

From “*Etigila Entito Enkalamu*” to “*Eitia Entito Enkalamu*”

How the Yes I Do programme changed lives in Kajiado County in Kenya



Preface

The **YES I DO** programme (2016-2020) aimed 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, was implemented in seven countries, namely Ethiopia, Kenya, Malawi, Mozambique, Zambia, Indonesia and Pakistan. In Kenya, the programme was implemented in the Kajiado West sub-county. The Yes I Do programme was implemented by an alliance consisting of Plan Netherlands, Amref, Rutgers, Choice for Youth and Sexuality and the KIT Royal Tropical Institute KIT. In Kenya, the Yes I Do alliance consisted of Amref Health Africa, Plan Kenya, Network for Adolescents and Youth of Africa (NAYA), Centre for the Study of Adolescence (CSA) and Ujamaa.

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Abbreviations

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical Research Foundation
ARP	Alternative Rite of Passage
AU	African Union
CBO	Community Based Organisation
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/ Cutting
HIV	Human Immunodeficiency Virus
ICRW	International Centre for Research on Women
IDI	In-depth Interview
KDHS	Kenya Demographic and Health Survey
KII	Key Informant Interview
KIT	Royal Tropical Institute
NGO	Non-Governmental Organisation
ODK	Open Data Kit
OHCHR	Office of the United Nations High Commissioner for Human Rights
PMTCT	Prevention of Mother To Child Transmission
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health and Rights
STI	Sexually Transmitted Infection
ToC	Theory of Change
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNDP	United Nations Development Programme
VCT	Voluntary Counselling and Testing
VSLA	Village Savings and Loan Association
YIDA	Yes I Do Alliance

KEY TERMS AND DEFINITIONS

Young adults: those aged 20-24 years

Youth: all females and males within the age range 15 to 24

Young people: those aged 10-24 years

Adolescents: individuals in the 10-19 years age group

Child marriage: any legal or customary union involving a girl or boy below the age of 18

Teenage pregnancy: all pregnancies before the age of 20

Female genital mutilation/cutting: all procedures involving partial or total removal of the external female genitalia or another injury to the female genital organs for non-medical reasons

Executive summary

INTRODUCTION

Child marriage, teenage pregnancy and female genital mutilation/cutting (FGM/C) are issues experienced by young girls that are interrelated and that reinforce each other. They have common root causes and social drivers such as gender inequality, social and cultural norms, poverty, and inadequate access to education and sexual and reproductive health and rights (SRHR) information and services. Child marriage and teenage pregnancy have adverse effects on the health and education of young girls, their economic opportunities and decision-making and agency. All three issues have negative influence on agency and empowerment of girls. Child marriage increases the likelihood of teenage pregnancy and the other way round while FGM/C can lead to either teenage pregnancy or child marriage. In many communities where FGM/C is practiced, it is a prerequisite for a girl to become a marriage partner. For a period of 5 years (since 2016), the Yes I Do Alliance, consisting of Plan Netherlands, Amref Netherlands, Choice for Youth and Sexuality, Rutgers and the KIT Royal Tropical Institute, and together with local partners, have been implementing a programme in the Kajiado West sub-county (intervention area) to address child marriage, teenage pregnancy and FGM/C.

OVERALL GOAL OF THE ENDLINE RESEARCH

The overall goal of the endline study was to provide insight into the magnitude, (interrelated) causes and effects of child marriage, teenage pregnancy and female genital mutilation/ cutting, as well as the extent to which these causes and effects are present in the intervention areas (Kajiado West County) of the Yes I Do programme in Kenya, compared to non-intervention areas (Kajiado Central), over a period of four years. In addition, the research aimed to provide insight into the different pathways of change, thereby testing the Theory of Change (ToC), and unravel why and how the Yes I Do interventions strategies do or do not contribute towards improved outcomes related to the three problems, and ultimately a decrease in child marriage, teenage pregnancy and FGM/C in Kajiado West County.

The specific objectives of the endline study in Kenya were six-fold and followed the pathways outlined in the ToC:

1. To explore (changes in) attitudes of community members and gate keepers around child marriage, teenage pregnancy and FGM/C, whether and to what extent they take action to prevent child marriage, teenage pregnancy and FGM/C and which factors influence this and how; over a period of four years in intervention (Kajiado West sub-county) and non-intervention areas (Kajiado Central sub-county)
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 (Kajiado West sub-county) and non-intervention areas (Kajiado Central sub-county)
3. To explore and analyse whether and to what extent adolescents take informed action on their sexual and reproductive health and which factors influence this and how; over a period of four years in intervention (Kajiado West sub-county) and non-intervention areas (Kajiado Central sub-county)
4. To explore and analyse whether and to what extent education and economic empowerment of girls provides them with alternatives beyond child marriage, teenage pregnancy and FGM/C after four years in intervention areas in Kajiado West sub-county
5. To provide insight into (changes in) developed and implemented laws and policies on child marriage, teenage pregnancy and FGM/C over a period of four years in Kajiado West sub-county and in Kenya in general
6. To contribute to the evidence on effective and context specific intervention strategies to eliminate child marriage and FGM/C and reduce teenage pregnancy

METHODOLOGY

For comparability purposes, the endline study was conducted in the same study sites as at baseline. These were Kajiado West sub-county (the intervention site) and Kajiado Central sub-county (the control site). In Kajiado West sub-county, the study was conducted in two wards where the Yes I Do programme was implemented: Iloodokilani and Ewauo Oo Nkidong’l. In Kajiado Central, two wards were selected as the control sites: Matapato and Purko wards.

A mixed methods approach was employed in the study, where both quantitative (household survey) and qualitative methodologies were used. A standardised electronic data collection tool was used to collect quantitative data from 1,368 respondents at baseline and 1,409 at endline where a clustered sampling approach was used to select villages (enumeration areas). The qualitative component of the study was done in the intervention area (Kajiado West sub-county). A total of ten Focus Group Discussions (FGDs), nineteen in-depth Interviews (IDIs) and two Key Informant Interviews (KIIs) were conducted. Study participants included girls, boys, parents, religious and traditional leaders, teachers, health and social workers, youth organization staff, NGO staff and policy makers.

RESULTS

GENERAL CHARACTERISTICS OF THE SURVEY RESPONDENTS

A total of 1,368 respondents were surveyed at baseline and 1,409 at endline with 76% being female in both study areas, as per the study design. The endline population was aged 15-19 (61%) and 20-24 (39%): 20% of the respondents were married, 26% had completed secondary education, completed upper primary (23%), not currently in school (33%) and 7% had no basic education. In comparison to the baseline population; 66% of the respondents in the intervention area were in school at baseline, as compared to 49% at endline. In the control area, 73% of the respondents were in school at baseline as compared to 67% at endline. School dropout was higher in the intervention area compared to the control area at both baseline (intervention: 28%, control: 17%) and endline (intervention: 32%, control: 21%). Males mainly dropped out of school because of lack of fees (baseline: 68.7%, endline: 50%) while females dropped out because of pregnancy (baseline: 52.5%, endline: 78%).

Most respondents were not employed at baseline (86%) and endline (80%). The employment was mainly self-employment or casual labour. In the intervention area, the primary source of income was pastoralism (81% at baseline; 52% at endline), casual labour (15%) and small business ownership (14%). In the control area, the primary source of income was pastoralism at base- (78%) and endline (71%). Only 18% of the respondents in the intervention area had ever participated in the Yes I Do programme.

CHILD MARRIAGE

The prevalence of child marriage among female respondents aged 18-24 years in the intervention area reduced by half from 30% at baseline to 16% at endline while in the control area there was a reduction from 11% to 2%. Furthermore, 17% of the girls below 18 years in the intervention area were married at baseline as compared to only 6% at endline. The results show a statistically significant decline in the prevalence of child marriage among girls below 16 years and young women aged 18-24 years in the intervention area as compared to the control area.

Over time, the percentage of married females who believed it was their choice to get married decreased – from 52% to 33% in the intervention area and from 63% to 42% in the control area. Similar to the baseline, results from the qualitative part showed that the underlying causes of child marriage were pregnancy, poverty, peer pressure as well as pressure from some parents to preserve family honour. There is a positive change in community awareness of the consequences of child marriage and consensus among respondents that there are no benefits to child marriage.

TEENAGE PREGNANCY

A slight – yet statistically insignificant – increase in the prevalence of teenage pregnancy among women aged 20 to 24 years can be observed in the intervention area, from 49% to 53% while in the control area the prevalence slightly decreased from 34% to 32%. While the prevalence of teenage pregnancy has not changed positively over time, the average age of first pregnancy increased in the intervention area by a year, from 16.1 at baseline to 17.1 at endline. The average age of first pregnancy also slightly increased in the control area from 16.9 to 17.3 years. The reported desire to become a mother when they did significantly decrease from 74% to 37% in the intervention area and from 78% to 45% in the control area. However, while the decrease in the intervention area is statistically significant, it is not

statistically significantly different from the trend in the control area.

Unlike during baseline, where most parents were reported to marry off girls who dropped out of school because of pregnancy, the qualitative data during endline revealed a positive change in the mind-set of the community members. While previously the only option for a pregnant girl was to get married, there is now a change in perception whereby the community has adopted a more positive view saying that “eitia entito enkalamu” – translated as the girl has “dropped the pen” – to show that she can still pick herself up (the pen) and proceed with school.

FEMALE GENITAL MUTILATION /CUTTING

The percentage of girls and young women who were circumcised in the intervention area remained stable (58% at baseline; 59% at endline) while in the control area, a marginal reduction of 4% occurred over the four-year period (46% at baseline; 40% at endline). In all the study sites and at both baseline and endline, most young women aged 15-24 reported not wanting their daughters to be circumcised. However, FGM/C is still considered to be the social norm by 59% of the girls and young women in the intervention area at endline, a slight decrease compared to baseline (68%). In the intervention area, there was an increase in the percentage of young women who believed that circumcision has no implication on their chances of marriage (36% at baseline and 60% at endline); while no change was observed in the control area (baseline: 49%, endline: 51%). In addition, the percentage of girls who feel good about their circumcision decreased considerably from 55% to 16% in the intervention area and from 56% to 17% in the control area. In addition, there is a statistically significant decrease in the percentage of boys and men aged 15 to 24 years who prefer a non-circumcised partner in the intervention area over the control area.

Despite the persisting practice of FGM/C in both areas, there seems to be a considerable shift in the circumstances of circumcision from open celebrations into a more clandestine practice. At baseline, the majority of circumcisions involved celebrations in both the intervention area (83%) and the control area (68%). At endline, celebrations decreased considerably to 41% in the intervention area. Similarly, in the control area, 69% of the girls were circumcised secretly, an increase of 40% since the baseline (29%). Similar results were reported in the qualitative part, where FGM/C practice was reported to continue largely in secret and among younger women, due to awareness among community members of the illegality of the practice.

Table 1 Summary of quantitative indicators tracked

1/2

Category and indicator	Baseline		Endline	
	Intervention	Control	Intervention	Control
Child marriage, teenage pregnancy and FGM/C				
% of girls and women (18-24 years) who were married or in a union before age 18 (i.e. child marriage)	77 (30.3%)	28 (10.7%)	54 (16.4%)	25 (9.4%)
% of girls and women (16-24 years) who were married or in a union before age 16 (i.e. child marriage)	61 (15%)	13 (3.3%)	11 (2.6%)	5 (1.2%)
% of girls below 18 years old who are currently married	32 (12.6%)	3 (1.2%)	2 (0.9%)	2 (0.8%)
% of young women (20-24 years) who had their first child under the age of 20 (i.e. teenage pregnancy)	96 (48.7%)	55 (34.4%)	127 (53.1%)	51 (32.1%)
% of girls and young women (15-24 years) who underwent FGM/C	292 (57.9%)	233 (45.8%)	326 (59%)	208 (39.8%)
SRHR behaviour				
% girls and young women (15-24 years) who can decide for themselves whom to date and go out with	375 (74.1%)	388 (76.1%)	444 (80.3%)	415 (79.5%)
% boys and young men (15-24 years) who can decide for themselves whom to date and go out with	150 (85.7%)	145 (84.3%)	139 (81.8%)	139 (84.8%)
% of girls and young women (15-24 years) that have ever utilized SRHR services, including modern contraceptives	380 (75%)	322 (62.9%)	356 (64.4%)	232 (44.4%)
% of boys and young men (15-24 years) that have ever utilized SRHR services, including modern contraceptives	102 (58%)	95 (54.9%)	88 (51.8%)	58 (35.4%)
% of girls/ young women and boys/ young men between 15 and 24 using a modern method of contraception (contraceptive prevalence rate)	NA	NA	192 (26.6%)	134 (19.5%)
% of young mothers aged 15-24 years indicating using MALE condoms	18 (8.3%)	10 (7.9%)	9 (3.9%)	12 (12.9%)
% of young fathers aged 15-24 years indicating using MALE condoms	2 (15.4%)	1 (16.7%)	12 (40%)	2 (13.3%)
% of not currently married boys/men (15-24 years) who prefer a non-circumcised female as future partner	102 (62.2%)	87 (51.8%)	81 (56.6%)	103 (69.1%)
% of girls and young women (15- 24 years) who have ever used contraceptives	NA	NA	193 (34.9%)	137 (26.2%)
% of boys and young men (15-24 years) who have ever used contraceptives	NA	NA	64 (37.6%)	45 (27.4%)

Table 1 Summary of quantitative indicators tracked

2/2

Category and indicator	Baseline		Endline	
	Intervention	Control	Intervention	Control
SRHR knowledge				
% girls and young women (15-24 years) who know how to prevent pregnancy using modern contraceptives	287 (56.6%)	248 (48.4%)	310 (56.1%)	293 (56.1%)
% boys and young men (15-24 years) who know how to prevent pregnancy using modern contraceptives	93 (52.8%)	94 (54.3%)	101 (59.4%)	109 (66.5%)
% 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"	261 (51.6%)	225 (44.1%)	319 (57.7%)	280 (53.6%)
% boys and young men (15-24 years) who disagree with the statement "It is not appropriate for a girl to propose to use a condom"	117 (66.9%)	85 (49.4%)	80 (47.1%)	67 (40.9%)
% girls and young women (15-24 years) who feel confident to insist on condom use every time they have sex	251 (49.6%)	228 (44.7%)	259 (46.8%)	341 (65.3%)
% boys and young men (15-24 years) who feel confident to insist on condom use every time they have sex	135 (77.1%)	117 (68%)	98 (57.6%)	116 (70.7%)
% girls and young women (15-24 years) who ever received education about sexuality and sexual health	290 (57.2%)	316 (61.7%)	406 (73.4%)	386 (73.9%)
% boys and young men (15-24 years) who ever received education about sexuality and sexual health	87 (49.7%)	108 (62.4%)	102 (60%)	103 (62.8%)
Education and economic empowerment				
% girls aged below 18 years who dropped out of school	45 (17.8%)	19 (7.6%)	24 (10.7%)	26 (10.2%)
% of girls below 18 years who left school due to marriage	8 (3.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
% of girls below 18 years who left school due to pregnancy	28 (11.1%)	12 (4.8%)	15 (6.7%)	11 (4.3%)
% girls aged 15-18 currently attending secondary school	94 (33.6%)	126 (42.3%)	48 (17.7%)	172 (55.3%)
% girls (15-18 years) who have a child and follow education	25 (43.1%)	14 (66.7%)	8 (22.9%)	3 (20.0%)
% young women (18-24 years) who are economically active outside of the household	56 (22%)	53 (20.2%)	84 (25.5%)	69 (25.9%)
% young women (18-24 years) who have received any income in the last six months	108 (42.5%)	77 (29.4%)	193 (58.7%)	153 (57.5%)

Table 2 Summary of qualitative indicators tracked

Changes relative to baseline:

Knowledge of gatekeepers about harms of child marriage and teenage pregnancy

Relative to the baseline, the endline participants reported that through the efforts of various stakeholders, particularly non-governmental organisations (NGOs), the church and community leaders, there has been an increased in the awareness on the dangers of child marriage and teenage pregnancy generally. During discussions with parents, it was reported that the Yes I Do programme has contributed to creating awareness of the negative consequences of child marriage and teenage pregnancy, explaining that the life of a girl who marries early is plagued with misery, she gives birth with less spacing and this negatively affects her health. Reference was also made to girls experiencing difficulties /complications of childbirth and a general hardship environment. Participants often emphasised that there are no benefits of child marriage and teenage pregnancy to girls or their families.

Attitudes and actions of gate keepers to prevent child marriage and teenage pregnancy

Relative to baseline, the endline participants agreed that there are some changes that they can identify. Examples were given where some parents are beginning to embrace formal education for both boys and girls as a protective measure against teenage pregnancy. In particular, parents acknowledged the role they need to play in supporting girls and protecting them from teenage pregnancy. Participants frequently mentioned gatekeepers such as NGOs, schools, religious leaders, health workers, teachers, the administration (chiefs, police). Religious leaders were mentioned more frequently. Through these gatekeepers, there has been awareness creation on the dangers of child marriage, which seems to have informed a repulsive attitude towards child marriage and teenage pregnancy. In one FDG with young men, the role of the chief was heralded in supporting and reinforcing adherence to the information provided by other stakeholders working in the community. There are instances where the chief has had to invoke the law and arrest the perpetrators of child marriage. In such instances, the girls who are rescued are taken to rescue centres where they can continue education.

Knowledge of gatekeepers about harms of FGM/C

As the case at baseline, the narratives at endline show that gatekeepers are aware of the harmful effects of FGM/C. Many explained that following the FGM/C experience, girls consider themselves or are regarded as ‘women’ and therefore ready to engage in sexual activities, which may lead to teenage pregnancy. Some added that FGM/C often leads to girls dropping out of school and may eventually enter child marriage.

Youth who feel they can advocate for themselves

It was reported that girls and boys were being given equal opportunities for education as a result of a few role models motivating parents to educate their girls too. Changes in girls’ agency seem to be overshadowed by notions of respect, obedience, discipline as the cornerstone of social and cultural norms underpinning the relationship between girls and boys, men and women, children and parents, community members and elders. The views on girls and boys regarding their prescribed roles in society influence how they can advocate for issues affecting their lives. For example, good girls and good boys follow instructions from parents – including accepting instructions regarding child marriage and FGM/C as a traditional practice. Although child marriage is still an important normative belief in the community, there is also evidence that some girls are daring enough to refuse, which indicates changes in personal autonomy. It was reported that girls might appear to “disobey” by running away from child marriage, often in search of education. Also, in some families, girls were being asked if they accept the choice of parents for a husband or not.

Current access to SRHR information by girls/ young women and boys/ young men aged 15 to 24 years

Similar to the baseline, the qualitative narratives show that young girls reported to receive SRHR information from teachers in schools, their peers, social media, churches, NGOs providing education, parents, and community health volunteers. It was also reported that girls are expected to mostly get information from their mothers while boys are expected to get information largely from their fathers. At endline, although the church was frequently mentioned as a source of sexual and reproductive health (SRH) information for young people, there were concerns by male parents about current activities in churches that predispose the youth to sexual activity. Some mentioned that church seminars could also be places where young people socialise and get the opportunity to engage in (unsafe) sexual activity. While some young participants were emphatic to state that they were being provided with reproductive health information by teachers in school (including taking exams on SRH topics), and at home, others spoke of not receiving enough sexual education.

Perceived autonomy of girls/ young women (15-24 years)

Participants reported observed changes in girls' autonomy, citing perceptions that one can find girls who have gone up to high school level uncircumcised, and participants believed that the Yes I Do programme made important contributions. Other participants spoke of girls being able to refuse forced marriages and instances where girls were consulted for their opinion in marital decisions, which represent a remarkable improvement over the situation at baseline when girls had little autonomy. On the other hand, girls expressed worry that they are unable to discuss sensitive issues related to sexuality. "When you utter any sexually-related word as a youth here, one would be regarded as disrespectful, so we can only speak out on other things but not sexual matters." (girls, 15-19 years). It also relates to how the young women dress (mode of dressing), communication with their elders, respect of customs and adherence to what parents say – especially instructions from fathers.

Girls indicating safety in and out of school is a problem

The endline participants spoke less about school safety but those who did, reported that schools were becoming safer for both boys and girls. The concerns about safety were more outside the school environment – having to walk long distances to school, roads that were bushy, and the use of boda-boda riders who may entice girls into sexual activity. Some participants spoke about the availability of more schools as a relief to parents who no longer have to send their children far away for education, contrary to the situation at baseline. Importantly, girls acknowledged that they are being allowed to go to school just like boys do, which further suggests improvement in school safety for girls.

of new or adjusted national and local laws (incl. bylaws) and policies prohibiting child marriage and FGM/C

The participants repeatedly mentioned laws and policies protecting girls' rights, including the Children's Act, the return to school policy, anti-FGM/C laws and the 100% transition from primary school to secondary school. Unlike the situation at baseline when there was little to say about the implementation of these laws, there was evidence that the laws and policies are being implemented, including reported instances of arrest of parents and circumcisers over FGM/C and child marriage. The qualitative narratives show that during the life of the Yes I Do programme, Kajiado County developed an anti-FGM/C policy together with stakeholders working in the county – the Yes I Do alliance's role in the development of the County policy was repeatedly acknowledged. Also, there was evidence of clear commitment towards the implementation of the County policy on FGM/C. Nonetheless, others raised concerns about implementation and the need for follow-up to ensure that all stakeholders and partners are engaged.

Policy makers actively/openly supporting gender equality and girls' rights

The narratives show that policy makers are now speaking openly when it comes to supporting SRHR and gender equality. For example, it was reported that health authorities support access to SRH services by young girls and boys, and health workers provide education on the negative consequences of FGM/C and teenage pregnancy to all young people. Also, education policies support girls and boys education and 100% transition from primary school to secondary school. It is clear from the narratives that the alliance partners have done a lot of advocacy and sensitisation on existing national policies and laws on FGM/C and child marriage and the need to support girl's education and this has enabled open discussion at the community level. At the same time, some participants spoke about unequal treatment of boys and girls, adding that gender-based violence is present in the community and is often meted out to girls and women. Others reported that within the Maasai community, a girl is still generally demeaned and only valued as an object for marriage.

Active engagement of men and boys in strategies reducing FGM/C, child marriage and teenage pregnancy

Similar to baseline and midline findings, the qualitative interviews at endline reported minimal active engagement of men and boys in strategies for reducing teenage pregnancy, child marriage and FGM/C. Male participants often highlighted what should be done as opposed to what they were actively engaged in to reduce these harmful practices.

CONCLUSION

The findings of this study are mixed whereby change in outcomes has been realized in some of the pathways, other outcomes have remained the same as compared to baseline, while some have shown a decline. The decline in the prevalence of child marriage in the intervention area is a major finding of this study. This could be attributed to increased community awareness of the consequences of child marriage and the fact that there is agreement among community members that there are no benefits of child marriage. There is also increased awareness and enforcement of the return to school policy. On the contrary, the prevalence of teenage pregnancy and FGM/C did not change in the intervention area over the programme period. The practice of FGM/C continues as a social norm, though largely in secret due to the fear of law enforcement.

The Yes I Do programme worked through and with local structures such as schools, the church, local leaders and the county government thus, in some way, entrenching the interventions in existing structures. The Kajiado County FGM/C policy provides a vehicle to drive FGM/C abandonment activities among the Maasai community. A policy that is home-grown is bound to spark ownership and acceptance by the local community and embrace change. The return to school policy provides a supportive environment for enhancing the girl child education and is likely to take root in the communities that have been supported by the Yes I Do programme.

RECOMMENDATIONS

PROGRAMME

1. The abandonment of FGM/C and child marriage is rarely a priority of communities who value the practices as social norms. FGM/C and child marriage eradication efforts should therefore be integrated into community priority development programmes such as water, sanitation, education or health care, that meet immediate community felt needs. This will also help to build community trust towards information provided by these programmes.
2. There is need to use local resources in the fight against FGM/C and child marriage (“insider approach”). For example, by educating members of the community, such as traditional leaders, religious leaders, girls who have grown up in the community and succeeded (in marriage or financially) without having gone through the cut, or fathers who have decided not to circumcise their daughters, and involve them as local champions.
3. Interventions addressing the SRHR of young people need to be broad-based and take into consideration the social, cultural and economic context of young people, and should be implemented over a longer period of time in order to elicit observable change.
4. Meaningful youth and men engagement need to have a more structured approach with specific interventions on gender equality and sexual health in addressing FGM/C and child marriage.
5. Schools are a major source of sexuality and sexual health information for young people and hence there is the need to strengthen school programmes including the role of teachers, peer educators and youth clubs.
6. There is a need to use existing community structures to enhance parent-adolescent communication and provide parents with accurate and right information to effectively communicate with their adolescent girls and boys.
7. Making schools safe for girls and effective economic empowerment interventions for young women and men to gain vocational skills and participate in income generating activities remain important goals to pursue as part of any women empowerment programme in the Kajiado County.
8. Efforts to ensure an effective implementation of the Kajiado County policy on the eradication of FGM/C need continuous attention and future programme activities should focus on holding duty-bearers accountable to enforce the laws and implement the policy.
9. In-depth discussions and community dialogues should go beyond threats and illegality of the practice, because while laws and policies are essential, they may not solve problems that are embedded in culture.

RESEARCH

1. The role of community development programmes in stimulating change of social and cultural norms and practices while building on the positive drivers of social change such as education, health, improved livelihood.
2. The effectiveness of the multifaceted / multicomponent approach in addressing embedded socio-cultural norms and practices using an insider focus.
3. Exploring social, cultural, religious and economic factors that facilitate and hinder access to and utilisation of SRH information and services by young people in the Maasai communities.
4. Studies that can specify economically viable activities for young women in the Maasai communities in Kajiado County can make an important contribution to women empowerment and to addressing child marriage and teenage pregnancy.
5. There is the need to monitor the implementation of the Kajiado County policy for the eradication of FGM/C and to evaluate its effectiveness in reducing the practice. The lessons could inform other Counties planning similar actions to address FGM/C in Kenya.

1. Introduction

1.1 BACKGROUND ON CHILD MARRIAGE, TEENAGE PREGNANCY AND FEMALE GENITAL MUTILATION/CUTTING

CHILD MARRIAGE

Child marriage, also referred to as early marriage, is defined as any legal or customary union involving a boy or girl below the age of 18. This definition draws from various conventions, treaties, and international agreements (CEDAW 1979). Girls suffer the most from child marriage. Even though it is considered a human rights violation, more than 30% of today's women in developing countries were married before their 18th birthday and a total of 70 million girls worldwide is affected, mostly in South Asia and Sub-Saharan Africa (UNICEF 2014)

Substantial research has been conducted on factors contributing to child marriage. A global analysis of factors associated with the risks of child marriage found that a low education level of girls, a large age gap between husband and wife and low household wealth, combined with regional differences, are predictors of child marriage (Jain and Kurz 2007). Child marriage is rooted in gender inequality. The lower status and value placed on girls perpetuate child marriage and its acceptability in many societies (Parsons et al. 2015). Social and cultural norms, including faith-related norms and values, influence the expected age of girls to marry (Gemignani and Wodon 2015). Social norms around female's education and participation in labour force give indications for a household's prioritization for investments in their education (Parsons et al. 2015). Faith-related factors include, for example, the fear for pregnancy before marriage, however, there is a large heterogeneity in how faith influences child marriage practices (Gemignani and Wodon 2015). Socio-economic status, educational levels and community contexts influence the likelihood of girls marrying early or as children: the poorest countries have the highest rates of child marriage and it is most common among the poorest within these countries, who have little resources to invest in alternative options for girls. Reasons for parents to marry off their daughters are mostly economic and social. In certain contexts, it is a tradition which provides parents pride and (short-term) financial benefits (Parsons et al. 2015).

In many settings, child marriage marks the beginning of frequent and unprotected sexual intercourse, leading to a greater risk of sexual transmitted infections (STIs), HIV and teenage pregnancy, high number of children and limited spacing. Many of the teenage pregnancies take place within marriage and the complications related to these pregnancies and childbirth are among the leading causes of death for girls aged 15 to 19 in low- and middle-income countries (UNFPA 2015; Kassa et al. 2018). Studies from Kenya and Zambia have shown that married adolescent girls had a 50% higher HIV rate compared to unmarried but sexually active girls. This was due to more frequent sexual intercourse, lower condom use and older partners who were more likely to be HIV-positive (Clark 2004). Besides these sexual and reproductive health (SRH) related consequences, girl brides and their children experience poorer overall health and nutrition. Compared to women who marry later, girl brides often have less access to information, education and health services (such as immunization), which is directly linked to decreased investments in education and health for their children (UNFPA 2015; WHO 2020).

When girls marry early, their formal education often terminates, which also prevents them from acquiring knowledge and skills that determine their prospects for employment opportunities (UNFPA 2015; Kirchengast 2016). Schools do not only provide education but also allow girls to develop social skills, networks and provide them with a support system enabling them to be mobile and participate in community activities. If girls do not go to school, their chances of participation in decision-making (within their own households and in the broader society) go down, and chances of being a victim to violence raise (Parsons et al. 2015). Girl brides face isolation from school, friends and workplaces and therefore lack social support critical for their emotional-wellbeing and economic opportunities. They lack the ability to negotiate safe sex, birth spacing and contraceptive use and protect themselves from gender-based violence (UNFPA 2015; Wodon et al. 2017).

TEENAGE PREGNANCY

Teenage or adolescent pregnancy, defined as pregnancy before the age of 20, is a reality for 7.3 million girls in developing countries every year. A recent study has indicated that teenage pregnancy is highly prevalent in Sub-Saharan Africa (for example, in Kenya in 2012, the pregnancy rate was 174 among 1,000 females aged between 15

and 19 years) and that the proportion of teenage pregnancies that end in (unsafe) abortions vary highly between countries (Sedgh et al. 2015). The causes and consequences of teenage pregnancy have been the topic of many studies and debates. Generally, all studies acknowledge that teenage pregnancies are associated with poor social and economic outcomes. Poverty, low education, being from an ethnic minority, lack of access to SRH information and services: all increase the likelihood for adolescent girls to become pregnant (UNFPA 2015). Studies have shown that young people from families with a low socio-economic status have a higher chance of teenage pregnancy (Miller et al. 2001). In addition, social and cultural norms and values at the family and societal levels play a role. For example, parent/child closeness or connectedness, parental supervision or regulation of children's activities, and parents' values against teen intercourse (or unprotected intercourse) influence young people's risk for teenage pregnancy. Living with one parent is also a determining factor, which is relevant in many low- and middle-income countries with high percentages of orphan hood. Experience with violence also increases the risk for teenage pregnancy (Miller et al. 2001). As stated above, many teenage pregnancies occur within marriage and in this case, they are mostly intended. However, at the same time, (unintended) teenage pregnancy is one of the most common reasons for child marriage in many countries, pointing to the interrelatedness of these two problems.

