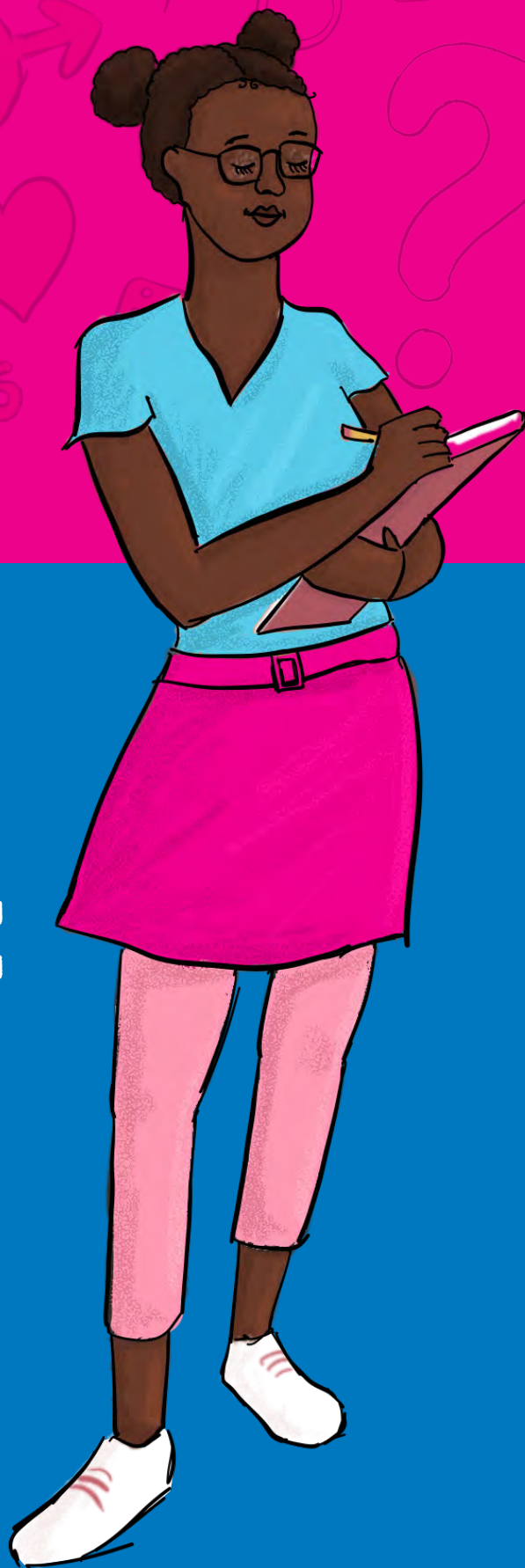


INSIGHTS FROM THE REAL CHOICES, REAL LIVES COHORT STUDY





*A teenage girl on
her way to school
in Vietnam.*

© Plan International

CONTENTS

01 INTRODUCTION	3	04 FINDINGS	31
1.1 Scope and aim of the research	8	4.1 Age and menarche: entry points for SRHR dialogue	32
1.2 Research questions	8	4.1.1 “Not yet”	32
1.3 Plan International’s work on SRHR	8	4.1.2 “She’s a woman now”	33
		4.1.3 Girls’ sexual orientation	36
02 METHODOLOGY	9	4.2 Risk mitigation prioritised over sexual wellbeing	
2.1 Data collection	10	4.2.1 SRHR dialogue as a risk mitigation strategy	37
2.2 Conceptual framework	11	4.2.2 Risk is individualised	37
2.3 Approach to analysis	13	4.3 Social and gender norms	42
2.3.1 Literature Review	13	4.3.1 Norms and roles influencing caregiver–adolescent SRHR dialogue	42
2.3.2 Primary Data Analysis	15	4.3.2 Norms around pregnancy	42
2.4 Limitations to methodology	15	4.3.3 Norms around GBV	45
2.5 Ethics and safeguarding	16	4.3.4 Heteronormativity and homophobia	47
03 LITERATURE REVIEW	17	4.4 Caregivers feel ill-equipped	48
3.1 Overview of literature on social and gender norms	18	4.5 Intergenerational dynamics of SRHR	50
3.1.1 Gender norms	19	4.5.1 Impact of caregivers’ own experiences on SRHR dialogue	50
3.1.2 Social networks and social influence	19	4.5.2 Breaking the cycle	52
3.2 The significance of gender and social norms for girls’ SRHR	20	4.6 Generational changes	53
3.2.1 Defining SRHR	20	4.6.1 Perceived changes in girls’ behaviours	53
3.2.2 SRHR norms	20	4.6.2 Changes in their communities	54
3.3 SRHR policy analysis for adolescent girls in each cohort country	21	4.6.3 Early marriages still persist	55
3.3.1 Latin America and the Caribbean	22	4.7 Recommendations made by caregivers and girls	57
3.3.2 West and East Africa	25	4.7.1 What caregivers say	57
		4.7.2 What the girls say	58
		05 CONCLUSION	59
		06 RECOMMENDATIONS	61
		07 ANNEXES	64
		Annex 1	65
		Annex 2	68
		Annex 3	69

ACKNOWLEDGEMENTS

Sincere thanks to the girls and their families in Benin, Brazil, Cambodia, Dominican Republic, El Salvador, the Philippines, Togo, Uganda and Vietnam for their insights and time over the years, without which this research would not be possible.

The Plan International Country Offices in Benin, Brazil, Cambodia, Dominican Republic, El Salvador, the Philippines, Togo, Uganda and Vietnam have provided oversight of all data collection. Over the years, many people have been involved in the data collection, most recently special thanks to our focal points on the study: Roland Djagaly in Benin; Fabiane Sereno and Raila Alves in Brazil; Chankrisna Sawada in Cambodia; Olga Figuereo in the Dominican Republic; Yesenia Segovia in El Salvador; to Manny Madamba in the Philippines; Abdoul Baki Labodja in Togo; Christopher Kugonza and David Aziku in Uganda, and Trung Truong Vu in Vietnam. Additional thanks to Abibou Mamadou in Benin, Celina Rosales and Anabel Berenice Amaya in El Salvador, Joseph Badabadi in Togo and Dai Luu Quang in Vietnam.

This report was written by Jenny Rivett and Isobel Fergus.

We are hugely grateful to the following for their feedback on the report and recommendations: Terry Roopnaraine, Bekky Ashmore, Lilli Loveday, Jacqueline Gallinetti, Joanna Shepherd, Jessie Freeman, Anjelia San Buenaventura, Raila Alves, Manny Madamba, Yesenia Segovia, Roland Djagaly, David Aziku, Chankrisna Sawada, Mono Mariano, Christopher Kugonza and Claudia Ulferts.

Since 2021, the study is generously funded by Plan National Offices in Canada, Denmark, Finland, France, Germany, Ireland, Sweden, Switzerland and the UK, and managed by Plan International Global. Prior to 2021, the study was managed and funded by Plan International UK.

Editor: Anna Brown

Design: Out of the Blue

Illustrations: © Hazel Mead 2020 – All rights reserved

*A girl from Uganda
harvesting her beans
to get them ready
for sale.*

© Plan International

01

INTRODUCTION



A 15-year-old girl and her brother in Cambodia search for fruit in the forest.

© Plan International

Since 2007, the longitudinal and qualitative ‘Real Choices, Real Lives’ (RCRL) study has been tracking the lives of girls and their families in nine countries around the world (see [Figure 1](#)). In 2021, 118 girls¹ and their families were participating in the study which has followed the girls since their births in 2006.

The study will continue to collect data until December 2024 when the girls reach the age of 18. It aims to document the social, economic, cultural and institutional factors that influence girls’ lives and their life chances, through the perspectives of girls and their families. The study has a distinct commitment to understanding the root causes of gender inequality by asking questions about beliefs, values and expectations which aim to uncover how gendered social norms and behaviours are created and sustained or shift over time.

Data on the study has now been gathered for 14 years, giving a unique insight into the life cycle of girls and the choices, decisions and realities that shape their lives. The girls in the study are now entering late adolescence. For girls across the world, adolescence is a particularly vulnerable time where gendered expectations become more pronounced. Like many other girls, the girls in the cohort study were expected by caregivers to change behaviours once they experience menarche. This expectation suggests that caregivers are not fully recognising the years of the years of adolescence as a unique and vulnerable period, especially in relation to girls’ sexual and reproductive health and rights (SRHR).

01 SRHR DEFINITION

The Guttmacher-*Lancet* Commission on Sexual and Reproductive Health and Rights defines SRHR as “a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achieving sexual and reproductive health relies on realizing sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy and personal autonomy respected
- freely define their own sexuality, including sexual orientation and gender identity and expression
- decide whether and when to be sexually active
- choose their sexual partners
- have safe and pleasurable sexual experiences
- decide whether, when and whom to marry
- decide whether, when and by what means to have a child or children, and how many children to have
- have access over their lifetimes to the information, resources, services and support necessary to achieve all the above, free from discrimination, coercion, exploitation and violence”



1. We recognise that gender is a multidimensional concept which influences people's identities and expressions in many ways and that gender identity goes beyond a binary field of male and female (though for the purposes of this study “girls” is used as an umbrella term). In this sense, most participants in the study were assigned female at birth, basing this on their sex characteristics.

A review on adolescent SRHR (defined in Box 1)² highlighted that many low- and middle-income countries have not yet made significant progress in narrowing health and gender gaps that could reduce risks of adverse SRHR outcomes for girls.³ Progress towards positive SRHR outcomes for adolescents requires more attention to be paid to how caregivers and families affect their children's health throughout the life course, with recognition of the critical window of opportunity in adolescence. Caregivers have been shown to play a central role in shaping the attitudes and perspectives of young adolescents and play a key role in the way that gender norms are learned during childhood and adolescence; they thus can be a powerful means for challenging or entrenching social and gender norms.⁴

Across the cohort countries, there are unequal gendered dynamics both at home and in communities. Our analysis shows that norms are perpetuated through shared social expectations

of how girls should behave in relation to their SRHR. These are also actively enforced through monitoring of girls' expected behaviours and through social sanctions of shame and taboo when girls transgress these expectations.

Caregivers' own life experiences, particularly around early marriage and pregnancy, often influence the approaches they take on SRHR. However, instead of translating to open dialogue around sex and relationships, it can result in a protective approach which puts the onus on girls to guard themselves from pregnancy and gender-based violence (GBV), further perpetuating the damaging norms that exist within these communities. The absence of detailed meaningful conversations around SRHR leaves girls uninformed and ill-equipped to deal with their own sexual and reproductive health (SRH), which often leaves them more vulnerable to unintended pregnancies, early marriages and unions, and GBV.

