YES I DO Alliance

Consolidated Annual Report 2016

General Information

Name of the organization	Stichting Plan Nederland
Postal address	P.O. Box 75454 1070 AL Amsterdam
Telephone number	+31 20 5495555
Email address	info@plannederland.nl
Name and email address of contact person	Ms. Monique Demenint Monique.Demenint@plannederland.nl +31 20 5495579 +31 6 15541059

Contents

1. Summary

The YES I DO Alliance (YIDA) consists of Plan Nederland (lead organization), Amref Flying Doctors, CHOICE for Youth and Sexuality, Royal Tropical Institute (KIT) and Rutgers. The programme is being implemented in seven countries: Ethiopia, Kenya, Mozambique, Malawi, Zambia, Pakistan and Indonesia. The programme runs from 2016 to 2020.

2016 was the start-up year for the YIDA. During the first half of the year inception workshops were held in the seven countries for Dutch YIDA staff and national alliance members to gain a common understanding of the overall vision, objectives and goals of the Theory of Change (ToC) and the YES I DO programme. Partners jointly developed context-specific ToCs and worked on outlines for the programme. Follow-up activities included making the generic monitoring and evaluation (M&E) framework country specific, further agreeing on intervention areas, making activity plans and budgets, selecting and contracting implementing partners and introducing the programme to key stakeholders. The start-up phase of the programme is described in the Inception Report dated June 2016.

The major enabling and hampering factors and the wider context for sexual and reproductive health and rights (SRHR) within the countries in terms of social and political actors and factors in relation to child marriage (CM), teenage pregnancy (TP) and female genital mutilation/cutting (FGM/C) are described. Baseline information for Yes I Do was collected through mixed-methods studies. On average, 1600 youth aged 15–24 were interviewed in each country, 25% males and 75% females. Qualitative data was collected to provide a more in-depth situational analysis related to CM, TP and FGM/C. Analysis of the information shows that Ethiopia, Mozambique and Pakistan have the highest prevalence of CM among girls aged 15–24 years. The TP rate is very high in Mozambique, followed by Malawi. In all countries where FGM/C is practised the baseline shows that this affects more than 50% of girls in our study. A summary baseline report is expected to be ready in early May 2017.

Alliance-building in the countries and preparing for implementation took longer than expected, due to agreeing on intervention areas, the complementarity of activities, making activity plans and budgets, finalizing M&E frameworks, signing contracts with alliance and implementing partners, recruiting key staff and introducing the programme to the communities. This resulted in a number of activities and budgets being carried forward to 2017. It is expected that most country alliances will be able to catch up on activities in 2017.

Harmonization of the alliance is taking place in the countries, and the alliances are in touch with other programmes working on CM and with the local Dutch Embassies. In the Netherlands, the three CM alliances set up Girls Not Brides the Netherlands (GNBN) and have regular contact with each other and the Dutch Ministry of Foreign Affairs.

Gender and inclusiveness are key components of Yes I Do and have been taken into account right from the design phase of the programme. Including boys, men and youth are cross-cutting strategies and part and parcel of the programme.

The YES I DO ToC and its five pathways of change are actively informing our programme. We will adjust the ToC and the assumptions based on implementation when necessary throughout the programme. The country-specific ToCs have not yet been adjusted in relation to the baseline outcomes. The findings from the baseline reports might lead to minor shifts.

The YIDA has an M&E coordination group to align and ensure the consistency of the different M&E processes (including the International Aid Transparency Initiative — IATI) in the countries. To optimally

guide countries in their M&E work, capacity-building on M&E is available, and partners have been able to express their needs in an M&E survey. A generic M&E framework is available and has guided the country-specific M&E frameworks, which are nearing finalization in early 2017. All YIDA partners prepared for reporting in IATI during 2016, and an IATI guideline for publishing results was developed.

Challenges in 2016 mainly related to building new alliances in the Netherlands and seven other countries, and in Pakistan and Ethiopia there were delays with the baseline studies. Working in an alliance, however, also provides major opportunities to share, learn and exchange knowledge; it also offers opportunities for joint creative problem-solving and joint responsibility for collectively achieving the goals set. A learning and research agenda will enable to support the partners on the gender transformative approach, meaningful youth participation, economic empowerment and addressing knowledge gaps.

Taking sufficient time to build new alliances is a lesson learned from 2016. From the baseline study it became clear that most girls have knowledge of SRHR, but their agency is restricted by their parents, community members, peer pressure and poverty.

2017 is the first year of full implementation for YES I DO. In all countries the key stakeholders, including (health) professionals in the intervention areas, will be further prepared and introduced to the programme to facilitate activities, and community members will be made aware of the negative aspects of CM, TP and, where relevant, FGM/C.

2. Introduction

In this report we present the progress made in 2016 for the YIDA, consisting of Plan Nederland (lead organization), Amref Flying Doctors, CHOICE for Youth and Sexuality, KIT and Rutgers. The YIDA has been set up to ensure that adolescent girls and boys enjoy their SRHR and achieve their full potential, free from all forms of CM, TP and FGM/C in seven countries: Ethiopia, Kenya, Mozambique, Malawi, Zambia, Indonesia and Pakistan.

In 2016 most activities were directed at setting up the alliances in the countries, enabling the local partners to get ready for implementation. Inception workshops enabled the different partners to lay the foundations for collaboration by getting to know each other, jointly understand the vision and mission of the YIDA, contextualize the YIDA ToC and set up local governance structures and indicator frameworks to enabling the programmes to be managed and monitored. The inception workshops were followed up by numerous alliance meetings in the countries to finalize the work started in the workshops and to create joint work plans.

During the second half of 2016, local researchers and young research assistants collected data in all countries on the causes and effects of CM, TP and FGM/C for the baseline reports to provide recommendations for the development of context-specific intervention strategies to eliminate CM and reduce TP and FGM/C. A mixed-methods approach was used, including questionnaires, focus group discussions, key informant interviews and in-depth interviews in intervention and control areas. The findings of all the research was compiled in baseline reports for each country. The baseline reports gave YIDA greater insight into the country-specific factors related to CM, TP and FGM/C. A synthesis of the baseline reports will be ready by the first week of May 2017.