As with child marriage, teenage pregnancy can have immediate and lasting consequences for a girl's health, education and income-earning potential, which is often passed on to her child(ren). As such, it alters the course of a girl's entire life. The health-related consequences of teenage pregnancy include risks of maternal death: the risk of death associated with pregnancy is about a third higher among 15- to 19-year-olds than among 20- to 24-year-olds (Sedgh 2015). Besides higher mortality, teenage pregnancy also contributes to illness and disability, related to fistula, complications from unsafe abortion, STIs and HIV (UNFPA 2015; WHO 2020). As with child marriage, teenage pregnancy also affects the education and economic opportunities of girls (and sometimes also for boys becoming fathers). The consequences include the interruption or termination of education and the accompanying lost opportunities regarding labour participation and status at the household and community level (Sedgh et al. 2015).

FEMALE GENITAL MUTILATION/ CUTTING

Female genital mutilation or cutting (FGM/C) comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons¹. Between 130 and 140 million girls and women in the world are estimated to have undergone FGM/C and more than three million girls are at risk every year (WHO 2011). FGM/C is a fundamental violation of girls' and women's rights and confronts girls and women with immediate and life- long physical and psychological distress (WHO 2008).

There are different types of FGM/C, which are classified into four categories. Type I involves partial or total removal of the clitoris and/or the prepuce (clitoridectomy). Type II involves partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Type III involves narrowing of the vaginal orifice with creation of a covering seal by cutting and a positioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). Type IV involves all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization. Types I, II and III female genital mutilation have been documented in 28 countries in Africa and in a few countries in Asia and the Middle East (WHO 2008).

Female genital mutilation/ cutting is mostly carried out on girls between the ages of 0 and 15 years. The age at which FGM/C is executed varies with local traditions and circumstances (UNICEF 2005). The prevalence of FGM/C also depends on ethnicity, local traditions and circumstances. In every society in which it is practiced, FGM/C is a manifestation of gender inequality that is deeply entrenched in social, economic and political structures (UNFPA and UNICEF 2014; WHO 2008). There is a strong link between FGM/C, marriageability and the construction of gender identities (Jones et al. 2004). Analysis of international health data shows a close link between women's ability to exercise control over their lives and their belief that FGM/C should be ended (UNICEF 2005). Where FGM/C is widely practiced, it is supported by both men and women, usually without question, and anyone departing from the norm may face condemnation, harassment, and ostracism. As such, FGM/C is a social convention governed by rewards and punishments, which are powerful forces for continuing the practice. In view of this conventional nature of FGM/C, it is difficult for families to abandon the practice without support from the wider community. In fact, it is often practiced

¹ www.who.int/mediacentre/factsheets/fs241/en/

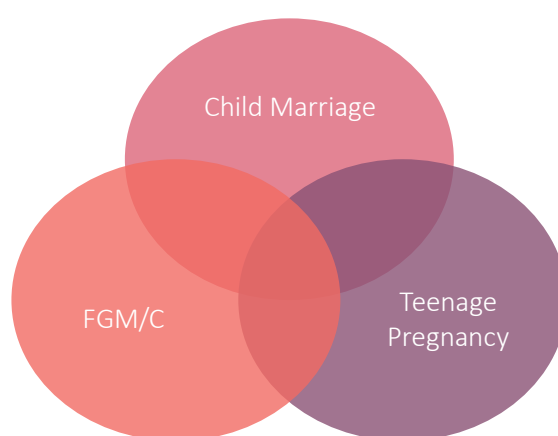
even when it is known to inflict harm upon girls because the perceived social benefits of the practice are deemed higher than its disadvantages (UNICEF 2005). In many societies where FGM/C takes place, it is believed to contribute (and be essential) in raising the girl properly and preparing her for adulthood and marriage, albeit the later becoming less important reason for FGM/C (Population Council 2018). In West Africa, it is embedded in coming-of-age rituals and girls' entry into women's secret societies (Fuambai 2000). Often, girls get awards after the FGM/C, and as such, it has become an important part of the cultural identity of girls and women and may also impart a sense of pride, a coming of age and a feeling of community membership (Behrendt and Moritz 2005).

Female genital mutilation/ cutting has many harmful consequences, both physically and psychologically. Women who have undergone genital mutilation have significantly increased risks for adverse events during childbirth, such as post-partum haemorrhage and other obstetric complications (Berg et al. 2014).

THE THREE PROBLEMS TAKEN TOGETHER

The problems of child marriage, teenage pregnancy and FGM/C are interrelated (Figure 1). They have common root causes and social drivers such as gender inequality, social and cultural norms, poverty, and inadequate access to education and sexual and reproductive health and rights (SRHR) information and services. Child marriage and teenage pregnancy have comparable impacts on the health and education of young girls, and therefore on economic opportunities, decision-making and agency of girls. Female genital mutilation/ cutting also has a negative influence on agency and empowerment of girls. Besides sharing common causes and consequences, these three issues can be mutually reinforcing: child marriage increases the likelihood of teenage pregnancy and the other way around and FGM/C can activate either teenage pregnancy or child marriage (Karumbi et al. 2017). Also, FGM/C and child marriage are directly linked to each other: in many areas where FGM/C is practiced, it is a prerequisite for marriage (World Vision 2014).






Figure 1 **Child marriage, teenage pregnancy and FGM/C being intertwined**



Following the above, programmes and interventions that aim to reduce child marriage, teenage pregnancy and FGM/C often share the same focus. They try to address social and cultural norms and values, enhance girl and women empowerment, increase access to SRH and education services and try to influence laws and regulations related to SRHR. They also involve the same actors, such as girls, boys, community members and other duty bearers that have an important role in society.

1.2 THE YES I DO THEORY OF CHANGE

The Yes I Do programme aims to contribute to enhancing adolescent girls' and boys' decision-making space on whether, when and whom to marry as well as on whether, when and with whom to have children. In addition, it aims to contribute to the fight against female genital mutilation/ cutting (FGM/C). The programme has been implemented in seven countries: Ethiopia, Indonesia, Kenya, Pakistan², Malawi, Mozambique and Zambia. The programme's theory of change has five strategic goals:

-  Pathway 1 Community members, gatekeepers and other stakeholders have changed attitudes and take action to prevent child marriage, teenage pregnancy and (where applicable³) FGM/C;
-  Pathway 2 Adolescent girls and boys are meaningfully engaged to claim their sexual and reproductive health and rights (SRHR);
-  Pathway 3 Adolescent girls and boys take informed action on their sexual health;
-  Pathway 4 Adolescent girls and boys have alternatives beyond child marriage, teenage pregnancy, and FGM/C through education and economic empowerment;
-  Pathway 5 Policy makers and duty bearers harmonize, strengthen and implement laws and policies on child marriage, FGM/C and sexual and reproductive health (SRH).

The five goals are related to five intervention strategies, illustrated by the interrelated boxes in the Theory of Change (ToC, Annex 1). 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 evidenced-based lobby and advocacy for improved legal and policy frameworks. These intervention strategies follow experiences of Alliance partners and global evidence available on what works in trying to reduce child marriage, teenage pregnancy and FGM/C (Malhotra et al. 2011; UNFPA 2012, 2015; WHO 2008). Regarding strategy 1, several interventions were targeted at building broad social movements, which can influence social norms in communities on child marriage, teenage pregnancy and FGM/C. The implementing partners engaged in advocacy towards policy makers and meaningfully engaged adolescent girls and boys to claim their SRH rights. Strategy 2 involved empowering and meaningfully engaging young people. In relation to this, multiple interventions have focused on the role of local government institutions, non-governmental organizations (NGOs) and community-based organizations (CBOs) in meaningfully engaging adolescent girls and boys in their policy making and programming. This aimed to increase the number of girls and boys effectively raising their voice; and to establish and sustain mechanisms for meaningful engagement of young people. In addition, government institutions', NGOs' and CBOs' policies and programmes would increasingly reflect the needs of young people in the field of SRHR. Strategy 3, on improving access to information and services, focused on increased access to quality and affordable youth-friendly SRHR and child protection information and services. Strategy 4, on education and economic empowerment for girls, aimed to increase the number of years in primary and secondary education for girls, and that girls have increased access to productive assets and economic opportunities. Finally, strategy 5 involved enhancing evidenced-based lobby and advocacy for improved legal and policy frameworks. The target was that policy makers and duty bearers develop and implement legislation and policies that are directed to eliminating child marriage and FGM/C and preventing teenage pregnancy.

As indicated in the ToC, the following core strategies were employed: promotion of gender transformative thinking, girls' empowerment, men and boys' engagement and meaningful youth participation. The assumptions that are underlying the ToC are provided in Annex 1.

² Stopped in 2019.

³ In Ethiopia, Indonesia and Kenya.

The research component of the Yes I Do programme involved a base-, mid- and endline study in each of the programme countries. These studies aim to provide insight into the (interrelated) causes and effects of child marriage, teenage pregnancy and FGM/C and the extent to which these causes and effects, and the three problems themselves, are present in the intervention areas of the Yes I Do programme over a period of four years. Also, the research aimed to provide insight into the different pathways of change, thereby testing the ToC, and unravelling why and how the Yes I Do intervention strategies did or did not contribute towards improved outcomes related to the five strategic goals. The baseline study, involving both qualitative and quantitative methods, was conducted in 2016 in all countries before the start of the implementation. This report presents results from the endline study in Kenya (analysis inclusive of base- and midline data).

1.3 CHILD MARRIAGE, TEENAGE PREGNANCY AND FEMALE GENITAL MUTILATION/CUTTING IN KAJIADO, KENYA

Child marriage and FGM/C are not only among the most prevalent (32% and 27%⁴) issues affecting adolescents' SRH in Kenya; there are also large regional differences, with pockets of FGM/C prevalence as high as 98% in the North-East Counties (KNBS 2010). According to the Kenya Demographic and Health Survey (KDHS) 2014, FGM/C is prevalent in Northern, Eastern, Rift valley and sections of Nyanza (Kisii and Kuria) (KNBS, IFC Macro 2014).

Kenya has made progress in curbing challenges related to child marriages, FGM/C and teenage pregnancies. The age at first marriage has increased over time, but child marriage is still very common even though it is illegal (KNBS, IFC Macro 2014). Teenage pregnancy is mainly due to child marriages; with almost one-quarter of women giving birth by the age of 18 and nearly half by the age of 20 and 18% of adolescent girls aged 15-19 are already mothers or pregnant with their first child (KNBS, IFC Macro 2014). Kenya is number 147 on the gender inequality index⁵. With most of Kenya's population being under the age of 25, and two out of every five people under the age of 15, there is an urgent need for change. Kenya has a stable economic growth (5.3% growth in GDP in 2014)⁶, but poverty rates are high among large parts of the population. Also, in Kenya, there is insufficient access to SRHR services and information for adolescents⁷.

The Yes I Do programme and its related research activities have been focused on the Maasai in Kajiado West, because studies have revealed that FGM/C though reducing gradually remains an issue of concern in many communities. Within the Maasai community, the FGM/C prevalence rate is at 93%, just slightly lower than in the Somali community at 97% despite interventions by the government, civil society organizations, faith-based organizations and bilateral agencies (UNFPA and UNICEF 2014). The Maasai community is an indigenous tribe based mostly in the southern part of Rift Valley in Kenya. The people are mostly pastoralists with a few practise crop-farming activities. The Maasai are among the Kenyan communities that still strongly practice their traditional beliefs, including FGM/C (Karanja 2003). They are reported to be numbering 841,622 in Kenya according to the 2009 national census (KNBS 2010). Overtime, the Maasai have resisted the urge by the government to adopt a sedentary lifestyle and instead opting to demand grazing right to many National Parks in Kenya, since they consider themselves to be a community gifted with cattle that they believe descended from their god "Enkai" (Maasai Education Discovery 2001).

The Maasai practice polygamy, and child marriage is deeply rooted in their culture, traditional belief and religion as part of their social life. The female genital mutilation rite is done to initiate a girl into womanhood (Karanja 2003). FGM/C has been practised in these communities for many years with many people still adamant to continue with the practice, which explains the slow progress in eradicating the practice. In order to conserve culture and as a result of economic pressures dictating that families must profit from marrying off their daughters for wealth, the Maasai still practice the tradition.

Before Maasai girls get married they must go through circumcision in a ceremony. The type of circumcision that the Maasai women go through is clitoridectomy. It is also worth noting that FGM/C among the Maasai is a cultural aspect and not religious practice. It is seen as an opportunity granted to a girl from childhood to womanhood. The harm associated with the practice is evident by the excessive bleeding that girls endure (Berg & Denison 2010).

4 <http://www.who.int/reproductivehealth/topics/FGM/C/prevalence/en/>
5 http://hdr.undp.org/sites/default/files/hdro_statistical_data_table5.pdf

6 <http://data.worldbank.org/>
7 <http://www.prb.org/pdf13/kenya-policy-assessment-report.pdf>

1.4 AIM AND OBJECTIVES OF BASE-, MID- AND ENDBLINE STUDY

Overall goal of the research:

To provide insight into the (interrelated) causes and effects of child marriage, teenage pregnancy and female genital mutilation/ cutting and the extent to which these causes and effects, and the three problems themselves, are present in the intervention areas (Kajiado West sub-county) of the Yes I Do programme in Kenya, compared to non-intervention areas (Kajiado Central sub-county), over a period of four years. In addition, the research aims to provide insight into the different pathways of change, thereby testing the ToC, 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, teenage pregnancy and FGM/C in Kajiado West County.

The objectives of the included:

1. To explore (changes in) attitudes of community members and gatekeepers around child marriage, teenage pregnancy and FGM/C, whether and to what extent they take action to prevent child marriage, teenage pregnancy and FGM/C and which factors influence this and how; over a period of four years in intervention (Kajiado West sub-county) and non-intervention areas (Kajiado Central sub-county)
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 (Kajiado West sub-county) and non-intervention areas (Kajiado Central sub-county)
3. To explore and analyse whether and to what extent adolescents take informed action on their sexual and reproductive health and which factors influence this and how; over a period of four years in intervention (Kajiado West sub-county) and non-intervention areas (Kajiado Central sub-county)
4. To explore and analyse whether and to what extent education and economic empowerment of girls provides them with alternatives beyond child marriage, teenage pregnancy and FGM/C after four years in intervention areas in Kajiado West sub-county
5. To provide insight into (changes in) developed and implemented laws and policies on child marriage, teenage pregnancy and FGM/C over a period of four years in Kajiado West sub-county and in Kenya in general
6. To contribute to the evidence on effective and context specific intervention strategies to eliminate child marriage and FGM/C and reduce teenage pregnancy

8 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, FGM/C and teenage pregnancy.

2. Methodology

2.1 STUDY TYPE

The evaluation employed mixed methods, it entailed a cross-sectional study conducted at three time points: baseline (2016), midline (May 2018) and endline (March 2020). The baseline and endline studies were mixed methods involving a quantitative household survey and qualitative interviews. The midline study employed qualitative methods only. The study aimed to evaluate the impact of the Yes I Do programme by collecting primary data to assess whether intervention strategies implemented over the course of four years have been effective in reducing child marriage, teenage pregnancy and/or FGM/C, as well as how, why and in which context these changes, if any, may have occurred. To attribute changes to the implementation activities, the quantitative part of the study included a control area.

2.2 STUDY AREAS

The base- and endline evaluation was conducted at two sites: Kajiado West sub-county (the intervention site) and Kajiado Central sub-county (the control site). Kajiado West sub-county has a population of about 182,849 people and is divided into five wards: Keekonyokie, Magadi, Iloodokilani, Ewaso oo Nkidong’I and Mosiro. The Yes I Do programme was implemented in two wards: Iloodokilani and Ewaso Oo Nkidong’I. In the Iloodokilani ward, four villages were selected for the study: KMQ, Mile 46, Oltepesi and Kilonito. In the Ewaso Oo Nkidong’I ward, five villages were selected: Kibiko, Oseero Onyoike, Najile, Olngarua and Enajooli.

Kajiado Central sub-county has a population of about 161,682 people and is divided into four wards: Matapato, Purko, Ildamat and Dalalekutuk wards. Matapato and Purko wards were selected as the control site. In the Matapato ward, three villages were selected: Bissil, Oloilelai and Maparasha, while in the Purko ward, two villages were selected: Nkaroni and Jumps. The selection of the wards was based on similarities of demographic characteristics such as health, employment and economic status, although in general, Kajiado Central is more urban than Kajiado West. To avoid spillover effects from intervention to control area, the control area was not close to the intervention area (see Annex 2 for a map of Kajiado County).

2.3 STUDY METHODS, SAMPLING AND RECRUITMENT PROCEDURES

2.3.1 QUANTITATIVE COMPONENT

A quantitative household survey among young women and men (15-24 years) was implemented in the intervention and control areas at base- and endline, following a clustered sampling approach in which each village was considered a cluster. The number of respondents per village was proportional to the village size. Within each village, households were randomly selected following a systematic sampling approach. The edge/ border of the village was used as the starting point for the household survey. Research assistants chose the first homestead to begin data collection where the first household with a girl or young women aged 15-24 was interviewed. Thereafter, there was a skip pattern to the third household to identify the next young girl to be interviewed. After interviewing three girls, each fourth respondent was a young man also aged 15-24. However, if after three young women, the next household did not have a young man, the closest household with a young man available was selected.

If multiple eligible respondents were currently living and available in the same household, one would be randomly selected by asking them to write their names on a piece of paper and folding it: the name whose paper was randomly picked by the interviewer was selected for interview. Scheduling of data collection was done at a time when most young people were at home (preferably in the evening and weekends).

In total, 2,777 young men and women were included in the study (Table 3), the statistical justification for the sample size can be found in Annex 3, including a comparison of the intended and achieved sample size. The study included more women (75%) than men (25%) as child marriage, teenage pregnancy and FGM/C more directly affect young women. However, understanding men’s norms and values is essential as they influence and are in turn influenced

1 Latest available preliminary census data.

by the practices and beliefs perpetuating child marriages, circumcision and teenage pregnancy. As such, men can be important drivers of change and including them in the study gave a more comprehensive insight into the local context.

The participants were asked questions related to their own experiences and opinions about child marriage, teenage pregnancy and FGM/C, but also on perceived community norms and values around sexuality and reproduction, young people’s ability to claim SRH rights, the role of stakeholders and traditional customs and economic empowerment.

Table 3 Overview of quantitative component

	Baseline			Endline		
	Intervention	Control	Total	Intervention	Control	Total
Young women (15-24 years)	507 (37.1%)	512 (37.4%)	1,019 (76.3%)	553 (39.3%)	522 (37.1%)	1,075 (76.3%)
Young men (15-24 years)	176 (12.9%)	173 (12.7%)	349 (23.7%)	170 (12.1%)	164 (11.6%)	334 (23.7%)
Total	683 (49.9%)	685 (50.1%)	1,368 (100%)	723 (51.3%)	686 (48.7%)	1,409 (100%)

2.3.2 QUALITATIVE COMPONENT

The qualitative component of the study was done in the intervention area (Kajiado West sub-county) using Focus Group Discussions (FGDs), In-Depth Interviews (IDIs) and Key Informant Interviews (KIIs). Study participants included girls, boys, young women and men, parents, religious and traditional leaders, teachers, health and social workers, youth organization staff, NGO staff and policy makers (see Table 4). Participants were purposively selected with the assistance of community mobilisers and the local administration (the chiefs and assistant chiefs). The variation in selection of participants was to enable data triangulation from the different categories of participants. The assumption was that participants of different ages, sex and position in society will have different experiences, opinions and views on the issues of teenage pregnancy, child marriage and FGM/C.

Qualitative data focused on experiences and opinions about social and cultural norms and values, community and youth participation in decision-making, sexual and reproductive rights, opportunities for schooling and economic empowerment, SRHR-related policies and laws. The topic guides were translated to the Maa language to facilitate the discussions and interviews. With the consent of the participants, all qualitative interviews and discussions were tape-recorded, and transcribed verbatim in English.

Table 4 Overview of qualitative component

Methods and participants	Baseline	Midline	Endline
Focus group discussions			
Girls (15-19 years)	3 groups (21 participants)	2 (16 participants)	2 (12 participants)
Young women (20-24 years)	1 group (7 participants)	2 (16 participants)	2 (16 participants)
Boys (15-19 years)	1 group (8 participants)	2 (16 participants)	NA
Young men (20-24 years)	2 groups (15 participants)	2 (16 participants)	2 (13 participants)
Female parents or caregivers	2 groups (14 participants)	1 (8 participants)	2 (16 participants)
Male parents or caregivers	1 (7 participants)	1 (8 participants)	2 (16 participants)
Chiefs	1 (4 participants)		-
In-depth interviews			
Girls (15-19 years)	2	2	2
Young women (20-24 years)	2	2	2
Boys (15-19 years)	2	2	-
Young men (20-24 years)	2	2	2
Parents or caregivers	2	2	2
Grandmothers or elderly women, circumciser	2	4	2
Religious and traditional leaders, chiefs	2	2	4
Teachers	1	2	2
Health and social workers	1	2	1
CBO and youth organization staff	1	2	2
Key informant interviews			
NGO staff and rescue centres	1	5	1
Policy makers	4	3	1
Stakeholder workshop			
Community representatives, NGO, CBO, youth, teachers, policy makers (health, education, social services)	1 workshop (20 participants)	1 workshop (20 participants)	1 workshop (25 participants)
Total number of participants	118	130	119

2.4 DATA COLLECTION AND ANALYSIS

Research assistants (15) who took part in the study had tertiary level education, and were of both genders (6 females) and fluent in English, Kiswahili and Maa languages. They also demonstrated competency in basic computer skills and were experienced in both qualitative and quantitative data collection. The research assistants were trained for five days before each phase of data collection, which included pilot-testing data collection tools.

The qualitative data analysis went through an iterative process and began during data collection with daily review meetings with research assistants to identify emerging themes, completeness of work and data inconsistencies. Using the coding framework and in responding to the objectives of the study, narratives were written on main themes. Content analysis of the data was based on the programme ToC.

The quantitative data were collected using a structured questionnaire which was developed based on a literature review and inputs from relevant actors. The questionnaire was an electronic version hosted on the Open Data Kit (ODK) platform and linked to the KIT server. This was a tablet-based questionnaire that had been programmed with in-built skip patterns to ensure that the relevant and appropriate questions were asked to the respective respondents. The questionnaire is available upon request.

The quantitative data analysis was performed using Stata version 15. Data were checked and cleaned for outliers or inconsistencies before data analysis. The endline and baseline data were compiled in a single database for comparative analysis. Descriptive statistics were computed, disaggregated by timing of the survey (base- and endline), population (control and intervention) and gender for all survey questions (an overview is available upon request). Difference-in-difference models were computed to analyse the trend over time in the intervention area as compared to the trend over time in the control area. These models aim to provide insight into the changes observed in the intervention area attributable to the Yes I Do programme. All models were adjusted for school attendance due to the considerable difference in school attendance between base- and endline. A description of the models can be found in Annex 4, including the results of all models.

2.5 QUALITY ASSURANCE

Processes that guaranteed good quality data were developed which included: research tools development based on existing and validated tools, data tools adjusted to local context and pre-tested before data collection and extensive training of research assistants including on ethical issues to ensure ethical conduct during data collection. Supervisor checks, de-brief meetings, applying the field protocol, exchange of field experiences between KIT and national researcher teams ensured quality as well.

2.6 ETHICAL CONSIDERATIONS

Ethical approval for the study protocol was obtained from AMREF Ethics and Research Committee (AMREF-ESRC P748/2020). Participation in this study was voluntary and privacy and confidentiality were always maintained. Once a young person (girl or boy) within a household had been identified for an interview, a private area, away from the rest of the household members was used to conduct the interview. FGD participants were reminded to not discuss or refer to opinions of fellow participants outside of the discussion venue.

3. Results

3.1 CHARACTERISTICS OF STUDY POPULATION

A total of 1,368 respondents were surveyed at baseline and 1,409 at endline. As per the sampling design, approximately 75% of the respondents were female in both study populations. The intervention study population was slightly older at endline, with 45% between the ages of 20 and 24 years as compared to 38% at baseline and 32% at base- and endline in the control area. At both base- and endline, in the intervention area, the percentage of respondents who were married was almost twice as high as in the control area. Eighteen percent (18%) of the respondents in the intervention area participated in the Yes I Do activities (Table 5).

Sixty-six percent (66%) of the respondents in the intervention area were in school at baseline, as compared to 49% at endline. In the control area, 73% of the respondents were in school at baseline as compared to 67% at endline. Among those who were in school in the intervention area, 39% was attending upper primary level and 43% was attending secondary level at baseline, as compared to 57% and 28% respectively, at endline. Although there was a considerable difference in school attainment between males and females in the intervention area at baseline, no difference was observed at endline.

The percentage of respondents who dropped out of school was higher in the intervention area as compared to the control area at both baseline (intervention: 28%, control: 17%) and endline (intervention: 32%, control: 21%). Although dropout rates did not vary considerably between males and females, reasons for dropping out did. Males mainly dropped out of school because of lack of fees or materials (baseline: 68.7%, endline: 50%) while female dropped out because of pregnancy (baseline: 52.5%, endline: 78%).

Most respondents were not employed at baseline (86%) and endline (80%). Employed respondents were mainly self-employed or casual labourers. Among households in the intervention area, the primary source of income came from pastoralism (81% at baseline; 52% at endline), casual labour (15%) and small business ownership (14%). In the control area, the primary source of income was pastoralism (baseline 78% and endline 71%).

Table 5 Demographic characteristics of survey respondents

	Baseline			Endline		
	Intervention	Control	Total	Intervention	Control	Total
Gender						
Female	507 (74%)	512 (75%)	1019 (74%)	553 (76%)	522 (76%)	1075 (76%)
Male	176 (26%)	173 (25%)	349 (26%)	170 (24%)	164 (24%)	334 (24%)
Other	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	683 (100%)	685 (100%)	1368 (100%)	723 (100%)	686 (100%)	1409 (100%)
Age						
15-19 years	422 (62%)	465 (68%)	887 (65%)	395 (55%)	467 (68%)	862 (61%)
20-24 years	261 (38%)	220 (32%)	481 (35%)	328 (45%)	219 (32%)	547 (39%)
Missing	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	683 (100%)	685 (100%)	1368 (100%)	723 (100%)	686 (100%)	1409 (100%)

Table 5 Demographic characteristics of survey respondents

	Baseline			Endline		
	Intervention	Control	Total	Intervention	Control	Total
Marital status						
Married	198 (29%)	93 (14%)	291 (21%)	187 (26%)	99 (14%)	286 (20%)
Unmarried	483 (71%)	589 (86%)	1072 (78%)	536 (74%)	587 (86%)	1123 (80%)
Missing	2 (0%)	3 (0%)	5 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	683 (100%)	685 (100%)	1368 (100%)	723 (100%)	686 (100%)	1409 (100%)
Education						
Junior Primary	23 (3%)	19 (3%)	42 (3%)	5 (1%)	2 (0%)	7 (0%)
Upper Primary	173 (25%)	158 (23%)	331 (24%)	202 (28%)	117 (17%)	319 (23%)
O level/Secondary	193 (28%)	258 (38%)	451 (33%)	97 (13%)	269 (39%)	366 (26%)
Vocational	8 (1%)	12 (2%)	20 (1%)	12 (2%)	24 (3%)	36 (3%)
University	52 (8%)	56 (8%)	108 (8%)	34 (5%)	38 (6%)	72 (5%)
Completed	132 (19%)	75 (11%)	207 (15%)	14 (2%)	23 (3%)	37 (3%)
Not currently in school	0 (0%)	0 (0%)	0 (0%)	291 (40%)	170 (25%)	461 (33%)
No education or basic education	102 (15%)	107 (16%)	209 (15%)	65 (9%)	36 (5%)	101 (7%)
Other	0 (0%)	0 (0%)	0 (0%)	3 (0%)	7 (1%)	10 (1%)
Missing	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	683 (100%)	685 (100%)	1368 (100%)	723 (100%)	686 (100%)	1409 (100%)
Employment status						
Employed	116 (17%)	77 (11%)	193 (14%)	159 (22%)	123 (18%)	282 (20%)
Not employed	566 (83%)	608 (89%)	1174 (86%)	564 (78%)	563 (82%)	1127 (80%)
Missing	1 (0%)	0 (0%)	1 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	683 (100%)	685 (100%)	1368 (100%)	723 (100%)	686 (100%)	1409 (100%)
Participation in the Yes I Do programme						
Yes	NA	NA	NA	127 (18%)	NA	127 (18%)
No	NA	NA	NA	596 (82%)	NA	596 (82%)
Missing	NA	NA	NA	0 (0%)	NA	0 (0%)
Total	NA	NA	NA	723 (100%)	NA	723 (100%)

Participants in the qualitative component of the study comprised young women and men aged 15 to 24 years, and male and female parents or caregivers. Community leaders including religious leaders, chiefs and teachers were also included in the study. Other stakeholders were interviewed as key informants: policy makers in the decentralized sectors of health and education as well as NGOs working in the study area (Table 4).

3.2 COMMUNITY CONTEXT AND MOBILISATION

3.2.1 SOCIAL AND CULTURAL BELIEFS, NORMS AND CUSTOMS

Participants were asked about any changes that they have observed and that can be attributed to Yes I Do. Relative to baseline, the endline participants agreed that there were some changes in the attitude of gatekeepers towards child marriage. Examples given were that some parents are beginning to embrace formal education for both boys and girls as a protective measure against teenage pregnancy. In particular, parents acknowledged the role they need to play in supporting girls and protecting them from teenage pregnancy. Participants frequently mentioned gatekeepers such as NGOs, schools, religious leaders, health workers, teachers, the administration (chiefs, police). Religious leaders were mentioned more frequently. Through these gatekeepers, there has been awareness creation on the dangers of child marriage, which seems to have informed a repulsive attitude towards child marriage and teenage pregnancy. In one FGD with young men, the role of the chief was heralded in supporting and reinforcing adherence to the information provided by other stakeholders working in the community. There were instances where the chief has had to invoke the law and arrest the perpetrators of child marriage

... In terms of education, it is better now. At least you can find parents now educating their children equally, both girls and parents. (FGD, young women 20-24 years)

... Education is changing things and you find that there are a few people who have stopped maybe because of education. R3: nothing much but slightly things are changing. At least people now know the importance of education for girls even after they fall pregnant. (FGD, male parents)

The practice of FGM/C is still in place; however, there were also reported gradual changes. Compared to baseline, the qualitative narratives suggest that FGM/C is now practiced largely in secret, because of enhanced knowledge among community members that the practice is illegal – a positive development in itself. It was reported that because of the high awareness of the anti-FGM/C law, people often tended to conduct FGM/C alongside male circumcision as a camouflage. This is a departure from the flamboyance that accompanied the traditional ceremonies around FGM/C in the past. Concerning FGM/C, even the slight changes that may be observable were linked to the role of NGOs in supporting the County authorities to ‘domesticate’ the anti-FGM/C law in Kajiado County by developing a County-specific policy to eradicate FGM/C. It seems that the processes that led to the development of the new policy contributed a lot to the awareness creation around the need to stop FGM/C.