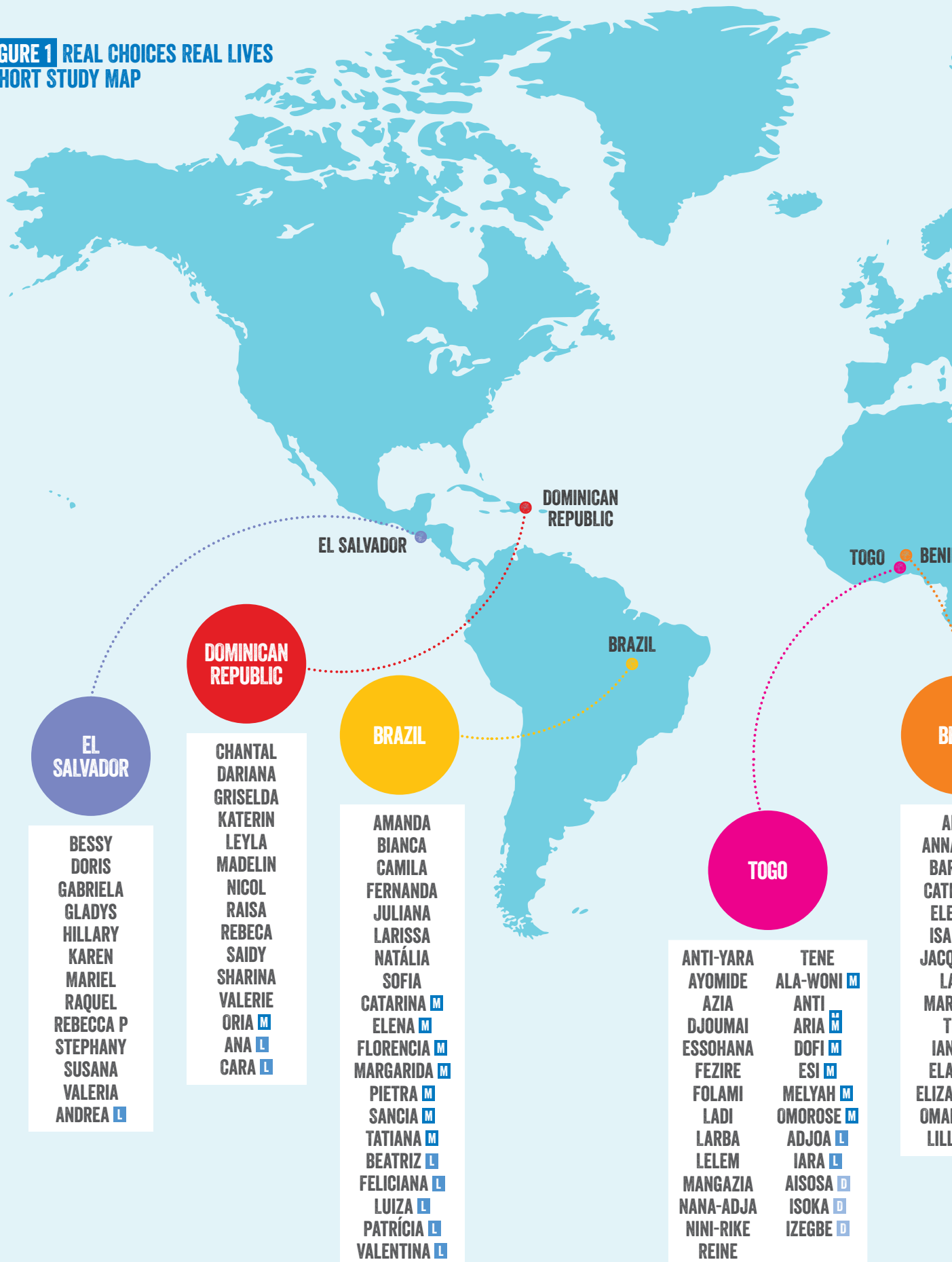


*Young girl on her way to school
in São Luís in north east Brazil.*

© Plan International

2. Starrs, A.M., Ezeh, A.C., Barker, G., Basu, A., Bertrand, J.T., Blum, R., Coll-Seck, A.M., Grover, A., Laski, L., Roa, M., Sathar, Z.A., Say, L., Serour, G.I., Singh, S., Stenberg, K., Temmerman, M., Biddlecom, A., Popinchalk, A., Summers, C., Ashford, L.S. (2018) 'Accelerate Progress – sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission.' *The Lancet* 391: 2642-92, [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(18\)30293-9.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)30293-9.pdf), accessed 19 May 2022
3. Santhya, K.A., Jejeebhoy, S.J. (2015) "Sexual and reproductive health and rights of adolescent girls: evidence from low- and middle-income countries". *Global Public Health* 10: 189–221
4. Cherewick, M., Lebu, S., Su, C. et al. (2021) "Adolescent, caregiver and community experiences with a gender transformative, social emotional learning intervention". *Int J Equity Health* 20, 55, <https://doi.org/10.1186/s12939-021-01395-5>

FIGURE 1 REAL CHOICES REAL LIVES
COHORT STUDY MAP





1.1 SCOPE AND AIM OF THE RESEARCH

This report aims to understand the gender and social norms present in key SRHR areas including sexual education, puberty, menstruation, romantic relationships, adolescent pregnancy as well as child, early, forced marriages and unions (CEFMU) and GBV from both the perspectives of the girls and their caregivers. This current report uses longitudinal analysis to explore findings up to 2021, when the cohort girls were 15 years old.

This report includes a wider overview of the literature on social and gender norms theory and why norms are important for adolescent SRHR before providing an overview of SRHR in each of the cohort countries. The [Findings](#) section of the report focuses on the RCRL interviews to offer insights into the way that girls and their caregivers approach and talk about SRHR while aiming to identify the social and gender norms that influence this approach.

1.2 RESEARCH QUESTIONS

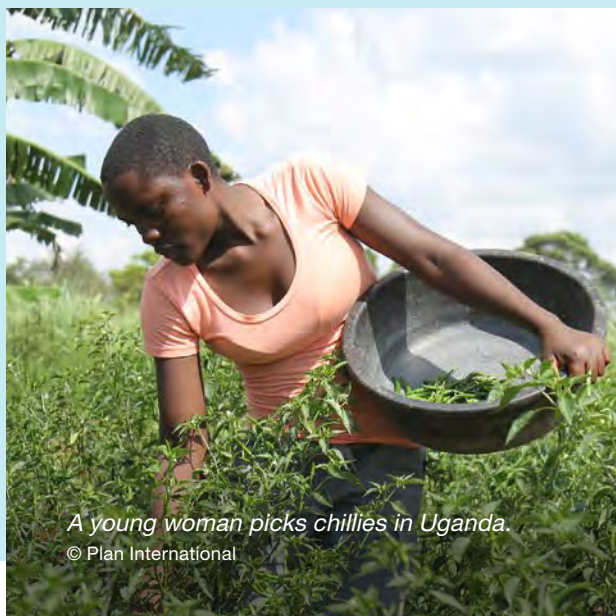
Our research questions are as follows:

01 What are the social and gender norms that prevail in adolescent girls' SRHR and how do they impact on girls?

02 Do these social and gender norms evolve over the life course of the cohort girls and their caregivers? In what ways?

Are there differences in beliefs, attitudes, and knowledge around SRHR between adolescent girls and their caregiver(s)?

03 What role do social and gender norms play in communication between caregiver(s) and adolescents on SRHR?



A young woman picks chillies in Uganda.
© Plan International

1.3 PLAN INTERNATIONAL'S WORK ON SRHR

Plan International's work on young people's SRHR has been developing over the past decade. Plan International supports comprehensive sexuality education and adolescent- and gender responsive SRHR services. Our work is underpinned by our principles of sex positivity, gender transformation and inclusion. We aim to tackle the root causes of gender inequality in order to contribute to sustainable change, such as shifting unequal power relations that control female sexuality.

Girls riding their bicycles to school in Cambodia.

© Plan International

02

METHODOLOGY

2.1 DATA COLLECTION

Data collection for the study has taken place on an annual basis and is carried out by Plan International country office teams that either are working in the communities where the girls live or are able to travel to their areas (see [Annex 1](#): Detailed location information for cohort girls).

Each round of data collection has consisted of a semi-structured interview with a primary caregiver of each girl, and since 2012, when the girls were six years old, an interview with the girl herself. The interviews are supported by participatory and age-appropriate methods. The primary focus of the research is on the girl and her immediate family. However, in seeking to explore and understand social and gender norms, the study has also incorporated broader evidence to inform analysis of the girl and her community as well as to understand wider influences.

In 2009, we conducted focus group discussions with adolescent relatives and neighbours of the cohort girls in Brazil, Uganda and the Philippines, and again in 2010 in Benin, Togo and Vietnam. In 2011, a selection of male caregivers in each country also responded to an in-depth “life history” interview and, in 2012, a similar interview was conducted with female caregivers.

Supporting research tools have also been used alongside the interviews, including a short survey that aims to capture a snapshot of the household structure, livelihood, and education of household members. Each year, the primary research tools have been redesigned to explore additional themes, or introduce new activities; however, questions on the study’s core thematic areas of education, health and SRHR, household and family dynamics, social networks, and gender norms are always included. In 2021, the research tools used semi-structured interviews with girls and caregivers to explore the core thematic study areas, incorporating also the impact of the COVID-19 pandemic on girls and their communities and internet and social media use. Vignettes were also used to discuss attitudes and experiences around girls’ participation and decision-making in communities, CEFMU, and family violence. All respondents (caregiver and girl) were asked to respond to a set of ten attitudes statements.



Schoolgirls shield from rain in the Philippines.

© Plan International

The country focal points manage the transcription of the interviews, while the translation process varies between countries (Plan International Global Hub coordinates translation of data in Spanish and French and country focal points coordinate translation of all other languages). Coding of transcripts and subsequent analysis of the data are carried out by the Plan International Global Hub team working on the study.

Location of cohort girls

The girls situated in Uganda and Togo live in low-income economies, according to World Bank classifications.⁵ The majority of cohort girls are situated in lower-middle-income economies (Benin, El Salvador, Philippines, Vietnam and Cambodia).⁶ The girls in the Dominican Republic and Brazil are classified as living in the upper-middle-income economies.⁷ However, all girls within each of the nine countries were sampled to be from among the poorest households within each country. See [Annex 1](#): Table 3 for detailed location information of where the girls are situated.

5. Classified by the World Bank as living on \$1,045 or less per annum in 2020.

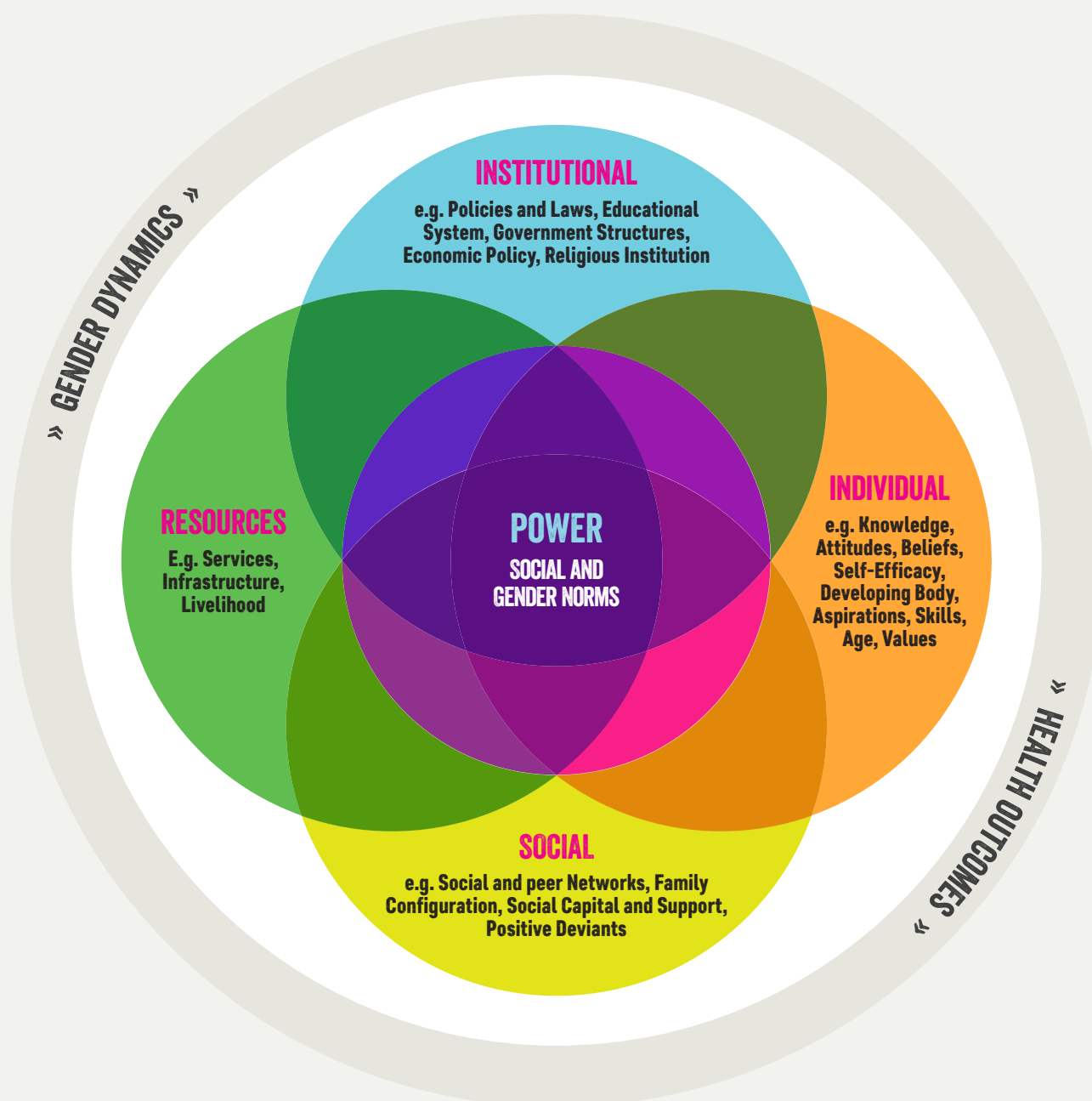
6. Classified by the World Bank as living on \$1,046 to \$4,095 per annum in 2020.

7. Classified by the World Bank as living on \$4,095 to \$12,695 per annum in 2020.

2.2 CONCEPTUAL FRAMEWORK

In order to answer the three research questions outlined in [section 1.2](#), we have further adapted Figure 2: ‘The Flower for Sustained Health: An integrated, socio-ecological framework for normative influence and change’ to be particularly focused around the socio-ecological context of an adolescent girl ([Figure 3](#)).

FIGURE 2 THE FLOWER FOR SUSTAINED HEALTH: AN INTEGRATED, SOCIO-ECOLOGICAL FRAMEWORK FOR NORMATIVE INFLUENCE AND CHANGE⁸



8. Institute for Reproductive Health (2017) *The Flower for Sustained Health: An integrated socio-ecological framework for normative influence and change: A Working Paper*. Learning Collaborative to Advance Normative Change. Washington, D.C.: Georgetown University.

FIGURE 3 PROPOSED ADAPTED CONCEPTUAL FRAMEWORK

Firstly, we use socio-cultural factors categorised as family/peers, society, community and the adolescent girl to demonstrate that these both have influence on and are influenced by social and gender norms (as well as each other) and are therefore reinforcing.

