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HER CHOICE

# Her Choice Baseline Study

## Synthesis Report

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# ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| **AISSR** | Amsterdam Institute for Social Science Research |
| **Ba** | Bangladesh |
| **Be** | Benin |
| **BF** | Burkina Faso |
| **CM** | Child marriage |
| **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 |
| **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 presents the findings of the Her Choice baseline study. 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 on the issue of child marriage. HC is an alliance of four Netherlands based organisations: Stichting Kinderpostzegels Nederland (SKN), The Hunger Project (THP) Netherlands, International Child Development Initiatives (ICDI) and the Amsterdam Institute for Social Science Research/University of Amsterdam (AISSR/UvA). The alliance, which seeks to support the creation of child-marriage free communities, works with a total of 32 local partners in 11 countries: Bangladesh, Benin, Burkina Faso, Ethiopia, Ghana, Mali, Nepal, Pakistan, Senegal, Sierra Leone and Uganda.

The AISSR/UvA is the research partner of the HC programme, seeking to examine the impact that the six HC strategies (see section 1.2) have on reducing the prevalence of child marriage. In order to do this, the baseline study will be followed by mid- and end-line studies in 2018 and 2020 respectively. The baseline study presented here was conducted by the AISSR/UvA, with the support of local researchers and (local) HC partner organisations.

A mixed-methods approach was utilised for the baseline study, building on both quantitative and qualitative data. A total of nine tools were used in each country – consisting of (semi-)structured surveys (with girls aged 12 - <18, household heads, heads of health centres, health centre staff, school principals, school teachers, village leaders and district administration personnel) and focus group discussions with school going young men and women. The two largest study populations were girls aged 12 - <18 (total of 5354) and household heads (total of 3421).

Capacity building of local partners was a central element to the baseline study. Local partners were trained to conduct baseline data collection, with the support of local research co-ordinators and the AISSR. Local research coordinators were responsible for data entry, initial analysis and development of country-level reports, following AISSR-made guidelines.

This synthesis report presents the data for the HC impact indicators and the (intermediate) outcome and output indictors for each of the six HC strategies. Data is presented at country level, with the explicit note that data collection took place in three to 20 villages per country, located in one to three (study) regions, and therefore is not a representative sample for the whole country.

### *Key findings*

- Girls' decision making over their marriage is very low in most countries. Boys have a greater space to make decisions – as found in FGDs – but this space too is still limited.

- The majority of child marriages are informal in nature – a likely explanation being the illegal nature of child marriage across the 11 countries.
- (Fear of) sexual debut and premarital pregnancy were amongst key reasons found as to why young women were "married off" or sought to get married themselves.
- Economic drivers were also key in explaining the persistence of child marriage; families may marry their girls young to ease economic hardship, because of the incentives of a higher bride price or lower dowry, or to improve the economic security of daughters. At the same time, young women (and men) were at times found to actively choose to marry early if they believed there was an economic benefit to doing so.
- Young women were found to have strikingly low levels of SRHR-related knowledge in most countries, even where they had received SRHR education. This may be because SRHR teachers themselves were found to lack training and knowledge on issues, and are shy in discussing certain topics with young people.
- Many girls did not know of the SRHR services available to them, and those that did made little use of them. Data concerning services provided and training received by health care workers indicate that most facilities could not be considered "girl-friendly".
- Contraceptive use was low amongst single young women who were sexually active, likely linked to their low levels of SRHR knowledge, and low use of SRHR services.
- Village leaders were caught between the imperative to implement national laws against child marriage and local norms and customs of early marriage.

### *Key programme implications*

- SRHR-related education for girls requires far more careful attention, with a focus on relevance and comprehensiveness. Improving SRHR-related education will also involve providing more comprehensive training and support to SRHR teachers and health staff.
- Country-specific criteria on youth friendly SRHR services and girl-friendly schools should be developed.
- Programme activities should be expanded to focus more strongly on young men and also target married young women.
- For community level activities geared to preventing CM and FGM/C, it is important to first develop an understanding of the local views of, and reasons for child marriage and FGM/C, and the types of marriage and FGM/C.

# 1. INTRODUCTION

## 1.1 Background

Child marriage remains widespread in developing countries, primarily affecting girls and young women; 14.2 million girls are married annually before they become adults (UNFPA 2012). In South Asia, 50% of girls are married before the age of 18, compared to 40% in Africa (IPFF 2006). Child marriage is commonly considered to be rooted in cultural and religious traditions, and underpinned by gender inequality and cycles of poverty. Marrying at a young age, and particularly early child bearing, is broadly recognized as detrimental to girls' health and wellbeing, restricting their access to education and income-earning opportunities, and often resulting in social isolation.

Harmful health aspects resulting from child marriage are teenage pregnancy (90% of births to adolescents occur within marriage (UNFPA 2013)), maternal mortality (a leading cause of death for 15-19 year old girls (Girls Not Brides 2017; UNFPA 2012)), an increased risk of sexually transmitted infections, and greater vulnerability to sexual gender-based violence (CARE 2012; Erulkarr and Muthengi 2003; 2009; IPFF 2006).

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 on the issue of child marriage. HC is an alliance of four Netherlands-based organisations that seeks to support the creation of child-marriage free communities. HC also aims to reduce incidence of female genital mutilation/cutting (FGM/C) in the communities they work. The organisations consist of the main applicant Stichting Kinderpostzegels Nederland (SKN), and 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 will run for five years, from January 2016 to December 2020, building on an earlier one-year child marriage programme implemented by SKN, THP and ICDI. Her Choice works in 11 countries in Sub-Saharan Africa and South Asia with a total of 32 local partner organisations. In four of the 11 countries, multiple partner organization implement the Her Choice programme: Bangladesh (2), Burkina Faso (8), Ethiopia (10) and Mali (6). In the remaining seven countries, the programme is implemented by one partner, that is, in Benin, Ghana, Nepal, Pakistan, Senegal, Sierra Leone and Uganda (see Annex 2 for details).

According to UNFPA (2012) and UNICEF (2016), rates of child marriage – measured as the percentage of women aged 20-24 who married before they turned 18 – are high in the 11 Her Choice programme countries. Bangladesh experiences the highest rates at 65%. Bangladesh also has the highest rates of child marriage under 15 in the world (29%). Out of the 11 countries, Ghana has the lowest rate of child marriage (21%). Globally, relatively

higher rates of child marriage occur in rural areas, among women of lower educational attainment levels and in households of lower economic status. (Table 38, A1[1]). In general, across the globe rates of child marriage appear to have been relatively static over recent years. However, Sierra Leone and Senegal have seen declining rates of child marriage and, conversely, Benin and Burkina Faso have seen increased rates of child marriage in the last decade (Walker 2013).

In the eight sub-Saharan African programme countries prevalence of female genital mutilation or cutting (FGM/C) is reportedly highest in Sierra Leone and Mali and lowest in Ghana and Uganda (UNICEF 2016a). In all countries but Mali and Sierra Leone, FGM/C has been officially banned – this happened as early as 1994 in Ghana and relatively recently in Uganda in 2010 (UNICEF 2013) (Table 39 A1). According to local HC partners, FGM/C does not take place in the Her Choice countries in South Asia.[2]

## 1.2 Her Choice programme strategies

To reduce child marriage in the 81 communities across the 11 Her Choice programme countries, the HC programme applies six strategies (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] A1 refers to Annex 1 – similarly, A2 to Annex 2 etc.

[2] However, see data on FGM in Pakistan published by, for example, 'Stop FGM in the Middle East & Asia' (http://www.stopfgmmideast.org). See also discussion of study limitations in section 2.9.

## 1.3 The role of the AISSR/UvA

The AISSR/UvA is the research partner of the Her Choice programme. The AISSR/UvA seeks to examine the impact the various Her Choice strategies have on preventing and reducing prevalence of child marriage in the different contexts, determining, for example, which (combination of) strategies seem to be effective, and which do not appear to work and why. In order to do this, the research team at UvA have conducted a baseline study in 2016. This baseline study will be followed by mid- and end-line studies in 2018 and 2020 (see the methodology section below for more detail), as well as more in-depth qualitative studies in the interim years.

## 1.4 This report

This synthesis report presents the key findings of the HC baseline study. It summarises the findings of the baseline studies at national level in all 11 programme countries The baseline served to assess the conditions prevalent in the target areas before the start of interventions. Crucially, the main purpose of the baseline study was to take a first measurement of the central indicators for change formulated for the Her Choice programme (Table 41 A1). The specific objectives of the study were to:

1. Serve as the first measure of all programme indicators (output, (intermediate) outcome, and impact indicators as per the Her Choice programme document), thus establishing the foundation for the programme's target setting and monitoring, evaluation and learning (MEL) system.
2. Validate and support the indicator measurements with additional information.
3. Develop ownership of local partner organisations and build their capacity with respect to impact evaluations.
4. Provide baseline data to inform programming of local HC partner organizations and Dutch HC Alliance members.

After this introduction, the report continues with an explanation of the research methodology in Chapter 2, including the study design, sampling and data collection methods and tools. The report then goes on to describe the study locations and populations (Chapter 3), and moves on to discuss the indicator and supporting data with regard to each of the six HC strategies (Chapter 4). The key findings are presented and discussed in the main text, with additional tables provided in Annexes 4 and 5. To facilitate comparison, countries in the same geographic region are grouped together in the tables and bar charts. Unless otherwise stated, the source of all tables and figures are the 2016 baseline surveys. Where (the majority of) denominators in a table are under 10, rates or ratios are presented in numbers as opposed to percentages. The concluding chapter, Chapter 5, discusses the main findings and gives some of the programmatic implications that arise from the baseline study.

In the report we use both the terms girls/boys and young women/men to indicate our female and male research participants aged 12 to 17. We use both child marriage and early marriage to mean marriage where at least one of the partners is under the age of 18.

# 2. METHODOLOGY

## 2.1 Study design

The AISSR/UvA are conducting a baseline, midline and endline study for Her Choice programme in order to evaluate the impact of the six strategies in the different contexts. The baseline study was conducted during the first half of 2016 prior to any HC programmatic intervention[3], the midline study will take place in the first quarter of 2018 after interventions have been implemented for one-and-a-half year, and the endline study will take place in the final year of the programme (2020). The design of the baseline study methodology started from the HC theory of change and the (original) 39 HC programme indicators for programme outputs, (intermediate) outcomes and impact (Table 41 A1).

In order to be able to measure 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).[4] For ethical reasons, it was decided not to work with 'pure' control sites but instead with comparison sites that will receive programme interventions, but at a slightly later stage; after the midline study data has been collected.

**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: ($\Delta T_{2018}$ -$\Delta C_{2018}$) | DiD 2: ($\Delta T_{2020}$ -$\Delta C_{2020}$) | DiD Total: ($\Delta T_{2020}$ -$\Delta C_{2020}$) |

The study followed a mixed methods design, building on both qualitative and quantitative methods. For the baseline study, semi-structured surveys were used, collecting primarily quantitative data, with additional qualitative supporting questions. Focus group discussions (FGDs) were used to collect additional qualitative data. During the years between the baseline, midline and endline study, more in-depth qualitative data will be collected and analysed by the research team at AISSR, (Research) Masters students and PhD candidates.

[3] But see discussion of research limitations (section 2.9)

[4] If necessary, a propensity score matching (PSM) technique will be used in combination with DiD to find the best match between treatment and control groups. Furthermore, nested models will be used to conduct multi-level comparative analysis.

## 2.2 Data collection tools

As with the methodology as a whole, the development of the research tools was based on the HC theory of change and the 39 programme indicators (Table 41 A1). AISSR developed questions to measure the value of these indicators, and then developed tools (questionnaires and FGD guides). In total, nine tools for data collection were used in each country; eight (semi-)structured questionnaires and one FGD topic guide. In order to allow for cross-country comparison, the same nine data collection tools were used in each of the 11 countries. As such, generic tools were initially created by AISSR.

The tools addressed each of the Her Choice target groups. Therefore, the study populations for the structured interviews were: Girls (12-<18 years), household heads, village leaders, heads of health centres, health centre staff (specifically those working on issues related to SRHR), school principals, school teachers and district leaders. The FGDs were held with school going young men and women (12-<18 years).

The original tools were developed in English and subsequently translated into French by the local researchers in Francophone HC countries. Tools were also 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.

## 2.3 Baseline training and finalisation of research tools

A central aim of the HC programme is to build capacity of local partners, including in the field of research and basic indicator construction. For this reason, it was decided to work with local HC partners during the baseline data collection and data entry rather than solely with external consultants. Local research coordinators were appointed to support local HC partners during the process of data collection and entry, and were made responsible for the supervision of data collection, data entry and analysis and write up of country reports. Partners and local researchers were involved in the piloting and adaption of the generic tools originally developed by the AISSR/UvA during baseline training workshops. These workshops were held in five countries (combining neighbouring countries) with partners and, where applicable, local researchers from all 11 countries, resulting in sets of country-specific (though cross-country comparable) tools.

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 and were instructed on, for example, the importance of being sensitive to the research environment, how to conduct sessions and how to ensure participants were aware of their rights.

AISSR provided a country-specific data collection handbook that was used as a support during the local training workshops and the data collection process.

## 2.4 Study populations and sampling strategy

### 2.4.1 Sampling strategy

A sampling strategy was developed and shared with partners and local researchers during the baseline training workshops. The basic premise of the sampling strategy is that in each village, a predefined minimum number of households with girls aged 12-<18 should be selected and then every girl between 12-<18 years from each of those households should be interviewed.

*Villages*

Partners identified both treatment and comparison villages. The corresponding treatment and comparison villages were from the same district and effort was made to select comparable villages, for example, those that shared similar characteristics regarding cultural and linguistic groups and rates of child marriage. In the selection of villages, local partners were instructed not to select villages that were in close proximity to each other, in order to avoid as much as possible any spill-over effects when activities are implemented. The selection criteria for villages were based on:

- Population density: 500 or less girls per village
- Relative proximity to the programme office and accessible by road (to ensure ease of access)
- Programme exposure: no (or very few) other activities on child marriage should have taken place in the village prior to the baseline

*Households and girls*

After the villages had been selected, researchers were to obtain information on the number of households in the village, randomly select about 80 households per village (e.g. using village records or transect walks) and interview these household's heads. Before conducting the interview with the household head, data enumerators were to confirm whether there were girls aged 12-<18 living in the household. If this proved *not* to be the case, the interview was not conducted and the household not included in the sample.

It was from the selected households that the girls were sampled. Data enumerators were instructed to interview every girl aged 12-<18 living in the household, until they had visited enough households to reach the designated sample size of girls. Researchers were to make appointments to interview the girls, and to return in order to interview any girls who were not present at the time of the interview.

*Village leaders*

For the village leader interviews, researchers were instructed to interview one to three leaders per village, where appropriate conducting a group interview. The criteria for the

selection of leaders were that they had lived in the village for at least ten years, and were knowledgeable and willing to share information on the village.

*Schools, school principals and teachers*

School principals were selected from the schools (one or more) that catered to young people between ages of 12-<18 years in the selected villages. The selection of teachers was based on whether they provided school-based education or sensitization on issues relating to SRHR, whether intra- or extra-curricular.

*Health centres, heads of health centres and SRHR staff*

The health centres (one or more) that catered to the selected villages were included in the sample, and the staff member in charge of each health centre was interviewed. In addition, health service providers who provided SRHR-related services to young people were included in the sample, whether or not they had received specific training in working with youth.

*District administration staff*

At the district level, the district administration staff were interviewed who are most involved in SRHR, education, community development, law enforcement, and social welfare.

### 2.4.2 Sample population size

Calculations for sample size per region were based on the confidence interval and confidence level, population size of girls aged 12-<18 (approximately 500 per village) and the percentage of child marriage by country. Sample sizes thus varied per country. Table 40 A1 provides the calculated sample sizes per study population and country.

On average, each (study) regional baseline sample consisted of 300 girls, aiming for representativeness at village level (5% confidence). In countries where multiple partners implement the programme in various regions, the baseline sample was multiplied by the number of regions (meaning that in the case of Burkina Faso, for example, the total baseline sample was composed of 900 girls, as the programme is implemented in three different study regions). In the cases of multiple local partners working in the same region, local partners jointly decided how to sub-divide the baseline samples between them at regional level.

## 2.5 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. Teams included a range of enumerators, depending on the sample size, and in order to obtain more reliable data, where possible, enumerator demographics corresponded with those of respondents; for example, younger female data collectors surveyed young women and male data collectors conducted FGDs with school going young men.

Supervisors were appointed from among local partner staff originally trained by the AISSR and were tasked with, among other things, coordination of the day-to-day data collection process and ensuring quality of the data collected. The local research coordinator supported the supervisors, while the AISSR provided support to the local researcher.

## 2.6 Data handling

AISSR provided data entry guidelines, detailing instructions for organization on storage of data. AISSR created country-specific templates for data entry using EpiData software, a freeware that allows for data entry and analysis. These templates were sent along with data-entry instruction guides to all country teams. Data entry was either done by the local research coordinator or by HC partner organisations. The local research coordinator was responsible for the quality of data entry. Partners stored hard copies of all questionnaires, sending 10% of the total sample to AISSR for quality control.

## 2.7 Data entry, analysis and reporting

Local researchers conducted initial quality checks of, for example, questionnaire coding which would allow matching of individual girl questionnaires with relevant household questionnaires. This initial quality control also involved checking for missing data and anomalies. The AISSR/UvA carried out multiple rounds of further in-depth quality control.

The AISSR created data analysis guides, providing instructions as to how to calculate the indicator values, how to construct composite indicators and which questions to focus on in the description of study populations, among other things. In most cases, the local researcher and their organizational colleagues conducted the initial data analysis. AISSR stayed in regular contact with local researchers and country teams during the data entry and analysis phase, and were on hand to address any questions and complications.

Quantitative data was converted from the EpiData templates to SPSS and analysed in SPSS using the instructions provided by AISSR. For country level reports, teams focused on analysis of findings by treatment and comparison site, different regions, and by married and unmarried girls. FGDs were - where possible - transcribed verbatim and translated into English or French. Country teams conducted an initial analysis of FGD data using an FGD matrix provided by AISSR, which was developed to order relevant FGD questions and answers in correspondence with Her Choice indicators. Qualitative data in the surveys were used to qualify quantitative data.

AISSR provided local researchers and country teams with a country-level report outline. Each country team provided a draft report to AISSR, which was then checked and sent back for revision before the final report was completed. For the present 11-country baseline report, the AISSR team meticulously checked and cleaned the raw quantitative data provided by the

country teams. The AISSR conducted its own analysis using SPSS, constructing the key indicators per strategy per country and region, which will be used later on as outcome indicators for assessing change when the midline data become available. In addition, this report details findings derived from the qualitative data that was obtained through the surveys as well as the FGD matrices and transcripts provided by country teams.

## 2.8 Ethical considerations and clearance

AISSR paid careful attention to the ethical issues in designing and implementing the Her Choice baseline study, especially in relation to young people under age of 18 years. The AISSR Ethical Advisory Board granted formal ethical clearance for the baseline study in all countries in June 2016. Since the impact evaluation is part of local HC partners' programmes, and because partners themselves supervised data collection, in the majority of cases, no separate country-specific ethical clearance was required for the baseline once local authorities in the study regions and districts had authorised the HC programme. Only in Uganda was separate ethical clearance needed, which was granted by the Mildmay Uganda Research and Ethics Committee.

During the data collection process, particular attention was given to young men and women to ensure they were comfortable, knew they were not being tested and knew that it would not be possible for anyone to trace back anything that they say to themselves. Questionnaires and FGD transcripts do not contain participants' names; instead – for analytical purposes – participants were given a unique code. In all cases, participants were asked to "opt in" rather than "opt out" of the research activities. Based on discussions held in the baseline workshops and prior experiences of the AISSR researchers of participant's discomfort in signing a formal consent document, verbal consent rather than written consent was requested by all participants.

Understanding the views of young women and other actors and the way that these views correspond with those around them is critical to the Her Choice programme. However, particular care has been taken during the write up to ensure that reporting on findings was done in a way that would not harm the individuals and communities that were involved in the study, especially when this concerned information and opinions that might counter those given by more powerful actors.

All participants were informed before the interview or FGD started that they were free to stop the interview or leave the discussion at any time. At the end of the interview, participants were reminded that they could withdraw statements or the entire interview if they chose to. A trust-person was allocated in each research site who participants could contact if they wanted to discuss anything further. If a case of abuse was reported, the interviewer notified this contact person who then took follow up action with the participant.

## 2.9 Reflections on study limitations

A number of issues have arisen in the process of conducting this research that may have impacted on the quality of the data and the rates of child marriage and FGM/C reported. Some key practical issues are listed below, with the countries that they apply in brackets. The information below was provided by local HC partners in response to a series of questions posed to each partner by AISSR. It should be noted that usually the issue only applies to one or few partners, not to all.

### 2.9.1 Issues affecting the reliability of data

- In certain cases, girls could not be interviewed without the presence or interference of their parents (Bangladesh, Benin, Pakistan, Sierra Leone, Uganda).
- In certain cases, teachers insisted on attending FGDs (Pakistan).
- Unreliable ages may have been given for girls, either because (i) girls and heads of household really did not know the correct age, for example, due to a lack of birth certificates (Benin, Burkina Faso, Ethiopia, Pakistan), or because (ii) respondents feared legal consequences and prosecution and so gave higher ages for married girls (Bangladesh, Ethiopia, Sierra Leone).
- Difficulty in getting reliable answers from respondents on CM and FGM/C due to fears of prosecution and/or the belief that data collectors were working for the government (Bangladesh, Benin, Burkina Faso, Ethiopia, Senegal, Sierra Leone).
- Girls struggling or refusing to answer more sensitive questions related to sexual relations (Bangladesh, Burkina Faso, Ethiopia, Ghana, Mali).
- CM and/or FGM/C rates may be lower than expected because data were collected in areas that are relatively easily accessible by car (this was one of the sampling criteria agreed upon during baseline workshops, because fieldwork in remote areas was considered too expensive) (Ethiopia).

### 2.9.2 Contextual factors affecting data collection

- Political unrest may have inhibited respondents' answers (Ethiopia).
- Illiteracy affected self-administered data collection on more sensitive topics, such as sexual activity – part of the girl's questionnaire could be self-administered if the data collector deemed this favourable (Pakistan, Burkina Faso).
- The rainy season made access difficult (Sierra Leone).
- Cohabitation (especially after pregnancy or rape) being common but not considered and reported as "marriage" (Sierra Leone).

### 2.9.3 Issues with data collection process

- In some countries, the sampling strategy was not implemented correctly. For example, in some settings, some girls sampled in schools rather than only in surveyed households were included, thereby distorting rates of CM and school attendance (Benin, Burkina Faso, Ethiopia, Senegal) and preventing nested modelling later on.

- Difficulty in accessing all girls in households, for example, when girls were working away from home (Burkina Faso, Senegal), had migrated for studies (Mali), or lived with distant relatives (Mali).
- In certain countries, partners conducted the baseline in villages where they have been running interventions for some time (Burkina Faso, Ethiopia, Uganda).
- Issues with data collectors: some partners made use of teachers as data collectors (Ethiopia), while in other settings data collectors were embarrassed to ask sensitive questions (Ghana).

### 2.9.4 Further limitations

Data collectors for the baseline were not professionals and some had no previous experience in data collection. This lack of experience may have had an effect on the quality of the data collected and can be seen, for example, in the quality of data gathered through FGDs, where in some contexts there was very limited use of probing. Transcripts of FGDs were also often incomplete, that is, rather than transcribing verbatim, summaries of young people's responses were often noted instead. As indicated earlier, using partners as data collectors was done purposefully in order to build the capacity of partners, and this capacity building will continue over the course of the Her Choice programme.

Some bias may have also come from the fact that partners collected data in their own programme villages. This situation may have resulted in interviewer bias, but also respondent bias where respondents were aware of the organisational affiliations of the data collector.

Finally, questions with regard to FGM/C were omitted from questionnaires and FGD guides used in South Asian HC countries – local partners reporting this procedure did not take place in the communities in which they worked. Given growing recognition of occurrence of FGM/C in, for example, Pakistan, this omission will be carefully reviewed during the mid- and endline evaluations.

During the process of the baseline study and data analysis, it has also become clear that there are issues with certain HC indicators – some either formulated incorrectly or formulated in such a way that they cannot be measured using the questions posed. The AISSR/UvA intend to review and adapt these indicators to ensure they are more relevant for the duration of the programme. For this baseline report, indicators 7, 12.1, 12.2, 36, and 38 were removed.

# 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 Table 42 A2. For the sake of confidentiality, villages are not identified in this report. All villages were in rural locations, accessible by road, within reasonable proximity (up to a few hours travel) to organisational offices.

## 3.2 Study populations

Table 2 presents the number of study participants per study population by country. Tables that give background information by study population can be found in Annex 3 (Tables 43-49 A3).

**Table 2: Number of tools administered per study population, by country**

| | *Eth* | *BF* | *Ma* | *Se* | *Pa* | *Ne* | *Ba* | *SL* | *Gh* | *Ug* | *Be* | *Total* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *(Study)regions* | 3 | 3 | 3 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | *18* |
| *Study populations* | | | | | | | | | | | | |
| Girls | 745 | 970 | 914 | 314 | 304 | 300 | 604 | 297 | 265 | 327 | 314 | *5354* |
| Households | 596 | 529 | 470 | 166 | 201 | 235 | 524 | 161 | 212 | 167 | 160 | *3421* |
| Villages | 20 | 16 | 13 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | *81* |
| Health Centres | 20 | 13 | 14 | 4 | 3 | 4 | 4 | 5 | 4 | 3 | 4 | *78* |
| SRHR Staff | 20 | 15 | 24 | 3 | 4 | 4 | 8 | 9 | 4 | 3 | 4 | *98* |
| Schools | 20 | 25 | 14 | 2 | 4 | 6 | 4 | 4 | 4 | 6 | 4 | *93* |
| Teachers | 26 | 24 | 27 | ? | 4 | 7 | 6 | 8 | 4 | 6 | 8 | *120* |
| Districts | 10 | 8 | 9 | 2 | 2 | 3 | 2 | 2 | 2 | 1 | 2 | *43* |
| FGDs (students) | 40 | 32 | 28 | 4 | 8 | 12 | 8 | 8 | 8 | 4 | 8 | *160* |

# 4. BASELINE FINDINGS

The findings chapter is divided in seven sections. We start by presenting the baseline level of impact indicators and continue with the indicators for each of the six Her Choice programme strategies. We present the measurement of indicators at country level in bar charts and tables. Annex 4 provides more detailed tables with indicator values, including the regional range for countries where data collection took place in more than one region. With most indicators we provide supporting information that confirms, contradicts or qualifies the indicator values. This supporting information is derived from the same or a different study population and from FGD findings. Annex 5 provides corresponding tables for the supporting data. The supporting information from FGDs is presented in text boxes.

When reading the findings, please note the following:

- Although we give findings per country, in each country data were collected in one up to seven regions (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 three villages in Ghana and Uganda to 20 in Ethiopia (see Annex 2). This means that the country data presented cannot be considered representative for the whole country or a particular region.
- When the term "*girls*" is used in the report, it refers to all interviewed single and married girls/young women in the age group 12 to 17 (thus below 18) years. The terms "young women" and "young men" are also used to refer to the same population.
- If we refer to a particular sub-group of young women, this will be indicated. When the denominator (N) is below ten, the report presents *numbers* and not the percentage.
- Information on FGM/C was reported to be not relevant to the South Asian countries included in this study. Such questions were removed from the tools and no data on FGM/C are provided for Bangladesh, Nepal and Pakistan.
- Where certain data is not available for a country, the country has been left out of tables and bar charts. This missing data may be due to the question not having been asked, or issues with the format of the data. Data from Benin is still incoming, and so only data for girls in Benin are currently included in this report.

