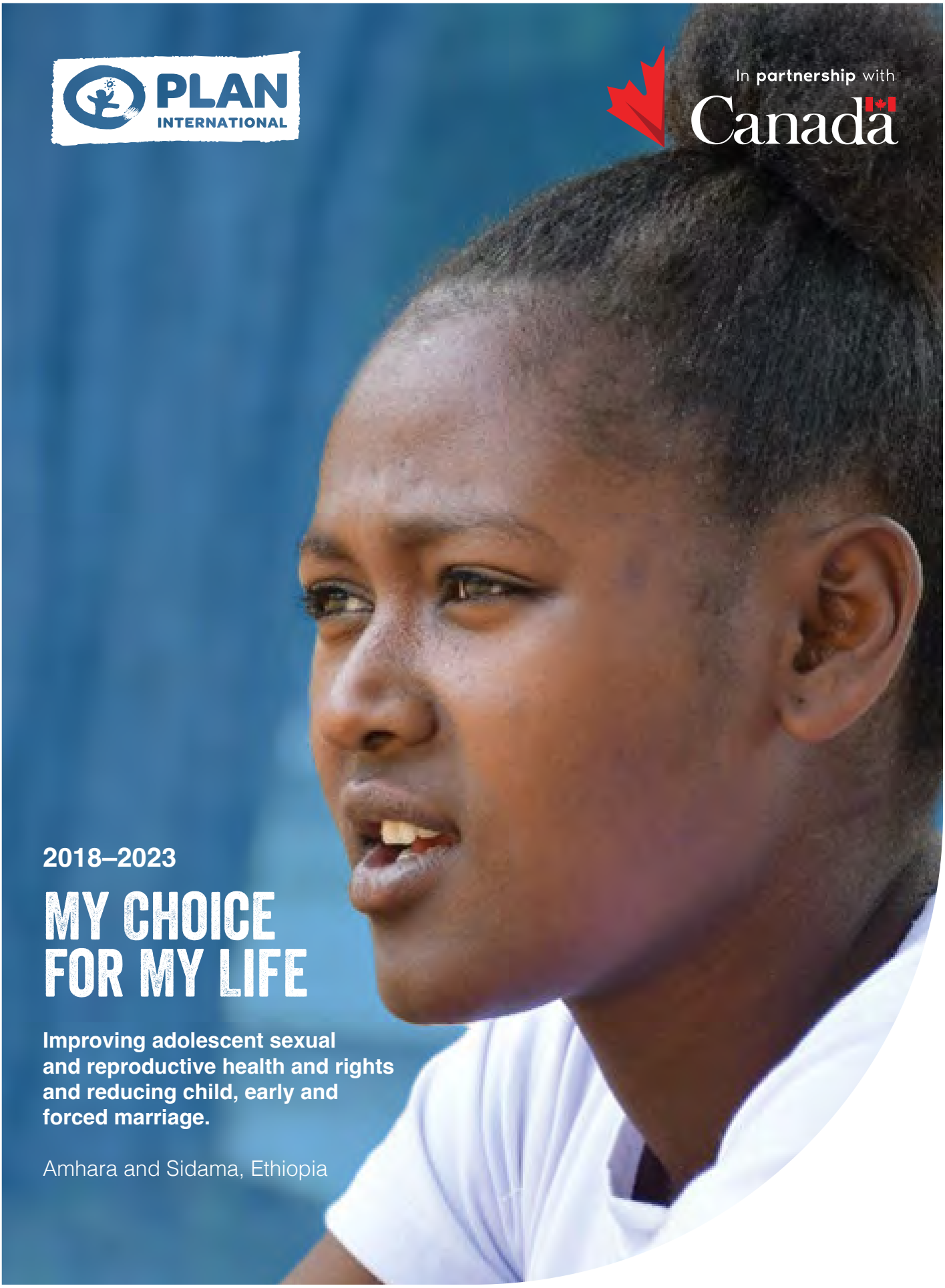
PLAN
INTERNATIONAL
In partnership with
Canada
2018–2023
MY CHOICE
FOR MY LIFE
Improving adolescent sexual and reproductive health and rights and reducing child, early and forced marriage.
Amhara and Sidama, Ethiopia

Tejitu, 15, (first row left) with fellow members of the school anti-child marriage group.

All photos courtesy of:

Plan International Ethiopia

Association for National Planned Program for Vulnerable Children and in Need-Ethiopia (ANPPCAN)

Jerusalem Children and Community Development Organization (JeCCDO)

Cover: Seble, a My Choice for My Life project participant

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ACRONYMS

ANPPCAN	Association for National Planned Program for Vulnerable Children and in Need (Ethiopia)
ASRH	Adolescent Sexual and Reproductive Health
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AYSRH	Adolescent and Youth Sexual Reproductive Health
CEFM	Child, Early and Forced Marriage
CP	Child Protection
FGM	Female Genitial Mutilation
GBV	Gender Based Violence
GE	Gender Equality
HTP	Harmful Traditional Practices
JeCCDO	Jerusalem Children and Community Development Organization
LARC	Long-acting reversible contraception
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SBCC	Social and Behaviour Change Communication
SGBV	Sexual and Gender-Based Violence
VSLA	Village savings and loans associations
MoWSA	Ministry of Women and Social Affairs

Abeba raises awareness in community of the harmful consequences of early marriage.

Wubishet, an adolescent program participant.

Zewditu, an adolescent program participant.

Fatima is a savings group leader in Amhara region.

Girls learn more about the dangers of child marriage during school discussion.

MY CHOICE FOR MY LIFE

Improving adolescent sexual and reproductive health and rights and reducing child, early and forced marriage.

My Choice for My Life was a five-year initiative aimed at reducing CEFM and poor sexual and reproductive health outcomes for adolescent girls and boys in targeted regions of Amhara and Sidama, Ethiopia.

Carried out by Plan International Ethiopia and Plan International Canada, in partnership with the Association for National Planned Program for Vulnerable Children and in Need-Ethiopia (ANPPCAN) in Amhara, and Jerusalem Children and Community Development Organization (JeCCDO) in Sidama, the project reached over 163,000 adolescents (104,728 female and 59,126 male).

My Choice for My Life worked closely with the Ethiopian Ministry of Women, Children and Youth; Ministry of Health; and Ministry of Education, among others, including their regional-level bureaus and woreda offices.

The project was supported by Global Affairs Canada, in alignment with Canada's Feminist International Assistance Policy. It focused on the realization of girls' rights to ASRHR and their right to decide if, when and whom to marry, by focusing on strengthening the agency of women and girls, engaging men and boys, and improving institutional responsiveness.

My Choice for My Life adopted a comprehensive, rights-based, and gender-transformative approach to closing the gaps in adolescent sexual and reproductive health and rights (ASRHR), and child protection, particularly regarding CEFM, by addressing demand, supply, and accountability barriers. It used tested modalities at the individual, community, and institutional level to increase girls' agency and decision-making, reduce the high prevalence of CEFM, and enhance demand for and utilization of sexual and reproductive health (SRH) and protection services by adolescent girls and boys, with a specific focus on girls.

> **My Choice for My Life** adopted a comprehensive, rights-based, and gender-transformative approach to closing gaps in adolescent sexual and reproductive health and rights and child protection, particularly regarding child, early and forced (CEFM) marriage.

