0.000 | 0.27 | 0.19 | 0.38 | 0.000 |
| Age (in years) | 1.07 | 1.02 | 1.13 | 0.009 | 1.08 | 1.02 | 1.15 | 0.009 |
| School attendance | 0.81 | 0.61 | 1.09 | 0.168 | 0.80 | 0.56 | 1.12 | 0.193 |
| **Outcome variable: Boys aged 15-24 who can decide for themselves whom to date and go out with** | | | | | | | | |
| Constant | | | | | 0.12 | 0.01 | 1.22 | 0.073 |
| Time | 0.71 | 0.41 | 1.25 | 0.237 | 0.80 | 0.45 | 1.44 | 0.457 |
| Age (in years) | 1.18 | 1.07 | 1.31 | 0.001 | 1.22 | 1.09 | 1.36 | 0.001 |
| School attendance | 1.04 | 0.59 | 1.80 | 0.902 | 1.51 | 0.81 | 2.84 | 0.195 |
| **Outcome variable: Girls between 15 and 24 that have ever utilized SRHR services** | | | | | | | | |
| Constant | | | | | 0.00 | 0.00 | 0.00 | 0.000 |
| Time | 3.91 | 2.96 | 5.17 | 0.000 | 3.94 | 2.84 | 5.47 | 0.000 |
| Age (in years) | 1.70 | 1.57 | 1.83 | 0.000 | 1.62 | 1.49 | 1.77 | 0.000 |
| School attendance | 0.17 | 0.13 | 0.23 | 0.000 | 0.42 | 0.29 | 0.60 | 0.000 |
| **Outcome variable: Boys between 15 and 24 that have ever utilized SRHR services** | | | | | | | | |
| Constant | | | | | 0.00 | 0.00 | 0.01 | 0.000 |
| Time | 4.71 | 3.04 | 7.27 | 0.000 | 6.51 | 3.91 | 10.82 | 0.000 |
| Age (in years) | 1.29 | 1.19 | 1.40 | 0.000 | 1.36 | 1.24 | 1.49 | 0.000 |
| School attendance | 0.41 | 0.27 | 0.61 | 0.000 | 0.87 | 0.53 | 1.44 | 0.596 |
| **Outcome variable: Young mothers aged 15-24 years indicating using MALE condoms** | | | | | | | | |
| Constant | | | | | 0.01 | 0.00 | 0.17 | 0.002 |
| Time | 3.99 | 1.53 | 10.39 | 0.005 | 4.00 | 1.52 | 10.55 | 0.005 |
| Age (in years) | 1.08 | 0.94 | 1.25 | 0.264 | 1.07 | 0.93 | 1.24 | 0.342 |
| School attendance | 0.84 | 0.38 | 1.89 | 0.678 | 1.13 | 0.49 | 2.61 | 0.766 |
| **Outcome variable: Young fathers aged 15-24 years indicating using MALE condoms** | | | | | | | | |
| Constant | | | | | 0.56 | 0.00 | 230.66 | 0.849 |
| Time | 3.00 | 1.08 | 8.36 | 0.036 | 3.53 | 1.15 | 10.83 | 0.028 |
| Age (in years) | 0.99 | 0.77 | 1.28 | 0.945 | 0.99 | 0.76 | 1.29 | 0.941 |
| School attendance | 0.98 | 0.34 | 2.84 | 0.975 | 1.60 | 0.48 | 5.38 | 0.443 |

| SRHR behaviour | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Univariable | | | | Multivariable | | | |
| | | 95%CI | | | | 95%CI | | |
| | B | Lower bound | Upper bound | P-value | B | Lower bound | Upper bound | P-value |
| **Outcome variable: Young women between 18 - 24 years old who have ever experienced sexual harassment** | | | | | | | | |
| Constant | | | | | 0.56 | 0.09 | 3.36 | 0.524 |