## 4.1 Impact indicators

**Impact 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 to have 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 1: IND1.1 Share of single girls who say to have control over if, when and who they marry (%)**

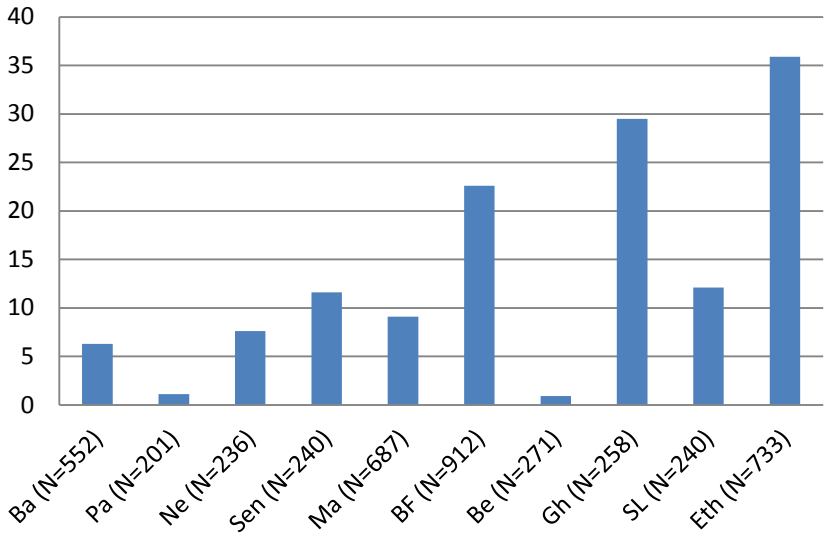
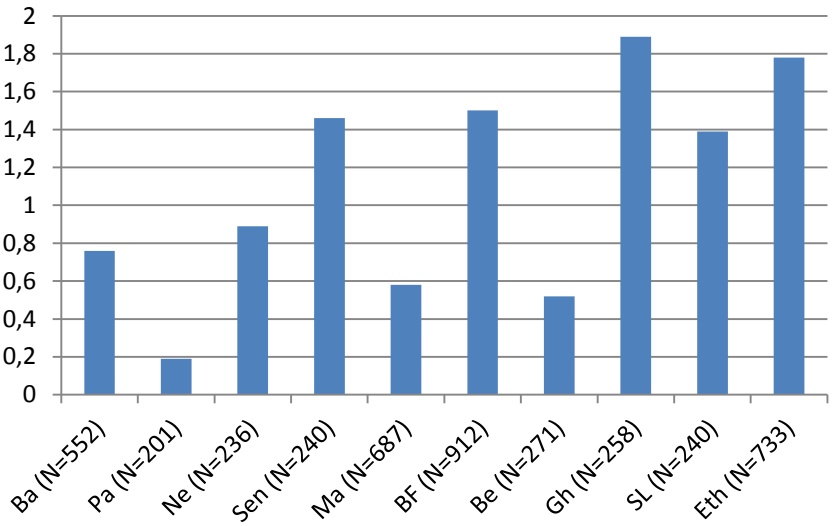



**Figure 2: IND1.2 Mean degree of control of single girls over the decision if, when and whom to marry (range 0 – 3)**




Decision-making power over marriage decisions is highest in Ghana and Ethiopia, where close to one-third of girls reported being able to oppose marriage against their will, and make decisions on when and who to marry. Decision-making power is lower in the South Asian countries, with Pakistan the lowest with only 1.1% of girls reporting to be able to make all three decisions. A similar low figure was found in Benin (0.9%). The figures are also low in Senegal and Mali where just one-tenth of girls can make these decisions (Figure 1). The big regional ranges in the data in Nepal and Mali have to be noted: For instance, whereas the mean for three regions is 9.1 for Mali, the regional figures range from 0% to 26.7% (Table 50 A4).

*Supporting information*

In most countries, a higher percentage of heads of households than of girls say they allow their daughters to make decisions on who and when to marry (Table 65 A5). Across countries, the most common reasons provided for not allowing their daughters to take these decisions, related to the household head considering the decision to be either too important for the girl to make (alone) and/or too difficult for the girl to make herself (Table 66 A5).

In most countries a minority of heads of households indicated they thought that child marriage was good for girls, albeit this 'minority' was at times quite substantial. Only in Pakistan over half of the household heads (57.2%) reported they thought child marriage was good for girls, while in Mali almost one-third of household heads (29.4%) thought child marriage was good for girls. By comparison, the figures in Senegal and Burkina Faso were, respectively, 22.5% and 15%, with lowest rates reported for Uganda (at 1,2%) (Table 67 A5).

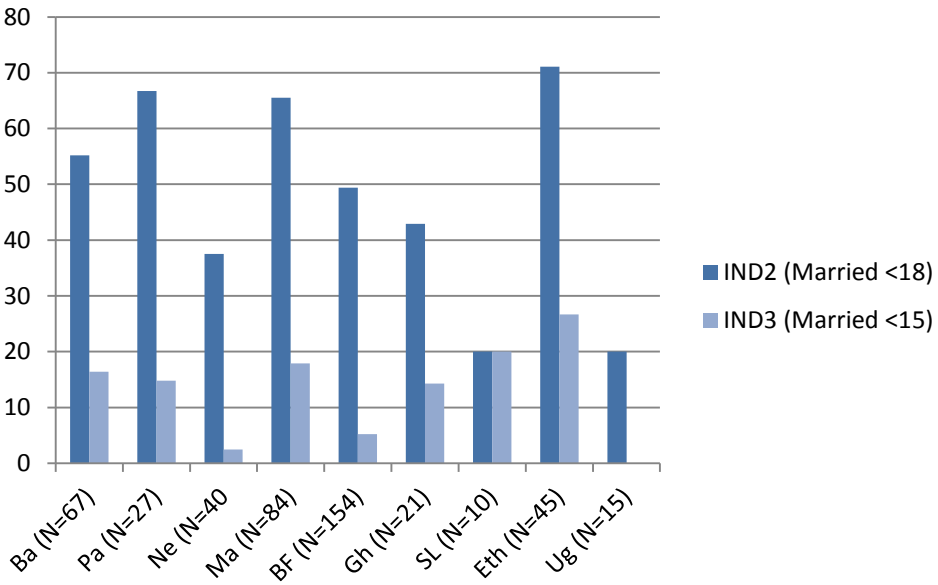
**Box 2: Control over decisions if, when and who to marry (FGDs)**

> '*Early marriage of girls [is] mainly parents' wish, […] early marriage of boys is their own wish because of love affairs'* (Girls & boys, Bangladesh)

There was widespread agreement among FGD participants in all countries that others tended to decide if, when and who a young women would marry (early) while young men tended to marry young of their own volition. The quote above reflects this broadly shared perception. Closer inspection of the FGD data nuances this picture somewhat, however. For example, girls were said to marry young because they fell in love, because they were not, or were no longer, motivated to stay in school and/or they (also) perceived marrying young as a means to secure a livelihood. In the words of a young woman in Ethiopia '*parents don't buy girls' clothing, only a husband does*'. In certain cases, young women seemed to regard marriage as entailing certain benefits that girls might not necessarily accrue within the parental home. While young men were said to more often marry early out of choice (see box 4), like young women, this choice was often a limited one, for example in the case of having 'impregnated' a girl or the (felt) need to comply with particular parental wishes.

**Indicators 2 and 3** represent globally used indicators for child marriage, that is, the percentage of women aged 20-24, married before the age of 18 or 15. The household surveys provide data on, among other things, gender, age, marital status and the age of first marriage of all the household members. Rates of women aged 20-24 years old who were married before age 18 vary considerably across countries, from a relatively low rate of 20% in Uganda and Sierra Leone to a high of 71.1% in Ethiopia. As the bar chart below clarifies, the rate of women between 20-24 married before the age of 15 years was still above 10% in six countries and 20% or above in two: Sierra Leone (20%) and Ethiopia (26.7%) (Figure 3; Table 51 A4).

**Figure 3: Share of women aged 20-24 in studied households who married before age 18 (IND2) and before age 15 (IND3) (%)**

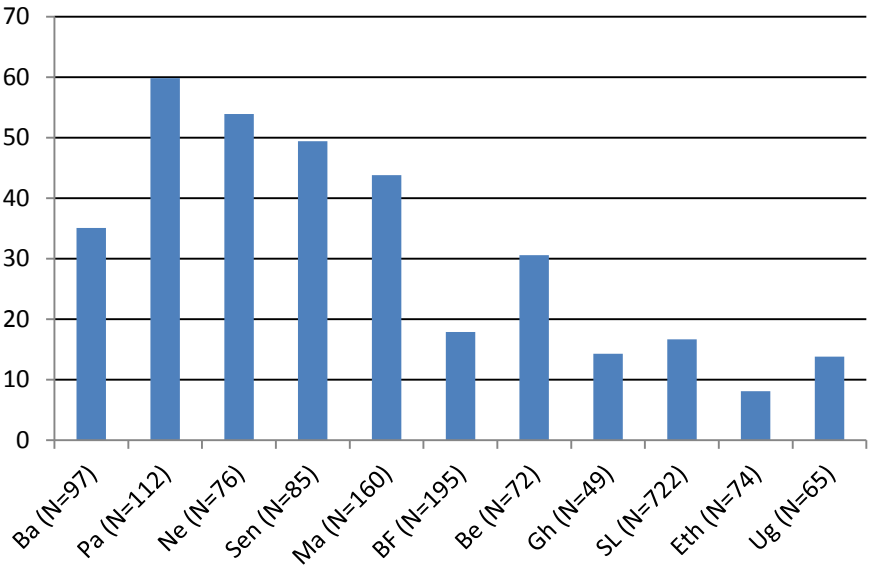



* None of the 20-24 year olds was married before 15 in Uganda

**Indicator 4** measures the share of interviewed girls who were married or 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 52 A4 shows that, of the 12-14 year olds very few were married, but that this figure increases sharply with age. The marriage rates of the 17-year olds most closely approach global indicators of child marriage, defined as share of 20-24 year olds who were married before they turned 18.

As can be seen in Figure 4, the data indicate that Ethiopia had the lowest percentage of 17-year old girls (ever) married (8.1%), whereas Pakistan had the highest (59.8%). Generally, the figures are higher in the South Asian countries, and in Mali and Senegal. 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. 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.

**Figure 4: IND4 Share of 17-year old girls (ever) married (%)**




*Supporting information*

Concerning types of marriage, in the three South Asian HC countries more than four out of every five girls report that their marriage was arranged. For instance, in Pakistan 94.1% of girls who have ever been married indicated being in an arranged marriage. Only one girl in respectively, Pakistan, Ghana and Sierra Leone reported having been forced to marry. In Nepal, 11% of girls reported they were in a love marriage and 6.3% that they had eloped with their now spouse. 'Love marriage' and elopement were less common in Pakistan and Bangladesh (Table 68 A5).[5]

Village leaders were asked to identify the three most common types of marriage in their villages. Most commonly mentioned marriages were those that had taken place in the mosque or church. In Burkina Faso and Ethiopia more than half of the village leaders reported 'informal' marriage to be common. Noteworthy is that few leaders mentioned formal marriages through registration; this form of marriage was only commonly found in sampled villages in Bangladesh and Pakistan, and in half of the sampled villages in Sierra Leone and Ghana. In Ethiopia, 'formal marriages' were mentioned regularly in only four out of 20 sampled villages. Striking is the occurrence of love marriage across villages in Nepal (Table 69 A5).

One of the negative effects of child marriage is early pregnancy, which is broadly recognised to pose a health risk for both the mother and child. In most countries around 40% of married girls had one or more children, while in Senegal this figure stood at 69.5% and in Ghana at

[5] The numbers of married girls in Ghana, Sierra Leone and Uganda were too small to draw conclusions as to common types of marriage. In the other HC countries in Africa questions as to marriage type were not asked.

71% (5 out of 7 married girls). In Sierra Leone and Ethiopia the percentage of married girls who had children was relatively lower, namely around 20%. Only a few single girls were found to have children, with the highest rates in Uganda (5.2%) and Sierra Leone (6.1%) (Table 3).

**Table 3: Share of girls with child(ren), by marital status (%)**

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Be* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Married* | *N= 52* | *N=103* | *N=63* | *N= 60* | *N=126* | *N=58* | *N=34* | *N=7* | *N=18* | *N=11* | *N=7* |
| With a child | 42.3 | 44.7 | 39.7 | 69.5 | 38.1 | 43.6 | 58.8 | 5/7 | 22.2 | 18.2 | 3/7 |
| *Single* | *N=552* | *N=201* | *N=237* | *N= 240* | *N=788* | *N=912* | *N=271* | *N=258* | *N=279* | *N=733* | *N=320* |
| With a child | 0.2 | 0.5 | 0 | 1 | 1.8 | 1.1 | 3 | 2.7 | 6.1 | 0.3 | 5.2 |

Qualitative information from village leaders and from FGDs with young school going women and men indicate that falling pregnant is 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.

**Box 3: Reasons for early marriage of girl (FGDs)**

The reasons for early marriage of girls mentioned by the FGD participants can be grouped in the four central themes listed below, illustrated by quotes from the FGDs.

**Theme 1: Poverty, securing livelihood and (additional) economic reasons**
Participants spoke of caregivers marrying young women early in order to relieve the burden girls were seen to pose on the family – the girl being another mouth to feed and yet unable to contribute to generating family income. Also, girls themselves may decide to marry early to escape poverty of their parental home (see Box 2). The second and third quote highlight the perceived role of caregivers in ensuring a young woman's future livelihood and the centrality of marriage in fulfilling that parental responsibility, with the latter quote also referring to the economic motive of paying a lower dowry when marrying girls at a young age.

> *'Parents also marry their girl at early age as they are unable to contribute in family income as most of the family on this area live below poverty line'* (Boys, Bangladesh)

> *'Families believe that if she gets married to a rich husband or someone with plots of land, she will have a good livelihood'* (Girls, Ethiopia)

> '*In hilly community if they do not marry their children then people […] will say that if they don't get their daughters married now, they won't find good husband later and also they will have to give more dowries as well'* (Girls, Nepal)

**Box 3 *(continued)*: Reasons for early marriage of girl (FGDs)**

**Theme 2: Regulating young women's sexuality**

Caregivers were found to be concerned about young women's sexuality and specifically, the possibility of a premarital pregnancy. Across the 11 countries, the FGD participants indicated that girls were married early as a means to prevent elopement, abduction, 'eve teasing' (Bangladesh and Nepal) and/or out of wedlock pregnancies, all of which were seen to cast shame upon the family. Early marriage was thus a means to prevent the possibility of girls bringing dishonour upon their family. The penultimate quote below brings into sharp relief concerns regarding young women's safety, and the apparent inevitability of sexual violence against unmarried women in particular. This quote – and participant narratives more broadly – is illustrative of the perception that once a young woman reaches a certain age, caregivers can no longer provide adequate protection. As the final quote indicates, neighbours and other community members may play a crucial role in decision-making processes of caregivers.

'*Les filles sont mariées tôt pour qu'elles ne soient pas engrossées par les jeunes du quartier. Alors qu'elles ne sont pas mariées*.' (Boys, Mali)

'*Parents don't trust their daughters as they grow older*' (Girls, Pakistan)

'[Parents marry their daughter] *si la fille est trop frivole'* (Girls, Burkina Faso)

'*She will be raped if she is not married'* (Boys, Ethiopia)

'*Often neighbours spread rumours about unmarried younger girls. […] When my elder sister was thirteen [our] neighbours complained to [my] parents that their daughter had pre-marital affairs. The neighbours also said that her sister's character is bad. After hearing these, her parents quickly marry off her sister.*' (Girls, Bangladesh)

**Theme 3: Education and early marriage**

Young people spoke of the relationship between education – of either girls and/or their parents/caregivers – and the occurrence of early marriage. Young people recounted caregivers' inability to finance girls' education combined with – as the quote from the girls' FGD in Ethiopia illustrates – the perceived lack of benefit of educating a girl. Young people referred to parental lack of awareness, of caregivers being 'uneducated,' implying that girls from educated families would not be married off early.

*'When [girls] lose hope in schooling, they drop out and get married'* (Girls, Ethiopia)

*'The community believes that education is not for girls. There is a saying that goes 'the kitchen is a girl's place''* (Girls, Ethiopia)

'[Girls are married early] *due to a lack of education of parents*' (Girls, Sierra Leone)

'*Girls are illiterate and [thus] easily persuaded*' (Girls, Nepal) and '*Because girls fail exams'* (Boys, Nepal)

### Box 3 *(continued)* Reasons for early marriage of girls (FGDs)

**Theme 4: Beliefs, customs and tradition**

This set of reasons might be defined in terms of what is 'commonly done,' or the 'way things are.' Upon closer inspection, the notion of 'social pressure' may best be understood in relation to efforts to regulate young women's sexuality in view of the shame that is brought upon families as a result of premarital sexual relations. Similarly, beliefs concerning young women's diminishing beauty and concurrent reduced chances of becoming married/securing a good marriage may be related to caregivers' (and possibly girls') concerns regarding her future livelihood. The below quote regarding parents going to heaven when marrying their daughter before she starts menstruating can be understood in relation to concerns regarding young women's sexuality and the need for regulation thereof, but similarly in relation to the perception that a young girl is more beautiful and thus better able to secure a good/beneficial match. These issues and possible underpinning motivations merit further research, however.

> *'The superstition in society that the beauty of [girls'] faces will be reduced when they become aged*' (Boys, Bangladesh)
>
> *'There is perception in the community that if a girls doesn't get married early, she will remain unmarried for the rest of her life*' (Girls, Ethiopia)
>
> '*Parents will go to heaven if they marry their daughter before menstruation'* (Girls, Nepal)
>
> *'La tradition qui fait qu'on donne des filles en mariage même avant leur naissance*' (Boys, Burkina Faso)

### Box 4: Reasons for early marriage of boys (FGDs)

Participants indicated that young men generally sought to complete (basic levels of) their education and securing an income before getting married. One young Pakistani man clarified: 'boys should not be married early as they first need to have a job,' while young men in Ethiopia talked about first needing to 'accumulate enough money,' indicative of men's primary responsibility as breadwinner.

While young men reportedly did not marry early as often as young women did, 'love affairs' was one of the most frequently mentioned reasons for young men's early marriage across the research sites. For example, young men in Ethiopia spoke of young men 'not letting another man marry the girl he loves,' young men in Ghana talked about 'satisfying sexual desires' as a reason for young men to marry early, while young men and women in Sierra Leone highlighted young men's desire to father children as a reason for young men's early marriage. Particularly the latter two quotes highlight that for young men too marriage appears to provide a legitimate context for sexual relations. This motive comes to the fore most strongly in the account provided by an FGD participant in Bangladesh of a young man who, according to the narrator, watched porn on his mobile phone and (as a result) threatened his parents that he would 'do suicide' if they did not marry him 'off' (FGD, boys, Bangladesh).

**Box 4 (*continued*): Reasons for early marriage of boys (FGDs)**

In Her Choice countries in Africa 'impregnating a girl' was reportedly an additional central driver for young men's early marriage. Participants furthermore explained young men's early marriage in relation to the (felt) need to secure a young woman's support for her mother-in-law in fulfilling domestic duties and/or for himself, for example, in tilling the land. Other young men spoke of young men complying with their parents' desire to 'see their grandchildren before they died' (Boys, Bangladesh). In a similar fashion, young people in Nepal spoke of young men marrying early to satisfy their parents wish to meet their daughter in law before they died. Young men and women in Pakistan mentioned 'religious guidelines' as a reason for early marriage of both young men and women, while in both Bangladesh and Nepal young people referred to parents marrying their sons early in an attempt to 'improve bad habits' (Nepal) and 'relieve addiction' (Bangladesh). Concerning the latter, while it was not clarified what kind of addiction marriage would relieve, the quotes suggest that young people believed that married life was regarded as having a positive influence on young men.

**Indicator 5** concerns the share of girls who have undergone FGM/C. Female genital cutting occurs only in the African HC countries, with rates varying considerably. In Uganda, Benin and Ghana, for example, the rate of girls who had undergone FGM/C was close to zero, while in Mali more than 97% of girls had undergone the procedure. In Burkina Faso, Sierra Leone and Ethiopia FGM/C was considerably more prevalent among married than among single girls (Table 4).

**Table 4: IND5 Share of girls to have undergone FGM/C, by marital status (%)**

| | *Be* | *BF* | *Sen* | *Ma* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|
| *Single girls* | *N= 271* | *N= 912* | *N= 249* | *N= 788* | *N= 258* | *N= 274* | *N= 733* | *N= 320* |
| **IND5** | **1.5** | **37.6** | **46.4** | **97.4** | **1.7** | **36.7** | **30.9** | **1.1** |
| *Married girls* | *N= 34* | *N= 58* | *N=61* | *N= 126* | *N= 7* | *N= 23* | *N= 11* | *N= 7* |
| **IND5** | **2.9** | **57.1** | **66.7** | **98.4** | **0** | **50** | **72.7** | **0** |

*Supporting information*

Unsurprisingly, only in Mali, where almost all girls involved in the study had been cut, the majority of heads of households (65.3%) were of the opinion that female genital cutting was good for girls, and 14,7% considered FGM/C to be good for parents. In all other countries, the majority of household heads regarded FGM/C to be bad for girls and parents: for instance, in Senegal 58% of household heads thought FGM/C was bad for girls and parents, while in Uganda 85.2% of household heads reported negative opinions about FGM/C (Table 70 A5).

Upon asking village leaders whether FGM/C was common in their villages, all four leaders involved in the study in Sierra Leone, 11 out of 13 in Mali and 10 out of 20 in Ethiopia indicated the procedure was regularly performed. In all other countries a minority (Burkina

Faso) or none of the village leaders report that FGM/C was commonly conducted at present. According to village leaders in Burkina Faso and Mali, FGM/C occurred at an early age (at age 1 in Burkina Faso and between 1 and 7 years old in Mali), while in Ghana and Sierra Leone the procedure was reported to take place during or after puberty (Table 71 A5).

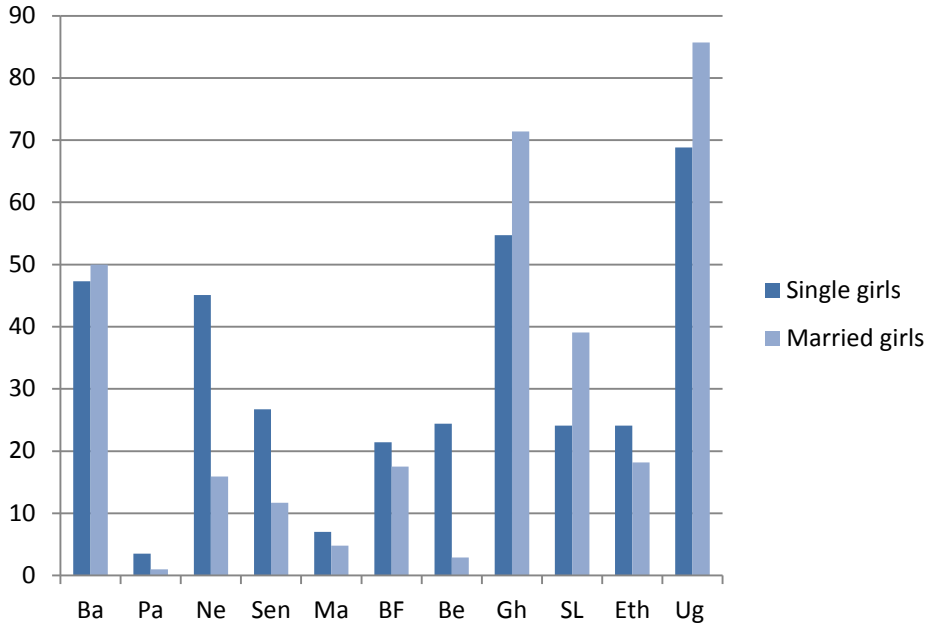
## 4.2 Indicators Strategy I: Invest in girls, their knowledge, skills and participation in society

Within the framework of Strategy I girls are offered various educational programmes with a view to building their knowledge and skills with respect to SRHR, public engagement and rallying for young women's decision-making power.

A central output of the programme concerns the number of girls educated on SRHR (IND29), including on negative effects of child marriage and FGM/C. The expected intermediate outcome relates to young women's comprehensive knowledge on SRHR (IND 18), with the outcome that they have confidence in opposing a marriage (IND6.1) and FGM/C procedure (IND6.2) against their will. In addition, expected outcomes relate to girls' skills to refuse unwanted sex (IND 7) and abilities to use contraception in a sexual relationship (IND8).

At baseline level, the range of surveyed girls who had received SRHR-related education (IND 29) varied greatly – from 3.5 % of single girls in Pakistan to 68.8% of single girls in Uganda. Generally, married girls were found to have received less education than single girls, except in the case of Bangladesh, Ghana, Uganda and Sierra Leone (Figure 5).

**Figure 5: IND29 Share of girls educated on SRHR-related issues (%)**



In-country regional variation in trained girls was also considerable: for instance, in Ethiopia the share of trained single girls ranged from 10.7% to 31.5% (Table 53 A4).

*Supporting information*

SRHR-related education was mostly given as part of the school curriculum and in certain countries (Mali and Burkina Faso) by health care workers. Only in Mali (16.4%) and Sierra Leone (22.7%) a substantial share of girls said they had received SRHR-related education from an NGO (Table 72 A5).

Young women who had taken part in SRHR-related education were asked about the topics that had been covered. The reported range of topics addressed during SRHR-related educational initiatives was found to be relatively comprehensive. The majority of young women (75% and over) in all countries reported having learned about the importance of girls' education and access to health care, the menstrual cycle and pregnancy, STIs and HIV, and male and female contraceptives. In most countries a majority (over 50%, but less than 75%) learned about negative effects of CM, laws against CM, and puberty and bodily changes. Considerable differences were found in terms of whether or not young women reported having been taught about intimate and sexual relationships, gender relations and equality (Table 73 A5). As will be discussed in greater detail below, and despite reports as to SRHR-related education received, young women displayed low levels of SRHR-related knowledge.

**Box 5: Sources of SRHR-related education and information (FGDs)**

During FGDs young people were asked how and where they received SRHR-related education and information. In some research sites, for example Sierra Leone and Burkina Faso, young people mentioned a very wide range of sources, including radio, school, various family members, NGOs, health centres, church clubs, youth clubs, media, internet and at markets/from street hawkers. Noteworthy is the fairly frequent mention of the Church and 'pastors' as sources of information, with young women in Benin making explicit mention of the 'Bible' as a source of SRHR-related information. In other contexts, such as Ethiopia, Bangladesh and Pakistan, young people reported extremely few or no sources of information. In Pakistan, for example, boys lamented the lack of information, clarifying that while there was a health centre where '*eldery women'* could go to for *'problems,'* there was nothing for men.

In Burkina Faso, Bangladesh, Pakistan (girls only), Ethiopia, Ghana, Nepal and Uganda young people reported having learned about SRHR in school and/or from teachers. In Nepal young women reported having learned about SRHR in school from visiting health workers, while young men in Nepal explicitly mentioned their teachers (only to admit to knowing very little '*because we do not have lessons on it'*). In the case of Ethiopia, during one FGD young women recounted having received SRHR-related education during biology class 'since grade 4,' while during an FGD in a different *kebele* [village] girls indicated never having received SRHR education in school. Young men from this same *kebele* did recall having had SRHR education at school, specifically during *'flag raising sessions.'* In Bangladesh young men and women mentioned their (science and physical education) textbooks contained SRHR-related information, but that their *'teachers avoid these topics and don't teach about these'* (Boys). Girls mentioned *'shyness'* on the part of both teachers and girl students to engage with SRH topics.

**Indicator 18,** the intermediate outcome of SRHR-related education concerns levels of comprehensive SRHR-related**.** Girls were deemed to have 'comprehensive knowledge' if they answered all following five questions correctly: 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) knows of male condom, 4) knows of contraceptive pills, and 5) mentions at least one negative effect of CM. Table 5 presents findings as to young women's comprehensive knowledge and the mean (minimum 0, maximum 5) by marital status, while Table 74 A5 presents the right knowledge to each of the five questions.

**Table 5: Share of girls with comprehensive knowledge on SRHR (IND18.1) and mean degree of knowledge on SRHR (IND18.2), by marital status (%)**

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|
| *Single girls* | *N=552* | *N=201* | *N=237* | *N=240* | *N=788* | *N=912* | *N=258* | *N=274* | *N=733* | *N=320* |
| **IND18.1** | **0.9** | **0** | **6.3** | **0.8** | **2.2** | **1.2** | **1.6** | **2.9** | **0.8** | **0** |
| **IND18.2** | **1.84** | **0.88** | **1.84** | **1.56** | **1.8** | **1.89** | **2.07** | **2.1** | **1.97** | **0.83** |
| *Married girls* | *N= 52* | *N=103* | *N= 63* | *N= 60* | *N=126* | *N= 58* | *N=7* | *N= 23* | *N= 11* | *N= 7* |
| **IND18.1** | **7.7** | **0** | **3.2** | **5** | **4.0** | **1.8** | **1/7** | **0** | **0** | **0** |
| **IND18.2** | **3.04** | **1.45** | **1.78** | **2.81** | **2.45** | **2.1** | **3.29** | **1.91** | **2.18** | **1.29** |

The rates of both single and married young women with comprehensive SRHR-related knowledge were found to be extremely low (close to zero in all countries). In Nepal, with the highest score for single girls, only 6.3% of single girls could answer all five questions correctly. In Bangladesh the highest score of married girls with comprehensive SRHR-related knowledge were found, but even in this case this rate was only 7.7%. The mean degree of SRH knowledge ranged from 0.83% (Uganda) to 2.1% (Sierra Leone) for single girls, and from 1.29% (Uganda) to 3.29% (Ghana) for married girls. Married girls in all countries bar Nepal and Sierra Leone score higher on mean SRHR-related knowledge than single girls.

*Supporting information*

With respect to the five specific questions that had been selected to assess levels of comprehensive knowledge, young women generally knew least as to when in the menstrual cycle a woman had most chance of becoming pregnant, with a low of 0.5% of single girls in Pakistan and a relative high of 20.3% of single girls in Nepal. Knowledge was low among single girls with regard to whether or not a woman could become pregnant the first time she had sexual intercourse, ranging from a low 7% in Pakistan to a relative high of 44.7% in Ghana. Single girls were most knowledgeable as to the negative effects of CM and, on the whole, married girls were more knowledgeable on all five topics (Table 74 A5).

### Box 6: 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)'. Below a number of quotes are provided to illustrate key themes emerging from the data.

