ORIGINAL RESEARCH ARTICLE

Assessing the impact of the journey plus curriculum on sexual and reproductive health and rights and behavioural change among Ugandan youth

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Abstract

The Journeys Plus curriculum was introduced by the Government of Uganda in 2020 to impart knowledge and empower youth to practice positive behaviours. It also focuses on fostering supportive environments for youths in homes, communities, health facilities, and schools. AMREF Uganda implemented the curriculum in the districts of Budaka, Mbale, Kween, Namayingo and Kalangala, Bukwo, Mayunge, Bugiri and Iganga. This paper explores the outcomes and effectiveness of the intervention and examines its impact on learning, behavioural change, and youth empowerment, using a phenomenological study design among 360 purposively selected young people (9 -14 years) and 80 adults. Aided by Atlas ti software, deductive analysis was applied to the study findings. The findings suggest that the Journeys Plus curriculum has proven effective in promoting behavior change, enhancing knowledge of sexual and reproductive health and rights, practical vocational skills, empowering young people against gender-based violence, and fostering meaningful peer relationships. *(Afr J Reprod Health 2025; 29 [4]: 63-77).*

Keywords: Journey's Plus Curriculum, Sexual and Reproductive Health and Rights

Résumé

Le programme Journeys Plus a été introduit par le gouvernement ougandais en 2020 pour transmettre des connaissances et donner aux jeunes les moyens d'adopter des comportements positifs. Il vise également à favoriser des environnements favorables aux jeunes dans les foyers, les communautés, les établissements de santé et les écoles. L'AMREF Ouganda a mis en œuvre le programme dans les districts de Budaka, Mbale, Kween, Namayingo et Kalangala, Bukwo, Mayunge, Bugiri et Iganga. Cet article explore les résultats et l'efficacité de l'intervention et examine son impact sur l'apprentissage, le changement de comportement et l'autonomisation des jeunes, en utilisant une conception d'étude phénoménologique auprès de 360 jeunes sélectionnés à dessein (9 à 14 ans) et 80 adultes. À l'aide du logiciel Atlas ti, une analyse déductive a été appliquée aux résultats de l'étude. Les résultats suggèrent que le programme Journeys Plus s'est avéré efficace pour promouvoir le changement de comportement, améliorer les connaissances sur la santé et les droits sexuels et reproductifs, les compétences professionnelles pratiques, l'autonomisation des jeunes contre la violence sexiste et favoriser des relations significatives entre pairs. *(Afr J Reprod Health 2025; 29 [2]: 63-77).*

Mots-clés: Programme Journey's Plus, santé et droits sexuels et reproductifs

Introduction

Globally, issues of sexual and reproductive health and rights (SRHR) pose significant challenges for young people, including HIV incidence, violence, poor access to contraception and reproductive health services, stigma and discrimination and economic dependenc[1-3]. These challenges are more pronounced in low- and middle-income countries, and particularly across Africa, where access to comprehensive healthcare and education remains limited[4,5,] with adolescents and youth facing high rates of unintended pregnancies, sexually transmitted infections (STIs), and gender-based violence (GBV)[6,7]. The continent grapples with the dual burden of addressing HIV/AIDS prevalence among young populations and combating pervasive social stigma that hinders prevention efforts and access to treatment[8]. In Uganda, these issues are further compounded by socio-economic disparities, cultural norms, and inadequate healthcare infrastructure[9]. Many young Ugandans lack

sufficient knowledge about SRHR, leading to heightened vulnerabilities to early pregnancies, unsafe abortions, and cycles of poverty perpetuated by limited access to education and economic opportunities[10,11]. Tackling these challenges requires targeted interventions that empower youth with accurate information, skills for healthy decision-making, and supportive environments that promote their rights and well-being.

In response to this critical need among Ugandan youth, the Government of Uganda, through the Ministry of Health, introduced the Journeys Plus Curriculum (JPC) in 2020[12,13]. This curriculum targets young people aged 9-14 years. A consortium of Amref Health Africa in Uganda, Cordaid, MIFUMI and the International Centre for Research on Women (ICRW), implemented the JPC across nine high burden districts, aiming to equip young people with essential social and emotional learning (SEL) competencies. These competencies include self-awareness, self-management, social awareness, relationship building, and responsible decision-making, all crucial for navigating challenges related to health, relationships, and personal development during adolescence.

The JPC is designed not only to impart knowledge but also to empower young people to practice positive behaviors and make informed decisions about their health and relationships[13]. By fostering a supportive environment within homes, communities, health facilities, and schools, the curriculum seeks to ensure the safety, protection, and health of youth. It integrates strategies to enhance learning outcomes and promote health and well-being, particularly in HIV prevention and management and empowering young people living with HIV to openly discuss their status, combat stigma, adhere to treatment regimens, and promote positive living within their communities[13].

Moreover, the Journeys Plus initiative emphasizes collaboration among school stakeholders to improve the overall well-being of children and youth. By modeling behaviors that empower young people to assert their health rights and advocate for themselves, the curriculum contributes to shaping a generation of proactive, informed, and resilient individuals and addresses the disproportionate burden of sexual reproductive health and rights violations and sexual gender-based violence(SGBV)[13]. The study explored the outcomes and effectiveness of the Journeys Plus program, focusing on its impact on learning, behavioral change, and the enhancement of self-esteem, attitudes, and self-efficacy among participating youth. The study also explored the barriers and facilitators to program implementation, as these are crucial to shaping the observed outcomes of the program.

Methods

The intervention

JPC is endorsed by the Ministry of Education and Sports with the aim of empowering a generation of informed empathetic and responsible primary school pupils 9- 14 years to lead change within their communities on issues of HIV awareness, stigma and gender-based violence. The objectives of JPC include ensuring children have a comprehensive education cycle; make informed decisions regarding their sexual health and relations; reflect on as discuss the prevention of social and health challenges including HIV and GBV among pupils; providing an enabling environment for pupils to have a safe space where they can willingly express themselves[12,13].

