STRENGTHENING HEALTH OUTCOMES FOR WOMEN AND CHILDREN (SHOW)

OVERVIEW OF MIDTERM EVALUATION REPORT

INTRODUCTION

The Strengthening Health Outcomes for Women and Children (SHOW) project is a 4.5 year multi-country, gender-transformative project funded with the support of Global Affairs Canada with the ultimate objective of contributing to the reduction of maternal and child mortality amongst vulnerable women and children, including adolescent girls, in targeted remote, underserved regions of **Bangladesh**, **Ghana**, **Haiti**, **Nigeria** and **Senegal**. By the end of year 3, the project had already made significant strides towards its MNCH and sexual and reproductive health and rights (SRHR) objectives through the following results:

- The percentage of pregnant women attending antenatal care at least four times has increased by 15 percentage points from 55 to 70 percent across all project areas in all five countries with the increase among adolescent mothers slightly higher (17 percentage points) than adult women (15 percentage points).
- The percentage of births attended by a Skilled Birth Attendant in project areas increased by an average of 9 percentage points overall from 57 to 66 percent, and 11 percentage points among adolescent mothers below 19 years of age from 57 to 68 percent.
- The percentage of women attending post-natal care within 48 hours of the birth increased by 15 percentage points, from 52 to 67 percent in project areas. Here too, the increase was even higher (20 percentage points) among adolescent mothers.
- Post-partum use of contraception has increased in four out of five countries, and the percentage of sampled health facilities deemed to be gender-responsive and adolescent-friendly increased by an average of 16 percentage points across all five countries.

The SHOW project addresses prevailing gender inequality and related barriers at the household, community and health system by working at three levels: the rights-holders (women and girls), moral duty-bearers (male partners, family and community members) and primary duty-bearers (health system strengthening and health facility). We use three intersecting gender-transformative strategies that address the condition and position of women and girls. The first strategy focusses on strengthening women and girls' agency and decision-making; the second engages men across spheres (from family members to socio-cultural gate-keepers) as active partners of change; and the third strategy addresses systemic gaps by focusing on quality of care that is respectful and responsive.

SHOW PROJECT FIGURES AT MIDTERM

871 HEALTH FACILITIES SUPPORTED

1.35 MILLION BENEFICIARIES REACHED, 800,000 OF WHICH ARE FEMALE

9,600+ INTERMEDIARIES TRAINED

The purpose of the midterm was to conduct a robust and objective mid-term data collection and analysis in order to measure indicators within the project and to compare the findings from the baseline study which was carried out in the first year of the project. In each of the five countries, the midterm survey included three main components for data collection, at the household level and at the health facility level, as well as additional data collection done to collect Adolescent Sexual and Reproductive Health and Rights (ASRHR) data from adolescents without children.

METHODOLOGY

A cross-sectional survey design using quantitative techniques was applied to conduct the midterm household and adolescents' surveys. A health facility assessment was conducted with facilities in the same geographic areas where the household and adolescent surveys were conducted. The primary respondents for the household survey were adolescent and adult mothers 15–49 with a child under 2 years of age. Male partners/male family members of the primary respondents were also surveyed using a separate questionnaire. The inclusion criterion used for the sampling of the adolescents' surveys were unmarried adolescent girls and boys (aged 15–19 years) without a live child who were primarily members of project supported adolescent groups or adolescents in locations where adolescent group formation was in progress. A similar methodology will be employed at project end, with the addition of the comparison area data collection (which was also employed at project baseline) and an expanded scope to include assessment of the project using the DAC criteria.

MIDTERM HIGHLIGHTS

**25% of all intervention facilities*

1,768 ADOLESCENT MOTHERS SURVEYED

2,550 ADULT MOTHERS SURVEYED

4,271 MALE PARTNERS SURVEYED

1,509 ADOLESCENTS WITHOUT CHILDREN SURVEYED *(including **752** adolescent girls)*

235* PRIMARY HEALTH FACILITIES SAMPLED

INCREASING UTILIZATION OF HEALTH SERVICES ACROSS THE CONTINUUM OF CARE

Antenatal care (ANC) attendance at least four times for pregnant women is a key recommendation in demand side communications and messaging, due to its clear positive impact on maternal and neonatal mortality. Data from the midterm revealed that across all project countries, the percentage of WRA attending 4 or more ANC consultations increased in project areas since the baseline study for both pregnant adolescent girls and women. Project stakeholders observe that SHOW interventions such as Gender transformative SBCC and mobilisation sessions (Community radio broadcasts, Theatre for Development, Evening with adolescent session, drama performance, Community dialogue [*causeries* in french]), support for CHW monitoring throughout the pregnancy period, and health care provider trainings, as well as awareness raising activities with community groups (especially mothers' and fathers' clubs), youth clubs, and health committees, have contributed to this improvement in coverage.

The data from the midterm showed an increase in usage of **skilled birth attendants** (SBAs), across all five countries, for both adolescent and adult mothers since the baseline study (except for adult mothers in **Bangladesh**). Adolescent mothers in **Ghana** experienced the largest increase from the baseline while the use of SBAs was highest overall in **Senegal**. Although **Nigeria** had the lowest rates during both the baseline and midterm, it demonstrated an increase from 24% to 35% in the midline.