Abeba works for the Bureau of Women and Social Affair in Amhara region. She raises awareness in the community about the negatives consequences of child marriage and says that since the My Choice for My Life project started working in the region, she has noticed a change in community behaviour.

KEY PROJECT RESULTS

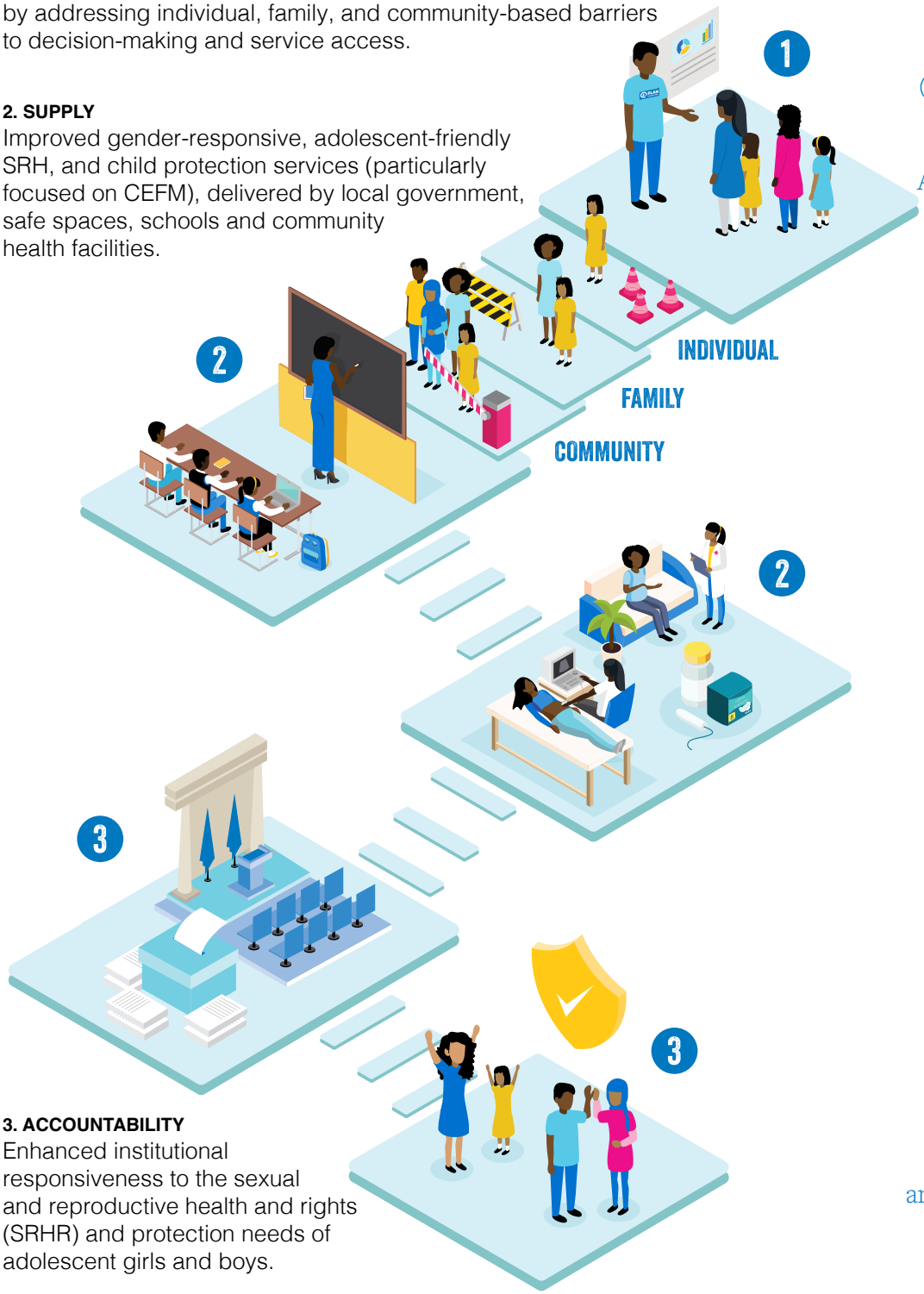
		BEFORE	AFTER
Percentage of adolescent girls and boys with adequate access to sexual and reproductive health and rights resources and services.	FEMALES	23.3%	71.6%
	MALES	31.9%	60.6%
Percentage of adolescent girls and boys with adequate decision-making regarding marriage and their own sexual and reproductive health.	FEMALES	39.7%	52.5%
	MALES	34.8%	57.9%
Average level of satisfaction of adolescent girls and boys with the quality and responsiveness of sexual and reproductive health services provided by targeted health facilities.	FEMALES	62%	77%
	MALES	66%	75%
Average level of gender-responsiveness and adolescent-friendliness of sexual and reproductive health services in targeted health facilities.	GENDER-RESPONSIVENESS	47%	87%
	ADOLESCENT-FRIENDLINESS	50%	88%

PROJECT THEORY OF CHANGE

The project was guided by a Gender Equality Strategy that adopted three interlinked approaches. All three of these approaches were operationalized within the project's three intermediate outcome areas and are grounded in the underlying assumption that adolescents in all their diversity have the power and potential to be positive change agents within their own lives; and that gender inequalities and unequal power relations need to be directly addressed for the full realization of adolescents' rights.

1. DEMAND
Increased agency of adolescents, especially girls, to access and utilize SRH services and information and to decide if, when and whom to marry, by addressing individual, family, and community-based barriers to decision-making and service access.

2. SUPPLY
Improved gender-responsive, adolescent-friendly SRH, and child protection services (particularly focused on CEFM), delivered by local government, safe spaces, schools and community health facilities.



3. ACCOUNTABILITY
Enhanced institutional responsiveness to the sexual and reproductive health and rights (SRHR) and protection needs of adolescent girls and boys.

My Choice for My Life targeted the root causes of CEFM and the systemic and structural barriers that adolescent girls (specifically) and boys face in exercising their SRHR.

At the heart of the project's theory of change was the recognition that unless gender inequalities and deep-rooted, harmful social and gender norms are tackled head-on, the full realization of ASRHR, including prevention of CEFM, is less likely to be achieved and sustained.

The project took a comprehensive, rights-based, and gender-transformative approach to address both demand and supply-side barriers, and enhance responsiveness and accountability of duty bearers, to reduce CEFM and improve ASRH outcomes.

Central to this approach was the individual and collective agency of adolescent girls and boys, including principles of autonomy, choice, agency and meaningful engagement to realize their SRHR and resist or refuse CEFM.

THE PROJECT'S LOGIC MODEL

The ultimate outcome is to contribute to the reduction of child early forced marriage and poor sexual reproductive health outcomes for adolescent girls and boys in the targeted regions in Amhara and Sidama.

INTERMEDIATE OUTCOMES

- **1100 –** Increased agency of adolescents, especially girls, to utilize SRH services and delay marriage (CEFM).
- **1200 –** Improved gender-responsive, adolescent friendly SRHR and child protection services, particularly CEFM, delivered by local government, safe spaces, schools and community health facilities.
- **1300 –** Enhanced institutional responsiveness to the SRHR and protection needs of adolescent girls and boys.