This report starts by describing the context in the seven countries and some figures on CM, TP and FGM/C, followed by the key results for each pathway for 2016. The following chapters deal with progress made on alliance-building, harmonization, gender equality and inclusiveness, monitoring &

evaluation, challenges and opportunities and lessons learned. The final chapter gives information on the YIDA finances for 2016.

3. Context

In this part of the report we will reflect on the enabling environment and the wider context for SRHR work in the seven YIDA countries: to what extent the (political) situation has changed — for example, have there been developments which influence the sexual and reproductive health (SRH) situation in general and the situation in relation to CM, TP and FGM/C in particular? In the second part of this chapter we present a summary of the baseline findings.

3.1 Kenya

Enabling factors

In Kenya there is a high level of political interest in reducing CM, TP and FGM/C. There is goodwill from health, gender and education ministries at national level, but also from the provincial and county administration. From the beginning they have supported the project and provided the technical support and information required.

The revised (2015) National Adolescent Sexual and Reproductive Health (ASRH) Policy is a comprehensive SRHR policy that also addresses the thematic concerns of the YIDA (CM, TP and FGM/C). It aims to empower young people by providing them with information and appropriate choices about their sexuality. The Government of Kenya is currently developing the implementation strategy for this policy.

Acceptance of the YES I DO programme by **community leaders and community target groups** is a condition for successful implementation. Hence there is an emphasis on building partnerships with relevant health stakeholders — i.e. county leaders, administrators, civil society organizations (CSOs), community-based organizations (CBOs), faith-based organizations (FBOs), the Ministry of Health and the Ministry of Education. The local administrations work closely with the different community groups to ensure that existing policies (such as the Prohibition of FGM Act of 2011) are implemented. The YIDA works together with these strong community groups that are advocating for the rights of children, and with a little capacity-building and exposure they will go a long way in protecting the rights of children, ensuring the sustainability of the programme.

Hampering factors

In 2014 the Marriage Act 2012, which allows polygamy, was adopted. This can put young spouses in particular at risk. Polygamy is common among a number of Kenya's ethnic groups such as the Maasai. In some tribes, a man may marry as many wives as he wants, as long as he supports them and their children. Through this Act, polygamy is no longer restricted to certain tribes or religions. The Act has been structured to take into account Islamic, Christian, Hindu and traditional marriage provisions.

The upcoming general elections are scheduled to be held on 8 August 2017; this may hamper the progress of YIDA programming. The elections may bring about tension among and in communities and delay the implementation of activities. Political leaders and even cultural leaders may be afraid to publicly support the YIDA's aim of ending FGM/C and CM because of the fear of losing influence and political votes for politicians and their key supporters.

Going underground: Because of the anti-FGM legislation in Kenya, communities sometimes react by going underground with the practice, circumcising at a younger age or taking girls across the border into Tanzanian Maasai communities. Therefore, the project will monitor closely whether community members have changed or might change their tactics regarding FGM/C.

The geography of the programme area in Kajiado: Kajiado West sub-county is really vast and has very tough terrain, making access difficult and expensive. The distances between wards are considerable (for example, schools are spread widely apart); coupled with the poor terrain and bad roads, they make travelling challenging and time-consuming. Therefore, the alliance is investigating whether a start can be made with some of the communities/villages in selected wards, to be followed by another group of communities/villages. Also, the office from where alliance partners operate has been changed to a more central location to better suit the logistical challenges.

3.2 Ethiopia

Enabling factors

The **Country Strategy for Adolescent and Youth Health for the period of 2016–2020** has been finalized. The government has decided to amend the National Youth Policy and is showing commitment to engage young people in the process of implementing this strategy. Responsible government offices understand the relevance of the YES I DO programme, appreciate the concept and have been supportive in facilitating smooth implementation of the programme. The government is positive about the youth-focused interventions on SRH and supports information delivery and empowerment work, as opposed to working on advocacy on rights issues.

The area of SRHE, especially FGM/C, CM and TP, is becoming a focus thematic area for many **like-minded organizations and initiatives**, which will create abundant opportunities to collaborate and form partnerships — for instance, on advocacy efforts — in the region. The alliance member organizations in the region of Amhara have a strong track record, and their best practices and intervention models have built trust with the government as well as with the community at large. This is a huge opportunity that can contribute to the project achievements and results in the future.

Hampering factors

Due to **political tension and unrest** in mid-2016 the intervention area was not safe. Schools were either not functioning fully or while functioning did not have a safe and inviting environment for students; the regular school year was, therefore, delayed until mid-October, and as a result school-based activities also started later than planned. Moreover, baseline data could only be partially collected due to political unrest in the region. This was especially the case for the Bahir Dar (Zuria) region, where intense manifestations of the recent political unrest were observed. On 8 October 2016 the Ethiopian government declared a state of emergency. Because of the intermittent pattern of the unrest, it is hard to predict how much it will affect the project in 2017. However, the political situation has stabilized and is not currently affecting implementation on the ground. Despite the recent events, the Memorandum of Understanding with the government has been signed. In addition, a population census will be conducted in the implementation area, and some of the key change agents and teachers of the Yes I DO programme will be occupied as data collectors for the census. This may affect the programme's planned community mobilization and school-focused activities.

3.3 Malawi

Enabling factors

There have been some positive recent legal developments in relation to the prevention of TP and CM in Malawi. The **Trafficking in Persons Act** (TIP Act 2015), which protects the rights of citizens, especially children, in Malawi was enacted. The **Constitutional Amendment on Age of the Child** unanimously adopted by the Parliament in 2017 raises the minimum age of marriage from 15 to 18 years, for both girls and boys. This amendment will support implementation of the YES I DO programme. The amendment aligns the Constitution with the 2015 Marriage, Divorce and Family Relations Act enacted by Parliament, and with Malawi's international and regional obligations under the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women and others, including Sustainable Development Goal 5 on gender equality. The **Access to Information Act** will help empower youth groups to access information for advocacy.

Other enabling factors are local leaders in the intervention areas who function as role models — for example, Chief Kachindamoto. This chief is renowned for terminating over 800 child marriages in her area. Although this did not happen in the YIDA intervention area, it is a good example, and linkages can be made, especially in achieving the outcomes under pathway 1. There are **new partnerships** for the YIDA: Youthnet and Counselling (YONECO) has experience working in the intervention area on SRHR. YONECO is the country coordinator for the More Than Brides Alliance, which is fighting CM in Mchinji. Other interesting organizations are the Forum for African Women Educationists in Malawi (FAWEMA), the Campaign for Female Education (CAMFED) and the Quadria Muslim Association of Malawi.