	ANC		SBA		PNC	
	BASELINE	MIDTERM	BASELINE	MIDTERM	BASELINE	MIDTERM
15–19	52%	69%	57%	68%	49%	69%
20–49	56%	71%	56%	64%	53%	66%
Overall	55%	70%	57%	66%	52%	67%

RESULTS ON THE CONTINUUM OF CARE: *The percentage of WRA 15–49 who received 4 or more ANC services, who were attended to by a skilled birth attendant and who received postnatal care within 2 days of giving birth*

Improvements were also observed in all five countries for Postnatal Care (PNC) within 2 days for both adolescent and adult mothers. The results also showed improvements in all five countries for PNC for newborn boys and girls, as compared to the baseline study results. The highest PNC rates were reported in **Senegal** followed by **Haiti**. While **Nigeria** recorded the lowest levels of PNC within 2 days, the project demonstrated notable progress on uptake from the baseline. For those mothers not accessing PNC services, the percentage of respondents stating there was "no need" for PNC services has gone down for all countries, expect **Nigeria**. For all five countries, nurses and midwives were the key service providers for PNC.

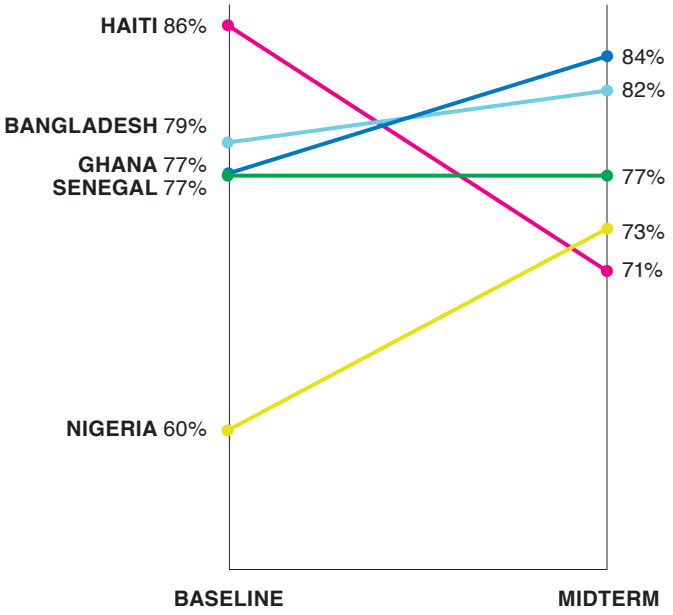
To help ensure a healthy pregnancy, safe delivery and the health of their newborn, it is critical that WRA and their partners are aware of the danger signs that may occur during the continuum of care. Changes in knowledge about danger signs along the continuum of care differed by country but did not demonstrate consistent improvements across all five SHOW countries. In **Bangladesh** improvements were seen in all three respondent groups. In **Ghana**, adolescent mothers remained stable, adult mothers decreased, and male respondents increased. In **Haiti**, adolescent mothers and male partners decreased slightly, while adult mothers remained stable but low. In **Nigeria** adolescent and adult mother decreased and male respondents increased. In **Senegal**, all three groups decreased.

Awareness of danger signs and strategies to address danger signs among WRA and their male partners is addressed through several interventions. Counselling by CHWs through household visits is a key intervention to spread these messages. Across the five countries, approximately 6,600 CHWs (including over 4,100 female CHWs) have been trained on how to provide comprehensive gender-responsive counselling to WRA and their partners during household visits. Additionally, these messages are delivered by health care providers during ANC consultation sessions and various SBCC activities. Over 2,800 HCPs (including over 900 female HCPs) were trained on providing ANC services.

MALE SUPPORT

Men's attitudes towards and activities supporting women's utilization of MNCH/SRH services, as well as promoting more gender equitable attitudes and behaviours in relationships for improved decision-making of WRA, is considered critical to improved health outcomes and health-related decision making of WRA. The midterm data revealed that men's knowledge of types of male support improved substantially in **Nigeria** and marginally in **Bangladesh** and **Ghana**. Fathers' Clubs play a pivotal role in engaging men in the project communities. Approximately 1000 Father's Clubs have engaged men in positive masculinities for improved MNCH and SRHR through gender transformative group activities at the community level. Qualitative monitoring data collected by Plan International in **Ghana**, **Haiti**, **Nigeria** and **Bangladesh** demonstrate significant success in behaviour change as a result of the Fathers' Club activity. These results were included in Promundo's *2019 State of the World's Fathers Report*.

FIGURE 1: *% of male partners who know at least two types of support that men can provide to female partners during pregnancy*



The importance of male engagement, such as helping with household chores, child rearing and attending ANC sessions with their partners, is also reinforced by CHWs during their household counselling visits. Male engagement is also featured in theatre for development performances and SBCC materials such as posters, radio broadcasts and documentaries. As well as through the engagement of traditional and religious leaders and the peer to peer community actions carried out by male gender equality champions.

