Psychosocial wellbeing of adolescents accessing REPSSI programmes

REPSSI

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2022 Endline Report

Recommended Citation:
REPSSI 2022, Psychosocial wellbeing of adolescents accessing REPSSI programmes; An Endline Report.

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Acknowledgements

This Endline Report is part of REPSSIs comprehensive efforts to assess the impact of our interventions. Data is collected and analysed at the beginning and at the end of each intervention on selected indicators. The Endline Report therefore highlights interventions that have made significant impact on intended beneficiaries.

We are deeply grateful to Monica Bandeira, our Head of Monitoring and Evaluation who has led the team of authors, including Elisabeth Kirkbride and Jessica –Leigh Paul that have written this report.

Content for this report has been collected from countries where REPSSI is implementing the SIDA funded SRHR project in East and Southern Africa. We appreciate the support of the Country Directors and Representatives and all the programme teams that worked with the authors to ensure that this report was completed.

We also appreciate staff from the REPSSI Regional Office, in particular Brighton Gwezera the Head of Programmes, and Vunda Dimula, the M&E Officer that have provided consultation during this process.

Lastly, we are grateful to SIDA for providing the funding for this programme. This work would not have been possible without the implementing partners in each country who work with REPSSI to bring psychosocial support to adolescents, their families, and communities. Government departments, schools, clinics, and NGO partners across the countries worked hand-in-hand with REPSSI to ensure the successful implementation of these programmes despite challenges faced. REPSSI country staff worked hard to ensure that implementation was achieved including data collection. Finally, we thank the children and young people who took part in REPSSI interventions and agreed to participate in our research so that we can improve how we work.

Project made possible with support from

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra
Swiss Agency for Development and Cooperation SDC

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Executive Summary

Overall

In sub-Saharan Africa, adolescents (aged 0 to 14 years) make up a large portion (42%) of the population (Statista, 2022). Adolescents in Africa are particularly vulnerable given the contextual challenges they face, like unemployment, food insecurity, and violence (Kulisewa et al., 2019; Sherr & Cluver, 2017). These factors have been linked to higher levels of depression, lower levels of perceived mental health, and higher anxiety (Amroussia et al., 2017; Burke et al., 2020; Katz et al., 2018; Reibling et al., 2017; Salami et al., 2017). At the same time, there is evidence of resilience amongst African adolescents (van Breda & Theron, 2018; Ebersöhn, 2017; Woollett & Thosmon, 2016). Sources of resilience include higher self-esteem, more prosocial behaviour, positive caregiving experiences, higher social support, as well as lower exposure to violence, physical punishment, and stigma (Cluver et al., 2020; Crowley et al., 2021; Macedo et al., 2018; Shenderovich et al., 2021; van der Wal & George, 2018; West et al., 2019; Woollett & Thomson, 2016). Knowing this, this report presents findings on the changes in adolescent wellbeing before taking part in REPSSI interventions, and after.

For this report, psychosocial wellbeing was assessed using a number of scales – Child & Youth Resilience Measure-Revised (CYRM-R) developed by Jefferies, McGarrigle, and Ungar (2019); the Patient Health Questionnaire-9 (PHQ-9) which measures levels of depression (Kroenke, Spitzer, & Williams, 2001), and the Rosenberg Self-esteem Scale (Rosenberg, 1965). Adolescents across all countries completed these scales, as well as answered some demographic questions. Additional thematic-specific scales were also used such as the 7-item Generalised Anxiety Disorder (GAD-7; Spitzer et al., 2006) and the Gender Equitable Men (GEM; Pulerwitz & Barker, 2007). The questionnaire used can be found in Annex 1. Beneficiaries who were part of REPSSI's country-specific intervention were invited to complete the questionnaire before taking part in the intervention (baseline) and after the intervention had concluded (endline). Prior to this research beginning, ethical clearance was obtained from the University of Pretoria in South Africa, and protocols including distress management, data collector training, informed consent, confidentiality, and anonymity were upheld throughout this research process. It is important to note here that only statistically significant changes have been reported on.

In total, 4124 baseline responses were collected across eleven African countries, and 2266 endline responses were collected. This represents a 55% retention rate, which is moderate. Baseline and endline data were collected from respondents in Angola (197, 9%), Eswatini (91, 4%), Kenya (294, 13%), Lesotho (176, 8%), Malawi (237, 10%). Mozambique (297, 13%), Namibia (107, 5%), South Africa (366, 16%), Uganda (79, 3%), Zambia (141, 6%), and Zimbabwe (281, 12%). Data was imported into STATA v14 for statistical analysis. Both descriptive and inferential statistics were conducted to examine the distribution of all variables, assess relationships between variables, and determine differences between groups.

Of the total sample at endline, 62% were female and the mean age was 17.5 years. Significantly fewer respondents (75% to 70%) indicated that they were in school. Of those not in school, 17% had finished school and 1% were enrolled in tertiary education. The main reasons for dropping before completing school was pregnancy (25%) and not having enough money for schooling (15%). Most respondents who were in school at endline were in Grade 10 (20%). In terms of other demographic factors, the majority of respondents at baseline and endline (66%) indicated that they did not have a tap with running water in their house, and 28% of respondents at baseline and at endline indicated that they went to sleep hungry one or more days in the past week. More respondents (73% to 76%) indicated that they looked

after younger children at home and significantly more (57% to 61%) said they look after sick people at home.

Respondents were asked about the losses they have experienced in their lives. At endline, 11% of respondents indicated that their mother had died and 22% indicated that their father had died. Additionally, 4% of respondents at baseline and 5% at endline said they don't know if their mother and/or father was alive, and 5% of respondents at baseline and 6% at endline had lost both parents.

80% of respondents at endline indicated that they have never been married. Of those that were or had been married at endline, 21% reported getting married at the age of 17, and 20% reported getting married at 18 years old. 44% reported that it was not their choice to get married. More respondents (23% to 25%) indicated that they had been pregnant or gotten someone pregnant. Of these, 94% at baseline and 90% at endline reported they had been pregnant once or twice, and 5% at baseline compared to 10% at endline said they have been pregnant three or four times. Of those who said they would like to become a parent, 12% at baseline compared to 9% at endline reported wanting to become a parent between 21 and 24 years of age. Few SRH services were accessed by this group, but access to a number of products and services improved significantly from baseline to endline, such as getting condoms (6% to 10%), sanitary pads (18% to 24%), medical male circumcisions (15% to 19%), and various forms of birth control (IUD, pill contraceptive, and injection).

Indicators of psychosocial wellbeing were measured, such as resilience. For this group, the mean CYRM-R score increased from 67.7 at baseline to 68.3 at endline, which indicate high levels of resilience. Overall, 52% of respondents (1177) showed an increase in resilience enablers from baseline to endline. The most significant shifts were seen in items related to feelings of belonging and connectedness – both related to one's family and friends. For instance, more respondents said that they feel their friends care about them when times are hard "a lot" or "quite a bit" (56% to 60%). Statements related to growth and gaining independence also showed some of the most significant positive shifts, as more respondents (79% to 82%) said that getting an education was important to them. These changes point to the presence of greater resilience enablers present in the lives of respondents, or the development of more awareness of these resilience enablers.

Depression was measured using the PHQ-9. For this group, the mean score decreased significantly from 5.5 at baseline to 4.7 at endline, which indicates mild depression or mental health distress. 52% of respondents (1178) from baseline to endline showed a decrease in depression scores and 11% more respondents (12% to 23%) did not experience any depression symptoms according to the PHQ-9. Change related to the PHQ-9 was arguably some of the most significant, as all of the items on the scale showed significant change from baseline to endline. Respondents reported reduced physical symptoms of depression, and fewer feelings of hopelessness. For instance, 54% of respondents reported that they did not experience poor appetite or overeating at all at baseline which increased to 63% at endline, and 68% at baseline compared to 75% at endline responded that they did not experience "Moving or speaking so slowly that other people could have noticed. Or the opposite" at all. Positive coping mechanisms such as social connections have been shown to increase resilience and help mitigate mental health difficulties such as depression (WHO, 2022A). Therefore, the increasing presence of resilience enablers could be the reason for the declining rates of depression as research has consistently demonstrated an inverse relationship between depression and resilience whereby higher levels of resilience are related to fewer mental health problems (Anyan & Hjemdal, 2016; Mesman et al., 2021).

The Rosenberg Self-Esteem Scale was used to assess adolescent's levels of **self-esteem**. A reasonably high degree of self-esteem is considered an important ingredient of mental health, whereas low self-esteem and feelings of worthlessness are common depressive symptoms (APA, 2020b). **The mean score for this group increased significantly from 28.9 at baseline to 29.5 at endline**. These scores are within the normal self-esteem range. **53% of respondents (1210) showed an increase in self-esteem scores** from baseline to endline. As with the PHQ-9 changes, all the changes on the Rosenberg Self-Esteem Scale were found to be significant. Some of the most notable changes included more respondents strongly agreeing with "On the whole, I am satisfied with myself" (44% to 52%), as well as "I feel that I have a number of good qualities" (34% to 43%). Again, given that the literature has shown the negative impact of COVID-19 on adolescents and youth, including increased stress, depression, a lack of psychosocial support, and low self-esteem (Sikhangezile & Modise, 2020), it is encouraging that respondents in this sample were able to increase their resilience, mental health, and self-esteem against a backdrop of mounting mental and physical health stressors. Also, as self-esteem has been highlighted as an enabler of resilience and of mental health, it makes sense that scores have increased as they are all inter-connected. Finally, all respondents were asked to what **degree they felt safe at home, in school, and in the community**, and to what degree they felt unsafe. **All four changes were found to be statistically significant, with all changes indicating greater feelings of safety, except for the change related to feeling safe at school.**

The changes above are especially positive given that the effects of COVID-19 not only create new challenges, but also intensify existing vulnerabilities and inequalities. Knowing this, it is expected that individuals (particularly those in adverse contexts) would experience worse mental health outcomes, more violence, greater food insecurity, reduced self-esteem, heightened stress, and take more risks. Therefore, any indication that individuals have remained at the same level they were at before or during the pandemic (baseline) is significant, and those who have improved since then is even more significant.

Thematic areas

The thematic-specific sections of this report cover a range of topics which are known to play a part in psychosocial wellbeing: HIV, early and unintended pregnancy (EUP), access to supportive healthcare services, feelings of connection, and exposure to violence. In addition to the above core sociodemographic and psychosocial wellbeing questions that were asked across all countries and thematic areas, additional questions were asked across countries who had similar thematic areas.

In **Angola, Namibia, and Zambia**, analysis showed that **40% of respondents experienced increased support received from schools, and significantly more respondents indicated that they had visited a health facility for health services in the previous 6 months**. For instance, **77% of respondents at baseline compared to 86% at endline said the healthcare provider made them feel comfortable, and 62% at baseline compared to 73% at endline reported that their school gives learners support to catch up with work when they have to miss class due to illness.** In **Kenya and Mozambique, respondents also felt more supported to access SRHR services at endline than they did at baseline**. The average number of forms of support from schools increased significantly (2.7 to 3.1) as did the average number of forms of support from health facilities (6.0 to 6.6). In **Uganda**, REPSSI worked with Transcultural Psychosocial Organisation (TPO) Uganda and other partners including Office of the Prime Minister (OPM) to promote social connectedness in the provision of health, education, and SRHR services, as well as support for families and communities to provide enhanced PSS, care, and protection to children, adolescents, and youth in emergency settings. Here, results were slightly different to the above as **fewer respondents**

(54% to 49%) indicated that they had visited a health facility for health services in the last six months, and support from schools did not improve. For instance, significantly more respondents (58% to 75%) said their teachers insisted on seeing their medical files. However, significantly more respondents who visited a health facility said they believed the information they shared with the healthcare provider would be kept confidential (42% to 64%) which could indicate an enhanced understanding of the principals of health service provision and a greater trust in healthcare providers.

Other significant changes in Namibia, Angola, and Zambia included the age at which respondents thought a girl should be when she first has sex; 3% fewer respondents (5% to 2%) indicated that a girl should be 12 years old and 3% more (17% to 20%) indicated that a girl should be 18 years old. Significantly more respondents also indicated that they have had sex (19% to 36%). Similar significant changes were also seen in Kenya and Mozambique, where more respondents at endline thought that girls (23% compared to 30%) and boys (22% compared to 28%) should be 18 years old when they first have sex, and significantly more respondents (17% to 31%) indicated that they have had sex. In Uganda, there was a significant difference between the ages at which respondents thought a girl versus a boy should become sexually active. 4% fewer respondents (24% to 20%) thought a girl should be 18 years old and 15% fewer (28% to 13%) thought a boy should be 18 years old. Also in Uganda, anxiety was measured using the GAD-7. Analysis showed that respondents were experiencing less mental health distress at endline than at baseline, as average scores decreased significantly (4.1 to 2.8) and more than half (57%) of respondents showed a decrease in anxiety scores from baseline to endline.

Zimbabwe and Malawi saw many significant changes from baseline to endline. For instance, the number of children that adolescent mothers had given birth to increased significantly from baseline to endline. 2% more mothers (85% to 87%) had given birth to one or two children and 4% more (5% to 9%) had given birth to three or four children. The amount of support mothers received from the father of their child[ren] also increased, where significantly more mothers said they receive financial support (46% to 63%) and emotional support (21% to 38%). Additionally, mothers reported having more employed adults in their household at endline than at baseline, and significantly more mothers reported having their own source of income (20% to 39%). Perhaps related to this was the finding that levels of parental stress declined significantly from baseline to endline, and 65% of mothers showed decreased parental stress levels. This was seen in changes like 24% of mothers at baseline compared to 57% at endline strongly agreeing with the statement "I feel close to my child(ren)." Additionally, mothers showed increased resilience, and just over half (51%) showed increased resilience scores from baseline to endline. In contrast to these positive findings, there was a significant increase in experiences of intimate partner violence (IPV), with 27% of mothers showing an increase in IPV from baseline to endline.

Results from adolescent fathers in Zimbabwe were also analysed and showed significant improvements in their gender attitudes. The majority (72%) showed more positive gender attitudes from baseline to endline, including 48% of men disagreeing with the statement "If someone insults a man, he should defend his reputation with force if he has to" at baseline compared to 81% at endline. In addition, fathers showed increased resilience, with the average BRS score increasing significantly (18.3 to 19.5) which suggests higher levels of resilience. Just over half (55%) showed increased resilience scores from baseline to endline. Related to this, parental stress levels of adolescent fathers decreased significantly from baseline to endline, with the average scores declining from 49.8 at baseline to 42.0 at endline. The majority (72%) showed decreased parental stress. In contrast to adolescent mothers experiencing more violence, there was a significant decrease in the average number of forms of IPV that were experienced by the fathers.

Lesotho was the only country where data on child marriage was collected. Interesting findings included that at baseline, the highest percentage of respondents (23%) indicated that the proper age for a girl to marry is 20 years old, while at endline most (26%) indicated age 25. Findings revealed that respondents thought that the proper age for a girl to marry is younger than for a boy. Related to this, the attitudes to child marriage questionnaire explored views and feelings about child marriage. Overall, there was a positive shift and 59% of respondents showed more attitudes against child marriage from baseline to endline. Positive findings included more respondents (54% to 66%) disagreeing or strongly disagreeing with the statement "Younger wives are better because they obey their husbands more." Additionally, significantly more respondents felt that a child could do something to stop getting married (64% to 78%), such as ask the police to stop it (35% to 46%). In contrast, there was a significant decline in beliefs of the negative consequences of child marriage (4.7 to 3.2). This indicates that, on average, respondents identified significantly fewer negative consequences to child marriage at endline than they did at baseline.

In response to the high levels of GBV in South Africa and Eswatini, REPSSI implemented a GBV-prevention project. Significant findings included the fact that after the intervention, more respondents had told friends not at their school about their victimisation experience (17% to 25%), and more respondents after the intervention (26% to 82%) reported they had engaged in activities to prevent GBV. As with the adolescent fathers in Zimbabwe, gender attitudes were more positive after the intervention than before, with more than half (56%) showing improved gender attitudes.

List of Acronyms

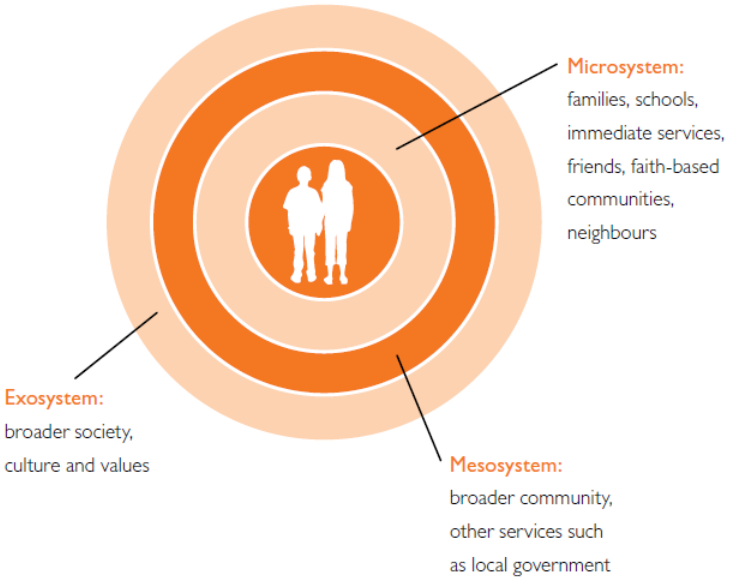
ADECC	Associação Para o Desenvolvimento Comunitário
ALHIV	Adolescents living with HIV
APA	American Psychological Association
ART	Anti-retroviral treatment
BRS	Brief Resilience Scale
CBCC	Community-Based Child Care
CYRM-R	Child and Youth Resilience Measure-Revised
DRC	Democratic Republic of Congo
EUP	Early and unintended pregnancy
ECD	Early childhood development
GAD	Generalised Anxiety Scale
GBV	Gender-based violence
GEM	Gender Equitable Men
HIV	Human immunodeficiency virus
IPV	Intimate partner violence
KORDP	Kenya Orphans Rural Development Program
KICOSHEP	Kibera Integrated Community Self-Help Programme (Uganda)
MECIAM	Malawi Early Childhood Initiative for Children of Adolescent Mothers
MHPSS	Mental Health and Psychosocial Support
NDoH	National Department of Health
OPM	Office of the Prime Minister (Uganda)
PHQ-9	Patient Health Questionnaire-9 item
PHIA	Population-based HIV Incidence Assessments
PTSD	Post-traumatic stress disorder
PSS	Psychosocial Support
REPSSI	Regional Psychosocial Support Initiative
SRHR	Sexual reproductive and health services
STI	Sexually transmitted infection
SAMRC	South African Medical Research Council
SADC	Southern African Development Community
TPO	Transcultural Psychosocial Organisation (Uganda)
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation
YWCA	Young Women's Christian Association

Context

In sub-Saharan Africa, adolescents (aged 0 to 14 years) make up a large portion (42%) of the population (Statista, 2022). Adolescence is a critical stage of development during which individuals are vulnerable to many risks, and at the same time, they are exposed to opportunities for development. Adolescents in Africa are particularly vulnerable given the contextual challenges they face (Kulisewa et al., 2019; Sherr & Cluver, 2017). Factors like low income, unemployment, inequality, food insecurity, and violence have been linked to higher levels of depression, lower levels of perceived mental health, and higher anxiety (Amroussia et al., 2017; Burke et al., 2020; Katz et al., 2018; Reibling et al., 2017; Salami et al., 2017). At the same time, there is evidence of resilience amongst African adolescents who are able to mobilise available protective resources to buffer against hardship and thrive even under severe adversity (van Breda & Theron, 2018; Ebersöhn, 2017; Woollett & Thosmon, 2016). Sources of resilience include higher self-esteem, more prosocial behaviour, positive caregiving experiences, higher social support, as well as lower exposure to violence, physical punishment, and stigma (Cluver et al., 2020; Crowley et al., 2021; Macedo et al., 2018; Shenderovich et al., 2021; van der Wal & George, 2018; West et al., 2019; Woollett & Thomson, 2016). The sections below consider these factors in some depth, and also provide country-specific contextualisation.