Hampering factors

The minimum age for marriage under the new marriage law is not absolute, since the Constitution of the Republic of Malawi (1994) allows those between 15 and 18 years to get married with parental consent, and only discourages marriages for those aged below 15 years. Unless the Constitution is immediately amended, the **new marriage law will lack authority**, since parents or guardians who want to practise CM will use the Constitution to do so.

3.4 Zambia

Enabling factors

There is a lot of **goodwill from the government** to end CM. There are national technical working groups on family planning, adolescent SRHR and safe motherhood. The government would like to roll out these working groups at the community level. The YIDA has a good working relationship with the House of Chiefs, the Ministry of Gender and the Ministry of Health, which will facilitate its work. The youth organization in the alliance is a member of the adolescent SRHR working group.

The government has introduced comprehensive sexuality education (CSE) in schools. This is a unique opportunity and a platform for young people to learn and talk about SRHR issues.

The drafting of a **child code bill**, which will harmonize the age of the child in all pieces of legislative in Zambia, is a big opportunity. A **Parliamentary Commission** is pushing to end CM, and is looking for partners to work with.

There is a lot of **support from various stakeholders such as traditional leaders and government officials** who recognize the problems of TP and CM. Supportive traditional leadership structures and government departments need to be strengthened as part of the programme. The existence **of many CBOs** working on SRHR in the implementation area offers good opportunities for cooperation.

Hampering factors

A **referendum on the bill of rights** held in Zambia in 2016 failed due to a turnout lower than the threshold of 50% required to validate the result. The bill of rights might be under discussion again in the upcoming year, which could affect the project, since themes such as CM are also included in the bill. However, it is currently not expected that this process will be of great risk to the project.

The Ministry of Gender has a new Minister (after elections in August 2016). The previous Minister was very passionate about addressing CM and TP. The alliance is currently waiting to see how the new Minister positions himself on these issues.

3.5 Mozambique

Enabling factors

In 1999 the Government of Mozambique established the **Programa Geração Biz (PGB)** as a multisectoral response to the SRH needs of young people. Since then the PGB has continued to support youth-friendly service provision in the health sector, school-based education and health services, and community-based information, communication and education activities delivered mainly through peer educators.

In December 2015 the Council of Ministers approved the National Strategy for the Prevention and Combating of Early Marriage (2015–2019). The law on abortion also recently (2014) became more progressive. The proportion of girls married and pregnant in adolescence decreased slightly between 1997 and 2011.

Other opportunities regarding the political situation in Mozambique include political dialogue taking place between the government and RENAMO, leading to a more stable political situation.

Hampering factors

The **political and economic situation** in Mozambique is unstable. This is due to increased political-military tension between the two major political parties resulting in a 'low-intensity war', particularly in the centre and the north of the country. Mozambique's import-based economy and high levels of corruption increase the national debt and have led to international donors such as the International Monetary Fund and the Dutch government freezing their contributions. The local currency (metical) is unstable and is expected to remain unstable for the coming year. This situation could create a potential risk for the implementation and outcome of the programme. Intervention areas are remote areas. A new phase of the political dialogue between the government and RENAMO is encouraging political stability in Mozambique, however.

3.6 Pakistan

Enabling factors

The Child Marriage Restraint Act 1929 (under which the minimum age is 18 years for boys and 16 years for girls) has been amended in Sindh province (declaring marriage under 18 for both girls and

boys as punishable by law), but implementation of the law remains weak. The major focus of YIDA advocacy in Sindh province will be to promote implementation of the new law.

The **partnership with the Alliance Against Child Marriages** is expected to support the advocacy efforts at the provincial level in Sindh. This partnership will also help increase linkages between the YES I DO programme and policymakers, and focus more on the issues of young people and for smooth implementation of the existing laws.

In Pakistan there is a network called HYPE which is a youth partnership for empowerment focused on advocating for young people's sexual and reproductive rights. It is very active in Sindh province and can be linked to the YIDA's Kiran youth leader groups. Partnership would include opportunities for capacity-building for young girls from remote, deprived areas of the YIDA intervention areas.

Hampering factors

Currently in Pakistan **international non-governmental organizations (NGOs) are facing strict scrutiny** by the government. The registration process for YIDA partners Rutgers and Plan is not yet complete, although special permissions (MoUs) have been obtained from the provincial and local governments to carry out project activities.

A **general election** will be held in Pakistan in 2018, which will bring about a lot of political activity even by the end of 2017. This might lead to the some uncertainty and security issues. This would not only affect the implementation of the activities on the ground but might also negatively affect the overall operations of international NGOs working in Pakistan. This is also linked to the relationship between the government and international NGOs, as to gain political mileage the government tends to further restrict the activities of such organizations.

3.7 Indonesia

Enabling factors

The YIDA in Indonesia is supported by the government through the Ministry of Women's Empowerment and Child Protection. Village and district government departments responsible for education and economic empowerment are a possible ally to help gain budget support from the government. Sukabumi district government, for instance, is very supportive: the head of the health office is very progressive when it comes to adolescent reproductive health.

The strengthening of village child protection committees (KPADs) in all villages within Yes I Do project areas will help all project partners implement project activities at the village level in collaboration with village governments.

Hampering factors

Under the 1974 Marriage Law, parental consent is required for all marriages under the age of 21. With parental consent, girls can legally marry from the age of 16, and boys at 19. Parents can petition marriage officers or district-level religious courts for an exemption for their daughter to marry even earlier than at age 16, with no minimum age limit. The vast majority of such exemption requests are accepted.

Since 2016 a **conservative trend towards SRHR** has become more prominent in Indonesia, not only from religious groups which openly promote marriages of very young girls but also from alliances consisting of highly educated professionals such as the Love Family Alliance (Aliansi Cinta Keluarga) that use strong communication strategies to spread messages with the intention of criminalizing

lesbian, gay, bisexual and transgender (LGBT) people, condemning premarital relations and opposing access to SRHR education and services for young people. It will be a challenge to counter these opinions.

Another challenge is the **rotation and promotion of staff within province and district governments**. This delays buy-in and ownership and requires repeated communication and coordination to introduce the YIDA.

