Impact evaluation of youth-friendly family planning services in Uganda

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Grantee Final Report

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Note to readers

This final impact evaluation grantee report has been submitted in partial fulfilment of the requirements of grant UPW.06 awarded under the Uganda Policy Window. 3ie is making it available to the public in this final report version as it was received. The encouragement design in the study did not lead to an increased uptake of the programme and therefore the identification strategy failed.

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Definition of Key Terms and Concepts

Adolescents: Persons between the ages of 10-19 years; **Young People** are those aged 10–24 years (WHO).

Contraceptive Prevalence Rate: The percentage of women between 15-49 years who are practicing or whose sexual partners are practicing any form of contraception.

Family Planning: The right of an individual to receive adequate information about the method of family planning of their choice and to determine responsibly and freely the number and spacing of their children.

Multiple or Concurrent Partnerships: People with concurrent sexual partnerships are involved in overlapping sexual partnerships where intercourse with one partner occurs between two acts of intercourse with another partner. For surveillance purposes, this is defined specifically as those occurring within the past six months.

Regular Sexual Partner: A marital or cohabiting sexual partner or one with whom sexual intercourse takes place frequently, with a sense of commitment and emotional attachment.

Sexually Active: A person is considered sexually active if he or she has had sexual intercourse in the past three months.

Youth-Friendly Services: Services that are accessible, acceptable and appropriate for young people. They are in the right place at the right price (free where necessary) and delivered in the right manner acceptable to young people. They are effective, safe and affordable. They meet the individual needs of young people who return when they need to and recommend these services to friends. The term is often used interchangeably with adolescent-friendly services.

Unmet Need for Family Planning: Percentage of women in reproductive age who are fecund and sexually active who desire to limit or space their births but are currently not using any contraceptive method

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Acronyms

ASRH	-	Adolescent Sexual Reproductive Health
CIP	-	Costed Implementation Plan
CHEWs	-	Community Health extension Workers
CPR	-	Contraceptive Prevalence Rate
CYPs	-	Couple Years of Protection
DFID	-	Department of International Development
DHO	-	District Health Officer
FGDs	-	Focus Group Discussions
FP	-	Family Planning
GoU	-	Government of Uganda
HC	-	Health Centre
HSSIP	-	Health Sector Strategic Investment Plan
JPP	-	UN Joint Program on Population
KPs	-	Key Populations
IUDs	-	Intra-uterine Devices
MoGLSD	-	Ministry of Gender, Labor and Social Development
MoH	-	Ministry of Health
NGO	-	Non-Governmental Organization
OPM	-	Office of the Prime Minister
PACE	-	Programme for Accessible health Communication and Education
PEs	-	Peer Educators
PNFP	-	Private Not For Profit
PSOs	-	Private Sector Organizations
RHU	-	Reproductive Health Uganda
RRHs	-	Regional Referral Hospitals
SDGs	-	Sustainable Development Goals
SBCC	-	Socio-behavioral Change Communication
SEDC	-	Socio-Economic Data Centre Ltd
SMS	-	Short Messaging Service
SRH	-	Sexual Reproductive Health
STI	-	Sexually Transmitted Infection
S/C	-	Sub-county
T/C	-	Town Council
TOC	-	Theory of Change
YFS	-	Youth Friendly Services
UBOS	-	Uganda Bureau of Statistics
UCPW	-	The Uganda Country Policy Widow
UDHS	-	Uganda Demographic Health Survey
UHMG	-	Uganda Health Marketing Group
VHTs	-	Village Health Teams
WHO	-	World Health Organization

Executive Summary

Overview, Background and Objectives

This report presents the results of an impact evaluation of selected components of the Family Planning (FP) Program of the Government of Uganda (GoU). More specifically, the objective is to analyze FP interventions implemented by the GoU that target young people aged 15-24, namely the Youth Friendly Services (YFS), commonly provided through *Youth Corners*. The YFS and sexual reproductive services (SRH) generally are also provided through outreach visits to communities and health camps and range from information, education and communication (IEC)/socio-behavior change communication (SBCC), counseling, FP product distribution, counseling, testing, and treatment of HIV and other sexually transmitted infections (STIs).

With support from partners, GoU has been instrumental in designing and delivering FP and SRH services targeting young people, but the impact of these services had not been empirically investigated. The objective of this evaluation was to empirically estimate the effects of youth-friendly FP programming, as well as identify if the effects are heterogeneous for young people already engaged in risky behaviors ex ante, for men versus women, and for youth in urban and rural areas.

Study Design, Methods and Implementation

This evaluation utilizes data from two large scale cross-sectional studies of 5,012 male and female respondents aged 15-24 years drawn from 16 districts across Uganda, surveyed at baseline and endline over a period of two years, as well as qualitative methods. The evaluation estimated the impact of utilization of youth-friendly FP services on health outcomes of interest, employing a randomized “encouragement design” as the identification strategy. While the evaluation entailed randomization at the sub-county level, data was collected at the individual level as the unit of observation. The objective of the randomized “encouragement design” was to generate experimental variation in the probability of utilizing FP/SRH services that could be exploited to estimate the impact of utilizing these services. It was assumed that youth in communities who receive the “encouragement” would be more likely to utilize FP/SRH services.

Key research questions for the evaluation were as follows:

- What is the impact of utilization of youth-friendly FP/SRH services on contraceptive utilization, abstinence, and unintended pregnancy among young people aged 15-24 in Uganda?
- Is there any evidence of heterogeneous effects, in which the benefits are particularly large for young people already engaged in risky behaviors ex ante?
- Are the effects of youth-friendly FP/SRH services different for young men and women, and in urban and rural areas?

The analysis examineda number of key outcomes of interest: abstinence and other sexual practices, contraceptive use, fertility, self-efficacy and related perceptions and communication/messaging about FP/SRH. The objective was to generate new evidence

around the effectiveness of youth-friendly FP services, filling a gap in the literature where there is limited evidence around the effects of these services.

Key Evaluation Results

When examining the effects of the encouragement treatment on the primary variables of interest, there is little evidence of any significant effect on contraceptive utilization, abstinence and fertility, or knowledge and self-efficacy. There is some evidence of a significant increase in age at first intercourse and a decrease in the probability of pregnancy in treatment communities, and weak evidence of an increase in confidence among youth that they could seek SRH services if desired. There is also no evidence that utilization of youth-friendly FP services is higher in treatment communities; in other words, the encouragement design was not effective in stimulating differential take-up of these services. Rather, take-up of services is high and consistent in both treatment and control commnunities. While identifying the causes of consistently high take-up was beyond the scope of this evaluation, possible reasons for the little success of the “encouragement design” include the short duration of the intervention and over-saturation of related messaging in the sampled communities.

Between the baseline and endline surveys, the pooled sample shows evidence of a significant increase in utilization of youth friendly reproductive health services (from 23% to 48%, $p<0.05$). Reported condom use at last sexual intercourse increases considerably (38.5% to 55.1%, $p<0.05$), as does use of other FP methods (38.8% to 50.1%, $p<0.05$). Reported consistent condom use also rises (24.2% to 32.2%, $p<0.05$). However, overall contraceptive prevalence rate (CPR) is stagnant due to declining use of some contraceptive methods. Reported unmet need for FP increases slightly over the period.

When examining variables linked to abstinence and fertility, the descriptive evidence suggests a significant share of the sample experienced a sexual debut during this period; 61% of the sample reports at baseline that they had never had sex, and 50% reports similarly at endline. The logistic regression model shows no differences in the probability of young people abstaining from sex in last three months at baseline and endline. The proportion of the sample reporting they intend to wait until marriage for sexual intercourse declines slightly (from 35% to 33%). However, the proportion reporting multiple concurrent partners also decreases slightly (from 24% to 17%). In all, there is no strong evidence of substantial shifts in sexual behaviour.

With respect to awareness of youth friendly FP services and measures of self-efficacy, awareness and self-efficacy is generally high even at baseline, and increases to 91% at endline. Other measures of attitudes and perceptions of ability and self-efficacy show little change over the period.

Conclusion

Evidence from this evaluation suggests that there has been a steady increase in utilization of youth-friendly FP services over the assessment period. This has been matched by an increase in reported condom use. However, other measures of contraceptive utilization have been stagnant, and there has been little change in fertility outcomes or other reproductive health

variables among the sample of interest. Further research may seek to generate additional evidence around the causal effects of youth-friendly FP services on health outcomes of interest, utilizing designs that would be effective in attributing observed shifts in youth health outcomes to the availability of youth-friendly FP services.

1 INTRODUCTION

1.1 Overview

This report presents the results of an impact evaluation of selected components of the Family Planning (FP) Program of the Government of Uganda (GoU). The GoU's FP Program is outlined in the Health Sector Development Plan (HSDP) 2014/15 – 2019/20, and the Costed Implementation Plan for Family Planning (CIP-FP) for the same period. The components of focus for the present study include FP Services for Young People aged 15 to 24 years. The Evaluation was undertaken by Socio-Economic Data Centre Ltd (SEDC) under the Uganda Country Policy Window (UCPW) funded by the Government of the United Kingdom through its Department for International Development (DFID). This evaluation, whose outcome will be utilized by the Ministry of Health (MoH) and other stakeholders, was coordinated by the Office of the Prime Minister (Uganda). On behalf of the GoU, the UCPW is coordinated by the Department of Monitoring and Evaluation (M&E) of the Office of the Prime Minister. Technical guidance was provided by the International Initiative for Impact Evaluation (3ie).

The impact evaluation focused on analyzing Youth Friendly Services (YFS) implemented by the GoU targeting young people aged 15-24, commonly provided at *Youth Corners*. Youth corners are designated places within existing health facilities where youth or adolescent-friendly health services are provided. The youth corners in Uganda were implemented under the Health Sector Strategic Plan III that spanned 2010/11–2014/15, and thus some of them have been in place since 2011.Through the UN Joint Program on Population (JPP), this initiative was among activities supported by the World Health Organization (WHO), starting with the development of adolescent friendly policies, strategies, standards as well as training manuals. The GoU and partner agencies, including the WHO, viewed this intervention as timely and necessary because young people aged 24 and below make up majority of the county's population (UBOS, 2016). The YFCs are established in select health units where youths meet to play and learn about health. Many YFCs are equipped with infrastructure that appeals to young people such as video and TV screens, CD players and indoor and outdoor games such as volleyball and football. YFCs are a response to the finding that youths shy away from seeking certain health services offered in open-to-all clinics for fear of being seen by parents or people who know them (WHO, 2017).

While static YFCs operate or are located at different levels of health facilities, ranging from health centre (HC) II level to referral hospital level, in place are also community-based SRH programs targeting young people in the country mostly supported by local external Civil Society Organizations (CSOs).The services offered, mainly through outreach events and health camps, range from information, education and communication (IEC)/socio-behavior change communication (SBCC), counseling, FP product distribution, counseling, testing, and treatment of HIV and other sexually transmitted infections (STIs).

1.2 Background

With a total fertility rate of 5.4 (UBOS 2016), Uganda's population growth rate of 3% is one of the highest in the world. Reproductive health indicators for young people remain very poor. Young adults become sexually active at an early age, with 62% of women aged 20-44 reporting their first sexual encounter before age 18 (UBOS 2016).

Despite the evidence of early onset of sexual intercourse among adolescents, contraceptive use is low, with only 9.4% among young people aged 15-19 reporting use of a modern method (UBOS2016). This contributes to unplanned/unwanted pregnancies, unsafe abortions and related complications, resulting in disproportionately high maternal mortality and morbidity rates.

Teenage pregnancy in Uganda is very high, as 25% of adolescents age 15-19 have already begun childbearing (UBOS 2016) and is also a major cause of school dropout. There is also limited cultural space to discuss sex and sexuality between parents/guardians and children, which means that often, young people are often left to seek information on sexual matters on their own or to experiment with sex, and hence, engage in risky sexual behavior with increased probability of teenage pregnancy, early marriage and early child-bearing.

Lack of, or limited, access by adolescent girls to FP, including contraceptive information, education, and services, is a major factor contributing to unwanted teenage pregnancy and maternal death. Unintended pregnancies lead to high levels of unplanned births, unsafe abortions, and maternal injury and death.

1.3 Problem Statement

The GoU with support from partners has been instrumental in designing and delivering FP and SRH services in general – including those targeting young people. However, the impact of these services had not been empirically investigated. Such information is critical if the GoU and its partners are to protect Ugandan young people from the dangers associated with unplanned and unintended pregnancies, equip them to make informed choices about their reproductive lives and harness the demographic dividend. This study was therefore proposed to evaluate the impact of youth-friendly FP programs on reproductive health and related outcomes for young people in Uganda.

1.4 Existing evidence and the Knowledge Gap

Previous studies conducted in different countries and contexts have found that limited knowledge about FP is a key determinant of people's negative perception of and lack of engagement in FP (Kaida et al 2005) as well as gender norms regarding roles of potential clients (Onyango, Owoko and Oguttu 2010; Nalwadda et al 2010; Ntozi and Odwee 1995). Evidence suggests that limited access to contraceptives contributes to the relatively low use of FP (Subramanian, L. et al., 2008; Lande and Geller, 1991; Bongaarts et al., 1990; Destler et al., 1990). Evidence has also long shown that well-designed programs can have a substantial impact on fertility and population growth (Bongaarts et al. 1990).

While there are many issues than influence FP service delivery, in part, men's opposition to or non-involvement in FP stands out to affect low contraceptive prevalence (Yue, O'Donneland Sparks 2010; Tuloro 2009; Dudgeon and Inhorn 2004). This group has historically been depicted as obstructive by impeding women's decision-making on use of FP (Greene 2000), or by remaining conspicuously absent altogether from FP service points due to lack of interest in matters related to FP and reproductive health in general. Ironically, at the same time, men, young and old, have been found to dominate decision-making regarding family size in many traditionally patriarchal settings (Soldan 2004; Oyediran and Isiugo-Abanihe 2002). In a large sense, this is an issue that has hitherto posed considerable challenges in many contexts especially in highly matrilineal communities such as Uganda and elsewhere. This issue also has been widely discussed in other literature (see Mosha, Ruben and Kakoko 2013; Hartmann et al 2012; Shattuck et al, 2011; Sternberg and Hubley 2004; Bawah 2002; Sharan and Valente 2002). While FP services traditionally targeted women, there is growing recognition that reproductive health is the joint responsibility of men and women since men often have significant influences on a couple's contraceptive use (Shahjahan et al 2013).Similarly, the perception that male condoms hinder sexual spontaneity is documented in many studies (e.g. Marchi et al 2008), and yet long-term methods such as vasectomy are considered not appropriate for young couples who intend to

conceive in the future (Kabagenyi et al 2014). Increasingly, actors/agencies promoting FP are encouraged to plan for and sustain a range of FP products to widen choice.

The existing literature around utilization of FP services in Uganda and the implications of these utilization patterns primarily seeks to characterize patterns of use descriptively using longitudinal and/or qualitative data (Renzaho 2017, Mary 2017, Maly et al., 2017). Two previous impact evaluations have evaluated the effect of antenatal counseling on post-partum use of FP (Ayiasi et al. 2015) and the effect of enhanced FP outreach (Lutalo2010). However, there has been no high-quality empirical evidence to date around the effects of government-provided FP services, especially youth-friendly services, on decision-making, attitudes and health outcomes for young people in Uganda. This impact evaluation seeks to fill this gap.

1.5 Research Questions in Pre-analysis Plan (PAP)

The main purpose of the study was to evaluate the impact of utilization of youth-friendly FP/SRH services on health outcomes of young people. The following specific questions guided the Evaluation;

- What is the impact of utilization of youth-friendly FP/SRH services on contraceptive utilization, abstinence, and unintended pregnancy among young people aged 15-24 in Uganda?
- Is there any evidence of heterogeneous effects, in which the benefits are particularly large for young people already engaged in risky behaviors ex ante?
- Are the effects of youth-friendly FP/SRH services different for young men and women, and in urban and rural areas?

1.6 Overview of Report Structure

This evaluation report is presented in 9 sections; the introductory section presents an overview of the impact evaluation of the national FP program with focus on youth friendly services. The background places the evaluation within the constellation of existing knowledge about FP youth corners and community-based SRH programs targeting young people. The objectives of the evaluation and key research questions in the pre-analysis plan are outlined. Under section 2, the national FP program is described in ample detail, including objectives, key components, and programmatic activities, and monitoring systems for tracking its implementation. The theory of change (TOC) adopted for this study, premised on the presumed relationship between the strategies implemented by the GOU and its partners, is presented. From the TOC, the primary outcomes and impacts of interest for this evaluation are derived.

To place this evaluation in its context, section 3 presents highlights of Uganda's demographics, and organization of the national health system. The background, rationale and context within which Adolescent Friendly Health Services (AFHS) in general and Youth Friendly Corners (YFCs) within health facilities operate are presented. Timelines of this impact evaluation (baseline, midline and endline activities) are presented in section 4.

Section 5 presents the quasi-experimental design adopted for this impact evaluation, a detailed description of the study area and population, sample size and sampling strategy, including the strategy used to assign treatment and control arms and how implementation activities during treatment were monitored. Also described are data collection and data analysis methods (both quantitative and qualitative). Section 6 and 7 present impact analysis and results of key evaluation questions (utilization of FP/SRH services and contraception, abstinence and fertility outcomes,

awareness and attitudes/self-efficacy, and communication about FP among sexual partners). Throughout the analysis of results, comparisons are made between treatment and control (section 6) and between the two assessment periods (baseline and endline). Section 8 presents a discussion of the impact evaluation results.

The last section (9) presents overall implications of the results from this evaluation and outlines specific suggestions for policy-makers and other influencers of FP among young people in Uganda. The evaluators also point out other implications/recommendations that could guide future FP policy and program implementation in the country.