IMMEDIATE OUTCOMES

1110 Increased knowledge of adolescent girls and boys on GE, CEFM and ASRHR, and related services.	**1120** Improved capacity of adolescent girls and boys to make decisions on ASRHR & CEFM.	**1130** Improved social capital and networking of adolescent girls.	**1210** Enhanced capacity of facility and community-based health providers to deliver protective, gender-responsive and adolescent-friendly SRH services and CP referrals.	**1220** Improved gender-responsive & adolescent-friendly environment for SRH and CP services at selected health facilities and CP safe spaces.	**1230** Enhanced capacity of CP service providers and actors to deliver gender-responsive & adolescent-friendly CP services.	**1310** Increased availability and dissemination of quality adolescent SRHR and CEFM data and evidence.	**1320** Enhanced capacity of government officials on COVID-19 and gender responsive planning & budgeting.	**1330** Enhanced ability of CBOs, particularly women and youth networks, to undertake evidence-based advocacy on CEFM prevention & ASRHR.

OUTPUTS

1111 SBCC strategy focusing on GE, CEFM and ASRHR developed & implemented.	**1121** Adolescent girls and boys mentored on Champions of Change for Gender Equality and Girls' Rights in selected woredas.	**1131** Male and female support groups revitalized/ strengthened and trained on GE, ASRHR & CEFM.	**1211** HEWs trained on protective, gender responsive, adolescent friendly SRH services and referrals including CP referrals.	**1221** AYSRH Units refurbished based on gender & adolescent needs assessments and government standards.	**1231** Local woreda government sector offices (Women and Children Affairs, police, judiciary) trained to implement existing policies, SOPs and laws on ASRHR, CEFM and other HTPs.	**1311** Project best practices (especially focusing on gender transformative approaches) and results documented and shared among communities, service providers, planners/decision makers and other Civil Society Organizations.	**1321** Government officials trained on gender responsive planning & budgeting.	**1331** Members of CBOs, particularly from women and youth networks, trained on evidence based advocacy.
1112 Peer-led Community Conversation sessions on GE, CEFM and ASRHR conducted with out of school children.	**1122** In School adolescents, including Child Parliamentarians, trained on age appropriate gender transformative life skills, GE, CEFM and ASRHR.	**1132** Youth and adolescent girl learning platforms created and strengthened.	**1212** Facility-based health care providers trained on protective, gender responsive adolescent friendly SRH services and referrals, including CP referrals, in line with National guidelines.	**1222** CP waiting rooms or safe spaces for adolescent girls and women resourced based on gender and adolescent needs assessment.	**1232** Functional School level CP protocols established by school governance members.		**1322** Government COVID-19 response plans supported.	**1332** Coordinated CBO evidence-based advocacy plan on women's and girls' empowerment, CEFM prevention and ASRHR developed & implemented.
	1123 Vulnerable adolescent girls trained and supported in their economic empowerment initiatives.	**1133** Community and religious leaders, traditional birth attendants and circumcisers trained as change agents to challenge existing harmful social norms and practices towards ASRH and CEFM.	**1213** Woreda health officials trained on Integrated Supportive Supervision (ISS) that includes protection, gender-responsive & adolescent friendly		**1233** Community-based CP actors (Idir, religious leaders, elders, CBOs) trained to respond to CP and ASRH issues.			

GENDER EQUALITY STRATEGY

All three of these approaches are operationalized across the project's theory of change and its three intermediate outcome areas. They are grounded in the underlying assumption that adolescent girls and boys have the power and potential to be positive change agents within their own lives. And that gender inequalities and unequal power relations need to be directly addressed for the full realization of adolescents' rights.

1. LEADERS OF CHANGE
Engaging adolescent girls and women

2. PARTNERS OF CHANGE
Engaging adolescent boys and men

3. STRENGTHENING INSTITUTIONAL RESPONSIVENESS
For adolescent girls and boys

Engaging adolescent boys and men

Peer educator leads discussion at school on the dangers of child marriage.

MY CHOICE FOR MY LIFE

A GENDER-TRANSFORMATIVE PROJECT

The project's gender equality strategy adopted three interlinked approaches.

ENGAGING ADOLESCENT GIRLS AND WOMEN AS LEADERS OF CHANGE

The project focused on building the agency of adolescent girls as leaders of change. Specifically, it equipped them with knowledge of SRHR, gender equality, and the effects of CEFM, including through peer-led Community Conversations and social and behaviour change communications. It built their assertiveness and resilience to make decisions affecting their health and well-being, and to act on those decisions, through in-depth life-skills training and the Champions of Change for Girls' Rights and Gender Equality program. A range of education, mentoring and collective action activities were undertaken, including strengthening their social capital and networks for greater voice and participation in decisions within the household and community, as well as in evidence-based advocacy efforts. Aligning with its core gender-transformative premise, this approach sought to leverage and foster the inherent power and agency of adolescent girls.

ENGAGING ADOLESCENT BOYS AND MEN AS PARTNERS OF CHANGE

Boys and men are critical stakeholders in efforts to promote gender equality and strengthen women's and girls' agency. The project's gender equality strategy thus engaged boys and men in the variety of roles they play related to increasing the agency of adolescent girls, promoting SRHR, and tackling CEFM. Adolescent boys were engaged as partners and potential partners with skills-building, peer engagement, and dialogue on gender with adolescent girls through Community Conversations, Peer-to-Peer Life Skills Education and the Champions of Change for Girls' Rights and Gender Equality program. As fathers and male caregivers of adolescent girls and boys, and as leaders, gatekeepers, and role models within the community, men were engaged with dialogue and training options through adult support groups and as agents of change.

STRENGTHENING INSTITUTIONAL RESPONSIVENESS TO ADOLESCENT GIRLS AND BOYS

The gender-responsiveness and adolescent-friendliness of institutions that deliver health, child protection and education services to adolescent girls and boys is critical in the creation of an enabling environment for increased agency of adolescent girls. It is also key to adequately meeting existing and increased demand for health and protection services. Informed by its gender equality strategy, the project focused on improving gender-responsive child protection and adolescent sexual and reproductive health (ASRH) services by providing capacity-strengthening to health staff and upgrading health service provision management systems. This included a range of training for health and child protection workers focused on adolescent health, sexual and gender-based violence (SGBV), and family planning. It also comprised training on evidence-based, gender-responsive approaches to budgeting and planning for local government officers. And it included support for improving the gender-responsive and adolescent-friendly environment at health facilities, the resourcing of child protection safe spaces, and the establishment of school-based child protection protocols.

Strengthening institutional responsiveness

Throughout the **My Choice for My Life project**, qualitative and quantitative data was constantly used to understand the various gender equality issues and to refine and adjust the project accordingly. The gender equality assessment carried out at the project's start informed all interventions and provided critical guidance for the social and behaviour change communications strategy. The project's midterm evaluation findings were used to further guide the strategy and influenced planning and project activities to specifically address gender equality gaps, barriers and issues.

MY CHOICE FOR MY LIFE

PROJECT PILLARS

PROJECT PILLAR 1

ADDRESSING DEMAND-SIDE BARRIERS

The project's first pillar, Demand, increased the agency of adolescents, especially girls, to access and utilize SRH services and information, and to decide if, when and whom to marry. It did this by addressing individual, family, and community-based barriers to decision-making and service access.

