Endline study Ghana

Get Up Speak Out programme

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List of abbreviations and acronyms

AIDS	Acquired Immunodeficiency Syndrome
COVID-19	Coronavirus Disease 2019
GUSO	Get Up Speak Out
HIV	Human Immunodeficiency Virus
IUD	Intra-Uterine Device
KIT	Royal Tropical Institute
NGO	Non-Governmental Organisation
PMTCT	Prevention of mother to child transmission treatment
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
VCT	Voluntary counselling and testing

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1. Introduction

This report describes the process and results of the endline study for Get Up Speak Out (GUSO) in Ghana, and provides an overview of the changes observed since the baseline and at the endline study phases. GUSO is a five year programme (2016-2020) developed by a consortium consisting of Rutgers, CHOICE for Youth and Sexuality, Dance4life, International Planned Parenthood Federation, Simavi and Aids Fonds. The programme is financed by the Dutch Ministry of Foreign Affairs under the sexual and reproductive health and rights (SRHR) Partnership Fund. As such, it is an SRHR Partnership with the Dutch Ministry of Foreign Affairs. The GUSO programme addresses the following problem: "Young people do not claim their sexual rights and their right to participation because of restrictions at community, societal, institutional and political levels. This hinders their access to comprehensive SRHR education and services that match their needs, and ability to make their own informed SRHR decisions." The GUSO consortium addresses this problem with a focus on seven countries: Ghana, Kenya, Uganda, Malawi, Indonesia, Ethiopia and Pakistan. The consortium and the in-country GUSO alliance partners aim to consolidate what has been started by the Unite for Body Rights (UFBR) and Access, Services and Knowledge (ASK) programmes. The overall ambition is to create country ownership for SRHR interventions under the lead of a country SRHR alliance that will be able to continue once the GUSO programme will come to an end.

This report presents the status of the sexual health and rights of young people in Ghana in 2020 and the changes seen since the baseline in 2017 and the midline in 2018. The Royal Tropical Institute (KIT) conceptualised the quantitative component of the endline study and coordinated it with local partners in Ghana. The report begins with describing some background information regarding the context of SRHR in Ghana, followed by the methodology used in the endline and the most important results. In addition, the state of the art of the programme in 2020 with respect to Outcome 1, Outcome 2 and Outcome 5a are added to this report. The report ends with a discussion section, in which the most noteworthy results are analysed and discussed and recommendations for the GUSO programme are given.

2. Background

Country and programme context

Young people between the ages of 10 and 24 constitute 31% of Ghana's population. Regardless of their marital status, 99% of the women and men in Ghana have knowledge about at least one contraceptive method, which means that this knowledge is almost universal. Contraception use among unmarried sexually active girls (15-19 years old) is 43.7%, and when married, this percentage is much lower i.e. 18.6%[1]. Young women aged 15-19 have the highest unmet need for family planning (51%)[2]. Only 20% of young women (15-24 years old) have comprehensive knowledge about HIV/AIDS and the HIV prevalence among women aged 15-49 is 2.8%. The prevalence of child marriage is 28.9% among girls,[3] which is relatively high, especially compared to boys, which is 3.5%[4]. The teenage pregnancy prevalence in Ghana of 14% is not among the highest in the world, but large regional differences are visible (36% in Northern Region and 27% in Upper East Region)[5]. The country ranks 127 on the gender inequality index[6].

[1] DHS Ghana (2014): https://dhsprogram.com/pubs/pdf/FR307/FR307.pdf
[2] % of currently married women aged 15-19.
[3] % women/men age 15-49 who were first married by age of 18.
[4] DHS Ghana (2014): https://dhsprogram.com/pubs/pdf/FR307/FR307.pdf
[5] DHS Ghana (2014): https://dhsprogram.com/pubs/pdf/FR307/FR307.pdf
[6] UNDP (2016) Gender Inequality Index: http://hdr.undp.org/en/composite/GII

In this context, the GUSO programme's long-term objective is that:

All young people, especially girls and young women, are empowered to realize their SRHR in societies with a positive attitude towards young people's sexuality.

KIT contributes to researching and evaluating the GUSO programme, which includes a base, mid and end-line. The quantitative baseline was successfully implemented in 2017 while the midline was conducted in 2018. The quantitative endline was conducted in 2020, followed by an analysis, presented in this report.

Main and specific objectives of the performance study

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

The evaluation will address the following specific objectives:

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

3. Methodology

The endline research was conducted in the context of the ongoing COVID-19 pandemic. Within Ghana measures taken to control the pandemic have included the closure of schools and reduced ability to travel within the country and meet in groups. Despite this, the endline study was able to proceed with minor adaptations including adherence to physical distancing and hygiene guidelines. Face-to-face interviews were still possible within national guidelines.

Methodology Performance Study

The performance study, jointly conducted by KIT and GUSO partners, focuses on measuring outcome indicators (part of objective 1). The study can be seen as a programme performance evaluation. The following generic indicators are measured as part of the performance study. The findings from this study are meant to contribute to the overall end evaluation. Triangulation and synthesis with other (qualitative) data will be carried out by the GUSO alliance.

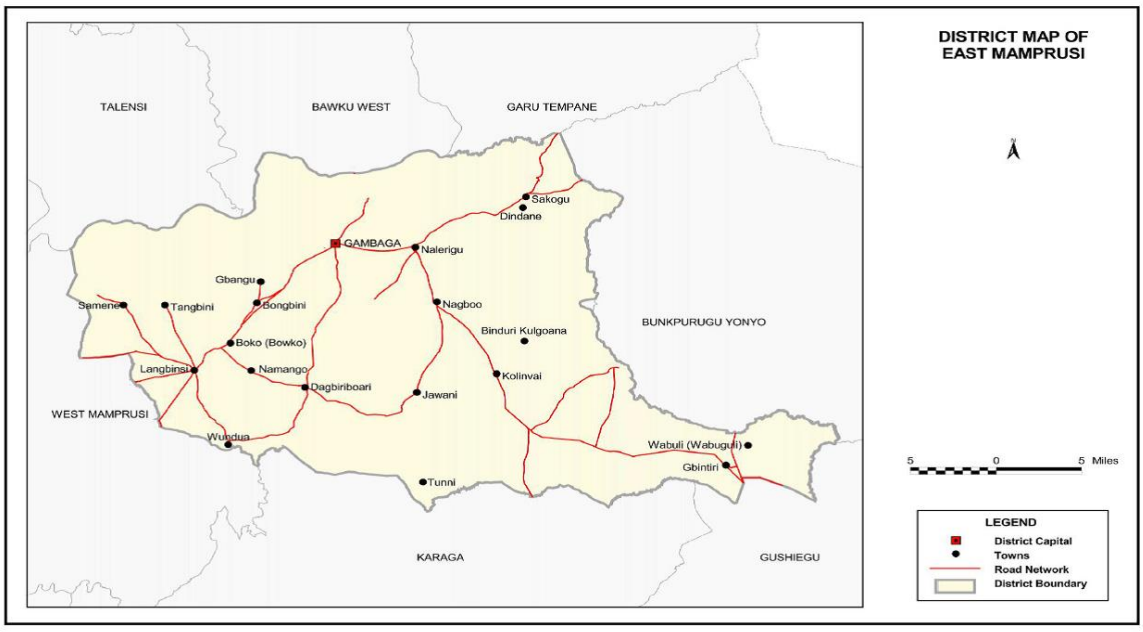
1) Increased % of young people who are reached with SRHR information and education from the GUSO programme
2) Increased % of young people who perceive the SRHR information and education as beneficial to them
3) Increased % of young people (from the catchment area) who access high-quality SRH services, including modern contraception and safe abortion for young people
4) Increased % of young people who use the referral system to access SRH services
5) Decreased % of young people with an unmet need for SRH services
6) Young people experience increased support from important stakeholders and gatekeepers in accessing and using SRHR information and services.

The above indicators were assessed using a quantitative survey. KIT developed a generic questionnaire for the GUSO alliance. This was consequently modified in collaboration with the GUSO country alliance and research team to be specific to the Ghanaian context. The questionnaire covers issues about girls' and boys' knowledge on SRHR, their level of access to SRHR information and services, whether they find the information and services beneficial and appropriate or not, contraception access and use, referral systems and the level of support received from relevant stakeholders. The questionnaire was first developed for the baseline that took place in 2017. For the midline, the same questionnaire was used to ensure comparability. Some questions were added to reflect the programme implementation and feedback was taken from the GUSO partners in Ghana.

At endline, additional questions were added to understand the impact of COVID-19 and related restrictions on the lives of young people. It is also expected that the pandemic may influence some study outcomes. These questions can serve to provide insight into this.

Study areas

The criteria for choosing the study area were that the GUSO intervention needed to be active there and that the areas needed to be the same as the baseline to ensure comparability. Hence, the study area of East Mamprusi District in Northern Ghana was chosen by the GUSO country alliance. The survey was conducted in Gambaga, Zogligu, Dagbiribuari, Langbina, Langbinsi, Samani, Wundua, Namangu, and Bowku (Figure 1).



Source: Ghana Statistical Service, Population and Housing Census

Figure 1 Map of district

Source: Ghana statistical service, Population & Housing Census, 2010

Study participants and sample size

The nature of the performance study did not require a sample size calculation, as the study focuses on how the measurements compare to the country-specific programme indicators and targets which have been set for them. Hence, the only consideration in arriving at a sample size was that the sample needed to be representative of the scale of the GUSO interventions and the population size of the catchment area. Furthermore, the sample size needed to be similar to the sample size during the midline in 2018.

Young people between the ages of 15 and 24 years were surveyed. Respondents were recruited at the via schools and health facilities (Table 1). The GUSO alliance was responsible for facilitating this. The sample consisted of 765 young people, which was the same as the sample size at the midline.

Table 1 Respondents sampled by school/health facility at endline

Study sites- schools and health facilities		n	%
Bowku	Unity JHS	19	2%
	Bowku CHPS	23	3%
	Other	0	0%
Dagbiribuari	Dagbiribuari D/A prim	30	4%
	Baptist Medical Centre	50	7%
	Other	0	0%
Gambaga	Gambaga presby JHS	84	11%
	Gambaga presby prim	64	8%
	Gambaga Health Centre	28	4%
Langbina	Langbina D/A prim	47	6%
	Sakogu Health Centre	23	3%
Langbinsi	Langbinsi A/G prim	33	4%
	Charity JHS	14	2%
	Unity JHS	11	1%
	RC JHS	48	6%
	Langbinsi Health Centre	24	3%
	Langbansi Presby Health Centre	6	1%
	Other	0	0%
Namangu	RC JHS	30	4%
	Namangu CHPS	32	4%
	Other	0	0%
Samani	RC Junior High School (JHS)	52	7%
	Samani CHPS	18	2%
	Other	0	0%
Wundua	District Assembly JHS	18	2%
	Other	0	0%
Zogligu	Zogligu D/A prim	110	14%
Other		1	0%
Total number of respondents		765	765

Training and data collection

The Ghana SRHR alliance was responsible for data collection with the support of KIT. Prior to data collection, the KIT team discussed the survey and changes that were made with the in-country team. Study sites and sample size were also discussed. After the survey was finalized, the KIT team familiarised the GUSO in-country team with the tablets. KIT provided tablets, infrastructure for the survey (incorporating the survey into a tablet-friendly format and the server needed to host the surveys) and the online tools such as guidelines and relevant instructions for the process. Considerations regarding the consent process and quality management of the data were discussed. Regular Skype calls were held and there was consistent communication via email during the data collection process.

Data quality assurance

Once a survey was completed on the tablet, it was automatically uploaded to the KIT-managed server. This allowed the KIT team and the GUSO alliance country staff to monitor the data real-time and point out any anomalies in sample size, composition or responses. Data quality was assured through the building in of skipping patterns and limitations for filling in of certain values in the survey forms in the tablets.

Data processing and analysis

Data were processed in Stata and basic demographics and statistics were analysed. Note that all percentages in the text are rounded[7].

In addition, the survey consisted of many multiple response questions where respondents could choose more than one answer. In this case, percentages are calculated by taking the number of responses to that question divided by the number of respondents who answered that question. This implies that each answer option is independent and the percentages for the set of answers/choices cannot be totalled, as it would exceed 100%%. For each of these questions, it is indicated in the report that multiple answers were permitted.

For many questions, the answer option of NGO was provided to the respondent. The responses to this must be interpreted with caution as NGOs often work with other stakeholders such as teachers and health workers, making it difficult to differentiate. Moreover, the survey design did not allow for the specific names of NGOs to be mentioned for purposes of feasibility. However, in questions related to the GUSO programme, GH Alliance was specifically mentioned.

Ethical considerations

Oral consent was obtained from the respondents and this was documented in the survey. Appropriate skipping patterns were employed in the survey in case of questions relating to sensitive issues such as abortion, contraception and sexually transmittable infections (STIs). Due to COVID-19, the methodology was adapted slightly to ensure that the endline could be conducted in an ethical and safe manner. For this reason, measures to mitigate COVID-19 were put in place during the fieldwork to ensure that it was aligned with the national regulations and considered the safety of respondents and the research team. This included provision and use of protective equipment, physical distancing and hygiene practices. Additional steps were taken to explain to respondents - which precautions research assistants were taking to mitigate against the chance of COVID-19 transmission. The GUSO staff in-country ensured adherence to these standards throughout the data collection.

Limitations

The survey conducted provides insight into several indicators directly connected to the GUSO programme. However, it is not possible to draw conclusions about changes at the district level, as the sampling method does not allow this. As mentioned earlier, there is no qualitative component which can shed deeper insight into the findings. However, this study serves to contribute to the larger evaluation of the programme. Hence, these findings will contribute to that triangulation and synthesis carried out by the GUSO alliance.

In addition, there were some changes in overall composition of the sample at endline compared to base- and mid-line. Although no statistical weights are applied to correct for this, where most relevant, results disaggregated by gender and age are discussed to mitigate for this effect.

[7] This may result in totals that exceed or do not exactly equal 100%.

In addition, there were some changes in overall composition of the sample at endline compared to base- and mid-line. Although no statistical weights are applied to correct for this, where most relevant, results disaggregated by gender and age are discussed to mitigate for this effect.

As mentioned, COVID-19 may confound some of the outcomes and findings. The added questions relating to COVID-19 are expected to mitigate this and provide better insight as to the probable effect of COVID-19 on survey findings.

4. Results

Demographics

The sample consisted of 765 young people, of whom 63% were young women and 37% were young men (Table 2). This is similar to the gender breakdown of the base- and midline samples, which both contained more young women than men. The total sample was similar or identical in size to those at baseline (737) and midline (765) respectively.

At endline, around 8 in 10 (82%) of respondents reported to be within the 15 to 19 years age bracket, and the remainder were aged between 20 to 24 years. This meant that the sample is slightly younger at endline than at base- and midline, when lower proportions of 76% and 71% (respectively) were in the 15 to 19 year age group. The younger age skew at endline was more apparent among the male respondents than the female, as the mean age of male respondents at endline was 17.1 years, compared to the mean male age at midline of 18.2 years. The mean age for female respondents was more similar across study stages: this was 17.5 years at endline compared to the 17.8 years for females at midline. At baseline the mean age of female respondents was similar to that of endline, at 17.5 years, while at baseline, males were older than those at endline with a mean baseline age of 18.5 years.

The survey covered nine districts. Among these the highest proportion of respondents was from Gambaga (23% of endline respondents), followed by the 18% of respondents from Langbinsi. The other seven districts accounted for 5-15% of respondents, apart from Wundua where only 2% of the sample was located.

Around 8 in 10 of the sample (82%) stated their ethnicity as Mamprusi, followed by the between 1-6% who stated their ethnicities as Frafa (6%), Komkomba (4%), Other (4%) and Gonja (1%). Mamprusi was also the most commonly stated ethnicity at base- and midline. The majority of the sample identified as being Muslim (71%), with almost all of the remainder (28%) identifying themselves as Christian. Only two respondents stated they had no religion.

A higher proportion of respondents (more than 7 in 10, or 74%) described themselves as single during the endline than at midline, when just under 6 in 10 (58%) young people stated this, or baseline (when around half (53%) described their relationship status in this way). This increase of single respondents at endline was mainly due to the decreased proportions stating that they had a boyfriend or girlfriend (just 17% at endline, compared to around a third each at midline at baseline; 33% and 36%, respectively). Similarly, while at endline 6% of respondents stated they were married, at midline 9% described their relationship status in this way, the same proportion as at baseline. This is consistent with the fact that the reported age of respondents at endline was younger. However, at endline there was a small increase in the proportion stating they lived together with a partner they were not married to (3% at endline, compared to 0% at midline). At endline 3 female respondents (<1%) stated that they had a girlfriend, and 7 male respondents stated they had a boyfriend (2%). The proportion of males stating they have a same-sex partner has increased slightly over time, while the proportion of females reporting same-sex relationships has remained steady. No endline respondent described themselves as being divorced. A small number (less than 1%) at base- and midline stated that they were divorced.

The data for reported household size is not consistent with reported household members, across all study stages. This data has therefore been excluded from the analysis.

Table 2 Sample demographics (by sex)

	Baseline						Midline						Endline					
	Young women		Young men		Total		Young women		Young men		Total		Young women		Young men		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Sample size	525	71%	212	29%	**737**	**100%**	453	59%	312	41%	**765**	**100%**	480	63%	285	37%	**765**	**100%**
15 - 19	419	80%	143	67%	**562**	**76%**	327	72%	214	69%	**541**	**71%**	384	80%	240	84%	**624**	**82%**
20 - 24	106	20%	69	33%	**175**	**24%**	126	28%	98	31%	**224**	**29%**	96	20%	45	16%	**141**	**18%**
District																		
Bowku	22	4%	7	3%	**29**	**4%**	70	15%	45	14%	**115**	**15%**	25	5%	17	6%	**42**	**5%**
Dagbiribuari	71	14%	12	6%	**83**	**11%**	36	8%	27	9%	**63**	**8%**	51	11%	29	10%	**80**	**10%**
Gambaga	99	19%	80	38%	**179**	**24%**	51	11%	51	16%	**102**	**13%**	113	24%	63	22%	**176**	**23%**
Langbina	50	10%	10	5%	**60**	**8%**	0	0%	0	0%	**0**	**0%**	33	7%	37	13%	**70**	**9%**
Langbinsi	125	24%	44	21%	**169**	**23%**	140	31%	94	30%	**234**	**31%**	96	20%	40	14%	**136**	**18%**
Namangu	28	5%	6	3%	**34**	**5%**	35	8%	30	10%	**65**	**8%**	38	8%	24	8%	**62**	**8%**
Samani	56	11%	31	15%	**87**	**12%**	50	11%	20	6%	**70**	**9%**	45	9%	25	9%	**70**	**9%**
Wundua	39	7%	11	5%	**50**	**7%**	60	13%	36	12%	**96**	**13%**	13	3%	5	2%	**18**	**2%**
Zogligu	33	6%	11	5%	**44**	**6%**	10	2%	9	3%	**19**	**2%**	66	14%	45	16%	**111**	**15%**
Other	2	0.4%	0	0%	**2**	**0.3%**	1	0.2%	0	0%	**1**	**0.1%**	0	0%	0	0%	**0**	**0%**
Ethnicity																		
Dagomba	43	8%	13	6%	**56**	**8%**	32	7%	28	9%	**60**	**8%**	11	2%	10	4%	**21**	**3%**
Frafa	48	9%	30	14%	**78**	**11%**	32	7%	23	7%	**55**	**7%**	31	6%	16	6%	**47**	**6%**
Gonja	20	4%	8	4%	**28**	**4%**	7	2%	10	3%	**17**	**2%**	2	0%	2	1%	**4**	**1%**
Komkomba	29	6%	11	5%	**40**	**5%**	7	2%	8	3%	**15**	**2%**	21	4%	11	4%	**32**	**4%**
Mamprusi	337	64%	116	55%	**453**	**61%**	312	69%	211	68%	**523**	**68%**	396	83%	235	82%	**631**	**82%**
Other	48	9%	34	16%	**82**	**11%**	63	14%	32	10%	**95**	**12%**	19	4%	11	4%	**30**	**4%**
Religion																		
Christian	158	30%	73	34%	**231**	**31%**	146	32%	87	28%	**233**	**30%**	131	27%	87	31%	**218**	**28%**
Muslim	364	69%	134	63%	**498**	**68%**	293	65%	211	68%	**504**	**66%**	348	73%	197	69%	**545**	**71%**
Traditional	1	0.2%	5	2%	**6**	**1%**	7	2%	8	3%	**15**	**2%**	0	0%	0	0%	**0**	**0%**
None	2	0.4%	0	0%	**2**	**0.3%**	7	2%	6	2%	**13**	**2%**	1	0.2%	1	0.4%	**2**	**0.3%**

Relationship status																		
Single	263	50%	124	58%	**387**	**53%**	260	57%	181	58%	**441**	**58%**	331	69%	232	81%	**563**	**74%**
Boyfriend	196	37%	1	0%	**197**	**27%**	145	32%	0	0%	**145**	**19%**	88	18%	7	2%	**95**	**12%**
Girlfriend	5	1%	65	31%	**70**	**9%**	4	1%	105	34%	**109**	**14%**	3	1%	30	11%	**33**	**4%**
Married	49	9%	17	8%	**66**	**9%**	44	10%	24	8%	**68**	**9%**	41	9%	7	2%	**48**	**6%**
Living together	11	2%	4	2%	**15**	**2%**	0	0%	1	0.3%	**1**	**0%**	17	4%	9	3%	**26**	**3%**
Widowed	0	0%	0	0%	**0**	**0%**	0	0%	0	0%	**0**	**0%**	0	0%	0	0%	**0**	**0%**
Divorced	1	0.2%	1	0.5%	**2**	**0.3%**	0	0%	1	0.3%	**1**	**0.1%**	0	0%	0	0%	**0**	**0%**
Number of household family members[8]																		
One to two	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Three to four	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Five to seven	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Eight or more	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Table 3 Sample demographics - education and employment (by sex)

	Baseline						Midline						Endline					
	Young women		Young men		Total		Young women		Young men		Total		Young women		Young men		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
School status																		
In school	332	63%	134	63%	**466**	**63%**	243	54%	171	55%	**414**	**54%**	363	76%	242	85%	**605**	**79%**
Out-of-school	193	37%	78	37%	**271**	**37%**	210	46%	141	45%	**351**	**46%**	117	24%	43	15%	**160**	**21%**
Highest level of education completed																		
No formal education	31	6%	4	2%	**35**	**5%**	17	4%	9	3%	**26**	**3%**	64	13%	13	5%	**77**	**10%**
Not finished	267	51%	96	45%	**363**	**49%**	48	11%	47	15%	**95**	**12%**	358	75%	240	84%	**598**	**78%**
Junior High	176	34%	63	30%	**239**	**32%**	287	63%	192	62%	**479**	**63%**	48	10%	27	9%	**75**	**10%**

[8] The data for reported household size is not consistent with reported household members, across all study stages. This data has therefore been excluded from the analysis.