Health care providers also received training on gender-responsive and adolescent friendly service provision including strategies to effectively engage with male partners

Looking at the level of support provided by male family members for the utilization of MNCH/ SRH services, the midterm results differ across the five countries. While each country saw a variety of trends along the continuum of care, looking at overall results (including responses from adolescent and adult mothers as well as male family members), increases from the baseline study to the midterm were recorded in **Bangladesh**, **Haiti** and **Nigeria**, while decreases were noted in **Ghana** and **Senegal**.

ROLE OF WOMEN IN HOUSEHOLD AND COMMUNITY DECISION MAKING

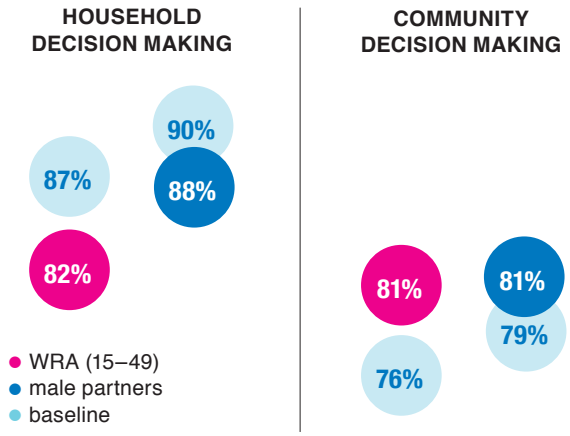
A key pillar of the gender equality strategy of the SHOW program is increasing the inherent individual and collective agency of women and girls including their health-related, overall household and community level decision-making, including their health-related, and household decision making. This objective is complemented by the male engagement and institutional strengthening components which seek to create an enabling environment for increased decision making by WRA.

Most respondents across all project countries with little or no sex and age based differential believe that women should participate in household level decision making, and midterm data aligns closely with baseline data in this regard, with a marginal decrease noted on average across countries. All respondent groups from all project countries were asked to specify who *actually* takes the primary decision on key household issues. Midterm results suggest that most adolescent and adult mothers in SHOW countries can decide on *breastfeeding* issues themselves, and respondents of both age groups actively participated in decisions regarding whether to *deliver at health facilities*. Although increasing from baseline to midterm, WRA of all ages reported their lowest level of participation in decisions related to monetary issues such as *management of available household cash*. Across all countries, adolescent girls and women report that decisions on family planning are increasingly made jointly with their partners. A similar, but less pronounced, trend can be observed in regard to decision making on ANC service utilization (except for **Haiti**).

SHOW's gender equality strategy places a massive effort to increase the meaningful participation and leadership of women and adolescent girls in community based structures and decision-making processes. On average across SHOW countries, there has been an increase in respondents who agree that women should participate in community level decision making.

Despite the general support for women's participation in community level decision making, women's participation in organized community groups remains low. Across all countries, adult mothers were more likely to be members than adolescent mothers. **Senegal** saw the greatest level of participation with 30% of adolescents and 47% of adult mothers reporting membership in community groups. The lowest results were seen in **Nigeria**, where there is the lowest level of accordance from respondents on women's participation in community groups; 4% of adolescents and 6% of adult mothers reported membership in a community organization.

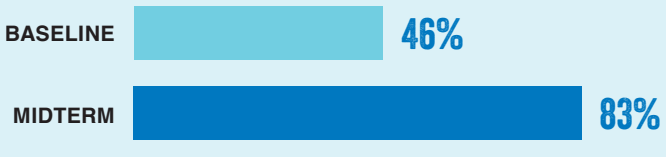
FIGURE 2: *The percent of WRA 15–49 and male partners who believe that women should participate in household level and community level decision making, baseline and midterm*



In terms of the level of support from male members of community organizations for reaching a decision on agenda items proposed by women, midterm data revealed a rather encouraging situation: across **all project countries**, a very small percentage of WRA regarded the level of male support as *poor* or *very poor*. *Very poor/no support* was only mentioned in **Haiti** and **Bangladesh**: by 9% of adolescent and adult mothers alike in **Haiti,** and by 5% of adolescent mothers in **Bangladesh**.

THE LEVEL OF SUPPORT PROVIDED BY MALE COLLEAGUES FOR WOMEN'S DECISION MAKING,

reported by adolescent and adult mothers who are members of community organizations



One way the project aims to support women and adolescent girls' participation in household and community level decision making is through the establishment and strengthening of women's support groups and adolescent girls' peer groups. The project invests in a targeted empowerment program that breaks down negative gender stereotypes, builds personal and social assets, and empowers women and adolescents to work together for the promotion and achievement of gender equality and girls' rights. In parallel community and household female influencers such as grannies in **Haiti** and **Senegal**, Queen Mothers in **Ghana** are engaged to promote gender equality and the empowerment of women and girls.

The establishment of Village Savings and Loans Association (VSLA) groups also contributes to this outcome. In addition to providing a platform for sensitization on gender equality and MNCH/SRHR, the VSLA activities provide an opportunity for women to take on leadership roles within the association. VSLA members received training on women's leadership, inclusive governance and gender equality. It is also expected that participation in these groups can enhance women's economic decision-making power within their household.