The components of Journey's Plus massages include Making a new friend; My life at school; knowing my school relationships; healthy and unhealthy relationships; why I want to be a cow a cow(diversity of human being); Gender box - gender equality; My body image; what is important to me(choice); Lets decide(decision making); Good communication; STIs and AIDS - what they are and how they can are transmitted; children living with HIV, impact and support; treatment and support for learners living with HIV; Stigma and discrimination; Gender and HIV; The meaning of consent; Solving problems; Seeking assistance; Positive bystander response to violence; Reporting of Violence and Abuse; Post violence care treatment and support; My morning pledge; and lastly Questions and answers. Clubs are formed in schools and they are supported by a facilitator. The curriculum implementation is supported by the facilitators guide and the pupil's materials. The children meet with the facilitator twice a week for 40-45 minutes to discuss a topic that is introduced by the facilitator in form of a statement or a story. The children engage with the topic using guided questions based on the facilitators guide[12,13].

Study design

The study applied a phenomenological study design which is a qualitative approach that is identified by the characteristics of description, reduction, intentionality and essence. Description is about explaining and investigating how something happens in a real context. Reduction is about managing bias by controlling one's thoughts and feelings about an observed situation. Essence is about the deliberate efforts of applying intuition, imagination and reflection to identify the relevant information that relates to the study. Intentionality that is correlating noesis and noema that is the linking of the objective statements about reality(noesis) on one hand and on the other, the conscious subjective reflection (noema) on the same[16-18].

The phenomenological study design is useful in examining the lived experiences and views of the study subjects so as to gain deeper insights and understanding of their narratives, thoughts, feelings, perceptions, meanings, beliefs and knowledge about a phenomena[16-18]. A phenomenon is a research a topic or issue that has been selected for investigation and in the case of this study, the journey's plus intervention. The phenomenological study design allows for the in-method triangulation, especially in correlating datasets from different methods that were used throughout the study. It enhanced and encouraged participation of all young people 9 to 14 years, and adult stakeholders involved in supporting the journeys plus implementation within the selected schools. The phenomenological study allowed for the deep exploration and understanding of the learners' perspectives and experiences of both the barriers and enablers of their adaptation to sexuality education contextualizing the young people both in and out of school. Furthermore, the design facilitated the collection of detailed descriptions from the children, their educators, and other stakeholders at the DLGs and youth led organizations (YLOs). This allowed participants and especially young people to espouse their agency, emotions, feelings, and experiences of the JPC within and beyond the school spaces.

Through interpretation, and documentation of the entire experiences of stakeholders from their point of view[19,20], the study capitalized on the agency of both young people and the viewpoint of adult stakeholders to understand the impact of the journey plus intervention on the lives of learners. This design therefore provided a platform for participants' reflections, assessments, interactions, and experiences of the program and explicitly documented it[21].

Study area

This research was implemented in four of the nine Journeys Plus intervention districts of the Consortium that included Mbale and Kween in Eastern Uganda, Kalangala an island district in the Central, and Bugiri in the East-Central region. Based on previous evaluations of the programme in the nine high burden districts, preference was placed on these four districts because of the scorecard analysis of their overall output in terms of program targets. Mbale had the best practices and outputs, Kalangala moderate and Bugiri and Kween having low output[16,22].

Study population

The study participants included men, women, boys and girls that were purposively selected from the four sampled districts.

Sample size and Sampling

In each of the purposively selected four districts, three sub-counties were randomly selected. Primary schools were grouped in each of the 3 selected sub-counties per a district and subjected to simple randomization[16, 22]. A total of 12 schools were selected, one school per a subcounty, three per a district. It is presumed that this sampling method gave an equal chance for every school in a sub county in the four districts a probability of being selected.

About 360 learners, both boys and girls from 12 primary schools, participated in the study's focus group discussions. Of these, 120 were in the age category 9-11 years and 240 were 12-14 years. All learners selected to participate in the study were beneficiaries of the journeys plus curriculum. Additionally, 80 adult stakeholders were recruited to participate in the study as key informants. These were purposively selected based on their knowledge and involvement in supporting the program implementation at various levels. While during the selection process inclusiveness was extended to

recruit children with disabilities (CWDs) within schools.

Data collection

A multi-methodological data collection approach was used to enhance and achieve inclusive participation especially for young people. The approach adapted and used child and youth centered techniques which are relevant in aiding young people express themselves and allowed their opinions about the program to be reported firsthand (23, 24. The data collection techniques included task-based activities (drawings), which allowed younger people 9-11 years old to be as expressive as possible. Equally, child focus group discussions (CFGDs) with young people 12-14 years of age, and focus group discussions (FGD) with parents of learners and key informant interviews (KII) with teachers and healthcare facility staff were used. This child and young people centered approach using multi-methods allowed for a methodological reinforcement as one method could overcame the weakness of another in the different age groups [23].

Data quality assurance and control

Ensuring data quality in this study involved training of the research team on data collection methodologies and ethical considerations, supplemented by standardized protocols. Instruments were meticulously designed, pre-tested, and refined for clarity and cultural appropriateness. Data collection was supervised by senior researchers, and consistency was maintained through dual-researcher involvement in FGDs and KIIs. Data transcription involved the use of professionals with a good command of all languages used in the study, followed by thorough data cleaning. Continuous feedback mechanisms ensured adherence to protocols and data integrity, resulting in reliable and credible findings.

Data management and analysis

Interviews with all study respondents and participants were audio recorded on gadgets including recorders, smart mobile phones or tablets phones. All recorded interviews were transcribed verbatim by the experienced consultants, following the completion of the data collection exercise. Data quality checks were conducted on the transcripts by the study supervisors and investigators. Transcripts were imported into Atlas. ti, and read several times to link the content to the thematic areas. Deductive thematic analysis was used to analyze the data and findings were summarized and presented in thematic form.

Ethical considerations

The research project sought ethical approval from the Uganda Christian University research ethics committee (UCU-REC) through the national research information management system (NRIMS) and further clearance from the Uganda National Council of Science and Technology (UNCST). To access the schools, permission was sought from the respective Chief Administrative Offices (CAO) through the department of District Education Office (DEO). At school levels, access was obtained through the offices of the head teacher. All adult participants were enrolled for the study upon signing an informed consent form. All young persons were granted permission to participate by their head teachers or journeys plus teachers[25,26] who signed an informed permission consent statement. It is from this that the young people were guided through an informed assent progress from which all those that signed were recruited as participants. All participants were provided with a signed copy of their consent form, were guaranteed confidentiality and anonymity of their information as well as enlightened on their rights as participants

Results

This section presents the findings of the study, presented thematically. Three themes are presented including the effectiveness of the intervention, and the barriers and enablers to implementation.