Senior High	43	8%	35	17%	**78**	**11%**	71	16%	36	12%	**107**	**14%**	8	2%	4	1%	**12**	**2%**
Tertiary	4	1%	14	7%	**18**	**2%**	28	6%	24	8%	**52**	**7%**	2	0.4%	0	0%	**2**	**0.3%**
Vocational Technical	4	1%	0	0%	**4**	**1%**	2	0.4%	4	1%	**6**	**1%**	0	0%	1	0.4%	**1**	**0.1%**
Current level of education																		
Junior high	306	58%	113	53%	**419**	**57%**	214	47%	145	46%	**359**	**47%**	348	73%	235	82%	**583**	**76%**
Senior high	15	3%	10	5%	**25**	**3%**	20	4%	17	5%	**37**	**5%**	15	3%	6	2%	**21**	**3%**
Tertiary	8	2%	10	5%	**18**	**2%**	8	2%	9	3%	**17**	**2%**	0	0%	1	0.4%	**1**	**0.1%**
Vocational	3	1%	1	0.5%	**4**	**1%**	1	0.2%	0	0%	**1**	**0.1%**	0	0%	0	0%	**0**	**0%**
Ever dropped out of school																		
Yes	164	31%	54	25%	**218**	**30%**	146	32%	100	32%	**246**	**32%**	133	28%	44	15%	**177**	**23%**
No	361	69%	158	75%	**519**	**70%**	307	68%	212	68%	**519**	**68%**	347	72%	241	85%	**588**	**77%**
Currently in work or employment																		
Yes	134	26%	81	38%	**215**	**29%**	159	35%	138	44%	**297**	**39%**	144	30%	81	28%	**225**	**29%**
No	391	74%	131	62%	**522**	**71%**	294	65%	174	56%	**468**	**61%**	336	70%	204	72%	**540**	**71%**
Type of work or employment																		
Casual, daily labour	23	4%	20	9%	**43**	**6%**	42	9%	20	6%	**62**	**8%**	35	7%	22	8%	**57**	**7%**
Contract work	6	1%	2	1%	**8**	**1%**	6	1%	14	4%	**20**	**3%**	0	0%	2	1%	**2**	**0.3%**
Subsistence farming	20	4%	24	11%	**44**	**6%**	16	4%	56	18%	**72**	**9%**	24	5%	26	9%	**50**	**7%**
Full-time permanent salaried employment	3	1%	6	3%	**9**	**1%**	5	1%	3	1%	**8**	**1%**	1	0.2%	3	1%	**4**	**1%**
Informal trading	32	6%	2	1%	**34**	**5%**	24	5%	0	0%	**24**	**3%**	29	6%	4	1%	**33**	**4%**
Part-time permanent salaried employment	2	0.4%	3	1%	**5**	**1%**	16	4%	6	2%	**22**	**3%**	0	0%	1	0.4%	**1**	**0.1%**
Self-employed	23	4%	11	5%	**34**	**5%**	37	8%	30	10%	**67**	**9%**	44	9%	17	6%	**61**	**8%**
Unpaid work (e.g. homemaker/ housewife)	11	2%	1	0.5%	**12**	**2%**	8	2%	6	2%	**14**	**2%**	11	2%	2	1%	**13**	**2%**
Other	14	3%	12	6%	**26**	**4%**	5	1%	3	1%	**8**	**1%**	0	0%	4	1%	**4**	**1%**

Of the 29% of respondents (n = 225) who were employed, 27% said that they were self-employed, followed by 25% engaged in casual labour and 22% engaged in farming. These were also the three most common employment categories at base- and midline (though at baseline an equal number stated they were in informal employment as were self-employed). The proportion of the sample who stated that they were self-employed has slightly increased since midline (when 23% stated this), also an increase from baseline when 16% of respondents in employment were self-employed. It is not clear whether COVID-19 has had an effect on these employment-related demographics, but overall the proportion who stated that they were working or in employment has dropped since midline when 39% stated this (Table 3). This is consistent with responses to the questions relating to the COVID-19 pandemic added at endline, which saw 11% of respondents stating that they were no longer able to work to the same extent due to the effects of the pandemic.

The proportion of respondents who indicated that they had ever dropped out of school was around 1 in 4 (23%), which has reduced since midline (when just under a third (32%) stated this) and baseline, when 30% said they had ever dropped out of school. This is a positive trend. However it should be noted that at endline female respondents were almost twice as likely to report having ever dropped out as males (28% of female respondents compared to 15% of males). Figure 2 gives an overview of the reasons young people gave for dropping out of school[9]. The most commonly stated reason for this at endline was illness (43%), followed by lack of fees (27%), domestic/family responsibilities (26%), and pregnancy or having a child (23%) (multiple responses were allowed). The reasons most commonly stated by respondents for having dropped out of school have therefore shifted slightly since base- and midline, although the most commonly stated four reasons have more or less remained the same. For example, at baseline the most common reason was pregnancy or having a child (36%), while at midline it was lack of fees/materials (35%), and at endline it was illness (43%).

It should be noted that there is a gendered aspect to the breakdown of the reasons for respondents dropping out of school, as well as to the likelihood of having ever dropped out of school[10]. Of the 184 respondents who dropped out due to pregnancy or having a child (one answer option) at base-, mid- and endline combined, all but 19 were young women. The proportion of young women stating this reduced over time; while at baseline pregnancy/having a child was by far the most common reason given by female respondents for dropping out of school (reported by almost half (47%) of female respondents who had dropped out), this reduced to around a third (36%) at midline but was still the reason most commonly reported by female respondents. At endline however, pregnancy/having a child was not the most commonly stated reason for dropping out of school among female respondents, as only 1 in 4 (26%) stated this compared to 39% who reported that the reason was related to illness. The numbers of males who reported having dropped out at each study stage is too low to merit a fruitful analysis of the trends in individual reasons for dropping out over time.

[9] Multiple responses were possible

[10] As noted above, at endline female respondents were almost twice as likely to report having dropped out of school as males

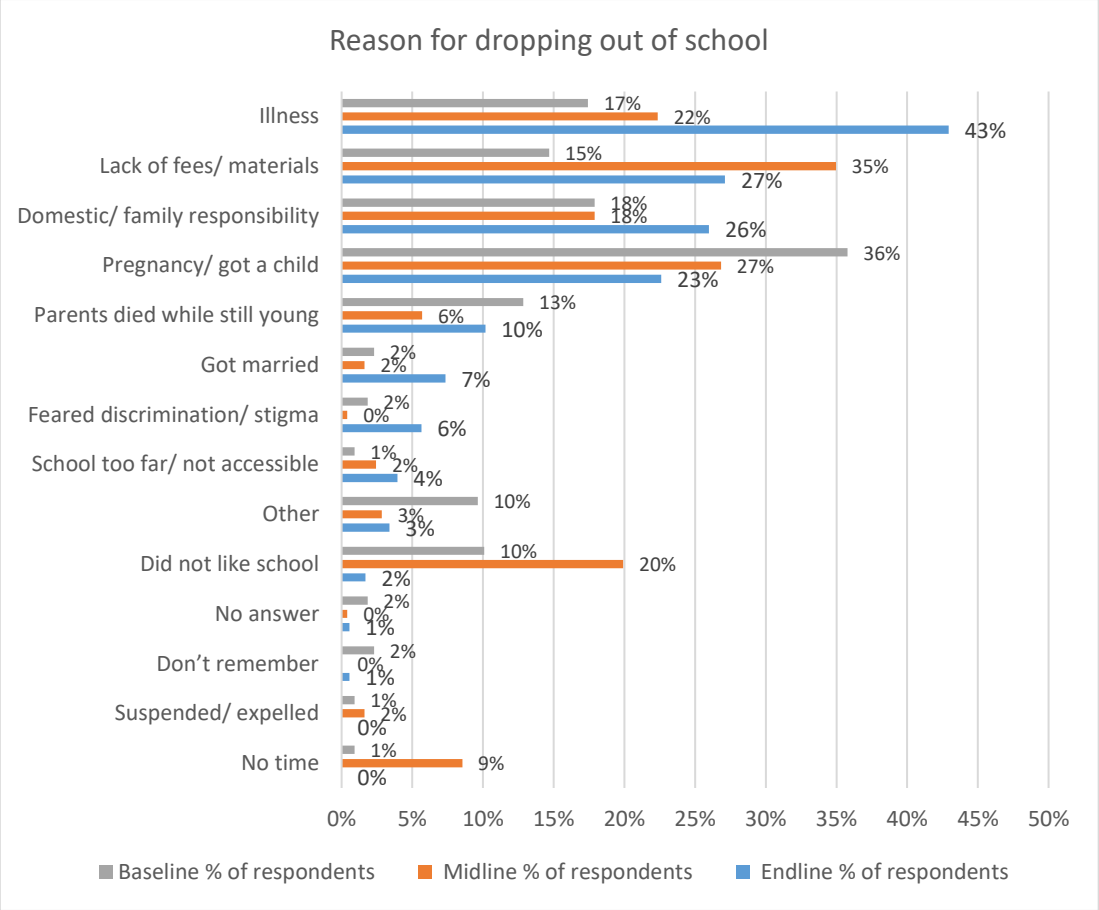


Figure 2 Reasons for dropping out of school (baseline n=311, midline n=156, endline n=180)

An overwhelming majority of the endline sample reported having ever participated in the GUSO programme. Ninety-eight percent (98%) of the endline sample reported this, whereas only 1% stated that they had not. Only 1 respondent stated that they did not know about the GUSO programme (Table 4). There was therefore an increase in the proportion stating that they had ever participated in the GUSO programme, from 82% at midline.

Table 4 Participation in GUSO

Have you ever participated in the GUSO Programme?	Midline						Endline					
	Young women		Young men		Total		Young women		Young men		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Yes	365	81%	259	83%	624	82%	472	98%	281	99%	753	98%
No	71	16%	38	12%	109	14%	7	1%	3	1%	10	1%
Don't know	3	1%	5	2%	8	1%	0	0%	1	0%	1	0%
Don't know GUSO	14	3%	10	3%	24	3%	1	0%	0	0%	1	0%

Changes regarding SRHR information and education

Changes in SRHR Information

Ninety-eight percent (98%) of respondents reported having ever received information about SRHR at endline, as compared to 88% at midline and 65% at baseline. There has therefore been a steady

increase in this indicator over time. Of these respondents, 99% reported having received the information through GUSO at endline. This proportion has also increased over time, from 2% at baseline, and 91% at midline. All of the sample (100%) said that they found it easy to obtain this information at the endline, an increase compared to the 8 in 10 at midline (80%) and baseline (84%). The decrease in reported ease of obtaining information from base- to midline may have been because an additional answer option of 'moderate' was added for this question at midline and 1 in 10 (11%) of the midline sample chose this as a response. As at previous stages of the study, almost all the young people who ever received information about SRHR (99%) said that they found it beneficial (Table 5). Please note that this indicator has been calculated differently at the midline (see footnote 2).

Table 5 SRHR information

		Total	
		n	%
# and % of young men and women between 15 – 24 years who ever received information about SRHR	Baseline	481	65%
	Midline	675	88%
	Endline	753	98%
# and % of young men and women who received SRHR information through GUSO (among those who did receive information)	Baseline	10	2%
	Midline	612	91%
	Endline	748	99%
# and % of young men and women who found it easy to obtain SRHR information	Baseline	405	84%
	Midline	540	80%
	Endline	750	100%
# and % of young men and women who found the information beneficial (among those who did receive information)[11]	Baseline	459	95%
	Midline	675	100%
	Endline	749	99%

Respondents more commonly reported receiving SRHR information from each possible source of information at endline compared to midline. (Figure 3). The only sources of information that bucked this trend were 'Traditional Leader', which decreased from 4% to 3%, and 'Teacher', which decreased from 90% to 82%. In addition, those stating that they received information from 'other' sources dropped, from 5% at midline to 0% at endline while those stating they received information from religious leaders only increased by one percentage point, from 1% to 2%. The majority of 'other' responses related to NGOs.

[11] This indicator was calculated differently at the midline compared to base- and endline. This change was discussed with the GUSO consortia. At baseline, respondents were directly asked if they found the SRHR information that they received beneficial. Their answer was used to calculate this indicator. However at the midline, respondents were asked to indicate which topics the SRHR information that they received covered. As a follow-up question, respondents were asked which topics they found beneficial. Those respondents whose only answer was that they did not find any of the topics of information beneficial were excluded from this indicator. At endline, the indicator was calculated in the same way as at baseline (using answers to a direct question about whether respondents found information beneficial).

At midline, however, fewer respondents reported receiving information from six of the twelve sources compared to baseline. This trend has therefore reversed at endline.

At midline, 9 in 10 (90%) young people reported that teachers were a source of the SRHR information they received/acquired[12], followed by half (51%) who got this information from a health provider. At endline, however, the most common source of information was peer educator/counsellor, followed by health providers (both just under 9 in 10 (87%)). Both youth clubs and peer educators/counsellors saw a large increase since base- and midline.

Young people at endline also commonly mentioned receiving information from youth clubs (84%), teachers (82%), and media (TV, radio, newspaper/magazine) (69%).

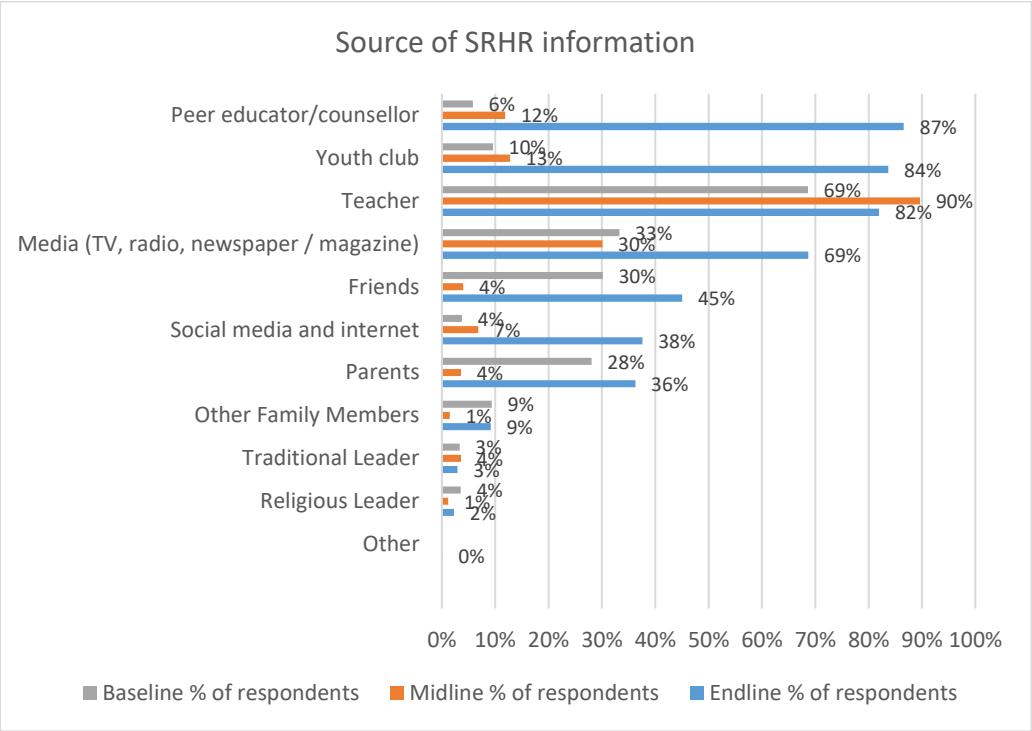


Figure 3 Source of SRHR information, % of respondents who stated these as ONE source of information, multiple answers were permitted for this question (baseline n=481, midline n=675, endline n=753)

When disaggregated by school status (Figure 3a), those who are in-school most commonly reported their sources of SRHR information to be teachers (96%), peer educators/counsellors (85%), youth clubs (84%), and health providers (84%). Those who were out-of-school also very commonly reported health providers (96%) peer educators/counsellors (85%), youth clubs (84%), and health providers (84%). In comparison to young people in-school, out-of-school youth were relatively less likely to report teachers and friends as sources of SRHR information, and more likely to report media and health providers.

[12] Multiple responses were possible

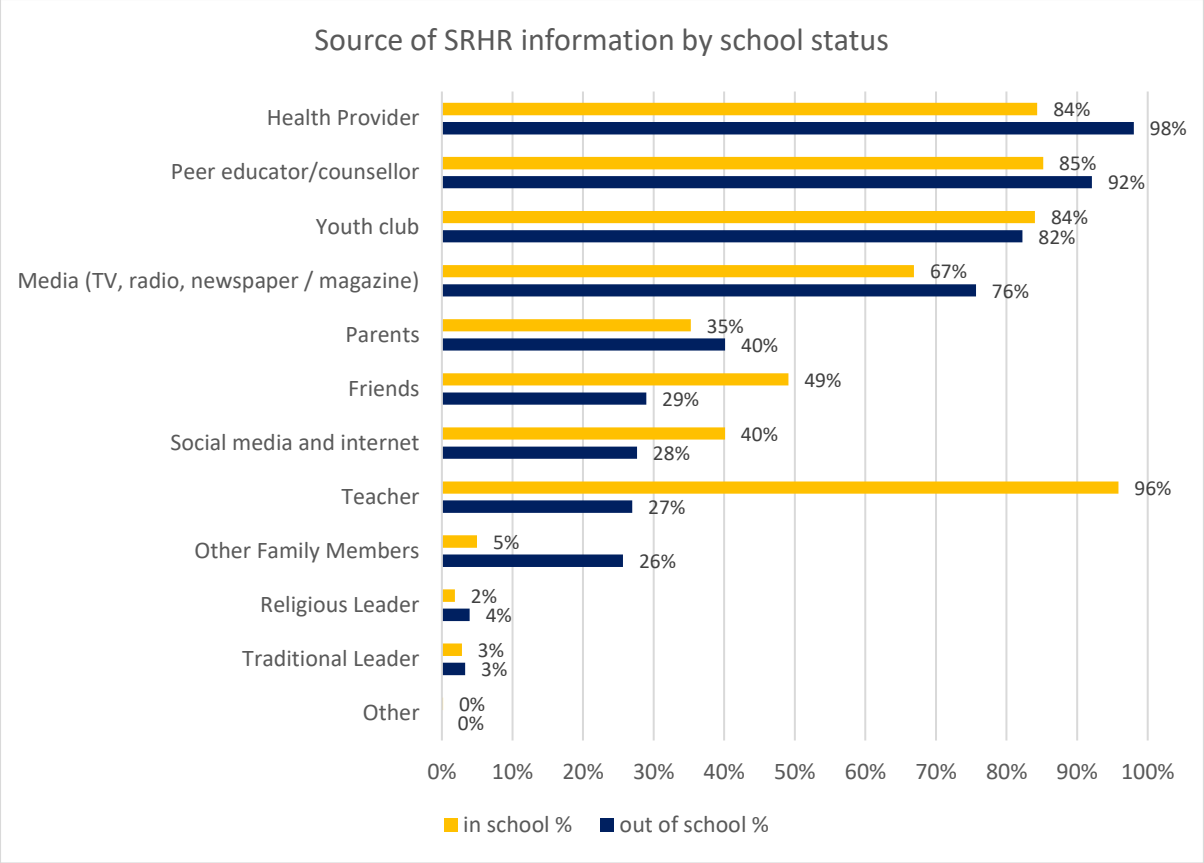


Figure 3a SRHR information and source for in- and out-of-school youth (Out-of-school n=152, In-school n=601)

Of those who received any SRHR information, all topics were reported as having been addressed by over 85% of respondents (Figure 4) [13]. There have been increases in the proportions of respondentsstating that they received information on all topics between midline and endline, with the largest absolute increases seen in 'Types of SRH services available' (from 52% to 91%), 'Where to access SRH Services' (from 60% to 95%), and 'Information regarding sexual harassment/abuse' (from 51% to 76%).

[13] This question was added at midline, hence no data for the baseline are available to compare.

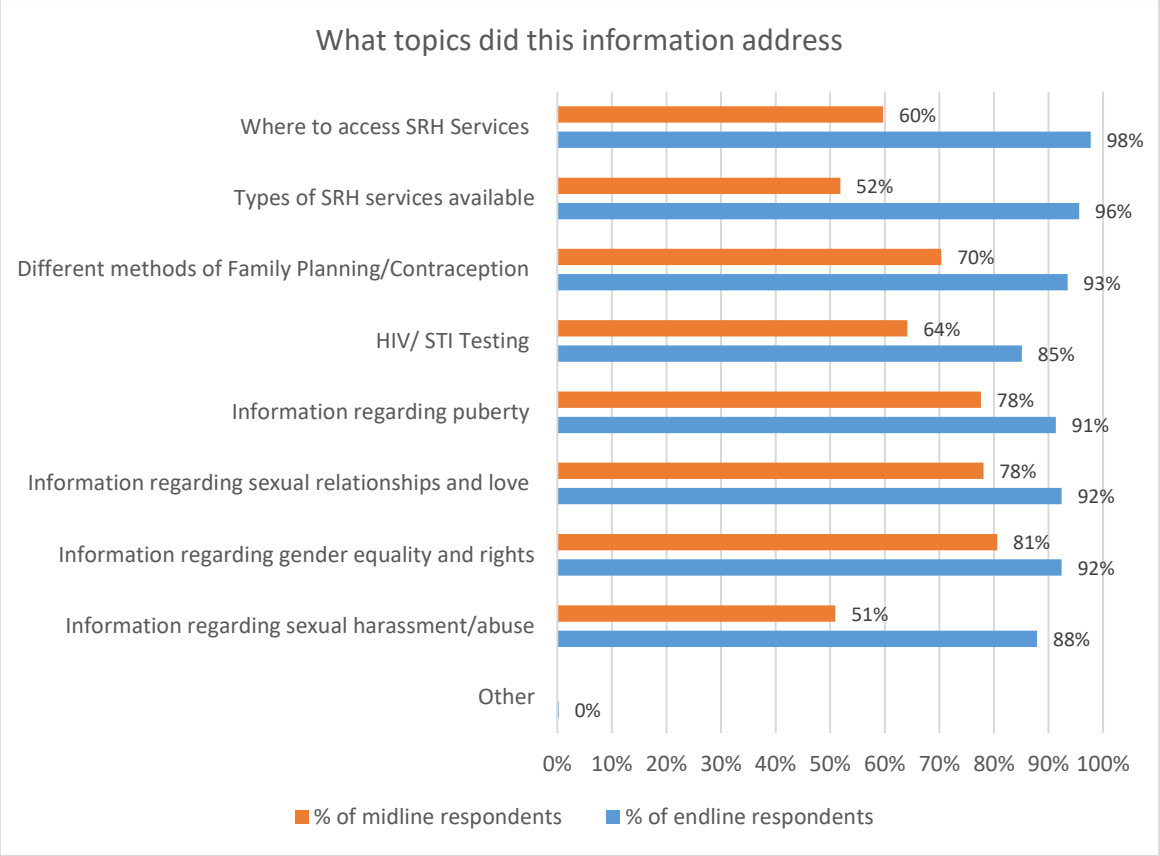


Figure 4 Topics that were addressed by the SRHR information (endline total n=753, midline total n=675)

Respondents were also asked which topics they found to be beneficial, of all the topics that were addressed. More than 75% of respondents[14] found each topic to be (one of the) 'most beneficial' (Figure 5).

While all topics were found beneficial by a large majority of respondents at endline, at midline this was not the case for any topics. There have therefore been large increases in the proportion of respondents finding topics of SRHR information to be (one of the) most beneficial from mid- to endline. This has been particularly marked in relation to 'Where to access SRH services' (an increase from 28% to 95%), and 'Types of SRH service available' (an increase from 26% to 91%). These were also the two topics most commonly found beneficial by respondents at endline. This could be attributable to the different way the question was asked at midline compared to base- and endline, which compromises direct comparability across study stages. At baseline, respondents were asked if they found (any of) the SRHR information that they received beneficial. If they responded that they had, they were then asked to state which of the information they found 'most beneficial' (they were able to indicate multiple topics as most beneficial). However at midline, respondents were asked to indicate which topics the SRHR information that they received had covered. As a follow-up question, respondents were asked which topics they found beneficial, with the additional possibility of responding that they did not find any of the topics of information beneficial. At endline, this question was asked in the same way as at baseline.

[14] Excluding the respondents who either didn't receive SRHR information (12 respondents), or who received SRH information but did not find SRH information on any of the topics beneficial (4 further respondents)

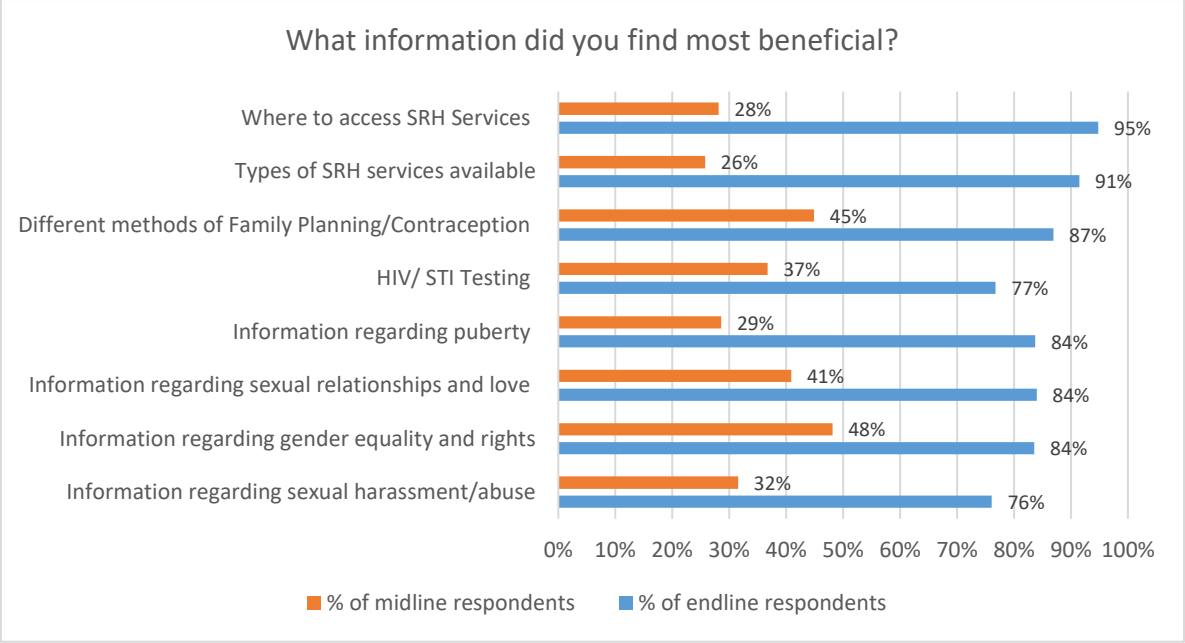


Figure 5 SRHR information topics that were found beneficial (multiple responses were possible) (midline n=675 , endline n=749)

Young people who received information on each topic were also more likely to find that information to be (one of) the most beneficial at endline, compared to midline. Across all topics, a higher percentage of respondents at endline indicated that they found information received on that topic beneficial than at midline[15]. As seen in Figure 6, this increase has been particularly pronounced in relation to 'Information regarding puberty'. Thirty-seven percent (37%) of the 193 respondents who received this information found it beneficial at midline, compared to 9 out of 10 (91%) who found it beneficial at endline. In addition, there have been large increases in the proportions of those finding information received on 'Where to access SRH services', and 'Types of SRH services available', both of which have seen 45-50 percentage point increases. More than 85% of respondents who received information on all topics found that information to be beneficial at endline.

