University of Amsterdam

AMSTERDAM INSTITUTE FOR SOCIAL SCIENCE RESEARCH

HER CHOICE

Her Choice

Midline Study

Synthesis Report

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CONTENTS

ACRONYMS AND ABBREVIATIONS

AISSR	Amsterdam Institute for Social Science Research
Ba	Bangladesh
Be	Benin
BF	Burkina Faso
BL	Baseline [study]
CM	Child marriage
CSE	Comprehensive Sexuality Education
DiD	Difference in difference
Eth	Ethiopia
FBO	Faith-based organisation
FGD	Focus group discussion
FGM/C	Female genital mutilation/cutting
Gh	Ghana
HC	Her Choice
ICDI	International Child Development Initiatives
IND	Indicator
Ma	Mali
MEL	Monitoring, evaluation and learning
MoA	Monitoring of Activity [forms]
ML	Midline [study]
Ne	Nepal
NGO	Non-governmental organisation
Pa	Pakistan
Sen	Senegal
SKN	Stichting Kinderpostzegels Nederland
SL	Sierra Leone
SPSS	Statistical Package for Social Science
SRHR	Sexual and reproductive health and rights
SSA	Sub-Sahara Africa
STI	Sexually transmitted infection
THP	The Hunger Project
Ug	Uganda
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UvA	University of Amsterdam
YFHS	Youth-friendly health services

EXECUTIVE SUMMARY

This report present the findings of the midline (ML) evaluation of the Her Choice programme (HC), coordinated by the research partner, AISSR/UvA.

The objectives of the evaluation were to:

1. Measure values of programme indicators in the 10 programme countries and explain any increase or decrease from study data and local partners' reports.
2. Evaluate partnership in the Her Choice Alliance.
3. Discuss progress against the Her Choice Theory of Change.
4. Give recommendations for programme activities and directions for the partnership in the remaining two years of the HC programme.
5. Formulate further data analysis plans and implications for the end-line study and impact evaluation.

Midline study

The midline study uses a difference-in-difference design with 'treatment' and 'comparison' study sites. In treatment locations, programme activities started following completion of baseline (BL) data collection in mid-2016. In comparison sites, activities started after finalization of ML data collection in 2018. Similar to the BL, a mixed-method approach was used to gather quantitative and qualitative data. ML data were collected in all 10 programme countries between April and June 2018.

The study involved nine study populations. In line with the difference-in-difference design, the ML sample of districts (N=42), villages (N=79), schools (N=87) and health centres (N=99) was identical to the BL sample. Again similar to the BL, participating households (N=3261), girls (N=5204), teachers (N=145), health staff (N=99) and female and male students (in 143 focus groups discussion) were purposively sampled to meet key criteria such as, respectively, presence of a young woman between 12-17 years, age, responsibility for SRHR-related teaching or health care provision to young people, within age-groups 12-14 and 15-17. While each midline participant was asked whether or not they had taken part in the baseline, this participation did not form a criterion for in- or exclusion in the midline. For practical reasons, no particular effort was made to locate baseline participants to take part in the midline study. Important changes during the midline data collection concern the transition from the paper-based baseline to the digitally-based midline study and posing additional questions to married girls.

This synthesis report presents the data for the HC output and (intermediate) outcome indicators per strategy as well as the impact indicators. In the analysis indicators' ML and BL values for treatment and comparison sites are compared. Tables and bar charts in the report present indicator findings at country level, whereas regional level data and supporting information can be found in annexes in a separate document.

Partnership review

AISSR conducted a review of the partnership with local partners of three programme countries (Ethiopia, Ghana and Uganda).

Key findings

Strategy I: Invest in girls, their knowledge, skills and participation in society

- In all countries the share of girls who had received SRHR-related education in the treatment villages was considerable higher than in the comparison villages, indicating programme activities. At midline a considerable increase in SRHR trained girls was found in all countries.
- In all countries young women's knowledge on SRHR in treatment villages increased at ML, with young women in treatment sites scoring higher on comprehensive knowledge measure than those in comparison sites. However, comprehensive knowledge remains low.
- Findings on girls who reported feeling able to oppose a marriage were ambiguous: Generally speaking, a smaller share of girls in the South Asian countries reported feeling able to oppose marriage.
- In most countries approximately half to three-quarters of young women who reported being sexually active used a contraceptive method – mainly condoms. Generally contraceptive use in ML treatment sites was higher than in comparison sites.
- At the time of the ML, a larger share of single and married girls in nearly all countries reported that they had spoken out about their rights, mainly in meetings of peers and in school. In all countries more girls in treatment sites reported speaking out than in comparison sites.

Strategy II: Improve access to formal education for girls

- In most countries, the share of schools with teachers trained to give education on SRHR has increased in the ML treatment sites.
- Almost all schools reported (at ML and BL) to have taken at least one measure to make their school more girl-friendly. Although the number of measures taken has increased in treatment sites, only few schools scored high on girl-friendliness.
- Despite having received training, a large share of teachers in the ML reported not feeling able and confident to teach their students about SRHR. These findings are similar to the BL.
- As in the BL, sizeable differences were found across countries in single girls' school enrolment, from a high of over 90% in Ghana and Ethiopia, to a low of 40% or lower in Benin and Bangladesh. On the whole, differences across treatment and comparison sites within countries were not extensive. Enrolment of married girls was generally much lower than that of single girls – in some countries no married girls reported being enrolled in school. However, generally enrolment of married girls in treatment sites is higher than in comparison sites.

Strategy III: Improve access to youth-friendly SRHR services for girls

- In all countries except Ethiopia a considerable share to all staff at ML reported to have had training on SRHR during the two years previous to data collection and a considerable share of interviewed health staff reported feeling able to provide these services. More staff reported feeling able to do so in treatment sites and more at ML than at BL.
- Across countries, more measures had been taken in treatment sites to make services more accessible to young people. Measures most often taken included making staff aware of harmful consequences of child marriage and FGM/C, and adjusting opening hours to allow young people to attend.
- The share of single girls who knew of SRHR-related services has increased in the vast majority of treatment and comparison sites (but was higher in treatment sites). Across countries a higher share of single young women in treatment villages reported that they had used SRHR services.

Strategy IV: Improve economic security of girls and their families

- In all countries, except Nepal and Uganda, the share of households with women supported with income generation was higher in treatment than comparison sites.
- Generally, a high share of heads of households with women supported across the 10 HC countries indicated that household income had increased as a result of income generation activities addressed at women.
- The economic status of households in the ML in six countries increased or was about similar to baseline. In four countries the economic status deteriorated compared to the baseline – village leaders in those countries said this decrease was due to natural disasters and political upheaval, which had negatively affected harvest and thus, income.

Strategy V: Mobilize communities to transform social norms that are detrimental to achieving gender equality

- At ML, a higher share of community leaders had been sensitized on negative effects of child marriage and FGM/C than at BL.
- An increase was found in most countries in the share of village leaders who reported having condemned child marriage in village meetings and in proportion of villages with community members who had organised activities on negative effects of CM.
- In virtually all countries, and more so in treatment sites, an increasing share of girls reported being able to consult a particular source on SRHR and feeling supported in decision making on early marriage.

Strategy VI: Create an enabling legal and policy environment on preventing child marriage

- An increasing share of villages in most countries have started developing by-laws against child marriage or are already having such by-laws during the midline, and more so in treatment sites.
- Birth registration remains problematic in most countries – only three districts in Burkina Faso and four in Mali are almost all births registered, according to respondents.
- An increasing share of girls was found to know of protective laws on CM and FGM/C.

Impact

- Compared to the BL, a larger proportion of young women in most countries reported they felt in control of marriage decisions, and in most countries this share was larger in treatment villages than in comparison villages. Overall, young women in South Asian countries reported feeling less 'in control' than in Sub-Saharan African countries.
- In all countries the share of 17-year old girls who were married had decreased at ML – with hardly any married girls in ML Burkina Faso, Ghana, Ethiopia and Uganda, both in treatment and comparison sites.

Information on marriages of married girls

- In most countries a minority of marriages was registered in the city hall – except for Pakistan where 100% were said to be registered thus. In Senegal (comparison site) and Mali, a considerable number of marriages was reportedly registered in the mosque.
- In Bangladesh and Pakistan, most married girls indicated they were living with their husband (between 86.1% and 92.1%), whereas in Nepal a minority said they were living with their spouse (15.4% in treatment and 25.0% in comparison sites). In other countries approximately half of married young women said they were living with their husband.
- ML data shows that young women usually did not marry old men: in Pakistan and Nepal, the majority was found to have married a teenager (below 20 years of age), whereas in other countries, the majority married a man in his 20s. Only a minority in all countries married a man in his 30s -- Mali being an exception, here approximately one-quarter married a man in his 30s.
- A considerable proportion of married girls already had a child or was pregnant at ML, up to a high of more than half in Pakistan. However, compared to shares of married girls with children at BL, the shares had decreased in all countries, which would indicate intensified attention to family planning, both by government and HC partners.

Programme implications

1. The programme should strive towards greater alignment of CSE contents and more focused attention for gender norms and relations, and power dynamics (for example, in intimate relations).
2. A nested approach to CSE is recommended to ensure that young people's knowledge related to SRHR issues is enhanced alongside, among other issues, addressing health care staff attitudes to provision of SRHR information and services to unmarried young people, supporting CSE teachers in building support for CSE in the communities where young people come from, sensitization and dialogue in communities to community norms on gender and sexuality of young people that are detrimental to young women. Changing these norms is a long process and requires a long term intervention adapted to local realities.
3. The programme should involve communities in putting in place measures to make schools more accessible to girls (and generally make schools more child-friendly).
4. The involvement of boys and men in programming should be enhanced, for example, in addressing sexual harassment. It is recommended that alliance members identify what local partners are doing and to build on that, as well as learning from other CM alliances with regard to this issue.
5. Intensified attention should be given to birth registration.
6. Prevention of CM should not be the only focus of the programme. Instead, more attention needs to be paid to married girls and barriers they face, for instance, in relation to educational participation, income generation, social and psychological well-being and child care support.
7. Greater emphasis should be placed on a) learning from each other (including Alliance members and local partners), and b) documentation as to what alliance members are already learning from each other.
8. The alliance should strive for progress, for example, on girl-friendly measures instead of expecting to attain all/a majority of (international) standards and criteria.
9. The alliance should consider making more use of the (generic) visualization tools that have been developed by Her Choice on i) youth-friendly health services, ii) girl-friendly schools and iii) comprehensive sexuality education, as well as the ICDI Girls QUAT. These visualization tools can be used in design of activities, discussion, and evaluation by stakeholders. The generic tools can be adapted to local contexts.

1. INTRODUCTION

1.1 Background Her Choice Alliance

Her Choice (HC) is one of three Sexual and Reproductive Health and Rights (SRHR) alliances working in partnership with the Netherlands Ministry of Foreign Affairs in the field of child marriage. HC is an alliance of four Netherlands-based organisations that seeks to work towards creating child-marriage free communities. HC also aims to reduce incidence of female genital mutilation/cutting (FGM/C). The HC alliance is composed of the main applicant Stichting Kinderpostzegels Nederland (SKN), and three co-applicants: The Hunger Project (THP), International Child Development Initiatives (ICDI) and the Amsterdam Institute for Social Science Research/University of Amsterdam (AISSR/UvA). The HC programme started in January 2016 and will be concluded in December 2020. Her Choice works in 10 countries in Sub-Saharan Africa and South Asia with a total of 30 local partner organisations. In four (out of the 10) countries, multiple partner organizations are involved in the implementation of the Her Choice programme. These countries are Bangladesh, Burkina Faso, Ethiopia and Mali. In the remaining six countries, the programme is implemented by one partner, that is, in Benin, Ghana, Nepal, Pakistan, Senegal, and Uganda (see Annex 2 for details).

To reduce the incidence of child marriage in the 10 Her Choice programme countries, the HC programme deploys six interlinked strategies (see Box 1).

Box 1: Her Choice programme strategies

1. **Investing in girls**, their knowledge, skills related to SRHR and participation in society.
2. **Keeping girls in school**: improving access to formal education for girls by supporting girl-friendly schools and building knowledge through schooling in general, and on SRHR in particular.
3. **Improving access to youth-friendly SRHR services for girls**: improving health services and by actively referring girls to health workers.
4. **Strengthening the economic security of girls and their families**: creating and supporting women's self-help groups with training and access to (financial) resources.
5. **Transforming social norms and traditional practices**: mobilising and supporting communities, including boys, men, women, leaders to promote girls' rights and gender equity, to achieve gender equity in education, decision-making, and access to services.
6. **Creating an enabling legal and policy environment on preventing child marriage**: supporting traditional leaders and (local) authorities to enforce national policies on preventing child marriage

Source: Her Choice website: http://www.her-choice.org/en/her-choice/programme/

1.2 The role of the AISSR/UvA

The AISSR/UvA is the Her Choice research partner. The central task of the AISSR/UvA in the alliance is to examine the impact of the Her Choice strategies in relation to the prevention and reduction of the prevalence of child marriage in the 10 different contexts. In order to measure programme impact, the AISSR/UvA research team conducted a mixed method baseline study in 2016, followed by the 2018 midline assessment that is detailed in the present report. The endline study will be carried out in 2020. In addition to the impact assessment, the AISSR/UvA is conducting more in-depth qualitative studies, including two doctoral research projects in Nepal and Pakistan.

1.3 Midline evaluation objectives

The objectives of the midline evaluation were to:

1. Measure values of programme indicators in the 10 programme countries and explain any increase or decrease from study data and local partners' reports.
2. Evaluate the partnership of the Her Choice Alliance.
3. Discuss progress against the HC Theory of Change.
4. Provide recommendations for programme activities and direction in the remaining two years of the HC programme.
5. Formulate further data analysis plans and implications for the end-line study and impact evaluation.

1.4 Report outline

The report is structured as follows. Chapter 2 details the research methodology, including study design, sampling and methods deployed to collect and analyse the data in the 10 programme countries (2.1); and the partnership review (2.2). Chapters 3-10 concern the midline study as conducted in the 10 project countries. Chapter 3 presents the study locations and populations, Chapter 4-10 detail study findings in relation to the six HC strategies and the impact indicators.

Chapter 11 presents findings of the partnership reviews of: 1) the four Her Choice alliance members; 2) between the HC Alliance and the Dutch Ministry of Foreign Affairs (MoFA); 3) HC Alliance, the other two Dutch child-marriage alliances and GNB Netherlands; and 4) HC Alliance members and local implementing partners in Ethiopia, Ghana and Uganda.

The concluding chapter (Chapter 12) discusses the main midline findings in view of the HC theory of change, and reflects on implications for the programme and research for the remaining two years of the Her Choice programme.

The report includes two annexes in a separate document which offer: 1) more detail with regard to the indicator values (for girls and households), including the regional values for countries where data were collected in more than one region, and 2) corresponding tables for the supporting data referred to in the report.

2. METHODOLOGY

2.1 Mid-line study in programme countries

2.1.1 Study design

As indicated earlier, the HC impact evaluation is based on the HC theory of change and the HC programme indicators for programme outputs, (intermediate) outcomes and impact (Annex 1). To allow for the measurement of the impact of programme interventions, that is, to attribute change on indicators to programme interventions, the study uses a difference-in-difference design (DiD) with treatment and comparison sites in each study location (Table 1). More methodological detail is provided in the baseline report.[1]

Table 1: Overview of study design

	Baseline	*Midline*	*Endline*	*1st Difference*	*2nd Difference*	*Total Difference*
Treatment	T_{2016}	T_{2018}	T_{2020}	T_{2018} -T_{2016}	T_{2020} -T_{2018}	T_{2020} -T_{2016}
Comparison	C_{2016}	C_{2018}	C_{2020}	C_{2018} -C_{2016}	C_{2020} -C_{2018}	C_{2020} -C_{2016}
				DiD 1: (ΔT_{2018} -ΔC_{2018})	DiD 2: ($\Delta T_{2020'}$ -ΔC_{2020})	DiD Total: (ΔT_{2020} -ΔC_{2020})

To measure impact, a mixed methods design is deployed, building on both qualitative and quantitative methods. Semi-structured surveys were primarily used to gather quantitative data, alongside some supporting qualitative data. Focus Group Discussions (FGDs) with young women and men were used to collect qualitative data.

2.1.2 Data collection tools

Nine sets of tools were used to gather data in the HC programme countries: eight (semi-) structured questionnaires and FGD topic guides. Prior to and during the midline training workshops, some changes were made to the tools used in the baseline study – excluding those that directly measured indicators – on the basis of the experience with the tools and questions during the baseline. For instance, during the baseline certain questions appeared to be ill-understood by participants while others were deemed too sensitive to ask in questionnaire format. Given the (large) scale of the study, an effort was made to reduce the number of (original) questions. New questions were only added where original questions measuring key indicators were found to yield insufficient quality data.

In baseline and midline tools were directed at the same Her Choice target groups. The study populations for the structured interviews were: Girls (12-17 years), household heads, village leaders, heads of health centres, health centre staff (specifically those working on issues related to SRHR),

[1] http://www.her-choice.org/en/her-choice-en/choice-baseline-study-child-marriage-11-countries/

school principals, school teachers (specifically those who provided school-based SRHR-related education or sensitization) and district leaders (who are most involved in SRHR, education, community development, law enforcement, and social welfare). Contrary to the baseline study, during which separate FGDs were conducted with a) school going young men and b) school going women between 12-17 years, during the midline study these two groups were further broken down according to age. That is, separate FGDs were carried out with a) school going young women between i) 12-14 years and ii) 15-17 years as well as with b) school going young men in these two age brackets. This division according to age was done with a view to increase comfort levels of young participants in particular and thereby generate more in-depth data from these younger participants.

Another important change during the midline concerns the transition from the paper-based baseline to the digitally-based midline study. For purposes of midline data collection and management, the AISSR/UvA made use of SurveyCTO. All tools (in English and French) were exported to Survey CTO by the AISSR/UvA research partner in Mali, Dr. Fousseynou Bah and tested multiple times during the midline training workshops. Upon finalisation of the English and French iterations of the tools, translations of the tools into all languages used during the baseline were uploaded onto SurveyCTO.

Tools were translated into local languages by research teams, where necessary supported by professional translators/linguists. Quality control of initial translations was done in collaboration with local HC partner organisations.

2.1.3 Midline training and finalisation of research tools

One of the central aims of the HC programme is to build capacity of local partners, including in the field of (applied) research. For this reason, it was decided to closely involve local HC partners in data collection rather than solely work with external consultants. Local research coordinators were appointed to support local HC partners during the data collection process, and were made responsible for the training of data collectors, supervision of data collection, analysis and write up of country reports. Two staff members from each HC partner (usually the HC country coordinator and the M&E officer) and local researchers were involved in (5-day) midline training workshops, which were facilitated by the AISSR in four countries between end January to mid-March 2018 (countries were clustered according to region or language used during the workshop).

After these training, AISSR organised a series of webinars for follow–up training of the local researchers on training, supervision, data handling, analysis and reporting. Manuals were written for training of enumerators, local partners' supervisors of fieldwork, and for the local researchers.

When the survey design and adaption process was completed, local researchers – in collaboration with the trained staff members from the HC partner organisations – conducted further workshops in each country to train local data collectors. During these workshops, data collectors practiced using the tools with the SurveyCTO application, and were instructed on, for example, the importance of being sensitive to the research environment, how to conduct FGD sessions and how to ensure participants were aware of their rights.

2.1.4 Study populations and sampling strategy

In line with the difference-in-difference design, the midline sample of districts, villages, schools and health centres was identical to the baseline, excluding one comparison village in Mali. Similar to the baseline, households, girls, teachers and health staff were purposively sampled to meet key criteria such as, respectively, presence of a young woman between 12-17 years, age, and responsibility for SRHR-related teaching or health care provision to young people. While each midline participant was asked whether or not they had taken part in the baseline, this participation did not form a criterion for in/exclusion from the midline. For practical reasons, no particular effort was made to locate baseline participants to take part in the midline study.

The midline report only presents data from the same districts as those included in the baseline. There were few changes to the study districts between midline and baseline: in Senegal, one district in another geographic region (Sedhiou) was added during the midline, and the total sample size increased (from 300 to 450 girls). However, data for Sedhiou have been analysed separately and will be used for the endline. In Nepal, one district (Makwanpur) was no longer included at midline. For the ML report the data for Makwanpur (that were included in the BL report) have been taken out of the comparison of midline-baseline data.

In four countries, data were collected in more than one study region; these regions are labelled R1,2,3 in the Indicator Annexes. In other countries, data were mostly collected in more than one geographic region, but these clustered in view of the small total sample size (i.e. if below 300 girls). The four countries with more than one study region are:

- Ethiopia: R1=Amhara; R2=SNNPR; R3=Oromia,
- Burkina Faso: R1=Haute Bassin & Boucle du Mohoun; R2=Centre Nord & Nord; R3=Centre Sud & Centre Ouest
- Mali : R1=Koulikoro & Bamako (in the latter only one T site); R2=Segou; R3=Mopti
- Bangladesh: R1=Dhaka; R2=Khulna.

Girls were selected through their households, where all girls in the age bracket 12-17 in a household were interviewed. The sample size of households may thus differ across countries, depending on the average number of girls aged 12-17 in households. For more detail concerning the sampling strategy, please refer to the baseline report.

2.1.5 Composition of local research teams

Data enumerators were recruited by local HC partner organisations, and were either field staff, university students and/or enumerators the partner organisations had worked with previously, during the baseline and/or other pieces of research. In order to obtain better quality data, where possible, enumerator demographics corresponded with those of respondents. For example, younger female data collectors conducted surveys with young women and male data collectors conducted FGDs with young school going men.

In most cases, supervisors of the data collection teams were the same as during the baseline and were working for one of the local Her Choice partners. Supervisors were tasked with, among other

things, coordination of the day-to-day data collection process and ensuring quality of the data collected and correct entry of data into SurveyCTO. Where possible, the AISSR worked with the same local research coordinator as during the baseline. Local research coordinators were tasked with providing support to the supervisors, ensuring the quality of data collection, the entry of data into SurveyCTO and reporting. The AISSR provided support to the local research coordinators.

2.1.6 Data analysis and reporting

Data files from SurveyCTO were transported to SPSS or Excel. For data analysis of quantitative findings we used SPSS. Qualitative data were analysed by thematic analysis of the data entered in excel spreadsheets.

Key study findings on indicator values – which are differentiated according to treatment and comparison sites, and midline and baseline – are presented in the report in bar charts and tables, and discussed in the main text. The bar charts included in this report present country-level data for indicators at the level of single girls and households, comparing Treatment (T) and comparison (C) site data for midline (ML) and baseline (BL). The ML bar chart is always presented on the left side, the BL bar chart always on the right side. It should be noted that because in approximately half of the 10 countries the total number of married girls was below 10, no bar charts were made for married girls. With a few exceptions, the data for the married girls are provided in the annexes.

To facilitate comparison, countries in the same geographic region are grouped together in tables and bar charts. Where (the majority of) denominators in a table is under 10, rates are presented in numbers rather than percentages. Supporting information is provided in relation to most indicators, specifically information that confirms, contradicts or qualifies the indicator values. This supporting information has been derived from focus group discussions (FGDs) or from surveys conducted with the same and/or different study population presented in the preceding figure or table. Supporting information from FGDs is presented in text boxes. At times, the interpretation of study findings draws on additional data derived from Monitoring of Activity (MoA) forms, which are annually completed by local partners. These MoA data may, for example, explain why there appears to be little progress on certain output indicators.

Each of the study findings chapters (4-10), begins with an introduction of the indicators for that strategy (in line with the theory of change), starting with the output indicators and moving on to intermediate outcome and outcome indicators.

When reading the study findings, please note the following:

- Although we present findings per country, data were collected in one up to seven geographic regions per country (with geographic regions in Mali, Senegal and Burkina Faso combined in study regions), and only a few villages per region. The total sample of villages could thus range from, for example, two villages in Uganda to 20 in Ethiopia (see Annex 2 for overview of study locations). Therefore, country-level data presented here cannot be considered representative for the entire country or region in question.
- When the term '*girls*' is used in the report, it refers to all interviewed single and married girls between 12 to 17 years (thus below 18 years of age). The term '*young women*' is used to refer

to the same population. Likewise the terms '*boys*' and '*young men'* are used to refer to the same population. Similarly, the terms *'child marriage'* and '*early marriage'* are used to refer to a marriage where at least one of the partners is below 18 years of age.

- If we refer to a particular sub-group of young women, for example married young women, this will be indicated.
- According to HC (research) partners, FGM/C does not occur in the study sites in the three South Asian countries. Existing literature would appear to confirm this finding. For this reason, questions pertaining to FMG/C were removed from the study tools and no data on FGM/C are provided for Bangladesh, Nepal and Pakistan.
- Where certain data are not available for a country, the country has been left out of tables and bar charts. Missing data may be due to a certain question not having been asked or issues with data formatting.

2.1.7 Ethical considerations and clearance

At the level of the AISSR and at national levels, ethical clearance for the impact evaluation as a whole was obtained in 2016. Please see the baseline study for more detail concerning ethical issues that have been taken into consideration.

2.1.8 Reflections on study limitations

The following section details study limitations as identified by the AISSR and local researchers.

In countries where laws against child marriage and/or FGM/C are increasingly enforced, including in Bangladesh and Senegal, local researchers reported that girls and HH who were approached for an interviews may have inflated the age of married girls, or have denied that girls were married, or circumcised and as such may have biased findings, lowering figures for CM and FGM/C.

Similar to the baseline, it was difficult to collect data on sexual activity of single girls, despite our effort to improve the introduction to questions on this topic and reformulation of certain some questions. The sensitivity of the subject is likely to have led to underreporting of sexual activity by unmarried young women.

The use of digital data collection during the midline has greatly improved the quality of quantitative data that was gathered and eased the data cleaning process. However, despite numerous rounds of testing, a mistake in a skip command was discovered following completion of data collection. The result of this error is that married young women were not asked any questions about sexual activity and use of contraception.

Local researchers reported that data collection was difficult in the Segou region of Mali and in some villages in Ethiopia, because of security issues. For this reason one comparison village in Mali was changed for the midline study.

In some countries, certain questions appeared to have been misunderstood during the baseline (by either interviewers and/or respondents). During midline training, more time was spent to clarify the

(purpose of) questions. This change in the training resulted in a few unexpected outcomes. For example, the share of HH with female entrepreneurs taking part in organised income generation activities was in the midline generally lower than in baseline. This decline could be due to the way questions on this topic had been interpreted during the baseline, namely as referring to female members contributing to HH income (our assumption regarding this misunderstanding is based on the way in which a follow-up question on how women were contributing to HH income – tended to be answered. While the question remained the same in the ML, interviewers were trained to stress that the question related to *organised* income-generation activities. Further analysis of these questions and corrections of baseline data will be done following completion of the midline report.

Some indicators used in the midline have not been measured in the baseline study, because the questions posed did not give reliable answers -- an example being on satisfaction with SRHR services used (IND12). Additionally, we added a number of indicators during the midline to more adequately measure the question at hand, for example, on girl-friendly schools (IND19.3).

The quality of qualitative data gathered during the midline has improved considerably when compared to the baseline. However, there remain important areas of improvement in this regard, particularly in terms of interviewer/FGD facilitator probing skills and in documentation.

Finally, in the baseline study, no data were available on some indicators for strategy IV in Pakistan. Therefore, no comparison between base and midline can be made for these indicators.

2.2 Monitoring of Activities Forms

As indicated earlier, local partners have completed an annual monitoring of activities (MoA) form. This form, which was designed by the AISSR, was designed to assess whether activities related to output indicators had taken place in treatment and comparison villages, schools, and health facilities and at district level. Local partners were requested to detail activities they organized, for example, in terms of duration, number and type of students or villages leaders trained, topics of training or discussion, who were the facilitators and trainers. (Until completion of midline data collection, no programme activities should have taken place in comparison sites.)

2.3 Partnership review

Chapter 11 details the methodology of the partnership review. The AISSR conducted a small scale review of the partnership at the level of local partners (from Ethiopia, Ghana and Uganda).

3. STUDY LOCATIONS AND POPULATIONS

3.1 Study locations

An overview of the study locations, by country, region, district and organisation can be found in Annex 2. For reasons of confidentiality, villages are not identified in this report.

Given the HC programme is implemented in rural sites, all research locations were in rural areas. Distances between treatment and comparison villages ranged from 2 to 50 km. All local researchers – with exception of the Nepalese researcher – reported that they do not expect spill-over effects of programme activities between treatment and comparison villages, because villages are far apart, with often no direct public transportation between the two, and villages use different schools and health facilities. However, spill-over was likely in one district in Nepal, where young people from the two villages attended the same school.

3.2 Study populations

Table 2 presents the total number of study participants per study population by country in mid and baseline studies. Tables offering a breakdown of study participants by treatment comparison sites (usually each approximately half of the total) can be can be found in Annex 3.

Table 2: Number of tools administered per study population, by country, and ML/BL

		Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*	*Total*
Study populations												
Girls	*ML*	600	307	289	304	1113	937	317	281	741	315	5204
	BL	604	304	200	312	914	967	305	265	744	327	4942
Households	*ML*	515	195	249	181	587	423	184	228	517	182	3261
	BL	524	201	150	166	470	529	160	212	574	167	3153
Villages	*ML*	4	4	4	4	16	17	4	4	18	4	79
	BL	4	4	3	4	13	16	4	4	20	4	76
Health Centres	*ML*	4	4	4	3	13	12	4	5	17	2	68
	BL	4	3	3	4	14	13	4	4	20	3	72
SRHR Staff	*ML*	8	2	4	6	23	22	4	5	24	1	99
	BL	8	4	4	3	24	15	4	9	20	3	94
Schools	*ML*	4	7	4	5	14	23	4	4	20	2	87
	BL	4	4	4	2	19	25	4	4	20	6	92
Teachers	*ML*	8	8	4	7	26	38	8	8	36	2	145
	BL	6	4	5	-	27	24	68	4	25	6	169
Districts	*ML*	2	2	2	2	9	7	4	2	11	1	42
	BL	2	2	2	2	9	7	4	2	11	1	42
FGDs (students)	*ML*	8	8	8	22	35	8	22	8	16	8	143
	BL	8	8	12	4	28	32	8	8	40	4	152

During the baseline and the midline study period (BL 2016, ML 2018) data were collected in the 10 HC programme countries from a total of 10,146 girls (4,942 BL; 5,204 ML) and 6,414 households (3,153 BL; 3,261 ML). The collected data cover 42 districts across the 10 countries. Slightly more than 50% of this population sample of the baseline and midline data was located in three of the programme countries – Burkina Faso, Mali and Ethiopia. This distribution is proportional to the scale of operation of local partners in these countries.