2 INTERVENTION AND THEORY OF CHANGE

2.1 National Family Planning Program, Objectives and Key Components

The national FP Program identifies five strategic priorities, one of which is relevant to the present evaluation. The first strategic priority of the CIP focuses on young people and is to "*Increase age-appropriate information, access, and use of FP amongst young people, aged 10–24 years*". Activities implemented in this regard include:

- Establishment of Youth Friendly Corners (YFCs) for FP/SRH
- Training of health workers in provision of youth friendly FP/SRH services
- Increasing service delivery hours to include outside school hours

The youth corners have been established in a phased manner as resources become available. To augment YFCs, the GoU and partner agencies also provide community-based youth friendly services mainly through outreach initiatives or health camps. Service providers use recreation activities; organize outreach activities alongside sports, music, dance, drama and any other edutainment activities to appeal to young people and increase uptake of FP/SRH services. Innovations include involvement of VHTs and other community health workers, peer-to-peer mechanisms, youth friendly "safe spaces", youth bashes, youth clubs and informal groups. A few agencies organize 'moonlight activities', where services are provided at night.

Most community-based FP/SRH programmes are actively supported by local resource persons to fill human resource capacity gaps and make extensive use of vibrant partnerships with existing health facilities in the communities for technical and logistical support, laboratory and medical services, outsourcing health workers and FP/SRH supplies and other testing equipment. The bigger agencies with support from external funding mechanisms support small organizations as Implementing Partners (IPs) and sub-grantees.

Beneficiaries of the youth corner and community based adolescent friendly services whose impact is under evaluation are multi-level. The primary beneficiaries are young people (15-24 years) with evidence suggesting many them in Uganda being sexually active. Other primary beneficiaries of the adolescent friendly services are the children of the users of FP services who benefit from the quality of life associated with planned and relatively smaller families.

2.2 Key Elements and Programmatic Activities

Uganda's Ministry of Health (MoH), in collaboration with partners, developed the country Family Planning Cost Implementation Plan 2015-2020 (FP-CIP) as an overarching document to provide national guidance for increased knowledge of access to family planning interventions. The plan emphasizes key strategic priorities that enhance the achievement of the National Family Planning Program objectives. Among these include strategic priority 1 namely, "*Increase age-appropriate information, access, and use of family planning amongst young people, ages 10–24 years*". Commitments were also made by GoU at the London Summit on Family Planning, held on 11 July 2012. At the summit, implementers, government and FP stakeholders united to determine priorities and set forth commitments and several commitments were made under, "*Uganda country commitments to FP2020*" among which this commitment was made "*Commitment 8: Roll out youth-friendly services in all government Health Centre IVs and district hospitals*."

The National Adolescent Health Policy for Uganda, 2004 is one of those policies according to the FP-CIP which aims at doubling the contraceptive use rate amongst sexually active adolescents; it also targets a reduction in the proportion of women that have their first child before age 20 from 59 of adult women to 30%. To increase access to FP for young people as strategic priority for the

FP-CIP, focus was placed on increasing knowledge and access amongst young people ages 10–24 years, establishing youth-friendly corners in clinics, and extending service delivery hours to include outside school hours to better accommodate youth. A demand creation strategy was set up since there was a wide gap between knowledge about contraceptives and utilization that indicated a clear need for refocusing the FP program and for change in the communication strategy to promote more widespread usage.

As a key element to the country FP program, specific demand creation efforts are targeted at male youth. While men share responsibility for reproductive health, lack of focus on them can infer that family planning is not their concern. Male involvement is crucial to a successful demand creation campaign. Barriers for uptake include power and gender dynamics that inhibit women from making open decisions on FP in their households. Dispelling myths and misconceptions amongst men (young and old) was considered important to ensuring their support of FP.As part of FP policy and program implementation, a communications strategy (including information packages for select media channels) was developed to (1) ensure tailored honest, objective, non-judgmental, accurate, clear, and consistent messaging around family planning in a multi-sectoral dimension (i.e. FP as a development intervention) and (2) target various audiences (including rural/urban youth, adolescents in and out of school settings, married youth, and key populations at risk etc.). A mass media campaign was developed and implemented, including radio spots, TV soaps/drama, print media, and mobile technology. In addition, non-health sector cadres were encouraged to lessen the burden on health care workers by incorporating positive FP messages in their programs. In addition, a demand creation strategy DC3: was set as follows; “To increase the knowledge and empowerment of young people, peer educators will be engaged and supported; media (print and online) targeting youth will be disseminated; and “edutainment” community events will provide the opportunity for knowledge exchange amongst young people and empower adults to help youth avoid teenage pregnancy.”

Important to note, Uganda’s approach to FP service availability is rights-based, emphasizing voluntarism, informed choice, free and informed consent, respect to privacy and confidentiality without having to seek third party authorization, equality and non-discrimination, equity, quality, client-centered care, participation and accountability. A service delivery strategy was set (SD9) to ensure Youth-friendly services are provided in clinics**.** Accordingly, the GoU revised its targets to reduce unmet need for FP to 10% and increase the modern contraceptive prevalence rate among all women to 50% by 2020.

Specifically, the national FP program and CIP, GoU committed to:

- Leveraging annually $US 20 million from its development partners, the domestic and international private sectors including philanthropies to bridge the funding gap for executing its Family Planning CIP.
- Allocating $US 5 million annually for procurement and distribution of RH/FP supplies and commodities to the last mile.
- Allocating annually at least 10% of the Reproductive, Maternal, Newborn and Child Health (RMNCAH) resources for adolescent-friendly family planning services.
- Implementing a robust social behavior change and communication strategy to increase demand and use of family planning services.
- Expanding the cadres of its skilled workforce to provide quality FP services and methods, including long acting and reversible and permanent contraceptives.

The updated commitment by GoU at the Family Planning Summit in London UK in 2017 on the program and service delivery commitments were that “Uganda commits to rolling out youth

friendly services in all Government Health Centre IVs and District Hospitals; strengthening the technical and institutional functionality of Uganda Health Marketing Group and National Medical Store in a dual public-private RH supplies distribution system; and continuing to support the public-private arrangement for increased access to FP services". GoU also planned to scale up partnerships with CSOs and private sector entities for FP outreach and community-based services to target hard to reach communities, and to invest in social marketing and social franchising approaches to ensure access to FP.

Some of the on-going interventions by the government, CSOs and private sector organizations (PSOs)at the time of this evaluation include:

- Training of FP service providers in both public and private health facilities in the provision of long-acting FP methods
- Service delivery through a variety of models including routine service provision, outreach, social franchising (through the private sector), and community-based distribution of commodities
- Task sharing such as community-based distribution (CBD) of injectable contraception by VHTs, tubal ligation by trained clinical officers, and provision of long-acting FP methods by midwives
- Innovations such as the voucher scheme, postpartum IUD, and postpartum FP to increase access
- Integration of FP into other services; FP was embedded into reproductive health (RH) services and broader community health programs including immunization and HIV/AIDS related interventions. This way, service providers were expected to scale up FP service provision and coverage.

Apart from the GoU, active actors include the Program for Accessible Health Communication and Education (PACE), Uganda Health Marketing Group (UHMG), Marie Stopes Uganda (MSU), Reproductive Health Uganda (RHU), UNICEF and UNFPA.

2.3 Monitoring Systems for tracking Implementation

The FP-CIP's performance management mechanisms are in place to measure the extent of activity implementation and help ensure that the country's FP program meets its objectives, ensuring coordination, and guiding any necessary course corrections. The FP-CIP and its monitoring system provide a framework for broad-based participation of stakeholders within and outside of the GoU and are inclusive of relevant groups and representatives from key populations in the implementation and monitoring of the plan. To determine impact, the FP-CIP lists estimates of the demographic, health, and economic impacts of the FP program, providing evidence for advocates to use to mobilize resources, and track progress/impact.

To meet the targeted increase in CPR and decrease in unmet need of FP by 2020, modalities and strategic outcomes are specified for monitoring, management, leadership, and accountability of FP activities at all levels to ensure FP goals are reached. There are established forums for coordination with numerous implementing CSO partners and stakeholders involved. These systems are essential to improve collaboration amongst partners and the MoH and to ensure that activities are implemented as a harmonized national effort. The ministry is tasked to track and monitor FP-CIP and provide support to implementing partners (IPs) to report activities and funding and identify gaps, including data outputs and timelines. MoH also receives feedback from IPs and is expected to undertake annual refresher trainings on gap analyses. Through training and sharing reporting tools, health care workers are expected to improve their reporting on FP indicators with a view to increase reporting into the national MoH database. In addition, a national FP research

agenda was planned to inform tracking activities while social accountability mechanisms were meant to engage clients to provide feedback on the quality of FP services and to effectively monitor procurement processes and financial flows through access to information.

Finally, the FP-CIP was planned to be assessed at mid-term and end-of-plan to inform future FP activities and programming; to assess progress and suggest areas of prevention or corrective action and to inform future FP strategy development, planning, and programming. Implementing stakeholders for the national FP program and CIP are brought together at the National Steering Committee which has representation from GoU, civil society/NGOs, development partners, the private sector, and community-based organizations.

2.4 Primary Outcomes and Impacts of interest

The following indicators and accompanying variable outcomes were derived in the theory of change (TOC) described in section 2.5 that guided this impact evaluation.

(a) Utilization of Sexual and Reproductive Health Services and Contraception

Specific outcome variables in this category include the following:

- Percentage of youth who have ever utilized youth-friendly FP and sexual and SRH services
- Percentage of sexually active youth who used a condom at last sexual intercourse
- Percentage of sexually active youth who used any other modern FP method[1] in the last three months
- CPR – the percentage currently using a contraceptive method.
- Percentage of sexually active youth who consistently use condoms
- Percentage of sexually active youth who report exposure to a sexually transmitted disease in last 12 months
- Unmet need for FP, defined as the percentage of the sample who expresses a preference for utilizing FP services but is not currently using

(b) Abstinence and Fertility Outcomes

Specific outcome variables in this category include the following.

- Percentage of youth who report that they have never had sexual intercourse
- Percentage of youth that had ever had sexual intercourse who report that they have abstained from sex for the past 6 months
- Percentage of unmarried youth who report the intention to abstain from sex until marriage
- Age at first sexual intercourse
- Percentage of youth reporting multiple concurrent partners or polygamous marriages in the past year
- Percentage of sexually active women who are currently pregnant or had a pregnancy or a live birth in the past two years
- Percentage of sexually active women who report having ever had an induced abortion
- Percentage of women either with no child or with a child under the age of two, who have adopted a FP method in the last two years in order to space/delay their next pregnancy

[1] Modern methods include contraceptive pills, injectables, male and female condoms, emergency contraception, IUDs, and male and female sterilization

(c) Awareness and Attitudes/Self-efficacy

Specific outcome variables in this category include the following.

- Percentage of youth reporting awareness of youth-friendly SRH services
- Percentage of youth reporting confidence that they could refuse sex if they did not desire it
- Percentage of youth who are confident that they could get their partner (s) to use contraceptives/condoms if they desire
- Percentage of youth who believe they could seek sexual and reproductive health information services if they needed them

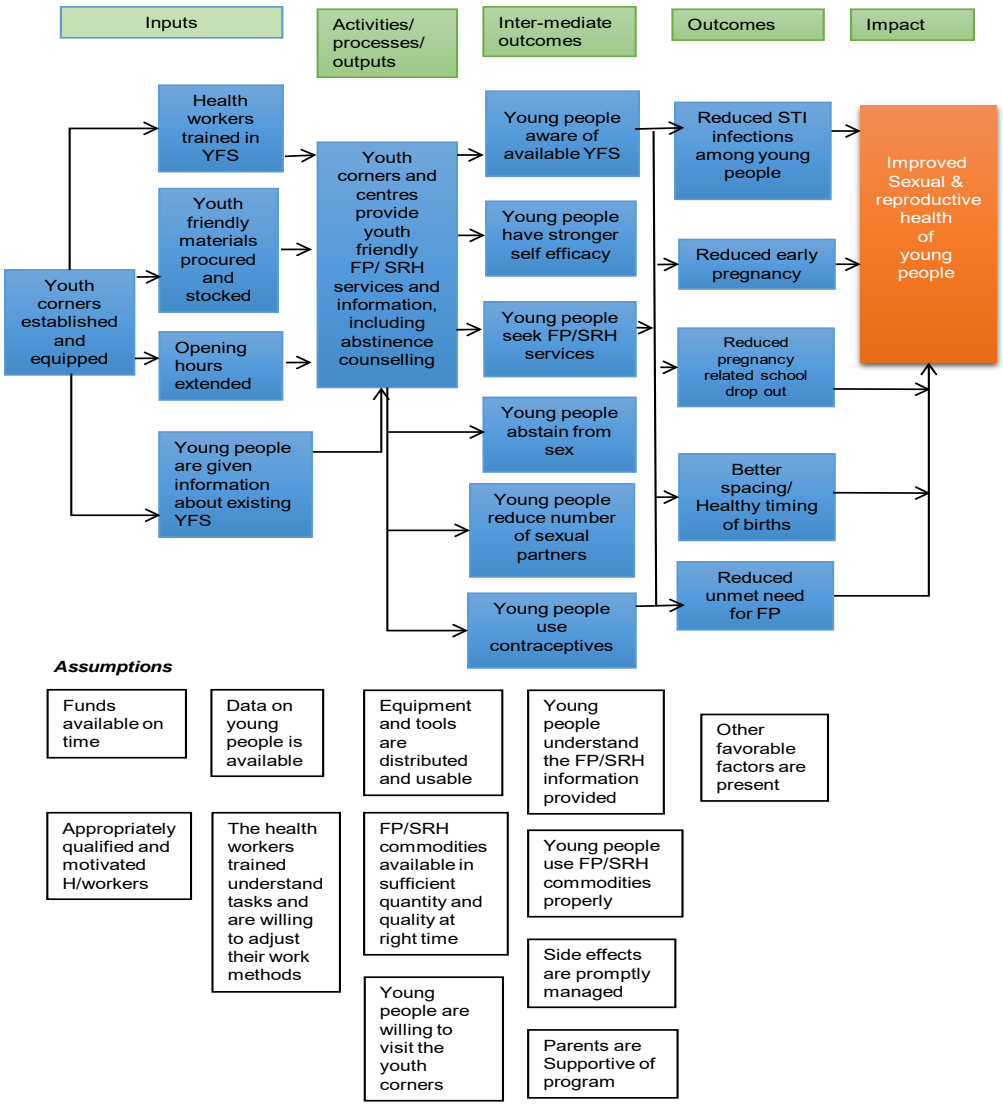
These indicators were measured both at Baseline and again at Endline, and within Treatment and Control sites to assess the impact of the "encouragement" intervention.

2.5 Theory of Change

The Theory of Change for FP/SRH services targeting young people, captured diagrammatically below, can be described as follows: If youth corners are established within existing health facilities; if they are well equipped with materials and commodities to serve the sexual and reproductive health needs of young people; if health workers are trained in providing adolescent friendly services (as defined in the Uganda Adolescent Reproductive Health Guidelines), and if working hours are adjusted to fit well with the hours that are convenient for young people; then the youth corners will provide adolescent friendly services to young people, i.e. services that are safe, accessible, and affordable to young people, as well as information and abstinence counseling.

Young people will in turn use the services provided – such as condoms and other contraceptive methods to reduce risky sexual behavior. Those who are not sexually active will continue to abstain from sex, thus delaying the onset of sexual activity. Some of those who are already sexually active may choose to suspend sexual activity i.e. adopt secondary abstinence. As a result of the adopted behaviours, there will be a reduction in the rate of sexually transmitted diseases, a reduction in unsafe abortion rates, a reduced rate of unintended pregnancies, reduced school dropout due to teenage pregnancy, delayed child bearing, an increase in child spacing/ healthy timing among married young people and reduced unmet need for FP among young people. All these outcomes would ultimately contribute to improved health of young people.

Figure 1: Theory of Change



For this causal chain to happen, it is assumed that funds will be available to establish and equip the youth friendly corners, train health workers, and provide information to young people about the available youth friendly services. It is also assumed that data on young people is available to facilitate planning and setting targets. The health workers who are trained must understand the tasks to be performed and be willing to adjust their work methods to suit young people. It is further assumed that the appropriate equipment and tools will be distributed and FP/SRH commodities will be available all the time in sufficient quantities. Young people who receive information about the existence of youth-friendly services must also be willing to visit the youth corners to get services.

It is further assumed that the young people will understand the FP/SRH information provided to them, they will use the contraceptives properly as instructed, and if they experience any side-effects, they will visit the youth corner again to have the side-effects managed appropriately. It is also important that the parents of the young people are supportive of the efforts to provide FP/SRH services to their young sons and daughters. Finally, it is assumed that other contextual factors will be favorable, such as a stable political, social and economic environment, free from conflict, stigma and discrimination.

However, as presented in the sections on findings and discussion of results, the conditions/assumptions for the successful implementation of YFCs such adequate availability of funds, stocks, adequate capacity of district staff, timely replenishments were not fully met during both the implementation and the impact evaluation of the FP program. There are ongoing attempts to increase the range of services provided, and introduce innovations in the mode of service delivery including direct FP services at static facilities, outreach events, community-based models involving VHTs, social marketing and franchising. Still, one long standing issue is how to ensure uninterrupted availability of the full range of services to meet specific needs of young people (in school or out-of school, single or married, and male or female). Implementation is partly affected by ineffective coordination of activities of partner agencies, glaring shortage of permanent and long acting FP services in public facilities, paucity of staff and inadequate “task-shifting” in facilities.

3 CONTEXT OF THE EVALUATION

This report is about an impact evaluation of a national FP program in Uganda, a country with a young and rapidly growing population. Uganda's current population was estimated at 34.6 million in 2014 and is projected to increase rapidly given demographic determining factors such as a decreasing infant mortality rate (UBOS 2014) and low contraceptive use.