... recently when there were arrests on FGM/C issues, it really scared people and I think it has either reduced or done in secret. Initially people used to hold ceremonies when circumcising either boys or girls but nowadays it is just for boys and girls are not reported. (FGD, male parents)

In terms of awareness creation regarding FGM/C, the change was attributed to interventions that have been conducted in the community. Specific reference was made to the Yes I Do Alliance in its role in sensitizing and creating awareness among community members, which may have contributed to perceived reduction in the practice of FGM/C in the community.

The small percentage that has stopped these practices have stopped because of the alliance. Since the 5 years of the alliance, most of the girls and parents listen to the alliance gospel. (FGD, young men 20-24 years)

Yes, there are changes since you can even find girls who have gone up to high school level uncircumcised as a result of such advocacy. (FGD, young women 20-24 years)

There were conflicting views from leaders about changes in child marriage, FGM/C and teenage pregnancy with some arguing that these practices had reduced, acknowledging that the changes could be due to increased access to information by community members through the activities of NGOs (including the Yes I Do programme partners) and government agencies. Participants avowed that although child marriage is still the norm in the community there

are some indications that the practice is on the decline. Compared to the baseline situation, participants pointed to changes in attitudes among some parents on child marriage, where they prefer their daughters to pursue formal education instead of getting married. Other participants reported that some young women are daring enough to refuse to be married off by their parents, explaining that young women may appear to “disobey” their parents’ wishes by running away from child marriage. In a situation where a girl has completed secondary or college education, parents would ask if the girl would accept the parents’ choice of a husband.

The quantitative data suggest that household chores such as cooking, cleaning and childcare are often done by female household members. According to female respondents, most of the cooking, cleaning and childcare is done by their mothers (baseline: 61%, endline: 42%) or by themselves (baseline 62%, endline: 42%). In both instances, the females reported a reduction of household responsibilities by females over time. Most male respondents however reported at baseline that their mother (89%) or sister (66%) were responsible for most of the cooking, cleaning and childcare at home as compared to 24% and 12% at endline respectively. Together, these responses suggest an improvement in the sharing of household chores among males and females at endline as compared to baseline. Regarding decision-making about household resources, the results show that men – especially fathers – are generally those making decisions about spending money.

3.2.2 THE ROLE OF GATEKEEPERS

From the qualitative narratives, the church was recognised as a strong player in the prevention of FGM/C, child marriage and teenage pregnancy. Religious leaders were reported to frequently provide information to the community on the harmful consequences of teenage pregnancy, child marriage and FGM/C. In the FGDs with young women (15-19 years), they reported receiving such information through youth seminars and talks from religious leaders. Information also included aspects of love, relationships and education at large. Depending on the circumstances, religious leaders provided support and at times provided shelter to girls who were running away from home because of refusal to be circumcised. Religious leaders were also reported to work with NGOs implementing various interventions in the community, frequently making references to NGOs such as NAYA and Amref.

Our religious leaders are playing very crucial roles in our community today. They are teaching our youths in church about good morals especially on issues regarding child marriage, teenage pregnancy and FGM/C.
(FGD, male parents)

Religious leaders discourage FGM/C. So, they preach against it. They discourage this practice totally.
(FGD, young men 20-24 years)

At baseline, the qualitative narratives showed that local traditional leaders as custodians of tradition and culture, were more inclined to support the practices of child marriage and FGM/C. However, it was reported that currently, there seem to be some divergent beliefs among traditional leaders, with some supporting the cultural practices of FGM/C and child marriage while others going against it openly, partly due to the fear of the law. It was reported that the role of some traditional leaders seems to have become lukewarm since they did not actively participate in encouraging or discouraging these practices. Some participants indicated that on the face value, traditional leaders appeared to be preaching against the practices in line with the law, but behind the scenes, some traditional leaders supported the continuation of FGM/C and child marriage.

The traditional leaders are divided because of the fear of the law. They don’t speak much nowadays. Even when a man and his wife decide to cut the girl, they do it secretly and always in the absence of the father of the girl who covers the act by going to the market. (FGD, young men 20-24 years)

Compared to the baseline situation, the narratives also point to a change in the approach to targeting traditional and religious leaders through training by NGOs. Participants cited instances where the traditional and religious leaders were trained together so that they can work as a team towards the elimination of FGM/C and child marriage. Others reported that some traditional leaders doubled up as elders in the church, which made it easier for them to pass on the end FGM/C messages to their community members. The narratives point to the church as potential key partner

in the elimination of FGM/C and child marriage campaign, because most community members go to church and have respect for their church leadership roles.

We have all our leaders in the fight against FGM/C, children to go school and early marriages. We thank God that our leaders are God fearing men and women. We have a traditional elder and he is also an elder in the church and even communication for our leaders can easily flow. (KII, policy maker, education)

The narratives also show that NGOs activities have led to teachers playing an important role in providing SRH information to girls in schools, contrary to the baseline situation when in-school sex education was limited. Participants believed that access to SRH information via schools has contributed to a reduction in teenage pregnancies as compared to the baseline situation. Participants reported that teachers did it through guidance and counselling and coordinating with external speakers, community role models and other NGOs to provide additional information on sexuality and reproductive health to students. Teachers also worked with NGOs to form clubs as platforms to provide talks to girls and boys on sexuality and health issues. In particular, it was frequently mentioned that female teachers usually had sessions in which they talk to girls about menstrual hygiene and teenage pregnancy.

Teachers are really playing a bigger role in this part. In our schools, they invite different people to come and talk to all students. Religious leaders are invited to preach and pray for them, they invite professionals to come and motivate them and even peer counsellors to come and guide them. (IDI, religious leader)

3.2.3 GATEKEEPERS' AWARENESS OF THE HARM CAUSED BY CHILD MARRIAGE, TEENAGE PREGNANCY, AND FEMALE GENITAL MUTILATION/ CUTTING

Relative to the baseline, the endline participants reported that through the efforts of various stakeholders, particularly NGOs, the church and community leaders, there has been an increase in the awareness of the dangers of child marriage and teenage pregnancy generally. During discussions with parents, it was reported that the Yes I Do programme has contributed to creating awareness of the negative consequences of child marriage and teenage pregnancy, explaining that the life of a girl who marries early is plagued with misery, she gives birth with less spacing and is thus her health is negatively affected. Reference was also made to young womens experiencing complications during childbirth and a general hardship environment. The role of the chief was heralded in supporting and reinforcing adherence to the information provided by other stakeholders working in the community. There were instances where the chief had to invoke the law and arrest perpetrators of child marriage. In such instances, the girls who are rescued are taken to rescue centres where they can continue education. Contrary to the baseline, the endline participants frequently emphasised that there are no benefits of child marriage and teenage pregnancy to girls or their families.

To me, there are many [disadvantages]. The girl will not complete education and therefore no jobs in the future. She cannot have freedom of expression since she is young and under the custody of a husband. She will not be able to perform some activities since she is not mature. So, all are negative. (IDI, youth leader)

Regarding teenage pregnancy, participants shared various consequences, largely focusing on the girl. These included child marriage and psychological harm to the girl. Gatekeepers reported that young women who fall pregnant often feel embarrassed, unworthy, and considered undisciplined, which contributes negatively to their progress, particularly with regard to education, as it often leads to school dropout. This in turn reduces their future economic prospects. Participants explained that some of the adverse effects of teenage pregnancy are a result of how the community negatively responds to a young girl who gets pregnant. They are often demeaned by the community, which affects their self-esteem and it was reported that some young women may also attempt to procure unsafe abortion.

As the case at baseline, the narratives at endline also show that gatekeepers were aware of the harmful effects of FGM/C. They explained that following the FGM/C experience, girls consider themselves or are regarded as 'women' and therefore ready to engage in sexual activities, which may lead to teenage pregnancy. Some added that FGM/C often leads to girls dropping out of school and some may enter child marriage at the same time. Infection was also reported to occur because of the sharing of instruments used for FGM/C.

3.3 YOUTH EMPOWERMENT

3.3.1 YOUTH ENGAGEMENT AND AUTONOMY

Regarding youth engagement, some participants talked about a changing trend where young people are being given an opportunity to participate and make contributions in community meetings. The church was also frequently cited as helping in improving intergenerational communication, with participants explaining that in these days, some fathers can talk to their daughters, as compared to in the past when this was not permitted. There were instances where respect between age groups and age sets was reported to have declined, this was largely attributed to cases of drug abuse among young people.

However, young women agency seemed to be overshadowed by notions of respect, obedience, discipline as the cornerstones of social and cultural norms underpinning the relationship between young people and their parents, other community members and elders. The perception towards young people regarding their prescribed roles in society influence how they can advocate for issues affecting their lives. For example, good girls and good boys should follow instructions from parents – including accepting instructions regarding child marriage and FGM/C as traditional practices. Although child marriage was still an important normative belief in the community, there is also evidence that some young women were daring enough to refuse, which indicates changes in personal autonomy. It was reported that girls might appear to “disobey” by running away from child marriage, often in search of education. In some families, girls were being asked if they accept the choice of parents for a husband or not.

The young [people] again are not given a chance to air out their views and hence only do what the older say.
(IDI, young man 24 years)

In our community, we have different age sets. The cultural laws demand that these age sets should respect each other, and so you hardly find them sitting together without a reason. However, in some areas, we find all age sets sitting together, especially if they have something to discuss relating to the community. (IDI, chief).

Other participants of the qualitative component reported observed changes in the autonomy of young women, citing that one can find young women who have gone up to high school level uncircumcised. They believed that the Yes I Do alliance made important contributions. Other participants spoke of young women being able to refuse forced marriage and instances where young women were consulted for their opinion in marital decisions, which represent a remarkable improvement over the situation at baseline when young women had little autonomy. On the other hand, young women expressed worry that they were unable to discuss sensitive issues related to sexuality.

ROLE OF YOUTH CLUBS IN THE COMMUNITY

As was reported in the interviews and FGDs, it seems that youth clubs are not prominent in the study area, painting a similar situation as at baseline when there was no mention of youth clubs at all. At endline, the discussion was mainly about existing youth organizations, which are geared towards youth economic empowerment, and not necessarily youth clubs. In an FGD with young men, youth clubs were reported to exist in the community for the purpose of self-help for the benefit of the members. They were reported to be engaged in buying and selling of livestock and using the profits for various purposes including paying for health-related bills and school fees for their siblings and children. For example, a sand harvesting and sale network was mentioned. There was no indication that youth clubs are involved in advocacy for elimination of FGM/C and child marriage. Some religious youth groups linked to churches exist, and their activities are related to the church. Compared to the baseline, some participants spoke about football clubs that engage young people in a positive way through physical exercises and improving youth living standards, but others were quick to add that such activities are more geared towards the boy than girl child. Young women reported that the formation of youth clubs was a desirable strategy of organizing themselves to make political and social demands.

Motivational groups in schools (school clubs) to encourage youth to work hard and complete education were also reported. However, from the teachers' perspective, youth clubs in schools were not very active, since there was more emphasis on academic preparedness for national exams. They explained that discussions in youth clubs such as sexuality education are not taken seriously since they are not examinable.

Yes, there are a few clubs. We used to have small clubs that we created for purposes of contributions in the aid of the less fortunate amongst the youth, also development. We collect the fund and buy certain things for each member in the group. We also help the community when they have fundraisers for the sick and other needy people in the community. (IDI, youth leader)

We had started them as a strategy to unite us as youths to help us to make social and political demands on matters relating to employments that have been discriminating us for long. (FGD, young women 15-19 years)

However, the quantitative survey responses show some level of young women participation in youth club activities. The data show that 28% of the female respondents and 25% of the male respondents had heard of the Yes I Do programme, while 17% of the female respondents and 19% of the male respondents indicated to have participated in the activities of the programme. Out of the female respondents who participated in the programme, the majority participated in youth club activities (67%) or community dialogues (33%). Both activities were also mostly attended by the male respondents who participated in the programme (youth club: 66%, community dialogues: 34%).

3.3.2 DISCUSSING SENSITIVE ISSUES AND INTER-GENERATIONAL COMMUNICATION

Similar to the baseline narratives, the endline data suggest that communication between youths and their elders was limited and largely influenced by social norms whereby youth are not expected to speak when they are among their elders. This also applies to decision-making involving young people, which seemed to be limited. Participants avowed that typically, youth are not able to communicate sensitive issues including sexuality with their elders.

When you utter any sexual related word as a youth here, one would be regarded as disrespectful, so we can only speak out on other things but not sexual matters. (FGD, young women 15-19 years)

These narratives are supported by findings from the quantitative survey, which show that topics such as dating, relationships, sexuality and sexual health were less likely to be discussed with family members, especially by boys, at endline. Furthermore, young women were less likely to speak about sensitive matters with their fathers in particular. For example, only 6% of the female respondents in both the intervention and control area felt comfortable discussing gender equality and girl's rights with adult men.

However, there was a statistically significant increase in the percentage of youth who find it easy to discuss sexuality and marriage with their parents in both intervention and control areas and for both genders. At baseline, 24% of respondents in the control area and 27% of the respondent in the intervention area found it easy to talk to their parents on the topics of sexuality and marriage, as compared to 34% and 35% at endline, respectively. The increase in the intervention area is not significantly different from the increase in the control area (OR: 0.9, p-value=0.489) (Table 6).

While there is some variation between baseline and endline and intervention and control areas, youth across the study populations were generally more comfortable discussing topics such as gender equality and girl's rights with people of their own age and gender. For example, at endline, female respondents in the intervention area were more comfortable discussing gender equality and girl's rights with girls their own age (86%), followed by boys their own age (56%), adult women (18%) and adult men (6%). Male respondents felt more comfortable discussing this topic with boys their own age (78%), followed by girls their own age (52%), adult men (25%) and adult women (10.6%).

Table 6 Easiness of talking about sexuality and marriage with parents

Youth who find it easy to talk to their parents about sexuality and marriage	Baseline		Endline	
	Intervention	Control	Intervention	Control
Girls and young women (15-24 years)	142 (28%)	114 (22%)	197 (36%)	174 (33%)
Boys and young men (15-24 years)	44 (25%)	50 (29%)	57 (34%)	59 (36%)
Total	186 (27%)	164 (24%)	254 (35%)	233 (4%)

3.4 YOUTH'S SEXUAL AND REPRODUCTIVE HEALTH KNOWLEDGE, BEHAVIOUR, INFORMATION ACCESS AND SERVICE UTILIZATION

3.4.1 YOUTH DISCUSSIONS AND WORRIES ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

In the qualitative component, young people were reported to frequently face the following SRH issues: teenage pregnancy, child marriage, complications during childbirth, peer pressure, STIs, embarrassment when attempting to access condoms, difficulties with communication about their sexual health issues e.g. menstruation, not receiving enough sexuality education, challenges in accessing SRH related services, lack of parental care, and social media as a negative influence. The quantitative data show that the percentage of respondents who had someone to talk to about their feelings, hopes or worries dropped between baseline (85%) and endline (72%) in the intervention area (Table 7). A similar but less drastic drop occurred in the control area. Female respondents in the intervention area talked more to their mother (baseline: 32%, endline: 32%), husband (baseline: 24%, endline: 25%), or sister (baseline: 16%, endline: 26%), while male respondents in the intervention area talked more to their brother (baseline: 37%, endline: 44%), father (baseline: 25%, endline: 18%) or mother (baseline: 16%, endline: 27%).

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	
	Intervention	Control	Intervention	Control
Girls and young women (15-24 years)	436 (86%)	403 (79%)	407 (74%)	381 (73%)
Boys and young men (15-24 years)	145 (82%)	132 (76%)	113 (66%)	109 (66%)
Total	581 (85%)	535 (78%)	520 (72%)	490 (71%)

At endline in the intervention area, for those youth who talked about their issues with family, most discussed their hopes and fears (65%), fears in life (61%), living life as a young person (61%) and rights and entitlement (62%). Topics such as dating and relationships (25%), what it means to be circumcised (43%) or questions about sexuality and sexual health (34%) were less frequently discussed with family. The responses were similar among male and female respondents and between the intervention and control area, except that female respondents were more likely to discuss how to prevent pregnancy with their family (47%) as compared to male respondents (26%). All topics were more frequently discussed with friends than with family. Especially marriage (70%), dating and relationships (76%), how to prevent pregnancy (73%) and questions about sexuality and sexual health (68%) were much more discussed with friends than with family. What it means to be circumcised was least often discussed with friends (50%).

At baseline, about 25% of the female respondents in the intervention area worried about topics such as teenage pregnancy, child marriage, not finishing school, compared to about 70% at endline. At baseline, around 15% of the male respondents worried about the same topics, and the percentage of males who were worried also increased over time (Table 8). In the control area at baseline, the percentage of male and female respondents who worried about aspects that concern the right of young people was much higher than in the intervention area, and differences between male and female respondents were small. At endline, the percentage of male and female respondents worrying increased considerably. Although male respondents in the intervention area still worries less than female respondents, the difference between the intervention and control area was much smaller at endline as compared to the baseline.

Table 8 Youth who worry about aspects that concern the rights of young people

Youth who worry about	Baseline		Endline	
	Intervention	Control	Intervention	Control
Girls and women (15-24 years)				
Early pregnancy	132 (26%)	293 (57%)	391 (71%)	409 (78%)
Child marriage	127 (25%)	279 (54%)	404 (73%)	411 (79%)
Not finishing school	129 (25%)	277 (54%)	395 (71%)	411 (79%)
To be worth a bride price only	123 (24%)	214 (42%)	368 (67%)	402 (77%)
To not decide for myself who to date	124 (24%)	270 (53%)	364 (66%)	380 (73%)
To be denied contraceptives	113 (22%)	245 (48%)	291 (53%)	340 (65%)
Boys and men (15-24 years)				
Early pregnancy	24 (14%)	103 (60%)	109 (64%)	133 (81%)
Early marriage	26 (15%)	96 (55%)	103 (61%)	128 (78%)
Not finishing school	31 (18%)	103 (60%)	108 (64%)	124 (76%)
To be worth a bride price only	24 (14%)	76 (44%)	82 (48%)	125 (76%)
To not decide for myself who to date	27 (15%)	94 (54%)	115 (68%)	122 (74%)
To be denied contraceptives	27 (15%)	81 (47%)	73 (43%)	109 (66%)

3.4.2 SEXUAL BEHAVIOUR

From the FGDs and IDIs, the overall agreement was that sexual debut for girls occurs as early as nine years, similar to the ten years mentioned by the baseline participants. Both male and female parents said that girls initiate sexual activity between nine and ten years, while key informants gave an estimate of 12 to 17 years. Female parents indicated that girls start sexual activity immediately after circumcision. Different from the qualitative narratives, from the quantitative data, self-reported age of sexual debut was higher. Fifty-nine percent (59%) of the male and female respondents in the intervention area reportedly had sexual intercourse (Table 9), at an average of 16.8 years (Table 10). Males were reported to begin engaging in sexual activities at a later age than females, although the quantitative data shows hardly any difference in the average age of first sexual activity or intercourse between males and females.

Where age could not be determined, there were often references to known events, such as after circumcision or more when they are in class four or six, which would be estimated between ages 12 and 14 years. At endline, signs of maturity or physical development were reported to trigger sexual activity for both boys and girls.

According to me, girls start engaging in sexual debut immediately after circumcision. And nowadays they are circumcised while young or sometimes when a girl starts experiencing some body development like breast growth. (FGD, young men 20-24 years)

Table 9 Engagement in sexual activity and intercourse at endline

		Endline	
		Sexual activity (petting, kissing etc.)	Sexual intercourse (penetrative)
Intervention	% of girls and women (15-24 years)	320 (58%)	321 (58%)
	% of boys and young men (15-24 years)	95 (56%)	104 (61%)
	Total	415 (57%)	425 (59%)
Control	% of girls and women (15-24 years)	219 (42%)	252 (48%)
	% of boys and young men (15-24 years)	83 (51%)	98 (60%)
	Total	302 (44%)	350 (51%)
Total		717 (51%)	775 (55%)

Table 10 Average age of sexual activity and intercourse at endline

	Endline			
	Intervention		Control	
	Sexual activity	Sexual intercourse	Sexual activity	Sexual intercourse
% of girls and women (15-24 years)	16.4	16.8	15.7	16.1
% of boys and young men (15-24 years)	16.8	17.0	15.9	16.3
Total	16.5	16.8	15.8	16.2

The quantitative data show that at endline, 55% of the females in the intervention area and 56% of the females in the control area had ever had a girl or boyfriend, as compared to 61% and 65% of the males in the intervention and control area, respectively (Figure 2).

Figure 2 Youth who have ever had a girl/boyfriend at endline

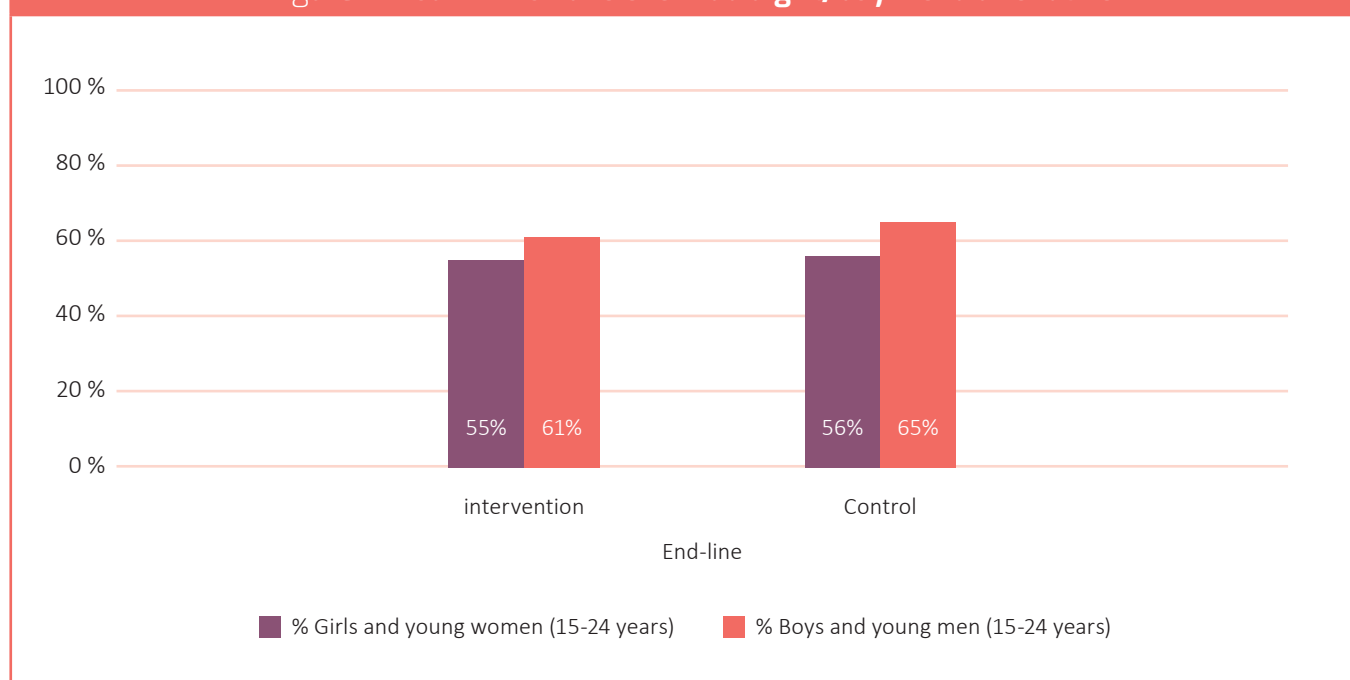
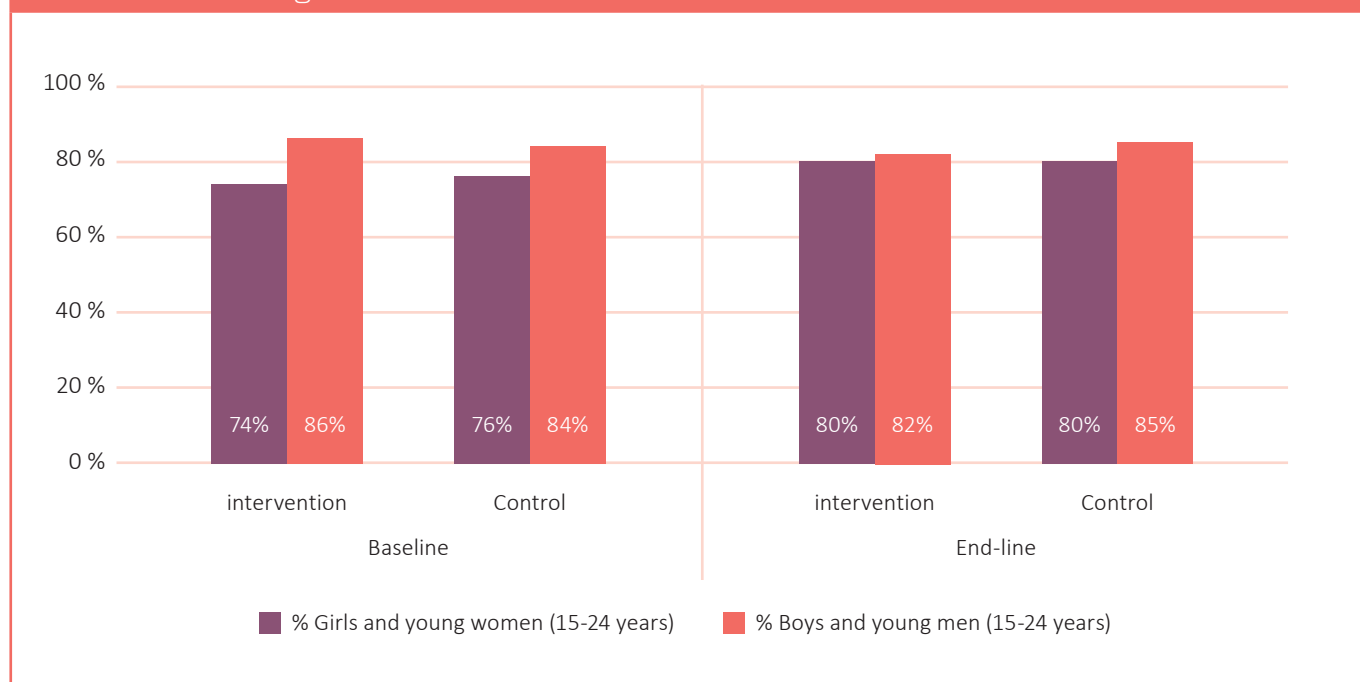


Figure 3 Youth who can decide for themselves whom to date



There was a statistically significant increase in the percentage of girls and young women who can decide for themselves whom to date, yet this increase was not statistically significantly different from the increase in the control area (OR: 1.2, p-value=0.455). No statistically significant changes in the percentage of boys and young men who can decide for themselves who to date could be observed in the intervention and control areas (Figure 3).

Married respondents were asked whether they experience physical violence at the hands of their partners. Among females in the intervention area, 70% did not experience physical violence at baseline, but this decreased to 49% at endline, while those who rarely experienced physical violence increased from 9% to 20% and those who sometimes experienced physical violence increased from 13% to 21%. A similar trend can be observed among females in the control area, where the percentage of married girls and women who never experienced physical violence dropped from 70% at baseline to 33% at endline. The percentage of females who rarely experienced physical violence increased considerably from 4% at baseline to 28% at endline, and females who sometimes experienced physical violence increased from 7% to 29%. The percentage of females who did not want to share this information decreased from 13% to 7%.

Overall, the percentage of females who have ever experience physical violence at the hands of their partner increased significantly in both the control and the intervention area, but the increase between base- and endline in the intervention area was significantly lower as compared to the control area (OR: 0.2, p-value<0.001).

Generally, married men experienced physical violence from their partner to a lesser extent than their female counterparts. However, while 92% of the males in the intervention area never experienced physical violence from their partner at baseline (and the remaining 8% did not wish to share), this dropped to 63% at endline. Out of those who did experience physical violence, the vast majority (90%) experienced it rarely. In the control area, most men did not experience physical violence (baseline: 80%, endline: 93%). At baseline, 20% were not comfortable sharing this information compared to none at endline.

3.4.3 SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS INFORMATION AND EDUCATION

Similar to the baseline, the qualitative narratives show that young people reported to receive SRHR information from teachers in schools, their peers, social media, churches, NGOs providing education, parents, and community health volunteers.

Sometimes we get this SRHR information from peer educators from organizations, for example AMREF, Action Aid and TICAH (Trust for Indigenous Culture and Health). (FGD, young women 15-19 years)

It was also reported that girls are expected to mostly get information from their mothers, while boys are expected to get information largely from their fathers. At endline, although the church was frequently mentioned as a source of SRHR information for young people, there were concerns from male parents about current activities in churches that predispose the youth to sexual activity. Some mentioned that church seminars could also be places where young people socialise and get the opportunity to engage in (unsafe) sexual activity.

There is no specific place here although church is expected to do [provide information] but it is failing. Nowadays when young people go to seminars and church services, either daytime or night, the objective of both parties is to get boyfriends or girlfriends. (FGD, male parents)

While some young participants were emphatic to state that they were being provided with reproductive health information by teachers in school (including taking exams on SRH topics) and at home, others spoke of not receiving enough sexuality education.

For the educated, they get the education at schools, but it is kind of hard for those who are not in school because they don't usually get information. (FGD, young men 20-24 years)

The quantitative data support the qualitative narratives on young people's access to SRHR information and show that access to sexuality and sexual health education has improved between baseline and endline, especially among girls and young women (Figure 4).