Tables offering detailed background information by study population can be found in Annex 4. Across the 10 countries, heads of interviewed households were mostly male, the highest share of female-head households (30-35%; ML) observed in Ghana, Ethiopia and Uganda. About half of the interviewed girls, 53.8% (ML) was between 12-14 years of age. Across countries, a varying share of girls and households taking part at ML had also been interviewed during the baseline study: from a low of 6% in Benin to a high of around 25% in Mali, Senegal, and Pakistan.

Both the base and midline samples of interviewed teachers include more males than females (47 females – 50 males BL; 58 females – 87 males ML). The majority of teachers were biology teachers. That said, the data indicate that teachers, especially those at primary school level, teach several disciplines. The types of health facility in communities involved in the study are the health centres and health posts. The majority of SRHR health workers is female (70 women – 29 men ML; 60 women -34 men BL), with a professional qualification of nurse and midwife.

Young women's marital status was expected to be an important variable. For this reason data are disaggregated according to marital status, that is, drawing a distinction between young women who reported that they were unmarried, and those who reported being or ever having been married. Table 3 shows the share and number of married/single 12-17 year old girls who took part in the study in the 10 countries – these numbers constitute the denominators for much of the subsequent analysis. These numbers are not included in the bar charts provided in this report (for reasons related to formatting and legibility). In many countries the share of married girls in relation to all girls between 12-17 years old seem to be low. Only in Senegal ML was this figure higher than 10% in treatment site (17.2%, to be precise). In ML comparison sites, the figure was above 10% in more countries: all Asian countries, Mali and Senegal; with a high of 22.2% of in Pakistan. However Chapter 10 presents data on the share of girls married by current age (Impact indicator 4), values showing that, in many countries, a considerable share of young women aged 17 was married.

Table 3: Marital status of girls 12-17, in ML and BL, by T/C by country (numbers and %)

	Midline						Baseline					
	Treatment			Comparison			Treatment			Comparison		
Country	*N*	*n (ever) married (%)*	*n single (%)*	*N*	*n (ever) married (%)*	*n single (%)*	*N*	*n (ever) married (%)*	*n single (%)*	*N*	*n (ever) married (%)*	*n single (%)*
Bangladesh	*300*	25 (8.3)	274 (91.3)	*300*	36 (12.0)	264 (88.0)	*305*	21 (6.9)	284 (93.1)	*299*	34 (11.4)	265 (88.6)
Pakistan	*154*	15 (9.7)	130 (84.4)	*153*	34 (22.2)	116 (75.8)	*150*	54 (36.0)	96 (64.0)	*154*	49 (31.8)	105 (68.2)
Nepal	*139*	13 (9.4)	126 (90.6)	*150*	16 (10.7)	133 (88.7)	*100*	24 (24.0)	76 (76)	*100*	35 (35.0)	65 (65.0)
Senegal	*116*	20 (17.2)	96 (82.8)	*188*	23 (12.2)	165 (87.8)	*153*	34 (22.2)	119 (77.8)	*155*	27 (17.4)	128 (82.6)
Mali	*557*	55 (9.9)	502 (90.1)	*556*	61 (11.0)	495 (89.0)	*460*	62 (13.5)	398 (86.5)	*454*	64 (14.1)	390 (85.9)
Burkina Faso	*466*	8 (1.6)	458 (98.4)	*471*	1 (0.2)	470 (99.8)	*509*	31 (6.1)	478 (93.9)	*458*	27 (5.9)	431 (94.1)
Benin	*157*	5 (3.2)	152 (96.8)	*160*	11 (6.9)	149 (93.1)	*150*	14 (9.3)	136 (90.7)	*150*	19 (12.7)	131 (87.3)
Ghana	*143*	1 (0.7)	142 (99.3)	*138*	2 (1.4)	136 (98.6)	*135*	3 (2.2)	132 (97.8)	*130*	5 (3.8)	125 (96.2)
Ethiopia	*371*	5 (1.3)	366 (98.7)	*370*	1 (0.3)	369 (99.7)	*381*	18 (3.7)	363 (96.3)	*341*	9 (2.7)	333 (97.3)
Uganda	*137*	1 (0.7)	136 (99.3)	*178*	4 (2.3)	174 (97.7)	*167*	6 (3.6)	161 (96.4)	*160*	6 (3.8)	154 (96.3)

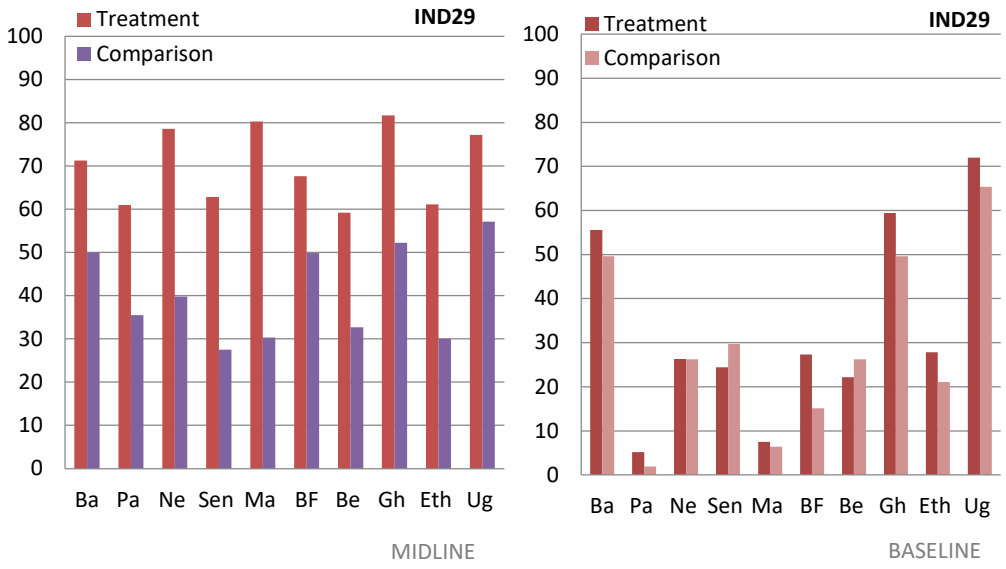
4. STRATEGY I - INVEST IN GIRLS, THEIR KNOWLEDGE, SKILLS AND PARTICIPATION IN SOCIETY

Introduction

Within the framework of Strategy I, girls are offered various educational programmes which aim to build their SRHR-related knowledge and skills, and their lobby and advocacy skills. A central output of the programme concerns the number of young women educated on SRHR **(IND29),** including on negative effects of child marriage and FGM/C. Expected intermediate outcomes relate to young women's comprehensive knowledge on SRHR **(IND18**), and the outcome that they have confidence in opposing a marriage **(IND6.1)** and FGM/C **(IND6.2)** against their will. In addition, expected outcomes relate to girls' abilities to use contraception in a sexual relationship **(IND8),** and that they speak out in community meetings on girls' rights and against child marriage and FGM/C **(IND9).**

Output indicators

Figure 1: IND29 Share of single girls educated on SRHR-related issues (%)



As Figure 1 reveals, at midline, in all countries the share of girls who had received SRHR-related education **(IND29)** in the treatment villages was considerable higher than in the comparison villages. Comparing midline with baseline data, a considerable increase can be seen in the share of young women trained in SRHR-related issues across the 10 countries. For instance, in Mali (treatment), this increase was from 7.5% of all girls trained at baseline to 80.3% at midline, in Pakistan, the share increased from 5.2% of all young women to 61.0%.

In-country regional variation in terms of the share of girls who had received SRHR-related education was also considerable. For example, in Bangladesh a considerably larger proportion of girls were

trained in Khulna than in Dhaka, and in Ethiopia the share of trained girls was larger in SNNPR than in the other two regions. Generally speaking, married young women were less likely to have taken part in a SRHR-related education initiative than single young women, excluding in Senegal treatment and Mali comparison sites (Table A1.1).

Supporting information on SRHR-related education of girls

Local partners' MoA reports support the findings on IND29. That is, in all countries, training of girls in various settings is conducted by (some of) the HC partners – either within the framework of in-school girl clubs, or during extra- or intra-curricular activities. Overall, less training is provided in primary schools compared to secondary schools, and less is provided to out-of-school girls than those in school. When reviewing the preliminary study findings, partners acknowledged there is considerable variation in the quality and degree of comprehensiveness of training provided across countries. For example, Ethiopian partners are at an advantage – one of the HC partners being a SRHR-related education specialist and providing teacher training in all other HC partners' programmes. In Burkina Faso, Nepal and Benin, HC partners liaise with government concerning the design of SRHR-related training manuals.

Young women who had received training were asked who provided this training, that is, whether this was a school, church, NGO (HC partner and/or other), or a health institution. At ML, we found that training was mainly organised by schools and NGOs – with a HC partner being the main NGO offering SRHR training in treatment sites. Particularly in in Nepal, Senegal, Mali, Benin, and Ghana a large share of young women were trained by an HC partner (Table A2.1).

Young women who had taken part in SRHR-related education were asked about the topics that had been covered during lessons. We used a checklist of topics that should be included in a comprehensive sexuality education initiative. Similar topics were addressed in most countries, including laws against and negative effects of CM, puberty, menstrual cycle and pregnancy, sexual violence and abuse. Strikingly, in African countries (except Uganda), during training more attention was given to intimate and sexual relations and contraceptives when compared to Asian countries (Table A2.2). It is important to note that since 2016, the Ministry of Gender in Uganda banned the provision of *comprehensive* sexuality education, and for this reason educators cannot engage with issues such as contraceptives and intimate relationships.

During FGDs with young secondary school going men and women, young people's main sources of SRHR-related information was discussed (see Box 2).

Box 2: Sources of SRHR-related education and information (FGDs)

During FGDs, young women and men were asked how and where they received SRHR-related education and information. The range of sources mentioned was very varied across treatment and comparison sites and countries, excluding Mali (specifically, 12-14 year old girls in one comparison site) and Pakistan. With regard to the latter, young people from treatment sites indicated a limited number of sources – girls referring to their mothers, elder sisters and teachers, boys to teachers and the Her Choice partner. Those in comparison sites in Pakistan for the most part indicated they did not have a source they could 'systematically' turn to, the boys in particular seemingly limited in this regard.

Excluding in Pakistan and Mali, health clinics and schools were most frequently identified as sources of SRHR-related information in both treatment and comparison sites. Following these two sources, parents and other family members, including older siblings, were third most frequently mentioned across treatment and comparison sites.

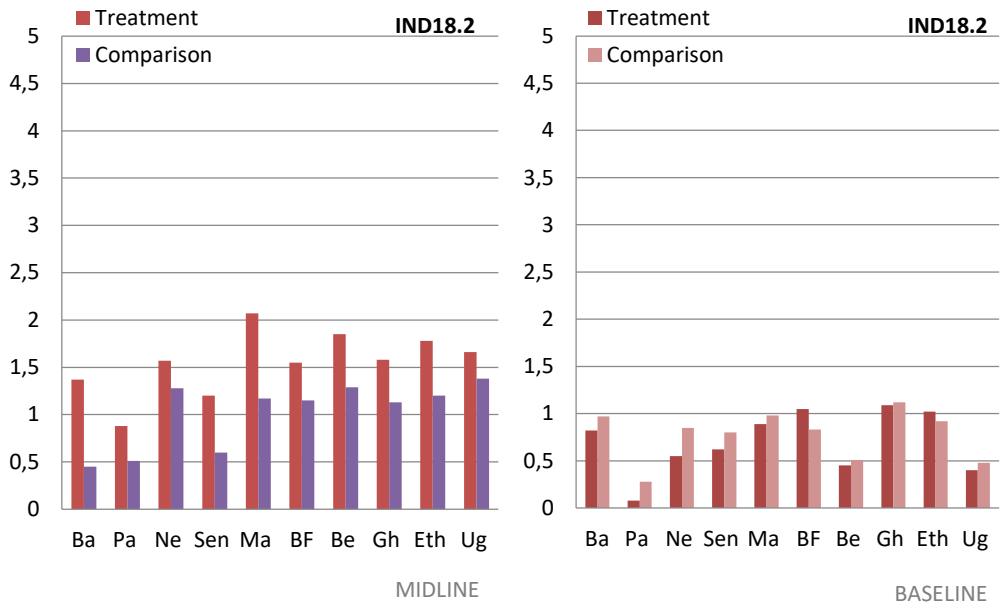
A notable difference with the baseline was the mention of a Her Choice partner as a source of SRHR-related information in (eight) treatment communities (and three comparison communities). Finally, while during the baseline young people often identified churches and pastors as sources of SRHR-related information, these mentioned only very infrequently during the midline. New were mentions of 'wise women' by young men in comparison sites in Senegal and relatively frequent mention of '(text)books'. In a number of cases, young people also spoke of extra-curricular clubs, with an equal division across treatment and comparison sites.

Intermediate outcome indicators

Indicators 18.1 and 18.2, the intermediate outcome of SRHR-related education, concern levels of SRHR-related knowledge**.** Young women were deemed to have 'comprehensive knowledge' if they were able to answer correctly on questions regarding the following five issues: 1) when in the menstrual cycle a girl can get pregnant, 2) whether a girl can get pregnant the first time she has sexual intercourse, 3) knowledge of existence of male condom, 4) knowledge of existence of contraceptive pills, and 5) able to mention at least one negative effect of CM (IND18.1). The first four questions were identified as essential minimum knowledge to prevent unplanned pregnancy, the fifth was included as an additional means to measure HC training. We acknowledge the limitations of some of these questions, for example, in countries such as Pakistan and Uganda, SRHR training cannot address condoms.

The share of girls with comprehensive knowledge – that is, who answered all five questions correctly – can be found in Table A1.2. Figure 2 presents findings as to young single women's mean degree of comprehensive knowledge (minimum 0, maximum 5) (Table A1.3).

Figure 2: IND18.2 Mean degree of knowledge of single girls on SRHR (range 0-5)



In all countries, comprehensive knowledge and mean degree of knowledge in the treatment villages in the midline study has increased when compared to the baseline. At midline, girls in the treatment sites also score considerably higher on comprehensive knowledge and mean level of knowledge compared to comparison sites. However, comprehensive knowledge is still very low – only in Mali the treatment sites the mean gets above 2. As noted earlier, issues such as condoms (and contraception more broadly) cannot be discussed with young people in countries such as Pakistan and Uganda.

Supporting information on girls' SRHR knowledge

With respect to the five specific questions that had been selected to assess levels of knowledge, young women generally knew least regarding questions when in the menstrual cycle a women has most chance of becoming pregnant (mid-cycle) and whether one can get pregnant the first time having sexual intercourse (yes). In all countries, and more so in treatment than in comparison sites, girls knew most about various negative effects of CM. In all countries, there is more knowledge on contraceptives in treatment sites. Finally, there is generally less knowledge on condoms in Asian countries than in African HC countries, but similar levels of knowledge on contraceptive pills (Table A2.3)

During FGDs, young people discussed their understanding of SRHR and what they would like to learn about SRHR (Box 3 and 4).

Box 3: What is SRHR? (FGDs)

During FGDs, young women and men were asked what came to mind when they heard the term 'sexual and reproductive health (and rights)'. Across countries, boys and girls in both treatment and comparison sites mostly associated the term SRHR with reproduction, women and children's health and avoidance of sexually transmitted infections. A quote from an FGD with young men in comparison site in Burkina Faso is illustrative in this regard: SRHR *'c'est le fait d'avoir les enfants sans les maladies'*.

In the context of Bangladesh, SRHR was often associated with secrecy, fear, 'wrong deeds' and SRHR being a 'frightening concept,' but young women also going on to say that despite its 'frightening' nature, 'it [was] now considered normal.' Notably, young women and men in Bangladesh were among the few to also speak of SRHR in relation to notions of pleasure (girls, 15-17, comparison) and to 'love making' (boys, 15-17, treatment). Young women and men in Nepal – in both treatment and comparison communities – were most exhaustive in terms of the range of subjects they associated with SRHR, whilst boys and girls (12-14) in comparison sites in Mali were the only ones who did not know what SRHR referred to at all.

Box 4: What do young people want and need to know about SRHR? (FGDs)

Similar to the baseline, when asked what young men and women wanted and needed to learn with regard to SRHR, many topics young people mentioned related to the subjects they associated with SRHR. Subjects included menstrual 'hygiene,' including how to make and use pads, contraceptives, how to prevent pregnancy and STIs, '*how a woman gives birth,'* and how to avoid 'wrong deeds' (boys, 15-17, T, Bangladesh). A young man (Ghana, comparison) spoke of wanting *'to know how to use a condom, so that I will not get any girl pregnant*,' while young women (Ghana, comparison) observed they needed to know more about '*safe and unsafe cycle of a girl, that is when to get pregnant and when not to get pregnant*.' The latter quote could be interpreted as indicative of the lack of knowledge young women (and men) have regarding menstrual cycles and when pregnancy can occur (see also data presented on IND18.2). In this light, it is worth noting the remark of young men in Bangladesh (15-17, comparison) that they wanted to learn more about SRHR *'[to] get rid of societal superstitions, [such as those about] girls' periods*' and young people's interest in learning not only about fertility also infertility. At the same time, the girls' remarks about when to get pregnant or not may also be reflective of another topic young people indicated they wanted to know more about, that is, about *'the right age for giving birth'* (girls, comparison, Nepal).

Other topics young people mentioned wanting to learn about included understanding bodily changes during puberty, early marriage, abortion and the health of mothers and children, specifically '*how the pregnant woman should take care of herself until childbirth and how to take good care of the baby'* (boys, 15-17, C, Burkina Faso). Young men in Mali (treatment) and young women in Nepal (comparison) also spoke of wanting to learn about children's health, and vaccination of children in particular. Young women in Bangladesh (treatment and comparison) and Pakistan (comparison) also referred to the need to learn about safety and '*how to protect themselves from sexual abuse and assault*.' With regard to the notion of safety, girls in Bangladesh referred to the value of having separate sexuality education classes for girls and boys. The data thus suggest that young people feel they do not know enough about these topics and required more comprehensive information. As male participants in an FGD in treatment community in Bangladesh indicated, there was a '*need for a truthful description of [SRHR]*' and boys in Mali (15-17, comparison) stating they wanted to know '*everything*.'

Continued on next page

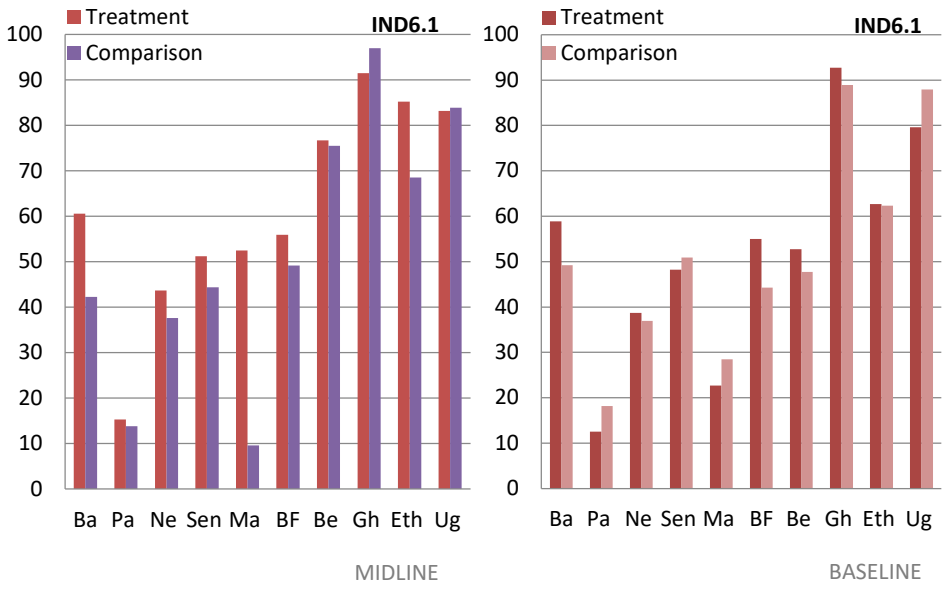
Box 4: What do young people want and need to know about SRHR? (FGDs) (cont.)

However, the similarity between topics associated with SRHR as detailed in Box 3 and the topics young people indicated they wanted and needed to learn more about may also be indicative of the narrow conception of SRHR young people have developed, that is, one focused on reproduction, disease and danger. That said, a range of other important topics were mentioned. For example, young people indicated their interest in sexuality and sexual relations more broadly. Girls in Ghana (comparison, 15-17) wanting to know about '*the purpose of sexual intercourse and how it is done,'* young Ugandan men wanting to know about '*the use of sex*,' young men in Bangladesh (12-14, comparison) interested in knowing '*how kisses are made'*, the '*proper rules to kiss [and] have sex'*, and '*tak[ing] off girls' panties*.' Young men in Ghana (comparison) also spoke of wanting to know about erectile problems, specifically about early or no ejaculation, and young men in Mali (15-17, treatment) indicating they wanted to know about women sexuality. Finally, a young man in Uganda referred to wanting to know how to 'manage his wife,' arguably highlighting the need to talk about gender relations and gender equality with young people.

Outcome indicators

Indicator 6.1, measures whether single girls feel able to oppose a marriage that is arranged against their wish. (Figure 3).

Figure 3: IND 6.1 Share of single girls who feel able to oppose CM (%)



In ML, the findings on girls who feel able to oppose a marriage against their wish are ambiguous. In Benin, Ghana, Uganda both in treatment and comparison villages, and treatment sites in Ethiopia, relatively more girls (over three-quarters) feel able to oppose a marriage than in the other countries, that is, in the three South Asian countries, and in Senegal, Mali, and Burkina Faso. The lowest shares were found in Pakistan, where only 15.3% of girls in the treatment sites and 13.8% in comparison sites reported they felt able to oppose a marriage, and in comparison sites in Mali where a mere 9.6% of girls indicated they felt able to oppose their marriage (against 52.5% in the treatment sites).

In Mali treatment sites, at midline, the share of girls who reported feeling able to oppose a marriage increased markedly from the baseline, and was much higher when compared to comparison sites. Similarly, in Ethiopia, this share had increased at midline level and was higher in treatment than in comparison sites. However, in other countries there was hardly any increase at ML compared to BL (for instance, Bangladesh, Nepal, and Burkina Faso), a decrease (Senegal), barely any difference between treatment and comparison, or even a higher share in comparison sites than in treatment sites (Ghana).

Regional differences are small. However, regional differences between treatment and comparison sites are at times ambiguous. For instance in Khulna (Bangladesh) and Oromia (Ethiopia) a higher share of girls in comparison sites felt they could oppose CM when compared to treatment sites (Table A1.4).

Supporting information on early marriage

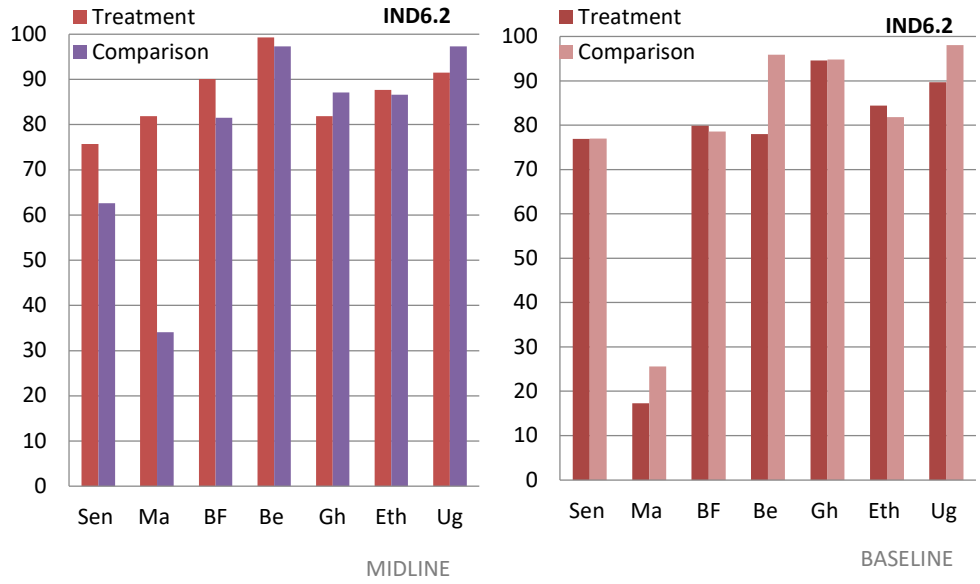
Box 5: Advantages and disadvantages of early marriage (FGDs)

In view of young people's apparent ease at reciting disadvantages of early marriage during the baseline, it was decided to focus on young people's views regarding the *advantages* of early marriage. Participants taking part in FGDs in Ghana, Mali and Pakistan listed few benefits, whilst in Bangladesh, Burkina Faso, Nepal, Senegal and Uganda a considerable number of possible advantages were listed in both treatment and comparison sites, of which 'tension free parents' (Bangladesh, T/C, 12-14 year old girls) seemed most prominent. Across the different countries listed above, the reduction of parental 'tension' appeared related to a) economic factors (early marriage as a means to reduce the daily burden on the family and/or ensure a lower dowry) and b) family honour – or 'relief from defamation'—that is, early marriage as a way of preventing teenage pregnancy and/or a girl running from home.

In Burkina Faso, young women did not regard early marriage as having any positive aspects, while young men reflected on early marriage as advantageous in that it allowed a girl to have children early on and to have many children, who would then – in the words of a participant from a comparison community – 'be able to help in the fields'. In Nepal, young men listed more disadvantages than advantages and listed more disadvantages than the young women involved in the FGDs. The younger women (12-14) in treatment sites in Nepal listed most positive aspects, indicating that early marriage would allow 'girls to have easy life,' would allow girls to 'earn moral values' or discipline, and that girls would 'be happy when they have a baby.'
In a similar fashion, young women in Senegal listed more advantages than disadvantages of early marriage, while only some young men (12-14 years) in comparison sites identified a possible advantage of marrying early. In Uganda, finally, young men listed a wider range of advantages, mentioning, for example, the possibility to 'have children early, because you never know when you will die,' the possibility to have sex, 'respect from parents and community members,' for boys 'having someone to cook and wash clothes,' and for the girls' parents, early marriage as a means to obtain 'bride price, soap and sugar.'

Indicator 6.2 measures the share of girls who have negative views of FGM/C (Figure 4).

Figure 4: IND6.2 Share of single girls who oppose FGM/C (%) (IND6.2)



In all treatment and comparison villages, the vast majority of single girls (from 80% to 99% across countries) reported that they opposed FGM/C. Mali formed an exception – in the comparison village only 34.1% of girls reported they were opposed FGM/C. At midline, slightly more girls in all countries indicated they were against FGM/C when compared to the baseline. Considering the low share of girls who opposed FGM/C in the baseline (17.3%), and the absence of legislation against FGM/C in Mali, the high share of girls opposing FGM/C in treatment villages in Mali is striking (81.9%). In the Malian comparison sites there was little change at ML compared to BL. These findings in Mali suggest HC programme impact (Table A1.5).

Box 6: What is female genital mutilation or circumcision? (FGDs)

Young people taking part in the midline study in the seven Sub-Saharan African countries were asked what they thought of when hearing the term 'female circumcision.' The most common responses was 'cutting or removal' of the clitoris, or parts of it, with many associating circumcision with the 'preventing girls from having sexual feelings.' Noteworthy in this regard was the association of circumcision with 'purification' (girls, 12-14 years, T, Mali), with the prevention of promiscuity as well as the prevention of early marriage. As young men (15-17 years) in Ghana indicated: '*[FGM] means that the clitoris which is the sensitive part is cut off to prevent girls from having sexual feelings to prevent early marriage*.' The use of the term 'early marriage' in this quote would seem to denote an *unlicensed* sexual relationship at a young age, that is, one that has not been approved by the family or community. In other instances, circumcision was associated with marriage – during an FGD in Burkina Faso, boys (12-14, T) responded by saying that '*L'excision, c'est se marier',* for example. Other young people engaged less with the actual definition or purpose of the procedure and more with the feelings the term evoked. As young men (15-17, T) in Burkina Faso explained: '*Quand j'entends parler d'excision, je pense au sang, je pense aux violences faites aux filles*,' and '*Moi, je pense surtout à la douleur.'*

Box 7: Positive and negative aspects of FGM/C (FGDs)

Young women and men from both treatment and comparison sites (in the Sub-Saharan African countries taking part in the Her Choice programme) suggested FGM/C had a range of benefits and disadvantages. In Benin there was broad consensus that FGM/C did not have any advantages, girls in treatment and comparison sites associating the practice with 'death of the girl,' and HIV and AIDS. The association with death was repeated more often across the other countries, with young men (treatment) in Burkina Faso suggesting the practice 'can make a girl sick,' referring to 'psychological trauma' and associating the procedure with '[loss] of blood' and (subsequent) death. Other disadvantages mentioned more frequently related to the potential of the practice '[spreading] disease since the blade is used on several people.'

Noteworthy were the contradictory statements regarding the relationship between FGM/C and birth, that is while some young people believed that a women who had been cut had more difficulty giving birth (or could not give birth at all), others suggested the practice allowed for easier child delivery, with girls (15-17, treatment) in Burkina Faso clarifying that 'some parents think that it will facilitate the birth.'

While the FGDs suggest that young people generally regarded FGM/C to largely have negative effects, the practice was seen by some as having certain benefits. These benefits mainly related to 'reduc[ing] sexual desire' and controlling female sexuality more broadly, and the subsequent positive effects of this reduction and control in terms of reducing teenage pregnancy. As a young man in Ghana (comparison) indicated, for example: 'I think it is good because it reduces the cases of teenage pregnancy. If it was being done here the teenage pregnancy cases will reduce.' (The addition of 'if' in this statement is striking, suggesting that while girls were not cut in this particular community, certain benefits were associated with the practice.)