| Time | 3.37 | 2.35 | 4.83 | 0.000 | 3.08 | 2.13 | 4.46 | 0.000 |
| Age (in years) | 1.03 | 0.95 | 1.11 | 0.503 | 0.97 | 0.89 | 1.05 | 0.456 |
| School attendance | 0.53 | 0.37 | 0.76 | 0.001 | 0.66 | 0.44 | 0.97 | 0.033 |
| **Outcome variable: Young men between 18 - 24 years old who have ever experienced sexual harassment** | | | | | | | | |
| Constant | | | | | 0.01 | 0.00 | 0.34 | 0.013 |
| Time | 3.96 | 1.80 | 8.69 | 0.001 | 4.70 | 2.07 | 10.68 | 0.000 |
| Age (in years) | 1.03 | 0.88 | 1.22 | 0.677 | 1.10 | 0.93 | 1.31 | 0.279 |
| School attendance | 1.19 | 0.60 | 2.36 | 0.612 | 1.82 | 0.86 | 3.84 | 0.117 |
| **Outcome variable: Married girls and young women between 15 - 24 years old who currently use contraception** | | | | | | | | |
| Constant | | | | | 0.00 | 0.00 | 0.01 | 0.000 |
| Time | 2.17 | 1.66 | 2.83 | 0.000 | 1.66 | 1.23 | 2.22 | 0.001 |
| Age (in years) | 1.38 | 1.31 | 1.45 | 0.000 | 1.29 | 1.23 | 1.37 | 0.000 |
| School attendance | 0.23 | 0.17 | 0.31 | 0.000 | 0.45 | 0.32 | 0.61 | 0.000 |
| **Outcome variable: Girls and women aged 15 - 24 years old who ever had children and use a modern form of contraceptive** | | | | | | | | |
| Constant | | | | | 0.21 | 0.04 | 1.05 | 0.058 |
| Time | 1.31 | 0.90 | 1.92 | 0.154 | 1.25 | 0.85 | 1.84 | 0.259 |
| Age (in years) | 1.09 | 1.01 | 1.18 | 0.027 | 1.08 | 1.00 | 1.17 | 0.039 |
| School attendance | 0.79 | 0.52 | 1.21 | 0.287 | 0.87 | 0.56 | 1.34 | 0.526 |
| **Outcome variable: Boys and young men aged 15 - 24 years old who ever had children and use a modern form of contraceptive** | | | | | | | | |
| Constant | | | | | 0.15 | 0.00 | 71.73 | 0.549 |
| Time | 1.45 | 0.51 | 4.17 | 0.487 | 1.34 | 0.43 | 4.13 | 0.612 |
| Age (in years) | 1.11 | 0.85 | 1.46 | 0.435 | 1.12 | 0.85 | 1.48 | 0.404 |
| School attendance | 0.69 | 0.22 | 2.10 | 0.509 | 0.73 | 0.22 | 2.44 | 0.612 |
| **Outcome variable: Married girls and young women between 15 - 24 years old who have ever been physically hurt by their partner** | | | | | | | | |
| Constant | | | | | 0.07 | 0.00 | 1.07 | 0.056 |
| Time | 1.54 | 0.90 | 2.62 | 0.113 | 1.59 | 0.91 | 2.77 | 0.100 |
| Age (in years) | 1.10 | 0.97 | 1.25 | 0.126 | 1.10 | 0.97 | 1.25 | 0.141 |
| School attendance | 1.08 | 0.53 | 2.20 | 0.825 | 1.22 | 0.58 | 2.55 | 0.603 |

| SRHR behaviour | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Univariable | | | | Multivariable | | | |
| | | 95%CI | | | | 95%CI | | |
| | B | Lower bound | Upper bound | P-value | B | Lower bound | Upper bound | P-value |