Each circle represents a socio-ecological category. The society category includes policies and regulations, institutions, services and infrastructure, and media and technology. The community category consists of information and communication, knowledge sources and access to spaces. The family and/or peers category includes family configuration, social support, communication, peer influence/

support and family influence/support. The adolescent girl category consists of self-efficacy/confidence, personal aspirations, knowledge and skills, beliefs, attitudes and values, body development and age, and perceived norms and risks.

Secondly, we note that the adolescent girl is influenced by these socio-ecological factors as well as social and gender norms but can also influence them. The framework demonstrates that social and gender norms are embedded in the social ecology which thus affects the sexual and reproductive health and rights of an adolescent girl.

See [Annex 2](#): Table 4 for the full list of data sources for our analytical framework.



2.3 APPROACH TO ANALYSIS

2.3.1 Literature Review

The literature review consisted of a broad literature search strategy through database searches, reference tracing and snowballing, applying the inclusion and exclusion criteria (see [Table 3](#)). Scientific and journal articles were searched on EBSCO and Google Scholar. The search strategy included specific searches for relevant articles on adolescence and SRHR and social and gender norms based on a predefined search string.⁹ Once duplicates were removed, titles and abstracts were initially screened based on relevance and the inclusion and exclusion criteria.

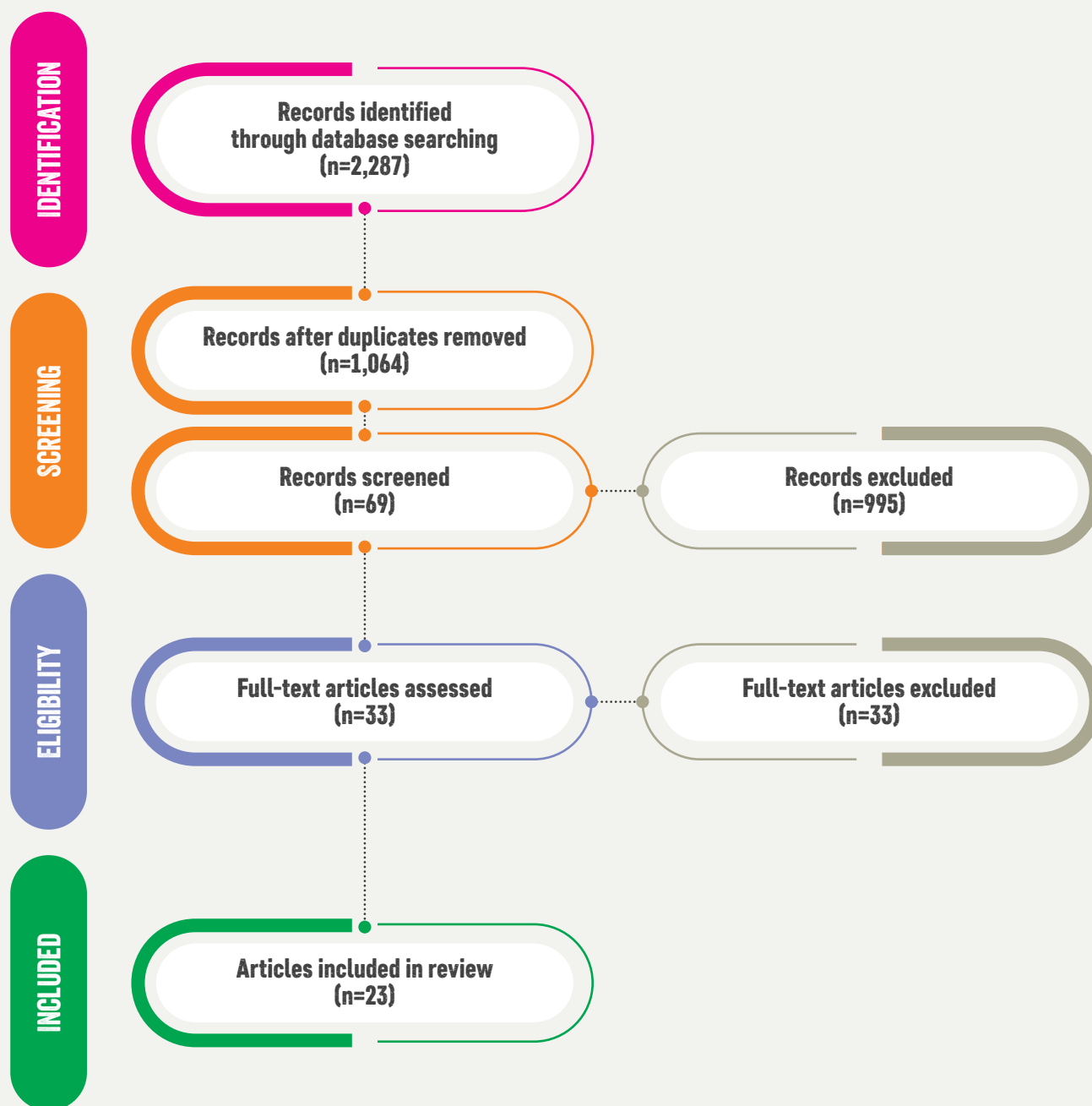
TABLE 1 INCLUSION AND EXCLUSION CRITERIA

ISSUE	INCLUSION	EXCLUSION
Population	Adolescent girls ¹⁰ aged 10–19 in Brazil, El Salvador, Dominican Republic, Benin, Togo, Uganda, Cambodia, Philippines and Viet Nam ¹¹	Studies on industrialised countries in Europe, North America and Oceania
Publication type	Peer-reviewed studies, contextual grey literature and working papers	
Study design and methods	Qualitative or mixed-methods research studies	
Date	<ul style="list-style-type: none"> Articles published in or after 2011 and up to December 2021 Grey literature was included in or after 2016 and up to February 2021 	Studies published in or before 2010
Language	English, Spanish and French	

9. Search string 1: TIAB = ("SRHR OR sexual health OR sex OR reproductive health OR adolescent health OR family planning OR menstrual health AND child* OR adolescent* AND girl OR female* OR young wom*n)
Search String 2: TIAB = (Social norm* OR gender norm* AND SRH OR "sexual reproductive" and health OR SRHR OR "sexual health" OR "sex OR reproductive health" OR "adolescent health" OR "family planning" OR "sexual activity" OR "Sexual education" OR relationship OR "romantic relationship" OR sexual relationships AND child* OR adolescent* AND girl OR female* OR young wom*n). Please note some key search terms were broken down into different areas of SRHR to allow for more accurate searching.

10. Literature on younger or older boys and young men was included if adolescent girls were also part of population group.

11. Overall, the review aimed to prioritise literature from RCRL countries, however where the literature is lacking for a particular context, we looked at similar contexts to gain insights.

FIGURE 4 VISUAL OVERVIEW OF SEARCH AND ELIGIBILITY ASSESSMENT FOR THE LITERATURE REVIEW¹²

The grey literature search mainly contributed to identifying gaps in the literature, as well as providing data overviews for the SRHR policy landscape in each of the RCRL countries. Targeted internet searches were conducted and websites on SRHR and/or norms were searched for relevant research or reports. This included (but was not

limited to): ODI GAGE (Gender and Adolescence: Global Evidence), World Health Organization (WHO), International Planned Parenthood Federation (IPPF), The Sexual Rights Database, United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), Guttmacher Institute, Plan International and Oxfam.

12. Based on: Moher, D., Liberati, A., Tetzlaff, J., Altman, D.G. (2009) "Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement". *BMJ* 339 :b2535 doi:10.1136/bmj.b2535



2.3.2 Primary Data Analysis

NVivo is the software that is used to store, sort and analyse the data for the cohort study. All transcripts from the in-depth interviews between 2007 and 2021 have been coded against a predefined codebook sorted into various thematic categories on the study. Over the years the codebook has developed and changed as new themes emerged and codes have been added and deleted as necessary. Every year coders on the study receive training and a guidance document to guide their coding with regular check-ins with the RCRL research team. All coders produce memos on each girl, a country report based on the data for that year as well as a data quality report. Kappa tests are run to check the consistency of coding between different coders for the duration of the coding period.

In keeping with the life-cycle approach used on the study, the entirety of the dataset was analysed for this report, which means that transcripts for caregivers between 2007 and 2021 were analysed, alongside transcripts with the girls from 2013 to 2021. However, there are increased examples on SRHR from the 2017 transcripts onwards (when the girls are reaching early adolescence).¹³

In order to carry out the analysis, initial NVivo compound queries were run, for example combining a text search query and a coding query such as “changing expectations of behaviour + SRHR education”. The data was then read through, categorised and analysed. For some thematic areas, coding queries were carried out and relevant data was read through, categorised and analysed. Ad hoc text search queries were used to check for gaps. All findings for each query were then grouped into key SRHR areas and were assessed against our conceptual framework grouped in three ways: 1) presence of a norm or a potential norm (empirical and normative norms and discussions of sanctions); 2) attitudes or beliefs that could influence a norm; and 3) socio-ecological factors that are present which have the potential to form, enforce or transform social norms.

2.4 LIMITATIONS TO METHODOLOGY

There are a number of limitations to the chosen approach to data collection, data analysis, and literature review that should be taken into consideration. As a multi-country study, it is important to acknowledge that consistency of data across the cohort can be limited. Collecting data from nine countries across three continents provides a unique opportunity to explore how girls' realities around the world compare at the same age. However, comparative analysis of data from nine distinct cultural contexts also presents a key challenge that requires careful consideration. This can be due to adaptations made by the in-country research teams to the research tools to ensure that they are as relevant as possible to the context. Translation of the data from local languages into English for analysis may also cause a level of nuance to be lost, although country office focal points are consulted to ensure that the risk of this is reduced as much as possible.

From the longitudinal perspective, the researchers who return to speak with the girls and their families may not be the same as the previous year. It is clear from the data that where the research team is known to the participants, and the researchers have previous experience on the study, the data quality is higher than where this is not the case. Research tools are redesigned each year to reflect the girls' age and where relevant to introduce new thematic areas. This means that rather than asking the same questions each year, key thematic areas can be discussed in distinct ways from year to year, which can impact the longitudinal analysis of data.

13. This is because annual interviews included direct questions to the girls and caregivers around SRHR.

While there is unique value in qualitative and longitudinal data collected from both the girls and a member of their family, in some cases the caregiver respondent may differ from year to year for a particular girl. This may be due to changes in a girl's living situation, or the availability of family members at the time of interview. This presents a limitation to the longitudinal analysis; however, hearing the perspectives of different family members can also provide additional insight into a girl's reality. This study prioritises girls' voices, and boys' perspectives are not directly captured, which presents a limitation for gender analysis. The analysis in this report acknowledges this limitation and discusses social expectations of boys, their behaviour, and values as described by girls and their caregivers only.

All data is coded in NVivo against the same code book each year, however the researchers coding the data differ from year to year which may affect the consistency of the coding. Researchers undergo training to ensure that the codebook is used as similarly as possible each year. However, analysis of qualitative data will always be limited by a certain level of subjective interpretation.

The literature review aims to triangulate the study data and strengthen analysis of community, local and national-level factors where girl and caregiver data provides limited insight. Due to time and language constraints, the literature reviewed is not exhaustive. Plan country office focal points have assisted in providing key background information on the study contexts where existing literature is limited.

2.5 ETHICS AND SAFEGUARDING

Plan International UK obtained ethics approval for the entirety of the project from Plan International Global Hub's Ethics Review Committee. Local ethics approval was also sought in countries where it was a requirement for social research – namely, in Brazil and Uganda. We have been granted local ethical approval for the ongoing RCRL study through Facultad Latinoamericana de Ciencias Sociales (FLACSO) in Brazil and Makerere University in Uganda.

All research activities are undertaken in line with Plan International's ethics and safeguarding policies and procedures. Any researchers on the study are required to adhere to strict codes of conduct and all received training on the tools, ethics and safeguarding prior to any data collection. Principles of confidentiality, anonymity and informed consent have been applied, with caregivers asked for consent on an annual basis and girls asked to give their assent (annually, since 2013).

We have a two-stage safeguarding and child protection process: in the first instance researchers report any safeguarding concerns as soon as they arise to the safeguarding focal point in the country office, who follows up in accordance with the protocols of that country. In the second instance (and to ensure nothing is missed), the analysis team who code the data also fill out a Child Protection Report which is sent to each country office by the RCRL research team to ensure all concerns are being addressed by the country office.

Additional safeguarding measures are put in place for the handling and transferring of data to the analysis team. The country office teams send the recording and transcriptions to the RCRL research team who anonymise all the data – e.g., changing real names to pseudonyms, removing location names etc. Pseudonyms are used in place of the girls' real names, and terms such as "Maricel's mother" or "Maricel's sister" are used when referring to family members. The country offices are asked to delete all recordings and transcriptions from devices used for collecting the data.



03

LITERATURE
REVIEW

Girls take part in La League soccer activity in Brazil - the La League project aims to empower adolescent girls with a view to prevent teenage pregnancies and marriage.