> *'[We think of] something bad'* and *'It is personal, secret'* (Girls, Bangladesh)
>
> *'[We think of] abduction, pregnancy […] and harmful traditional practices'* (Boys, Ethiopia)
>
> *'[SRHR] is related to having health sexual relations and also think about the problems it can bring, [such as] STIs.'* (Boys, Ghana)
>
> *'Cleanliness of the reproductive system'* (Girls, Uganda) and *'Keeping the reproductive organs healthy'* (Boys, Uganda)
>
> *'No family planning [means parents will not be able to provide] for the needs of children in a balanced manner'* (Girls, Ethiopia)
>
> *'La contraception, l'espacement des naissances [et comme on] prendre soin des enfants'* (Boys, Mali)
>
> *'[We think about] menstruation, about girls becoming shy and fashionable and looking in the mirror frequently.'* (Girls, Nepal)

The quotes above are reflective of a number of issues. First, they highlight the largely negative connotations of the term 'SRHR' among young people involved in the study, whereby sexual relations are largely discussed in relation to various risks, notably (teenage) pregnancy and STIs. Young women in Sierra Leone mentioned thinking about the '*rape and abuse'* of young women when they heard the term 'SRHR.' In light of the latter, the remark *'Bad things come to our minds*' (FGD, young women, Ethiopia) is possibly unsurprising. Particularly in the case of Ethiopia the notion of 'harmful traditional practices' was frequently mentioned in relation to SRHR, which is likely to refer to early marriage and FGM/C.

Second, young people referred to the relationship between sexual intercourse and reproduction. As young women taking part in an FGD in Sierra Leone stated, 'SRHR' was about *'men and women reproducing,'* while young women taking part in an FGD in Ethiopia clarified: '*It is sexual intercourse between a male and a female who have come of age for procreation.'* The reference to 'coming of age' and 'men and women' suggests that reproduction – and thus sexual relations – was seen as happening within the realm of adulthood.

Third, the quotes suggest that the SRHR-related education provided to young people was largely of a factual nature: addressing bodily changes during adolescence, family planning, questions of personal health and hygiene.

While the final quote above suggests that young people also thought about emotions and emotional changes during adolescence (as well as denoting a slightly more light hearted understanding of 'SRHR'), overall, participants' accounts suggested there was little attention for discussion of feelings, relationships or sexuality and sexual relations as potentially positive.

It should be noted that many young men taking part in FGDs in Pakistan, Nepal, Bangladesh as well as Uganda did not know what the term 'SRH' referred to.

### Box 7: What do young people want and need to know about SRHR? (FGDs)

When asked what they felt young men and women *should* and wanted to learn about SRHR, very similar topics were mentioned as those they had received education on (see Box 5), suggesting that the education received was not sufficiently comprehensive. For example, during an FGD in one of the research sites in Ghana, girls mentioned learning about teenage pregnancy in school and the reproductive system. When asked what they would like to learn about, the same girls reported wanting to learn about menstruation (*'when a girl should bleed'*) and pregnancy (*'can a girl get pregnant before menstruation?'*). Noteworthy here is that girls taking part in the FGDs in Ghana indicated that the information they received from home differed to that which they were taught in school.

In addition, young people indicated that young women/men ought to and/or wished to learn about (the negative effects of) early marriage and early pregnancy, FGM, and how to *'prevent sexual relations'* or *'how to control their sexuality'* (Girls, Burkina Faso; Boys, Ghana).

Young people also mentioned wanting to learn how to have a *'satisfying married life'* (FGD, Bangladesh), suggesting they were also interested in learning about more than prevention of disease, pregnancy and the consequences of 'harmful traditional practices.'

The excerpt below from an FGD with young men in Nepal is illustrative of just how little some young people involved in the study seemed to know about sex and sexual relationships:

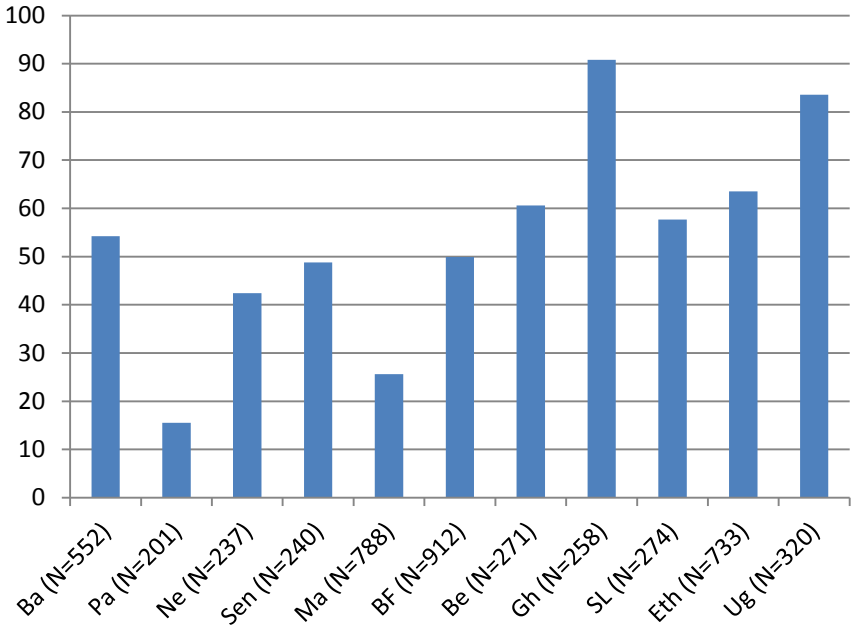
> Facilitator*: In your view, do youths today want to know about sexual and reproductive health?*
> Participant 1 (P1): *They do want to know*.
> Facilitator: *Why do they want to know*?
> […]
> P1: *Can you tell me about what is sex? Can I get information on that?*
> Facilitator: *I just wanted to ask whether youths want to know about the sexual health or not*?
> P1: *No, can you provide information on sexual health. What is sex*?
> Facilitator: *Ok, I will answer that question later*.

Following this exchange the facilitator tried to find out whether young people wanted to learn about SRHR and why. Striking about this exchange is the young man's apparent desire to find out 'what sex is' (rather than engage with questions posed by the facilitator), suggesting he knows (very) little himself.

Reflective of the lack of knowledge was the statement made during an FGD with girls in Ethiopia that they *'want to know about things we don't know.'* Levels of knowledge appear to be so low that young people are not even aware of the kinds of SRHR-related topics and issues they could potentially learn about.

**Indicator 6.1,** which is an outcome indicator, measures whether girls feel able to oppose a marriage that is arranged against their will. At baseline level the percentage of girls who thought they were able to do so, ranged from a low of 15.5% in Pakistan to a high of 90.8% in Ghana (Figure 6). Within countries there was considerable regional variation, for instance, in Mali the rate of girls who believed they could oppose such a marriage ranging from 8.2% to 43.8% (Table 54 A4).

**Figure 6: IND6.1 Share of single girls who feel they can oppose CM (%)**




*Supporting information*

**Box 8: When is marriage too early? (FGDs)**

> *'Early marriage means getting married before maturity, which means getting married below the age of 18'* (Boys, Ethiopia)

FGD participants listed a wide range of possible age brackets to define when a marriage was too early. As the quote above illustrates, many identified 18 years as the cut off year for both young women and men. Many other age ranges were also mentioned, making it difficult to identify any common trends. Noteworthy was the tendency among participants to set lower cut off ages for women when defining when a marriage was early than for they did for young men. For example, a group of young men (Ethiopia) indicated that 'too early' for a young woman or a young man was when marriage took place between, respectively, 14-17 years and between 15-16 years of age, while young women in Sierra Leone stated that marriage was too early for a young woman when she was 14 years and too early for a young man when he was 18 years old. In addition to providing specific age ranges, participants provided responses that were more open to interpretation, for example:

> *'Early marriage is forced marriage, or marriage without consent'* (Girls, Sierra Leone)

> *'Early marriage is when couples are still going to school'* (Boys, Ghana)

> *'[Early marriage is] when a girl is married against her will'* (Girls, Burkina Faso)

> *'[Early] marriage is marriage before getting physical strength'* (Boys, Bangladesh)

As the quotes show, an 'early' marriage was not always defined in relation to chronological age but instead related to notions of consent, force, physical maturity and schooling trajectories. Young people's engagement with such notions might indicate greater awareness of, among other things, formal child rights and the health-related consequences of early marriage and childbearing.

### Box 9: Advantages and disadvantages of early marriage (FGDs)

> *'Early marriage [means] the girl will be strong when giving birth, and marrying a wealthy man will mean a girl and her baby [are] taken care of'* (Girls, Ghana)
>
> *'[Early marriage] brings about independence and freedom'* (Girls & Boys, Uganda)
>
> *'Girls are not physically matured when early marriage is done so it will be danger for both mother and child also they will not have bright future and financially also they will be weak'* (Boys, Nepal)

Highlighted by the quotes above, young women and men identified a range of possible benefits as well as harms that could result from an early marriage. On the whole, participants listed (far) more disadvantages than advantages of an early marriage.

**Benefits** related to attaining independence, having access to resources, being able to satisfy 'sex desires' (Boys, Uganda) and providing safety for young women. Concerning the latter, young men in Bangladesh indicated that *'it is not safe for a young unmarried girl to move around,'* suggesting that the status as married woman might offer a degree of protection from sexual harassment.

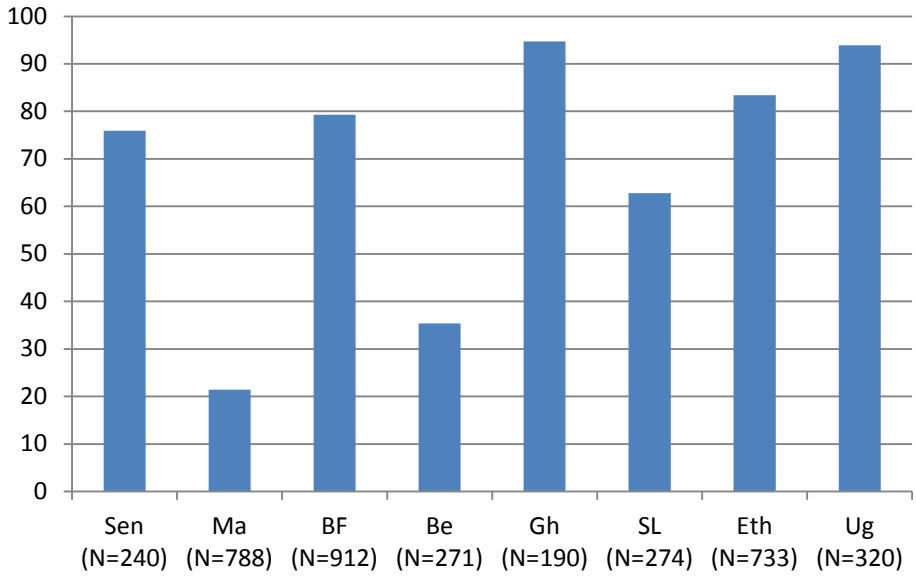
**Negative impacts** of early marriage related primarily to health concerns for mother and child, girls 'stopping their education' (Girls, Pakistan), the inability of young mothers/parents to bear responsibility for the care of a child, domestic 'quarrels' and domestic violence. Conflict, violence and divorce were mentioned on several occasions, young women in Bangladesh indicating, for example, that:

> *'Due to early marriage rate of divorce is increasing in society and it is one of the most negative impact of early marriage. [A] girl's face [will be] damaged because of giving birth at [an early] age, then the husband get married with other girl as he lose concentration over her. [This will] make chaos in the family.'*
>
> *'Due to early marriage girls have to face physical torture by her husband. Sometime their husband also divorce them.'*
>
> *'Because of early marriage both mother and baby suffer from malnutrition and family trouble increased.*

The quotes highlight that early marriage was regarded to potentially have broader ramifications, negatively affecting not only the physical health of mother and child but also relating early marriage to poverty and/or neglect (malnutrition) and as leading to disunion in families. Other than hinting at the reduced power of a young woman in marriage and in relation to her spouse and in-laws, and explaining that a young woman's *'body and mind are not yet ready for marital life and responsibilities'*, the precise 'why' of the domestic strife was not made explicit in young Bangladeshi women's or young men's accounts. In statements made by young Ghanaian women, the 'fighting' also appeared to be related to (relative) age. On their view, 'fighting' happened because 'you are not developed for marriage,' with an additional disadvantage of a woman's (or man's) young age being a 'lack of knowledge on how to raise a family.' Marriage and raising a family, in other words, was seen to require a degree of maturity on the part of both partners.

**Indicator 6.2** measures the percentage of girls who have negative views of female genital cutting. In the countries where (relatively) high rates were found of girls having undergone FGM/C (such as Mali and Sierra Leone), lower percentage of girls indicated they considered female genital cutting in negative terms (Figure 7). It should be noted that in research sites in Burkina Faso and Ethiopia, variations between regions were small, whereas in Mali these were substantial – with a range from 4% to 44.8% (Table 54 A4).

**Figure 7: IND6.2 Share of single girls who oppose FGM/C (%)**




*Supporting information*

**Box 10: What is female circumcision? (FGDs)**

Given FGM/C reportedly does not occur in South Asian countries involved in the Her Choice programme, this subject was only discussed with young people from the (eight) Sub-Saharan African countries involved in the programme. When asked what they thought of when hearing the term 'female circumcision,' young people would explain it as *'the cutting off of the upper side of the girl's genitalia'* (Girls, Ethiopia), the cutting of the *'vagina'* (boys, Ethiopia), the *'cutting of the clitoris'* (Girls, Uganda). Upon hearing the term, others indicated they thought of, for example, *'an old custom'*(Burkina Faso) or a *'harmful traditional practice'* (Girls, Ethiopia).

### Box 11: Positive and negative aspects of FGM (FGDs)

Girls and boys in the FGDs associated the practice of female circumcision with various negative health consequences, pain and fear:

> *'Ça me fait penser au sida, à la gonococcie, à la syphilis*' (Boys, Burkina Faso)

> *'En tout cas ['excision] me fait penser à la mort parce que [...] le jour quand elle va avoir un mari, quand elle va tomber enceinte au niveau de l'accouchement ça peut être dur et puis ça peut entraîner la mort de la femme et même du bébé'* (Boys, Burkina Faso)

> *'Ça évoque la douleur et la peur'* (Girls, Mali)

> *'[We feel] very disturbed'* (Girls, Ethiopia)

The negative dimensions and consequences of female circumcision are evident in the accounts provided by young people, and it is striking how often young people speak of the (extra) pain during delivery, blood loss and potential haemorrhage, and *'even death'* (girls, Burkina Faso). Female circumcision was also related to conflict and *'multiple marriage'* because *'Since her sexual desire is dead, there won't be any love between her and her husband'*(Girls, Ethiopia).

At the same time, participants accounts reflect the importance female circumcision is seen to have.

> *'[L'excision aide] la fidélité'* (Girls, Benin)

> *'[L'avantage] c'est moins de frivolité des filles [et] ça facilite le coït'* (Boys, Burkina Faso)

> *'Si une fille n'est pas excisé, elle ne pourra pas avoir d'enfants. L'excision est bonne car elle permet à la fille d'avoir un mari et des enfants rapidement'* (Boys, Mali)

> *'Ça aide une femme à avoir des enfants [et] réduit l'envie sexuelle de la fille'* (Girls, Mali)

The quotes highlight the perceived relationship between circumcision and sexual drive, suggesting the regulatory function circumcision was seen to have. As the first quote from Mali indicates, circumcision was also associated with the transition to womanhood – or in the words of a young Uganda man: *'a way to prove adulthood'* – marriage and consequently, reproduction. Circumcision was thus also regarded as a marker of adulthood as, crucially, respectability. *'[A circumcised girl] is respected,'* young men in Ethiopia clarified.

Views as to whether circumcision was positive or negative were very mixed, with arguments as to the negative health consequences running side by side with those as to the symbolic value of circumcision.

Outcome **indicator 8** relates to use of contraceptives by girls who have started to have sexual relations (here also referred to as girls who are sexually active). Young women were asked whether they had ever had sexual relations with a man, either voluntary or involuntary (Table 6).

**Table 6: Share of girls who reported to have had sexual intercourse, by marital status (%)**

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Be* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Single* | *N=552* | *N=201* | *N=237* | *N=240* | *N=788* | *N=912* | *N=271* | *N=258* | *N=274* | *N=733* | *N=320* |
| Had sex | 0.9 | 2.0 | 0.4 | 3.3 | 7.2 | 15.4 | 44.6 | 10.9 | 10.6 | 3.8 | 33.1 |
| *Married* | *N=52* | *N=103* | *N=63* | *N=60* | *N=126* | *N=58* | *N=34* | *N=7* | *N= 23* | *N= 11* | *N=7* |
| Had sex | 100 | 100 | 100 | 100 | 54.0 | 70.7 | 91.2 | 7/7 | 26.1 | 72.7 | 6/7 |

Generally, a low percentage of single girls reported having had sex, the rates in South Asian countries being particularly low. Relatively higher rates were reported in Burkina Faso (15.4%), Uganda (33.1%) and Benin (44.6%). However, it should be noted that for most single girls involved in the study it was difficult to answer questions as to sexual activity given premarital sex is frowned upon in all HC research sites. Data from Mali and Sierra Leone suggest that early marriage does not always entail the start of sexual relations – in Mali, for example, about half of married girls stated that they did not have sexual relations with their husband, while in Sierra Leone only 26% of married girls indicated they had started having sexual relations with their husband. Conversely, in the three Asian countries, Senegal and Ghana all married girls reported having sexual relation with their husbands.

**Indicator 8** measures the share of the sexually active girls who answered in the affirmative to the question whether she or the man used anything to prevent pregnancy. Contraceptive use among married women in Bangladesh is relatively high (two-thirds of married women), whereas in Pakistan only 12.6% of married women reported using contraceptives. Similarly low rates were found in most African HC programme countries – approximately 15% – except for Burkina Faso (31.7%). Contraceptive use by single sexually active women ranged between 25% in Ethiopia to 68.6% in Uganda (Table 7).

**Table 7: IND 8 Share of sexually active girls who use contraception, by marital status (%)**

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Be* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Single* | *N= 5* | *N=4* | *N= 1* | *N= 8* | *N= 57* | *N=140* | *N=121* | *N= 28* | *N= 29* | *N= 28* | *N=106* |
| **IND8** | **1/5** | **1/4** | **1/1** | **2/8** | **29.8** | **48.6** | **46.3** | **38.5** | **36.7** | **25** | **68.6** |
| *Married* | *N=52* | *N=103* | *N= 63* | *N= 60* | *N= 68* | *N= 41* | *N= 31* | *N= 7* | *N=6* | *N= 8* | *N= 6* |
| **IND8** | **66.7** | **12.6** | **15.9** | **16.7** | **14.7** | **31.7** | **29** | **3/7** | **1/6** | **5/8** | **5/6** |

*Supporting information*

With respect to the type of contraception used, the (albeit limited) data suggest that single girls mainly used male condoms and married girls pills and male condoms. In Mail, Burkina Faso, Ghana and Sierra Leone some young women also mentioned using female condoms (Table 75 A5).

Questions were also asked as to whether sexually active young women sought to prevent sexually transmitted infections, including HIV. Generally, single girls more frequently indicated using methods (male or female condoms) with a view to preventing STIs than did married girls. The maximum use rates of condoms for STI/HIV prevention by single girls was 41.4% in Burkina Faso and 33.3% (Mali) and the minimum 17.2% in Sierra Leone. By way of comparison, in Mali only 14.9% of married young women used a condom with the aim to prevent STIs (Table 76 A5).

**Indicator 9** measures one of the other intended outcomes of SRHR-related education, that is, young women's ability to speak out about young women's and men's rights in public meetings, including their right to education, not to marry before legal age of marriage and not to undergo FGM/C. They could do so, for instance, during community meetings, in school, or rallies. Table 8 shows that in most countries only a few single and married young women indicated having spoken out, with relatively more single girls in Senegal doing so (23.8%), followed by single girls in Uganda (19.7%). Generally, except in Burkina Faso, relatively more single than married girls speak out in community meetings.

**Table 8: IND9 Share of girls who have spoken out in community meetings/rallies on their rights (%)**

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Be* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Single girls* | *N=552* | *N=201* | *N=237* | *N=240* | *N=788* | *N=912* | *N=271* | *N=258* | *N=274* | *N=733* | *N=320* |
| **IND9** | **10.9** | **2** | **1.3** | **23.8** | **4.7** | **11** | **15.9** | **15.1** | **13.9** | **5** | **19.7** |
| *Married girls* | *N= 52* | *N=103* | *N= 63* | *N= 60* | *N=126* | *N= 58* | *N= 34* | *N= 7* | *N= 23* | *N= 11* | *N= 7* |
| **IND9** | **5.8** | **1** | **1.6** | **5** | **1.6** | **17.2** | **5.9** | **2/7** | **13** | **0** | **1/7** |

## 4.3 Indicators Strategy II: Improve access to formal education for girls

Within the context of the HC programme, teachers and school managers are going to be trained on SRHR and schools will be supported to create more girl-friendly environments with a view to improving young women's access to formal education.

**Indicator 30.1** measures the share of schools with trained SRHR teachers. **Indicator 30.2** measures the share of interviewed teachers that had received education on SRHR.

**Table 9: IND30.1 Share of schools with trained teachers**

| | *Ba* *N= 4* | *Pa* *N=4* | *Ne* *N=5* | *Sen* *N=2* | *Ma* *N= 14* | *BF* *N= 25* | *Gh* *N= 4* | *SL* *N= 4* | *Eth* *N=20* | *Ug* *N= 3* |
|---|---|---|---|---|---|---|---|---|---|---|
| **IND30.1** | **1/4** | **0** | **0** | **1/2** | **2/14** | **5/25** | **2/4** | **3/4** | **9/20** | **1/3** |

The data indicate that it was only in Sierra Leone that a majority of schools had teachers who had received training to teach young people about SRHR. In Pakistan and Nepal none of the schools had SRHR trained teachers (Table 9).

As mentioned in section 2.5.1, sampling of teachers for the baseline study was geared to including those that provided students with SRHR-related education. Data in Table 10 indicate that many teachers who were providing SRHR education at the time of the baseline study had not received any specific SRHR-related training themselves. In Pakistan and Nepal, for example, none of the teachers had received any such training. Conversely, in Sierra Leone 7 out of 8 had been trained.

**Table 10: IND30.2 Share of interviewed teachers trained**

| | *Ba* *N= 6* | *Pa* *N= 4* | *Ne* *N= 7* | *Ma* *N= 27* | *BF* *N= 24* | *Gh* *N= 4* | *SL* *N=8* | *Eth* *N= 25* | *Ug* *N= 6* |
|---|---|---|---|---|---|---|---|---|---|
| **IND30.2** | **3/6** | **0** | **0** | **7/27** | **11/24** | **2/4** | **7/8** | **3/25** | **3/6** |

*Supporting information*

The accounts provided by teachers who had received SRHR-related training indicate that their training often had not been comprehensive. Questions were asked as to who had organised the training, which topics had been addressed, length of training, whether in-service supervision was provided, and whether teachers were satisfied with the training received. The data indicate that most teachers (across the 11 countries) had taken part in a training provided by an NGO or had received in-service training offered by a (governmental) teacher training institution. Burkina Faso formed somewhat of an exception – here 3 out of 11 trained teachers reported having received training from a health institution. Teachers in

Ghana and Sierra Leone indicated having taken part in pre-service SRHR-related training. Most commonly mentioned training topics in nearly all countries included: reproductive systems, puberty (female), menstruation, STIs, pregnancy and abstinence. Less frequently mentioned topics related to intimate relationships, contraceptives and puberty (male). Only in Bangladesh and Ethiopia did all trained teachers involved in the study report that they considered the training to have been sufficient, in the other countries this was a minority of trained teachers. Very few teachers who were providing SRHR-related education to young people at the time of the study mentioned receiving in-service support. The few who did – in Bangladesh, Burkina Faso, Ghana and Ethiopia – received support from government and /or NGOs (Table 77 A5).

**Indicator 31** measures the share of school principals who reported having taken measures to make their school more girl-friendly. Nearly all school principals indicate they have taken such measures (Table 11).

**Table 11: IND31 Share of schools taken girl friendly measures, according to school principal**

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|
| | *N= 4* | *N= 4* | *N= 5* | *N= 2* | *N= 14* | *N= 25* | *N= 4* | *N=4* | *N=20* | *N= 6* |
| **IND31** | **4/4** | **4/4** | **5/5** | **2/2** | **12/14** | **19/25** | **4/4** | **4/4** | **15/20** | **6/6** |

*Supporting information*

Concerning the measures taken and/or that could be taken to improve the girl-friendliness of schools, principals involved in the study mentioned a wide range of issues (Table 78 A5.) At the same time, some principals reported not having taken or having planned any particular steps. The most popular measures taken – but not by all – related to appointing a school counsellor, establishing a girls' club and creating separate sanitary facilities for girls and boys. Very few principals mentioned having sanitary pads available or having their schoolyard fenced.[6] None of the schools had taken or was planning a set of comprehensive measures to make the school more accessible to girls.

[6] Features of 'girl-friendly' schools mentioned here were identified by local HC partners during the baseline training workshops.

**Box 12: Creating girl-friendly schools (FGDs)**

Young people identified factors relating to young women's safety on the road to school and their safety more broadly as crucial to creating more 'girl-friendly' schools. Young women in Burkina Faso, for example, suggested having caregivers accompany young people on the road to school or housing young people in families residing close to schools, while young men in Burkina Faso suggested going to school in groups and improving lighting in the home (so girls would not need to go outside in the evenings in order to study).

Young people also spoke of 'sensitising' communities as to the importance of education in order to reduce the constraints on, particularly, young women's educational participation posed by caregivers' lack of awareness of the positive potential of education, including for young women.

In other words, young people identified a range of solutions with respect to addressing largely structural issues which were seen to impede regular school attendance of young women in particular.

Only on occasion did young people recommend actions to change the behaviour of young women themselves, young men in Burkina Faso, for example, suggesting that *'sexy clothing'* should be prohibited to improve young women's safety in and on the way to school. Arguably, these remarks are reminiscent of broader tendencies of victim blaming in cases of sexual assault and harassment.

The intermediate outcomes of HC activities related to Strategy II are that teachers are able and feel confident to teach about SRHR **(indicator 19.1**), that schools are girl-friendly (**indicator 19.2)** and that girls are enrolled in school during the last year **(indicator 20**).

Only in Sierra Leone and Uganda all teachers report to be able and confident to teach about SRHR (Table 12).

**Table 12: IND19.1 Share of teachers able and confident to teach SRHR**

| | *Ba* *N= 6* | *Pa* *N= 4* | *Ne* *N= 7* | *Ma* *N= 25* | *BF* *N= 24* | *Gh* *N=4* | *SL* *N=8* | *Eth* *N= 25* | *Ug* *N= 6* |
|---|---|---|---|---|---|---|---|---|---|
| **IND19.1** | **3/6** | **2/4** | **5/7** | **7/25** | **12/24** | **2/4** | **8/8** | **16/25** | **6/6** |

*Supporting information*

Virtually all SRHR teachers involved in the study were of the opinion that girls require additional and/or different SRHR-related education than boys. The main reasons given by teachers included girls being more vulnerable (with respect to their SRHR), facing different problems, needing to learn about pregnancy and childbirth, and girls being too shy to ask questions with boys in the class. Most teachers across most HC programme countries stated that they were able to address all questions that students posed. Exceptions were Pakistan, where two out of four indicated they felt capable of doing so, Mali (13/27), Burkina Faso (14/24) and Ethiopia (16/25). When asked which issues they found difficult to address,

responses varied, but commonly mentioned 'sensitive issues' included sexual orientation, sexual abuse, sexual pleasure, masturbation and sexual intercourse (Table 79 A5).

**Box 13 : Satisfaction with school-based SRHR-related education (FGDs)**

While there is little data on the participants' satisfaction with school-based SRHR-related education, FGDs do indicate that, in most settings, schools and teachers are a source of information on SRHR. As discussed earlier, the quality of this education seemed to vary considerably; accounts of young people from, for example, Burkina Faso, Uganda and Ghana suggest that – relatively speaking – more comprehensive education was provided, while young people from Bangladesh and Pakistan indicated that provision of SRHR-related education in (and outside of) schools was virtually non-existent. Young people in Uganda, Sierra Leone, Ghana, Burkina Faso, Benin and Nepal indicated having found the education provided '*interesting and useful*' (Girls, Benin). At the same time, however, as for example young men and women in Burkina Faso also mention that *'questions often are not answered,'* suggesting – in combination with the low levels of correct SRHR-related knowledge of young people involved in the study – that there is definite scope for improvement.

**Indicator 19.2** measures the present status of girl-friendliness of schools as reported by principals. In all countries bar Pakistan and Ethiopia the majority of principals claimed their schools were girl-friendly (Table 13). However, when analysing the measures taken (as reported by the principal) and using the most basic measures of girl-friendliness, it can be concluded that not all schools that reported to be girl-friendly actually merit this status.