| **Outcome variable: Married boys and young men between 15 - 24 years old who have ever been physically hurt by their partner** | | | | | | | | |
| Constant | | | | | 0.00 | 0.00 | 7.99 | 0.087 |
| Time | 4.00 | 0.71 | 22.50 | 0.116 | 5.33 | 0.83 | 34.01 | 0.077 |
| Age (in years) | 1.37 | 0.75 | 2.53 | 0.306 | 1.70 | 0.85 | 3.40 | 0.135 |
| School attendance | 0.49 | 0.87 | 2.81 | 0.426 | 0.54 | 0.08 | 3.71 | 0.528 |

| SRHR support | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Univariable | | | | Multivariable | | | |
| | | 95%CI | | | | 95%CI | | |
| | B | Lower bound | Upper bound | P-value | B | Lower bound | Upper bound | P-value |
| **Outcome variable: Young women and men between 15 - 24 years old who find it easy to talk to their parents about sexuality and marriage** | | | | | | | | |
| Constant | | | | | 0.04 | 0.02 | 0.11 | 0.000 |
| Time | 0.53 | 0.42 | 0.66 | 0.000 | 0.53 | 0.42 | 0.67 | 0.000 |
| Age (in years) | 1.08 | 1.04 | 1.13 | 0.000 | 1.13 | 1.09 | 1.18 | 0.000 |
| School attendance | 1.30 | 1.04 | 1.62 | 0.019 | 1.59 | 1.23 | 2.05 | 0.000 |
| **Outcome variable: Girls and young women (15-24 years) who find it difficult to access contraceptives as a young person** | | | | | | | | |
| Constant | | | | | 0.22 | 0.08 | 0.59 | 0.003 |
| Time | 2.12 | 1.67 | 2.69 | 0.000 | 1.97 | 1.54 | 2.51 | 0.000 |
| Age (in years) | 1.10 | 1.05 | 1.14 | 0.000 | 1.07 | 1.02 | 1.12 | 0.008 |
| School attendance | 0.62 | 0.49 | 0.79 | 0.000 | 0.82 | 0.63 | 1.08 | 0.156 |
| **Outcome variable: Girls and young women between 15 - 24 years old who agree that their parents or relatives decide their future partner** | | | | | | | | |
| Constant | | | | | 0.45 | 0.13 | 1.52 | 0.197 |
| Time | 0.91 | 0.67 | 1.23 | 0.537 | 0.94 | 0.69 | 1.28 | 0.685 |
| Age (in years) | 0.97 | 0.92 | 1.02 | 0.261 | 0.97 | 0.91 | 1.03 | 0.281 |
| School attendance | 1.03 | 0.76 | 1.39 | 0.845 | 0.95 | 0.68 | 1.34 | 0.779 |
| **Outcome variable: Boys and young men between 15 - 24 years old who agree that their parents or relatives decide their future partner** | | | | | | | | |
| Constant | | | | | 0.24 | 0.02 | 2.54 | 0.239 |
| Time | 1.22 | 0.68 | 2.21 | 0.502 | 1.11 | 0.60 | 2.03 | 0.746 |
| Age (in years) | 1.01 | 0.91 | 1.12 | 0.855 | 0.98 | 0.88 | 1.10 | 0.764 |
| School attendance | 0.66 | 0.36 | 1.20 | 0.171 | 0.64 | 0.33 | 1.24 | 0.183 |
| **Outcome variable: Girls and young women who have someone at home with whom they can talk about feelings/hopes or worries** | | | | | | | | |