COVID-19

REPSSI's focuses is on mental health and psychosocial wellbeing and the links between this and social, health, and education outcomes for youth. This focus means that one needs to take a number of factors into consideration which can influence this wellbeing. Not only this, but to better understand the results of this report in context, it is important to know how COVID-19 has impacted adolescents in sub-Saharan Africa during the implementation of these projects. To do this, Bronfenbrenner's (1979) Ecological Systems Theory can be used to better understand the effects of COVID-19 disruptions on individuals. This theory explores how one's environment is multi-layered, and how these layers create a larger ecological system which impacts directly on a person.



COVID-19 has impacted all layers of this system, as individuals, networks, communities, and society have been affected in a multitude of ways. To better understand these impacts, one study conducted by Gittings et al. (2021) qualitatively explored and documented the experiences, challenges, and coping strategies of adolescents from the Western and Eastern Capes of South Africa during the Level 4 COVID-19 lockdown. The findings from this research highlighted some of the broader-level consequences of the COVID-19 pandemic responses such as aggravated poverty, job losses, changes in the provision of social services, heightened domestic violence, and increased food insecurity. Deaths due to the redirection of critical resources to respond to the pandemic, housing losses, increased mental illness, increased adolescent pregnancy, and school dropouts have also been highlighted as grave broader-level consequences of the COVID-19 pandemic in many countries (Yoshikawa et al, 2020). Of course, these broader-level challenges have an impact on individuals (as demonstrated by the above ecological systems model) including increased stress levels and reduced psychosocial wellbeing (Octavius et al., 2020). For example, Sikhangezile and Modise (2020) found that during COVID-19, Zimbabwean youth have been experiencing stress, depression, a lack of psychosocial support at home, a loss of feeling of control over one's life, low self-esteem, and a loss of aspiration. Lockdown itself has been shown to have affected young people's mental health, as it has effectively cut them off from sources of social support from extended family and friends.

Most of the REPSSI interventions were school-based, and there is recognition of the negative impact of COVID-19 on adolescents in school in particular. As many schools were closed due to lockdowns, young people were especially cut off from their peers and friends, meaning that young, school-going people have experienced a lack of peer support, academic learning, play, and opportunities to learn social skills (Sikhangezile & Modise, 2020; Jansen, 2020). In line with this, a 2021 MIET Africa report on the impact of COVID-19 on SADC youth (based on the analysis of data from interviews, an online survey, and focus group discussions with 381 respondents) showed that 62% of the youth respondents reported feeling sadder due to lockdowns, and just under three-quarters of the youth respondents reported feeling more worried now than they did before the pandemic. This report also highlighted increased instances of substance abuse by adolescents during lockdown, as well as an increase in gender-based violence (GBV). Child Helplines in Zimbabwe, South Africa, and Madagascar noted a 15–27% increase in calls

received from young people reporting GBV, with cases of forced marriage also being reported (MIET Africa, 2021).

Along with the above, it is also important to consider who is most affected, and that some individuals will be more negatively affected than others for a variety of reasons (WHO, 2022A). Gittings et al. (2021) highlight that the negative consequences discussed above may be especially prominent amongst young people living in contexts of precarity and limitation. Adolescents; young parents; women; working class individuals; those with pre-existing mental health challenges; and those who are already lacking sufficient social support were highlighted as being most affected by the negative consequences of COVID-19 (Gittings et al, 2021; Parker, Morris & Hofmeyr, 2020; WHO, 2022A; WHO, 2022B; Octavius et al., 2020). Therefore, the effects of COVID-19 not only create new challenges, but also intensify existing vulnerabilities and inequalities. It is therefore vital to keep in mind these kinds of COVID-19-related impacts on the micro-, meso-, and exo-systems in terms of how these have impacted the beneficiaries of this project, the families and peers of beneficiaries, project implementers and staff, government and social services, and communities, and to consider these impacts alongside the results presented in this report. Knowing this, it is expected that individuals (particularly those in adverse contexts) would experience worse mental health outcomes, more violence, greater food insecurity, reduced self-esteem, heightened stress, and take more risks. **Therefore, any indication that individuals have remained at the same level they were at before or during the pandemic (baseline) is significant, and those who have improved since then is even more significant.** To further understand the results presented below, a literature review outlining key findings related to psychosocial wellbeing and the thematic-specific areas of REPSSI's projects is presented below.

Psychosocial wellbeing

The World Health Organisation's (WHO) definition of mental health is "a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2020A, p. 12). In this research, good mental health is reflected in low levels of depression and high levels of self-esteem. These were measured through the Patient Health Questionnaire-9 (PHQ-9) which measures levels of depression, and the Rosenberg Self-esteem Scale, respectively. Psychosocial wellbeing is a multidimensional construct that incorporates psychological, social, physical, economic, emotional, cultural, and spiritual determinants of health (Kumar, 2020). It includes the full range of what is good for a person, such as feeling happy and hopeful, having positive social relations and a supportive environment, coping with challenges through the use of appropriate life skills, and having security, protection, and access to quality services (INEE, n.d). The following sections consider resilience, depression, and self-esteem as part of psychosocial wellbeing, but it should be remembered that these factors are very much inter-connected and have only been separated below for ease of understanding and discussion.

Resilience

Resilience, or the ability to navigate to the resources that can sustain wellbeing, is seen as an important buffer against the negative impact of the challenge's adolescents are confronted with (van Breda & Theron, 2018). As mentioned above, research has shown that despite experiencing high-risk factors due to poverty, individuals continue to adapt to adversity and express wellbeing (Ebersöhn, 2017). For instance, in their critical review of South African child and youth resilience studies, van Breda and Theron (2018) identified four resilience-enablers, namely personal (such as agency and meaning-making), relational (including support and opportunities for growth), structural (like financial wellbeing

and community safety), and spiritual or cultural (such as spiritual beliefs and cultural values). The literature highlights the positive contribution improved resilience can have on the wellbeing of adolescents in Africa, and researchers like Casale et al. (2019) suggest strengthening social support and community-based interventions to protect at-risk adolescents from poor mental health. Related to resilience is empowerment, which can be understood as the bridge that connects individual power (like resilience) to social power (Brodsky & Cattaneo, 2013). Therefore, resilience is an important part of any empowerment efforts, as work within the individual is important before any meaningful and sustainable work can be done in the social. Protective resources which may be resilience-enabling have been measured using the Child & Youth Resilience Measure-Revised (CYRM-R) developed by Jefferies, McGarrigle, and Ungar (2019). The Child and Youth Resilience Measure (CYRM) is a measure of the resources (individual, relational, communal, and cultural) available to individuals that may bolster their resilience.

Depression

This research follows the American Psychological Association's (APA) definition of depression, which is "a negative affective state, ranging from unhappiness and discontent to an extreme feeling of sadness, pessimism, and despondency, that interferes with daily life..." (APA, 2020a). Depression is a significant problem in many contexts, and a cross-sectional study with adolescents (10–19-year-olds) in six sub-Saharan African countries (Burkina Faso, Ethiopia, Ghana, Nigeria, Tanzania, and Uganda) found depressive symptoms and suicidal behaviour to be common, but associated with factors that can be prevented, such as food insecurity, poor access to health care, and substance use (Nyundo et al., 2019). Similarly, in Namibia, preventable factors like early and unintended pregnancy (EUP); HIV; poor diet; substance use; and multiple sexual partners have been shown to contribute to mental health distress (Peltzer & Pengpid, 2017). In Uganda, the prevalence of major depressive disorder was found to be 18% amongst urban adolescents (Kyohangirwe et al., 2019) and 11% amongst adolescents from Central Uganda (Nalugya-Sserunjogi et al., 2016). It is important to note here that the COVID-19 pandemic has resulted in a loss of income, and this has adversely affected food security, household dynamics, and healthcare-seeking behaviour, worsening adolescent depressive symptoms (Enane et al., 2021; Pinchoff et al., 2021). For example, Pinchoff et al. (2021) found that adolescents had 2.5 higher odds of depressive symptoms if COVID-19 was causing them to skip meals and if their adult head of household reported depressive symptoms. Adolescents also had 2.5 higher odds of skipping necessary health services if their adult head of household had lost full income (Pinchoff et al., 2021).

Even without considering the compounding impacts of COVID-19, mental illness is rife. A study conducted by Quarshie et al. (2021) on adolescents between the ages of 12 and 17 in Eswatini found that 17% of the participants reported to have had suicidal ideation, 21% made a suicide plan, and 15% had attempted suicide in the past 12 months. In Kenya, Osborn et al. (2020) identified a high prevalence of depressive symptoms (46%) among adolescents (n=658) aged 13 to 19 years. Additionally, using data from the 2015 Mozambique Global School-Based Health Survey to conduct a cross-sectional study of 1918 in-school adolescents, Amu et al. (2020) found that the prevalence of psychosocial distress among in-school adolescents in Mozambique is relatively high (21%) compared to rates found in studies in other sub-Saharan African countries (Amu et al., 2020; Siziya & Mazaba, 2015; Seidu et al., 2021). While there are many factors which contribute to these high rates of mental illness and distress, research from Kenya (Mutavi et al., 2018), South Africa (West et al., 2019; Swain, Pillay, and Kliewer, 2017), Malawi (Brar et al., 2020; Skeen et al., 2016), Uganda (Nalugya-Sserunjogi et al., 2016), Zimbabwe (Munetsi et al., 2018), and Tanzania (Cherenack et al., 2020) found significant associations between exposure to violence, post-traumatic stress disorder (PTSD) and depression in adolescents. On the other hand,

factors such as social support and self-esteem have been identified as protective (Gentz et al., 2021; Besthorn et al., 2018; Kalomo, 2018).

Self-esteem

Self-esteem is defined as "the degree to which the qualities and characteristics contained in one's self-concept are perceived to be positive […]. A reasonably high degree of self-esteem is considered an important ingredient of mental health, whereas low self-esteem and feelings of worthlessness are common depressive symptoms" (APA, 2020b). In a quantitative study of depressive symptoms in Namibia, Kalomo (2017) found that HIV stigma, self-esteem, and social support were all significantly associated with depression, and that HIV-related stigma was the largest risk factor. Importantly, self-esteem was found to be the largest protective factor with respect to depressive symptoms. This means that improving self-esteem could assist in mitigating experiences of depression. Here, the ways in which various psychosocial wellbeing indicators are linked is evident. Similarly, in their qualitative study on adolescent pregnancy in Eswatini, Niemeyer Hultstrand et al. (2020) found that factors such as poor community conditions and low self-esteem contributed to young women in the community's decisions to engage in relationships which often involved abuse, inequality, and unprotected sex, which oftentimes led to unplanned pregnancy.

HIV

Briefly mentioned above, HIV is intertwined with psychosocial wellbeing. In 2021, 1.5 million new individuals were infected with HIV, and there are currently more than 38 million people living with HIV (UNAIDS, 2022). According to Statista (2022), out of all the countries in the world, countries in sub-Saharan Africa have the highest rates of HIV. Eswatini (28%), Lesotho (21%), and Botswana (19%) have the highest rates of HIV in the world, followed by South Africa (18%), Namibia (12%), and Zimbabwe (12%). However, some groups have been found to be more at-risk than others. For instance, in Eswatini, Mavundla (2020) found that a woman is two to four times more likely to be infected with HIV than a man, with female adult HIV prevalence being 35% compared to male prevalence of 19%. In a study conducted in Mozambique, not only were adolescents (particularly female adolescents) found to be most at risk and most affected by HIV, but adolescents (between 15 and 19 years of age) living with HIV have been shown to have worse HIV care outcomes compared to adults and children as they experience limited knowledge and understanding of HIV and ART, as well as lower rates of testing, antiretroviral therapy coverage, adherence, and viral suppression (Lamb et al., 2015; Nachega et al., 2009; Teasdale et al, 2021). Further evidence of this comes from research from the Population-based HIV Incidence Assessments (PHIA) conducted in Eswatini, Lesotho, Malawi, Zambia, and Zimbabwe which found that only 56% of adolescents living with HIV (ALHIV) were aware of their HIV-positive status, and among

those who know their status, just 50% were on anti-retroviral treatment (ART) and 35% on ART had a suppressed viral load (Low et al., 2020).

Not only is HIV itself a major concern, but as mentioned in the preceding section on depression, a number of studies have shown a link between depression and ALHIV (Kulisewa et al., 2019; Sherr and Cluver, 2017). For example, among ALHIV in Malawi, 19% were found to be depressed (Kim et al., 2015). Moreover, research on ALHIV in Uganda found a prevalence rate of 52% for clinical depression, which was found to be linked to fewer economic and social supports (Cavazos-Rehg et al., 2020). Additionally, research on the psychological wellbeing and adherence to antiretroviral therapy (ART) of ALHIV in Zambia found that 25% showed a high prevalence of depressive symptoms (Okawa et al., 2018), and in South Africa, Dietrich et al. (2016) reported that 33% (262/789) of ALHIV met the criteria for probable depression, while Buckley et al. (2020) found a prevalence of 14% for depressive disorder, 35% suicidality and 22% PTSD symptoms (n=162). In Angola, being HIV-positive has also been associated with high levels of emotional distress and poorer mental health outcomes in pregnant women who have HIV compared to pregnant women without HIV (Bernatsky et al., 2007).

Adolescent and young mothers

Adolescent pregnancy occurs in all countries, but adolescent pregnancies are more likely to occur in marginalised communities, communities facing poverty, communities with limited formal education, and those with limited access to employment opportunities (UNICEF, 2013). Commonly cited reasons for adolescent pregnancy include the pregnancy being unplanned, early marriage, sexual violence, wanting a child, poor knowledge of contraceptives, and limited knowledge of and access to sexual and reproductive health and rights (SRHR) services (Ehlers, 2010; Kurebwa, 2017; Mbawa et al., 2018). The WHO (2020B) reported that in developing areas, an estimated 21 million girls aged 15 to 19 years become pregnant every year and approximately 12 million of these girls give birth. Even more concerning is that during COVID-19, Shikuku et al. (2021) found increasing trends for adolescent pregnancy, adolescent maternal deaths, and stillbirths. Complications during pregnancy and childbirth are the leading cause of death for this age group of girls, and babies of adolescent mothers face higher risks of low birth weight, preterm delivery, and severe neonatal conditions (Neal et al., 2015). On top of this, adolescent mothers face challenges and risks like increased mental illness, social stigma, dropping out of school, a lack of support, heightened violence, reduced educational and employment opportunities, limited access to services and support, and greater risk of HIV (Toska et al., 2020; Kumar et al., 2018). Other challenges have been evidenced in studies like that of Owolabi et al. (2017) which reviewed the standard of antenatal care in 13 countries in West Africa. Using Demographic and Health Survey data, this research found that adolescent mothers started receiving antenatal care later on in their pregnancy than adults and young adults did, and they had fewer antenatal visits which meant that they received less prenatal and antenatal care than older women did. Additionally, depression is common among pregnant adolescents (Osok et al., 2018). In Kimbui et al.'s (2018) study in Kenya, more than half (52%) of the sample of pregnant adolescents study were found to have severe depression according to Becks Depression Inventory. Niemeyer Hultstrand et al. (2020) investigated underlying factors that could contribute to the high prevalence of teenage pregnancies and found low self-esteem, poor community conditions (which also contributed to women engaging in transactional relationships characterised by abuse, gender inequality, and unprotected sex), and limited access to birth control contributed to high adolescent pregnancy rates.

SRHR and health services

Adolescents, young women, and young men face obstacles in accessing SRHR services. Reasons for this include barriers which exist within families, like low levels of support or communication; denial of adolescent sexual desire and activity by adults; and poor understanding of risk by adolescent girls and boys (Shatilwe et al., 2022). Other barriers are related to community norms and values such as stigma, discrimination, and low levels of community support for adolescent SRHR services. Still others are structural and related to the provision of services such as: absence of age-appropriate services; restrictive practices in some settings such as the need for parental/caregiver/spousal consent to access SRHR services; economic factors; distance to health facilities; and inadequate training of staff (Shatilwe, 2022). For example, long travel hours to reach the nearest clinic was one of the leading challenges found to be affecting accessibility and utilisation of healthcare for pregnant adolescent girls in Namibia (Shatilwe et al., 2022). In Zimbabwe, Ehlers (2010) conducted a quantitative study to identify factors which hindered adolescent mothers' access to contraceptives. Structured interviews with 43 adolescent mothers revealed that a lack of sex education before puberty, concerns over infertility after using contraceptives, and not knowing about contraceptives (including emergency contraceptives and termination of pregnancy options) all contributed to adolescent mothers not using contraceptives (Ehlers, 2010). This is concerning, as access to SRHR and other health services is important for a number of reasons. Studies show that access to prenatal care significantly influences pregnancy outcomes. In 995 Angolan women aged 13 to 46, Nimi et al. (2016) found that inadequate prenatal care visits were more common in younger, less educated, poorer women, those who use public hospitals, and those who felt more dissatisfied with care. This is a worry, as having fewer visits (as well as late entry into care) have been found to be significantly associated with low birth weight and preterm delivery (Nimi et al., 2016). Proper and timely care is not only important for adolescent mothers, though. In Adams' (2021) study, ALHIV identified the following factors as enabling them to overcome stigma: (1) HIV knowledge and future-oriented goals; (2) disclosure to others; (3) medication-taking strategies and strategic disclosure; and (4) a supportive clinic environment. Therefore, adolescents could seriously benefit from adolescent-friendly healthcare services (Falcão et al, 2021; Teasdale et al, 2021). These include things like accessible services (including expanded clinic hours and training healthcare providers on adolescent care), peer support, and support from caregivers (Reif et al, 2020; MacPherson et al, 2015).

Violence

Violence has been mentioned a few times in the preceding sections, again highlighting how these factors are all interlinked. GBV is understood as "violence that is directed at an individual based on [their] biological sex OR gender identity. It includes physical, sexual, verbal, emotional, and psychological abuse, threats, coercion, and economic or educational deprivation…" (Ott, 2017). IPV is understood as violence committed by a partner and includes "any behaviour within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship. Examples of types of behaviour are… acts of physical violence; sexual violence; emotional (psychological) abuse; intimidation; [and] controlling behaviours (WHO, 2012). Whilst violence can affect both males and females, females are particularly vulnerable to GBV and IPV, including emotional, physical, and sexual violence. This sort of violence puts women's physical and psychological health at risk. Physical problems include trauma to reproductive organs, acquisition of sexually transmitted infections (STIs) including HIV, unwanted pregnancies leading to unsafe abortions, whilst psychological trauma manifests as depression, low self-esteem, poor school performance, and school dropout (Mapiko & Chinyoka, 2017).