**Table 13: IND19.2 Share of schools principals who claim their school to be girl-friendly**

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|
| | *N= 4* | *N=4* | *N= 5* | *N=2* | *N=14* | *N= 25* | *N= 4* | *N=4* | *N= 20* | *N= 6* |
| **IND19.2** | **3/4** | **1/4** | **3/5** | **2/5** | **9/14** | **15/25** | **3/4** | **2/4** | **5/20** | **5/6** |

*Supporting information*

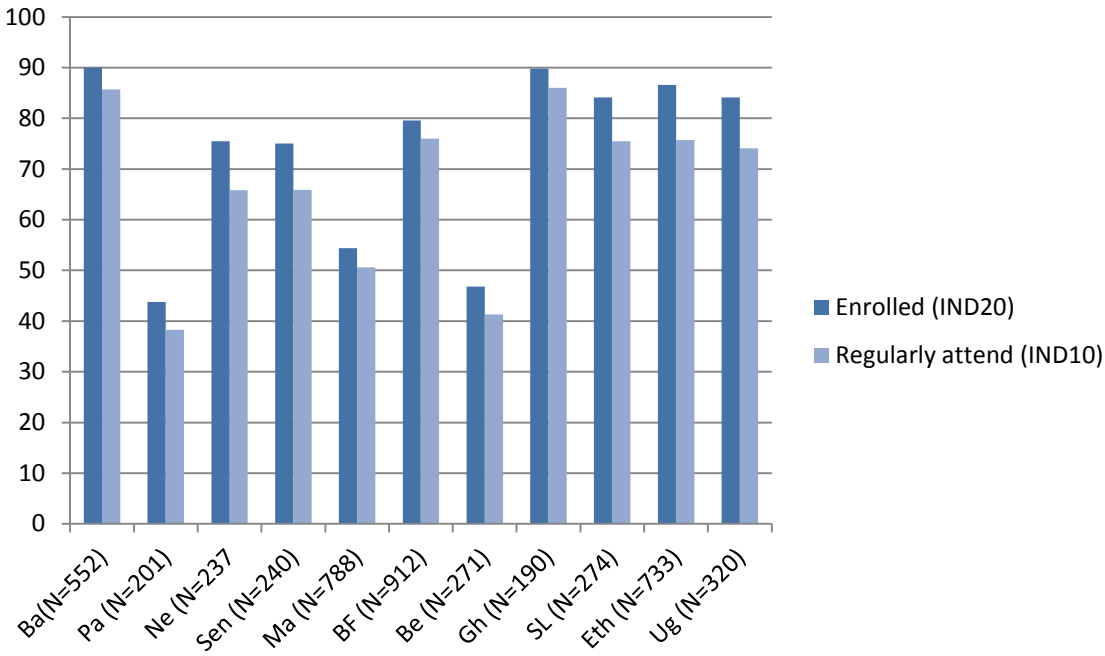
Village leaders' views on girl-friendliness of the primary and secondary schools in their area are presented in Table 80 A5. On the whole, excluding village leaders in Ghana and Ethiopia, leaders were more positive about the girl-friendliness of primary schools than secondary schools. In Ghana and Ethiopia the majority of village leaders were negative about their primary schools. Given students generally had to go to school on foot, the proximity of the school to the village formed the main reason village leaders gave for defining 'their' primary schools as girl-friendly.

While village leaders' reasons for considering the schools lacking in girl-friendliness varied, a number of reasons or factors were mentioned consistently across countries, that is, the distance between schools and villages and the lack of (separate) sanitary units for girls. In

Bangladesh the main reason stated for considering secondary schools girl-unfriendly related to the phenomenon of what was referred to as 'eve-teasing,' that is, the harassment of young women by (young) men. In Ethiopia village leaders also spoke of the fear of abduction of girls on the way to school.

**Indicator 20,** intermediate outcome**,** measures girls' enrolment in formal education in the preceding year. **Indicator 10,** the outcome indicator, measures the share of girls who regularly attended school during the previous year (regular attendance defined as at least four days in a week). This latter indicator was included given school enrolment does not necessarily mean regular school attendance.

**Figure 8: Share of single girls enrolled in formal education (IND20) and regularly attending school (IND10)**




School enrolment of single girls was found to be high in Bangladesh and Ghana, with 90% being enrolled in school. While in most of the other HC countries more than three-quarters of single girls were enrolled, relatively low enrolment rates were found in Pakistan, Benin and Mali. Comparing single girls' school enrolment with their attendance, substantial differences – of 10% or more – can be seen across the following countries: Ethiopia, Senegal, Nepal, and Uganda (Figure 8). The enrolment rates of married girls were noticeably lower than those of single girls in all countries. For married girls Benin (0%) and Pakistan (1%) score extremely low, while Sierra Leone is among the highest. Regional differences for school enrolment were considerable in all countries (Table 56 A4). There are no data as to whether married in-school girls were enrolled before they were married.

*Supporting information*

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. Central reasons given by girls related to their having to do household chores, the family having insufficient income and/or girls having to work to contribute to the household income (the latter mainly mentioned by young women in Bangladesh). Approximately 5% of single girls in Bangladesh, Pakistan, Nepal and Ghana mentioned harassment on the way to school as another reason for not being enrolled in school or irregular attending school (Table 81 A5).

In most countries, excluding Pakistan, Nepal and Benin, more than 60% of the single girls who are not enrolled in school or do not attend regularly, indicated they would like to go to school, or regularly attend. Across countries, fewer married girls tended to report wanting to be enrolled or attend regularly, with exception of married girls in Burkina Faso and Benin (respectively, 63.3% and 51.6%) (Table 82 A5).

**Box 14: Reasons for not attending school and suggested measures to improve educational participation of boys and girls (FGDs)**

Reasons for not attending school were largely located outside the school. That is, during FGDs young women and men primarily identified obstacles to school participation in the home/family, drawing attention to a) household poverty – meaning parents could not pay for transportation, school fees or materials, girls had to stay at home to do chores and/or boys having to work 'for parents in the market' (Ghana) or 'in the fields' (Burkina Faso, Ghana), and/or b) caregivers' lack of interest or awareness of the importance of (formal) education. Additional factors that inhibited school participation related to lack of safety of young women on the road to school, the distance to school, (fear of) corporal punishment in school, and a lack of infrastructure and learning materials in schools. Young women in Burkina Faso, for example, indicated that girls (and boys) did not go to school was due to their being '*afraid of the stick.'*

Concerning how to enhance school attendance and participation, young people in different countries (excluding those in South Asia) identified '*banning physical punishment*' as an important means. In Benin and Nepal additional – and arguably very basic - factors were mentioned that could support more regular school attendance, including availability of electricity, water, a fan in the classroom during summer months and *'comfortable desk and bench in the classroom'* (Nepal). With regard to number, quality and behavior of **teachers,** various suggestions were also provided. Young people in Benin speak of the need for *'teacher recruitment,'* young people in Ghana talk about the need for *'adequate teachers'* and *'teacher punctuality*,' while young people in Nepal spoke of the need for *'teachers regularly attend[ing] the class'* and improving teachers' abilities to *'properly manage the class*.' In Ghana young women mentioned additional teacher-related factors, stating that *'teachers should stop telling the children they are tired when it's their time/period to come and teach.'*

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

To increase access to SRH services for young people, the HC programme will train health staff on youth friendly SRHR services (**IND32**) and referral systems will be set up between schools and health facilities **(IND33**).

**Table 14: IND32 Share of health centre staff who have received training on SRH during the previous year**

| | *Ba* *N=8* | *Pa* *N=4* | *Ne* *N=4* | *Sen* *N=3* | *Ma* *N=24* | *BF* *N=15* | *Gh* *N=4* | *SL* *N=8* | *Eth* *N=20* | *Ug* *N=3* |
|---|---|---|---|---|---|---|---|---|---|---|
| **IND32** | **5/8** | **3/4** | **2/4** | **2/3** | **4/24** | **2/15** | **2/4** | **1/8** | **3/20** | **1/3** |

The baseline shows that many health staff – who are to provide SRHR services to young people – have not received training in SRH during the year previous to the baseline study. Relatively speaking, more staff members in the South Asian countries and in Senegal report having received such training (Table 14).

*Supporting information*

With respect to the topics of the training received, interviewed trained health staff mainly mentioned general SRH issues, such as contraceptive methods and reproduction ('pregnancy'). Excluding a limited number of health care workers in Bangladesh, there was no mention of having received training on working with young people. The few staff members in Bangladesh who did indicate having taken part in a training that paid particular attention to young people reported learning about early pregnancy (two health care workers) and early marriage (one health care worker). One health care worker in Bangladesh, Senegal and Uganda mentioned having participated in training on menstruation and puberty. Government and NGOs were the most commonly mentioned providers of training workshops. Most staff considered the training they had received to be adequate, with some receiving follow-up supervision after training (Table 83 A5).

**Indicator 33** measures the share of schools that have established referral systems for SRH with health centres**.** As Table 15 shows, the majority of schools in Nepal and Uganda have set up a referral system with health care centres. In the other HC programme countries none or only few schools have established any formal relationship.

**Table 15: IND33 Share of schools with referral mechanisms to health centres**

| | *Ba* *N= 4* | *Pa* *N= 4* | *Ne* *N= 5* | *Sen* *N= 2* | *Ma* *N=14* | *BF* *N=25* | *Gh* *N= 4* | *SL* *N=4* | *Eth* *N=20* | *Ug* *N= 6* |
|---|---|---|---|---|---|---|---|---|---|---|
| **IND33** | **2/4** | **1/4** | **4/5** | **1/2** | **4/14** | **6/25** | **1/4** | **3/4** | **1/20** | **5/6** |

*Supporting information*

**Box 15: Referral systems between schools and health services (FGDs)**

A minority of young people involved in FGDs reported knowing of referral systems between their school, SRHR-related services and/or other services/institutions. Young people involved in FGDs in Uganda, for example, indicated being sent to the health officer in the school and being sent to a health centre (although different health centres were mentioned by young women and men attending the same school). However, in most cases, young people indicated they did not know of any referral system (for example, Pakistan, Bangladesh, Nepal, Ethiopia, Ghana). Tellingly, young women in Ghana reported that *'the school has never helped students access a health facility when there are questions regarding SRH since the clinic normally closes at 2 pm while school is in progress.'*

In some instances, young people mentioned examples of teachers having referred students to a health centre or hospital for 'other' (non-SRHR-related) health issues, or a case of a female teacher allowing girls to go home when they were menstruating (Bangladesh). With regard to the former, young women in Bangladesh taking part in an FGD indicated that: '*there is a co-ordination between school and health service system. We can learn about various subjects related to good health like cleanliness, various water borne diseases, but [there is] no service from school related to sexual and reproductive health.'*

While most young people indicated they did not know of any referral system between schools and health centres with respect to SRHR-related issues (or stated there was none), some mentioned health extension workers and doctors visiting schools to provide health-related education, and police officers coming to teach young women about *'harassment prevention'* (FGD Girls, Ethiopia). However, there appeared to be little unanimity between young women and men with respect to whether there were referral systems in place or not. That is, when a group of young women from a particular school would mention a referral mechanism during an FGD, this 'finding' was usually not confirmed by their male peers from the same school (or vice versa). In Bangladesh, for example, young women in two separate FGDs indicated that *'school authorities do not take any steps [in case of harassment]'*, while their male counterparts talked of teachers taking action on behalf of young women who were harassed by young men.

The intermediate outcomes of the activities for Strategy III are: a) health workers feel able and are confident to provide youth friendly health services (**IND21**) and b) health care centres provide SRH services to young people (**IND22**).

Only in Ghana did all health care workers report they felt confident and were able to provide SRHR services to young people. In Nepal, Senegal, Sierra Leone and Uganda almost all health care workers indicated they felt confident and capable. In other HC programme countries relatively fewer staff reported feeling confident and able to provide SRHR services to young people (Table 16). When asked whether they were able to address all questions young people asked them, only all health care workers in Ghana answered in the affirmative (Table 84 A5)

**Table 16: IND21 Share of health centre staff who are able and confident to provide YFHS**

| | *Ba* *N= 8* | *Pa* *N= 4* | *Ne* *N= 4* | *Sen* *N=3* | *Ma* *N=24* | *BF* *N=15* | *Gh* *N= 4* | *SL* *N=8* | *Eth* *N=20* | *Ug* *N= 3* |
|---|---|---|---|---|---|---|---|---|---|---|
| **IND21** | **1/8** | **2/4** | **3/4** | **2/3** | **16/24** | **9/15** | **4/4** | **7/8** | **6/20** | **2/3** |

The extent to which a health care centre offered youth friendly services was assessed by, among other things, asking health care workers whether unmarried young women and men and school students came in for advice, services and/or products. Table 17 presents the findings for health care facilities. The data indicate that only in Sierra Leone and Uganda all health care centres included in the study were said to provide services to unmarried young women and men, including those attending (secondary) school. In Nepal none of the four health centres did so and in Pakistan only one out of three.

**Table 17: IND22 Share of health facilities that offer YFHS, according to health staff**

| | *Ba* *N= 4* | *Pa* *N= 3* | *Ne* *N= 4* | *Sen* *N= 4* | *Ma* *N=24* | *BF* *N=13* | *Gh* *N= 3* | *SL* *N=8* | *Eth* *N=20* | *Ug* *N= 3* |
|---|---|---|---|---|---|---|---|---|---|---|
| **IND22** | **2/4** | **1/3** | **0/4** | **3/4** | **19/24** | **9/13** | **2/3** | **8/8** | **17/20** | **3/3** |

*Supporting information*

Those in charge of health care facilities were asked as to the kinds of measures they had taken to make a centre more youth friendly. Interviewees tended to report having taken one or two measures, but none mentioned having taken a comprehensive range of steps. Examples of measures taken included; having partaken in specialized training on youth issues, discretion (with respect to services offered to young women), advocacy, extended opening hours, provided awareness raising training, providing contraceptives to young people (Uganda, Ethiopia, Mali), providing SRHR education in schools (Ethiopia) or giving free services (Senegal) (Table 85 A5).

In most countries only a few village leaders indicated knowing about SRHR-related services for young people – with the exception of Ghana and Sierra Leone where three out of the four leaders (in each country) knew about the availability of such services, followed by Senegal where two out of four leaders were aware of such services. While some leaders knew of SRHR-related services for young people, not all of these considered services to be adequate (excluding Burkina Faso where the four leaders who knew of SRHR-related services for young people also considered these to be adequate) (Table 86 A5).

The outcomes of the activities related to Strategy III include that girls know of SRHR-related services (**IND11.1**) and make use these services (**IND11.2**).

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

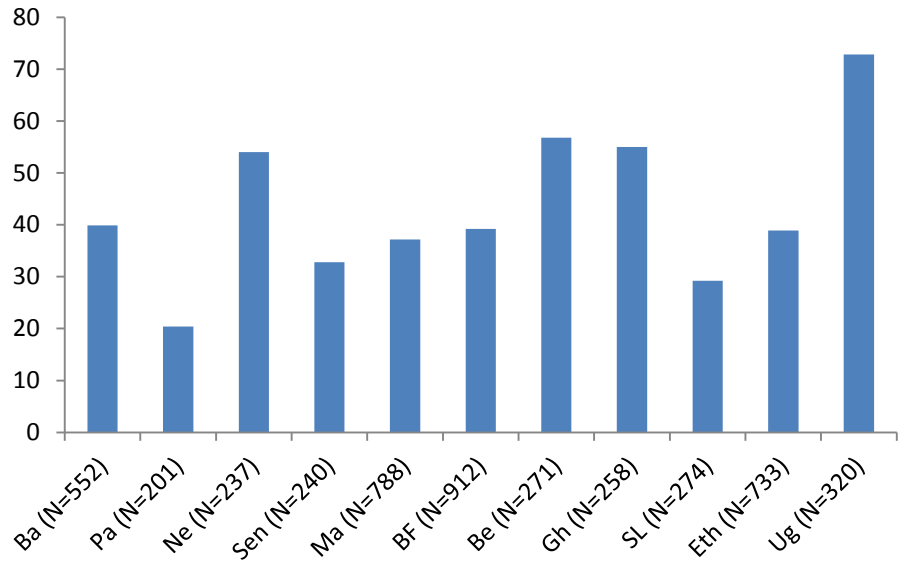



**Figure 10: IND11.1 Share of married girls who know of SRHR services (%)**

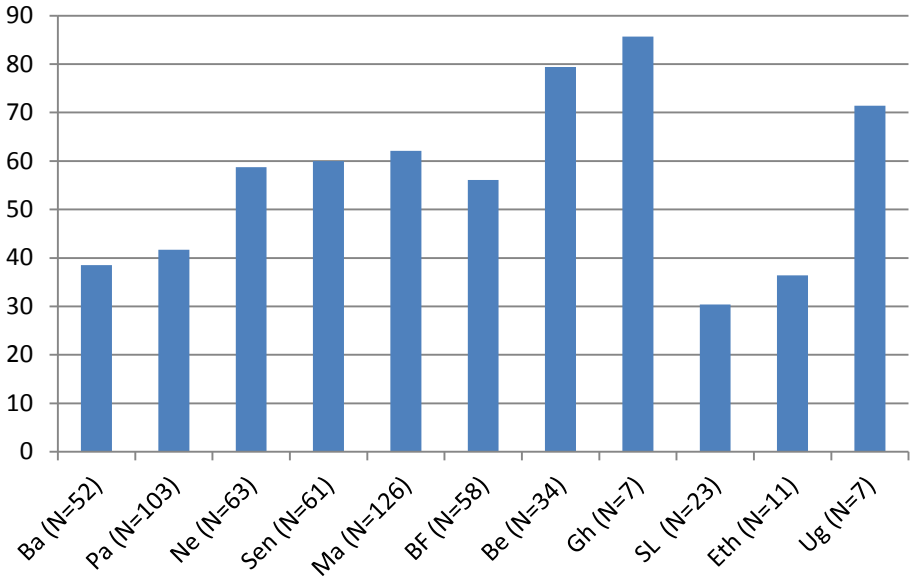



Figure 9 shows that in most countries a minority of single girls know where to access SRHR services. Knowledge of available services is greater in Uganda, Benin, Nepal and Ghana; in Uganda just under three out of every four girls know about available SRHR services, while in Benin, Nepal and Ghana just over half of young women know of such services. As might be

expected, across the 11 countries more married young women were found to know of SRHR services than single young women, possibly due to their having accessed services for ante-natal, delivery and post-natal care (Figure 10). Table 18 similarly highlights this difference between married and single young women, revealing that considerable larger number of married young women utilized SRHR services than did single young women.

**Table 18: IND11.2 Share of girls who knew of SRHR-related services and visited a clinic for SRHR services, by marital status (%)**

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Be* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Single girls* | *N=223* | *N= 41* | *N=128* | *N=76* | *N=291* | *N=357* | *N=151* | *N=129* | *N= 83* | *N=281* | *N=236* |
| **IND11.2** | **19.7** | **53.7** | **14.8** | **13.2** | **14.8** | **14.3** | **19.9** | **7.8** | **27.7** | **8.2** | **36.9** |
| *Married girls* | *N= 20* | *N=43* | *N= 37* | *N= 38* | *N= 77* | *N= 32* | *N= 26* | *N= 6* | *N= 7* | *N= 4* | *N= 5* |
| **IND11.2** | **40** | **74.4** | **70.3** | **55.3** | **23.4** | **37.5** | **73.1** | **2/6** | **3/7** | **2/4** | **3/5** |

*Supporting information*

The share of single girls who utilised SRHR-related services and had been referred to these services ranged between approximately 20% and 60%. Other young single women who made use of these services reported having gone on their own accord, that is, they had not been referred to the services. Relatively more single girls were referred to SRHR-related services in Burkina Faso (62.7%), while relatively more single girls in Nepal went on their own accord (here only 21.1% indicated they had been referred). Differences were small between single and married young women with respect to whether they had been referred to services or had gone on their own (Table 87 A5).

By far the central reason stated as to why young women did not utilise SRHR-related services related to their never having had an SRHR-related problem (around eight or nine out of every ten girls). For those who had experienced an SRHR-related problem, in most countries the primary reason for not utilizing health services had to do with young women feeling ashamed to visit an SRHR-related service (one-third to more than half of cases). Other reasons for not using a service had to do with the health centre being too far away and services being too expensive (Table 88 A5).

## 4.5 Indicators Strategy IV: Improve economic security of girls and their families

To improve the economic security of young women and families, the HC programme intends to support female entrepreneurs with microcredit schemes and income generation activities **(IND34).** At the time of the baseline, income generation activities for women were already taking place in some research sites in HC programme countries (these being organised within the framework of other programmes). In Ghana, for example, 87.7% of households

reported female household members who were being supported economically (Table 19). This high figure can be explained by the fact that the Ghanaian research sites study villages were in the catchment area of an already existing THP Epicentre – with one of the main THP programme activities in such centres being economic empowerment of women and communities (already before the HC programme started).

**Table 19: IND34 Share of households with female entrepreneurs supported, reported by household heads (%)**

| | *Ba* *N=524* | *Ne* *N=235* | *Sen* *N=162* | *Ma* *N=470* | *BF* *N=529* | *Gh* *N=212* | *SL* *N=161* | *Eth* *N=596* | *Ug* *N=167* |
|---|---|---|---|---|---|---|---|---|---|
| **IND34** | **10.1** | **29.4** | **58.6** | **26.8** | **55.8** | **87.7** | **20.5** | **13.3** | **26.9** |

*Supporting information*

The main types of activities supporting female entrepreneurs mentioned by household heads were micro- and small enterprise (78.8% in Ghana), food for work and safety net programmes (especially in Francophone west Africa: 67.4% in Senegal; 64.5% in Burkina Faso and 41.4% in Mali) and NGO savings and credit schemes (Table 89 A5).

In most countries, existing income generation activities targeting women form a crucial source of support in relation to household income (**Indicator 23**). Accounts of heads of households that had female members taking part in micro-credit schemes or income generating activities across the 11 HC countries indicate that these households enjoyed increased levels income due to the activities women were involved in (Table 20, **IND23.1)**

**Table 20: IND23.1 Share of households with females supported who report an increased income for the household due to income generation interventions targeted at women (%)**

| | *Ba* *N= 49* | *Ne* *N= 69* | *Sen* *N= 95* | *Ma* *N= 126* | *BF* *N= 295* | *Gh* *N= 191* | *SL* *N= 35* | *Eth* *N= 77* | *Ug* *N= 64* |
|---|---|---|---|---|---|---|---|---|---|
| **IND23.1** | **83.7** | **50.7** | **85.3** | **77.8** | **81.4** | **49.2** | **40** | **85.7** | **51.6** |

N= Households with female entrepreneurs supported

If we take the total sample of households, we see that a lot can still be gained with respect to income generation. That is, the baseline data show that only in the cases of Senegal (50%), Ghana (44.3%) and Burkina Faso (45.4%) are a considerable share of households already benefiting from increased income thanks to income generation activities for women. Across other countries this share is between 7.8% (Bangladesh) and 20.9% (Mali) (Table 21, **IND23.2**).

**Table 21: IND23.2 Share of total households who report an increased income for the household due to income generation interventions targeted at women (%)**

| | *Ba N=524* | *Ne N=235* | *Sen N=162* | *Ma N=470* | *BF N=529* | *Gh N=212* | *SL N=161* | *Eth N=596* | *Ug N=167* |
|---|---|---|---|---|---|---|---|---|---|
| **IND23.2** | **7.8** | **14.9** | **50** | **20.9** | **45.4** | **44.3** | **8.7** | **11.1** | **19.8** |

Outcome **indicator 13** – improved economic status of households as a result of programme activities – can only be measured as of the mid-term in 2018. Figure 11 presents the baseline data as to reported economic status of households, in four categories: a) struggle for sufficient food the entire year, b) problems getting sufficient food part of the year, c) having food the whole year but problems accessing funds for primary needs, such as schooling, and d) food the whole year, and have sufficient resources to send children to school.

**Figure 11: Economic status of households (%)**

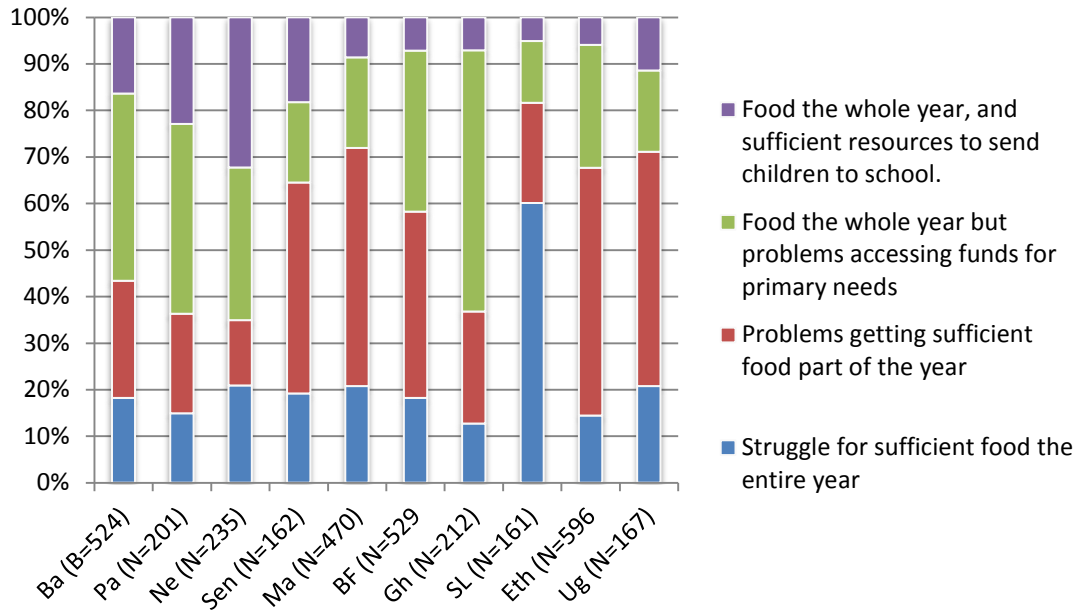



Figure 11 shows that Her Choice programmes work in economically poor communities. Between 67.7% and 95.4% of households have insufficient food and/or cash for basic needs. The South Asian communities included in the baseline study appear to somewhat better off in that a higher percentage of households report having sufficient food the entire year and enough funds to cover primary needs. However, at the other end of the spectrum – that is, the households that struggle to get sufficient food the whole year round – the figures are similar across the South Asian and African countries (approximately between 15 and 20%). In Sierra Leone, many more households were found to belong to the category of households that struggled most (60.1%).

*Supporting findings*

Data derived from household questionnaires concerning households' abilities to meet basic needs and/or send their children to (primary/secondary) school were triangulated with data gathered from village heads. The latter data support the results derived from the household questionnaires, that is, confirming that within the research communities a substantial share of households indeed could not meet their basic needs (Table 90 A5).

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

Within the framework of Strategy V, the HC programme will organise community level activities, including training of community leaders and other relevant community stakeholders as to, among other issues, the negative effects of early marriage and FGM/C, and the importance of education for girls **(IND35).** It is expected that these activities will lead to leaders and trained community members publicly condemning early marriage and FGM/C in village meetings as well as promoting education for young women and men **(IND24**). This intermediate outcome should, in turn, lead to the outcome of whole villages rejecting early marriage and FGM/C **(IND14**) and lead to girls feeling supported in their decision-making on SRHR-related issues, including CM and FGM/C **(IND15**).

At baseline level, it was found that all villages in Uganda had trained community leaders. In other HC countries no to no more than half of the villages included in the study had trained leaders, except Burkina Faso, where 9 out of the 16 villages had trained leaders (Table 22).

**Table 22: IND35 Share of villages with trained leaders, reported by village leaders**

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|
| | *N= 4* | *N= 4* | *N= 4* | *N=4* | *N=13* | *N=16* | *N= 4* | *N=4* | *N=20* | *N= 4* |
| **IND35** | **1/4** | **0/4** | **2/4** | **2/4** | **2/13** | **9/16** | **1/4** | **1/4** | **10/20** | **4/4** |

*Supporting information*

In many countries outreach activities against child marriage, and FGM/C were found to already be taking place – this finding is based on interviews conducted with district level participants who were asked whether such activities already take place in the study villages. Strikingly, no activities were taking place at district level in Pakistan, and district level activities in Mali were limited; in only three out of nine districts activities were reported to be taking place (Table 23).

### Table 23: Share of districts with outreach activities on CM (and FGM/C) in communities

| | *Ba* *N= 2* | *Pa* *N= 2* | *Ne* *N= 3* | *Sen* *N=2* | *Ma* *N=9* | *BF* *N= 8* | *Gh* *N= 2* | *SL* *N=2* | *Eth* *N=11* |
|---|---|---|---|---|---|---|---|---|---|
| With outreach activities | **2/2** | **0/2** | **3/3** | **2/2** | **3/9** | **7/8** | **2/2** | **2/2** | **8/11** |

The most commonly reported targets for district activities were young women and men, caregivers a d traditional and religious leaders. Arguably, this list of actors could in many cases be considered to represent the best part of the community. In Burkina Faso, Mali, Sierra Leone and Senegal activities against FGM/C were reportedly also taking place in the sampled districts. In Sierra Leone, activities geared to preventing FGM/C also targeted traditional healers and circumcisers.

**Indicator 24** measures the share of community leaders who publicly condemned CM during village meetings. In Nepal, Senegal and Uganda all village leaders reported they had publicly condemned CM in village meetings, whereas in Bangladesh and Pakistan none of the village leaders indicated they had done so, and in Mali only very few (Table 24).