| Constant | | | | | 0.08 | 0.03 | 0.24 | 0.000 |
| Time | 1.07 | 0.84 | 1.38 | 0.574 | 1.08 | 0.83 | 1.40 | 0.583 |
| Age (in years) | 1.10 | 1.05 | 1.15 | 0.000 | 1.17 | 1.11 | 1.23 | 0.000 |
| School attendance | 1.31 | 1.02 | 1.69 | 0.035 | 2.01 | 1.49 | 2.70 | 0.000 |
| **Outcome variable: Boys and young men who have someone at home with whom they can talk about feelings/hopes or worries** | | | | | | | | |
| Constant | | | | | 0.08 | 0.02 | 0.47 | 0.005 |
| Time | 4.32 | 2.83 | 6.61 | 0.000 | 4.61 | 2.95 | 7.19 | 0.000 |
| Age (in years) | 1.06 | 0.98 | 1.13 | 0.127 | 1.09 | 1.01 | 1.18 | 0.036 |
| School attendance | 0.80 | 0.54 | 1.19 | 0.270 | 1.24 | 0.78 | 1.99 | 0.365 |

| Teenage pregnancy | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Univariable | | | | Multivariable | | | |
| | | 95%CI | | | | 95%CI | | |
| | B | Lower bound | Upper bound | P-value | B | Lower bound | Upper bound | P-value |
| **Outcome variable: Girls and women aged 20-24 who had a child before 20** | | | | | | | | |
| Constant | | | | | 29.60 | 0.12 | 7444.12 | 0.230 |
| Time | 1.94 | 1.32 | 2.87 | 0.001 | 2.56 | 1.12 | 5.86 | 0.026 |
| District (Chadiza/Petauke) | 0.96 | 0.67 | 1.40 | 0.850 | 0.78 | 0.41 | 1.48 | 0.439 |
| Age (years) | 0.90 | 0.80 | 1.02 | 0.099 | 0.65 | 0.52 | 0.82 | 0.000 |
| Child marriage (yes/no) | 33.35 | 8.05 | 138.24 | 0.000 | 50.62 | 8.83 | 290.21 | 0.000 |
| Currently using contraceptives (yes/no) | 3.18 | 2.16 | 4.70 | 0.000 | 3.24 | 1.69 | 6.20 | 0.000 |
| Ever received sexuality education (yes/no) | 0.44 | 0.26 | 0.76 | 0.003 | 0.50 | 0.16 | 1.62 | 0.251 |
| Attending secondary education (yes/no) | 0.59 | 0.38 | 0.90 | 0.014 | 0.94 | 0.36 | 2.44 | 0.900 |
| Attending any education (yes/no) | 1.64 | 1.08 | 2.49 | 0.020 | 2.41 | 1.15 | 5.04 | 0.020 |
| Ever dropped out of school (yes/no) | 5.00 | 2.92 | 8.57 | 0.000 | 8.25 | 3.43 | 19.85 | 0.000 |
| Received income in past 6 months (yes/no) | 1.38 | 0.80 | 2.41 | 0.250 | 1.19 | 0.38 | 3.71 | 0.759 |
| Employed (yes/no) | 1.60 | 1.07 | 2.40 | 0.022 | 1.68 | 0.82 | 3.47 | 0.157 |
| Mother's education (Primary) | 1.00 | 1.00 | 1.00 | | 1.00 | 1.00 | 1.00 | |
| Junior secondary | 0.87 | 0.44 | 1.72 | 0.680 | 0.93 | 0.31 | 2.77 | 0.901 |
| Senior Secondary | 0.56 | 0.12 | 2.58 | 0.458 | 0.91 | 0.04 | 19.36 | 0.952 |
| No education | 0.82 | 0.53 | 1.29 | 0.400 | 0.75 | 0.33 | 1.71 | 0.498 |
| Father's education (Primary) | 1.00 | 1.00 | 1.00 | | 1.00 | 1.00 | 1.00 | |