[15] The one exception to this is information on 'other' topics, which no respondents indicated they found most beneficial at endline. This is due to changes made to the skip pattern which meant that this answer option was not automatically displayed to respondents.

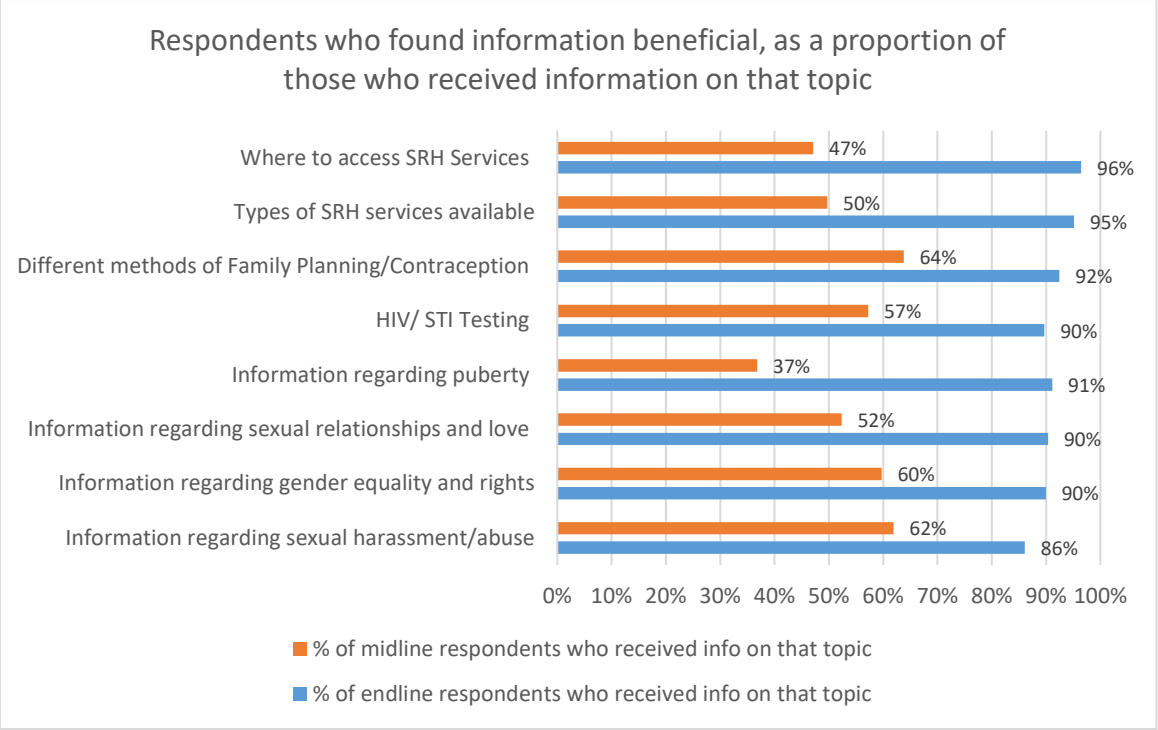


Figure 6 SRHR information topics that were found beneficial, as a proportion of those who received information on this topic (midline n=675 , endline n=749)

The vast majority of young people felt that the information was beneficial because they could use it in their daily life or that the information met their needs (94%), that the information was easy to understand (94%) and that the provider made the respondent feel comfortable (88%) (Figure 7). These were also common responses at midline, stated by the majority of respondents, but the proportions indicating these reasons have increased at endline in comparison to midline.

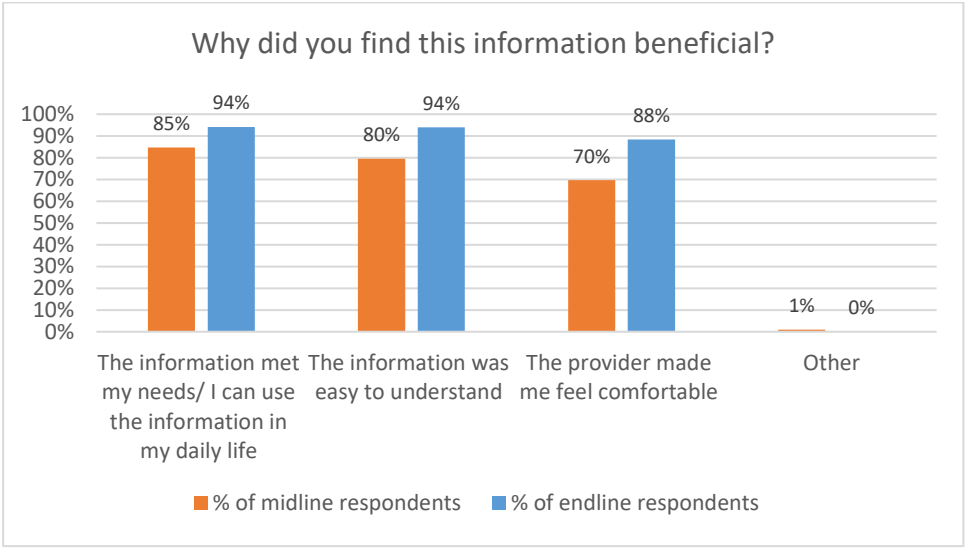


Figure 7 Reasons why the SRHR information (topics) was beneficial (midline n=675, endline n=749)

Twelve (12) respondents at endline indicated that they had never received SRHR information, which was just 1.6% of the total sample. This figure has decreased since midline, when 11.8% reported this, and is much lower than the 34.7% who reported this at baselines.

When asked about the reasons for not receiving SRHR information, respondents mostly stated that the information was not available or not needed (Figure 8). The small numbers of respondents to this question, particularly at endline, make it difficult to draw broader conclusions about trends in perceived reasons for not receiving SRH information.

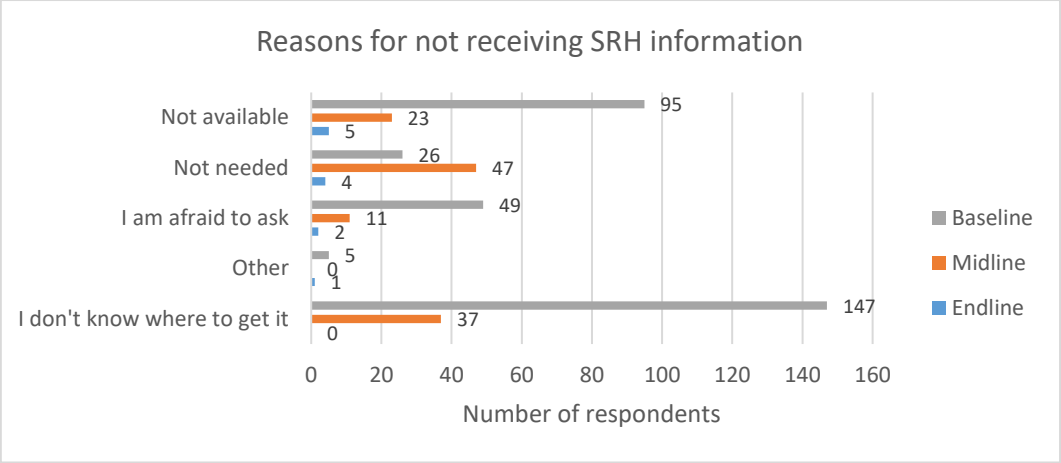


Figure 8 Number of respondents who listed these as one of the reasons for not receiving SRHR information (baseline n=256, midline n=90, endline n=12)

Changes in SRHR Education

The majority of young people surveyed had (ever) received SRHR education at all three study stages. The proportion of those who stated this has increased in comparison to baseline, and has remained steady in comparison to the proportion who had received SRHR education at midline. At baseline, 60% of respondents had ever received SRHR education, in comparison to 85% of respondents at midline. This proportion remained steady at endline, when 86% reported ever receiving SRHR education (Table 6).

Across mid- and endline, almost all respondents found the education received beneficial (over 99% at both of these study stages), although direct comparability across study stages is compromised due to the different way that this question was asked at midline. This proportion has increased since baseline, when a smaller majority of 93% of respondents had found the information beneficial. This could be partly attributed to the difference in how the question was asked at midline, compared to baseline and endline[16].

Table 6 SRHR education

		Total	
		n	%
	Baseline	442	60%

[16] This indicator was calculated differently at the midline compared to baseline and endline. This change was discussed with the GUSO consortia. At the baseline and endline, respondents were directly asked if they found the SRHR information that they received beneficial. Their answer was used to calculate this indicator. However at the midline, respondents were asked to indicate which topics the SRHR information that they received covered. As a follow-up question, respondents were asked which topics they found beneficial. Those respondents whose only answer was that they did not find any of the information (topics) beneficial were not included in this indicator.

# and % of respondents between 15 – 24 years who ever received education about SRHR	Midline	649	85%
	Endline	655	86%
# and % of respondents who found the education beneficial (of those who received education)	Baseline	409	93%
	Midline	649	100%
	Endline	652	100%

Respondents at all three stages were asked why they had not received SRHR education. At baseline, respondents most commonly stated that they did not know why they had not received SRHR education (42%) (Table 7). The second most common response was 'other' (27%), closely followed by 'Subject not reached yet in school' (26%). At midline, the proportion who did not know why they had not received SRHR education had increased to 78% (n=90). At endline, the most common response was 'other' (52% of respondents), and the second most common response was that the respondent's did not know (43%). Most of the elaborations given for the 'other' responses at endline related to the participant not attending school regularly, or having dropped out of school before this was taught. At base- and midline these were also common reasons given under 'other', but several respondents also stated that their not receiving SRHR education was attributable to a lack of available/appropriate teacher.

Table 7 Reasons for not receiving SRHR education

Reasons for not receiving SRHR education	Baseline		Midline		Endline	
	n	%	n	%	n	%
Don't know	124	42%	90	78%	47	43%
Other	80	27%	8	7%	57	52%
School does not provide	15	5%	11	9%	3	3%
Subject not reached yet in school	76	26%	7	6%	3	3%
My school stopped providing it due to COVID-19 and the restrictions[17]	n/a	n/a	n/a	n/a	0	0%
Total	295		116		110	

Across base-, mid- and endline, teachers were the most commonly cited source of SRHR education. This percentage citing teachers has increased slightly over time, from 91% at baseline to 96% at endline (Figure 9). Higher percentages of young people cited each source of SRHR education at endline compared to base- and midline. The percentage of respondents citing each source of SRHR education therefore increased over time. This is particularly notable in regards to peer educators (an increase from 7% at baseline to 76% at endline), and health workers (an increase from 14% to 74%). Apart from friends and school nurses or counsellors, more than 70% of respondents cited each answer option as a source of SRHR education.

[17] Answer option added at endline

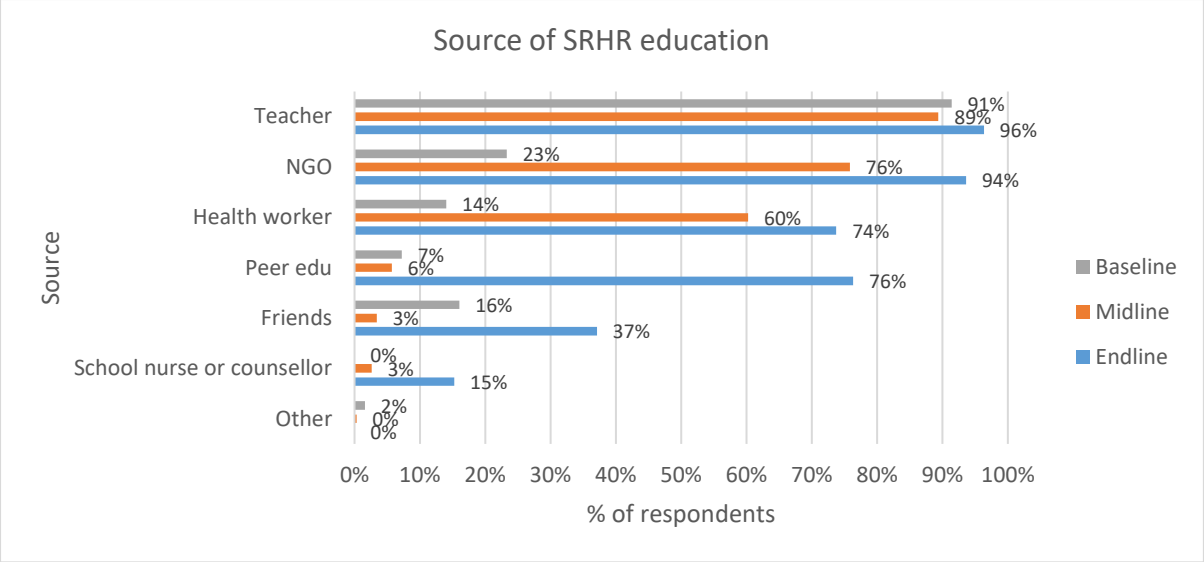


Figure 9 Source of SRHR education (baseline n=442, midline n=649, endline n=655)

Respondents who reported receiving SRHR education were asked which topics were covered. At endline, a large majority of these respondents reported that every topic that was read out to them was covered (Figure 10)[18]. These topics were wide ranging and comprehensive as can be seen in Figure 10. For each topic, more than 9 out of 10 (90%) respondents reported that topic was covered in the education they had received. The one exception was 'HIV/STI testing', which 86% of respondents who had received SRHR education reported was covered. At midline all topics were reportedly covered according to a majority of respondents, but the proportions reporting that these topics were covered has increased since midline in all cases.

The most notable changes from mid- to endline were the large increases in respondents indicating they received education regarding 'Types of SRH services available' (a 44 percentage point increase from 51% of respondents at midline to 95% at endline), 'Where to access SRH services' (an increase from 65% to 97%), and 'Different methods of family planning/contraception' (from 68% to 92%).

[18] This does not include the 'other' option.

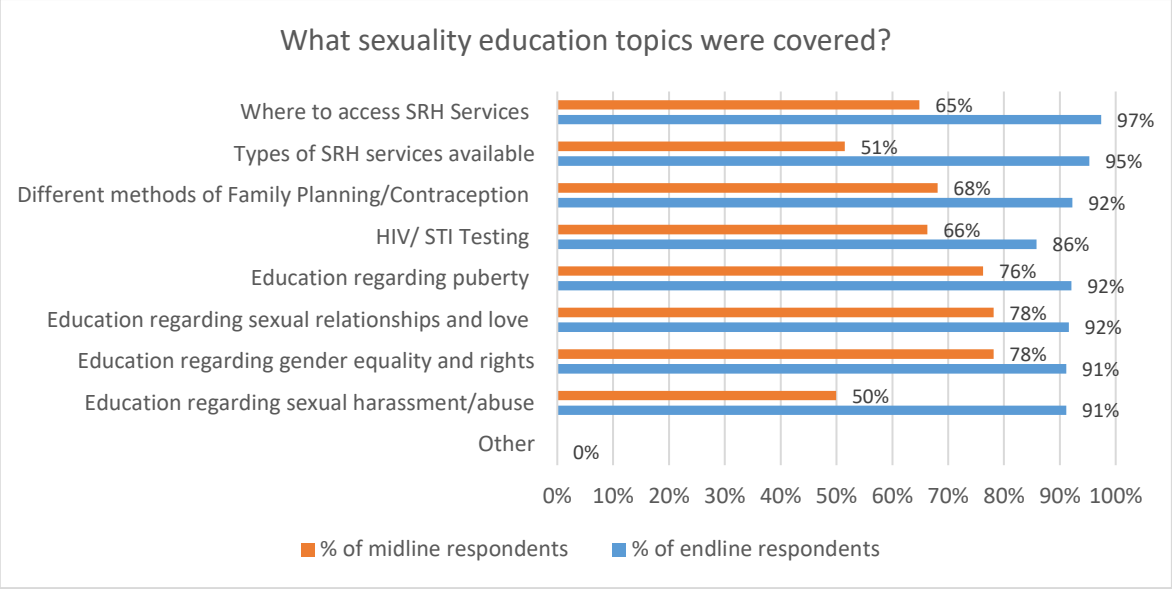


Figure 10 Topics that the SRHR education addressed (midline n=649, endline n=655)

As Figures 11 illustrates, there were considerable increases between mid- and endline in the proportion of respondents who reported finding different topics of SRHR education beneficial. These increases were also present among those who had received education on that specific topic (Figure 12). This was the case for all topics of education. At endline, at least 85% of those who had received education on any given topic found that education beneficial across all topics (Figure 13). At midline, 40%-65% of respondents who received education on any given topic found it most beneficial.

At endline, respondents who received education on the topics of 'Where to access SRH services', and 'Types of SRH services available' were particularly likely to state that they found this education beneficial (95% and 93% respectively). These were also the topics of information that respondents were most likely to report finding most beneficial.

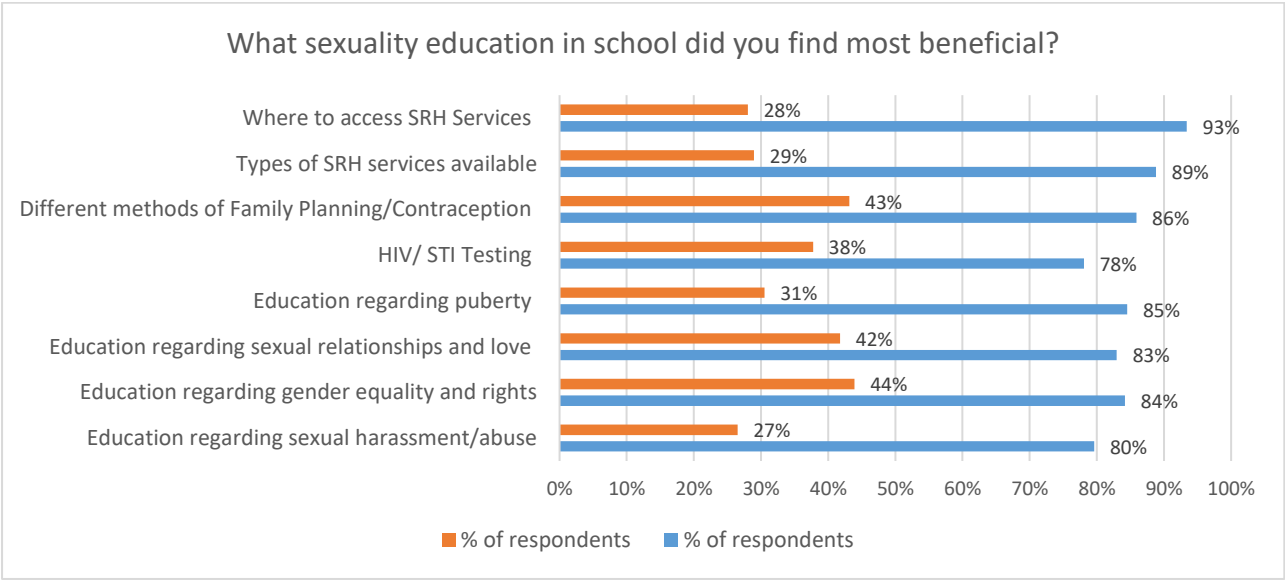


Figure 11 Topics of SRHR education that were found beneficial (midline n=649, endline n=652)

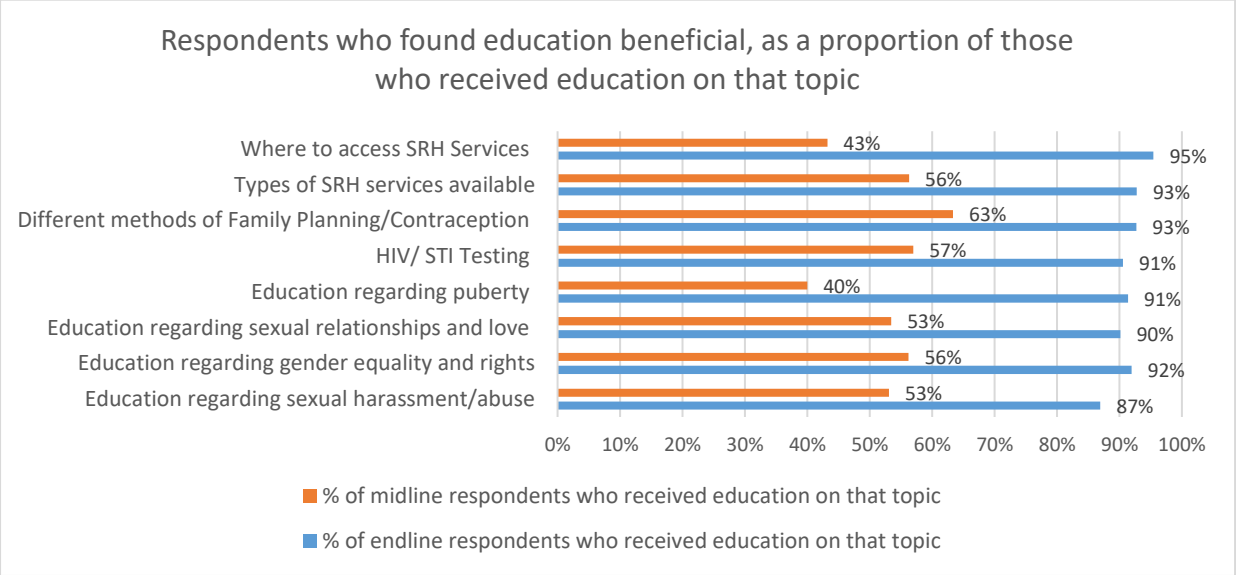


Figure 12 SRHR education topics that were found beneficial, as a proportion of those who received education on this topic (n varies by topic of education)[19]

Respondents were also asked why they found the SRHR education they received beneficial. At endline, respondents commonly stated that the information was easy to understand (95%), the information met their needs/the respondent could use it in their daily life (one answer option) (93%) and that the provider made them feel comfortable (90%) (Figure 13). The proportion of respondents stating each of these reasons has increased from mid- to endline.

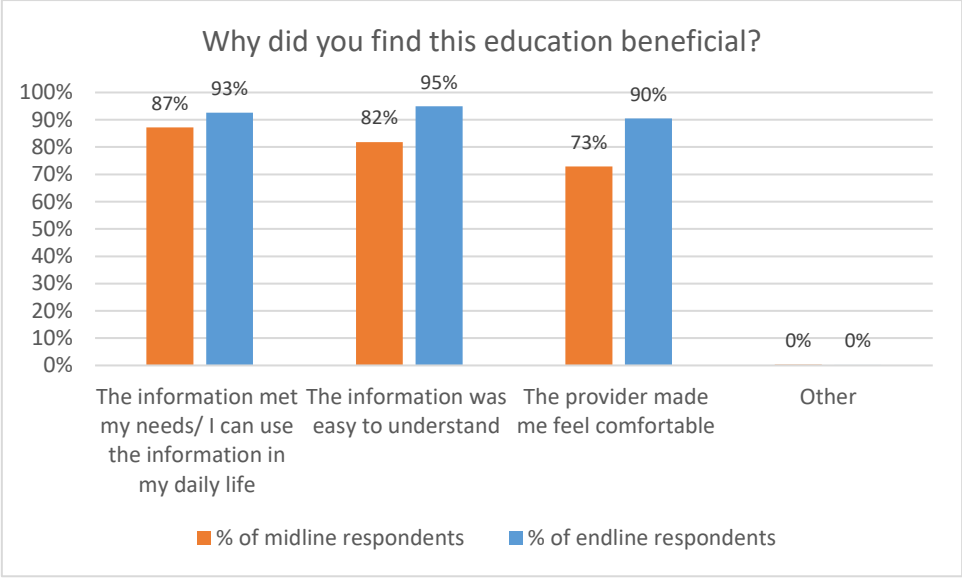


Figure 13 Reasons why the SRHR education was found to be beneficial at (midline n=649, endline n=652)

[19] The proportion of respondents who indicated 'other' in response to this question is not reflected in this graph, due to the adjusted skip pattern at endline, which meant that the 'other' option did not appear for respondents in the same way that it did at midline. This affects comparability. Note that at midline while 11 respondents indicated that they received education on 'other' topics, 13 stated that 'other' topics were one of the most beneficial.