### Table 24: IND24 Share of villages with leaders who condemned CM in village meetings, reported by village leaders

| | *Ba* *N= 4* | *Pa* *N= 4* | *Ne* *N= 4* | *Sen* *N=4* | *Ma* *N=13* | *BF* *N=16* | *Gh* *N= 4* | *SL* *N=4* | *Eth* *N=20* | *Ug* *N= 4* |
|---|---|---|---|---|---|---|---|---|---|---|
| **IND24** | **0/4** | **0/4** | **4/4** | **4/4** | **2/13** | **10/16** | **3/4** | **2/4** | **17/20** | **4/4** |

In some villages, leaders reported that other village members also organise activities on, for example, the negative effects of early marriage (**Indicator 25**). In more than half of villages in Ethiopia (12/20), Senegal (3/4) and Uganda (3/4), other community members were reported to have organised such activities. In Mali and Bangladesh, on the other hand, none of the villages were said to have members speaking out against CM (Table 25).

### Table 25: IND25 Share of communities with village members who organize activities on negative effects of CM, reported by village leaders

| | *Ba* *N= 4* | *Pa* *N= 4* | *Ne* *N= 4* | *Sen* *N=4* | *Ma* *N=13* | *BF* *N=16* | *Gh* *N= 4* | *SL* *N=4* | *Eth* *N=20* | *Ug* *N= 4* |
|---|---|---|---|---|---|---|---|---|---|---|
| **IND25** | **0/4** | **1/4** | **2/4** | **3/4** | **0/13** | **6/16** | **¼** | **2/4** | **12/20** | **3/4** |

*Supporting information*

The majority of village leaders in Nepal (4/4), Senegal (3/4) and Sierra Leone (3/4) reported young people actively participated in community meetings. In Bangladesh on the other hand, none of three leaders mentioned active participation of young people, and in other HC programme countries a minority reported young people speaking out. It should be noted that in the case of Ethiopia, this 'minority' was a substantial one – that is, 7/20 (Table 26).

**Table 26: Share of communities with young people who speak out in community meetings on the rights of girls, reported by community leaders**

| | *Ba* *N= 4* | *Pa* *N= 4* | *Ne* *N= 4* | *Sen* *N=4* | *Ma* *N=13* | *BF* *N=16* | *Gh* *N= 4* | *SL* *N=4* | *Eth* *N=20* | *Ug* *N= 4* |
|---|---|---|---|---|---|---|---|---|---|---|
| With vocal young people | 0/4 | 1/4 | 4/4 | 3/4 | 1/13 | 2/16 | 2/4 | 3/4 | 7/20 | 1/4 |

As indicated, the expected outcome of community level HC activities relates to communities condemning CM and FGM/C (**IND14.1, IND14.2**). At baseline level it was found that this rejection of CM reportedly already took place in all communities involved in the study in Bangladesh, in three quarters of the study communities in Senegal and Uganda, and in 14/20 communities in Ethiopia. In Pakistan and Nepal none of the communities reported they rejected CM (Table 27).

**Table 27: IND14.1 Share of communities that reject CM, reported by village leaders**

| | *Ba* *N= 4* | *Pa* *N= 4* | *Ne* *N= 4* | *Sen* *N=4* | *Ma* *N=13* | *BF* *N= 16* | *Gh* *N= 4* | *SL* *N=4* | *Eth* *N=20* | *Ug* *N= 4* |
|---|---|---|---|---|---|---|---|---|---|---|
| **IND14.1** | **4/4** | **0/4** | **0/4** | **3/4** | **5/13** | **6/16** | **2/4** | **2/4** | **14/20** | **3/4** |

*Supporting information*

Principals in all countries, except Uganda, indicated they had encountered students that had been forced to marry – this was especially the case in Bangladesh, where three out of four principals reported having encountered such cases, and in Mali and Ethiopia where half of the interviewed principals reported being confronted with such cases (Table 91 A5). This finding indicates that although communities were said to reject it, the practice of child marriage persists.

In the communities where FGM/C appeared to be practiced (see Table 4), most village heads reported their community rejected FGM/C (**IND14.2).** None of the communities in Sierra Leone reported they rejected FGM/C while in Mali only three out of 13 communities indicated they did so (Table 28).

**Table 28: IND14.2 Share of villages that reject FGM/C, reported by village leaders**

| | *BF* | *Sen* | *Ma* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|
| | *N= 16* | *N=3* | *N=13* | *N= 4* | *N=4* | *N=20* | *N= 1** |
| **IND14.2** | **14/16** | **3/3** | **3/13** | **4/4** | **0/4** | **20/20** | **1/1** |

***** FGM/C reportedly takes place in one of the 4 communities

*Supporting information*

Only principals in Mali, Sierra Leone and Ethiopia mentioned having come across students that were forced to be circumcised (Table 92 A5). In the case of Sierra Leone, this finding may be explained by the fact that FGM/C was reported to take place at an older age (between 15 and 19 years). With regard to Mali this finding is more surprising as FGM/C is said to be carried out when girls are young, that is, between 1 - 7 years old (Table 71 A5).

An expected outcome of HC activities is that, once community leaders have been trained and villages condemn CM and FGM/C, girls should feel supported in their decision-making on SRHR-related issues, including on CM and FGM/C.

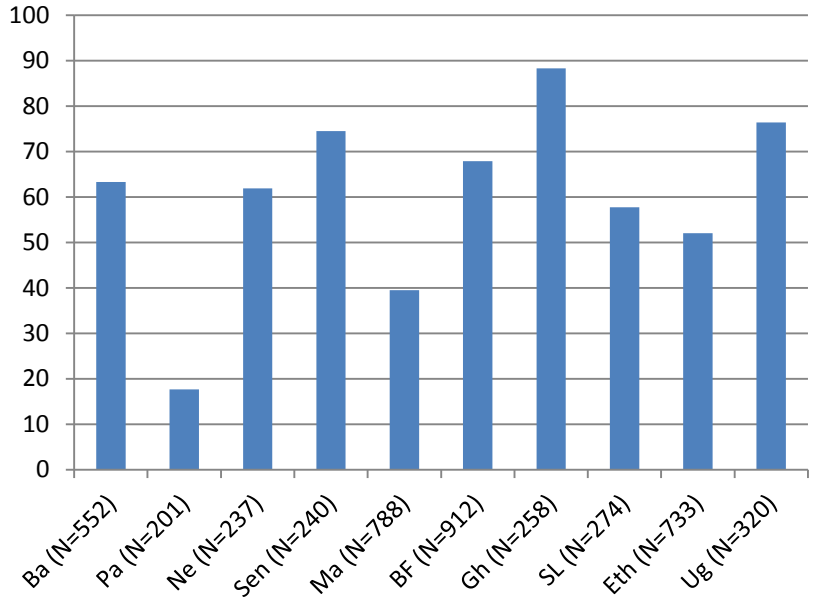
At baseline level, many girls already indicated they felt supported by others with respect to SRHR-related decisions **(IND15.1**), with married young women reporting feeling this way more so than single young women. Relatively fewer young women felt supported in SRHR-related decisions in Ethiopia, Sierra Leone and Mali (Tables 29 and 60 A4).

**Table 29: IND15.1 Share of girls who feel supported in decision-making on SRHR, by marital status (%)**

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Be* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Single* | *N= 552* | *N= 201* | *N= 237* | *N= 240* | *N= 788* | *N= 912* | *N= 271* | *N= 258* | *N= 274* | *N= 733* | *N= 320* |
| **IND15.1** | **72.4** | **59.2** | **63.3** | **54.9** | **32.2** | **57** | **71.6** | **73.2** | **38.6** | **34.7** | **84.1** |
| *Married* | *N= 52* | *N=103* | *N= 63* | *N=60* | *N= 126* | *N= 58* | *N=34* | *N= 7* | *N= 23* | *N=11* | *N= 7* |
| **IND15.1** | **75** | **54.4** | **69.8** | **83.1** | **44.4** | **58.9** | **85.3** | **100** | **59.1** | **36.4** | **6/7** |

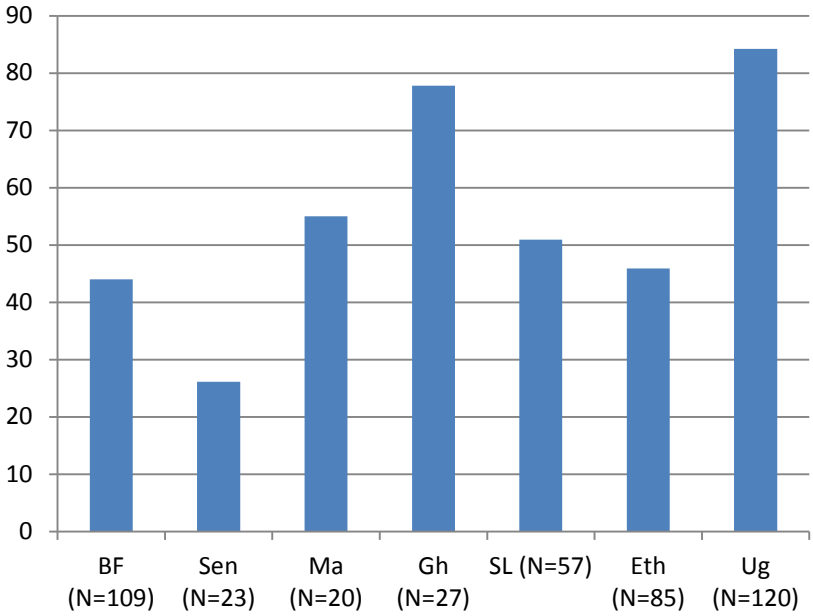
A village with trained and active community leaders who sensitise their community on the negative effects of child marriage is expected to lead to more single girls being supported when they do not want to marry. With respect to young women feeling supported in decisions regarding early marriage (**IND15.2),** at baseline level it was generally found that in settings where child marriage rates were higher, single girls felt less supported in decision-making processes regarding CM, with a low of 17.7% of girls in Pakistan (Figure 12).

**Figure 12: IND15.2 Share of single girls who feel supported in decision-making on CM (%)**




The share of uncircumcised young women who felt supported in their desire not to be circumcised (**IND15.3**) differed across countries: from a low 26.1% of young women in Senegal feeling supported in this regard to a high of 77.8% in Ghana (Figure 13).

**Figure 13: IND15.3 Share of uncircumcised girls who do not want to be circumcised who feel supported in decision-making on FGM/C (%)**



*Supporting information*

Concerning whom girls felt they could turn to when they did not want to marry, these persons varied across countries. Young women mainly mentioned other relatives – their siblings and/or mother. Very few young women mentioned their father, teachers or health care workers. In Burkina Faso, girls appeared to have some confidence in community leaders and police: 15.2% and 10.4% of girls reporting they would turn to these two respective sets of actors. A considerable share (17.9%) of young women in Ethiopia also indicated that they would turn to the police (Table 93 A5).

Many school principals in most countries (except Uganda and Pakistan) reported that, if need be, they would support girls in opposing a forced marriage and FGM/C. However, few principals reported girls having sought help from teachers with regard to (preventing) a marriage (Table 30).

**Table 30: School support to girls in opposing CM and FGM/C, as reported by principals (share)**

| | *Ba N=4* | *Pa N=4* | *Ne N=5* | *Sen N=2* | *Ma N=14* | *BF N=25* | *Gh N=4* | *SL N=4* | *Eth N=20* | *Ug N=6* |
|---|---|---|---|---|---|---|---|---|---|---|
| Support girls in opposing CM | 4/4 | 0/4 | 3/5 | 1/2 | 6/14 | 10/25 | 2/4 | 4/4 | 17/20 | 1/6 |
| Support girls in opposing FGM/C | - | - | - | 0/2 | 3/14 | 7/25 | 2/4 | 1/4 | 16/20 | 1/6 |
| Girls turned to teacher for help to oppose CM | 1/4 | 0/4 | 2/5 | 0/2 | 3/14 | 4/25 | 0/4 | 4/4 | 10/20 | 1/6 |

**Box 16: Where can young people go if/when they have SRH-related questions or concerns? (FGDs)**

Across research sites and countries, most young people listed a range of actors and institutions they could turn to in case they had questions or concerns with regard to SRHR-related issues. Caregivers, siblings, health workers, teachers, friends. Young women in Ghana also referred to *'responsible adults'* and both young women and men in Ghana spoke of turning to elders. Some young men in Nepal also referred to elders as a source of potential support. Young women and men in Ethiopia mentioned being able to go to the police, with young men in Ghana also mentioning the police as a source of support in case of harassment. Noteworthy is the frequent mention of health centre (staff), particularly given the quantitative survey data suggest that across the 11 countries young women were made little to no use of health centres if they had SRHR-related concerns.

In Pakistan very few options were named, girls mentioning their mothers and teachers, but half of the boys indicating they would not be able to turn to anyone. The other half of the boys involved in FGDs in Pakistan did mention a few actors, parents, friends and a homeopathic doctor (the latter two only mentioned by two individual participants).

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

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, the legal minimum age for marriage for young women is 18 years in most countries. However, in some countries this minimum age is lower: in Burkina Faso it is 17 years for young women, and in Mali, Senegal and Pakistan the legal minimum age is 16 years.

The existence of a law does not mean it is enforced. 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 in relation to law enforcement. 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.

At baseline level only a few communities were found to have by-laws against early marriage (**IND26.1**), relatively most in Ethiopia (6/20) and only very few were in the process of developing them (**IND 37.1**). (Tables 31 and 32).

### Table 31 IND26.1 Share of communities with by-laws concerning CM, reported by community leaders

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|
| | *N= 4* | *N= 4* | *N= 4* | *N=4* | *N=13* | *N=16* | *N= 4* | *N=4* | *N=20* | *N= 4* |
| **IND26.1** | **0/4** | **0/4** | **¼** | **¼** | **3/13** | **1/16** | **0/4** | **0/4** | **6/20** | **2/4** |

### Table 32: 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* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|
| | *N= 4* | *N= 4* | *N= 3* | *N=3* | *N=10* | *N=15* | *N= 4* | *N=4* | *N=14* | *N= 2* |
| **IND37.1** | **0/4** | **0/4** | **1/3** | **2/3** | **0/10** | **1/15** | **0/4** | **1/4** | **0/14** | **2/2** |

Concerning by-laws against FGM/C (**IND26.2**), only one out of 16 communities in Burkina Faso, and one out of 13 in Mali had established by-laws, whereas three in Burkina Faso were in the process of developing such by-laws **(IN37.2**). None of the other countries had by-laws against FGM/C or were in the process of developing these (Tables 33 and 34).

**Table 33: IND26.2 Share of communities with by-laws concerning FGM/C, reported by community leaders**

| | *BF* *N= 16* | *Sen* *N=4* | *Ma* *N=13* | *Gh* *N= 4* | *SL* *N=4* | *Eth* *N=20* | *Ug* *N= 4* |
|---|---|---|---|---|---|---|---|
| **IND26.2** | **1/16** | **2/4** | **1/13** | **0/4** | **0/4** | **5/20** | **0/4** |

**Table 34: 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**

| | *BF* *N= 15* | *Sen* *N=2* | *Ma* *N=12* | *Gh* *N= 4* | *SL* *N=4* | *Eth* *N=15* | *Ug* *N= 4* |
|---|---|---|---|---|---|---|---|
| **IND37.2** | **3/15** | **0/2** | **0/12** | **0/4** | **0/4** | **1/15** | **0/4** |

The programme aims to facilitate regular consultative meetings at district level between all stakeholders and actors on, among other issues, CM, SRHR, access to education and FGM/C. **(IND39**). In most districts in all the 11 countries, consultation meetings between local stakeholders on CM, FGM/C and SRHR were already taking place (Table 37).

**Table 35: IND39 Share of districts with consultation and informational meetings between (local) government agencies and civil society institutions related to SRHR**

| | *Ba* *N= 2* | *Pa* *N= 2* | *Ne* *N= 3* | *Sen* *N=2* | *Ma* *N=9* | *BF* *N= 8* | *Gh* *N= 2* | *SL* *N=2* | *Eth* *N=11* |
|---|---|---|---|---|---|---|---|---|---|
| **IND39** | **2/2** | **2/2** | **3/3** | **2/2** | **3/9** | **2-4*/8** | **2/2** | **2/2** | **7/11** |

* Different respondents in same district with different answers (yes/no meetings)

One of the intended Intermediate outcomes of activities at district level is birth registration of all children **(IND27**). When births are not registered and young women do not have a birth certificate, it is more difficult to ascertain whether or not a young woman is, for example, legally under-age for marriage. During the baseline study, district informants were asked to estimate the share of births registered: whether this was almost all births, a majority or births, etc. Birth registration is routine in Nepal where almost all births are registered. In Ethiopia, in eight out of 11 districts, births were reportedly not registered at district (*Woreda*) level at all (Table 36). The Ethiopian district respondents said such registration has yet to be started.

### Table 36: IND27 Share of districts with specific share of births registered, according to district officials

| | *Ba* *N= 2* | *Pa* *N= 2* | *Ne* *N= 3* | *Sen* *N=2* | *Ma* *N=9* | *BF* *N= 8* | *Gh* *N= 2* | *SL* *N=2* | *Eth* *N=11* |
|---|---|---|---|---|---|---|---|---|---|
| **Almost all (IND27)** | **0** | **1/2** | **3/3** | | **9*/9** | **7*/8** | **0** | **0** | **0** |
| More than half | 1/2 | 1/2 | 0 | **0*** | | | 0 | 2/2 | 0 |
| About half | 0 | 0 | 0 | | | | 1/2 | 0 | 1/11 |
| Less than half | 1/2 | 0 | 0 | 2*/2 | | 1*/8 | 1/2 | 0 | 1/11 |
| Hardly any | 0 | 0 | 0 | | | | 0 | 0 | 1/11 |
| No birth registration | 0 | 0 | 0 | | | | 0 | 0 | 8/11 |

* In Senegal, Mali and Burkina Faso the question was asked whether the majority of births were registered, not further broken won as in the other countries – we interpreted *majority* as more than half or almost all

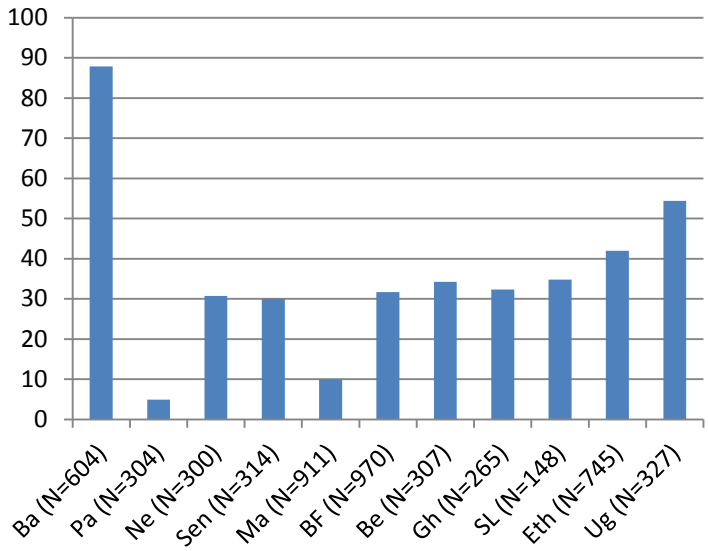
An intended intermediate outcome of district level HC activities relates to districts having established a system where people can report when they deem the law has been/is being broken **(IND28**). Table 37 presents district representatives' responses as to whether people report violations of laws concerning child marriage and/or sexual assault – such reporting being deemed an indication that the system is operational. Many district representatives, except in Mali, responded that such a system was indeed in place. However, when they were asked to specify, few could provide any detail.

### Table 37: 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* *N= 2* | *Pa* *N= 2* | *Ne* *N= 3* | *Sen* *N=2* | *Ma* *N=9* | *BF* *N= 8* | *Gh* *N= 2* | *SL* *N=2* | *Eth* *N=11* |
|---|---|---|---|---|---|---|---|---|---|
| **IND28** | **2/2** | **2/2** | **3/3** | **2/2** | **2/9** | **5/8** | **2/2** | **2/2** | **9/11** |

When (by-)laws are in place and enforced, it is expected that young women are aware there are laws that protect them against child marriage and FGM/C **(IND16.1, 16.2)**, and that they also know where to report violation of these laws At baseline level, knowledge levels of girls as to existence of laws against CM varied greatly across countries – with the highest level of awareness found in Bangladesh (87.9% of girls reported they knew of such laws), and lowest levels in Pakistan (4.9%) and Mali (9.9%) (Figure 14).

**Figure 14: IND16.1 Share of girls who know about protective laws on CM (%)**

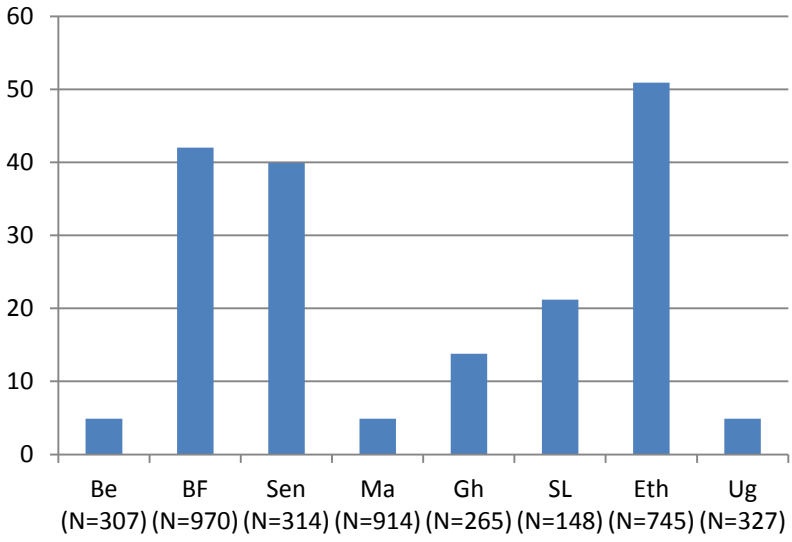



*Supporting information*

It is important to note that not all young women who indicated they were aware of the existence of laws against CM knew the legal minimum age of marriage. The share of girls who knew there was a law and who knew the legal minimum age was highest in Bangladesh (95.7%), Ethiopia (82.1%) and Uganda (82.7), while it was low in Pakistan (6.7%) and Burkina Faso (11.6%) (Table 94 A5).

The knowledge among girls on the laws against FGM/C (**IND16.2**) was highest in Ethiopia, where 50% of girls knew there was such law, and lowest in Mali, Benin and Uganda (4.9% in all three countries) (Figure 15).

**Figure 15: IND16.2 Share of girls who know about protective laws on FGM/C (%)**



# 5. CONCLUSION

## 5.1 Discussion

In this section we reflect on the most salient issues with respect to the methodology and the findings of the baseline study. First, a range of limitations of the study were identified (Section 2.9), many of which were caused by the twin aim of the research component of the HC programme, that is, to also build the research capacity of HC partners. We have taken these limitations into account in the analysis of data gathered and will seek to overcome these during the mid- and endline studies.

However, it is important to note that the advantages of involving local partners in the data collection have been found to outweigh the disadvantages. Not only did the close involvement of HC partners indeed contribute to developing partners' research capacity and experience, but their active involvement has had the added benefit of heightening partners' commitment to, and interest in, the baseline study findings. Partners' stake in the study has been particularly noticeable during the country visits that the AISSR/UvA is currently conducting with a view to presenting detailed country and partner-specific baseline data and using these findings as a basis for discussions as to planning (adjusting/refocusing) programme activities of HC partners. Collaboration with all HC partners has been positive and we are convinced that we can build on and strengthen these new partnerships during the years to come.

With regard to the – central – findings, the data shows that young women's decision-making power in decisions relating to their marriage is very low in most countries. The HC survey findings as to young women's relatively weak position in such decision-making processes are confirmed by data gathered during FGDs, where young people's accounts indicated that, in the case of young women, marriage-related decisions are made for them by others, while in the case of young men, it was the men themselves that took decisions as to if, who and when to marry. It is important to note that the decision-making space of young men was also limited, that is while they were seen to be at an advantage, this advantage was a relative one.

At odds with the accounts provided by young women and men and data gathered through the surveys with young women, was data gathered from heads of households. In general, heads of households accorded greater decision-making power to young women than the young women themselves believed they had. However, in most countries heads of households also indicated that it was the family elders that took final decisions.

The findings with respect to the impact indicator regarding child marriage (IND2) – the share of women between 20-24 years who were married before they turned 18 – are:

a) similar to national DHS data in Nepal and Burkina Faso,
b) show higher rates than previously found in Pakistan, Mali, Ghana and Ethiopia, or

c) reveal lower rates in the case of Bangladesh, Sierra Leone and Uganda.

The fact that the baseline study was only conducted in a limited number of regions per country may explain some of these differences, as these regions might in practice be characterised by either lower or higher CM rates than the national average. For example, rates in Punjab, Pakistan as well as in Amhara, Ethiopia – where the baseline data were gathered – are higher than national averages.

The percentages of 17-year old girls found to be married (impact indicator 4) were lower than national averages stated in previous studies, with the exception of Pakistan, Nepal, Benin and Senegal. The same explanation as for IND 2 may apply, but, at the same time, these differences may also, at least in part, be explained by the sensitivity of the questions. Particularly in some settings, household heads may have sought to hide the age and/or marital status of their daughters. This possible source of bias will be attended to carefully during the midline and endline studies.

A striking finding relates to the informal nature of most child marriages. Except for Pakistan and Bangladesh, where marriages are formally registered, most marriage were found to have been arranged informally between families and/or registered in a mosque or church. Since child marriage is illegal in most countries and/or in certain settings marriage before the legal minimum age is permissible with parental consent, this finding is not entirely surprising. Tellingly, as a District officer in Burkina Faso told the researchers during the pretesting of the baseline tools: '*Officially*, c*hild marriage does not exist, because it is not recognised by the law.'*

Given in many settings social norms dictate that a married couple should seek to have children as early as possible, it was not surprising to find that many married girls had started having children. It is worth noting that married young women were not asked whether they were pregnant at the time of the interview – it is likely that posing this question would have revealed even higher percentage of young women who had started child-bearing.

The data indicate that (fear of) young women's sexual debut and premarital pregnancy formed one of the two major reasons why young women were 'married off' or sought a marriage themselves. The data confirm that premarital sexual relationships, and pre-marital pregnancy in particular, were disapproved of highly and perceived as a source of dishonour for the girl and her family. The taboo-like nature of premarital sexual activity meant it was difficult to gather reliable data from single girls with regard to questions as to whether they had ever had a sexual relation. With regard to this issue, the data indicate that premarital sexual relations were least reported in the three South Asian countries.

The other major reason for early marriage relates to household poverty. The study findings indicate that most households in the villages where Her Choice works struggle to have sufficient food and/or money to cover their basic needs. In these villages, girls move to the

husbands' family after marriage. When a daughter marries, her own family thus has one less mouth to feed. A poor family may want to marry a girl at a young age because the younger girl brings a higher bride price (in African countries) and needs to bring in a lower dowry (In Asian countries). It is crucial to note that decisions to marry daughters at a relatively young age are not only motivated by concerns as to the economic situation of the household alone, but instead may be driven by caregiver concerns as to the economic security of the young woman. In addition, accounts of young women and men suggest that the potential economic benefits of marriage can also motivate young women themselves to look for a spouse, or agree to a proposal to marry early, whether this proposal is made by their caregivers and/or a (young) man.

School enrolment was found to vary considerably across countries. In all countries differences were found between enrolment and regular attendance, as well as lower enrolment and attendance rates found among married girls. The data indicates that marriage forms a reason to drop out of school and that not attending school formed a reason for early marriage. Notable was that many school principals claimed their school was girl-friendly, but upon closer examination – that is, of the measures put in place – many schools did not deserve this label.

Particularly striking were the very low levels of SRHR-related knowledge of young women in most countries, despite some young women having received SRHR-related education in school. Survey and FGD findings show that education topics mainly relate to reproductive health problems, and the negative effects of sexual relations, such as pregnancy and STIs. It is possible that these low levels of knowledge are explained by teachers' own lack of training and knowledge – many of them not having received any SRHR-related training themselves. Young people taking part in FGDs suggest teachers were too shy to tackle certain topics, particularly when addressing female students. The latter is particularly noteworthy given nearly all teachers involved in the baseline indicated that they believed that girls required separate SRHR-related education given their greater vulnerability to SRHR problems and given their 'timidity' when it came to talking about SRHR-related issues.

Contraceptive use was low among single girls who indicated they had been or were involved in a sexual relationship. This finding may be explained by other data emerging from the baseline, particularly the earlier mentioned lack of SRHR-related education received, the lack of knowledge regarding, for example, when in the menstrual cycle pregnancy can occur, which methods could be used to prevent pregnancy or where contraceptives were available.

Girls were found to make little use of SRHR services, with many of them not knowing about the availability of these services. While health care providers involved in the study indicated that their service was youth-friendly, the lack of training of health care providers in providing services to young people and the limited measures taken to make services youth-friendly suggest that most health facilities cannot be understood to be 'youth-friendly.'

The data indicate that village leaders were caught between on the one hand the imperative to implement national laws (against child marriage) and on the other hand, local norms and traditions. Cooperation of community members was considered be crucial to village leaders' efforts to establish local by-laws against CM, but at the same time, the data show that not all leaders were convinced of the importance to stop child marriage. Finally, it was found that while relevant District services were motivated to enforce existing legislation on CM, they often lack necessary means to do so.