| Junior secondary | 1.16 | 0.62 | 2.17 | 0.649 | 1.06 | 0.42 | 2.68 | 0.898 |
| Senior Secondary | 0.53 | 0.25 | 1.13 | 0.099 | 0.61 | 0.21 | 1.75 | 0.360 |
| Tertiary | 0.41 | 0.04 | 4.62 | 0.468 | 1.96 | 0.08 | 50.90 | 0.685 |
| No education | 0.96 | 0.56 | 1.65 | 0.891 | 0.99 | 0.42 | 2.34 | 0.975 |
| Household size (1-2) | 1.00 | 1.00 | 1.00 | | 1.00 | 1.00 | 1.00 | |
| 3-4 | 7.12 | 1.95 | 26.05 | 0.003 | 15.32 | 0.91 | 258.02 | 0.058 |
| 5-7 | 5.54 | 1.52 | 20.17 | 0.009 | 12.49 | 0.75 | 208.63 | 0.079 |
| 8+ | 4.49 | 1.21 | 16.60 | 0.024 | 14.57 | 0.87 | 243.68 | 0.062 |

| Teenage pregnancy | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Univariable | | | | Multivariable | | | |
| | | 95%CI | | | | 95%CI | | |
| | B | Lower bound | Upper bound | P-value | B | Lower bound | Upper bound | P-value |
| **Outcome variable: Girls and women aged 15-24 who had a child before 20** | | | | | | | | |
| Constant | | | | | 0.00 | 0.00 | 0.04 | 0.000 |
| Time | 2.36 | 1.83 | 3.04 | 0.000 | 1.80 | 1.09 | 2.97 | 0.021 |
| District (Chadiza/Petauke) | 1.02 | 0.80 | 1.31 | 0.845 | 0.68 | 0.44 | 1.05 | 0.079 |
| Age (years) | 1.34 | 1.28 | 1.41 | 0.000 | 1.00 | 0.92 | 1.09 | 0.931 |
| Child marriage (yes/no) | 19.81 | 9.83 | 39.92 | 0.000 | 12.85 | 4.38 | 37.68 | 0.000 |
| Currently using contraceptives (yes/no) | 7.68 | 5.77 | 10.21 | 0.000 | 3.56 | 2.26 | 5.61 | 0.000 |
| Ever received sexuality education (yes/no) | 1.41 | 1.07 | 1.85 | 0.014 | 1.61 | 0.98 | 2.63 | 0.059 |
| Attending secondary education (yes/no) | 0.32 | 0.22 | 0.45 | 0.000 | 1.78 | 0.89 | 3.55 | 0.102 |
| Attending any education (yes/no) | 0.15 | 0.11 | 0.19 | 0.000 | 0.29 | 0.16 | 0.52 | 0.000 |
| Ever dropped out of school (yes/no) | 12.25 | 8.64 | 17.38 | 0.000 | 7.36 | 4.34 | 12.49 | 0.000 |
| Received income in past 6 months (yes/no) | 1.87 | 1.29 | 2.73 | 0.001 | 1.63 | 0.79 | 3.34 | 0.185 |
| Employed (yes/no) | 2.39 | 1.81 | 3.18 | 0.000 | 1.58 | 0.96 | 2.59 | 0.069 |
| Mother's education (Primary) | 1.00 | 1.00 | 1.00 | | 1.00 | 1.00 | 1.00 | |
| Junior secondary | 0.84 | 0.54 | 1.30 | 0.439 | 0.80 | 0.41 | 1.59 | 0.533 |
| Senior Secondary | 0.48 | 0.18 | 1.32 | 0.158 | 1.74 | 0.33 | 9.16 | 0.511 |
| No education | 1.12 | 0.83 | 1.50 | 0.455 | 0.82 | 0.48 | 1.39 | 0.464 |
| Father's education (Primary) | 1.00 | 1.00 | 1.00 | | 1.00 | 1.00 | 1.00 | |
| Junior secondary | 1.20 | 0.79 | 1.82 | 0.387 | 1.29 | 0.70 | 2.38 | 0.410 |
| Senior Secondary | 0.86 | 0.51 | 1.44 | 0.563 | 0.76 | 0.35 | 1.62 | 0.478 |