©Plan International



Girls at school in Uganda.

©Plan International

3.1 OVERVIEW OF LITERATURE ON SOCIAL AND GENDER NORMS

There is a large and interdisciplinary literature which explores what social norms are and why people comply with them. However, consensus on what social norms are and how they influence behaviour (both across and within disciplines) is limited. For this report, Cislighi and Heise's (2020) definition is a good starting point: "social norms are rules of action shared by people in a given society or group; they define what is considered normal and acceptable behaviour for the members of that group".¹⁴

According to Bicchieri's (2005) definition of social norms, there are some key components that make up a social norm, notably that social norms consist of empirical expectations (what I think others do) and normative expectations (what I think others expect me to do).¹⁵ Bicchieri states that people conform to a social norm if both empirical and normative expectations are in place, in that most other people conform to the norm and expect them to conform to it (and would disapprove if they did not).¹⁶ Another important note is that social norms carry social implications – i.e. rewards when followed and sanctions when not followed.¹⁷

Much of the literature conceptualises norms as separate from and often opposing personal attitudes.¹⁸ This difference is an important one to note as some people may want one thing but are pushed by the norm to do the opposite.¹⁹ This report considers where individuals appear to be reiterating prevalent norms or expressing personal attitudes that may not align with those of their family or wider community.

ATTITUDE » What I believe

EMPIRICAL EXPECTATIONS/ DESCRIPTIVE NORMS » What I think others do

NORMATIVE EXPECTATIONS/ INJUNCTIVE NORMS » What I think others expect me to do

14. Cislighi, B. and Heise, L. (2020) 'Gender norms and social norms: differences, similarities and why they matter in prevention science.' *Sociology of Health & Illness* 42(2), ISSN 0141-9889, pp. 407–422 doi: 10.1111/1467-9566.13008, accessed 9 December 2021.

15. Bicchieri, C. (2005) *The Grammar of Society: The Nature and Dynamics of Social Norms*. Cambridge: Cambridge University Press. Doi:10.1017/CBO9780511616037, accessed 15 December 2021.

16. Ibid.

17. Mackie, G., Moneti, F., Denny, E. and Shakya, H. (2015) "What are social norms? How are they measured?" Working Paper, accessed 21 December 2021.

18. Bicchieri, C. (2005) *The Grammar of Society: The Nature and Dynamics of Social Norms*. Cambridge: Cambridge University Press, doi:10.1017/CBO9780511616037, accessed 15 December 2021.

19. Prentice, D.A. and Miller, D.T. (1996) "Pluralistic Ignorance and the Perpetuation of Social Norms by Unwitting Actors", 28, 161–209, accessed 14 December 2021.

3.1.1 Gender norms

According to the literature, gender norms are a subset of social norms. There are four key features in the gender norm discourse:

01 Gender norms are learned in childhood through the process of socialisation;²⁰ they are then reinforced (or contested) through the family or the larger social context.

02 Inequitable gender norms reflect and preserve inequitable power relations that are often disadvantageous to women and girls.²¹

03 Gender norms are embedded in and reproduced through institutions. Policies and regulations, decision-making processes and biases embodied in how institutions operate are a function of a given gender system.²²

04 Gender norms are produced and reproduced through social interaction, as individuals engage in practices that signify, align or contest various notions of masculinity or maleness and femininity or femaleness.²³

The gendered norms of girls' socio-cultural environments begin to play a heightened role in shaping their trajectories during adolescence, with research suggesting the years between ages 10 and 14 are a particularly sensitive period during which age-related social norms become more strictly enforced.^{24,25}

It is important to note that we refer to social and gender norms within this particular dataset and cannot draw wider conclusions or generalisations on the wider population within which the cohort girls live, given the small size of the sample. For the purpose of this report we are defining social and gender norms as follows:^{26, 27}

02 DEFINITIONS OF SOCIAL AND GENDER NORMS

Social norms: Social norms are perceptions about which behaviours are appropriate and typical within a given group of people. They are mainly informal rules, often unspoken or unwritten, that most people absorb, accept, and follow. They carry social implications – i.e. rewards when followed and sanctions when not followed.

Gender norms: Gender norms are a subset of social norms. They describe how we are expected to behave as a result of the way we or others identify our gender.



3.1.2 Social networks and social influence

Understanding social norms as the unwritten rules that shape people's behaviour in a given community also requires consideration of the social networks and relationships that maintain norms and transfer "rules" onto the next generation. Research has found that often actors who reiterate dominant discourses do not themselves identify these as social norms and may not necessarily have reflected on why they hold such beliefs. By analysing the attitudes and behaviours of multiple people in a social network such as a household or a community – including where individuals express similar or differing beliefs – it is possible to explore what underpins norms in more depth.²⁸ This is of particular interest for efforts to shift social norms that exacerbate inequalities, including gender inequality, and perpetuate harmful practices and behaviours including GBV.

20. Tenenbaum, H.R., Leaper, C. (2002) "Are parents' gender schemas related to their children's gender-related cognitions? A meta-analysis". *Developmental Psychology*, 38(4), 615–630. <https://doi.org/10.1037/0012-1649.38.4.615>, accessed 6 December 2021.

21. Connell, R. and Pearse, R. (2014) "Gender Norms and Stereotypes: A Survey of Concepts, Research and Issues About Change", UN Women Expert Group Meeting "Envisioning women's rights in the post-2015 context", New York, accessed 6 December 2021.

22. Cislighi, B. and Heise, L. (2020) op. cit.

23. West, C. and Zimmerman, D.H. (1987) "Doing Gender". *Gender & Society*, 1(2), pp.125–151, accessed 6 December 2021

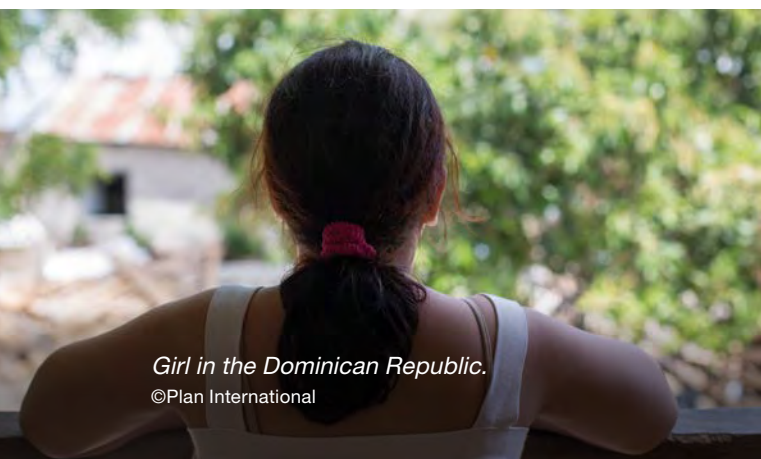
24. Kågesten, A., Gibbs, S., Blum, R.W. et al. (2016) "Understanding factors that shape gender attitudes in early adolescence globally: a mixed-methods systematic review", *PLoS ONE* 11(6): e0157805.

25. Blakemore, S.J. and Mills, K.L. (2014) "Is adolescence a sensitive period for sociocultural processing?" *Annual Review of Psychology* 65(1): 187–207

26. The Social Norms Learning Collaborative (2021) *Monitoring Shifts in Social Norms: A Guidance Note for Program Implementers*. April 2021. Washington, D.C.

27. Gender norms definition taken from ALIGN website, "About Norms", <https://www.alignplatform.org/about-norms>, accessed 4 January 2022.

28. Cislighi, B. and Shakya, H. (2018) "Social Norms and Adolescents' Sexual Health: An Introduction for Practitioners Working in Low and Mid-income African countries". *African Journal of Reproductive Health*, 22(1). pp. 38–46. ISSN 1118-4841.



Girl in the Dominican Republic.

©Plan International

3.2 THE SIGNIFICANCE OF GENDER AND SOCIAL NORMS FOR GIRLS' SRHR

3.2.1 Defining SRHR

Work on SRHR addresses a range of overlapping factors including menstrual health, contraception and family planning, gender-based violence, abortion, maternal health, and sexually transmitted infections. SRHR also includes sexual wellbeing, not only regarding safety, but positive individual and relational experiences. (See [Box 1](#) in the introduction.)

3.2.2 SRHR norms

It is clear that services alone do not improve health outcomes, but that social, cultural and economic factors have a strong influence on adolescent SRHR. In recent years, social norms theory has for the first time been applied in low- and middle-income countries (LMICs) to address a variety of health-related challenges but the majority of the literature on adolescent girls and social norms has focused on female genital mutilation/cutting, child marriage and intimate partner violence.³³

Norms surrounding SRHR are often rooted in unequal gender roles, can be tied to age-related expectations of girls or women and boys or men, and are based on heteronormative expectations of sexuality.³⁴ How these norms influence individuals at different points in their lives and impact on SRHR outcomes for girls and women in particular is an area requiring greater attention.³⁵ Social norms-based analysis and programming are part of an increased focus on the key period of adolescence in terms of it shaping girls' future sexual and reproductive outcomes, as well as their current health and wellbeing.³⁶ Understanding how SRHR norms get stronger – or potentially weaker – in a girl's life and who or what the driving factors are in embedding compliance with norms can inform efforts to replace normative beliefs at the root of negative SRHR outcomes for girls.³⁷

A key factor in the study of social norms is socialisation, the process of transferring attitudes and behaviours that are “acceptable” to society onto an individual, and gender socialisation, that sees the transfer of gendered expectations onto individuals based on the gender they were allocated at birth. Theory within the psychology field indicates that socialisation, or the “learning” of social norms, is a gradual process wherein everyday exposure to attitudes, observation of behaviours, and treatment by others during an individual's childhood and adolescence embed “automatic” compliance with norms.²⁹

Social norms are only one driver of behaviour, and it is vital to explore social norms alongside the interacting social, institutional, cultural, and political contexts of people's lives to transform gender-power inequalities. In the case of the RCRL study, girls' agency is also central to their ability to make meaningful choices. Social and gender norms can restrict or enhance their agency. Kabeer defines agency as the ability to define one's own choices and act upon them.³⁰ It can take the form of negotiation, deception and manipulation, subversion and resistance.³¹ These interacting social, institutional, cultural, and political influences shape the agency of an adolescent girl, but the agency exercised by the individual can also reproduce, modify or transform structures.³²

29. Ibid.

30. Kabeer, N. (2020) “Three faces of agency in feminist economics: capabilities, empowerment and citizenship” in eds G. Berik and E. Kongar, *Handbook of Feminist Economics*. New York: Routledge

31. Ibid.

32. Gammage, S., Kabeer, N. and van der Meulen Rodgers, Y. (2016) “Voice and Agency: Where are we now”, *Feminist Economics*, 22:1, 1-29, DOI: 10.1080/13545701.2015.1101308

33. Cislighi, B. and Heise, L. (2019) “Using social norms theory for health promotion in low-income countries”, *Health Promotion International*, 34, 616–23, accessed 8 December 2021.

34. Davin, C. (2021) “Social Norms Atlas: Understanding global social norms and related concepts.” *Social Norms Learning Collaborative*. Available at: <https://www.alignplatform.org/resources/social-norms-atlas-understanding-global-social-norms-and-related-concepts#:~:text=The%20Social%20Norms%20Atlas%20is,programs%20in%20achieving%20targeted%20outcomes>, accessed 19 May 2021.

35. Plesons, M., Patkar, A., Babb, J., Balapitiya, A., Carson, F., Caruso, B.A., Franco, M., Manzenski Hansen, M., Haver, J., Jahangir, A., Kabiru, C.W., Kisangala, E., Phillips-Howard, P., Sharma, A., Sommer, M., and Chandra-Mouli, V. (2021) “The state of adolescent menstrual health in low- and middle-income countries and suggestions for future action and research”, *Reproductive Health*, 18:31, DOI: 10.1186/s12978-021-01082-2

36. Buller, A.M. and Schulte, M.C. (2018) “Aligning human rights and social norms for adolescent sexual and reproductive health and rights”, *Reproductive Health Matters*, 26:52, 1542914, DOI: 10.1080/09688080.2018.1542914

37. Buller, A.M. and Schulte, M.C. (2018) “Aligning human rights and social norms for adolescent sexual and reproductive health and rights”, *Reproductive Health Matters*, 26:52, 1542914, DOI: 10.1080/09688080.2018.1542914

3.3 SRHR POLICY ANALYSIS FOR ADOLESCENT GIRLS IN EACH COHORT COUNTRY

Transforming norms cannot be viewed in a vacuum; practices and beliefs are held in place by a mix of structural, social and individual-level factors. The social norms and cultural beliefs of decision makers themselves shape the cultures and regulations within the state, and laws are a key barrier or enabler

for influencing social behaviours. Policy or laws that uphold and protect the SRHR of adolescents help to advance SRHR in any context. In order to understand the context of the findings, this literature includes an overview of the policy landscape of each of the RCRL countries in relation to SRHR.