SHOW works to increase women's participation in community health governance by raising awareness about the importance of women's participation and leadership in addition to adolescents participation. CHCs, which support all the health-related community level activities and also serve as link agents between the community and the health facilities, were trained on gender inclusive governance and female leadership.

Overall, there are 1,450 VSLAs across all five countries and 18,400 community groups have been sensitized on gender equality, women's and girls' rights, MNCH/SRHR and male engagement through high impact gender transformative approaches such as women's support groups, father's clubs, adolescent groups.

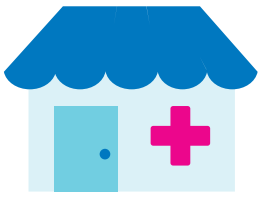
1,450 VSLAs ACROSS 5 COUNTRIES

18,400 COMMUNITY GROUPS

FACILITY SERVICES

A key component of the SHOW project is working with public health facilities and ministries of health to increase the quality and availability of **gender responsive and adolescent friendly MNCH and SRH services**.[1]

Health facility results	OVERALL RESULTS	
	BASELINE	MIDTERM
The percentage of health facilities that provide gender responsive and adolescent friendly MNCH/SRH services	28%	61%
The percentage of health facilities that provide gender responsive and adolescent friendly family planning services	17%	27%
The percentage of health facilities that provide gender responsive and adolescent friendly referral services	47%	46%
The percentage of health facilities that have environmentally friendly waste disposal methods	54%	80%



The data from the midterm shows that the percentage of health facilities providing gender responsive and adolescent friendly MNCH/SRH services has increased in **Ghana**, **Haiti, Bangladesh** and **Senegal** while remaining stable in **Nigeria.** In terms of performance on key criteria associated with MNCH/SRH services, the midterm data shows that across all the countries, since the baseline there has been an increase in the percentage of health facilities with adolescent corners and with IEC materials related to pregnancy/ASRHR in all countries except **Senegal**.

1. *To assess if health facilities were providing gender responsive and adolescent friendly MNCH/SRH services, a composite of specific factors was used, including both infrastructure and service-related issues. Factors include: facility staff training on GE and adolescent friendliness; availability of GE and adolescent friendly service guidelines; sufficient privacy for patients through separate rooms/areas for counseling, check-ups, and breastfeeding; and accommodation of male partners/family members during counseling.*

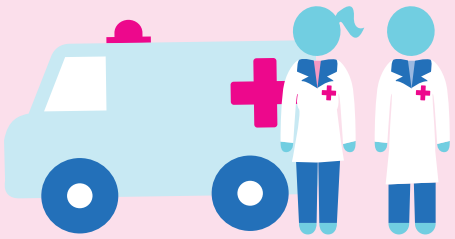
The SHOW project trains health care providers on quality gender responsive, adolescent friendly and environmentally safe MNCH/SRH service delivery.

Training for health service providers, included building their capacity in both skills and knowledge base on thematic areas such: Antenatal Care (ANC); Postnatal Care (PNC); Family Planning (FP); Integrated Management of Neonatal and Child Illness (IMNCI); Normal vaginal delivery; infection prevention; management of third stage labor (MTSL), Antepartum Hemorrhage (APH) and Postpartum Hemorrhage (PPH), and eclampsia; Infant and Young Child Feeding (IYCF); post-abortion care; biomedical waste management; supportive supervision; maternal and newborn death audits; and on standards for gender responsive and adolescent friendly services.

The SHOW project also works with health facilities and ministries of health to increase the quality and availability of **gender responsive and adolescent friendly family planning (FP) services**.[2]

The indicators from the baseline study were generally very low, and the percentage of facilities providing gender responsive and adolescent friendly family planning services across all countries increased, except for **Bangladesh** (the increase in **Nigeria** was very small). Based on the midterm data, it was observed that most of the sampled health facilities provided detailed explanation on the benefits of delaying and spacing pregnancies and also provided explanations on the different contraceptive options available.

In terms of health facilities that provide **gender responsive and adolescent friendly referral services**, the midterm data shows strong increases in **Ghana** and **Haiti**, while there were decreases in **Bangladesh**, **Nigeria** and **Senegal**. Key discussion topics during the referral period were to check with patients for family accompaniment, to explain the reason behind providing referrals, to suggest transportation methods and to listen to and address any concerns the patients might have.



Activities strengthening referral services across all five countries include training for health care providers and ambulance drivers on gender responsive and adolescent friendly referral protocols, safe transport in addition to developing Maternal Awareness and Referral Tracking, or MART, in Bangladesh and State referral guidelines in Nigeria). In Bangladesh, these trainings also leveraged ICT solutions, while in Senegal, advocacy meetings were held with local authorities on strengthening community referral networks.