Young people were asked if they were advised to access SRH services when they received SRHR information or education. Ninety-six percent (96%) indicated that they had been advised to access services, while at baseline this was 71%, and at midline, this was 92%. The proportion of respondents who were advised to do this has therefore increased over time. Of these respondents who had been advised at midline, more than half (57%) said that they went on to access services after they were advised, compared to 85% at endline[20]. Therefore at endline, a higher proportion of those that were advised also accessed services. No large differences were observed between genders at mid- or endline in either rate of referral or rate of access following referral. More information about the referral system can be found in the sub-section on SRH services.

At endline, 86% of respondents indicated that the person who advised them was a peer educator, followed by NGO (85%), and teacher (73%). At midline, three quarters (77%) of respondents indicated that the person who advised them was from an NGO, followed by teacher (72%) and health worker (58%). Therefore there has been a large increase in the proportion stating they were advised by a peer educator, which has increased by 81 percentage points from just 5% at midline. All other sources of referral have also increased since midline, having previously increased between base- and midline for NGOs, teachers, health workers, and mobile platform. Relatively few endline respondents stated that they received referrals from online (2%) and mobile platform (4%) sources. Any decrease or increase related to the response 'NGO' must be interpreted with caution as NGOs often work with other actors, making it harder to distinguish between the actual source.

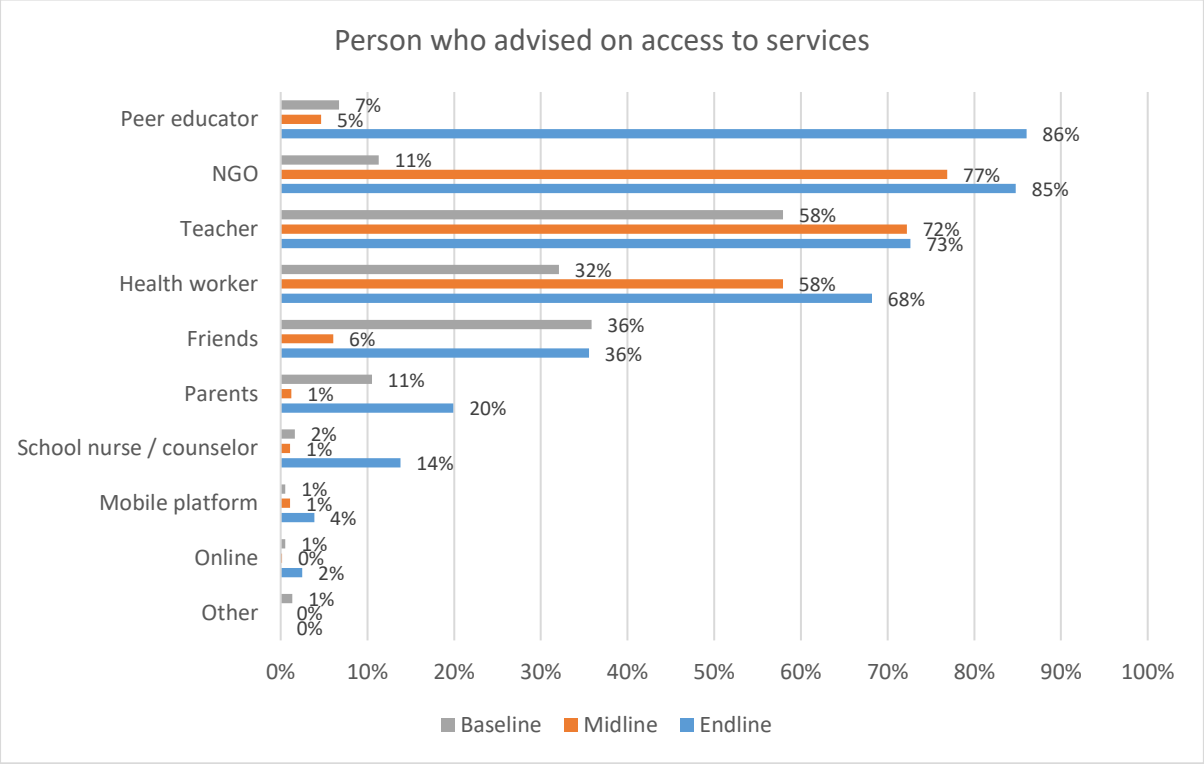


Figure 14 Person/s who advised on access to SRHR services during sex education (baseline n=371, midline n=644, endline n=723)

Table 8 Summary indicators outcome 3

[20] The question 'When you were advised to access services, did you access them?' was added at midline, therefore no data is available for baseline.

Outcome 3	Corresponding indicator	Baseline	Midline	Endline
Increased % of young people who are reached with SRHR information and education from the GUSO programme	% of young men and women (15-24 years) who ever received information about SRHR	65%	88%	98%
	% of young men and women (15-24 years) who received SRHR information through GUSO (of those who did receive information)	2%	91%	99%
	% of young men and women (15-24 years) who ever received education about SRHR	60%	85%	86%
Increased % of young people who perceive the SRHR information and education as beneficial to them	% of young men and women who found the information beneficial	95%	100%	99%
	% of young men and women who found the education beneficial (of those who did receive education)	93%	100%	100%

SRHR rights

Respondents in Ghana were also asked about their awareness of SRHR. Almost four out of five (88%) of the total sample at midline indicated that they had ever received information about their sexual rights, with no difference between female and male respondents. At endline this increased to almost all (97%) respondents, again with no difference between genders.

Eighty-eight percent (88%) of the respondents stated that they received information about sexuality rights from a health provider, followed closely by 87% who mentioned peer educators/counsellors as one of their sources for this information. Respondents also commonly mentioned youth clubs as a source (84%) (Figure 15). The proportions who reported receiving information on sexual rights from the range of sources listed increased from mid- to endline in almost all cases. The one exception to this is those naming teachers as a source of this information, which has decreased slightly from 89% to 81% at endline.

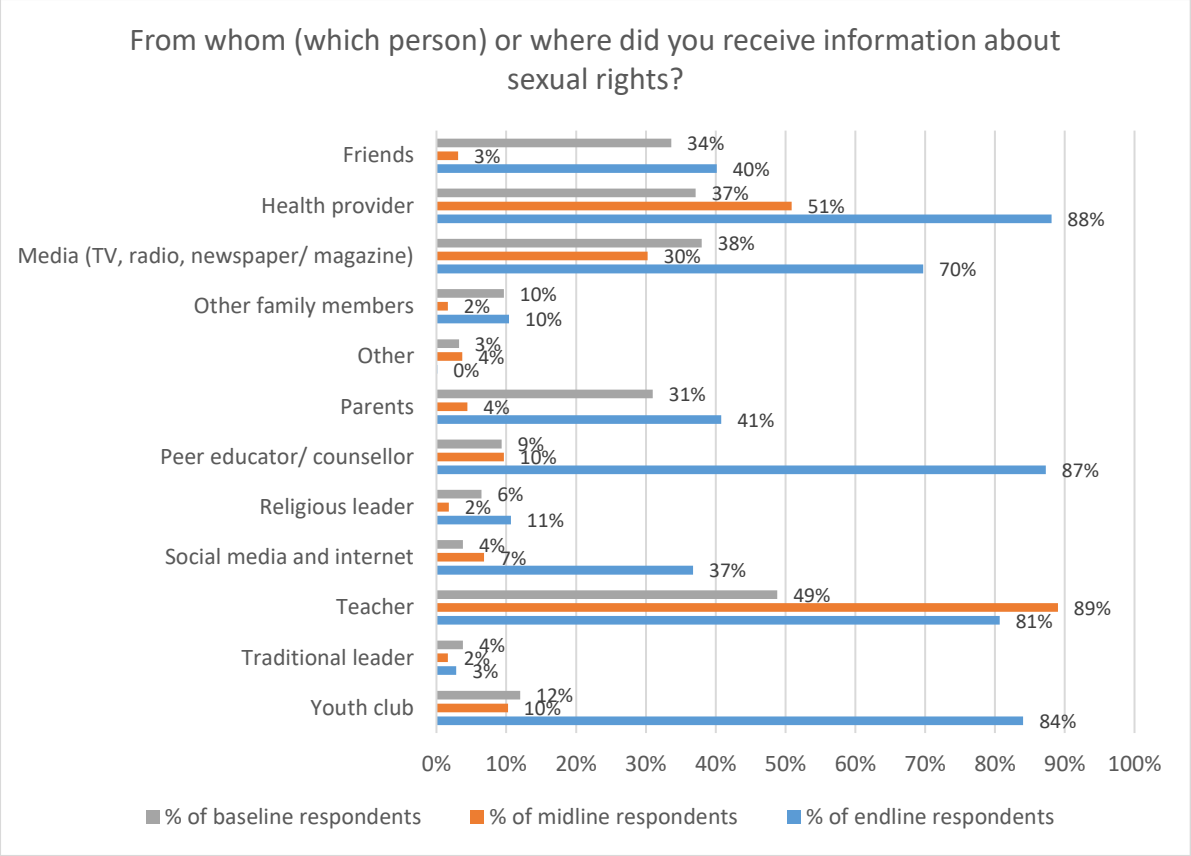


Figure 15 Source of information about sexuality rights (baseline n=342, midline n=674, endline n=740)

At endline, 96% of young people said that they had knowledge about their right to SRH. Ninety-two percent (92%) of respondents said that they had knowledge on their right to have access to SRH services. Between 85-90% stated that they had knowledge of the other areas of SRHR listed (Figure 16). These were also commonly stated areas of knowledge at midline. Overall the proportions of respondents stating they had knowledge of each area of rights has increased over study stages. At endline, 85% or more of respondents stated they had knowledge of each area of rights. Similarly, the proportion of respondents who stated that they do not have knowledge of any of the rights outlined has decreased from 1 in 4 (26%) at baseline, to 4% at midline and finally 2% at endline.

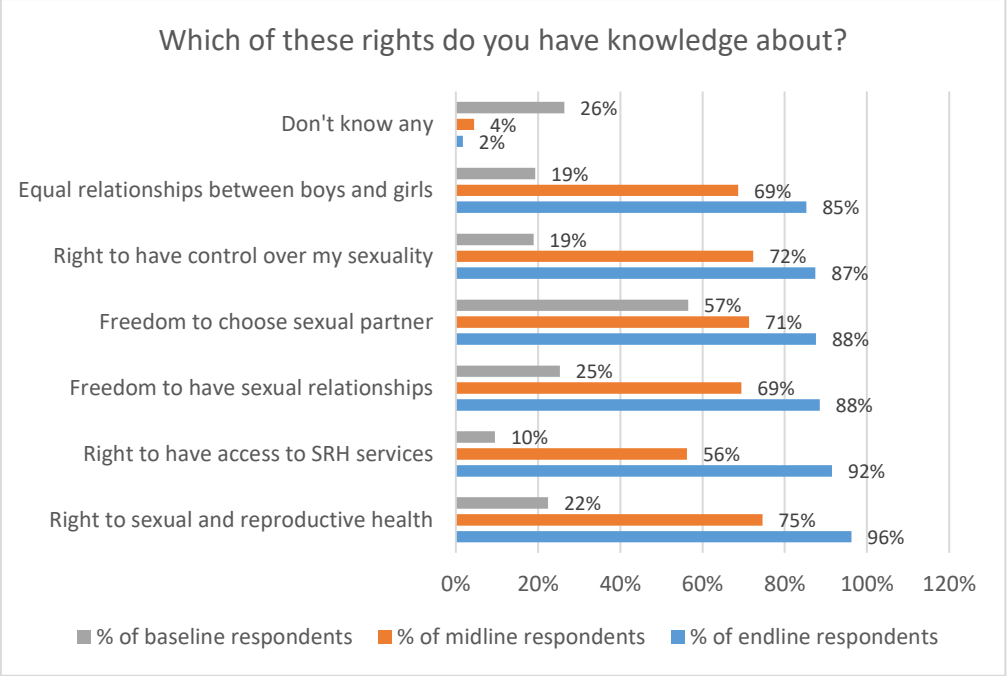


Figure 16 Knowledge of rights (baseline n=736, midline n=763, endline n=765)

Respondents were also asked about which of these rights they felt supported to enjoy. More than 4 out of 5 respondents at endline stated they felt supported to enjoy all the rights they were asked about (Figure 17). For all the rights specified, at endline, more young people felt supported to enjoy them compared to midline. The largest increases were seen in respondents feeling supported to enjoy their right to have access to SRH services.

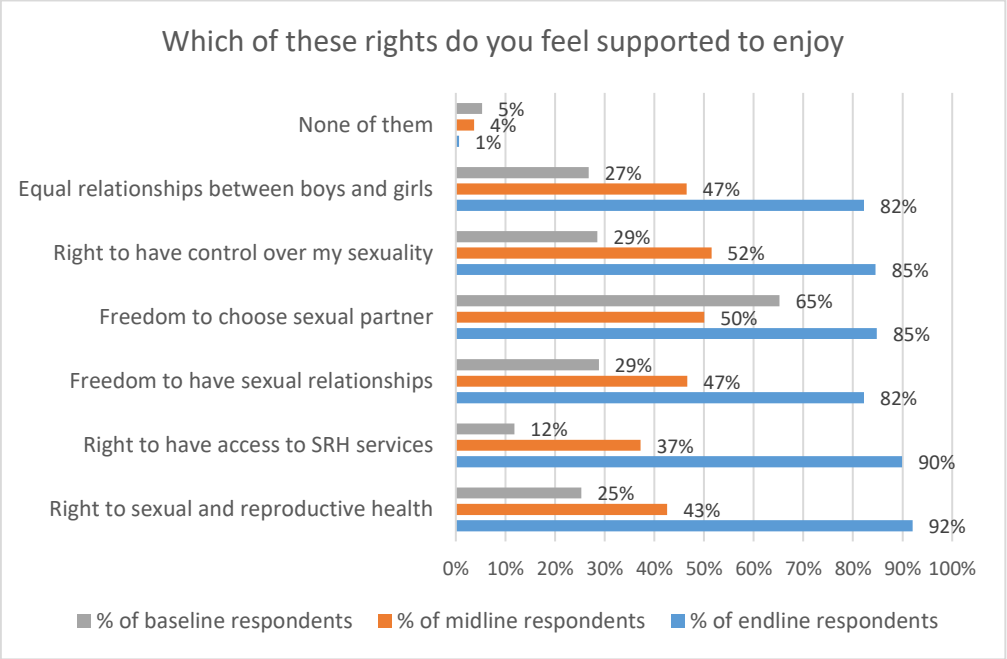


Figure 17 Support to enjoy these rights (baseline n=736, midline n=763, endline n=765)

Changes regarding Contraception and Sexual Activity

Respondents were asked about the use of contraception, and about their sexual activity.

The proportion of respondents who reported ever having had sex had decreased since midline; just over a third (36%) at endline reported this compared to around half (47%) at midline. This remains the case when disaggregating by age; i.e. when comparing those of the same ages across study stages, lower proportions of those at endline reported ever having had sex at most ages. More young men (42%) reported this than young women (27%) at endline, a gender gap that was also apparent at midline but has since widened (Table 9). This question was added at midline, therefore there is no baseline data to compare.

At endline, approximately two thirds (66%) of respondents who had ever had sex stated they had done so in the past 12 months. This was an increase compared to less than half (44%) at midline.

The survey also explored condom use among young people (Table 10). Respondents were asked whether they had used a condom in the last 12 months and if they had used a condom at last intercourse. The proportion of respondents who reported the former increased slightly since midline, from 15% to 18% at endline. This question was asked to all respondents, and has increased despite the fact that the proportion of respondents who report having had sex has decreased since midline. This is consistent with the increase of reported condom use at last intercourse among those who have ever had sex. The proportion of those who had ever had sex who used a condom at last sexual intercourse increased from around a third (35%) to more than half (53%) from mid- to endline.

Table 9 Sexual activity by sex

		Young women		Young men		Total	
		n	%	n	%	n	%
# and % of young men and women between 15 - 24 years old who have ever had sex[21]	Midline	228	50%	134	43%	362	47%
	Endline	202	42%	76	27%	278	36%
# and % of young men and women between 15 - 24 years old who had sex in past 12 months (of those who had ever had sex)[22]	Midline	105	46%	56	42%	161	44%
	Endline	134	66%	49	64%	183	66%

As mentioned above, at baseline, respondents were not asked whether they had ever had sex. Instead, a proxy was used to determine the status of sexual activity. When asked why respondents were not using contraception, many indicated that they were sexually inactive. Excluding these respondents, around 1 in 4 (23%) stated that they used a condom during their last sexual intercourse. Therefore, the proportion of those who were sexually active and used a condom during last sexual intercourse at endline (53%) may have increased since baseline as the figures based on this proxy measure suggest, but direct comparability is compromised by the different way in which this was calculated at baseline.

Table 10 Contraception by sex

	Young women	Young men	Total

[21] This question was added at midline, hence no baseline data are available
[22] This question was added at midline, hence no baseline data are available

		n	%	n	%	n	%
# and % of respondents between 15 – 24 years who know at least one way to prevent pregnancy[23]	Baseline	510	97%	206	97%	716	97%
	Midline	445	98%	307	98%	752	98%
	Endline	480	100%	285	100%	765	100%
# and % of respondents between 15 – 24 years who report currently using any contraception[24]	Baseline	149	28%	80	38%	229	31%
	Midline	115	25%	71	23%	186	24%
	Endline	168	35%	64	22%	232	30%
# and % of respondents between 15 – 24 years who would like to use contraception in the future (among those who do not use it)	Baseline	239	64%	78	59%	317	62%
	Midline	243	72%	182	76%	425	73%
	Endline	261	84%	196	89%	457	86%
# and % of respondents between 15 – 24 years who used condoms in the past 12 months[25]	Baseline	55	10%	61	29%	116	16%
	Midline	70	15%	46	15%	116	15%
	Endline	86	18%	51	18%	137	18%
# and % of respondents between 15 – 24 years who used a condom at last sexual intercourse (of those who had ever had sex)[26]	Baseline	60	17%	51	38%	111	23%
	Midline	67	29%	61	46%	128	35%
	Endline	101	50%	47	62%	148	53%

Respondents were asked if they knew any methods to prevent pregnancy. Over time, there were no major differences between genders. However at mid- and endline, a larger proportion of female respondents reported currently using any contraception (Table 10). This is partly explained by the higher proportion of female respondents who had ever had sex. When we compare current use of contraception among those who have had sex in the previous 12 months, we see that this gap between genders has narrowed, as 81% of young women in this group use contraception compared to 76% of young men.

Similarly, at all study stages similar proportions of males and females reported using a condom in the past 12 months; however, once those who had not had sex in the past 12 months were excluded,

[23] Those who indicated don't know or/and other were counted as those who did not know how to prevent pregnancy

[24] Reported contraception use is high relative to reported levels of sexual activity. Following discussion with the research team, this could be due to a misinterpretation of related survey questions on the part of respondents and/or enumerators, some of whom appear to have provided information about whether they had *ever* used contraception, rather than whether they were currently using contraception.

[25] This was asked to all young people

[26] At mid- and endline, only those who indicated that they ever had sex were asked this. At baseline this question was asked to all respondents. As a proxy measure for having never had sex, those who reported that their reason for not using contraception were excluded from the baseline data for this indicator. Direct comparability is therefore limited from baseline to other study stages.

more males than females reported using a condom in this time period. Therefore the higher reported use of condoms by women among all respondents obscures the fact that among sexually active youth, more young men report using condoms compared to young women. We also see that over time it appears to be the case that condom use among respondents is dropping. However, once those who have never had sex are excluded, we see that the proportion who used sex at last sexual intercourse has increased (although direct comparability from baseline to other study stages is not possible, for the reason discussed above). Therefore the reduction in reported condom use among all respondents over time is attributable to the lower levels of sexual activity among endline respondents, rather than lower use of condoms among those respondents who are sexually active.

Almost all young people knew at least one way to prevent pregnancy across all genders over time. Very few respondents (less than 3% at all study stages) indicated that they did not know of any way to prevent pregnancy. Figure 18 shows the change over time of the proportion of respondents that had knowledge of different methods of contraception. From mid- to endline there were increases in the proportions of those reporting knowledge of all listed methods of preventing pregnancy with the one exception of withdrawal. This was the case across genders. The largest increases from base- to endline were in those reporting knowledge of the implant (from just 3% at baseline to 68% at endline), female condoms (from 33% at baseline to 93% at endline, and the pill (from 26% at baseline to 86% at endline). It is concerning that there has been an overall increase since baseline regarding knowledge on use of withdrawal as a method to prevent pregnancy. According to programme staff, this may be explained by misinformation received from social media and peers.

No large differences were observed between genders at endline in knowledge of different methods to prevent pregnancy. This represents a slight shift from base- and midline, when males were more likely to report knowledge of male condoms, and less likely to report knowledge of contraceptive injections, and the pill (Figure 18).

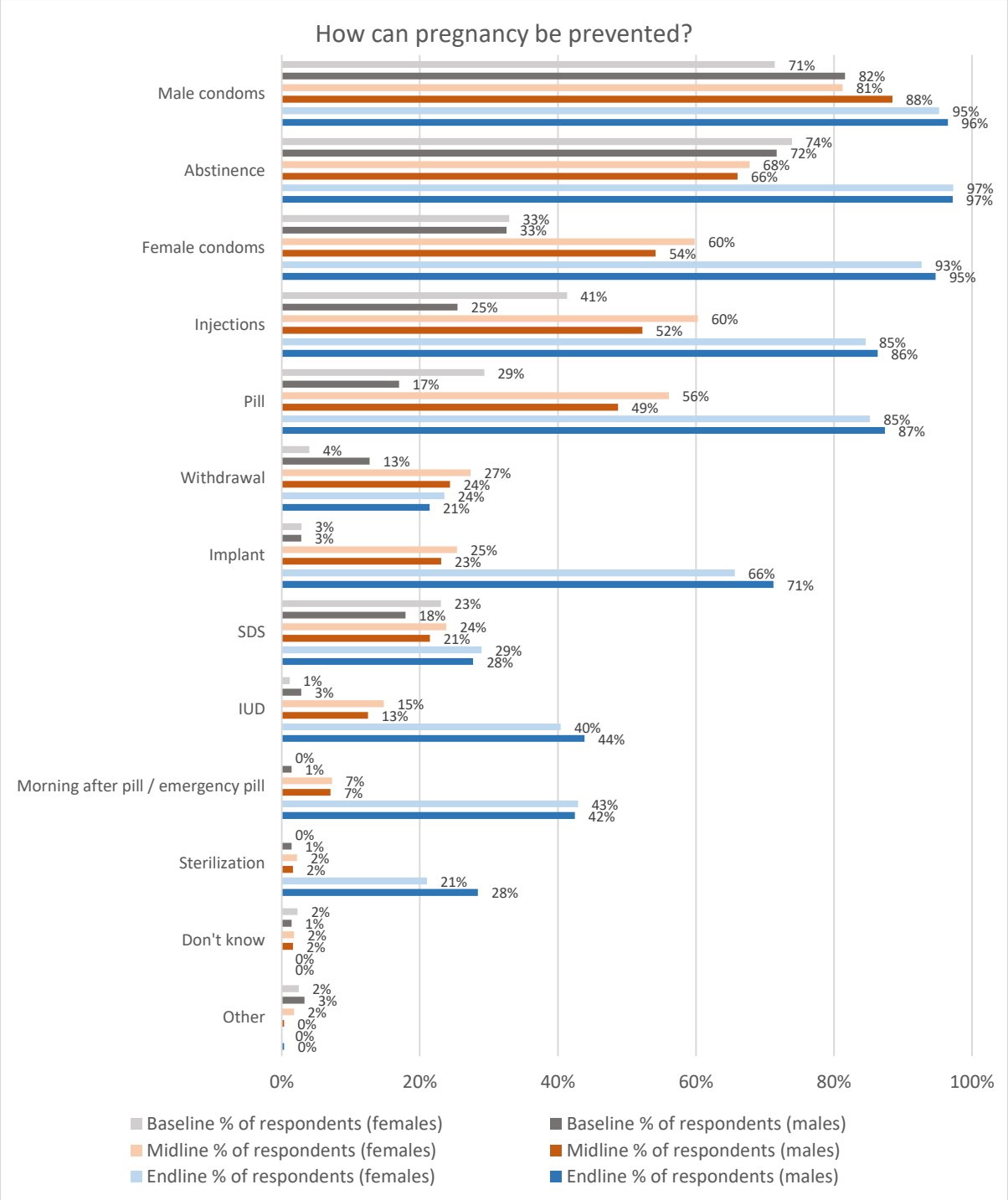


Figure 18 Knowledge of ways to prevent pregnancy, by gender (baseline females n=525, baseline males=212, midline females n=453, midline males n=312, endline females n=480, endline males n=285)

In total, 232 young people (around a third, or 30%) indicated that they were using contraceptives at endline. This has increased since midline. This is consistent with the higher proportion who report having had sex in the previous 12 months. However, following discussion with the research team, it should be noted that the high rates of reported contraceptive use could also be due to a misinterpretation of two of the survey questions on the part of respondents and/or enumerators at endline. Information appears to have been provided by (some) respondents about whether and which methods of contraception they had *ever* used, rather than whether and which methods they were

currently using. This may explain why more than 1 in 5 (22%) endline respondents report using 6 or more methods of contraception.