TABLE 2 SNAPSHOT OF KEY SRHR INDICATORS FOR RCRL COUNTRIES

INDICATOR	BRAZIL	DOMINICAN REPUBLIC	EL SALVADOR	BENIN	TOGO	UGANDA	CAMBODIA	PHILIPPINES	VIETNAM
Age of consent ³⁸	14 yrs	18 yrs	18 yrs	18 yrs	16 yrs	18 yrs	15 yrs	16 yrs	18 yrs
Legal age to marry ³⁹	18 yrs ⁴⁰	18 yrs	18 yrs ⁴¹	18 yrs ⁴²	Females: 18 yrs Males: 20 yrs ⁴³	18 yrs ⁴⁴	18 yrs ⁴⁵	18 yrs	Females: 18 yrs Males: 20 yrs
Child marriage, women married by age of 18 (% of women aged 20–24 who are married or in a union) ⁴⁶	26%	36%	26%	31%	25%	34%	19%	17%	11%
Adolescent birth rate (per 1,000 women aged 15–19) ⁴⁷	59.1	94.3	69.5	83.2	89.1	118	50.2	54.2	30.9
Contraceptive prevalence, any method (% of married or in-union women of reproductive age, 15–49 years) ⁴⁸	80.2%	69.5%	71.9%	15.5%	23.9%	41.8%	56.3%	54.1%	77.5%
Unmet need for family planning (% of married or in-union women of reproductive age, 15–49 years) ⁴⁹	No data	11.4%	11.1%	32.3%	34%	26%	12.5%	16.7%	6.1%
Violence against women ever experienced, intimate partner (% of female population ages 15 and older) ⁵⁰	16.7%	28.5%	14.3%	23.8%	25.1%	49.9%	20.9%	14.8%	34.4%
Maternal mortality ratio (deaths per 100,000 live births) ⁵¹	60	95	46	397	396	375	160	121	43

38. Age of Consent (2022) "Legal Ages of Consent by Country", <https://www.ageofconsent.net/world>, accessed 4 May 2022.

39. Pew Research Centre (2016) "Marriage Laws around the world", https://assets.pewresearch.org/wp-content/uploads/sites/12/2016/09/FT_Marriage_Age_Appendix_2016_09_08.pdf, accessed 4 May 2022.

40. Can marry from 16 years with parental permission.

41. Although the law authorises marriage from the age of 14 if both the boy and girl have reached puberty, if the girl is pregnant, or if the couple has a child.

42. Allows underage marriage (14 to 17) with parental consent, the consent of the underage individuals, and authorisation of a judge.

43. Although both may marry under these ages with parental consent.

44. Implementation of the law is weak with marriage of underage girls by parental arrangement common, particularly in rural areas.

45. Can marry from 16 years with parental permission.

46. United Nations Development Programme (2020) *Human Development Report*, <https://hdr.undp.org/data-center>, accessed 4 May 2020

47. Ibid.

48. Ibid.

49. Ibid.

50. Ibid.

51. Ibid.



3.3.1 Latin America and the Caribbean

BRAZIL

In Brazil, the fertility rate is 1.7 children per woman, with a high adolescent birth rate of 59.1 (see [Table 2](#)). Brazil has a universal public health system (Sistema Único de Saúde) and adolescents have universal free access to public health services and contraception.⁵² The HIV epidemic in Brazil is classified as stable and HIV treatment and self-testing kits are freely available to all with Brazil being one of the first 40 countries to provide self-testing.⁵³

Since 1996, sex education has been included in the National Curriculum of the Brazilian Ministry of Education as a cross-cutting theme linked to other school subjects.⁵⁴ However, education is decentralised and thus varies by state, so about 45 per cent of schools have sexuality education programmes.⁵⁵ Provision of comprehensive sexuality education (CSE) in primary schools is not a requirement.⁵⁶ Debate has been critical of setbacks related to SRHR in the country since 2018, resulting from the influence of religious conservatism in the legislative branch of government.⁵⁷ Political initiatives have included curtailing debate around sexuality and gender in schools.⁵⁸

Under Brazil's penal code, abortion is only permitted to save a woman's life, where the pregnancy is the result of rape or on other limited grounds. However, Brazil's health system has increased the number of health clinics and hospitals where abortions are available for women who fit the penal code's exceptions.⁵⁹ Still, few women obtain such non-punishable abortions, since doctors and hospitals have generally required a judicial authorisation to carry out the procedure.⁶⁰ The incidence of unsafe abortion is high.

The adoption of the 2001 "Maria da Penha" law aimed to fight intimate partner violence, but implementation has lagged.⁶¹ In 2019, 1 million cases of intimate partner violence and 5,100 cases of femicide were pending before the courts.

Brazil legalised same sex marriage in 2013, LGBTIQ+ couples have adoption rights and the right to change gender is legal.⁶² The supreme court also banned violence and discrimination based on sexual orientation and gender identity in 2019 but violence and discrimination against LGBT populations continue.⁶³ The national Human Rights Ombudsman's Office reported to Human Rights Watch that, between January and June 2020, it received 1,134 complaints of violence, discrimination and other abuses against LGBT people.⁶⁴

52. Sexualrightsdatabase.org (2022) "Sexual Rights Database", <https://sexualrightsdatabase.org/countries/403/Brazil>, accessed 14 March 2022.

53. Avert (2022) "HIV and AIDS in Brazil", <https://www.avert.org/professionals/hiv-around-world/latin-america/brazil>, accessed 23 March 2022.

54. Quaresma da Silva, D., Ulloa Guerra, G. and Sperling, C. (2013) "Sex education in the eyes of primary school teachers in Novo Hamburgo, Rio Grande do Sul, Brazil", *Reproductive Health Matters*, 21(41), 114-123, DOI: [10.1016/S0968-8080\(13\)41692-0](https://doi.org/10.1016/S0968-8080(13)41692-0)

55. Sexualrightsdatabase.org (2022) op. cit.

56. United Nations Development Programme (2020) *Human Development Report*, <https://hdr.undp.org/en/countries/profiles/BRA>, accessed 23 March 2022.

57. Reis Brandão, E., da Silva Cabral, C. (2019) "Sexual and reproductive rights under attack: the advance of political and moral conservatism in Brazil", *Sexual and Reproductive Health Matters*: 27(2), 76-86, DOI: [10.1080/26410397.2019.1669338](https://doi.org/10.1080/26410397.2019.1669338)

58. Ibid.

59. Human Rights Watch (2022) *Human Rights Watch: Women's Human Rights: Abortion*, <https://www.hrw.org/legacy/women/abortion/brazil.html>, accessed 23 March 2022.

60. Ibid.

61. Human Rights Watch (2021) "Brazil Events of 2020", <https://www.hrw.org/world-report/2021/country-chapters/brazil>, accessed 4 May 2022.

62. Equaldex (2022) "LGBT Rights in Brazil", <https://www.equaldex.com/region/brazil>, accessed 4 May 2022.

63. Johnson, A. (2021) "Epidemic of Violence: Brazil shocked by barbaric gang rape of gay men". The Guardian, 9 June, <https://www.theguardian.com/global-development/2021/jun/09/epidemic-of-violence-brazil-shocked-by-barbaric-gang-rape-of-gay-man>, accessed 4 May 2022.

64. Human Rights Watch (2021) "Brazil Events of 2020", <https://www.hrw.org/world-report/2021/country-chapters/brazil>, accessed 4 May 2022.

DOMINICAN REPUBLIC

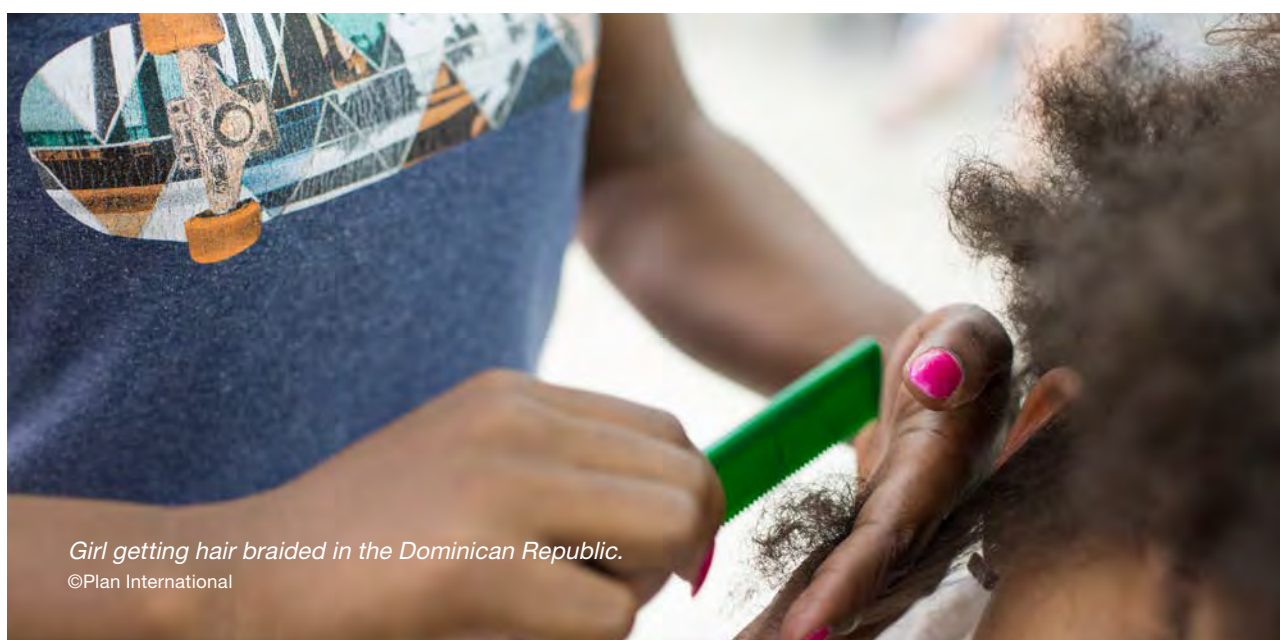
The Dominican Republic's fertility rate is 2.4 births per woman with the highest adolescent pregnancy rate in Latin America and the Caribbean (see [Table 2](#)). The government has developed a national strategy to reduce adolescent pregnancy but it remains high. The Dominican Republic has not implemented comprehensive sexuality education in schools. Some schools do offer SRHR workshops but there is no mandatory consistent approach. This leaves girls and boys to navigate their sexual wellbeing and relationships without sufficient information. In many parts of the country, there is no place for girls to access confidential, non-stigmatising, adolescent-friendly SRH services.⁶⁵

The Dominican Republic has successfully managed the HIV epidemic. An estimated 70,000 Dominicans are living with HIV, with subgroups such as key populations and migrants more at risk.⁶⁶ The country has made substantial progress in the enrolment of patients on antiretroviral therapy and by 2019 the number of those on treatment had increased by 63 per cent over the previous five years.⁶⁷

The maternal mortality rate in the Dominican Republic is almost twice the regional average (see [Table 2](#)), and the neonatal mortality rate is high at 19.4 per 1,000 births.^{68,69} Dominican authorities have pledged to eliminate preventable maternal deaths with a goal of reaching 70 deaths per 100,000 live births.⁷⁰

Abortion in the Dominican Republic is prohibited with no exceptions increasing the risks to the health and safety of affected women and girls. An estimated 25,000 women and girls are treated for complications from miscarriage or abortion in the public health system each year and complications from abortion or miscarriage account for at least 8 per cent of maternal deaths.⁷¹

The Dominican Republic reported the highest incidence of women's deaths at the hands of their partner or former partner in 2020 (1.0 per 100,000 women).⁷² Same-sex activity in the Dominican Republic is legal but same-sex marriage is unrecognised.⁷³ LGBTIQ+ Dominicans are subjected to violence and discrimination based on their sexual orientation and/or gender identity.⁷⁴



Girl getting hair braided in the Dominican Republic.

©Plan International

65. Human Rights Watch (2019) '“I felt like the world was falling down on me”: Adolescent Girls Sexual and Reproductive Health and Rights in the Dominican Republic', <https://www.hrw.org/report/2019/06/18/i-felt-world-was-falling-down-me/adolescent-girls-sexual-and-reproductive-> accessed 15 March 2022.
66. AIDS Healthcare Foundation (2022) Dominican Republic - HIV/AIDS Testing - AIDS Healthcare Foundation, <https://www.aidshealth.org/global/dominican-republic/#:-:text=In%202018%2C%20an%20estimated%2070%2C000.compared%20to%20men%20at%201%25>, accessed 13 March 2022.
67. PEPFAR (2019) “Dominican Republic Country Operational Plan”, https://2017-2021.state.gov/wp-content/uploads/2019/09/Dominican-Republic_COP19-Strategic-Directional-Summary_public.pdf, accessed 17 March 2022.
68. The United Nations Population Fund (2018) “Dominican Republic 2018”, https://www.unfpa.org/sites/default/files/DO_UNFPA_Results_07_27.pdf, accessed 17 March 2022.
69. United Nations Department of Economic and Social Affairs (2022) *SDG Global Database*, <https://unstats.un.org/sdgs/indicators/database>, accessed 23 March 2022.
70. Human Rights Watch (2022) “It’s Your Decision, It’s Your Life”, <https://www.hrw.org/report/2018/11/19/its-your-decision-its-your-life/total-criminalization-abortion-dominican-republic>, accessed 14 March 2022.
71. Ibid.
72. United Nations Gender Equality Observatory for Latin America and the Caribbean (2020) “Women’s deaths at the hands of their intimate partner or former partner”, <https://oig.cepal.org/en/indicators/womens-deaths-hands-their-intimate-partner-or-former-partner>, accessed 4 May 2021.
73. Equaldex (2022) “LGBT Rights in Dominican Republic”, <https://www.equaldex.com/region/dominican-republic>, accessed 4 May 2022.
74. Human Rights First (n.d.) Fact sheet, <https://www.humanrightsfirst.org/sites/default/files/dominican-republic-fact-sheet.pdf>



Girls playing football in El Salvador.