Effectiveness of the intervention on behavior change, SRHR and GBV

This section shows findings from the learners on the five sub-themes; acquisition of desired behavior, knowledge on SRHR, HIV prevention and management, young people as agents of managing

SGBV, meaningful peer friendships and vocational and hands on skilling.

Acquisition of knowledge on sexual reproductive health

The findings show that the Journeys plus learners have acquired the desired sexual and reproductive health. The young people 9-11 years old saw the intervention as one that provided them with vast knowledge and skills and behaviors as far our sexual reproductive health.

Some of the statements from the focus group participants included the following:

"Maintaining personal hygiene, especially during our periods, is crucial for our health. It's something we should talk about more often. By discussing it together, we can support each other and break the silence that often surrounds these issues." (Participant 7, FGD, Kween)

The study findings showed that the learners had gained skills and strategies of avoiding unsolicited attention from potential child abusers whose entry points were mainly the offering of free gifts. The girls understood these situations as potential avenues for contracting HIV and related infections, pregnancies and SGBV.

"I understand now that accepting gifts from strangers can lead to problems. Girls need be able to recognize and avoid people who might try to harm us" (Participant 5, FGD, Bugiri).

The phrase "*no gifts for sex"* was synonymous with repulsion of unsolicited sexual advances from strangers.

"Stop taking things from strangers and stop telling boys to buy you something because you get pregnant, or you will get married early when you are still in school" (Participant 5, FGD, Mbale).

A discussion with the boys that centered around the wording "I always say no for sex", one participant highlighted that boys too, were prone to SGBV especially from older women in the community. Boys noted that they use group protection to wade off sexual advances.

"We as boys, also face a risk of sexual violence, especially from older women in the community. One way of staying safe is by moving in groups, like when we go to and from school" (Participant 1, FGD, Mbale).

Relevance of the journeys plus intervention to sexual and reproductive health and rights

According to the study participants, Journeys plus intervention assisted the younger people (9-11) years to assert their sexual and reproductive rights due to their awareness of their sexual and reproductive health rights. The level of awareness included the SRHR *dos* and *don'ts, bodily awareness, personal hygiene* and strategies that could protect them from potential perpetrators. This was attributed to the topic "know your body" where most of the young people revealed that they adapted meaningful behavior that enhanced their primary health care attributes. Participants in a mixed FGD revealed how they previously struggled with some of their body's changes, including not knowing how to go about emotional and hormonal imbalances. A critical appreciation of how getting to know the changes in their bodies was reflected in narratives such as this below.

"I learnt about body changes of our bodies, I learnt that a girl has menstruation period, children grow pubic hair, girls grow breasts, girls get hips, also learnt about feelings where you can tell what one is feeling, when they are angry, when they are happy" (Participant 2, FGD, Kalangala).

"Before, we didn't feel comfortable. Learning about personal hygiene and how to take care of ourselves that has changed that. Now, we feel more self-aware in our everyday lives." (Participant 5, FGD, Mbale).

The interactions with young people and the review of the children's drawing highlighted some of their concerns of how early marriages put young girls at risk of contracting HIV and dropping out of school. The finding revealed that several of them have the knowledge regarding the facts on the epidemic, how it affects victims and had clues on how to manage it. The general perception that young people constructed around HIV was that it was acquired through sexual activity that had implications on the strategies that they undertook to prevent themselves from infection. Key among these was abstinence. Discussions further revealed how young people were advised to love and care for their fellow peers

who were infected with diseases rather than discriminate against them.

“I have had sex before and it was okay, but I stopped after being taught about its risks towards my life and others” (Participant 5, FGD, Kalangala).

". Abstinence is good. You prevent infection" (Participant 3, FGD, Mbale).

" It is important to support and love our peers who are infected with diseases like HIV, we need to show them understanding and care so that they live well" (Participant 2, FGD, Mbale).

The data also showed misconceptions around the facts about HIV among young people. This was noted mainly in Bugiri where some of the perceptions from the young people were misguided notions on transmission.

“When an HIV infected person urinates in a place and you also urinate in the same place, you will acquire HIV virus. And others say that if a person defecates in a toilet and you also do the same in that toilet, you also acquire HIV” (Participant 3, FGD, Mbale).

Young people as agents of managing SGBV.

The Journey’s plus intervention provided a platform through which young people’s empowerment was seen in this aspect of standing up for themselves and others when faced with SGBV situations including early marriages. During the FGDs, girls argued that they had become more assertive, and their levels of self-esteem had increased in as far as managing sexual related violence that was targeted towards them. The ways of managing this situation included refusing the abuse, raising alarms, seeking for help, and reporting the case to the relevant authorities.

“When you find someone, who is being forced into a marriage, report the person who is forcing her or him to the police, to the teachers and to the LC chairperson 2 because he is the person in charge of children’s rights” (Participant 1, FGD, Mbale).

It is also important to observe that female genital mutilation (FGM) is a socio-cultural practice among some of the Kupusabiny communities. The girls in this community were quick to point out how the Journey’s Plus intervention had enlightened them on the negative effects of the practice.

“From the time I heard about the disadvantages of Female Genital Mutilation, I have changed my mind about circumcision and now I am devoted to education, my dream is to become a doctor and to be a responsible mother in the future”(Participant 1, FGD, Mbale).

Meaningful peer friendships

One of the purposes of the mixed group discussions was to assess and explore how boys and girls interacted together with specific interest in their self-esteem and efficacy to articulate complex topics in SRHR and SGBV. The findings showed that boys had developed positive attitudes and behaviors towards SRHR issues including menstrual hygiene.

“When they tell us[boys] that girls get menstrual periods… it doesn't mean that you have to run away from her or laugh at her, you need to support her or you can talk to the senior woman teacher to come and help her” (Participant 2, FGD, Kalangala).

To collaborate the findings from the boys, the girls in some of the group discussions in Mbale acknowledged how helpful their male peers were during the menstrual moments especially when they were in class.

"The boys in our group have been really supportive during our menstrual moments, especially when we're in class. It's great to have their understanding and help" (Participant 3, FGD, Mbale).

Beyond management of menstrual hygiene, analogies such “making cross gender friends and relationships including speaking to them without fear” were specifically explored for a deeper understanding. The findings revealed that both adolescent boys and girls had been empowered to overcome the stereotypical tendencies associated with cross-gender friendships.