4. Baseline information

4.1 Summary of baseline studies

In 2016, baseline studies were implemented in all seven countries: mixed-methods studies were done in both intervention and control areas, with the exception of Ethiopia and Indonesia. The studies were implemented by national researchers with a team of young research assistants under the guidance of KIT. A survey tool was used to collect quantitative data, and tablets were used for performing the survey. On average, 1600 youth aged 15–24 were interviewed in each country; 25% of the sample were males, and 75% females. Qualitative data was collected to provide a more in-depth situational analysis related to CM, TP and FGM/C, and to provide insights into the process, changes observed, contributing factors and barriers to intervention. Key informant interviews (KIIs) were conducted with health workers, administrative leaders and NGO staff. Focus group discussions (FGDs) were conducted with female and male 15–19 and 20–24 age groups and parents/guardians. Semi-structured interviews (SSIs) were conducted with girls and boys (aged 15–19 and 20–24), caregivers, health workers and teachers.

The overall key figures from the baseline studies are presented in the table below. The prevalence of CM among girls aged 15–24 years is highest in Ethiopia, Mozambique and Pakistan. The TP rate is very high in Mozambique, followed by Malawi. In all countries where FGM/C is practised the baseline shows that this affects more than 50% of girls in our study.

	CM among girls (15-24 years)		CM among boys (15-24 years)		Teenage pregnancy among girls (15-24 years)		FGM/C among girls 15-24 years	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Ethiopia	211	25,9	6	1,7	107	13,1	433	53,1
Indonesia	178	15,4	4	1,1	220	19	851	73,4
Kenya	139	13,6	3	0,9	256	25,1	525	51,8
Malawi	193	16,2	6	1,5	499	41,8	NA	NA
Mozambique	357	28,9	23	9,3	682	55,3	NA	NA
Zambia	87	8,6	1	0,2	257	25,5	NA	NA
Pakistan	308	26,5	63	14,3	273	23,5	NA	NA

Notes: These figures do not account for any anticipated marriages between 15-18 and teenage pregnancies between 15-19 years of age.
These figures include both intervention and control area.

4.2 Ethiopia

In **Ethiopia** the study was implemented in two *woredas* (districts) in Amhara region — namely, Kewet woreda in north Shewa zone and Bahirdar Zuria woreda in west Gojjam zone — but was not completed due to the prevailing political unrest. No control areas were selected due to the availability of too many other partnerships and interventions. Girls have good access to family planning services, and this is

also visible in the low TP rate. Evidence from the baseline quantitative survey shows that 29.3% of the respondents were married[1] at the time of the baseline survey. Of the married respondents, four out of every five were married before the age of 18. As expected, girls comprise the overwhelming majority (97%) of underage marriages (211/217), and only six boys experienced CM. Although Amhara region does not have the highest FGM/C figures nationally, the baseline shows high figures, and the impression is that in reality it is higher, as FGM/C is forbidden and thus under-reported.

4.3 Kenya

In **Kenya** the study was conducted in Kajiado county. Kajiado West was chosen as the intervention area (Ilodokilani and Ewaso Oo Nkidong'i), and Kajiado Central (Matapato and Purko) as the control area. While a declining trend in FGM/C practices can be observed among the Maasai community, FGM/C is still very prevalent (51.8%); therefore, concerted efforts still need to be made to comprehensively address the problem and consequently eliminate the practice. Some leaders who are expected to enforce legislation against FGM/C and CM play a part in the cultural practices. Furthermore, men who were seen to be household heads and key decision-makers in the homes and communities are never consulted on FGM/C and CM issues with regard to related interventions. The availability, access and utilization of family planning services is minimial in these communities.

4.4 Malawi

In **Malawi** the study was administered in Traditional Authorities (TAs) Liwonde (intervention area) and Chikwewo (control area). A total of 1598 youth aged 15–24 participated in the survey. Around 75% of the respondents were females, and 25% were males. Most of the respondents were aged 18+ (69.4%), and the rest (30.6%) were under 18 years. This study demonstrated that TP and CM are major SRH problems among young people, and that TP leads to marriage in most cases. For the people in Machinga the high prevalence of poverty and initiation ceremonies are among the factors which lead to early pregnancy and thus CM. Despite the existence of a minimum legal age for marriage, the baseline findings show that young people still marry below the age of 18.

4.5 Zambia

In **Zambia** quantitative data was collected from 1006 female and 449 male participants aged 15–24 years from Petauke, Chadiza (intervention districts) and Katete (control district). The qualitative part of the study was implemented in the intervention area. Causes of both CM and TP included a lack of education, a lack of economic opportunities and poverty. Many participants referred to cultural customs, traditions and social norms as contributing to high levels of CM and TP, despite the known adverse consequences. Some respondents reported that traditional leaders and teachers sometimes play a role in contributing to TP and CM. Tradition was implicated in some specific areas in terms of the teenage girls and boys being exposed to traditional ceremonies which mostly centred on teaching them how to navigate the world of marriage, which raised curiosity in them to experiment with sex. Peer pressure was also mentioned, as girls and boys thought that it was 'cool' to marry young.

4.6 Mozambique

In **Mozambique** the baseline study was administered by a team from the UniLurio University in Nampula in close collaboration with KIT staff. A total of 715 girls and boys in Mogovolas (intervention area) and 767 girls and boys in Murrupula (control area) participated in the survey. Among the seven YIDA countries, CM and TP rates are highest in Mozambique. While CM is not seen as something positive, it is widely practised and accepted, fuelled by a number of causes such as poverty, socio-cultural practices, the lack of prospects for the future, TP and adolescents feeling grown up or wanting

[1] Including divorced, separated and cohabiting.

to have their own (sexual) partner. Poverty limits educational opportunities and restricts future prospects. TP is very common in Nampula and, in contrast to the decreasing CM rate, is increasing over time. CM is an important contributor to TP. Causes of TP include becoming sexually active at an early age; generational issues with children not listening to their parents, and parents not being equipped to talk with their children; young people not being informed about SRH issues and not having access to SRH services or contraceptives; sexual abuse, including by school teachers; and exploitation by parents.