©Plan International

EL SALVADOR

There are several laws in El Salvador that mention the right and need for sexual education. Additionally, the Ministry of Education revised its curriculum to integrate sexuality education at all levels, but it does not have the authority to mandate and standardise it as it is not a law.^{75,76}

There are several legal instruments in El Salvador which underline the importance of young people's sexual and reproductive health, including access to services. According to the Technical Guidance on Family Planning Care, adolescents are a group that deserves "special attention" with regard to contraception and states that they should be able to access such services from the age of 10.⁷⁷ However, despite legal protections, research shows that there is sometimes a disconnect between law and practice.⁷⁸ In El Salvador, the fertility rate is 2.2 children per woman, with a high adolescent birth rate of 69.5 (see [Table 2](#)). The provision of services is discretionary, and some clinics refuse without parental consent when the person is under 18.⁷⁹

El Salvador bans abortion in all cases and terminating a pregnancy can send a woman to jail for up to eight years. In some cases, a judge can find women guilty of aggravated homicide which can mean up to 50 years. Past attempts to decriminalise abortion in El Salvador have been unsuccessful, including two proposals in 2018 to allow abortion under certain exceptions that legislators failed to bring to a vote.⁸⁰ In 2021, there was a landmark ruling in the Inter-American Court of Human Rights (highest judicial body for human rights in the Americas): the court deemed the Salvadoran government responsible for the death of Manuela, a woman who in 2008 was sentenced to 30 years in prison for aggravated homicide after suffering an obstetric emergency that resulted in her pregnancy loss.⁸¹ Manuela died in prison from cervical cancer, after receiving inadequate medical diagnosis and treatment. In a ruling that applies to countries throughout Latin America and the Caribbean under the Court's jurisdiction, health care staff can no longer refer women to law enforcement when they come to hospital seeking abortion care and other reproductive health services.⁸²

Rates of GBV are extremely high. A 2017 national survey found that 67 per cent of women have suffered some form of violence in their lifetime, including sexual assault, intimate partner violence (IPV) and abuse by family members.⁸³

Same-sex activity in El Salvador is legal but same-sex marriage and civil unions are banned.⁸⁴ A Human Rights Watch report confirms the Salvadoran government's own acknowledgement that LGBT people face "torture, inhuman or degrading treatment, excessive use of force, illegal and arbitrary arrests and other forms of abuse, much of it committed by public security agents."⁸⁵

75. Sexualrightsdatabase.org. (2022) "Sexual Rights Database", <https://sexualrightsdatabase.org/countries/468/El%20Salvador>, accessed 14 March 2022.

76. Rios, L. (2019) "Can sex education make a difference amid El Salvador's violent, conservatism?" NBC [online], 19 July, <https://www.nbcnews.com/news/latino/can-sex-education-make-difference-amid-el-salvador-s-violence-n1026201>, accessed 4 May 2022.

77. Ministerio de Salud Pública y Asistencia Social (2008) "Guía Técnica de Atención en Planificación".

78. IPPF (2014) "Sobrepoteados y desatendidos. Un estudio multipaís sobre las barreras legales para acceso de la gente joven a los servicios de salud sexual y reproductiva", http://www.ippf.org/sites/default/files/ippf_coram_el_salvador_report_es_web.pdf, accessed 16 March 2022.

79. Ibid.

80. Al Jazeera (2021) "The abortion cases that could force El Salvador to loosen its ban", <https://www.aljazeera.com/news/2021/3/14/the-abortion-cases-that-could-force-el-salvador-to-loosen-its-ban>, accessed 16 March 2022.

81. Centre for Reproductive Rights (2012) "Manuela v. El Salvador (Inter-American Court of Human Rights)", <https://reproductiverights.org/case/manuela-v-el-salvador-inter-american-court-of-human-rights/>, accessed 15 March 2022.

82. Ibid.

83. Nugent, C. (2019) "Violence Against Women in El Salvador Is Driving Them to Suicide - Or to the U.S. Border", Time Magazine, 14 May, <https://time.com/5582894/gender-violence-women-el-salvador/>, accessed 4 May 2022.

84. Equaldex (2022) "LGBT Rights in Dominican Republic", <https://www.equaldex.com/region/dominican-republic>, accessed 4 May 2022.

85. Human Rights Watch (2021) "'I'm Lucky to Still Be Alive' Violence and Discrimination Against LGBT People in El Salvador", https://www.hrw.org/sites/default/files/media_2021/03/%E2%80%9C9C%E2%80%999m%20Lucky%20to%20Still%20Be%20Alive%E2%80%9D.pdf, accessed 4 May 2022.



3.3.2 West and East Africa

BENIN

In 2004, Benin adopted The Person's and Family Code, aimed at eliminating discrimination against women and girls, and abolishing discriminatory provisions of the customary law of Dahomey, including polygamy and the age of marriage.⁸⁶ However, many citizens rely on oral traditions so adherence to legislative law can be low in some communities that function according to "living law".⁸⁷

Since 2018, CSE has been included in the secondary school curriculum.⁸⁸ Education about HIV/AIDS and sexually transmitted infections is mandated in the curriculum of basic, secondary and tertiary levels but the law requires there to be prior consultation with parents on the content and materials.⁸⁹

Social and cultural norms also hinder access to SRH information and services for adolescents and young people. The percentage of adolescents having had sex by 15 years stands at 12 per cent for females and 6.2 per cent for males.⁹⁰ The Benin government provides direct support for contraceptives and family planning is included in the Minimum Package of Services that the government requires each facility to provide.⁹¹ However, only 9.3 per cent of women aged 15 to 49 report using a modern method of contraception.⁹² The most prevalent methods are male condoms (3.5 per cent), injectables (2 per cent), implants (0.9 per cent), oral contraceptive pills (0.5 per cent) and female sterilisation.⁹³

In 2020, HIV fell to 0.9 per cent from 1.4 per cent in 2001.⁹⁴ The number of adolescents aged 10 to 19 years living with HIV is 2,600 for females and 2,200 for males.⁹⁵

The percentage of adolescents who are married or in a union before the age of 15 was 9 per cent (females) and 0.4 per cent (males).⁹⁶ The number of girls aged 15 to 19 years who reported physical violence in the last 12 months was 13 per cent, and sexual violence was 3 per cent.

See information on abortion in Benin in section 4.2.2: [Box 4](#).

Benin does not criminalise same-sex activity, but same-sex marriage is not legal – although there is no legal protection against discrimination based on sexual orientation and gender identity.⁹⁷ Same-sex relationships are not generally accepted in Benin.

86. Sexualrightsdatabase.org (2022) "Sexual Rights Database", <https://sexualrightsdatabase.org/countries/482/Benin>, accessed 14 March 2022.

87. Ibid.

88. IPPF (2021) "Adapting Family Planning in Times of Crisis: Bringing Comprehensive Sexuality Education Online in Benin", <https://africa.ippf.org/resource/adapting-family-planning-services-times-crisis-bringing-comprehensive-sexuality-education> accessed 14 March 2022.

89. Sexualrightsdatabase.org (2022) op. cit.

90. World Health Organization and Human Reproduction Programme Research for Impact (2021) "Benin Contraception within the context of adolescents and reproductive lives: Country Profile" https://cdn.who.int/media/docs/default-source/hrp/adolescents-srh-country-factsheets-2021.pdf?sfvrsn=62aec9d5_17, accessed 26 April 2022.

91. Guttmacher Institute (2015) "Contraceptive Use in Benin", <https://www.guttmacher.org/sites/default/files/factsheet/fb-benin-contraception.pdf> accessed 15 March 2022

92. Guttmacher Institute (2016) "Contraceptive Failure Rates in the Developing World: An Analysis of Demographic and Health Survey Data in 43 Countries."

93. Ibid.

94. World Bank (2022) "Prevalence of HIV, total (% of population ages 15-49) - Benin | Data", <https://data.worldbank.org/indicator/SH.DYN.AIDS.ZS?locations=BJ> accessed 24 March 2022.

95. World Health Organization and Human Reproduction Programme Research for Impact (2021) "Benin Contraception within the context of adolescents and reproductive lives: Country Profile". https://cdn.who.int/media/docs/default-source/hrp/adolescents-srh-country-factsheets-2021.pdf?sfvrsn=62aec9d5_17, accessed 26 April 2022.

96. Ibid.

97. Equaldex (2022) "LGBT Rights in Benin", <https://www.equaldex.com/region/benin>, accessed 4 May 2022.

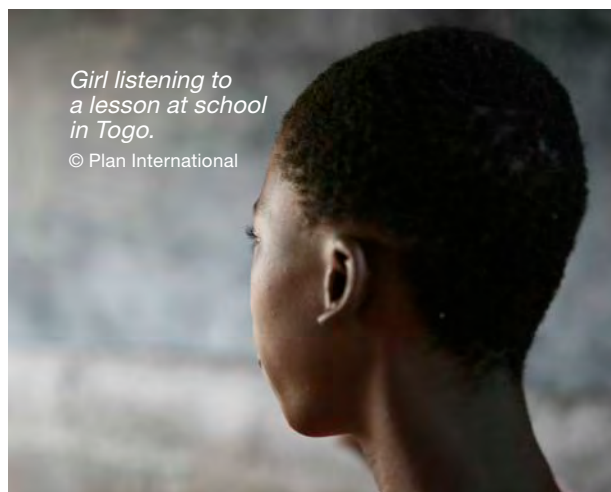
TOGO

In 2020, Togo had a population of 8.2 million.⁹⁸ The extent to which country laws and regulations guarantee full and equal access to sexual and reproductive healthcare, information and education to women and men aged 15 years and older stood at 73 per cent in 2019.⁹⁹ However, the laws and regulations are not fully realised due to an underfunded health system.¹⁰⁰

The percentage of adolescents who report having sex by the age of 15 is 10 per cent for girls and 9 per cent for boys. By comparison, 19 per cent of females and 7 per cent of males report being sexually active in the last month.¹⁰¹ A 2007 law on reproductive health¹⁰² provides adolescents with access to contraception and post-abortion services. According to the World Bank, the prevalence of contraceptive use stood at 24 per cent in 2017.¹⁰³ Unmet need for modern methods of contraception was 49 per cent for married girls or girls in a union and 61 per cent for those unmarried or not in a union.¹⁰⁴ The number of adolescents living with HIV is 4,700 for females and 3,700 for males.

Key sexual and reproductive health indicators are improving. The total fertility rate decreased to 4.2 births per woman in 2019 from 4.5 births per woman in 2015.¹⁰⁵ The adolescent birth rate is in decline from previous years (see Table 2).¹⁰⁶ The maternal mortality rate is also decreasing (see Table 2).¹⁰⁷

Laws and regulations do not mandate sexuality education in schools.¹⁰⁸ A lack of curricula and low budgeting for sexual education needs as well as low consideration by health and education authorities of the need for sexual education means that there is almost non-existent sexual education curricula within the national formal and informal education system and vocational training.¹⁰⁹



The percentage of adolescents who report being married or in a union before the age of 15 years is 6.4 per cent for females and 0.4 per cent for males.¹¹⁰ The percentage of girls aged 15 to 19 years who report physical violence in the past month is 11 per cent and those who report sexual violence is 1 per cent.

Female genital cutting was banned by law in Togo in 1998 but it is still practised, primarily among nomadic and ethnic minority families and mostly in the Central Region where 17 per cent of women aged 15 to 49 reported that they had been excised.¹¹¹ The cultural practice has decreased significantly from an overall prevalence of excision of 10 per cent among women aged 45 to 49 and a prevalence of 2 per cent among girls aged 15 to 19.¹¹² However, there is also a likelihood of under-reporting.

In Togo, abortion is permitted on the basis of health or therapeutic grounds, such as cases of rape, incest and foetal impairment.¹¹³ LGBTIQ+ persons face institutional and cultural discrimination as same-sex relationships are still illegal and are highly stigmatised.¹¹⁴

98. World Bank (2022) "World Development Indicators", <http://datatopics.worldbank.org/world-development-indicators>, accessed 14 March 2022.

99. UN Stats (2022) <https://unstats.un.org/sdgs/dataportal/countryprofiles/TGO#goal-5>, accessed 8 March 2022.

100. GIZ (n.d) "ProSanté: strengthening the health system", <https://www.giz.de/en/worldwide/70760.html>, accessed 19 March 2022.