A survey conducted with 1394 randomly selected men living in Cape Town in South Africa found that 41% of participants had physically abused a female partner within the last 10 years (Abrahams, Jewkes & Lauscher, 1999) and a survey conducted by Statistics South Africa (Stats SA), the South African Medical Research Council (SAMRC), and the National Department of Health (NDoH) found that 28% of women over the age of 18 had experienced emotional, physical, or sexual violence from a partner. Additionally, in a study conducted in Kenya with 2360 female adolescents (aged 11-15 years), one-third had experienced at least one form of violence (Kabiru et al., 2018) and in Zimbabwe, about 2 in 5 women reported experiencing physical or sexual violence in their lifetimes (ZimStat & UNICEF, 2019).

While the prevention of GBV is the focus of a number of REPSSI's country-specific projects, exposure to other forms of violence is also important to consider in relation to psychosocial wellbeing, as exposure to violence is associated with depression, suicidality, substance abuse, reproductive health issues, and low self-esteem (Mathur et al., 2018; Mutavi et al., 2018). For instance, research from South Africa (West et al., 2019; Swain, Pillay, and Kliewer, 2017), Malawi (Brar et al., 2020; Skeen et al., 2016), Kenya (Mutavi et al., 2018), Uganda (Nalugya-Sserunjogi et al., 2016), Zimbabwe (Munetsi et al., 2018), and Tanzania (Cherenack et al., 2020) found significant associations between exposure to violence, post-traumatic stress disorder (PTSD) and depression in adolescents, pointing to the impact violence can have on mental health and the need to address this. Moreover, Verhey et al. (2018) found significant associations between exposure to violence, PTSD, and depression in adolescents, and Amu et al. (2020) found that those who have been bullied, those who have been attacked, and/or those who have attacked others were shown to have higher probabilities of being psychosocially distressed, again pointing to the negative impact that violence can have on mental health (Peltzer & Pengpid, 2020).

Methodology

Data collection

The tools used during this research (Annex 1) focussed on gathering data on the psychosocial wellbeing and mental health of children and adolescents. The tools selected were based on REPSSI's definition of what is included in psychosocial wellbeing. Existing tools that have been used in similar contexts were identified to cover the aspects outlined by REPSSI. The tool is divided into two sections. The first section was completed by all participants and covers demographic questions that may influence or impact on psychosocial wellbeing, psychosocial wellbeing scales, and access to SRHR services. The second section has questions linked to the specific thematic areas covered per country.

Data analysis

Once all responses were collected, data was uploaded into a cloud-based server which uses data encryption in transit, at rest, and on all backups. Confidentiality was maintained throughout all study procedures by storing locator information separate from participant data. The only limit to confidentiality was in the case of a team member learning of child abuse, in which case mandatory reporting requirements for the relevant country would have been followed. This was not found in this sample. Given the research design, quantitative data collection and analysis was used. The primary analysis focused on the description of the wellbeing status of respondents. Data was imported into STATA v14 for statistical analysis. Both descriptive and inferential statistics were conducted to examine the distribution of all variables, assess relationships between variables, and determine differences between groups.

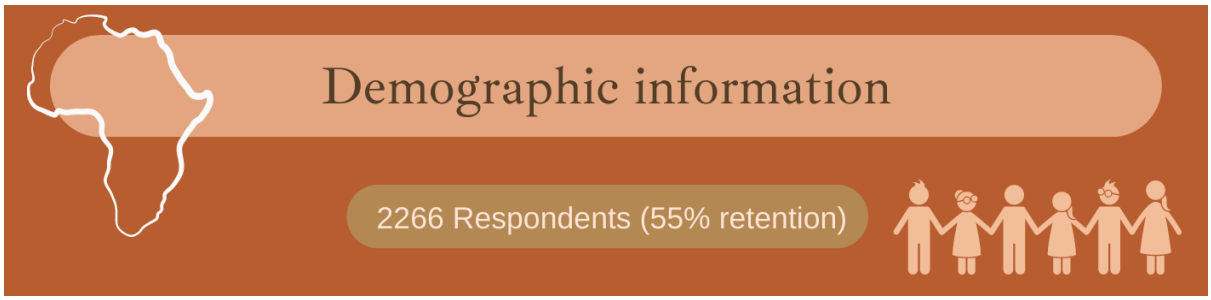
Ethical considerations

Prior to this research beginning, ethical clearance was obtained from the University of Pretoria in South Africa where REPSSI is headquartered, as the same data has been collected across different countries as part of REPSSI's monitoring and evaluation. While the questionnaire posed no more than minimal risk to participants, the study population of adolescents represents a high-risk group. We therefore implemented additional safety monitoring. We took steps to minimise risk through the careful training and selection of data collectors, sensitive data collection procedures, and the development of a Distress Protocol. The Distress Protocol outlines steps to be taken if abuse, maltreatment, or mental health problems were suspected and included contact details of relevant organisations that participants could be referred to within the country. Non-probability purposive sampling was used whereby adolescents involved in the intervention were invited to participate. An adolescents' decision to participate in the research did not affect their eligibility to participate in the intervention. Data collection processes varied slightly from country to country, but there were some commonalities. In all countries, data collectors were required to have various qualifications and/or experience which made them suitable and appropriate data collectors for this research. All data collectors received at least 2 days of training, and the research purpose, process, forms, and data collection tools were explained during this training. Moreover, respondent participation was voluntary, and consent and/or assent was obtained prior to any research beginning. Once consent and/or assent was obtained, one-on-one interviews took place and data was captured using either tablets or smartphones. Additionally, participants whose responses indicated severe mental health distress were followed up with. Participants benefitted from participation in the interventions, not directly from the accompanying research.

Limitations

There is no control group and limited qualitative data which affects the degree to which changes can confidently and solely be attributed to the intervention, as there may have been other factors at play which have not been controlled for. Also, this sample includes participants in specific interventions, so they are not randomly selected. This limits the generalisability of this research as the sample is not entirely representative of a larger population. However, these results do provide evidence of significant change for a number of individuals who were involved in this intervention. Future research could include a control group and could also include qualitative analysis to investigate what the participants themselves thought could be contributing factors to their change in scores (both positive and negative changes).

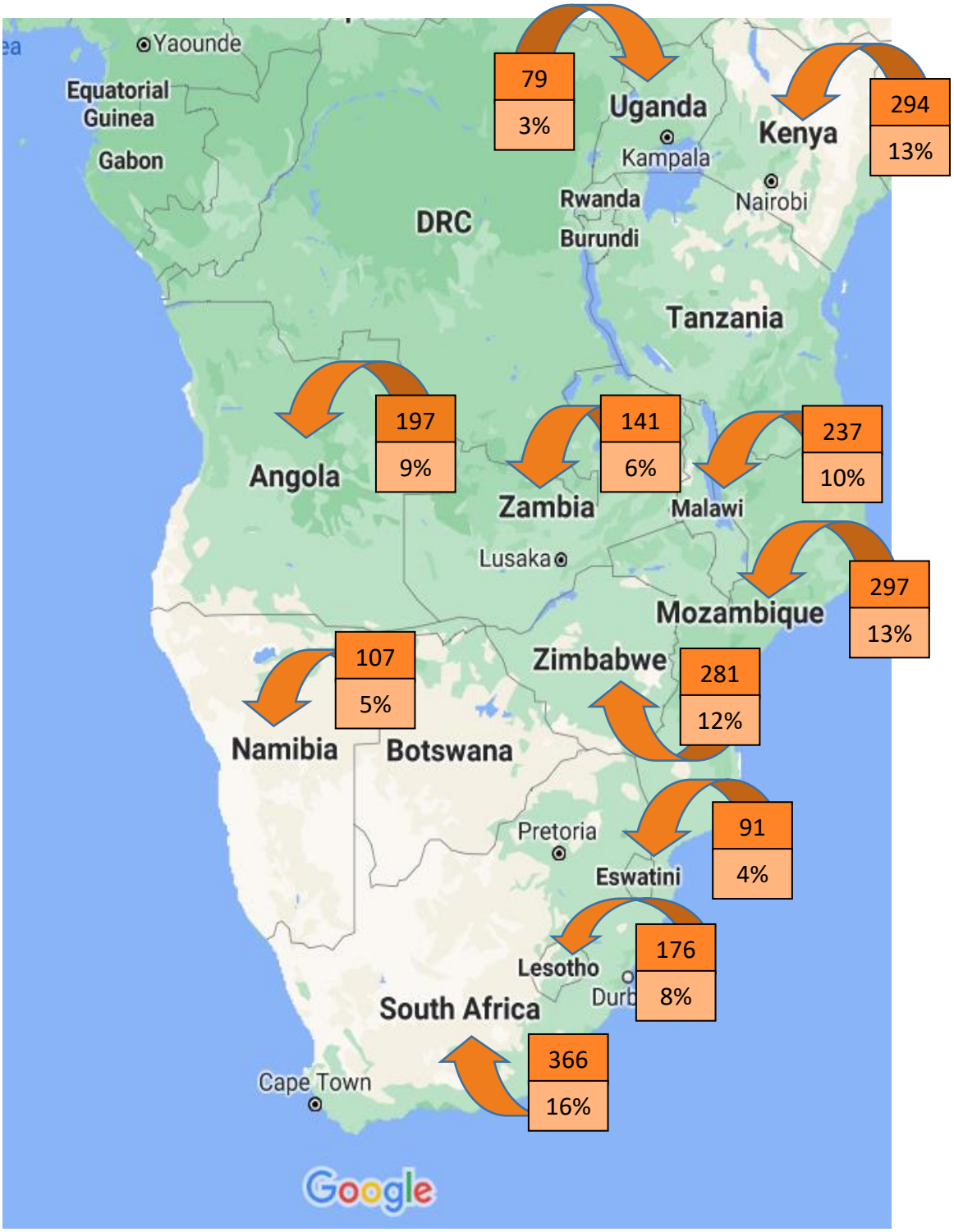
Results Overall



A total of 4124 baseline responses were collected across eleven African countries, and 2266 endline responses were collected. This represents a 55% retention rate of respondents from baseline to endline. There is considerable variation in what can be considered a good retention rate as it depends on a number of factors such as sample size, time between assessment points, and reasons for non-retention. In this context, the retention rate can be considered moderate. Some of the reasons for not being able to obtain endline responses include respondents relocating; not attending an intervention session or initial meeting; being unavailable to take part in the endline assessment due to communication challenges (phones not reachable or numbers not working); or data inconsistencies.

The number of baselines and endlines per country is reflected in the table and figure below:

Country	# of baselines	# of endlines	# of dropouts	% retention rate
Angola	385	197	188	51%
Eswatini	128	91	37	71%
Kenya	391	294	97	75%
Lesotho	349	176	173	50%
Malawi	349	237	112	68%
Mozambique	499	297	202	60%
Namibia	300	107	193	36%
South Africa	724	366	358	51%
Uganda	201	79	122	39%
Zambia	312	141	171	45%
Zimbabwe	486	281	205	58%
Total	4124	2266	1858	55%


Yaounde
Equatorial Guinea
Gabon
DRC
Uganda
Kampala
Rwanda
Burundi
Kenya
Nairobi
Tanzania
79
3%
294
13%
Angola
197
9%
Zambia
141
6%
Malawi
237
10%
Lusaka
Mozambique
297
13%
Zimbabwe
281
12%
Namibia
107
5%
Botswana
Pretoria
Eswatini
91
4%
Lesotho
176
8%
South Africa
Cape Town
366
16%
Google

Of the total sample at endline, 1415 (62%) were female and 851 (38%) were male. The ages of respondents at endline ranged between 12 to 29, with a mean age of 17.5 years[1].The majority of respondents at endline were 15 years old (15%), followed by 14 years old (14%), and 17 years old (13%).

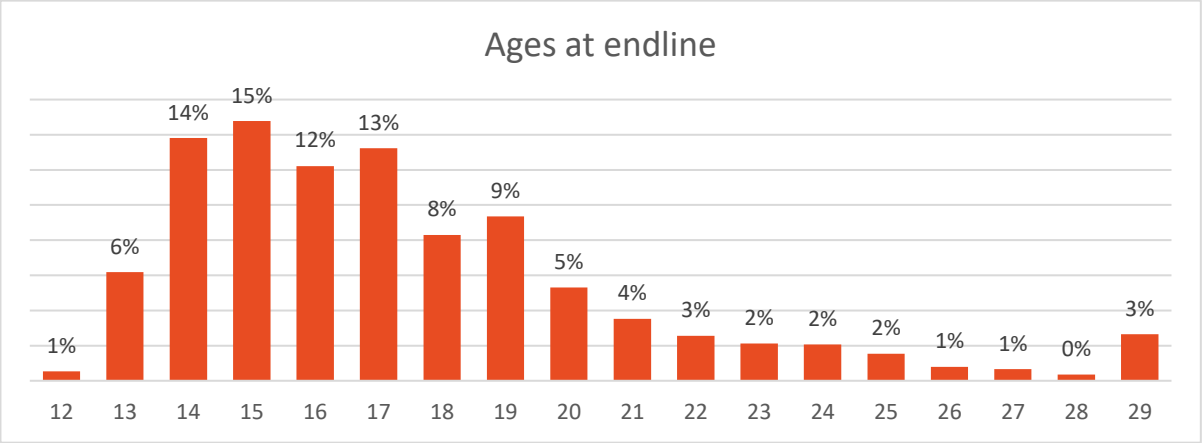
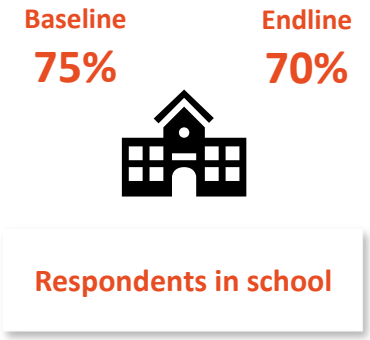


Figure 1: Ages of respondents

At baseline, 75% of respondents (1698) indicated that they were in school. At endline, 70% of respondents (1576) indicated that they were in school, which was a significant change[2]. The grades of respondents who were in school ranged between 3 and 12 at endline, with 1% who indicated they were enrolled in tertiary education (college or technical/vocational training). Most respondents at endline were in Grade 10 (20%), followed by Grade 9 (19%), and Grade 8 (19%). At endline, 28% (194) dropped out because they did not have enough money for their schooling, 25% (174) said they had dropped out due to pregnancy, followed by 19% of respondents (134) saying they were not in school because they had dropped out (reason not specified), and 17% (119) of respondents had finished school. Other reasons for not being in school included sickness or disability, getting married, failing, or losing interest in school.



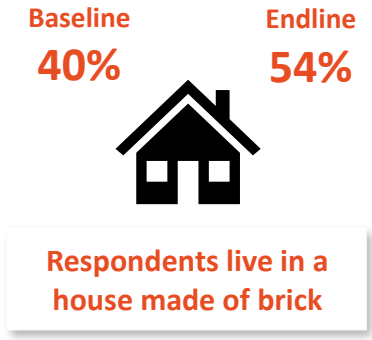
[1] Following the World Health Organisation's (WHOs) definition, "adolescence is the phase of life between childhood and adulthood, from ages 10 to 19". Although REPSSI works primarily with adolescents, some youth were also included in the interventions. For example, the interventions working with adolescent mothers included those who are not necessarily currently adolescents, but they were adolescents when they had their first child.

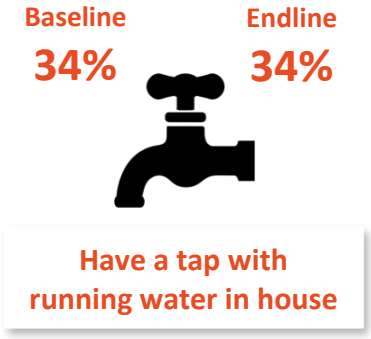
[2] p = 0.000

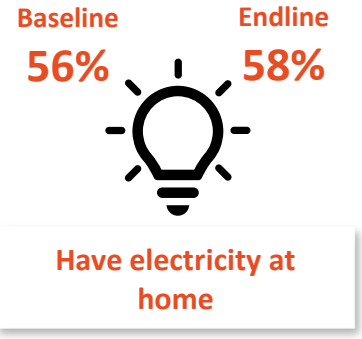
Most respondents at baseline (40%) and endline (54%) indicated that they lived in a house made of brick. 23% of respondents at baseline compared to 21% at endline reported living in a hut made of traditional materials, and 25% of respondents at baseline reported living in a house made with steel sheets and this decreased to 20% at endline. 11% of respondents at baseline indicated that they lived in a block of flats, and this decreased to 5% at endline. These differences were statistically significant.[3] The majority of respondents at baseline and at endline (66%) indicated that they did not have a tap with running water in their house, while 56% (1278) of respondents at baseline and 58% (1308) at endline indicated that they have electricity connected to their house.[4]

Type of home	Baseline	Endline	
House made of brick	40%	54%	↑
Hut made of traditional materials	23%	21%	↓
House made with steel sheets	25%	20%	↓
Block of flats	11%	5%	↓
Living on the street	0.2%	0.2%	-
Children's home	0.4%	0.2%	↓

Figure 2: Type of home

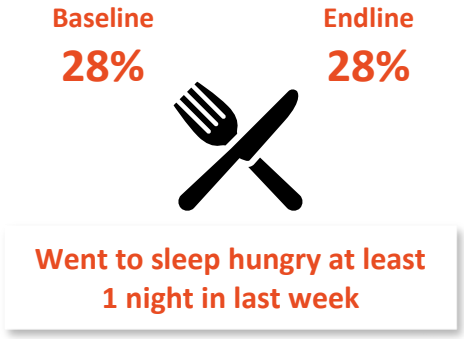




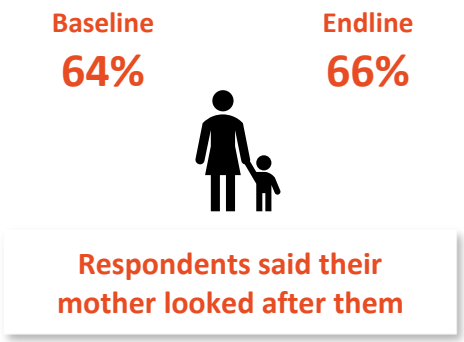


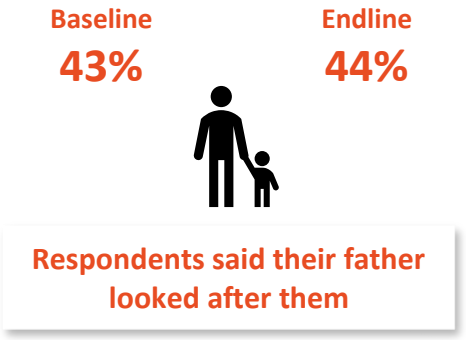
[3] p = 0.000
[4] p = 0.368

28% of respondents at baseline and at endline indicated that they went to sleep hungry one or more days in the past week. 16% of respondents at baseline and 15% at endline indicated that they had two or more days hungry in the last week. This change was not statistically significant.[5] The mean number of days respondents went to bed hungry in the last week was 0.5 at baseline and at endline[6]. As outlined in the contextual literature review section of this report, food insecurity is a known risk factor for mental health conditions, with COVID-19 worsening this for many people (WHO, 2022A; Gittings et al., 2021). In early 2020, COVID-19 prompted an acute global recession leaving millions of people unemployed and promoting a rise in extreme poverty (Mahler et al., 2021). Families experienced greater food insecurity, more crowding, and less access to healthcare services (Hearst et al., 2021). COVID-19 has also exacerbated many health and social inequalities (WHO, 2022A). For instance, families whose children rely on school feeding programmes could no longer had access these when schools closed due to the pandemic. However, these results show that respondents' food security remained fairly consistent from baseline to endline.