GENDER-TRANSFORMATIVE AND ADOLESCENT-FRIENDLY SOCIAL AND BEHAVIOUR CHANGE COMMUNICATIONS

My Choice for My Life implemented a series of social and behaviour change communication (SBCC) activities informed by a strategy focused on gender equality; CEFM; and ASRHR.

The project's SBCC approach was key to achieving results including a significant increase in the percentage of adolescent girls and boys with adequate practical knowledge on SRHR, CEFM and related services. For females, this increased from 35% to 75.7%. And for males, it rose from 37.6% to 76%.

The SBCC strategy was developed based on a thorough situation and barrier analysis, and was informed by the project's baseline evaluation, gender equality, and child protection systems assessments.

It identified effective communication channels and key messages to guide the project's communications, considering all spectrums of the community in terms of age, gender, status and role, and level of understanding, personal views, and perceptions on ASRHR and CEFM. It identified entry points and channels of dissemination for proposed activities to promote adolescent girls' and boys' rights on SRH and protection, reject harmful traditional practices (HTP) such as GBV and CEFM, and strengthen gender-responsive service delivery.

Key messages on each of these areas were developed, validated, and translated with the engagement of project participants, including adolescents, caregivers, religious leaders, influential community members and government sector representatives.

The project's SBCC activities and materials included radio spots and radio listeners groups, mass mobilization events, billboards, brochures, and job aids for health and protection workers. SBCC messages were also integrated in group activities with adolescents and adults to contribute to the project's goal of increased knowledge to make more informed decisions.

Importantly, the project's midterm evaluation revealed that more was required to support a deeper understanding of gender equality stereotypes, roles, and responsibilities among adolescents and parents and to support the reduction of SGBV.

To address this, the project reinforced its SBCC messaging on gender stereotypes and SGBV, including for example, emphasizing the equal right of women and girls to consent to sexual activity and that lack of consent is not a justification for violence.

By the project's end, the degree to which adolescents perceived women and girls as equal to men and boys increased from 41% to 53% among female adolescents, and 42% to 60% among male adolescents. The extent to which women and girls were perceived as equal to men and boys by families and community leaders rose from 36% to 56% among adult females, and 39% to 47% among adult males.

This experience highlights the value of being able to deliver new or adapted key messages based on emerging issues, updated evidence, or revised approaches, rather than the one-time production of all social and behaviour change messages and materials. Yet it also suggests that changing perceptions of gender equality is challenging and takes time.

Additional SBCC learnings reinforced the importance of quality translation of communications materials into the local languages best understood by participants. As an example, there were barriers for some participants to clearly understand key messages in materials that were first created or translated into Amharic only.

> My Choice for My Life contributed to changes in attitudes and behaviours at the individual level in adolescents, their families, and community members. Over time, this can support an intergenerational change of social norms within families and communities on SRHR, gender equality, and the prevention of CEFM and strengthen the demand for services.

Messages of mutual respect among Awi children.

Health extension workers review social and behaviour change communication materials for use in their work.

A community conversation group in Sidama. To reach out-of-school youth, the project used an existing model of community conversations for adolescent peer education.

A peer-to-peer life skills education facilitator leading a session in Awi Zone.

ADOLESCENT GROUP PROGRAMMING: COMMUNITY CONVERSATIONS, PEER-TO-PEER LIFE SKILLS EDUCATION, AND CHAMPIONS OF CHANGE FOR GIRLS' RIGHTS AND GENDER EQUALITY

To increase adolescent girls' and boys' knowledge on GE, CEFM and ASRHR, and related services, and enhance their capacity to make decisions, the project implemented several adolescent group programs.

These interventions helped to achieve:

- An increase in the percentage of adolescent girls and boys with adequate personal skills and confidence to assert their rights and express their decisions. Among female adolescents, this rose from 36.5% to 83.4%. Among male adolescents, it improved from 44.1% to 84.2%.
- A growing percentage of adolescent girls and boys with adequate practical knowledge on SRHR, CEFM and related services. For females, this improved from 35% to 75.7%. And for males, it climbed from 37.6% to 76%.

COMMUNITY CONVERSATIONS

To reach out-of-school youth, the project used an existing model of community conversations for adolescent peer education on SRHR, gender equality and CEFM. Community Conversations provided over 19,000 adolescents (12,303 females and 6,879 males) space to gather, learn, discuss, and reflect on issues that contribute to their knowledge and decision-making power. Topics included goals and self-esteem, gender stereotypes, family planning and relationships, and accessing health and protection services.

Adolescent-friendly and context-specific learning materials were developed by the project team, guided by the project's social and behaviour change communication and gender equality strategies and drawing from existing materials.

A key lesson learned in the project was the importance of the inclusion of adolescents living with disabilities. Project activities, approaches, and materials need to be inclusive and relevant. And gaps in staff awareness and competency to meet the needs of girls and boys with disabilities must be addressed. The project also noted that creating safe, inclusive, and participatory learning environments was essential in Community Conversations and other adolescent programming, including for supporting participants' regular attendance and active participation. Positive practices included engaging participants in preparing bylaws, or ground rules, for the group, and in deciding on the group meeting time.

> "To make the sessions more attractive for adolescents, we try to manage the session using question-answer and drama. As result, we avoid making the session boring and got their full attention to complete the session actively."
>
> – REFLECTIONS FROM ADOLESCENT FACILITATORS

PEER-TO-PEER LIFE SKILLS EDUCATION

Adolescents engaged in peer-to-peer education programs on life skills, including communication, self- esteem, GBV, gender equality and ASRHR through strengthened or re-established school clubs. The peer-to-peer program involved in-school girls and boys aged 10–14 years and 15–19 years, and was facilitated by adolescents, including school club leaders, who were supported with training and mentoring.

Over 29,600 adolescents (18,168 females and 11,437 males) in 192 schools participated. To support the program, an adolescent-friendly and context-specific learning manual

A Champions of Change boys group in Awi Zone.

A Champions of Change girls group in Awi Zone.

was developed by the project team, drawing from existing materials. Participating schools were supported with stationary materials and mini-media supplies, such as speakers and microphones
.
These Peer-to-Peer Life Skills Education programs are expected to continue, as schools have chosen to take them on.

The project learned that adolescent participation, particularly for programs held after school, was sometimes limited by a lack of permission from parents and caregivers who did not see the programs' value. Promising practices for engaging parents included using school parent days to connect and encouraging adult support group members to enroll their children in adolescent programs.

> "I have improved my communication skill and now I can lead any meetings in the presence of large gathering standing in front of my friends."
>
> – FEMALE PEER-TO-PEER LIFE SKILLS EDUCATION PARTICIPANT

Striving for variety in session approaches and avoiding duplication or repetition of content in modules was recommended. The project noted that session fatigue or burnout among adolescents was a challenge that could contribute to a lack of regular attendance.

Facilitating sessions through drama and poetry, or other artistic ways of communicating encouraged the active participation of the group and enabled understanding of key messages. Using cultural dress or costumes were ideas to consider.

Another positive practice was involving teachers in some sessions, when relevant and requested by adolescents, for example to support better understanding of topics such as the biological explanation
of menstruation.