The contraceptive Prevalence Rate (CPR) among married women improved to 39% in 2017 for all methods (UBOS 2016) from 30% in 2016. CPR for modern methods improved from 26% to 35%. There was a decrease in couple years of protection (CYP) to 2,156,240 in 2016/17 from 2,242225 in 2014/15. Although there was an increase in the number of Implants and IUDs, there was a decrease in the users for all other methods and most significantly for male condoms. As previously noted in the background section, young adults become sexually active at an early age in Uganda, with 62% of women aged 20-44 becoming sexually active before age 18 (UBOS 2016). Yet contraceptive use among adolescents is low, leading to a high rate of unplanned pregnancies, unsafe abortions and related complications.

Across socio-cultural and geo-political divides in the country, adolescents and young people generally in Uganda face a host of other sexual and reproductive health challenges. Complicated child births and abortions often requiring emergency obstetric care are widespread. Sexually transmitted infections (STIs) including HIV are also common. Large families with poorly spaced children define a typical Ugandan rural community (WHO 2017).

A recent study conducted in Kampala, the capital of Uganda showed that over three quarters of young people knew where and how to access condoms, pills, intrauterine devices, or birth control implants for planning birth control purposes, but the proportion was significantly lower among 13–17-year-old participants (Renzaho 2017). However, female condoms, post-exposure prophylaxis, and abortion services remain inaccessible and unaffordable to a majority of the population. In a study documenting SRH experiences, many adolescent girls discussed their knowledge of STIs, particularly HIV, but most of these participants were more concerned about protecting themselves from HIV than preventing pregnancy (Mary 2017).In addition, while girls were able to decide whether or not to engage in sex, their decisions were substantially influenced by external pressures including economic vulnerability and pressure from boys and men (Maly et al 2017).

The target for the GoU's FP programme 2014/15-2019/20 is to reduce unmet need for family planning to 10 percent[2] and increase the modern contraceptive prevalence rate (mCPR) amongst married and women in union to 50% by 2020. The Ugandan goals also enshrine the commitments that the GoU made at the London Summit of July 2012, and the resulting commitments known as the FP2020. The GOU made several significant commitments. Among others, these included:

- Develop and implement an integrated FP campaign
- Improve reproductive health (RH) commodity distribution and effective service delivery, review post-shipment testing policy to reduce delays in the release of vital RH supplies, including FP supplies from the National Drug Authority

[2]Unmet need for family planning refers to fecund women who are not using contraception, but who wish to postpone the next birth (spacing) or who wish to stop childbearing altogether (limiting).

- Scale up partnerships with civil society organizations and the private sector for FP outreach and community-based services, including social marketing, social franchising, and task sharing linked to a comprehensive training program
- Partner with appropriate private sector bodies and institutions for the integration of maternal health and FP/RH and HIV/AIDS information and services for their employees and families
- Roll out youth-friendly services in all government Health Centre IVs and district hospitals
- Strengthen the institutional capacity of the public health facilities and community-based distributors to provide family planning and increase choice and quality of care at all levels

Uganda has an organized national health system and health delivery in place within the strategic framework laid out in the Health Sector Strategic and Investment Plans (HSSIP). The national health system is comprised of both private and public sectors. The private health sector is comprised of mainly Private Not for Profit (PNFP) and Private Health Practitioners (PHPs) contributing about 50% of health care delivery. Within the public sector, health services delivery is decentralized within national, districts and health sub districts. The lowest level is supposedly the community health workers known as Village Health Teams (VHTs) based in villages, facilitating health promotion, service delivery, community participation, and empowerment for various aspects including family planning. Next in the hierarch yare the Health Centre IIs (1690 in total), which provide a first level of interaction between the formal health sector and communities. These provide outpatient and community outreach services including FP products and services. Next are the Health Centre IIIs (953 in total) and these provide basic preventive, health promotion and curative services, including a wider range of FP/SRH services. The youth corners –YFCs - are established at this level and at facilities higher in the health structure. The next levels are Health Centre IV (171 countrywide) and general hospitals (45 in total), which provide Health Centre III broad services such as surgeries and blood transfusions. The Regional Referrals Hospitals (RRHs) provide a higher level with more specialized clinical services and also involve teaching and research. Each of the RRHs has an YFC for provision of FP/SRH. The 14 RRHs and one of the two National Referral Hospitals[3] are most comprehensive. See Figure 2.

[3] The second National Referral Hospital is a Mental Referral facility.

Figure 2: Structure of Health Services in Uganda

Source: Compiled from MoH 2014 (b) and MoH 2000

Although VHTs are considered a major entry point for community-based FP/SRH service delivery structure, there has not been significant investment in building their capacity. Much effort has of recent gone towards finalizing the community Health Extension Workers (CHEWs) policy and strategy, with a view to introduce another layer of community health workers between the VHTs and the HCIIs.

The introduction of YFCs and other youth friendly services in the country's health infrastructure and community based systems is meant to ensure effective delivery of FP and related SRH services to young people, but also help health workers to identify cases of teenage pregnancy,

counsel the girls against criminal abortions and even engaging their parents to help them return to school after giving birth (WHO, 2017)

Another objective of the Adolescent Friendly Health Service (AFHS) initiative, as they are variously termed, is to facilitate capture of reliable and relevant data. The tools include the Activity Attendance List, Activity Program List, Outreach Evaluation Form and Referral Form. The YFC and school health clubs were given data capturing tools to record information on variables such as the number of youths attending, the nature of their health needs and referrals made. The data captured was expected to guide the review of the AFHS program and enable the MoH appreciate the burden of health needs linked to adolescents and what further interventions to introduce in health services delivery (WHO, 2017)

4 TIMELINE OF THE EVALUATION

The impact evaluation was carried out in three major phases, namely, (i) baseline, (ii) midline, and (iii) endline. The baseline survey was preceded by a process evaluation, which was conducted in 2016. The process evaluation explored the implementation issues of FP programs in Uganda. Based on the results of the process evaluation, the impact evaluation was launched with the baseline survey conducted between November 2016 and March 2017. The midline phase collected qualitative data to further provide insight into community-based youth-friendly services and collected quantitative data that profiled the characteristics of youth corners. The activities for this impact evaluation phase were as follows:

Activities	**2016**	**2017**	**2018**								**2019**		
			1	2	3	4	5	6	7	8	9	10	11
			April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Baseline Study													
Midline Study													
Design of encouragement materials													
Shooting of video clips													
Design interpersonal engagement													
Pretest of information materials													
Encouragement design implementation													
Monitoring of encouragement activities													
Monitoring service utilization													
Design of data collection tools for endline													
Endline data collection													
On-going stakeholder engagement													
Data analysis and report writing													

5 EVALUATION DESIGN, METHODS AND IMPLEMENTATION

5.1 Design

The overall design utilized two large-scale quantitative surveys (baseline and endline), conducted with a sample of young people (15-24 years) in selected sites across Uganda utilizing as well additional qualitative methods. This evaluation estimated the impact of utilization of youth-friendly FP services on health outcomes of interest, employing a randomized "encouragement design" as the identification strategy. While the evaluation entailed randomization at the sub-county level, data was collected at the individual level as the unit of observation. The objective of the randomized "encouragement design" was to generate experimental variation in the probability of utilizing FP/SRH services that could be exploited to estimate the impact of utilizing these services. It was assumed that youth in communities who receive the "encouragement" would be more likely to utilize FP/SRH services

5.2 Study Area and Population

The evaluation was conducted in all regions of the country, given that the GOU's FP/SRH Program is nationwide. The regions include Northern, West Nile, Eastern, Western, Central and Karamoja. A total of 16 districts were covered out of the current 117 districts of Uganda. At least two districts represented each region. The selection of districts was purposive to cover districts with established youth corners. In each district, two sub-counties were selected (1 rural and 1 peri-urban/town council) with exception of Kampala which is urban. Within each selected sub-county, 2 parishes were randomly selected and then 2 villages from each selected parish were studied. See Table 1.

Table 1: Distribution of Selected Districts by Region

Region	District	Region	District
Central	Kampala	North-east	Moroto
Central	Mpigi	North-east	Nakapiripirit
Central	Mubende	South-west	Kabale
East	Bududa	West	Bundibugyo
East	Bugiri	West	Kabarole
East	Kamuli	South- west	Sheema
East	Mbale	North	Gulu
North-west	Arua	North	Kitgum

5.3 Sample Size and Strategy

Data from the Uganda Demographic Health Survey (UDHS) of 2006 to 2011 was used to compute the contraceptive prevalence rates that were used in the power calculations to determine the desired sample size. This was intended to ensure that the sample for the baseline and endline surveys was comparable to the demographic characteristics of the targeted young people. Percent of contraceptive use among sexually active young people has been very low over time increasing from 18.1% to only 20.5% between 2006 and 2011. It was hypothesized that with the intervention—using "encouragement design" in implementation clusters – we would be able to increase FP use (detectable effect) between 5-6%.

The power calculation provided a sample of young people aged 15-24 years considering a 95% response rate[4]. At impact evaluation, this allowed for the detection of 5-6% point improvement in FP use among young people with a power of 0.8 after intervention. In deriving the sample size, Stata13 software was used by applying "clustersampsi" command. A sample (n) of 5,012 was included in the endline survey in 16 districts, giving a response rate of 96.53% of targeted 5192.

The impact evaluation used a household survey. The unit of observation was the individual young person aged 15-24 years randomly selected from each sampled household. The total number of households with at least one young person in the age bracket of interest in a village/cell formed a cluster. A cluster in this case was equivalent to a village/cell. Depending on the size of the village/cell, averagely, 22households with a young person of 15-24 years of age was sampled in each. Systematic random sampling was applied to select the 22 households in each of the selected villages/cells. The number of clusters (villages/cells) in each arm of the evaluation (intervention and control) was 118. Thus, a total of 236 clusters were included in the impact evaluation, to be drawn from 16 districts.

A summary distribution of the sample is presented in Table 2. Young people who were selected at baseline were not necessarily those selected at endline; these were treated as two independent cross-sectional surveys. The attrition from 5058 at baseline to 5012 at endline was random and reflects only a slightly lower response rate. The two samples remain comparable as shown in Table 2.

Table 2: Sample distribution by socio-demographic characteristics

Indicators	Baseline Feb, 2017	Endline Nov, 2018
	(N=5058)	N=5012)
Location characteristics		
Urban	31.3%	35.3%
Rural	68.9%	64.7%
Sex		
Male	48.8%	47.5%
Female	51.2%	52.5%
Age		
15-19	63.1%	59.7%
20-24	36.9%	40.2%
Highest level of education		
No education	2.6%	6.0%
Primary incomplete	29.2%	33.3%
Completed primary	17.2%	19.1%
Secondary or higher	50.9%	41.6%

5.4 Strategy for assigning Treatment

The pre-analysis plan developed for the evaluation called for randomization to be conducted at the sub-county level, stratifying by district and by rural/urban status. Following the randomization procedure, sub-counties were assigned to *treatment status* or *control status*. The sample included 16 districts, 98 sub-counties, and 236 villages. The objective of stratification was to ensure an

[4] Various studies conducted in Uganda (e.g. UDHS 2016 returned 98.2% response rate) and our experience in previous related assignments shows minimal cases of non-response/refusals to participate in health surveys involving face to face interviews

equal balance of treatment and control communities in each district and among rural and urban communities. All YFCs in the study sample were comparable in terms of access, services, presence of health staff and equipment available as much as practically possible. In effect, too, the YFCs in treatment and control matched on baseline characteristics of young people (see table 3). This also enabled estimation of heterogeneous effects of the intervention among different segments of youths. Randomization cells that included all study communities in a district were undertaken; this yielded46 randomization cells, at least two for each of the 16 districts excepting Kampala. (All sampling units within Kampala were coded as urban, and accordingly there was one sampling cell for Kampala).

We then used the random number generator within Stata to generate a random number with a different value for each site. Within each stratification cell, sub-counties with an indicator below the median were assigned to the control group while those with an indicator above the median were assigned to the treatment group. The randomization was conducted using the "setseed" function to ensure it is stable and replicable.

The list of treatment and control communities thus generated was utilized in order to plan activities designed to encourage utilization of youth-friendly services in the intervention communities. In the control communities, services were offered on a routine basis. A full list of the treatment and control sites can be found in appendices.

For three months, the Evaluation Team implemented the planned encouragement activities in the intervention sites as follows:

a) *Distribution of Information Fliers*; The teams visited each of the intervention sites twice a month, delivering between 1,000 to 2,000 copies of information fliers in both English and the respective 9 local languages spoken in the regions where implementation of the encouragement activities was taking place, namely; Runyankole-Rukiga, Luganda, Lugbara, NgaKarimojong, Lumasaba, Lusoga, Luo, Runyoro-Rutooro, and Lwamba/Lubwisi. In total, each site received between 10,000 – 16,000 fliers depending on the size of their catchment area and the diversity of languages used. The actual distribution was entrusted to youth peer workers, village health teams (VHTs) or other volunteers already working with the sites.

b) *Dissemination of Video Clips*; The video clips showed the picture/physical site of the youth corner/ centre, and the services available, and featured one or more of the health workers at the Youth Corner explaining the services available, the opening hours, and urging the young people to come for services. These were developed and played both at the youth corners/centres in the case of those with video equipment or given to operators of local video halls in the trading centres, who played them before screening their commercial videos. The video clips were for a length of 10 – 15 minutes.

c) *Sending of SMS messages*; Site-specific bulk SMS messages were sent to the telephone numbers of young people in the intervention communities twice every month between August and October 2018, making a total of 6 times. The telephone numbers of the young people which had been collected during at baseline were updated during the first field visits carried out in this phase.

d) *Inter-personal engagement*; These included outreach visits, sports events, community meetings, and other events conducted by the health facility staff and implementing agencies. These activities were aimed at engaging young people further to increase their awareness of available youth-friendly services and ultimately, their utilization of services.

Some Youth Corners were already conducting outreach activities and other community events, while several had planned or wished to conduct them but either lacked resources or the motivation to do so. Through our discussions with them, action plans / workplans were agreed and additional events were implemented. Whereas the evaluation team did not provide additional resources to the youth corners, various options of raising resources to facilitate such outreach visits were discussed including lobbying their head-offices, integrating of FP/SRH activities with other activities, and prioritizing FP/SRH activities. On average, implementing sites conducted outreach visits to 4 to 6 communities, visiting each twice within the period of three months.

In a large sense, many of the encouragement activities were not completely distinct from what was already happening as the part of the FP program's SBCC plan; the intent was to intensify SBCC within designated localities, adding innovations such as locality-specific fliers, video clips, and SMS directed targeted at young people within the sub-county of interest. The encouragement package (fliers, video clips and SMS) also carried specific information meant to inform young people about the presence of YFC in their locality, range of services available at YFC, opening hours, whom to contact in case more information was needed, and the fact that the services are free and convenient for young people. The evaluation team participated in design and translation of content of all encouragement messages. Outreach events generated much more SBCC since these were interactive.

Table 3: Sample distribution by treatment and control

	Treatment		Control	
Indicators	**Baseline Feb, 2017**	**End line Nov, 2018**	**Baseline Feb, 2017**	**End line Nov, 2018**
	N=1804	**N=2742**	**N=3354**	**N=2274**
Age				
15-19	60.0%	57.7%	64.8%	62.2%
20-24	40.0%	42.2%	35.2%	37.7%
Sex				
Male	47.8%	48.1%	49.4%	46.8%
Female	52.2%	51.9%	50.6%	53.2%

5.5 Monitoring of Implementation Activities during Treatment

To ensure that planned encouragement design activities went as planned, the evaluation team put in place a mechanism for regular monitoring of these activities. The main monitoring mechanism consisted of field visits every 2 to 3 weeks by the team to the various intervention sites. During these visits, team members held meetings with youth corner/centre staff, volunteers, health facility administrators, district officials, and other relevant stakeholders. They also met and discussed with young people themselves and assess functionality status of youth-friendly sites (e.g. presence of stocks of medicines and supplies for FP). They also ascertained if promotional materials such as filers, SMS messages and video clips were reaching target groups. When feasible, the teams participated in the distribution of information materials. Team members prepared monitoring reports from the field to be discussed and used as basis for planning subsequent action.

In addition to updating the team about the progress in implementation, monitoring visits were useful in maintaining contact with the youth corners/centres, motivating the health workers and other youth corner staff to keep up the momentum of providing youth-friendly services. Evaluation

teams were kept aware of activities going on in the different sites. Besides on-spot monitoring visits, other monitoring measures included telephone calls and review of service records.

5.6 Challenges in Implementation of Treatment

During July 2018, several youth corners/centres under the intervention group faced stock-out of some of the FP/ SRH products and commodities. For instance, the youth corner at Buwama HC IV had stock-outs of STI drugs; stock-outs were also reported by youth corners in Kabarole and Bundibugyo District. The stock-out affected some of the encouragement activities because health workers could not encourage the youth to come for services when some services were not available in clinics. For the period August to October, this challenge was minimized in intervention sites of interest.

Throughout the implementation of the evaluation, a limitation was that the evaluation team was not in full control over FP/SRH activities in the control sites. The RCT encouragement design used was meant to generate experimental variation in programmatic exposure comparing across the treatment and control sites, but there were other programmatic shifts in sampled communities that were outside of the evaluation team's control. More specifically, some of the control sites received additional interventions including demand creation activities similar to the activities in the intervention sites.

The evaluation team was also sensitive to the challenges of minimizing bias introduced by Hawthorne or testing effects. Our "encouragement design" primarily entailed interaction with health service providers at health units and peer educators/village health teams in intervention sites with whom with uniform, clear instructions to "set the stage" by communicating to young people about available FP services and encouraging uptake for improved SRH. The primary research participants (young people 15-24 years) were not to be alerted they are subjects of any experiment. Although working with peer educators/VHTs would ordinarily constitute "weak link" in intervention sites, the evaluation team is confident that any Hawthorne effects would be more relevant for provider behavior than beneficiary (young people) behavior. In the case of this impact evaluation, it is unlikely that individual youth respondents would be motivated to shape their responses to questions in order to improve their standing or reputation vis-à-vis the data collection team.