In a similar fashion, young women in Uganda associated FGM/C with a reduction of 'early marriage,' suggestive (once again) of teenage pregnancy as a critical causal factor of early marriage. According to boys in Mali (12-14, treatment), cutting 'makes the relationship between the man and the woman harmonious,' while their slightly older peers (15-17, treatment) indicated that FGM/C caused 'problems in sexual life of the man and the woman.' There seemed to be most consensus between young women and men of different ages, and across treatment and comparison in Senegal – participants speaking of the earlier mentioned perceived benefit of 'circumcised' girls abstaining from sex until marriage combined with the association of cutting with 'purity,' health and womanhood. Young men (12-14, treatment) observing that a girl who is not cut 'is not a girl and is not considered as such by the community.' According to these participants 'something' had to be removed from the girl 'otherwise she will be sick.' The notion that an uncut girl not being considered a (proper) girl is in keeping with literature on the function of FGM/C a means to mark the passage into womanhood and a member of the community.

Supporting information: Sexual activity and sexual harassment (Introduction to IND8)

Indicator 8 relates to the use of contraceptives by girls who were sexually active (defined as girls who have or ever had sex with a man, either voluntary or involuntary). Due to an erroneous skip in the digital questionnaire, only single girls were asked this question during midline data collection. As was expected, questions on sexual activity were very sensitive and proved very difficult for girls to answer. (These difficulties had also been encountered during the baseline and remained, despite our efforts at midline to improve the introductions to these questions, clarifying the programmatic purpose of these questions and offering repeated assurances as to the confidentiality of information provided.)

Similar to the baseline, at midline none or only one or two of the single girls in the three Asian countries, and in Senegal and Ethiopia reported they were sexually active (Table A2.4). When presenting these findings, local partners were asked whether they thought that single girls really do not have sexual relations or that they just not (dare) report this. Most partners emphasised the latter, that is, clarifying that the low response rate had to do with young unmarried women not speaking openly about (their) sexual relations. Therefore, it is likely that underreporting occurred. That said, partners in Mali reported that in treatment areas girls were more open – possibly due to Her Choice partner's activities to sensitize communities on the need to prevent pregnancies through the use of contraceptives. According to local partners in Ethiopia reporting for Amhara Region, and in Pakistan very few girls have premarital sex and will get married if found pregnant (or killed, in the case of Pakistan). In the view of the partner in Senegal, more sexual activity occurs in reality than is reported.

In view of findings emerging from qualitative BL data concerning sexual harassment and following discussions with local partners, young women were asked more detailed questions on verbal and physical harassment of a sexual nature during the ML (Table A2.6). Verbal harassment of a sexual nature was found to be highest among girls in treatment and comparison sites of Uganda (T: 45.3%; C: 40.1%) and Bangladesh (T: 35.3% and C: 30.3%). In South Asia, verbal harassment is often referred to as 'eve teasing.' (It should be noted that this term has been criticized as it is considered to be inadequate to capture the experience of harassment experienced by women). Partners in Bangladesh report that 'eve-teasing' is often a warning sign for parents to 'marry off' their daughter. In treatment sites in Pakistan, Nepal and Burkina Faso, approximately 10% of girls said they had suffered from verbal harassment of sexual nature. Generally – excluding in Ghana – more girls in treatment sites reported experiencing verbal harassment than in comparison sites.

Box 8: 'Eve teasing:' HC partner input, Bangladesh

During the validation stage of the midline report, one of the HC partners in Bangladesh offered further detail on the subject of eve teasing, clarifying that this referred to:
A kind of sexual harassment of a young woman. At present, it has become a big problem in Bangladesh. Most of the girls cannot walk on the streets without being teased by the opposite sex. […] Many female students stopped their studies and even going outdoors. Most of them become a victim of child marriage. […] . [Young women] frequently undergo […]vulgar comments, unnecessary touching, pushing & shoving in the streets and mostly in public transports. Other women are frequently harassed at workplaces by male supervisors, colleagues or bosses. There are a lot of ways by which women are harassed. Some of the typical examples would be a vulgar stare, a wink, an opportune clap, a sly whistle, a needless collision, an apparent casual touch, a persistent stare, passing uncouth comments, the purring of an evocative song, despicable gestures, bikes soaring close with hands stretched intending to take a feel of the girl's body, passing by in slow-moving cars with loud music with a number of boys inside eyeing the girls in order to measure her up.

In all countries, physical harassment of a sexual nature was reportedly lower than verbal harassment, except for Ghana where it was higher – more than 10% of girls reporting physical harassment. Crucially (given the widespread occurrence of 'eve teasing' reported above), similar figures were found in Bangladesh. Uganda had highest share of girls who reported physical harassment – more than 25%.

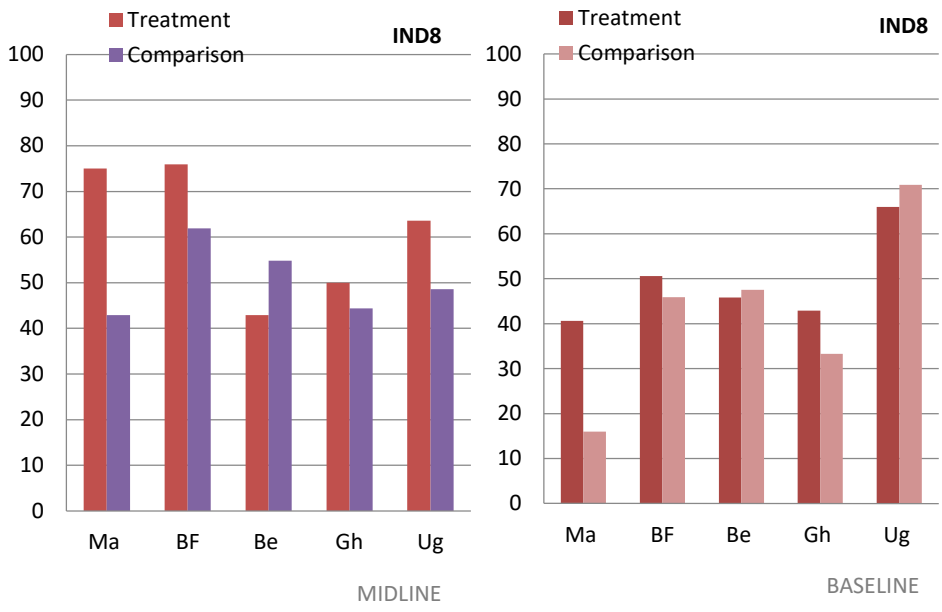
Uganda and Ghana had the highest share of girls reporting that a man tried to have sex with them against their will, and generally more in treatment than comparison sites: in Ghana treatment 14.0% against 9.4% in comparison sites, and in Uganda 16.8% in treatment and 13.6% in comparison sites. Possibly the higher figures in treatment sites are due to girls in these communities having been made more aware of their rights, what constitutes sexual harassment and what is unacceptable behaviour. The Ugandan HC partner explained this difference by suggesting that girls in the treatment site may be more aware of their sexual rights and existing reporting channels on sexual harassment. Similarly, the partner in Ghana indicated that it is possible that, as a result of girls' clubs, the 'Child Marriage Preventive Committee' and the promotion of girl friendly school environments, girls' confidence has increased and they have become more assertive.

Young women who had experience of a man wanting to have sex with them against their will, reported that the offenders were mostly young men under 18 years of age who were not the husband, followed by older men who were not the husband. In Mali, husbands were identified as those who tried to have sex with young women against their will in 25.8% of cases in treatment sites and 38.2% in comparison sites (Table A2.7).

In Bangladesh, Mali, Burkina Faso and Uganda, the majority of girls reported they had not spoken to anyone about the experience (of a man wanting to have sex with her against her will). The main reason young women gave related to their feelings of shame and/or because they did not think anyone would listen.

Figure 5 presents the country values of **IND 8** for those five countries with more than 15 single girls reporting to be sexually active.

Figure 5: IND8 Share of sexually active single girls who use contraception (%)



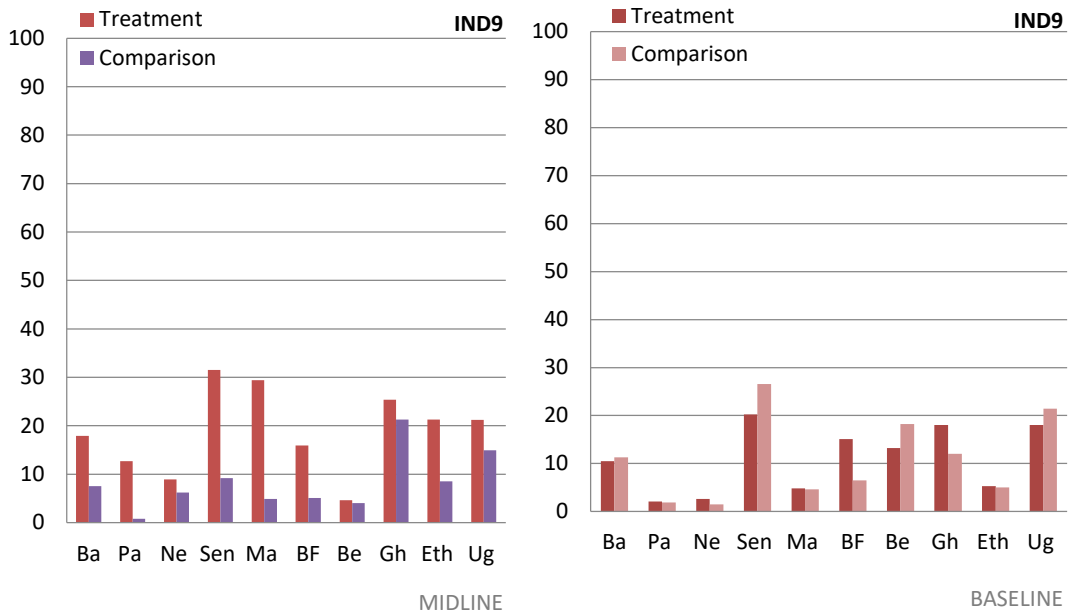
In most countries about half to three-quarters of the girls in the ML answered in the affirmative to the question whether she or the man used anything to prevent a pregnancy. Reported contraceptive use was especially high in treatment villages in Mali and Burkina Faso (75% of girls) and Uganda (63.6%), although in the case of the latter, reported use at ML was lower than at BL. Generally contraceptive use in midline treatment sites was higher than in comparison sites, with exception of Benin where it was higher in comparison site. Contraceptive use in the ML increased when compared to the BL in Mali, Burkina Faso, Ghana, and in comparison sites in Benin. In treatment sites in Benin and Uganda a slight decrease in contraceptive use was found at ML, and a more sizeable decrease was found in comparison sites in Uganda. The Ugandan local partner was not able to offer a definitive explanation for this decrease (in comparison sites), but said it could be due to reduced availability of contraceptives for young people, following withdrawal of some big suppliers of contraceptives (Table A1.6).

Supporting information: Type of contraceptives used

In all countries, the majority of girls reported using condoms, a considerable proportion (30%) in treatment sites in Mali also reporting use of contraceptive pills (Table A2.5).

Indicator 9 measures another intended outcome of SRHR-related education, that is, girls' ability to publicly speak out about young people's rights, including their right to education, not to marry before the legal age of marriage and not to undergo FGM/C. The programme encourages young women to speak out during community meetings or rallies, or in school, for example.

Figure 6: IND9 Share of single girls who have spoken out in community meetings/rallies on their rights (%)



When compared to baseline, a larger share of single and married girls in all countries, excluding in Benin, reported at midline that they had spoken out about their rights in public meetings. Additionally, in all countries more girls in treatment sites reported speaking out compared to comparison sites. The increase is especially striking in treatment sites in Mali and Pakistan.

The share of single girls speaking out is generally much higher than the share of married girls – with the exception of treatment sites in Senegal and Mali, where figures for married and single young women were comparable (Table A1.7).

Supporting information on girls and young people speaking in public

In most countries, girls who indicated that they spoke out about SRHR-related issues in public, against CM and/or FGM/C, reported that their audience tended to be their peers. Common settings for such 'speaking out' were classrooms or school meetings. In Senegal, a considerable share of girls in treatment sites who reported speaking out did so during community meetings – 83%. The seven girls in Benin who mentioned they had spoken out had all done so during community meetings. Strikingly, half of the girls in Ghana who had spoken out about these matters had done so in the market (Table A2. 9)

At midline, compared to baseline, a higher proportion of village leaders in almost all countries, and especially in treatment sites, reported that young people speak out in community meetings and talk about SRHR, negative effects of child marriage and/or FGM/C (Table A2.8).

5. STRATEGY II - IMPROVE ACCESS TO FORMAL EDUCATION FOR GIRLS

Introduction

The second programme strategy of Her Choice is geared to improving young women's access to formal education by addressing possible school access and attendance related barriers for girls. To this end, the HC programme organises the following activities: teacher training on SRHR **(output indicators 30.1 and 30.2**), and promotion and support to schools to create more girl-friendly environments (**output indicator 31**). These actions are expected to lead to intermediate outcome of more teachers feeling able and confident to teach about SRHR (**IND 19.1),** more schools being girl friendly **(IND19.2)** and a higher share of girls being enrolled in school **(IND20).** The outcome indicator for Strategy 2 is more girls regularly attending school **(IND 10),** although it is acknowledged that being enrolled in school does not necessarily mean regular attendance.

Output indicators

Principals of schools were asked whether their school had teachers trained in SRHR (IND 30.1).

Table 4: IND30.1 Share of schools with teachers trained to give SRH education

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML T N=	*2*	*4*	*2*	*2*	*7*	*13*	*2*	*2*	*18*	*1*
ML T IND30.1	**2/2**	**1/4**	**2/2**	**1/2**	**3/7**	**3/13**	**0/2**	**2/2**	**2/10**	**1/1**
ML C N=	*2*	*3*	*2*	*5*	*7*	*10*	*2*	*2*	*18*	*1*
ML C IND30.1	**0/2**	**0/3**	**0/2**	**2/5**	**1/7**	**2/10**	**0/2**	**0/2**	**1/18**	**0/1**
BASELINE										
BL T N=	*2*	*2*	*2*	*1*	*12*	*13*	*4*	*1*	*10*	*4*
BL T IND30.1	**0/2**	**0/2**	**0/2**	**0/1**	**--**	**4/13**	**--**	**0/1**	**0/10**	**--**
BL C N=	*2*	*2*	*2*	*1*	*15*	*9*	*4*	*2*	*10*	*2*
BL C IND30.1	**1/2**	**0/2**	**0/2**	**0/1**	**--**	**1/9**	**--**	**1/2**	**0/10**	**--**

Note: -- missing data.

In most countries, the share of schools with teachers trained on SRHR has increased in the ML treatment sites, compared to the baseline. In the ML in Bangladesh, Nepal, Ghana and Uganda all schools in treatment sites had teachers trained in SRHR related education, whereas no school in comparison villages in these four countries had trained teachers. The other extreme was Benin where none of the schools had teachers trained. Feedback from the partner in Benin suggests that the apparent lack of teacher training on SRHR in Benin may be due to the training not having been 'branded' as either related to SRHR or CSE.

Supporting information on schools with trained teachers

MoA forms clarify that local partners in all countries have trained teachers and/or school managers on SRHR, mainly in secondary schools. Only in one Ethiopian school was a counsellor trained instead.

As mentioned in section 2.1.4, the sampling of teachers for the study was geared to including those who provided students with school-based SRHR-related education. Interviewed teachers were asked whether they ever received training in SRHR-related education (IND 30.2).

Table 5: IND30.2 Share of interviewed teachers trained to give SRHR-related education

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML T N=	*2*	*4*	*2*	*6*	*14*	*22*	*4*	*4*	*18*	*1*
ML T IND30.2	**--**	**3/4**	**1/2**	**4/6**	**10/14**	**14/22**	**3/4**	**1/4**	**16/18**	**1/1**
ML C N=	*4*	*4*	*2*	*4*	*14*	*16*	*4*	*4*	*18*	*1*
ML C IND30.2	**3/4**	**0/4**	**0/2**	**3/4**	**3/14**	**6/16**	**1/4**	**3/4**	**4/18**	**0/1**
BASELINE										
BL T N=	*3*	*1*	*1*	*1*	*12*	*13*	*4*	*2*	*12*	*--*
BL T IND30.2	**2/3**	**0/1**	**0/1**	**1/1**	**25.0**	**53.8**	**4/4**	**2/2**	**8.3**	
BL C N=	*3*	*3*	*2*	*1*	*15*	*11*	*4*	*2*	*13*	*--*
BL C IND30.2	**1/3**	**0/3**	**0/2**	**0**	**26.7**	**36.4**	**4/4**	**0/2**	**15.4**	

Note: --missing data.

In Mali, Burkina Faso, Ethiopia, Benin and Pakistan the majority (14/22 in Burkina Faso) to almost all (10/12 in Mali, 16/18 in Ethiopia) teachers reported they had been trained in treatment villages, and strikingly more than in the comparison sites and in the baseline. In other countries figures were too small to draw conclusions, or were similar for treatment and comparison sites (Table 5). The discrepancy in data provided by teachers and school principals in Benin is noteworthy and – in combination with feedback from the HC partner – suggests that school principals may not have been aware of the SRHR-related contents of the training teachers had received. Clearer communication to school principals on the contents and purposes of training is recommended, particularly given teachers need support from school management to teach what is often perceived – by teachers, students and communities – as a controversial subject.

Supporting information on training of teachers (Table A2.10)

Teachers were asked to provide further detail about the training they had received, including who had organised the training, which topics had been addressed, whether in-service supervision was offered, and whether teachers were satisfied with the training received. In addition, teachers' were asked whether they had suggestions for improvement of the training and support. Training in Mali and Burkina Faso was often delivered by government (pre-service or in-service), whereas in the other countries almost all teachers in treatment sites spoke of having been trained by an NGO. In comparison sites in Senegal, Burkina Faso, Benin and Ethiopia some teachers similarly reported having received training from an NGO.

On the whole, the range of topics covered during training appeared to be quite extensive (excluding in comparison sites in Bangladesh and Senegal). Findings were ambiguous with regard to the question whether teachers thought the training they received was sufficient.

Teachers gave useful comments on the training they had received and how it could be improved. These suggestions included: provide visual aids to use in class, offer longer and/or refresher training, sensitise students' parents/caregivers, adjust training to student age groups, and better integrate the subject into the formal curriculum with dedicated hours in the school time table.

Indicator 31 measures the share of school principals who reported having taken measures to make their school more 'girl-friendly.'

Table 6: IND31 Share of schools taken girl friendly measures, according to school principal

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML T N=	*2*	*4*	*2*	*2*	*7*	*13*	*2*	*2*	*10*	*1*
ML T IND31	**2/2**	**3/4**	**2/2**	**1/2**	**7/7**	**13/13**	**2/2**	**2/2**	**8/10**	**1/1**
ML C N=	*2*	*3*	*2*	*5*	*7*	*10*	*2*	*2*	*10*	*1*
ML C IND31	**2/2**	**3/3**	**2/2**	**4/5**	**6/7**	**10/10**	**1/2**	**2/2**	**9/10**	**1/1**
BASELINE										
BL T N=	*2*	*2*	*3*	*1*	*7*	*14*	*2*	*2*	*10*	*4*
BL T IND31	**1/2**	**2/2**	**3/3**	**1/1**	**6/7**	**11/14**	**0/2**	**2/2**	**7/10**	**--**
BL C N=	*2*	*2*	*3*	*1*	*7*	*11*	*2*	*2*	*10*	*2*
BL C IND31	**2/2**	**2/2**	**3/3**	**1/1**	**6/7**	**9/11**	**2/2**	**1/2**	**4/10**	**--**

Note: -- missing data.

Almost all school principals, at both in midline and baseline, indicated they had taken at least one measure to make their school more girl-friendly (Table 6).

Supporting information on girl-friendly measures

Principals involved in the study mentioned a wide range of measures taken to improve girl-friendliness of their schools. The questionnaire contained a list of measures, which were constructed on the basis of a review of (development agency) standards for girl-friendly schools and following extensive discussion with local partners and alliance members. These measures were: Schools having: a counsellor; a referral system for girls (to authorities, health centre); good quality separate sanitation facilities for girls (toilet); a girl club/mini media unit; a gender balanced body of staff; dignity kit for girls in need; staff trained on gender sensitivity; girls rooms/safe rooms for girls; water point. Additional measures were: the school is fenced and seeks to involve girls in expressing thoughts and claiming rights. Most popular measures, taken in at least some schools in most countries, related to the school having a school counsellor, separate toilet facilities for girls and boys, a water point and involving girls in decision-making processes. In some treatment schools dignity kits had also been provided, especially in Mali where 6/7 schools reported they had such kits (Table A2.11).

Box 9: Creating girl-friendly schools (FGDs)

The most common themes emerging from FGDs as to how to improve the girl-friendliness of schools related to, on the one hand, girls' safety in and on the way to school, and provisions made for girls when they were menstruating, listing sanitary pads, washing facilities and a suggestion to purchase extra uniform for girls in case they stain their clothing. As a young woman noted (Ghana, treatment) '[…] *there is no changing room to go or when it even happens that we mistakenly stain our clothes [during our period], no room for us to even go and take our bath and also tidy ourselves. We need a changing room.'* While 'changing rooms' were not often mentioned, girls did often refer to the need for separate latrines for girls and boys, a measure which arguably relates to the need for (extra) privacy when menstruating *and* safety.

Young women also mentioned the need for a female teacher or counsellor who could '*deal with SRH matters.'* Teachers were discussed in connection with school safety in a broader sense – as one boy observed (Nepal, 15-17, comparison): '*Teacher tease student and insult them in front of everyone so they don't come to school […] so because of these reasons students don't come to school.'* In a somewhat similar vein, a young woman taking part in an FGD in Nepal (12-14, comparison) indicated that '*The teachers should treat the students as their own child. They should not beat them.'* The data thus highlight that while clear measures that still need to be taken to improve conditions in schools for girls, 'child-friendliness' more broadly also requires careful attention.

Intermediate outcome indicators

After principals had reported the measures that they had taken to make their school girl-friendly, they were asked to rate the girl-friendliness of their school on a scale from 1-4: being 1) not, 2) somewhat, 3) rather, or 4) very girl-friendly. When they gave their school 3 or 4, they scored positive on Indicator 19.2.

Table 7: IND19.2 Share of schools principals who claim their school to be girl-friendly

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML T N=	*2*	*4*	*2*	*2*	*7*	*13*	*2*	*2*	*18*	*1*
ML T IND19.2	**2/2**	**1/4**	**2/2**	**1/2**	**3/7**	**3/13**	**0/2**	**2/2**	**2/10**	**1/1**
ML C N=	*2*	*3*	*2*	*5*	*7*	*10*	*2*	*2*	*18*	*1*
ML C IND19.2	**0/2**	**0/3**	**0/2**	**2/5**	**1/7**	**2/10**	**0/2**	**0/2**	**1/18**	**0/1**
BASELINE										
BL T N=	*2*	*2*	*2*	*1*	*12*	*13*	*4*	*1*	*10*	*4*
BL T IND19.2	**0/2**	**0/2**	**0/2**	**0/1**	**--**	**4/13**	**--**	**0/1**	**0/10**	**--**
BL C N=	*3*	*2*	*2*	*1*	*15*	*9*	*4*	*2*	*10*	*2*
BL C IND19.2	**1/3**	**0/2**	**0/2**	**1/1**	**--**	**1/9**	**--**	**1/2**	**0/10**	**--**

Note: *-- missing data/wrong variable in the dataset (Et).*

Many school principals, in both ML and BL, scored their school as rather or very girl friendly, whereas very few measures were found to have been taken to that end in the BL. In Bangladesh, Nepal, Mali, Benin and Ghana, all principals considered their school to be girl-friendly. In Pakistan, Burkina Faso, Ethiopia and Uganda school principals were more modest in their claim of girl-friendliness of their school (Table 7).

To give a more objective measure of girl-friendliness, **IND19.3** was added in the midline study, which assesses the number of measures taken by schools to make the school girl-friendly, with a maximum of 11 possible measures. Possible measures included 'fencing' the schools (to improve safety), providing separate sanitation facilities for girls and offering emergency sanitary pads.

Table 8: IND19.3 Mean number of girl-friendly measures taken by schools (range 0-11)

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML T N=	*2*	*4*	*2*	*2*	*7*	*13*	*2*	*2*	*10*	*1*
ML T IND19.3	**5.5**	**4.7**	**6**	**2.5**	**7.7**	**4.3**	**3**	**7.5**	**6.4**	**3**
ML C N=	*2*	*3*	*2*	*3*	*7*	*10*	*2*	*2*	*10*	*1*
ML C IND19.3	**4**	**3**	**2**	**5**	**3.2**	**3.1**	**2**	**6.5**	**3**	**7**

When looking at the number of measures actually taken, very few schools involved in the study can be considered girl-friendly. Should we use half of the measures (6/11) as a cut-off point, then all treatment schools in Nepal, Mali, Ghana and Ethiopia can be considered 'girl-friendly' as well as all comparison schools in Ghana and Uganda. When discussing this matter during the validation stage, local HC partners indicated that in many settings, schools have other priorities, such as having (sufficient) classrooms or sufficiently qualified teachers available. In many cases, schools do not have the resources necessary to make schools more *girl* friendly. HC partners in Ethiopia and Ghana indicated that, generally speaking, school principals that they work with (have come to) understand the concept of girl-friendly schools and appreciate the need to promote girl-friendly schools. They foresee that the HC visualization tools developed in 2018 could further support bringing about change in this regard.

Supporting information on girl friendly schools

Very few HC partners (in a few countries) reported in the MoA forms that they provided support to schools in taking measures to make schools more girl friendly in 2016 and 2017. Partners in Bangladesh, Mali, and Ghana did report having provided such support. As midline data shows, schools in Nepal and Ethiopia also scored positively on IND19.3 (Table 8), which may be due to activities undertaken in early 2018. Another explanation for this positive scoring could relate to activities undertaken by other organisations or government institutions.

Village leaders also commented on the girl-friendliness of schools in their area. They were first asked what steps primary and secondary schools had taken to make them more accessible for girls. After listing these steps, they were asked to score the girl-friendliness of the schools in their area on a scale (ranging from 1) yes, 2) to a certain extent, or 3) no). Village leaders In Bangladesh and Benin considered all primary schools in their community girl-friendly, whereas in other countries leaders

were more divided: some leaders considered primary schools not girl-friendly or only to a certain extent. Especially in Pakistan, Ghana (treatment), Ethiopia and Uganda (treatment), village leaders were critical about primary schools, that is, they considered schools to not be girl-friendly. With regard to secondary schools, only in Mali (treatment), Benin and Uganda (comparison), village leaders considered all secondary schools in their village girl-friendly (Table A2.14).

SRHR teachers were asked whether they occasionally lacked confidence to speak to students about SRHR-related issues and whether they are able to address all questions that learners raise **(IND19.1).**

Table 9: IND19.1 Share of teachers reporting to be able and confident to teach SRHR

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML T N=	*4*	*4*	*2*	*6*	*12*	*22*	*4*	*4*	*18*	*1*
ML T IND19.1	**1/4**	**2/4**	**2/2**	**3/6**	**7/12**	**8/22**	**2/4**	**2/4**	**15/18**	**1/1**
ML C N=	*4*	*4*	*2*	*4*	*14*	*16*	*4*	*4*	*18*	*1*
ML C IND19.1	**2/4**	**0/4**	**2/2**	**1/4**	**6/14**	**8/16**	**2/4**	**2/4**	**17/18**	**1/1**
BASELINE										
BL T N=	*3*	*1*	*1*	*1*	*12*	*13*	*4*	*2*	*12*	*--*
BL T IND19.1	**1/3**	**0/1**	**1/1**	**1/1**	**25.0**	**69.2**	**3/4**	**2/2**	**66.7**	
BL C N=	*3*	*3*	*2*	*1*	*15*	*11*	*4*	*2*	*13*	*--*
BL C IND19.1	**2/3**	**1/3**	**1/2**	**0/1**	**20.0**	**27.3**	**3/4**	**0/2**	**61.5**	

Note: --missing data.

At midline, a large share of teachers reported they did not feel able and confident to teach their students about SRHR, with exception of teachers in treatment and comparison sites in Nepal and Uganda, where all teachers indicated they felt able and confident), and in treatment and comparison sites in Ethiopia, where nearly all teachers reported feeling able and confident. These findings are similar to the BL (Table 9).

Supporting information on teachers feeling confident to teach SRHR

When asked, a considerable number of teachers in all countries indicated that they felt unable to address all questions that students posed with regard to SRHR, with the exception of teachers in Nepal (all reporting they did feel able to do so). Teachers were asked an open question as to what kinds of SRHR-related questions they found difficult to address. Responses varied across countries. Topics that were mentioned most frequently across countries related to: sexual intercourse, sexual orientation, sexual pleasure, sexual abuse, masturbation, and same sex relations (Table A2.12).

When probing teachers who had difficulties with answering certain questions as to why they experienced certain questions as (more) difficult, they explained that they were concerned about caregiver and community reactions, that they struggled to teach students of the opposite sex, with younger teachers also speaking of their difficulties in teaching older students. Additionally, some teachers raised their concern with regard to teaching young people about contraception and how this might, in their view, make students 'curious' to try out (and engage in premarital sexual relations).

Box 10: Satisfaction with school-based SRHR-related education (FGDs)

Views differed among young people as to the quality of their SRHR-related education, with opinions most consistently positive regarding information provided by a Her Choice partner and most varied in relation to the education offered in schools. Concerning the latter, young women in Bangladesh (T/C), boys in Pakistan (T/C) and girls in Pakistan (C) indicated they had not received (much) SRHR-related education in schools and/or were told by their teachers to learn about these issues at home. Satisfaction with Her Choice SRHR-related education was explicitly mentioned in a) Bangladesh: girls (12-14, T) and boys (12-14 and 15-17, T), b) Ghana: boys (T/C), and c) Pakistan: girls (T), with boys indicating their dissatisfaction because the 'NGO came only once or twice to discuss it,' however. The latter could be read as a criticism of the HC partner in this treatment site – if indeed 'the NGO' referred to an HC partner. The remark could also be an indication that the young men involved in the FGDs simply want and need more sessions on SRHR-related issues with the NGO concerned.

Data from FGDs with young people in Bangladesh, Ghana, Nepal and Uganda are most detailed as to the contents of SRHR-related education in schools. These FGDs also provide most detail as to suggested areas for improvement. As mentioned above, young women and men in treatment sites in Bangladesh mentioned having received SRHR-related education from the Her Choice partner, indicating their satisfaction with the format used, that is, they appreciated the space for discussion and Q&A (here referring to questions and *advices*). Girls between 15-17 years in the treatment site (Bangladesh) also mentioned female teachers providing girls 'advices.' Young people in comparison sites indicated their dissatisfaction with the education provided in schools – girls and boys between 12-14 years, for example, being told to 'learn it at home.' The older young people in the comparison site seemed to have received a bit more SRHR-related education in schools, for example via their physical education teacher, from textbooks or the Union Health Officer, but all expressed their dissatisfaction with the education received.