| Tertiary | 0.21 | 0.03 | 1.70 | 0.144 | 0.80 | 0.08 | 8.28 | 0.848 |
| No education | 1.31 | 0.93 | 1.86 | 0.123 | 1.14 | 0.65 | 1.99 | 0.648 |
| Household size (1-2) | 1.00 | 1.00 | 1.00 | | 1.00 | 1.00 | 1.00 | |
| 3-4 | 2.49 | 1.00 | 6.17 | 0.049 | 15.17 | 2.12 | 108.59 | 0.007 |
| 5-7 | 1.23 | 0.50 | 3.00 | 0.655 | 20.94 | 2.96 | 148.34 | 0.002 |
| 8+ | 1.29 | 0.53 | 3.17 | 0.578 | 21.84 | 3.07 | 155.20 | 0.002 |

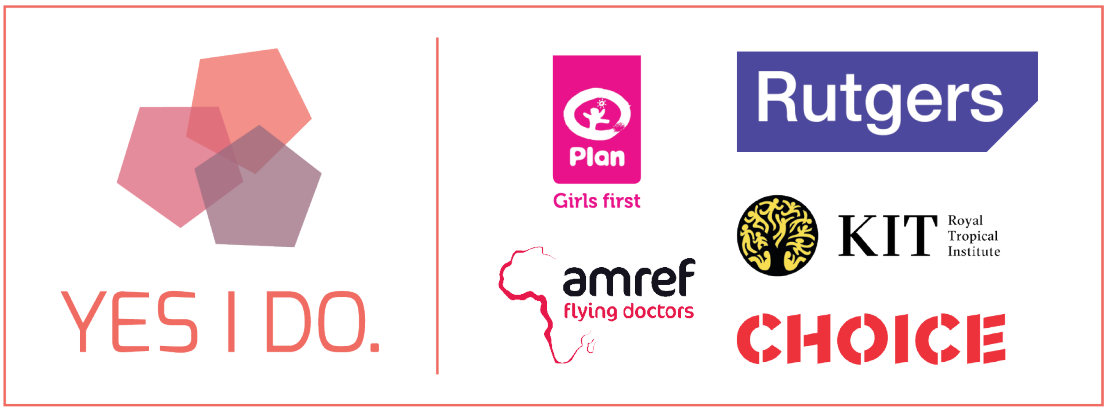
| Teenage pregnancy | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Univariable | | | | Multivariable | | | |
| | | 95%CI | | | | 95%CI | | |
| | B | Lower bound | Upper bound | P-value | B | Lower bound | Upper bound | P-value |
| **Outcome variable: Young women (20-24 years) who wanted to become parents at that time** | | | | | | | | |
| Constant | | | | | 0.03 | 0.00 | 1.50 | 0.080 |
| Time | 1.12 | 0.63 | 1.97 | 0.708 | 0.99 | 0.55 | 1.78 | 0.979 |
| Age (in years) | 1.18 | 1.00 | 1.40 | 0.053 | 1.15 | 0.97 | 1.36 | 0.114 |
| School attendance | 0.47 | 0.24 | 0.93 | 0.031 | 0.51 | 0.25 | 1.04 | 0.063 |

| Pregnancy and marriage | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Univariable | | | | Multivariable | | | |
| | | 95%CI | | | | 95%CI | | |
| | B | Lower bound | Upper bound | P-value | B | Lower bound | Upper bound | P-value |
| **Outcome variable: Ever married mothers aged 15 - 24 years old who were first married and then became pregnant** | | | | | | | | |
| Constant | | | | | 0.08 | 0.00 | 3.12 | 0.178 |
| Time | 0.34 | 0.18 | 0.65 | 0.001 | 0.33 | 0.17 | 0.62 | 0.001 |
| Age (in years) | 1.07 | 0.91 | 1.26 | 0.397 | 1.09 | 0.92 | 1.28 | 0.319 |
| School attendance | 1.04 | 0.44 | 2.45 | 0.923 | 0.77 | 0.32 | 1.87 | 0.561 |
| **Outcome variable: Ever married mothers aged 15 - 24 years old who became pregnant and were married in the same year** | | | | | | | | |
| Constant | | | | | 0.65 | 0.04 | 11.89 | 0.774 |
| Time | 1.08 | 0.64 | 1.82 | 0.775 | 1.16 | 0.68 | 1.98 | 0.593 |
| Age (in years) | 1.01 | 0.89 | 1.16 | 0.839 | 1.00 | 0.88 | 1.15 | 0.962 |
| School attendance | 1.62 | 0.79 | 3.32 | 0.184 | 1.68 | 0.81 | 3.49 | 0.164 |
| **Outcome variable: Ever married mothers aged 15 - 24 years old who became pregnant and were then married** | | | | | | | | |
| Constant | | | | | 1.42 | 0.07 | 30.87 | 0.822 |
| Time | 2.19 | 1.22 | 3.92 | 0.009 | 2.10 | 1.16 | 3.81 | 0.014 |
| Age (in years) | 0.93 | 0.81 | 1.07 | 0.340 | 0.93 | 0.81 | 1.08 | 0.349 |