"We have learned how to make friends and communicate well with each other, including friendships with both boys and girls" (Participant 3, FGD, Kalangala).

Vocations and hands-on skills

The findings indicate that the boys and girls learned sanitary pad making, baking and gardening and some of them were sharing this information were their peers that were not directly benefiting from the skills training.

"*From the time Heroes came, the girls know how to make reusable sanitary pads and we have been able to also teach our friends at home, but the only problem is that we don't have the materials for making these pads whenever we need them" (Participant 2, FGD, Kween).*

"Some of us have taken what we've learned and shared it with friends who aren't in the program and others in our community" (Participant 4, FGD, Kween).

It is also important to observe that some of those that were involved in baking and gardening lessons were already using the skill to earn some money.

"Learning how to bake has helped me discover a talent I didn't know I had. Now, I bake on weekends and make some money" (Participant 2, FGD, Mbale).

"We are growing the seedlings, we shall sell them, get money and buy pens, books, uniform, and other things for school" (Teacher, KII, Kween).

Barriers to the implementation of the intervention

This section presents results on the barriers to implementation of the program and is categorized into 8 subthemes including attitude of stakeholders; fitting the program activities into already existing school timetables; interruptions in learning; expectations of the stakeholders; Confidentiality issues at the healthcare facilities; prioritization of school curriculum over the intervention; Confidentiality issues at the healthcare facilities; and Stock outs of drugs at health facilities and the resultant users' trust issues as elaborated upon in the following sub-sections.

Attitudes of stakeholders

Some respondents expressed hostilities from local communities towards the school projects. In one of the communities in Kalangala a school project garden as well as other learning materials were destroyed. Such attitudes demotivated and derailed the learning trends and morale among the learners.

"They came here when the school was closed and destroyed part of the garden because children were spending time here and coming early in the morning" (Teacher, KII, Kalangala).

"Threats from where we come from…telling us that those things we get the children involved in are not important" (District leader, KII, Mbale).

Fitting the program activities into already existing school timetables

Key informant data highlighted the challenge of co-opting the curriculum activities in an already fully packed school timetable. The Ministry of Education and Sports curriculum timetable had not allocated time to Journey's Plus. The implications were that at times Journey's Plus activities conflicted with the main school curriculum and with involvement of just a couple of teachers.

"Ministry has already set their timetable. So, implying that when they are teaching Journeys Plus things, there is a subject they are affecting which is not taught during that time" (KII, Education official, Kween).

"We have two days in a week but you find that our sessions are late in the evening when children are about to go home so we usually have about an hour to teach everything for that day" (KII, program teacher, Kalangala).

Interruptions in learning

The findings pointed to interruptions in learning that were linked to absenteeism of both the learners and teachers. In Kween district, absenteeism was rampant during planting and harvesting seasons when the learners' attendance at school was so irregular as they often were asked to stay back at home to support the family in farm activities.

"Mummy was not feeling well those days and asked me and my sister to stay home and help in the maize garden. The weeds had over grown and it was raining" (Participant 4, FGD, Kween).

In addition, teachers argued that issues of hunger due to poverty pushed learners out of class and

school to find something to eat, highlighting the high operational costs, for instance, high food costs that forced schools to send all learners with fees balances back home.

"Poverty hinders us attending all sessions. A session can be held while like 4 people are absent, and when we come back, we find that the rest are ahead of us because we were sent back home for school fees" (Participant 2, FGD, Kalangala).

Expectations of the stakeholders

Results revealed how monetarized driven community agendas were affecting implementation. Some organizations had made it a trend to remunerate community members when they participate in their program activities. This was seen from the lens of an appreciation for their time spent, hence, the general appeal from the community was that of children being compensated for participation in Journey Plus activities.

"They tell their children not to participate unless they sign for some money. many organizations that come to these communities have taught people that after participation they must be paid. Sometimes we don't find them at home because they have gone to the garden or gone to look after the animals" (KII, program teacher, Kween).

Learner exception was equally appreciated as a barrier. Findings showed that learners had high tangible expectations from the program beyond what they were receiving.

"They should bring for us things that make us happy as children, some of us feel like we are wasting time, like when we come here, they make us run minus giving us anything not even sweets." (Participant 4, FGD, Kalangala).

Confidentiality issues at the healthcare facilities

Confidentiality and privacy issues caused health choice tensions among the young people and their health service providers. One such thing was the inability of some supporting health workers to maintain patient-health worker confidentiality. In so doing, health workers revealed that sometimes they could not hold back their own opinions about the young people they supported and they would let out patient's confidential information. It was therefore no surprise to hear statements such as:

"Musawo (health worker), you come! Please see this child, I am from giving her Jadelle implant for 5 years" (KII, Health facility staff, Kalangala).

Ethical challenges in SRHR service provision

The findings suggested that when health workers faced ethical challenges of transferring prescribed STI treatment for young people to third parties including drug shops or other privately-run health centers within their communities. The cause was due to drug stock outs or expiration. The health workers noted that they cannot guarantee the training and ethical backgrounds of the persons in these alternative health units when it comes to sustaining the confidentiality of such young people.

"These clinics and drug shops in the villages are run by people they know and you find that the learners fear to go and ask for these sensitive medicines or treatment" (KII, Health worker, Kween).

It is also important to observe that the need for financial resources to access those drugs may mean that the youths may need to ask for money that may mean that they have to disclose their health conditions to their guardians.

Conflict with existing national and international guidelines

Health workers further revealed that some of the young people's barriers emanated from the conflicting standpoints between the known public health guidelines provided by the government and the community realities. 9 to14-year-olds are ineligible by age for enrollment into contraceptive usage through family planning as per government public health guidelines unless there is an accompanying adult to provide consent.

"We have the eligibility age group [challenge]. For example, if a child has not turned 15 years old, according to the World Health Organization & MOH, that child is still a minor… We find a challenge whereby a child of 14 years has come for family planning, does not want the caretaker to

know ... What we do is counseling about abstinence, delay sex. Sometimes they listen, sometimes they refuse, and we improvise with barrier methods of family planning like use of condom because we cannot go ahead to give them the hormonal method which may cause complications and according to the guideline, the child is underage" (KII, Health worker, Kween).