In Ghana, young people in treatment and comparison sites spoke of their science and social studies teachers, the 'patron teacher' in the girls/boys' clubs and epicentre nurses providing SRHR-related education. Young women (15-17 years, treatment) talked about lessons dealing with *how to use condom* [and other contraceptives] *so that you will not get pregnant*, and *how to abstain from sex for our education*. Young men (15-17 years) were most vocal as to what could be improved, those in treatment and comparison sites indicating, for example, that teachers should use *pictures and other [audio] visual aids, for clarity*, adding that *SRH teachers should be clear and use appropriate terms and names during SRHR education.* Young men recommended teachers: '[D]*escribe issues clearly and into detail to avoid doubt, confusion and misconception, and to prevent curious students from seeking clarity at inappropriate places*.'

One young man further clarified: '*The teachers do not go into the specifics of what happens during sex so curious students always try to find out what the teachers are not explaining to them.*'

These data clearly highlight young people's desire for more comprehensive information and more openness from teachers. According to young men in comparison sites, SRHR lessons taught by the (epicentre) nurse were better than those provided by the teachers, suggesting she was more 'suited to the topic and knows more' than their teachers. These young men also indicated that they wanted 'more practical' SRHR lessons, suggesting that lessons may be taught in too abstract a manner. In one school in comparison site, young men talked about the value of separate classes for boys and girls. They explained that:

> *Girls should not be present when males are being taught adolescent reproductive health and when females are being taught adolescent reproductive health males should not be present because we are shy*.

The reference to 'because we are shy' suggests that teachers (and nurses) may not yet have been able to create an atmosphere in which young people – young men, in any case – feel sufficiently safe to discuss intimate matters with the other gender present.

Continued on next page

Box 10: Satisfaction with school-based SRHR-related education (cont.)

Young women in treatment sites in Nepal explicitly mentioned receiving SRHR-related education from a female health teacher, the 15-17 year olds highlighting their satisfaction with 'menstrual hygiene' information they received and skills they developed (in making re-usable sanitary pads). Conversely, girls in comparison sites indicated their desire to have a female teacher teach young women about SRHR, rather than their male teacher. Regardless of gender, these girls indicated that their teacher 'should explain nicely, in detail and should share open floor where girls can ask questions frequently.' They specified that girls should have 'courage enough to ask their question even if he is male teacher,' indicating that, as in the case of the Ghanaian young men mentioned above, young people did not always feel sufficiently safe to ask the questions they wanted to. The matter of safety was also alluded to by young men in Nepal (15-17 years, comparison), stating that 'teachers need to be more conscious while teaching, [and] avoid situation where students can be uncomfortable, especially girls.' It is unclear whether these young men are perhaps referring to the same male teacher as the girls above. Nevertheless, the data indicate that 'safety' needs to be looked into.

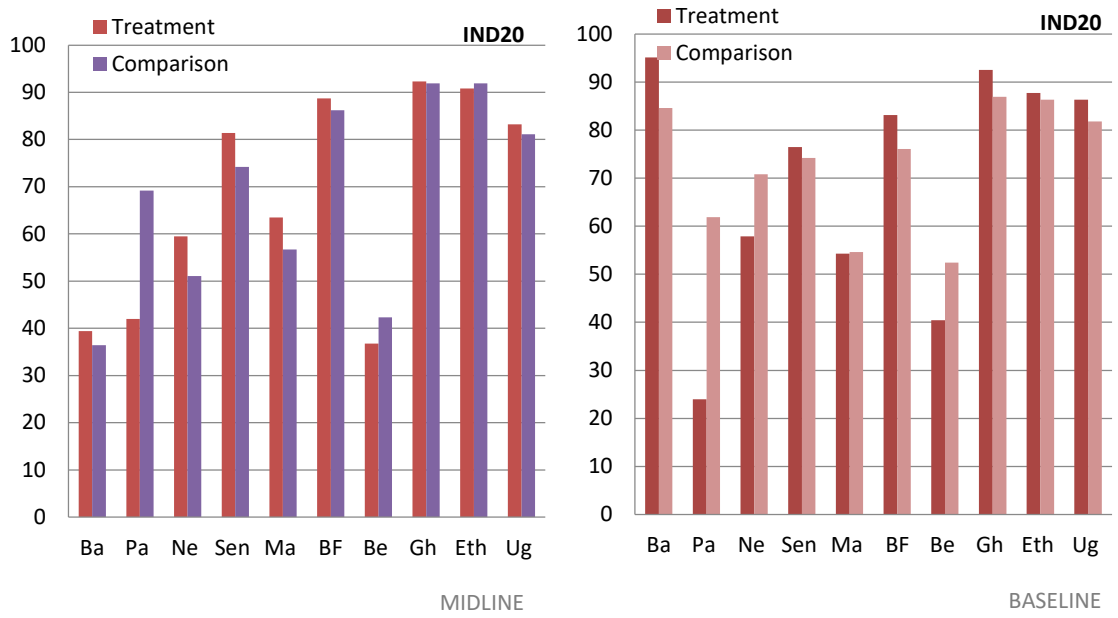
Young men in treatment sites in Nepal expressed the wish to have a 'proper' health teacher, clarifying they currently received SRHR education from their English and maths teachers who were not sufficiently knowledgeable. Despite making mention of teachers needing to be more 'conscious' when teaching, the FGD data suggest that young men in comparison sites were positive about the education received, one specifying that:
They teach us very well. These days girls and boys laugh when they hear someone saying condom but our teacher teaches us very well, they tell us that we should use condoms while having sex. They don't mean it in negative way, they have taught us better than what are written on books.

Young women and men in Uganda – across treatment and comparison sites – talked about taking part in SRHR-related education, provided by teachers ('senior woman' teachers, in the case of girls) and health workers. The list of topics on which they had received education was quite detailed, and suggested a clear normative position, that is, young people were given many 'do not's', such as having sexual intercourse (before marriage), spending time with 'bad peer groups, 'sugar daddies,' elongating the clitoris, and marrying early. One group of girls reported being told not to have sexual intercourse during or directly after menstruation to avoid pregnancy, suggesting that information provided in schools was not always accurate.

We asked all girls whether they were enrolled in school. Indicator **20** measures girls' enrolment in formal education during the preceding year, by marital status.

Figure 7 shows considerable differences in single girls' school enrolment across countries, from a high of 92,3% in Ghana and Ethiopia and over 80% in Uganda and Burkina Faso, to a low of 40% or lower in Benin and Bangladesh. The latter is surprising given that, at baseline level, the share of girls enrolled was over 80%. In most countries, differences across treatment and comparison sites within countries are not extensive, bar in Senegal and Pakistan – with the surprising finding of higher enrolment in comparison site in the latter.

Figure 7: IND20 Share of single girls (12-17) enrolled in formal education



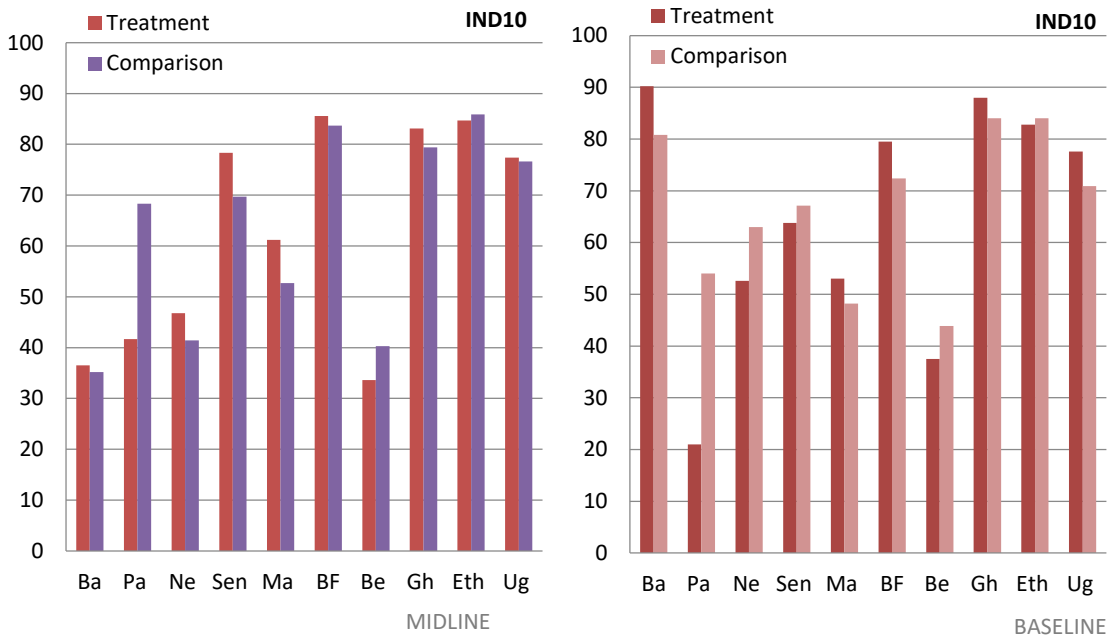
On the whole, differences between BL and ML are also not noteworthy, with exception of Bangladesh. As indicated, at ML the drop in enrolment rates in Bangladesh was very large: from a high than 95% at BL to approximately 40% at ML. In Bangladesh, regional variation was also considerable (see Table A1.8), with 61% enrolment in Dhaka region and only 16.5% in Khulna. Thus, data indicates that the low country figure for ML Bangladesh is mainly due to an extreme drop in enrolment in Khulna – from baseline 96.5%. However, there is also a very considerable drop in Dhaka, from BL 95.1% to ML 61%. The partners in Bangladesh could not sufficiently explain the situation during the validation stage of the midline. The apparent reduction in enrolment may be due to how the question was understood, that is, it is possible that at ML, young women interpreted 'enrolment' as referring to the 'first-time' enrolment (or 'registration') in school rather than whether they were *currently* in school. In addition, the BL sample of girls in Khulna was from a higher social segment than the ML sample. A final possible explanation for the lower ML figure may relate to the timing of the midline, that is, data collection occurred during the transition period from one level of education to another (e.g. primary to secondary). Young women taking part in the study may thus not have been enrolled in school at the time of the midline but waiting to enrol in, for example, secondary school.

Enrolment of married girls was generally far lower than that of single girls, for example in Mali in treatment 63.5% of single against 18.2% of married girls were enrolled. In Pakistan, Benin, Ghana and Uganda none of the married girls was enrolled in school. Table A1.8 shows that in the countries with more than 13 married girls per treatment/comparison sites, enrolment of married girls in treatment sites was higher than in comparison sites.

Outcome indicator

Indicator 10 measures the share of girls who reportedly regularly attended school during the previous year, with 'regular' attendance defined as at least four days in a week. This latter indicator was included in the study given school enrolment does not necessarily mean regular school attendance.

Figure 8: IND10 Share of single girls regularly attending school (%)



Trends of figures for regular attendance did not differ greatly from enrolment. Worth noting is that these shares were generally a few percentage points lower than enrolment rates. Greatest differences were found in Ghana with more than 10% lower regular attendance than enrolment (Table A1.9; Figure 8).

Supporting information on reasons why some girls are not enrolled in school or not regularly attend

Girls who were not enrolled in school at all or did not attend regularly were asked why they were not enrolled/did not attend regularly. The main reasons given by girls related to having to do household chores and taking care of siblings. Strikingly, a considerable share of girls in Pakistan treatment sites reported the fact they were harassed on the way to school as a reason (Table A2.15).

Box 11: Reasons for not attending school and suggested measures to improve educational participation of boys and girls (FGDs)

Across Her Choice project countries and treatment and comparison sites, young men and women provided extensive lists of often inter-related reasons why young people did not attend school and what measures might be taken to improve participation in school. The first set of reasons related to economic costs and benefits of education. Many young people identified poverty as a key factor inhibiting school participation. They spoke of parents' and guardians' limited resources to send (all) their children to school, with girls in Nepal specifying the 'son preference' of many parents, that is, parental tendency to prioritise sons' education over and above that of their daughters in the case of limited financial resources, which might entail girls not attending school at all or boys being sent to private schools and their female sibling(s) to cheaper state-funded schools (which are regarded as being of lesser quality). Young people referred to the level of school fees, but also costs of school materials, including uniforms. Related to the costs of uniforms, young men in Uganda alluded to having just one uniform, which they would have to wear 'the whole week' and how it got 'dirty from long distances [between home- school] on dirty roads.' Remarks such as these, combined with girls' frequent remarks about the lack of adequate facilities in schools for menstruating girls, suggest that attending to school can be physically uncomfortable for both boys and girls.

Returning to the broader theme of economic costs and opportunities, school-aged young men in particular spoke of having to help parents (in the fields) or seeking work elsewhere to contribute to household income, or – according to boys taking part in FGDs in Burkina Faso (12-14years, comparison), going to 'Nigeria to work and save money to buy a motorbike.' Girls (15-17 years, comparison) in Nepal reported that:

> *Female adolescents feel that there is no worth of studying as at the end they have to get married. So, there is no worth of sending them to school.*

School enrolment and lack thereof was thus also attributed to the lack of (appropriate) opportunities post-school. Young women hereby not only referred to the prospect of marriage as in the case of this quote, but in various country settings, like young men also referred to the lack of jobs for graduates, thereby reducing the perceived value of education. The reasons highlighted above, combined with frequent references to the need to 'raise parents' awareness' of the benefits of education, particularly for young women and, to a slightly lesser degree, raising young people's awareness of these benefits, suggest that doubts remain in Her Choice communities as to the short and long-term value of sending children to school.

The second set of – related – reasons given for not attending school related to the quality of education, with an emphasis on teachers. Reference was made to young people not being 'interested,' not 'wanting' to attend and, on occasion, 'laziness' (Bangladesh, Benin, and Burkina Faso). The allusions to lack of interest and 'laziness' may be due to schools being seen as little relevant to young people, both in short and long-term and in that sense, relates to the (economic) benefits mentioned earlier. However, young people also mentioned teacher absenteeism, for example, in Benin and Senegal, indicating that this absenteeism discouraged students to come to school.

Suggestions on how to improve school attendance were also illustrative in this regard – young people recommending, for example, teachers be 'more friendly' and that school employ 'qualified' teachers, indicating that some young people experienced teachers as 'unfriendly' and lacking qualifications.

In what domain in particular young people believed teachers to lack qualifications, excluding in relation to SRHR-related education and the occasional mention of a desire for English language teachers, was not explored in more detail, but warrants further scrutiny. The issue of 'friendliness' will be explored further below. The following excerpt is illustrative of a number of the points raised above, highlighting their interlinkages:

> *Boys don't bother about school and don't come to school. If we say something [in class] then there are few teachers who don't bother about it. If teacher don't bother then students also start misbehaving. They think teachers won't do anything, so we can do whatever we want to do. Teachers must care about these things* (boys, 15-17 years, treatment, Nepal).

Continued on next page

Box 11: Reasons for not attending school and suggested measures to improve participation (cont.)

The quote shows how some teachers' perceived lack of interest in students and education may contribute to young people disengagement from school.

In relation to school quality, improving school infrastructure was also often mentioned as a means to encourage more young people to attend schools – participants speaking of, among other issues, the lack of electricity, the need for more and better classrooms ('fixing potholes'), sanitary facilities, library and sports facilities.

A third set of issues concerns safety of young people in and on their way to school, the former pertaining to students' sense of safety in relation to their peers but above all, their teachers. The following quotes, all drawn from data gathered in Ghana, are indicative of the lack of safety young people seemed to experience in their schools:

> *When the teacher asks a question and you are not able to answer him, the moment you see him raise his cane you get scared and this will prevent some girls from coming to school* (boys, 15-17 years).
>
> *Teachers should not cane girls and insult when they cannot follow the lesson.* (girls, 15-17 years)
>
> *Some (male) teachers should avoid playing with us as girlfriends*. (girls, 15-17 years)

Finally, young people mentioned administrative barriers which hampered their school attendance. In Senegal, particular mention was made of birth certificates as a prerequisite for school enrolment (the absence thereof thus an impediment), while in Burkina Faso young women spoke of the need for schools to allow girls 'older than 7' to enrol and boys in Ghana indicating that older students' enrolled in lower classes dropped out of school because they felt 'ashamed towards their peers when they are older than most pupils'.

In closing, the data thus indicates that school enrolment (and attendance) was hampered by a range of closely interlinked issues, relating primarily to questions of economic costs and benefits, and (perceived and felt) educational quality – illustrating the need for a multi-level and multi-pronged strategy to get and keeping young people in school.

Supporting information: HH heads reporting on schooling status of their children

Heads of households were asked whether any of their school-going age children were not enrolled in school and what the gender of these children was. The highest shares of HH reporting children not going to school were in treatment sites in Nepal and Benin, followed by those in comparison sites in Benin and treatments sites in Pakistan. In Senegal and Burkina Faso around one-fifth of HH reported they had children who were not going to school. In the other HC countries these rates were much lower and corresponded with enrolment rates reported by girls. Considering the low enrolment figures reported by interviewed girls, the low figures as reported by HH heads in Bangladesh are surprising: only 10.1% in T and 15.4% in C not attending school, according to HH heads (Table A2.16).

Supporting information: Enrolment in school of married girls before/after marriage

In the midline study special attention was given to the relation between marriage and education. It is generally accepted that a relation exists between marriage and school participation, but the direction of this relation is not yet fully understood: are girls who are not in school more likely to marry and/or do girls leave school when they marry? We asked married girls whether they were enrolled in school just before they got married. We also asked what happened after they were

married, that is, whether they continued school (in less, same, or higher frequency), stopped school or started school (in case they did not go to school before their marriage) (Table A2.17).

In Bangladesh and Senegal (treatment), the majority of young women were enrolled in school before they married, and in Ethiopia all four married girls and Burkina Faso (comparison) the one married girl were enrolled in school. In Nepal (treatment), Senegal (comparison), and Mali and Burkina Faso (treatment), a considerable number of married girls were enrolled in school before they married. In all other sites, only a minority of girls had been enrolled – in Pakistan only one married girl in comparison sites was enrolled before her marriage, for example.

In Bangladesh, the vast majority of girls stopped schooling when they got married, and this trend was also found in other countries, with the exception of Senegal. In Senegal, more than half of the married young women continued their schooling – although some girls in treatment sites reported that their attendance was less frequent. From informal conversations in Senegal and UvA Research Master research we know that some families who marry their daughter negotiate her continued school attendance, with school fees/expenses covered by the husband. None of the married girls said that they *started* schooling after marriage.

Local partners were asked whether there was any legislation in place that prohibited or promoted married girls from continuing their formal education. Partners reported that governments in Ethiopia and Pakistan are working on policies to encourage married young women return to school, whilst in Uganda and Ghana, such national policies are already in place. In Ethiopia, married girls can also enroll in the integrated functional adult literacy program. No partners spoke of legislation *prohibiting* married young women from continuing their schooling. However, whether or not policies are in place to promote married young women's educational participation, available data suggests that married young women may feel ashamed to go back to school and/or may be teased by their peers and teachers when they do. There are some ''success'' stories in Uganda, Ghana and Burkina Faso where HC partners have successfully worked with families, schools and girls to get married girls or teenage unmarried mothers back in school (see Her Choice website).

6. STRATEGY III - IMPROVE ACCESS TO YOUTH-FRIENDLY SRHR SERVICES FOR GIRLS

Introduction

To increase young people's access to SRHR services, the HC programme offers training to health staff on youth friendly SRHR services (**IND32**). In addition, referral systems between schools and health facilities are being set up or improved **(IND33**). These activities are designed to lead to the intermediate outcomes of more health workers feeling confident and able to provide SRHR services to young people **(IND21)** and more health facilities offering youth friendly health services (**IND22).** The outcomes of the activities are that more girls are aware of where to access SRH services **(IND11.1),** use these services if they need them **(IND11.2),** and that they have a positive perception of the services they used **(IND12).**

Output indicators

Health staff taking part in the study was asked whether they had received any training on providing tailored SRHR services for youth during a) the past one year (IND32.1) and b) the past two years, which corresponded with the period between Her Choice BL and ML studies (IND32.2). (Note that indicator 32.2 was measured at ML only.)

Table 10 shows that in all countries, excluding Ethiopia, a large number of staff at ML reported they had received such training during the two years prior to ML data collection. In comparison sites in Pakistan, Nepal, and Benin, none of the staff reported having had such training.

Table 10: Share of health centre staff who has received training on SRHR during the previous year (IND32.1) and during previous two years (IND32.2)

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML T N=	*4*	*1*	*2*	*5*	*12*	*15*	*2*	*3*	*10*	*1*
ML T IND32.1	**1/4**	**0/1**	**1/2**	**2/5**	**9/12**	**7/15**	**2/2**	**2/3**	**1/10**	**1/1**
ML T IND32.2	**2/4**	**1/1**	**1/2**	**4/5**	**10/12**	**7/15**	**2/2**	**2/3**	**1/10**	**1/1**
ML C N=	*4*	*1*	*2*	*5*	*11*	*7*	*2*	*2*	*14*	*0*
ML C IND32.1	**1/4**	**0/1**	**0/2**	**4/5**	**3/11**	**0/7**	**0/2**	**0/2**	**1/14**	
ML C IND32.2	**1/4**	**0/1**	**0/2**	**4/5**	**3/11**	**1/7**	**0/2**	**1/2**	**1/14**	
BASELINE										
BL T N=	*4*	*3*	*1*	*2*	*12*	*9*	*2*	*3*	*9*	*--*
BL T IND32.1	**3/4**	**2/3**	**1/1**	**1/2**	**1/12**	**0/9**	**2/2**	**1/3**	**1/9**	
BL C N=	*4*	*1*	*1*	*1*	*12*	*6*	*2*	*1*	*11*	*--*
BL C IND32.1	**2/4**	**1/1**	**1/1**	**1/1**	**3/12**	**2/6**	**1/2**	**1/1**	**2/11**	

Note: --missing data.

Supporting information on training of health staff

According to MoA form reports, training of health staff on SRHR services for (un)married young people took place in all countries, mainly at health centre level. Some of the partners in Mali, Bangladesh, Burkina Faso and Pakistan also offered training to lower level health staff in health posts and/or community health workers. HC partners noted the (extremely) high staff turnover in health centres in many HC project areas. This turnover has obviously diminishes the potential impact of Her Choice in its project areas.

With respect to the topics of the training received, the trained health staff reported topics they learned about. Most often mentioned topics were contraceptive methods, followed by early marriage, early pregnancy, puberty, sexual relationships, and youth friendly methods. None of the health staff mentioned having received what might be considered a comprehensive training on youth friendly health services (Table A2.18). It is important to note in this regard that HC partners need to align their work with government policies on, in this case, SRHR provision for young people. While doing so might mean that training might be less 'comprehensive,' in the long-run, alignment is deemed more conducive to bringing about change.

In the treatment sites, Her Choice partners were the most commonly mentioned providers of training workshops, whereas in the comparison sites these were other organisations only. Only in Mali, in two comparison sites did health staff report they had received training from a Her Choice partner.

School principals were asked whether there referral mechanism in place between their school and a health clinic, NGO and/or other health provider in case a girl needs SRHR-related services or information (IND33).

Table 11: IND33 Share of schools with referral mechanisms to health centres

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML T N=	*2*	*4*	*2*	*5*	*7*	*13*	*2*	*2*	*10*	*1*
ML T IND33	**2/2**	**2/4**	**1/2**	**3/5**	**7/7**	**4/13**	**2/2**	**1/2**	**3/10**	**1/1**
ML C N=	*2*	*3*	*2*	*5*	*7*	*10*	*2*	*2*	*10*	*1*
ML C IND33	**0/2**	**2/3**	**0/2**	**3/5**	**1/7**	**4/10**	**2/2**	**0/2**	**3/10**	**0/1**
BASELINE										
BL T N=	*2*	*2*	*3*	*1*	*7*	*14*	*2*	*2*	*10*	*4*
BL T IND33	**1/2**	**0/2**	**2/3**	**0/1**	**1/7**	**6/14**	**0/2**	**0/2**	**1/10**	**4/4**
BL C N=	*2*	*2*	*3*	*1*	*7*	*10*	*2*	*2*	*10*	*2*
BL C IND33	**1/2**	**1/2**	**2/3**	**1/1**	**3/7**	**0/10**	**1/2**	**1/2**	**0/10**	**1/2**

As Table 11 shows, all schools in treatment sites in Bangladesh, Mali, Benin and Uganda had a referral system in place. In other countries, half or fewer schools in treatment sites had such a

system in place, whereas figures in comparison sites reveal a more mixed picture: in Benin, for example, all comparison site schools also had a referral system in place, in Ethiopia the number was (also) equal to T site schools (namely a mere 3/10), whilst in, for example, Bangladesh, Nepal, Ghana and Uganda none of the schools in comparison sites had a referral system in place.

Comparison of BL and ML data indicates that at ML more schools have referral systems in place, but data also indicate that the total increase is due to increases across both treatment and comparison sites. Only in Ghana has the situation remained the same: similar to BL, one treatment school had a referral system in place at ML and no schools in comparison sites reported having such a system.

Supporting information on referral mechanisms

Partners in most countries, excluding in Nepal and Pakistan, reported (MoA) that they had facilitated the set-up of referral mechanisms between schools, health facilities, communities, and/or peer educators.

Box 12: Referral systems between schools and health services (FGDs)

Not one clear picture emerged from the FGD data with regard to this topic. At times, young people indicated there was no, or they did not know of, any referral system between their school and health services (and/or other institutions), or clarified that there never had been any need for any external services. In Ethiopia, for example, girls and boys (T) clarified that if the issue was 'school capability' then students would be sent to health centers (with a letter from the school), with boys clarifying that if the matter concerned a legal issue, the school would work with the *kebele*'s girls' right committee.

In other cases, young people (Bangladesh, girls, 12-14 T) referred to explicit guidelines offered by school as to the health centre that young people can go to if they have certain issues or to specific NGOs for certain procedures, for example, 'Dalit or Shomadhan for blood tests [and] free treatments'(Bangladesh, boys 12-14, T) or in case of sexual harassment, girls were reportedly 'sometimes redirected by female teachers to the Hunger Project'(Bangladesh, boys, 15-17, T). However, the older girls and boys in Bangladesh (T, 15-17) indicated there were 'no communication channels between school and health services'.

Young people also indicated that if a student had a health issue, parents would take them to the health centre, with young women in comparison sites in Pakistan clarifying that health and sexual harassment-related issues were '[kept] in home' or (in the case of sexual harassment), considered to be 'internal family matters'. In Uganda, boys spoke of girls being:

> *[R]eferred but not for help. If she is suspected of pregnancy, [she is] brought to health centre for testing. If [the test result is] positive, [she is] expelled from school.*

This extract highlights that at times, referral systems and school-health sector collaboration may serve purposes of surveillance rather than as a means to promote young people's health and quality of school participation.

Intermediate outcomes

To measure IND21, health care workers were asked two questions: 1) whether they always felt able to provide services to young people and 2) whether felt they have been able to address all issues and questions that married and unmarried young people come to the clinic for.

Table 12: IND21 Share of health centre staff who is able and confident to provide YFHS

	Ba	Pa	Ne	Sen	Ma	BF	Be	Gh	Eth	Ug
MIDLINE										
ML T N=	*4*	*1*	*2*	*5*	*12*	*15*	*2*	*3*	*10*	*1*
ML T IND21	**2/4**	**1/1**	**2/2**	**3/5**	**12/12**	**13/15**	**2/2**	**3/3**	**8/10**	**1/1**
ML C N=	*4*	*1*	*2*	*5*	*11*	*7*	*2*	*2*	*14*	*1*
ML C IND21	**2/4**	**0/1**	**1/2**	**4/5**	**7/11**	**7/7**	**0/2**	**1/2**	**3/14**	**1/1**
BASELINE										
BL T N=	*4*	*3*	*1*	*2*	*12*	*9*	*2*	*3*	*9*	*--*
BL T IND21	**3/4**	**1/3**	**1/1**	**2/2**	**60.0**	**5/9**	**2/2**	**3/3**	**3/9**	
BL C N=	*4*	*1*	*1*	*1*	*12*	*6*	*2*	*1*	*11*	*--*
BL C IND21	**2/4**	**0/1**	**1/1**	**1/1**	**60.0**	**4/6**	**1/2**	**1/1**	**3/11**	

Findings indicate that in treatment sites in Nepal, Mali, Benin, Ghana and Uganda, and comparison sites in Burkina Faso and Uganda, all staff reported feeling capable and able to answer all young people's questions, whereas in other countries and/or sites (slightly) fewer staff felt capable of doing so (Table 12). Compared with the baseline, an increase in this share can also be seen in Mali (T and C), and in treatment areas in Burkina Faso and Ethiopia.

The extent to which a health care centre offered services that could be deemed 'youth friendly' (IND22) was assessed by asking health care workers the following kinds of questions: whether unmarried young women and men, and school going young people came in for SRHR advice, services and/or products.

Table 13: IND22 Share of health facilities that provide services to unmarried young people, according to health staff

	Ba	Pa	Ne	Sen	Ma	BF	Be	Gh	Eth	Ug
MIDLINE										
ML T N=	*4*	*1*	*2*	*5*	*12*	*15*	*2*	*3*	*10*	*1*
ML T IND22	**4/4**	**1/1**	**2/2**	**5/5**	**12/12**	**15/15**	**2/2**	**3/3**	**9/10**	**1/1**
ML C N=	*4*	*1*	*2*	*5*	*11*	*7*	*2*	*2*	*14*	*1*
ML C IND22	**4/4**	**1/1**	**2/2**	**5/5**	**10/11**	**7/7**	**2/2**	**2/2**	**11/14**	**1/1**
BASELINE										
BL T N=	*4*	*3*	*1*	*2*	*12*	*9*	*2*	*3*	*9*	*--*
BL T IND22	**4/4**	**3/3**	**1/1**	**2/2**	**83.3**	**8/9**	**2/2**	**3/3**	**8/9**	
BL C N=	*4*	*1*	*1*	*1*	*12*	*6*	*2*	*1*	*11*	*--*
BL C IND22	**3/4**	**1/1**	**1/1**	**1/1**	**83.3**	**6/6**	**2/2**	**1/1**	**9/11**	

At ML, virtually all health staff stated that their health facility offered services to young people, including unmarried people and school going youth. Only in Ethiopia did some health care staff indicate they did not provide services to married *and* unmarried people (1/10 in T sites and 3/14 in C sites) (Table 13).