Of those using contraception, there was a decrease in the proportion of respondents who reported to be using male condoms since midline (from 62% to 48%). While this was the most common response at base- and midline, at endline the most commonly reported method of contraception in use (among those using contraception) was the contraceptive injection (Figure 19). The proportion of respondents who reported using injections has therefore increased, with over half (53%) of endline respondents using this form of contraception compared to 38% at midline. The proportion who were using all other contraceptive methods has also increased from midline. There are particularly large increases reported from mid- to endline in relation to use of the morning after pill, withdrawal, female condoms, and contraceptive implants. Between base- and midline trends were more mixed, with decreases in the reported use of some contraceptive methods such as injections, abstinence and safe days, while there were increases observed in the use of male condoms, the pill, female condoms, and withdrawal. As noted above, responses relating to which methods of contraception respondent were using may in fact relate to which methods of contraception respondents have ever used. The increase in use of withdrawal as a contraception method is concerning. This increase also aligns with the increase seen in the proportion of young people who reported withdrawal as a pregnancy prevention method.

When disaggregating by gender, we see that a higher proportion of women than men report using any contraception at endline (35% of young women compared to 22% of young men). Due to the low numbers of male respondents who reported the use of contraception (n=64 at endline), it is difficult to further examine change in the use of particular contraceptive methods among respondents disaggregated by gender.

Respondents who were single were far less likely to report using contraception than other respondents. However, at endline, 16% of single respondents still reported that they were using contraception. This proportion has increased from base- and midline, as at both stages 8-11% of single respondents reporting using contraception. Not all of those who were married reported using contraception at endline, as 15% of these respondents reported not doing so. Similarly, 42% of those who had a girlfriend, and those who had a boyfriend stated they were not using contraceptives.

Young people who shared that they were not using contraception were also asked if they would like to do so (in the future). Over time, the proportion of those who said yes increased, from 62% at baseline to 73% at midline and 86% at endline. It should be noted that when we look at the reasons given by these respondents for not wanting to use contraception (in the future), we see that a large majority of reasons for this at both mid- and endline relate to not being currently/ever being sexually active. At endline only 14 of the 457 respondents who stated that they would like to use contraception in the future gave reasons for current non-use that can be characterised as relating to barriers of access, knowledge or availability. These 14 respondents stated that they did not know where to get contraception, did not know about contraception, were not able to negotiate the use of contraception with their partner, or that they were concerned about side-effects. This is a considerable decrease from midline, when 108 of the 425 respondents who did not currently use contraception but would like to in the future gave reasons of this nature relating to lack of knowledge, access or availability of a suitable contraceptive option. At baseline 67 of 317 respondents who did not currently use contraception but would like to in the future gave reasons of this nature.

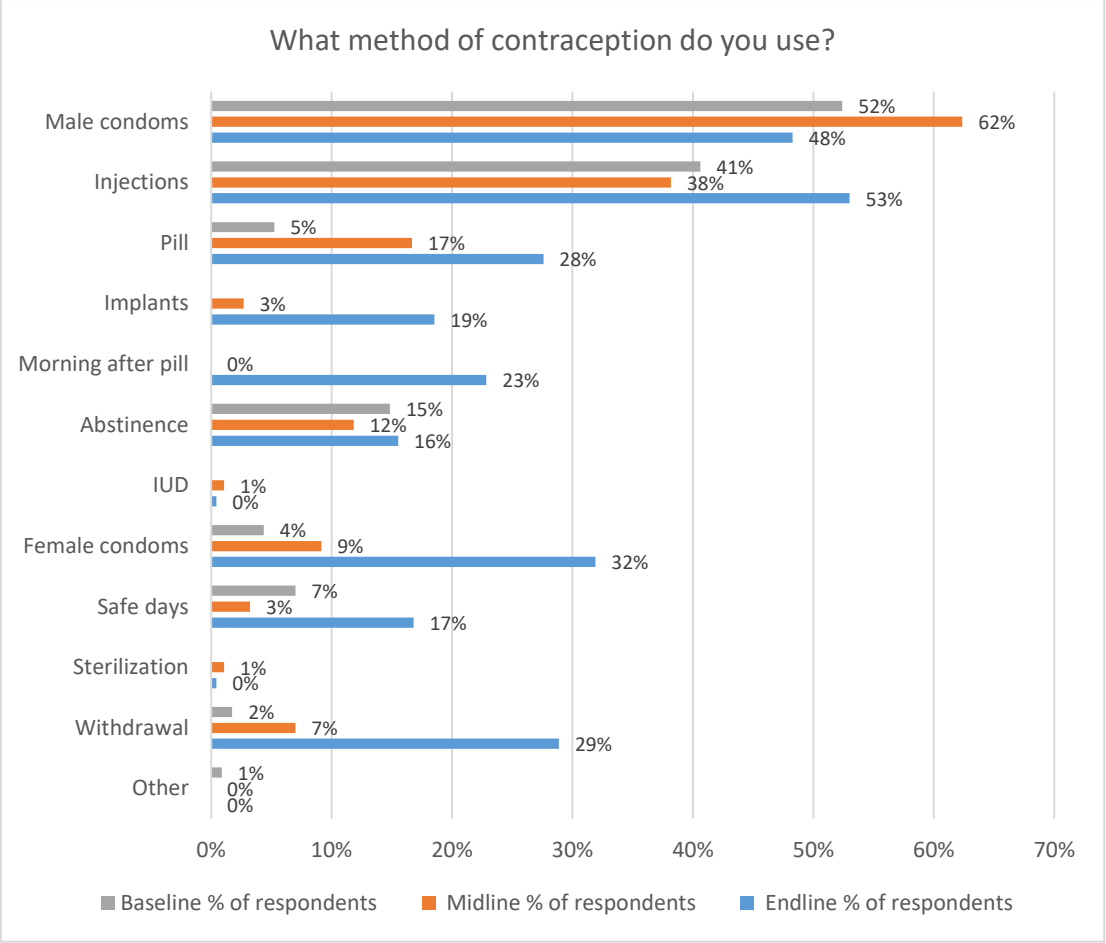


Figure 19 Methods of contraception used (baseline n=229, midline n=186, endline n=232)

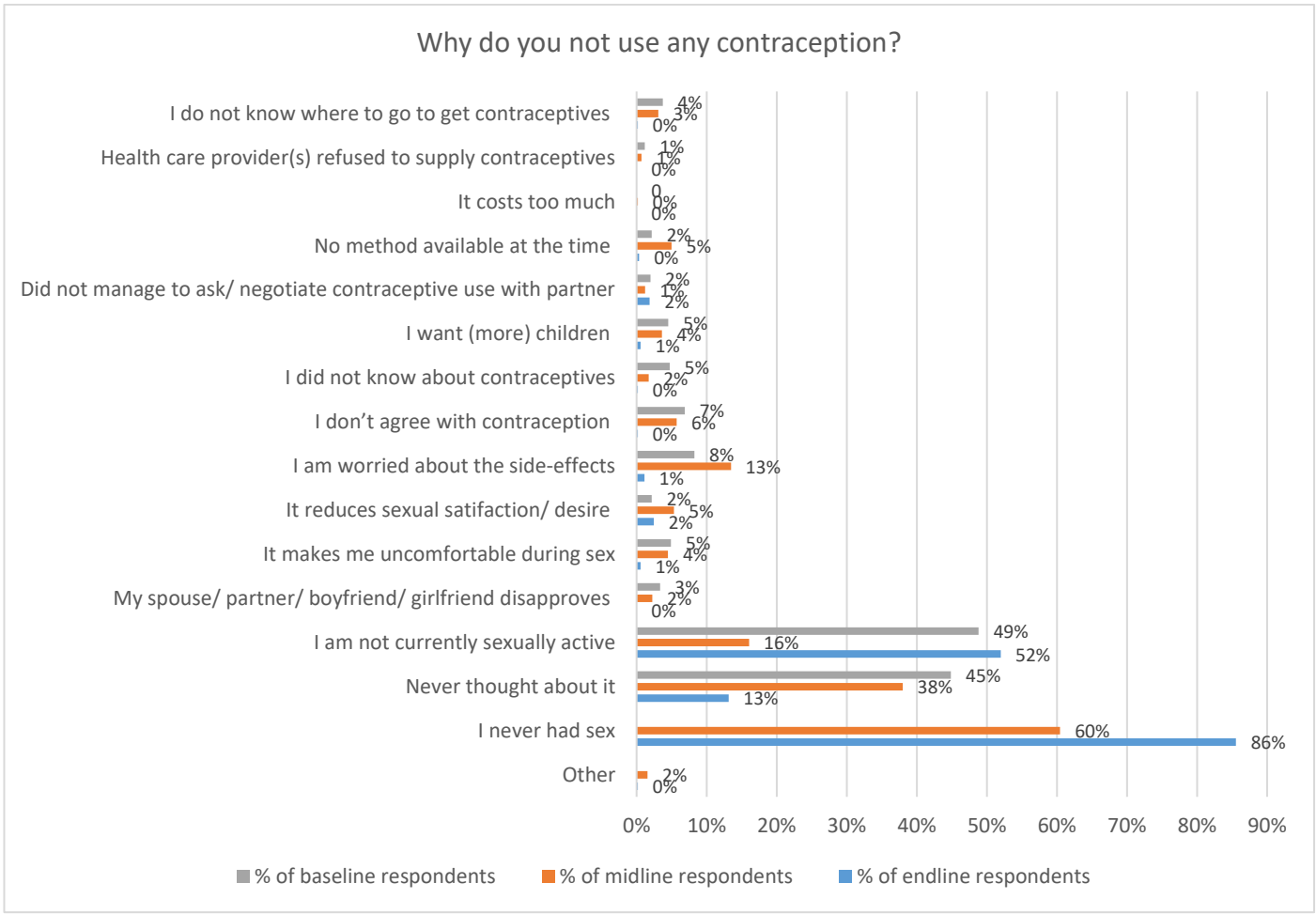
Of the 7 in 10 (70%) endline respondents that did not use contraception, around half (52%, n=277) of them reported that they were not currently sexually active, while 86% (n=456) reported that they had never had sex as one of the responses relating to why they did not use contraceptives. When this is cross-referenced against responses to the question on whether respondents had ever had sexual intercourse, we see most of the respondents who stated they didn't use contraception due to never having had sex indeed reported that they had never had sex (96%, n=436). However, 19 respondents (4%) reported otherwise, and one respondent did not wish to share this. Therefore, of the 466 respondents who reported never having had sex and not using contraception, the vast majority (436) reported that *never* having had sex was <u>one</u> reason they were not using contraception.

The other 30 respondents in this group (those who stated they never had sex and were not using contraception) reported either that they were not *currently* having sex, they had never thought about it, they were worried about side effects, or that contraception reduced sexual satisfaction. This suggests that a small minority of respondents did not necessarily make a clear distinction between never having had sex, not currently having sex, and not thinking about using contraception. This is also understandable as young people who have never had sex or are not currently sexually active may not always think about using contraception. Moreover, multiple responses were allowed for this question.

Other reasons for not using contraception that did not relate to sexual inactivity were reported by very few respondents at endline (less than 3% of respondents in all cases) (Figure 20). There have therefore been reductions across time in those reporting these reasons for non-use of contraception.

As discussed above, at endline only 14 of the 457 respondents who stated that they would like to use contraception in the future (but did not do so now) gave reasons for current non-use that can be characterised as relating to barriers of access, knowledge or availability as one of their answers. Of these 14 respondents, only 1 reported having had sex in the previous 12 months (the other 13 stated that they had not, so it can be inferred that they are not sexually active). This respondent stated that they were not able to ask or negotiate the use of contraception with their partner, and that it made them uncomfortable during sex.

When we look at those respondents who stated that they *were* sexually active and were not currently using contraception but would like to in the future, we see that there are only 9 endline respondents in this group. This is a reduction from 36 respondents who fell into this group at midline[27]. The reason most commonly stated by this group for not using contraception at endline was that the respondent had never thought about it (stated by 4 of these 9 sexually active respondents). Additionally, 3 respondents stated that they wanted to have a child. One other stated that it reduced satisfaction, and one stated they did not ask/negotiate contraceptives with their partner and that it makes them uncomfortable during sex. At midline, sexually active respondents who were not using contraception but wanted to in the future most commonly reported worrying about side-effects (18 of 36 respondents), wanting a child (17 of 36), and never having thought about it (11 of 36).



[27] Baseline respondents were not directly asked whether they had ever had sex or had done so in the previous 12 months, so direct comparability with baseline data is not possible

Figure 20 Reasons for not using contraception (baseline n=508, midline n=579, endline n=533)

Respondents were asked from whom or where they were provided their contraceptive method. Eighty-two percent (82%) of endline respondents indicated that a health facility/ medical staff provided the contraception they used. Respondents at endline also commonly reported obtaining their contraceptives from community health workers (around half, or 48%) and pharmacies/shops (a third, or 34%). There has been a reduction from mid- to endline in the proportion of respondents who reported provision of contraceptives from peer educators (from 6% to 3%), outreach services (from 24% to 3%), schools (from 15% to 0%), and youth clubs (2% to 0%). Other sources have seen increases since midline. The fall in outreach services and schools is worth noting.

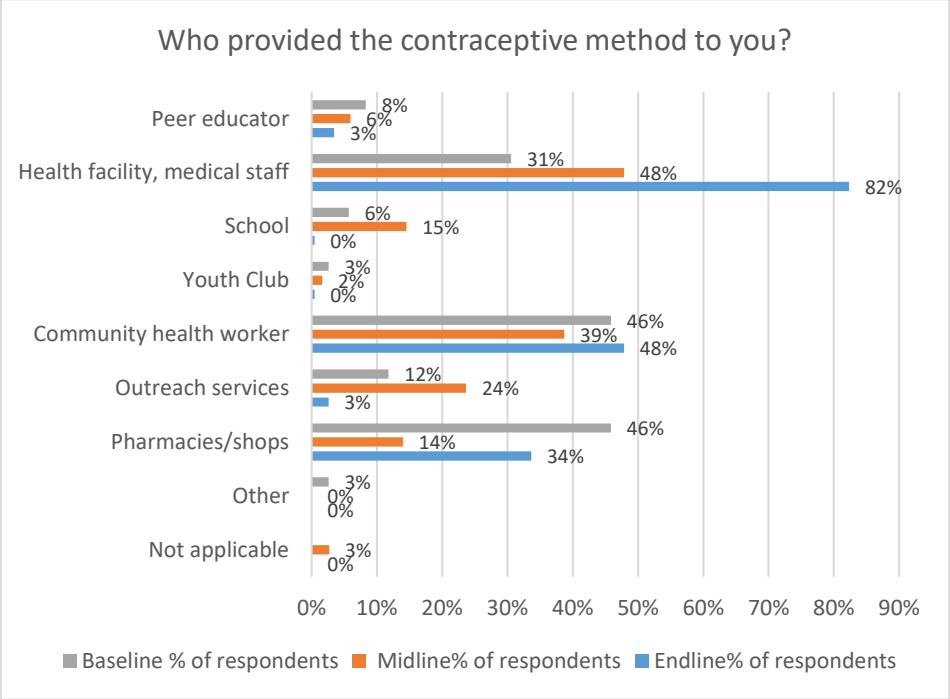


Figure 21 Reported provider of contraceptive method (baseline n=229, midline n=186, endline n=232)

Changes regarding pregnancy and parenthood

The mean age at first pregnancy has increased over time. At endline, the mean age was 18.0 years which increased from 16.7 years at midline and 17.2 years at baseline.

In the case of young men, the mean age at which they had their first child also increased over time. At endline, this was 19.8 years, which increased from 17.6 years at midline and 18.2 years at baseline. The mean age of first fatherhood was slightly higher than mean age at first pregnancy.

There was a decrease in the proportion of young women who reported ever having been pregnant over time (from 29% at baseline to 20% at endline). There has also been an increase in the proportion of those young women who said that they chose to become pregnant, from 25% at baseline to 29% at midline and 42% at endline. There was also slight decrease over time in the proportion of young women who have a child (from 20% at baseline to 15% at endline).

In the case of young men, there was an overall decrease from baseline to endline in the proportion who have ever had a child, from 14% at baseline to just 3% at endline. There was a slight decrease in the proportion of these respondents who said they wanted to become a father at that time. However the very small numbers of respondents in this group (just 23 respondents at endline) means that it is

difficult to draw conclusions about trends over time in the desire for fatherhood among male respondents with a child. The decreases in pregnancies and fatherhood could also be linked to the fact that the endline sample included younger respondents than at base- and midline.

There was a reduction in those reporting an age at first pregnancy of under 20 years old (teenage pregnancy), although this was still reported by a large majority of those who had ever been pregnant. This decreased from 84% at baseline and 78% at midline to 74% at endline. There was also a reduction between base- and endline in those reporting an age at first fatherhood of below 20, but due to the small numbers of respondents reporting fatherhood any trends in these further disaggregated figures should be interpreted with caution.

Table 11 Pregnancy and fatherhood

		Total	
		n	%
# and % of young women who have ever been pregnant	Baseline	152	29%
	Midline	101	22%
	Endline	98	20%
# and % of young women who chose the become pregnant (of those who have ever been pregnant)	Baseline	38	25%
	Midline	29	29%
	Endline	41	42%
Age at first pregnancy			
Less than 20 years old	Baseline	127	84%
20 years or older		25	16%
Less than 20 years old	Midline	79	78%
20 years or older		22	22%
Less than 20 years old	Endline	73	74%
20 years or older		25	26%
# and % of young women who have a child	Baseline	105	20%
	Midline	55	12%
	Endline	74	15%
# and % of young men who have a child	Baseline	29	14%
	Midline	46	15%
	Endline	23	3%
# and % of young men between 15 – 24 years of age who reported wanting to become a father	Baseline	10	34%
	Midline	23	50%
	Endline	9	39%
Age at first fatherhood			
Less than 20 years old	Baseline	18	62%
20 years or older		11	38%
Less than 20 years old	Midline	27	59%
20 years or older		19	41%
Less than 20 years old	Endline	11	48%
20 years or older		12	52%

Across all study stages, young women and men were more likely to say that it was a girl's rather than a boy's responsibility to prevent pregnancy. However the proportion of respondents stating this has decreased considerably over time. At the same time, at endline respondents were far more likely than at base- or midline to say that it was the responsibility of *both* boys and girls to prevent pregnancy (Figure 22). While at base- and midline male respondents were less likely to view this as the responsibility of both genders, at endline there are no large differences observed between male and female respondents in regards to this.

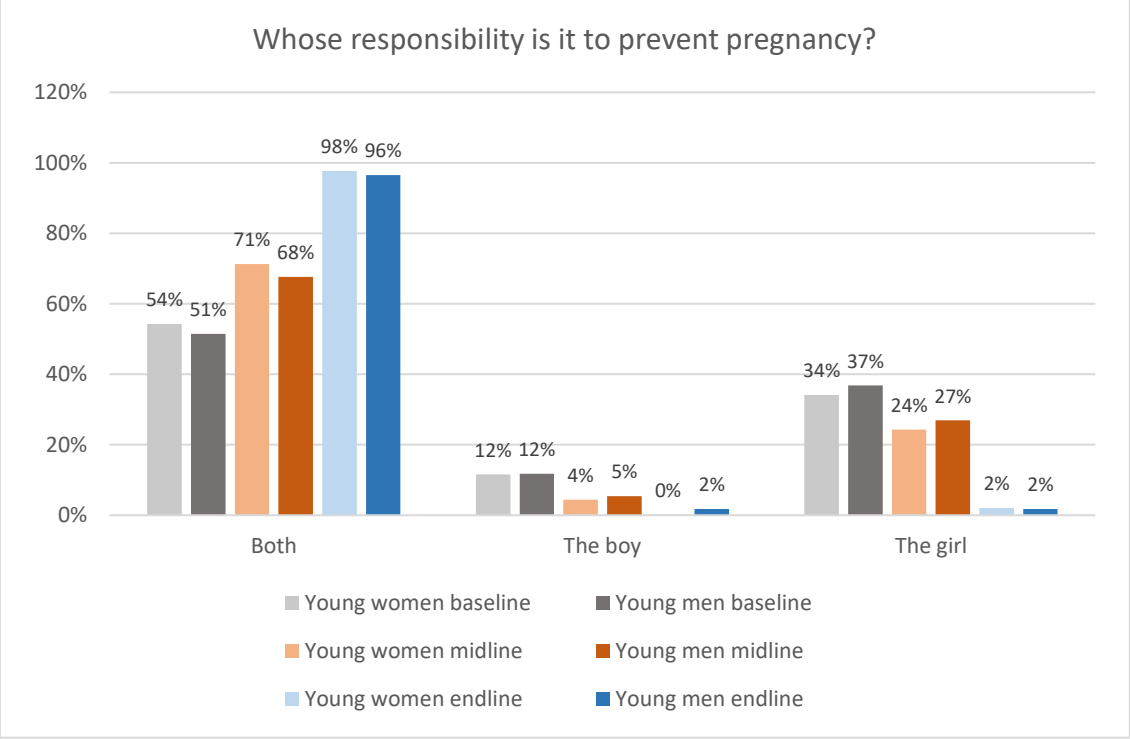


Figure 22 Responsibility to prevent pregnancy across study stages and genders (baseline young women n=525, baseline young men n=212, midline young women n=453, midline young men n=312, endline young women n=480, endline young men n=285)

Changes regarding SRH services

There was a considerable increase in the number of young people who (ever) used SRH services over time. This almost doubled from 43% at baseline and 44% at midline to 81% at endline. This meant that only 1 in 5 (19%) young people indicated that they had never used any SRH services at endline. Most of the change occurred between mid and endline.

Very few respondents reported not knowing about any SRH services (2 respondents at endline, 5 at midline and 29 at baseline). In general the proportion of respondents who had ever used individual services has increased between mid- and endline for all services, with the exceptions of slight reductions of 1-6 percentage points in the proportion using abortion services, STI treatment, and antenatal and postnatal care services. This is similar to the pattern of change between base- and midline, which saw small or moderate rises in the use of most services, with the exception of small reductions of 1 to 3 percentage points in the proportions accessing antenatal and postnatal care, and family planning services. Those who used services at endline mainly used life skills and sexuality counselling (72%), VCT or HIV testing (65%), STI testing (58%), and hotlines (50%), all of which saw large increases over time (Figure 23). While there was a slight reduction in the proportion of respondents accessing family planning services over time, these were still accessed by a large minority

of 45% respondents at endline, in a context where only 36% of respondents report having ever had sex.