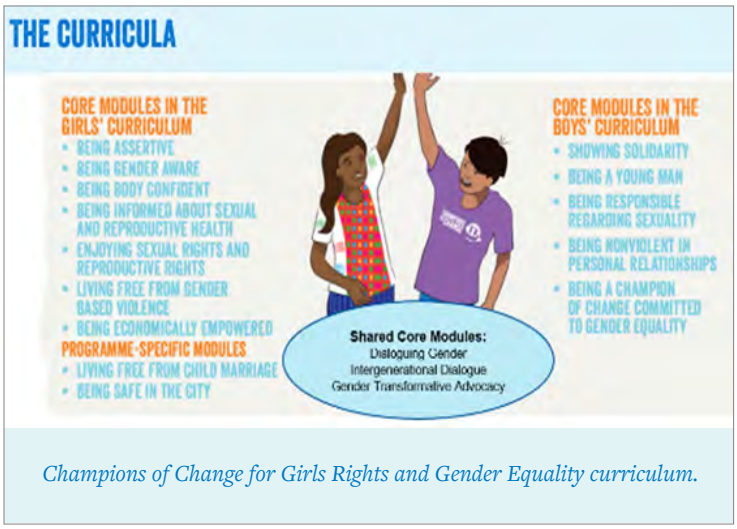
Menstrual hygiene management impacted adolescent group program participation and attendance, and school attendance. Promising practices included the provision of reusable sanitary pads to participants, and in some cases, the provision and equipping of a dedicated room for menstrual hygiene management at school.

CHAMPIONS OF CHANGE FOR GIRLS' RIGHTS AND GENDER EQUALITY

Champions of Change for Girls' Rights and Gender Equality is Plan International's flagship community-wide strategy for promoting gender equality and social norm change through youth engagement and peer-to-peer mobilization.

This program model engages adolescent girls and boys in critical reflections on gender dynamics and supports them in building their skills and capacities in their process toward increased agency. Champions of Change contributes to developing a real understanding among youth about the impact of their cultural, social and personal contexts for changes in norms, attitudes and behaviours.

The My Choice for My Life project was the first time the Champions of Change program was implemented in



Champions of Change for Girls Rights and Gender Equality curriculum.

Champions of Change curriculum materials were contextualized and then translated. This was the first time the program was implemented in Ethiopia.

A member of a village savings and loan group in Sidama who started a micro-business in her village.

Health extension workers participated in training on Adolescent and Youth Health.

The My Choice for My Life project was the first time the Champions of Change program was implemented in Ethiopia.

"

Now I am feeling equal with men and can negotiate or explain things to my husband. If I had this chance of being a Champions of Change member a number of years ago, I would have not dropped out of school and married to face early childbirth pains and problems.

Now I know many things and am raising community and household awareness to other girls and advising parents to respect the rights of their children and send them to health centre for any SRH services.

I know some other members who have helped girls be safe and reported some cases of child marriage of girls to kebele manager, which were cancelled."

– 19-YEAR-OLD FEMALE CHAMPIONS OF CHANGE PARTICIPANT, BENSA, SIDAMA

Ethiopia. Over 3,000 adolescents (1,698 females and 1,397 males) in the woredas of Bensa in Sidama, and Guangua in Awi zone of Amhara, took part. Curriculum materials were contextualized – adapted to the social, cultural, and legal context of Ethiopia and the communities with which the project would be working – and then translated into Amharic.

Champions of Change has purposely developed separate curricula for girls and boys. Used in tandem, the curricula provide a comprehensive and inclusive community-wide, child-centred approach to gender equality. The journey for girls focuses on agency, self-esteem, rights awareness, and collective power, while the boys' journey focuses on unpacking dominant masculinities to understand how boys are affected by social norms, and how they can support girls' rights and gender justice for all.

Boys and girls come together several times during their journeys to discuss their changing views on gender and social transformation, and to work on outreach activities. The curricula take a comprehensive look at gender equality, including key contents in comprehensive sexuality education and GBV prevention.

A positive practice noted in the project's Champions of Change and Community Conversation sessions was incorporating lived-experience and story-sharing. For example, married women directly shared their practical experiences in sessions to help create a better understanding among participants about the possible effects of early marriage on their future lives and to inform decision-making.

ADULT SUPPORT GROUPS AND AGENTS OF CHANGE

To create an enabling, protective, and responsive environment for adolescents to exercise their SRHR and prevent CEFM, the project engaged a range of community structures including male and female caregivers, and community and religious leaders to recognize and challenge harmful social and gender norms and practices that affect ASRHR and perpetuate CEFM.

These interventions were key to achieving project results including:

- The average level of support provided by families, community members, peers, and leaders for ASRHR for adolescent girls and boys and CEFM prevention rose from 38% to 63% among females and 39% to 60% among males.
- The extent to which women and girls were perceived as equal to men and boys by families and community leaders rose from 36% to 56% among adult females, and 39% to 47% among adult males.

> "We are seeing very good results as far as warding off child marriage is concerned."
>
> – PRIEST BEHAYILU BOGALE, CHANGE AGENT, SIDAMA

The project arranged intergenerational dialogues and adult support groups, reinforcing capacity to identify child protection issues, support surveillance and reporting mechanisms, and help change attitudes by promoting ASRHR and CEFM prevention. Over 1,600 adults were directly engaged, including 826 females and 775 males.

Over 800 community and religious leaders (266 females and 549 males) were trained as change agents to challenge existing harmful social and gender norms and practices towards ASRH and CEFM. Identified as cultural gatekeepers and critical entry points to reach adolescent girls and boys, and their parents and caregivers, the project engaged these powerful change agents to educate and influence community members to recognize the benefits of gender equality, break down barriers to obtaining ASRHR, and challenge harmful social and gender norms leading to CEFM and HTP.

> "The project has started to create confidence in women to start discussions with their spouses on the fate of their adolescent girls regarding marriage."
>
> – CHANGE AGENT, SIDAMA

There were numerous examples of change agents and adult support group members taking concrete steps to discourage and **reduce CEFM and HTP:**

- Some religious leaders engaged by the project went on to only give permission to those 18 or older to marry.
- Community associations, including the horse-riding association, banned members who arranged CEFM in their kebele. The horse-riding association also agreed they would not accompany a CEFM wedding ceremony by horse, which is the respectful cultural custom in the community.
- A local church council committee, traditional elders, and a kebele council all adopted measures prohibiting and sanctioning CEFM and HTP.

A refresher training with adult support groups.

VULNERABLE ADOLESCENT GIRLS TRAINED AND SUPPORTED IN THEIR ECONOMIC INITIATIVES

The project supported the financial assets of over 400 adolescent girls through the establishment and strengthening of village savings and loan associations and providing structured support for economic activities. This strengthened girls' economic status, increased their financial assets, and bolstered individual and collective agency. It also built economic safety nets for girls to help mitigate gender-related barriers in accessing services or issues they face at the household and community levels.

In both Amhara and Sidama regions, different microenterprises were started. For example, small shops, poultry farms, sheep fattening, traditional drinks, coffee trade, retail vegetable selling, and weaving traditional cloth. Lessons learned included there was a range of expectations from project participants around financial support based on other program experiences. Adolescents also faced particular challenges with saving money leading to some withdrawals from VSLAs.