When asked who looks after them, the majority (64% at baseline and 66% at endline) said that this was their mother, followed by their father (43% at baseline and 44% at endline). 20% of respondents at baseline and 18% at endline reported their sibling looks after them, and 14% of respondents at baseline reported being looked after by their grandmother which decreased slightly to 13% at endline. The findings are presented in Figure 8 (Annex 2).





[5] p = 0.738
[6] p = 0.659

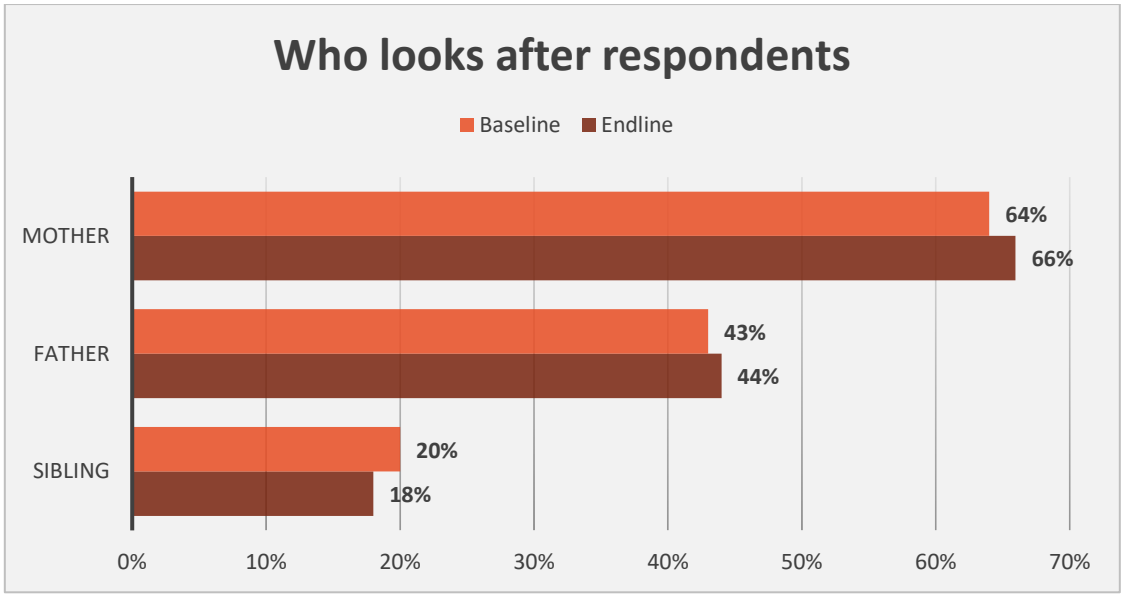
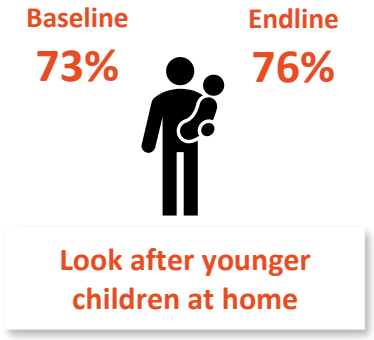
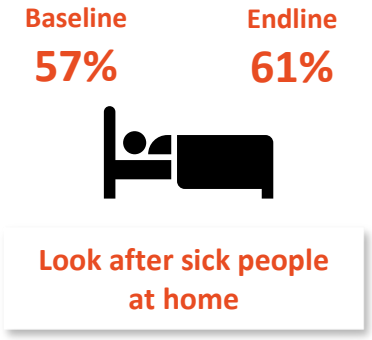


Figure 3: Who looks after respondents

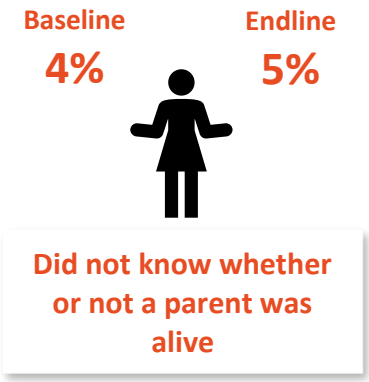
Many respondents at baseline (73%) and at endline (76%) indicated that they looked after younger children at home[7]. Additionally, 57% of respondents at baseline said that they look after sick people at home, which increased significantly to 61% at endline.[8]

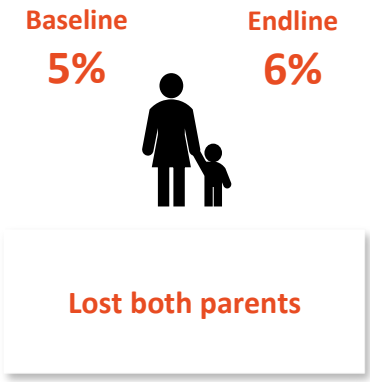




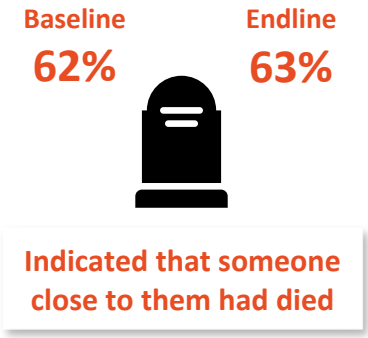
Respondents were asked about the losses they have experienced in their lives. 11% (252) of respondents at baseline and 11% (258) at endline reported they had lost their mother, and 22% (475) of respondents at baseline compared to 23% (502) at endline indicated that they had lost their father. Additionally, 4% of respondents at baseline (81) and 5% at endline (121) said they don't know if their mother and/or father was alive, which was a significant change[9], and 5% of respondents at baseline (120) and 6% at endline (134) were double orphans (i.e., had lost both parents).

[7] p = 0.019
[8] p = 0.001
[9] p = 0.004





The number of respondents who indicated that someone close to them had died did not change significantly from baseline to endline, with 62% (1397) at baseline and 63% (1435) at endline reporting they had lost someone close to them. During COVID-19, many people experienced major adversities and while the number of respondents who had lost someone close to them did not change significantly from baseline to endline, it is important to remember that respondents may still have witnessed someone close to them getting ill or suffering or death, which, like any adversity, can negatively impact mental health (WHO, 2022A).



83% of respondents (1872) at baseline and 80% (1807) at endline indicated that they have never been married. Of those that were or had been married at endline, 21% (96) reported getting married at the age of 17, and 20% (93) reported getting married at 18 years old. 46% at baseline and 50% at endline indicated that their partner was over the age of 20 when they got married. 44% (199) of those who were or had been married reported that it was not their choice to get married, and 29% (132) indicated that they had felt pressure to get married. This pressure came from their close family (51%) and extended family (23%), primarily. Of those who were not or had not been married, 78% of respondents indicated that they would like to get married at baseline and at endline. The majority (37% at baseline and 40% at endline) said they would like to get married between the ages of 25 and 29, while 2% fewer respondents (9% at baseline to 7% at endline) reported wanting to get married between the ages of 18 and 20.

Age	Age at which you would like to get married			Age at which you would like to become a parent		
	Baseline	*Endline*		*Baseline*	*Endline*	
<18	1%	1%	-	1%	1%	-
18-20	9%	7%	↓	4%	3%	↓
21-24	12%	11%	↓	12%	9%	↓
25-29	37%	40%	↑	35%	39%	↑
30-34	25%	27%	↑	33%	33%	-
35+	16%	14%	↓	15%	15%	-

Figure 4: Ages at which respondents who like to marry and become pregnant

23% of respondents at baseline (528) indicated that they had been pregnant or gotten someone pregnant, and this increased to 25% of respondents (561) at endline, which was not a significant change[10]. Of these, 94% at baseline and 90% at endline reported they had been pregnant once or twice, and 5% at baseline compared to 10% at endline said they have been pregnant three or four times. Of those who had never been pregnant or gotten someone pregnant, 98% of respondents at baseline said that they would like to become a parent, and this increased to 99% at endline. Of these, the majority (35% at baseline and 39% at endline) said they would like to become a parent between the ages of 25 and 29, and 12% of respondents at baseline compared to 9% at endline reported wanting to become a parent between 21 and 24 years of age. These slight changes indicate a shift towards wanting to become parents at an older age.

[10] p = 0.251

Sexual reproductive health

Access to SRHR Services

Respondents were asked if they had accessed several forms of sexual reproductive health services in the previous six months (see Figure 9, Annex 2). Few services were accessed by this group, but access to a number of products and services did improve significantly from baseline to endline, such as getting condoms, sanitary pads, medical male circumcisions, and various forms of birth control.

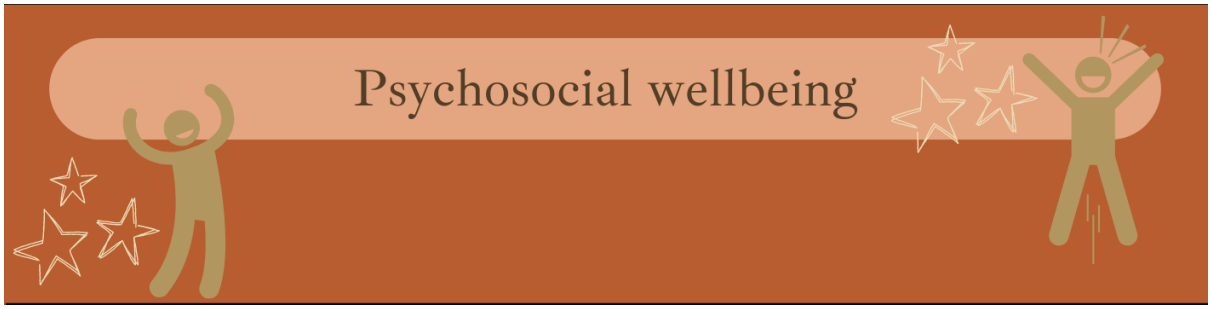
Baseline **6%** **Endline** **10%**

Got condoms

Baseline **18%** **Endline** **24%**

Of females got sanitary pads

Despite increases in the number of respondents accessing SRHR services seen, numbers are still low. Research has shown that the COVID-19 pandemic has negatively affected SRHR access, particularly for girls (Cousins, 2020; UNFPA, 2021). For instance, Zulaika et al. (2022) found that girls experiencing COVID-19 containment measures had twice the risk of falling pregnant prior to completing secondary school and three times the risk of school dropout relative to pre-COVID-19 learners. Girls in the COVID-19 cohort were also more likely to be sexually active and less likely to report their first sex was consensual (Zulaika et al., 2022). The majority of girls in the COVID-19 cohort (81%) also reported worsening household economic status, and COVID-19-related stress was common (Zulaika et al., 2022). Therefore, COVID-19 has negatively affected SRHR access and psychosocial wellbeing, with adolescent girls being particularly at-risk. In addition, COVID-19 has seen an increase in GBV and sexual violence which can result in EUP and other complications for adolescent girls (Piquero et al., 2021; Musa et al., 2021; Kons et al., 2022).



Resilience enabling factors

The Child & Youth Resilience Measure-Revised (CYRM-R) was used to assess resilience. The tool score can range between 17 and 85. Cronbach's alpha for the 17 items of the CYRM-R scale showed the questionnaire reached the acceptable reliability level, $\alpha = 0.85$. For this group, the mean score was 67.7 at baseline, the lowest was 18 and the maximum was 85. At endline, the mean score increased slightly to 68.3 with 17 being the lowest score and 85 being the highest. This was not statistically significant[11], and both scores indicate high levels of resilience. This scale also has two subscales: personal resilience (range: 10-50) and caregiver resilience (range: 7-35). At baseline, the mean personal resilience score was 39.7 (minimum 11 and maximum 50), which increased significantly to 40.1 at endline (with scores ranging from 10 to 50)[12]. The mean caregiver resilience score was 28.0 at baseline, which increased slightly to 28.2 at endline[13]. Scores ranged between 7 and 35 at both baseline and endline. 52% of respondents (1177) showed an increase in resilience enablers from baseline to endline.

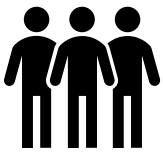
52%

Showed increased resilience from baseline to endline

Baseline **44%** **Endline** **54%**

Felt that they have chances to show others that they are growing up and can do things by themselves "A lot"

Baseline **49%** **Endline** **56%**



Felt that they know how to behave/act in different situations (such as school, home, and church)

[11] p = 0.070
[12] p = 0.042
[13] p = 0.252

Overall, the vast majority of individuals at baseline (70%) and endline (73%) had high levels of resilience, and 28% at baseline and 25% at endline had moderate resilience according to this scale. Only 2% of respondents had low resilience at baseline and endline. While there were slight shifts in the number of respondents whose scores can be categorised as low, moderate, or high resilience, these were not statistically significant[14].

CYRM-R score group	Baseline	Endline	% Change	
17-39 (Low)	2%	2%	0%	-
40-62 (Moderate)	28%	25%	-3%	↓
63-85 (High)	70%	73%	+3%	↑

Figure 5: Frequency of resilience score group

Responses to individual items on the CYRM-R are presented in Figure 10 (Annex 2). Overall, the most significant shifts in resilience were seen in items related to feelings of belonging and connectedness – both related to one's family and friends. For instance, more respondents said that they talk to their family and/or caregiver(s) about how they feel "a lot" or "quite a bit" after the intervention (61%) than before the intervention (58%), and more respondents said that they feel their friends care about them when times are hard "a lot" or "quite a bit" after the intervention (60%) than before (56%).

Statements related to growth and gaining independence also showed some of the most significant positive shifts, as 79% of respondents said that getting an education was important to them at baseline, compared to 82% at endline. Also, a lot more respondents said that they know how to behave or act in different situations after the intervention (56%) compared to before (49%). This could also be related to respondents feeling more connected to others, feeling like a part of their community, and going through personal growth.

Another big change was seen in responses to the statement "I have chances to show others that I am growing up and can do things by myself." Here, 44% of respondents said that they have "a lot" of these chances at baseline, and 54% said this at endline. Again, feelings of independence, personal growth, and being able to share and connect with others are shown to have been positively impacted. This points to the presence of greater resilience enablers, or the development of more awareness of these resilience enablers. This is especially noteworthy knowing that one direct impact of COVID-19 has been lockdown and social restrictions which were implemented to protect people's health, but at the same time reduced social connections that contribute to mental health (WHO, 2022A; Octavius et al., 2020; WHO, 2022B).

[14] p = 0.124

Baseline
31%

Endline
36%

Say their friends care about them when times are hard

"A lot"

Mental health

Mental health was measured using the PHQ-9, which has a possible range of between 0 and 27 with a higher score indicating higher levels of mental health distress. Cronbach's alpha for the 9 items of the PHQ-9 scale showed the questionnaire to reach acceptable reliability, $\alpha = 0.79$. For this group, the mean score was 5.5 at baseline which decreased significantly to 4.7 at endline[15]. Both scores indicate mild depression or mental health distress. Scores ranged between 0 and 27 at baseline and at endline. 52% of respondents (1178) from baseline to endline showed a decrease in depression scores on the PHQ-9, and 11% more respondents from baseline (12%) to endline (23%) did not experience any depression symptoms according to the PHQ-9. 1% of respondents showed severe mental health distress at baseline and at endline.

52%

Respondents showing decreased depression

PHQ-9 score group	Baseline	Endline	% Change	
0 (None)	12%	23%	+11%	↑
1-9 (Mild)	70%	62%	-8%	↓
10-18 (Moderate)	16%	14%	-2%	↓
19-27 (Severe)	1%	1%	0%	-

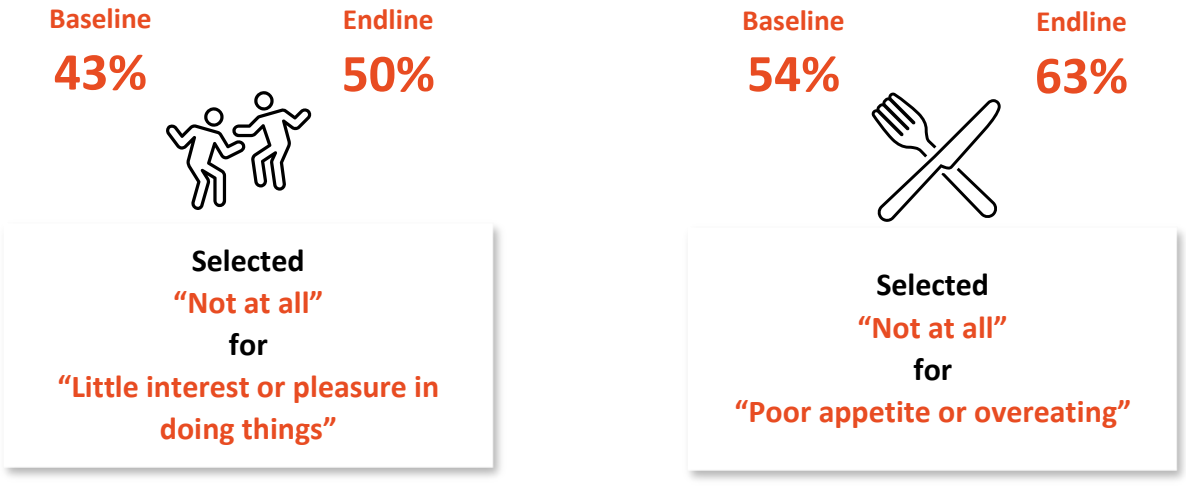
Figure 6: Frequency of mental health score group

[15] p = 0.000

Change related to the PHQ-9 was arguably some of the most significant, as all of the items on the scale showed significant change from baseline to endline (presented in Figure 11 of Annex 2). Fewer respondents reported feeling little interest or pleasure in doing things, and feeling down, depressed, or hopeless at endline than at baseline. Physical symptoms were reduced too. For instance, 58% at baseline said that they did not experience "Trouble falling asleep, staying asleep, or sleeping too much" at all, and this increased to 64% of respondents at endline, and 49% of respondents said that they did not experience "Feeling tired or having little energy" at all at baseline, and this increased to 57% at endline.

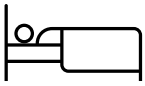
Other positive changes related to physical symptoms included 54% of respondents reporting that they did not experience a poor appetite or overeating at all at baseline which increased to 63% at endline, and 68% at baseline compared to 75% at endline responded that they did not experience "Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual" at all. Again, these positive shifts are in contrast to the fact that many people have reported increased mental health problems (such as depression and anxiety) since the COVID-19 pandemic began (WHO, 2022A, WHO, 2022B; COVID-19 Mental Disorders Collaborators, 2021). There have also been indications of more widespread suicidal thoughts and behaviours driven by factors such as low social support, poor physical health, loneliness, isolation, and pre-existing mental health difficulties (WHO, 2022B). Therefore, the improvements in mental health distress in this study show positive change for many respondents against a backdrop of increasing mental health stressors.

As mentioned previously, positive coping mechanisms such as social connections have been shown to increase resilience and help mitigate mental health difficulties such as depression (WHO, 2022A). Therefore, the increasing presence of resilience enablers could be the reason for the declining rates of depression as research has consistently demonstrated an inverse relationship between depression and resilience, whereby higher levels of resilience are related to fewer mental health problems (Anyan & Hjemdal, 2016; Mesman et al., 2021).