A core objective of the SHOW project is to support health facilities to employ **environmentally safe waste disposal methods** across the five project countries.[3] The midterm data showed an increased percentage of sampled health facilities that utilize environmentally safe waste disposal methods across all countries, except **Senegal**, where results remained stable, since the baseline study. In **Bangladesh**, significant improvements were seen in the area of having waste disposal procedures and separate colored bins for waste disposal. In **Ghana**, the percentage of sampled health facilities having waste disposal procedure increased. In **Haiti**, significantly more health facilities reported having separate colored bins for disposal.

In Bangladesh, the project has provided 71 facilities with equipment and supplies with further plans for placenta pits and protected bury pits (two areas where midterm results remained low). A total of 40 facilities in Ghana, 11 in Haiti, 236 in Nigeria and 48 in Senegal, have been provided with equipment and supplies.

2. *To assess if health facilities were providing gender responsive and adolescent friendly MNCH/SRH services, a composite of specific factors was used, including both infrastructure and service-related issues. Factors include: facility staff training on GE and adolescent friendliness; availability of GE and adolescent friendly service guidelines; sufficient privacy for patients through separate rooms/areas for counseling, check-ups, and breastfeeding; and accommodation of male partners/family members during counseling.*

3. *To assess whether sampled health facilities have environmentally friendly waste disposal methods, a composite indicator was developed using several key criteria, including availability of a) waste disposal procedure, b) functional incinerator, c) functional placenta pit, d) separate colored bins for waste disposal and e) secured boxes for disposing sharp objects.*

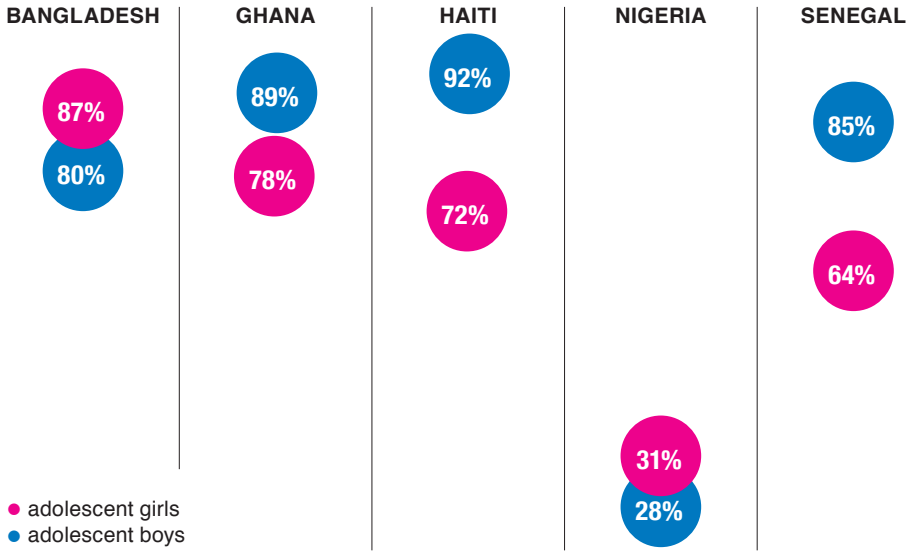
ANALYSIS OF ADOLESCENT DATA

The adolescent survey component of the midterm survey was designed to gain a greater understanding of the level of awareness and knowledge of SRHR issues among adolescent boys and girls aged 15–19 years. Capturing the perceptions of adolescents was only possible once the full SRHR strategy for the project was developed and the project's strategy for unmarried adolescents and the formation of the adolescent groups could be defined for each country. For this reason, adolescent data was not collected at the baseline.[4]

SOURCES OF SRHR INFORMATION FOR ADOLESCENT BOYS AND GIRLS

The midterm data in **Bangladesh**, **Ghana** and **Haiti** showed that approximately three quarters of adolescents felt that there were people in the community from whom they could receive SRHR information. In **Nigeria**, this rate was close to one third while rates in **Senegal** were lower for girls than boys. Mothers were an important source of information for adolescent girls, while adolescent boys noted friends as a key source. In **Ghana** and **Nigeria** both adolescent boys and girls noted teachers as an important source of information. In all countries except **Nigeria** and **Bangladesh**, more boys than girls said they have access to SHRH information.

FIGURE 3: *The percentage of adolescent girls and boys who said that there was someone available in their community to provide information on sexual and reproductive health and rights*



In terms of menstrual health, the majority of girls, across both age groups (15–17 and 18–19) in all countries reported having received information, specifically from their mothers. Though there were a notable percentage of girls in the younger age group of 15–17 years of age, in both **Haiti** and **Senegal**, who reported having no one to discuss issues of menstrual health.

One of the main interventions in SHOW targeting unmarried adolescents are the adolescent groups, which serves as a platform for raising awareness on MNCH, ASRHR and gender equality issues. The Champions of Change (CoC) in Haiti and expanded Peer Education in all countries featuring core themes from the CoC are some strategic program interventions that not only builds self-esteem and promotes adolescents to step forward and play meaningful role in participation and decision-making spaces within households and communities. These CoC and peer education sessions, led by trained facilitators using government approved curriculum, provide a platform for adolescent girls and boys to discuss physiology and issues around sexual and reproductive health while understanding their sexual and reproductive rights.