> "I am currently able to get my basic necessities and I am leading my good life."
>
> – VSLA MEMBER IN SIDAMA

Masresha is a youth health focal person at her local health centre.

My Choice for My Life contributed to the sustained availability of trained and motivated health professionals with adequate knowledge and clinical competency to provide gender-responsive, adolescent-friendly, and protective SRH services.

PROJECT PILLAR 2

ADDRESSING SUPPLY-SIDE BARRIERS

The project's second pillar, Supply, focused on improving gender-responsive and adolescent-friendly SRH and child protection services delivered by local government, safe spaces, schools, and community health facilities. This also included coordination with services provided by informal child protection actors in the community.

ENHANCING THE CAPACITY OF HEALTH WORKERS

The project carried out targeted training to enhance the capacity of facility and community-based health providers to deliver protective, gender-responsive, and adolescent-friendly SRH services and child protection referrals.

These training activities contributed to important project results:

- A significant increase in adolescent girls' and boys' adequate access to sexual and reproductive health and rights resources and services. For females, it increased from 23.3% to 71.6%. For males, it rose from 31.9% to 60.6%.
- An improvement in adolescent girls' and boys' level of satisfaction with the quality and responsiveness of sexual and reproductive health services provided by targeted health facilities. For females, it improved from 62% to 77%. For males, it increased from 66% to 75%.
- A marked enhancement of the gender-responsiveness and adolescent-friendliness of sexual and reproductive health services in targeted health facilities. Gender-responsiveness indicators improved from 47% to 87% and adolescent-friendliness climbed from 50% to 88%.

The project's training for health providers included:

- Adolescent and Youth Health training for health extension workers – Over 200 health extension workers participated in multi-day training and additional refresher training on Adolescent and Youth Health. No standard, national training package on adolescent and youth health programs had yet been developed for health extension workers. So, the training covered existing national content including:
  - Public health significance of adolescent and youth health.
  - Adolescents' growth and development.
  - Communicating with adolescents and youth.
  - AYSRH issues including abortion, vulnerability and risk-taking behaviours.
  - Family planning services for adolescents and youth.
  - Care for adolescents during pregnancy, testing, care, childbirth and postnatal care.
  - HIV and STIs among adolescents and youth.
  - Psychoactive substance use, mental health problems and non-communicable diseases.
  - Adolescents' nutrition.
  - Adolescent and youth-responsive health system: Minimum service delivery standards and service packages.
  - Multi-sectoral referral linkages (both vertical and horizontal).

  And added complementary material from Plan International on:
  - Gender equality – Concepts of gender and gender equality, the intersection of gender and social determinants of health, effects of gender socialization on ASRH outcomes, GBV, GBV procedures and protocols for treatment, and referral of GBV cases presented at health facilities.
  - Child protection – Types and forms of violence against children, child protection risks, barriers to reporting, indicators of child abuse, link between ASRHR and violence against children, and implications for health extension workers' roles.
  - Child and young people safeguarding – "Do no harm" principle, gender-responsive child safeguarding, safeguarding policy, code of conduct for working with children and young people, safeguarding responsibilities, how to respond to disclosures of abuse, safeguarding reporting and response protocol, ethics/confidentiality.
  - CEFM – Underlying factors of CEFM, impact of CEFM on girls and appropriate remedies and management and role of health extension workers in prevention.
- Adolescent and Youth Health training for health-facility-based workers – Health care providers from each of the 32 targeted health facilities in the project areas participated in multi-day training and further refresher training on Adolescent and Youth Health. The training focused on improving gender-responsive and adolescent-friendly SRH services including referrals, and contributing to increased family planning utilization, preventing and reducing unintended or unwanted teenage pregnancy and unsafe abortions, and ultimately improving ASRHR outcomes. It addressed gaps in health facility service provision for adolescents, exacerbated by high staff turnover and shortages of trained healthcare providers. Curriculum content followed a similar outline to the health extension workers

training detailed above. Formal requests were made to prioritize female health worker training participation. In the context of higher numbers of male health workers in some project districts, this measure still resulted in greater rates of male participation (54 female trainees and 120 male trainees).

- Clinical training on SGBV – A four-day training on clinical case management of SGBV was provided for 70 (15 female and 55 male) healthcare professionals assigned at adolescent and youth-friendly service units and emergency outpatient departments at project-supported health facilities, along with caseworkers (three female and three male) providing social services in child protection safe spaces. This training was added due to continued concerns about SGBV, particularly the effect of the current conflict in the northern part of the country. It included theory and demonstration, with role play on case assessment, diagnosis, and management. Curriculum content drew from national training materials, recommended themes from Plan International, and World Health Organization guidelines, including:

  - Introduction: Gender concepts and terminologies, SGBV and types of violence, magnitude and consequences of GBV, multi-sectoral response/approach to GBV, legal context and professional ethics in response to SGBV
  - Clinical response and management of SGBV: Clinical assessment, clinical care for SGBV survivors, follow-up for survivors of SGBV
  - Psychological care and psychosocial support: Psychological and social consequences of SGBV, psychological and social interventions, referral for social services, rehabilitation and/or social reintegration
  - Trauma-informed approach/care and basic counseling services for survivors of SGBV, communication best practices
  - SGBV prevention: Primary prevention, strategies to prevent SGBV and role of health care providers
  - Monitoring and evaluation: Basic concepts

  Participants reported that this training's subject matter was particularly challenging, and so further follow-up coaching and mentoring were added in collaboration with local government offices.

- Long-acting reversible contraception (LARC) methods training – Multi-day training on comprehensive family planning and long-acting reversible contraception methods was provided to healthcare professionals working at project-supported health facilities. The health facility assessment had identified a knowledge and skill gap among front line health workers in how to administer LARCs, despite the high demand among adolescent girls and young women for the service. The training included demonstrations and practical exercises for the insertion and removal of intrauterine devices and implants. The training approach also used interactive lecture, role play, paired/group discussions and presentations, instructional video, and clinical field practice with coaching and mentorship.

- Integrated Supportive Supervision training – Officials were trained in integrated supportive supervision that includes protection, gender-responsive, and adolescent-friendly considerations. Professionals from regional, zonal, and woreda-level Health, Education, and Women and Social Affairs offices were equipped with strengthened skills and updated tools, including a revised checklist for ensuring service provision, technical standards, and quality of ASRH services. The approach focused on helping supervisors and staff observe good practices and areas for improvement, facilitate dialogue, and provide a comprehensive overview of service provision quality. This training informed follow-up mentorship visits to project-supported health facilities. It strengthened collaboration with local officials and promoted the sustainability of improvements made to services.

IMPROVING THE GENDER-RESPONSIVE AND ADOLESCENT-FRIENDLY ENVIRONMENT FOR SEXUAL AND REPRODUCTIVE HEALTH SERVICES AT SELECTED HEALTH FACILITIES

The project refurbished and supplied Adolescent and Youth Sexual Reproductive Health (AYSRH) Units at targeted health facilities based on gender and adolescent needs assessments and government standards. A total of 12 health facilities were assisted, six from each region. With these upgrades and materials, the average gender-responsiveness and adolescent-friendliness rating of targeted health-facilities' resources and physical environment rose from 32% at the start of the project to 94%.