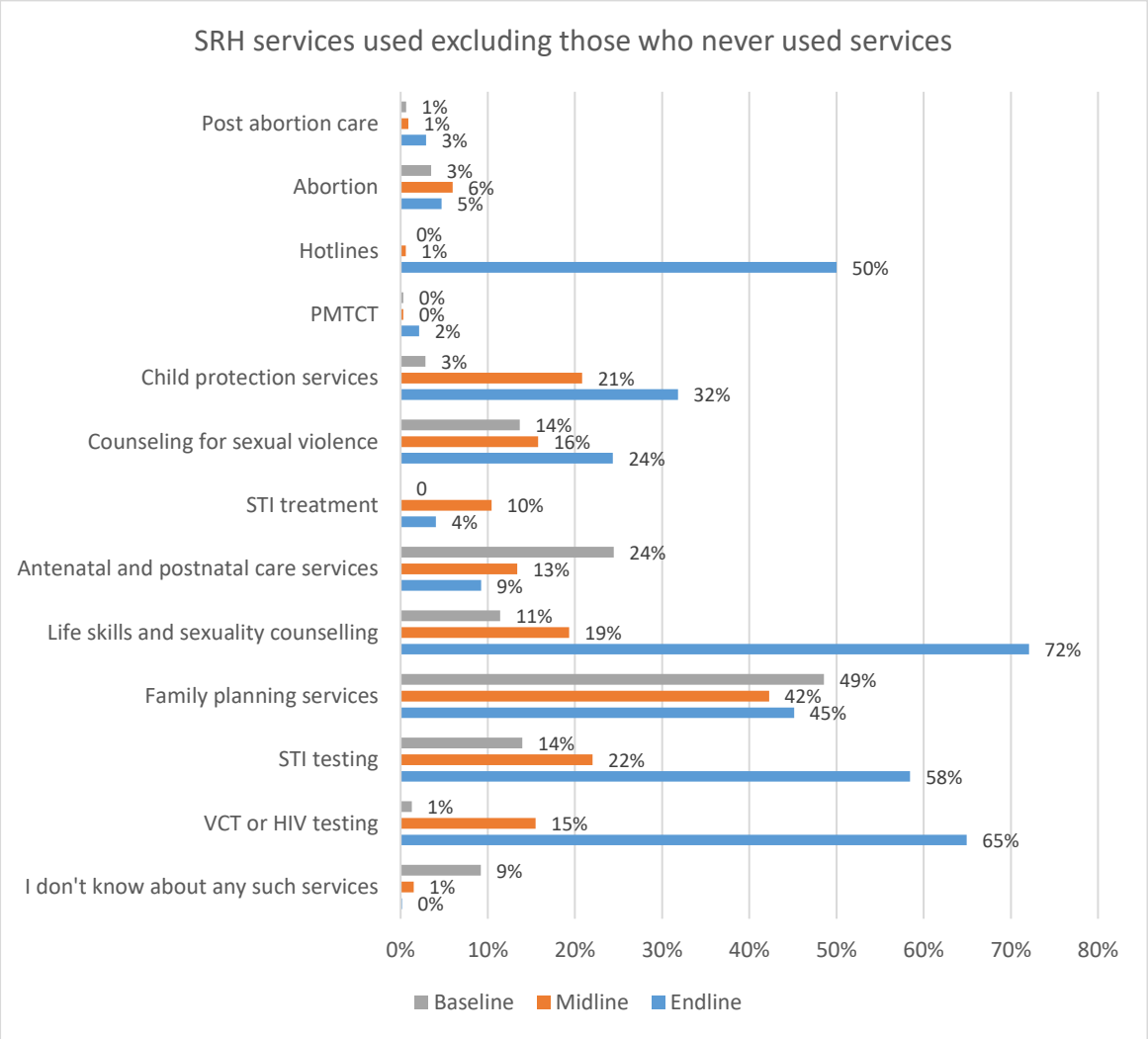


Figure 23 SRH services used (excluding those who said that they have never used a service, baseline n=315, midline, n=336, endline n=616)

Those young people who indicated using STI or HIV-related services were asked whether they had had an STI in the past 12 months as a follow-up question. Twenty endline respondents indicated that they had, which represents 5% of the 432 respondents who sought STI or HIV-related services (Table 12). Due to the large increase in the proportion of respondents accessing such services over time, this proportion has remained fairly steady despite the large increase at endline in the absolute number of respondents who report having an STI in the past 12 months. At baseline, 2 respondents reported having had an STI in the previous 12 months (7% of the 46 respondents accessing related services), while at midline 5 respondents reported this (6% of those 86 respondents).

At endline, 18 of the 20 respondents who reported having an STI in this time period were young women. Only 2 young men who had used STI or HIV-related services reported this, despite the fact that 41% of those accessing these services were young men. However, the absolute numbers of those having had an STI are very low, so any disaggregated comparisons should be interpreted with caution.

Table 12 Self-reported prevalence of STIs in the previous 12 months (of those who ever used related services)

	Baseline		Midline		Endline	
	n	%	n	%	n	%
# and % of young men and women between 15 – 24 years who had an STI in the past 12 months (of those who used related services)	3	7%	5	6%	20	5%
Total respondents (those who used related services)	46		86		432	

Respondents who had not used any SRH services were asked why they had never used them (Figure 24). By far the most common response at endline was that the respondent never had the need to go (93% of endline respondents). Seven percent (7%) reported that they felt too shy to access these services. All other reasons were reported by 3% or less of respondents at endline. This is similar to the pattern of responses to this question at base- and midline. However, there has been an increase at endline in the proportion of respondents reporting that they never having the need to go, and reductions in those reporting other barriers to access. For example, there have been reductions in reporting of disapproval of parents (from 13% at midline to 2% at endline), feeling shy (from 19% at baseline to 17% at midline, and 7% at endline), prohibitive costs (from 11% at midline to 0% at endline) and lack of availability of services (from 12% at baseline to 1% at endline).

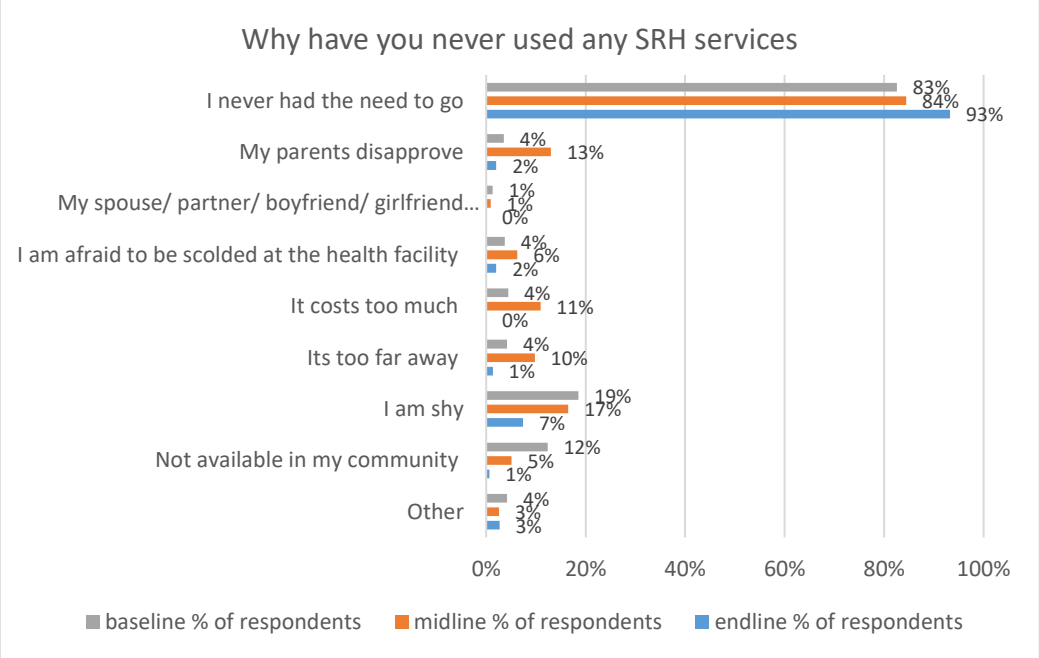


Figure 24 Reasons for not using SRH services (baseline n=453, midline n=430, endline n=149)

Respondents who had ever used SRH services (the majority of the sample at endline, and just under half of respondents at other study stages) were asked about where or through whom they accessed these services (Figure 25). At endline, the most common source of services was health facility/medical staff (86%), followed by community health workers (66%). At midline these were also the two most

commonly reported source of services (both 40%). At baseline, community health workers (49% of respondents) and health facilities (45%) were also the two most commonly reported sources. There has therefore been an increase in the proportion reporting these sources, while they have remained the two most commonly reported across study stages.

The most noteworthy change at endline was the large increase in those stating that they accessed services through pharmacies/shops (reported by 19% at baseline, which then dropped to just 1% at midline, and increased again to 34% at endline). There was a large increase from baseline in respondents stating their SRHR service source was youth clubs (from 6% to 30%). There has also been an increase in the proportion indicating peer educators as a source of SRHR service (from 5% at baseline to 33% at endline[28]), and in those indicating schools (from 4% at baseline to 25% at endline – though this did reduce from the midline when 31% reported this).

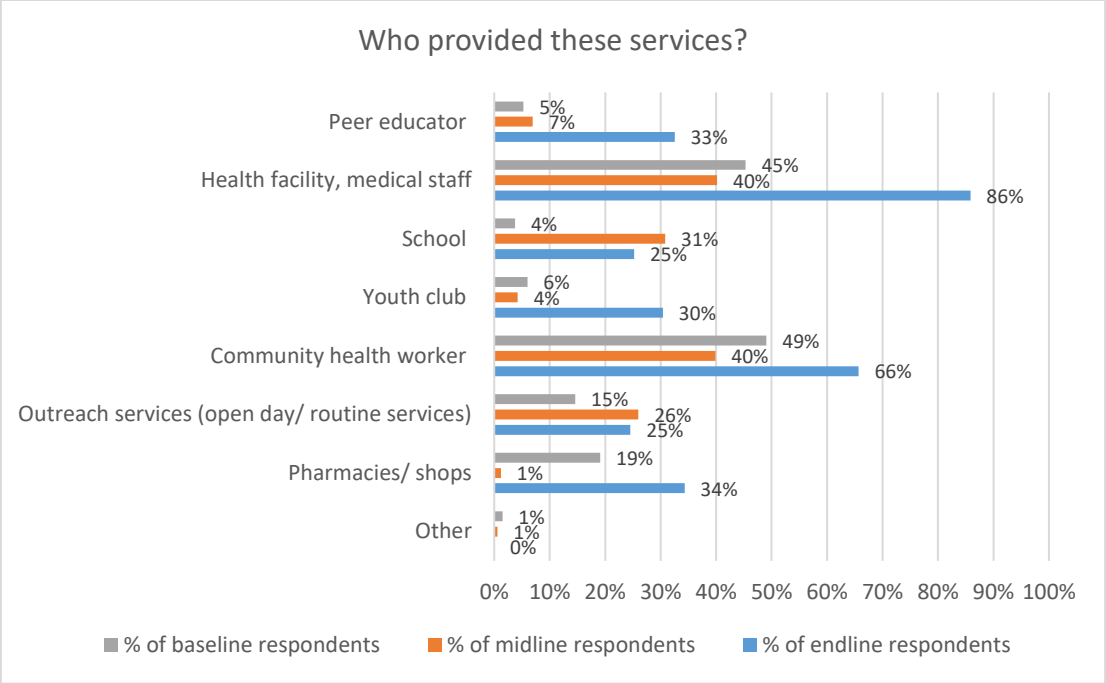


Figure 25 Who provided SRH services used, (baseline n=267, midline n=331, endline n=615)

Respondents were also asked how they perceived the quality of the services when they last used them (Figure 26). There has been a positive shift over time, with more young people reporting excellent quality in particular. At all study stages very few respondents felt that the service quality was very bad or low when they last accessed any service.

[28] However, we did not see a similar increase in young people reporting peer educators to be the provider of their contraceptive method

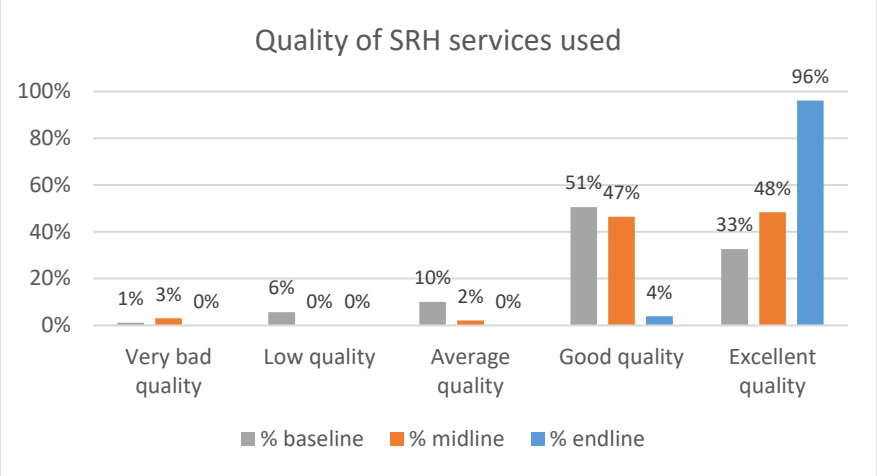


Figure 26 Quality of the SRH services over time (baseline n=2676, midline n=331, endline n=615)

Respondents were also asked to state some of the characteristics of the services they had used[29]. A majority of endline respondents mentioned each of these positive characteristics, with the exception of availability of medicines (reported by only 10% of endline respondents). These proportions have increased since midline in all cases, again with the exception of availability of medicines (which has decreased from 16% to 10% of respondents). It is not clear whether this is related to the ongoing COVID-19 pandemic.

All respondents who used services (100%) at endline felt that the service was easily accessible, an increase from the 86% who felt this at midline. In addition, 95% felt the service had a friendly and respectful health provider, a large increase from 36% at midline. Large majorities of more than 9 in 10 (92%) also stated that the service was affordable or free (an increase from 27% at midline), and that the service had a private area for consultation where one could not be seen by others (Figure 27). This also increased from 39% at endline.

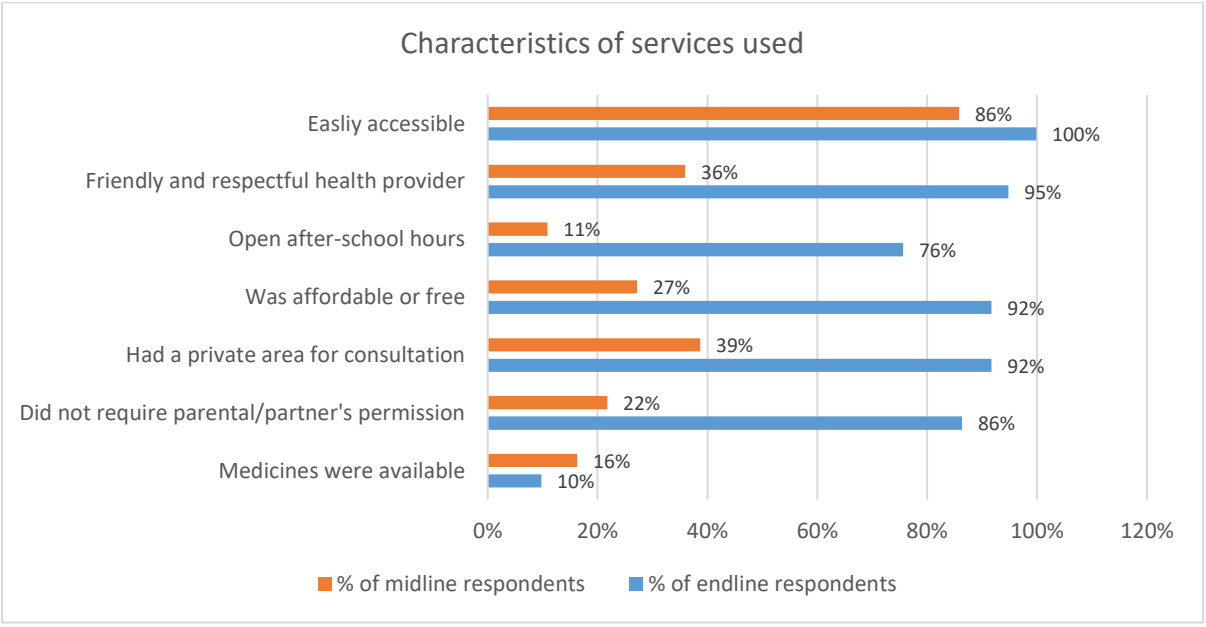


Figure 27 Characteristics of the SRH services used (midline n=331, endline n=615)

[29] This question was added at midline, therefore there is no baseline data to compare.

Respondents were also asked if they were referred to the SRH service or contraception the last time they used it[30]. The proportion of respondents who were referred increased from just over half (54%) at baseline to three quarters (76%) at midline, and increased again to 87% at endline (Figure 28). The figure for baseline must be interpreted with caution as a formal referral system was not yet in place as the programme had just begun, and could have referred to an informal referral system.

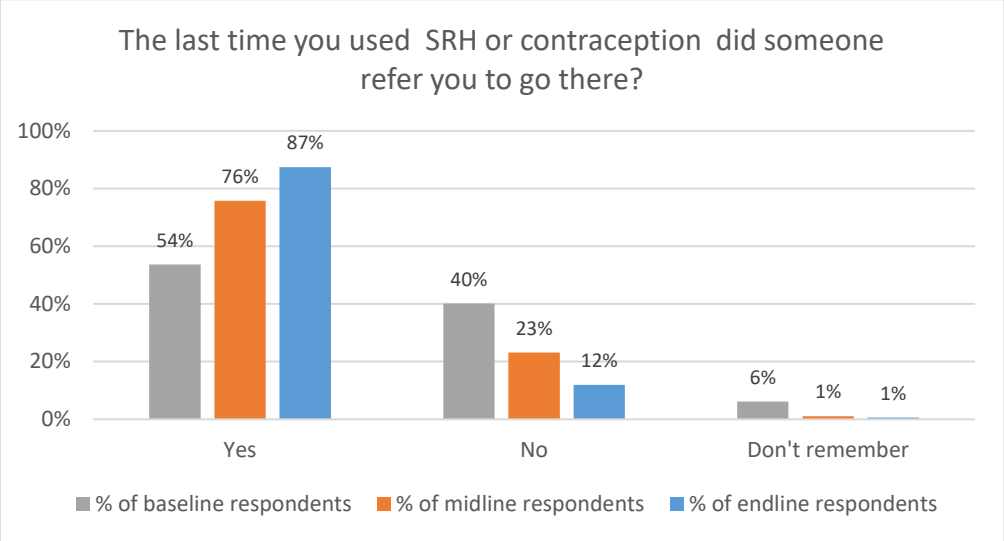


Figure 28 Referral to last use of contraception and/or SRH services (baseline n=326, midline n=363, endline n=628)

Of those who were referred to contraception and/or SRH services at last use, the most common source of referral at endline was teachers (36%) (Figure 29). The next most common response at endline was peer educators (32%). The proportion of respondents choosing this answer option also represented the largest increase over time, from 3% at baseline to 1% at midline and a large increase to 32% at endline.

While larger proportions of respondents reported being referred by teachers and peer educators over time, there have been reductions in the proportions who report being referred by friends (from 29% at baseline to 3% at endline), health workers (from 52% at baseline to just 2% at endline),and parents (from 4% at baseline to 0% at endline). At baseline, young people may have been referring to informal referral systems when they mentioned friends and parents as referral points. This could explain the reductions at mid- and endline. The proportion of respondents indicating they were referred by NGOs has also dropped from 38% at midline to 26% at endline, though this represents an overall increase from 2% at baseline. Responses relating to NGOs must be interpreted with caution, as they often work together closely with schools making it hard for respondents to clearly differentiate between the two.

[30] The question asked was 'You indicated that you have used contraception and/or SRHR services. The last time you used either of these, did someone refer you to go there?'

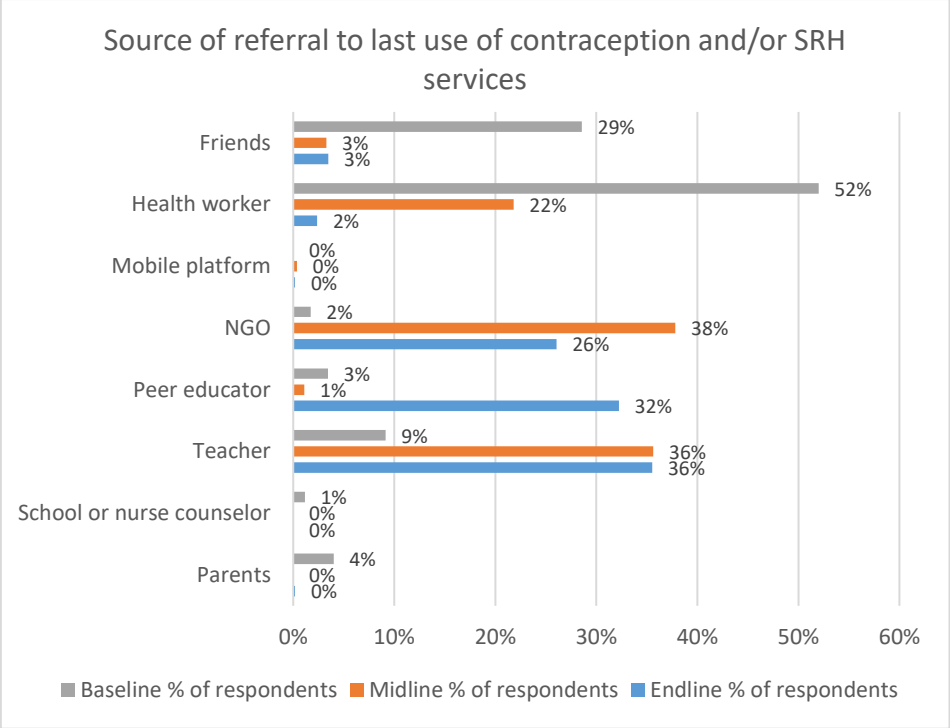


Figure 29 Source of referral to last use of contraception and/or SRH services, (baseline n=175, midline n=275, endline n=549)

The thirty respondents who mentioned that they had used either abortion or post-abortion services were asked two follow-up questions about their use of these services. Almost all of them (29) reported that the abortion services they used were carried out by a doctor or certified nurse. This was also the most common response at midline, when all respondents reported that this. At baseline this was also the most common response (7 of 12 respondents), but respondents had also commonly stated the service was carried out by themselves (5 respondents). The 1 respondent at endline who reported that an 'other' person carried out the abortion services then specified that they had accessed this service in order to receive education about abortion services, rather than to have an abortion procedure carried out. This endline respondent has therefore been excluded from the data relating to the following question on how their abortion was conducted.

In relation to the way in which the abortion was conducted, the most common method at endline was medical (24 of 30 respondents), followed by surgical (5 respondents). At both mid- and endline all respondents reported that their abortion was carried out either surgically or medically. At baseline however, while 7 of 12 respondents specified this, 1 respondent stated the procedure was a traditional one in addition to 4 respondents who specified an 'other' method (Table 13). At baseline 4 respondents stated they received abortion services carried out by an 'other' method; on examination of the text responses in relation to these, one of these responses has been classified as relating to a medical abortion as they mention acquiring drugs from a pharmaceutical professional. The remaining 3 all mention the intake of drugs but it is not clear which type of drugs they are referring to. These respondents using 'other' methods all reported carrying out their abortions themselves.

Table 13 Abortion

	Baseline	Midline	Endline
	n	n	n
Who carried out abortion services			
Doctor or certified nurse	7	21	29

Other	0	0	1
Self	5	0	0
Total respondents	**12**	**21**	**30**
How was the abortion conducted?			
Medical	6	13	24
Surgical	2	8	5
Traditional way	1	0	0
Other	3	0	0
Total respondents	**12**	**21**	**29**

Young women in the sample were asked which products they used to manage their period (Figure 30). Of the 480 endline respondents, all but one indicated that they were menstruating. The vast majority of respondents (95%) reported that they are using non-reusable menstrual pads. No endline respondents reported using tampons or menstrual cups, while some did report using cloths (14%) and reusable pads (16%). Similarly at midline, the majority of respondents stated that they used non-reusable pads (83%) or cloths (22%) while four reported using tampons and none reported using menstrual cups. This question was not asked at baseline.

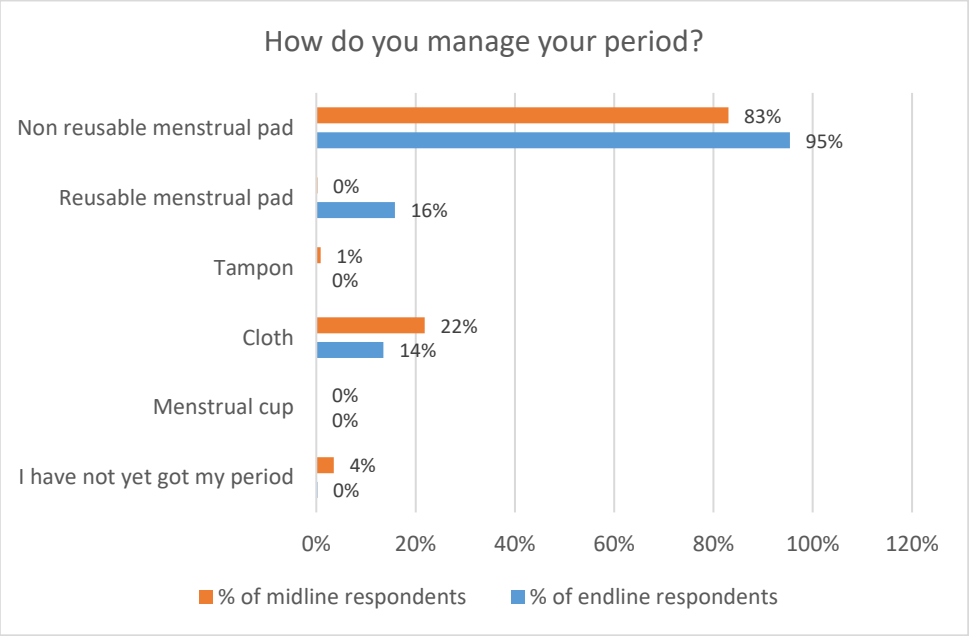


Figure 30 Menstrual health products used to manage menstruation (midline n=453, endline n=480)

Table 14 Summary Outcome 4 indicators

Outcome 4	Corresponding indicator	Baseline	Midline	Endline
Increased % of young people (from the catchment area) who access high-quality SRH services, including modern contraception and safe abortion for young people	% of young people who report never having used SRH services	57%	56%	19%
	% of young people between 15 – 24 years who report currently using any contraception	31%	24%	30%

Increased % of young people who use the referral system to access SRH services	# of young people between 15 – 24 years who indicated they were referred when they used contraception and/or SRHR services last time	54%	76%	87%
Decreased % of young people with an unmet need for contraception	% of young people that did not use contraception, who indicated that they would like to use it in the future	62%	73%	49%
	% of young men and women that did not use contraception, who indicated that they would like to use it in the future (excluding those that did not use contraception due to sexual inactivity)[31]	60% (156 of 260)	78% (36 of 46)	60% (9 of 15)
Decreased % of young people with an unmet need for SRH services	% of young men and women that did not use SRH services and wanted to use them (excluding those who did not have the need to go)	17%	16%	7%

Changes in social support of stakeholders

The following figures give an overview about the social support that young people reported receiving from stakeholders and those around them. These figures represent the perceptions of young people of how easy it was to talk to these groups about SRHR; whether these stakeholders understood young people when discussing these topics; and whether they felt these stakeholders supported young people's access to and use of related information and services.