4.7 Indonesia

In **Indonesia** the baseline study focused on CM, TP and FGM/C in two districts: Lombok Barat in West Nusa Tenggara province and Sukabumi in West Java province. There are no intervention and control areas in this study. Our quantitative data shows that girls encounter social pressure — from family, community and peers — to marry at a young age. The practice of CM is more prevalent in Lombok Barat than in Sukabumi. One consequence is that a considerable proportion of young women involved in CM drop out of school. Reasons for CM include: avoiding extramarital sex or *zina,* which is forbidden in Islam; economic factors, as marrying off daughters can help alleviate the economic burden of the family; CM is a cultural tradition, especially in Lombok Barat, of *merariq*; people have relatively low aspirations regarding education, so marriage is considered more important than education; and unintended pregnancy. Both communities perceive FGM/C as a cultural practice. FGM/C is not considered violence against women, since it is perceived as having no medical or non-medical consequences. Interviewees considered FGM/C as a virtue for women and as a means to control their sexual desires.

4.8 Pakistan

Sindh province in **Pakistan** has high rates of CM and TP. To explore these two phenomena in detail, this baseline study was conducted in two districts of Sindh: Umerkot (intervention) and Sanghar (control). The overall prevalence of CM among married girls was 58.1%, with 60.6% in Umerkot and 55.2% in Sanghar. Both girls as well as boys encounter social pressure — from family, community and peers — to marry at a young age. Such pressure is more on girls than boys. CM intertwines with TP. TP can lead to CM, and conversely CM often leads to TP. More than half of respondents (54.8%) in Umerkot and 86.6% in Sanghar agreed that marriage is a solution to save family honour. One important finding is that only 23% of the respondents had knowledge about the minimum legal age for marriage. According to 47.1% of females from Umerkot and 42.8% from Sanghar, most/all marriages were performed without the consent of brides. Some 38.6% of males from Umerkot and 46.9% from Sanghar agreed with this statement.

5. Results for 2016

During the first half of 2016, inception workshops took place in all countries, with Dutch YIDA staff and national alliance members gaining a common understanding of the overall vision, objectives and goals of the ToC and the YES I DO programme. Partners jointly developed context-specific ToCs and worked on outlines for the programme. They were able to share experiences and discuss challenges and opportunities for programmes on CM/TP and FGM/C.

During the workshops, we also discussed the YIDA governance structure, including the roles and responsibilities, M&E, local coordination mechanisms, input for operational research and the need for a joint learning agenda. Follow-up activities included making the generic M&E framework country specific, further agreeing on intervention areas, making activity plans and budgets, selecting and

contracting implementing partners and introducing the programme to key stakeholders. The start-up phase of the programme is elaborately described in the YIDA Inception Report dated June 2016.

During the course of 2016 **recruitment** of national coordinators and other staff took place. Having local coordinators in place helped build the national alliances, ensured that governance structures became operational and enhanced and improved the communication between partners. In the countries, the programme was launched to create visibility and familiarize community members as well as (local) government and other key stakeholders with the programme and create a sense of ownership.

In the latter part of 2016 all countries made a start with the implementation of activities in relation to the five pathways of the ToC. An impression of these activities is presented below. In each country the alliance comprises of different alliance members and their implementing partners.

Fewer activities than envisaged were implemented after the initial start-up phase. A number of activities were postponed to 2017, because more work than originally anticipated had to be done within the country alliances to finalize discussions on intervention areas, agree on the complementarity of activities, agree on activity plans and budgets, finalize M&E frameworks, sign contracts with implementing partners and alliance members, recruit in-country coordinators, introduce the programme to the communities and sign MoUs with government. Postponing activities until 2017 led to under-expenditures and budget being carried forward to 2017. It is expected that most country alliances will be able to catch up on activities in 2017.

5.1 Results by pathway

The pathways of change are presented below, with examples from different countries of key results under each one.

5.11 Results for pathway 1

To change deeply rooted cultural beliefs and practices regarding CM, TP and FGM, it is necessary to discuss the harm for girls, their parents and community members. Therefore, in all countries strategies will be implemented **to change attitudes of community members and gatekeepers so that they take action to prevent CM/TP and FGM/C**. Activities under this pathway included preparing the ground in the communities for the programme through orientation sessions for different community stakeholders such as religious and traditional leaders. Awareness-raising activities in the communities directed towards key stakeholders and in- and out-of-school youth will enhance the knowledge of community members on the themes of the YES I DO programme.

In the YIDA countries different members of selected communities (including cultural and spiritual leaders) were trained on the effects of FGM/C, and community (intergenerational) dialogues between young people and elders as well as with boys and men commenced. Intergenerational dialogues encourage youth to express their opinions about SRHR, which is exceptional, as in most cultures in YIDA countries young people's voices are not listened to. In **Ethiopia** teachers, school management, parent–teacher–student associations and other groups were identified and informed about the programme. Groups received information on SRHE, and issues such as harmful socio-cultural factors that foster CM, TP and FGM/C were discussed. In Pakistan agents of change within Kiran clubs were selected, and club members were trained on leadership and decision-making skills.

In **Malawi** community members were sensitized on existing gender-related laws, and discussions took place on harmful cultural practices, including CM and TP. Community members developed action plans for them to take up initiatives to speak out against CM and TP. YIDA staff of partner organizations from Mozambique, Malawi, Ethiopia and Zambia received training on the Champions of Change (CoC) model

for them to be able to deliver training to other staff members of partner organizations in the alliance. The CoCs will train peer educators to become agents of change themselves and contribute to building social movements in the coming years. In **Mozambique** community radio managers were trained so that they can address issues related to CM and TP in their programmes, and so that the alliance can work with the radio stations to broadcast their messages.

5.12 Results for pathway 2

Under pathway 2 **(adolescent girls and boys are meaningfully engaged to claim their SRHR)**, young people are engaged and trained on advocacy and meaningful youth participation (MYP), including leadership skills and communication with a special focus on CM and TP. In **Ethiopia** and **Kenya** youth training activities took place — for example, Ethiopian Youth Council Members were trained on MYP and youth–adult partnerships (YAPs). The main topics of the training included leadership, communication, SRHE and CSE. Youth members organized focus group discussions on TP, male engagement and early marriage. In Kenya activities included training for in- and out-of-school youth on SRHR, including FGM/C. To engage with opinion leaders, a meeting was conducted to discuss how influential leaders (especially men) can take a public stand against FGM/C.