5.7 Data Collection Methods

Selected methods of data collection were utilized to generate both quantitative and qualitative data to answer research questions.

5.7.1 Quantitative data

A structured questionnaire was administered to young people (male and female) aged 15-24 through personal interviews to generate quantitative data. Using the structured questionnaire, the survey collected information on socio-demographic characteristics, child-bearing history, current reproductive health and sexual behavior, knowledge and attitudes about family planning, level of uptake of current family planning practice, barriers and enabling factors to family planning use, future family planning intentions, and educational and employment status. This information enabled detailed and empirical analysis of the impact of utilization of youth-friendly family planning/SRH services. See questionnaire appended.

5.7.2 Qualitative data

Qualitative data were collected through focus group discussions (FGDs) and in-depth interviews. Discussion guides and unstructured interview guides were designed to collect data.

Focus group discussions (FGDs) – FGDs were held with young men aged 15-24, young women aged 15-24, parents of young people, and peer educators for youth friendly FP/SRH services. A total of 5 FGDs were conducted for each category of participants. Each FGD consisted of 8 – 12 participants. The purpose of these FGDs was to collect general views and experiences on roll out of youth friendly FP/SRH services in the community, and also explore any socio-economic and cultural factors that constitute barriers or enablers to FP uptake and use. Peer educators were in particular asked to discuss their roles in creating demand for FP services, experiences, challenges and suggestions for improving demand amongst young people. The FGD guide is appended.

In-depth interviews with key informants – In-depth interviews were conducted with key informants at national and district level. Key informants were selected based on their specialized knowledge on family planning interventions in Uganda, their uptake and the factors affecting them. Key informants were selected from implementing agencies such as PACE, UHMG, RHU and Mariestopes. District key informants included District Health Officers (DHOs), Maternal and Child Health staff and District Health Educators. Health workers in a sample of health facilities providing family planning services were selected from different levels of health facilities (hospitals, HCIVs, and HCIIIs). Interview guide is appended.

5.8 Data Processing and Analysis

All duly filled questionnaires were verified, edited and open-ended responses coded before being entered into the computer. Field editing was done for all completed questionnaires immediately after the interview. Data entry was done using the *Epidata* computer software, which is open source software rich in data validation tests for controlling data entry errors. After entry, the data was then exported to SPSS and frequency distributions were generated to help identify data points for cleaning. In addition, a program to label the values and variables was written using SPSS syntax.

To determine the net changes in intended outcomes attributed to the assessment type (endline or baseline), multivariate analysis was performed involving several predictor variables including type of assessment. The analysis was based on several project outcomes as dependent variables focusing on key project domains. The domains included; abstinence and other sexual practices, contraceptive use, fertility, self-efficacy and related perceptions and communication/messaging. Since the outcome indicators of interest were binary in nature, a logistic regression methodology was adopted. The methodology assumes that the logit transformation of each outcome variable has a linear relationship with the predictor variables and hence establishes a relationship between a binary outcome indicator and a group of predictor factors. The logistic regression is based on the maximum likelihood method with the following equation;

$$\text{logit}(p) = \log(p/(1-p)) = \beta_0 + \beta_1 * \mathbf{x}_1 + \ldots + \beta_k * \mathbf{x}_k$$

where

P is the probability of occurrence of outcome **y**
$x_1, \ldots, x_k$ are the **k** predictor factors/variables
$\beta_0, \beta_1, \ldots, \beta_k$ are the **k** estimated coefficient values

Each exponentiated coefficient is the net change in odds in the multiplicative scale for a unit increase in the corresponding predictor variable at a fixed value of each of the other variables.

Beyond bivariate analysis and logistic regression comparing baseline and endline results, the key specifications of interest analyzed the impact of the encouragement intervention, regressing utilization of FP services and other outcomes of interest (utilization of contraception, fertility, and diverse measures of reproductive health) on a dummy variable for treatment assignment.

For the qualitative data, notes from key informant interviews and FGDs were transcribed and typed into a *Microsoft Word* computer program. The notes were transcribed verbatim to ensure complete capturing of the responses of the study participants. An analysis matrix grid was prepared to enable easy reading and comparison of responses from different groups. Thematic and content analysis was adopted to categorize the data and to establish patterns along the study objectives. Themes and sub-themes relevant to the objectives of the study were then identified to enable qualitative coding.

5.9 Quality Control Measures

Quality control measures utilized in this impact evaluation are described in detail in the appendix.

5.10 Ethical Measures

Throughout the different phases of the impact evaluation, the study team was aware of and put in place measures to ensure that relevant ethical standards for undertaking research among human subjects were observed. The team was conscious of the fact that sections of the study population were minors under the age of 18, who therefore required additional measures to safeguard their rights and vulnerability. The measures undertaken during surveys and other interactions with the study participants included observation of informed consent, voluntary participation, confidentiality and anonymity, and respecting the privacy of participants. In the case of youth aged 15-17 years consent was sought at two levels: i.e. from their caretakers/parents and from the young people themselves. Appropriate assent and consent forms for study participants were prepared and used during surveys and FGDs (see appendix). In addition, permission was sought from the heads of Districts and health facilities where data was collected.

To ensure confidentiality, all discussions (FGDs and in-depth interviews) with youth, their parents and peer educators were conducted in places that ensured privacy. Participants in group discussions were also urged not to discuss or share information got from the discussion with other people in the community who were not party to the group discussions. Confidentiality and privacy were critically important given that some of the information sought from the youth was of a sensitive nature.

6 IMPACT ANALYSIS AND RESULTS OF KEY EVALUATION QUESTIONS

6.1 Utilization of Sexual and Reproductive Health Services and Contraception

When examining the effects of the encouragement treatment on the primary variables of interest, there is little evidence of any significant effect on contraceptive utilization, abstinence and fertility, or knowledge and self-efficacy. When difference-in-difference specifications are estimated, including a dummy for post-treatment and an interaction with the treatment variable, there is no evidence of any differential shifts in treatment communities in contraceptive utilization (see table 4). Most important, there is also no evidence that utilization of youth-friendly services is higher in treatment communities. This may reflect the short duration of the encouragement intervention, or over-saturation of related messaging in the treatment communities.

Table 4: Utilization of FP/SRH services and contraception

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Utilization of youth-friendly services	Condom use at last intercourse	Use of other modern FP methods	CPR	Consistent condom use	STD exposure	Unmet need
	b/se	b/se	b/se	b/se	b/se	b/se	b/se
Treatment	0.003	-0.010	0.003	-0.028	0.041	-0.004	0.003
	(0.050)	(0.056)	(0.040)	(0.031)	(0.049)	(0.017)	(0.017)
Post	0.215***	0.049	-0.089**	-0.037	-0.057*	-0.062***	0.014
	(0.039)	(0.039)	(0.038)	(0.028)	(0.029)	(0.017)	(0.018)
Post~x~Treatment	0.077	-0.016	0.019	0.042	-0.047	-0.025	-0.009
	(0.051)	(0.054)	(0.052)	(0.038)	(0.044)	(0.022)	(0.026)
Constant	0.233***	0.557***	0.518***	0.522***	0.301***	0.216***	0.068***
	(0.033)	(0.039)	(0.036)	(0.024)	(0.031)	(0.013)	(0.012)
N	9897.000	3989.000	5888.000	5667.000	5186.000	6280.000	4349.000
r2	0.067	0.002	0.007	0.001	0.009	0.009	0.000
="* p<0.1	** p<0.05	*** p<0.01"					

6.2 Abstinence and Fertility Outcomes

When examining the effects of the encouragement treatment on the primary variables of interest, there is some evidence of a significant increase in age at first intercourse and a decrease in the probability of pregnancy in treatment communities (see Table 5).

When difference-in-difference specifications are estimated, including a dummy for post-treatment and an interaction with the treatment variable, there is no evidence of any differential

shifts in treatment communities on abstinence and fertility, though we also observe a more rapid increase in treatment communities in youth reporting that they never had sexual intercourse, and a more rapid decrease in youth reporting that they intend to wait until marriage for sexual initiation.

Table 5: Abstinence and fertility

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Never had sexual intercourse	Intends to wait until marriage	Age at first intercourse	Reports multiple concurrent partners	Pregnant in last two years	Ever had induced abortion	Dropout due to pregnancy	Uses family planning for spacing
	b/se	b/se	b/se	b/se	b/se	b/se	b/se	b/se
Treatment	-0.053	0.063	0.443**	-0.032	-0.077**	-0.012	-0.010	0.090**
	(0.061)	(0.059)	(0.190)	(0.028)	(0.031)	(0.024)	(0.038)	(0.035)
Post	-0.158***	0.026	0.377**	-0.092***	-0.620***	-0.077***	0.019	
	(0.040)	(0.036)	(0.144)	(0.020)	(0.022)	(0.020)	(0.034)	
Post~x~ Treatment	0.091*	-0.100**	-0.418**	0.039	0.113**	-0.001	0.005	
	(0.049)	(0.045)	(0.186)	(0.030)	(0.047)	(0.027)	(0.050)	
Constant	0.642***	0.317***	16.132***	0.258***	0.859***	0.118***	0.141***	0.613***
	(0.047)	(0.042)	(0.096)	(0.020)	(0.017)	(0.018)	(0.028)	(0.027)
N	7891.000	3509.000	5838.000	4873.000	3692.000	2341.000	10036.000	4831.000
r2	0.015	0.003	0.007	0.009	0.278	0.023	0.001	0.009
="* p<0.1	** p<0.05	*** p<0.01"						

In one of the communities placed under treatment as part of the encouragement design, the evaluation team came across many cases of young people under the age of majority and consent serving as spouses in homes;

> *…as I talk to you now, look at my brother's house… the girl there has not yet made 18 years of age, but she has a child…she got married at 16 years. Early marriages are still rampant in homes* (Parent of young persons, Nyahuka TC, Bundibugyo District)

At health facilities regularly visited by the evaluation team for monitoring activities under the treatment arm, majority of mothers seeking ANC were evidently young, and many under age.

6.3 Awareness and Attitudes/Self-efficacy

When examining the effects of the encouragement treatment on the primary variables of interest, there is weak evidence of an increase in confidence among youth that they could seek SRH services if desired (see Table 6).

When difference-in-difference specifications are estimated, including a dummy for post-treatment and an interaction with the treatment variable, there is no evidence of any differential shifts in treatment communities. There is some evidence of a more rapid increase in the percentage of youth reporting awareness of youth-friendly SRH services.

Table 6: Awareness and attitudes/self-efficacy between Treatment and Control

	(1)	(2)	(3)	(4)
	Reported awareness of youth-friendly SRH services	Confident can refuse sex	Confident they could get partners to use contraception	Confident they could seek SRH services
	b/se	b/se	b/se	b/se
Treatment	-0.042	0.014	-0.027	0.043*
	(0.036)	(0.016)	(0.024)	(0.025)
Post	0.030	0.039***	-0.061**	0.042*
	(0.023)	(0.014)	(0.029)	(0.022)
Post~x~Treatment	0.069*	0.002	0.070	-0.040
	(0.040)	(0.020)	(0.044)	(0.033)
Constant	0.848***	0.869***	0.724***	0.825***
	(0.020)	(0.013)	(0.020)	(0.019)
N	10060.000	10075.000	10075.000	10075.000
r2	0.011	0.004	0.003	0.003
="* p<0.1	** p<0.05	*** p<0.01"		

One of the commonly cited contribution GoU and partners in the national FP program interventions is the intensified socio-behavioral communication campaign, mainly about the building ability, motivation and self-efficacy among young people to seek SRH/FP services. Key influencers and young people themselves explained the role these demand creation campaigns have played.

> *Initially, in this area, girls were getting married at very early age because they lacked information but now, we are seeing them come to seek for information and to access condoms… which to me is a step in increasing utilization* (District programs coordinator BRAC, Bududa District)

> *Yes, we know that at least all our girls are now informed on use of short-term contraceptive remedies … most girls are more familiar with the use of injectables which last for three months* (District Programs Coordinator BRAC, Bududa District)

In some of the health facilities, partly due to shortage of staff, the idea to ensure that young people are served by health workers who nearly share similar demographic characteristics with clients visiting the facility has not been fully implemented.

Services providers should help us …and employ our age-mates. I cannot ask for condoms from an old man or woman in a facility (Female young person in FGD, Mpigi TC)

…even in an ordinary shop, I can't fail to buy condoms from my fellow youth …when you buy condoms from an old woman she will say "my grandson, you have also started?" (Male young person in FGD, Mpigi TC)

The long-standing misconceptions about FP have also not been eliminated from scores of young people and key influencers in the community.

It is not necessary (to use contraceptives) *because it can make the eggs extend deep inside the body and when the time for getting pregnant comes, you may fail to get the pregnancy* (Young person in FGD, non-FP user, Kamuli District)

…social cultural perceptions about FP still affect some young people…they are worried that contraceptives can make them produce pre-matures and children with disabilities… (Youth Chairperson, Uganda Red Cross, Mbale District)

7 CHANGES DURING PERIOD OF ASSESSMENT FOR KEY EVALUATION QUESTIONS

7.1 Utilization of Sexual and Reproductive Health Services and Contraception

While overall the proportion of young people currently using (or whose partner is using) contraceptives has not changed any significantly over the period of assessment, there is a remarkable rise in proportion among sexually active young people who used condoms, or whose partner used condoms (38.5% to 55.1%, $p<0.001$) or other FP method (38.8% to 50.1%, $p<0.001$) at last sex. The proportion reporting consistent use of condoms also increased (24.2% to 32.2%, $p<0.001$).

Service providers and parents/guardians attest to observable change among young people in relation to FP methods:

> *The number* (of FP users) *has increased…some time back we used to receive 3 to4 pregnant young girls for ANC every day but now we spend long without receiving any in such age group … they now use contraceptives* (Peer Educator, Mubende Referral Hospital)

> *These young girls secretly go for family planning contraceptives, because if it were not the case, all these small girls would be pregnant*… (Parent of young person, Nyahuka T/C, Bundibugyo District)

Among the methods young people reported to be using to avoid pregnancy over the assessment period, pills and injectables registered slight increase (1.9% and 4.0% respectively) while male condoms showed a reduction (9.2%) as the main method of FP. At 3.3%, IUDs utilization shows a sharp rise from 1.8%. The perception that male condoms hinder sexual spontaneity is documented in many studies (e.g. Marchi et al 2008), and yet long-term methods such as vasectomy are considered not appropriate for young couples who intend to conceive in the future (Kabagenyi et al 2014). Changes in methods reported to be used by young people to avoid pregnancy between the two periods of assessment show evidence of statistical significance ($p<0.001$). Overall, the burden of FP is skewed towards females, as evidenced in FP methods which attracted more interest/use during the assessment period. A higher utilization of FP services reported appears mainly driven by an increase in demand for FP from women.

Over the two assessment periods, more young people opted for general public health facilities such as hospitals and health centres as their source of contraceptives (52.9% compared to 42%, $p<0.001$). Establishment of separate, youth friendly service points in many public facilities partly explains this rise. Stand-alone youth centres as main source remained nearly the same since these are only a few. Other sources of contraceptives did not attract much interest among young people. One of the sticking challenges about youth centres/corners remains the sustainability of their operations in cases where external support has been withdrawn. Over the assessment period, this challenge appeared to affect a number of these youth friendly service points:

> *We had youth friendly corners, which have ceased long ago, under UNFPA and Straight Talk Foundation, but it's long when they last operated. One was in Kiganda, Kasanda district, and another one in Kasambya* (ADHO, Mubende District).

Whereas the impact evaluation shows no differences of statistical significance by age, sex or locality among young people reporting currently using (or whose sexual partner is using) contraceptives, sharp increases were reported both among teenagers (15-19 years) and older

adolescents (20-24 years) in condom use and other FP methods at last sex (p<0.05 for both indicators). Males compared to females reported higher proportion on the two indicators as well (p<0.05). The changes in proportions of young people who reported using other FP methods in last 3 months are relatively smaller than at last sex. During the assessment period, a higher proportion of young people showed interest in using contraceptive methods in the next 12 months (50.7% from 43.9%, p<0.001).

The logistic regression analysis (see Table 7) reveals that the likelihood of using condoms in the last 3 months at endline was significantly higher than the likelihood at baseline (OR=1.780, p<0.001). Similarly, respondents who were male, never married and urban residents were associated with significantly higher likelihood of condom use in the last 3 months compared to their counterparts (OR=1.586, OR=2.208, OR=1.227 respectively). The other significant contributing factors included visiting a youth corner at the health facility (OR=1.626, p<0.001) and discussing FP with a health professional (OR=1.346, p<0.001). Respondents who felt confident that one could refuse sex if he or she did not desire it had about 34.3%; a significantly higher likelihood to use condom in the last 3 months (p<0.012) compared to those who lacked the confidence.

Table 7: Predictors of condom use among young people in last 3 months

Dependent variable: Used condoms in the last 3 months

Variable	Odds Ratio (OR)	Significance (p-value)	95.0% C.I. for OR	
			Lower	Upper
Assessment type				
End-line	1.780	0.000	1.553	2.041
Baseline	1.000			
Sex of respondent				
Male	1.568	0.000	1.373	1.790
Female	1.000			
Current marital status				
Never married	2.208	0.000	1.896	2.570
Ever married	1.000			
Ever visited a youth corner at health facility where SRH and FP are provided				
Yes	1.626	0.000	1.412	1.872
No	1.000			
I feel confident that I can refuse sex if I do not desire it				
Agree	1.343	0.012	1.067	1.691
Disagree	1.000			
Discussed family planning with a health professional				
Yes	1.346	0.000	1.154	1.571
No	1.000			
Location				
Urban	1.227	0.002	1.075	1.400
Rural	1.000			

More revealing, the logistic regression analysis shows that young people at endline were 11 times more likely to use other (non-condom) methods to prevent pregnancy in last 3 months compared

to the likelihood at baseline ($p<0.05$). Similarly, respondents in the "single, never married" category scored higher odds (OR=1.737, $p<0.05$) on utilization of other method of contraception than their married counterparts. Sex of respondent, level of education or visiting a youth corner were not significantly associated with change in likelihood of using other (non-condom) methods of preventing pregnancy in last 3 months. Locality of residence of young people did not either. Table 8 presents the details.