## 5.2 Programme implications

A number of programmatic implications can be drawn from the baseline study:

- The quality of SRHR-related education for young people requires far more attention. HC partners should seek to support relevant actors in the development and delivery of more comprehensive education that is tailored to the lived realities of young people in different settings.
- Education of SRHR teachers and SRHR health care workers should include training on communication with young people, with a particular focus on addressing 'sensitive' issues, in addition to the provision of comprehensive SRHR-related education, products and services.
- The Her Choice programme should – in collaboration with local partners and drawing on existing materials – develop guidelines with country-specific criteria for youth friendly SRHR services and girl-friendly schools.
- Activities focusing on young men should be intensified, focusing on their involvement in gender transformative change.
- Where possible, programme activities should include a focus on married girls, paying particular attention to their educational participation, and access to SRHR-related education, services and products.
- Activities at community level geared towards preventing child marriage and FGM/C should be informed by understanding of local ideas concerning, and reasons for, child marriage and FGM/C, and (most) prevalent types of marriage and FGM/C.

In addition to these general implications, the AISSR/UvA is engaging with HC partners in the 11 countries to identify and discuss responses to country and partner-level findings. Country-level findings are also presented in country-level reports. During 2017 AISSR will present the baseline findings in as many HC countries as is feasible. So far, at the time of writing, visits have been made to Bangladesh, Benin, Burkina Faso, Ethiopia, Ghana and Uganda. Based on the baseline findings presented, HC partners in Burkina Faso and Bangladesh decided to strengthen activities geared towards young men with a view to addressing sexual harassment (which was found to be common cause for early marriage in these settings). In Ghana, where baseline data highlighted that many girls marry early to escape poverty, the HC partner decided to place greater emphasis on sensitising girls on the social implications of early marriage.

## 5.3 Implications for the midline study

In order to address the various limitations highlighted in section 2.9 and ensure that the reported data is as accurate and reliable as possible, the AISSR/UvA will take particular care when designing the midline evaluation, attending to the suitability of research tools and questions, organisation of training, supervision and reporting of data collection. In addition, and where possible, more in-depth qualitative research will be done to allow for triangulation of the existing data.

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# ANNEXES

## Annex 1: Tables and maps for Introduction and Methodology

### Figure 16 A1: Map of Her Choice programme countries

Source: http://www.her-choice.org/en/home/

### Table 38 A1: Share of women aged 20-24 married before they turned 18, by demographics in the 11 Her Choice programme countries

| *Countries* | | | *Residence* | | *Education* | | | *Household Wealth* | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total prevalence | Married by 15 | Rural | Urban | None | Primary | Secondary or Higher | Poorest 20% | 2nd | 3rd | 4th | Richest 20% |
| Bangladesh | 65 | 29 | 70.3 | 53.3 | 82 | 80.4 | 57.2 | 83 | 78 | 72 | 59 | 46 |
| Benin | 32 | 11 | 46.8 | 18.8 | 47.1 | 27.8 | 6.1 | 57 | 51 | 45 | 27 | 11 |
| Burkina Faso | 52 | 10 | 61.2 | 26.8 | 59.8 | 41.5 | 3 | 61 | 64 | 60 | 57 | 26 |
| Ethiopia | 41.2 | 16 | 49 | 21.7 | 62.9 | 37.5 | 10.3 | 59 | 56 | 47 | 42 | 22 |
| Ghana | 21 | 5 | 37.7 | 12.7 | 46.5 | 41.6 | 15.3 | 22 | 31 | 52 | 5 | 27 |
| Mali | 55 | 15 | 76.5 | 60.4 | 77 | 64.3 | 37.9 | 73 | 78 | 77 | 76 | 58 |
| Nepal | 40.7 | 10 | 42.9 | 26.9 | 71.7 | 56.7 | 22.9 | 62 | 52 | 48 | 36 | 17 |
| Pakistan | 24 | 3 | 29.3 | 15.6 | 40 | 22.8 | 9.9 | 49 | 33 | 24 | 18 | 10 |
| Senegal | 32.9 | 12 | 49.3 | 16.9 | 48.1 | 26 | 6.2 | 57 | 46 | 32 | 22 | 13 |
| Sierra Leone | 44 | 18 | 61.1 | 30.4 | 64.2 | 51.8 | 12.1 | 62 | 63 | 65 | 45 | 23 |
| Uganda | 40 | 10 | 51.8 | 26.9 | 66.8 | 48.4 | 13.8 | 62 | 59 | 47 | 49 | 26 |

Source: Adapted from UNFPA 2012 and also using statistics and information from Girls Not Brides country profiles online (see http://www.girlsnotbrides.org/where-does-it-happen/).

### Table 39 A1: Prevalence of FGM by age group country and national legislation, by country

| *Country* | *Prevalence of FGM (%)* | | *National Legislation on FGM?* |
|---|---|---|---|
| | Girls aged 0 to 14 | Girls & women aged 15 to 49 | |
| Benin | 0.2 | 9 | Yes, banned in 2003 |
| Burkina Faso | 13 | 76 | Yes, banned in 1996 |
| Ethiopia | 24 | 74 | Yes, banned in 2004 |
| Ghana | 1 | 4 | Yes, banned in 1994 (amended 2007) |
| Mali | - | 89 | No legislation |
| Senegal | 13 | 25 | Yes, banned in 1999 |
| Sierra Leone | - | 90 | No legislation |
| Uganda | 1 | 1 | Yes, banned in 2010 |

Source: UNICEF global databases 2016 (based on DHS, MICS and other nationally representative surveys) and UNICEF 2013

### Table 40 A1: Calculated sample size per study population and country

| *Study population* | *Eth* | *BF* | *Ma* | *Se* | *Pa* | *Ne* | *Ba* | *S L* | *Gh* | *Ug* | *Be* | *Total* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Girls | 750 | 900 | 900 | 300 | 300 | 300 | 600 | 300 | 250 | 300 | 300 | 5200 |
| Households | 400 | 480 | 480 | 160 | 160 | 160 | 320 | 160 | 133 | 160 | 160 | 2773 |
| Villages | 20 | 16 | 14 | 4 | 4 | 6 | 4 | 6 | 4 | 4 | 4 | 86 |
| Health Centres | 20 | 16 | 14 | 4 | 4 | 6 | 4 | 6 | 4 | 2 | 4 | 84 |
| SRHR Staff | 40 | 32 | 28 | 8 | 8 | 12 | 8 | 12 | 8 | 2 | 8 | 168 |
| Schools | 20 | 16 | 14 | 4 | 4 | 6 | 4 | 6 | 4 | 4 | 4 | 84 |
| Teachers | 40 | 32 | 28 | 8 | 8 | 12 | 8 | 12 | 8 | 4 | 8 | 168 |
| Districts | 11 | 8 | 7 | 2 | 2 | 3 | 2 | 3 | 4 | 1 | 2 | 45 |
| FGD | 40 | 32 | 28 | 8 | 8 | 12 | 8 | 12 | 8 | 4 | 8 | 168 |

## Her Choice indicators

Table 41 A1 presents the original 39 Her Choice indicators with measuring questions

Notes:

- Some indicators (or components of composite indicators) may not be applicable in some countries and can be skipped.
- The denominator differs across indicators.
- Most indicators are calculated for married and single girls separately.
- There were introductory questions before asking sensitive questions such as on FGM and sexual activity.
- Some indicators could not be measured (indicated)

### Table 41 A1: Her Choice indicators, and measuring questions by strategy

| INDICATORS | MEASURING QUESTIONS |
|---|---|
| IMPACT | |
| #1.1 Share of single girls who feel they can exercise control over the decision if, when and whom to marry<br>#1.2 Degree of control of single girls over the decision if, when and whom to marry | Would you feel able to oppose a marriage that was arranged against your will?<br>Who decides when you should marry? (you)<br>Who decides who you should marry? |
| #2 Share of women aged 20-24 married/in union before age 18 | Household sheet on members of household |
| #3 Share of women aged 20-24 married/in union before age 15 | Household sheet on members of Household |
| #4 Share of girls under 18 (ever) married/in union, by age year | Are you currently married?<br>Have you ever been married? |
| #5 Share of girls under 18 circumcised | Have you been circumcised? |
| STRATEGY 1 INVEST IN GIRLS, THEIR KNOWLEDGE, SKILLS AND PARTICIPATION | |
| #6.1 Share of single girls who feel they can oppose CM against their will<br>#6.2 Share of girls who feel they can oppose FGM against their | Would you feel able to oppose a marriage that was arranged against your will?<br>Do you think it is a good thing for girl to get circumcised? |
| #7 Share of girls who feel able to refuse unwanted sex (not measured) | Suppose someone tried to force you to have sex, what would you do?<br>If you do/did not want to have sex with your husband are/were you able to refuse it? (for married girls) |
| #8 Share of sexually active girls who use contraception | Did you or the man do anything to prevent pregnancy? |
| #9 Share of girls who have spoken out in community meetings/rallies on their rights | Have you ever spoken in public / in a group on the importance of girls under 18 years decide for themselves about marriage? |
| #18.1 Share of girls with comprehensive knowledge on SRHR<br>#18.2 Degree of knowledge on SRHR by girls | When in the menstrual cycle can a girl get pregnant if she has sex?<br>Can a girl get pregnant the first time she has sex?<br>What methods exist to prevent pregnancy (know pills and condoms)?<br>Are there any negative effects of child marriage? |
| #29 Share of girls trained | Do you or did you receive any education on issues related to sexual and reproductive health and rights – during classes or after school? |
| STRATEGY 2 IMPROVE ACCESS TO FORMAL EDUCATION FOR GIRLS | |
| #10 Share of girls regularly attending school in the last year | Did you attend school regularly (= at least 4 days a week) last year? |
| #19.1 Share of teachers able and confident to teach SRHR<br>#19.2 Share of schools that are girl-friendly | Do you occasionally lack confidence to speak to students about SRH-related issues?<br>Are you able to address all questions learners raise?<br>How girl- friendly do you believe your school to be? |
| #20 Share of girls enrolled in formal education | Are you enrolled in school this year? |
| #30 Number of teachers trained | How many female teachers have been trained to provide SRH-related education?<br>How many male teachers have been trained to provide SRH-related education? |
| #31 Number of schools taken girl friendly measures | What steps have been taken to make your school girl-friendly? |

| | |
|---|---|
| STRATEGY 3 IMPROVE ACCESS TO YOUTH-FRIENDLY SRHR SERVICES FOR GIRLS | |
| #11.1 Share of girls who know of SRHR services<br>#11.2 Share of girls who had a SRHR problem and visited a clinic for SRHR services | Do you know of any health clinic/facility(s) that you can go to if you have a sexual or reproductive health issue or question?<br>Have you ever visited this health facility for an SRHR-related issue? |
| #12.1 Share of girls accessing SRHR services with positive perception (not measured)<br>#12.2 Degree of positive perception on SRHR services by girls (not measured) | Did you think the health worker was friendly or not friendly?<br>Did the health staff respect your confidentiality?<br>Were the visiting hours convenient?<br>Did the service help you resolve your problem? |
| #21 Share of health workers who are able and confident to provide YFHS | Do you think you have been able to address the issues and questions that all married or unmarried girls or boys come to the clinic for?<br>Do you always feel capable to provide services to young people? |
| #22 Share of health facilities that offer YFHS | Do unmarried girls come to the health centre for SRH information, services or products?<br>Do school going girls and boys also seek services from your centre? |
| #32 Number of health workers trained | Have you been trained in SRHR during the last year |
| #33 Number of referral mechanisms in place between school and health service | In case a girl needs SRHR-related services or products, is there a referral mechanism in place in your school with health clinic, NGO or traditional healer? |
| STRATEGY 4 IMPROVE THE ECONOMIC SECURITY OF GIRLS AND THEIR FAMILIES | |
| #13 Share of households reporting an improved economic status | Regarding the economic status of the household which of these statements would you consider most applicable to your household? |
| #23 Share of households who reported an increased income for the household due to income generation interventions addressed at women | Has the family income increased because of the involvement of female household members in the activity(ies)? |
| #34 Number of households with female entrepreneurs supported | How many females participate in income generation activities? |
| STRATEGY 5 – MOBILIZE COMMUNITIES TO TRANSFORM SOCIAL NORMS | |
| #14.1 Share of communities that reject CM<br>#14.2 Share of communities that reject FGM | What position does this village take with regard to girls and boys marrying below the legal minimum age?<br>What is the position of the village administration on female circumcision? |
| #15.1 Share of girls who feel supported in decision making on SRHR<br>#15.2 Share of single girls who feel supported in decision making on CM<br>#15.3 Share of girls who feel supported in decision making on FGM | If you want to talk or have questions about SRH issues, could you consult someone or a particular source?<br>Is there someone who could help you to negotiate with your parent(s)/ caregiver(s) should they want to marry you to someone that you don't want to marry (at that time)?<br>Are there people who can help you negotiate with your parents /caregivers should they want you to get circumcised against your wish? |
| #24 Share of communities with leaders who condemned CM in village meetings | Have any of the village leaders' condemned CM and/or female circumcision in village meetings? |
| #25 Share of communities with village members who organize activities against negative effects of CM | Have any members of your village organized activities to educate other village members on the negative effects of CM/female circumcision? |

| | |
|---|---|
| #35 Number of communities with trained village leaders | Have any village leaders been trained on the negative effects of CM / female circumcision and/or the importance of sending girls to school? |
| #36 Number of communities with village members who organise activities against CM, FGM etc. | How many village members actively advocate against CM / female circumcision, and teach about rights of girls to education, and having a say in decisions that affect them? |
| STRATEGY 6 – CREATE AN ENABLING LEGAL AND POLICY ENVIRONMENT PREVENTING CM | |
| #16.1 Share of girls who know about protective laws on CM<br>#16.2 Share of girls who know about protective laws on FGM | Do you know whether there is any law that states at what age girl can marry / a boy can marry?<br>Are there any laws that state that a girl should get circumcised/not circumcised |
| #26.1 Share of communities with by-laws concerning CM<br>#26.2 Share of communities with by-laws concerning FGM | Does the village have by-laws against CM?<br>Does the village have by-laws against female circumcision? |
| #27 Share of districts where most births are registered | What is your estimate of the proportion of births that is registered? |
| #28 Share of districts that have an operational reporting system to document and act upon breaking of laws concerning CM/sexual assault | Do people report violation of laws concerning female circumcision, child marriage and/or sexual assault? |
| #37.1 Number of communities (that have no by-laws yet) in the process of developing by-laws CM – | *If no by-laws on CM:* Is the village in the process of developing them?<br>If no by-laws on FGM: Is the village in the process of developing them? |
| #38 Number of districts (or other local administrative level) that have established means to enforce laws on CM (not measured) | What means do you have to enforce laws on child marriage and female circumcision? |
| #39 Number of districts with consultation and informational meetings between (local) government agencies and civil society institutions related to SRHR | Are there meetings at district level between (local) government agencies and civil society on SRH for young people, child marriage, female circumcision, girls' education? |

# Annex 2: Study locations and partners

### Table 42 A2: 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 | Boussouma département | |
| | Nord | AJBF | Ouahigouya département | |
| | Centre Sud | AZLY | Guiba département | |
| | Centre Ouest | Songtaaba | Ramongo département | |
| | | THP | Sapouy département | THP |
| Ethiopia | Oromia | ADDA | 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 | ICDI |
| | Province No. 1 | | Morang | |
| | Province No.5 | | Banke | |
| Pakistan | Punjab | Bedari | Chakwal | ICDI |
| | | | Vehari | |
| Senegal | Tambacounda | ENDA JA | Tambacounda | SKN |
| | Kolda | | Kolda | |
| Sierra Leone | Western | OFP | Western Area | ICDI |
| | Northern | | Kambia | |
| Uganda | South-Eastern | THP | Iganga | THP |

# Annex 3: Tables: Background of Study populations

### Table 43 A3: Background variables of girls (%)

| | *Ba* *N=604* | *Pa* *N=304* | *Ne* *N=300* | *Sen* *N=314* | *Ma* *N=914* | *BF* *N=970* | *Be* *N=307* | *Gh* *N=265* | *SL* *N=297* | *Eth* *N=745* | *Ug* *N=327* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Age | | | | | | | | | | | |
| 12 | 13.1 | 5.6 | 16.7 | 19.7 | 0 | 13.4 | 14.1 | 15.8 | 18.9 | 18.7 | 14.8 |
| 13 | 21.7 | 15.1 | 13 | 12.7 | 29.3 | 15.5 | 14.1 | 24.9 | 12.5 | 19.5 | 18.5 |
| 14 | 17.5 | 9.2 | 15.3 | 12.1 | 22.8 | 16.3 | 15.4 | 16.3 | 10.4 | 21.6 | 17.9 |
| 15 | 19.2 | 13.2 | 13 | 14.6 | 16 | 16.9 | 18.4 | 12.8 | 15.8 | 20.3 | 13 |
| 16 | 12.4 | 20.1 | 16.7 | 13.7 | 14.4 | 17.3 | 14.4 | 11.7 | 18.2 | 9.9 | 15.7 |
| 17 | 16.1 | 36.8 | 25.3 | 27.1 | 17.5 | 20.5 | 23.6 | 18.5 | 24.2 | 9.9 | 20.1 |
| Religion | | | | | | | | | | | |
| Islam | 92.1 | 100 | 16.7 | 99.7 | 95.2 | 57.2 | 23.6 | 9.9 | 66.3 | 28 | 61.5 |
| Christianity (any) | 0 | 0 | 2.7 | 0.3 | 3.5 | 38.6 | 30.8 | 85.5 | 30.3 | 71.5 | 37.4 |
| Hinduism | 7,9 | 0 | 48.3 | 0 | 0 | 0 | 28.3 | 0 | 0 | 0 | 0 |
| Buddhism | 0 | 0 | 32.3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Animist | 0 | 0 | 0 | 0 | 1.3 | 0 | 0 | 0 | 0 | 0 | 0 |
| With disability | 1,2 | 0.7 | 1 | 1 | 0.7 | 0 | 14.3 | 3.1 | 5.8 | 3.8 | 3.4 |
| Member of club or group | 2,6 | 0.7 | 4.7 | 9.6 | 4.4 | 1 | 2 | 32.6 | 24.4 | 30.6 | 33.3 |

### Table 44 A3: Background variables of Households (%)

| | *Ba* *N=524* | *Pa* *N=201* | *Ne* *N=235* | *Sen* *N=166* | *Ma* *N=470* | *BF* *N=529* | *Gh* *N=212* | *SL* *N=161* | *Eth* *N=596* | *Ug* *N=167* |
|---|---|---|---|---|---|---|---|---|---|---|
| Respondent | | | | | | | | | | |
| Mother of girls | 7.6 | 10.9 | 20.4 | 7.8 | 14.9 | 59.4 | 25 | 28.8 | 17.2 | 33.5 |
| Father of girls | 86.8 | 64.7 | 63.8 | 88 | 83 | 38.2 | 57.1 | 65.6 | 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 | 7.1 | 61.5 | 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 | 21.2 | 9.3 | 0.3 | 9 |
| Protestant | 0 | 0 | 2.6 | 0.6 | 0.6 | 6.3 | 40.1 | 13.7 | 35 | 24 |
| Orthodox | 0 | 0 | 0 | 0.6 | 0.6 | 2.7 | 5.2 | 0 | 39.1 | 0 |

### Table 45 A3: Background variables on villages

| | *Ba* *N= 4* | *Pa* *N= 4* | *Ne* *N= 4* | *Sen* *N= 4* | *Ma* *N= 13* | *BF* *N= 16* | *Gh* *N= 4* | *SL* *N= 4* | *Eth* *N= 20* | *Ug* *N= 4* |
|---|---|---|---|---|---|---|---|---|---|---|
| Estimated mean # households | 950 | 438 | 2644 | 375 | 201 | 261 | 353 | 4500 | 1562 | 310 |
| Range # households | 400-1200 | 300-500 | 665-4290 | 15-800 | 28-1000 | 12-650 | 150-500 | 3000-4000 | 680-6000 | 200-540 |
| Keep birth registers | 2 | 2 | 4 | 4 | 8 | 13 | 1 | 3 | 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 | 4 | 1 | 20 | 4 |
| With secondary school(s) | 4 | 4 | 3 | 4 | 6 | 14 | 2 | 1 | 13 | 1 |
| Health services available | | | | | | | | | | |
| Hospital | 0 | 2 | 1 | 0 | 0 | 2 | 0 | 2 | 5 | 2* |
| Health centre | 2 | 2 | 0 | 0 | 6 | 12 | 0 | 4 | 9 | 2* |
| Health post | 0 | 0 | 4 | 2 | 2 | 4 | 4 | 0 | 17 | 1* |
| Other | 0 | 2 | 2 | 2 | 4 | 2 | 0 | 0 | 1 | |
| None | - | 1 | - | - | 1 | - | - | - | - | - |
| No answer | 2 | - | - | - | - | - | - | - | - | - |

* Uganda unreliable data on health facilities

### Table 46 A3: Background variables on schools

| | *Ba* *N= 4* | *Pa* *N= 4* | *Ne* *N= 5* | *Sen* *N= 2* | *Ma* *N= 14* | *BF* *N= 25* | *Gh* *N= 4* | *SL* *N=4* | *Eth* *N= 20* | *Ug* *N= 6* |
|---|---|---|---|---|---|---|---|---|---|---|
| School level | | | | | | | | | | |
| Primary | *3* | *2* | *5* | *1* | *10* | *8* | *4* | *0* | *20* | *3* |
| Secondary | *4* | *2* | *5* | *1* | *4* | *17* | *4* | *4* | *0* | *3* |

### Table 47 A3: Background variables for teachers

| | *Ba* *N= 6* | *Pa* *N= 4* | *Ne* *N= 7* | *Ma* *N=27* | *BF* *N=24* | *Gh* *N= 4* | *SL* *N= 8* | *Eth* *N=25* | *Ug* *N= 6* |
|---|---|---|---|---|---|---|---|---|---|
| Gender | | | | | | | | | |
| Female | 1 | 4 | 3 | 5 | 7 | 0 | 3 | 18 | 6 |
| Male | 5 | 0 | 4 | 12 | 15 | 4 | 5 | 5 | 0 |
| Level of education | | | | | | | | | |
| First cycle secondary | 0 | 0 | 0 | - | 1 | 0 | 0 | 5 | 0 |
| Second cycle secondary | 0 | 0 | 0 | - | 8 | 0 | 0 | 2 | 0 |
| Teacher training college | 2 | 0 | 0 | - | 6 | 2 | 7 | 14 | 4 |
| University | 4 | 4 | 7 | | 0 | 2 | 1 | 2 | 2 |
| Teach SRH: | | | | | | | | | |
| Intra-curricular | 5 | 0 | 5 | - | - | 1 | 5 | - | 0 |
| Extra-curricular | 0 | 4 | 0 | - | - | 0 | 0 | - | 0 |
| Both intra- and extra | 1 | 0 | 2 | - | - | 3 | 3 | - | 6 |

### Table 48 A3: Background variables for health centres

| | *Ba* *N=4* | *Pa* *N=3* | *Ne* *N=4* | *Sen* *N=4* | *Ma* *N=14* | *BF* *N=13* | *Gh* *N=3* | *SL* *N=5* | *Eth* *N=20* | *Ug* *N=3* |
|---|---|---|---|---|---|---|---|---|---|---|
| Type of health centre | | | | | | | | | | |
| Hospital | 0 | 1 | 0 | 0 | 0 | 2 | 0 | 0 | 1 | 0 |
| Health Centre | 2 | 1 | 0 | 0 | 10 | 5 | 0 | 5 | 13 | 3 |
| Health post | 1 | 0 | 3 | 4 | 2 | 4 | 3 | 0 | 6 | 0 |
| Community clinic/unit | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SRH services provided | | | | | | | | | | |
| Antenatal care | 4 | 1 | 4 | 3 | 14 | 12 | 3 | 5 | 17 | 3 |
| Post-natal care | 4 | 2 | 4 | 3 | 14 | 12 | 3 | 5 | 17 | 2 |
| Infertility problems | 0 | 2 | 0 | 0 | 6 | 8 | 1 | 0 | 6 | 1 |
| Sexual problems | 1 | 3 | 4 | 0 | 7 | 11 | 1 | 4 | 8 | 2 |
| Natural delivery | 0 | 2 | 3 | 4 | 12 | 12 | 1 | 1 | 15 | 1 |
| Caesarean section | 3 | 0 | 0 | 0 | 2 | 3 | 0 | 0 | 0 | |
| Contraception/family planning | 1 | 3 | 4 | 2 | 14 | 13 | 2 | 5 | 18 | 2 |
| Abortion | 2 | 2 | 1 | 0 | 1 | 3 | 0 | 1 | 5 | 2 |
| Post-abortion care | 1 | 2 | 2 | 0 | 9 | 9 | 0 | 0 | 10 | 1 |
| Care after sexual violation | 1 | 0 | 0 | 0 | 6 | 4 | 0 | 1 | 3 | 1 |
| Issuing of birth certificates | 0 | 1 | 2 | 3 | 10 | 10 | 2 | 4 | 7 | 1 |

### Table 49 A3: Background variables for health staff

| | *Ba* *N=8* | *Pa* *N=4* | *Ne* *N=4* | *Sen* *N=3* | *Ma* *N=24* | *BF* *N=15* | *Gh* *N=4* | *SL* *N=9* | *Eth* *N=20* | *Ug* *N=3* |
|---|---|---|---|---|---|---|---|---|---|---|
| Gender | | | | | | | | | | |
| Female | 6 | 4 | 4 | 1 | 16 | 11 | 3 | 9 | 5 | 1 |
| Male | 2 | 0 | 0 | 2 | 8 | 4 | 1 | 0 | 15 | 2 |
| Qualification | | | | | | | | | | |
| Midwife | 0 | 0 | 0 | 0 | 4 | 13 | 0 | 2 | 5 | 1 |
| Medical Doctor | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Nurse | 0 | 0 | 0 | 1 | 5 | 1 | 4 | 7 | 5 | 2 |
| Health Officer | 2 | 0 | 0 | 0 | 6 | 0 | 0 | 0 | 3 | 0 |
| Health Assistant | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Lady health visitor | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Health planning assistant | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ANM | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Matron | 0 | 0 | 0 | 1 | 6 | 0 | 0 | 0 | 0 | 0 |
| Health extension worker | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 0 |

## Annex 4: Tables: Baseline values of Her Choice indicators

This annex present the full tables for the indicators, including the regional ranges as far as not presented in the main text. The source of all tables are the 2016 baseline surveys. Where the majority of denominators in a table are below 10, rates or ratios are presented in numbers as opposed to percentages.