At BL, this picture was more diversified, that is, there was greater variation in the number of health staff reporting they offered services to both married and unmarried young people, and in no case did all health staff report providing such services.

Supporting information on youth friendly services

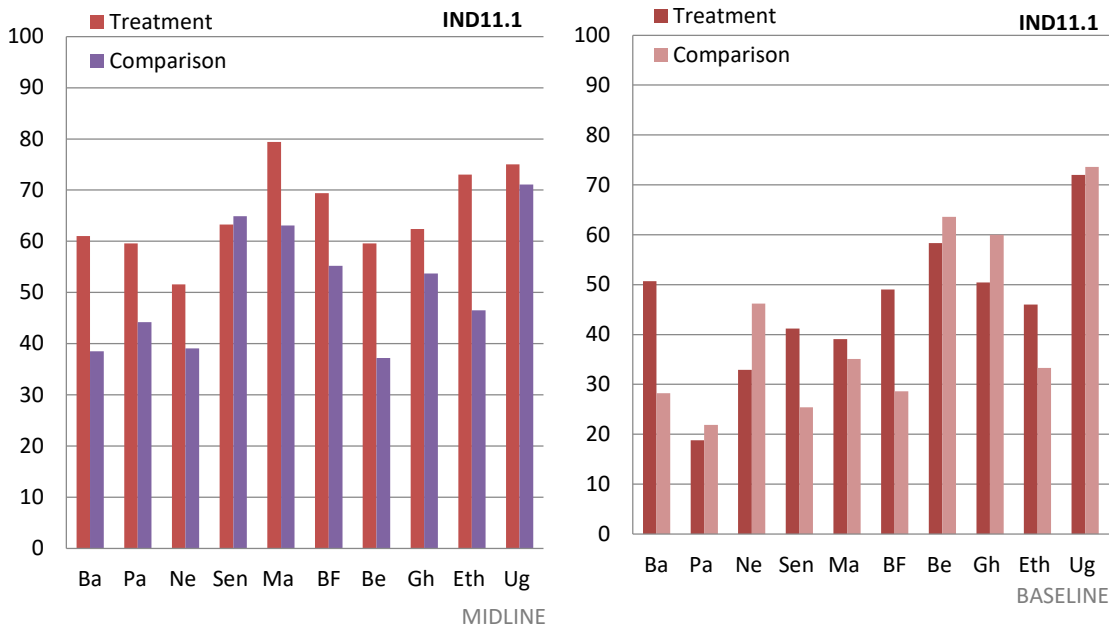
Those in charge of health care facilities were asked an open question about the kinds of measures they had taken to make their centre more youth friendly. Responses were categorised using a shortlist of six measures, constructed from existing literature on YFHS and in discussion with HC partners. These measures included: services for young people are private, health workers know harmful consequences of child marriage, health workers know harmful consequences of FGM/C, referral system are established with school(s), opening hours allow youth to attend, and services are available to all youth (married and non-married). Across countries, more measures were taken in treatment sites than comparison sites. Measures most often taken in treatment sites across countries related to staff being knowledgeable about harmful consequences of child marriage and FGM/C, adjusting opening hours to allow young people to attend, and making services available to all youth. None of the health facilities reported having taken all six measures (Table A2.19).

Very few partners reported in MoA forms having given support to health facilities in terms of putting in place measures to make the services more accessible to young people and more youth-friendly, except for some partners in Bangladesh, Benin, Burkina Faso, Ghana, and Mali.

Outcome indicators

At midline, the share of single girls who knew of SRHR-related services (**IND11.1)** has increased compared to BL in near to all treatment sites and for the majority of comparison sites. Also, in the midline, across countries, a higher share of girls was aware in the treatment villages than in the comparison villages. Midline figures for single girls in treatment villages were in all above 50% (Nepal lowest with 51.6%) and ranged to a high of 79.4% among single girls in Mali. The most notable increases in proportions of girls with this knowledge were found in Pakistan, Senegal, Mali and Ethiopia, and particularly in treatment sites (Figure 9).

Figure 9: IND11.1 Share of single girls who know of SRHR services (%)

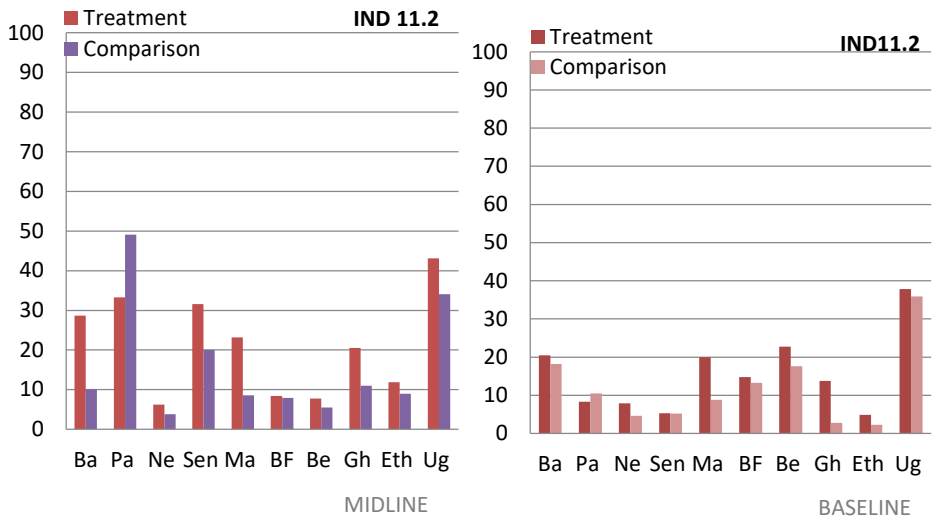


Married young women were generally more aware of SRHR services than single young women. This finding is not entirely surprising given a considerable number of married young women will have accessed a health service related to pregnancy and delivery. At ML, overall, the share of married girls who knew of SRHR-related services had increased when compared to baseline data. Most notable increases were found among married young women in Bangladesh, Pakistan, and in treatment sites in Nepal and Senegal. In Mali, the proportion of married young women with this knowledge had also risen considerably, up to 95% of married young women in comparison sites (presenting a slightly larger increase than in treatment sites). The proportion of married young women with this knowledge had decreased considerably in comparison sites in Nepal and slightly in comparison sites in Senegal. For married young women figures for awareness of services ranged from 69.2% in Nepal to 93.3% in Pakistan (Table A1.10).

Girls who reported being aware of SRHR services, were asked whether they had ever utilized these services **(IND 11.2)**. Across countries a higher share of single girls in the treatment villages had utilized the services than girls in comparison villages, except for Pakistan, where more girls in the comparison villages visited (Figure 10).

Overall, and as expected, utilization was higher among married girls, probably due to pregnancy related visits. Utilization of SRHR services in the treatments sites in the midline study had increased compared to the baseline in all countries, except Benin, and sometimes dramatic: notably in Pakistan (Table A1.11).

Figure 10: IND11.2 Share of single girls who knew of SRHR services and visited a clinic for SRHR services, by marital status (%)



Supporting information on use of SRH services

By far the central reason stated across countries as to why some young women who knew of the services did not utilise SRHR-services related to not having had an SRHR-related problem or question – in treatment sites in Nepal and Ghana, for example, respectively 97% and 98.6% of young women indicated this formed their main reason. For those who had experienced a SRHR-related problem, the most commonly cited reason for not utilizing health services had to do with shame (Table A2.21).

In the baseline it had not been possible to measure girls' satisfaction with the visited health services (IND12), because the questions were not sufficiently sensitive: All girls in the baseline who visited said to be fully satisfied. In the midline we reworded the questions and now got slightly more varied responses. We had four questions measuring perceptions: 1) Did you think the health worker was friendly or not friendly?; 2) Did the health staff respect your confidentiality or not?; 3) Were the visiting hours convenient or not?; 4) Did the service help you resolve your problem or not? If the girl had positive perception on all four questions, she was scoring yes on **indicator 12.1** (share of girls having positive perception of the services they visited). **Indicator 12.2** measures the mean of the responses to the 4 questions, ranging from 0 to 4.

Overall, in the majority of countries, single and married girls (T and C) reported positive perceptions about the SRHR services they had used. In Benin, Ghana and treatment villages Nepal, all single and married girls who visited the health service had positive perceptions, and thus also scored 4 on the mean. Relatively least satisfied were girls with the services in treatment villages in Bangladesh (44.4% single positive; 3/9 married girls positive) and comparison sites in Ethiopia (57.1% of single girls positive).

The mean degree of positive perception of services largely confirms the shares reported above (IND12.1). That is, in all countries, the mean degree was 3.6 or higher excluding in Bangladesh (single and married, T and C), Nepal (single, C), Ethiopia (single, T and C). Particularly in Bangladesh treatment the mean score was low (mean for single girls 2.9 and for married 2.4) (Table A1.13).

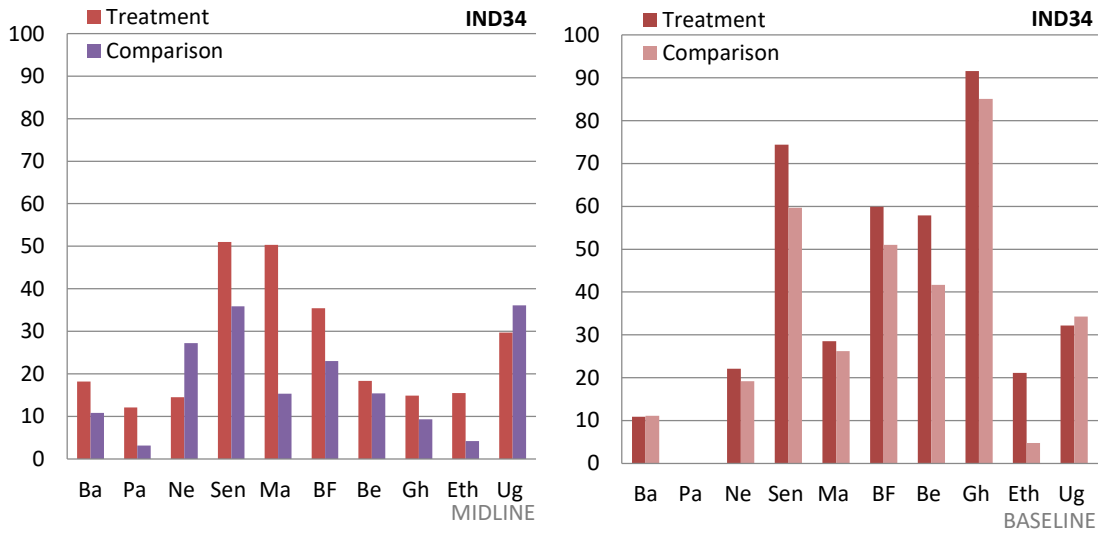
7. STRATEGY IV - IMPROVE ECONOMIC SECURITY OF GIRLS AND THEIR FAMILIES

Introduction

Poverty is known to be one of the major drivers of child marriage. Building on the assumption that lower poverty rates will reduce the economic incentive for child marriage, Her Choice Strategy IV is geared to improving economic security of young women and their families. Within the framework of Strategy IV, microcredit schemes and income generation activities are organised to support female entrepreneurs and entrepreneurship, the intended output being a higher share of households in Her Choice communities with supported female family members **(IND34).** The intermediate outcome of these activities is an increased family income for a higher share of households **(IND23)** and the outcome of activities in Strategy IV relate to an improved economic status of households **(IND13).**

Output indicators

Figure 11: IND34 Share of HH with female entrepreneurs supported, reported by HH heads (%)



In all countries, except Nepal and Uganda, the share of households with women supported with income generation was higher in treatment than comparison sites. However, the share of HH with female entrepreneurs taking part in organised income generation activities at midline was generally lower than at baseline level. Only in Bangladesh (T), Nepal (C), Uganda (C), and Mali (T) did these rates rise at ML, in the latter considerably. The seeming decrease in many settings could be due to the way in which questions were interpreted in the baseline, that is, it is possible that the question was interpreted in terms of whether female members were contributing to HH income. More analysis is needed to determine whether women in Her Choice communities are being reached by income generating activities, and subsequently which women, how they are reached and how involvement in such activities is benefiting women and their families. Please note that the indicator was not measured at BL in Pakistan (Table A1.14).

Supporting information

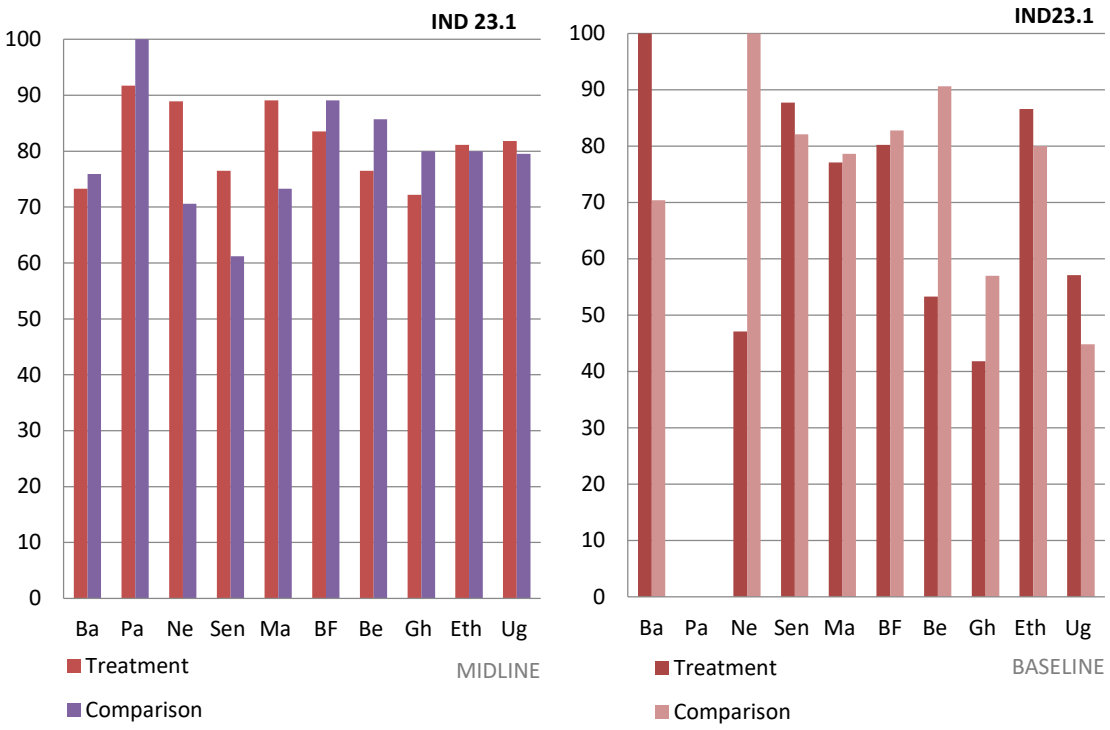
In all countries, excluding in Nepal and Pakistan, (some) partners' MoA reports detail support given to the creation of women's groups or strengthening of existing women's groups. The MoA forms also report on supporting female entrepreneurs with training or funds, in all countries, except for in Pakistan and Uganda by (some) partners.

The main types of activities to support female entrepreneurs mentioned by household heads were NGO saving and credit scheme (Senegal, T and C), food for work/safety net programmes (Senegal and Burkina Faso, T and C), micro and small enterprise (Ghana, T and C), and 'other' (Ghana and Uganda, T and C), with 'other' referring to respectively, farming, and 'hiring to dig' and selling (Table A2.31). At ML, in treatment sites in Mali, Benin and Ethiopia, more than 50% of HH heads indicated that a Her Choice partner was the main implementer of the income generating support scheme/initiative, in Senegal just below 50% (Table A2.23).

Intermediate outcome indicators

Households that included female members who took part in micro-credit schemes or income generating activities were asked whether levels of household income had increased as a result of the activities that women were involved in **(IND23).**

Figure 12: IND23 Share of households with females supported who report an increased income due to income generation interventions targeted at women (%)



Generally, a high share of heads of households across the 10 HC countries indicated that household income had indeed increased, ranging from 88.9% in Nepal (treatment) to 81.8% in Uganda

(treatment). As Figure 12 highlights, across countries at midline the share of households reporting higher levels of income due to interventions targeted at women had increased, in treatment sites, except for in Senegal and Bangladesh. The increase was highest in Nepal, Benin, Mali, Ghana and Uganda.

In Bangladesh some notable differences can be seen at regional levels. While in R2 all HH heads in treatment and comparison sites reported an increase in income, in R1 these shares were respectively, 53.8% and 61.1% (fewer reported an increase in treatment sites, in other words) (Table A1.15).

Outcome indicator

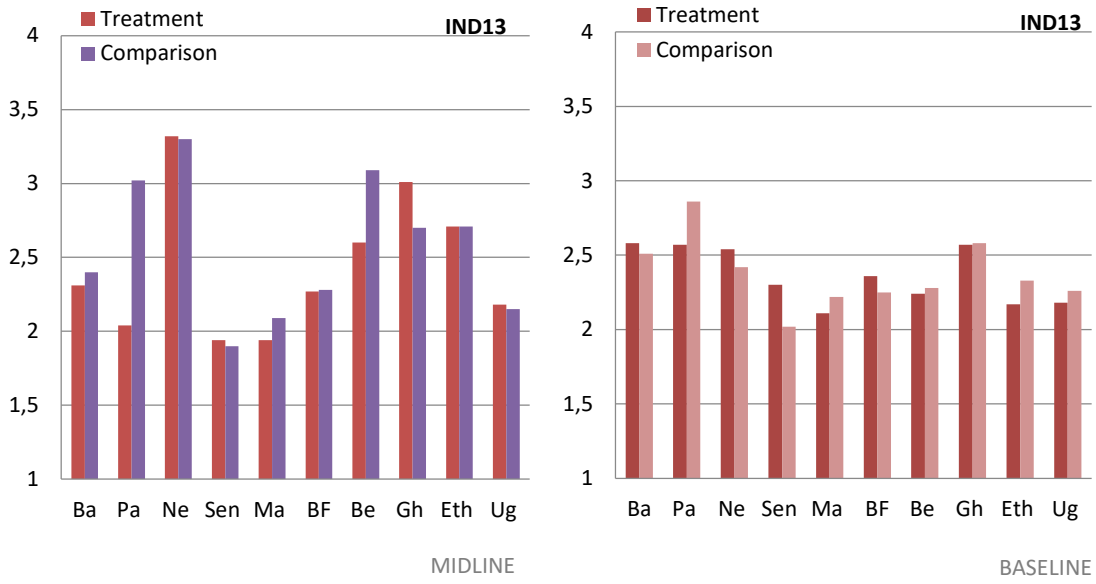
I**ndicator 13** relates to households' improvement in economic status as a result of programme activities. Table A1.29 presents the data regarding reported economic status of households at ML and BL, drawing a distinction between households in four economic strata, that is, households who: 1) struggle for sufficient food the entire year, 2) have problems getting sufficient food part of the year, 3) have food the whole year but experience problems accessing funds for primary needs, such as schooling, and 4) have food the whole year round, and have sufficient resources to send their children and/or wards to school.

We acknowledge that stratum four comprises different economic classes, from just enough to get by to well-off. We decided that the four strata we use were most relevant to capture differences between households in rural communities that Her Choice works in, which are characterised by high poverty rates. With this indicator we expect to gain insight into the proportion of households that struggle to cover costs related to sending their children to school (strata 1-3) relative to those that do not face such financial barriers (stratum 4).

At midline, most notable increases in HH reporting to belong to the poorest stratum (1) were found in treatment sites in Pakistan, Senegal and Mali. The most striking decrease in HHs reporting to belong to the poorest stratum (1) was found in treatment and comparison sites in Nepal. Most notable increases in HHs reporting to belong to the wealthiest stratum (4) were similarly found in Nepal (T and C). In Ghana (T), a notable increase of HHs belonging to 3rd stratum, and in treatment sites in Ethiopia noteworthy decrease was found in stratum 2 (second poorest) and increase in stratum 4 (wealthiest).

For easier comparison between ML and BL, we calculated the mean economic status ranging from 1 (poorest) to 4 (richest) **(IND13**). (Figure 13)

Figure 13: IND13 Mean economic status reported by HH (range 1-4)



Increases in the mean economic status were noted at midline in treatment and comparison sites in Nepal, Ghana, Benin and Ethiopia, and in comparison sites in Pakistan. At midline, a decreased mean economic status was reported in treatment sites in Bangladesh, Pakistan, Senegal, and Mali. This decrease was also found in comparison sites in the same countries, excluding Pakistan. In Uganda and Burkina Faso, the mean remained rather stable in treatment and comparison sites.

Compared to BL, at *regional level*, an increase in mean economic status was found in treatment and comparison sites in R1 in Bangladesh, and in R2 and R3 in Ethiopia. A decrease in mean economic status was found in treatment and comparison sites in R2 in Bangladesh, in R2 in Burkina Faso and in R3 in Mali. In all but one case, this decrease meant that the mean economic status dropped to below stratum 2 (second poorest) (Tables A1.17).

Supporting findings on economic status

During interviews, village leaders and district officials were asked to report on any natural or political shocks that may have affected the HC programme, including the economic status of HH. Below is an overview of reported shocks which are likely to have affected the decrease in mean levels of income found at midline in three (of the four) countries with decreased mean economic status indicated above (the question was not asked/answered in the case of Mali), and for Burkina Faso with rather stable (low) economic status:

- Bangladesh: village leaders reported that communities had been affected by flooding in 2017 which had damaged the harvest. While the authorities provided food relief for ten months, this relief had not been sufficient.
- Pakistan: in treatment sites, leaders spoke of 'continuous financial crises for farmers,' referring to the 'very high' costs of, among other items, fertilizer and the low market value of crops.

- Senegal: leaders referred to various detrimental events, including a large fire and ‘political changes.’ In both treatment and comparison sites, leaders referred to a ‘violent wind [that] destroyed crops and housing.’
- Burkina Faso: village leaders in comparison sites referred to a violent wind and a fire that had destroyed livelihoods. In treatment and comparison sites, leaders spoke of a famine, which according to leaders in treatment sites was the result of a drought. In comparison sites, reference was also made to a bad rainy season and ‘banditry.’

8. STRATEGY V - MOBILIZE COMMUNITIES TO TRANSFORM SOCIAL NORMS THAT ARE DETRIMENTAL TO ACHIEVING GENDER EQUALITY

Introduction

Sexual activity and contraceptive use by unmarried young women is severely frowned upon in many contexts, including Her Choice communities. In many countries in the Global South, a girl is expected to marry when she is found to be or suspected of being sexually active and/or becomes pregnant, a marriage serving as a means to, among other things, prevent the loss of honour for a girl and her family. Such gendered norms also underpin caregivers' tendency to prioritise their sons' education over their daughters', Within the framework of Strategy V, the HC programme organises various forms of community level activities, including training of relevant community stakeholders, and facilitation of community dialogue on, for example, negative effects of early marriage and FGM/C, and the importance of girls' education.

Key outputs include an increasing number of village leaders who have been trained on the negative effects of child marriage and FGM/C **(IND35).** These activities are expected to lead to the following intermediate outcomes: trained stakeholders publicly condemning early marriage and FGM/C in village meetings, and promoting education for both young women and men **(IND24**) and so inspiring other community members to organise activities in the village against CM and FGM/C **(IND25**). These intermediate outcomes, in turn, are expected to lead to whole villages rejecting early marriage and FGM/C **(**outcome **IND14**). A village with trained and active leaders and members (who sensitise their community on the negative effects of child marriage) is expected to lead to girls feeling supported in their decision-making on SRHR-related issues, and more single girls feeling supported to *not* marry when they do (yet) not want to do so, and who feel supported in decision-making against FGM/C **(IND15**).

Output indicators

Table 14: IND35 Share of villages with trained leaders, reported by village leaders

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML T N=	*2*	*2*	*2*	*2*	*8*	*8*	*2*	*2*	*8*	*2*
ML T IND35	**1/2**	**2/2**	**1/2**	**2/2**	**7/8**	**7/8**	**2/2**	**2/2**	**5/8**	**0/2**
ML C N=	*2*	*2*	*2*	*2*	*8*	*8*	*2*	*2*	*8*	*2*
ML C IND35	**2/2**	**0/2**	**0/2**	**0/2**	**1/8**	**3/8**	**1/2**	**0/2**	**1/8**	**0/2**
BASELINE										
BL T N=	*2*	*2*	*1*	*2*	*7*	*8*	*2*	*2*	*10*	*2*
BL T IND35	**1/2**	**0/2**	**0/1**	**2/2**	**2/7**	**4/8**	**1/2**	**1/2**	**4/10**	**2/2**
BL C N=	*2*	*2*	*1*	*2*	*6*	*8*	*2*	*2*	*10*	*2*
BL C IND35	**0/2**	**0/2**	**0/1**	**1/2**	**0/6**	**5/8**	**0/2**	**0/2**	**6/10**	**2/2**

At midline, an overall increase in the share of villages with trained leaders can be seen. In treatment sites in Mali the share of villages with trained leaders increased most -- from 2/7 at baseline to 7/8 at midline. Noteworthy too is that the number of villages with trained leaders at ML decreased in Uganda to 0/2 (at BL this being 2/2) (Table 14). The latter finding merits further examination.

Supporting information on sensitizing community leaders

In all countries, except Nepal, (some) partners report in MoA forms that they have sensitized community and religious leaders on negative effects of child marriage and FGM/C, and on the importance of girls' school enrolment. Additionally, they report that community change agents have been mobilized.

Intermediate outcome activities

Table 15: IND24 Share of villages with leaders who condemned CM in village meetings, reported by village leaders

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML T N=	*2*	*2*	*2*	*2*	*8*	*8*	*2*	*2*	*8*	*2*
ML T IND24	**2/2**	**1/2**	**2/2**	**2/2**	**5/8**	**5/8**	**2/2**	**2/2**	**4/8**	**0/2**
ML C N=	*2*	*2*	*2*	*2*	*8*	*8*	*2*	*2*	*8*	*2*
ML C IND24	**2/2**	**0/2**	**1/2**	**1/2**	**0/8**	**2/8**	**2/2**	**2/2**	**3/8**	**0/2**
BASELINE										
BL T N=	*2*	*2*	*1*	*2*	*7*	*8*	*2*	*2*	*10*	*2*
BL T IND24	**0/2**	**0/2**	**1/1**	**2/2**	**2/7**	**6/8**	**1/2**	**1/2**	**9/10**	**0/2**
BL C N=	*2*	*2*	*1*	*2*	*6*	*8*	*2*	*2*	*10*	*2*
BL C IND24	**1/2**	**0/2**	**1/1**	**1/2**	**0/6**	**4/8**	**0/2**	**2/2**	**8/10**	**2/2**

Indicator 24 measures the share of community leaders who publicly condemned CM during village meetings. In most countries, there was an increase in the share of leaders in treatment villages who publically condemned CM. In Burkina Faso and Ethiopia, on the other hand, the share of villages with leaders who condemned CM during village meetings decreased. It is important to note that, similar to IND35 and subsequent indicators in this strategy, these findings are based on surveys conducted with very small samples (Table 15).

Table 16: IND25 Share of communities with village members who organize activities on negative effects of CM, reported by village leaders

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML T N=	*2*	*2*	*2*	*2*	*8*	*8*	*2*	*2*	*8*	*2*
ML T IND25	**2/2**	**2/2**	**0/2**	**2/2**	**5/8**	**4/8**	**2/2**	**2/2**	**5/8**	**0/2**
ML C N=	*2*	*2*	*2*	*2*	*8*	*8*	*2*	*2*	*8*	*2*
ML C IND25	**1/2**	**0/2**	**1/2**	**1/2**	**0/8**	**4/8**	**1/2**	**2/2**	**3/8**	**0/2**
BASELINE										
BL T N=	*2*	*2*	*1*	*2*	*7*	*8*	*2*	*2*	*10*	*2*
BL T IND25	**0/2**	**1/2**	**1/1**	**1/2**	**0/7**	**4/8**	**0/2**	**0/2**	**7/10**	**1/2**
BL C N=	*2*	*2*	*1*	*2*	*6*	*8*	*2*	*2*	*10*	*2*
BL C IND25	**0/2**	**0/2**	**0/1**	**2/2**	**0/6**	**2/8**	**0/2**	**1/2**	**5/10**	**2/2**

In relation to **IND25**, the most striking finding at ML relates to the increase in the share of villages with village members who organize activities on negative effects of CM in treatment sites in almost all countries, with exception of Ethiopia where the share decreased compared to the baseline (Table 16).

Outcome indicators

As indicated, the expected outcome of community level HC activities relate to communities condemning CM and FGM/C (**IND14.1, IND14.2**).

Table 17: IND14.1 Share of communities that reject CM, reported by village leaders

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML T N=	*2*	*2*	*2*	*2*	*8*	*8*	*2*	*2*	*8*	*2*
ML T IND14.1	**1/2**	**0/2**	**2/2**	**2/2**	**4/8**	**2/8**	**2/2**	**2/2**	**5/8**	**0/2**
ML C N=	*2*	*2*	*2*	*2*	*8*	*8*	*2*	*2*	*8*	*2*
ML C IND14.1	**1/2**	**0/2**	**1/2**	**1/2**	**3/8**	**2/8**	**1/2**	**1/2**	**2/8**	**1/2**
BASELINE										
BL T N=	*2*	*2*	*1*	*2*	*7*	*8*	*2*	*2*	*10*	*2*
BL T IND14.1	**2/2**	**0/2**	**0/1**	**0/2**	**3/7**	**4/8**	**1/2**	**1/2**	**6/10**	**1/2**
BL C N=	*2*	*2*	*1*	*2*	*6*	*8*	*2*	*2*	*10*	*2*
BL C IND14.1	**2/2**	**0/2**	**0/1**	**0/2**	**2/6**	**2/8**	**1/2**	**1/2**	**8/10**	**2/2**

At ML, increases in villages that rejected CM – according to village leaders – were found in treatment and comparison sites in most countries, while decreases in the share of such villages were found in Bangladesh, Burkina Faso, Ethiopia (comparison only), and Uganda. At midline, as at baseline, none of the village leaders in Pakistan rejected CM in village meetings (Table 17).