| School attendance | 0.53 | 0.23 | 1.23 | 0.138 | 0.65 | 0.28 | 1.55 | 0.334 |

| Child marriage | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Univariable | | | | Multivariable | | | |
| | | 95%CI | | | | 95%CI | | |
| | B | Lower bound | Upper bound | P-value | B | Lower bound | Upper bound | P-value |
| **Outcome variable: Girls and women aged 16-24 who were married or in a union before age 16** | | | | | | | | |
| Constant | | | | | 0.00 | 0.00 | 0.01 | 0.000 |
| Time | 0.60 | 0.23 | 1.59 | 0.302 | 0.36 | 0.13 | 0.97 | 0.044 |
| Age (in years) | 1.39 | 1.14 | 1.70 | 0.001 | 1.33 | 1.07 | 1.65 | 0.009 |
| School attendance | 0.16 | 0.04 | 0.70 | 0.015 | 0.23 | 0.05 | 1.07 | 0.061 |
| **Outcome variable: Girls and women aged 18-24 who were married or in a union before age 18** | | | | | | | | |
| Constant | | | | | 0.00 | 0.00 | 0.02 | 0.000 |
| Time | 0.86 | 0.54 | 1.37 | 0.523 | 0.61 | 0.37 | 1.00 | 0.048 |
| Age (in years) | 1.31 | 1.17 | 1.48 | 0.000 | 1.27 | 1.12 | 1.43 | 0.000 |
| School attendance | 0.29 | 0.15 | 0.15 | 0.000 | 0.33 | 0.16 | 0.65 | 0.001 |
| **Outcome variable: Girls below 18 years old who are currently married** | | | | | | | | |
| Constant | | | | | 0.00 | 0.00 | 0.00 | 0.005 |
| Time | 1.07 | 0.31 | 3.75 | 0.916 | 1.03 | 0.29 | 3.65 | 0.967 |
| Age (in years) | 3.60 | 1.28 | 10.10 | 0.015 | 3.60 | 1.28 | 10.11 | 0.015 |
| School attendance | - | - | - | - | - | - | - | - |
| **Outcome variable: Married girls and young women (15-24 years), who perceive that it was their choice to get married** | | | | | | | | |
| Constant | | | | | 2.43 | 0.13 | 43.91 | 0.547 |
| Time | 1.33 | 0.76 | 2.34 | 0.315 | 1.30 | 0.73 | 2.31 | 0.378 |
| Age (in years) | 0.99 | 0.87 | 1.13 | 0.908 | 0.99 | 0.87 | 1.13 | 0.917 |
| School attendance | 0.78 | 0.37 | 1.63 | 0.508 | 0.85 | 0.40 | 1.81 | 0.667 |
| **Outcome variable: Young women (18-24 years) who were child brides, and who were married to an adult man** | | | | | | | | |
| Constant | | | | | 2.73 | 0.00 | 5134.06 | 0.794 |
| Time (time)** | 0.71 | 0.16 | 3.19 | 0.654 | 0.68 | 0.15 | 3.12 | 0.617 |
| Age (in years) | 1.05 | 0.74 | 1.49 | 0.775 | 1.07 | 0.75 | 1.52 | 0.715 |
| School attendance | - | - | - | - | - | - | - | - |

| Education | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Univariable | | | | Multivariable | | | |
| | | 95%CI | | | | 95%CI | | |
| | B | Lower bound | Upper bound | P-value | B | Lower bound | Upper bound | P-value |