## Impact indicators

### Table 50 A4: Share of single girls who feel they can exercise control over if, when and whom to marry (IND1.1) and mean degree of control of single girls (IND1.2) (%)

| | *Ba* *N=552* | *Pa* *N=201* | *Ne* *N=236* | *Sen* *N=240* | *Ma* *N=687* | *BF* *N=912* | *Be* *N=271* | *Gh* *N=258* | *SL* *N=240* | *Eth* *N=733* |
|---|---|---|---|---|---|---|---|---|---|---|
| IND 1.1 | 6.3 | 1.1 | 7.6 | 11.6 | 9.1 | 22.6 | 0.9 | 39.5 | 12.1 | 35.9 |
| *Range* | *5.1-7.6* | | *0-18.8* | | *0-26.7* | *16.6-30.9* | | | | *26.3-43.6* |
| IND 1.2 | 0.76 | 0.19 | 0.89 | 1.46 | 0.58 | 1.5 | 0.52 | 1,89 | 1.39 | 1.78 |
| *Range* | | | *0.2- 1.6* | | *0.2-1.4* | *1.4-1.5* | | | | |

### Table 51: A4 Share of women aged 20-24 in studied households who were married before age 18 (IND2) and before age 15 (IND3) (%)

| | *Ba* *N= 67* | *Pa* *N= 27* | *Ne* *N=40* | *Ma* *N= 84* | *BF* *N= 154* | *Gh* *N= 21* | *SL* *N= 10* | *Eth* *N= 45* | *Ug* *N= 15* |
|---|---|---|---|---|---|---|---|---|---|
| IND2 | 55.2 | 66.7 | 37.5 | 65.5 | 49.4 | 42.9 | 20 | 71.1 | 20 |
| IND3 | 16.4 | 14.8 | 2.5 | 17.9 | 5.2 | 14.3 | 20 | 26.7 | 0 |

### Table 52 A4: IND4 Share of girls (ever) married/in union, by current age (%)

| | Ba | Pa | Ne | Sen | Ma | BF | Be | Gh | SL | Eth | Ug |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Age 12* | *N= 79* | *N= 17* | *N= 50* | *N=62* | *N= 0* | *N =128* | *N=43* | *N=42* | *N=256* | *N=139* | *N=48* |
| IND4 | 0 | 5.9 | 0 | 4.9 | - | 0 | 0 | 0 | 3.6 | 0.7 | 2.1 |
| Range | | | | | | | | | | 0 – 1.8 | |
| *Age 13* | *N= 131* | *N=46* | *N=39* | *N=40* | *N=268* | *N=151* | *N=43* | *N=66* | *N=37* | *N=144* | *N=60* |
| IND4 | 0 | 6.5 | 0 | 2.6 | 2.2 | 0 | 0 | 0 | 2.7 | 1.4 | 0 |
| Range | | | | | 0 – 7.1 | | | | | 0-3..9 | |
| *Age 14* | *N=106* | *N=28* | *N=46* | *N=38* | *N=208* | *N=158* | *N=47* | *N=43* | *N=31* | *N=161* | *N=58* |
| IND4 | 0.9 | 7.1 | 6.5 | 2.7 | 7.7 | 3.2 | 8.5 | 0 | 9.7 | 2.5 | 0 |
| Range | 0 – 2 | | 0-15.8 | | 0-18.8 | 0 -4.5 | | | | 0 – 5.4 | |
| *Age 15* | *N=116* | *N=40* | *N=39* | *N=46* | *N=146* | *N=164* | *N=56* | *N=34* | *N=47* | *N=151* | *N=42* |
| *IND4* | *7.8* | *12.5* | *5.1* | *19* | *12.3* | *4.3* | *7.1* | *2.9* | *4.3* | *4* | *2.4* |
| *Range* | *5.2-10.3* | | *0 – 1/5* | | *0 – 30* | *1.9-6.5* | | | | *0 – 8.8* | |
| *Age 16* | *N=75* | *N=61* | *N=50* | *N=43* | *N=132* | *N=165* | *N=44* | *N=31* | *N=54* | *N=74* | *N=51* |
| *IND4* | *14.7* | *42.6* | *36* | *23.8* | *15.9* | *10.9* | *11.4* | *0* | *7.4* | *4.1* | *2* |
| *Range* | *7.1-24.2* | | *10.5- 63.6* | | *0 – 36* | *7.1-18.5* | | | | *0 – 7.5* | |
| *Age 17* | *N=97* | *N=112* | *N=76* | *N=85* | *N=160* | *N=195* | *N=72* | *N=49* | *N=72* | *N=74* | *N=65* |
| IND4 | 35.1 | 59.8 | 53.9 | 49.4 | 43.8 | 17.9 | 30.6 | 14.3 | 16.7 | 8.1 | 13.8 |
| Range | 26.5-43.8 | | 6.7 - 90 | | 0-68.6 | 4.3-29.2 | | | | 0-14.3 | |

## Indicators Strategy I

### Table 53 A4: IND29 Share of girls trained on SRHR, by marital status (%)

| | Ba | Pa | Ne | Sen | Ma | BF | Be | Gh | SL | Eth | Ug |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Single* | *N=552* | *N=201* | *N=237* | *N=240* | *N=788* | *N=912* | *N=271* | *N=258* | *N=274* | *N=733* | *N=320* |
| IND29 | 47.3 | 3.5 | 45.1 | 26.7 | 7 | 21.4 | 24.4 | 54.7 | 24.1 | 24.1 | 68.8 |
| Range | 39.3-66.1 | | 21-72.9 | | 0-12.4 | 16-26.9 | | | | 10.7-31.5 | |
| *Married* | *N= 52* | *N=103* | *N= 63* | *N= 60* | *N=126* | *N= 58* | *N= 34* | *N= 7* | *N= 23* | *N= 11* | *N= 7* |
| IND29 | 50 | 1 | 15.9 | 11.7 | 4.8 | 17.5 | 2.9 | 5/7 | 39.1 | 18.2 | 6/7 |
| Range | 44.4- 56 | | 14.3-25 | | 0- 2/7 | 12.4-18.8 | | | | 0 - 25 | |

### Table 54 A4: IND6.1 Share of single girls who feel they can oppose CM (%)

| | Ba | Pa | Ne | Sen | Ma | BF | Be | Gh | SL | Eth | Ug |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | *N= 552* | *N= 201* | *N= 237* | *N=240* | *N= 788* | *N=912* | *N= 271* | *N= 258* | *N=274* | *N= 733* | *N=320* |
| IND6.1 | 54.2 | 15.5 | 42.4 | 48.8 | 25.6 | 49.9 | 50.6 | 90.8 | 57.7 | 63.5 | 83.6 |
| Range | 37.6-69.7 | | 22.6-86.5 | | 8.2-43.8 | 41.3-60.6 | | | | 58.6-76.2 | |

### Table 55 A4: IND6.2 Share of single girls who oppose FGM (%)

| | *Be* | *BF* | *Sen* | *Ma* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|
| | *N=271* | *N= 912* | *N=240* | *N= 788* | *N= 190* | *N= 274* | *N= 733* | *N= 320* |
| IND6.2 | 35.4 | 79.3 | 75.9 | 21.4 | 94.7 | 62.8 | 83.4 | 93.9 |
| Range | | 74.6 – 84 | | 4 – 44.8 | | | 80.5 – 85.2 | |

## Indicators Strategy II

### Table 56 A4: IND20 Share of girls enrolled in formal education, by marital status (%)

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Be* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Single* | *N=552* | *N=201* | *N=237* | *N=240* | *N=788* | *N=912* | *N=271* | *N=258* | *N=274* | *N=733* | *N=320* |
| IND20 | 90 | 43.8 | 75.5 | 75 | 54.4 | 79.6 | 46.8 | 89.8 | 84.1 | 86.6 | 84.1 |
| Range | | | 59.5-92.7 | | 35.9-75.8 | 69.1-89.8 | | | | 66.4-95 | |
| *Married* | *N= 52* | *N=103* | *N= 63* | *N= 60* | *N=126* | *N= 58* | *N= 34* | *N= 7* | *N= 23* | *N= 11* | *N= 7* |
| IND20 | 19.2 | 1 | 9.5 | 8.3 | 31.7 | 31.6 | 0 | 2/7 | 59.1 | 63.6 | 1/7 |
| Range | | | 7.9-1/4 | | 0/5 - 42 | 25-37.5 | | | | 1/3-75.2 | |

### Table 57 A4: IND10 Share of girls regularly attending school, by marital status (%)

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Be* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Single* | *N=552* | *N=201* | *N=237* | *N=249* | *N=788* | *N=912* | *N=271* | *N=258* | *N=274* | *N=733* | *N=320* |
| IND10 | 85.7 | 38.3 | 65.8 | 65.9 | 50.6 | 76 | 41.3 | 86 | 75.5 | 75.7 | 74.1 |
| Range | 77-94.2 | | 54.8-78.1 | | 28.9 -74.5 | 66.4-82.7 | | | | 45- 87.2 | |
| *Married* | *N= 52* | *N=103* | *N= 63* | *N= 61* | *N=126* | *N= 58* | *N= 34* | *N= 7* | *N=23* | *N= 11* | *N= 7* |
| IND10 | 17.3 | 1 | 7.9 | 8.2 | 27 | 29.3 | 0 | 2/7 | 60.9 | 36.4 | 1/7 |
| Range | 14.8-20 | | 0-9.5 | | 0 -42 | 25-30.3 | | | | 0 - 50 | |

## Indicators Strategy III

### Table 58 A4: IND11.1 Share of girls who know of SRHR services, by marital status (%)

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Be* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Single* | *N=552* | *N=201* | *N=237* | *N=249* | *N=788* | *N=912* | *N=271* | *N=258* | *N=274* | *N=733* | *N=320* |
| IND11.1 | 39.9 | 20.4 | 54 | 32.8 | 37.2 | 39.2 | 56.8 | 55 | 29.2 | 38.9 | 72.8 |
| *Range* | 24.9- 54.9 | | 36.7- 76 | | 13.1- 68 | 32.2-45.5 | | | | 10.1-53.4 | |
| *Married* | *N= 52* | *N=103* | *N= 63* | *N= 61* | *N=126* | *N= 58* | *N=34* | *N= 7* | *N= 23* | *N= 11* | *N= 7* |
| IND11.1 | 38.5 | 41.7 | 58.7 | 60 | 62.1 | 56.1 | 79.4 | 6/7 | 30.4 | 36.4 | 5/7 |
| *Range* | 20- 55.6 | | 44.7- 81 | | 36.4-73.5 | 50-62.5 | | | | 0 – 37.5 | |

### Table 59 A4: IND11.2 Share of girls who knew of SRH services and visited a clinic for SRHR services, by marital status (%)

| | Ba | Pa | Ne | Sen | Ma | BF | Be | Gh | SL | Eth | Ug |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Single* | *N=223* | *N=41* | *N=128* | *N=76* | *N=291* | *N=357* | *N=151* | *N=129* | *N=83* | *N=281* | *N=236* |
| IND11.2 | 19.7 | 53.7 | 14.8 | 13.2 | 14.8 | 14.3 | 19.9 | 7.8 | 27.7 | 8.2 | 36.9 |
| Range | 16.4 – 26.8 | | 0 – 34.6 | | 0- 33.7 | 10.7 – 19.6 | | | | 5.2 - 20 | |
| *Married* | *N=20* | *N=43* | *N=37* | *N=38* | *N=77* | *N=32* | *N=26* | *N=6* | *N=7* | *N=4* | *N=5* |
| IND11.2 | 40 | 74.4 | 70.3 | 55.3 | 23.4 | 37.5 | 73.1 | 2/6 | 3/7 | 2/4 | 3/5 |
| Range | 2/5 – 40 | | 64.7 – 76.5 | | 0 – 7/9 | 26.3 - 60 | | | | 0 – 2/8 | |

## Indicators Strategy V

### Table 60 A4: IND15.1 Share of girls who feel supported in decision making on SRHR, by marital status (%)

| | Ba | Pa | Ne | Sen | Ma | BF | Be | Gh | SL | Eth | Ug |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Single* | *N=552* | *N=201* | *N=237* | *N=240* | *N=788* | *N=912* | *N=271* | *N=258* | *N=274* | *N=733* | *N=320* |
| IND15.1 | 72.4 | 59.2 | 63.3 | 54.9 | 32.2 | 57 | 71.6 | 73.2 | 38.6 | 34.7 | 84.1 |
| Range | 72 – 72.7 | | 57 – 69.8 | | 8.2 - 55 | 53.9 – 63.1 | | | | 26.2 – 40.5 | |
| *Married* | *N=52* | *N=103* | *N= 63* | *N= 60* | *N=126* | *N= 58* | *N=34* | *N= 7* | *N= 23* | *N= 11* | *N= 7* |
| IND15.1 | 75 | 54.4 | 69.8 | 83.1 | 44.4 | 58.9 | 85.3 | 100 | 59.1 | 36.4 | 6/7 |
| Range | 68 – 81.5 | | 66.7-4/4 | | 7.8 – 68.5 | 42.9 – 62.5 | | | | 0 - 50 | |

### Table 61 A4: IND15.2 Share of single girls who feel supported in decision making on CM (%)

| | Ba | Pa | Ne | Sen | Ma | BF | Be | Gh | SL | Eth | Ug |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | *N=552* | *N=201* | *N=237* | *N=240* | *N=788* | *N=912* | *N=271* | *N=258* | *N=274* | *N=733* | *N=320* |
| IND15.2 | 63.3 | 17.7 | 61.9 | 74.5 | 39.5 | 67.9 | 59.8 | 88.3 | 57.7 | 52 | 76.4 |
| Range | 62.4 – 64.2 | | 33.9-88.5 | | 7.8-68.5 | 65.3-70.5 | | | | 40.4-57.2 | |

### Table 62 A4: IND15.3 Share of uncircumcised girls who do not want to be circumcised who feel supported in decision making on FGM (%)

| | BF | Sen | Ma | Gh | SL | Eth | Ug |
|---|---|---|---|---|---|---|---|
| | *N= 109* | *N= 23* | *N= 20* | *N= 27* | *N= 57* | *N= 85* | *N= 120* |
| IND15.3 | 44 | 26.1 | 55 | 77.8 | 50.9 | 45.9 | 84.2 |
| *Range* | 38.1 – 56.7 | | 0 – 2/2 | | | 38.1 – 57.9 | |

N= Number of uncircumcised girls who do not want to be circumcised

## Indicators Strategy VI

### Table 63 A4: IND16.1 Share of girls who know about protective laws on CM (%)

| | *Ba* *N=604* | *Pa* *N=304* | *Ne* *N=300* | *Sen* *N=314* | *Ma* *N=911* | *BF* *N=970* | *Be* *N=307* | *Gh* *N=265* | *SL* *N=148* | *Eth* *N=745* | *Ug* *N=327* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IND16.1 | 87.9 | 4.9 | 30.7 | 30 | 9.9 | 31.7 | 34.2 | 32.3 | 34.8 | 42 | 54.4 |
| Range | 83.8 – 92.1 | | 24 – 35 | | 0 – 26.3 | 28.7 – 36.5 | | | | 29.6 – 52 | |

### Table 64 A4: IND16.2 Share of girls who know about protective laws on FGM (%)

| | *Be* *N= 307* | *BF* *N= 970* | *Sen* *N= 314* | *Ma* *N= 914* | *Gh* *N= 265* | *SL* *N= 148* | *Eth* *N= 745* | *Ug* *N=327* |
|---|---|---|---|---|---|---|---|---|
| IND16.2 | 4.9 | 42 | 39.9 | 4.9 | 13.8 | 21.2 | 50.9 | 4.9 |
| Range | | 36.2 – 48.9 | | 0 – 10.1 | | | 41.4 - 65 | |

# Annex 5: Tables: Supporting information for indicators

## Supporting Impact indicators

### Table 65 A5: Girls can decide, when, who and if they marry, according to Household Heads (%)

| | *Ba* *N= 524* | *Pa* *N= 201* | *Ne* *N= 235* | *Sen* *N= 166* | *Ma* *N= 470* | *BF* *N= 529* | *Gh* *N= 212* | *SL* *N= 161* | *Eth* *N= 596* | *Ug* *N= 167* |
|---|---|---|---|---|---|---|---|---|---|---|
| When | 19.2 | 2.5 | 36.2 | 66 | 27.1 | 79.1 | 67 | 46 | 51.4 | 36 |
| Who | 16.3 | 3 | 37.9 | 71.6 | 41.2 | 86.5 | 68.4 | 54 | 49.1 | 57.3 |
| If | 17.6 | 1.5 | 39.1 | - | - | - | 67.5 | 59.9 | - | 55.1 |

### Table 66 A5: Why girls cannot make decision on marriage, according to household head (%)

| | *Ba* *N=309* | *Pa* *N=197* | *Ne* *N=151* | *Sen* *N=99* | *Ma* *N=468* | *BF* *N=387* | *Gh* *N=89* | *SL* *N=56* | *Eth* *N=284* | *Ug* *N=28* |
|---|---|---|---|---|---|---|---|---|---|---|
| Decision too important for household | 54.9 | 46.7 | 86.8 | 45.5 | 62 | 54 | 88.8 | 30.4 | 35.2 | 51.29 |
| Too difficult a decision | 24.5 | 29.9 | 13.2 | 35.7 | 26.1 | 24.5 | 7.9 | 41.1 | 60 | 25.9 |

### Table 67 A5: Household heads' opinion on child marriage (%)

| | *Ba* *N= 524* | *Pa* *N= 201* | *Ne* *N= 235* | *Sen* *N= 162* | *Ma* *N= 470* | *BF* *N= 529* | *Gh* *N= 212* | *SL* *N= 161* | *Eth* *N= 596* | *Ug* *N= 167* |
|---|---|---|---|---|---|---|---|---|---|---|
| Good for girls | 8.9 | 57.2 | 9.4 | 22.5 | 29.4 | 15.4 | 1.9 | 5 | 6.3 | 1.2 |
| Good for parents | 14.5 | 9.3 | 21.3 | 5.1 | 23.3 | 4.5 | 0.9 | 0.6 | 2.7 | 1.2 |
| Bad for girls and parents | 61 | 23.2 | 51.9 | 61.6 | 36.7 | 71.3 | 90.6 | 93.1 | 76.9 | 93.3 |
| Good for parents but bad for girls | 13.7 | 8.8 | 15.7 | 2.9 | 8 | 3.1 | 2.4 | 1.3 | 8.8 | 2.5 |
| Good for girls but bad for parents | 0.4 | 1.5 | 0.9 | 0.6 | 0.2 | 2 | 3.3 | 0 | 1.5 | 1.8 |

### Table 68 A5: Type of marriage that married girls had (%)

| | *Ba* *N=52* | *Pa* *N=103* | *Ne* *N=63* | *Gh* *N=7* | *Ug* *N= 11* |
|---|---|---|---|---|---|
| Arranged | 84.3 | 94.1 | 82.5 | 2/7 | 27.3 |
| Elopement | 2 | 2 | 6.3 | 0 | 45.5 |
| Love marriage | 7.8 | 1 | 11.1 | 1/7 | 27.3 |
| Forced marriage | 0 | 1 | 0 | 1/7 | 0 |

### Table 69 A5: Most common types of marriages according to village leaders (multiple response, three options)

| | *Ba* *N=4* | *Pa* *N=4* | *Ne* *N=4* | *Sen* *N=4* | *BF* *N=16* | *Gh* *N=4* | *SL* *N=4* | *Eth* *N=20* | *Ug* *N=4* |
|---|---|---|---|---|---|---|---|---|---|
| Formal through registration | 4/4 | 3/4 | 1/4 | 1/4 | 1/16 | 2/4 | 2/4 | 4/20 | 0 |
| Informal | 2/4 | 2/4 | 0 | 0 | 9/16 | 1/4 | 2/4 | 15/20 | 0 |
| Paying of dowry | 4/4 | 2/4 | 1/4 | 0 | 5/16 | | | 3/20 | 0 |
| Paying of bride price | | 0 | 0 | 0 | 4/16 | 4/4 | 1/4 | 7/20 | 1/4 |
| Elopement (without parental consent) | ¼ | 0 | 1/4 | 0 | 0 | 0 | 0 | 0 | 3/4 |
| Love (with parental consent) | ¼ | 0 | 4/4 | 0 | 0 | 0 | 0 | 0 | 0 |
| Register with village head | 0 | 1/4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Arranged marriage | 0 | 1/4 | 4/4 | 0 | 0 | 0 | 0 | 0 | 0 |
| Religious – Church | 0 | 0 | 1/4 | 1 | 12/16 | 4/4 | 2/4 | 10/20 | 4/4 |
| Religious – Mosque | 0 | 0 | 0 | 4 | 15/16 | 4/4 | 3/4 | 5/20 | 3/4 |

### Table 70 A5: Household heads' opinion on FGM (%)

| | *BF* *N=529* | *Sen* *N=162* | *Ma* *N=470* | *Gh* *N=212* | *SL* *N=161* | *Eth* *N=596* | *Ug* *N=167* |
|---|---|---|---|---|---|---|---|
| Good for the girls | 13.9 | 18.8 | 65.3 | 0 | 20.7 | 19.5 | 0 |
| Good for the parents | 1.2 | 5.8 | 14.7 | 0 | 10.7 | 3.2 | 2 |
| Bad for girls and parents | 75.8 | 58 | 11.1 | 71.4 | 60.7 | 63.8 | 85.2 |
| Good for parents but bad for girls | 2.2 | 2.5 | 3.1 | 0.5 | 4.7 | 4.6 | 2 |
| Good for girls but bad for parents | 0.2 | 0 | 0.4 | 0.5 | 0 | 0.3 | 0.7 |

### Table 71 A5: Village leaders reporting on that FGM is common and on normal age for FGM

| | *BF* *N=16* | *Sen* *N=4* | *Ma* *N=13* | *Gh* *N=4* | *SL* *N=4* | *Ug* *N=4* |
|---|---|---|---|---|---|---|
| FGM is common nowadays | 3/16 | 0/4 | 11/13 | 0/4 | 4/4 | 0/4 |
| Normal age (before) | 1 | - | 1 – 7 | 15 – 19 | 15 – 19 | - |

## Supporting Strategy I

### Table 72 A5: Organisers of training, reported by girls who received SRH training (%)

| | *Ba* *N=317* | *Pa* *N=8* | *Ne* *N=117* | *Sen* *N=69* | *Ma* *N=61* | *BF* *N=205* | *Gh* *N=146* | *SL* *N=75* | *Eth* *N=178* | *Ug* *N=226* |
|---|---|---|---|---|---|---|---|---|---|---|
| School | 77.6 | 5/8 | 97.4 | 72.5 | 63.9 | 58.7 | 88.4 | 78.7 | 89.3 | 88.5 |
| NGO | 11.7 | 0 | 4.3 | 4.5 | 16.4 | 13 | 8.9 | 22.7 | 5.1 | 7.1 |
| Church | 0 | 0 | 0 | 0 | 1.6 | 2 | 8.9 | 4 | 5.1 | 0.4 |
| Health Institution | 6.6 | 0 | 3.4 | 9 | 9.8 | 22 | 4.1 | 8 | 10.7 | 3.1 |
| Other | 0 | 1/8 | 0 | 0 | 8.2 | 16.5 | 2.1 | 4 | 5.7 | 0.9 |

### Table 73 A5: Subjects taught in training according to girls who received SRH training (%)

| | *Ba* *N=317* | *Pa* *N=8* | *Ne* *N=117* | *Sen* *N=61* | *Ma* *N=61* | *BF* *N=201* | *Be* *N=67* | *Gh* *N=148* | *SL* *N=75* | *Eth* *N=176* | *Ug* *N=226* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Importance of girls education | 90.9 | 5/8 | 79.5 | 86.9 | 88.5 | 89.4 | 85.1 | 77 | 97.3 | 89.8 | 86 |
| Importance of girls access to health care | 88.6 | 6/8 | 82.1 | 72.1 | 82 | 87.6 | 79.1 | 64.2 | 90.5 | 83.6 | 82.7 |
| Menstrual cycle and pregnancy | 88 | 5/8 | 83.8 | 80.6 | 77 | 87.7 | 79.1 | 84.9 | 94.7 | 81.4 | 88.5 |
| STIs & HIV/AIDS | 71.9 | 1/8 | 76.9 | 72.6 | 78.7 | 90.1 | 83.6 | 83.7 | 94.7 | 89.8 | 83.6 |
| Male contraceptives | 48.9 | 2/8 | 82.9 | 70 | 63.9 | 80.3 | 62.7 | 58.9 | 71.2 | 57.1 | 40.3 |
| Female contraceptives | 64.4 | 1/8 | 85.5 | 63.8 | 77 | 81.2 | 61.2 | 52.4 | 85.3 | 84.2 | 59.4 |
| Laws against child marriage | 80.4 | 1/8 | 55.6 | 70.2 | 59 | 69.5 | 74.6 | 51.7 | 80 | 81.8 | 57.1 |
| Negative effects of CM | 89.3 | 0 | 89.7 | 78.7 | 63.9 | 73.6 | 74.6 | 59.6 | 84 | 92.1 | 67.9 |
| Laws against FGM/C | - | - | - | 42.1 | 36.1 | 75.5 | 10.4 | 32.2 | 74.7 | 82.5 | 15.6 |
| Negative effects of FGM/C | - | - | - | 49.1 | 45.9 | 83.3 | 7.5 | 33.8 | 70.7 | 88.1 | 24.1 |
| Sexual violence, harassment and abuse | 61.5 | 5/8 | 60.7 | 52.6 | 49.2 | 65.5 | 79.1 | 59.3 | 89.3 | 68.4 | 63.8 |
| Female and male reproductive system | 57.1 | 0 | 84.6 | 44.6 | 55.7 | 65.8 | 55.2 | 65.5 | 82.7 | 70.6 | 72.8 |
| Puberty and bodily changes | 0 | 0 | 0 | 54.4 | 47.5 | 71.4 | 0 | 86.9 | 92 | 80.2 | 87.9 |
| Intimate and sexual relationships | 0 | 0 | 0 | 47.2 | 60.7 | 59.5 | 0 | 75.2 | 73.3 | 60.5 | 59.6 |
| Gender equality | 0 | 0 | 0 | 40.4 | 26.2 | 47.9 | 0 | 39.7 | 75.7 | 78.2 | 31.7 |

### Table 74 A5: Correct answer to the specific questions measuring comprehensive knowledge, by marital status (%)

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Gh* | *SL* | *Eth* |
|---|---|---|---|---|---|---|---|---|---|
| *Single girls* | *N=552* | *N=201* | *N=237* | *N=240* | *N=788* | *N=912* | *N=258* | *N=274* | *N=733* |
| Know can get pregnant mid-cycle | 4.2 | 0.5 | 20.3 | 3.2 | 9.1 | 4.8 | 12 | 5.1 | 8.5 |
| Know pregnant first time have sex | 22.7 | 7 | 23.6 | 24.7 | 27.7 | 36.3 | 44.7 | 19.3 | 32 |
| Know male condom | 21.7 | 2 | 33.3 | 17.9 | 20.7 | 29.4 | 37.6 | 21.5 | 17.9 |
| Know contraceptive pill | 38 | 8.5 | 28.3 | 23,8 | 39.2 | 23.7 | 24.4 | 52.6 | 35.9 |
| Know a negative effect of CM | 92 | 69.7 | 70 | 76.9 | 59.2 | 67 | 82.6 | 72.3 | 83.8 |
| *Married girls* | *N= 52* | *N=103* | *N= 63* | *N= 60* | *N=126* | *N= 58* | *N=7* | *N= 23* | *N= 11* |
| Know can get pregnant mid-cycle | 30.8 | 1.9 | 20.6 | 20 | 14.3 | 8.8 | 1/7 | 0 | 27.3 |
| Know pregnant first time have sex | 65.4 | 35 | 34.9 | 48.3 | 60.3 | 54.4 | 6/7 | 30.4 | 36.4 |
| Know male condom | 53.8 | 20.4 | 25.4 | 40 | 32.5 | 24.6 | 4/7 | 26.1 | 27.3 |
| Know contraceptive pill | 80.8 | 35.9 | 36.5 | 61.7 | 54 | 36.8 | 6/7 | 43.5 | 45.5 |
| Know a negative effect of CM | 92.3 | 65 | 60.3 | 82.2 | 56.8 | 63.2 | 6/7 | 82.6 | 63.6 |

### Table 75 A5: Type of method used by girls who said they or the man used anything to prevent pregnancy, by marital status (%)

| | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Gh* | *SL* | *Eth* |
|---|---|---|---|---|---|---|---|---|
| *Single girls* | *N=1* | *N=1* | *N=2* | *N=17* | *N=69* | *N=10* | *N=12* | *N=7* |
| Sex during safe period | 0 | 0 | 0 | 11.8 | 18.8 | 0 | 8.3 | 0 |
| Withdrawal | 0 | 0 | 0 | 0 | 13 | 0 | 16.7 | 1/7 |
| Male condom | 1/1 | 1/1 | 1/2 | 64.7 | 66.7 | 90 | 25 | 4/7 |
| Female condom | 0 | 0 | 1/2 | 11.8 | 21.7 | 10 | 8.3 | 0 |
| Pill | 0 | 0 | 0 | 29.4 | 4.3 | 20 | 33.3 | 2/7 |
| IUD | 0 | 0 | 0 | 11.8 | 2.9 | 0 | 41.7 | 0 |
| Diaphragm | 0 | 0 | 0 | 0 | 7.2 | 0 | 8.3 | 0 |
| *Married girls* | *N=12* | *N=10* | *N=9* | *N=10* | *N=13* | *N=3* | *N=1* | *N=5* |
| Sex during safe period | 0 | 10 | 0 | 20 | 15.4 | 1/3 | 0 | 1/5 |
| Withdrawal | 33.3 | 0 | 0 | 10 | 0 | 0 | 0 | 0 |
| Male condom | 25 | 50 | 3/9 | 30 | 46.2 | 2/3 | 0 | 0 |
| Female condom | 0 | 10 | 1/9 | 0 | 15.4 | 0 | 0 | 0 |
| Pill | 41.7 | 40 | 6/9 | 80 | 7.7 | 0 | 1/1 | 2/5 |
| IUD | 0 | 10 | 0 | 0 | 0 | 0 | 0 | 0 |
| Diaphragm | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

### Table 76 A5: Share of girls who used method to prevent HIV and STI, by marital status (%)

| | *Pa* | *Ne* | *Ma* | *BF* | *Be* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|
| *Single girls* | *N=4* | *N= 1* | *N= 57* | *N= 140* | *N= 103* | *N=28* | *N= 29* | *N=26* | *N=106* |
| Used methods | 1/4 | 0 | 33.3 | 41.4 | 28.2 | 32.1 | 17.2 | 26.9 | 57.3 |
| *Married girls* | *N=88* | *N= 63* | *N= 68* | *N= 41* | *N= 26* | *N= 7* | *N= 4* | *N= 8* | *N= 7* |
| Used methods | 1.1 | 4.8 | 14.9 | 36.6 | 7.7 | 3/7 | 0 | 2/8 | 4/7 |