Supporting information: Village heads' opinion on circumstances when they agree to marriage below the legal age

In the midline study some village leaders report on several circumstances under which they would support boys and girls to marry below the legal age. First, the main circumstance which village leaders in particular in West African countries (Burkina Faso and Mali) report as a main reason for marriage is a pregnancy of the girl, even 'if the boy is stubborn despite refusal of this union.' In Burkina Faso some additional reason for marrying a girl under the legal age for marriage could be if a girl runs off with her boyfriend or if her parents will not allow her to stay in the house: *'If the girl seems mature and capable of carrying a pregnancy, and if the boy she wants to marry is at least capable of supporting her, then we accept the marriage'*. (treatment village)

Second, in Ghana in the comparison areas village leaders report that if the girl's family decides to marry her, it is difficult to intervene, even if the girl is below the legal age for marriage. Third, Ethiopia and Uganda are the only countries that report no support for marriage below legal age for girls, and to some extent for boys (in the comparison areas). In the treatment areas the village leaders report to support marriage for boys if parents believe they have to marry. Fourth, in Pakistan village leaders would support marriage for a girl below the legal age for marriage if the girl is orphaned. In fact, they say that her relatives will marry her at an early age just to be 'freed from the burden of the girl.'

Table 18: IND14.2 Share of villages that reject FGM/C, reported by village leaders

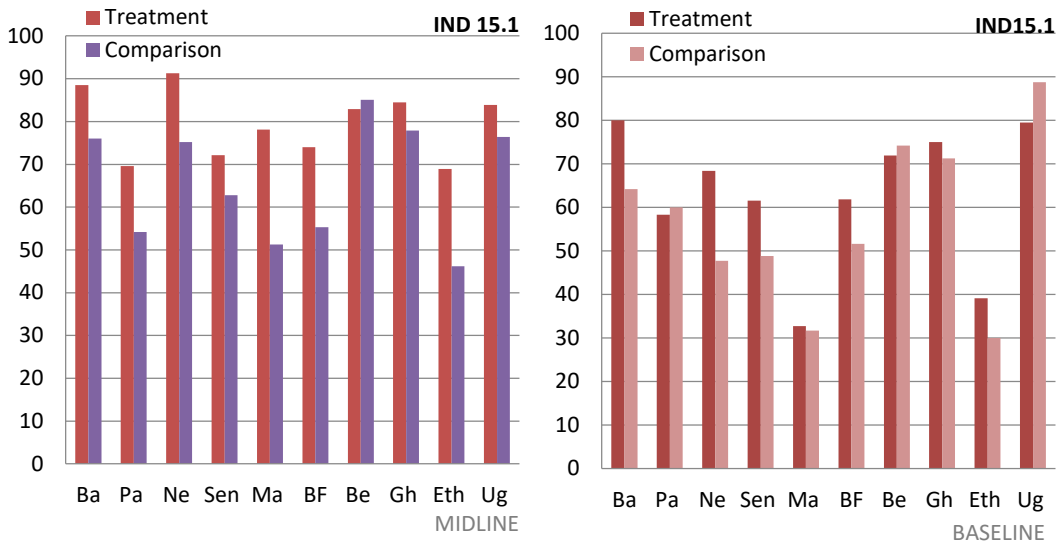
	Sen	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE							
ML T N=	*2*	*8*	*8*	*2*	*2*	*8*	*2*
ML T IND14.2	**2/2**	**1/8**	**5/8**	**2/2**	**0/2**	**5/8**	**--**
ML C N=	*2*	*8*	*8*	*2*	*2*	*8*	*2*
ML C IND14.2	**2/2**	**0/8**	**2/8**	**2/2**	**2/2**	**4/8**	**--**
BASELINE							
BL T N=	*2*	*7*	*8*	*2*	*2*	*10*	*2*
BL T IND14.2	**0/2**	**1/7**	**7/8**	**2/2**	**2/2**	**10/10**	**1/2**
BL C N=	*2*	*6*	*8*	*2*	*2*	*10*	*2*
BL C IND14.2	**0/2**	**2/6**	**7/8**	**2/2**	**2/2**	**10/10**	**0/2**

Note: -- missing data.

At ML, an increase in the share of villages rejecting FGM/C, according to their leaders, was found in Senegal, and stayed the same in Benin. Decreases in this share were found in all other settings in which data were gathered on this subject (Mali, Burkina Faso, Ghana and Ethiopia), with the sharpest decrease found in treatment sites in Ethiopia (Table 18).

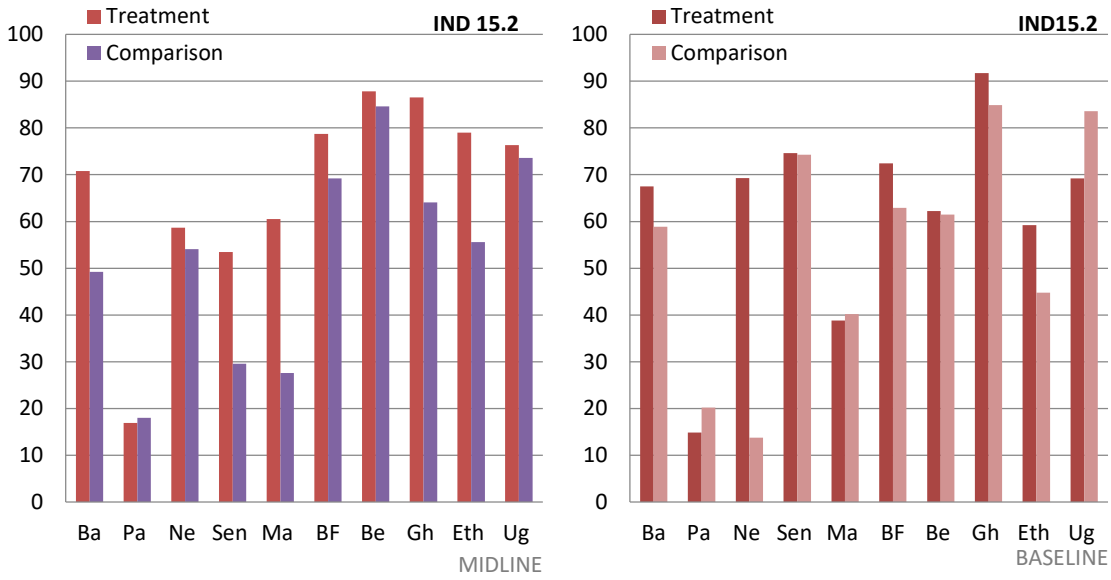
As mentioned earlier, an expected outcome of HC activities is that, once community leaders have been trained and villages condemn CM and FGM/C, girls feel supported in their decision-making on SRHR-related issues, including on marriage and FGM/C. Figure 14 highlights the share of girls who felt they could consult a particular source (or set of sources) on SRHR-related matters **(IND15.1).**

Figure 14: IND15.1 Share of single girls who feel they can consult a source on SRHR issues (%)



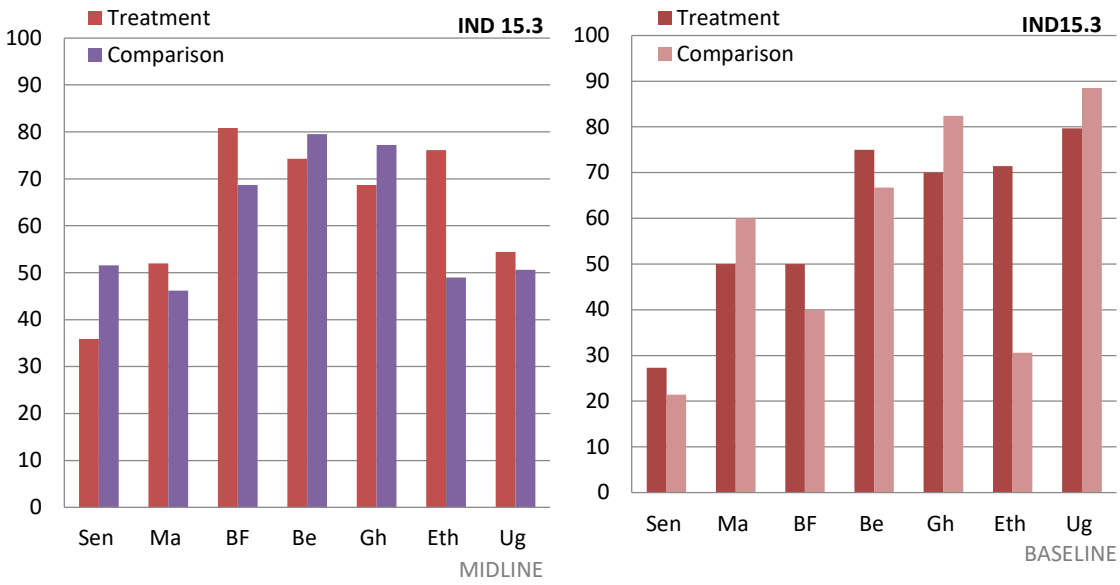
The share of girls who felt they could consult a source on SRHR-related matters increased in virtually all research settings, only in comparison sites in Pakistan and Uganda did this figure drop. Most striking increases in this share of girls were found among single girls in Nepal, single girls in treatment sites in Mali (across all three regions), in treatment sites in R1 in Burkina Faso, and in treatment sites in Ethiopia (and particularly in R2 and R3) (Table A1.18).

Figure 15: IND15.2 Share single girls who feel supported in decision-making on CM (%)



Relative to the baseline, an increase in the overall share of single girls who felt supported in marriage-related decision-making were found in treatment sites in Bangladesh, Pakistan, Mali, Burkina Faso, Benin, Ethiopia, and Uganda. A decrease in these shares at midline was found in treatment sites in Nepal, Senegal, and Ghana, and in comparison sites in Bangladesh, Pakistan, Senegal, Mali, and Ghana. There was some regional variation with regard to this indicator. In Bangladesh the share of girls feeling supported *decreasing* in treatment sites in R2 whilst rising in R1, for example (Table A1.19).

Figure 16: IND15.3 Share of uncircumcised girls who feel supported in decision making on FGM/C (%)



At midline, an increase in the share of uncircumcised girls who felt supported in decision-making on FGM/C in treatment sites was found in Senegal, Mali, and Ethiopia. The share decreased in other treatment sites. Steepest increases were found in comparison sites in Ethiopia and Senegal, and in treatment and comparison villages in Burkina Faso, while the sharpest decreases in these shares were found in treatment and comparison sites in Uganda (Table A1.20). The reasons why the shares of girls who feel supported in these decision appears to have decreased in so many communities requires further research.

9. STRATEGY VI - CREATE AN ENABLING LEGAL AND POLICY ENVIRONMENT ON PREVENTING CHILD MARRIAGE

Introduction

The HC programme departs from the principle that young women should be protected against child marriage by national and local (by-) laws. In all HC programme countries there are laws in place that stipulate the minimum age for marriage for young women and men. In line with international standards, in most countries the legal minimum age for marriage for young women is 18 years. It is critical to note that in four HC programme countries the legal age for girls to marry without parental consent is lower than 18 years: in Pakistan, Mali and Senegal, the legal age for girls to marry without parental consent is 16 years, while in Burkina Faso it is 17 years. Although minimum legal age for girls to marry is 18 years in the other countries, in Benin, Ghana, and Uganda, marriage for girls below 18 years old is possible with parental consent. In Nepal, the legal age for marriage is 20 years. Legal minimum age to marry for boys is higher than that for girls in some countries: Bangladesh and Burkina Faso 21 years, Mali, Senegal and Pakistan, 18 years (www.girlsnotbrides.org).

The existence of a law does not mean it is enforced. In light of difficulties in national enforcement of legislation, the HC programme seeks to support a) communities to develop by-laws against child marriage and FGM/C at community level, and b) district departments to better enforce existing laws. District level stakeholder consultation meetings also form a part of Strategy VI activities. Within the HC programme and this report, 'district' is defined as the lowest level of government administration.

Output and intermediate outcome indicators

Table 19: IND26.1 Share of communities with by-laws concerning CM, reported by community leaders

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML T N=	*2*	*2*	*2*	*2*	*8*	*8*	*2*	*2*	*9*	*2*
ML T IND26.1	**1/2**	**0/2**	**1/2**	**1/2**	**1/8**	**4/8**	**0/2**	**1/2**	**1/9**	**2/2**
ML C N=	*2*	*2*	*2*	*2*	*8*	*8*	*2*	*2*	*9*	*2*
ML C IND26.1	**0/2**	**0/2**	**0/2**	**0/2**	**1/8**	**1/8**	**0/2**	**0/2**	**1/9**	**1/2**
BASELINE										
BL T N=	*2*	*2*	*1*	*2*	*7*	*8*	*2*	*2*	*10*	*2*
BL T IND26.1	**0/2**	**0/2**	**0/1**	**0/2**	**2/7**	**0/8**	**0/2**	**0/2**	**4/10**	**1/2**
BL C N=	*2*	*2*	*1*	*2*	*6*	*8*	*2*	*2*	*10*	*2*
BL C IND26.1	**0/2**	**0/2**	**1/1**	**1/2**	**1/6**	**1/8**	**1/2**	**0/2**	**2/10**	**1/2**

Increases in shares of communities with CM-related by-laws found in treatment villages in Bangladesh, Nepal, Senegal, Burkina Faso, Ghana, and Uganda. In Burkina Faso, this proportion rose steeply. A decrease in the share of communities with CM-related by-laws was found in comparison

sites in Senegal and Benin. Additionally, a considerable decrease was found in treatment sites in Ethiopia. Given the sample of communities remained constant from baseline to midline, the reported decreases are somewhat puzzling. Whether interviewees misinterpreted the question (at base or midline) and what number of communities at present has these by-laws warrants further attention.

Table 20: IND37.1 Share of communities (that have no by-laws yet) in the process of developing by-laws CM, reported by community leaders

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML T N=	*1*	*2*	*1*	*1*	*7*	*4*	*2*	*1*	*7*	*0*
ML T IND37.1	**0/1**	**1/2**	**0/1**	**1/1**	**4/7**	**1/4**	**0/2**	**0/1**	**1/7**	
ML C N=	*2*	*2*	*2*	*2*	*7*	*7*	*2*	*2*	*7*	*1*
ML C IND37.1	**0/1**	**0/2**	**0/1**	**0/2**	**1/7**	**1/7**	**0/2**	**0/2**	**0/7**	**0/1**
BASELINE										
BL T N=	*2*	*2*	*1*	*2*	*5*	*8*	*2*	*2*	*6*	*1*
BL T IND37.1	**0/2**	**0/2**	**0/2**	**1/2**	**0/5**	**0/8**	**1/2**	**0/2**	**0/6**	**1/1**
BL C N=	*2*	*2*	*0*	*0*	*5*	*8*	*1*	*2*	*8*	*1*
BL C IND37.1	**0/2**	**0/2**			**0/5**	**1/8**	**0/1**	**0/2**	**0/8**	**1/1**

Most research communities do not have CM-related by-laws. Compared to the baseline, an increase is noted in the share of communities in treatment sites that were in the process of developing CM-related by-laws – in treatment sites in Mali the increase is considerable (from 0 to 4/7 (Table 20).

Table 21: IND26.2 Share of communities with by-laws concerning FGM/C, reported by community leaders

	Sen	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE							
ML T N=	*2*	*8*	*8*	*2*	*2*	*8*	*2*
ML T IND26.2	**1/2**	**0/8**	**5/8**	**--**	**--**	**2/8**	**--**
ML C N=	*2*	*8*	*8*	*2*	*2*	*8*	*2*
ML C IND26.2	**1/2**	**0/8**	**1/8**	**--**	**0/2**	**0/8**	**--**
BASELINE							
BL T N=	*2*	*7*	*8*	*2*	*2*	*10*	*2*
BL T IND26.2	**0/2**	**0/7**	**1/8**	**1/2**	**0/2**	**2/10**	**0/2**
BL C N=	*2*	*6*	*8*	*2*	*2*	*10*	*2*
BL C IND26.2	**2/2**	**1/6**	**0/8**	**1/2**	**0/2**	**3/10**	**0/2**

Note: -- missing data/no response by the village leader.

Most research communities do not have by-laws related to FGM/C. At midline, an increase in the share of communities with FGM-related by-laws was found in treatment sites in Senegal and Burkina Faso (the increase here being considerable), and in comparison sites in Burkina Faso (from 0/7 to

1/8). A decrease in this share was found in comparison sites in Senegal, Mali, and Ethiopia (Table 21). How the share could have decreased since the baseline (seeing the sample remained constant) needs to be explored further.

Table 22: IND37.2 Share of communities (that have no by-laws yet) in the process of developing by-laws on FGM/C, reported by community leaders

	Sen	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE							
ML T N=	*1*	*8*	*3*	*2*	*2*	*6*	*--*
ML T IND37.2	**0/1**	**1/8**	**1/3**	**--**	**0/2**	**1/6**	
ML C N=	*1*	*8*	*7*	*2*	*2*	*8*	*--*
ML C IND37.2	**0/1**	**0/8**	**1/7**	**--**	**0/2**	**0/8**	
BASELINE							
BL T N=	*2*	*7*	*8*	*1*	*2*	*8*	*2*
BL T IND37.2	**0/2**	**0/7**	**2/8**	**0/1**	**0/2**	**0/8**	**0/2**
BL C N=	*0*	*5*	*8*	*1*	*2*	*7*	*2*
BL C IND19.3		**0/5**	**1/8**	**0/1**	**0/2**	**1/7**	**0/2**

Note: -- missing data.

Minor increases were found at midline in the share of villages that were in the process of developing FGM-related by-laws (Table 22). The decrease on IND37.2 in Burkina Faso is due to the increase in communities in this country that currently do have such by-laws (see IND26.2 above).

Another intermediate outcome of the HC programme are regular consultative meetings on, among other issues, CM, SRHR, young women's access to education and FGM/C at district level between all relevant stakeholders and actors **(IND39**).

Table 23: IND39 Share of districts with consultation and informational meetings between (local) government agencies and civil society institutions related to SRHR

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML N=	*2*	*2*	*2*	*2*	*9*	*7*	*4*	*2*	*11*	*1*
ML IND39	**2/2**	**--**	**2/2**	**2/2**	**6/9**	**3/7**	**3/4**	**2/2**	**4/11**	**1/1**
BASELINE										
BL N=	*2*	*2*	*2*	*2*	*9*	*7*	*4*	*2*	*11*	*1*
BL IND39	**2/2**	**2/2**	**2/2**	**2/2**	**2/9**	**6/7**	**--**	**2/2**	**6/11**	**--**

Note: Different respondents in same district with different answers (yes/no meetings). – missing data.

As Table 23 shows, the share of districts that organise meetings with regard to the above mentioned topics remained stable in most countries. An increase in this share was found in Mali, and a slight decrease was noted in Burkina Faso and Ethiopia.

Supporting information

MoA reports reveal that in most countries, HC partners have been supporting district level authorities in organising awareness raising activities on CM/FGM/C laws, excluding in Pakistan, Senegal and Uganda.

Another intended intermediate outcome of activities at district level is birth registration of all children **(IND27**). When births are not registered and young people do not have a birth certificate, it is more difficult to ascertain whether or not a young person is, for example, legally under-age for marriage. District informants were asked to estimate the share of births registered: whether this was almost all births, a majority of births, etc. (Table A2.28).

Table 24: IND27 Share of districts with almost all births registered, according to district officials

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML N=	*2*	*2*	*2*	*2*	*9*	*7*	*4*	*2*	*11*	*1*
ML IND27	**0/2**	**--**	**0/2**	**--**	**4/9**	**3/7**	**0/4**	**0/2**	**0/11**	**--**
BASELINE										
BL N=	*2*	*2*	*2*	*2*	*9*	*7*	*4*	*2*	*11*	*1*
BL IND27	**0/2**	**1/2**	**1/2**	**0/2**	**0/9**	**0/7**	**--**	**0/2**	**0/11**	**--**

Note: -- missing data.

At midline, birth registration of all children remains problematic in all countries. Only in Burkina Faso and Mali at ML it has increased, with 3 out of 7 districts in Burkina Faso and 4 out of 9 districts in Mali reporting that all births are registered. In Pakistan and Nepal at midline none of the districts reported that almost all births were registered, whereas at baseline in each country there was one out of the two districts reporting so (Table 24).

Supporting information on birth registration

With regard to the estimated share of reported registered births, progress has been made in most countries. For example, Benin, less than half of births were registered at BL while at ML more than half were said to be registered. Similarly, in Ethiopia, in five out of the 11 districts, at BL officials reported that hardly any birth was registered, whereas at ML, none of the districts were in this category (Table A2.28).

Household heads were asked whether they had registered all births, some births, or none. Findings somewhat contradicted reports by District officials. Surprisingly, a large share of HH in both treatment and comparison sites in Bangladesh, Pakistan, Nepal, Mali, and Burkina Faso reported they had officially registered the birth of all their children. The highest shares of HH not registering children were found in Ethiopia (approximately 85%) and Uganda (approximately 65%). In Ghana, responses were more or less evenly distributed between all, some, none. Differences between treatment and comparison sites were small, so most likely increases are not attributable to the HC programme (Table A2.27).

District officials expanded on the problems they face related to birth registration, which can be roughly divided in obstacles at community/family and at administrative level. At community and family level, district officials in Bangladesh, Burkina Faso, Benin, Ethiopia, Senegal, and Nepal mentioned illiteracy and 'ignorance' of parents as a reason for not registering births. District officials in Bangladesh and Burkina Faso reported that the costs of birth registration formed a barrier for some families. In Nepal, district officials mention that birth registration of children of divorced parents or when parents do not have a marriage certificate is difficult. Another main obstacle mentioned relates to the place of delivery, that is, in Burkina Faso, Benin and Uganda, many women reportedly give birth at home or outside a health facility, and many parents do not immediately register a birth in these cases. In some cases, people only seek to register a birth when a birth certificate is required, for example, to enrol in school (e.g. South Asia).

At the administrative level, several obstacles were reported. In Ghana and Ethiopia, district officials stressed logistical problems, such as the lack of infrastructure required for delivering birth registration forms in rural areas, and occasional break-downs of the registering system. In Mali and Ethiopia, there was no public servant dedicated to registration at ML, and in Burkina Faso, there was insufficient staff to fill in the birth registers. In Uganda, district officials indicated that the administration has limited resources to print the birth registration forms. Finally, in Ethiopia and Mali, district officials reported that the local community agents appointed to facilitate birth registration were not always motivated or present, further lowering registration levels.

The main channel through which district authorities promote birth registration is through sensitizing the communities – be it with radio communication or community sessions on the importance of the birth act. In Mali, emphasis is also placed on creating better linkages between health facilities and district offices for birth registration. In Burkina Faso, birth registration has been promoted with birth registration campaigns at the community level, but also making birth registration free of charge in the town hall. In Ethiopia, district officials mentioned that they organize community events to promote birth registration, and work closely with religious institutions. District officials in Uganda reported mobile health centers where births can be registered. In Pakistan and Nepal, the public awareness campaigns emphasise that birth certificates are mandatory for school enrollment.

An intended intermediate outcome of district level HC activities relates to the establishment of a district-level system that allow for reporting of suspected cases of CM, FGM/C or sexual assault by community members **(IND28**). Table 25 presents district representatives' responses as to whether people report violations of laws concerning child marriage and/or sexual assault – such reporting deemed an indication that the system is operational.

Table 25: IND28 Share of districts that (report to) have an operational reporting system to document and act upon breaking of laws concerning CM/FGM/C/sexual assault

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
MIDLINE										
ML N=	*2*	*2*	*2*	*2*	*9*	*7*	*4*	*2*	*11*	*1*
ML IND28	**2/2**	**--**	**2/2**	**1/2**	**2/9**	**3/7**	**2/4**	**2/2**	**5/11**	**1/1**
BASELINE										
BL N=	*2*	*2*	*2*	*2*	*9*	*7*	*4*	*2*	*11*	*1*
BL IND28	**2/2**	**2/2**	**2/2**	**2/2**	**2/9**	**3/7**	**--**	**2/2**	**7/11**	**0/1**

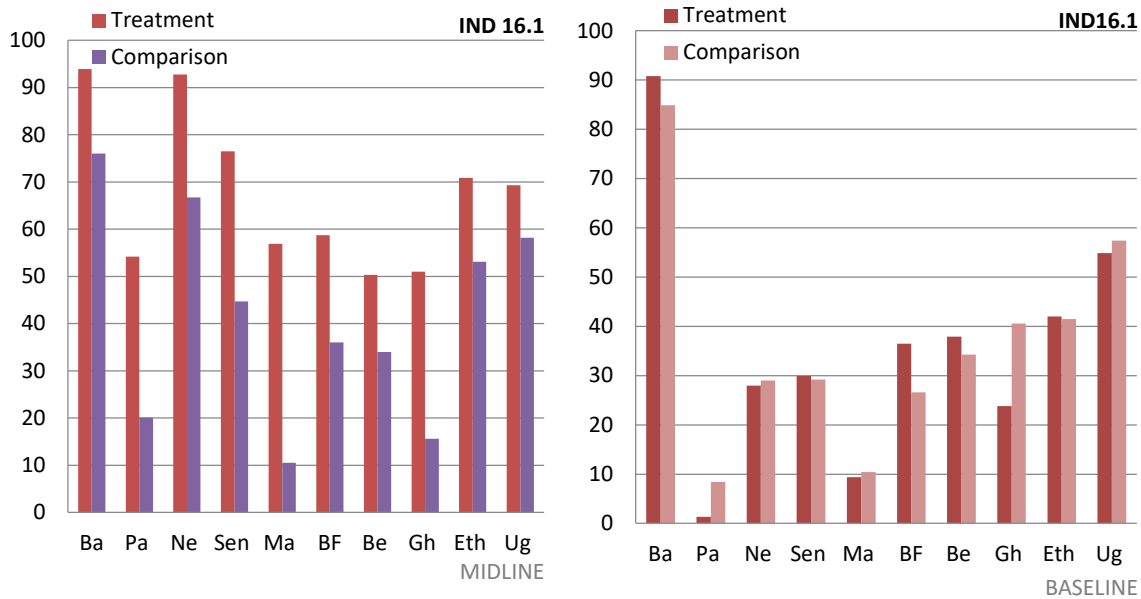
Note: -- missing data.

At midline, not much change was found with respect to **IND28**. As in baseline, in Bangladesh, Nepal and Ghana all districts said they have such reporting systems, and in Burkina Faso still 3 out of 7 districts. In ML the district in Uganda now has one. Decreases in shares of districts with such a reporting system were in Senegal and in Ethiopia (the latter considerable) (Table 25). Similar to indicators reported on above **(IND26.1** and **IND26.2**), given the sampled districts remained constant, the decrease found on this indicator merits further scrutiny.

Outcome indicators

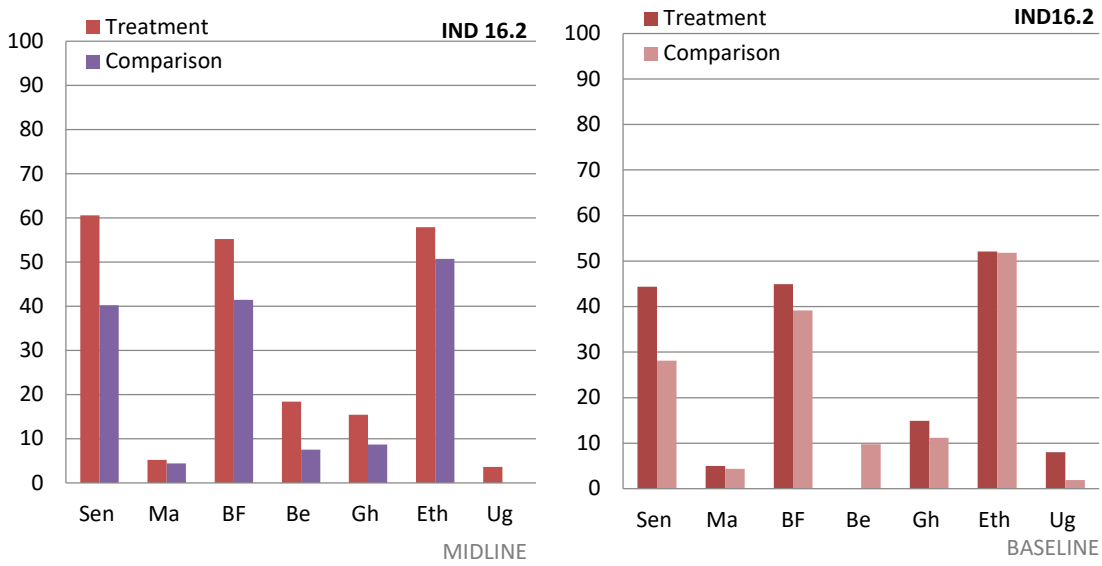
When (by-)laws are in place and are enforced, it is expected that young women are (better) aware of the existence of laws against child marriage and FGM/C **(IND16.1, 16.2)**, Figures 17 and 18 respectively show knowledge levels of girls as to existence of laws against CM, and FGM/C.

Figure 17: IND16.1 Share of single girls who know of protective laws on CM (%)



Considerable changes were noted on this indicator: in the majority of communities the shares of girls who knew of protective CM-related laws had increased notably, with particularly big changes found in treatment sites in Pakistan, Nepal (here the increase in comparison sites was also extensive), Senegal, Mali, Ghana and Ethiopia. Only in comparison sites in Ghana had the share decreased, and a small decrease was noted in treatment sites in R3 in Burkina Faso (Table A1.21).

Figure 18: IND16.2 Share of single girls who know about protective laws on FGM/C (%)



At midline, in all countries a higher share of girls in treatment sites compared to comparison sites were aware of existence of laws against FGM/C. Compared to baseline, increases in the share of single girls who know protective laws on FGM/C were found in Senegal, Burkina Faso, and in treatment sites in Benin, Uganda and Ethiopia. (Table A1.22).