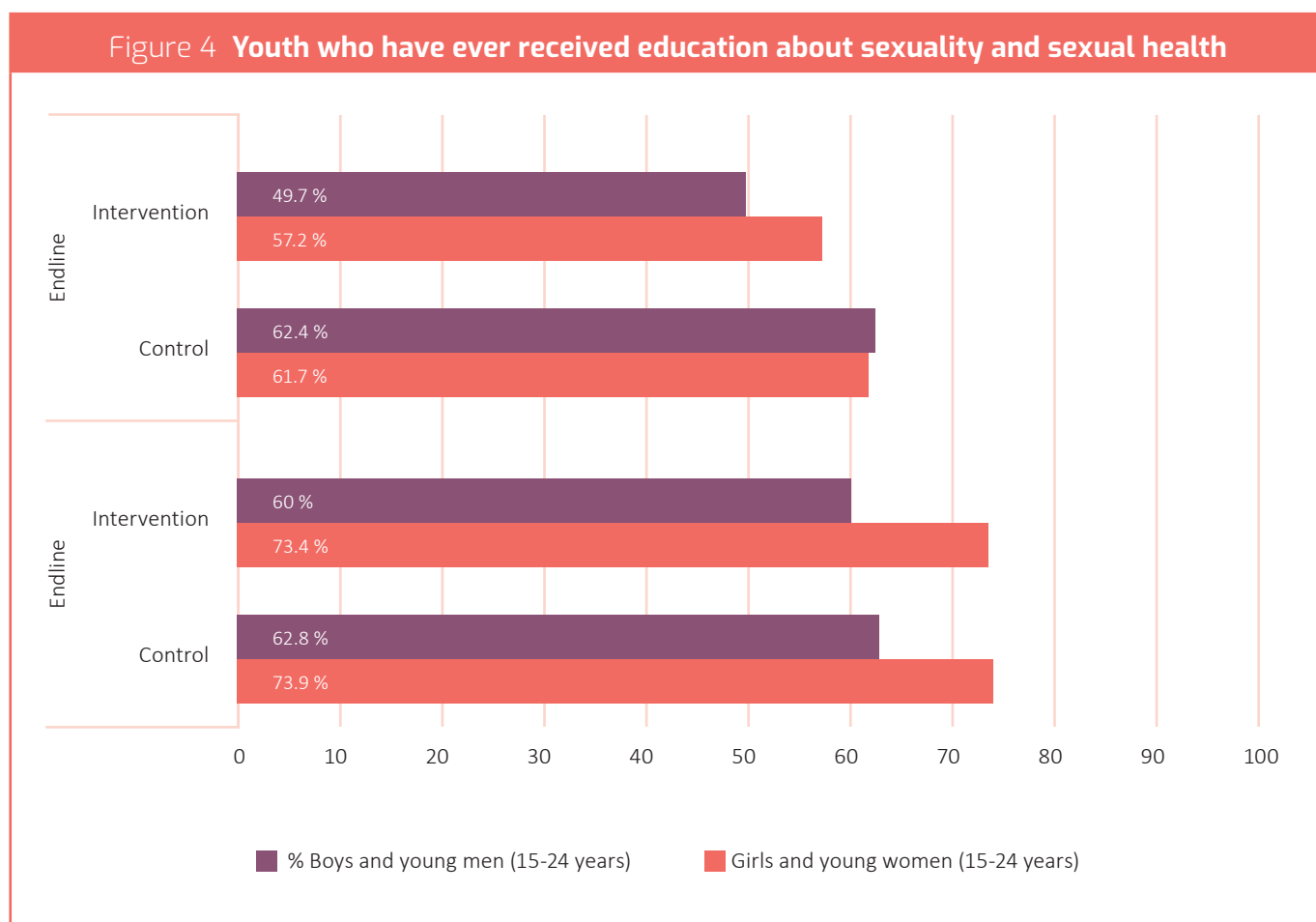


Table 11 **Most common current source and preferred source of sexuality education**

	Sources of sexuality education	Most common current source: teacher	Most common preferred source: school
Intervention			
Baseline	Girls and women (15-24 years)	189 (37%)	227 (45%)
	Boys and young men (15-24 years)	54 (31%)	63 (36%)
	Total	243 (36%)	290 (42%)
Endline	Girls and women (15-24 years)	224 (41%)	290 (52%)
	Boys and young men (15-24 years)	44 (26%)	61 (36%)
	Total	268 (37%)	351 (49%)
Control			
Baseline	Girls and women (15-24 years)	216 (42%)	232 (45%)
	Boys and young men (15-24 years)	78 (45%)	88 (51%)
	Total	294 (43%)	320 (47%)
Endline	Girls and women (15-24 years)	254 (49%)	366 (70%)
	Boys and young men (15-24 years)	66 (40%)	108 (66%)
	Total	320 (47%)	474 (69%)

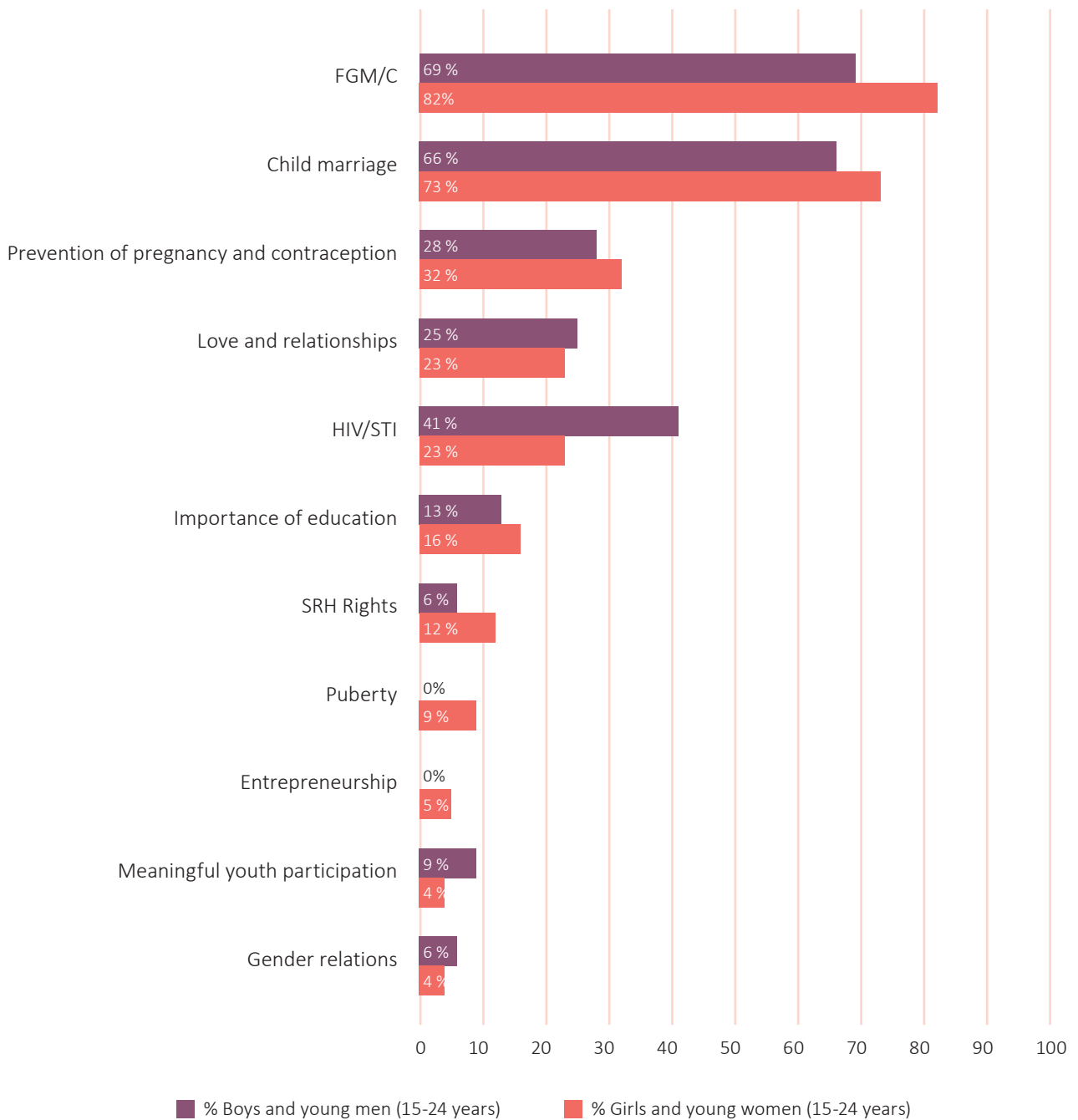
At baseline, 57% of the female respondents in the intervention area and 62% of the female respondents in the control area ever received sexuality education. The percentages were higher at endline, with 73% of the female respondents in the intervention area and 74% of the female respondents in the control area having ever received sexuality education. A similar increase can be observed among males in the intervention area, from 50% at baseline to 60% at endline, while it remained stable in the control area. In general, sexuality and sexual health education for young women between 15 and 24 years has significantly improved in the intervention area and the control area, but there was no significant increase in the intervention area over the control area (OR: 1.2, p-value=0.281).

The most common current sources of information were largely in line with the preferred sources of information (Table 11). Most respondents receive SRHR information from a teacher. However, while 65% of respondents in the intervention area received SRHR information from a teacher at baseline this decreased to 53% at endline. The sources that increased were peer educators – from 11% to 29% - and youth club – from 4% to 16%. While a similar increase in peer educators as the current source of SRHR information can be observed in the control area (baseline: 14%, endline: 26%), teachers remained stable (baseline 69%, endline: 65%). Other reported sources that increased in the control area are friends (baseline:7%, endline: 20%) and health providers (baseline: 11%, endline: 20%).

The most preferred source of SRHR information in both the intervention and control area is school (Table 11). At baseline, 42% of the respondents in the intervention area reported the school to be the preferred source of SRHR information, in addition to the church or mosque (27%), home (26%) or the health centre (23%). At endline, the preferred sources were largely the same as at baseline, with schools being the most preferred source (49%), followed by home (28%), the church or mosque (24%) and the health centre (20%). In the control area, the same preferred sources of SRHR information were mentioned. However, a considerable increase can be observed in school as the preferred source from 47% at baseline to 69% at endline. The health centre as a preferred source increased from 20% at baseline to 34% at endline, and home increased from 23% at baseline to 36% at baseline.

Respondents who participated in the Yes I Do programme (95 female and 32 male respondents) were asked which topics they thought were beneficial (Figure 5). Out of the 11 topics that were addressed, FGM/C and child marriage were most often reported as beneficial. Over 20% of the respondents who participated in the Yes I Do programme considered prevention of pregnancy, love and relationship and HIV/STI to be the beneficial topics. The importance of education, SRH rights, puberty, entrepreneurship, meaningful participation and gender relations were least often reported as beneficial (<20%).

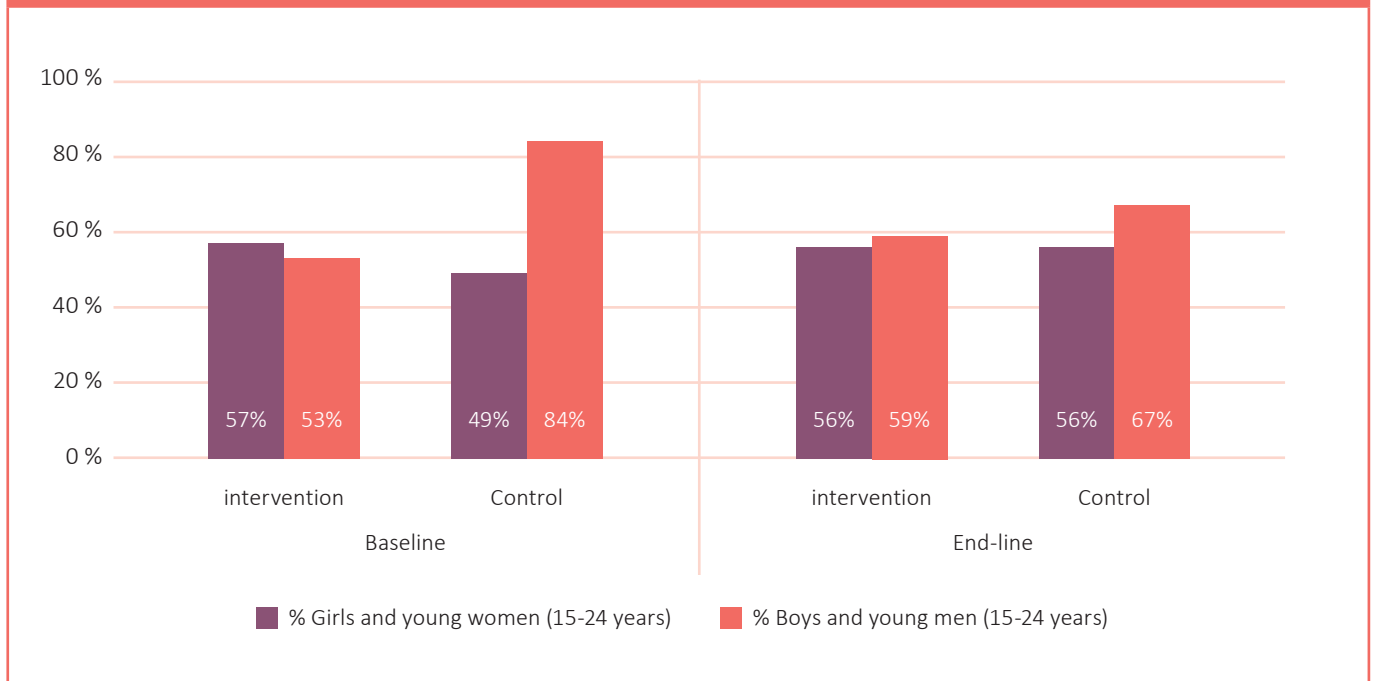
Figure 5 Topics addressed in Yes I Do activities that youth find beneficial (endline)



3.4.4 CONTRACEPTION KNOWLEDGE AND USE

Despite the increase in the percentage of respondents who received sexuality education, knowledge of modern contraceptives to prevent pregnancies remained unchanged between base- and endline in the intervention area and slightly increased in the control area (Figure 6). Among female respondents in the intervention area, 57% at baseline and 56% at endline knew at least one modern contraceptive, while a slight increase from 53% at baseline to 59% at endline was observed among male respondents. Less than half of the female respondents in the control area had knowledge of modern contraceptives as compared to 54% of their male counterparts at baseline. Both females and males saw an increase at endline to 56% and 67% respectively. There is a statistically significant increase in the change in knowledge of contraception in the control area as compared to the intervention area among females (OR: 0.0.7, p-value<0.05) but not among males (OR: 0.8, p-value=0.511).

Figure 6 Knowledge of prevention of pregnancy using modern contraceptives



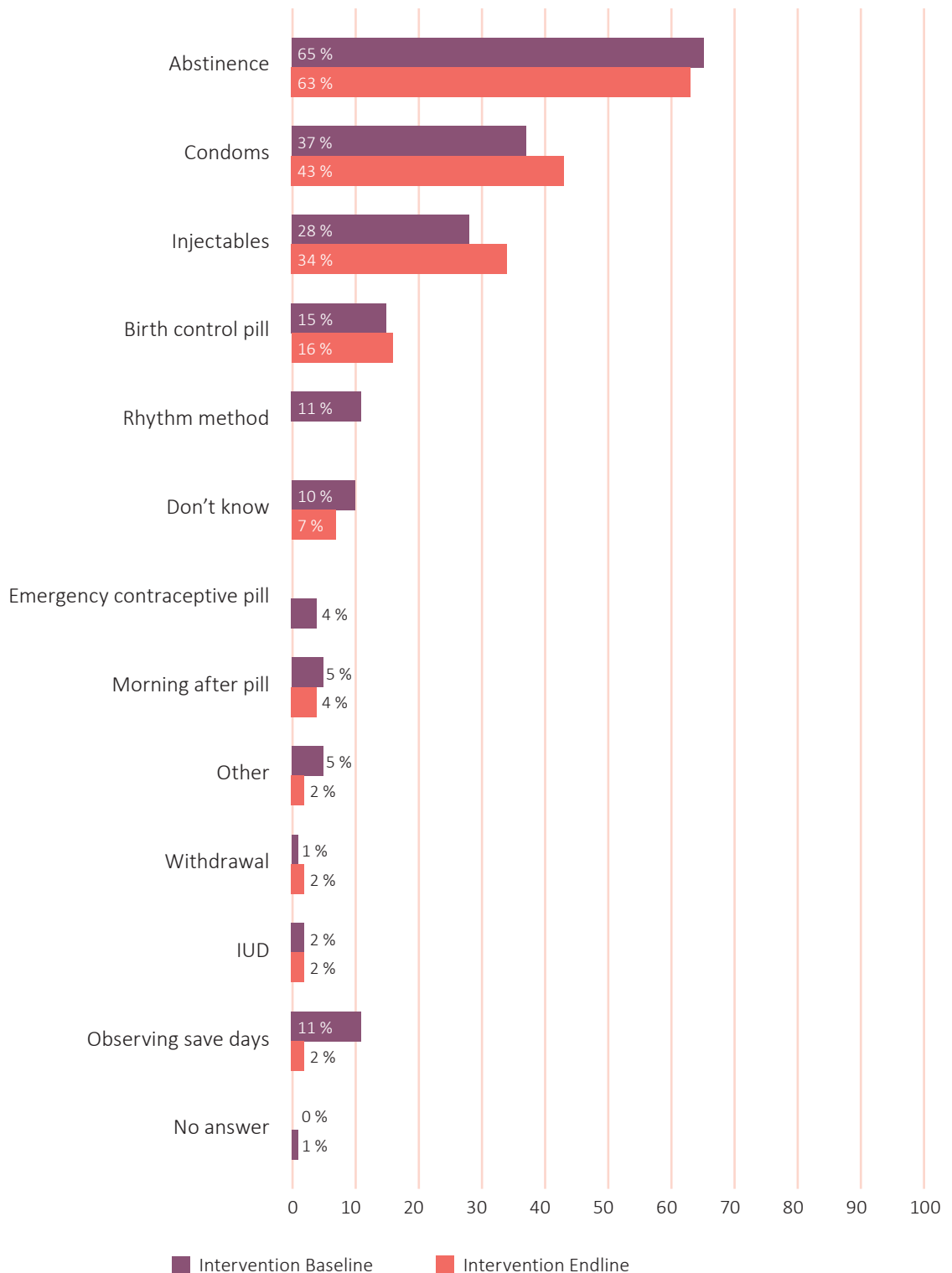
Abstinence was by far the best-known contraceptive among respondents in the intervention area at both base- (65%) and endline (63%). Yet, the percentage of respondents who know that pregnancy can be prevented using condoms increased from 37% at base- to 43% at endline, and knowledge of injectables increased from 28% at base- to 34% at endline (Figure 7).

Knowledge of contraceptive methods was in line with the reported availability of contraceptives in the study areas. Injectables and male condoms were known to be available by over 50% of the respondents in the intervention and control areas, followed by contraceptive pills, which were reportedly available according to 28% of the respondents in the intervention area and 22% of the respondents in the control area.

At endline, 47% of the female respondents in the intervention area who ever had a child, currently used a modern form of contraception as compared to 42% in the control area, and there is a decrease of almost 10% in both groups as compared to the baseline. At endline, the contraceptive prevalence rate was much higher among female respondents who ever had a child than among female respondents who never had a child. Only 11% of female respondents who never had a child used a modern form of contraceptives in the intervention area and this was 14% in the control area. The most used form of contraception among women who ever had a child were injections. Very few women used condoms as a contraceptive. At baseline, 8% of the mothers aged 15-24 in both the intervention and control area used a condom, this decreased to 4% in the intervention area and increased to 13% in the control area at endline. The decrease in the use of condoms among mothers in the intervention area is not significantly different from the increase in the control area (OR: 0.3, p-value=0.062). The most used form of contraception among fathers were condoms, out of the 30 young fathers in the intervention area at endline, 12 (40%) used male condoms as compared to 2 (13%) out of 15 fathers in the control area. The remaining fathers did not use any contraceptives.

Respondents were asked under what circumstances a person could access a modern form of contraception. Twenty-three percent (23%) of the females in the intervention area believed that one could always access modern contraceptives at baseline, which increased to 34% at endline. In addition, the percentage of female respondents in the intervention area who believed one could never access contraceptives dropped from 13% at baseline to 3% at endline. At the same time, the percentage of male respondents in the intervention area who thought that one can always access contraceptives fell from 62% at baseline to 35% at endline, mainly due to an increase in those who responded 'don't know' (35%) at endline. In the control area, the percentage of female respondents who believed one can always access contraceptives decreased from 24% at baseline to 20% at endline, while this increased from 17% at baseline to 27% at endline among their male counterparts. The percentage of female respondents who found it difficult to access contraceptives as a young person significantly increased over time in the control area as compared to the intervention area (OR: 0.5, p-value<0.001).

Figure 7 Knowledge of types of contraceptive methods in the intervention area



Respondents were asked to give their level of agreement on six statements related to the use of contraceptives (Figure 8). Fewer female respondents in the intervention area believed that it is not appropriate for young women to propose to use a condom at endline (22%) as compared to baseline (33%). This did not translate into increased confidence to insist on condom use during sex, which slightly decreased from 50% at baseline to 47% at endline. While the percentage of male respondents (in the intervention area) who believed that it is not appropriate for young women to propose to use a condom was lower (25%) than the percentage of female respondents (33%) who thought that at baseline, at endline, it increased to 31%, which is almost 10% higher as compared to female respondents (22%). At the same time, the confidence to insist on condom use among male respondents also decreased considerably from 77% at baseline to 58% at endline.

Figure 8 Topics addressed in Yes I Do activities that youth find beneficial

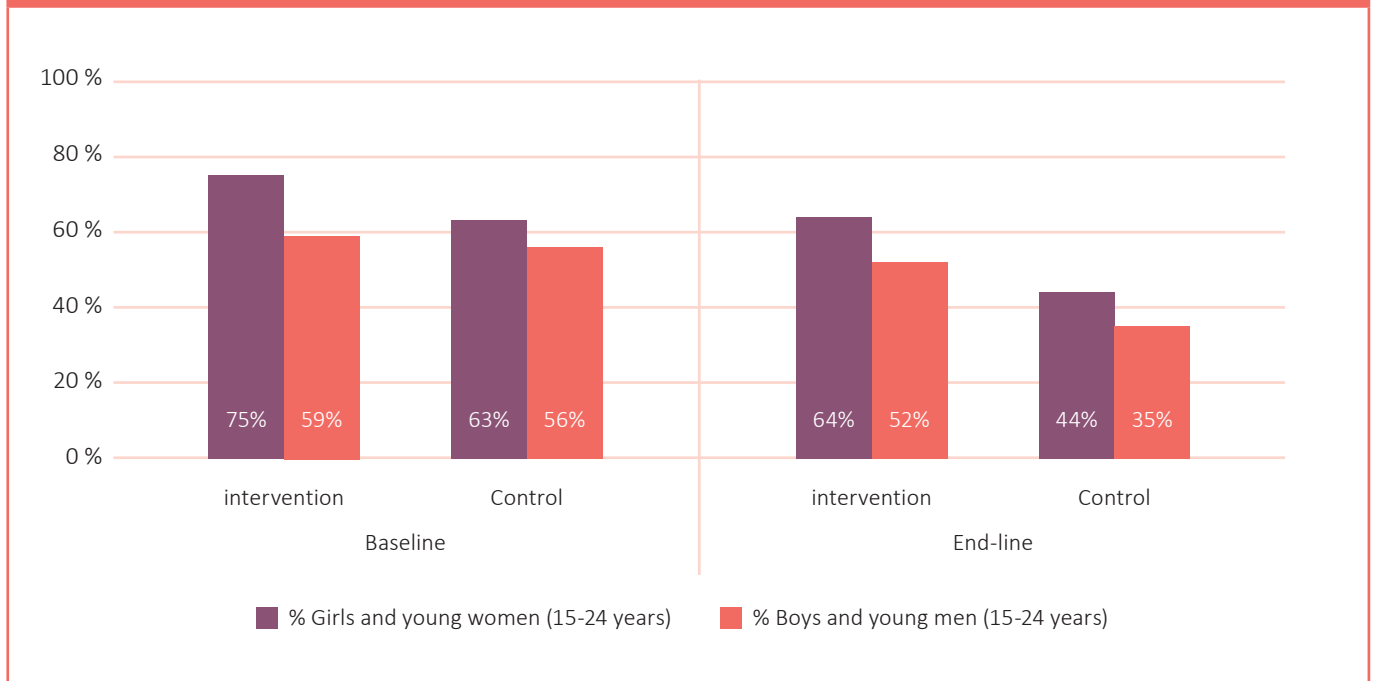


There is a significant increase in the percentage of girls and young women aged 15 to 24 who disagree with the statement that it is not appropriate for a girl to propose to use a condom in the intervention area (OR: 0.9, p-value=0.487). The percentage of female respondents in the control area who agreed with the statement was higher as compared to the percentage of female respondents in the intervention area, and it remained stable between base-(43%) and endline (40%). Interestingly, the percentage of female respondents who felt confident to insist on condom use every time they have sex increased from 45% at baseline to 65% at endline in the control area (whereas in the intervention area, this percentage decreased).

3.4.5. SEXUAL AND REPRODUCTIVE HEALTH SERVICE PROVISION AND UTILIZATION

Utilization of SRH services significantly decreased in both the intervention and the control area, and among female and male respondents (Figure 9). While at baseline, 75% of the female respondents in the intervention area had

Figure 9 Youth who have ever used SRH services



ever used SRH services this decreased to 64% at endline. A similar decrease is observed among male respondents in the intervention area from 59% at baseline to 52% at endline. The reduction is larger in the control area, where utilization of SRH services decreased from 63% at baseline to 44% at endline among female respondents and from 56% at baseline to 35% at endline among male respondents. However, there is no statistically significant difference in the decrease in utilization of SRH services between the intervention and control area among females (OR: 1.3, p-value=0.258) or males (OR: 1.9, p-value=0.052).

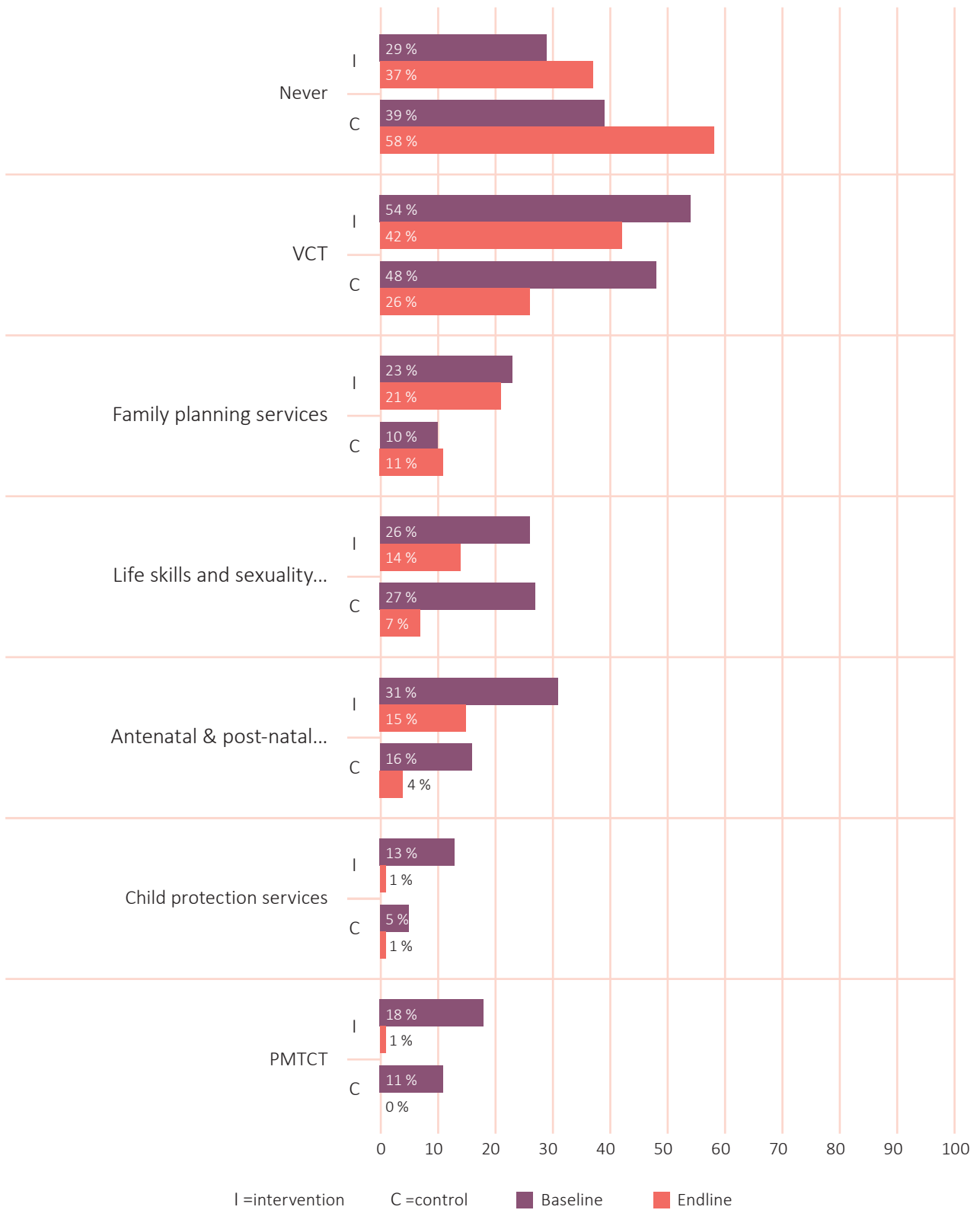
Respondents were asked what type of SRH services they had used (Figure 10). At baseline, the most frequently used SRH services in the intervention area were voluntary counselling and testing (VCT, 54%), followed by antenatal and postnatal services (31%), life skills and sexuality counselling (26%) and family planning services (23%). VCT remained the most frequently used service in the intervention area at endline as well (42%), but a considerable decrease can be observed in the utilization of antenatal and post-natal services (15%) and life skills and sexuality counselling (14%). Furthermore, while child protection services were used by 13% of the respondents in the intervention area at baseline, this decreased to 1% at endline, and prevention of mother to child transmission (PMTCT) services decreased from 18% at baseline to 1% at endline. (Table 10; this table does not present services that were used by 2% or less of the respondents, such as hotlines, abortion and post-abortion care).

Like the intervention area, VCT services were the most used SRH services in the control area. Approximately 48% of the respondents who ever used SRH services used VCT services at baseline as compared to 26% at endline. Just like in the intervention area, utilization of antenatal and postnatal services decreased considerably from 16% at baseline to 4% at endline, life skills and sexuality education decreased from 27% at baseline to 7% at endline and PMTCT services decreased from 11% at baseline to 0% at endline (Figure 10).

Respondents in the intervention and control areas accessed the SRH services from the same providers. Seventy-six percent (76%) and 79% of the respondents who ever used SRH services in the intervention and control area respectively, received their services from a health facility or medical staff at endline. Some also received services at school (intervention area: 18%, control area: 20%) or in a private clinic (intervention area: 10%, control area: 20%).

At endline, respondents who never used SRH services were asked to give reasons for non-use. Most respondents in the intervention and control areas either did not know about the services, never had the need to go or never thought about it. Accessibility issues such as costs, travel distance or disapproval by family or spouse were rarely mentioned as reasons not to use SRH services.

Figure 10 Types of SRH services used by respondents



3.5 TEENAGE PREGNANCY

3.5.1 PREVALENCE OF TEENAGE PREGNANCY

Teenage pregnancy was more prevalent in the intervention area as compared to the control area and remained stable in both areas over time (Table 12). A slight increase in the prevalence of teenage pregnancy among women aged 20 to 24 years can be observed in the intervention area, from 49% at baseline to 53% at endline. In the control area, the prevalence slightly decreased from 34% at baseline to 32% at endline. However, there is no statistically significant change in the prevalence of teenage pregnancy between base- and endline or compared to the control area for girls and women aged 15 to 24 years (OR: 1.0, p-value=0.896), as well as women aged 20 to 24 years (OR: 1.1, p-value=0.727). While the prevalence of teenage pregnancy has not changed positively over time, the average age of first pregnancy increased in the intervention area by a year, from 16.1 years at baseline to 17.1 years at endline. To a lesser extent, the average age of first pregnancy also increased in the control area from 16.9 years at baseline to 17.3 years at endline. Furthermore, the reported desire to become a mother when they did, decreased considerably over time. At baseline, 74% of the teenage mothers in the intervention area and 78% of the teenage mothers in the control area wanted to become pregnant when they did. This decreased considerably to 37% in the intervention area and 45% in the control area. While the decrease in the intervention area is statistically significant, it is not statistically significantly different from the trend in the control area (OR: 0.4, p-value=0.144).