In all countries, initial conditions have been put in place, and first activities have taken place to get youth involved at all levels of the programme and to act as role models to initiate change.

5.13 Results for pathway 3

For pathway 3 **(adolescent boys and girls take informed action on their sexual health)**, it is important for boys and girls to have access to SRH information and services. Equally important is to train professionals such as social workers and health care providers how to provide youth-friendly services. Therefore, integrating CSE is an important strategy involving teachers, students and the community and introducing them to life skills-based education (LSBE). LSBE teaches participants to be able to think critically, take decisions, manage stress, communicate interpersonally and be assertive, and it instils a sense of self-awareness. CSE focuses on rights and needs in relation to young people's SRH. In **Pakistan** and **Indonesia** the whole-school approach is applied.

In **Ethiopia** teachers from different schools were selected and trained on SRH and CSE, and students received CSE training and enrolled in existing SRH or gender clubs within their schools, where they will be able to enhance their knowledge on SRHE. School management is trained to strengthen these school clubs.

In **Zambia** the programme was introduced to the education authorities and school head teachers to get their buy-in and to discuss CSE for schools in the area. In **Malawi** a first training session on advocacy, leadership skills and human rights took place for in-school youth for them to become change agents and advocates on SRHR, and young people were trained to conduct social audits to hold health facilities accountable in providing youth-friendly services. Media professionals were also trained in media engagement on the prevention of CM and TP; issues such as school dropout rates and health indicators were shared with the trainees. Training for health care providers and social workers took place to increase the availability youth-friendly services.

5.14 Results for pathway 4

Pathway 4 is **about providing alternatives for girls beyond CM, TP and FGM/C through education and economic empowerment.** Activities under this pathway have not yet started in all countries.

In **Zambia** a start was made with mobilizing village agents, who after training are to implement village savings and loans associations. In **Kenya** and **Pakistan** market scans were carried out, and employers were sensitized on short-term placement or internships for school graduates. Skills training for youth also took place to explain that alternative options are possible — for example, that girls can have a technical profession. In **Indonesia** YIDA partner Perkumpulan untuk Peningkatan Usaha Kecil (PUPUK — the Association for Advancement of Small Business) has started an assessment on the existing community learning centres (Pusat Kegiatan Belajar Masyarakat — PKBM) that have been built and supported by the government for those who are out of school for certain reasons. Workshops on strengthening PKBM were conducted in all three districts, and a national-level workshop on this was held on 5 January 2017 in Jakarta. Stakeholders from various government offices and other organizations took part in these workshops. PUPUK also started a market analysis in all three districts which will be completed early 2017.

5.15 Results for pathway 5

Key activities under pathway 5 **(policymakers and duty bearers develop and implement laws and policies on CM/FGM/C)** include reaching out to key staff at local and national governmental departments of health, education and social development to ensure that laws on CM and FGM/C are put in place or when they are, to ensure that they are implemented. Therefore, in **Mozambique** a training of government officers from an array of different departments took place to increase their awareness of girls' rights and increase their knowledge on SRH for youth and CM and TP issues.

In **Ethiopia** a first five-day training took place on leadership, with participants from the Ethiopian Youth Council and youth representatives and staff from implementing partners. Youth association leaders from different areas were selected and trained on basic leadership skills, advocacy and youth engagement. In **Indonesia** they took the opportunity to link up with the national online campaign #KATAKAMU to collect statements from young people between 10 and 24 years old on eliminating CM. In **Malawi** community leaders and gatekeepers were engaged in an activity to strengthen community by-laws and policies against CM and TP. To support advocacy activities, a number of materials were produced such as t-shirts and posters with the message 'End Child Marriage, Educate the Girl Child'.

5.2 Cross-cutting issues

In addition to the five pathways, the YIDA also works on cross-cutting strategies: girls' empowerment, male engagement, the gender transformative approach and MYP. Cross-cutting activities will be integrated into all intervention strategies — for example, in the messaging on the importance of girls' education and the positive role men can play in countering CM. Orientation sessions include boys and girls, men and women.

Also, topics such as gender equality and girls' empowerment are included in the LSBE and CoC training. Different training sessions building on leadership skills encourage young people to take action within their own life and to lobby community members and leaders as well as official duty bearers. The YIDA national steering committees in the countries all include youth representatives.

6. Alliance-building

Partnership-building is a continuous process, whereby partners need to get to know each other, clarify their expectations and organizational interests, understand the different organizational backgrounds

and cultures and invest in building trust. Synergy and effective collaboration are crucial to obtain results, but this takes time and concerted effort. Working towards an equal alliance in which both larger and smaller organizations operate as equal partners requires partners to trust each other and to be open about their organizational interests. Previous experience of working in alliances shows that when partners have time to build their partnership this pays off in collaboration within the alliance and, ultimately, in achieving the set objectives.

Each country had its own specific alliance-building process, including setting up local implementing teams and national steering committees to oversee the programme. Alliance members and their implementing partners in the countries were selected because of their specific expertise, knowledge and experience to create added value in implementation. Moving forward as an alliance depended on several factors, including the number of alliance members and implementing partners, previous experience of working in partnership and already having structures on the ground.

In some countries the alliance worked well from the start. For example, in Pakistan the alliance is very small, with only Plan and Rutgers as alliance partners in the country and CHOICE giving technical input on MYP from the Netherlands. In other countries the process is more complex, as more country offices and implementing partners are involved. In Malawi, Kenya and Ethiopia, for instance, not all partners were already operational in the selected intervention areas. In some countries — for instance, Zambia and Mozambique — time and effort were needed for the youth-led organizations and the other alliance partners to arrive on the same page regarding governance and programmatic issues.

Thus some alliances could only move forward after a number of intense meetings on the complementarity of activities in selected intervention areas and agreeing on the project design and set-up. Creating a single alliance identity right from the start is a challenge for partnerships, especially when compromises regarding individual organizational priorities or ways of working have to be made. National coordinators are crucial in this process, as they are responsible for managing and coordinating the programme implementation and ensuring synergy and joint direction for all alliance members. Most national coordinators were only recruited in the second half of 2016, but the positive effect of having local coordination in place is now showing. However, most countries indicate there is room for improvement when it comes to communication, sharing and exchanging information, and creating involvement and ownership (joint planning). Enhanced harmonization will benefit the collaboration and messaging to the partners, communities and stakeholders involved.