Baseline
49%

Endline
57%



Selected "Not at all" for "Feeling tired or having little energy"

Self-esteem

Self-esteem was measured using the Rosenberg Self-Esteem Scale, which has a possible range of between 10 and 40, with a higher score indicating higher levels of self-esteem. Cronbach's alpha for the 10 items of the questionnaire did reach an acceptable reliability, $\alpha = 0.71$. For this group, the mean score was 28.9 at baseline which increased significantly to 29.5 at endline[16]. These scores are within the normal self-esteem range. At baseline, scores ranged between 18 and 40, and endline scores ranged between 16 and 37. 53% of respondents (1210) showed an increase in self-esteem scores from baseline to endline.

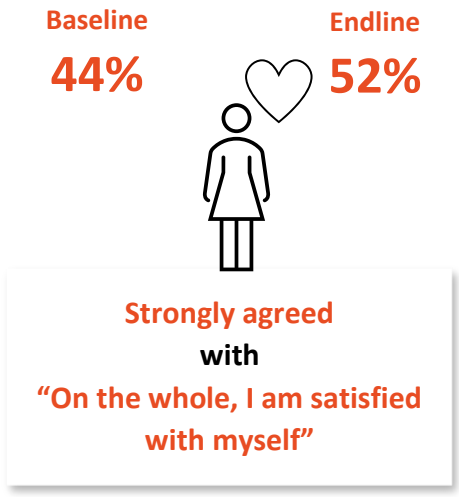
53%

Respondents showing increased self-esteem

As with the PHQ-9 changes, all the changes on the Rosenberg Self-Esteem Scale were found to be signficant (refer to Figure 12 in Annex 2). Some of the most notable changes included 44% of respondents strongly agreeing with the statement "On the whole, I am satisfied with myself" at baseline and this increased to 52% after the intervention, as well as 34% strongly agreeing with "I feel that I have a number of good qualities" at baseline, which increased to 43% at endline. This was also true for negatively worded items, such as "All in all, I am inclined to feel that I am a failure." Here, 23% of the respondents strongly disagreed at baseline, and this increased to 26% at endline. Similarly, 22% at baseline and 25% at endline strongly disagreed with "I certainly feel useless at times."

[16] p = 0.000

Again, given that the literature has shown the negative impact of COVID-19 on adolescents and youth, including increased stress, depression, a lack of psychosocial support, and low self-esteem (Sikhangezile & Modise, 2020), it is encouraging that respondents in this sample were able to increase their resilience, mental health, and self-esteem against a backdrop of mounting mental and physical health stressors. Also, as self-esteem has been highlighted as an enabler of resilience and of mental health, it makes sense that scores have increased as they are all inter-connected.

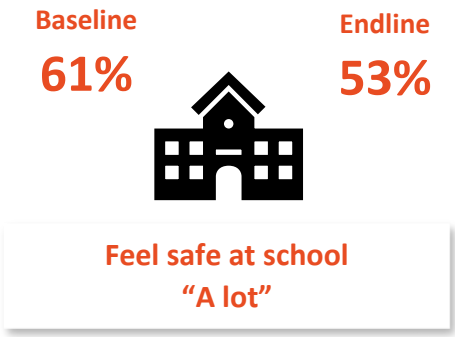


Feeling safe

Respondents were asked to what degree they felt safe at home, in school, and in the community, and to what degree they felt unsafe. Results are presented in. All four changes were found to be statistically significant, with all changes indicating greater feelings of safety, except for the change related to feeling safe at school.

Question		Baseline	Endline		p
I feel safe at home	Not at all	4%	3%	↓	0.006
	A lot	70%	73%	↑	
I feel safe at school	Not at all	5%	9%	↑	0.000
	A lot	61%	53%	↓	
I feel safe in my community	Not at all	9%	8%	↓	0.007
	A lot	42%	45%	↑	
I don't feel safe	Not at all	48%	52%	↑	0.000
	A lot	15%	11%	↓	

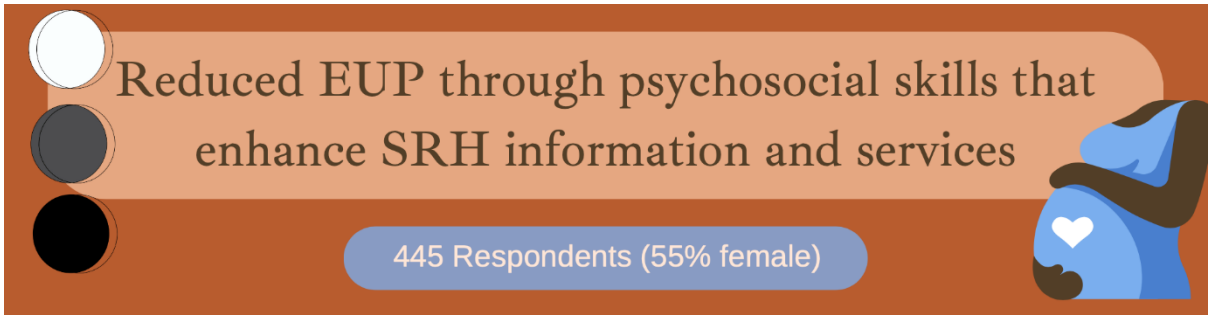
Figure 7: Responses to all safety questions



Thematic areas

As part of the evaluation of the interventions, baseline and endline data was collected and analysed to determine the changes that occurred in beneficiaries. In addition to the above core sociodemographic and psychosocial wellbeing questions that were asked across all countries and thematic areas, additional questions were asked across countries who had similar thematic areas. The table below lists the six thematic areas, their associated countries, how many responses were collected in total, and the percentage of female respondents.

Thematic Area	Countries	Total number of respondents	% Female
Ending child marriage	Lesotho	176	63%
Improved HIV outcomes through psychosocial skills that enhance HIV prevention and services	Kenya Mozambique	591	57%
Improved SRHR and social connectedness for adolescents in humanitarian emergencies	Uganda	79	49%
Improved outcomes for adolescent mothers (and fathers) through psychosocially informed MCHC	Malawi Zimbabwe	518	81%
Prevention of gender-based violence	South Africa Eswatini	457	59%
Reduced EUP through psychosocial skills that enhance SRH information and services	Angola Namibia Zambia	445	55%
		2 266	62%



Adolescent birth rates in Angola, Namibia, and Zambia are very high, which led to this intervention focussing on reducing EUP and improving access to SRH information and services. Angola has one of the highest adolescent birth rates in the world at 143 births per 1000 women aged 15 to 19 (compared to the global average of 41 births per 1000 girls ages 15-19) (World Bank, 2020A). Angola also has high rates of maternal mortality (MacPherson et al., 2015). In Namibia, the adolescent fertility rate is 58 births per 1000 girls between the ages of 15 and 19, which is markedly higher than the global average of 41 (World Bank, 2020A). In Zambia, 31% of women aged 20 to 24 years gave birth before the age of 18 in 2019 (UNICEF, 2019, 2021A). In addition to these high rates of adolescent pregnancy, women in Angola, Namibia, and Zambia face many barriers to accessing healthcare and SRH services, including inadequate facilities and resources, living in rural areas, not being able to afford services, inequality, stigma, and a lack of knowledge about contraceptives and SRHR (Decker & Constantine, 2011; Nimi et al., 2016).

Angola

Project implementation information	
Sites of implementation	11 schools in Moxico.
Implementing partners	Government of Moxico Province – Directorate of Education & Department of Public Health. National Radio of Angola in Moxico.
Implementing process	Principals, senior school staff, and teachers were trained on assessing and improving the school PSS environment, life skills for adolescents, and establishing and managing school clubs. Bi-weekly radio program in Portuguese and local language Tchokwe. Each radio program had a duration of 30 minutes, and included participation of parents and children by phone.
Beneficiaries	20 to 35 children per club aged 11 to 17 from primary and secondary schools.
Recruitment process	Voluntary participation. Before clubs formation, school principals and teachers organised meetings with parents/caregivers to inform them about the project and mobilise them to support their children's participation, as well as allow them to come for extra class activities.
Content	Psychosocial life skills. SRHR provided by the Department of Public Health.
# of sessions held	1 per week for at least 18 weeks.

Namibia

Project implementation information	
Sites of implementation	10 schools within the Opuwo District of the Kunene Region in Northern Namibia.
Implementing partners	Ministry of Education, Arts, and Culture.
Implementing process	Life Skills teachers were commissioned to execute the project at grassroots level. The project engaged traditional leaders and local authorities through community conversations. Training of teachers in PSS was conducted for 30 government officials.
Beneficiaries	Adolescents and young people between 13 to 21 years of age.
Content	Peer Pressure; HIV; Teenage Pregnancy; Unsafe Abortion; SRHR; EUP; Relationships, Contraceptives; Choices; Self Esteem and Self Awareness; Safe Environments; Career Development; and Prevention of Alcohol and Drug Abuse.
# of sessions held	12 groups of ±30 learners.

Zambia

Project implementation information	
Sites of implementation	160 schools in Katete, Sinda, Livingstone, and Kazungula, as well as homes during COVID-19 using the door-to-door implementation model.
Implementing partners	Ministry of Education.
Implementing process	REPSSI worked with the Zonal In-service Coordinators (ZIC's) to identify community-based implementers that were trained in the delivery of psychosocial life-skill sessions and SRHR to adolescents through pre-existing school clubs. These implementers worked closely with the guidance and counselling teachers who were also trained. Community dialogues on sex and sexuality were held with community members. REPSSI aired psychosocial life-skills-based SRHR interactive programmes on local radio.
Beneficiaries	Adolescents aged 10 to 19 years.
Content	PSS-Life-Skills with a focus on self-awareness, self-management, social awareness, relationship skills, and responsible decision-making.
# of sessions held	2 sessions twice a month for a total of 17 sessions per group – totalling 320 sessions in 160 schools.
Intervention length	August 2020 - May 2022.

Support to access SRHR services

Respondents who were in school (443 at baseline and 411 at endline) were asked to select which forms of support their school provided in relation to accessing SRHR services. 40% of respondents showed increased support received from schools. In addition, significantly more respondents indicated that they had visited a health facility for health services in the previous 6 months (34% to 41%). Significant shifts in types of support and access are shown below:

Baseline **96%**  **Endline** **89%**

Respondents said their school gives learners permission to go the clinic

Baseline **62%**  **Endline** **73%**

Respondents said their school gives learners support to catch up with work when they have to miss class due to illness

Baseline **34%**  **Endline** **41%**

Had visited a health facility for health services in the previous 6 months

Baseline **77%**  **Endline** **86%**

Respondents said the healthcare provider made them feel comfortable

Sexual debut

The age at which respondents thought a boy should be when he first has sex did not change significantly from baseline to endline. On the other hand, the age at which respondents thought a girl should be when she first has sex did change significantly from baseline to endline. For instance, 3% fewer respondents (5% to 2%) indicated that a girl should be 12 years old and 3% more (17% to 20%) indicated that a girl should be 18 years old. Results are presented in Table 13 of Annex 3. In addition, significantly more respondents indicated that they have had sex (19% at baseline to 36% at endline). Of the respondents who had not had sex, there was a significant change in the ages at which they think they will be when they first have sex. Most respondents at baseline (13%) indicated they would be 25 years old when they first have sex, and the majority at endline (16%) indicated they would be 30 years old.

This intervention aimed to teach learners (together with their caregivers) psychosocial skills which they can apply to aid them in navigating certain challenges. The core areas of learning include skills and knowledge; emotional and spiritual wellbeing (intrapersonal wellbeing); and social wellbeing (interpersonal wellbeing). This intervention also focussed on HIV prevention and services and aimed to increase the number of persons who are tested, enrolled in treatment, and adhere to treatment. There is a demonstrated need for this intervention in a number of countries, including Kenya and Mozambique. Mozambique is one of 10 countries identified as being most affected by HIV in the world and has the world's 7th highest HIV prevalence rate among people between the ages of 15 and 49 at 12% (World Population Review, 2020). However, HIV in Mozambique is not equally or evenly distributed across the population, as youth (those between 15 and 24 years of age) are particularly vulnerable (Muleia et al, 2020). In 2018, it was estimated that there were 140 000 adolescents between 10 and 19 years of age living with HIV in Mozambique, and those aged 12–17 years made up 14% of the total population living with HIV (UNAIDS, 2021). Kenya is also greatly affected by HIV, and while the number of children living with HIV in Kenya declined from 180 000 in 2010 to 111 500 in 2020, infection rates among young people (ages 15-24) remain concerning (UNICEF, 2021). As highlighted at the beginning of this report, HIV is associated with decreased psychosocial wellbeing. For instance, in a sample of 270 ALHIV in Kenya, more than half (53%) showed symptoms of depression (Gaitho et al., 2018).

Kenya

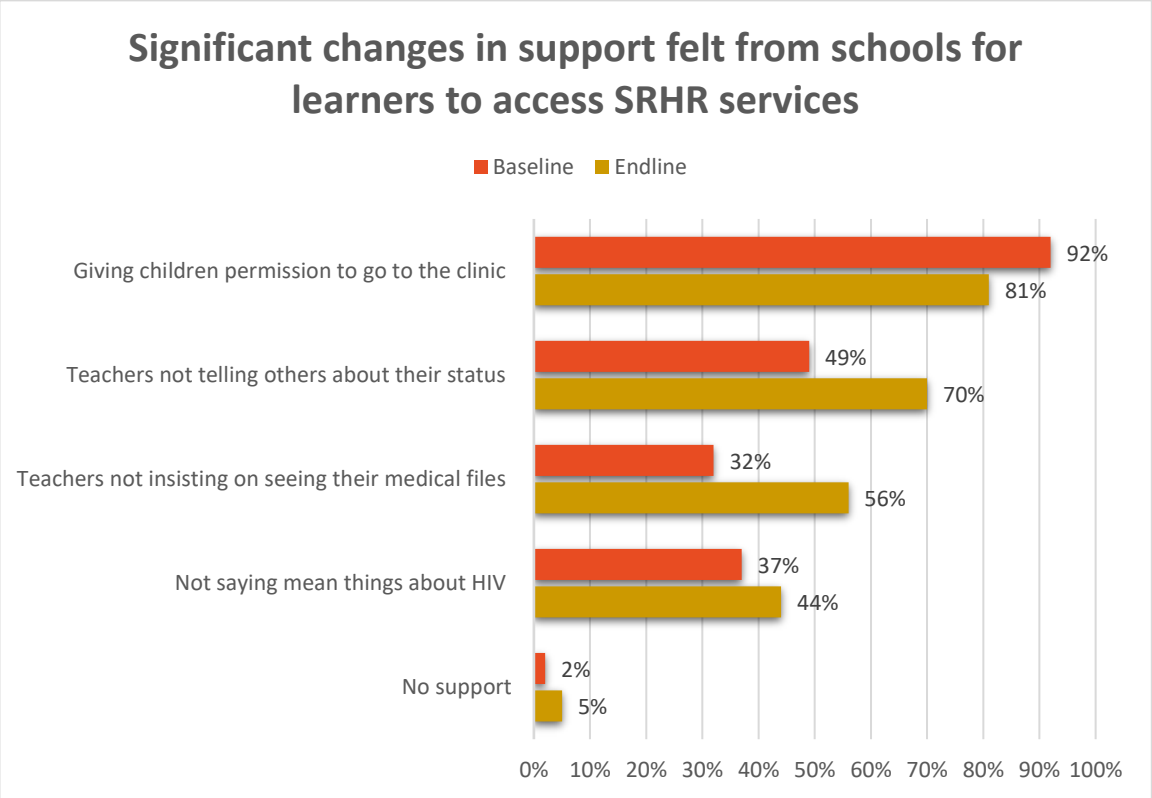
Project implementation information	
Sites of implementation	Upper primary and lower secondary schools from both Nairobi and Busia.
Implementing partners	Kibera Community Self-Help Program (KICOSHEP) in Nairobi Kenya Orphans Rural Development Program (KORDP) in Busia.
Beneficiaries	Adolescents aged 10 to 19.
Recruitment process	Invitation to participate and voluntary participation.
Content	Psychosocial Skills for Young People intervention: skills and knowledge; emotional and spiritual wellbeing (intrapersonal wellbeing); and social wellbeing (interpersonal wellbeing). Celebrate Your Life intervention: provide psychosocial support to patients, their families, and communities in order to increase the number of persons who are tested, enrolled in treatment, and adhere to treatment.
# of sessions held	17 per group.

Mozambique

Project implementation information	
Sites of implementation	Maputo Province and Beira City.
Implementing partners	Associação KUGARISSICA. ADECC.
Beneficiaries	Adolescents and young people aged 10 to 24.
Content	Psychosocial Skills for Young People intervention: skills and knowledge; emotional and spiritual wellbeing (intrapersonal wellbeing); and social wellbeing (interpersonal wellbeing). Celebrate Your Life intervention: provide psychosocial support to patients, their families, and communities in order to increase the number of persons who are tested, enrolled in treatment, and adhere to treatment.
# of sessions held	17 per group.

Support to access SRHR services

Respondents who were in school (589 at baseline and 480 at endline) were asked to select which forms of support their school and healthcare facilities provides in terms of accessing SRHR services. The average number of forms of support from schools increased significantly from 2.7 at baseline to 3.1 at endline. The average number of forms of support from health facilities also increased significantly from 6.0 at baseline to 6.6 at endline. This means that respondents felt significantly more support from their school and from health facilities in terms of accessing SRHR services after the intervention compared to before.



Baseline
73%

Endline
86%

Respondents said the health-care provider treated them in a manner that made them feel respected

Baseline
51%

Endline
68%

Respondents said their parents/guardians would be supportive of them coming to this health facility for SRH services

Baseline
45%

Endline
58%

Respondents said the healthcare provider respected their opinion and decisions even if they were different from theirs

Sexual debut

The ages at which respondents thought a girl and a boy should be when they first have sex changed significantly from baseline to endline (Table 14, Annex 4). Interestingly, more respondents at endline thought that girls (23% compared to 30%) and boys (22% compared to 28%) should be 18 years old when they felt have sex, and significantly more respondents (17% at baseline to 31% at endline) indicated that they have had sex. This is to be expected given the time between baseline and endline and the fact that children are more likely to engage in sex as they get older.