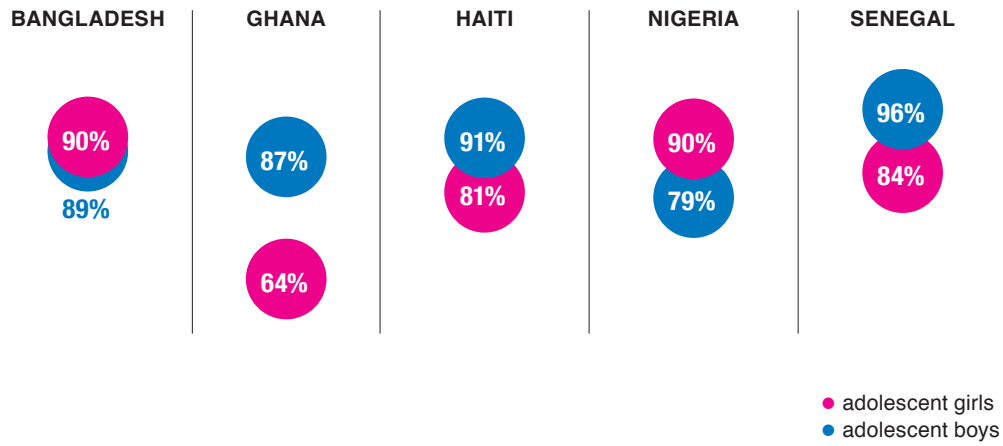
In addition, the Evening with Adolescents sessions between community leaders and adolescents, IEC and SBCC materials and theatre for development all have components focused on ASRHR and contribute to raising awareness among adolescents on MNCH, ASRHR and GE issues.

4. *The inclusion criteria for the adolescent survey were adolescent girls and boys aged 15–19 without a live child and who are members of project supported adolescent groups. However, this was not the case in Nigeria, as the adolescent groups were still in the process of formation when the data collection took place. In Nigeria, adolescents were selected from those communities where the process of group formation was ongoing.*

ADOLESCENT KNOWLEDGE OF AND ACCESS TO FAMILY PLANNING METHODS

The midterm data showed a variety of results in terms of knowledge of modern contraception. The majority of both adolescent boys and girls in both age groups across all countries were aware of modern contraceptive methods, cited contraceptive use as a means of avoiding pregnancy, with condoms/ injectables/ pills being most commonly reported as the contraception they were aware of. Adolescent boys knowledge was higher than than of girls in all countries except Bangladesh and Nigeria. A majority of both adolescents were also aware that girls may become pregnant by having sexual intercourse only one time.

FIGURE 4: *The percentage of adolescent girls and boys that have heard of modern contraceptive methods*



Source of information on modern contraceptive was also reported as part of the midterm data. Media, in terms of television and radio, as well as community events, education talks, and school courses were noted across all countries by both male and female adolescents as important sources of information. In terms of who they would seek out to gain information on modern contraceptive, most adolescent girls across all countries reported relying on mothers, sisters, friends, teachers and doctors/ nurses. The majority of adolescent boys reported relying on friends, teachers, followed by doctors/ nurses.

KNOWLEDGE OF STIS AND THE BENEFITS OF DELAYING PREGNANCY AND BIRTH SPACING

The vast majority of adolescent respondents across all countries had heard of HIV/AIDS – girls 15–17 reported the least awareness (86%) while girls 18–19 and boys 18–19 in **Haiti** reported the highest awareness (100%). The percentage of adolescent girls and boys who knew factual information about HIV/ AIDS was also high in all countries, this included information such as how to reduce the risk of getting HIV/ AIDS and how HIV/ AIDS is spread. There were however still a number of misconceptions held by a percentage of respondents. These included the belief that HIV/AIDS is caused by evil spirits, HIV/AIDS is transmitted through sex only and that women cannot become infected with HIV/AIDS if she is having sex only with her husband. The rates of Sexually Transmitted Infections (STI) knowledge among adolescents, both boys and girls, were considerably lower than HIV/ AIDS knowledge.

FIGURE 5: *The percentage of adolescent girls and boys who have heard of HIV/AIDS*