Table 8: Predictors of use of other pregnancy prevention methods in last 3 months

Dependent variable: Used any other method to prevent pregnancy in last 3 months

Variable	Odds Ratio (OR)	Significance (p-value)	95.0% C.I. for OR	
			Lower	Upper
Assessment type				
End-line	11.749	0.000	9.566	14.431
Baseline	1.000			
Sex of respondent				
Male	0.741	0.001	0.618	0.888
Female	1.000			
Highest education level				
Primary incomplete	0.707	0.000	0.590	0.847
Others	1.000			
Current marital status				
Never married	1.737	0.000	1.390	2.169
Ever married	1.000			
Primary provider of your household basic needs				
Spouse	0.695	0.018	0.514	0.941
Both Spouse and self	0.605	0.023	0.392	0.932
Others	1.000			
Ever visited a youth corner at health facility where SRH and FP				
Yes	0.815	0.041	0.670	0.992
No	1.000			
Location				
Urban	0.829	0.035	0.696	0.987
Rural	1.000			

Despite improvements in utilization of non-condom methods of preventing pregnancy, young people in many places are still grappling with challenges of accessing products of their preferred choice; some of them opt to take whatever is available:

> *Clinics don't have most of the family planning products, when you go there, the attendants sweet talk you to accept the type of contraceptives on shelf…yet a person should have a choice to decide on the method she likes* (Young girl, dissatisfied FP user, Kamuli District)

Concerns were also expressed in a few cases about how youth friendly the services are; a case in point is the discomfort of young people served by providers who do not march the demographic profile of the potential user. The most vivid case is for male community-based distributors of contraceptives who pose a challenge for young female users to approach for service.

We have VHTs administering injectable contraceptives, but the challenge is that some of the VHTs are male…. some young girls don't find it comfortable to be served by the male providers (Nursing Officer, Bushika HCII, Bududa District).

7.2 Abstinence and Fertility Outcomes

Although the national FP program emphasizes abstinence from sex for young, unmarried boys and girls, this impact evaluation shows a decline in the proportion of young people who reported abstaining from sex during the assessment period(50.3% and 38.7% respectively, $p<0.001$). Similar results are evident on other indicators such as self-reports of multiple, concurrent sexual relationships and induced abortion. Age at onset of sexual intercourse reported among sexually active young people remained nearly the same.

Participants in focus group discussions and key informant interviews expressed similar concerns about sexual behavior of young persons and attendant repercussions:

> *The rate of teenage pregnancies in this community is very high…we have so many school drop-outs especially girls because of* (behavioral and economic challenges) … *these engage in sexual acts resulting into early marriages…* (Parent of young person, Nankoma S/C, Bugiri District)

> *These girls start sexual activity at a tender age and know that they can of course get pregnant. But they are secretly using contraceptives…* (Parent of young person, Nyahuka T/C, Bundibugyo District)

The logistic model showed no significant differences in likelihood of young people to abstain from sex in last 3 months during the assessment period. Instead, the likelihood of female young people to abstain from sex in past 3 months rose significantly higher than the likelihood for male young people (see Table 9). Similarly, respondents who were male or never married or urban residents were associated with significantly higher likelihood of condom use in the last 3 months compared to their counterparts.

Table 9: Predictors of abstinence from sex among young people in last 3 months

Dependent variable: Have not had sexual intercourse during the past 3 months (Abstinence)

	Odds Ratio (OR)	Significance (p-value)	95.0% C.I for OR	
			Lower	Upper
Sex of respondent				
Male	1.000			
Female	1.500	0.000	1.277	1.745
Highest level of education		0.047		
None/no education	1.094	0.678	0.715	1.676
Primary incomplete	0.797	0.008	0.674	0.942
Completed primary or higher	1.000			
Current marital status of respondent				
Single/never married	2.439	0.001	1.423	4.178
Widowed/divorced/separated	3.264	0.000	1.799	5.922
Married/cohabiting– monogamous	0.459	0.004	0.269	0.784
Married /cohabiting – polygamous	1.000			
Primary provider of basic needs				
Self	0.657	0.001	0.507	0.850
Spouse	0.443	0.000	0.290	0.678
Both Spouse and self	0.451	0.003	0.267	0.761
Parents	0.970	0.811	0.759	1.241
Other	1.000			
Knows place in community where SRH and FP services are provided				
Known	1.000			
Not known	1.302	0.002	1.106	1.531
Discussed family planning with a health professional in the last few months				
Yes	1.000			
No	1.728	0.000	1.436	2.080

The other significant contributing factors included marital-status (OR=2.439, p<0.05 for single, never married, OR=3.246, p<0.001 for separated/widowed) and knowledge of place in community where SRH and FP services are provided. Respondents with no education had a slightly higher likelihood not to have had sexual intercourse in last 3 months than their counterparts with some formal education (OR=1.094, p<0.05).

7.3 Awareness and Attitudes/Self-efficacy

Results of this impact evaluation show evidence of slight improvement on several indicators for ability and self-efficacy perceptions related to FP/SRH among young people during the period of assessment. Outstanding is the proportion of young people who are confident that they could get their partner (s) to use contraceptives/condoms if they desired (6.7% increase, p<0.001) or insist on condom use every time they feel their partners and themselves should use condoms (4.1% increase, p<0.001). Only a slight reduction was reported in proportion of young people who feel shy to ask for condoms, pills or other contraceptive services at health facilities.

For some of the indicators, performance was already high at onset of assessment; for instance, the proportion of young people who believe they could seek sexual and reproductive health information services if they needed them was 86.9% at baseline; the share of young people in the sample reporting confidence that they could refuse sex if they did not desire it was 91.4% at baseline as well.

The observations and experiences key informants and young people shared partly explain the changes in ability and self-efficacy among young people to obtain FP/SRH services;

> *…Young female people are now coming for FP methods like Sayana Press injections… VHTs also provide contraceptives such as emergency pills and condoms within the villages … it has helped to reduce on drop out from schools as a result of early pregnancies* (In-Charge HIMS, Bugiri District)

> *..availability is high and the cost of these FP commodities has reduced, for instance, if a young person can't go to the government health facilities for free services, they can afford a sachet of microgynon pills for 1,000/= only* (less than 30 cents of a US dollar) *which last one for a month….access is easy because of private clinics around*… (Linkage and Referral Supervisor BAWILHA, Bundibugyo District)

Except for confidence among young people that they can get their partner to use a contraceptive method, other indicators of attitudes and self-efficacy perceptions show only slight changes even when analyzed by age, sex and locality of usual residence of respondents. Among youth in urban areas, a change of 7.9% is reported during period of assessment on proportion of young people that can get their partner to use a contraceptive method. About 5% change on the same indicator is observed among both male and female respondents. Feeling shy to ask for condoms, pills, or other contraceptive services at health facilities reduced among females by 7.9%. This, and the fact that the proportion of young boys who have ever supported their female partners to use a contraceptive method significantly increased from 17.9% at baseline to 44.9% at endline, shows that young men continue to put the onus of FP on women.

The logistic model showed significant less likelihood of young people to feel confident that they can refuse sex if they do not desire it. Instead, the regression reveals that the likelihood of young people who know a place in community where SRH and FP services are provided to feel confident to refuse sex was about 52% higher than the likelihood for those who do not know where to obtain FP/SRH services.Other measures of attitudes and perceptions of ability and self-efficacy show little change over the assessment period (see Tables 10 and 11).

Table 10: Predictors of perceived feeling of confidence to refuse sex if not desired
Dependent variable: I feel confident that I can refuse sex if I do not desire it

Variable	Odds Ratio (OR)	Significance (p-value)	95.0% C.I for OR	
			Lower	Upper
Assessment type				
End-line	0.768	0.016	.620	.952
Baseline	1.000			
Highest level of education				
Primary incomplete	0.749	0.008	.606	.926
Others	1.000			
Primary provider of basic needs				
Spouse	0.604	0.000	0.465	0.784
Others	1.000			
Knows place in community where SRH and FP services are provided				
Known	1.512	0.001	1.176	1.944
Not known	1.000			

The regression model shows that the likelihood to feel shy to ask for condoms pills or other contraceptive services at health facilities was 23% higher among young people at onset of assessment period than the likelihood at endline ($p<0.05$). Other factors include highest level of education and current marital status of young people (see Table 11)

Table 11: Predictors of perceived shyness to ask for contraceptives at health facilities

Dependent variable: I feel shy to ask for condoms pills or other contraceptive services at health facilities

Variable	Odds Ratio (OR)	Significance (p-value)	95.0% C.I for OR	
			Lower	Upper
Assessment type				
End-line	1.000			
Baseline	1.229	0.008	1.055	1.432
Sex of respondent				
Male	0.555	0.000	0.483	0.639
Female	1.000			
Age of respondent	0.894	0.000	0.870	0.919
Highest level of education				
None/no education	2.368	0.000	1.679	3.339
Educated	1.000			
Current marital status of respondent				
Ever married	1.515	0.023	1.059	2.168
Never/currently Married	1.000			
I feel confident that I can refuse sex if I do not desire it				
Agree	1.658	0.000	1.329	2.063
Disagree/not sure	1.000			

Regression analysis further shows that the likelihood to feel confident that one can get her/his sexual partner(s) to use condoms if they desire it was significantly higher at endline (OR=1.456, $p<0.001$) than the likelihood at baseline. Other factors include sex of respondents (OR for males =1.845, $p<0.001$) than the likelihood among female young people), highest level of education

(those with some education scored OR=2.747, p<0.001) and knowledge of place in community where SRH and FP services are provided (OR=1.349, p<0.05).

Table 12: Predictors of perceived confidence to get partner(s) to use condoms

Dependent variable: I am confident that I can get my partner(s) to use condoms if I desire it

Variable	Odds Ratio (OR)	Significance (p-value)	95.0% C.I for OR	
			Lower	Upper
Assessment type				
End-line	1.456	0.000	1.231	1.723
Baseline	1.000			
Sex of respondent				
Male	1.856	0.000	1.592	2.163
Female	1.000			
Age of respondent	1.087	0.000	1.053	1.121
Highest level of education				
None/ no education	1.000			
Some education	2.747	0.000	1.919	3.933
Knows place in community where SRH and FP services are provided?				
Known	1.349	0.001	1.131	1.610
Not known	1.000			
I feel confident that I can refuse sex if I do not desire it				
Agree	1.000			
Disagree/not sure	2.812	0.000	2.260	3.500
Location				
Urban	1.413	0.000	1.200	1.664
Rural/Trading Centre	1.000			

Regression analysis showed no significant differences in likelihood of young people to believe they can seek sexual and reproductive health services if they needed them during the assessment period. Instead, the regression reveals that the likelihood of young people to believe they can seek sexual and reproductive health services if they needed them is significantly influenced by possession of some education (OR=3.0, p<0.001), knowledge of place in community where SRH and FP services are provided (OR=2.491, p<0.001), discussion of family planning with a health professional in the last few months (OR=1.701, p<0.05) and living in urban areas most of the time (OR=1.441, p<0.05). The likelihood of young people to believe they can seek sexual and reproductive health services if they needed them associated with those who feel confident that one can refuse sex if one does not desire it is about 3 times that of those who lack confidence (p<0.05).

Table 13: Predictors of perceived ability to seek FP/SRH services if needed

Dependent variable: I believe I can seek sexual and reproductive health services if I needed them

	Odds Ratio (OR)	Significance (p-value)	95.0% C.I for OR	
			Lower	Upper
Age of respondent	1.158	0.000	1.111	1.208
Highest level of education				
Some education	3.004	0.000	1.956	4.614
None/ no education	1.000			
Knows place in community where SRH and FP services are provided?				
Known	2.491	0.000	1.817	3.417
Not known	1.000			
I feel confident that I can refuse sex if I do not desire it				
Agree	1.000			
Disagree/not sure	2.963	0.000	2.251	3900
Discussed family planning with a health professional in the last few months				
Yes	1.701	0.001	1.251	2.313
No	1.000			
Location				
Urban	1.4481	0.004	1.127	1.861
Rural/Trading Centre	1.000			

8 DISCUSSION

The GoU in collaboration with members of the Reproductive Health Group from the fraternity of development partners and CSOs have undertaken demonstrable support to health facilities, private and public, to provide sustainable SRH services and heavily subsidized FP commodities to young people. Youth corners are a popular feature at many health facilities, deliberately set aside to offer youth friendly FP/SRH services. As a result, uptake of FP/SRH services has improved over the period of the national FP program implementation.

The objective of this impact evaluation was to utilize a quasi-experimental design incorporating an encouragement design to increase utilization of family planning services in a randomly selected subset of treatment communities. However, the results show that utilization of youth-friendly services was consistent across treatment and control communities, and thus the encouragement design was not successful in stimulating differential take-up. While the available data does not allow researchers to directly identify the channels for this phenomenon, it may reflect the short duration of the encouragement design and over-saturation of messages relative to family planning services in both treatment and control communities.

The paucity of staff at static health facilities and for conducting outreach is a long-standing challenge in a resource stressed country such as Uganda. Health facilities are often not adequately stocked with FP commodities due to challenges with contraceptive security (Subramanian et al., 2008). Attention is required not only on the service supply side but also enhancing adoption of modern contraceptive use by placing equal focus on access to and affordability of the services, and awareness campaigns on FP use (Andi et al 2014).

The unmet need of contraceptives is still high considering the 5% MoH target. Some of the barriers to access and utilisation of contraceptive services include limited spousal involvement in utilizing FP services as shown by gaps in uptake for male-controlled methods. Cases of shortage of skilled staff to provide some FP services have long been documented (MoH 2014; Ninsiima 2010; Mukasa 2009); both supply and demand-driven constraints to the accessibility of FP services are also widespread. To realize more benefits of FP at population level, the country needs to balance demand creation interventions with effective, uninterrupted supply of FP products and supplies in the health system to the lowest facility or community-based structure possible.

This impact evaluation clearly shows that the results of SBCC for young people focusing on abstinence from sex may not be as impressive as intervention agencies had planned. Quite many young people are sexually active and in need of FP products to avoid risk of early first pregnancy or another unplanned pregnancy or child birth. Given the above, Priority Number 1 in the Uganda Family Planning Costed Implementation Plan, 2015–2020 (FP-CIP), namely, to “Increase age-appropriate information, access, and use of FP amongst young people, aged 10–24 years” is very relevant. The planning and targeting is right except that much more work is required to implement and realize national targets more effectively.

A major concern for FP programmes is a narrow range of services for young people, mostly short acting FP products and, therefore, limited options open to young clients in most public facilities offering FP services. The limited options are more pronounced in relation to men’s interests who only have two reliable options, namely, male condoms and vasectomy that are in their direct control, and yet long-term methods such as vasectomy are considered not appropriate for young people who intend to reproduce in the future. This poses strain on overall effectiveness of male-controlled FP, which both the service providers and clients must grapple with.

The lesson from this impact evaluation is that FP scale out, like any other community or public health intervention, requires sustained effort at program level to not only identify target categories, but also reach them with a package of commodities. To deliver an effective FP program and register more positive results, attention is required to enhance adoption of modern contraceptive use by placing equal focus on access to the services, beyond demand creation campaigns on FP use.

There is evidence from this impact evaluation of increasing acceptance of the idea of FP among young people. Service providers say the change could be slow but the data shows that it is noticeable. The discussions among key stakeholders during qualitative interviews were less about whether or not people should plan for their family size, and more about the “dangers” of using particular modern FP products, especially hormonal contraceptives and IUDs.

This impact evaluation shows that there are notable improvements in levels of support and communication between sexual partners about FP; a departure from the long-standing retrogressive attitudes of men toward their adoption of male-controlled FP and their negative influence on partners’ utilization of FP generally.

9 IMPLICATIONS OF EVALUATION RESULTS FOR POLICY AND PRACTICE

The results of this evaluation suggest key implications for policy and practice.

Utilization of youth-friendly services is relatively high, and as a result, it is not easy to stimulate further increases in utilization via demand creation activities. In this case, a differential deployment of informational materials in treatment communities was not successful in increasing changing existing patterns of service use.

Currently, the momentum for FP is growing but, still, actors need to undertake more advocacy initiatives for FP at the highest political level and within various levels. At the sector and MoH level, relevant policy and planning frameworks exist to guide FP interventions. A major gap is at the level of commitment on the part of Government to commit the necessary resources for sustained and uninterrupted provision of FP commodities and other inputs such as staff.

Barriers to maximizing the supportive role of young men in FP have been widely discussed in this report, and in previous studies. The issue is how to stimulate more spousal/partner discussion of FP and register overt spousal support. Attention on male spouses at programmatic level is still required. Appropriate counseling and monitoring of clients with specific focus on young men is necessary.

While young people are showing growing interest in FP, service providers should pay attention to challenges related to availability of services young people most prefer, institutional capacity issues at public and community-based service delivery points to increase choice. Actors should continue to explore models to deliver services that the youth will find attractive.

Further, utilization of family planning on average is increasing rapidly among youth, and accordingly there are substantial differences evident in health indicators between the baseline and endline survey (separated by a period of eighteen months). This may reflect broader socio-economic shifts, changing attitudes, and shifts in the services available. Future research must be cognizant of these shifts and seek to control carefully for variation in health indicators over time.