Overall, at endline, young people felt more at ease, more understood and more supported by stakeholders in relation to SRHR compared to base- and midline (particularly baseline), with the one exception of traditional/community chiefs. However, there were general increases in the proportions of respondents stating 'neutral' responses to these questions at endline, following reductions in responses of this nature between base- and midline. More respondents indicated 'neutral' particularly when asked about traditional leaders and religious leaders. This could be as they may have limited interaction with them and hence may not know how to respond.

Respondents were first asked about how easy they found it to talk to various stakeholders about sexuality, contraception and relationships (scored on a 5-point Likert scale from very difficult to very easy) (Figure 31). There was a very high degree of variation in how respondents rated the various stakeholders in relation to this at baseline, and these gaps have reduced somewhat at endline. The average scores for all stakeholders have generally slightly increased or remained steady from mid- to

[31] The way that this indicator was calculated differed at baseline compared to mid- and endline, and therefore they are not directly comparable. At mid- and endline respondents were asked directly if they had been sexually active ever or in the previous 12 months, and those who reported they had not were excluded from this indicator. At baseline respondents were not asked this directly. Sexual inactivity was instead inferred from responses to the question about why respondents were not using contraception: those indicating that they were not using contraception due to sexual inactivity were excluded from this indicator at baseline. It is therefore possible that some sexually inactive baseline respondents were not excluded from this indicator, as they may have given other reasons, such as not knowing about contraception, for their non-use of contraception. Those who stated their reason for non-use of contraception was sexual inactivity were also excluded at mid- and endline.

endline, following larger increases from base- to midline. The one exception to this is traditional/community chiefs, who around half (54%) of endline respondents reported finding it easy/very easy to talk to, compared to 87% of midline respondents, meaning there was a fairly large drop in this from mid- to endline. Therefore, while having increased overall at endline compared to the baseline rate of 25%, this proportion has decreased from mid- to endline.

The largest overall rating increases from base- to endline were observed for (local) political leaders (who 32% of baseline respondents found it easy to speak to, compared to 89% of endline respondents) and religious leaders (a group which only 22% of baseline respondents found it easy/very easy to speak to, compared to 46% of endline respondents).

Overall at endline, respondents' peers were rated easiest to speak to, followed by health workers/providers, partners/spouses, and teachers. These were also the four groups respondents found it easiest to speak with at midline. At baseline, peers, partners/spouses, and teachers were also rated highest in this regard (health workers were not asked about at baseline). The stakeholders with the lowest average scores in relation to this at endline were religious leaders, and traditional/community chiefs (but it should be noted that these groups also saw the largest improvements in rating from base- to endline).

In general, there were more pronounced positive trends observed in relation to ease of talking to stakeholders about SRHR between base- and midline, than from mid- to endline. However, these gains have been consolidated at endline.

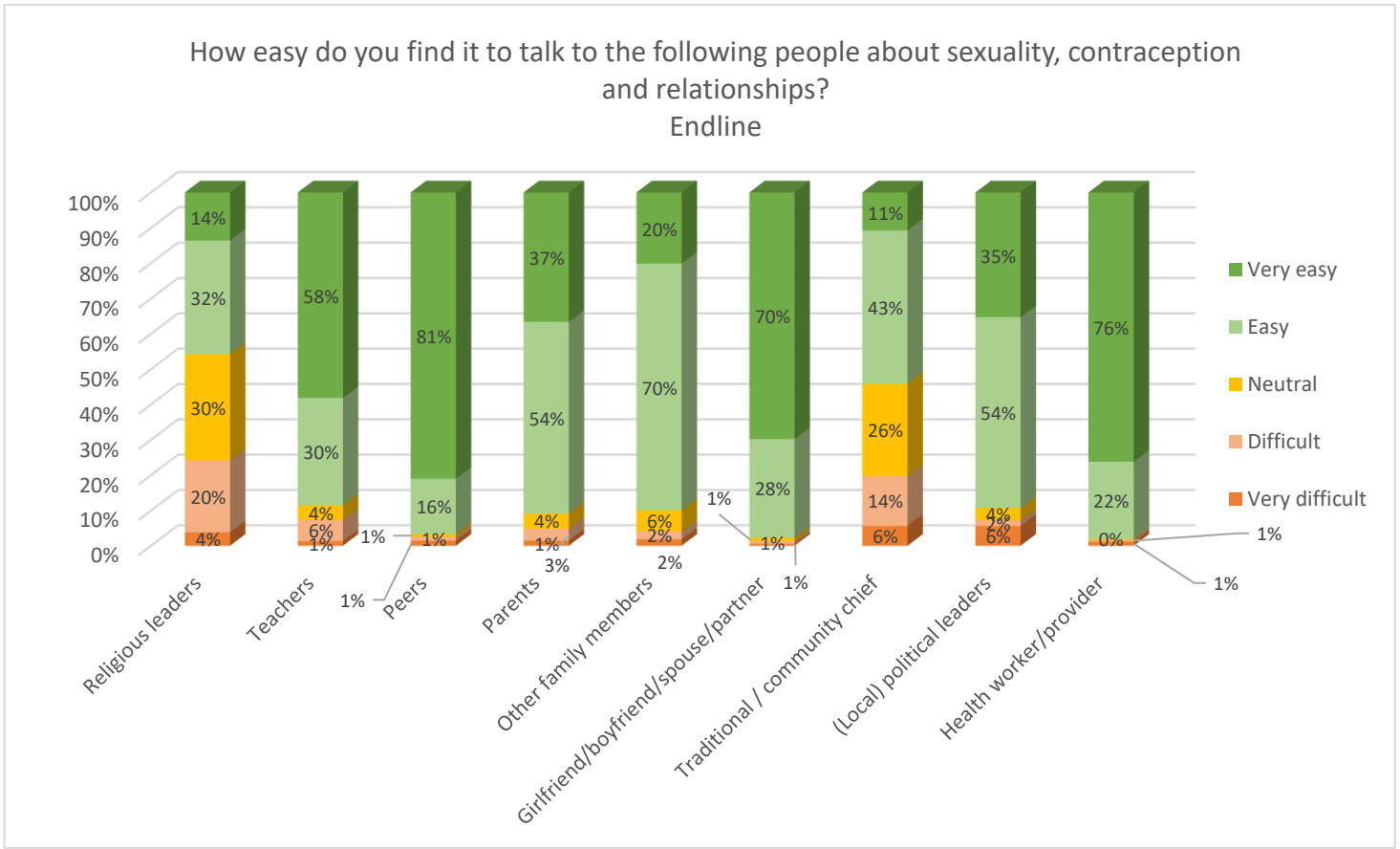


Figure 31 Perceived ease of speaking to different stakeholders about sexuality, contraception and relationships at endline (for each stakeholder n=765)

Respondents were asked how well understood they felt by various stakeholders while talking about these topics (scored on a 5-point Likert scale from not understood to very understood) (Figure 32). At endline, respondents felt most understood by peers (96% felt understood/very understood), health workers (98% felt this), peers (96%), and girlfriends/boyfriends/spouses (98%). Overall, respondents gave the lowest ratings in regards to feeling understood when discussing these topics to religious leaders (46% at endline felt very understood or understood), and traditional/community chiefs (56% felt very understood or understood). Therefore, the general pattern seen here at endline is very similar to that observed in relation to how easy respondents find it to speak with stakeholders, as indicated above.

A similar trend is also observed in these responses over time when we compare them to how the ease of speaking with various stakeholders has changed across study stages; more respondents reported 'neutral' feelings at endline compared to base- and midline, but overall average scores have remained steady or improved slightly from mid- to endline, following larger average increases from base- to midline. Again, the one exception to this is traditional/community chiefs, who 88% of midline respondents felt understood/very understood by, compared to 56% of endline respondent. However, it should also be noted that a large improvement is still observed overall for traditional/community chiefs between base- and midline, despite the decline from mid- to endline. Similarly, while they were still awarded some of the lowest ratings by respondents, local political leaders and religious leaders have seen the largest increases of all stakeholders from base- to midline. Large increases were also observed in relation to the proportion of respondents that felt understood/very understood by other family members (from 43% from baseline to 91% at endline) and parents (from 54% to 91%).

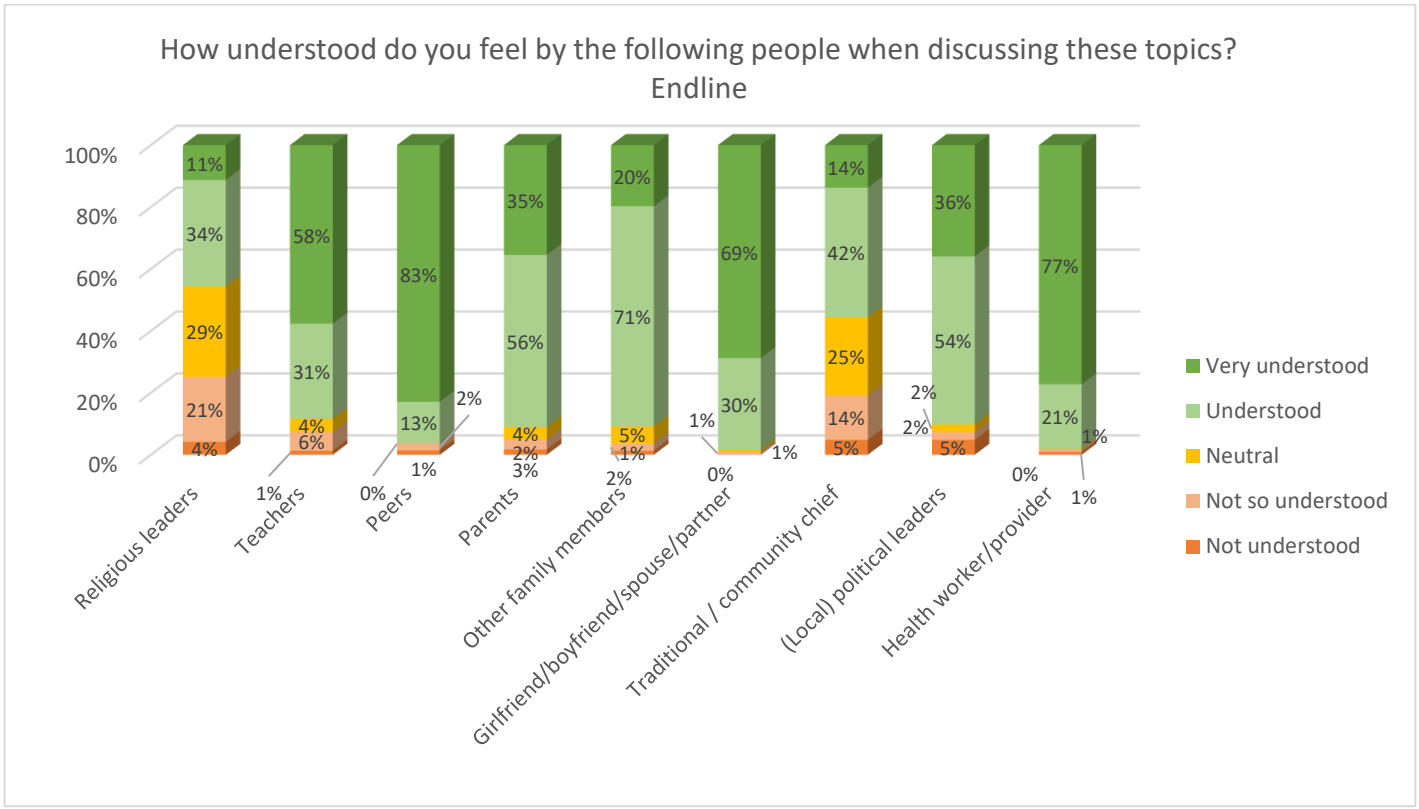


Figure 32 Perceived level of understanding of different stakeholders when young people are discussing SRHR topics (for each stakeholder n=765)

A similar pattern emerges over time when comparing the extent to which young people felt supported by stakeholders in their access to SRH services and education. Across most stakeholder groups, the majority of respondents felt supported at endline regarding access to SRH services and sexuality education. However, this was not the case for religious leaders (47% felt supported/very supported).

This is noteworthy when we consider that at baseline less than half of respondents felt supported/very supported by religious leaders (12%), parents (47%), other family members (40%), traditional/community chiefs (21%), and local political leaders (29%). There have therefore been large increases across all stakeholder groups from base- to endline, most of which were already apparent at midline. It should also be noted that the groups respondents felt least supported by also saw the largest increases in their perceived support to young people over time. For example, at baseline just 12% felt supported by religious leaders, which increased considerably to 57% at midline and then decreased slightly to 47% at endline. Large improvements were also observed between base- and endline in the proportions of respondents who felt supported/very supported by teachers (which saw an increase from 59% to 89% who felt supported), parents (from 48% to 91%), other family members (40% to 92%), traditional/community chiefs (21% to 56%) and local political leaders (from just 29% to a large majority of 90% at endline).

Again, the largest proportions reported feeling supported by health workers/providers (99%), peers (98%) and girlfriends/boyfriends/spouses (98%). This was the case across all study stages.

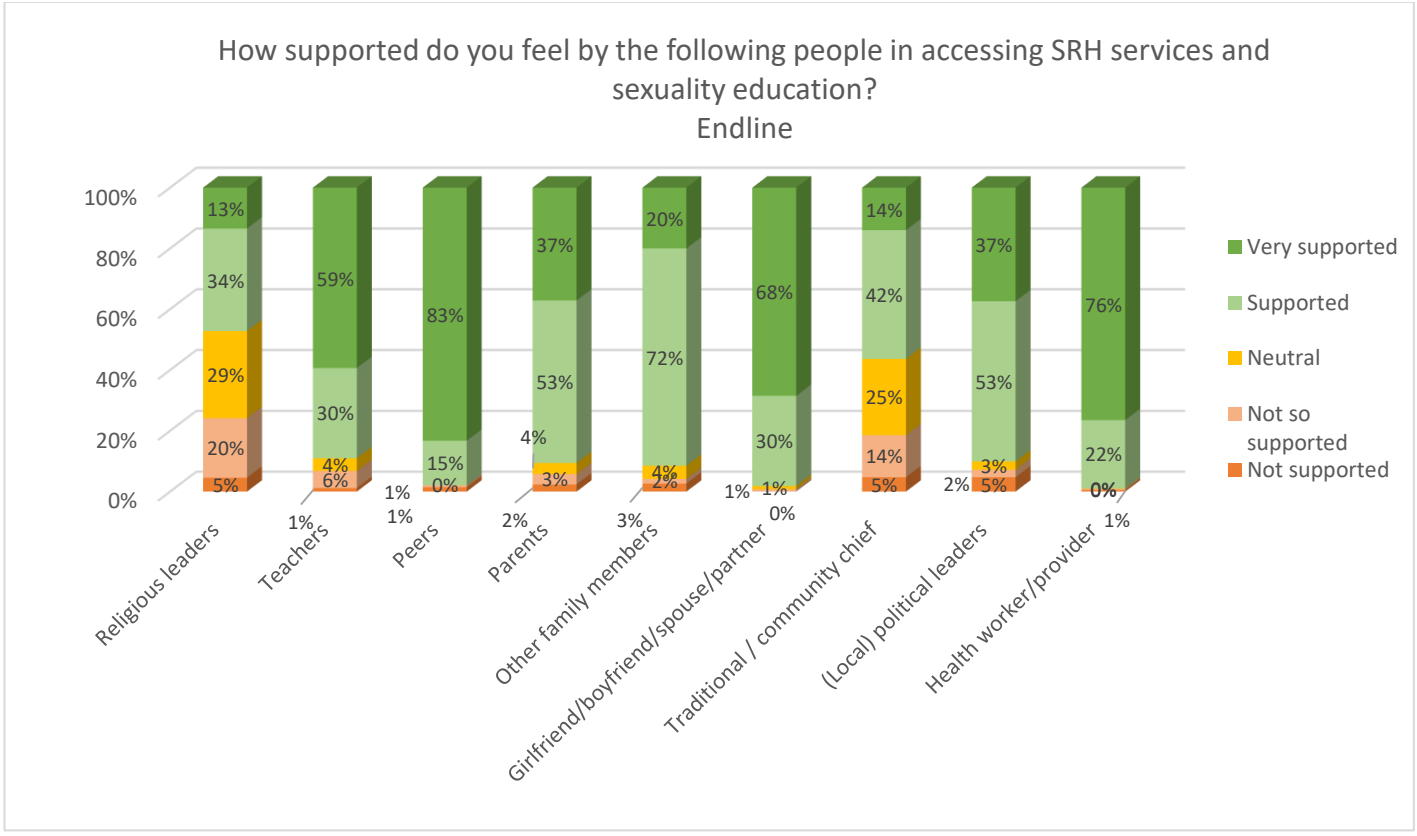


Figure 33 Perceived level of support of different stakeholders in the community for access to sexuality education and SRH services for young people (for each stakeholder n=765)

Changes in personal attitudes and opinions

Figures 34 and 35 summarise the personal attitudes and opinions of respondents at endline. The changes since base- and midline in responses to these statements have been positive in all but one case. For example, at endline we see more respondents agreeing that they feel confident and able to make decisions, and fewer respondents agreeing that repressive patriarchal practices such as domestic abuse are acceptable. The one exception to this positive trend is in attitudes to same-sex sexual relationships.

The statements that elicited the strongest responses from endline respondents were 'I feel confident that I can use a condom every time if I have sexual intercourse in the future' which 97% of respondents agreed/strongly agreed with, 'I feel I am able to make the decision myself if I want to have sex or not' (which 95% of respondents agreed/strongly agreed with), and 'It is acceptable to me for people of the same sex to have a sexual relationship' (just 3% of respondents agreed/strongly agreed with this statement). As mentioned above, the proportion of respondents agreeing with this last statement has decreased over time, from 12% at baseline to 8% at midline and finally just 3% at endline.

Higher proportions of respondents report what can be characterised as positive shifts in attitude over time in relation to:

- Feeling guilty/ashamed when they have sexual feelings (33% agreed at baseline, compared to 31% at midline and 15% at endline)
- Feeling confident that they can use a condom every time if they have sexual intercourse in the future (67% agreed at baseline, while 86% agreed at midline, compared to 97% at endline);
- Feeling able to make the decision if they want to have sex or not (77% agreed at baseline, and 92% at midline, compared to 95% at endline);
- Those who believe that girls and women should always obey a man (this reduced from 46% at baseline to 25% at midline and finally to 19% at endline);
- Feeling afraid about changes that occur in their body during puberty (46% of respondents agreed that they felt afraid about this at baseline, and while at midline this increased slightly to 51% it then dropped considerably to 21% at endline);
- Those who agree they would be ashamed if someone in their family had HIV (a decrease from 46% at baseline, to 32% at midline and finally 20% at endline);
- Feeling able to participate in decision-making for their own health care (an increase from 74% at baseline to 90% at midline and a large majority of 95% at endline);
- Those who agree that it is acceptable for husbands to beat their wives if they argue with them (a decrease from 20% at baseline to 18% at midline and 12% at endline)

Also positively, there have been increases since midline[32] in the proportions agreeing with all the statements beginning with 'I feel confident to…' , and a slight increase in the proportion stating they wish they had more respect for themselves. Overall, all shifts in personal attitudes and opinions since base- and midline appear to have been positive with the one exception of attitudes towards same sex relationships, discussed above. No large differences were observed between genders for attitudes and opinions.

[32] This group of questions was added at midline

A very large majority of respondents (above 90%) agreed that they felt confident to get tested for STIs (96%), to get tested for HIV (95%), and to get condoms from a pharmacy, health clinic or shop (91%). A large majority of 89% felt confident to use sexual and reproductive health (SRH) services when needed.

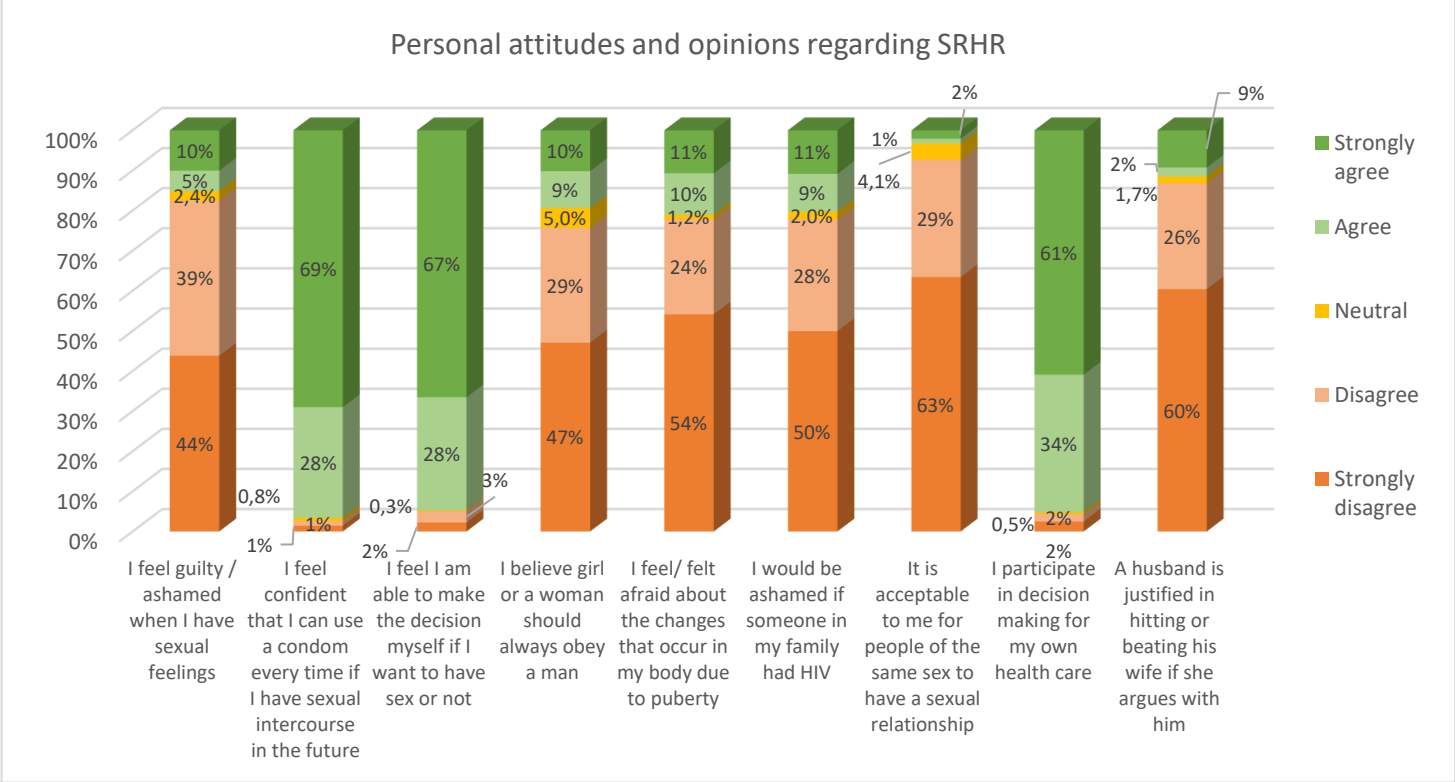


Figure 34 Personal attitudes and opinions about SRHR (for each attitude/opinion n=765)

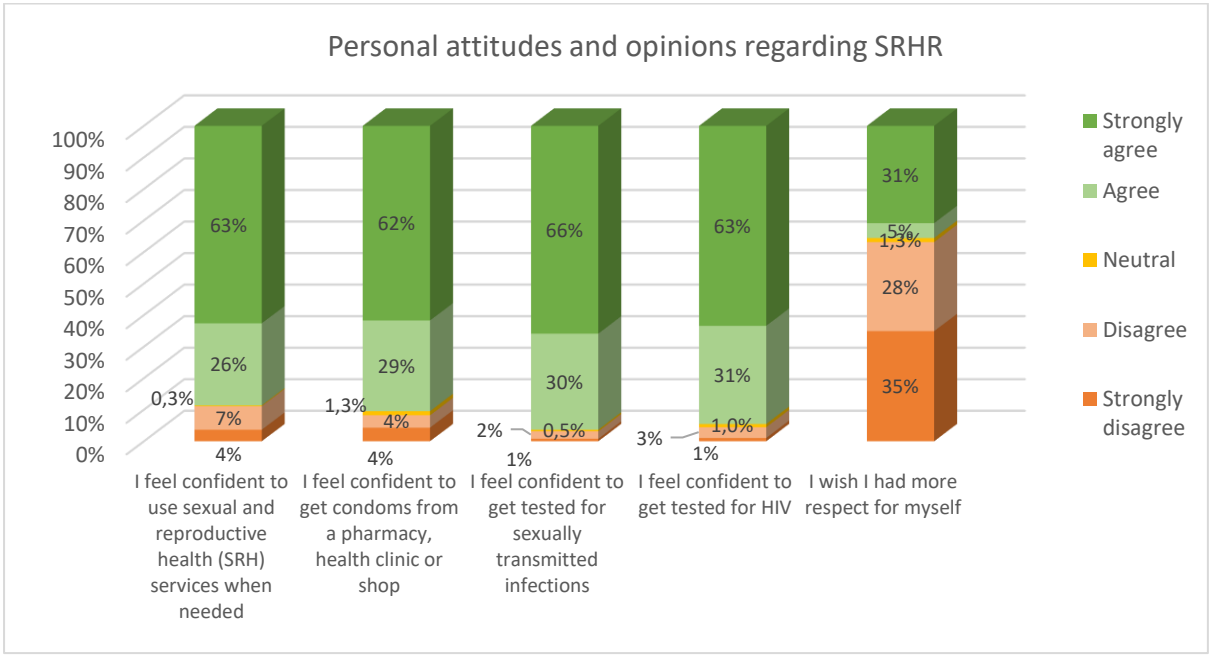


Figure 35 Personal attitudes and opinions about empowerment and SRHR (for each attitude/opinion n=765) [33]

There have been increases since midline in the proportion of young women, and young men stating that they feel able to resist and seek help if someone forced them to do something against their wishes (Table 15). Ninety-nine percent (99%) of those at endline felt that they would be able to resist if someone forced them to do something against their wishes (an increase from 96% at midline), and 86% stated that they were able to seek help (a large increase from 44% at midline).