Table 12 **Pregnancy and parenthood**

	Baseline		Endline	
	Intervention	Control	Intervention	Control
Girls and women (15-24 years)				
Who had their first child under the age of 20	96 (49%)	55 (34%)	127 (53%)	51 (32%)
Who reported to have ever been pregnant	NA	NA	185 (77%)	81 (51%)
Who wanted to become parents at that time ¹	71 (74%)	43 (78%)	47 (37%)	23 (45%)
Average age at first pregnancy	16.1	16.9	17.1	17.3
Boys and men (15-24 years)				
Who had their first child under the age of 20	4 (2%)	3 (2%)	7 (3%)	6 (4%)
Who wanted to become parent at that time ¹	2 (50%)	1 (33%)	6 (86%)	3 (50%)
Average age at first child	18.0	15.5	18.1	17.3

¹ Out of those who had a first child before the age of 20

It is clear from the quantitative data that teenage pregnancy is still very common in the intervention area, only 11% of the respondents did not know a girl who had children before the age of 20 at endline. Thirty-three percent (33%) of the respondents knew five or more young women who fell pregnant before the age of 20, and 40% reported that it was very common. Even though the percentage of respondents who did not know a girl who had children before the age of 20 was lower in the control area (20%), it was still reported to be very common according to 32% of the respondents.

According to the respondents at endline, if an unmarried girl falls pregnant, she can turn to her family members or to the chief. However, the percentage of respondents who believed that a girl who falls pregnant can turn to her family members was much lower in the intervention area (43%) as compared to the control area (72%). In addition, the percentage of respondents in the intervention area who believed that a girl can turn to the chief (63%) was higher than the percentage of respondents who believed that a girl can turn to her family members (43%).

3.5.2 CAUSES AND CIRCUMSTANCES OF TEENAGE PREGNANCY

During the qualitative interviews and discussions, causes and circumstances leading to teenage pregnancy were explored, with a focus of examining any changes relative to the baseline. At baseline, participants mentioned early sexual debut, long distance to school, peer pressure and lack of parental supervision as contributing factors influencing young people's sexual practices and thus teenage pregnancy. At endline, early sexual debut, poverty, FGM/C, girls' sleeping arrangements and distance to schools were mentioned as some of the circumstances that contribute to teenage pregnancy, suggesting that the circumstances under which teenage pregnancy happens remained relatively the same in the intervention area. However, additional issues were mentioned at endline as contributing factors. For example, smartphones were cited as items that young people, would really like to own and they were reported as one of the items that pull young women towards sexual relations that might lead to teenage pregnancy. In addition, it was observed that young women experience challenges in meeting their necessities such as sanitary pads, which their parents and especially mothers may simply not afford.

... because the girl is not able to buy for herself the sanitary materials, they start getting boyfriends who will buy for them, and the compensation will be having sex. This will lead these girls to become pregnant.
(IDI, youth leader)

Young men were reported to scout and begin to cultivate rapport with a family that has a young woman they are interested in and eventually the young man gets a leeway to the young woman's homestead with less restriction. Mothers complained on how they were blamed for their daughter's behaviour they have no control over, given that they cannot monitor the young women who may engage in sexual activity on their way to school or to the market.

... you see, if a young man is interested with a certain girl, he identifies her parents especially the mother to the child and gives her unwarranted financial supports even at the market pretending to be a good young community member or neighbour. (FGD, male parents)

Female genital mutilation/cutting was also cited as one of the contributing factors to teenage pregnancy. The belief that once a girl has been cut, it is fine for her to engage in sexual activities means that these girls are also vulnerable to teenage pregnancy. It was argued that FGM/C is a major challenge, because after the cut girls feel like "real women" and start engaging in sexual acts which in turn lead to pregnancies and child marriages.

Normally, it is not the action of the cut that is bad, but the commissioning of the fact that when a girl is cut, she is a woman and can do all that women can do (IDI, chief)

As was reported in another study exploring factors influencing teenage pregnancy among Maasai girls in Kajiado West Sub-County (Olenja et al. 2020), sleeping arrangements were also cited as one of the cultural practices that contribute to teenage pregnancy. Traditionally, young people who are beyond ten years or who have been circumcised are not expected to sleep in the same house with their parents. They therefore sleep in a separate house and it may be with mixed gender. It is also open to other (young) men from the neighbourhood. This exposes young women to sexual activity that may be solicited or unsolicited. As a result, unintended pregnancy may occur.

... girls sleep in their own house with boys on the other side. This exposes them to chances of meeting boys and through enticement, they can easily be impregnated. So, there is need to improve on sleeping patterns to avoid these in the future. (IDI, youth leader)

The religious leader interviewed stated that night vigils did account for some of the teenage pregnancies. However, in his church he had instituted measures that ban night meetings, including ensuring that young women must come with their mothers and that they must go back home together. This was to protect the young woman from exposure to (young) men and the possibility of teenage pregnancy.

Distance to schools was also mentioned as a contributing factor to teenage pregnancy. Participants explained that in their communities, schools are far apart. The long distances therefore pose a problem for young girls who need

to get to school daily. While boys may be able to provide security to girls on the way to and from school, it can be an avenue for sexual exploitation.

Mostly, these young girls go to far schools alone and could be raped which they don't talk about. They end up getting pregnant not knowing who is responsible. (IDI, circumciser)

3.5.3 WAYS OR PROGRAMMES TO PREVENT TEENAGE PREGNANCY

Participants were asked what is being done towards preventing teenage pregnancy in the community. Responses were given in terms of what should be done rather than what was done. Various (possible) activities to prevent pregnancy were listed which included: restriction of girl's movement, educating young women on pregnancy prevention, providing information on sexual health, counselling the girls and encouraging them to focus on education. Recognizing the vulnerability that comes with girls going to school, marketplaces or churches, one of the suggestions – especially from parents – was the restriction of movement for girls as a way of reducing their chances of getting pregnant.

We restrict movement. For instance, night vigils and other aimless visits to other places which are less important. (FGD, female parents)

Educating young people on the prevention of teenage pregnancy as well as providing information on the negative consequences of teenage pregnancy were cited as antidotes to teenage pregnancy. Parents acknowledged the role they need to play in supporting children in general and in protecting them in particular from teenage pregnancy. This was explained to include telling them about negative impacts of pregnancy while in school as well as showing them the positive side of one having a baby when the right time comes.

Yes, I think we as the parents should take the initiative to talk to our young girls and boys to take precautions against these early pregnancies. (FGD, male parents)

We are supposed to speak to our children on issues of pregnancy without fear rather than waiting for it to happen and act when it's too late. (FGD female parents)

Young women expressed desire to be provided with SRH information from various sources including their parents, NGOs and youth fora.

They should be given sexuality education especially on the consequences of early pregnancies... Educated on the issues concerning early pregnancies, marriages and all these issues in general. (FGD, young women 15-19 years)

At baseline, it was highlighted that health centres were available but that young people could not always access them because of distance from home, poor roads and infrastructure, or due to service providers' attitudes. The endline quantitative data show that contraception was not widely used but the situation seems different from the baseline. The qualitative narratives at endline show a general awareness that young women need to protect themselves through contraception to avoid pregnancy. At the same time, it was also indicated that contraceptive use is viewed negatively at the community level, suggesting that better information provision is needed to improve contraceptive use. Whereas the young women (20 -24 years) reported about other contraception use, in the FGD their younger counterparts (15-19 years) expressed preference for the abstinence-only method, partly because of not trusting that men will be using condoms and partly because of the belief that condoms are not reliable. Young men confirmed that young women who use contraceptives can be perceived negatively:

It is so negative around as if you get a girl using family planning methods, you perceive her so negatively. (FGD young men, 20-24 years)

The view of the policy makers and administrators was that young girls should be encouraged to focus on education,

which can protect them from teenage pregnancy. Participants explained that such information should be provided through chiefs, community meetings and churches to challenge girls on the importance of education and achieving their goals in life and that the County administration is focused on ensuring a 100% transition from primary to secondary education, based on the laws from the government. Religious leaders suggested the need for them to keep girls occupied during school holidays by providing counselling sessions.

3.5.4 THE LIVES OF TEENAGE MOTHERS: CONSEQUENCES OF TEENAGE PREGNANCY

Relative to the baseline, the endline participants reported that through the efforts of various stakeholders, particularly NGOs, the church and community leaders, there has been an increase in the awareness on the dangers of child marriage and teenage pregnancy (see section 3.2.3).

The qualitative narratives explain what teenage pregnancy means to young women and to the society at large and some positive changing trends can be observed. Participants explained that teenage pregnancy is one of the most disempowering episodes in a young woman's life in that it can either precipitate child marriage or a discontinuation of a her education, unless there is a deliberate effort to help her out. Participants reported that such young women often turn to their parents, especially their mothers, for help. A good example was given where a young woman went back to school after giving birth while her mother took care of the baby.

In some cases, some parents will get them back to school. I also got pregnant at the age of 15 years and requested my mother to allow me to go back to school and continue with my education. She agreed and that is how I got myself back to school but on the condition that my boyfriend takes care of my young baby's needs. (FGD, young women 15-19 years)

This is an important change from the baseline mind-set when the only option for a pregnant girl was to get married. This change was clearly explained by one of the key informants who noted that initially, when a girl drops out of school as a result of pregnancy, people say "*etigila entito enkalamu*" meaning the girl has "broken a pen" implying that she cannot proceed with school. However, the community has now adopted a more positive view saying "*eitia entito enkalamu*" translated as the girl has "dropped the pen". This is to show that she can still pick herself up (the pen) and proceed with school. This is a slogan that was invented to show parents that teenage pregnancy is not the end of schooling and that a pregnant girl can be given a second chance to proceed with education (IDI, chief)

.... we give her a second chance. Her mother will take care of the baby and the girl would go back to school. However, she is warned that in case she becomes pregnant for the second time she will definitely get married. (FGD, male parents)

While more young mothers were reported to go back to school, young people in FGDs said that this was not the case for all and that this depends on the family situation of the girl.

It depends with the family she comes from, because some parents may decide to marry them off and others may decide to get them back to school, which is more and more becoming the case. (FGD, young women 20-24 years)

Most of them are married off and hence become women, but some run to rescue centres where they have a second chance to school, but very few. (FGD, young men 20-24 years)

3.6 CHILD MARRIAGE

3.6.1 PREVALENCE OF CHILD MARRIAGE

The prevalence of child marriage among female respondents between the ages of 18 and 24 years in the intervention area has halved from 30% at baseline to 16% at endline. Child marriage before the age of 16 also decreased from

15% at baseline to 3% at endline among women between the ages of 16 and 24. In the control area, the prevalence of child marriage was 11% (among women aged 18-24 years) and the prevalence of child marriage before the age of 16 was 3% (among women aged 16-24 years) at baseline – already much lower as compared to the intervention area. These percentages saw a slight decrease (2%) at endline. Furthermore, 17% of the girls below the age of 18 in the intervention area were married at baseline as compared to only 6% at endline (Table 13). There is a statistically significant decrease in the prevalence of child marriage among young women aged 18-24 in the intervention area as compared to the control area (OR: 0.5, p-value<0.05). There is also a significant decrease in the prevalence of child marriage before the age of 16 years among females aged 16 to 24 in the intervention area as compared to the control area (OR: 0.2, p-value<0.05).

Child marriage was and remains something that happens to girls and hardly to boys. The prevalence of child marriage among men was below 5% in all study groups and almost all girls who were married before the age of 18 were married to a man aged 18 years or older. There is a statistically significant decrease in the percentage of young women who believed it was their choice to get married in both the intervention and the control area (OR: 1.8, p-value=0.122). The percentage of young women who believed it was their choice to get married decreased from 52% to 33% in the intervention area, and from 63% to 42% in the control area.

Table 13 Child marriage

	Baseline		Endline	
	Intervention	Control	Intervention	Control
Girls and women (18-24 years) who were married or in a union before age 18 (i.e. child marriage)	77 (30%)	28 (11%)	54 (16%)	25 (9%)
Girls and women (16-24 years) who were married or in a union before age 16 (i.e. child marriage)	61 (15%)	13 (3%)	11 (3%)	5 (1%)
Girls below 18 years old who are currently married	44 (17%)	10 (4%)	14 (6%)	8 (3%)
Married girls and young women (15-24 years), who perceive that it was their choice to get married	96 (52%)	55 (63%)	53 (33%)	35 (42%)
(Married) young women (18-24 years) who were child brides, and who were married to an adult man	71 (92%)	28 (100%)	52 (96%)	23 (92%)
Boys and young men (18-24 years) who were married or in a union before age 18 (i.e. child marriage)	3 (4%)	0 (0%)	4 (3%)	4 (4%)

3.6.2 KNOWLEDGE OF THE MINIMUM AGE OF MARRIAGE AND PERCEPTIONS ABOUT THE IDEAL AGE OF MARRIAGE

There was a lack of knowledge of the legal minimum age of marriage across the study populations. While the perceived knowledge of legal minimum age of marriage has increased among males and females in the control area and among males in the intervention area, this did not translate into increased actual knowledge.

As shown in Table 14, in the intervention area, 37% of the female respondents had perceived knowledge of the minimum age of marriage at baseline, while 13% was able to provide the correct legal age of marriage. At endline,

the perceived knowledge decreased slightly to 31% and the actual knowledge decreased to 10%. Among male respondents, the perceived knowledge of the minimum age of marriage increased from 6% at baseline to 16% at endline, but the actual knowledge remained at 5%. In the control area, the perceived knowledge of the minimum legal age of marriage tripled, from 15% at baseline to 51% at endline among female respondents and from 21% at baseline to 62% at endline among male respondents. Actual knowledge, on the other hand, only increased with 9% among female respondents (from 6% to 15%) and with 3% among male respondents (from 7% to 10%). Further analysis shows a statistically significant increase in the percentage of female respondents (OR: 0.2, p-value<0.001) and male respondents (OR: 0.2, p-value<0.001) who have perceived knowledge of the legal minimum age of marriage in the control area over the intervention area. While there is also a statistically significant increase in the actual knowledge in the control area among female respondents, this increase is not statistically significantly different from the trend in the intervention area (OR: 1.0, -p-value=0.972).

Table 14 Perceptions and knowledge on age of marriage

	Baseline		Endline	
	Intervention	Control	Intervention	Control
Young women (15-24 years) who perceive to have knowledge of legal minimum age according to statutory law	186 (37%)	79 (15%)	174 (31%)	266 (51%)
Young men (15-24 years) who perceive to have knowledge of legal minimum age according to statutory law	10 (6%)	37 (21%)	28 (16%)	102 (62%)
Young women (15-24 years) who have actual knowledge of legal minimum age for girls according to statutory law	67 (13%)	33 (6%)	53 (10%)	76 (15%)
Young men (15-24 years) who have actual knowledge of legal minimum age for girls according to statutory law	9 (5%)	12 (7%)	8 (5%)	17 (10%)

The ideal age to marry was around 23 years for females and around 25 years for males, according to female and male respondents in the intervention area at base- and endline. In the control area, the results were the same at baseline, but the ideal age of marriage slightly decreased at endline to 22 years for females and 24 years for males.

3.6.3 CIRCUMSTANCES OF AND REASONS FOR CHILD MARRIAGE

At baseline, participants referred to economic reasons, a response to teenage pregnancy and the desire to enhance the status of young women in the community as drivers of child marriage. To the endline participants, the main reasons for child marriage were teenage pregnancy, FGM/C, and peer pressure. Participants explained that when girls get pregnant early while in school, they are married off by their fathers as a form of punishment. Another reason that was given was that once a young woman gets married early, she begin to have children early and can therefore have many children over her reproductive age.

Girls get married early only when they become pregnant and their fathers marry them off as punishment. This is done to ensure that she serves as an example to the rest. (FGD, female parents)

R3: It depends, because when one marries early, they will be able to have children early families which are good. R5: In Addition to what R3 is saying, marrying early is also good because they always say, "the earlier the better". (FGD young men 20-24 years)

From the quantitative data, at baseline, 67% of the respondents in the intervention area and 68% of the respondents in the control area reported that someone intervened if children are married. A negligible difference was observed at endline, where 70% of the respondents in the intervention area reported that someone intervenes as compared to 67% of the respondents in the control area. In the intervention area, this person was reported to be usually a law enforcement agent (baseline: 41%, endline: 45%) or others such as the chief (baseline: 56%, endline: 36%). In the control area this person was reported to be usually an NGO staff (baseline: 42%, endline: 32%) or the police (baseline: 51%, endline: 35%).

According to male and female respondents at baseline in the intervention area, the frequency with which authorities intervene was sometimes (40%), followed by rarely (24%), frequently (22%), all the time (12%) and never (1%). At endline, 54% of all respondents responded with 'sometimes', followed by rarely (19%), all the time (14%), frequently (13%) and never (0%).

At baseline in the control area, 34% of female and male respondents believed that authorities rarely intervene in child marriage, followed by all the time (26%), frequently (20%) and sometimes (18%). At endline, 38% of the respondents thought authorities intervene sometimes, followed by frequently (29%), rarely (21%) or all the time (10%).

3.6.4 ATTITUDES AROUND CHILD MARRIAGE

A few participants identified only one benefit of getting married: having children early. This view was reiterated by young men in an FGD who contended that the "earlier the better" (see previous section). However, similar to the baseline, the majority of the participants reported that there are no benefits of child marriage, which is interesting in a community that still upholds the practice of child marriage. It could mean that there is now increased community awareness of the negative consequences of child marriage. However, even though there are areas in the community where the practice is ongoing, the understanding of the negative consequences of child marriage among the Maasai community was clear and it was expressed in various ways. In an FGD with women, they all agreed that there are no benefits of child marriage. The same view was expressed by men.

There are no benefits at all. This is a big problem because when a young girl marries at an early age, she will not be able to take up the wife's responsibilities. The same case applies to a young boy. He will not be able to take care of the family. (FGD, male parents)

Further discussions noted that although there are ways in which child marriage affects the couple equally, specific areas were identified where the girl is disproportionately affected. A common issue that was raised alluded to misunderstandings between the couple due to immaturity as well as poverty and financial difficulties that they may experience.

If the marriage is for a young girl, it has no benefit, since the girl will not complete her studies and she will forever become a beggar. She has no job, so everything she wants is from the husband. (IDI, youth leader)

Again, similar to the baseline, it was also observed that young women who marry early are overworked and often bear responsibilities for which they are not well prepared. In one instance, it was reported that some of the child brides are so young, that one was seen in the market crying because she missed the location of her husband within the market. In FGDs with young women, it was pointed out that child brides give birth with less spacing which can negatively affect their health.

... no benefit instead she goes through a lot of trouble since she might experience giving birth to too many children she cannot bear. Imagine if she is young and happens to come to a family where her in-laws are ruthless. So, it's hard anyway. (FGD, young women 20-24 years)

This is in line with findings from the survey at both base- and endline. The majority of the respondents disagreed with the statement that there are advantages for young people to get married below 18 years. Although there appears to be little variation over time and between the intervention and control area on this topic, a slight increase in the

percentage of respondents who agreed that there are advantages to marry under 18 years can be observed in the intervention area. On the other hand, while the percentage of respondents who agreed that there are disadvantages to marriage under 18 years for young people remained stable in the intervention area, this decreased in the control area (Table 15).

There appears to be a more positive attitude regarding a girls' autonomy in marriage in the intervention area at endline, as compared to the control area. There is a decrease in the percentage of respondents who agreed that a girl should be allowed to choose for herself whom to marry from 95% at baseline to 75% at endline in the control area, while this remained stable around 90% in the intervention area. A similar trend can be observed for the percentage of respondents who believed that a girl should never be forced or compelled into marriage, which has decreased in the control area while it has increased in the intervention area (Table 15).

Despite these generally positive attitudes around the autonomy of young women in marriage, beliefs around gender roles within marriage remain conservative. Over 70% of the respondents in the intervention and control areas believe that a wife should be subservient to her husband at endline. However, this is a substantial decrease as compared to baseline, when 95% of the respondents in the intervention area and 97% of the respondents in the control area believed that a wife should be subservient to her husband. A similar trend can be observed for the percentage of respondents who believed that men should be the head of the household. At baseline, approximately 95% of respondents in the intervention and control area believed that men should be the head of the household, as compared to 88% (intervention area) and 76% (control area) at endline (Table 15).

The percentage of respondents in the intervention area who felt it is okay to physically punish a girl if she dishonours her family increased from 36% at baseline to 41% at endline, while it decreased in the control area from 44% at baseline to 24% at endline (Table 15).

Table 15 Attitudes on child marriage and gender roles in marriage

	Baseline		Endline	
	Intervention	Control	Intervention	Control
Respondents who agree with the following statements:				
There are advantages to marriage under 18 for girls	23 (3%)	27 (4%)	52 (7%)	25 (4%)
There are advantages to marriage under 18 for boys	21 (3%)	39 (6%)	69 (9%)	31 (5%)
There are disadvantages to marriage under 18 for girls	588 (87%)	573 (84%)	637 (88%)	522 (76%)
There are disadvantages to marriage under 18 for boys	567 (83%)	535 (79%)	585 (81%)	513 (75%)
A girl should be allowed to choose for herself whom to marry	613 (90%)	649 (95%)	635 (88%)	516 (75%)
A girl should never be forced or compelled into marriage	563 (83%)	589 (86%)	680 (94%)	532 (78%)
A wife should be subservient to her husband	643 (95%)	661 (97%)	520 (72%)	504 (73%)
Men should be the heads of their household	648 (95%)	637 (94%)	638 (88%)	519 (76%)
It is sometimes ok to physically beat or punish a girl if she dishonours her family	244 (36%)	298 (44%)	297(41%)	168 (24%)

3.6.5 INTER-LINKAGES BETWEEN MARRIAGE AND PREGNANCY

In the intervention area, the number of ever married teenage mothers between the ages of 15 and 19 years decreased from 55 to 25 (Table 16). At baseline, among female respondents in the intervention area who experienced both a teenage pregnancy and a child marriage at baseline, 43% experienced a child marriage first followed by a teenage pregnancy, 36% experienced both events in the same year, and 20% experienced a teenage pregnancy first followed by a child marriage. At endline, however, the majority of female respondents who experienced both events did that in the same year (50%) and only 13% (n=2) were child brides first before pregnancy.

A similar trend can be observed in the control area. Among female respondents who experienced both events, the percentage who were child brides first decreased from 45% at baseline to 0% at endline. The percentage who first experienced a teenage pregnancy followed by a child marriage increased from 9% (n=1) at baseline to 33% (n=2) at endline.

At baseline, ever married mothers were more likely to be married before becoming pregnant in both the intervention area (42%) and control area (44%), followed by a marriage and pregnancy in the same year (intervention: 31%, control: 35%) and were least likely to be pregnant before marriage (intervention: 26%, control: 21%). At endline, this shifted towards pregnancy before marriage (intervention: 46%, control: 47%) or pregnancy and marriage in the same year (intervention: 46%, control: 35%) (Table 16).

Table 16 Inter-linkages between marriage and pregnancy

	Baseline		Endline	
	Intervention	Control	Intervention	Control
Number of (ever) married teenage mothers (15-19 years) ¹	55	12	25	9
(Ever) married teenage mothers (15-19 years) who first experienced a child marriage followed by a teenage pregnancy	19 (43%)	5 (45%)	2 (13%)	0 (0%)
(Ever) married teenage mothers (15-19 years) who first experienced a teenage pregnancy followed by a child marriage	9 (20%)	1 (9%)	6 (38%)	2 (33%)
(Ever) married teenage mothers (15-19 years) who experienced a teenage pregnancy and a child marriage in the same year	16 (36%)	5 (45%)	8 (50%)	4 (67%)
(Ever) married mothers (15-24) who were first married and then became pregnant	72 (42%)	36 (44%)	13 (8%)	13 (18%)
Married mothers (15-24) who first became pregnant and were then married	45 (26%)	17 (21%)	73 (46%)	35 (47%)
Married mothers (15-24) who married and became pregnant in the same year	53 (31%)	28 (35%)	73 (46%)	26 (35%)

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

As was established at baseline, the interlinkage between marriage and pregnancy was explained in various ways. For example, a girl who gets pregnant is likely to be married off at whatever age and is likely to experience repeated teenage pregnancy by virtue of her age.

Sometimes age is not a factor here. You see when one is pregnant, she is married off consequently to her falling pregnant. (FGD, young women 15-19 years)

From the discussions, it was invariably clear that a girl who undergoes FGM/C is likely to get married as the next step in her life cycle. It seems that there was an agreement that FGM/C is a precursor to child marriage and teenage pregnancy.

FGM/C is a major challenge, because after the cut they feel real women and start engaging in sexual acts which in return leads to pregnancies and early marriages. (FGD, young men 20-24 years)

Pregnant young women are often married off by their parents. This was confirmed by the young women in the FGDs and other study participants including men, women, boys and community leaders. As indicated in section 3.5.4, it all depends on the parents and especially the father who may decide to (not) marry his daughter off.

Other parents will get her married, for example like my case when I got pregnant at the age of 15 years. I wanted to go back to school but my parents forced me to get married and that's what happened. (FGD, girls 15-19 years)

It [child marriage] still exists but it is reducing and the girls are also causing it because they get pregnant at an age of 16 and hence [this] leads to child marriage but [there is] no case where a girl is removed from school and married off. (IDI, social worker)

3.6.6 DECISION-MAKING DYNAMICS IN RELATION TO MARRIAGE, INCLUDING REFUSAL

There is an increase in the percentage of males and females who agree that their parents decide their future partner in both the intervention and the control area (Table 17). The increase is significantly higher in the control area versus the intervention area for females (OR: 0.4, p-value<0.001) but not for males (OR: 0.6, p-value=0.106).

	Baseline		Endline	
	Intervention	Control	Intervention	Control
Girls and young women (15-24 years) who agree that their parents or relatives decide their future partner	133 (26%)	113 (22%)	170(31%)	247 (47%)
Boys and young men (15-24 years) who agree that their parents or relatives decide their future partner	31 (18%)	37 (21%)	52 (31%)	83 (51%)

The survey results also suggest girls' and young women's increasing awareness of the circumstances of their marriage. A decreasing percentage of girls and young women (15 and 24 years) who were ever married felt like it was their choice to get married at endline as compared to baseline. This decreased from 44% at baseline to 38% at endline in the intervention area and from 63% at baseline to 44% at endline in the control area. There is no statistically significant difference between the control and the intervention area (OR: 1.8, p-value=0.122). Likewise, the percentage of girls and young women who felt pressured into marriage increased from 44% at baseline to 52% at endline in the intervention area, while it increased from 28% at baseline to 46% at endline in the control area. In line with these findings, an increasing percentage of girls and young women felt that it was not the right time to get married in both the intervention (baseline: 47%, endline: 66%) and the control area (baseline: 37%, endline: 58%).

Some participants spoke of young women being able to refuse forced marriages and instances where young women were consulted for their opinion in marital decisions, which represent remarkable improvements over the situation at baseline when young women had little autonomy. Although decision-making around child marriage was mostly vested in the parents and especially the father, there were reported instances of refusal of child marriage by the

girls. Some girls were reported to run away if they did not want to get married but rather continue with education. They run to the chief, their grandmothers or rescue centres. This was reported to occur mainly among girls who have some formal education or wanting to pursue education. There may also be instances where a girl runs away as a result of pregnancy. These views were reiterated by a wide range of stakeholders who stressed the role of parents in decision-making for the marriage of their daughters and sons, but also observed that there are some instances that may accord a girl decision-making power.

Girls are not given the privilege to make decisions and boys too, because culture perceives that if your father lives, you are not a man. (IDI, social worker)

The groom will not have influence because all the dowry is paid by the father.
(IDI, religious leader)

Marriage has changed currently: youth make decisions to marry.
(IDI, circumciser)

Girls are making the decision to marry.
(IDI, teacher)

In a few instances, it was noted that young women may decline going back to school after giving birth, choosing to get married due to peer pressure. The young women may choose to get married, especially if they saw their married friends being groomed and taken care of well by their husbands.

3.6.7 WAYS OR PROGRAMMES TO PREVENT CHILD MARRIAGE

One key aspect of the Yes I Do programming was to implement various interventions aimed at the prevention of harmful cultural practices that lead to child marriage. As discussed in section 3.2.3, the participants in the qualitative study component reported that through the efforts of various stakeholders, particularly NGOs, the church and community leaders, there has been an increased awareness on the dangers of child marriage. In one FGD with young men, it was reported that the Yes I Do programme has contributed to creating awareness of the negative consequences of child marriage and existing laws protecting girls' rights. Some chiefs were said to invoke the law and arrest perpetrators of child marriage. When a child marriage was cancelled, the concerned young women were taken to rescue centres where they could continue with education. During FGDs with young women, they observed that to prevent child marriage for girls, it was important to keep them in rescue centres as well as sustaining awareness creation within the community.

To educate the community on the dangers and the disadvantages of early child marriage.
(FGD, young women 15-19 years)

Questions were also raised about what should be done to curtail child marriage. Overwhelmingly it was argued that it is imperative to encourage parents to take their daughters to school and this could include parents supporting their daughters to go back to school after childbirth. Young women were quick to point this out, acknowledging that this was the case where parents are educated.

... there have been stories here and there of mothers volunteering to take care of their daughters' babies to give them a chance to go back to school. However, these phenomena are common in families where parents are educated. (FGD, young women 20-24 years)

The link between child marriage and FGM/C was cited and some participants thought that the programmes spearheaded by Amref (as part of the Yes I Do Alliance) have contributed to highlighting the plight of girls experiencing FGM/C and how this keeps them out of school. It was therefore argued that focusing on the abandonment of FGM/C is a way of curtaining child marriage. These sentiments were echoed by the community leadership as expressed in the following quotes:

... with the help of Amref, we have several families we have already reported due to FGM/C and child marriages and [they] have serious cases to answer and we are doing this to ensure that no girl misses her goal in life. (IDI, chief)

... the key ways to end child marriage is by eliminating certain cultural activities like FGM/C that provoke early marriages. The other way is sensitizing the community about the negative effects of early marriages. (IDI, religious leader)

... education is the main thing that can finish child marriage. Also, eradication of FGM/C and other cultural activities like some ceremonies. (IDI, youth leader)

An important point to note came from one of the young women, who indicated that to curtail child marriage it would be important to guide young women presumably by providing information and creating awareness, but also facilitating the use of contraceptives among sexually active young women.

3.7 FEMALE GENITAL MUTILATION/ CUTTING

3.7.1 PREVALENCE, CIRCUMSTANCES AND ATTITUDES AROUND FEMALE GENITAL MUTILATION/ CUTTING

The quantitative data show that over the study period, the percentage of girls and young women who were circumcised remained relatively stable in the intervention area (58% at baseline; 59% at endline) while in the control area, a marginal reduction of 4% occurred over the period (Table 18).