Baseline
23%

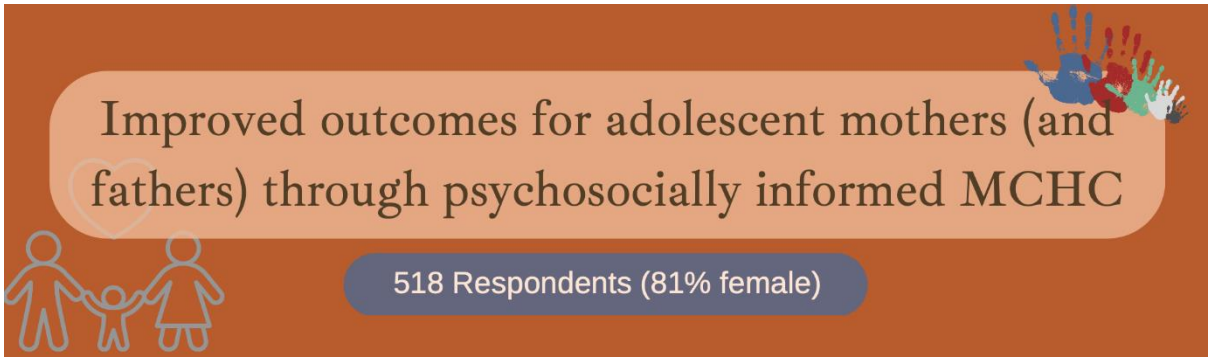
Endline
30%

Respondents who think a girl should be 18 years old when she first has sex

Baseline
17%

Endline
31%

Respondents who indicated that they have had sex



As mentioned above, the accessibility of healthcare facilities is influenced (in part) by the attitudes and knowledge of healthcare workers. Knowing this, REPSSI worked with adolescent and young mothers (as well as fathers in Zimbabwe) to support them to overcome challenges associated with unplanned motherhood. It should be noted here that while not all respondents are currently adolescents, they were all adolescents (i.e., teenagers up to 19) when they had their first child. This project was implemented in Malawi and Zimbabwe. In Malawi, the adolescent birth rate is 131 births per 1000 adolescents between the ages of 15 and 19 (World Bank, 2020B). Moreover, girls aged 15 to 19 years old are twice as likely to die during childbirth when compared with women 20 years and older, and complications during pregnancy and childbirth are the leading cause of death for young women aged 15 to 19 in Malawi (UNFPA, 2022B). In Zimbabwe, the adolescent birth rate is 110 births per 1000 women between the ages of 15 to 19 (ZimStat & UNICEF Zimbabwe, 2019). In a qualitative study by Kurebwa (2017), adolescents indicated that they were not utilising SRH services for various reasons including social stigma, lack of information, poor quality service, and the negative attitude displayed by some nurses and counsellors at their nearest health centre. Adolescent mothers in Zimbabwe often experience stigma, social isolation and a lack of employment and educational opportunities, factors which are also all linked to poor mental health outcomes (Mbawa et al., 2018; Tinago et al., 2021). The Malawi sample was made up exclusively of adolescent and young mothers, whereas the Zimbabwe sample included adolescent mothers and fathers.

Malawi

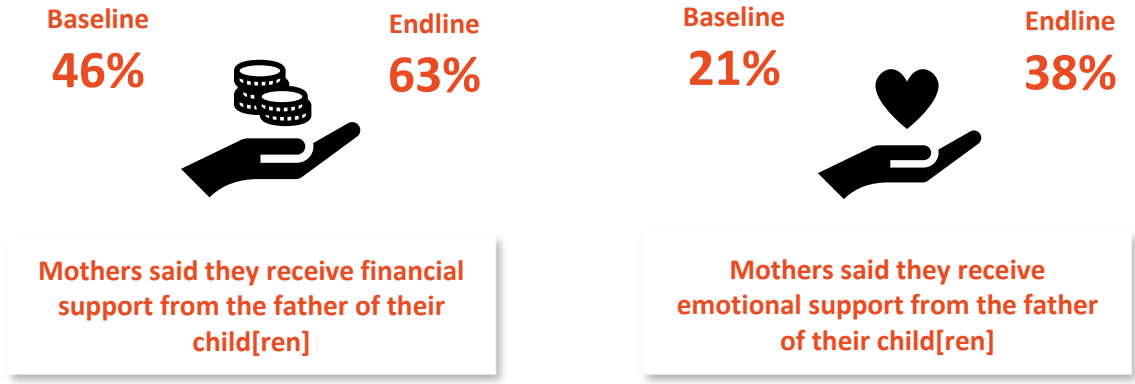
Project implementation information	
Sites of implementation	4 Community-Based Child Care centres (CBCC) in Blantyre and Machinga
Beneficiaries	360 adolescent mothers and their children
Recruitment process	Adolescent mothers who were a part of MHPSS (funded by Sweden) and their young children who are beneficiaries of the MECIAM (Malawi Early Childhood Initiative for children of Adolescent Mothers) project funded by Comic Relief were invited to participate

Zimbabwe

Project implementation information	
Sites of implementation	Chipinge, Epworth, and Rushinga
Implementing partners	Simukai in Chipinge Shanduko yeUpenyu in Epworth National AIDS council and Department of Social Development and Ministry of Youth in Rushinga.
Implementing process	Group leaders, mentors, and healthcare workers in the communities ate trained on the content. Group leaders recruit for and facilitate Mother to Mother groups and Father to Father Groups. Community conversations were also conducted.
Beneficiaries	Adolescent & young mothers and fathers
Recruitment process	Health care workers were actively involved in recommending young mothers in the waiting shelters to join the support groups. Support group leaders recruit members of their community
Content	*My Space* tool *& Lean on Me* tool: Group psychosocial support (PSS) Relationship building GBV SRHR HIV Early childhood development (ECD) Positive parenting Positive masculinity
# of sessions held	At least 8/group of +-20 participants
Intervention length	April 2019 to December 2021

Adolescent mothers

The number of children that adolescent mothers (419) had given birth to changed significantly from baseline to endline (refer to Table 15, Annex 5). At baseline, 85% of mothers had given birth to one or two children and 5% had given birth to three or four children. At endline, 87% had given birth to one or two children, and 9% had given birth to three or four children. Mothers received an average of 1.7 forms of support from the father of their child[ren] at baseline which increased significantly to 2.1 at endline. Two individual changes related to support received were statistically significant:



The average number of adults who were employed per household increased significantly from baseline (0.5) to endline (0.6). 29% of respondents at baseline compared to 32% at endline said they have one adult in the household who is employed, while 6% at baseline and 7% at endline said they have two adults in the household who are employed. Additionally, significantly more mothers reported having their own source of income at endline (20% to 39%).

Baseline **29%** **Endline** **32%**

Have one employed adult in the household

Baseline **20%** **Endline** **39%**

Mothers reported having their own source of income

Levels of parental stress declined significantly from baseline to endline, with average scores decreasing from 46.2 at baseline to 41.9 at endline. Overall, 65% of mothers showed decreased parental stress levels.

65%

Mothers showed decreased levels of parental stress

Responses to all 18 items on the Parental Stress Scale were statistically significant (see Table 16, Annex 5), including the following:

Baseline **24%** **Endline** **57%**

Strongly agreed with "I feel close to my child(ren)"

Baseline **25%** **Endline** **58%**

Strongly agreed with "I find my child(ren) enjoyable"

Baseline 29% Endline 49%

Strongly disagreed with "The behaviour of my child(ren) is often embarrassing or stressful to me"

Baseline 34% Endline 49%

Strongly agreed with "My child(ren) is an important source of affection for me"

The Brief Resilience Scale (BRS) was also used to assess mothers' psychosocial wellbeing. Mothers showed increased resilience, with the average BRS score increasing significantly from 18.1 at baseline to 18.9 at endline. Just over half (51%) showed increased resilience scores from baseline to endline. Individual responses to four out of six BRS items were statistically significant:

Baseline 36% Endline 48%

More mothers agreed with "I tend to bounce back quickly after hard times"

Baseline 22% Endline 30%

More mothers disagreed with "I have a hard time making it through stressful events"

Baseline 22% Endline 34%

More mothers disagreed with "It is hard for me to snap back when something bad happens"

Baseline 22% Endline 31%

More mothers disagreed with "I tend to take a long time to get over setbacks in my life"

There was a significant increase in the average number of IPV experiences that the mothers had (1.2 at baseline to 1.8 at endline). Overall, 27% of mothers showed an increase in IPV from baseline to endline. The forms of IPV that changed significantly from baseline to endline are presented in Table 17 (Annex 5) and included the following:

Baseline 5%

Endline 11%

Mothers said that a partner had followed them or hung around outside their home or work

Baseline 10%

Endline 16%

Mothers said a partner had told them they were crazy, stupid, or not good enough

Adolescent fathers

Adolescent fathers in Zimbabwe (99) showed significant improvements in their gender attitudes, with average scores increasing from 51.9 at baseline to 62.1 at endline. The majority (72%) showed more positive gender attitudes from baseline to endline. As presented in Table 18 (Annex 5), responses to 21 out of the 24 items of the scale changed significantly from baseline to endline, including:

Baseline 33% Endline 80%

Fathers disagreed with "The husband should decide to buy the major household items"

Baseline 26% Endline 64%

Fathers disagreed with "A woman's role is taking care of her home and family"

Baseline 48% Endline 81%

Fathers disagreed with "If someone insults a man, he should defend his reputation with force if he has to"

Baseline 55% Endline 91%

Fathers disagreed with "A real man produces a male child"

The BRS was also used to assess the resilience levels of the adolescent fathers in addition to the CYRM-R. Fathers showed increased resilience, with the average BRS score increasing significantly from 18.3 at baseline to 19.5 at endline. Just over half (55%) showed increased resilience scores from baseline to endline. All responses to the individual items on the BRS were statistically significant, and these are presented in Table 19 of Annex 5.

Relatedly, parental stress levels of adolescent fathers decreased significantly from baseline to endline, with average scores declining from 49.8 at baseline to 42.0 at endline. The majority (72%) showed decreased parental stress.

72%

Fathers showed decreased levels of parental stress

Numerous changes in responses to individual items on the parental scale were statistically significant (Table 20, Annex 5), including:

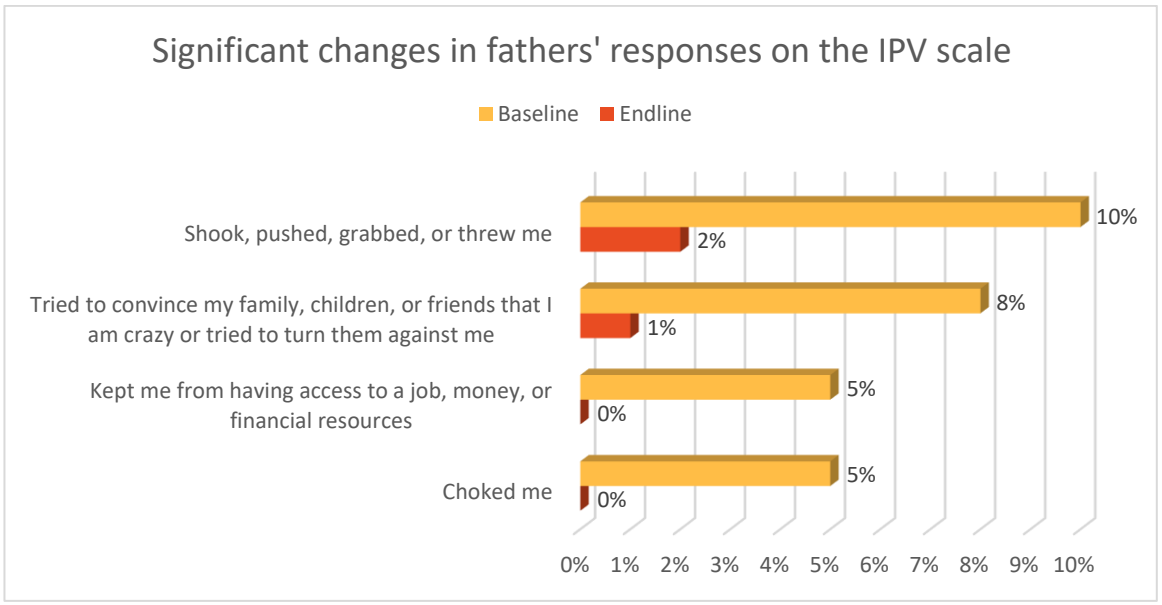
Baseline	Endline
4%	33%

Fathers strongly agreed with "I am happy in my role as a parent"

Baseline	Endline
5%	41%

Fathers strongly agreed with "I enjoy spending time with my child(ren)"

Significantly more fathers indicated that they had been in an intimate relationship at endline (71%) compared to baseline (46%). Contrary to the increased IPV experienced by the adolescent mothers, there was a significant decrease in the average number of forms of IPV that were experienced by the fathers (0.7 at baseline to 0.3 at endline). However, 10% of fathers showed an increase in IPV from baseline to endline. The forms of IPV that changed significantly from baseline to endline were:

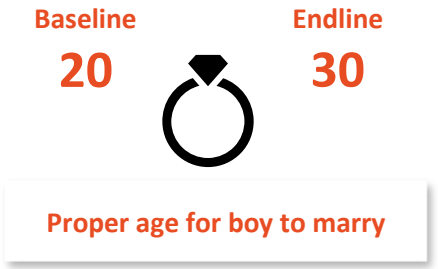


Child marriage is a concern in Lesotho, impacting on families and communities. Although the minimum legal age of marriage in Lesotho is 18 years for boys and 16 years for girls, under Article 27, both boys and girls can marry before the ages of 18 and 16 years respectively with the permission of the Minister and with parental consent (Girls Not Brides, 2022). In addition, the Laws of Lerotholi (the codification of the Lesotho's Customary Law) allows boys and girls to be married as long as they are over puberty age. The prevalence rate for child marriage by the age of 15 is 1% and by the age of 18 is 16% (Girls Not Brides, 2022).

Project implementation information	
Sites of implementation	Berea, Mafeteng, and Maseru.
Implementing partners	Young Women Christian Association (YWCA).
Beneficiaries	Adolescents and young people between 13 to 20 years of age.

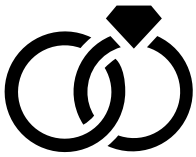
Attitudes to child marriage

There was a change in respondents' beliefs around the proper age to get married. At baseline, the highest number of respondents (23%) indicated that the proper age for a girl to marry is 20 years old, while at endline most (26%) indicated age 25. For boys, the highest percentage of respondents (17%) at baseline indicated that a boy should be 20 years old when he first gets married, and the highest percentage at endline (16%) indicated age 30. The youngest age that respondents thought is appropriate for a girl to marry is 14 whereas for boys it was 16. These changes were not found to be statistically significant. However, the differences in responses between the proper age for a girl to marry and the proper age for a boy to marry were statistically significant (Table 21, Annex 6). This means that respondents thought that the proper age for a girl to marry is younger than the proper age for a boy to marry.



The attitudes to child marriage questionnaire explored views and feelings about child marriage. The score reached the acceptable reliability level, α=0.73. For this group, the mean score was 31.02 at baseline which increased significantly to 32.6 at endline. This shows a positive shift, as a higher score indicates more attitudes against child marriage. The maximum score was 40 at baseline and endline, with the lowest score being 14 at baseline and 13 at endline. 59% of respondents showed more attitudes against child marriage from baseline to endline.

59%



Respondents showing attitudes against child marriage

Three changes from baseline to endline were found to be statistically significant:

Baseline **30%** **Endline** **17%**

Respondents agreed or strongly agreed with If a girl under 18 falls pregnant, she has to get married

Baseline **39%** **Endline** **21%**

Respondents agreed or strongly agreed with If a boy under 18 makes a girl pregnant, he has to marry her

Baseline **54%** **Endline** **66%**

Respondents disagreed or strongly disagreed with Younger wives are better because they obey their husbands more

At baseline, 64% of respondents felt that a child could do something to stop getting married, and this increased significantly to 78% at endline. Two suggestions of what could be done changed significantly from baseline to endline:

Baseline **35%** **Endline** **46%**

Respondents felt that the best way for a child to stop getting married would be to ask the police to stop it

Baseline **19%** **Endline** **10%**

Respondents felt that a child can just refuse to get married

However, overall, there was a decline in beliefs of the negative consequences of child marriage (Table 22, Annex 6). For this group, the mean score was 4.7 at baseline which decreased significantly to 3.2 at endline. This indicates that, on average, respondents identified significantly fewer negative consequences to child marriage at endline than they did at baseline. The decrease in beliefs around the potential negative consequences of child marriage seem somewhat contradictory to the findings above where more respondents showed attitudes against child marriage from baseline to endline. Some significant changes related to this included:

Baseline **67%** **Endline** **53%**

Respondents felt that a consequence of child marriage is that the child cannot finish school

Baseline **68%** **Endline** **44%**

Respondents felt that a consequence of child marriage is that it is difficult to raise children when a person is young

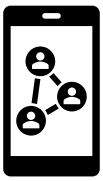
Exposure to activities on ending child marriage

52% of respondents at baseline said that they had heard or seen something in the media on ending child marriage, and this increased significantly to 73% at endline. Two changes from baseline to endline were statistically significant:

Baseline **16%** **Endline** **25%**

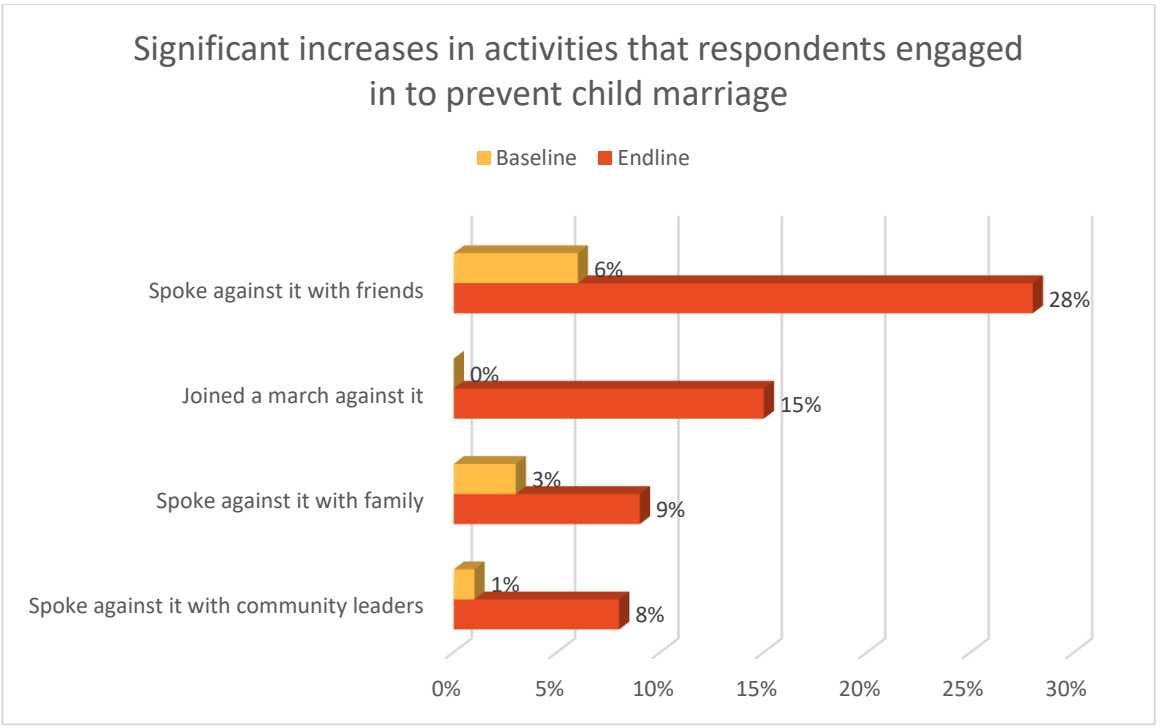
Respondents had seen information on ending child marriage on TV

Baseline **68%** **Endline** **44%**



Respondents said they saw information on ending child marriage online (Facebook, websites, etc.)

Significantly more respondents from baseline (12%) to endline (53%) indicated that they had engaged in activities to prevent child marriage. The following findings were statistically significant:


Significant increases in activities that respondents engaged in to prevent child marriage
Baseline
Endline
Spoke against it with friends
6%
28%
Joined a march against it
0%
15%
Spoke against it with family
3%
9%
Spoke against it with community leaders
1%
8%
0%
5%
10%
15%
20%
25%
30%

In response to the high levels of GBV in South Africa and Eswatini, REPSSI implemented a GBV-prevention project. This project was designed and implemented as the *Say No! to GBV* project to address the issues fuelling GBV, mitigate the effects of GBV, and contribute to the enhancement of protection for children, adolescents, and young people. To outline how great a problem GBV is in South Africa, Jewkes et al. (2002) conducted a community-based study with 1306 randomly selected women from three provinces in South Africa. The study allowed the researchers to estimate the prevalence of physical violence women experienced by a current or ex-partner as being between 19% to 28%. In Eswatini, approximately 1 in 3 girls have experienced some form of sexual abuse by 18 years of age, and 48% of women have experienced some form of sexual violence in their lifetime (UNFPA, 2022B).