Enablers to the implementation of the intervention

The section presents enablers to the implementation of the program, grouped into five sub-themes including long duration of program implementation; information sections to avert negative community attitudes; use of peer sessions; recognition of the sensitivity of some of the topics; Collaboration between program peer educators, schools and healthcare facilities; and enabling environment at the health facilities as discussed below.

Long duration of program implementation.

While it was notable that most of the learners had at least two active learning days during the week for the program, they expressed mixed feelings about the amount of time spent on the activity. In one of the schools, the learners went from saying that they had enough learning and interactive time to highlighting how their conceptualization of the issues within the curriculum kept improving as time appreciated. This aspect suggested that the passing of time and continuous learning had provided an opportunity for the learners to better understand and appreciate the content within the curriculum as noted in one of the FGDs in Mbale.

""We have been learning for a while now, we repeat some topics for those who missed. We use the time we have with the teachers to consult from them what we have forgotten or did not understand well" (Participant 2, FGD, Mbale).

Information-sessions to avert negative community attitudes

Learner experiences revealed that teachers went extra miles to influence attitude and perceptions of parents and caregivers who did not appreciate the impact of the program on their children. These shared experiences were further collaborated by the teachers indicating that they provided parents and guardians information related the program as expressed in one of the FGDs in Bugiri.

"Our teacher came home and talked to my parents, they had refused me to attend saying that I will get spoilt but they allowed me after talking to the teacher"(Participant 5, FGD, Bugiri).

Use of peer groups

The findings showed that peer grouping facilitated learning. Using menstruation as an example, the 12–14-year-old adolescent girls argued that it was unwise to teach them menstrual issues with 9-11-year-old girls.

"We don't like it when they mix us with those in P.4, we are in P.7 and they are young, they don't understand these things and they just be laughing"(Participant 5, FGD, Kween).

Recognition of the sensitivity of some topics

The sensitivity of some of the topics discussed in the program was further seen as building curiosity among other ineligible learners. This was reported in some of the schools in Kween where ineligible learners gathered around the windows to eavesdrop. This meant that the JPC teachers were torn in between sending these ineligible learners away and conducting their classes.

"We often face a dilemma where younger learners come and gather around the classroom where we teach from, we want them to get the information but they are young and may not understand well, we do not want those unintended consequences"(KII, Program teacher, Kween).

Collaboration between program peer educators, schools and healthcare facilities

The links between the healthcare system and the peer educators (volunteers)s acted as a support system that enhanced SRHR seeking behavior, reduced teenage pregnancies and increased uptake of contraceptives among young people. It cemented the link between the young people in the community (including school) and the health facilities. The peer educators were reported as champions of peer-to-peer program activities that specifically targeted

adolescent health related issues within the community including condom distribution, short-term contraceptive methods like Sayana press which is a self-admissible injectable.

"So, we are working with some community volunteers under the program. So, before those young people come here, they usually have health education out there in the community, schools. And sometimes, these volunteers connect them to us using their lists"(KII, Health worker, Mbale).

"We have improved on the family planning uptake and there is some reduction in teenage pregnancies. It was too much around 2019 and 2020 around there, but due to those interventions in the community at least we see them reduce because we have talked to them… adolescents fear the facility, so we have empowered from the ground. If they are empowered, they can come"(KII, Health Worker, Kalangala).

Enabling environment at the healthcare facilities

While several young people revealed that they visited a health facility and interacted with a health worker whenever they made a visit, the conversations from health workers corroborated that the health facilities were safe and friendly spaces, which facilitated young people's agency in seeking help from health workers. All health workers revealed that youth friendly corners were a safe space that attracted young people to seek SRHR services. As a way of making them friendly, the spaces had social activities like games and television services that attracted youths to come to the health facilities. The youth's presence at the health facility was used as an opportunity to discuss SRHR information. In order to promote health seeking behaviours among the youth, the SRHR health service providers need to ensure, confidentiality, privacy, courteousness, be non-judgmental and provide special days for services to the youth.

"The youth friendly corner is located (behind) in a less busy area within the facility. This strategic location encourages young people to access the services without fearing or attracting attention from other members of the public" (KII, Health Worker, Mbale).

"To support teenage mothers with this service, we run an adolescent antenatal day every Monday where pregnant adolescents 15 to 19 years are given priority"(KII, Health Worker, Mbale).

"When they come, we try to use friendly language, we do not judge them. A child comes, I want family planning, and then for you, you say, you are a young child, you are immoral and foolish. We are trying to limit that. Those days a child would come, and the nurse would say, "eeh, even that little one"(KII, Health worker, Mbale)?

Discussion

The study has explored the outcomes and effectiveness of the Journeys Plus program, focusing on its impact on learning, behavioral change, HIV awareness, agency in managing SGBV and the enhancement of self-esteem, attitudes, and self-efficacy as well as the barriers and facilitators to program implementation. The findings indicate significant positive impacts of the Journeys Plus curriculum on young people in Uganda across several domains.

The intervention successfully facilitated learning and behavioral change among the learners by empowering them with essential knowledge and skills that improved their awareness and practices related to menstrual hygiene, personal safety, and the prevention of HIV and other infections. These findings can be explained by the fact that the intervention effectively enhanced knowledge on Sexual and Reproductive Health and Rights (SRHR) among young participants. It fostered awareness of SRHR issues such as consent, prevention of early marriages, and the risks associated with harmful practices like Female Genital Mutilation (FGM). Participants reported feeling empowered to assert boundaries against potential threats like sexual advances and gifts from strangers, demonstrating increased confidence and knowledge in managing their own safety. This empowerment signifies increased confidence and knowledge in managing their own safety. Comprehensive educational interventions can effectively reduce vulnerability to sexual exploitation and abuse among youth, thereby contributing to improved sexual and reproductive health outcomes[27-29]. This proactive approach supports public health goals by promoting informed decision-making, reducing risky behaviors related

to HIV and STIs, and fostering a culture of respect for boundaries and consent.

Journey's Plus has contributed to HIV prevention and management, the intervention significantly increased awareness among young people. Participants learned about the transmission and prevention of HIV, emphasizing abstinence and safe sexual practices. The public health significance here is that the intervention equipped learners with essential knowledge to protect themselves and others from HIV, which can lead to reduced transmission rates, improved health outcomes, and empowered decision-making among youth, contributing significantly to broader efforts in combating HIV/AIDS and promoting overall community health. While misconceptions persisted in some areas, such as knowledge on HIV transmission, overall, the curriculum positively influenced attitudes and behaviours related to sexual health and HIV prevention. The findings are supported by several literature[29-31].