| **Outcome variable: Girls aged below 18 years who dropped out of school** | | | | | | | | |
| Constant | | | | | 0.48 | 0.00 | 84.46 | 0.779 |
| Time | 0.79 | 0.54 | 1.17 | 0.240 | 0.58 | 0.35 | 0.96 | 0.035 |
| Age (in years) | 1.54 | 1.20 | 1.99 | 0.001 | 1.17 | 0.85 | 1.61 | 0.321 |
| School attendance | 0.05 | 0.03 | 0.08 | 0.000 | 0.04 | 0.02 | 0.08 | 0.000 |
| **Outcome variable: Girls below 18 years who left school due to marriage** | | | | | | | | |
| Constant | | | | | 0.00 | 0.00 | 42.20 | 0.095 |
| Time | 0.35 | 0.04 | 3.42 | 0.369 | 0.34 | 0.04 | 3.36 | 0.358 |
| Age (in years) | 2.76 | 0.63 | 12.13 | 0.180 | 2.90 | 0.62 | 13.56 | 0.175 |
| School attendance | - | - | - | - | - | - | - | - |
| **Outcome variable: Girls and women aged 20-24 years who left school due to pregnancy** | | | | | | | | |
| Constant | | | | | 1.20 | 0.06 | 25.74 | 0.905 |
| Time | 1.54 | 0.98 | 2.41 | 0.058 | 1.69 | 1.06 | 2.69 | 0.027 |
| Age (in years) | 0.89 | 0.78 | 1.02 | 0.094 | 0.93 | 0.81 | 1.06 | 0.269 |
| School attendance | 1.94 | 1.24 | 3.05 | 0.004 | 2.05 | 1.28 | 3.30 | 0.003 |
| **Outcome variable: Girls aged 15-18 currently attending secondary school** | | | | | | | | |
| Constant | | | | | 0.00 | 0.00 | 0.01 | 0.000 |
| Time | 0.95 | 0.66 | 1.38 | 0.797 | 1.00 | 0.68 | 1.46 | 0.982 |
| Age (in years) | 1.48 | 1.24 | 1.77 | 0.000 | 1.48 | 1.24 | 1.77 | 0.000 |
| School attendance | - | - | - | - | - | - | - | - |

| Employment | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Univariable | | | | Multivariable | | | |
| | | 95%CI | | | | 95%CI | | |
| | B | Lower bound | Upper bound | P-value | B | Lower bound | Upper bound | P-value |
| **Outcome variable: Girls between 18 and 24 years old who are economically active outside of the household** | | | | | | | | |
| Constant | | | | | 0.00 | 0.00 | 0.02 | 0.000 |
| Time | 7.33 | 4.64 | 11.58 | 0.000 | 6.98 | 4.37 | 11.16 | 0.000 |
| Age (in years) | 1.22 | 1.12 | 1.33 | 0.000 | 1.20 | 1.09 | 1.31 | 0.000 |
| School attendance | 0.60 | 0.41 | 0.88 | 0.008 | 1.10 | 0.71 | 1.68 | 0.676 |
| **Outcome variable: Girls between 18 and 24 years old who have received any income in the last six months** | | | | | | | | |
| Constant | | | | | 0.31 | 0.03 | 3.34 | 0.337 |
| Time | 0.20 | 0.12 | 0.32 | 0.000 | 0.17 | 0.10 | 0.27 | 0.000 |
| Age (in years) | 1.00 | 0.91 | 1.11 | 0.937 | 1.02 | 0.91 | 1.14 | 0.699 |
| School attendance | 0.85 | 0.54 | 1.34 | 0.484 | 0.54 | 0.33 | 0.90 | 0.018 |


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