6.1 Harmonization

In all countries contacts with the Dutch Embassy have been established, and Dutch Embassy staff are invited to YIDA meetings when relevant. In 2016, harmonization also took place by means of a joint trip to Pakistan by the three Dutch CM alliances and BUZA to further introduce the programme to the Dutch Embassy and agree on sharing information and support and cooperation between the three alliances in Pakistan. The joint trip also provided opportunities for the Dutch representatives to discuss the programme with partners from the different alliances involved. With some Embassies renewed efforts to work together will have to take place due to staff turnover.

6.2 In the Netherlands

Harmonization in the Netherlands is taking place through scheduled meetings between the three CM alliances, including regular meetings with the research institutions (Population Council, University of Amsterdam and KIT) and meetings between the three CM alliances and the Dutch Ministry of Foreign Affairs.

In 2016 the three CM alliances worked intensely together in setting up Girls Not Brides the Netherlands. On 7 November they organized a joint advocacy event for parliamentarians and a launch event where a first impression of the baseline reports was given, and Mabel van Oranje held a group discussion attended by Lambert Grijns (Dutch SRHR Ambassador), Frank Noteboom (Policy Advisor on Human and Child Trafficking) and Margaride Jeiambe (youth advocate from Mozambique).

6.3 Gender equality and inclusiveness

Gender, male engagement and MYP are cross-cutting issues for the YES I DO programme, as described in the YES I DO programme document. These topics have been taken into account right from the design phase of the programme. Special attention will also be paid to ensuring that the material used is gender transformative and includes examples for youth and males.

Gender inequality is one of the root causes of CM, TP and FGM/C. Addressing the underlying factors regarding CM, TP and FGM/C is done throughout the programme interventions in all pathways.

For example, under strategic objective 1, gender norms in the communities are addressed by raising awareness and involving boys and men. Another example is the integration of gender equality in Kenya by introducing mixed fora for women and men. In Kenya women role models will be identified and trained to give support to community members, especially in relation to FGM/C. As Maasai culture is patriarchal in nature, women and girls are encouraged to participate in the programme, and where leadership is required, the programme ensures that women are given the opportunity to lead and the community is sensitized to accept this.

In Pakistan the concept of 'Happy Family' is being introduced in communities. The Happy Family approach has a strong focus on gender equality and decision-making. The change agent approach in Pakistan and other countries focuses on building girls' confidence and leadership skills. Gender equality is also discussed during theatre plays in communities but also when liaising with parents, teachers and community members.

Training on the gender transformative approach took place in January 2017 in Malawi and Zambia and will be implemented in other countries to further develop a joint understanding of gender equality and approaches needed in the programme. Partners will also be trained on applying MYP.

For all activities where target groups are selected, partners ensure that they select both boys and girls. When it is necessary to target girls separately, the partners will do so. Implementing partners have gender policies which include guidelines on planning and implementing activities respecting the needs of both boys and girls.

6.4 Specific age groups

In the YES I DO programme the age group for interventions targeting girls and boys is between 10 and 24 years old. For the baseline study the minimum age for a participant was set at 15, as this is a requirement for obtaining ethical approval.

7. Theory of Change

The YES I DO ToC and its five pathways of change are actively informing our programme. We will adjust the ToC and the assumptions based on implementation when necessary throughout the programme.

The country-specific ToCs have not yet been adjusted in relation to the baseline outcomes. The findings from the baseline reports might lead to minor shifts or adjustments. In Ethiopia and Kenya some small

adjustments were made. In most countries a review of the ToCs will take place in 2017; these review sessions will also provide the opportunity to discuss and adjust the assumptions and the need to adjust the strategies.

For the YES I DO programme we intended that partners would plan jointly and work together in the intervention areas, but in 2016 we saw that in practice it is a difficult process to align activities in one geographical area and implement the full ToC. In some countries this process took longer than expected.

8. Monitoring and evaluation

8.1 M&E Coordination Group

The alliance desk and the M&E Coordinator, in close cooperation with the YIDA M&E officers/advisors from each alliance partner in the Netherlands, established the M&E Coordination Group in early 2016. The M&E Coordination Group aligns and ensures coordination of the different M&E processes (including IATI) of the YIDA in the countries to stimulate coherence between the different countries. Additionally, the group provides advice and support regarding the quality and effectiveness of the M&E, discusses results from M&E and lessons learned in the countries and identifies needs and possible support for capacity-strengthening in the countries.

8.2 Capacity inventory

To optimally guide countries in monitoring their programmes (tool development, data collection, data analysis and interpretation) and address their capacity-building needs, an inventory of the available in-country M&E capacity, the need for capacity-building support and methods/tools that are currently being used by partners in the countries was done. Information was gathered and analysed from all implementing partners in the seven countries.

8.3 M&E plan and framework

The generic M&E plan was designed in 2016. It informs and guides the YIDA and its stakeholders in steering the programme in the right direction and achieving maximum impact. The main focus of the generic M&E plan is on learning, steering and accountability. A generic M&E framework guided the development of country-specific M&E frameworks. The framework was developed to facilitate the flow of data and presented indicators with corresponding and suggested methods, frequency and responsibilities for data collection, analysis and reporting. The generic M&E framework was finalized in July 2016, and the country-specific M&E frameworks are nearing finalization in early 2017.

8.4 Reporting

All YIDA partners started setting up and publishing information in the IATI system in 2016. They registered their organizations in Aidstream, set up and published their organization's accounts in the IATI registry and created their YES I DO programme activity for each country.

For the reporting and publication of results of YIDA activities, the YIDA Desk developed a proposal on transparency, IATI reporting for YIDA and IATI guidelines for publishing results. The guidelines describe how the YIDA is organizing its own programme steering, monitoring and donor reporting on activities and results in IATI in such a way that actual progress in the field is adequately reflected (without double counting) and transparency assured. In addition, this document facilitates the aligning of IATI publication of all YIDA results by the IATI publishing partners.

9. Challenges and opportunities for the YIDA

9.1 Challenges

A lot of challenges (hampering factors) and opportunities (enabling factors) have been described in Chapter 3.

The YIDA is a large alliance, with five alliance members in the Netherlands, operational in seven countries where different alliance members and their country offices and implementing partners are responsible for implementing the programme. In a number of countries (Kenya, Ethiopia and Malawi) all alliance partners are implementing part of the programme. The large number of organizations involved requires a lot of coordination, communication and fine-tuning among partners.