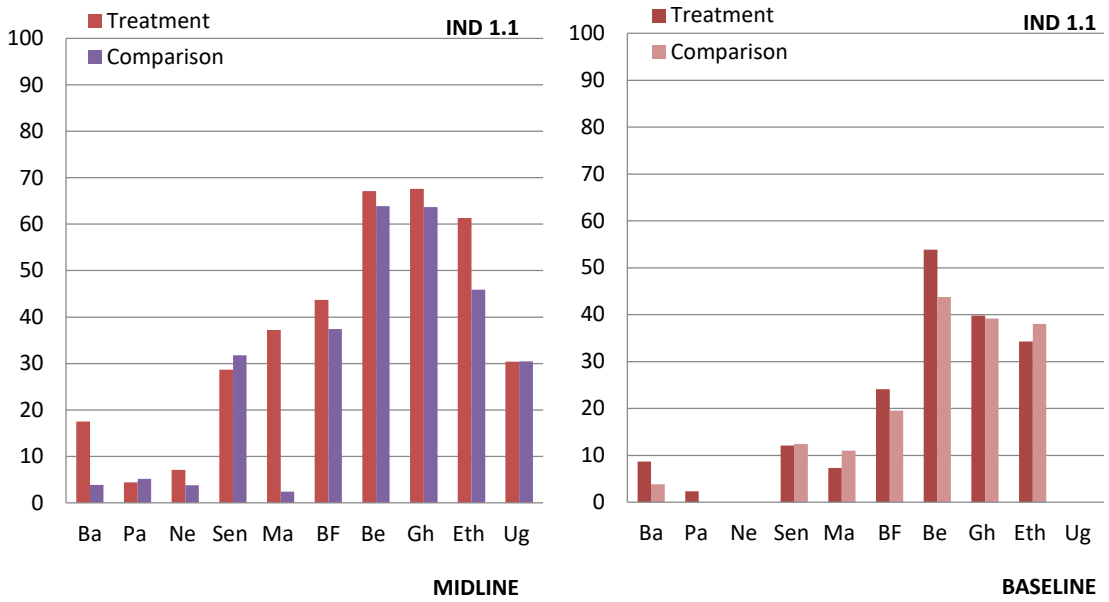
10. IMPACT INDICATORS - GIRLS' DECISION MAKING POWER AND RATES OF CHILD MARRIAGE AND FGM/C

Introduction

The ultimate expected impact of the six HC strategies pertains to an increased share of girls feeling they have control over marriage decisions and are able to refuse a marriage against their will **(IND1.1 and 1.2),** as a result of increased knowledge and skills, and as a result of support provided by their families, communities, schools, health services, and the law. Additional impacts related to a reduced share of girls getting married before they turn 18 or 15 years old **(INDs 2, 3, 4),** and a reduced proportion of girls having undergone FGM/C **(IND5).**

Indicators 1.1 and 1.2 relate to the perceived control that single girls have over marriage decisions. We asked young women three questions: whether they 1) can oppose marriage against their will, 2) can decide *when* they marry and 3) can decide *who* they marry. Indicator 1.1 measures the percentage of young women who perceive having control over all three. Indicator 1.2 gives the mean degree of control, ranging from 0 to 3 (0= no control, 1 = weak control, 2 = some control, 3 = control).

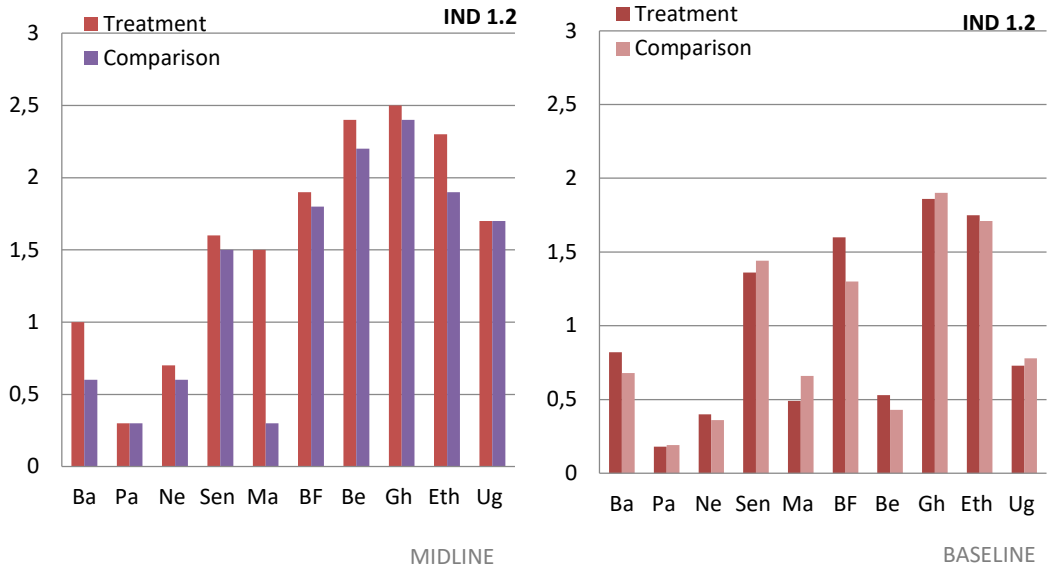
Figure 19: IND1.1 Share single girls who feel they can exercise control over if, when and who to marry (%)



Compared to BL, a larger share of girls in most countries reported feeling in control of (all three) marriage decisions, and in most countries the share was bigger in treatment villages than in comparison villages. Overall, young women in South Asian countries indicated feeling less control than in those in Sub-Saharan African countries. In Pakistan in particular, very few girls in both treatment and comparison villages (4%, 5%) reported feeling they had decision-making power, but

similarly low figures are found in comparison sites in Nepal (3.8%). However, decision-making power also differs across the Sub-Saharan African HC countries, with Senegal, Mali and Uganda at the lower end (not higher that 37.2%, in Mali), Burkina Faso in the middle (approximately half of the girls in both treatment and comparison sites reporting they had power to decide on their marriage), and Benin, Ghana and Ethiopia towards the higher end with over 60% of girls indicating they felt able to decide about their marriage (Figure 19; Table A1.23).

Figure 20: IND1.2 Mean degree of control of single girls over decisions if, when and who to marry (range 0-3)



Mean levels of decision-making power (range 0-3) also increased at midline in most countries, in treatment and some comparison sites. Only in both treatment and comparison sites in Ghana and Benin, and treatment site in Ethiopia, this mean was more than 2, that is, young women reporting they felt able to decide about two of the three issues related to CM (if, when, who). In Pakistan, Nepal, Bangladesh, and Mali (comparison), on the other hand, the mean was less than one (Figure 20; Table A1.24).

Supporting information on decision making of girls on their marriage

Looking at which of the three marriage decisions (*when, who* and *if*), young women reported they had more or less control over, those in South Asia reported to have least control over *who* they married. In Senegal, Mali, and Uganda, relatively fewer young women indicated they could decide as to *when* they married. In other countries, the division across the three questions (when, who and if) was more or less even (Table A2.31).

HH heads were asked whether the girls in their household had a say in if, when and who to marry. Lowest scores were found in the South Asian countries and in Mali comparison. Especially in Nepal, very few daughters or wards are said to be allowed to decide about their marriage: while an increase from BL, this figure was still less than one-tenth at ML (Table A2.33). The decision being 'too

important for the household' formed the main reason given by HH heads for involvement of others in decisions concerning the marriage of a (grand)daughter or ward – suggestive of a marriage being regarded as a liaison between families and not just spouses (Table A2.32).

Married girls were asked about the decision-making processes related to their own marriage. They were first asked who had been involved: 1) they themselves only, 2) others only, 3) a joint decision. In all countries except Benin, 'others only' formed the principal deciding party. Especially many married girls in Bangladesh, Pakistan (treatment) and Mali (comparison) reported 'others only' – up to 86%. The majority of girls in most countries – from half in Senegal (comparison) to 80% in Pakistan (comparison) agreed with the marriage that had been decided by others. In Senegal (treatment) only 45% indicated that they had agreed to the marriage (15% spoke of not agreeing, and 40% did not respond to the question). In Bangladesh and Mali, the majority of girls who did not agree with the marriage that had been decided by others said they expressed disagreement – but still had to marry (Table A2.35).

Box 13: Control over decisions if, when and who to marry (FGDs)

Decisions if, when and who to marry were reportedly varyingly controlled by girls, caregivers and/or elders. There appeared to be little consensus regarding these decisions between girls of different ages, between girls and boys, or across treatment/comparison sites. Drawing on data from a number of countries in each region, the section below is geared to illustrating the diversity of responses to these questions.

South Asia

Girls in Bangladesh and Pakistan (12-14, 15-17, treatment and comparison) were most unanimous: most reporting that parents and/or elders decided if, when and who a girl was to marry. According to young women in Bangladesh, a girl could only influence these decisions by eloping or if she '*had an education and wished to work.*' Girls in Pakistan indicated that girls might try to influence decisions by speaking to their elder sister or mother, but that this was the only avenue available to her. Most girls in Nepal indicated that only 'few' girls controlled these decisions. For example, young women (15-17 years, comparison) clarified that 'some do not say [anything] fearing the prestige of their family in the community, they fear that the prestige of their family will go down if they any such things,' referring to countering parents' views regarding who girls should marry. An exception, according to girls, were 'educated parents' – they would 'agree, they do as per their daughter's wish' as to whom to marry (girls, 15-17, comparison). The same group also clarified that:

> *Those who earn money by themselves and are skilful like those who know sewing and knitting, they can make decisions [if to marry]. But those who stay only at home, cook food, do household chores, farming, are afraid of their mother and father. They cannot even tell their parents.*

These quotes are an exception to the otherwise fairly unanimous views expressed as to girls lack of control with regard to these decisions.

Continued on next page

Box 13: Control over decisions if, when and who to marry (FGDs) (cont.)

West Africa

In Benin, girls (12-14, 15-17) in treatment sites reported that the majority of girls could decide *if* to marry (comparison: some), and girls in both age groups and across treatment and comparison explained that at least half, the majority or 'all' could decide who to marry (girls of 15-17 years reporting 'some' could control this decision being the exception). In Burkina Faso, 12-14 year old girls (treatment) said this decision was out of their hands, whilst their elder peers (15-17) reported that girls could take this decision. On the whole, girls in Ghana stated that they could not control decisions as to if, when and who to marry. As a young woman (treatment, Ghana) indicated, in response to the question whether girls could decide if to marry, 'I can never tell my mum I will not marry.' In Mali and Senegal, most girls reported that their parents (fathers, in particular) decided *who* they were to marry and that girls would not counter this decision for 'fear of disappointing parents' (12-14, treatment, Senegal). The same girls referred to the Her Choice partner, stating that most were fearful of telling their parents when they wanted to marry before knowing [of] Enda Jeunesse Action,' and that while girls could currently not decide if they married, that might change with 'the arrival of Enda Jeunesse Action.' Young women in treatment sites in Mali (15-17 years) reported that while they could not decide *who* to marry, they could decide *when* they were to marry, and some even *if.*

East Africa:

On the whole, girls in Ethiopia and Uganda responded in the negative when asked about young women's control over decisions if, when and who to marry. Girls in Uganda (all age groups and across treatment and comparison) were most positive about control over decisions *who* to marry, clarifying that the majority of girls decided on this matter, with girls in comparison sites explaining 'most [girls] marry their peers,' which was taken as an indication of girls' agency in this particular regard. *When* girls were to marry might seem like girls' own decision, but girls indicated that parents might 'passively' exert influence on the timing of marriage by their 'inability to pay school fees after primary school.'

Indicators 2 and 3 represent globally used indicators for child marriage, that is, the percentage of women (between 20-24 years) who were married before reaching the age of 18 or 15. The Her Choice household surveys provide data on, among other things, gender, age, marital status and the age of first marriage of all the household members. As figures 11 and 12 highlights, rates of women between 20-24 years old who were married before age 18 and 15 vary considerably across countries.

Findings for **IND2** and **IND3** are ambiguous. At ML, an increase can be seen in some countries in the share of women aged 20-24 years who reported having been married before respectively 18 and 15 years of age, while in other countries, a decrease was found. Striking are the high shares of women married before 18 years in Burkina Faso and Ethiopia, whereas indicator 4 findings will show that very few 17 year-old girls reported being married in these countries. Marriage below 15 years was relatively high in Nepal (comparison sites) and Mali (treatment sites). (Tables A1.25; Figures 21, 22)

Figure 21: IND2 Share of women aged 20-24 in studied HH who got married before age 18 (%)

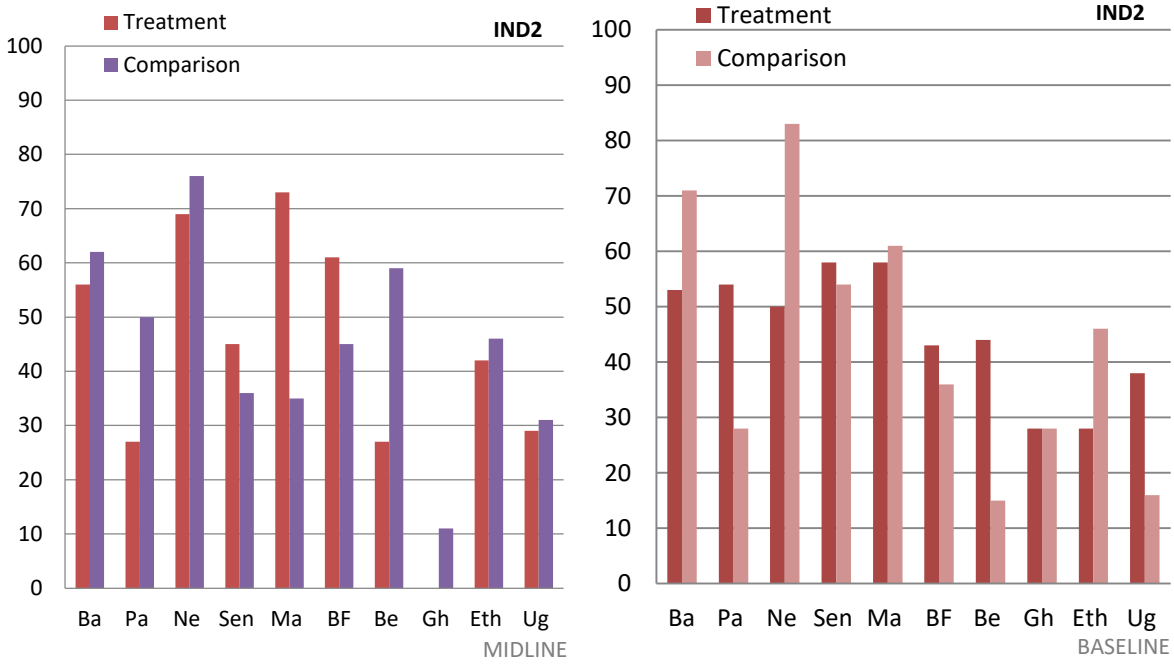
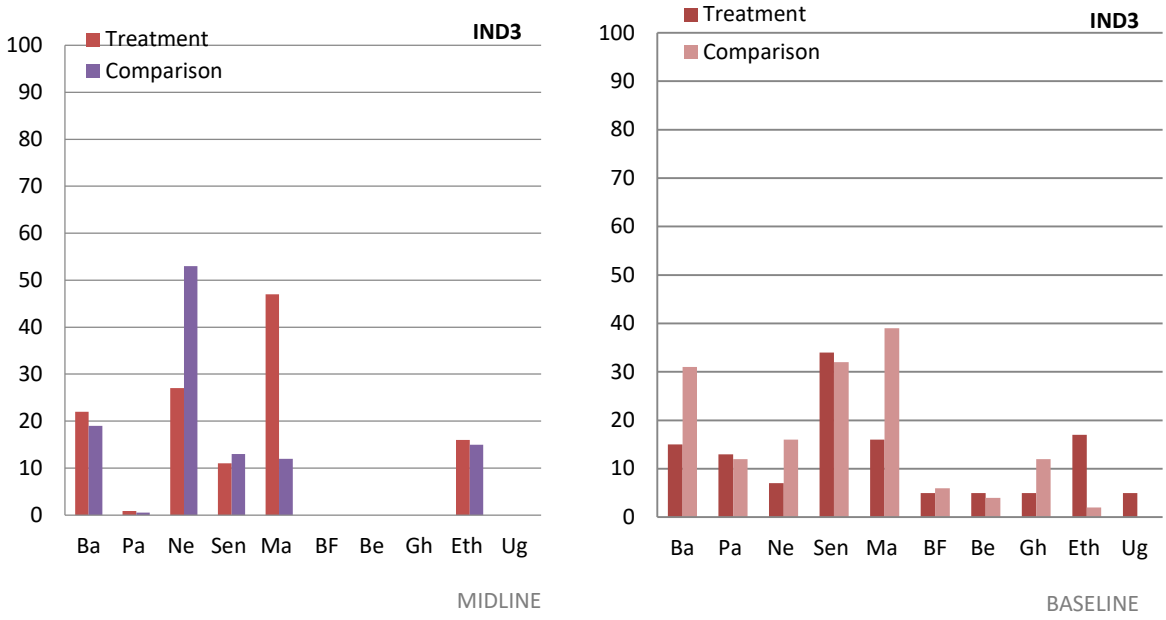
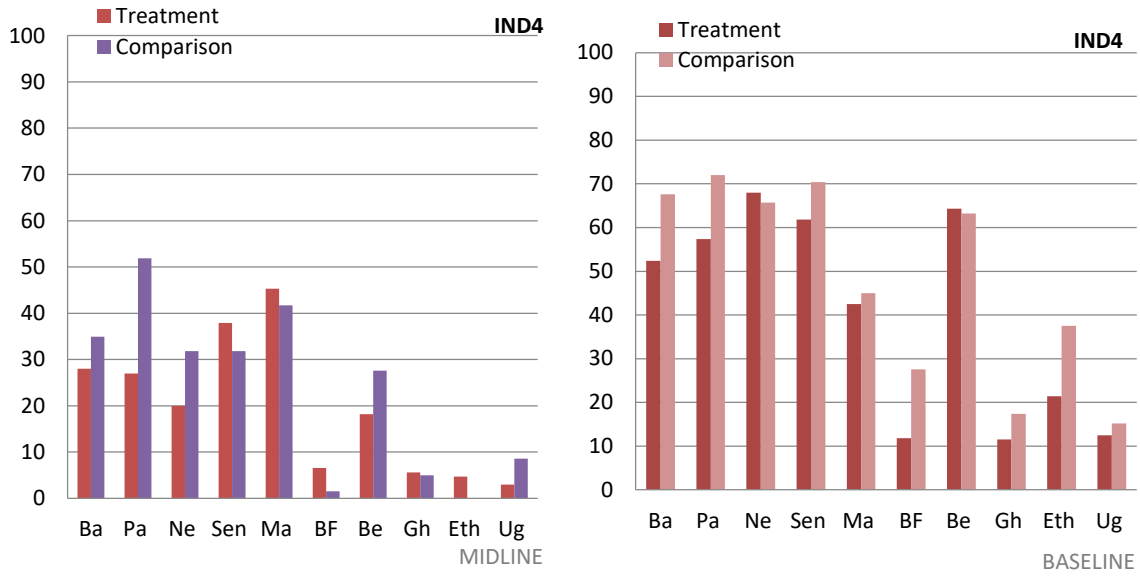


Figure 22: IND3 Share of women aged 20-24 in studied HH who got married before age 15 (%)



Indicator 4 measures the share of interviewed girls who were married, were living with a man at the time of the study or had ever been married, disaggregated by age at the time of the study. Table A1.26 shows that very few of the 12-14 year olds were married, but that the proportion of married girls increases sharply with age. The marriage rates of the 17-year olds most closely approximates global indicators of child marriage, defined as the share of 20-24 year olds who were married before they turned 18 (Figure 23).

Figure 23: IND4 Share of 17-year old girls (ever) married (%)



In all countries the share of married 17 yea- old young women had reduced compared to the BL – with hardly any married girls in ML Burkina Faso, Ghana, Ethiopia and Uganda, both in treatment and comparison sites. In Mali no change was observed. The reductions are greatest in the South Asian countries, and in Senegal and Benin (Table A1.26).

Decrease in these shares cannot be attributed to HC programme activities alone – in comparison sites a decrease was also noted. In most countries there are government campaigns to end child marriage and other civil society interventions. Another possible reason for the lower figures – also reported by local researchers – is that there is underreporting by girls and HH because they fear prosecution, with intensified enforcement of national laws against child marriage. Married girls may have been reported to be 18 years of age or above (and thus not eligible to take part in the HC impact study), or were reported to be single.

Supporting information by married girls on type and ways of marriage (only in ML)

In the midline we asked more information about married young women's marriage (Table A2.5). In most countries, a minority of marriages had been registered in the city hall – except for Pakistan, where 100% was said to have been registered there. In Senegal (comparison) and Mali, a considerable proportion of marriages were registered in the mosque. In Nepal, and more so in comparison sites, marriages were informal. In Uganda and Benin, all (of the few) marriages were informal. Bride price was exchanged more often in Senegal and Mali, and in all (of the few) marriages in Benin. Only a minority of girls reported they took dowry with them in Bangladesh and Nepal (treatment), none in Pakistan or Nepal (comparison) (Table A2.34).

In Bangladesh and Pakistan, most married girls started living with their husband (between 86.1% and 92.1%), whereas in Nepal a minority did, 15.4% in treatment and 25.0% in comparison sites. In other countries, approximately half of the married girls said they started living with their husband.

An important finding was that girls did not usually marry old men: In Pakistan and Nepal, the majority married a teenager, whereas in other countries, the majority married a man in his 20s. Only a minority in all countries married a man in his 30s, although relatively more in Mali (approximately one-quarter married a man in his 30s (Table A2.35).

Supporting information on teenage pregnancy and childbearing

One of the negative effects of child marriage is early pregnancy, which is broadly recognised as posing a health risk for both mother and child. Very few of the single girls reported they were pregnant at the time of the midline interview or had a child: none in the South Asian countries and under 2.7% (highest in treatment village Benin) in other countries. It should be noted that it was only after baseline data collection that we realised the importance of asking about pregnancy. We thus only asked about pregnancy during the ML.

A considerable share of married girls already had a child or was pregnant, up to more than half in Pakistan. The lowest figures were found in Nepal, which can be due to the fact that only few girls reported that they had started living with their husband. Table 26 details the share of married young women who had one or more children, and those who were pregnant in countries with a considerable number of married young women (see for all countries Table A2.37).

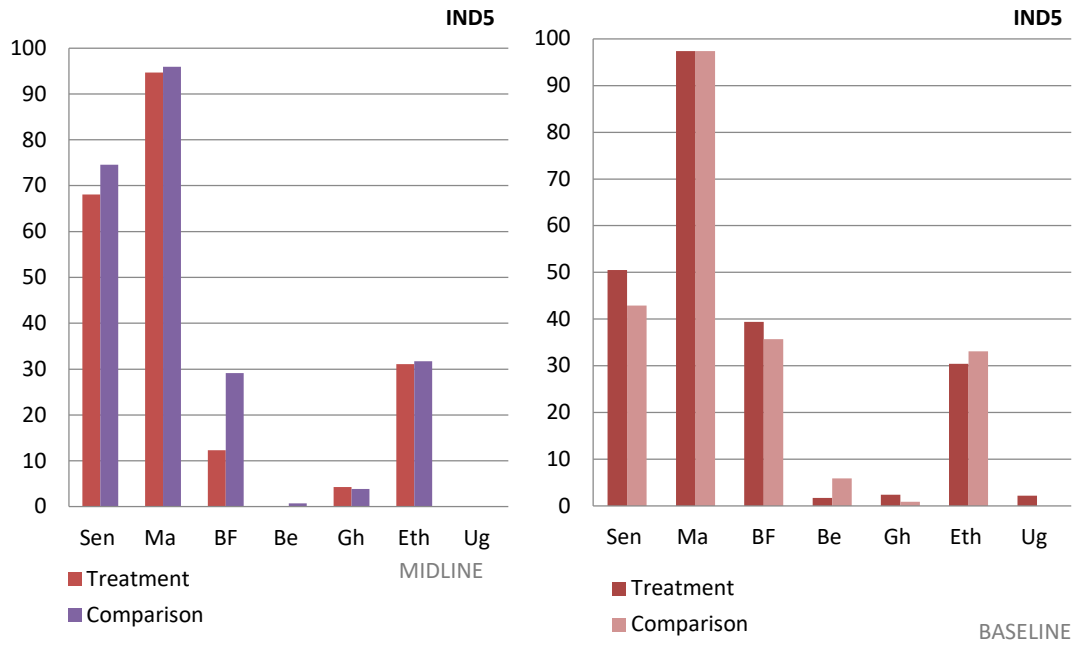
Table 26: Share of married girls with children and reported being pregnant at the time of the interview (%)

	Ba		*Pa*		*Ne*		*Sen*		*Ma*		*Be*	
MIDLINE	T	C	T	C	T	C	T	C	T	C	T	C
Married N=	*31*	*38*	*15*	*36*	*13*	*16*	*27*	*19*	*59*	*61*	*7*	*11*
With child	**9**	**18**	**33.3**	**13.9**	**7.7**	**6.3**	**37.0**	**21.1**	**18.6**	**18.0**	**4/7**	**7/11**
Currently pregnant	**9.7**	**13.2**	**20.0**	**33.3**	**0**	**0**	**3.7**	**10.5**	**13.6**	**16.4**	**1/7**	**3/11**
BASELINE												
Married N=	*19*	*33*	*54*	*49*	*24*	*35*	*34*	*26*	*62*	*64*	*14*	*18*
With child	**42.1**	**42.4**	**48.1**	**40.8**	**37.5**	**45.7**	**64.7**	**73.1**	**38.7**	**37.5**	**57.1**	**61.1**

Qualitative data from interviews with village leaders and from FGDs with young school going women and men indicate that pregnancy forms an important reason for marriage. That is, in the event of a premarital pregnancy, marriage provides a means to prevent the shame of being a single mother and/or having an unmarried daughter with a child.

Indicator 5 concerns the share of girls who have undergone FGM/C. Female genital cutting is only performed in Her Choice programme communities in the seven Sub-Saharan African countries, with rates varying considerably (Figure 24).

Figure 24: IND5 Share of girls to have undergone FGM/C (%)



The share of girls undergone FGM/C is similar in ML and BL in Mali and Ethiopia. Almost all girls in Mali had FGM. Share of girls undergone FGM/C in Burkina Faso has reduced in ML, especially in treatment sites. In Senegal the share of girl circumcised has increased to approximately 70% in ML (for treatment and comparison sites) from below 50% in BL. Hardly any girls underwent FGM/C in Benin, Ghana and Uganda (Table A1.27). Not much change was expected in ML compared to BL because girls are usually circumcised at a young age, below 5 years.

Supporting information: Age of FGM/C

Most girls, who reported that they had been cut, did not know the age this had taken place. However, those who knew mentioned ages from 0 to 4 (Table A2.40). Village leaders reporting on the normal age for FGM/C also indicate ages below 7 years. However, in Burkina Faso, in more than half of the villages normal age is 16, and in Ethiopia, two village leaders in treatment and two in comparison sites reported that the normal age for FGM/C was 10-11 years old. However, the other village leaders in Ethiopia reported they did not know the age (Table A2.39).

11. LOCAL PARTNERS' PERSPECTIVE ON HER CHOICE ALLIANCE PARTNERSHIP

11.1 Methods

The review was conducted during the regional linking and learning meeting in Ethiopia between 8 and 12 October 2018. During the 3-hour session, facilitated by one of AISSR researchers, the partners reflected on their partnership with: 1) Alliance members in Netherlands; 2) Each other across countries; 3) Partners in one country (for Ethiopian partners).

The facilitator started by giving a presentation, reiterating the set-up and stakeholders of the Her Choice Alliance, and explaining the core principles of a partnership (diversity, equity, openness, mutual benefit and courage) and why these are key to a successful partnership. The presentation continued with pointing at challenges to these principles, for instance power imbalance, anxiety about difference, competing interests, hidden agendas, and uncertainty. For the presentation the consultants of the Partnership Learning Loop (PLL) allowed her to show part of the slides (with appealing comics) which they used during the October 2018 feedback meeting with HC alliance members.

Divided by country groups, the local partners were invited to comment on the principles and challenges related to 1) the building of the partnership, to the set-up and design (whether objectives and plans were clear and shared, and co-created), 2) the (daily) operations in relation to the set-up and procedures in communication, decision making and learning culture; 3) collaborative mind-set, whether they feel engaged, whether there is openness and transparency and equity.

Participants were requested to write their reflections on post-it notes and paste on flipcharts. They were to paste their notes under: successes, hindrances, and adjustments deemed necessary related to: Communication; Learning culture; Decision making; Collaborative mind-set and skills; Partner engagement; Openness and transparency; and Equity. They were also asked to reflect on the added value of the HC programme, thereby differentiating for beneficiaries and for their own organisation?

11.2 Findings

Generally the partnership between local partners and alliance members was highly positively looked at. Successes mentioned were many more than hindrances. Partners have some useful suggestions for improvements.

Communication: *Successes* in communication were that it was freely, two ways, smooth, transparent, timely (so that activities can be implemented as planned), clear, that Alliance members are tolerant for any inconveniences in technical problems in communication, and that feedback is given in timely manner. Communication was the only topic that had some *hindrances,* but these were mainly related to network interruptions, that they sometimes delay in reporting and that they are asked to give additional information late (in a few instances). The partners had some recommendations for *adjustments*; To always request information that needs to be included in reports at the start of the

reporting period, to diversify communication medium – i.e. phone, text message/WhatsApp etc. instead of only email. Partners recommend a common platform, which can have success stories.

Equality: Partners did not into have any hindrance in equality, but said they mutually respect all partners.

Decision making they see as collaborative and collective mainly, in communication they can make collective decisions; THP pointing at that there is usually discussion before any decisions are made. Only some of the partners (SKN) commented that decisions are made in The Netherlands most of the time without their consultation and they recommended that HQ should encourage all partners to give recommendations as input for decisions.

Openness and transparency there are only successes mentioned: that this is the culture within Her Choice Alliance

Collaborative mind set is also valued very positively. However, for themselves they have some adjustments that within the organization there should be teambuilding so that more people from the organization are involved

Learning culture: Mainly successes, using other partners to share experiences, capacity building though regular monitoring and follow up is appreciated, as well as learning workshops, and the budget is considered adequate for sharing and learning. However, recommended adjustment is that they would like The Netherlands to facilitate and promote more inter-country learning

Partners were very positive on partner engagement, they appreciate the amicability, and one groups feels that having all partners engage and involved in implementation is the main reason they are progressing according to plans.

Added value *for the beneficiaries* that partners see is that their own services are better, they can reach a bigger target group, in a wider area, that good practices are shared among regions/countries that there are stronger referral linkages, that the programme brings a lot of information and skills (for example reusable sanitary pads), that they learn from other organisations better quality of services. *For their own organisation*: Capacity building, being able to enhance outreach, get higher reputation and visibility in terms of organizations working on child marriage, gender and women empowerment programs, publicity, synergy and strength at regional and national level, could introduce training manual to other organisations within Her Choice (DEC: CSE Meharebe manual to different organization in Ethiopia), enhanced capacity on managing SRH project (learning from one another).