## Supporting Strategy II

### Table 77 A5: Information from SRHR trained teachers on training and support they had received

| | *Ba* | *Ma* | *BF* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|
| *Teachers trained* | *N=3* | *N=7* | *N=11* | *N=2* | *N= 7* | *N= 3* | *N= 3* |
| Training organized by | | | | | | | |
| Government: Pre-service | 0/3 | 0/7 | 0 | 1/2 | 1/7 | 0 | 0 |
| Government: In-Service | 2/3 | 1/7 | 0 | 1/2 | 5/7 | 1/3 | 1/3 |
| NGO | 1/3 | 6/7 | 4/11 | 1/2 | 3/7 | 2/3 | 1/3 |
| FBO | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Health Institution | 0 | 0 | 3/11 | 0 | 0 | 0 | 0 |
| Subjects covered | | | | | | | |
| Reproductive systems | 2/3 | 5/7 | 7/11 | 2/2 | 4/7 | 0 | 2/3 |
| Menstruation | 3/3 | 2/7 | 7/11 | 2/2 | 6/7 | 2/3 | 1/3 |
| Female Puberty | 3/3 | 5/7 | 4/11 | 0 | 5/7 | 0 | 1/3 |
| Intimate relationships | 0 | 1/7 | 4/11 | 1/2 | 0 | 0 | 1/3 |
| Abstinence | 1/3 | 2/7 | 6/11 | 2/2 | 1/7 | 0 | 0 |
| STIs | 2/3 | 3/7 | 9/11 | 2/2 | 2/7 | 2/3 | 0 |
| Pregnancy | 2/3 | 3/7 | 7/11 | 1/2 | 6/7 | 1/3 | 0 |
| Male contraceptives | 0 | 0 | 4/11 | 0 | 2/7 | 1/3 | 0 |
| Female contraceptives | 0 | 0 | 5/11 | 0 | 4/7 | 2/3 | 0 |
| Sexual abuse | 1/3 | 1/7 | 2/11 | 0 | 3/7 | 2/3 | 0 |
| Gender stereotypes | 1/3 | 0 | 1/11 | 1/2 | 1/7 | 1/3 | 0 |
| Gender equality | 0 | 0 | 4/11 | 1/2 | 3/7 | 2/3 | 0 |
| HIV/AIDs | 0 | 0 | 0 | 2/2 | 3/7 | 0 | 1/3 |
| FGM/C | 0 | 0 | 2/11 | 2/2 | 3/7 | 0 | 0 |
| Male Puberty | 0 | 0 | 0 | 0 | 1/7 | 0 | 0 |
| Training was sufficient | 3/3 | 1/7 | 6/11 | 1/2 | 1/7 | 3/3 | 1/3 |
| | | | | | | | |
| *Teachers* | *N=6* | *N=24* | *N=4* | *N=4* | *N=8* | *N=5* | *N=6* |
| In-Service support offered? | 1/6 | 0 | 3/4 | 1/4 | 0 | 1/5 | 1/6 |
| *Teachers supported* | *N= 1* | *N=0* | *N= 3* | *N= 1* | *N=0* | *N= 1* | *N= 1* |
| Who provides in-service support? | | | | | | | |
| Government | 1/1 | - | 0 | 1/1 | - | 1/1 | 0 |
| NGO | 0 | - | 2/3 | 1/1 | - | 0 | 0 |
| FBO | 0 | - | 0 | 0 | - | 0 | 0 |
| Support is sufficient | 0 | - | 0 | 0 | - | 0 | 0 |

### Table 78 A5: Girl-friendly measures taken and that could be taken by schools, reported by school principal

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|
| *School taking girl friendly measures* | *N=4* | *N=4* | *N=5* | *N=2* | *N=12* | *N=25* | *N=4* | *N=4* | *N=15* | *N=6* |
| Measures taken? | | | | | | | | | | |
| School counsellor | 1/4 | 0 | 1/5 | 0 | 9/12 | 10/25 | 2/4 | 3/4 | 11/15 | 6/6 |
| Referral system | 3/4 | 0 | 2/5 | 1/2 | 4/12 | 7/25 | 0 | 3/4 | 10/15 | 0 |
| Separate toilet facilities | 4/4 | 3/4 | 4/5 | 1/2 | 7/12 | 5/25 | 2/4 | 2/4 | 9/15 | 0 |
| Girls Club | 0 | 0 | 0 | 1/2 | 1/12 | 0 | 1/4 | 1/4 | 10/15 | 6/6 |
| Suggestion box | 1/4 | 0 | 1/5 | 0 | 0 | 0 | 0 | 0 | 2/15 | 1/6 |
| Accessible to disabled | 0 | 1/4 | 1/5 | 0 | 3/12 | 7/25 | 1/4 | 4/4 | 5/15 | 0 |
| Fenced | 0 | 3/4 | 1/5 | 1/2 | 3/12 | 1/25 | 0 | 0 | 7/15 | 0 |
| Gender balanced staff | 0 | 2/4 | 2/5 | 1/2 | 0 | 3/25 | 0 | 1/4 | 5/15 | 0 |
| Dignity kit | 0 | 1/4 | 2/5 | 0 | 1/12 | 0 | 0 | 0 | 1/15 | 1/6 |
| First Aid kit | 1/4 | 0 | 4/5 | 0 | 1/12 | 2/25 | 0 | 2/4 | 3/15 | 1/6 |
| Staff trained on gender | 0 | 0 | 1/5 | 0 | 4/12 | 3/25 | 1/4 | 4/4 | 2/15 | 0 |
| Separate counselling rooms | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2/4 | 2/15 | 2/6 |
| | | | | | | | | | | |
| *All school principals* | *N=4* | *N=4* | *N=5* | *N=2* | *N=14* | *N=25* | *N=4* | *N=4* | *N=20* | *N=6* |
| What further measures could be taken? | | | | | | | | | | |
| School counsellor | 2/4 | 2/4 | 2/5 | 1/2 | 11/14 | 11/25 | 2/4 | 2/4 | 9/20 | 1/6 |
| Referral system | 1/4 | 0 | 2/5 | 1/2 | 3/14 | 8/25 | 1/4 | 0 | 8/20 | 0 |
| Separate toilet facilities | 0 | 0 | 2/5 | 0 | 3/14 | 9/25 | 2/4 | 3/4 | 12/20 | 2/6 |
| Girls Club | 1/4 | 2/4 | 2/5 | 1/2 | 6/14 | 13/25 | 3/4 | 2/4 | 4/20 | 2/6 |
| Suggestion box | 0 | 1/4 | 2/5 | 0 | 2/14 | 6/25 | 0 | 1/4 | 11/20 | 0 |
| Accessible to disabled | 2/4 | 0 | 1/5 | 1/2 | 3/14 | 4/25 | 0 | 1/4 | 10/20 | 0 |
| Fenced | 2/4 | 0 | 2/5 | 0 | 3/14 | 17/25 | 1/4 | 2/4 | 8/20 | 3/6 |
| Gender balanced staff | 0 | 1/4 | 2/5 | 0 | 3/14 | 12/25 | 1/4 | 1/4 | 6/20 | 0 |
| Dignity kit | 2/4 | 1/4 | 1/5 | 1/2 | 0 | 9/25 | 1/4 | 3/4 | 16/20 | 0 |
| First Aid kit | 2/4 | 1/4 | 0 | 0 | 3/14 | 7/25 | 1/4 | 0 | 8/20 | 0 |
| Staff trained on gender | 1/4 | 1/4 | 1/5 | 0 | 3/14 | 13/25 | 3/4 | 0 | 14/20 | 2/6 |
| Separate counselling rooms | 1/4 | 1/4 | 3/5 | 0 | 0 | 3/25 | 1/4 | 1/4 | 17/20 | 1/6 |

### Table 79 A5: Teachers views on teaching SRHR education

| *Teachers* | *Ba N=6* | *Pa N=4* | *Ne N=7* | *Ma N=27* | *BF N=24* | *Go N=4* | *SL N=8* | *Eth N=25* | *Ug N=6* |
|---|---|---|---|---|---|---|---|---|---|
| Girls require additional/different SRHR education to boys | 4/6 | 3/4 | 7/7 | 16/27 | 22/24 | 4/4 | 8/8 | 24/25 | 6/6 |
| The main reasons given are that girls are more susceptible to SRH issues, face different problems, need to learn about pregnancy and childbirth and girls are too shy to ask questions with boys in the class. | | | | | | | | | |
| Able to address all questions? | 5/6 | 2/4 | 7/7 | 13/27 | 14/24 | 3/4 | 8/8 | 16/35 | 6/6 |
| | | | | | | | | | |
| *Teachers who could not address all questions* | *N=1* | *N=2* | *N=0* | *N=14* | *N=10* | *N=1* | *N=0* | *N=9* | *N=0* |
| What questions are difficult to address? | | | | | | | | | |
| Contraception | 0 | 0 | - | 1/14 | 2/10 | 0 | - | 2/9 | - |
| Sexual orientation | 1/6 | 1/2 | - | 2/14 | 3/10 | 1/1 | - | 7/9 | - |
| Sexual abuse of girls | 1/6 | 0 | - | 2/14 | 2/10 | 1/1 | - | 1/9 | - |
| Sexual abuse of boys | 0 | 0 | - | 2/14 | 2/10 | 0 | - | 1/9 | - |
| Sexual pleasure | 0 | 1/2 | - | 3/14 | 3/10 | 1/1 | - | 4/9 | - |
| Same sex relationships | 0 | 1/2 | - | 1/14 | 2/10 | 0 | - | 5/9 | - |
| Intercourse | 0 | 1/2 | - | 1/14 | 4/10 | 0 | - | 3/9 | - |
| Masturbation | 0 | 1/2 | - | 5/14 | 2/10 | 1/1 | - | 7/9 | - |

### Table 80 A5: Village leader's views' on the status of girl-friendliness of the primary and secondary schools in their area (not all villages have secondary schools in their area)

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|
| *Villages with primary schools* | *N= 4* | *N= 4* | *N= 4* | *N=4* | *N=13* | *N=16* | *N= 4* | *N=4* | *N=20* | *N= 4* |
| School girl-friendly? | | | | | | | | | | |
| Yes | 3/4 | 4/4 | 2/4 | 4/4 | 9/13 | 14/16 | 0 | 0 | 5/20 | 3/4 |
| No | 1/4 | 0 | 1/4 | 0 | 4/13 | 1/16 | 4/4 | 2/4 | 11/20 | 0 |
| To a certain extent | 0 | 0 | 1/4 | 0 | 0 | 1/16 | 0 | 2/4 | 4/20 | 1/4 |
| *Villages with secondary schools* | *N=4* | *N=4* | *N=3* | *N=4* | *N=6* | *N=14* | *N=2* | *N=4* | *N=13* | *N=1* |
| School girl-friendly? | | | | | | | | | | |
| Yes | 0 | 3/4 | 1/3 | 4/4 | 2/6 | 10/14 | 1/2 | 1/4 | 0 | 1/1 |
| No | 3/4 | 1/4 | 0 | 0 | 4/6 | 3/14 | 1/2 | 1/4 | 7/13 | 0 |
| To a certain extent | 1/4 | 0 | 0 | 0 | 0 | 1/14 | 0 | 2/4 | 6/13 | 0 |

### Table 81 A5: Reasons for not (regularly) attending school according to girls who do not (regularly) attend, by marital status (%)

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Be* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Single girls* | *N=64* | *N=110* | *N=86* | *N=55* | *N=198* | *N=159* | *N=141* | *N=17* | *N= 33* | *N=108* | *N=67* |
| Harassed in/on way to school | 4.7 | 3.6 | 5.8 | 1.8 | 1 | 1.9 | 0.7 | 5.9 | 0 | 0.9 | 0 |
| Household chores | 17.2 | 24.5 | 40.7 | 16.4 | 63.1 | 29.6 | 31.9 | 0 | 3 | 36.1 | 7.5 |
| Taking care of siblings | 0 | 1.8 | 1.2 | 3.6 | 7.6 | 0.6 | 5.7 | 0 | 3 | 0.9 | 1.5 |
| Taking care of sick relative | 1.6 | 0.9 | 1.2 | 3.6 | | 3.1 | 2.1 | 0 | 3 | 4.6 | 3 |
| Work to support family income | 28.1 | 12.7 | 0 | 3.6 | 5.1 | 5.7 | 12.1 | 0 | 0 | 4.6 | 0 |
| Insufficient money | 21.9 | 11.8 | 18.6 | 16.4 | 6.6 | 34.6 | 13.5 | 11.8 | 36.4 | 21.3 | 64.2 |
| | | | | | | | | | | | |
| *Married girls* | *N=42* | *N=100* | *N=60* | *N=54* | *N=49* | *N=29* | *N-32* | *N=5* | *N=7* | *N=5* | *N=6* |
| Harassed in/on way to school | 2.4 | 1 | 0 | 0 | 0 | 0 | 0.6 | 0 | 1/7 | 0 | 0 |
| Household chores | 40.5 | 42 | 48.3 | 5.6 | 75.5 | 27.6 | 28.3 | 0 | 0 | 1/5 | 0 |
| Taking care of siblings | | 3 | 5 | 0 | | 6.9 | 4.6 | 0 | 0 | 0 | 0 |
| Taking care of sick relative | 0 | 0 | 0 | 3.7 | 4.1 | 0 | 1.7 | 0 | 0 | 0 | 0 |
| Work to support family income | 7.1 | 8 | 3.3 | 0 | 8.1 | 6.9 | 11 | 0 | 1/7 | 1/5 | 0 |
| Insufficient money | 14.3 | 10 | 13.3 | 13 | 2 | 20.7 | 13.9 | 0 | 3/7 | 1/5 | 4/6 |

### Table 82 A5: Share of girls not (regularly) attending school who would like to, by marital status (%)

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Be* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Single girls* | *N=64* | *N=113* | *N=83* | *N=53* | *N=198* | *N=159* | *N=133* | *N=19* | *N=35* | *N=109* | *N=67* |
| Like to go to school | 59.4 | 33.6 | 45.8 | 69.8 | 34.3 | 65.4 | 32.3 | 78.9 | 68.6 | 88.1 | 86.6 |
| *Married girls* | *N=43* | *N=99* | *N=60* | *N=51* | *N=49* | *N=30* | *31* | *N=5* | *N=7* | *N=5* | *N=6* |
| Like to go to school | 39.5 | 17.2 | 36.4 | 29.4 | 32.7 | 63.3 | 51.6 | 3/5 | 3/7 | 1/5 | 4/6 |

N= Single/married girls not attending school

## Supporting Strategy III

### Table 83 A5: Information on training received by health centre staff who had SRH training

| | *Ba* *N=5* | *Pa* *N=3* | *Ne* *N=2* | *Sen* *N=2* | *Ma* *N=4* | *BF* *N=2* | *Gh* *N=2* | *SL* *N=1* | *Eth* *N=3* | *Ug* *N=1* |
|---|---|---|---|---|---|---|---|---|---|---|
| Topics of training | | | | | | | | | | |
| Care of new born children | 3/5 | 0 | 0 | 1/2 | 1/4 | 0 | 0 | 0 | 0 | 0 |
| Sexual relationships | 1/5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Contraceptive methods/family planning | 1/5 | 2/3 | 2/2 | 1/2 | 3/4 | 1/2 | 2/2 | 1/1 | 3/3 | 0 |
| Puberty/menstruation | 2/5 | 0 | 0 | 1/2 | 0 | 0 | 0 | 0 | 0 | 1/1 |
| Early marriage | 1/5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Early pregnancy | 2/5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Abortion | 0 | 1/3 | 0 | 1/2 | 0 | 0 | 0 | 0 | 1/3 | 0 |
| STI/HIV | 0 | 0 | 0 | 0 | 0 | 1/2 | 0 | 0 | 2/3 | 1/1 |
| Girl/user-friendly methods | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1/1 | 1/3 | 0 |
| Training provided by | | | | | | | | | | |
| Hospital/health centre | 2/5 | 0 | 0 | 0 | 2/4 | 0 | 0 | 1/1 | 0 | 0 |
| Government | 2/5 | 3/3 | 1/2 | 1/2 | 0 | 1/2 | 2/2 | 0 | 0 | 0 |
| NGO | 1/5 | 0 | 1/2 | 1/2 | 2/4 | 1/2 | 1/2 | 1/1 | 2/3 | 0 |
| Training was adequate | 5/5 | 3/3 | 2/2 | 2/2 | 4/4 | 2/2 | 2/2 | 1/1 | 2/3 | 1/1 |
| Follow-up supervision after training? | 0 | 2/3 | 1/2 | 2/2 | 1/4 | 2/2 | 2/2 | 1/1 | 2/3 | 1/1 |
| *Health centre staff who had follow-up supervision* | *N=0* | *N=2* | *N=1* | *N=2* | *N=1* | *N=2* | *N=2* | *N=1* | *N=2* | *N=1* |
| Follow up was sufficient | - | 2/2 | 1/1 | 1/2 | 1/1 | 1/2 | 2/2 | 1/1 | 1/2 | 1/1 |

### Table 84 A5: Health centre staff who are able to address all issues and questions from youth

| | *Ba* *N= 7* | *Pa* *N= 1* | *Ne* *N= 4* | *Sen* *N=3* | *Ma* *N=18* | *BF* *N=11* | *Gh* *N= 4* | *Eth* *N=15* | *Ug* *N= 3* |
|---|---|---|---|---|---|---|---|---|---|
| Able to address all questions | 1/7 | 0/1 | 3/4 | 2/3 | 16/18 | 8/11 | 4/4 | 9/15 | 2/3 |

### Table 85 A5: Measures taken to make health centres youth friendly (according to head of health centres that are considered girl-friendly)

| | *Ba* *N=2* | *Pa* *N=1* | *Ne* *N=0* | *Sen* *N=4* | *Ma* *N=7* | *BF* *N= 9* | *Gh* *N=2* | *SL* *N=4* | *Eth* *N=12* | *Ug* *N=3* |
|---|---|---|---|---|---|---|---|---|---|---|
| Specialist training/knowledge | 1/2 | 0 | - | 0 | 1/7 | 1/9 | 0 | 0 | 1/12 | 0 |
| Conscious of early marriage | 1/2 | 0 | - | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Discretion in dealing with girls | 1/2 | 0 | - | 0 | 1/7 | 0 | 0 | 2/4 | 0 | 0 |
| SRH advice | 1/2 | 0 | - | 1/4 | 0 | 0 | 0 | 0 | 0 | 0 |
| Advocacy | 0 | 1/1 | - | 1/4 | 0 | 2/9 | 0 | 0 | 0 | 0 |
| Establishment of separate units | 0 | 1/1 | - | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Long opening hours | 0 | 0 | - | 0 | 1/7 | 2/9 | 0 | 0 | 0 | 0 |
| Awareness raising | 0 | 0 | - | 0 | 2/7 | 2/9 | 0 | 1/4 | 1/12 | 0 |
| Provide contraceptives | 0 | 0 | - | 0 | 1/7 | 0 | 0 | 0 | 3/12 | 3/3 |
| Creation of health clubs | 0 | 0 | - | 0 | 0 | 0 | 1/2 | 0 | 0 | 0 |
| Girl-friendly atmosphere | 0 | 0 | - | 0 | 0 | 0 | 1/2 | 0 | 0 | 0 |
| Referrals | 0 | 0 | - | 0 | 0 | 0 | 0 | 1/4 | 0 | 0 |
| Provide education and trainings in schools | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | 6/12 | 0 |
| Free services | 0 | 0 | - | 2/4 | 0 | 0 | 0 | 0 | 0 | 0 |

### Table 86 A5: Village leader's views' on SRHR services available for young people

| | *Ba* *N= 2* | *Pa* *N= 4* | *Ne* *N= 4* | *Sen* *N=4* | *Ma* *N=13* | *BF* *N=16* | *Gh* *N= 4* | *SL* *N=4* | *Eth* *N=20* | *Ug* *N= 4* |
|---|---|---|---|---|---|---|---|---|---|---|
| Services are available | 0/2 | 0 | 2/4 | 1/4 | 4/13 | 4/16 | 3/4 | 3/4 | 7/20 | ¼ |
| *Services available* | *N=0* | *N=0* | *N=2* | *N=1* | *N=4* | *N=4* | *N=3* | *N=3* | *N=7* | *N=1* |
| Services are adequate | - | - | 1/2 | 1/1 | 2/4 | 4/4 | 2/3 | 2/3 | 2/7 | 0/1 |

### Table 87 A5: Girls who went to health centre who were referred (as opposed to went on own initiative), by marital status (%)

| | *Ba* | *Pa* | *Ne* | *Sen* | *Ma* | *BF* | *Be* | *Gh* | *SL* | *Eth* | *Ug* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Single girls* | *N=44* | *N=19* | *N=19* | *N=11* | *N=43* | *N=51* | *N=30* | *N=9* | *N=21* | *N=23* | *N=82* |
| Referred | 36.4 | 34.4 | 21.1 | 45.5 | 51.2 | 62.7 | 53.3 | 2/9 | 47.6 | 34.8 | 57.3 |
| *Married girls* | *N=8* | *N=32* | *N=26* | *N=21* | *N=18* | *N=12* | *N=19* | *N=2* | *N=3* | *N=2* | *N=3* |
| Referred | 0 | 57.9 | 26.9 | 57.1 | 50 | 41.7 | 57.9 | 0 | 1/3 | 0 | 1/3 |

### Table 88 A5: Why girls who had heard of health centre had not visited (%)

| | *Ba* *N=188* | *Pa* *N=28* | *Ne* *N=119* | *Sen* *N=88* | *Ma* *N=496* | *BF* *N=219* | *Be* *N=120* | *Gh* *N=122* | *SL* *N=48* | *Eth* *N=237* | *Ug* *N=117* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Never had such an issue | 81.4 | 75 | 89.1 | 79.5 | 88.7 | 83.6 | 93.3 | 90.2 | 83.3 | 90.7 | 78.6 |
| Ashamed to go | 10.6 | 7.1 | 7.6 | 6.8 | 7.9 | 12.8 | 1.7 | 0.8 | 6.3 | 3.8 | 9.4 |
| Too far away | 2.7 | 3.6 | 0.8 | 0 | 1.2 | 1.4 | 0.8 | 1.6 | 2.1 | 0.4 | 2.6 |
| To expensive | 1.1 | 0 | 0 | 1.1 | 0.6 | 0.9 | 0.8 | 0.8 | 4.2 | 0 | 0 |
| Didn't have time to go | 1.6 | 3.6 | 2.5 | 3.4 | 1 | 0 | 1.7 | 1.6 | 0 | 0.8 | 2.6 |
| Issue resolved in another way | 1.6 | 7.1 | 0 | 0 | 0.4 | 0.5 | 0.8 | 2.5 | 0 | 0.8 | 2.6 |

N= Girls who had heard of health centre but had not visited

## Supporting Strategy IV

### Table 89 A5: Type of activities supporting female entrepreneurs (according to household head) (%)

| | *Ba* *N= 57* | *Ne* *N=69* | *Sen* *N=95* | *Ma* *N=128* | *BF* *N=277* | *Gh* *N=184* | *SL* *N=31* | *Eth* *N=84* | *Ug* *N=52* |
|---|---|---|---|---|---|---|---|---|---|
| NGO saving and credit scheme | 10.5 | 1.4 | 21.1 | 25 | 3.5 | 0 | 12.9 | 10.7 | 3.8 |
| Food for work/safety net problems | 15.8 | 0 | 67.4 | 41.4 | 64.5 | 7.6 | 12.9 | 28.6 | 11.5 |
| Micro & small enterprise | 19.3 | 17.4 | 6.3 | 25.8 | 11.1 | 78.8 | 25.8 | 13.1 | 26.9 |

N=Households where female entrepreneurs are supported

### Table 90 A5: Information of village leaders on economic status of households in village

| Village leaders | Ba N= 4 | Pa N= 4 | Ne N= 4 | Sen N=4 | Ma N=13 | BF N=16 | Gh N= 4 | SL N=4 | Eth N=20 | Ug N=4 |
|---|---|---|---|---|---|---|---|---|---|---|
| *Households cannot meet food needs* | | | | | | | | | | |
| Near to all | 0 | 0 | 0 | 0 | 3/13 | 1/16 | 1/4 | 0 | 1/20 | 0 |
| Majority | 1/4 | 0 | 1/4 | 1/4 | 4/13 | 5/16 | 2/4 | 1/4 | 3/20 | 1/4 |
| Half | 1/4 | 1/4 | 0 | 2/4 | 3/13 | 7/16 | 1/4 | 3/4 | 7/20 | 0 |
| Minority | 2/4 | 2/4 | 2/4 | 1/4 | 3/13 | 2/16 | 0 | 0 | 8/20 | 3/4 |
| Hardly anyone | 0 | 0 | 1/4 | 0 | 0 | 1/16 | 0 | 0 | 0 | 0 |
| Missing answer | 0 | 1/4 | 0 | 0 | 0 | 0 | 0 | 0 | 1/20 | 0 |
| *Cannot send children to primary school* | | | | | | | | | | |
| Near to all | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Majority | 1/4 | 0 | 0 | 2/4 | 1/13 | 0 | 1/4 | 0 | 1/20 | 2/4 |
| Half | 1/4 | 2/4 | 1/4 | 0 | 4/13 | 5/16 | 1/4 | 2/4 | 5/20 | 0 |
| Minority | 0 | 1/4 | 0 | 1/4 | 5/13 | 6/16 | 1/4 | 2/4 | 12/20 | 1/4 |
| Hardly anyone | 2/4 | 0 | 3/4 | 1/4 | 3/13 | 5/16 | 1/4 | 0 | 1/20 | 1/4 |
| Missing answer | 0 | 1/4 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| *Cannot send children to secondary school* | | | | | | | | | | |
| Near to all | 0 | 0 | 0 | 0 | 1/13 | 0 | 0 | 0 | 0 | 1/4 |
| Majority | 2/4 | 0 | 1/4 | 2/4 | 6/13 | 3/16 | 2/4 | 0 | 4/20 | 1/4 |
| Half | 0 | 2/4 | 0 | 0 | 3/13 | 4/16 | 0 | 3/4 | 8/20 | 0 |
| Minority | 0 | 1/4 | 1/4 | 1/4 | 2/13 | 7/16 | 2/4 | 1/4 | 8/20 | 2/4 |
| Hardly anyone | 2/4 | 0 | 2/4 | 1/4 | 1/13 | 2/16 | 0 | 0 | 0 | 0 |
| Missing answer | 0 | 1/4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## Supporting Strategy V

### Table 91 A5: Share of principals who have come across girls being forced to marry

| | Ba N= 4 | Pa N= 4 | Ne N= 5 | Sen N=2 | Ma N=14 | BF N=25 | Gh N= 4 | SL N=4 | Eth N=20 | Ug N= 6 |
|---|---|---|---|---|---|---|---|---|---|---|
| Had students being forced to marry | 3/4 | ¼ | 2/5 | 1/2 | 7/14 | 6/25 | 1/4 | 3/4 | 10/20 | 0/6 |

### Table 92 A5: Share of principals who have come across girls circumcised

| | BF N= 25 | Sen N=2 | Ma N=14 | Gh N= 4 | SL N= 4 | Eth N= 20 | Ug N= 6 |
|---|---|---|---|---|---|---|---|
| Had students being forced to FGM/C | 0 | 0 | 2/14 | 0 | 4/4 | 6/20 | 0 |

### Table 93 A5: Share of single girls who mentioned specific person to help negotiate against forced marriage (*multiple response*) (%)

| | *Ba* *N=347* | *Pa* *N=35* | *Ne* *N=146* | *Sen* *N=166* | *Ma* *N=308* | *BF* *N=599* | *Be* *N=167* | *Gh* *N=213* | *SL* *N=149* | *Eth* *N=364* |
|---|---|---|---|---|---|---|---|---|---|---|
| Mother | 23.9 | 48.6 | 19.2 | 14.5 | 48.1 | 22.2 | 89.2 | 45.1 | 16.1 | 9.9 |
| Father | 1.4 | 8.6 | 6.8 | 1.8 | 6.5 | 7 | 70.7 | 28.6 | 6 | 6.3 |
| Sister(s) | 25.4 | 34.3 | 49.3 | 15.1 | 24 | 8.2 | 33.5 | 32.4 | 8..7 | 33.2 |
| Brother(s) | 17 | 2.9 | 42.5 | 16.3 | 8.8 | 10 | 6.6 | 27.2 | 3.4 | 36.3 |
| Other relative | 35.2 | 0 | 46.6 | 47.3 | 32.5 | 36.4 | 3 | 53.1 | 37.6 | 19.2 |
| Peers | 6.3 | 0 | 19.9 | 2.4 | 3.6 | 2.3 | 1.8 | 31.5 | 6 | 20.9 |
| Teacher | 9.2 | 0 | 2.1 | 10.4 | 8.8 | 13.5 | 1.8 | 23.5 | 16.8 | 32.1 |
| Health Worker | - | 0 | 0.7 | 1.8 | 2.3 | 3.3 | 1.8 | 19.7 | 6.7 | 3.3 |
| Neighbour | 0.9 | 0 | 24 | 3.7 | 7.8 | 2.8 | 1.8 | 21.1 | 7.4 | 8.5 |
| Community leader | 0.3 | 0 | 4.1 | 14 | 10.7 | 15.2 | 1.8 | 31.5 | 25.5 | 5.5 |
| Religious leader | - | 0 | 0 | 12.8 | 4.2 | 9.3 | 1.8 | 23 | 24.8 | 2.2 |
| Police | 5.2 | 0 | 0.7 | 4.3 | 0.6 | 10.4 | 1.8 | 21.1 | 26.8 | 17.9 |

N= Girls who have support in negotiating if they do not want to marry someone

## Supporting Strategy VI

### Table 94 A5: Share of girls who know the correct minimum age for marriage of girls and boys (%)

| | *Ba* *N=532* | *Pa* *N= 15* | *Ne* *N=92* | *Sen* *N=89* | *Ma* *N= 90* | *BF* *N= 293* | *Be* *N=102* | *Gh* *N=81* | *SL* *N= 108* | *Eth* *N= 312* | *Ug* *N=179* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| For girls | 95.7 | 6.7 | 63 | 24.7 | 6.7 | 11,6 | 72.1 | 39.5 | 79.6 | 82.1 | 82.7 |
| For boys | 74.7 | 66.7 | 47.8 | 22 | 17.3 | 47.3 | 70.9 | 32.4 | 36.1 | 29.7 | 65.9 |

N=girls who state they know laws on child marriage