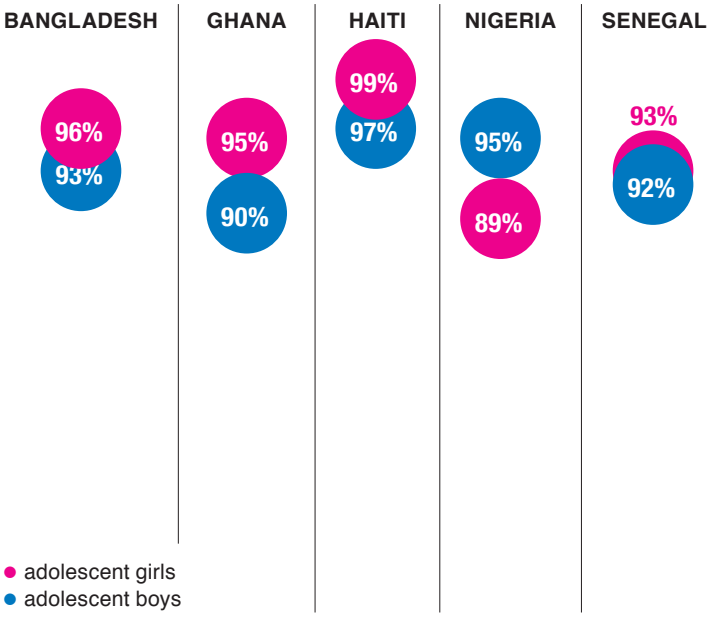
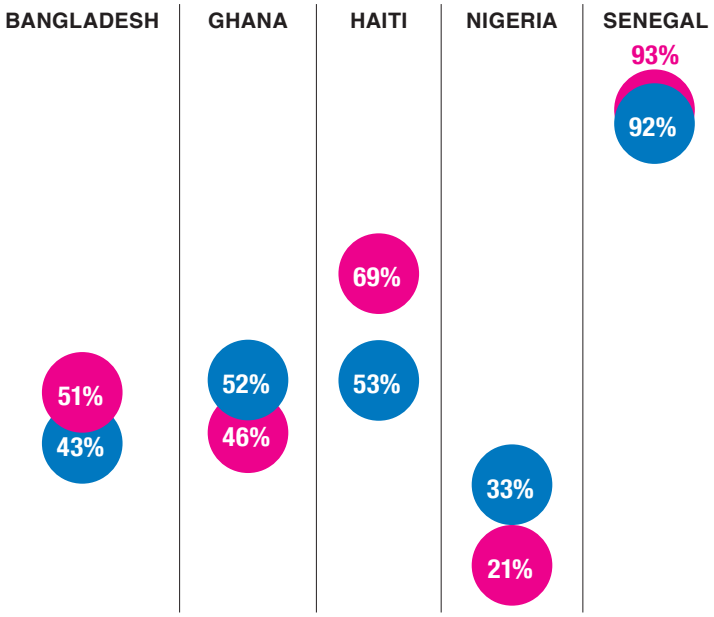


FIGURE 6: *The percentage of adolescent girls and boys who have heard of other sexually transmitted infections*



There were mixed results regarding the knowledge of the benefits of delaying pregnancy. A high percentage of respondents from **Bangladesh** (83%-94%) reported that there were benefits to delaying pregnancy. In **Nigeria**, across all age groups and sex of respondents, awareness about benefits of delaying pregnancy is relatively low, under 40% of respondents. Results in the other countries ranged from 44% to 77% with older adolescent girls (except in **Haiti**) demonstrating the highest knowledge. Responses also varied across countries and age/sex groups with regards to knowledge about the benefits of spacing pregnancies. A high percentage of respondents across both age groups and sexes from **Bangladesh** said that there were benefits of spacing pregnancies. The percentage of girls from both age groups is also high in **Nigeria**, but significantly less so among adolescent boys. In **Haiti**, across all age groups and across sex of respondents, awareness about benefits of spacing pregnancies seems relatively low at around 50% overall. In general, younger adolescents seem to be less aware of the benefits of spacing pregnancies than older adolescents.

FIGURE 7: *The percentage of adolescent girls and boys who know of any benefit of delaying pregnancy*

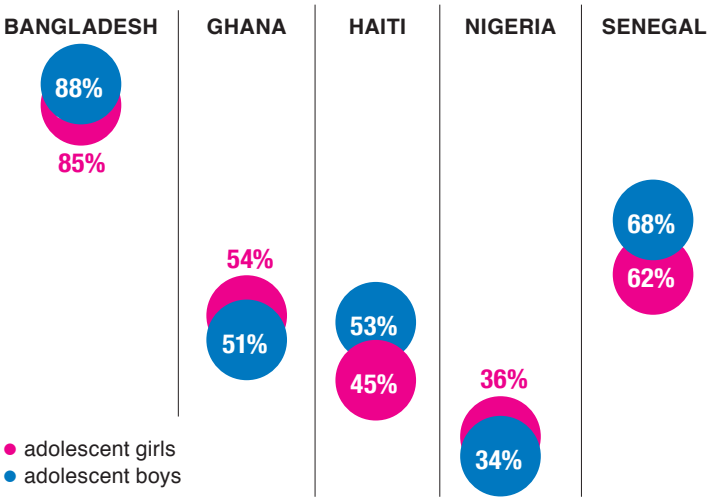
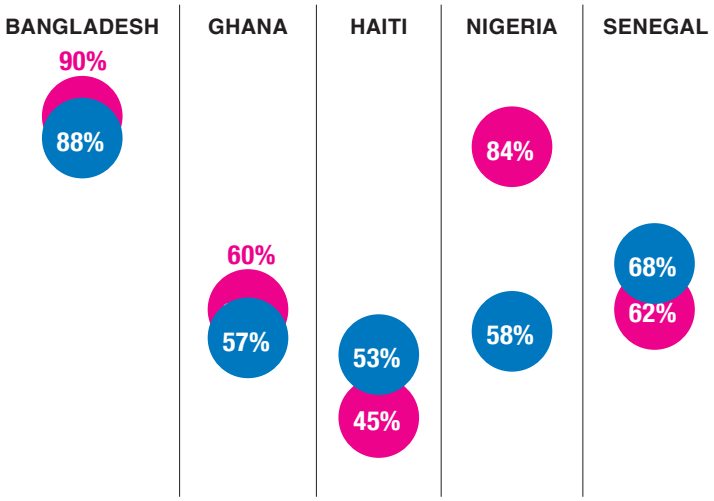