	Baseline		Endline	
	Intervention	Control	Intervention	Control
Girls and young women (15-24 years) who underwent FGM/C	292 (58%)	233 (46%)	326 (59%)	208 (40%)
Girls and young women (15-24 years) who want their daughters to be circumcised	28 (6%)	24 (5%)	25 (5%)	34 (7%)
Unmarried boys and young men (15-24 years) who prefer a non-circumcised partner in the future	102 (62%)	87 (52%)	81 (57%)	103 (69%)

The reported high practice of FGM/C in the intervention area seems to agree with the attitude towards the practice. FGM/C is still considered to be the social norm by 59% of girls and young women in the intervention area at endline, a decrease as compared to baseline (68%).

Nonetheless, the vast majority of girls and young women in the intervention area did not want their daughters to be circumcised (5%), yet this percentage did not change as compared to baseline (6%) (Table 18). What has changed, is the belief that circumcision increases the chances of marriage, which is confirming the qualitative narratives. At baseline, 36% of the girls and young women in the intervention area believed that circumcision has no implications on their chances of marriage as compared to 60% at endline, while no change was observed in the control area (baseline: 49%, endline: 51%).

In addition, the percentage of female respondents who felt good about their circumcision decreased considerably from 55% at baseline to 16% at endline in the intervention area and from 56% at baseline to 17% at endline in the

control area. In addition, there is a statistically significant decrease in the percentage of unmarried boys and young men aged 15 to 24 years who preferred a non-circumcised partner in the intervention area over the control area (OR: 0.5, p-value<0.05). The percentage of unmarried boys and young men (15-24 years) who preferred a non-circumcised partner in the future reduced by 5% in the intervention area and increased with 17% in the control area between base- and endline (Table 18). Despite the persisting practice of FGM/C in both areas, there seems to be a considerable shift in the circumstances of circumcision from ceremonies to secrecy. While at baseline, the vast majority of circumcisions were performed during a ceremony in both the intervention area (83%) and the control area (68%), at endline, the percentage of females who were circumcised during a ceremony decreased considerably to 41% in the intervention area. Similarly, in the control area, 69% of the females were circumcised secretly at endline, an increase of 40% since baseline (29%). Over all, the majority of circumcisions were reportedly performed secretly (57%).

3.7.2 AWARENESS ON CONSEQUENCES OF FEMALE GENITAL MUTILATION/ CUTTING

Most respondents reported being aware of the negative consequences of FGM/C. In an FGD with young men (20-24 years), they reported that girls from other communities, who are not circumcised, perform better in their education than the girls from their community (who are circumcised). They also noted that after girls are cut, they begin to engage in sexual activity whereby they could become pregnant and probably end up in child marriage. In an FGD with young women (15-17 years), it was reported that girls who are cut are likely to bleed heavily during childbirth.

The Yes I Do Alliance partners were reported to have made a contribution towards creating awareness on the consequences of FGM/C by conducting community sensitization meetings, and training of local leaders such as chiefs and religious leaders. In an IDI with a 20-year-old woman, NAYA and Amref were mentioned.

M: What organizations are campaigning against these practices in this community?

R: NAYA, and other NGOs like Amref.

M: What difference is caused to the community as according to their campaign?

R: FGM/C is decreasing to an extent that it's practiced under waters now.

The chiefs are sensitizing on the effects, the church too is enlightening the community, and the governmental laws are also being enforced to them that still practice.

(IDI, youth Leader)

People especially from this organization like Plan are telling the members of the community to stop FGM/C. (FGD, young women 20-24 years)

It was well known among boys and girls and young men and women in the intervention and control area that FGM/C is against the law, with little variation between base- and endline. However, knowledge on specific consequences of FGM/C seem to have decreased, especially in the intervention area. A minority of girls and young women believed that FGM/C can cause menstrual problems. This decreased from 21% at baseline to 16% at endline in the intervention area, while a negligible increase from 24% at baseline to 26% at endline is observed in the control area. The percentage of girls and young women who knew that FGM/C can cause fertility problems decreased the most, from 39% at baseline to 17% at endline in the intervention area and from 43% at baseline to 30% at endline in the control area. Knowledge of sexual problems (baseline: 41%, endline: 31%) and problems with labour (baseline: 50%, endline: 39%) as a consequence of FGM/C decreased with approximately 10% each in the intervention area, while knowledge on sexual problems slightly increased (baseline:37%, endline: 44%) and problems with labour remained stable (baseline:57%, endline: 57%) in the control area. Finally, while knowledge on school dropout and child marriage as consequences of FGM/C increased among girls and young women in the control area, no changes were observed in the control area.

3.8 EDUCATION AND ECONOMIC EMPOWERMENT

3.8.1 ACCESS TO (HIGHER) EDUCATION AND ECONOMIC OPPORTUNITIES

The quantitative analysis shows a reduction in the percentage of young women aged 15-18 years currently attending secondary school from 34% at baseline to 18% at endline in the intervention area while registering an increase of 13% from 42% at baseline to 55% at endline in the control area (Table 19).

Table 19 Education and economic empowerment				
	Baseline		Endline	
	Intervention	Control	Intervention	Control
Education				
Girls aged 15-18 currently attending secondary school	94 (34%)	126 (42%)	48 (18%)	172 (55%)
Girls aged below 18 years who dropped out of school	45 (18%)	19 (8%)	24 (11%)	26 (10%)
Girls below 18 years who left school due to marriage	8 (3%)	0 (0%)	0 (0%)	0 (0%)
Girls below 18 years who left school due to pregnancy	28 (11%)	12 (5%)	15 (7%)	11 (4%)
Girls (15-18 years) who have a child and follow education	25 (43%)	14 (67%)	8 (23%)	3 (20%)
Boys below 18 years who left school due to marriage	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Economic empowerment				
Young women (18-24 years) who are economically active outside of the household	56 (22%)	53 (20%)	84 (26%)	69 (26%)
Young women (18-24 years) who have received any income in the last six months	108 (43%)	77 (29%)	193 (59%)	153 (58%)
Young men (18-24 years) who are economically active outside of the household	35 (42%)	21 (20%)	71 (59%)	43 (43%)
Young men (18-24 years) who have received any income in the last six months	44 (52%)	31 (29%)	92 (76%)	70 (70%)

For girls aged below 18 years who dropped out of school, the converse happened between intervention and control areas: while the data show a 7% reduction in the percentage of those who dropped out of school in the intervention area, the control area registered a marginal increase of 2% (see Table 19). In addition, while the percentage of girls below 18 years who left school due to marriage remained stable over the time period of this study, those who left school due to pregnancy marginally reduced by 4% and 1% in the intervention and control areas respectively. Similarly, there is a significant decrease in the percentage of young women (15-18 years) who have a child and follow education over time in both the intervention and control areas, and the biggest change occurred in the control area (47% reduction). No boy or young man had to leave school due to marriage within the entire study period (Table 19).

With regard to economic empowerment, there is a 4% increase in the percentage of young women (18-24 years) who were economically active outside of the household in the intervention area as compared to a 6% increase in the control area between base and endline. For young women (18-24 years) who have received any income in the last six months, there were significant increases in both the intervention area (16%) and even more pronounced in the control area (29%) between baseline and endline. In the case of young men (18-24 years), the data show large increases in the percentage of those who were economically active outside of the household (17% in the intervention area; 23% in the control area) and those who have received any income in the last six months (24% in the intervention area; 41% in the control area) between base- and endline (Table 19).

3.8.2 SAFETY AT SCHOOLS

The endline participants spoke less about school safety, but those who did, reported that schools were becoming safer for both boys and girls. The concerns about safety were more outside the school environment: having to walk long distances to school, roads that were bushy, and the use of boda-boda riders who may entice girls into sexual activity. Some participants spoke about the availability of more schools as a relief to parents who no longer have to send their children far away for education, contrary to the situation at baseline. Importantly, young women acknowledged that they are being allowed to go to school just like young men do, which further suggests improvement in school safety for girls.

Schools are accessible to the children; quality is somehow low and [they] are safe.
(IDI, social worker)

... because the boda-boda riders sometimes lure girls by giving them lifts to school.
(FGD, young men 20-24 years)

3.8.3 ACCESS TO ECONOMIC EMPOWERMENT OPPORTUNITIES

The Maasai rely on pastoralism as the mainstay of the economy. Thus, the main source of income is sale of livestock. There is also diversification of income sources from sand harvesting and marble stones at KMQ. Boda-boda business has increasingly become one of the main sources of income as the demand for transport has increased. Participants reported very limited economic opportunities for women – they were largely engaged in beadwork and the sale of milk as petty trade. Men were reported to be more engaged in livestock trade. The contribution of the Yes I Do programme to the economic situation was not apparent as the situation did not seem different from the baseline. It seems the programme did not implement varied activities aimed at economic empowerment besides the Village Savings and Loan Associations (VSLAs).

First, our women are not employed and don't own anything for income. Therefore, its only men who own cows, sheep and goats. That's what their families depend on to feed and pay school fees for their sons and daughters. There is not any other income other than livestock. (FGD, male parents)

Overall employment opportunities were limited and this was clearly illustrated in the FGDs and interviews. Young men explained how they took advantage of education only to be disappointed by lack of employment after completion. Being mainly a rural setting, employment opportunities were very limited. A religious leader summarized the situation:

We are also getting many students joining universities, a sign of quality education. The only challenge is lack of jobs for those completing their universities and colleges. (IDI, religious leader)

Relative to the baseline, positively, the narratives also show that more young people (males and females) are now going to school and completing secondary or college education with the hope of accessing employment opportunities. However, the lack of employment was a major discouragement to taking children to school. Education was seen to drain families without any return. This situation was well articulated in a FDG with young women.

Some parents are even convincing their sons and daughters to get married early since going to school and incurring all the education costs seems not to bare any benefits. These statements have since appeared to be true since none of those who have completed their education like undergraduate level, all have no jobs.
(FGD, young women 15-19 years)

The percentage of young women and men in the intervention area who believed that economic empowerment is a solution against child marriage was 76% at baseline but only 38% at endline. In the control area on the other hand, this percentage slightly increased from 48% at baseline to 55% at endline.

3.9 POLICY AND LEGAL ISSUES

3.9.1 KNOWLEDGE AND AWARENESS OF LAWS

The vast majority of marriages are not registered, and where a marriage is registered it usually entails a religious registration and rarely a statutory registration. Registration of marriage has decreased among females in the intervention area from 31% at baseline to 17% at endline, as compared to a slight increase among females in the control area from 24% at baseline to 27% at endline. Among the few females whose marriages were registered, there is an increase in the percentage of females with a copy of their marriage certificate from 16% at baseline to 44% at endline in the intervention area, compared to a slight decrease in the control area from 50% at baseline to 44% at endline.

3.9.2 LOCAL LAWS AND POLICIES

The participants of the qualitative study component repeatedly mentioned laws and policies protecting girls' rights, including the Children's Act, the return to school policy, anti-FGM/C laws and the 100% transition from primary to secondary school.

One of the laws is the children's act 2001, which states that FGM/C is a crime. (KII, religious leader)

Unlike the situation at baseline when there was little to say about the implementation of these laws, there was evidence that the laws and policies are being implemented, including reported instances of arrest of parents and circumcisers over FGM/C and child marriage. The qualitative narratives show that during the life of the Yes I Do programme, Kajiado County developed an anti-FGM/C policy together with stakeholders working in the county – specifically, the Yes I Do alliance's role in the development of the County policy was repeatedly acknowledged. In addition, there was evidence of clear commitment towards the implementation of the County policy on FGM/C. Nonetheless, others raised concerns about implementation and the need for follow-up to ensure that all stakeholders and partners are engaged.

Yes, laws are there but people break the laws they make. No one is pushing these laws into implementation.
(IDI, social worker)

We need to bring everybody on board, partners on board, implementation of the law, the FGM/C policy which was launched in November last year in the county, we need to refer to these and work with the County government and make sure that this policy is implemented and that communities are taken through this.
(KII, NGO partner)

Key informants were also aware of the existing laws but noted that enforcement of the laws is a major challenge. With regard to enforcing laws related to FGM/C, one of the key informants expressed the view that sensitization should continue so that people will see the need of stopping the practice other than the laws forcing them, citing other cultural practices that they have eliminated by themselves.

Policy makers from the health, education and social services sectors spoke openly about supporting SRHR of young people and gender equality. For example, health policies support access to SRH services by young people, health workers provide education on the negative consequences of FGM/C and teenage pregnancy, and education policies support young peoples' education and a 100% transition from primary to secondary school. Participants spoke about advocacy on existing national policies and laws on FGM/C and child marriage and support for girl's education, and this seems to have opened up discussions on gender equality at the community level.

Notwithstanding the seemingly breakthrough in gaining support for gender equality, other participants spoke about unequal treatment of boys and girls among the Maasai community and added that gender-based violence is often meted out to girls and women. An interview with a social worker demonstrated that within the Maasai community, a girl is generally demeaned and only valued as an object for marriage. It was also observed that practices such as FGM/C only cement the low status of women as FGM/C can lead to child marriage.

In terms of treatment of the boy-child and girl-child, it was indicated that there is more favouritism towards boys than girls. This was observed in the attention to education. When there is a decision to be made regarding education against scarce resources, the tendency is to choose to send the boy to school and leave the girl at home. However, different participants reported the changing trend where the education of the girl-child is beginning to receive equal attention as the education of boys.

4. DISCUSSION

In this section, we discuss the key findings of the study. The study aimed to provide insight into the (interrelated) causes and effects of child marriage, teenage pregnancy, FGM/C and the extent to which these causes and effects, and the three issues are present in the intervention area of the Yes I Do programme in Kenya, compared to the control area, over a period of four years. In addition, the endline study aimed to provide insight into the different pathways of change, thereby testing the ToC, 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, teenage pregnancy and FGM/C in the intervention area compared to the control area. 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, first, we summarise the findings on the three main impact indicators of the Yes I Do programme: child marriage, teenage pregnancy and FGM/C.

4.1 CHILD MARRIAGE REDUCES BUT TEENAGE PREGNANCY AND FEMALE GENITAL MUTILATION/ CUTTING CONTINUE TO PERSIST IN KAJIADO COUNTY

There is a statistically significant decrease in the prevalence of child marriage among women aged 18-24 years in the intervention area (from 30% to 16%) compared to the control area. However, at baseline, the control area already had a lower prevalence of child marriage among women aged 18-24, (11%) and hence saw a slight decrease over time of 2%. In addition, in both the intervention and control areas, there was a significant decrease in the percentage of married females who believed it was their choice to be married. This was reflected in the qualitative findings which show an increased community understanding of the negative consequences of child marriage and a general agreement across men, women, girls, boys and gatekeepers that there are no benefits of child marriage. This views could be attributed to information received through the Yes I Do programme. Such positive changes in line with the assumptions of the Yes I Do ToC have not been observed regarding teenage pregnancy and FGM/C. Rather, the endline data show that teenage pregnancy is more prevalent in the intervention area as compared to the control area and remained stable in both areas over time. Similarly, the percentage of girls and young women who were circumcised in the intervention area remained relatively stable (58% at baseline; 59% at endline) while in the control area, a marginal reduction of 4% occurred over the period of four years.

Child marriage seems to be an 'easy pick' issue, amenable to change and can be the most important contribution of the Yes I Do programme in Kajiado West sub-county. Compared to teenage pregnancy and FGM/C, the fight against child marriage enjoys high-level political commitments at the continental and the national levels. The African Union (AU) launched the first-ever Campaign to End Child Marriage in Africa in 2014 (AU, 2014), and since then, most countries have taken practical steps towards ending child marriage. In 2017, Kenya became the 19th country to launch the AU Campaign to End Child Marriage in Africa. The National Plan against Sexual Exploitation of Children in Kenya (2018-2022) recognises child marriage as a harmful practice that contributes to child sexual abuse and exploitation, and outlines activities to engage men as community champions in reducing child marriage. These political commitments seem to have provided an enabling environment for programming around child marriage, unlike teenage pregnancy and FGM/C. However, child marriage and FGM/C are both harmful practices which hold back many women and girls throughout their lives and where the two exist together, the impact on girls' lives is even greater (Population Council 2018). The dynamic between child marriage and FGM/C is such that both share the same drivers and where one harmful practice is successfully eradicated, the other practice may still be retained (World Vision 2014). Therefore, albeit the reduction in child marriage, the ToC assumption that "only a combined approach of strategies will reduce child marriage, FGM/C and teenage pregnancy" holds. It remains imperative that future campaigns and programmes on FGM/C continue to tackle child marriage, and vice versa.

Teenage pregnancy can be addressed through expanding adolescents' access to SRH information and services. However, there has been a significant decline in the utilisation of SRH services (ever use) in both the intervention and control area among males and females between baseline and endline. Evidence shows that SRHR interventions targeting young people have shown success in improving SRHR knowledge and attitudes, but this is not likely to translate into a reduction in teenage pregnancy and incidence of HIV/AIDS. It has been suggested that i) improvements in SRHR knowledge and attitudes may not necessarily lead to change in sexual behaviour; ii) the sexual behaviour changes observed may

be below the threshold level required to result in the desired significant change on the biological measures such as teenage pregnancy, iii) interventions may require a longer implementation period so as to achieve a positive effect, and iv) social, cultural and economic factors around adolescent sexual health play a major role in the sexual behaviour of young people and these have not been well articulated in the design of most interventions (Harrison et al. 2010; Michielsen et al. 2010). An important outcome of the Yes I Do programme towards teenage pregnancy is that for young women who get pregnant, they do not necessarily have to get married, as was previously the case. Rather they have the option of “picking up” themselves and going back to school after childbirth as reported in this study.

Exposure to the Yes I Do programme was relatively low in the intervention area. Close to three out of 10 young people interviewed during the endline had heard of the programme and close to two out of 10 had ever participated in programme activities. It is unclear why we observe low participation in the programme, but Kajiado West sub-county is very vast and coverage of the programme could therefore have been limited. It suggests the need for careful consideration of the demographic factors of the Maasai settlements, including the pastoralist lifestyle in programme design to ensure full coverage. Similarly, resource implications for implementing a programme in the Maasai setting require careful consideration. Understanding the broader applicability of these lessons to future programmes is the next challenge for the Yes I Do partners.

During the endline report validation process, it became clear that similar programmes such as the Yes I Do were implemented in the control area by other partners, which could partly explain the observed reduction of teenage pregnancy in the control area. In addition, the control area (Kajiado Central sub-county) seems to be more urbanised, closer to services and the population may be more exposed to media messages as compared to the intervention area of Kajiado West which is more rural, has fewer development partners and limited services. These socio-demographic differences can also partly explain the reduction of teenage pregnancy in the control area. Although in a real-world complex intervention such as the Yes I Do programme, preventing ‘contamination’ is not always possible, the findings suggest the need for future programmes to carefully select the control area to ensure that it consists of elements that present exactly the same characteristics of the intervention area, except for the exposure to interventions in the latter (Kinser & Robins, 2013).

4.2 PATHWAY 1 – COMMUNITY MEMBERS, GATEKEEPERS AND OTHER STAKEHOLDERS HAVE CHANGED ATTITUDES AND TAKE ACTION TO PREVENT CHILD MARRIAGE, TEENAGE PREGNANCY AND FEMALE GENITAL MUTILATION/ CUTTING

Under pathway 1 of the Yes I Do ToC, the endline study aimed at exploring changes in attitudes of community members and gatekeepers towards child marriage, teenage pregnancy and FGM/C, the extent to which they take action to prevent these practices, and identifying factors that influence this over a four year period. Programme activities were geared towards the formation of a social movement capable of transforming the norms perpetuating the three issues. From the findings, there are signs that a social movement is beginning to establish and a collective actions of different stakeholders is beginning to yield dividends for girls and young women. For example, the Maasai community is now embracing formal education for both girls and boys compared to the situation at baseline. There is a change in the perception and value placed on education among girls and boys, community members and gatekeepers. These changes could be attributed to the Yes I Do interventions as well as the enforcement of government policy by traditional leaders resulting in changes in social norms around girls’ education (Parsons et al. 2015). Various gatekeepers, including traditional leaders and religious leaders, are sources of education and information on the negative effects of these practices (child marriage and FGM/C), as well as providing a “to run to” environment for girls and young women who are escaping FGM/C and child marriage. In particular, chiefs were said to be instrumental in rescuing young women who have been married off by their parents as well as enforcing the return to school policy for young mothers. This is also in line with the findings of the mid-term evaluation of the Yes I Do programme where positive changes regarding girls’ education were reported (Gitau et al. 2018). Evidence indicates that one more negative impact of child marriage is the less likelihood of girl brides completing their secondary education and it is concluded that one of the best ways of delaying marriage is keeping girls in school (Quentin et al. 2017). Thus, the renewed emphasis on keeping girls in school might have contributed to the observed reduction in child marriage.

The endline study shows that unintended teenage pregnancy continues to be a problem in both the intervention and control areas. The percentage of teenage mothers who wanted to become pregnant when they did decreased considerably from 74% at baseline to 37% at endline in the intervention area and from 78% at baseline to 45% at endline in the control area. While this decrease is statistically significant in the intervention area, the difference in the trends between intervention and control is not significant. This change in the perception towards unintended teenage pregnancy could be attributed to increased knowledge and the realisation of the negative consequences of teenage pregnancy among teenage mothers such as dropping out of school, child marriage and feelings of shame and embarrassment. In spite of this change in attitude, teenage pregnancy remains a concern. This shows that although the young women are aware of the negative consequences of teenage pregnancy, they are still vulnerable to unintended teenage pregnancy. The knowledge received by young people is good but it does not fit in the social environment where they can have open discussion with others. This is seen from the sleeping arrangements, the cultural practice of FGM/C and the community's negative view of the use of contraception by young women. From the local context, teenage pregnancy seems accommodated so long as the young woman involved has gone through FGM/C cultural practice. This is unlike in other communities where pregnant girls might be reprimanded or punished (Maly et al 2017). Under such circumstances, enhanced knowledge alone is not enough.

The results of this study show that the practice of FGM/C continues as a social norm, though largely done in a clandestine manner. The percentage of girls and young women circumcised in the intervention area remained the same between base- and endline. However, there has been a positive change in the belief that circumcision has no implication on marriage from 30% at baseline to 60% at endline; and fewer young women feel good about their circumcision status. On the contrary, there is a statistically significant decrease in the percentage of boys and men aged 15 to 24 years who prefer a non-circumcised girl in the intervention area over the control area. This shows that FGM/C continues to be highly valued among the Maasai community and hence the demand for the practice among women and girls is still high because of the pressure to conform to traditional social norms. Men and boys still push girls to undergo the practice by continuing to prefer to marry young women who have undergone FGM/C. There has been some change in the action taken by gatekeepers on circumcisers or parents who circumcise and marry off their teenage daughters. The local administration represented by the chiefs, religious and traditional leaders have undergone sensitization on the anti-FGM/C law, by local government agencies and NGOs including the Yes I Do partners. This has led to actions such as arrests of parents and/or circumcisers and rescuing of girls from child marriage. Therefore, there seems to be an increased awareness about the illegality of FGM/C and the need to stop the practice, which is in line with the ToC assumption that "through rights awareness and alternatives, people will take action to change their social environment". However, despite the punitive actions, the community still perceives the practice to be of value. Due to the fear of the law and as a way of evading the law, FGM/C practice has been driven underground; largely performed in secrecy. Whereas there is awareness and readiness to abandon FGM/C, social norms favour the status quo and hence individuals are reluctant to stop the practice as they perceive that there is a social price to pay. There is therefore a need for more in-depth discussion beyond the illegality of the practice. While laws are essential, they may not solve problems that are embedded in culture. Meaningful engagement of boys, parents (men and women) and other gatekeepers such as chiefs and religious leaders, with clearly defined intervention activities is likely to produce some positive results. In addition, interventions such as the Alternative Rites of Passage (ARPs), which address FGM/C from a cultural perspective could also be more promising in providing alternatives to initiation into adulthood by Maasai girls (AHA, 2020).

A report by World Vision International (2011) has emphasised the importance of recognising that stopping FGM/C is rarely a community priority and it is often seen as a foreign as well as an intrusion to the community's values and norms. It is therefore important to ensure that FGM/C abandonment efforts are integrated into development programmes addressing priority needs of the community. For example, the Maasai of Kajiado West are a pastoralist community where water is a scarce resource. Having a water and sanitation project that includes aspects of sensitizing the community on the negative effects of FGM/C as well as the importance of girl child education may create an avenue where the community may begin to "listen". It is also important to ensure that FGM/C activities are community-led, using local resources to enhance ownership and allow community members to draw their own conclusions (World Vision 2011). During the validation process, it became clear that Amref was implementing a water and sanitation project in Kajiado Central sub-county that has a component of abandonment of FGM/C, which seems to be having a positive impact on FGM/C abandonment in the control area of this study. Implementation of community-based

programmes that have a positive impact on the livelihood of the community members, as an addition, helps meet community needs and build trust among community members, who are then likely to regard the information provided on FGM/C and other harmful practices to be of good intention (UNICEF 2010).

Table 20 Recommendations – Pathway 1

Programme
The abandonment of FGM/C and child marriage is rarely a priority of communities who value the practices as social norms. FGM/C and child marriage abandonment efforts should therefore be integrated into community development programmes such as on water, sanitation, education or health care. This will help to build trust of the community towards information provided by the programmes. There is a need to use local resources in the fight against FGM/C and child marriage, e.g. by educating traditional leaders, religious leaders, parents, teachers, young women who have grown up in the community and succeeded (in marriage or financially) without having gone through the cut, or fathers who have decided not to circumcise their daughters; and involve them as local champions. In-depth discussions and community dialogues with the key stakeholders of the local community should go beyond threats and the illegality of the practice because while laws and policies are essential, they may not solve problems that are embedded in culture. In this regard, interventions such as ARPs, which take a more traditional approach, are recommended.
Research
Research is needed on the role of other physical community development projects in stimulating or facilitating change of social and cultural norms and practices while building on the positive drivers of social change such education, health, improved livelihood. Furthermore, future research could investigate the effectiveness of multifaceted / multicomponent approached in addressing embedded socio-cultural norms and practices using an insider focus.

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 programme aimed to increase the level of meaningful engagement of adolescent girls and boys in community activities, programmes and policies – thereby claiming their rights. Related to this is pathway 3, about adolescents taking informed action on their SRH.

From the qualitative interviews, there was minimal active engagement of men and boys in strategies to reducing teenage pregnancy, child marriage and FGM/C. Male participants often highlighted what should be done as opposed to what they were actively engaged in to reduce these harmful practices. However, other results show that there is some positive change in the communication between youth and their elders, whereby young people are given an opportunity to speak out about their concerns during community gatherings and political meetings. This gives an opportunity for young people to air their concerns, mainly social and economic – on jobs, allocation of resources by the county government for youth projects. On the other hand, the social norm around intergenerational dialogues continues to reflect the traditional expectation of limited interaction between elders and younger persons. The Maasai community embraces the culture of having community members clustered into age sets, whereby open communication between older and younger age sets is limited. Communication between younger men and their elders remains largely influenced by the social norm of respect of their elders which negates open discussion between the two with older men wielding more power over younger men.

Quantitative findings also show that discussion of sensitive issues between young people and their elders remains a challenge. If a young person utters a sexual word in front of elders, they are said to be disrespectful and undisciplined. Quantitative data also show that only 6% of girls and young women are able to discuss gender equality and girls' rights with adult men. Topics such as dating, relationships, sexuality and sexual health were less likely to be discussed with parents and especially parents of the opposite gender. The results also show that youth are more comfortable discussing sensitive issues with young people of their own age and gender. Adolescent-parent communication has been reported to be a challenge especially around sensitive issues (Kamangu et al. 2017). Similar findings are reported in this study, whereby although young people expect to get SRH information from their parents (girls from mothers and boys from fathers), discussion around sensitive issues with parents was limited. The finding suggests that there are still barriers in terms of adult-young people engagement on issues related to SRH. Therefore, there is a need to encourage engagement by creating neutral platforms facilitated by community healthcare providers and/ or social workers. This will help to create awareness and bridge the communication and interaction gap by emphasising the importance of effective engagement among adolescents and their parents on matters related to risks associated with sexual behaviours and erroneous reproductive health choices (Motsomi et al. 2016).

While community youth clubs were not prominent in the intervention area, there were youth self-help groups which were geared towards economic empowerment such as selling and buying livestock and sand harvesting; the proceeds of which were used for education and health care. It is unclear why such youth groups were not linked to the Yes I Do Programme. Programme staff who participated in the study spoke about school clubs that were implemented by the alliance partners (Ujamaa was frequently mentioned), including organising refresher training to evaluate the retention and application of skills taught in the clubs. They also spoke about how they linked community advisory teams to the government led Area Advisory Councils, as well as linking beacon teacher movements to the county and national beacon teacher's movement. However, the level of engagement of such groups in advocacy for prevention of pregnancy, child marriage or FGM/C was not apparent. From the teachers' perspective, school youth clubs were said to be inactive as the emphasis in schools was mainly on completion of the education curriculum and academic preparedness for exams; the emphasis on sexuality education was not taken seriously since the subject is not examinable.

ACCESS TO AND UTILISATION OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS INFORMATION AND SERVICES

The study shows a significant increase in the percentage of girls and young women who have ever received education about sexuality and sexual health in both the intervention area (from 52% at baseline to 73% at endline) and the control area (from 62% at baseline to 74% at endline). In the qualitative narratives, the school was reported to be a source of SRHR information by both female and male participants. In the schools, the information is provided by teachers who are responsible for guidance and counselling, student role models and invited speakers. Other sources of information include churches, health facilities, and NGOs. The Yes I Do Alliance was also mentioned by young females and males as a source of information.

The findings show an enhanced access to SRHR education and information, yet the percentage of female respondents who knew at least one modern method of contraception in the intervention area remained unchanged (57% at baseline and 56% at endline). Among male respondents, there was a slight increase from 53% at baseline to 59% at endline. In the control area, there was a slight increase among both females (50% to 56%) and males (54% to 67%). The female respondents in the control area seem to have had more exposure to information on contraception than the females in the intervention area, largely due to the aforementioned reasons, including the demographic advantage of the control area.

Abstinence was the most commonly known way of pregnancy prevention by young people in the intervention area (65% at baseline and 63% at endline). However, knowledge of condoms, injectables and pills as contraceptive methods increased between baseline and endline and yet there has been a 10% reduction on the use of contraception among females (15-24 years) who had ever had a child between baseline and endline in both the intervention and control area. This could be because girls and young women with pregnancy experience have ended up in marriage, where they might have the expectation that within marriage, one does not need to use contraception. The most common

contraceptive method used among females was the injection. This is in line with the data in the KDHS (2014) where it was reported that the injection is the most common type of contraceptive method used; with 26% of currently married women using the injectable (KNBS IFC Macro, 2014). The data also show a positive change in females' perceptions of accessing contraceptives, especially in the intervention area, where the percentage of females who believed one can always access contraceptives increased from 23% at baseline to 34% at endline. In addition, the percentage of females who believed that one can never access contraceptives declined from 13% to 3%. This was despite the community's negative perception that young women who use contraception are of low moral values. A study conducted in Ethiopia on condom use among single young men found that young men who were likely to use a condom at last sex were those who knew of a friend who had used a condom and young men who were not worried of what the community would think of them if they were found using condoms (Jain et al. 2018). Programmes that advocate for condom use and contraceptives in general should therefore include aspects of addressing community social norms that hinder condom use and build on the social environment that facilitates condom and contraceptive use.