Building national alliances from scratch takes time and effort and resulted in having to postpone activities to 2017 and include them in activity plans and budgets for 2017 and beyond. Staff recruitment took place mostly during the second half of 2016. This was unfortunate because it is important to include key staff right from the beginning in the inception workshops to enable them to fully understand the programme.

Also, the alliance in the Netherlands experienced challenges in starting to work as an alliance, to agree on ways of working, develop the structures and work together. As the ToC is jointly implemented in countries, this implies a lot of fine-tuning and communication between different alliance members.

In Mozambique the local collaboration with Population Services International (PSI) under pathway 3 has not yet taken shape, as the exact expectations, roles and responsibilities still need to be worked out in more detail. A temporary solution is that youth partner Coalizão is now implementing activities under this pathway.

There were also delays in the baseline process. For example, in Pakistan the Dutch researcher could not obtain a visa for the planned workshop with the local researchers, and the local team had to work without tablets, which caused delays in processing the data for the report. In Ethiopia there were delays due to the political situation; therefore, the additional baseline studies are planned for April 2017.

Getting ready to report via IATI took a lot of time to agree on how to report at outcome level in IATI as an alliance. In the latter half of 2016, the YIDA guidelines on IATI were developed, which is helpful. The publishing process will be evaluated in mid-2017, and adjustments to the guide will be made where necessary to assist the alliance members. To be able to visualize the data in IATI, the YIDA still needs a dashboard.

In addition to challenges on alliance-building, the YIDA was also confronted with the challenge of SRHR being a sensitive issue. In Indonesia, for instance, it is not clear whether the government supports FGM/C; therefore, the issues need to be introduced and treated with care. In Ethiopia it is not allowed to discuss ‘rights’. Cultural practices around CM, TP and FGM are deeply rooted in society, and it takes time to create enabling environments, where the knowledge of community members, leaders, teachers and professionals concerning SRHR is enhanced in a way that allows community members, including youth, to adjust their behaviour.

9.2 Opportunities

Working in alliances encourages learning and the sharing of expertise and knowledge between organizations, as well as a sense of joint responsibility and collaboration in achieving the goals collectively. By implementing a joint programme and national coordination, the country alliances report being able to apply creative joint problem-solving.

In the Netherlands, the YIDA allows its members to share their knowledge and learn from each other on the cross-cutting issues, for example. The partnership with the Dutch Ministry of Foreign Affairs is appreciated, as the Ministry also functions as a link to the other two CM alliances. The Girls Not Brides national partnership is a further opportunity to collectively exchange knowledge, learn and communicate with each other and external stakeholders. The Dutch Ministry of Foreign Affairs also connects the alliance to the CM programme implemented by UNICEF/UNFPA. A number of joint sessions for information exchange were successfully organized in 2016.

The first YIDA Alliance Day in the Netherlands also provided insights into the challenges and opportunities for working in partnership as well as the lessons learned.

9.3 Support needed

Countries expressed the need for support in the following areas:

- the gender transformative approach such as training, planning and budgeting, updating (three countries);
- MYP — for example, training, scaling up, materials, tools and manual (four countries);
- M&E with respect to additional budget and staff, training and technical assistance (five countries); and
- sharing best practices and experiences with other countries (three countries) and the YIDA in the Netherlands

These expressed needs will be addressed by means of technical assistance from the alliance partners in the Netherlands, as they have specific expertise to offer on these subjects. Specific M&E support is also part and parcel of the programme. The YIDA will also implement a learning agenda and a specific research agenda to address certain knowledge gaps.

Other needs for capacity-building expressed include: additional staff (programme and M&E), English lessons, community development, income-generating activities, medical outreach and programme management.

10. Lessons learned

At this stage of the programme lessons learned are mostly at the level of the alliance, in the 2017 report we will be able to present lessons learned related to the programme level.

Key in working as equal partners in alliances is communication; it needs to be frequent, and joint meetings at regular intervals with alliance members play an important role in creating mutual understanding, trust and ownership. It is equally important to communicate and share the same kind of information not only to alliance members in the Netherlands and in the seven countries but also to

other key stakeholders. Constant engagement of key stakeholders in the communities as well as stakeholders from (local) government is essential.

In most countries alliance building takes time and partner organizations need to get to know and trust each other. In some countries it was relatively new for alliance partners to work on equal terms with a youth-led partner. An important lesson learned was to allow time and mutual learning to make this work.

The baseline studies were done by a team of Dutch researchers in close collaboration with national researchers with young research assistants in order to strengthen validity of the data, this way of working, having outsiders doing the studies was for some organisations new and needed time to be understood.

Capacity building is a strong component of the Yes I Do Alliance between northern and southern partners but also among northern and among southern partners and stakeholders. Subjects for capacity building include gender transformative programming, meaningful engagement of young people, and research and analysis. More capacity building in M&E is needed for partner organizations in the Netherlands as well as in countries. A needs assessment for M&E has been done for the country partners, capacity support will be given in 2017 based on this assessment.

11. Looking forward

2017 is the first year of full implementation of the YES I DO programme. In all countries the key stakeholders, including (health) professionals, in the intervention areas will be further prepared and introduced to the programme to facilitate activities, and community members will be made aware of the negative aspects of CM, TP and, where relevant, FGM/C. Further in-country alliance-building will take place through joint thematic training — on the gender transformative approach, for example. Capacity-building on M&E will be based on a needs survey which took place in 2016; the first training is planned to take place in May 2017 in Ethiopia and Kenya, and later in the year in the other countries.

The baseline reports will be finalized in the first half of 2017. From May onwards a start will be made to conduct operational research focusing on specific gaps in knowledge or testing assumptions made at the start of the programme. Changes in the context will be actively monitored, and the ToC will be adjusted if deemed necessary.

Finance

The YIDA 2016 consolidated financial report has been approved by the YIDA Board of Directors. Plan Nederland as the lead organization for the YIDA programme received a non-qualified audit statement from PricewaterhouseCoopers (PwC) for the period 2016.

The financial report shows that overall spending for 2016 for the YIDA is as forecast in the budget. With a total expenditure of 91% we are slightly under budget; therefore, there has been no delay in overall spending.