Eswatini

Project implementation information	
Beneficiaries	Adolescents between 13 and 20 years old.

South Africa

Project implementation information	
Sites of implementation	Schools in Diepsloot and Soweto.
Implementing partners	Afrika Tikkun. June 16 Foundation.
Implementing process	Trained facilitators visit schools on a weekly basis and go through the intervention content with groups of beneficiaries.
Beneficiaries	Adolescents between 12 to 19 years of age.
Content	Empowering Girls (puberty; sex and sexuality; self-defence; confidence; relationship building); Peace is a Decision (violence; sex and sexuality; puberty; relationship building; masculinity); Making our Communities Safer community conversation; PSS Lifeskills (self-awareness; self-management; relationship building; conflict resolution; and decision-making)
# of sessions held	10 sessions per group.
Intervention length	June 2020 - October 2021.

Experiences of victimisation

Only one individual change was statistically significant on the Juvenile Victimisation Scale, and of the respondents who had experienced at least one of the forms of victimisation listed (384 at baseline and 376 at endline), significantly more told friends not at their school about their victimisation experience (17% at baseline to 25% at endline).

Baseline 5%

Endline 9%

Respondents said a boyfriend or girlfriend or anyone they went on a date with slapped or hit them

Baseline 17%

Endline 25%

Respondents told friends not at their school about their victimisation experience

Significantly more respondents after the intervention (26% at baseline to 82% at endline) reported they had engaged in activities to prevent GBV. Of these, significantly more respondents spoke against it with family (41% to 52%). Whilst significantly fewer spoke against it in the media (12% to 3%) or joined a march against it (33% to 17%). Important to note here is that although proportionally fewer respondents had engaged in the latter two activities (percentage wise), the actual number of respondents who engaged in these activities increased. For example, 25 more respondents joined a march against GBV (39 to 64), which represents a percentage of 33% at baseline and 17% at endline.

Baseline 26%

Endline 82%

More respondents engaged in activities to prevent GBV

Gender Attitudes

The gender attitudes of participants in the *Say NO! to GBV* intervention improved significantly from an average GEM score of 60.5 at baseline to 61.8 at endline. This indicates more positive gender attitudes after the intervention than before. More than half (56%) showed improved gender attitudes, and the following individual changes were statistically significant:

Significantly fewer respondents agreed with…	Significantly more respondents disagreed with…
If someone insults a man, he should defend his reputation with force if he has to (17% → 11%)[17]	A woman should tolerate violence to keep her family together (80% → 85%)
A woman who has sex before she marries does not deserve respect (12% → 5%)	Men should be outraged if their wives ask them to use a condom (69% → 76%)
A real man produces a male child (14% → 9%)	A woman's role is taking care of her home and family (37% → 44%)
A woman should obey her husband in all things (25% → 16%)	A man should have the final word about decisions in his home (60% → 69%)

[17] Partially agreed

REPSSI worked with TPO Uganda and other partners including OPM to promote social connectedness in the provision of health, education, and SRHR services, as well as support for families and communities to provide enhanced PSS care and protection to children, adolescents, and youth in emergency settings. According to the United Nations High Commissioner for Refugees (UNHCR) and Uganda's Office of the Prime Minister (OPM), Uganda is home to 1.36 million refugees and asylum-seekers, including 985 512 from South Sudan, 36 677 from Burundi, 271 967 from Democratic Republic of Congo (DRC), and 70 988 refugees from Ethiopia, Eritrea, Rwanda, Somalia, and Sudan, among others (UNHCR, 2020). Overall, an estimated 81% of all new refugees in Uganda are women and children (UNICEF, 2022). Current funding is mainly geared towards immediate needs such as water and healthcare, but there are significant numbers of unaccompanied children, children living with disability, HIV, in early marriages, or engaged in child labour. Additionally, there are no psychiatrists, few social workers, and limited programmes for these marginalised children.

Project implementation information	
Sites of implementation	Kiryandongo refugee camp.
Implementing partners	TPO Uganda. Synergos.
Implementing process	Field officers from TPO and other civil society partners were trained to support child protection caregivers as they work with groups of children. The child protection caregivers facilitated the Social Connectedness workshops and supported communities as they implemented their plans to enhance social connectedness.
Beneficiaries	Adolescents between 12 and 18 years.
Recruitment process	Child protection caregivers identified children for the project.
Content	Journey of Life.

Support to access SRHR services

For this group, 54% of respondents at baseline and 49% at endline indicated that they had visited a health facility for health services in the last six months. Respondents who were in school were also asked in what ways their schools support children in accessing SRHR services. An average of 2.8 forms of support were identified at baseline and this decreased slightly to 2.7 at endline, indicating that support from schools did not improve. The following individual changes were found to be significant:

Baseline 42% Endline 64%

Respondents believed that the information they shared with the healthcare provider would be kept confidential

Baseline 58% Endline 75%

Respondents said their teachers insist on seeing their medical files

Sexual debut

The age at which respondents thought a girl or a boy should become sexually active did not significantly change from baseline to endline. However, there was a significant difference between the ages at which respondents thought a girl versus a boy should become sexually active (Table 23, Annex 7). 4% fewer respondents (24% to 20%) thought a girl should be 18 years old and 15% fewer (28% to 13%) thought a boy should be 18 years old. Additionally, for those who had not had sex yet, there was a statistically significant change in the ages at which respondents thought they would be when they first have sex (Table 24, Annex 7). 9% fewer respondents (12% to 3%) thought they will be 18 years old when they first have sex, and 21% more respondents (6% to 27%) thought they will be 20 years old.

Anxiety

Anxiety was measured using the Generalised Anxiety Disorder 7-item scale, which has a possible range of 0 to 21 with higher scores indicating higher levels of anxiety. Cronbach's alpha for the 7-items of the questionnaire did reach an acceptable reliability, $\alpha = 0.79$. For this group, the mean score was 4.1 at baseline (ranging between 7 and 12), which decreased significantly to 2.8 (ranging from 0 to 18). This means that respondents were experiencing less mental health distress at endline than they were at baseline. More than half (57%) of respondents showed a decrease in anxiety scores from baseline to endline.

57%

Respondents showed decreased anxiety levels

Two changes from baseline to endline were found to be statistically significant:

Baseline 47% Endline 70%

More respondents selected "Not at all" for "Not being able to stop or control worrying"

Baseline 48% Endline 65%

More respondents selected "Not at all" for "Worrying too much about different things"

Conclusion

This report has considered results collected from various REPSSI interventions across a number of African countries, namely Angola, Eswatini, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Uganda, Zambia, and Zimbabwe. In total, 4124 baseline responses and 2266 endline responses were collected across eleven African countries (55% retention rate). Demographic information across all the countries has been described, and a number of interesting findings were evidenced. For example, findings revealed the significant impact of pregnancy on school dropouts (as 25% of those not in school), and the responsibilities young respondents have (like looking after younger children and sick people at home). Respondents are also facing hunger (although this did not change during COVID-19), and percentages of respondents getting married, falling pregnant or getting someone else pregnant were also fairly consistent from baseline to endline. Access to a number of SRHR products and services did improve significantly from baseline to endline, such as getting condoms (6% to 10%), and sanitary pads (18% to 24%). These are noteworthy during COVID-19 where EUP and transactional sex increased, and when access to services was limited due to lockdowns and the redirection of critical health resources.

In terms of psychosocial wellbeing, while changes in average resilience scores were not found to be significant, 52% of respondents (1177) showed an increase in resilience enablers from baseline to endline. Items related to feelings of belonging and connectedness (both related to one's family and one's friends) and items related to growth and gaining independence saw positive shifts, which points to the presence of greater resilience enablers, or the development of more awareness of these resilience enablers from baseline to endline. Significant findings in relation to the other psychosocial wellbeing scales used was the decrease in depression and the increase in self-esteem. Over half of the respondents showed decreases in depression or mental health distress, and respondents indicated that they had fewer feelings of hopelessness and despair, and fewer physical symptoms like tiredness, fidgeting, and loss of appetite. In terms of self-esteem, 53% of respondents (1210) showed an increase from baseline to endline. As with the PHQ-9 changes, all the changes on the Rosenberg Self-Esteem Scale were found to be significant.

In terms of thematic-specific findings, there were many positive and significant shifts. In Angola, Namibia, and Zambia, analysis showed that 40% of respondents experienced increased support from schools in terms of accessing SRHR services, and significantly more respondents indicated that they had visited a health facility in the previous 6 months at endline compared to baseline. In Kenya and Mozambique, respondents also felt more supported to access SRHR services at endline than they did at baseline. In Uganda, results were slightly different as fewer respondents (54% to 49%) indicated that they had visited a health facility for health services in the last six months, and support from schools did not improve. This points towards the unique country- and context-specific nature these interventions are working within and highlights that the same intervention my not be as successful in multiple contexts for a number of reasons. Despite this, in Uganda, analysis showed that respondents were experiencing less anxiety at endline than they were at baseline.

Reduced stress was also seen amongst adolescent mothers in Malawi and Zimbabwe, where 65% of mothers showed decreased parental stress levels from baseline to endline. Additionally, mothers showed increased resilience, as just over half (51%) showed increased resilience scores from baseline to endline. Other positive changes included the increased support mothers received from the father of their child[ren], mothers reported having more employed adults in their household at endline than at baseline, and significantly more mothers reported having their own source of income at endline (20%

to 39%). In contrast to these positive findings, there was a significant increase in the average number of experiences of IPV mothers had. This was also in contrast to the significant decrease in the average number of forms of IPV that were experienced by adolescent fathers in Zimbabwe. Fathers also reported other positive changes, including improvements in gender attitudes, increased resilience, and reduced stress levels.

Gender attitudes were also assessed in South Africa and Eswatini. Significant findings included the fact that after the intervention, more respondents had told friends not at their school about their victimisation experience (17% at baseline to 25% at endline), and more respondents after the intervention (26% at baseline to 82% at endline) reported they had engaged in activities to prevent GBV. As with the adolescent fathers in Zimbabwe, gender attitudes were more positive after the intervention than before, and more than half of the respondents (56%) showed improved gender attitudes. In Lesotho, results were somewhat mixed. Findings revealed that there was a positive shift in terms of attitudes to child marriage and 59% of respondents showed more attitudes against child marriage from baseline to endline. Additionally, at baseline, 64% of respondents felt that a child could do something to stop getting married, and this increased significantly to 78% at endline. However, overall, there was a decline in beliefs of the negative consequences of child marriage.

Knowing that sources of resilience include higher self-esteem, more social support and connection, positive caregiving experiences, and reduced stigma (Cluver et al., 2020; Crowley et al., 2021; Macedo et al., 2018; Shenderovich et al., 2021; van der Wal & George, 2018; West et al., 2019; Woollett & Thomson, 2016), it is evident that these interventions have worked to build resilience. Also, given that the literature has shown the negative impact of COVID-19 on adolescents and youth, including increased stress, depression, a lack of psychosocial support, and low self-esteem (Sikhangezile & Modise, 2020), it is encouraging that respondents in this sample were able to increase their resilience, mental health, and self-esteem against a backdrop of mounting mental and physical health stressors. The effects of COVID-19 not only created new challenges, but also intensified existing vulnerabilities and inequalities. Knowing this, it is expected that individuals (particularly those in adverse contexts) would experience worse mental health outcomes, greater food insecurity, reduced self-esteem, and heightened stress. While there is no control group to compare the above changes to, it is clear that individuals involved in these interventions have experienced positive changes, and that there is a demonstrated need for these interventions – evident from the literature review and the changes seen in the beneficiaries.

To further strengthen this report and these interventions, it is recommended that qualitative interviews be conducted with beneficiaries, caregivers, and project staff to better understand their on-the-ground experiences and to highlight the individuals at the heart of these interventions. Additionally, these interviews might be useful in addressing the retention rates across countries. It is noted that COVID-19 played a significant role in the number of dropouts, but it would also be useful to hear from those directly involved to see how retention could be improved. These interviews would also be useful to better contextualise and understand some of the results presented above – the positive and negative changes, and those that are not statistically significant. This would help better articulate findings which appear contradictory or confusing, such as those related to experiences of IPV in Zimbabwe, reduced support from schools to access SRHR services in Uganda, and the consequences of child marriage in Lesotho. This would also provide more information on changes which were found to be the most significant and biggest shifts, specifically around gender attitudes, actions to reduce GBV, parental stress, and access to supportive SRHR services (in some countries) to find out what makes these interventions so successful.

Finally, it is important to highlight and pay attention to the range of changes that have been presented above. While some changes in scale scores provide evidence of significant change, other change is evident only when looking at individual items on the scale, or at the percentage of respondents who increased or decreased their score. This may be because many respondents seem to start off from a good place at baseline (especially in terms of resilience and self-esteem), and so broader level changes in scores may not always be evident. It is therefore important to present and understand the more nuanced changes from baseline to endline.

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Annexures

Annex 1 – Data collection tool

The tool used during this research focussed on gathering data on the psychosocial wellbeing and mental health of children and adolescents. The tools selected were based on REPSSI's definition of what is included in psychosocial wellbeing. Existing tools that have been used in similar contexts were identified to cover the aspects outlined by REPSSI. The tool is divided into two sections. The first section will be completed by everyone and covers demographic questions that we know from research may influence or impact on psychosocial wellbeing, psychosocial wellbeing scales, and access to SRHR services. The second section has questions linked to the specific thematic areas covered per country.

Section 1 - ALL			
Scale	**What it covers**		
Demographic	Comprehensive demographic information including: • Geographic information • Gender • Age • Schooling • Type of dwelling • Access to basic services • Hunger • Caregiver/family information • Losses experienced • Marriage • Pregnancy		
Psychosocial wellbeing scales:	**What it measures**	**Possible range**	**Higher score indicates**
Child & Youth Resilience Measure-Revised (CYRM-R)	Resilience, and social connectedness	17-85	Better resilience or more resilience enablers
	Personal resilience	10-50	Better personal resilience or more personal resilience enablers
	Caregiver resilience	7-35	Better caregiver resilience or more caregiver resilience enablers
Patient Health Questionnaire-9 (PHQ-9)	Broad measure of mental health (specifically depression)	0-27	More symptoms of depression
Rosenberg Self-Esteem Scale	Self-esteem	10-40	Higher levels of self-esteem
Feeling safe	If they feel safe in different places and overall		
Sexual Reproductive Health Access	Access to several SRH services in last six months		
Section 2			
Thematic area - SEXUAL REPRODUCTIVE HEALTH & EARLY AND UNINTENDED PREGNANCIES			
Scale	**What it covers**		
Support felt from school	Degree to which the school support different aspects related to sexual reproductive health needs		
	What it measures	**Possible range**	**Higher score indicates**
Assessment of clinic services - Adapted from the WHO - Guide to	Support from health facilities for adolescents	0-10	More adolescent friendly space

assessing health services for adolescent clients			
Sexual Debut	Appropriate age for sex, if they have had, what age where they or do they think they will be when they first have sex		
Thematic area - ADOLESCENT MOTHERS/FATHERS			
Scale	What it covers		
Demographic additional	Number and ages of children, relationship status, who they live with, support from fathers of their child(ren), own source of income		
	What it measures	Possible range	Higher score indicates
Brief Resilience Scale	Resilience	6-30	Better resilience
Parental Stress Scale	Parental Stress Levels of Mothers	18-90	Higher parental stress levels
Composite Abuse Scale Revised - Short Form (CASR-SF)	Experiences of Intimate Partner Violence in last 6 months and if their children witnessed it	0-15	More experiences of IPV
Thematic area - CHILD MARRIAGE			
Scale	What it measures	Possible range	Higher score indicates
Child Marriage Attitudes	Attitudes towards child marriage	14-40	More progressive attitudes towards child marriage
Child Marriage Consequences and Prevention	What can children do if they do not want to get married, the consequences of child marriage, exposure to media on prevention of child marriage, actions taken against child marriage	0-12	Greater understanding of the potential negative consequences of child marriage
Thematic area - PREVENTION OF GENDER BASED VIOLENCE			
Scale	What it measures	Possible range	Higher score indicates
Juvenile Victimization Questionnaire (some items)	Exposure to victimization	0-14	More forms of victimization selected
Reporting of experiences	Did they report, if yes, to who, if no, then why		
GBV prevention actions	Did they do anything to prevent GBV		
Gender Equitable Men (GEM) Scale	Gender attitudes	24-72	More positive gender attitudes
Thematic area - SOCIAL CONNECTEDNESS FOR ADOLESCENTS IN HUMANITARIAN EMERGENCIES			
Scale	What it measures	Possible range	Higher score indicates
Generalized Anxiety Disorder 7-item (GAD-7)	Anxiety	0-21	More symptoms of anxiety & poorer mental health

Annex 2 – Overall tables & graphs

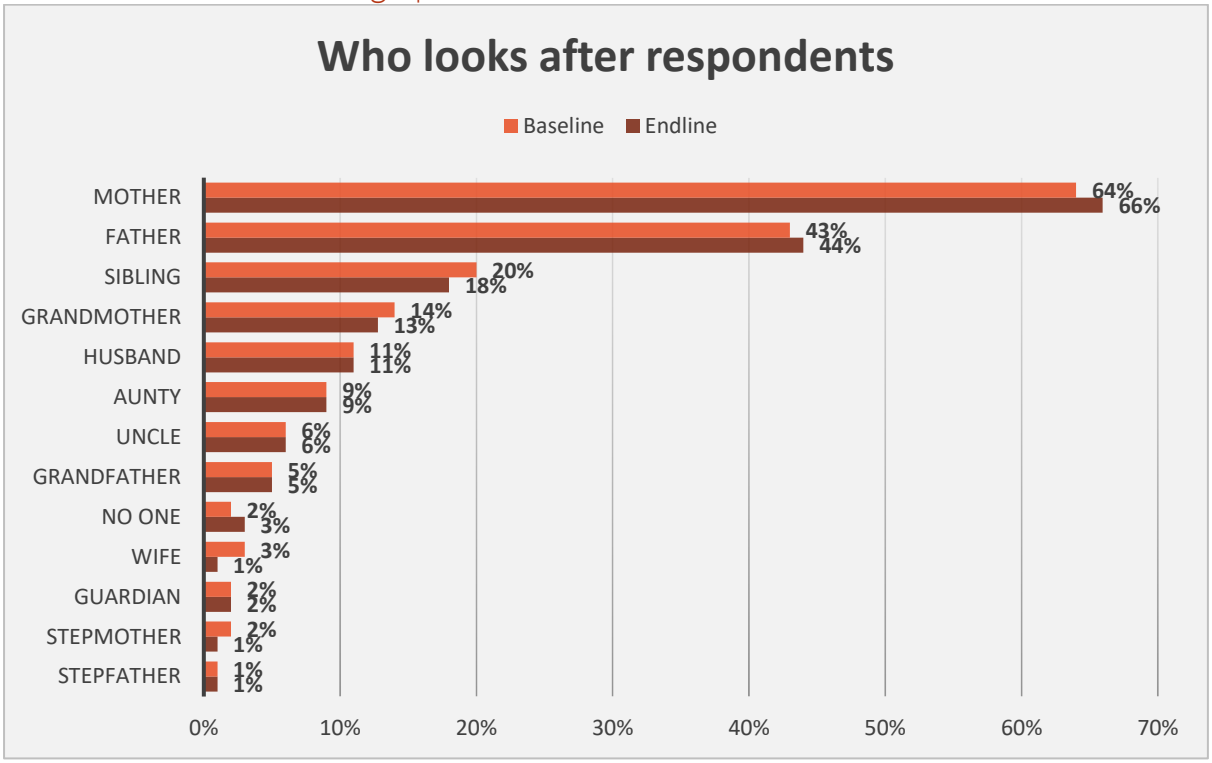

Figure 8: All responses to who looks after responses

Question	Yes Baseline	Yes Endline	% Change		p
Got condoms	6%	10%	+4%	↑	**0.000**
Been tested for HIV	24%	25%	+1%	↑	0.678
Been tested for STIs	6%	8%	+2%	↑	**0.011**
Received ART	5%	8%	+3%	↑	**0.002**
Received PrEP (pre-exposure prophylaxis)	0.5%	1%	+0.5%	↑	**0.016**
Received PEP (post-exposure prophylaxis)	1%	1%	-	-	0.589
Girls only					
Got an Intrauterine Device (IUD)	1%	2%	+1%	↑	**0.004**
Got the pill	8%	10%	+2%	↑	0.185
Got a birth control injection	10%	13%	+3%	↑	0.035
Antenatal check-ups for your baby – while pregnant	7%	7%	-	-	0.820
Gave birth at a clinic or hospital	7%	6%	-1%	↓	0.093
Postnatal check-ups for you or your baby	11%	9%	-2%	↓	0.235
Help with breastfeeding from a healthcare worker	6%	6%	-	-	0.640
Got sanitary pads	18%	24%	+6%	↑	**0.000**
Got a cervical cancer vaccination	2%	5%	+3%	↑	**0.000**
PMTCT (only pregnant girls)	3%	5%	+2%	↑	**0.002**