There has been a significant decline in the utilisation of SRH services (ever use) in both the intervention and control area among males and females between baseline and endline. Despite the decline, the percentage of young people who had ever accessed SRH services in the intervention area was slightly higher than in the control area. The most commonly SRH services accessed were VCT in both the intervention and control area, followed by family planning. There was also a significant reduction in use of life skills, sexuality education and antenatal and postnatal care. Lack of knowledge about existing services, not having the need to go for the services and never thinking about the services were some of the reasons why young people have never used services. These findings suggest that the ToC assumption of meaningfully engaging young people as pre-requisite for increased access and uptake of quality SRH services and information was not fully met. During the interviews, it became apparent that the Yes I Do programme in Kajiado West did not focus on increasing young people's access to SRH services hence it is not possible to attribute the effect of the programme activities on SRH service use by young people. The finding raises questions about the implementation fidelity of the programme since access to services was one of the pathways of change of the programme's ToC.

Table 21 Recommendations – Pathways 2 and 3

Programme
<p>Interventions addressing the SRHR of young people need to be broad based and take into consideration the social, cultural and economic context of young people, and should be implemented over a sufficient period of time in order to illicit observable change.</p> <p>Meaningful youth engagement needs to have a more structured approach with specific intervention activities on gender and sexual health. Schools are a major sources of sexuality and sexual health information for young people and hence there is a need to strengthen school programmes including the role of the teachers, peer educators and youth clubs. Existing community structures should be used to enhance parent-adolescent communication and parents should be given accurate and appropriate information so that they can effectively communicate to their adolescent girls and boys.</p>
Research
<p>There is a need for further research to explore social, cultural, religious and economic factors that facilitate or hinder access to and utilisation of SRH information and services.</p>

4.4 PATHWAY 4

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

Pathway 4 of the Yes I Do programme focused on promoting education and economic empowerment for adolescent girls and boys and young adults by exposing them to alternatives beyond child marriage and teenage pregnancy. Regarding education, the endline study found that instead of an expected positive trend in the intervention area resulting from the implementation of the Yes I Do programme activities, the percentage of girls who were currently attending secondary school decreased from 34% in 2016 to 18% in 2020. An increasing trend was observed in the control area, where girls currently attending secondary school increased by 13% over the past four years. There was also a reduction in the percentage of girls who have a child and follow education in both intervention and control areas, but the biggest change occurred in the control area (50% reduction).

It is unclear why there is no effect of the Yes I Do intervention on stimulating education as an alternative beyond child marriage and teenage pregnancy. However, the reduction in the percentage of girls leaving school due to marriage or pregnancy in the intervention area as compared to the control area is an important positive development. Further, survey respondents reported that more young people (females and males) attend school and complete secondary or college education with the hope of brightening their employment opportunities. The qualitative narratives support these positive developments in education as participants reported that girls felt safer in schools. However, as was reported during the midline study, concerns about girls' safety when travelling to and from schools because of the long distances, roads being too bushy, and the possibility of boda-boda riders enticing girls into sexual activity remain. The endline results show that compared to young women, no young man had to leave school due to marriage or making a young woman pregnant in both study areas, which suggests that despite progress, inequality in access to education in terms of retention and successful outcome is still the reality for many Kenyan girls. Many young women are forced into child marriage, experience FGM/C and sexual exploitation, among other concerns, and they all lead to young women inability to achieve education. A recent qualitative study involving participants of four counties reported that socio-cultural and economic factors contributed to girls being out of school, especially in rural communities where cultural practices including FGM/C and early forced marriages are persistent (Mwakio 2017). The author added that poverty was frequently mentioned by participants as affecting girls' education, because many young women drop out of school to find jobs to meet their basic needs.

Regarding economic empowerment as an alternative to child marriage and teenage pregnancy, again, the endline data do not point to the Yes I Do programme having made a difference. Rather it seems there is a general improvement in the economic outlook for young women in the Maasai communities in the Kajiado County. Young women (18-24 years) reported improvement in being economically active outside of the household and in receiving income in the last six months preceding the survey. Less surprisingly, young men (18-24 years), were more economically active outside of the household and compared to females, more males received income in the last six months. These findings mirror what has been extensively reported in the literature regarding the socio-economic status of young women or women in general. Across the developing world, the majority of young women are working in the informal sector or are engaged in care work, where the work is invisible and unpaid (Taylor and Perezniето 2014). Initiatives such as revision of regulations to increase women's participation in the labour market; skills training; policy reforms on regulations that hinder young women's empowerment; setting up of micro-credit schemes; use of technology to access markets such as mobile phones to release women's time in caring and domestic work; fostering of partnerships by providing funding to women; cash transfers and welfare fund; subsidised or publicly provided child care as well as improving infrastructure services such as water and electricity have been noted to improve women's economic empowerment (Taylor and Perezniето, 2014). Many of these activities were beyond the scope of the Yes I Do programme, except the VSLAs, that were mentioned to be implemented to support female parents to save and access loans to meet the basic needs of their children. Given that VSLAs was one main component focusing on economic empowerment and yet it did not come up strongly in this study, future efforts to assess the role of the VSLA intervention in enhancing economic empowerment and its association with reducing teenage pregnancy and child marriage is necessary.

There is a persisting gender inequality in access to education and economic opportunities in the Maasai communities in Kajiado County. The qualitative narratives further indicate a continued unequal treatment of boys and girls among the Maasai community. It was reported that gender-based violence is present in the community and is often meted out to girls and women, and a girl is generally demeaned and only valued as an object for marriage. Women were also reported to have limited voice in the community, signalling the point that gender equality remains a target goal. At midline, it was reported that gender equality as a concept appears to be poorly understood within the Maasai community and some policymakers do not consider issues such as child marriage, teenage pregnancy and FGM/C to be related to gender inequality in the society (Gitau et al. 2018). Gitau et al. (2018) added that frequently it is the pregnant girl who is blamed and expected to carry the burden and consequences of the pregnancy.

The endline results confirm these earlier findings and echo the need for interventions to address gender inequalities and to empower women and girls on education and livelihoods outcomes in the Maasai communities in Kajiado West County. Evidence shows that interventions that address gender inequalities and empower women and girls generally have positive or at least neutral outcomes and avoid harm, and so are worth pursuing (Kraft et al. 2014).

Table 22 Recommendations – Pathway 4

Programme
Increasing access to education for girls and effective economic empowerment interventions for young women and men to gain vocational skills and participate in income generating activities remain important goals to pursue as part of any women empowerment programme in Kajiado County.
Research
Studies that can specify economically viable activities for young women in the Maasai communities in Kajiado County will make an important contribution to women empowerment and to addressing child marriage and teenage pregnancy.

4.5 PATHWAY 5

POLICY MAKERS AND DUTY BEARERS DEVELOP, REFORM AND IMPLEMENT POLICIES AS WELL AS ENFORCE LAWS ON CHILD MARRIAGE, FEMALE GENITAL MUTILATION/ CUTTING AND TEENAGE PREGNANCY

Contrary to the baseline and midline situation, the endline data show an increased awareness about the laws and policies protecting girls’ rights in the intervention area. Participants frequently made references to the Children’s act, the return to school policy, anti-FGM/C laws and the 100% transition from primary school to secondary school. A Kajiado County policy for the eradication of FGM/C was also mentioned as a concrete result of the Yes I Do programme’s and other NGOs’ continued advocacy in the county. The positive findings at endline suggest that the Yes I Do Alliance in Kenya made good use of the baseline and midline recommendations to continue awareness raising on existing laws and regulations and the programme activities seem to have focused on holding duty bearers accountable to enforce the laws and regulations. These efforts seem to have broken the strong hold of social norms and their influence on the County policymakers, leading to the enactment of policies to eradicate FGM/C, confirming the ToC assumption that policymakers are as much influenced by social norms, as people in communities.

The endline data show that the increase in awareness of the laws is yet to be translated into policy implementation to protect girls’ SRH rights. The Kajiado end FGM/C policy is yet to be fully implemented due to resource constraints and many births and marriages are still not being registered. Evidence indicates that efforts to achieve legal identity for all girls and boys, including birth registration for all, can contribute to ending child marriage (Lucia and Marina 2016). Thus strengthening of birth and marriage registration systems, backed by legal reforms to establish sound legal frameworks against child marriage are essential steps to end this prevalent practice in the Maasai communities in Kenya. However, as demonstrated in the work of the Yes I Do Alliance in Kenya, since established social norms and

poverty are underlying causes of child marriage in Kajiado County, laws alone may not achieve sustainable results. The eradication of child marriage and FGM/C will require a sustained multifaceted response such as the Yes I Do programme to continue to address the root causes (WHO 2012).

Table 23 Recommendations – Pathway 5

Programme
Efforts to ensure an effective implementation of the Kajiado County policy on the eradication of FGM/C need continuous attention and future programme activities should focus on holding duty-bearers accountable to enforce the laws and implement the policy.
Research
There is a need to monitor the implementation of the Kajiado County policy for the eradication of FGM/C and to evaluate its effectiveness in reducing the practice. The lessons could inform other Counties planning similar actions to address FGM/C.

4.6 CROSS-CUTTING STRATEGIES

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

Regarding youth engagement, the endline data show that 28% of the female respondents and 25% of the male respondents had heard of the Yes I Do programme, while 17% of the female respondents and 19% of the male respondents indicated to have participated in the activities of the programme. Most young people participated in youth club activities (67%) or community dialogues (33%). The endline data also show a statistically significant increase in the percentage of youth who found it easy to discuss sexuality and marriage with their parents in both the intervention and control areas and for both genders. While there is some variation between base- and endline and intervention and control area, youth across the study populations were generally more comfortable discussing topics such as gender equality and girls' rights with people of their own age and gender. The qualitative narratives support these findings and suggest that communication between the youth and their elders was limited and was largely influenced by social norms whereby young people are not expected to speak when they are among elders, which limits young people's meaningful participation in the decision-making space. Similarly, young people were not able to communicate sensitive issues including sexuality topics with their elders because of social norms regarding discipline and respect that guide the communication between young people and their elders. The normative belief of not questioning elders, even when the elders are wrong, is seen as a sign of discipline and respect, which further limits young peoples' meaningful participation in decision-making. The findings point to the situation at midline where the need for more meaningful youth engagement to enable young people to advocate against FGM/C, child marriage and to take responsibility for teenage pregnancy was emphasised.

However, our results also show a changing trend where young people are given opportunities to participate and make contributions in community meetings. The church was frequently mentioned as helping in improving intergenerational communication in a manner that was never experienced in the past.

Our results also show that the Yes I Do alliance made efforts to engage boys and men and the wider community towards gender transformation as a promising strategy in promoting girls empowerment. However, the engagement of boys and men remains weak. Men engagement, gender equality and girls' empowerment are all pre-requisites for preventing teenage pregnancy, and ending child marriage and FGM/C. It is therefore important that future programmes pay particular attention to these cross-cutting issues.

4.7 STRENGTHS AND LIMITATIONS OF THE STUDY

The inclusion of the control area was to allow the research team to conclude that any change observed in the intervention area is due to the Yes I Do programme, rather than to other factors. However, the choice of a control area that was demographically slightly different from the intervention area, in addition to the fact that similar programmes were implemented in the control area, made it impossible to draw meaningful conclusions on the outcomes of the Yes I Do programme (in the intervention area) versus the control area. Nonetheless, the inclusion of the control area adds rigour to the study design. Another strength of the study is the mixed methods approach, which has allowed data triangulation and validity checks. Such a design is useful in understanding potential contradictions between quantitative results and qualitative findings and gives a voice to study participants, thus ensuring the results are grounded in participants' experiences with the Yes I Do programme.

Finally, although the data was collected just before the implementation of COVID-19 safety measures, the fact that data analysis and validation processes could only be conducted virtually, with research team members reaching each other across oceans might have affected the overall quality of the study.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSION

This study was expected to provide insight into the different pathways of change, thereby testing the ToC, 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, teenage pregnancy and FGM/C in Kajiado West County. The findings of the study are mixed whereby positive changes in outcomes have been realized in relation to some of the strategic goals, others have remained the same, while other outcomes were negative. One of the main positive changes is the significant decrease in child marriage in the intervention area. This could be attributed to increased community awareness of the consequences of child marriage and the fact that there is agreement among community members that there are no benefits of child marriage. There is also increased awareness and enforcement of the return to school policy (after teenage pregnancy). On the contrary, the prevalence of teenage pregnancy and FGM/C increased in the intervention area over the programme period.

The assumption that a combined approach of strategies will reduce child marriage, FGM/C and teenage pregnancy is sound and potentially feasible. However, because of the sociocultural and deeply embeddedness of the causes of the three issues, a period of four years may only begin to show an indication of change, especially as the programme's coverage in the intervention area seemed limited. It is evident from this study that in provision of SRHR information to young people, the school, the home environment, churches, health facilities and peer educators all have a role to play. To be able to reduce child marriage, a concerted effort has to be made to keep girls and young women in school as well as to ensure their safety. Concurrently providing information on FGM/C to the youth and engaging elders who are the gatekeepers/custodians of established social norms are critical for buy-in; in addition to engaging young men who currently continue to prefer to marry young women who have been circumcised. Understanding the structural context of these interrelated problems is critical for positioning the strategies to address barriers for impact. This should also entail an analysis of the factors and processes at various levels that influence changes in cultural practices in each setting. This is in recognition of the observation that change in social norms is a slow process requiring initiation from within the community (UNFPA and UNICEF 2018).

REFLECTION ON SUSTAINABILITY OF THE YES I DO INTERVENTIONS

The Yes I Do programme worked through and with local structures such as schools, the church, local leaders and the County government and thus, in some way, entrenched the interventions in existing structures. The Kajiado County FGM/C policy provides a framework to drive the activities towards the abandonment of FGM/C among the Maasai community. A policy that is home-grown is bound to spark ownership and acceptance by the local community to embrace change. Some of the approaches such as the return to school policy are already widely known and with the support of the County administration, girl child education is likely to take root in the communities that have been supported by the Yes I Do programme.

5.2 RECOMMENDATIONS FOR FUTURE PROGRAMMES

1. The abandonment of FGM/C and child marriage is rarely a priority of communities who value the practices as social norms. FGM/C and child marriage eradication efforts should therefore be integrated into community priority development programmes such as water, sanitation, education or health care, that meet immediate community felt needs. This will also help to build community trust towards information provided by these programmes.
2. There is need to use local resources in the fight against FGM/C and child marriage (“insider approach”). For example, by educating members of the community, such as traditional leaders, religious leaders, young women who have grown up in the community and succeeded (in marriage or financially) without having gone through the cut, or fathers who have decided not to circumcise their daughters, and involve them as local champions.
3. Interventions addressing the SRHR of young people need to be broad-based and take into consideration the social, cultural and economic context of young people, and should be implemented over a longer period of time in order to elicit observable change.
4. Meaningful youth and men engagement need to have a more structured approach with specific interventions on gender equality and sexual health in addressing FGM/C and child marriage.
5. Schools are a major source of sexuality and sexual health information for young people and hence there is the need to strengthen school programmes including the role of teachers, peer educators and youth clubs.
6. There is a need to use existing community structures to enhance parent-adolescent communication and provide parents with accurate and appropriate information to effectively communicate with their adolescent girls and boys.
7. Making schools safe for girls and effective economic empowerment interventions for young women and men to gain vocational skills and participate in income generating activities remain important goals to pursue as part of any women empowerment programme in the Kajiado County.
8. Efforts to ensure an effective implementation of the Kajiado County policy on the eradication of FGM/C need continuous attention and future programme activities should focus on holding duty-bearers accountable to enforce the laws and implement the policy.
9. In-depth discussions and community dialogues should go beyond threats and illegality of the practice, because while laws and policies are essential, they may not solve problems that are embedded in culture.

5.3 RECOMMENDATIONS FOR FURTHER RESEARCH

1. The role of community development programmes in stimulating change of social and cultural norms and practices while building on the positive drivers of social change such as education, health, improved livelihood.
2. The effectiveness of the multifaceted / multicomponent approach in addressing embedded socio-cultural norms and practices using an insider focus.
3. Exploring social, cultural, religious and economic factors that facilitate and hinder access to and utilisation of SRH information and services by young people in the Maasai communities.
4. Studies that can specify economically viable activities for young women in the Maasai communities in Kajiado County can make an important contribution to women empowerment and to addressing child marriage and teenage pregnancy.
5. There is the need to monitor the implementation of the Kajiado County policy for the eradication of FGM/C and to evaluate its effectiveness in reducing the practice. The lessons could inform other Counties planning similar actions to address FGM/C in Kenya.

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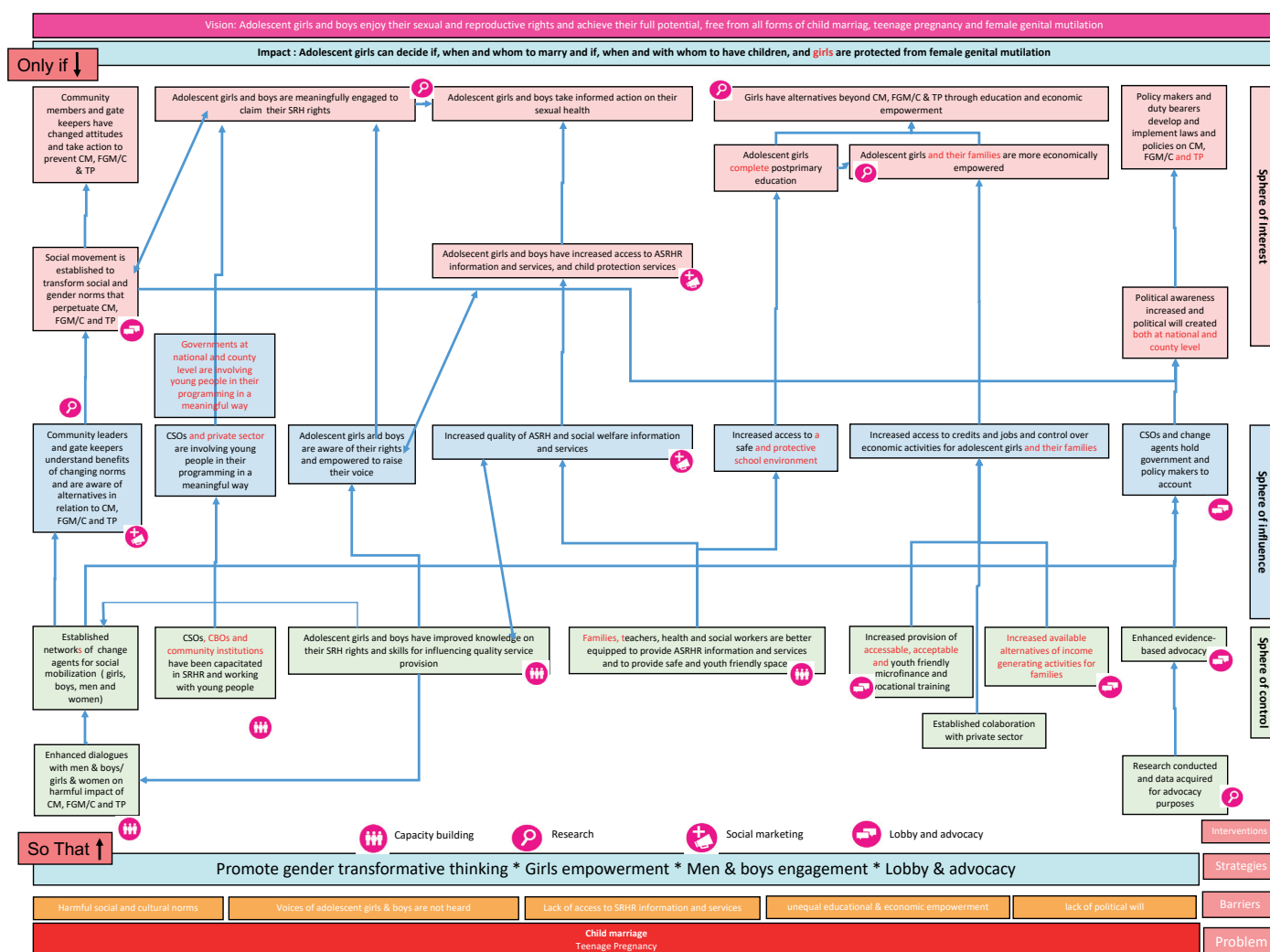
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7. ANNEXES

1. KENYA YES I DO PROGRAMME THEORY OF CHANGE AND ASSUMPTIONS



ASSUMPTIONS

1. Only a combined approach of strategies will reduce child marriage, FGM/C and teenage pregnancy¹.
2. Policy makers are as much influenced by social norms, as people in communities².
3. Change agents are willing to organize themselves to influence community members and to hold duty bearers accountable³.
4. When adolescent girls and boys have improved knowledge concerning their rights, they want to organize themselves to influence others⁴.
5. When adolescent girls finish post-primary education, they have more chances to be economically empowered⁵.
6. Through rights awareness and alternatives, people will take action to change their social environment⁶.
7. Meaningful youth engagement is required for increased access and uptake of quality ASRHR services and information⁷.
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

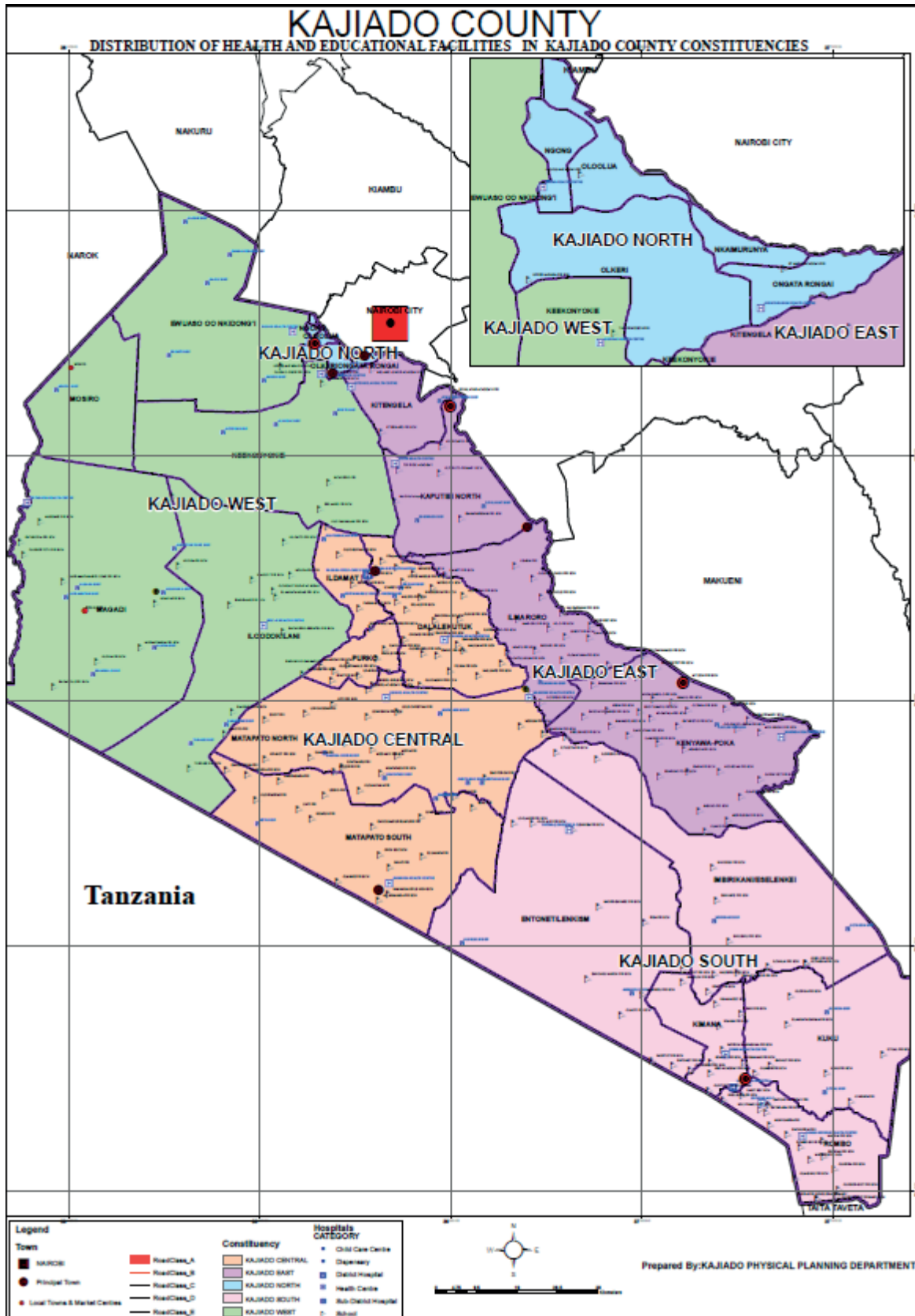
8 Participate: the voice of young people in programmes and policies, IPPF, 2008

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. MAP OF KAJIADO COUNTY



3. SAMPLE SIZE CALCULATIONS

Sample size calculations					
Indicator	Prevalence		Sample size per group		
	Baseline	Endline	Women ¹	Men	Total
Teenage pregnancy	18%	17%	335	111	446
FGM/C	21%	11%	396	131	527
Child marriage	27%	17%	507	167	674

¹ $\alpha = 0.05$, $\beta = 0.8$, AR: 0.2, DEFT = 1.5

Effect size: A 10 percentage point change between base- and endline 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 teenage pregnancy, FGM/C and child marriage according to the 2014 DHS. Out of the three key indicators child marriage has the highest prevalence and as such yields the highest (most conservative) sample size.

Sample size calculations			
	Intended	Achieved	
		Baseline	Endline
Intervention			
Boys	167	176 (105%)	170 (102%)
Girls	507	507 (100%)	553 (109%)
Total	674	683 (101%)	723 (107%)
Control			
Boys	167	173 (104%)	164 (98%)
Girls	507	512 (101%)	522 (103%)
Total	674	685 (102%)	686 (102%)

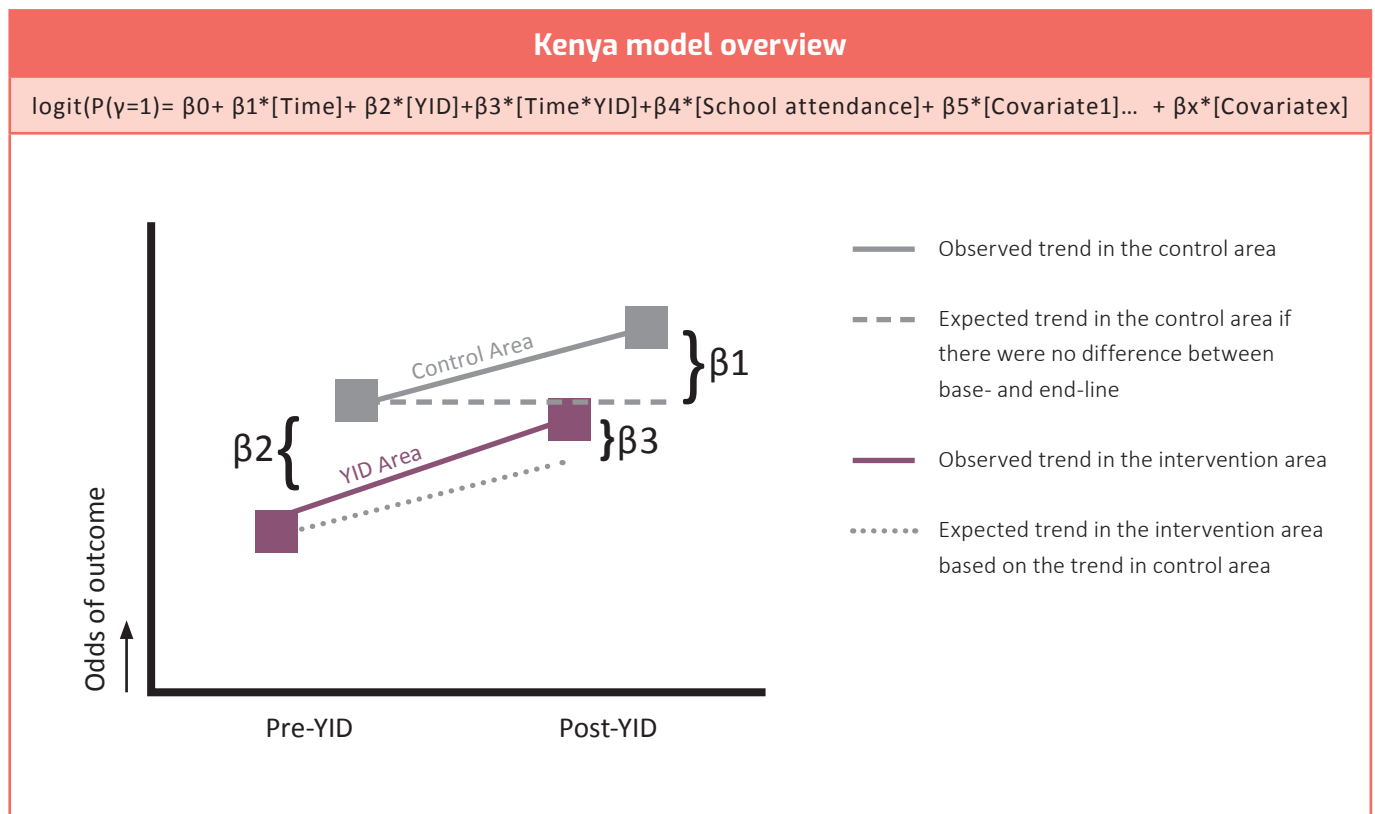
4. DIFFERENCE-IN-DIFFERENCE MODELS

Overview and description of models

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

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

The overview below describes the model in more detail.



y: The binary outcome variable (different for each model)

β_0 : Baseline odds of outcome variable at baseline in the control area

β_1 : quantifies the trend over time in the control area. I.e. the odds in the control area at baseline vs endline. In the tables it is referred to as 'Time'.

β_2 : quantifies the difference between the intervention and control area at baseline. I.e. the odds in the control area at baseline vs the odds in the intervention area at baseline. In the tables it is referred to as 'YID intervention'.

β_3 : quantifies the difference between the expected trend in the intervention area if it would follow the same trend as the control area and the observed trend. In the tables it is referred to as 'YID : Time'. If this variable is significant, it means that the trend in the intervention area is statistically significantly different from the trend in the control area.

β_4 (not in schematic overview): quantifies the association between the outcome and school attendance at baseline in the control area (control variable).