Lastly, while there is correlational evidence suggestive of a substantial impact of government-provided youth-friendly services on health indicators, further research is needed with innovative experimental designs that would generate clearer causal evidence about the relationship between these services and health outcomes.

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APPENDICES

Appendix I: Sampling and Data Tables

Table 14: Sub-county/Division clusters allocated to Treatment and Control arms

No.	Sub-county/cluster*	Study Arm	Frequency	
			N	%
	ARUA HILL	Control	81	1.6
	AWACH	Control	83	1.7
	BUBUKWANGA	Treatment	85	1.7
	BUDUDA TC	Control	79	1.6
	BUFUNDA	Control	84	1.7
	BUGIRI WESTERN DIVISION	Treatment	84	1.7
	BUKIGAI	Control	84	1.7
	BUKINDA	Control	84	1.7
	BUKONDE	Treatment	84	1.7
	BUKUUKU	Treatment	81	1.6
	BULOPA	Control	84	1.7
	BULUCHEKE	Control	84	1.7
	BUTAASI	Control	84	1.7
	BUWAMA	Treatment	84	1.7
	BUWUNGA	Control	83	1.7
	KABALE CENTRAL DIVISION	Treatment	84	1.7
	KAGONGO	Control	77	1.5
	KAKOMONGOLE	Treatment	84	1.7
	KAMULI MUNICIPAL SOUTH	Control	86	1.7
	KARAGO	Treatment	85	1.7
	KASAMBYA	Treatment	81	1.6
	KASAMBYA TC	Treatment	84	1.7
	KASHAMBYA	Control	85	1.7
	KAWEMPE	Treatment	83	1.7
	KAZO	Control	82	1.6
	KAZO TC	Control	84	1.7
	KICHWAMBA	Control	82	1.6
	KIGANDA	Control	83	1.7
	KIRUHURA TC	Control	65	1.3
	KITAGATA	Treatment	85	1.7
	KITAGATA TC	Treatment	83	1.7
	LAYIBI	Control	85	1.7
	MAGONGO	Control	79	1.6
	MBALE NORTHERN DIVISION	Treatment	84	1.7
	MOROTO NORTHERN DIVISION	Treatment	84	1.7
	MPIGI TC	Treatment	86	1.7
	MUBENDE EASTERN	Treatment	86	1.7
	MUCWINI	Treatment	85	1.7
	MUDUUMA	Control	84	1.7
	MUTERERE	Control	84	1.7
	NADUNGET	Control	85	1.7
	NAKAPIRIPIRIT TC	Treatment	85	1.7
	NAKATSI	Control	84	1.7
	NAKAWA	Treatment	84	1.7
	NALUTUNTU	Control	86	1.7
	NAMALU	Control	83	1.7
	NAMWENDWA	Treatment	85	1.7
	NANKOMA	Treatment	84	1.7
	NKOZI	Treatment	84	1.7
	NTANDI	Control	85	1.7
	NYAHUKA	Treatment	78	1.6

	OMUGO	Control	84	1.7
	PANDWONG	Treatment	94	1.9
	RIVER OLI	Control	84	1.7
	RUBAGA	Control	84	1.7
	RWAMUCUCU	Treatment	86	1.7
	UNYAMA	Treatment	84	1.7
	Total		5012	100.0

*At the time of endline survey some of the clusters had been split into more sub-counties/town councils. To keep the same sites as at baseline, the catchment areas were maintained irrespective of the new demarcations.

Table 15: Changes in contraceptive use during period of assessment

Indicators	Baseline Feb, 2017	Endline Nov, 2018	Significance (p. value)
• %ge of young people 15-24 years who are currently using (or whose sexual partner is using) a contraceptive method.	49.0%	50.7%	0.228
• %ge of sexually active young people who used a condom at last sexual intercourse	38.5%	55.1%	0.000
• %ge of sexually active young people who used any other modern Family Planning method at last sexual intercourse	38.8%	50.1%	0.000
• %ge of sexually active young people who used any other modern Family Planning method in the last 3 months	43.8%	87.3%	0.000
• %ge of sexually active, unmarried young people who consistently use condoms	24.2%	32.2%	0.000

Table 16: Changes in methods young people are using to avoid pregnancy

FP method mentioned	Baseline Feb, 2017	Endline Nov, 2018	Significance (p. value)
Pills	9.4%	11.5%	.000
Injectable	16.5%	20.5%	
Emergency contraception	.2%	1.0%	
Male condoms	53.5%	44.3%	
Female condoms	.8%	1.4%	
IUD	1.8%	3.3%	
Male sterilization	0%	0%	
Female sterilization	0%	0%	
Lactational amenorrhea	1.7%	1.3%	
Periodic abstinence	4.4%	4.0%	
Withdrawal	5.1%	8.2%	

Table 17: Changes in source of contraceptive method currently using

Source of FP services/products	Baseline Feb, 2017	Endline Nov, 2018	Significance (p. value)
Youth Friendly Corner/Centre	4.9%	4.4%	
General health facility	42.0%	52.9%	
Private clinic	25.8%	26.4%	
Pharmacy-Drugstore	4.2%	4.6%	
Peer educator-youth centre	.6%	.4%	
VHT	2.6%	.9%	.000
School nurse-midwife	.3%	.1%	
Ordinary shop-market	1.5%	.8%	
TBA-traditional healer	.1%	.1%	
Friends	1.2%	1.5%	
CBOs	.8%	.3%	
Mission hosp-clinic	.3%	.4%	
It is a Natural method	3.4%	5.4%	

Table 18: Changes in contraceptive use during assessment period by Age, Sex and Locality

	Indicator							
Characteristic	currently using (or whose sexual partner is using) a contraceptive method %		used a condom at last sexual intercourse %		used any other modern Family Planning method in the last 3 months %		used any other modern Family Planning method at last sexual intercourse %	
	Baseline	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**
Age								
15-19	46.7	45.5	41.4	65.2	6.2	13.3	35.2	46.4
20-24	51.4	55.1	36.3	48.1	5.1	8.0	41.7	53.1
Sex								
Male	52.6	51.4	45.4	63.4	3.7	7.6	36.6	46.8
Female	43.6	49.9	31.0	45.9	8.0	12.6	41.2	53.1
Residence								
Urban	53.0	51.0	46.6	60.5	4.2	7.9	37.8	48.8
Rural	47.2	50.4	35.0	51.4	6.2	11.7	39.3	50.9

Table 19: Changes in sexual behaviors among young people during assessment period

Indicators	Baseline Feb, 2017	Endline Nov, 2018	Significance (p-value)
• %ge of young people who report that they have never had sexual intercourse	50.3%	38.7%	.000
• %ge of young unmarried people who report the intention to abstain from sex until marriage	51.1%	49.5%	.000
• Age at first sexual intercourse reported among sexually active young people			
• 14yrs and below	21.4%	21.2%	.169
• 15-17 years	48.7%	51.1%	
• 18yrs and above	29.9%	27.6%	

Table 20: Changes in self- efficacy and related perceptions during assessment period

Indicators	Baseline Feb, 2017	Endline Nov, 2018	Significance (p-value)
• %ge of young people who feel shy to ask for condoms, pills or other contraceptive services at health facilities	40.9%	37.5%	.001
• %ge of young people who are confident that they could get their partner (s) to use contraceptives/condoms if they desired	67.8%	73.1%	.000
• %ge of young people reporting confidence that they could refuse sex if they did not desire it	91.4%	88.2%	.000
• %ge of young people who feel confident that they can insist on condom use every time they feel their partners and themselves should use condoms	64.0%	68.1%	.000
• %ge of young people who believe they could seek sexual and reproductive health information services if they needed them	86.9%	87.6%	.267

Table 21: Changes in self-efficacy and related perceptions during assessment period by Age, Sex and Locality

	Indicator							
Characteristic	Confident that they can get their partner to use a contraceptive method %		Feel shy to ask for condoms, pills or other contraceptive services at health facilities %		Confident they can insist on condom use every time he/she has sex %		Believe they could seek sexual and reproductive health information services if they needed them %	
	Baseline	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**
Age								
15-19	64.2	70.1	49.3	46.9	61.5	66.1	83.9	85.0
20-24	73.9	77.7	26.7	23.6	68.3	71.2	92.0	91.6
Sex								
Male	73.5	78.9	32.7	33.7	70.1	74.5	87.4	89.3
Female	62.3	67.9	48.8	40.9	58.2	62.3	86.3	86.1
Residence								
Urban	65.0	72.9	40.8	36.7	62.2	67.1	85.8	87.5
Rural	73.8	73.5	41.1	38.8	68.0	69.8	89.3	87.9

Appendix II: Quality Control Methods

The following quality control measures were employed to ensure that the reliability and validity of all endline data.

- *Recruitment of study personnel*: Careful recruitment of experienced research personnel including Research Assistants and Field Supervisors with extensive experience in conducting qualitative and quantitative studies involving young people. The selection also took into consideration fluency in the local languages spoken in the study communities.
- *Training of the research team*: A three (3) -days training workshop for all survey personnel to equip them with the information and skills considered critical to conduct a survey among young people to ensure consistency in the application of approaches and methods was conducted.
- *Pretesting survey instruments:* The tools for data collection were pre-tested before the commencement of main data collection to ensure that questions and issues of discussion would generate correct responses, smooth question flow and general acceptability of the questions in the structured questionnaire to young people. Second, the pre-test allowed the senior researchers on the team to assess the competencies of the Research Assistants in locating the respondents, creating rapport, obtaining the interview, and recording responses.
- *Team meetings and team working:* The core team constantly held regular team meetings to follow-up on work progress, addressing emerging challenges and sharing ideas.
- *Voluntary consent:* All the young people who participated in this study were not coerced or enticed to participate using material incentives. The participants were approached and rapport established to voluntarily participate in the study. Thus, informed consent and assent was sought in advance of interviews to ensure would-be participants have time to consider their involvement and ask questions
- *Data entry*: Double entry was done, and data cleaning was undertaken to remove any errors and inconsistencies in the dataset.

Appendix III: Impact Evaluation Tools

Impact Evaluation of Government of Youth Family Planning Services in Uganda (October 2018)

QUESTIONNAIRE FOR ENDLINE SURVEY
(Male & Female Young People 15-24 years)

SECTION 1: HOUSEHOLD IDENTIFICATION AND SCREENING QUESTIONS

100 Date of interview DD-MM-YYYY: [__|__]-[__|__]-[_2_|_0_|_1_|_8_]		
101 Interviewer's Name		
102. District		
103. Sub-County/Division		
104. Parish/Ward		
105. Village		
106. Location	Urban Trading Centre Rural	1 2 3
107. Household ID		
108. Result of the interview	Completed interview Interview interrupted Incomplete interview Refused ***(Stop Interview)*** Other *(specify)*	1 2 3 4 5
Time started Time completed:	[___|___:___|___] [___|___:___|___]	

Checked by Supervisor:	Name of Supervisor:
Date	

CONSENT SECTION

Good morning/afternoon sir/madam. My name is _____. I am part of a team working with Socio-Economic Data Centre together with Ministry of Health supported by the Office of the Prime Minister conducting research on health issues by interviewing young people both males and females aged 15 and 24. The purpose of this study is to understand health behavior and views related to youth-friendly Family Planning and sexual and reproductive health services**.** I would like to discuss these issues relating to all these with you. The information gathered here will remain confidential and I will not write down your name or any information that can identify where you live or who you are**.** You were chosen by chance and your participation in this study is voluntary.

Note*: The interviewee must give his or her informed consent by agreeing to be interviewed. If participation is refused,* ***thank the respondent*** *and go to the next sampled household.*

SECTION 2: SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENT

Qn.	Question/Filter	Responses	Code	Skip
201.	**RECORD SEX OF RESPONDENT**	Male Female	1 2	
202.	How old are you? **RECORD COMPLETED YEARS** **PROBE**: In which year were you born? **RECORD YEAR**_____	_____		
203.	Can you read or write in any language?	Yes, in English Yes, in local language Yes, with difficulty (any language) No, not at all	1 2 3 4	
204.	What is the highest level of education that you have attained?	None/ no education Primary incomplete Completed primary Secondary or higher	1 2 3 4	1 = Go to 206
205.	Are you currently enrolled in school?	Yes No Just completed a level, not sure to continue	1 2 3	1 or 3 = Go to 207
206.	What are the reasons that you are not is school?	Financial reasons Got pregnant Not interested Other	1 2 34	
207.	What is your religious denomination?	None Muslim Roman Catholic Protestant Other- Christian Other/ traditional beliefs	1 2 3 4 5 6	
208.	Do you currently live with any of your biological parents?	Yes, both parents Yes, with father only Yes, with mother only None	1 2 3 4	
209.	Who is the primary provider of your household basic needs?	Self Spouse Both Spouse and self Parents Other (specify)_____	1 2 3 4 5	
210.	Do you work to earn money?	Yes No	1 2	2 = Go to 301
211.	What is your primary occupation? **(ONLY ONE)**	Peasant farmer Salaried/wage earner Petty trading Business/Commercial Security uniformed forces BodaBoda rider Dependent on parents Other (specify)_____	1 2 3 4 5 6 7 8	

SECTION 3: SEXUAL PRACTICES INCLUDING ABSTINENCE

I am going to ask you some questions relating to your sexual practices, a few may sound personal but I request that you share with me your experience. Please, be as truthful as you can.

Qn.	Question/Filter	Responses	Code	Skip
301.	What is your current marital status?	Single/never married Widowed/divorced/separated Married/cohabiting– monogamous Married /cohabiting – polygamous	1 2 3 4	2,3,4= Go to 303
302.	(**IF NOT MARRIED**) Have you ever had sexual intercourse?	Yes No No response (***probe***)	1 2 3	1=Go to 304
303.	(**IF NEVER HAS SEX**) When do you plan/intend to begin having sexual intercourse?	Number of years ..... When I get married Not sure	1 2 3	1-3=Go to 612
304.	Do you have a regular sexual partner?	Yes No	1 2	2=Go to 306
305.	How many regular sexual partners do you have currently?	Number of partners		
306.	How old were you when you first had sexual intercourse?	_____years Don't know/Don't remember		
307.	Have you had sexual intercourse during the past 3 months?	Yes No	1 2	1=Go to 310
308.	Have you had sexual intercourse during the past 6 months?	Yes No	1 2	1=Go to 310
309.	How many sexual partners have you had in the past 12 months?	Number of partners		
310.	(**IF EVER HAS SEX BUT CURRENTLY NOT MARRIED**) Do you intend to have sexual intercourse during the next 12 months?	Yes No Will depend	1 2 3	
311.	(**IF NEVER HAD SEX**) Have you ever considered the idea not to have sex till you marry/get married?	Yes No	1 2	

SECTION 4: CONTRACEPTIVE USE

I am going to ask you some questions relating to contraceptives generally and condom use in particular, a few may sound personal but I request again that you share with me your experience. Please, be as truthful as you can.

Qn.	Question/Filter	Responses	Code	Skip
401.	Have you ever used condoms when having sexual intercourse?	Yes No No response (***probe***)	1 2 3	2=Go to 406
402.	The last time you had sexual intercourse did you or your partner use a condom?	Yes No Don't know	1 2 3	2=Go to 404
403.	What was the relationship between you and the last person with whom you used a condom?	Regular partner, not cohabiting Cohabiting partner Spouse Casual partner Other (specify)_____	1 2 3 4 5	
404.	What was the relationship between you and the last person with whom you did not use a condom?	Regular partner Cohabiting partner Spouse Casual partner Other (specify)_____	1 2 3 4 5 6	

		Not applicable (always used a condom)		
405.	Have you used condoms in the last 3 months?	Yes Only in some cases/situations No Don't know	1 2 3 4	
406.	The last time you had sexual intercourse did you or your partner use **any other** method of preventing pregnancy?	Yes No Don't know	1 2 3	2, 3 = Go to 409
407.	The last 3 months you had sexual intercourse did you or your partner use **any other** method of preventing pregnancy?	Yes No Don't know	1 2 3	2 or 3=Go to 409
408.	Whose decision was it to use the method? Was it mainly your decision, your partner's decision or a joint decision?	My decision His/her decision Joint decision	1 2 3	All = Go to410
409.	(**IF NO METHOD WAS USED**), Whose decision was it not to use a contraceptive method ? Was it mainly your decision, your partner's decision or a joint decision? (**IF DNK AT 406&407, DO NOT ASK, GO TO 410**)	My decision His/her decision Joint decision	1 2 3	
410.	How often do you use a condom? Would you say…….. (**PROBE BYREADING CODES**)	Every time I have sex The first few times I meet a new partner Only with those I don't trust Quite rarely	1 2 3 4	
411.	How often did you use a condom when you had sex in the **last 12 months?***Would you say you used a condom every time, most of the time, sometimes, or never?*	Never Sometimes Most of the time Every time	1 2 3 4	
412.	Do you yourself like to use condoms during sexual intercourse or simply feel compelled to use them?	I like using condoms I feel compelled to use condoms	1 2	
413.	What are the reasons you use condoms? (**MULTIPLE RESPONSES ALLOWED)**	To avoid unplanned pregnancy To prevent HIV infection To prevent STIs	1 2 3	
414.	Have you ever had sex under the influence of alcohol or drugs?	Yes No Not sure/don't recall	1 2 3	2, 3 = Go to 501
415.	In the last 6 months, have you ever had sex under the influence of alcohol or drugs?	Yes No Not sure/don't recall	1 2 3	

SECTION 5: SEXUALLY TRANSMITTED INFECTIONS

I am going to ask you some questions relating to sexually transmitted diseases, a few may sound personal but I request that you share with me your experience. Please, be as truthful as you can.