Nine of the facilities required minor refurbishment work to meet the Ministry of Health standard for health centres, including painting of walls, fixing broken windows and doors, and minor floor work. Supplies provided included medical equipment, waste management equipment including coloured bins and safety boxes for sharp waste materials, generator, laundry machine, cleaning and hygiene supplies, and youth-friendly recreational materials such as table tennis and play kits.

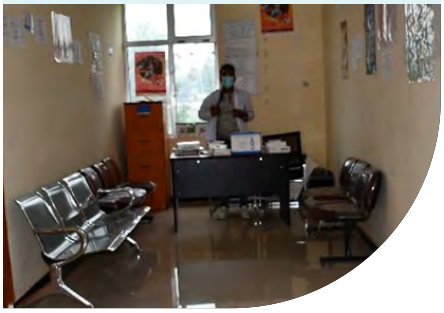
The goal was to create welcoming spaces for adolescent girls and boys, conducive to the delivery of quality ASRH services, and to encourage adolescents to seek such services out.

Additionally, to address chronic water shortages and further strengthen the health facilities, rooftop rainwater-harvesting schemes water were installed. A good practice noted by the project was the arrangement of an experience-sharing event among staff at a refurbished health facility and those at another facility, to explore how similar changes might be made with existing resources and to encourage learning from each other.

> “The CP safe space established in our woreda makes a difference for our case management process. Before the opening of the CP safe space, ending the case with a reasonable penalty was hard to achieve, largely due to the process being interrupted by criminals and their supporters. Now things have changed, and we are highly motivated.”
>
> – WOREDA JUSTICE OFFICE STAFF

Clinical training on sexual and gender-based violence was provided for healthcare professionals and caseworkers at child protection safe spaces.

The project refurbished and supplied Adolescent and Youth Sexual Reproductive Health Units at 12 health facilities.



Child protection safe space inauguration ceremony in Banja woreda, Awi zone, Amhara.

Other learnings included the possible negative impact of commodity shortages on uptake among adolescents, including shortages of some contraceptive supplies. Making pregnancy tests available at all health facilities was seen to increase the ability to provide early counseling services for teenage pregnancy. Ensuring that adolescent health services were available at convenient, and sometimes extended, hours for adolescents was also noted to be key.

RESOURCING CHILD PROTECTION SAFE SPACES

Six child protection waiting rooms, or safe spaces, for adolescent girls and boys were resourced and equipped based on gender and adolescent needs assessments. This intervention improved the availability of timely, quality, gender-responsive and age-appropriate protection services for survivors of SGBV, including CEFM.

The spaces were refurbished and provided with materials and supplies, including furniture, art and drawing materials, recreational kits, and safety and security materials.

Service providers and case workers were provided training on case management and referral pathways and participated in the trauma-informed clinical SGBV course co-offered to health facility workers. This better equipped service providers to use survivor-centred and trauma-informed approaches to supporting SGBV child survivors, provide access and referrals to the range of services child survivors need as part of their healing and recovery, and ensure proper case management processes. Supportive supervision was provided to bolster and sustain quality care and services to ensure continual learning and reflection of child protection staff and provide continuity on what quality care looks like across different CP spaces.

The project assisted child protection safe spaces in covering expenses of basic services, including transportation and costs related to referrals to medical and justice services for survivors of SGBV, their caregivers and accompanying government officers, thus improving access by directly addressing financial barriers for child survivors. All six of the child protection safe spaces began providing services for survivors during the project period. These included adolescents admitted to the spaces for care who received psychosocial support, legal and medical services, meals, and accommodation, and who were later reintegrated with their caregivers.

These safe spaces have now been fully handed over to local government offices with their commitment, including allocated budget, to continue their operation, ensuring SGBV response in the form of quality, multi-sectoral care to child survivors.

A valuable project learning was that the absence of Vital Events Registration Agency services at the kebele level could sometimes lead to delays, or the absence of evidence, regarding the age of adolescents exposed to CEFM.

Other legal-related challenges experienced included instances of interference by elders in legal processes for CEFM and abduction cases, leading to interruption and delays. There was also a subjective legal decision on FGM, as the related criminal law remains open to different interpretations.

"

One of the SGBV survivors who was admitted in the CP safe space was referred for additional health services at a nearby hospital. However, her father frequently insisted on having her back home without finishing all the prescribed health services that might bring lifelong health problems.

He was advised not to do this and was encouraged to let his daughter complete her care. As a result, she finished all the prescribed medical services and once back at the CP space, she was supported with legal and psychosocial support.

The legal process was completed with a reasonable penalty and I'm happy to be part of this. I'm motivated. Some of the challenges have been resolved and we will do more now that we have such a conducive environment."

– INSPECTOR, WOREDA POLICE

SCHOOL-LEVEL CHILD PROTECTION PROTOCOLS ESTABLISHED, INCLUDING REPORTING AND RESPONDING MECHANISMS

With the project's support, functional school-level child protection protocols, including reporting and responding mechanisms, were established by school governance faciltiy members.

This activity recognized the protective role of schools, and the role of school governance actors in developing policies to help keep children safe and address issues such as CEFM.

The protocol includes basic concepts, beliefs, objectives and goals of child protection, types of child abuse, good practices for engaging with children, and roles and responsibilities of child protection stakeholders such as school management, school clubs, child parliament, justice bodies and other government offices.

It has helped to create a clearer sense of protective responsibilities and school accountability, which in turn contributes to strengthening a protective ecosystem for children at the school level.

To operationalize the approach and strengthen referral linkages, training was conducted for 467 school-based actors (146 female and 321 male) from all project woredas.

The protocols were printed and distributed widely to over 170 schools. Social and behaviour change communications materials were produced, including posters using child-friendly and gender-responsive language, outlining types and forms of child abuse and violence, and reporting guidance (who, where and how to report). As a result, school-based community members, including children, have a better shared understanding of the protocol's purpose and what to do in the event of incidents. This has contributed to both prevention and response efforts at the school level and created a more protective environment for children.

School clubs were supported to utilize reporting and responding mechanisms, and to organize Child Day-related sensitization events. These initiatives have helped to strengthen the capacity of children and youth to actively question and openly challenge stereotypes and bias and support them to speak out against CEFM and other child abuse.

Bi-annual school-level child protection protocol review meetings were organized, including participants from school clubs and school management. They reviewed the efficiency, child-friendliness, gender-responsiveness and safety/confidentiality of the reporting mechanisms and protocols, and actions required to make improvements.

The result was school-level actors engaging in an ongoing process of learning and reflection on how to improve the CP protocols. This helped to highlight a further need for anonymous and confidential reporting mechanisms in schools to enhance disclosure of child protection issues including CEFM. Secure and anonymous suggestion/reporting boxes were then distributed.

At review meetings, school community members reported a change in the attitude of in-school adolescents. They have become more familiar with the actions they have to take, and where and how to report an incident. School management has also been encouraging such actions, including through steps such as announcements during morning flag ceremonies.

"

Some participants bring early marriage arrangement cases they heard about to us through the girl advisor teacher. Even if we have not yet arranged for an anonymous reporting mechanism, it is demonstrating that they have concerns, not only about themselves, but about their friends too."

– MALE SCHOOL PRINCIPAL FROM BANJA

Girls take part in Champions of Change group meeting in Sidama region.