β_5 - β_x : odd ratios for other covariates included in the model, this is only relevant for the following outcome variables: FGM/C, teenage pregnancy and child marriage.

The following outcome variables were modelled:

Outcomes	
Theme	Outcome variable
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 below 18 years who left school due to pregnancy
Education	Girls aged below 18 years who dropped out of school
	Girls aged 15-18 currently attending secondary school
	Girls aged 15-18 who have a child and follow education
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
FGM/C	Girls between 15 - and 24 years who underwent FGM/C
	Boys and men (aged 15-24 years) who are not married who prefer a non-circumcised female as future partner
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
SRHR behavior	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
	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

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
	Boys aged 15-24 who feel confident to insist on condom use every time they have sex
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

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 18-24 who were married or in a union before age 18								
Constant					0.28	0.18	0.43	0.000
YID intervention	2.60	1.84	3.66	0.000	2.79	1.67	4.68	0.000
Time	0.60	0.44	0.82	0.002	0.68	0.37	1.24	0.206
YID : Time	0.98	0.70	1.39	0.931	0.48	0.23	0.99	0.046
School attendance	0.15	0.09	0.24	0.000	0.14	0.09	0.23	0.000
Outcome variable: Girls and women aged 16-24 who were married or in a union before age 16								
Constant					0.30	0.19	0.45	0.000
YID intervention	3.15	2.29	4.33	0.000	3.26	2.02	5.24	0.000
Time	0.53	0.40	0.71	0.000	0.58	0.33	1.02	0.059
YID : Time	0.99	0.71	1.36	0.930	0.44	0.22	0.88	0.020
School attendance	0.10	0.07	0.15	0.000	0.09	0.06	0.13	0.000
Outcome variable: Married girls and young women (15-24 years), who perceive that it was their choice to get married								
Constant					1.39	0.86	2.25	0.173
YID intervention	0.58	0.40	0.84	0.004	0.47	0.27	0.81	0.007
Time	0.63	0.44	0.89	0.009	0.47	0.25	0.89	0.021
YID : Time	0.62	0.42	0.91	0.014	1.84	0.85	3.99	0.122
School attendance	2.85	1.79	4.53	0.000	2.51	1.55	4.04	0.000

Child marriage								
	Univariable				Multivariable (n=1012)			
		95%CI		P-value		95%CI		P-value
	B	Lower bound	Upper bound		B	Lower bound	Upper bound	
Outcome variable: Girls and women aged 18 - 24 years who were married below the age of 18								
Constant					0.01	0.00	0.15	0.002
YID Intervention	2.60	1.84	3.66	0.000	2.55	1.22	5.34	0.013
Time	0.60	0.44	0.82	0.002	0.96	0.43	2.17	0.926
YID : Time	0.98	0.70	1.39	0.931	0.35	0.14	0.91	0.031
Age in years	1.17	1.08	1.27	0.000	0.98	0.87	1.10	0.759
Teenage pregnancy (yes/no)	47.07	23.73	93.34	0.000	34.56	14.36	83.18	0.000
Underwent FGM/C (yes/no)	6.78	4.10	11.22	0.000	1.99	1.02	3.89	0.044
Ever received sexuality education (yes/no)	0.30	0.22	0.42	0.000	0.56	0.35	0.88	0.013
Ever dropped out of school (yes/no)	2.78	2.01	3.85	0.000	0.86	0.53	1.39	0.532
Received income in past 6 months (yes/no)	0.63	0.46	0.88	0.006	0.78	0.47	1.29	0.330
Employed (yes/no)	0.61	0.40	0.92	0.019	1.06	0.57	1.96	0.864
Mother received any education (yes/no)	0.24	0.13	0.44	0.000	0.83	0.37	1.87	0.650
Father received any education (yes/no)	0.35	0.21	0.59	0.000	0.59	0.29	1.22	0.158
Attending secondary education (yes/no)	0.06	0.02	0.18	0.000	0.31	0.08	1.23	0.097
Attending any education (yes/no)	0.15	0.09	0.24	0.000	0.47	0.23	0.94	0.034
Household size (1-2)	1.00	1.00	1.00		1.00	1.00	1.00	
3-4	5.34	1.62	17.52	0.006	5.87	0.73	47.14	0.096
5-7	4.36	1.33	14.27	0.015	6.22	0.77	50.28	0.086
8+	1.12	0.31	4.02	0.867	2.10	0.24	18.42	0.504

Teenage pregnancy

	Univariable				Multivariable			
		95%CI		P-value		95%CI		P-value
	B	Lower bound	Upper bound		B	Lower bound	Upper bound	
Outcome variable: Girls and women aged 20-24 years who had their first child under the age of 20								
Constant					0.94	0.64	1.38	0.749
YID intervention	2.10	1.56	2.84	0.000	1.69	1.06	2.69	0.029
Time	1.10	0.83	1.47	0.502	0.80	0.48	1.32	0.381
YID : Time	1.76	1.29	2.40	0.000	1.12	0.59	2.12	0.727
School attendance	0.24	0.17	0.33	0.000	0.25	0.18	0.36	0.000
Outcome variable: Girls and women aged 15-24 years who had their first child under the age of 20								
Constant					0.98	0.73	1.32	0.895
YID intervention	2.45	2.00	3.02	0.000	1.88	1.33	2.66	0.000
Time	1.02	0.84	1.25	0.809	0.68	0.47	0.99	0.043
YID : Time	1.80	1.45	2.23	0.000	1.03	0.64	1.66	0.896
School attendance	0.09	0.07	0.12	0.000	0.09	0.07	0.12	0.000
Outcome variable: Young women (20-24 years) who wanted to become parents at that time								
Constant					0.74	0.40	1.38	0.343
YID intervention	0.83	0.49	1.40	0.485	1.20	0.58	2.49	0.618
Time	0.28	0.16	0.47	0.000	0.44	0.17	1.11	0.082
YID : Time	0.28	0.15	0.50	0.000	0.43	0.14	1.33	0.144
School attendance	0.57	0.27	1.18	0.131	0.41	0.19	0.90	0.026

Teenage pregnancy								
	Univariable				Multivariable (n=797)			
		95%CI		P-value		95%CI		P-value
	B	Lower bound	Upper bound		B	Lower bound	Upper bound	
Outcome variable: Girls and women aged 20-24 who had a child before 20								
Constant					2043.5	107.2	38970.5	0.000
YID Intervention	2.02	1.55	2.62	0.000	1.11	0.59	2.10	0.746
Time	1.01	0.78	1.30	0.964	0.94	0.49	1.79	0.846
YID : Time	1.54	1.16	2.03	0.003	1.55	0.67	3.56	0.307
Age in years	0.71	0.67	0.76	0.000	0.63	0.55	0.72	0.000
FGM/C (yes/no)	4.94	3.66	6.66	0.000	4.12	2.54	6.67	0.000
Child marriage (yes/no)	29.92	15.05	59.48	0.000	33.47	13.27	84.41	0.000
Ever received sexuality education (yes/no)	0.44	0.33	0.58	0.000	0.56	0.36	0.88	0.011
Ever dropped out of school (yes/no)	7.00	5.25	9.34	0.000	6.54	4.33	9.87	0.000
Received income in past 6 months (yes/no)	0.58	0.45	0.75	0.000	1.22	0.77	1.94	0.391
Employed (yes/no)	0.38	0.28	0.52	0.000	0.80	0.48	1.34	0.390
Mother received any education (yes/no)	0.32	0.23	0.46	0.000	0.67	0.36	1.27	0.218
Father received any education (yes/no)	0.56	0.40	0.78	0.001	1.45	0.77	2.74	0.248
Attending secondary education (yes/no)	0.55	0.37	0.82	0.003	1.41	0.68	2.91	0.356
Attending any education (yes/no)	0.38	0.29	0.51	0.000	0.45	0.26	0.76	0.003
Household size (1-2)	1.00	1.00	1.00		1.00	1.00	1.00	
3-4	2.43	1.39	4.27	0.002	2.00	0.81	4.92	0.133
5-7	0.69	0.40	1.20	0.185	2.11	0.85	5.21	0.105
8+	0.46	0.26	0.81	0.007	1.06	0.40	2.78	0.904

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					0.91	0.56	1.48	0.702
YID intervention	0.73	0.47	1.12	0.151	0.83	0.48	1.44	0.506
Time	0.14	0.09	0.24	0.000	0.22	0.10	0.49	0.000
YID : Time	0.13	0.07	0.25	0.000	0.48	0.17	1.39	0.177
School attendance	1.39	0.83	2.32	0.214	0.83	0.48	1.45	0.515
Outcome variable: Ever married mothers aged 15 - 24 years old who became pregnant and were then married								
Constant					0.26	0.14	0.46	0.000
YID intervention	1.20	0.79	1.82	0.398	1.31	0.68	2.50	0.419
Time	2.70	1.82	4.00	0.000	3.27	1.55	6.90	0.002
YID : Time	2.17	1.45	3.24	0.000	0.79	0.33	1.90	0.603
School attendance	0.99	0.60	1.63	0.971	1.38	0.81	2.36	0.238
Outcome variable: Ever married mothers aged 15 - 24 years old who became pregnant and were married in the same year								
Constant					0.48	0.29	0.81	0.006
YID intervention	1.11	0.74	1.67	0.619	0.98	0.54	1.77	0.945
Time	1.60	1.10	2.33	0.015	1.24	0.61	2.54	0.549
YID : Time	1.69	1.14	2.52	0.009	1.45	0.62	3.36	0.392
School attendance	0.75	0.45	1.25	0.266	0.87	0.51	1.48	0.610

FGM/C								
	Univariable				Multivariable			
		95%CI		P-value		95%CI		P-value
	B	Lower bound	Upper bound		B	Lower bound	Upper bound	
Outcome variable: Girls between 15 - and 24 years who underwent FGM/C								
Constant					2.35	1.84	3.02	0.000
YID intervention	1.88	1.58	2.24	0.000	1.40	1.07	1.82	0.014
Time	0.93	0.78	1.10	0.398	0.68	0.53	0.89	0.005
YID : Time	1.58	1.30	1.93	0.000	1.28	0.89	1.85	0.185
School attendance	0.26	0.21	0.31	0.000	0.26	0.22	0.32	0.000
Outcome variable: Boys and men (aged 15-24 years) who are not married who prefer a non-circumcised female as future partner								
Constant					0.48	0.31	0.75	0.001
YID intervention	0.97	0.72	1.32	0.864	1.51	0.97	2.36	0.070
Time	1.21	0.89	1.64	0.225	2.24	1.40	3.60	0.001
YID : Time	0.87	0.61	1.24	0.439	0.49	0.26	0.92	0.026
School attendance	2.30	1.65	3.19	0.000	2.66	1.86	3.78	0.000

FGM/C								
	Univariable				Multivariable			
	B	95%CI		P-value	B	95%CI		P-value
		Lower bound	Upper bound			Lower bound	Upper bound	
Outcome variable: Girls and women aged 15 - 24 years who underwent FGM/C								
Constant					0.0	0.0	0.3	0.001
YID Intervention	1.88	1.58	2.24	0.000	1.34	0.85	2.12	0.202
Time	0.92	0.77	1.09	0.326	0.83	0.55	1.27	0.388
YID : Time	1.57	1.29	1.91	0.000	1.01	0.56	1.83	0.969
Age in years	1.24	1.20	1.28	0.000	1.17	1.08	1.27	0.000
Teenage pregnancy (yes/no)	7.95	6.18	10.23	0.000	3.02	1.99	4.59	0.000
Child marriage (yes/no)	6.78	4.10	11.22	0.000	2.10	1.11	3.95	0.022
Ever received sexuality education (yes/no)	0.84	0.70	1.02	0.074	1.16	0.82	1.64	0.414
Ever dropped out of school (yes/no)	4.25	3.41	5.30	0.000	1.51	1.04	2.19	0.031
Received income in past 6 months (yes/no)	1.26	1.06	1.51	0.011	0.97	0.69	1.37	0.877
Employed (yes/no)	1.41	1.09	1.82	0.009	0.90	0.61	1.32	0.589
Mother received any education (yes/no)	0.41	0.33	0.52	0.000	0.68	0.45	1.03	0.069
Father received any education (yes/no)	0.35	0.28	0.44	0.000	0.48	0.32	0.73	0.000
Attending secondary education (yes/no)	0.53	0.44	0.64	0.000	0.89	0.58	1.37	0.594
Attending any education (yes/no)	0.25	0.21	0.31	0.000	0.85	0.58	1.25	0.408
Household size (1-2)	1.00	1.00	1.00		1.00	1.00	1.00	
3-4	2.04	1.22	3.41	0.007	0.98	0.49	1.98	0.957
5-7	1.07	0.66	1.76	0.778	1.16	0.58	2.32	0.671
8+	0.89	0.54	1.47	0.658	1.01	0.49	2.07	0.974

SRHR behaviour								
	Univariable				Multivariable			
		95%CI		P-value		95%CI		P-value
	B	Lower bound	Upper bound		B	Lower bound	Upper bound	
Outcome variable: Girls aged 15-24 who can decide for themselves whom to date and go out with								
Constant					1.98	1.52	2.59	0.000
YID intervention	0.98	0.80	1.20	0.829	1.00	0.74	1.34	0.991
Time	1.33	1.09	1.64	0.006	1.37	1.01	1.85	0.041
YID : Time	1.26	0.99	1.60	0.064	1.17	0.77	1.78	0.455
School attendance	1.61	1.30	1.98	0.000	1.73	1.39	2.15	0.000
Outcome variable: Boys aged 15-24 who can decide for themselves whom to date and go out with								
Constant					4.44	2.52	7.83	0.000
YID intervention	0.95	0.63	1.42	0.791	1.27	0.70	2.30	0.436
Time	0.91	0.60	1.37	0.646	1.19	0.65	2.18	0.576
YID : Time	0.82	0.52	1.29	0.384	0.64	0.28	1.47	0.297
School attendance	1.11	0.72	1.71	0.638	1.09	0.69	1.72	0.715
Outcome variable: Girls between 15 and 24 that have ever utilized SRHR services								
Constant					5.46	4.15	7.17	0.000
YID intervention	1.97	1.65	2.35	0.000	1.49	1.12	1.98	0.006
Time	0.55	0.46	0.65	0.000	0.39	0.30	0.51	0.000
YID : Time	1.17	0.96	1.44	0.118	1.25	0.85	1.83	0.258
School attendance	0.26	0.21	0.32	0.000	0.24	0.19	0.30	0.000
Outcome variable: Boys between 15 and 24 that have ever utilized SRHR services								
Constant					1.79	1.16	2.78	0.009
YID intervention	1.46	1.08	1.98	0.013	1.02	0.66	1.58	0.940
Time	0.60	0.44	0.81	0.001	0.38	0.24	0.60	0.000
YID : Time	1.09	0.77	1.54	0.642	1.85	0.99	3.44	0.052
School attendance	0.83	0.60	1.14	0.249	0.70	0.50	1.00	0.048
Outcome variable: Young fathers aged 15-24 years indicating using MALE condoms								
Constant					0.31	0.03	3.16	0.322
YID intervention	2.90	0.73	11.50	0.131	0.69	0.05	10.01	0.786
Time	2.41	0.60	9.62	0.214	0.50	0.03	7.92	0.622
YID : Time	3.87	1.17	12.81	0.027	6.90	0.28	167.44	0.235
School attendance	0.78	0.21	2.84	0.708	0.69	0.17	2.84	0.612

SRHR behaviour

	Univariable				Multivariable			
		95%CI		P-value		95%CI		P-value
	B	Lower bound	Upper bound		B	Lower bound	Upper bound	
Outcome variable: Young mothers aged 15-24 years indicating using MALE condoms								
Constant					0.06	0.03	0.13	0.000
YID intervention	0.58	0.32	1.04	0.067	0.95	0.41	2.21	0.903
Time	0.78	0.43	1.41	0.412	1.95	0.78	4.85	0.152
YID : Time	0.40	0.19	0.84	0.016	0.31	0.09	1.06	0.062
School attendance	2.28	1.24	4.21	0.008	2.14	1.13	4.06	0.019
Outcome variable: Boys and young men aged 15 - 24 years old who ever had children and use a modern form of contraceptive								
Constant					1.28	0.18	8.96	0.805
YID intervention	1.34	0.43	4.17	0.614	0.21	0.02	1.89	0.162
Time	0.77	0.25	2.39	0.656	0.12	0.01	1.40	0.090
YID : Time	1.85	0.64	5.32	0.253	19.53	1.18	322.34	0.038
School attendance	1.78	0.56	5.67	0.331	1.31	0.36	4.77	0.683
Outcome variable: Girls and women aged 15 - 24 years old who ever had children and use a modern form of contraceptive								
Constant					0.95	0.63	1.42	0.788
YID intervention	1.18	0.85	1.63	0.323	1.18	0.75	1.88	0.471
Time	0.70	0.52	0.95	0.023	0.72	0.41	1.26	0.246
YID : Time	0.83	0.60	1.14	0.253	1.07	0.55	2.08	0.847
School attendance	1.35	0.95	1.92	0.090	1.30	0.90	1.87	0.157
Outcome variable: Young men between 18 - 24 years old who have ever experienced sexual harrassment								
Constant					0.06	0.02	0.21	0.000
YID intervention	0.92	0.39	2.13	0.839	0.64	0.14	2.80	0.549
Time	1.66	0.69	4.00	0.261	1.26	0.36	4.35	0.718
YID : Time	1.30	0.54	3.15	0.564	1.45	0.24	8.83	0.687
School attendance	0.77	0.33	1.79	0.542	0.83	0.33	2.08	0.690

SRHR behaviour

	Univariable				Multivariable			
		95%CI		P-value		95%CI		P-value
	B	Lower bound	Upper bound		B	Lower bound	Upper bound	
Outcome variable: Young women between 18 - 24 years old who have ever experienced sexual harrassment								
Constant					0.13	0.08	0.21	0.000
YID intervention	0.96	0.71	1.30	0.801	0.81	0.44	1.49	0.501
Time	3.43	2.42	4.86	0.000	3.15	1.92	5.17	0.000
YID : Time	1.82	1.33	2.49	0.000	1.05	0.52	2.13	0.894
School attendance	0.74	0.54	1.01	0.060	0.85	0.60	1.19	0.342
Outcome variable: Married girls and young women between 15 - 24 years old who have ever been physically hurt by their partner								
Constant					0.20	0.11	0.37	0.000
YID intervention	0.90	0.61	1.32	0.586	2.11	1.07	4.17	0.030
Time	2.80	1.92	4.06	0.000	7.64	3.65	15.98	0.000
YID : Time	1.42	0.97	2.09	0.074	0.21	0.09	0.51	0.000
School attendance	0.64	0.39	1.03	0.068	0.77	0.46	1.29	0.316

SRHR knowledge

	Univariable				Multivariable			
		95%CI		P-value		95%CI		P-value
	B	Lower bound	Upper bound		B	Lower bound	Upper bound	
Outcome variable: Girls aged 15-24 who know how to prevent pregnancy using modern contraceptives								
Constant					2.05	1.61	2.61	0.000
YID intervention	1.18	0.99	1.40	0.066	1.18	0.91	1.53	0.212
Time	1.16	0.97	1.37	0.099	1.25	0.96	1.61	0.092
YID : Time	1.10	0.90	1.34	0.346	0.70	0.49	1.00	0.049
School attendance	0.38	0.31	0.46	0.000	0.37	0.31	0.46	0.000
Outcome variable: Boys aged 15-24 who know how to prevent pregnancy using modern contraceptives								
Constant					1.64	1.06	2.53	0.027
YID intervention	0.84	0.62	1.14	0.270	0.87	0.56	1.35	0.541
Time	1.47	1.08	1.99	0.014	1.46	0.92	2.32	0.107
YID : Time	1.07	0.75	1.53	0.695	0.81	0.43	1.51	0.511
School attendance	0.70	0.50	0.98	0.039	0.74	0.52	1.05	0.088
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					1.02	0.81	1.29	0.877
YID intervention	1.27	1.07	1.50	0.007	1.25	0.97	1.62	0.086
Time	1.38	1.16	1.64	0.000	1.44	1.12	1.85	0.005
YID : Time	1.38	1.13	1.68	0.001	0.88	0.62	1.25	0.487
School attendance	0.67	0.55	0.80	0.000	0.71	0.59	0.86	0.000
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					1.17	0.76	1.80	0.480
YID intervention	1.61	1.19	2.18	0.002	1.98	1.27	3.10	0.003
Time	0.57	0.42	0.77	0.000	0.66	0.42	1.04	0.071
YID : Time	0.81	0.57	1.14	0.225	0.63	0.34	1.18	0.150
School attendance	0.96	0.70	1.33	0.825	0.83	0.59	1.18	0.303

SRHR knowledge								
	Univariable				Multivariable			
		95%CI		P-value		95%CI		P-value
	B	Lower bound	Upper bound		B	Lower bound	Upper bound	
Outcome variable: Girls aged 15-24 who feel confident to insist on condom use every time they have sex								
Constant					1.02	0.81	1.29	0.873
YID intervention	0.76	0.64	0.90	0.002	1.07	0.83	1.39	0.580
Time	1.42	1.20	1.69	0.000	2.17	1.68	2.80	0.000
YID : Time	0.77	0.64	0.94	0.010	0.42	0.29	0.59	0.000
School attendance	0.83	0.69	1.00	0.045	0.79	0.66	0.96	0.017
Outcome variable: Boys aged 15-24 who feel confident to insist on condom use every time they have sex								
Constant					2.80	1.75	4.47	0.000
YID intervention	0.92	0.67	1.27	0.614	1.47	0.90	2.40	0.127
Time	0.69	0.50	0.95	0.023	1.01	0.62	1.64	0.967
YID : Time	0.54	0.37	0.77	0.001	0.37	0.19	0.72	0.004
School attendance	0.93	0.66	1.33	0.706	0.78	0.53	1.13	0.186
Outcome variable: Girls aged 15-24 who ever received education about sexuality and sexual health								
Constant					1.06	0.83	1.35	0.631
YID intervention	0.90	0.75	1.08	0.279	0.89	0.68	1.16	0.379
Time	1.91	1.59	2.29	0.000	1.81	1.38	2.38	0.000
YID : Time	1.53	1.23	1.90	0.000	1.23	0.84	1.80	0.281
School attendance	1.62	1.34	1.96	0.000	1.81	1.48	2.22	0.000
Outcome variable: Boys aged 15-24 who ever received education about sexuality and sexual health								
Constant					1.10	0.71	1.72	0.661
YID intervention	0.72	0.53	0.98	0.034	0.54	0.34	0.84	0.007
Time	1.26	0.92	1.70	0.145	1.03	0.64	1.66	0.894
YID : Time	1.08	0.76	1.54	0.661	1.80	0.96	3.40	0.068
School attendance	1.81	1.30	2.51	0.000	1.96	1.38	2.78	0.000

SRHR knowledge

	Univariable				Multivariable			
		95%CI		P-value		95%CI		P-value
	B	Lower bound	Upper bound		B	Lower bound	Upper bound	
Outcome variable: Young men aged 15 - 24 years old who perceive to have knowledge of legal minimum age according to statutory law								
Constant					0.34	0.21	0.56	0.000
YID intervention	1.07	0.78	1.46	0.690	2.23	1.36	3.65	0.001
Time	1.61	1.17	2.22	0.003	3.21	1.94	5.28	0.000
YID : Time	0.84	0.58	1.22	0.359	0.21	0.11	0.41	0.000
School attendance	0.70	0.50	0.98	0.036	0.75	0.53	1.08	0.120
Outcome variable: Young men aged 15 - 24 years old who have actual knowledge of legal minimum age according to statutory law								
Constant					0.09	0.04	0.21	0.000
YID intervention	0.55	0.30	1.02	0.057	0.70	0.28	1.73	0.436
Time	1.26	0.69	2.30	0.445	1.43	0.63	3.22	0.390
YID : Time	0.62	0.28	1.35	0.227	0.59	0.17	2.09	0.415
School attendance	0.81	0.43	1.51	0.503	0.78	0.40	1.50	0.450
Outcome variable: Young women aged 15 - 24 years old who perceive to have knowledge of legal minimum age according to statutory law								
Constant					0.17	0.13	0.23	0.000
YID intervention	1.03	0.86	1.23	0.773	2.98	2.19	4.05	0.000
Time	1.96	1.62	2.35	0.000	5.31	3.94	7.16	0.000
YID : Time	0.87	0.71	1.07	0.182	0.15	0.10	0.23	0.000
School attendance	1.14	0.94	1.39	0.176	1.23	1.01	1.51	0.043
Outcome variable: Young women aged 15 - 24 years old who have actual knowledge of legal minimum age according to statutory law								
Constant					0.08	0.05	0.12	0.000
YID intervention	0.24	0.17	0.35	0.000	0.23	0.11	0.48	0.000
Time	2.84	2.01	4.02	0.000	2.95	1.97	4.42	0.000
YID : Time	0.50	0.33	0.76	0.001	0.98	0.42	2.33	0.972
School attendance	1.21	0.87	1.69	0.256	1.07	0.75	1.52	0.709

SRHR support

	Univariable				Multivariable			
		95%CI		P-value		95%CI		P-value
	B	Lower bound	Upper bound		B	Lower bound	Upper bound	
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					0.33	0.27	0.42	0.000
YID intervention	1.12	0.95	1.32	0.176	1.17	0.92	1.51	0.206
Time	1.53	1.30	1.81	0.000	1.58	1.24	2.01	0.000
YID : Time	1.37	1.14	1.64	0.001	0.89	0.64	1.24	0.489
School attendance	0.88	0.74	1.05	0.146	0.96	0.80	1.14	0.631
Outcome variable: Girls and young women who have someone at home with whom they can talk about feelings, hopes or worries								
Constant					3.85	2.90	5.11	0.000
YID intervention	1.23	1.00	1.52	0.046	1.69	1.21	2.36	0.002
Time	0.59	0.47	0.72	0.000	0.77	0.57	1.03	0.078
YID : Time	0.73	0.58	0.92	0.007	0.60	0.39	0.92	0.018
School attendance	0.91	0.73	1.13	0.389	0.88	0.70	1.10	0.251
Outcome variable: Boys and young men who have someone at home with whom they can talk about feelings, hopes or worries								
Constant					3.01	1.85	4.90	0.000
YID intervention	1.18	0.84	1.66	0.336	1.61	0.94	2.75	0.081
Time	0.51	0.36	0.72	0.000	0.66	0.40	1.08	0.100
YID : Time	0.65	0.44	0.94	0.024	0.62	0.31	1.25	0.183
School attendance	1.18	0.82	1.69	0.370	1.00	0.68	1.46	0.985
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	0.34	0.58	0.000
YID intervention	0.75	0.62	0.90	0.002	1.13	0.84	1.52	0.435
Time	1.98	1.64	2.40	0.000	2.94	2.23	3.88	0.000
YID : Time	0.94	0.76	1.16	0.569	0.39	0.26	0.57	0.000
School attendance	0.59	0.49	0.72	0.000	0.58	0.47	0.71	0.000

SRHR support

	Univariable				Multivariable			
	95%CI				95%CI			
	B	Lower bound	Upper bound	P-value	B	Lower bound	Upper bound	P-value
Outcome variable: Boys and young men between 15 - 24 years old who agree that their parents or relatives decide their future partner								
Constant					0.30	0.18	0.49	0.000
YID intervention	0.57	0.41	0.80	0.001	0.76	0.44	1.31	0.323
Time	2.78	1.97	3.92	0.000	3.57	2.17	5.88	0.000
YID : Time	1.05	0.72	1.53	0.798	0.56	0.28	1.13	0.106
School attendance	0.76	0.54	1.07	0.117	0.92	0.63	1.35	0.680
Outcome variable: Girls and young women (15-24 years) who find it difficult to access contraceptives as a young person								
Constant					0.82	0.64	1.04	0.100
YID intervention	0.49	0.41	0.58	0.000	0.70	0.54	0.92	0.009
Time	1.64	1.38	1.95	0.000	2.42	1.87	3.13	0.000
YID : Time	0.66	0.54	0.81	0.000	0.45	0.31	0.64	0.000
School attendance	0.87	0.73	1.05	0.140	0.79	0.65	0.95	0.015

Education								
	Univariable				Multivariable			
		95%CI		P-value		95%CI		P-value
	B	Lower bound	Upper bound		B	Lower bound	Upper bound	
Outcome variable: Girls aged below 18 years who dropped out of school								
Constant					0.59	0.29	1.17	0.128
YID intervention	1.73	1.16	2.58	0.007	2.16	1.15	4.05	0.016
Time	0.80	0.54	1.18	0.260	1.09	0.55	2.15	0.804
YID : Time	0.89	0.55	1.44	0.639	0.51	0.21	1.23	0.134
School attendance	0.11	0.07	0.18	0.000	0.11	0.07	0.19	0.000
Outcome variable: Girls below 18 years who left school due to pregnancy								
Constant					0.46	0.20	1.05	0.065
YID intervention	2.08	1.23	3.51	0.006	1.77	0.80	3.91	0.157
Time	0.66	0.40	1.10	0.114	0.60	0.24	1.52	0.284
YID : Time	1.00	0.55	1.81	0.990	0.99	0.31	3.17	0.985
School attendance	0.08	0.05	0.15	0.000	0.08	0.05	0.15	0.000
Outcome variable: Girls aged 15-18 who have a child and follow education								
Constant					0.05	0.03	0.08	0.000
YID intervention	2.22	1.22	4.03	0.009	1.99	1.01	3.91	0.046
Time	0.27	0.13	0.53	0.000	0.20	0.06	0.69	0.011
YID : Time	0.61	0.28	1.32	0.213	1.57	0.35	7.02	0.555
Outcome variable: Girls aged 15-18 currently attending secondary school								
Constant					0.73	0.58	0.92	0.008
YID intervention	0.36	0.28	0.46	0.000	0.69	0.49	0.97	0.031
Time	0.99	0.78	1.25	0.927	1.69	1.23	2.33	0.001
YID : Time	0.27	0.19	0.38	0.000	0.25	0.15	0.42	0.000

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 have received any income in the last six months								
Constant					0.39	0.29	0.54	0.000
YID intervention	1.38	1.09	1.75	0.007	1.80	1.23	2.63	0.002
Time	2.49	1.95	3.17	0.000	3.31	2.29	4.80	0.000
YID : Time	1.86	1.44	2.42	0.000	0.59	0.36	0.98	0.041
School attendance	0.86	0.67	1.10	0.223	1.08	0.83	1.40	0.584
Outcome variable: Girls between 18 and 24 years old who are economically active outside of the household								
Constant					0.32	0.22	0.45	0.000
YID intervention	1.05	0.80	1.39	0.722	1.04	0.66	1.63	0.878
Time	1.29	0.98	1.71	0.073	1.41	0.92	2.16	0.115
YID : Time	1.16	0.86	1.57	0.321	0.83	0.46	1.47	0.517
School attendance	0.58	0.43	0.79	0.000	0.59	0.43	0.81	0.001