Additionally, the learners demonstrated agency in managing Sexual and Gender-Based Violence (SGBV) abuses. They exhibited increased assertiveness and knowledge in identifying and reporting instances of violence, including early and forced marriages and other forms of abuse. The curriculum empowered participants to stand up against societal norms and practices that perpetuate violence, fostering a supportive environment for victims and promoting community awareness and intervention. These findings are similar to those reported in other studies where comprehensive sexuality education was a strategy for SGBV prevention[32-34]. The public health significance of these findings is substantial as they signify a critical step towards creating safer communities. The curriculum has promoted a culture of accountability and support, ultimately contributing to the prevention and reduction of SGBV. Such initiatives are essential for promoting health, safety, and well-being among young people, addressing systemic issues, and promoting positive social change.

Furthermore, meaningful peer friendships emerged as a crucial outcome of the curriculum. Participants reported improved social skills and relationships across gender lines, creating a supportive network where young people felt comfortable discussing sensitive topics like menstruation and personal hygiene. This inclusive approach promoted mutual respect and understanding among peers, contributing to a positive school and community environment. Such outcomes have equally been reported by [35] highlighting how through a menstruation hygiene program, men and boys in India embraced supporting menstrual needs for women and girls freely within the households, community and in schools. How helpful the boys are therefore in this regard suggests how well the curriculum has demystified the stereotype around menstruation for girls especially in public spaces such as schools, boosting their confidence and self-efficacy in seeking and accepting help from boys. This resonates the argument by *Kasiime et al(2020)* [36] that school spaces are ambient places to address issues related to menstrual stigma and enforce menstrual literacy.

Lastly, vocational and hands-on skills training provided practical benefits to participants, such as learning to make reusable sanitary pads and engaging in gardening and baking projects. These activities not only equipped young people with marketable skills but also instilled a sense of responsibility and entrepreneurship, enhancing their self-esteem and economic prospects. The program therefore addressed both immediate and long-term public health outcomes, as the activities not only equip learners with marketable skills but also promote economic independence and self-sufficiency, which are crucial for improving overall well-being[34]. By fostering a sense of responsibility and entrepreneurship among participants, the curriculum enhances self-esteem and resilience, factors that contribute positively to mental health and social integration[34]. Ultimately, such initiatives empower youth to lead healthier and more productive lives, thereby contributing to community development and sustainable public health outcomes.

The barriers to program implementation were many and multidimensional with several implications. Firstly, negative community attitudes and hostility towards school or community projects threaten the safety and continuity of initiatives, potentially undermining efforts to improve health outcomes. Secondly, challenges in fitting program activities into already packed school timetables hinder effective learning and comprehensive delivery of curriculum content, indicating the importance of integrating health education seamlessly into existing educational frameworks to

optimize learning outcomes without disrupting core academic schedules. Thirdly, interruptions in learning due to absenteeism among both learners and teachers, jeopardize program effectiveness. Addressing these challenges requires holistic approaches that support school attendance and mitigate economic barriers to education.

Expectations of monetary incentives from community members and learners themselves have always limited success of programs[37] and reflect broader socio-economic disparities and misconceptions about development assistance. Additionally, confidentiality breaches by healthcare systems and stock outs of essential medications undermine trust in health services and compromise young people's access to critical healthcare.

The enablers of program implementation were several, and facilitated the positive outcomes amidst challenges above. Provision of consistent engagement over an extended period allowed for repeated exposure to SRHR topics, reinforcing understanding and enabling practical application of knowledge[39,40]. Secondly, proactive information sessions conducted to mitigate community attitudes proved instrumental in gaining community acceptance and support. Program teachers and educators undertook efforts to engage directly with parents and caregivers, addressing concerns and misconceptions about the program's impact on adolescent learners. The strategic use of peer groups within the program enhanced learning effectiveness. Tailoring educational sessions to specific peer categories ensured that content was age-appropriate and relevant, fostering an environment conducive to open discussions on sensitive SRHR topics. This approach not only promoted peer-to-peer support but also minimized distractions, allowing for focused learning and deeper engagement among participants[41,42].

Strong collaboration between program stakeholders- including peer educators, schools, and healthcare facilities played a pivotal role in overcoming logistical challenges and bridging gaps in SRHR service delivery. Peer educators acted as crucial links between young people and health resources, facilitating access to essential services and information within the community. This collaborative effort ensured that program objectives were effectively integrated into existing healthcare structures, promoting sustainable health-seeking behaviors among adolescents. Lastly, the creation of youth-friendly and safe spaces within healthcare facilities was instrumental in encouraging adolescent participation and engagement with SRHR services. These designated spaces, equipped with amenities and staffed by trained health workers, ensured confidentiality, respect, and non-judgmental care. Such environments are pivotal in building trust among young people, empowering them to seek necessary health interventions and support without fear or hesitation[43,44].

Strengths and limitations

The study strengths included focused intervention evaluation, comprehensive participant pull, age appropriate focus, application of a phenomenological study design, robust data analysis and a wide range of outcomes. The study specifically evaluated the Journeys Plus curriculum in various districts, providing targeted insights into its impact on youth behavior and empowerment. This specificity strengthens its relevance for assessing the intervention's success. The inclusion of 360 young people and 80 adults across multiple districts ensured a diverse representation of perspectives, enhancing the study's credibility and applicability to similar settings. By concentrating on youth aged 9–14 years, the study effectively captured insights into a critical developmental stage, where behavioral and cognitive shifts are most impactful.

The qualitative approach allows for an in-depth exploration of participants' lived experiences, providing rich, contextual data on the curriculum's impact. The use of Atlas.ti software and deductive analysis ensures a systematic and rigorous approach to data interpretation, enhancing the validity of the findings.

The study addressed multiple dimensions, including SRHR knowledge, vocational skills, GBV resistance, and peer relationships, offering a holistic view of the curriculum's benefits.