Qn.	Question/Filter	Responses	Code	Skip
501.	In the last 12 months, have you noticed any abnormal discharge from your genitals that lasted a few days?	Yes No Don't Recall	1 2 3	2=Go to 503
502.	**IF YES** When was the last time you had a discharge from your genitals?	0-6 months ago 7-12 months ago More than a year ago	1 2 3	
503.	In the last 12 months, have you had sores/ulcers itching on your genitals?	Yes No Don't recall	1 2 3	2 or 3=Go to 506

504.	Did you receive medical treatment for any of these conditions?	Yes No	1 2	2 =Go to 506
505.	When was the last time you suffered from any STI or presented STI symptoms?	0-6 months ago 7-12 months ago More than a year	1 2 3	
506.	Do you feel comfortable accessing STI and other sexual health services?	Yes No	1 2	1 =Go to 508
507.	What discourages you from seeking treatment for STI and other sexual health services? **(CIRCLE ALL REASONS MENTIONED)**	Don't know where to access services Service is very far Service is very expensive Fear for embarrassment Lack of privacy at health unit Do not trust staff Medications may not be available Wait times too long Prefer to wait for problem to improve on its own Other (specify)_____	1 2 3 4 5 6 6 8 9 10	
508.	Has your spouse/partner(s) ever suffered from sores/ulcers on their genitals?	Yes No Not sure/Don't know Not applicable / no spouse or regular partner	1 2 3 4	

SECTION 6: PREGNANCY, CHILDBEARING AND REPRODUCTIVE STATUS

I am now going to ask you some questions relating to pregnancy, childbearing and reproductive status with some possibly sounding personal but I request that you share with me your experience. Please, be as truthful as you can.

Qn.	Question/Filter	Responses	Code	Skip
601	(**GIRLS ONLY**) Have you ever been pregnant?	Yes No	1 2	2 = Go to 612
602	(**BOYS ONLY**) Have you ever made a girl pregnant?	Yes No Don't know	1 2 3	2 or 3 = Go to 612
603	(**GIRLS ONLY**) In the past 2 years, have you been pregnant?	Yes No	1 2	2 = Go to 612
604	(**BOYS ONLY**) In the past 2 years have you made a girl pregnant?	Yes No Don't know	1 2 3	2 or 3 = Go to 612
605	What was the outcome of the pregnancy?	Delivered Aborted Miscarried Still pregnant Don't know	1 2 3 4 5	
606	(**GIRLS ONLY, ABOVE 18 YEARS, EVER HAD SEX**) Have you ever performed an abortion?	Yes No	1 2	1 =Go to 608 2 = Go to 610
607	(**BOYS ONLY, ABOVE 18 YEARS, EVER HAD SEX**) Has your sexual partner(s) ever performed an abortion?	Yes No Don't know/not sure	1 2 3	2 or 3 = Go to 610

Qn.	Question/Filter	Responses	Code	Skip
608	(**GIRLS ONLY, ABOVE 18 YEARS, EVER HAD SEX**) In the past 2 years, have you ever performed an abortion?	Yes No	1 2	
609	(**BOYS ONLY, ABOVE 18 YEARS, EVER HAD SEX**) In the past 2 years has your sexual partner ever performed an abortion?	Yes No Don't know/not sure	1 2 3	
610	**CHECK Q 601 & 604, IF YES** Do you have children of who you are the biological parent?	Yes No	1 2	2= Go to 614
611	How many children of your own do you have?	[___|___]		
612	(**IF MARRIED GO TO 616 IF UNMARRIED ASK**) Have you ever thought about the age at which you should get married?	Yes No	1 2	2= Go to 614
613	(**IF YES**) At what age would you like to get married?	[___|___]		
614	(**IF HAS CHILDREN GO TO 618; IF NOT ASK**) Have you ever thought about the age at which you should start having children?	Yes No	1 2	2= Go to 616
615	(**IF YES**) At what age would you like to start having children?	[___|___]		
616	Have you ever thought about the number of children you want(ed) to have?	Yes No	1 2	2= Go to 701
617	How many children would you (have) like(ed) to have?	[___|___]		
618	(**IF HAS CHILDREN**)Do you want another child? (**PROBE;** Do you think your current number of children is …..? (**READ THE OPTIONS**)	Not enough Enough Excessive	1 2 3	
619	**IF HAS NO CHILDREN,** What number of children would you like to have?	……		

SECTION 7: UTILISATION, INVOLVEMENT IN UPTAKE AND ACCESS TO FAMILY PLANNING SERVICES

Qn.	Question/Filter	Responses	Code	Skip
701.	**[CHECK IF EVER HAD SEX, IF NEVER HAD SEX GO TO 734]** Are you currently using any contraceptive method/family planning method to avoid pregnancy (or your spouse/partner getting pregnant)? **INTERVIEWER: ASK EVEN SINGLE/NEVER MARRIED** **FOR MEN: if you have multiple partners, please answer this question with reference to your primary partner.**	Yes No	1 2	2= Go to 705
702.	**[CHECK IF EVER HAD SEX, HAS NO CHILD OR WITH CHILD UNDER AGE OF 2]**	Yes No	1 2	2= Go to 706

Qn.	Question/Filter	Responses	Code	Skip
	In the last 2 years, have you used any family planning method in order to delay pregnancy or space your next pregnancy or your partner's next pregnancy?			
703.	What is the **main** method you are using to avoid getting/making your partner pregnant?	Pills Injectables Emergency contraception Male condoms Female condoms IUD Male sterilization Female sterilization Lactational amenorrhea Periodic abstinence Withdrawal Other (specify)_____	1 2 3 4 5 6 7 8 9 10 11 12	
704.	What are the reasons for using this method? **MULTIPLE RESPONSES ALLOWED)**	Prevents STIs & HIV Cheaper Lasts longer Always available Easy to get Easy to use No side effects More effective Recommended by doctor Recommended by a friend Partner preference Other (specify)_____	1 2 3 4 5 6 7 8 9 10 11 12	
705.	What are the reasons that you are not using any method to avoid getting pregnant /your spouse getting pregnant? **MULTIPLE RESPONSES ALLOWED)**	No need Want more children Fear of side-effects Desire to get child of different sex Do not know of any method Contraception is expensive or hard to access Religious objections Parents or others would disapprove Partner objects to use of contraceptive methods Other (specify)_____	1 2 3 4 5 6 7 8 9 10	
706.	Is your spouse/partner using any method to delay pregnancy or space your next pregnancy or your partner's next pregnancy?	Yes No Not sexually active Don't know/Not sure	1 2 3 4	2= Go to 709 3, Go to 729
707.	What is the main method you or spouse/partner is currently using to avoid pregnancy? (**ONLY ONE RESPONSE**)	Pills Injectables Emergency contraception Male condoms Female condoms IUD Male sterilization Female sterilization Lactational amenorrhea	1 2 3 4 5 6 7 8 9	

Qn.	Question/Filter	Responses	Code	Skip
		Periodic abstinence	10	
		Withdrawal	11	
		Other (specify)_____	12	
708.	What are the reasons for using this method? **MULTIPLE RESPONSES ALLOWED)**	Prevents STIs & HIV	1	ALL= Go to 710
		Cheaper	2	
		Lasts longer	3	
		Always available	4	
		Easy to use	5	
		No side effects	6	
		More effective	7	
		Recommended by doctor	8	
		Recommended by a friend	9	
		Partner preference	10	
709.	What are the reasons that you or your spouse/partner is / are not using any contraceptive method? **(MULTIPLE RESPONSES ALLOWED)**	No need	1	ALL= Go to 716
		Want more children	2	
		Fear of side-effects	3	
		Desire to get child of different sex	4	
		Do not know of any method	5	
		Contraception is expensive or hard to access	6	
		Religious objections	7	
		Parents or others would disapprove	8	
		Partner objects to use of contraceptive methods	9	
		Other (specify)_____	10	
710.	(**CHECK FOR THOSE USING ANY CONTRACEPTIVE METHOD**) For how long have you been using this method?	Used it only once	1	
		Up to 1 month	2	
		>1 month – 3 months	3	
		> 3months – 6 months	4	
		>6 months – 1 year	5	
		> 1 year	6	
		On and off	7	
711.	Are you satisfied with the main current contraceptive method you are using?	Yes	1	
		No	2	
712.	Is your spouse/partner satisfied with the current contraceptive method he/she is using (**INTERVIEWER CHECK QN 706, IF NO GO TO 714**)	Yes	1	
		No	2	
		Don't know	3	
713.	**IF NO IN 711:** Why are you not satisfied with the current contraceptive method? (**MULTIPLE ANSWERS ALLOWED**)	Discomforts	1	
		Spouse/partner gets irregular menstrual periods	2	
		Side effects	3	
		Cost	4	
		Inconvenience of using it	5	
		My partner doesn't support it	6	
		Fear about fertility / infertility	7	
		Other (specify)_____	8	
714.	On whose initiative did your spouse/partner start using the contraceptive method currently using?	Own (partner) initiative	1	
		My (respondent) initiative	2	
		Both of us	3	

Qn.	Question/Filter	Responses	Code	Skip
		Health worker	4	
		Friend	5	
		Other (specify)_____	6	
715.	(**ASK ONLY BOYS/MEN**) Did you discuss with your spouse/partner about the choice of the contraceptive method she's using?	Yes	1	
		No	2	
716.	(**ASK ONLY BOYS/MEN**) Have you ever suggested to your spouse/ partner to use contraceptive services?	Yes	1	2= Go to 718
		No	2	
717.	What are the reasons that you suggested to your spouse to use contraceptive services?	Raising children, we can afford	1	
		Health reasons	2	
		Economic reasons	3	
		Keep her body shape	4	
		Other	5	
718.	Have you ever supported your spouse/ partner to use a contraceptive method?	Yes	1	2=Go to 721
		No	2	
719.	How did you support/are you supporting her?	Taking her to the clinic	1	
		paying for contraception	2	
		Allowing/ agreeing to use contraception	3	
		Other (specify)_____	4	
720.	What are the reasons that you supported your spouse to use contraceptive/family planning services? **(MULTIPLE RESPONSES ALLOWED)**	Raising children we can afford	1	
		Health reasons	2	
		Economic reasons	3	
		Keep her body shape	4	
		Partner decision	5	
		Other (specify)_____	6	
721.	(**ASK ALL**) Would you support/encourage your spouse/partner to use a contraceptive method or seek other reproductive health services?	Yes	1	2= Go to 723
		No	2	
722.	What are the reasons that you would support/encourage your spouse/partner to seek contraceptive / reproductive health services?	Raising children we can afford	1	
		Health reasons	2	
		Economic reasons	3	
		Keep her body shape	4	
		Other (specify)_____	5	
		Don't know	6	
723.	(**CHECK QN: 703/706 IF RESPONDENT/SPOUSE USES FP COMMODITIES, IF YES, THEN ASK THIS QUESTION**) For the method of FP/contraceptive that you/your spouse use now, where did you get it from the last time you bought/got it? **(REMEMBER; This question does not apply to those using periodic abstinence, withdraw, lactational amenorrhea; for such cases GO TO 727)**	Youth Friendly Corner	1	
		General health facility	2	
		Private clinic	3	
		Pharmacy/Drugstore	4	
		Peer educator/youth centre	5	
		VHT	6	
		School nurse/midwife	7	
		Ordinary shop/market	8	
		TBA/traditional healer	9	
		Friends	10	
		CBOs	11	
		Mission hosp / clinic	12	
		It is a Natural method	13	
		Other (specify)_____	14	
724.	What is the **MAIN** reason you/your spouse/partner chose this place to get your method?	Close to home	1	
		Staff nice and competent	2	
		No other choice	3	
		Offers more privacy	4	

Qn.	Question/Filter	Responses	Code	Skip
		Short waiting time	5	
		Open for Long hours of services	6	
		Low cost	7	
		Recommended by friends	8	
		Free services	9	
		Other (specify)_____	10	
725.	Who recommended this method to you/your spouse/partner (***CURRENT METHOD***)?	Provider	1	
		Friend	2	
		Parent /Partner	3	
		VHT	4	
		Clinic/ Maternity staff	5	
		Other health worker	6	
		Drug shop staff	7	
		Pharmacy staff	8	
		Other (specify)_____	9	
726.	Where did you/your spouse get contraceptives the first time you started using them?	Youth Friendly Corner	1	
		General health facility	2	
		Private clinic	3	
		Pharmacy/Drugstore	4	
		Peer educator/youth centre	5	
		VHT	6	
		School nurse/midwife	7	
		Ordinary shop/market	8	
		Other (specify)_____	9	
727.	**(ONLY NON-USERS):** Why aren't you/your spouse using a **modern** contraceptive method at the moment? (**MULTIPLE RESPONSE ARE POSSIBLE)** ***ALSO ASK THIS QUESTION TO THOSE WHO ARE USING PERIODIC ABSTINENCE, WITHDRAWAL, LACTATIONAL AMENORRHEA***	Spouse/partner want(s) to get pregnant	1	
		Religion doesn't allow it	2	
		Spouse doesn't allow it	3	
		Family doesn't allow it	4	
		It's bad for my/her health	5	
		Method not available	6	
		Too expensive	7	
		Too many side effects	8	
		Not sexually active	9	
		Other (specify)_____	10	
728.	**ASK ALL RESPONDENTS** What is the contraceptive method you would prefer to use or would like your spouse/partner to use? **ONLY ONE ANSWER**	Pills	1	
		Injectables	2	
		Emergency contraception	3	
		Male condoms	4	
		Female condoms	5	
		Diaphragm	6	
		Foams/Gel	7	
		IUD	8	
		Implants	9	
		Male sterilization	10	
		Female sterilization	11	
		Lactational amenorrhoea	12	
		Periodic abstinence	13	
		Withdrawal	14	
		Other traditional	15	
729.	**ASK ALL NOT USING ANY MODERN FP WHO EVER HAD SEX**:	Yes	1	2= Go to 732
		No	2	

Qn.	Question/Filter	Responses	Code	Skip
	Do you intend to useto use any FP/contraceptive method in the next 12 months?			
730.	**ASK ALL CURRENTLY USING OR SPOUSE IS USING AN FP METHOD**: Do you intend to continue using any FP/contraceptive method in the next 12 months?	Yes No	1 2	2= Go to 732
731.	Which main method do you intend to use in the next 12 months? (**ONE ANSWER**)	Female sterilization Male sterilization Pill IUD Injectables Implants Male Condom Female condom Lactational Amenorrhea Periodic abstinence Withdrawal Emergency Contraception Other (specify)_____ Unsure	1 2 3 4 5 6 7 8 9 10 11 12 13 14	
732.	If you wanted to get a contraceptive method / services, where would you go? **(MULTIPLE RESPONSES ALLOWED)**	Youth Friendly Corner General health facility Private clinic Pharmacy/Drugstore Peer educator/youth centre VHT School nurse/midwife Ordinary shop/market TBA/traditional healer Other (specify)	1 2 3 4 5 6 7 8 9 10	
733.	How far from your home is the nearest place where you could obtain a contraceptive method of your preference?	____/___ Kms		
734.	(**QUESTIONS 734-738 APPLY TO ALL RESPONDENTS, NOT ONLY THOSE SEXUALLY ACTIVE**) (**IF UP TO THIS POINT, YOUTH CORNER IS NOT MENTIONED THEN ASK**) Have you ever visited a youth corner at a public hospital/clinic/health facility where SRH and FP services exclusively for young people are provided?	Yes No	1 2	1=Go to 736
735.	Do you know any place in this community (county or district) where SRH and FP services exclusively for young people are provided?	Yes No	1 2	2=Go to 738
736.	When was the last time you visited a youth corner?	0-6 months ago 7-12 months ago More than a year	1 2 3	
737.	The last time you visited the youth corner, what services were you offered?	Counseling for abstinence Condoms Other FP commodities/products General SRH/FP information Other (specify)_____	1 2 3 4 5	

Qn.	Question/Filter	Responses	Code	Skip
		No service	6	
738.	(**ONLY FOR THOSE WHO HAVE NEVER VISITED YOUTH CORNER**) What are the reasons you have never visited a youth corner?	Feel I have no need Want to bear children Fear being seen at the place Don't like services offered Location is too far Hours are not convenient Do not trust staff Have no idea about youth corner Other (specify)_____	1 2 3 4 5 6 7 8 9	
739.	(**ASK ONLY GIRLS/WOMEN**) Have you ever failed to use contraception (non-condom methods) because your husband/partners disapprove?	Yes No	1 2	
740.	Have you ever concealed your use of contraception from a husband/partner? Or from parents?	Yes from partner Yes from parent No	1 2 3	
741.	Have you ever suggested condom use to your husband/partner?	Yes No	1 2	1=Go to 745
742.	Do you fear any consequences if you suggest condom use to a husband/partner?	Yes No	1 2	1=Go to 745
743.	What consequences do you fear if you suggest condom use to a husband/partner?	Partner's disapproval Partner ending the relationship Partner may initiate infidelity Psychological violence Physical violence Other (specify)_____	1 2 3 4 5 6	
744.	(**CHECK THOSE WHO HAVE EVER VISITED ANY FACILITY FOR FP**) The last time you visited a health facility for purposes of seeking FP services; did you go with your partner?	Yes No	1 2	
745.	(**ASK ALL**) if you were to visit a health facility for purposes of seeking FP services in the future, would you go with your partner?	Yes No	1 2	1=Go to 747
746.	What are the reasons you would not go with your partner to visit a health facility for purposes of seeking FP services in the future?	Partner's disapproval Partner ending the relationship Partner may initiate infidelity Psychological violence Physical violence Other (specify)_____	1 2 3 4 5 6	
747.	**CHECK FOR THE MARRIED/ EVER HAD SEX NOT USING FP SERVICES** Would you like using FP services, which currently you are not using?	Yes No	1 2	

SECTION 8: ATTITUDES AND OPINIONS ABOUT FAMILY PLANNING SERVICES

In the next couple of statements I am interested in hearing your opinion on contraception/ family planning. Please tell me if you "agree" or "disagree" Whenever I say 'I' am referring to 'You'.