FIGURE 8: *The percentage of adolescent girls and boys who know of any benefits to spacing pregnancies*



ADOLESCENT ACCESS AND DECISION MAKING ON SRH SERVICES

With regards to barriers to accessing SRHR services, the midterm data showed that the perception of adolescent girls and boys is that unmarried adolescent girls experience more resistance and disapproval than married adolescent girls in terms of assessing SRHR services. The key reasons behind such resistance or disapproval were religious reasons and stigma.

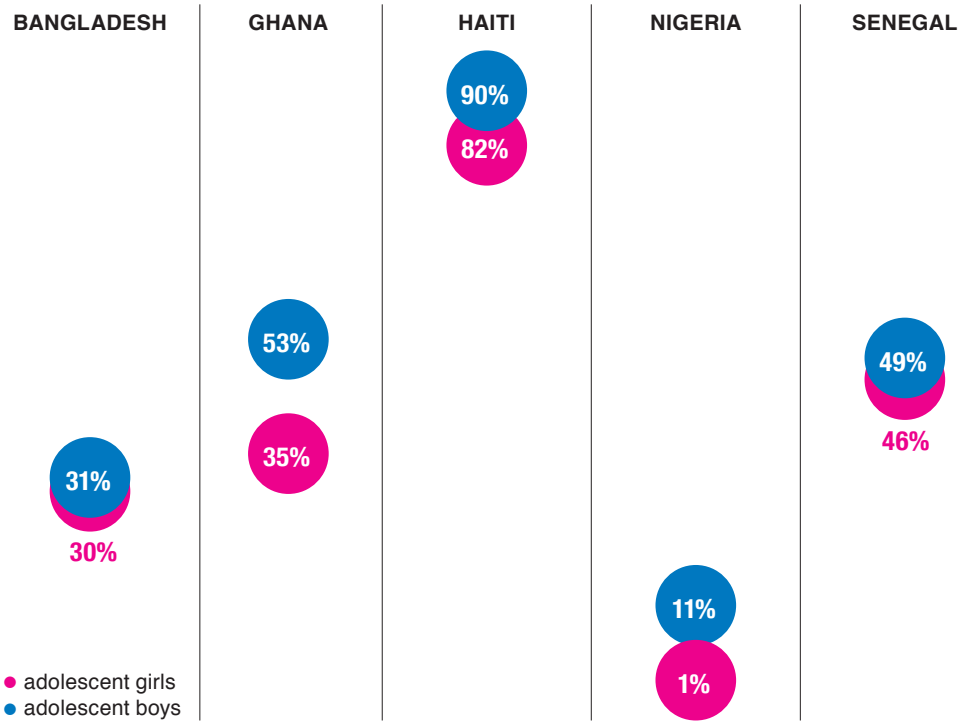
In terms of decision making with regards to SRHR issues, the midterm survey asked both young and older adolescent girls and boys if un/married adolescent girls had the right to refuse sex with their husband or partner. The overall results from all countries showed that a higher percentage of respondents felt that unmarried adolescent girls had a right to refuse sex more so than married adolescent girls.

ADOLESCENT PERCEPTIONS OF HOUSEHOLD AND COMMUNITY LEVEL DECISION MAKING

The survey asked respondents to report on their involvement in household and community decision making. Respondents across all countries reported that decisions should be made collectively with parents regarding a variety of issues, such as whether or not they can work outside the home, whether they can seek SRH information for themselves, whether they can seek SRH services for themselves, whether or not they can be in a romantic relationship, and others.

The survey measures the perceptions of adolescents regarding how often adolescent girls and boys participate in community decision making process. The respondents reported that the active participation of adolescent girls and boys in decision making is quite frequent in **Haiti**, moderate in **Senegal**, **Bangladesh** and **Ghana**, but not so frequent in **Nigeria**. some variation between girls and boys in Ghana and Nigeria, with boys reporting a higher level of participation in both instances. Moreover, adolescent boys and girls from 18–19 years age group reported participating a little more than their counterparts from the 15–17 years age group, with the exception of **Senegal**. The respondents also report the reasons for which adolescent boys and girls do not actively participate in the community-level decision making. The most commonly mentioned reasons included being too busy with school, lack of skill or capacity, not being informed about the meeting and tendency of adults to take over the discussion across all project countries. Cultural or social acceptance of adolescents seems to be an issue in **Ghana**, **Nigeria** and **Senegal**. Moreover, respondents reported that adolescent girls in **Nigeria** and **Senegal** do not take part in community-level decision making because they feel that it is not their role.

FIGURE 9: *The percentage of adolescent girls and boys who report that adolescents always or often participate in decision making in their communities*



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