Tizita is a Champions of Change facilitator in Sidama region.

13-year old Fethia is a peer educator in Amhara region. A grade 7 student, she leads discussions at her school as part of the My Choice for My Life project.

Group discussion on the dangers of child marriage at school.

The My Choice for My Life project is working with girls so they can access sexual and reproductive health services & make their own decisions about when and who to marry.

Posters of the child protection protocol, including pictorial and written description of where cases can be reported, were created and distributed to schools.

Fethia, 13, leads discussion at her school on the dangers of child marriage.

PROJECT PILLAR 3
ENHANCING ACCOUNTABILITY

The project's third pillar, Accountability, improved the responsiveness of relevant institutional offices and actors to the specific SRHR, and protection needs, of adolescent girls and boys.

LOCAL GOVERNMENT OFFICIALS TRAINED ON GENDER-RESPONSIVE PLANNING AND MANAGEMENT

Plan International Ethiopia, in collaboration with the MoWSA, provided targeted foundational and refresher training to enhance the capacity of district public officials to effectively undertake gender-responsive, evidenced-based planning and management. Fifty staff (15 females and 35 males) from zonal and woreda Health, WSA, Education, Attorney General, Bureau of Finance and Economic Development and Planning offices took part.

The training was highly participatory, and participants shared experiences from their actual planning processes. The refresher training, in particular, was timed to coincide with the annual planning period of participants' respective offices. Training participants committed to use the knowledge and skills obtained from the training during their planning.

Additional on-the-job coaching, mentoring and follow-up support to health care providers and child protection actors related to gender-responsive, data-driven planning and management was provided by the sector focal persons who were part of this training.

EVIDENCE-BASED ADVOCACY TRAINING FOR COMMUNITY-BASED ORGANIZATIONS

To complement institutional strengthening, the project enhanced the ability of community-based organizations, particularly women and youth networks, to undertake evidence-based advocacy on CEFM prevention and ASRHR.

Over 400 members of community organizations (216 female and 191 male), including the Women's Association and Youth Association in Sidama, were trained on evidence-based advocacy. Adapted from the Women's Voice and Leadership project in Ethiopia and other resources, a training manual was developed to support the groups' capacity to conduct advocacy on ending CEFM and promoting gender equality and ASRHR.

The training employed methodologies including plenary discussion, group work, and presenting case stories. After the training, participants listed their major community problems that affect adolescent girls, boys, and young women. For example, CEFM, rape, HTP and child labour. Participants prepared an advocacy plan to be implemented using various platforms in the community, including Children's Day, media, Women's Day and different community gatherings.

DOCUMENTING AND DISSEMINATING PROJECT BEST PRACTICES AND RESULTS

As part of efforts to enhance the responsiveness of relevant institutions to the specific SRHR, and protection needs, of adolescent girls and boys, the My Choice for My Life project has documented and disseminated project assessments, studies, results, and best practices, including gender-transformative approaches.

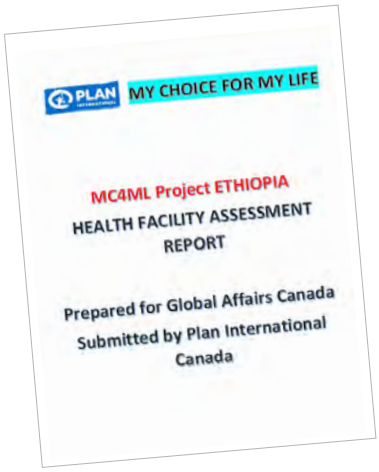
This forms a part of the project's objective to increase the availability of quality adolescent SRHR and CEFM data and evidence among adolescents, service providers, planners and decision makers, community-based organizations, and other relevant actors. Throughout the project, evidence including its gender equality assessment, child protections systems assessment, health facility assessment, baseline evaluation and midterm evaluation studies, lessons learned exercise, and now this report, have been shared through numerous fora and channels.

Hopefully, this practice also reflects to the many actors who participated and contributed to this project their critical contributions and the impacts of their engagement.

Gender-responsive planning and management refresher training.

Community organizations identify issues for advocacy.

→ Throughout the project, evidence including assessments, evaluation studies and a lessons learned exercise have been shared.



My Choice for My Life contributed to the capacity of civil society organizations, government, and multi-sectoral spaces to sustain actions focused on ASRHR, child protection and preventing CEFM.

Fatima is a savings group leader in Amhara region.

PROJECT LEARNINGS IN A DYNAMIC AND CHALLENGING CONTEXT

Adapting to COVID-19, conflict and economic challenges.

The My Choice for My Life project was implemented during the global COVID-19 pandemic and a period of significant challenges in the Ethiopian context, including conflict and economic volatility. This required the project to adapt in response to critical risks and restrictions, while remaining focused on achieving its objectives of improving ASRHR and reducing CEFM.

Support for regional COVID-19 response plans was quickly added into the project's health-system-strengthening activities. A focus on infection prevention and control was also built into the training program series for facility-based health workers. COVID-related restrictions on face-to-face gatherings required significant pauses, and later accelerations, in the project's many group-based activities.

The Tigray conflict in the northern region was proximate to one of the project's two geographic programming areas, Awi Zone in Amhara Region. Clinical training on SGBV was added to the capacity-strengthening series offered to health and child protection workers, in part due to increased concerns related to the conflict and the effects of the pandemic. Communities witnessed some changes in the prevalence of HTP, such as CEFM and female genital mutilation, as people displaced by conflict were uprooted to new areas. Social and behaviour change activities aimed to take these shifts into account.

Inflation and currency devaluation also presented challenges and required the project team to adapt its approach to items ranging from fuel usage and travel scheduling to accessing single-time cash flow for project deliverables.

Ultimately, a consistently proactive approach to risk management became, out of necessity, the norm during the project period.

TIME AND EFFORT INTENSIVE PROJECT FOUNDATIONAL WORK: IMPLICATIONS FOR SEQUENCING AND DESIGN

As detailed in this report, the My Choice for My Life project adopted a comprehensive, rights-based and gender-transformative approach to closing gaps in ASRHR, and child protection, particularly regarding CEFM.

And while this method was ultimately successful in achieving key project results, it required numerous time- and effort-intensive pieces of foundational project work before core project activities could begin. The project's assessments on gender equality, health facilities and child protection systems were all required to inform its comprehensive interventions. The social and behaviour change communications strategy was also developed ahead of major communications activities. Several substantial group activity manuals and curricula were fully contextualized – that is, adapted to the social, cultural, and legal context of Ethiopia and the communities with which the project would be working – and then translated into Amharic, prior to the actual startup of groups.

Thus, this project offered a valuable reality check on the significant time and labour realistically required to generate multiple, high-quality foundational tools for a comprehensive, multi-sector project design. A key learning for practitioners is the realistic estimation of this investment and its implications for the sequencing of project activities.

When her mother fell ill when she was 16, Debritu had to drop out of school. Not long afterwards, her father decided to marry her off. With the support of the My Choice for My Life project, she was able to stop her marriage.

Clinical training on sexual and gender-based violence was added to the capacity-strengthening series for health and child protection workers, in part due to increased concerns related to conflict and the effects of the pandemic.

Distribution of face masks

Girl takes part in Champions of Change group meeting in Sidama region.

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