Question	Yes Baseline	Yes Endline	% Change		p
Boys only					
Medical male circumcision	15%	19%	+4%	↑	0.023

Figure 9: Overall responses to SRHR services questions

Question		Baseline	Endline		p
I get along with people around me	Not at all	7%	7%	-	0.800
	A lot	50%	50%	-	
Getting an education is important to me	Not at all	1%	2%	↑	0.001
	A lot	79%	82%	↑	
I know how to behave/act in different situations (such as school, home, and church)	Not at all	3%	4%	↑	0.000
	A lot	49%	56%	↑	
My parent(s)/caregiver(s) really look out for me	Not at all	2%	3%	↑	0.037
	A lot	67%	68%	↑	
My parent(s)/caregiver(s) know a lot about me (e.g., who my friends are, what I like to do)	Not at all	7%	7%	-	0.384
	A lot	46%	47%	↑	
If I am hungry, there is enough to eat	Not at all	10%	10%	-	0.263
	A lot	36%	33%	↓	
People like to spend time with me	Not at all	5%	4%	↓	0.701
	A lot	44%	45%	↑	
I talk to my family/caregiver(s) about how I feel (e.g., when I am hurt or sad)	Not at all	17%	14%	↓	0.019
	A lot	35%	38%	↑	
I feel supported by my friends	Not at all	14%	11%	↓	0.016
	A lot	33%	34%	↑	
I feel that I belong/belonged at my school	Not at all	5%	7%	↑	0.000
	A lot	59%	54%	↓	
My family/caregiver(s) care about me when times are hard (e.g., if I am sick or have done something wrong)	Not at all	4%	4%	-	0.896
	A lot	61%	60%	↓	
My friends care about me when times are hard (e.g., if I am sick or have done something wrong)	Not at all	13%	9%	↓	0.000
	A lot	31%	36%	↑	
I am treated fairly in my community	Not at all	10%	10%	-	0.063
	A lot	37%	39%	↑	
I have chances to show others that I am growing up and can do things by myself	Not at all	7%	5%	↓	0.000
	A lot	44%	54%	↑	
I feel safe when I am with my family/caregiver(s)	Not at all	2%	2%	-	0.058
	A lot	69%	72%	↑	
I have chances to learn things that will be useful when I am older (like cooking, working, and helping others)	Not at all	2%	3%	↑	0.172
	A lot	60%	63%	↑	
I like the way my family/caregiver(s) celebrates things (like holidays or learning about my culture)	Not at all	6%	5%	↓	0.297
	A lot	51%	51%	-	

Figure 10: Overall responses to CYRM-R items

Question		Baseline	Endline		p
Little interest or pleasure in doing things	Not at all	43%	50%	↑	0.000
	Nearly every day	12%	10%	↓	
Feeling down, depressed, or hopeless	Not at all	54%	58%	↑	0.045
	Nearly every day	6%	5%	↓	
Trouble falling asleep, staying asleep, or sleeping too much	Not at all	58%	64%	↑	0.000
	Nearly every day	6%	6%	-	

Question		Baseline	Endline		p
Feeling tired or having little energy	Not at all	49%	57%	↑	0.000
	Nearly every day	6%	5%	↓	
Poor appetite or overeating	Not at all	54%	63%	↑	0.000
	Nearly every day	6%	6%	-	
Feeling bad about yourself - or that you're a failure or have let yourself or your family down	Not at all	66%	71%	↑	0.002
	Nearly every day	4%	3%	↓	
Trouble concentrating on things, such as reading the newspaper or watching television	Not at all	59%	66%	↑	0.000
	Nearly every day	7%	4%	↓	
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	Not at all	68%	75%	↑	0.000
	Nearly every day	4%	3%	↓	
Thoughts that you would be better off dead or of hurting yourself in some way	Not at all	79%	83%	↑	0.003
	Nearly every day	3%	2%	↓	

Figure 11: Overall responses to PHQ-9 items

Question		Baseline	Endline		p
On the whole, I am satisfied with myself	Strongly Agree	44%	52%	↑	0.000
	Strongly Disagree	3%	3%	-	
At times I think I am no good at all	Strongly Agree	7%	8%	↑	0.000
	Strongly Disagree	17%	20%	↑	
I feel that I have a number of good qualities	Strongly Agree	34%	43%	↑	0.000
	Strongly Disagree	2%	3%	↑	
I am able to do things as well as most other people	Strongly Agree	36%	43%	↑	0.000
	Strongly Disagree	1%	2%	↑	
I feel I do not have much to be proud of	Strongly Agree	11%	12%	↑	0.005
	Strongly Disagree	14%	15%	↑	
I certainly feel useless at times	Strongly Agree	7%	6%	↓	0.010
	Strongly Disagree	22%	25%	↑	
I feel that I'm a person of worth, at least on an equal plane with others	Strongly Agree	34%	41%	↑	0.000
	Strongly Disagree	2%	3%	↑	
I wish I could have more respect for myself	Strongly Agree	35%	41%	↑	0.002
	Strongly Disagree	2%	2%	-	
All in all, I am inclined to feel that I am a failure	Strongly Agree	5%	6%	↑	0.017
	Strongly Disagree	23%	26%	↑	
I take a positive attitude toward myself	Strongly Agree	35%	43%	↑	0.000
	Strongly Disagree	3%	4%	↑	

Figure 12: Overall responses to Rosenberg Self-Esteem Scale

Annex 3 – Reduced EUP through psychosocial skills that enhance SRH information and services

Age group	Age respondents think a girl should first have sex				Age respondents think a boy should first have sex			
	Baseline	*Endline*	*% Change*		*Baseline*	*Endline*	*% Change*	
12	5%	2%	-3%	↓	5%	1%	-4%	↓
18	17%	20%	+3%	↑	19%	22%	+3%	↑
20	17%	14%	-3%	↓	18%	14%	-4%	↓

25	8%	7%	-1%	↓	9%	8%	-1%	↓
30	3%	7%	+4%	↑	5%	7%	+2%	↑

Figure 13: Age at which respondents think girls and boys should become sexually active

Annex 4 – Improved HIV outcomes through psychosocial skills that enhance HIV prevention and services

Age group	Age respondents think a girl should first have sex				Age respondents think a boy should first have sex			
	Baseline	*Endline*	*% Change*		*Baseline*	*Endline*	*% Change*	
18	23%	30%	+7%	↑	22%	28%	+6%	↑
20	21%	16%	-5%	↓	24%	15%	-9%	↓
25	10%	9%	-1%	↓	15%	9%	-6%	↓
30	6%	5%	-1%	↓	6%	6%	0%	-

Figure 14: Age at which respondents think girls and boys should become sexually active

Annex 5 – Improved outcomes for adolescent mothers (and fathers) through psychosocially informed MCHC

Number of children given birth to	Baseline	Endline	% Change	
0 – I'm pregnant	10%	2%	-8%	↓
1	70%	64%	-6%	↓
2	15%	23%	+8%	↑
3	4%	7%	+3%	↑
4	1%	2%	+1%	↑
5	0%	0.5%	+0.5%	↑

Figure 15: Number of children mothers have given birth to

Parental Stress Scale		Baseline	Endline		p
I am happy in my role as a parent	Strongly Agree	22%	38%	↑	0.000
	Strongly Disagree	5%	5%	-	
There is little or nothing I wouldn't do for my child(ren) if it was necessary	Strongly Agree	12%	23%	↑	0.000
	Strongly Disagree	5%	10%	↑	
Caring for my child(ren) sometimes takes more time and energy than I have to give	Strongly Agree	8%	9%	↑	0.000
	Strongly Disagree	7%	14%	↑	
I sometimes worry whether I am doing enough for my child(ren)	Strongly Agree	13%	22%	↑	0.000
	Strongly Disagree	4%	7%	↑	
I feel close to my child(ren)	Strongly Agree	24%	57%	↑	0.000
	Strongly Disagree	1%	1%	-	
I enjoy spending time with my child(ren)	Strongly Agree	29%	58%	↑	0.000
	Strongly Disagree	1%	1%	-	
My child(ren) is an important source of affection for me	Strongly Agree	34%	49%	↑	0.000
	Strongly Disagree	1%	0%	↓	
Having child(ren) gives me a more certain and optimistic view for the future	Strongly Agree	28%	39%	↑	0.003
	Strongly Disagree	2%	1%	↓	
The major source of stress in my life is my child(ren)	Strongly Agree	8%	8%	-	0.000
	Strongly Disagree	9%	26%	↑	
	Strongly Agree	10%	5%	↓	0.000

Parental Stress Scale		Baseline	Endline		p
Having child(ren) leaves little time and flexibility in my life	Strongly Disagree	8%	17%	↑	
Having child(ren) has been a financial burden	Strongly Agree	6%	7%	↑	0.000
	Strongly Disagree	12%	23%	↑	
It is difficult to balance different responsibilities because of my child(ren)	Strongly Agree	4%	5%	↑	0.007
	Strongly Disagree	12%	17%	↑	
The behaviour of my child(ren) is often embarrassing or stressful to me	Strongly Agree	3%	3%	-	0.000
	Strongly Disagree	29%	49%	↑	
If I had it to do over again, I might decide not to have child(ren)	Strongly Agree	11%	18%	↑	0.000
	Strongly Disagree	18%	31%	↑	
I feel overwhelmed by the responsibility of being a parent	Strongly Agree	11%	17%	↑	0.002
	Strongly Disagree	8%	12%	↑	
Having child(ren) has meant having too few choices and too little control over my life	Strongly Agree	5%	7%	↑	0.000
	Strongly Disagree	12%	18%	↑	
I am satisfied as a parent	Strongly Agree	21%	41%	↑	0.000
	Strongly Disagree	3%	4%	↑	
I find my child(ren) enjoyable	Strongly Agree	25%	58%	↑	0.000
	Strongly Disagree	1%	0%	↓	

Figure 16: Mothers' responses to Parental Stress Scale

Items	Experienced this		% change	
	Baseline	*Endline*		
Used or threatened to use a knife or gun or other weapon to harm me	4%	8%	+4%	↑
Followed me or hung around outside my home or work	5%	11%	+6%	↑
Threatened to harm or kill me or someone close to me	3%	9%	+6%	↑
Choked me	5%	8%	+3%	↑
Harassed me by phone, text, email or using social media	5%	11%	+6%	↑
Told me I was crazy, stupid, or not good enough	10%	16%	+6%	↑
Hit me with a fist or object, kicked, or bit me	11%	16%	+5%	↑
Kept me from seeing or talking to my family or friends	9%	13%	+4%	↑
Kept me from having access to a job, money, or financial resources	8%	13%	+5%	↑

Figure 17: Mothers' experiences of IPV

Question	Disagree			p
	Baseline	*Endline*		
There are times when a woman deserves to be beaten	51%	80%	↑	0.000
A woman should tolerate violence to keep her family together	54%	76%	↑	0.000
It is alright for a man to beat his wife if she is unfaithful	56%	79%	↑	0.001
A man can hit his wife if she won't have sex with him	62%	86%	↑	0.001
If someone insults a man, he should defend his reputation with force if he has to	48%	81%	↑	0.000
A man using violence against his wife is a private matter that shouldn't be discussed outside the couple	43%	73%	↑	0.000
Men are always ready to have sex	47%	74%	↑	0.001
A man needs other women even if things with his wife are fine	49%	69%	↑	0.012
You don't talk about sex, you just do it	57%	78%	↑	0.003

Question	Disagree			p
	Baseline	*Endline*		
A woman should not initiate sex	55%	81%	↑	0.000
A woman who has sex before she marries does not deserve respect	58%	89%	↑	0.000
Women who carry condoms on them are easy	54%	72%	↑	0.005
Men should be outraged if their wives ask them to use a condom	46%	74%	↑	0.000
It is a woman's responsibility to avoid getting pregnant	36%	72%	↑	0.000
Only when a woman has a child is she a real woman	49%	86%	↑	0.000
A real man produces a male child	55%	91%	↑	0.000
Changing diapers, giving a bath, and feeding kids is the mother's responsibility	35%	70%	↑	0.000
A woman's role is taking care of her home and family	26%	64%	↑	0.000
The husband should decide to buy the major household items	33%	80%	↑	0.000
A man should have the final word about decisions in his home	31%	68%	↑	0.000
A woman should obey her husband in all things	28%	51%	↑	0.001

Figure 18: Fathers' responses to Gender Equitable Men Scale

Questions		Baseline	Endline		p
I tend to bounce back quickly after hard times	Agree	21%	51%	↑	0.000
	Disagree	11%	10%	↓	
I have a hard time making it through stressful events	Agree	30%	27%	↓	0.000
	Disagree	13%	41%	↑	
It does not take me long to recover from a stressful event	Agree	34%	48%	↑	0.001
	Disagree	15%	20%	↑	
It is hard for me to snap back when something bad happens	Agree	25%	27%	↑	0.000
	Disagree	17%	43%	↑	
I usually come through difficult times with little trouble	Agree	34%	44%	↑	0.001
	Disagree	10%	16%	↑	
I tend to take a long time to get over setbacks in my life	Agree	30%	35%	↑	0.000
	Disagree	13%	33%	↑	

Figure 19: Fathers' responses to the Brief Resilience Scale

Question		Baseline	Endline		p
I am happy in my role as a parent	Strongly agree	4%	33%	↑	0.000
	Strongly disagree	3%	4%	↑	
There is little or nothing I wouldn't do for my child(ren) if it was necessary.	Strongly agree	2%	40%	↑	0.000
	Strongly disagree	4%	3%	↓	
Caring for my child(ren) takes more time and energy than I can give	Strongly agree	1%	3%	↑	0.000
	Strongly disagree	2%	11%	↑	
I sometimes worry whether I am doing enough	Strongly agree	6%	15%	↑	0.000
	Strongly disagree	1%	8%	↑	
I feel close to my child(ren)	Strongly agree	10%	33%	↑	0.000
	Strongly disagree	3%	3%	-	
I enjoy spending time with my child(ren)	Strongly agree	5%	41%	↑	0.000

	Strongly disagree	1%	2%	↑	
My child(ren) is an important source of affection for me	Strongly agree	11%	24%	↑	0.000
	Strongly disagree	2%	5%	↑	
Having child(ren) gives me a more certain and optimistic view for the future	Strongly agree	10%	14%	↑	0.000
	Strongly disagree	1%	4%	↑	
The major source of stress in my life is my child(ren)	Strongly agree	5%	2%	↓	0.000
	Strongly disagree	5%	27%	↑	
Having child(ren) leaves little time and flexibility in my life	Strongly agree	4%	3%	↓	0.000
	Strongly disagree	2%	16%	↑	
Having child(ren) has been a financial burden	Strongly agree	3%	3%	-	0.000
	Strongly disagree	8%	28%	↑	
It is difficult to balance different responsibilities	Strongly agree	2%	6%	↑	0.000
	Strongly disagree	7%	16%	↑	
The behaviour of my child(ren) is often embarrassing	Strongly agree	2%	0%	↓	0.000
	Strongly disagree	11%	39%	↑	
If I had it to do over again, I might decide not to have child(ren)	Strongly agree	2%	1%	↓	0.000
	Strongly disagree	8%	35%	↑	
I feel overwhelmed by the responsibility of being a parent	Strongly agree	3%	11%	↑	0.001
	Strongly disagree	5%	10%	↑	
Having child(ren) has meant having too few choices	Strongly agree	1%	1%	-	0.000
	Strongly disagree	6%	13%	↑	
I am satisfied as a parent	Strongly agree	10%	48%	↑	0.000
	Strongly disagree	4%	1%	↓	
I find my child(ren) enjoyable	Strongly agree	9%	44%	↑	0.000
	Strongly disagree	3%	1%	↓	

Figure 20: Fathers' responses to the Parental Stress Scale

Annex 6 - Ending Child Marriage

Age group	Proper age of marriage for a girl				Proper age of marriage for a boy			
	Baseline	*Endline*	*% Change*		*Baseline*	*Endline*	*% Change*	
18	13%	10%	-3%	↓	13%	7%	-6%	↓
20	23%	11%	-12%	↓	17%	10%	-7%	↓
25	15%	26%	+11%	↑	14%	13%	-1%	↓
30	10%	12%	+2%	↑	16%	16%	0%	-

Figure 21: Responses to proper age to marry

Consequences of child marriage	Baseline	Endline		p
Cannot finish school	67%	53%	↓	0.007
Difficult to raise children when you are young	68%	44%	↓	0.000
Do not have enough money to support the family	47%	34%	↓	0.012
Bad for her health	45%	31%	↓	0.008
Misses out on youth	39%	20%	↓	0.000
Lose all your friends	30%	12%	↓	0.000
Become a slave to the family	28%	12%	↓	0.000

Figure 22: Consequences of child marriage

Annex 7 – Improved SRHR and social connectedness for adolescent girls and boys in humanitarian emergencies

Age group	Age respondents think a girl should first have sex				Age respondents think a boy should first have sex			
	Baseline	*Endline*	*% Change*		*Baseline*	*Endline*	*% Change*	
18	24%	20%	-4%	↓	28%	13%	-15%	↓
20	9%	20%	+11%	↑	11%	25%	+14%	↑
20+	49%	48%	-1%	↓	49%	51%	+2%	↑

Figure 23: Ages at which respondents think girls and boys should become sexually active

Age group	Age respondents think they will be when they first have sex			
	Baseline	*Endline*	*% Change*	
18	12%	3%	-9%	↓
20	6%	27%	+21%	↑
20+	78%	63%	-15%	↓

Figure 24: Age at which respondents think they will first become sexually active