Limitations of the study

The limitations of the study included potential sampling bias, restricted age range, reliance on self-reported data, lack of comparison group, short term focus, geographic and culture specific and limited adult perspective. The purposive selection of participants might limit the generalizability of the

findings, as the sample may not fully represent the broader population of youth and adults in the districts. Focusing only on youth aged 9–14 excludes older adolescents who might have different experiences or outcomes with the curriculum. The study may be subject to social desirability bias, where participants provide responses they perceive as favorable rather than entirely accurate. Without a control group, it is challenging to attribute observed changes solely to the Journeys Plus curriculum, as external factors could also influence outcomes. The study might not capture long-term effects of the curriculum on behavior and empowerment, limiting insights into sustained impacts. While the districts included are diverse, the findings may not be applicable to regions with different cultural or socio-economic contexts. Although adults are included, their number (80) is relatively small compared to the youth sample, potentially underrepresenting their views on the curriculum's broader community impact.

Addressing these limitations in future studies, such as incorporating control groups, expanding the age range, and increasing the adult sample size, could provide a more comprehensive understanding of the curriculum's long-term efficacy and broader applicability.

Implications of the study to policy and practice

The study has highlighted the benefits of JPC that point to the need to the need to mainstream it into the national school curriculum. The study has also highlighted the need for government and other actors to invest time and financial resources in schools, health facilities and skilling teachers and health facility staff to ensure that the learning spaces are safe for the JPC curriculum.

The study is directly informing SRHR and SGBV campaigns in terms of the words and ways of running campaigns for young people. Peer to peer campaigns, and affirmation messages seems to make meaningful acquisition of the messages. The findings also point to the need to reflect on the learning process, identify gaps and rework accordingly.

There is need to address the misconceptions as they could potentially risk the management of HIV within school spaces and beyond as they could reinforce HIV-related stereotypes and facilitate stigma which could negatively affect learners and other community members living with HIV.

Strengthening healthcare systems and ensuring adherence to confidentiality protocols are essential for sustaining trust and improving health-seeking behaviors among youth. Lastly, it is important to dialogue on the conflicts between program guidelines and national health policies, particularly regarding age eligibility for certain health services such as access to contraceptives. These expectations necessitate transparent communication and community involvement strategies to align program goals with local priorities and perceptions. the importance of aligning interventions with established health regulations to ensure ethical and legal compliance. Addressing these conflicts requires collaborative efforts between implementing partners, healthcare providers, and regulatory authorities to harmonize guidelines and promote consistent service delivery.

Conclusion

The Journeys Plus curriculum in Uganda highlights its holistic approach to youth empowerment and its positive impact on the lives of participants. It has proven effective in promoting behavior change, enhancing SRHR knowledge, empowering young people against GBV, fostering meaningful peer relationships, and equipping them with practical vocational skills. In amplifying their voices, the programme has impacted on young people in the central district of Kalangala, the east-central districts of Bugiri, Mayuge, Iganga as well as Namayingo and in the eastern districts of Budaka, Mbale, Bukwo and Kween through platforms where they can now influence learning, build partnerships, and be more directly involved in the design, implementation and monitoring of program activities that directly relate and concern them.

References

1. Amuche NJ, Emmanuel EI and Innocent NE. HIV/AIDS in sub-Saharan Africa: current status, challenges and prospects. 2017.
2. WHO. Adolescent pregnancy 2024 [Available from: https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy.
3. UNICEF. Adolescent HIV 2024 [Available from: https://data.unicef.org/topic/hivaids/adolescents-young-people/.

4. Germain A, Sen G, Garcia-Moreno C and Shankar M. Advancing sexual and reproductive health and rights in low-and middle-income countries: Implications for the post-2015 global development agenda. Global public health. 2015;10(2):137-48.
5. Ravindran TS and Govender V. Sexual and reproductive health services in universal health coverage: a review of recent evidence from low-and middle-income countries. Sexual and reproductive health matters. 2020;28(2):1779632.
6. Mohamed S, Chipeta MG, Kamninga T, Nthakomwa L, Chifungo C, Mzembe T, Vellemu R, Chikwapulo V, Peterson M and Abdullahi L. Interventions to prevent unintended pregnancies among adolescents: a rapid overview of systematic reviews. Systematic Reviews. 2023;12(1):198.
7. Naidoo K, Adeagbo O and Pleaner M. Sexual and reproductive health needs of adolescent girls and young women in sub-Saharan Africa: research, policy, and practice. SAGE open. 2019;9(3):2158244019859951.
8. Schweitzer A-M, Dišković A, Krongauz V, Newman J, Tomažič J and Yancheva N. Addressing HIV stigma in healthcare, community, and legislative settings in Central and Eastern Europe. AIDS Research and Therapy. 2023;20(1):87.
9. Renzaho AM, Kamara JK, Georgeou N and Kamanga G. Sexual, reproductive health needs, and rights of young people in slum areas of Kampala, Uganda: a cross sectional study. PloS one. 2017;12(1):e0169721.
10. Tumwakire E, Ashaba S, Mubangizi Vand Gavamukulya Y. Sexual and reproductive health knowledge and practices among youth with and without mental illness in Uganda: a comparative study. Tropical Medicine and Health. 2022;50(1):51.
11. Amanu A, Birhanu Z and Godesso A. Sexual and reproductive health literacy among young people in Sub-Saharan Africa: evidence synthesis and implications. Global health action. 2023;16(1):2279841.
12. MOH. Uganda Country Operational Plan (COP) 2022 Strategic Direction Summary April 27, 2022 2022 [Available from: https://www.state.gov/wp-content/uploads/2022/09/Uganda-COP22-SDS.pdf.
13. RTI. USAID/Uganda Literacy Achievement and Retention Activity; Facilitator’s Guide: Journeys Plus Activity Handbook for Pupils 2020 [Available from: https://ierc-publicfiles.s3.amazonaws.com/public/resources/SharEd_Facilitators%20Guide_Journeys%20Plus%20Activity%20Handbook%20for%20Pupils_Nov_2020.pdf.
14. Ross DA, Dick B, Ferguson J and Organization WH. Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries: World Health Organization; 2006.
15. MacCarthy S, Saya U, Samba C, Birungi J, Okoboi S and Linnemayr S. “How am I going to live?”: exploring barriers to ART adherence among adolescents and young adults living with HIV in Uganda. BMC public health. 2018;18(1):1-11.
16. Bryman A. Social research methods. 4 ed: Oxford University Press; 2012.
17. Creswell JW. Qualitative Inquiry and Research Design: Choosing Among Five Approaches. 3rd edition: Washington DC: Sage. 2012.
18. Creswell JW. Research Design: Qualitative, Quantitative and Mixed Methods Approaches. 4 ed. Thousand Oaks, CA: Sage publication; 2014.
19. Creswell JW. Qualitative inquiry and research design: Choosing among five traditionsfive traditions.1998.
20. Mason J. Mixing methods in a qualitatively driven way. Qualitative Research. 2006;6(1):9-25.
21. Wertz FJ, Charmaz K, McMullen LM, Josselson R, Anderson R and McSpadden E. Five ways of doing qualitative analysis : Phenomenological Psychology, Grounded Theory, Discourse Analysis, Narrative Research, and Intuitive Inquiry. New York: The Guilford Press; 2011.
22. Bryman A. Social research methods. International Edition ed. United Kingdom: Oxford University Press; 2016.
23. Abebe T. Multiple methods, complex dilemmas: negotiating socio-ethical spaces in participatory research with disadvantaged children. Children's Geographies. 2009;7(4):451-65.
24. Punch S. Multiple methods and research relations with young people in rural Bolivia. In: Limb MandDwyer C, editors. Qualitative Methodologies for Geographers. London2001. p. 165-80.
25. Alderson P. Ethics. 2014 2019/03/25. In: Understanding Research with Children and Young People [Internet]. London: SAGE Publications, Inc.; [85-102]. Available from: http://sk.sagepub.com/books/understanding-research-with-children-and-young-people.
26. Alderson P and Morrow V. The ethics of research with children and young people : a practical handbook. 2nd ed. London: Sage Publications Ltd; 2011.
27. UNICEF. ACTION TO END CHILD SEXUAL ABUSE AND EXPLOITATION 2020 [Available from: https://www.unicef.org/media/89106/file/CSAE-Brief-v2.pdf.
28. Radford L, Allnock DandHynes P. Preventing and responding to child sexual abuse and exploitation: Evidence review. Preventing and Responding to Child Sexual Abuse and Exploitation: Evidence Review Lorraine. 2015;6(3):1-167.
29. Wurtele S and Miller-Perrin C. What Works to Prevent the Sexual Exploitation of Children and Youth. 2017. p. 176-97.
30. Schneider M and Hirsch J. Comprehensive Sexuality Education as a Primary Prevention Strategy for Sexual Violence Perpetration. Trauma, Violence, & Abuse. 2018;21:152483801877285.
31. Millanzi WC, Osaki KM and Kibusi SM. The effect of educational intervention on shaping safe sexual behavior based on problem-based pedagogy in the field of sex education and reproductive health: clinical trial among adolescents in Tanzania. Health psychology and behavioral medicine. 2022;10(1):262-90.