11.3 Recommendations

The following recommendations were voiced by HC local partners:

a) Alliance members should request information that needs to be included in reports at the start of the reporting period.
b) Alliance members are requested to diversify their modes of communication, that is, phone, text message/WhatsApp, skype etc., instead of only email. Partners recommend a common platform, which can include success stories.
c) Continue the set-up of the alliance in which all partners are engaged in implementation (as this is regarded as a key reason for planned progress).
d) Emphasis on involving more people from an organization in the HC programme.
e) Greater focus on inter-country learning during the remainder of the programme (as happens during regional meetings).

12 CONCLUSIONS

12.1 Progress in relation to Theory of Change

The midline study reveals that, on the whole, progress has been made on most indicators in Her Choice treatment sites relative to comparison sites, and relative to the baseline situation. Obvious progress has been made on output indicators such as the share of girls who have received SRHR-related education, shares of schools with teachers trained on SRHR-related matters, share of health staff trained to give SRHR services to young people, share of community leaders sensitized on negative effects of chid marriage and FGM/C. Most of the respondents trained or sensitized, said this was done by a Her Choice partner.

Progress has also been achieved in relation to a range of intermediate outcome indicators, such as the indicator pertaining to the girls' SRHR knowledge, community leaders speaking out against child marriage, and the proportion of household heads reporting increased household income as a result of income-generating activities that female household members were involved in. Progress has been already noted on some outcome indicators, including girls' awareness and use of SRHR services and knowledge of national laws against CM. Positive change was also found with regard to certain impact indicators, including an increase in the share of girls feeling able to make decisions on their marriage. However, we will need further analysis to determine whether the positive changes in the (intermediate) outcome and impact indicators can be (mainly) attributed to Her Choice programme activities or are also due to circumstances and other actors.

On certain intermediate outcomes, no real progress was found. For example, despite training, at midline a large share of teachers in most countries still reported they did not feel able to teach or answer all students' questions with regard to SRHR. Teachers' difficulties in this regard were primarily related to the cultural sensitivity of SRHR. In light of teachers discomfort in teaching about SRHR-related matters, the limited scope of SRHR-related contents that young women reported learning about is unsurprising. Taken together, these two factors, that is, teachers' lack of confidence and the limited scope of SRHR-related education that young women (and men) receive, may explain, at least partially, why – despite an increase in SRHR-related knowledge comparative to BL – young women in treatment sites still displayed low levels of SRHR-related knowledge at ML. These findings illustrate the interconnected nature of the different strategies of the Her Choice programme.

It is also important to consider how the use of a single standard may contribute to the apparent lack of progress in terms of, in this case, 'comprehensive' SRHR knowledge. For example, in countries such as Pakistan and Uganda, young people cannot be expected to have learned about condoms at school. When developing the endline study, the AISSR will seek to refine measurement of indicators on 'comprehensive' SRHR-related knowledge. Care also needs to be taken to avoid adjustments are made in, for example, SRHR teacher training programmes *in order to* meet programme indicators.

Despite the limitations referred to above, it is recommended that Her Choice carefully reviews what teachers are taught with regard to SRHR, and where and how the quality of teacher training and in-service support can be improved – for example, by offering refresher training to teacher trainers.

The CSE visualisation tool, developed by Her Choice, can help in review of current training and development of improved training curricula. Following the suggestions by teachers participating in the study, the Her Choice programme could facilitate access to visual teaching aids, which teachers report they currently lack.

Midline data reveal discrepancies between the views of, among other actors, young people, village leaders and school principals with regard to questions such as girl friendliness of schools. Further discussion seems warranted with principals and village leaders as to young people's experiences of their education, especially with regard to issues of corporal punishment and appropriate sanitary facilities. As noted in the report, in many ways, schools have yet to become child friendly, let alone cater to particular needs of girls and young women. HC partners observed that achieving girl friendly criteria oftentimes require resources that schools simply do not have. Involving surrounding communities in creating child- and girl-friendly schools may take some of the burden of the school principals – as is already happening in some countries (Ethiopia and Bangladesh).

As reported, at midline, although in most countries the share of households that included female members taking part in organised income generation activities was higher in treatment than comparison sites, generally the share had decreased compared to the baseline. While this question merits further research (specifically, whether it was interpreted correctly by respondents), the decreased mean economic status in four of the 10 countries suggests that further strengthening of this component of the programme would be important and, where possible, should take into account the kinds of political and natural shocks reported by communities.

Midline data reveal a mixed picture on outcome indicators related to the proportion of girls who felt supported in decisions related to SRHR issues, early marriage and FGM. In many treatment sites, an increase was found in shares of single girls who felt supported in SRHR related issues, CM-related decision-making and opposing FGM/C. These issues warrant further attention in programming and future research. With respect to future research, it will be crucial to better determine what kind of support girls might need to 'feel supported,' either to oppose CM and/or FGM themselves or for future generations, the latter particularly pertinent given many girls are cut during infancy.[2]

Qualitative data and local partner reports indicate that (fear of) teenage pregnancy poses one of the primary reasons for child marriage in many countries. In view of this finding, one of the central recommendations emerging from the midline relates to the need to more strongly focus on strategy V in the HC programme, that is, on sensitizing communities and families on young people sexuality and SRHR-related needs, and addressing the taboos around these topics.

Overall, the midline study reveals reduced rates of child marriage compared to the baseline – which points at impact of the Her Choice programme, and national programmes. However, in all likelihood, according to local researchers' reflections, these low rates partially result from underreporting – young women, families and communities potentially being fearful of repercussions of reporting a

[2] See also: WHO (2019) Female genital mutilation (FGM), at: https://www.who.int/reproductivehealth/topics/fgm/prevalence/en/) , accessed on 25/01/2019

marriage before the legal minimum age. Research also shows that the considerable international and national investment in this matter has driven the practice underground.[3]

12.2 Programme implications

Below a list is provided of main recommendations and programme implications that follow from the study findings and were discussed during an HC alliance midline validation meeting:

a) The programme should strive toward greater alignment of CSE contents and more focused attention for gender norms and relations, and power dynamics (for example, in intimate relations).
b) A nested approach to CSE is recommended to ensure that young people's knowledge related to SRHR issues is enhanced alongside, among other issues, addressing health care staff attitudes to provision of SRHR information and services to unmarried young people, supporting CSE teachers in building support for CSE in the communities where young people come from, sensitization and dialogue in communities to community norms on gender and sexuality of young people that are detrimental to young women. Changing these norms is a long process and requires a long term intervention adapted to local realities.
c) The programme should involve communities in putting in place measures to make schools more accessible to girls (and generally child-friendly).
d) The involvement of boys and men in programming should be enhanced, for example, in addressing sexual harassment. It is recommended that alliance members identify what local partners are doing and to build on that, as well as learning from other CM alliances with regard to this issue.
e) Intensified attention should be given to the importance of birth registration.
f) Prevention of CM should not be the only focus of the programme. Instead, more attention needs to be paid to married girls and barriers they face, for instance, in relation to educational participation, income generation, social and psychological well-being and child care support.
g) Greater emphasis should be placed on learning from each other (i.e. including Alliance members and local partners) – and to better document what we are already learning from each other.
h) The alliance should strive for progress, for example, on girl-friendly measures instead of expecting achievement of majority of measures against international standards.
i) The alliance should consider making more use of the (generic) visualization tools that have been developed by Her Choice on i) youth-friendly health services, ii) girl-friendly schools and iii) comprehensive sexuality education, as well as the ICDI Girls QUAT. These visualization tools can be used in design of activities, discussion, and evaluation by stakeholders. The generic tools can be adapted to local contexts.

[3] See, for example, Harper, C. et al. (eds) (2018) *Empowering adolescent girls in developing countries: gender justice and norm change. Gender Justice and Norm Change.*New York & London: Routledge

12.3 Implications for research and further data analysis

During the final phase of the Her Choice programme, the AISSR will seek to take the following steps to improve the quality of data collection and analysis:

a) During the endline, further analyse the influence of national and other NGO initiatives to more accurately measure Her Choice programme impact.
b) Further refine questions on sexual activity of young women, and improve data collectors' skills in gathering data on this subject.
c) Further refine indicators and follow-up questions. For instance, the indicator 'girls feel able to oppose marriage against their wish' (IND6.1), does not actually measure that they can refuse marriage once they are faced with the situation. Similarly, measuring 'comprehensive knowledge' does not tell us if young women will (be able to) use knowledge gained. Skills but also barriers to actively using knowledge should be (further) measured.
d) Further assessment of inter-country learning potential, particularly what other countries and teams can learn from teams where greatest progress was made in terms of training and SRHR knowledge. Further analysis needs to be done of the organisers of training – for instance, the HC partner in Benin report that the increase in mean comprehensive SRHR knowledge might be (partly) due to other training or sources of information.

Next steps in data analysis

The AISSR team will conduct more in-depth analysis of midline and baseline data sets and seek to disseminate these in blogs, academic papers, posts and policy briefs. In these write-ups, the AISSR will focus on specific data, for example, one particular strategy, topic (e.g. the position of married girls, sexual harassment, and/or 'choice'), or tools (e.g. FGDs). Additionally, analysis of country/region and partner data will be carried out and discussed with partners in the already planned regional linking and learning meetings.

Next steps in the quantitative analysis

In order to more closely examine the effects of the HC programme and the possible impact of socio-economic characteristics of girls and households on programme indicators, an econometric model will be deployed. In addition to analysing the data at the individual and household level, we will aim to include data collected from village leaders, teachers, school principals, and SRHR health workers in this analysis. By linking these different tools to the data we have on the girls and the households, we will develop a multi-level (nested) model. Each tool will be a different layer of information in our model. First, this will enable us to draw a more precise picture of the context in which the programme is implemented. Second, we will be able to examine to what extent the different strategies contribute to the outcome indicators that we measure. Based on this information, we expect to be able to develop hypotheses about the different ways in which the socio-economic characteristics and community factors (e.g., village by-laws on CM) impact on programme indicators.

Based on preliminary assessment of the quality of the data – in which we examined the percentage of missing responses, number of girls and household interviewed, information on reported (sampling) errors during data collection – the following countries were pre-selected for the first phase of the above mentioned nested analysis: Pakistan, Bangladesh, Nepal, and Mali. If possible,

we will develop a regional break-down of the analysis for Bangladesh and Mali. Another avenue for analysis will look more specifically at the programmatic level and the set HC targets. In particular, what is the observed percentage change in selected indicators from the baseline to the midline, and to endline (through a difference-in-difference model).

In closing, the initial analysis of the midline data reveals progress is being made. Further analysis will more clearly demonstrate the extent to which change can be attributed to specific strategies of the HC programme in the different country contexts.

Annex 1: Her Choice indicators

	INDICATORS (#)
IMPACT	1.1 Share of single girls who feel they can exercise control over the decision if, when and whom to marry 1.2 Mean degree of control of single girls over the decision if, when and whom to marry (range 0-3)
	2 Share of women aged 20-24 married/in union before age 18
	3 Share of women aged 20-24 married/in union before age 15
	4 Share of girls under 18 (ever) married/in union, by age year
	5 Share of girls under 18 circumcised
STRATEGY I: INVEST IN GIRLS, THEIR KNOWLEDGE, SKILLS AND PARTICIPATION	
Outcome	6.1 Share of single girls who feel they can oppose CM against their will 6.2 Share of girls who oppose FGM
	8 Share of sexually active single girls who use contraception
	9 Share of girls who have spoken out in community meetings/rallies on their rights
Intermediate outcome	18.1 Share of girls with comprehensive knowledge on SRHR 18.2 Mean degree of knowledge on SRHR by girls (Range 0-5)
Output	29 Share of girls who received SRHR related education
STRATEGY II: IMPROVE ACCESS TO FORMAL EDUCATION FOR GIRLS	
Outcome	10 Share of girls regularly attending school in the last year
Intermediate outcome	19.1 Share of teachers able and confident to teach SRHR 19.2 Share of schools that are girl-friendly 19.3 Mean number of measures taken to make schools girl-friendly (out of 11)
	20 Share of girls enrolled in formal education
Output	30 Share of teachers trained to give SRHR related education to young people
	31 Share of schools taken girl friendly measures
STRATEGY III: IMPROVE ACCESS TO YOUTH-FRIENDLY SRHR SERVICES FOR GIRLS	
Outcome	11.1 Share of girls who know of SRHR services 11.2 Share of girls who knew of SRHTR services and visited a clinic for SRHR services
	12.1 Share of girls accessing SRHR services with positive perception 12.2 Mean degree of positive perception on SRHR services by girls (range 0-4)
Intermediate outcome	21 Share of health workers who are able and confident to provide YFHS
	22 Share of health workers who provide services to unmarried young people, including secondary school students
Output	32 Share of health workers trained to provide SRHR services to young people
	33 Share of schools with referral mechanisms in place between school and health service
STRATEGY IV: IMPROVE THE ECONOMIC SECURITY OF GIRLS AND THEIR FAMILIES	
Outcome	13 Mean economic status reported by HH (range 1-4)
Intermediate outcome	23 Share of households with female entrepreneurs supported who reported an increased income for the household due to income generation interventions addressed at women
Output	34 Share of households with female entrepreneurs supported
STRATEGY V: MOBILIZE COMMUNITIES TO TRANSFORM SOCIAL NORMS	
Outcome	14.1 Share of communities that reject CM 14.2 Share of communities that reject FGM
	15.1 Share of girls who feel supported in decision making on SRHR 15.2 Share of single girls who feel supported in decision making on CM 15.3 Share of girls who feel supported in decision making on FGM
Intermediate outcome	24 Share of communities with leaders who condemned CM in village meetings
	25 Share of communities with village members who organize activities against negative effects of CM, FGM etc
Output	35 Share of communities with trained village leaders

STRATEGY VI: CREATE AN ENABLING LEGAL AND POLICY ENVIRONMENT PREVENTING CM	
Outcome	16.1 Share of girls who know about protective laws on CM 16.2 Share of girls who know about protective laws on FGM
Intermediate outcome	26.1 Share of communities with by-laws concerning CM 26.2 Share of communities with by-laws concerning FGM
	27 Share of districts where almost all births are registered
	28 Share of districts that have an operational reporting system to document and act upon breaking of laws concerning CM/sexual assault
Output	37.1 Share of communities (that have no by-laws yet) in the process of developing by-laws on CM 37.2 Share of communities (that have no by-laws yet) in the process of developing by-laws on FGM
	38 Share of districts (or other local administrative level) that have established means to enforce laws on CM
	39 Share of districts with consultation and informational meetings between (local) government agencies and civil society institutions related to SRHR

Annex 2: Study locations and partners

Country	*Region*	*Partner*	*District*	*Alliance member*
Bangladesh	Khulna Division	DALIT	Jessore district	ICDI
	Dhaka Division	THP	Kishoreganj district	THP
Benin	Couffo Département	THP	Djakotomey & Klouékanmè	THP
	Borgou Département		N'Dali & Pèrèrè	
Burkina Faso	Haut Bassin	Maia	Bobo Dioulasso département	SKN
	Boucle du Mouhoun	Demba Ngnouma	Kassoum département	
	Centre Nord	AFDP	Rouko département	
		ADEP Koudougou	Boussouma département	
	Nord	AJBF	Ouahigouya département	
	Centre Sud	AZLY	Guiba département	
	Centre Ouest	ADEP Kaya	Ramongo département	
		THP	Sapouy département	THP
Ethiopia	Oromia	ADAA	Kofele woreda	SKN
			Wendo woreda	
	Amhara	THP	Merhabete woreda	THP
		FSC Bahir Dar	Libo kemkem woreda	SKN
		FSC Dessie	Jamma woreda	
		WCAT	Farta woreda	
		ESD	Ensaro woreda	ICDI
	SNNPR		Malga woreda	
		BICDO	Dara woreda	SKN
		LIA	Shashego woreda	
Ghana	Central	THP	Mfantsiman	THP
	Eastern		Upper Manya	
Mali	Koulikoro	APEFD	Tougouni commune	SKN
		APSEF	Diedougou commune	
		TAGNE		
			Doubabougou communie	
		ENDA Bamako	Kalabancoro commune	
	Bamako		Commune V	
	Mopti	ATAM/Mopti	Fakala commune	
		JIGUISEME	Pignari Bana commune	
	Segou	ENDA Benkadi	Touna commune	
Nepal	Province No. 3	CWIN	Makwanpur – only baseline	ICDI
	Province No. 1		Morang	
	Province No.5		Banke	
Pakistan	Punjab	Bedari	Chakwal	ICDI
			Vehari	
Senegal	Tambacounda	ENDAJA	Tambacounda	SKN
	Kolda		Kolda	
	Sedhiou		Sediou only midline	
Uganda	South-Eastern	THP	Iganga	THP

Annex 3: Study population sizes

Midline: Study populations by T/C

	Ba		*Pa*		*Ne*		*Sen^*		*Ma*		*BF*		*Be*		*Gh*		*Eth*		*Ug*	
	T	C	T	C	T	C	T	C	T	C	T	C	T	C	T	C	T	C	T	C
Girls	300	300	154	153	139	150	153	151	557	556	466	471	157	160	143	138	371	370	137	178
Households	247	268	99	96	124	125	97	84	292	295	223	200	93	91	121	107	262	255	74	108
Villages	2	2	2	2	2	2	2	2	8	8	8	8	2	2	2	2	8	8	2	2
Health Centres	2	2	3	1	2	2	2	1	6	7	8	4	2	2	3	2	10	7	1	1
SRHR Staff	4	4	1		1	2	2	3	3	12	11	15	7	2	2	3	2	10	14	1
Schools	2	2	4	3	2	2	2	3	7	7	13	10	2	2	2	2	10	10	1	1
Teachers	4	4	4	4	2	2	4	3	12	14	22	16	4	4	4	4	18	18	1	1
Districts	2		2		2		2		5		7		2	2	2		9		1	
									2	2							1	1		

Note: ***^Senegal – excluding Sedhiou region.***

Baseline: Study populations by T/C

	Ba		*Pa*		*Ne**		*Sen*		*Ma*		*BF*		*Be*		*Gh*		*Eth*		*Ug*	
	T	C	T	C	T	C	T	C	T	C	T	C	T	C	T	C	T	C	T	C
Girls	305	299	150	154	100	100	155	157	460	454	509	458	150	150	135	130	380	344	167	160
Households	277	247	99	102	77	73	92	74	248	222	280	249	80	80	108	104	283	264	92	75
Villages	2	2	2	2	1	1	2	2	7	6	8	8	2	2	2	2	10	10	2	2
Health Centres	2	2	2	1	1	1	2	2	7	7	8	5	2	2	2	2	10	10	2	1
SRHR Staff	4	4	2	2	1	1	2	1	12	12	9	7	2	2	3	1	9	11	2	1
Schools	2	2	2	2	2	2	1	1	1	7	7	14	11	2	2	2	2	10	10	4
Teachers	3	3	1	3	3	2	1	1	12	15	13	11	4	4	2	2	12	13	4	2
Districts	2		2		2		2		5		7		2		2		9		1	
									2	2							1	1		

Note: ****Nepal – excluding Central region.***

Annex 4: Background characteristics of study populations

Table A4.1: Background of girls (%) - BL

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
N=	*604*	*304*	*300*	*314*	*914*	*970*	*307*	*265*	*745*	*327*
Age										
12	13.1	5.6	16.7	19.7	0	13.4	14.1	15.8	18.7	14.8
13	21.7	15.1	13	12.7	29.3	15.5	14.1	24.9	19.5	18.5
14	17.5	9.2	15.3	12.1	22.8	16.3	15.4	16.3	21.6	17.9
15	19.2	13.2	13	14.6	16	16.9	18.4	12.8	20.3	13
16	12.4	20.1	16.7	13.7	14.4	17.3	14.4	11.7	9.9	15.7
17	16.1	36.8	25.3	27.1	17.5	20.5	23.6	18.5	9.9	20.1
Religion										
Islam	92.1	100	16.7	99.7	95.2	57.2	23.6	9.9	28	61.5
Christianity (any)	0	0	2.7	0.3	3.5	38.6	30.8	85.5	71.5	37.4
Hinduism	7,9	0	48.3	0	0	0	28.3	0	0	0
Buddhism	0	0	32.3	0	0	0	0	0	0	0
Animist	0	0	0	0	1.3	0	0	0	0	0
Member of club or group	2,6	0.7	4.7	9.6	4.4	1	2	32.6	30.6	33.3

Table A4.2: Background variables of girls (%) ML

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
N=	*600*	*307*	*289*	*304*	*1113*	*937*	*317*	*281*	*741*	*315*
Age										
12	16.8	6.5	16.6	22.0	23.5	16.0	18.9	20.3	21.7	21.6
13	18.0	13.7	19.4	17.4	19.3	15.8	18.6	15.3	17.4	11.4
14	18.5	12.7	15.6	18,8	18,0	18.7	13.9	18.5	18.8	18.7
15	15.0	17.3	15.6	13.5	13.7	17.0	17.4	14.9	21.5	13.3
16	12.8	20.2	16.6	11.5	12.3	15.6	11.7	17.4	11.5	13.3
17	18.8	29.6	16.3	16.8	13.2	17.0	19.6	13.5	9.2	21.6
Religion										
Islam	93.7	100	27.3	99.7	95.7	63.7	32.2	8.2	27.3	50.2
Christianity (any)	0	0	0	0.3	4.3	34.0	46.4	63.7	72.2	49.8
Hinduism	6.3	0,0	72.7	0	0	0	0	0	0	0
Buddhism	0	0	0	0	0	0	0	0	0	0
Animist	0	0	0	0	0	2.1	14.2	0	0	0
Member of club or group	9.0	5.9	30.1	34.9	26.1	17.5	21.1	60.9	43.7	31.4
Interviewed in baseline	0	0	0	0	0	0	0	0	0	0
Yes	17.5	27.7	10.0	26.6	25.2	18.8	6.3	29.9	12.6	7.6
No	81.8	68.4	80.6	71.4	73.9	79.2	92.4	70.1	72.2	92.1
Don't know	0.5	3.6	9.3	2.0	0.5	1.8	1.3	0	14.8	0

Table A4.3: Background variables of Households (%) – BL

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
N=	*524*	*201*	*235*	*166*	*470*	*529*	*160*	*212*	*596*	*167*
Respondent										
Mother of girls	7.6	10.9	20.4	7.8	14.9	59.4	10.6	25	17.2	33.5
Father of girls	86.8	64.7	63.8	88	83	38.2	88.1	57.1	81.6	61.7
Mother in law	0	1.5	4.3	0	0	0	0	0	0	0
Father in law	0.6	10.9	5.5	0	0.2	0	0	0	0	0
Predominant religion										
Muslim	92.4	100	13.6	98.8	94.9	61.1	33.8	7.1	24.4	63.5
Buddhist	0	0	35.3	0	0	0	0	0	0	0
Hindu	7.6	0	48.5	0	0	0	0	0	0	0
Catholic	0	0	0	0	2.8	23.6	15.6	21.2	0.3	9
Protestant	0	0	2.6	0.6	0.6	6.3	6.9	40.1	35	24
Orthodox	0	0	0	0.6	0.6	2.7	0.6	5.2	39.1	0

Table A4.4: Background variables of Households (%) – ML

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
N=	*515*	*195*	*249*	*181*	*587*	*423*	*184*	*228*	*517*	*182*
Head of HH										
Mother of girls 12-17	12.8	9.2	8.8	22.7	11.6	15.6	8.2	30.3	30.6	36.3
Father of girls 12-17	75.3	80.5	81.9	66.3	87.1	78.3	91.3	55.7	67.3	55.5
Other	11.8	10.3	9.2	11.0	1.4	6.1	0.5	14.0	2.1	8.2
Respondent										
Mother of girls	13.6	55.4	63.5	31.0	14.3	18.0	50.0	45.6	53.0	56.0
Father of girls	74.2	32.3	33.3	50.3	82.2	73.8	41.3	37.7	42.2	30.2
Mother in law	1.2	2.1	0	18.8	0	0.2	0.5	0	0	0
Father in law	3.1	2.1	0	0	0	0	0	0	0	0
Predominant religion										
Muslim	93	100	26.1	99.4	95.7	64.8	39.1	7.5	23.6	50.0
Buddhist	0	0	0	0	0	0	0	0.4	0	0
Hindu	7	0	73.9	0	0	0	0	0	0	0
Catholic	0	0	0	0	3.4	22.5	12.5	18.4	0.2	7.7
Protestant	0	0	0	0	0.2	5.9	0	18.0	35.2	33.0
Orthodox	0	0	0	0	0	0	0	4.4	40.2	0
Interviewed in baseline										
Yes	17.3	36.9	28.5	32.0	41.4	31.2	37.5	36.8	16.4	15.9
No	78.4	56.9	68.7	64.1	53.7	62.4	60.3	60.1	62.1	82.4
Don't know	3.9	5.6	2.8	3.9	4.9	6.1	2.2	3.1	21.5	1.6
Size of HH										
Mean	5.09	6.90	6.05	11.7	5.25	8.61	8.01	5.72	6.19	6.13
Min	2	2	2	4	2	2	2	2	2	2
Max	25	23	16	51	31	38	31	16	15	13

Table A4.5: Background variables on villages - BL

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
N=	*4*	*4*	*4*	*4*	*13*	*16*	*4*	*4*	*20*	*4*
Estimated mean # households	950	438	2644	375	201	261	80	353	1562	310
Range # households	800	200	3,625	785	972	638	92	350	5320	240
Keep birth registers	2	2	4	4	8	13	0	1	1	0
Keep marriage registers	1	2	4	2	7	5	0	0	1	0
With primary school(s)	4	4	4	4	13	16	0	4	20	4
With secondary school(s)	4	4	3	4	6	14	0	2	13	1

*** Uganda unreliable data on health facilities.**

Table A4.6: Background variables on villages - ML

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
N=	*4*	*4*	*4*	*4*	*16*	*17*	*4*	*4*	*16*	*4*
Estimated mean # households	696	4,600	1,013	650	11,971	985	738	325	1,288	877
Range # households	249	14,600	557	1,985	140,840	4,920	1,150	300	3,400	1,700
Keep birth registers	2	4	4	3	50.0	71.0	3	1/4	62.5	0
Keep marriage registers	1	4	4	2	25.0	30.0	1	0	56.3	1
With primary school(s)	4	3	4	1	93.7	100	3	4/4	44.0	4
With secondary school(s)	4	4	4	2	74.9	76.4	4	3/4	31.3	4

Table A4.7: Background variables for teachers - BL

	Ba	*Pa*	*Ne*	*Se*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
N	*6*	*4*	*7*	*2*	*27*	*24*	*4*	*4*	*25*	*6*
Gender										
Female	1	4	3	0	5	7	0	0	18	6
Male	5	0	4	2	12	15	4	4	5	0

Table A4.8: Background variables for teachers - ML

	Ba	*Pa*	*Ne*	*Se*	*Ma*	*BF*	*Gh*	*Be*	*Eth*	*Ug*
N=	*8*	*8*	*4*	*7*	*26*	*38*	*8*	*8*	*36*	*2*
Gender										
Female	3	5	2	0	7	19	4	0	18	1
Male	5	3	2	7	19	19	4	8	18	1
Main subject of teaching										
Biology/Chemistry		1			6	14		8		
General science	2	1		4						1
Mathematics	1			1		3	2			
Physical education	4	3								
Language		2		1	3	2	1			1
History						1				
All disciplines - primary		1		1	17	15	2			
Others			4			2	3			
Interviewed in baseline										
Yes		1	2	3	7	8	3	1	6	0
No		2	2	3	15	21	5	6	24	0
Missing answer		5		1	4	9		1	6	2

Table A4.9: Background variables for health centres - BL

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Gh*	*Be*	*Eth*	*Ug*
N=	*4*	*3*	*4*	*4*	*14*	*13*	*3*	*4*	*20*	*3*
Type of health centre										
Hospital	0	1	0	0	0	2	0		1	0
Health Centre	2	1	0	0	10	5	0	3/4	13	3
Health post	1	0	3	4	2	4	3		6	0
Community clinic/unit	1	0	1	0	0	0	0	1/4	0	0

Table A4.10: Background variables for health centres - ML

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
N=	*4*	*4*	*4*	*3*	*13*	*12*	*4*	*5*	*17*	*2*
Type of health centre										
Hospital										
Health Centre	4	4			5	9			9	1
Health post			2	3	5	1	3	4	2	1
Community clinic/unit			2		3	2		1		
No answer							1		6	

Table A4.11: Background variables for health staff - BL

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
N=	*8*	*4*	*4*	*3*	*24*	*15*	*4*	*4*	*20*	*3*
Gender										
Female	6	4	4	1	16	11	3	3	5	1
Male	2	0	0	2	8	4	1	1	15	2
Qualification										
Midwife	0	0	0	0	4	13	1/4	0	5	1
Medical Doctor	0	0	0	0	1	0		0	0	0
Nurse	0	0	0	1	5	1	1/4	4	5	2
Health Officer	2	0	0	0	6	0		0	3	0
Health Assistant	2	0	0	0	0	0	1/4	0	0	0
Lady health visitor	0	4	0	0	0	0		0	0	0
Health planning assistant	1	0	0	0	0	0		0	0	0
ANM	0	0	4	0	0	0		0	0	0
Matron	0	0	0	1	6	0		0	0	0
Health extension worker	0	0	0	0	0	0	1/4	0	4	0

Table A4.12: Background variables for health staff - ML

	Ba	*Pa*	*Ne*	*Sen*	*Ma*	*BF*	*Be*	*Gh*	*Eth*	*Ug*
N=	*8*	*2*	*4*	*6*	*23*	*22*	*4*	*5*	*24*	*1*
Gender										
Female	3	2	4	4	17	18	4	3	15	
Male	5	0	0	2	6	4	0	2	9	1
Qualification										
Midwife				1	4	8	1		7	
Medical Doctor							1		3	
Nurse		1	2		10	2	1	4	6	
Health Officer			1	1	2	1	1		1	
Health Assistant	2		1	1					7	1
Lady health visitor		2	1	1						
Health planning assistant										
ANM										
Matron										
Health extension worker										
Other	6	3	3		7	11		1		
Interviewed in baseline										
Yes	4	1	1	1	11	2	1	1	3	
No	4	1	1	5	9	12	1	1	13	1
Don't know			2		3		2	1	8	