101. World Health Organization and Human Reproduction Programme Research for Impact (2021) "Togo Contraception within the context of adolescents' and reproductive lives: Country Profile", https://cdn.who.int/media/docs/default-source/hrp/adolescents-srh-country-factsheets-2021.pdf?sfvrsn=62aec9d5_17, accessed 26 April 2022.

102. Guttmacher Institute (2008) "Development in Laws on Induced Abortion: 1998-2007", <https://www.guttmacher.org/journals/ipsrh/2008/developments-laws-induced-abortion-1998-2007>, accessed 19 March 2022.

103. World Bank (2022) "World Development Indicators", <http://datatopics.worldbank.org/world-development-indicators>, accessed 14 March 2022.

104. World Health Organization and Human Reproduction Programme Research for Impact (2021) "Togo Contraception within the context of adolescents' and reproductive lives: Country Profile", https://cdn.who.int/media/docs/default-source/hrp/adolescents-srh-country-factsheets-2021.pdf?sfvrsn=62aec9d5_17, accessed 26 April 2022.

105. World Bank (2022) "World Development Indicators", <http://datatopics.worldbank.org/world-development-indicators>, accessed 14 March 2022

106. UNDP (n.d.) *Human Development Reports*, <https://hdr.undp.org/data-center>, accessed 14 March 2022

107. Ibid.

108. UNDESA (2022) "SDG Indicators Database", <https://unstats.un.org/sdgs/dataportal/countryprofiles/TGO#goal-5>, accessed 14 March 2022.

109. Plan International Togo, "Country Strategy 2019-2023"

110. World Health Organization and Human Reproduction Programme Research for Impact (2021) op. cit.

111. Plan International Togo, op. cit.

112. Ministère de la Planification, du Développement et de l'Aménagement du Territoire - MPDAT/Togo, Ministère de la Santé - MS/Togo and ICF International, 2015. Enquête Démographique et de Santé au Togo 2013-2014. Rockville, Maryland, USA: MPDAT, MS and ICF International.

113. Centre For Reproductive Rights (2022) "The World's Abortion Laws", <https://reproductiverights.org/maps/worlds-abortion-laws/?country=TGO>, accessed 24 March 2022.

114. Ibid.

UGANDA

The Guttmacher Institute highlights serious gaps in SRH services for adolescent women in Uganda, highlighting that an estimated 648,000 women aged 15 to 19 are sexually active and do not want a child in the next two years but among this group, more than 60 per cent have unmet needs for modern contraception.¹¹⁵

The National Sexuality Education framework is the central policy for sexuality education in Uganda.¹¹⁶ However, the contents of this framework are centred around religious and cultural values.¹¹⁷ The framework stresses sexual abstinence. All age groups learn about sexual education in some form. However, the curriculum under each section only includes topics considered age-appropriate. For instance, the objective “to appreciate the importance of virginity and sexual abstinence” starts from the age of six upwards.¹¹⁸

The Uganda Demographic Health Survey (DHS) (2016) indicates that adolescents may make their sexual debut at an early age; among 20- to 29-year-olds, 11 per cent of men and 18 per cent of women said that they had begun sexual activity below the age of 15 years.¹¹⁹ Early unprotected sexual activity and high levels of adolescent pregnancy (see [Table 2](#)) also contribute to maternal and neonatal mortality.¹²⁰ Health workers often have stigmatising views towards adolescent girls and mothers, who have difficulty in accessing SRH services.¹²¹

Maternal mortality rates remain high (see [Table 2](#)), due to inadequate obstetric care, low literacy and cultural norms leading to poor health-seeking behaviours.¹²²

Uganda has 1.4 million people living with HIV and women and young women in particular are disproportionately affected, with 62,000 girls aged 10 to 19 years HIV-positive.¹²³ Same-sex activities are criminalised. Punitive laws and stigmatising attitudes towards men who have sex with men, sex workers, and people who inject drugs has meant that these groups who are most vulnerable to infection are far less likely to engage with HIV services.¹²⁴

The percentage of girls who are married or in a union is 7 per cent (before age 15) and 0 per cent for males (see [Table 2](#) for figures before 18).¹²⁵ The percentage of girls aged 15 to 19 who report physical violence in the last 12 months is 23 per cent, and 5 per cent for sexual violence.

For information on abortion in Uganda see section 4.2.2: [Box 4](#).



A young girl tends to her tree saplings in Uganda.

©Plan International

115. Guttmacher Institute (2019) “In Uganda, Sexual and Reproductive Health Services fall short for adolescents”, <https://www.guttmacher.org/news-release/2019/uganda-sexual-and-reproductive-health-services-and-information-fall-short>, accessed 24 March 2022

116. Sexualrightsdatabase.org (2022) “Sexual Rights Database”, <https://sexualrightsdatabase.org/countries/457/Uganda>, accessed 24 March 2022.

117. Ministry of Education and Sports (2018) “National Sexuality Education Framework”, <https://s3-eu-west-1.amazonaws.com/s3.sourceafrica.net/documents/119376/UNFPA-68-090518.pdf>

118. Ibid.

119. Uganda Bureau of Statistics (UBOS) and ICF (2018) Uganda Demographic and Health Survey 2016, <https://dhsprogram.com/pubs/pdf/FR333/FR333.pdf>, accessed 14 March 2022.

120. Plan International Uganda, Country Strategy 2017–2021

121. Ibid.

122. World Bank (2022) “World Development Indicators”, <https://data.worldbank.org/indicator/SH.STA.MMRT?locations=UG>, accessed 14 March 2022.

123. Be in the know (2020) “At a glance: HIV in Uganda”, <https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/Uganda>, accessed 14 March 2022

124. Ibid.

125. United Nations Development Programme (2020) Human Development Report, <https://hdr.undp.org/data-center>, accessed 4 May 2020.



3.3.3 South-East Asia

CAMBODIA

Cambodia has a total population of 16.7 million,¹²⁶ of whom about 5.9 million people are aged up to 17 years.¹²⁷ Cambodia has adopted policies and programmes in key areas to improve the delivery of sexual and reproductive health services and has made strides in improving maternal and child health in rural areas.¹²⁸

Cambodia's Minimum and Complementary Packages of activities lists services to be provided by hospitals which include maternal healthcare (including emergency obstetric and newborn care), family planning, abortion, treatment of HIV and AIDS and STIs, and cervical cancer prevention, detection and treatment.¹²⁹

The percentage of adolescents having had sex by the age of 15 was 1.4 per cent (females) and 0.3 per cent (males), while 12.4 per cent of female adolescents aged 10 to 19 report being sexually active in the last month compared to 4 per cent for male adolescents.¹³⁰ The percentage of adolescent girls aged 15 to 19 who are married or in a union that report an unmet need for contraception is 15 per cent.¹³¹

The maternal mortality ratio per 100,000 live births has decreased from 472 in 2005 to 160 in 2021 (see [Table 2](#)). The fertility rate is in decline at 2.5 births per woman in 2019 (see [Table 2](#) for the adolescent birth rate).¹³² However, the percentage of adolescents who have given birth varies widely across provinces.¹³³

The Cambodian Ministry of Education this year began rolling out a more holistic approach to health education, providing information on sexual health issues that are more comprehensive than existing biology classes.¹³⁴ The curriculum includes attention to bullying and LGBTIQ+ discrimination.¹³⁵

The prevalence of HIV in the general population (15 to 49 years) has steadily declined over the past decade.¹³⁶ The number of adolescents (10 to 19 years) living with HIV is 1,800 for females and 1,800 for males.¹³⁷

The percentage of girls married or in a union before the age of 15 is 2 per cent for girls and 0 per cent for males (see [Table 2](#) for rates before 18).¹³⁸ Three per cent of girls aged 15 to 19 report physical violence in the past 12 months and 0.2 per cent report incidents of sexual violence.

Abortion in Cambodia is legal upon request within the first 12 weeks of pregnancy.¹³⁹

126. World Bank (2022) "World Development Indicators", <https://data.worldbank.org/indicator/SH.STA.MMRT?locations=UG>, accessed 14 March 2022.

127. UNICEF (2018) *A Statistical Profile of Child Protection in Cambodia*, <https://www.unicef.org/cambodia/media/711/file>, accessed 24 March 2022.

128. UNFPA (2019) "Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage", https://www.unfpa.org/sites/default/files/pub-pdf/SRHR_an_essential_element_of_UHC_2020_online.pdf

129. UNFPA (2019) "Sexual and Reproductive Health and Rights: An essential element of universal health coverage", https://www.unfpa.org/sites/default/files/pub-pdf/SRHR_an_essential_element_of_UHC_2020_online.pdf, accessed 10 March 2022.

130. World Health Organization and Human Reproduction Programme Research for Impact (2021) "Cambodia Contraception within the context of adolescents' and reproductive lives: Country Profile", https://cdn.who.int/media/docs/default-source/hrp/adolescents-srh-country-factsheets-2021.pdf?sfvrsn=62aec9d5_17, accessed 26 April 2022.

131. Ibid.

132. World Bank (2022) "World Bank Development Indicators", <https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=KH>, accessed 10 March 2022.

133. UNICEF (2018) op. cit.

134. VOA Khmer (2020) "Education Ministry to Incorporate Mental Health, Sex Education into Curriculum", <https://www.voacambodia.com/a/education-ministry-to-incorporate-mental-health-sex-education-into-curriculum-/5638955.html>

135. Ibid.

136. Joint United Nations Programme on HIV/AIDS (2015) 2014 *HIV and AIDS Estimates*, UNAIDS.

137. UNAIDS (2020) "Trends of new HIV infections", <http://aidsinfo.unaids.org>, accessed 16 April 2022.

138. World Health Organization and Human Reproduction Programme Research for Impact (2021) "Cambodia Contraception within the context of adolescents' and reproductive lives: Country Profile".

139. Centre For Reproductive Rights (2022) "The World's Abortion Laws", <https://reproductiverights.org/maps/worlds-abortion-laws/?country=KHM>, accessed 24 March 2022.

PHILIPPINES

The heavy influence of Christian values and social norms make it difficult for women and girls to take control of their sexual health in the Philippines.¹⁴⁰ In 2012, the government passed a bill (The Responsible Parenthood, Reproductive Health and Population and Development Act) that provides free or subsidised access to contraception, sexual education and maternal care. However, emergency contraceptive pills are considered as “abortifacients” and are not permitted through the Philippines National Drug Formulary System.¹⁴¹ Many women end up having more children than they want, and unintended pregnancy is high because of a high unmet need for contraception.¹⁴² The percentage of adolescent girls aged 15 to 19 with an unmet need for modern contraception methods was 28 per cent for those married or in a union and 62 per cent for those unmarried/not in a union.

According to the Act, age-appropriate sexuality education is mandated for 10 to 19 years in non-sectarian schools, however only with parental consent.¹⁴³ The country has the highest adolescent pregnancy rate in Asia (see [Table 2](#)).¹⁴⁴

In March 2022, the Philippines raised the age of consent from 12 to 16 years.¹⁴⁵ The percentage of girls aged 15 to 19 years who report ever having sex is 12 per cent and those who report having sex by age 15 is 2 per cent.¹⁴⁶ The Philippines also has the fastest-growing HIV epidemic in the Asia and Pacific region with a 237 per cent increase in annual new HIV infections between 2010 and 2020.¹⁴⁷ The government passed the Act with the aim of tackling SRHR issues such as adolescent pregnancy, pregnancy-related deaths and a rise in HIV/AIDS. However, many in civil society argue that the bill does not go far enough and should provide appropriate reproductive health information to adolescents without preconditions.¹⁴⁸



Girl at convenience store in the Philippines.

©Plan International

Abortion is illegal under all circumstances in the Philippines.¹⁴⁹ However, abortion is still common but is performed under unsafe conditions which contributes to the high maternal mortality ratio (see [Table 2](#)).¹⁵⁰

The percentage of girls who are married or in a union before the age of 15 is 2 per cent (see [Table 2](#) for figures before the age of 18).¹⁵¹ The percentage of girls aged 15 to 19 who report physical violence in the past 12 months is 6 per cent and sexual violence is 1 per cent.

Sexual acts between people of the same sex are legal but same-sex marriage is not legal in the Philippines.¹⁵² LGBTIQ+ people still experience discrimination, bullying and sometimes violence, as there is no national anti-discrimination law that offers protection. Many LGBTIQ+ people cannot claim their basic rights and can be discriminated against at work and denied access to services.¹⁵³

140. UNESCO, UNFPA, UNAIDS, UNDP and Youth Lead (2013) *Young People and the Law in Asia and the Pacific: A review of laws and policies affecting young people's access to sexual and reproductive health and HIV services*, p.19

141. Sexualrightsdatabase.org (2022) “Sexual Rights Database”, <https://sexualrightsdatabase.org/countries/475/Philippines>, accessed 14 March 2022.