However, less positively, there was also a large increase in the percentage stating that they would not dare tell anyone if this happened, for both young men and young women (multiple answer responses were permitted, which is why it is possible for the proportions of respondents selecting each answer option to have increased) (Table 16).

Table 15 Reaction in case of force [34]

In general, if someone tries to force me to do something against my wishes, I:		Young women		Young men		Total	
		n	%	n	%	n	%
Am able to resist	Midline	434	96%	303	97%	737	96%
	Endline	476	99%	285	100%	761	99%
Am able to seek help	Midline	200	44%	138	44%	338	44%
	Endline	405	84%	254	89%	659	86%
Would not dare to tell anyone	Midline	7	2%	1	0%	8	1%
	Endline	108	23%	83	29%	191	25%
Other	Midline	1	0%	0	0%	0	0%
	Endline	0	0%	0	0%	0	0%

Impact of COVID-19

Almost all respondents (100% rounded to the nearest percent) reported that COVID-19 had changed their life (Figure 36). One young women reported that COVID-19 had had no effect on her life. Of the areas in which COVID-19 and related restrictions had changed their life, a majority of respondents had noticed changes in relation to not being able to (fully) participate in school classes (but being able to watch classes on TV) (52% of respondents). This was the most common change noted by respondents. In addition, 40% of respondents felt stressed, anxious and worried more now than before, while a third (32%) reported that they were not able to participate in school classes and were unable to watch classes on TV. A small minority of 11% also stated that they were not able to fully work at that moment.

No large gender differences were observed, but slightly more males reported being affected by falling household income (22% of men reported changes to their life in this regard, compared to 17% of women), and not being able to fully work (11% of men reported this compared to 8% of women). Slightly more men (56%) than women (49%) also reported not being able to participate in school classes (but being able to watch these on TV). Very similar proportions across genders reported an

[33] These questions were added at the midline hence no baseline data is available to compare.
[34] This was added at the midline hence no baseline data is available to compare.

increase in stress and worry, and in being less able to participate in school classes without being able to watch them on TV. Only one female respondent reported experiencing more violence or other abuse as a result of COVID-19.

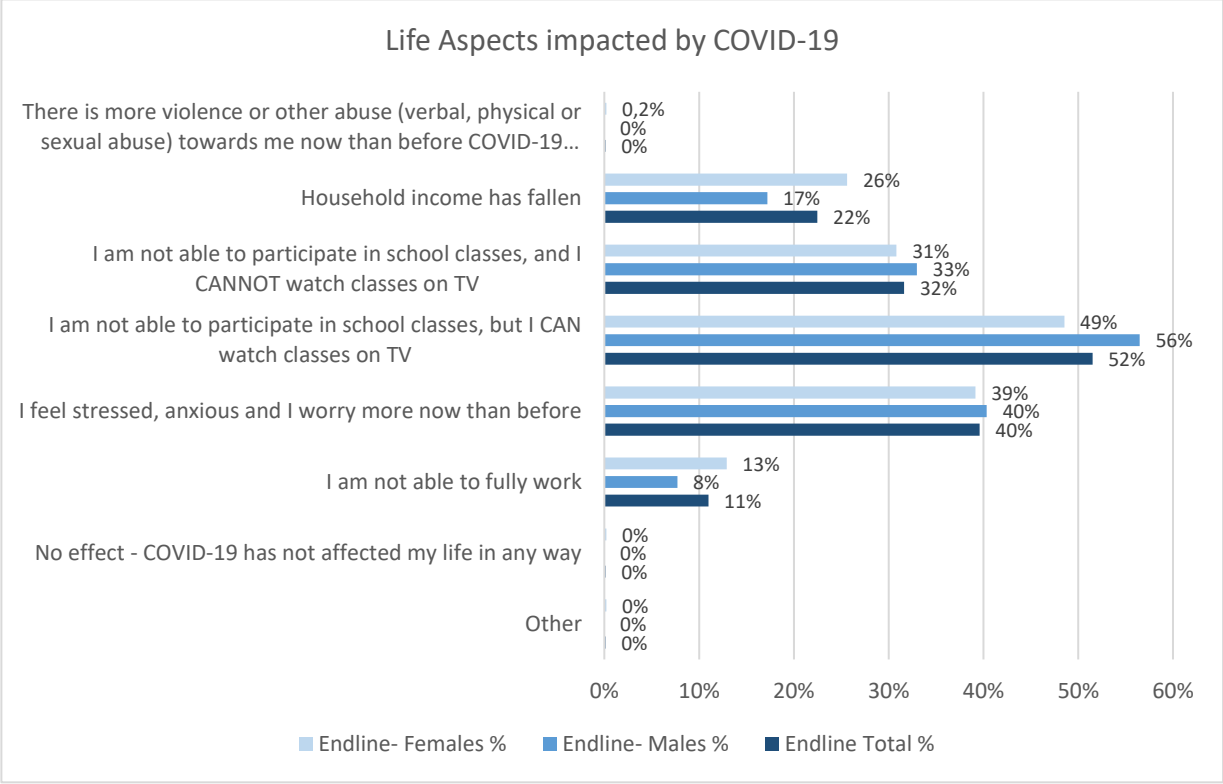


Figure 36 Effects of COVID-19 on areas of life by gender (female n=480, male n=285, total n=765)

While almost all respondents reported feeling that COVID-19 has affected their lives in general, only 13% reported having had problems with sexual and reproductive health during this period (Table 19). More young women (15%) reported this than young men (10%).

Table 16 Problems with SRHR during COVID-19 pandemic

During this COVID-19 pandemic, did you have problems with your sexual and reproductive health?	Young women		Young men		Total	
	n	%	n	%	n	%
Yes	73	15%	28	10%	101	13%
No	407	85%	257	90%	664	87%
Don't know	0	0%	0	0%	0	0%
Total respondents	480		285		765	

Those that reported having problems with sexual and reproductive health during the pandemic were asked a follow-up question about the areas in which they had experienced problems (Figure 37). A majority of respondents reported experiencing 'difficulty accessing SRHR-related education' (70 of 101 respondents reported this), with around 60% of respondents reporting 'difficulty accessing SRH services including contraception'.

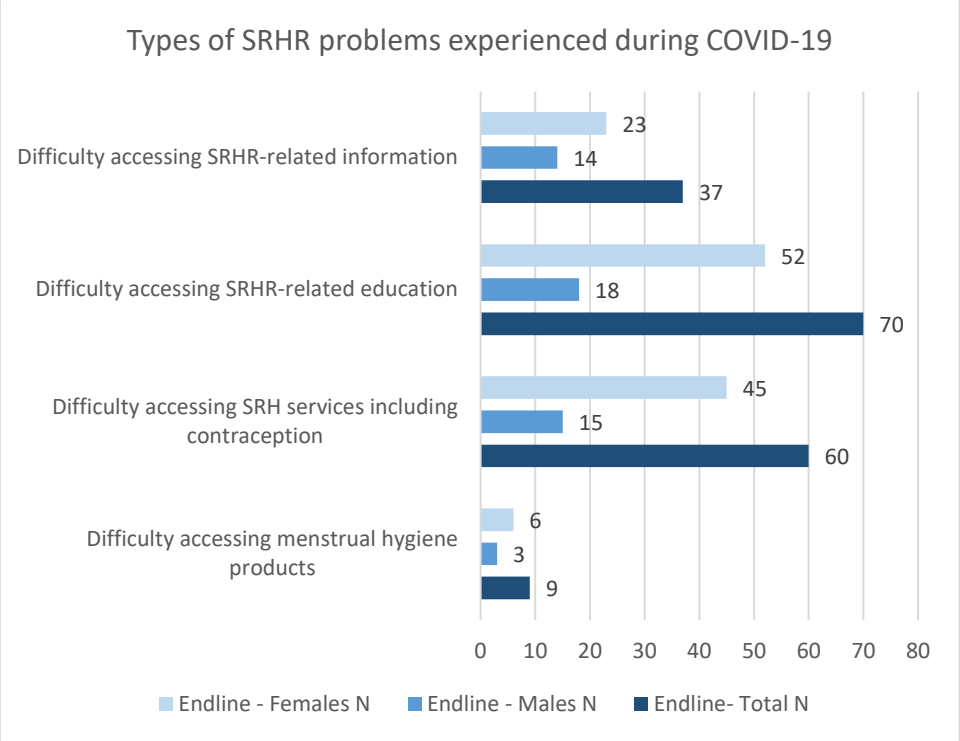


Figure 37 Type of SRH problems experienced during COVID-19 pandemic, by gender (females n=73 , males n=28, total n=101)

Influence on the GUSO programme

The proportion of respondents who reported feeling that they could influence the GUSO programme has increased since midline from 97% to almost all respondents (100%) (Table 17). This was true across genders. Fewer respondents stated that they did not know the intervention.

Table 17 Perceptions of ability to influence the GUSO programme

Do you feel like you can influence the GUSO intervention?		Young women		Young men		Total	
		n	%	n	%	n	%
Yes	Midline	424	97%	296	98%	720	97%
	Endline	478	100%	284	100%	762	100%
No	Midline	11	3%	3	1%	14	2%
	Endline	1	0%	1	0%	2	0%
Don't know	Midline	0	0%	0	0%	0	0%
	Endline	0	0%	0	0%	0	0%
I don't know GUSO	Midline	4	1%	3	1%	7	1%
	Endline	0	0%	0	0%	0	0%

Those who reported that they had participated in GUSO activities (98% of the total sample) were asked a follow-on question to investigate which specific activities they had participated in (Table 18)[35]. The most common responses were 'SRH education/information' (91% of respondents), 'Youth club' (76%), 'Youth-friendly health services' (76%). Several activities and services were participated in or used by a majority of respondents, with the exceptions of 'Social accountability' (40%), Star camps (36%) and 'Vocational training' (27%) which saw lower figures of participation. There were no large differences observed between genders in participation in or use of activities and services.

Table 18 Activities participated in through the GUSO programme by gender at endline

What type of GUSO activities or services have you participated in or used? This can be as a service user, a participant, an implementer, or an activity leader.	Young women		Young men		Total	
	n	%	n	%	n	%
Community dialogues	277	59%	157	55%	434	57%
Outreach activities	303	64%	173	61%	476	63%
Social accountability	189	40%	115	40%	304	40%
SRH education/ information	429	91%	261	92%	690	91%
Star camps	171	36%	103	36%	274	36%
Vocational training	139	29%	66	23%	205	27%
Youth club	349	74%	230	81%	579	76%
Youth-friendly health services	353	75%	221	78%	574	76%
Other	2	0%	2	1%	4	1%
Don't know	2	0%	2	1%	4	1%
Total respondents	**472**		**285**		**757**	

[35] This question was added at endline

Discussion, conclusions and recommendations

This section discusses key findings, outlines conclusions and recommendations.

The endline study gives us an insight into how young people were **involved in the GUSO programme.** Over time it is clear that more young people have become aware of the programme and have participated in it and received information through it. Results are very positive, with large increases in the proportion of young people receiving SRHR education and information that they find beneficial, and increases in knowledge of and access to SRH services and contraception. Personal attitudes and opinions also show positive trends over time, as do the levels of support and understanding that respondents feel they receive from a range of stakeholders.

The vast majority of young people reported having (ever) received **SRHR information**, with a fairly large increase observed since midline. Of those young people who had received SRHR information, the proportion who had received it through GUSO increased considerably over time - from 2% at baseline to 99% at endline.

Peer educators, health providers, youth clubs and **teachers** were all very common **sources of SRHR information,** as well as being **important sources of information on sexual rights.** The proportions of respondents receiving information from all of these sources increased considerably since midline, with the one exception of teachers, which dropped from 90% to 82%. **In general, it is clear that the role of the peer educators has become more important over time.** This is in line with the observations of the programme staff who indicated that more efforts had been taken to engage young people as facilitators. They have become more common providers of SRH education, have advised and given referral regarding these services, and are now common sources of information on sexual rights. However, this shift was not observed in relation to provision of contraception. This pattern is largely **similar** to the **more prominent role that youth clubs and health providers/medical staff** have been seen to play over time in respondents' access to SRH information, education, referral to services, and information about sexual rights.

Health facilities/medical staff were also observed to be the **most common provider of contraceptives and SRH services**, a role, which has become increasingly prominent over time. It is worth noting that community health workers, peer educators and pharmacies/shops were also more commonly mentioned in relation to provision of SRH services, but this trend was not observed for contraceptives. **In relation to SRHR education, it is not surprising that teachers** were the **most common source**. NGOs continue to be a common source, but these results must be interpreted with caution as NGOs often work with other stakeholders like teachers, which makes it difficult for respondents to differentiate between the two.

In general, the data suggest that a large **majority of young people received SRHR information and SRHR education across all topics** discussed, and that this has increased over time. More than 85% of the sample mentioned that they had received information and education on each of these topics. As a positive shift, all topics were more commonly mentioned within the information and education that young people received. **Large majorities of young people also found the information and education they received on all topics to be beneficial, and these proportions also increased since midline**. Information on puberty was found to be particularly beneficial.

It is worth noting that more young people received information regarding SRH services (on types and locations for access) and this was well-received by them. It is clear that young people are exposed to an increasingly diverse and comprehensive set of topics on SRHR, and have found these topics to be

increasingly beneficial over time. However, we cannot comment extensively on the quality of the information and education that young people received.

Overall respondents reported being **more aware of their sexual rights** over time. They also report **receiving information on these rights from a wider range of sources** over time. We see that **health providers, peer educators, teachers, and youth clubs** are important sources of information on rights, and that the role of **peer educators and youth clubs in particular has become more important** over time. Overall it is clear that a large majority of respondents have knowledge about a wide range of sexual rights, with **particular increases noted on the right to have access to SRH services**. Young people also felt more supported to enjoy their sexual rights – again, particularly in regards to their right to have access to SRH services. This is consistent with the above-mentioned result that more young people reported received information/education on SRH services.

The referral system appears to be working well. Ninety-six percent (96%) of young people were 'advised' to access services when they last received SRHR information or education, while 87% of those who used SRH or contraceptive services reported that they were referred to these the last time they used them. This has increased from midline to endline. In addition, the proportion of those who went on to access services after they were advised to do so has also increased, from 57% at midline to 85% at endline. It is also clear that the quality of SRH services increased over time. **Almost all (96%) of those who used services at endline indicated that the quality was excellent**. This was a **substantial positive shift** over time from midline when only about half the young people had said this.

When unpacking the components of quality, the largest positive changes over time were the increased proportions of young people who found the service to be staffed by friendly and respectful health providers (from 36% at midline to 95% at endline), to be open after-school hours (from 11% to 76%), to be affordable or free (from 27% to 92%), and to not require parental or partner permission (from 22% to 85%). In fact, the **only service characteristic that did not see a positive increase from mid- to endline was the availability of medicines**, and it is not clear to what extent COVID-19 may have affected this. In general, as per the data, it can be inferred that **9 in 10 of the young people found the service they last accessed to have the characteristics that could constitute being a youth-friendly health facility:** a friendly and respectful health provider, it was affordable or free, there was privacy, it was easily accessible, it was open after-school hours, and it did not require parental or a partner's consent. This is a positive finding.

Roughly **one third of young people surveyed at endline have ever had sex**, and of these, around two thirds are currently sexually active (meaning they have had sex in the previous 12 months). This means that **the majority have never had sex, and an even larger majority have not had sex in the past 12 months**. Rates of sexual activity have decreased since midline. This is consistent with the higher proportions of respondents who report being single at endline. This reduction is still apparent when we compare those within the same age year groups from mid- to endline (so it is not explained by a change in age profile of respondents). More young women report being sexually active than young men, a gender gap that was also apparent at midline but has since widened. The data on use of contraception must be interpreted with caution. Reported contraceptive use is high (30% at endline), especially given that most young people are not sexually active and only 24% of endline respondents report having sex in the previous 12 months. In addition, many respondents report using multiple methods of contraception. Following discussion with the research team, this could be due to a misinterpretation of two of the survey questions on the part of (some) respondents and/or enumerators. Information appears to have been provided by some about whether and which methods of contraception respondents had *ever* used, rather than whether and which contraceptives they were currently using.

Nine in ten of those who stated that they did not currently use contraception but would like to in the future also stated that the reason they did not currently use contraception was that they are not sexually active (or had never had sex). This suggests that the majority of respondents' lack of current use of contraception is not necessarily due to barriers of access, knowledge or availability, but is rather attributable to sexual inactivity. In addition, of those who reported being in a relationship (i.e. having a girlfriend/boyfriend or being married), most reported currently using contraception. In general **it does not appear that there is a high level of unmet need for contraception among respondents, including among those who are currently in relationships.**

There has also been a **positive increase in the use of SRH services** among young people. While at base- and midline only around 4 in 10 young people surveyed had ever used SRH services, **at endline 8 in 10 young people reported this**. The use of individual services was generally higher than or similar to reported level of use at midline, and generally higher than at baseline. Those services that have been used by fewer respondents at endline are consistent with the lower reported sexual activity of young people at endline; for example there have been slight reductions of 1-6 percentage points in the proportion using abortion services, STI treatment, and antenatal and postnatal care services, and family planning services. Those who **used services at endline mainly used life skills and sexuality counselling, VCT or HIV testing, STI testing, and hotlines,** all of which saw large increases in use over time. **Only two endline respondents (<1%) reported not knowing about SRH services, which is a very positive change since baseline when 9% of respondents reported this.**

Respondents' **knowledge of a broad range of modern ways to prevent pregnancy also appears to be increasing**. This is particularly the case for young men, who had previously reported lower levels of knowledge of a broad range of contraceptive methods than women. We see this gap has closed at endline and there are now no notable differences between genders in knowledge of contraceptive methods. There have been increases in those indicating knowledge of all types of contraception. These **increases have been particularly pronounced (relative to base- and midline levels of knowledge) in regards to knowledge of sterilisation, the morning after pill, the IUD and the implant**. Among modern methods of contraception, male and female condoms continue to be the most commonly reported method to prevent pregnancy, with the proportion that report knowledge of these having increased at endline. More than 9 in 10 endline respondents have knowledge of four or more methods of contraception. However, there is a concerning finding that emerges from this study. High proportions of young people over time report withdrawal as a pregnancy prevention method and as a method they use. According to programme staff, this could be due to misinformation from social media or peers. Future work should focus on providing accurate information about the risks of using withdrawal and the alternatives available- both at the level of awareness, but also while providing SRH services and contraceptives.

The data also gives insight to which **stakeholders** were key for young people when it came to exercising their SRHR. Overall **young people's perceptions of the support, understanding and ease of speaking with stakeholders has remained steady or improved slightly from mid- to endline, following larger average increases from base- to midline**. Positive trends are observed across all stakeholders in relation to each of the three aspects of support, ease of conversation, and understanding explored through the survey, with the **one slight exception of traditional/community chiefs**. For this stakeholder, while rates of perceived support, understanding and ease of conversation have increased overall since baseline, there was a notable drop between midline and endline. This could be because more respondents reported feeling 'neutral'. This could imply that they had limited interaction with traditional/community chiefs and hence could not comment. Overall, respondents still report **feeling most understood and supported by their peers, romantic partners**, and **health**

workers. However, they felt **less understood and supported by authority figures** such as political, traditional and religious leaders. However, the proportions reporting **positive feelings in relation to authority figures of this kind were among the largest increases over time** (with the caveat relating to the change between mid- and endline regarding traditional/community chiefs outlined above). As dsiscussed in the validation session, this indicates the **effectiveness of current efforts to engage authority figures** in improving young people's SRHR. It is important that these efforts continue, as stakeholders such as religious leaders, traditional/community chiefs, teachers and health workers are in a position to either reinforce or undermine the Alliance's efforts, due to their considerable influence on young people's lives. Large increases were also observed in relation to the proportion of respondents that felt understood/very understood by other family members and parents.

Lastly, the survey also explored changes over time in the **personal attitudes of young people** around their SRHR. Overall, at endline, **there are very positive shifts observed in personal attitudes relating to the self-confidence** of young people. When it comes to **attitudes on gender and sexuality**, **there are many positive results, though homophobic views persist and appear to have become more ingrained over time.** It is noteworthy that a large majority of 87% now disagree that a husband is justified in beating his wife if she argues with him, while 76% disagree that women and girls should always obey men. It is also positive that the number of young people who are accepting of those with HIV have increased over time. This is also consistent with the finding that many of the respondents reported using VCT and STI testing services themselves. Similarly, endline respondents were far more likely than at base- or midline to say that it was the responsibility of *both* boys and girls to prevent pregnancy, with almost all respondents at endline stating they felt this. **These changes in gender attitudes indicate that gender-transformative approaches may be working**. Overall there are no notable differences across genders in the prevalence of patriarchal attitudes. Additionally, the **proportion of respondents who feel confident to access services has increased over time**, and a very large majority of respondents (around 9 in 10 or more) agreed that they felt confident to get tested for STIs, to get tested for HIV, to get condoms from a pharmacy, health clinic or shop, and to use sexual and reproductive health (SRH) services. This is also consistent with the higher use of SRH services, and that many respondents did report going to the pharmacy/shop to access services.

Lastly, it is clear that the **COVID-19 pandemic and related restrictions have affected the lives of almost all young people.** This is particularly pronounced in relation **being able to attend school classes** (both physically and virtually). It is also clear that **young people's mental health has also been affected** and they recognise this. Young people's SRHR was less affected (13% mentioned this, or 101 respondents). The majority of these 101 respondents said they experienced difficulty in accessing SRH services (including contraception), and SRHR education. Lastly, one respondent reported an increase in violence or abuse since the COVID-19 pandemic.

The data and findings clearly show that the programme has had positive outcomes on the lives of young people. To ensure sustainability of the programme and outcomes, and to mitigate the setbacks from the pandemic, the Alliance should focus on reaching young people with mental health and SRHR-related support, and ensure they return to education once schools reopen. Awareness about SRHR has certainly improved over time, as has the role of peer educators in providing SRH services and education. This should be built upon in order to encourage young people to continue to take action to exercise their SRHR.

Limitations

Social and cultural norms with regards to the sexual behaviour of young people may have resulted in responses being affected by social desirability bias. Other limitations have been outlined in the methodology section.