	STATEMENT	Agree	Disagree	Not sure
801.	I feel confident that I can refuse sex if I do not desire it	1	2	3
802.	I feel shy to ask for condoms, pills or other contraceptive services at health facilities	1	2	3
803.	It is ok for a woman/girl to suggest to her male partner that they use a condom or another method to avoid pregnancy	1	2	3
804.	I would recommend a friend to use FP methods/Contraception	1	2	3

805.	**(IF IN SCHOOL)** My teachers would be annoyed with me if they discovered I was asking for condoms, pills or other contraceptive methods	1	2	3
806.	My parents would be annoyed with me if they discovered I was asking for condoms, pills or other contraceptive methods	1	2	3
807.	My friends would laugh at me/ tease me if they found out that I was asking for condoms, pills or other contraceptive services	1	2	3
808.	Health workers at the clinic/health facility would be annoyed with me if I went to them to ask for condoms, pills, or other contraceptive services	1	2	3
809.	Health workers at the clinic/ health facility would tell my parents or teachers if I went to them to ask for condoms, pills or other contraceptive services	1	2	3
810.	I am confident that I can insist on condom use every time I feel my partner and I should use them	1	2	3
811.	I am confident that I can get my partner(s) to use contraceptives/condoms if I desire it	1	2	3
812.	I believe I can seek sexual and reproductive health information services if I needed them	1	2	3

SECTION 9: EXPOSURE TO INFORMATION AND COMMUNICATION FP SERVICES AT YOUTH CORNERS AND IN GENERAL COMMUNITY

I am going to ask you some questions relating to access of FP and SRH services. Please, be as truthful as you can.

Qn.	Question/Filter	Responses	Code	Skip
901.	Have you ever seen or heard any communication/messages/activities about family planning/youth friendly sexual and reproductive services?	Yes No	1 2	2=Go to 904
902.	Where have you seen or heard any messages /communication/activities about family planning/youth friendly sexual and reproductive services? **PROBE TO GET MORE SOURCES; MULTIPLE RESPONSES ARE ALLOWED**	Health worker Village health worker Television Radio Phone voice messages Phone text messages Wall branding Poster Sign posts Branded T-shirt / Aprons Drama / Videos Mobile Mega phones Static mega phones Rig Truck Others specify)_____	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	

903.	What was the main message communicated in the activities that you have heard/seen? **MULTIPLE RESPONSES ARE ALLOWED**	Use family planning Space your children Use IUD Use Implants Use FP injectables Use FP pills Use female/male sterilization Use long term family planning methods Others (specify)_____	1 2 3 4 5 6 7 8 9	
904.	In the last 3 months, have you discussed family planning with a health professional?	Yes No	1 2	
905.	In the last 3 months, have you been visited by a peer educator or health worker to talk about SRH or family planning services for the youth?	Yes No	1 2	
906.	In the last 3 months, have you attended any peer group activity on youth friendly SRH or family planning?	Yes No	1 2	
907.	In the last 3 months, have you attended any community activity or event such as outreach by health workers where youth friendly SRH or family planning issues were discussed?	Yes No	1 2	
908.	In the last 3 months, have you seen flier with messages encouraging young people to seek SRH or family planning services?	Yes No	1 2	
909.	In the last 3 months, have you watched a video or recorded documentary where health workers encourage young people to seek SRH or family planning services?	Yes No	1 2	
910.	In the last 3 months, have you received any SMS message encouraging young people to seek SRH or family planning services?	Yes No	1 2	
911.	In the last 3 months, have you been informed in any way about the importance of seeking SRH or family planning services by peers or family members?	Yes No	1 2	
912.	(**ONLY ASK THOSE WHO ANSWERED YES TO ALL OR ANY Q904-Q911**) Following the encouragement you received from health visits/outreach, peers, family or through watching the video or SMS, did you visit the facility/space/youth corner you were invited to seek SRH or family planning services?	Yes No	1 2	2 = Go to 917

913.	Following your visit to the youth friendly corner, which SRH services did you receive? **(MULTIPLE RESPONSES ALLOWED)**	Counseling Family planning, STI treatment HIV testing and counseling SGBV counseling Post Abortion Care Antenatal Care Delivery Postnatal care Others (Specify)_____ None I simply went there to see	1 2 3 4 5 6 7 8 9 10 11 12	
914.	Were you satisfied with the way you were handled at the health facility/youth corner/space?	Yes No	1 2	
915.	Would you return to this facility for SRH and family planning services?	Yes No	1 2	
916.	Would you recommend fellow youth to go to same facility for SRH and family planning services?	Yes No	1 2	
917.	In the next 6 months, do you plan/intend to visit the facility/space/youth corner you were invited to seek SRH or family planning services?	Yes No	1 2	
918.	In the last 3 months, have you ever visited any other health facility where SRH and family planning services are provided?	Yes No	1 2	
919.	(**ONLY ASK THOSE CURRENTLY MARRIED AND THEN; FOR SINGLE, NEVER MARRIED END INTERVIEW**) Have you ever discussed your desired family size with your partner?	Yes No	1 2	
920.	Do you think your partner/husband wants more children than you, less children than you, or the same number of children as you?	More Less Same Number Has no partner Not sure/Don't know	1 2 3 4 5	
921.	How would you rate the quality of sexual and reproductive health including family planning services provided in health facilities within your community?	Very good Fairly good Moderate Poor Very poor	1 2 3 4 5	

END INTERVIEW

Consent Form for Young People 18 years and above

[To be read to—or read by—and signed on behalf of the head of household or representative]

CONSENT FORM: Hello, my name is _____from Socio-Economic Data Centre (SEDC). I am part of a team of people who are doing research by interviewing people about health issues on behalf of Government of Uganda Family Planning Program. The purpose of the study is to understand issues associated with use of family planning among young people in Uganda**.**

We would like to discuss these issues with a member of you. Every young person 15-24 years in the country has an equal chance of being included in this study**.** The information gathered here will remain confidential and I will not write down your name or any information that can identify where you live or who you are**.** You have been selected to participate in this study not because anything is known about you, but purely by chance to represent other young people that live in this community.

You have been chosen by chance (randomly) without any judgment made. Participation in the study by you is voluntary and you will not be affected in any way if you choose not to participate. There are no direct benefits for participants into the study. However, your views and opinions will inform better implementation of various programs intended to increase availability and affordability of family planning services and improving the health of young people in Uganda. You can choose to participate but you may stop or end the interview at any time without any penalty if you so wished.There are no wrong answers, and hence you will not be judged.

You may get feelings of discomfort discussing your reproductive health preferences and experiences with me, as well as increased feelings of anxiety in relation to being at risk of unplanned pregnancy. In addition, as a result of participating in this study, you may become distressed and stigmatized because matters related to reproductive health experiences are personal. But we shall make all efforts to ensure that the information you give us is not revealed to other people. However, if for any reason, you feel uncomfortable during the interview/discussion, you are free to discontinue your participation without any repercussions whatsoever.

We would like to ask you questions and the discussion may last 30-45 minutes. The interview will be strictly face-to-face and individual between you and me. You will identify a quiet and private place where the interview can be conducted. All data based on this research will be reported in aggregate form. No individual respondents will be identified.

Do you agree to participate?

Tick appropriately:
☐*Please tick* **The interviewee agrees to be interviewed**

Signature of Interviewer: _____ **Date:** _____

Interviewer's name: _____ **Time:** _____
(Please print name)

INFORMATION SHEET

Who are we?
We are a research team working for SEDC on behalf of Government of Uganda Ministry of Health and Office of the Prime Minister.

What are we doing? (Purpose)
We are conducting a countrywide study about young peoples' involvement in family planning. Your participation in this study and information provided will help to inform health promotion programs specifically involvement of young people in family planning programs.

Selection criteria
You have been selected randomly (by chance) to participate in this study. You are free to participate or not. However, your participation will be important in helping to inform health improvement in Uganda.

Participation
Participation in the study is voluntary. If you accept to participate, I will ask you questions about yourself, your household, your knowledge and perceptions about family planning. Some questions will be so personal but feel free to respond as am here not to judge you but to learn from you. The interview will take 45-60 minutes. You are free to stop the interview any time or not answering a question that you feel not comfortable with. You can choose to participate but you may stop at any time without any penalty if you so wished.

Confidentiality
All information provided will be confidential. Your name will not appear anywhere on our records and your responses will not be read or shared with another person not part of our research team.

Benefits
There are no direct benefits for participants into the study. However, your views and opinions will inform implementation of interventions that aim at increasing availability and affordability of family planning services and improving the health of women in Uganda.

Risks
You may get feelings of discomfort discussing your reproductive health preferences and experiences with me, as well as increased feelings of anxiety in relation to being at risk of unplanned pregnancy. In addition, as a result of participating in this study, you may become distressed and stigmatized because matters related to reproductive health experiences are personal. But we shall make all efforts to ensure that the information you give us is not revealed to other people not even your partner. However, if for any reason, you feel uncomfortable during the interview/discussion, you are free to discontinue your participation without any repercussions whatsoever.

Questions

Do you have any questions or concerns about the study that I can respond to before we proceed? If you have any questions at any time, you can contact:

Prof. Narathius Asingwire, contact: +256-752-790-594/+256-782-439033
Dr. Denis Muhangi, contact: +256-772-445198/+256-701791602
Dr. Swizen Kyomuhendo, contact: +256-772-931070/+256-702540011

Impact Evaluation of Government of Youth Family Planning Services in Uganda (October 2018)

FGD Guide
Parents / Caregivers of Young People

Introduction

The purpose of the FGDs is to explore any social, economic and cultural factors that may constitute barriers or enablers to family planning uptake and use. These may include factors such as social norms, gender norms, cultural values, poverty, and other factors.

Record the following details:

- District, Sub-county, Parish
- Number of FGD participants
- Ages of participants
- Date, Time and Venue of FGD
- Name of Moderator & Note taker

1. SRHR/FP/contraceptive use for young people
    - What are the main issues / challenges facing youth/ adolescents (aged 15-24) in this community?
    - At what age do these young people become sexually active in this community?
    - What is the extent of teenage pregnancies in the community
    - To what extent do you young people use any methods to avoid pregnancies
    - What do you as parents think about contraceptive use for young people?
    - What is the extent of early marriages?
    - What is the extent of HIV among adolescents / youths aged 15-24?

2. Information and Services on SRHR/FP for young people
    - Do young people get any information about how to keep safe from HIV and unwanted pregnancies?
    - Where do they get the information from?
        - Who provides the information?
        - Do parents discuss with their adolescent children about issues of sexuality, pregnancy, HIV, etc? If not, What are the reasons?
    - What services are available to help young people avoid HIV/STIs/teenage pregnancy?
        - Who provides these services
        - Where are they provided?
    - To what extent do the young people utilize these services?
    - What changes have taken place in the last 2 to 3 years in the availability of information and services for FP/SRHR targeting young people?

- What are parents doing to keep their adolescents safe from HIV/STIs and teenage pregnancies?

3. Suggestions
    - What else should can be done to help address the challenges young people face in their sexual lives?

Thank You

Impact Evaluation of Government of Youth Family Planning Services in Uganda (October 2018)

FGD Guide
YOUNG MEN AND WOMEN AGED 15-24

Introduction

The purpose of the FGDs is to explore any social, economic and cultural factors that may constitute barriers or enablers to family planning / SRHR uptake and use. These may include factors such as social norms, gender norms, cultural values, poverty, and other factors. Your responses will be most appreciated.

Record the following details:

- District, Sub-county, Parish
- Number of FGD participants
- Ages of participants
- Date, Time and Venue of FGD
- Name of Moderator & Note taker

1. Knowledge, attitudes and beliefs
    - What is understood by Family Planning/contraception?
    - Is it necessary for young people (15-24) to use contraception?
        - Why is it necessary
        - What are the benefits
        - What are the dangers if not used?
    - What is the source of your information on FP
    - How often do you get this information on FP?

2. Practices
    - What are you doing to avoid pregnancies; probe FP methods used; sources of FP services
    - Who uses contraception – compare males and females; married and unmarried
    - What else are you doing to live a healthy sexual and reproductive life?

3. Availability and Access
    - Are there places in this town/sub county where one can get contraceptive services?
    - What kind of places are these? Probe: NGO, FBO or Government of Uganda owned
    - What kind of FP services are provided at the place? Probe: How friendly are they for young people, any cost related to use of FP services at any of these facilities—if yes, how much and for what?, probe also for distance to the FP delivery health facilities; what kind of people provide these services (age)
    - What changes have taken place in the availability and quality of services over the last 2 to 3 years?
4. Challenges and Suggestions

- Are there any challenges you face in using FP/SRHR services? Probe on what these are
- What can be done to help address the challenges you have mentioned?
- What else should be done to reduce teenage pregnancies and early child bearing among young people in this area?

Thank You

Impact Evaluation of Government of Youth Family Planning Services in Uganda (October 2018)

Interview Guide

DISTRICT HEALTH STAFF– INCLUDING HIV FOCAL PERSON, FOCAL PERSON FOR ADOLESCENT HEALTH/YOUTH FRIENDLY SERVICES, MATERNAL AND CHILD HEALTH STAFF, AND DISTRICT HEALTH EDUCATORS.

Introduction

This study is being undertaken by Socio-Economic Data Centre in collaboration with the Ministry of Health and the Office of the Prime Minister. The purpose of this study is to understand the Family Planning / Sexual Reproductive Health Services available that target young people aged 15-24, how these young people utilize these services and the factors that affect the demand and utilization of services. Your responses will be most appreciated.

Record:

District: _____

Town/sub-county: _____

Position of Respondent_____ Tel: _____

1. Please tell me the state of FP/SRHR services in this district; probe:
    - availability of specific youth-friendly services for young people
    - Who provides these services?

2. Comment on the functionality and quality of youth-friendly services

3. What changes have taken place in the scope, quality or nature of FP/SRHR services available here over the last 2 – 3 years?

4. Have any health workers in the LG received training in delivery of youth friendly FP services over the past 3 years? Probe for: Who provided the training [probe: whether NGO—specify, Local or Central Government]; How many members of staff were trained? What was the content of the training?

5. What interventions are implemented in the district to increase demand for FP/SRHR services for young people

6. What is going well in the delivery of FP services, (especially to young people (both male and female 15-24) and adult male aged 24-54 years) and where are you having challenges?

7. What suggestions do you have to create demand for FP services among young people (both male and female 15-24) and adult male aged 24-54 years?

8. What other aspects of the larger social, cultural, political, and economic environment influence the uptake of interventions?

Impact Evaluation of Government of Youth Family Planning Services in Uganda (October 2018)

Interview Guide

STAFF FROM PARTNER AGENCIES INVOLVED IN IMPLEMENTING OR SUPPORTING FAMILY PLANNING/SRHR WORK

Introduction

This study is being undertaken by Socio-Economic Data Centre in collaboration with the Ministry of Health and the Office of the Prime Minister. The purpose of this study is to understand the Family Planning / Sexual Reproductive Health Services available that target young people aged 15-24, how these young people utilize these services and the factors that affect the demand and utilization of services. Your responses will be most appreciated.

Record the following details:

Name of Partner Organization

Position of Respondent

Tel. Contact

Date, Time and Venue of Interview

Name of Interviewer & Note taker

1. How long have you been implementing FP/SRHR interventions in this area (Sub County, district or country—if interviewing national level officials?

2. What interventions have you implemented to promote FP/SRHR services for young people in this community?

3. What procedures are used to generate demand and attract young people to use services? How successful have they been?

4. What is the level of acceptance among youth of FP/SRHR services?

5. What is the level of acceptance among parents / caregivers of young people for their adolescents to use FP/SRHR services?

6. What have been the achievements so far in reaching young people with FP/SRHR services?

7. How has the utilization /demand for FP/SRHR services changed over the last 2 – 3 years?

    - What are the possible reasons for this change?

8. What are the gaps that you have so far identified in strategies, performance, and results?

9. What else should be done? If you were to re-design the project, what would you change?

10. What other aspects of the larger social, political, and economic environment influencing intervention uptake?

11. What is the potential to sustain what has been put in place? How else can the project activities and benefits be sustained?

    Thank You

Impact Evaluation of Government of Youth Family Planning Services in Uganda (October 2018)

Interview Guide

HEALTH WORKERS IN A SAMPLE OF HEALTH FACILITIES PROVIDING FAMILY PLANNING/SRHR SERVICES (HOSPITALS, HCIVs, AND HCIIIs).

Introduction

This study is being undertaken by Socio-Economic Data Centre in collaboration with the Ministry of Health and the Office of the Prime Minister. The purpose of this study is to understand the Family Planning / Sexual Reproductive Health Services available that target young people aged 15-24, how these young people utilize these services and the factors that affect the demand and utilization of services. Your responses will be most appreciated.

Record:

Name of Health Facility/Youth Corner:

_____

District: _____

Town/sub-county: _____

Position of Respondent_____

Tel: _____

1. Please tell me available FP/SRHR services at this Youth corner/health facility; probe: availability of specific FP services for young people
2. What are the ways that you use to increase demand and uptake of FP/SRHR services among young people? How effective have those ways/ strategies been? Which strategy has been most effective?
3. What is the level of service utilization of FP/SRHR services by young people over the last 1 to 2 years? [***We would like to complete this form to get some figures, please if you would help me access this information – refer to secondary data extraction form. You can first complete the interview and then fill in the form later***]
4. What more needs to be done to further generate demand for FP/SRHR services among young people?
5. What other aspects of the larger social, cultural political, and economic environment influencing family planning/SRHR service uptake?
6. Have any health workers at this facility received training in delivery of FP/SRHR services to young people over the past 3 years? Probe for: Who provided the training [probe: whether NGO—specify, Local or Central Government]; How many members of staff were trained?