32. Makleff S, Garduño J, Zavala RI, Barindelli F, Valades J, Billowitz M, Silva Márquez VI and Marston C. Preventing intimate partner violence among young people—a qualitative study examining the role of comprehensive sexuality education. Sexuality research and social policy. 2020;17(2):314-25.
33. Cahill H, Kern ML, Dadv and B, Cruickshank EW, Midford R, Smith C, Farrelly AandOades L. An integrative approach to evaluating the implementation of social and emotional learning and gender-based violence prevention education. International Journal of Emotional Education. 2019;11(1):135-52.
34. UNFPA. COMPREHENSIVE SEXUALITY EDUCATION AS A STRATEGY FOR GENDER-BASED VIOLENCE PREVENTION 2021 [Available from: https://www.aidsdatahub.org/sites/default/files/resource/unfpa-comprehensive-sexuality-education-strategy-gbv-prevention-2021.pdf.
35. Mahon T, Tripathy A and Singh N. Putting the men into menstruation: the role of men and boys in community menstrual hygiene management. Waterlines. 2015:7-14.
36. Kansiime C, Hytti L, Nalugya R, Nakuya K, Namirembe P, Nakalema S, Neema S, Tanton C, Alezuyo C and Musoke SN. Menstrual health intervention and school attendance in Uganda (MENISCUS-2): a pilot intervention study. BMJ open. 2020;10(2):e031182.
37. Jacobson SL, Brooks S, Giles C, Johnson L and Ylimaki R. Successful leadership in three high-poverty urban elementary schools. Leadership and policy in schools. 2007;6(4):291-317.
38. Corley AG, Sprockett A, Montagu D and Chakraborty NM. Exploring and monitoring privacy, confidentiality, and provider bias in sexual and reproductive health service provision to young people: A narrative review. International Journal of Environmental Research and Public Health. 2022;19(11):6576.
39. Schaaf M, Boydell V, Topp SM, Iyer A, Sen G and Askew I. A summative content analysis of how programmes to improve the right to sexual and reproductive health address power. BMJ Global Health. 2022;7(4):e008438.
40. Wilson M, Cutherell M, Musau A, Malakoff S, Coppola A, Ayenekulu M, Mtei E and Ogbondeminu F. Implementing adaptive youth-centered adolescent sexual reproductive health programming: learning from the Adolescents 360 project in Tanzania, Ethiopia, and Nigeria (2016-2020). Gates Open Research. 2022;6.
41. Boggiss AL, Consedine NS, Schache KR, Wallace-Boyd K, Cao N, Hofman PLandSerlachius AS. Exploring the views of adolescents with type 1 diabetes on digital mental health interventions: What functionality and content do they want? Diabetic Medicine. 2021;38(11):e14591.
42. Williams DJ and Neville FG. Qualitative evaluation of the mentors in violence prevention pilot in Scottish high schools. Psychology of Violence. 2017;7(2):213.
43. Gebrie M, Asrade G, Tsehay CT, Yazachew L and Dellie E. Quality of adolescent and youth-friendly health services in Dehana district public health facilities, northeast Ethiopia: Using the Donabedian quality framework. PLoS One. 2021;16(10):e0258718.
1. 44. Mulugeta B, Girma M, Kejela G, Meskel FG, Andarge E and Zerihun E. Assessment of youth-friendly service quality and associated factors at public health facilities in southern Ethiopia: a facility-based cross-sectional study. BioMed Research International. 2019;2019.45. https://iercpublicfiles.s3.amazonaws.com/public/resources/Journeys%20Plus%20Mini%20booklet%20for%20Pupils.pdf