142. UNFPA, WHO and Inter-agency Working Group on SRH and HIV Linkages (2021) “Sexual Reproductive Health and Rights Infographics Snapshot – Philippines”, <https://apps.who.int/iris/bitstream/handle/10665/349696/WHO-SRH-21.157-eng.pdf?sequence=1&isAllowed=y>, accessed 17 March 2022.

143. Amnesty International (2012) “Reproductive rights gains for women in the Philippines”, <https://www.amnesty.org/en/latest/news/2012/12/imperfect-philippines-health-law-still-fresh-start-women-s-rights/>, accessed 24 March 2022.

144. UNDESA (2019) “World Population Prospects: The 2019 Revision”, Rev 1. New York, <https://population.un.org/wpp/>, accessed 30 April 2020.

145. Reuters (2022) “Philippines raises age of sexual consent from 12 to 16”, <https://www.nbcnews.com/news/world/philippines-raises-age-sexual-consent-12-16-rcna18939>, accessed 4 May 2022.

146. World Health Organization and Human Reproduction Programme Research for Impact (2021) “The Philippines Contraception within the context of adolescents’ and reproductive lives: Country Profile”, https://cdn.who.int/media/docs/default-source/hrp/adolescents-srh-country-factsheets-2021.pdf?sfvrsn=62aec9d5_17, accessed 26 April 2022.

147. National HIV/AIDS & STI Surveillance and Strategic Information Unit of the Department of Health – Epidemiology Bureau (2020) *A Briefer on the Philippine HIV Estimates*, https://doh.gov.ph/sites/default/files/publications/A%20Briefer%20on%20the%20PH%20Estimates%202020_08232021.pdf, accessed 24 March 2022.

148. Amnesty International (2012) op. cit.

149. Centre For Reproductive Rights (2022) “The World’s Abortion Laws”, <https://reproductiverights.org/maps/worlds-abortion-laws/?country=PHL>, accessed 24 March 2022.

150. UNFPA, WHO and Inter-agency Working Group on SRH and HIV Linkages (2021) “Sexual Reproductive Health and Rights Infographics Snapshot – Philippines”, <https://apps.who.int/iris/bitstream/handle/10665/349696/WHO-SRH-21.157-eng.pdf?sequence=1&isAllowed=y>, accessed 17 March 2022.

151. World Health Organization and Human Reproduction Programme Research for Impact (2021) “Philippines Contraception within the context of adolescents’ and reproductive lives: Country Profile”, https://cdn.who.int/media/docs/default-source/hrp/adolescents-srh-country-factsheets-2021.pdf?sfvrsn=62aec9d5_17, accessed 26 April 2022.

152. Stonewall (2018) *Global Workplace Briefing: The Philippines*, https://www.stonewall.org.uk/system/files/philippines_global_workplace_briefing_2018.pdf, accessed 4 May 2022.

153. Ibid.

VIETNAM

Vietnam has one of the most progressive legal frameworks for SRHR in Asia through the National Strategies on Population and Reproductive Health (2001–2020).¹⁵⁴ The country has made substantial progress in improving sexual and reproductive health outcomes over the past decades and was one of only nine countries to achieve the maternal mortality reduction target of the MDGs in 2015.¹⁵⁵ However, poorer populations often have difficulty in accessing and using reproductive health services. In 2019, the maternal mortality rate stood at 43 per 100,000 live births – yet this rate is two to three times higher among ethnic minorities.¹⁵⁶

UNFPA data finds that 70 per cent of married women use some form of contraception, with several modern methods available.¹⁵⁷ However, many family planning campaigns fail to address the growing number of young Vietnamese who are sexually active before marriage, as premarital sex is considered taboo.¹⁵⁸

Sexuality education is referred to as population education in Vietnam and the 2003 Population ordinance mandates that it be provided at state-run education institutions at each grade and level.¹⁵⁹ However civil society organisations report that comprehensive sexuality education is lacking. Vietnam's sex education policies and practices do not include mandatory discussion of sexual orientation and gender identity.¹⁶⁰

Abortion is legal in Vietnam, which has a largely unrestricted abortion policy environment.¹⁶¹ Between 2015 and 2019, the abortion rate increased by 16 per cent and the share of unintended pregnancies ending in abortion rose from 64 per cent to 75 per cent.¹⁶²

Sexual acts between people of the same sex are legal in Vietnam.¹⁶³ In 2014, the National Assembly removed same-sex unions from a list of forbidden relationships; however, the update did not allow for legal recognition of same-sex relationships.¹⁶⁴ In 2015, the National Assembly updated the Civil Code to remove the prohibition in law that prevented transgender people from changing their legal gender; however, it did not provide for a transparent and accessible procedure for changing one's legal gender.¹⁶⁵ Sexual and gender minority children and young adults in Vietnam face stigma and discrimination.

154. Centre for Creative Initiatives in Health and Population (n.d.) "Country Profile on Universal Access to Sexual and Reproductive Rights in Vietnam", <https://arrow.org.my/wp-content/uploads/2017/04/Country-Profile-on-SRR-Vietnam.pdf>, accessed 29 March 2022.

155. UNFPA Vietnam (n.d.) "Sexual and Reproductive Health", <https://vietnam.unfpa.org/en/node/15212>, accessed 29 March 2022.

156. Ibid.

157. UNFPA Vietnam (n.d.) op. cit.

158. Ibid.

159. Sexualrightsdatabase.org (2022) "Sexual Rights Database", <https://sexualrightsdatabase.org/countries/416/Viet%20Nam>, accessed 29 March 2022.

160. Human Rights Watch (2020) "My Teacher said I had a disease: Barrier to the Right to Education for LGBT Youth in Vietnam", <https://www.hrw.org/report/2020/02/13/my-teacher-said-i-had-disease/barriers-right-education-lgbt-youth-vietnam>, accessed 4 May 2022.

161. Centre For Reproductive Rights (2022) "The World's Abortion Laws", <https://reproductiverights.org/maps/worlds-abortion-laws/?country=VNM>, accessed 29 March 2022.

162. Guttmacher Institute (2022) "Vietnam country profile", <https://www.guttmacher.org/geography/asia/viet-nam>, accessed 29 March 2022.

163. Equaldex (2022) "LGBT Rights in Vietnam", <https://www.equaldex.com/region/vietnam>, accessed 4 May 2022.

164. Human Rights Watch (2020) "My Teacher said I had a disease: Barrier to the Right to Education for LGBT Youth in Vietnam", <https://www.hrw.org/report/2020/02/13/my-teacher-said-i-had-disease/barriers-right-education-lgbt-youth-vietnam>, accessed 4 May 2022.

165. Ibid.



04

FINDINGS

Girls holding hands in Togo.
©Plan International



Girl in El Salvador playing football on beach.

©Plan International

Where findings are relevant to the full cohort or only individual respondents and countries, we have stated this, otherwise the findings present instances when multiple people across a number of countries stated similar views/opinions or where views/opinions frequently aligned in the dataset.

4.1 AGE AND MENARCHE: ENTRY POINTS FOR SRHR DIALOGUE

Dominant attitudes across the cohort data regarding SRHR education are evidenced, defined as what caregivers deem as “appropriate” and “inappropriate” for girls to know about SRHR and when it is acceptable for them to learn about it. Across the longitudinal data, caregivers state that they think that talking to girls about SRHR is important and necessary – however these conversations come at certain appropriate moments in a girl’s life.

4.1.1 “Not yet”

It is notable that throughout the girls’ childhood and early adolescence, caregivers say that they are still “too young” to learn about SRHR, either because they think it is not relevant at their age, or because they think it is not appropriate or acceptable for them to learn. A key point in a girl’s life cited by caregivers as the moment when they will begin, or permit, discussion of SRHR is menarche – or the first menstrual cycle. On menstruation, some caregivers state that they *intend* to take a positive approach to discussing the topic with the girls, but only when the girls actually start menstruating rather than in advance, to prepare them for the experience. Caregivers considered discussions of menstruation irrelevant, or inappropriate, until a girl actually has her first period. Ly’s mother in Vietnam, for example, said in 2017 (when Ly was 11 years old) that when Ly

gets her first period she does intend to tell her about menstruation, but that she “*can’t*” explain it to her now. A mother in Togo took a similar approach:

“Djoumai is more informed than previous years because I have been gradually giving her bits of information since she started her periods.”

DJOUMAI’S MOTHER, TOGO, 2021

Where caregivers report communication with girls about SRHR, the topics they address are generally not comprehensive. Menstrual hygiene and “appropriate” behaviours during menstruation – including avoiding certain activities, spaces, clothing, and foods – are some of the subjects that caregivers feel comfortable speaking to girls about. In some cases, this is regarded as information that girls should receive before they start menstruation, while in others it is only regarded as relevant when the girls have already started their first period. However, it is clear that even in cases where girls have begun menstruating, the age-appropriateness reasoning for avoiding discussion of SRHR continues to be cited by many caregivers.

Similar reasonings are expressed by caregivers regarding other aspects of SRHR. Conversations around sex are not normalised across the cohort countries. Although some caregivers do indicate that it is a topic they intend to speak about at a later point, this is again tied in a number of cases to age-appropriateness; the topic being regarded as irrelevant at this age. Even in the case of Folami (Togo, 2021) who is 15 years old and who had a baby last year, her mother still thinks she is too young to know everything about SRHR. However, her mother does intend to talk to her about how to avoid a second pregnancy.

The longitudinal data shows that often caregivers cite an “appropriate” age to talk to girls about SRHR that is just a little bit older than the girl’s current age – whatever that age happens to be. For example, in 2016 when Andrea (El Salvador) was 10 years old, her great-grandmother said that talking about SRHR “*still doesn’t apply*” but that once Andrea is “*11 years old, then yes, because she’s going to be entering into adolescence*”. Ayomide’s grandmother in Togo made a similar statement in 2017 when Ayomide was 11 years old:

“I don’t talk to her about issues related to sex as she is still too young. I will wait until she is between 12 and 14, when she enters adolescence.”

AYOMIDE’S GRANDMOTHER, TOGO, 2017

This is a notable commonality between the caregivers and the girls in the longitudinal data regarding the age at which girls say they would like to be, or should be, taught about SRHR; they too refer to the “appropriate” age that is either a few years older than their current age, or the age they associate with becoming an adult – in some cases 18, in others 20. This may be an indicator of norms present in communities and messages passed to girls from caregivers where sex is deemed inappropriate to talk about until girls are older. This is the case across most of the cohort countries until the most recent rounds of data collection, where at ages 14 and 15 many of the girls in the Latin American and Caribbean countries view this information as necessary and relevant to them. By contrast, girls in Togo, Benin, and Uganda in particular continue to identify older ages as the appropriate moment:

“I don’t think it’s a good idea, we are still children. I think we should start talking about these things when we’re 15 because we will be big and at secondary school.”

THEA, 11, BENIN, 2017

“I know it may not be possible, but 18 years of age is the most appropriate age for girls to learn about it. [Why?] Because by 18 years she might have at least gone through all the lower classes. Otherwise, she may end up having intercourse with a man thus getting pregnant and this will be the end of her studies.”

BETI, 15, UGANDA, 2021

Beti’s example indicates that similarly to attitudes expressed by many of the cohort caregivers, she associates learning about SRHR with being sexually active. Therefore, norms around when it is “appropriate” for girls to be sexually active influence when it is acceptable for them to learn about SRHR – which is leaving girls uninformed and unprepared.

4.1.2 “She’s a woman now”

Across the cohort data, there is a strong association between menarche and the beginning of womanhood and therefore an expected readiness for a girl to begin to behave

like an adult woman. Both the girls and their caregivers refer to “the change” as a pivotal, and inevitable, moment in a girl’s life when she is no longer considered a child, but a “young woman” or a “grown-up”. Adolescence is rarely recognised as a unique transition period in itself, with menarche instead marking the immediate shift from girl to woman. Andrea’s mother in El Salvador refers to Andrea’s friends who have “*already had their change*” (i.e., have begun menstruating) as being “*like young women now*” (El Salvador, 2017).

“She’s going to be 13 this Saturday, but she’s not a girl [i.e. woman] yet, she’s just a child, she hasn’t menstruated yet.”

JULIANA’S GRANDMOTHER, BRAZIL, 2019

With this irrevocable change come new social expectations for girls to adhere to behaviours regarded as acceptable and to stop certain activities they used to enjoy. One cohort mother in El Salvador shares that her daughter is expected to behave like a lady now and must learn to “sit down properly”. Many of the cohort girls vocalise these normative expectations; explaining what others expect of them once they start menstruating:

“If I will have menstruation already, and I should not play with boys more often because of that. We need to be more refined if we’re grown-ups already.”

EDWINA, 12, PHILIPPINES, 2018

While some girls repeat these dominant discourses without comment, others indicate that they have struggled with these new rules but feel social pressure to change their behaviour. Rosamie’s experience, for example, shows the level of sensitivity to social sanctions that girls are subject to when they don’t adhere to norms or “acceptable” behaviours:

“Ahm, it’s hard. Because there was no such thing before. You are young, you can play, you can roam. Now not anymore, because it’s embarrassing when you’re told, ‘You’re already a young woman, yet you’re still playing outside.’ Then others hear it. It’s embarrassing.”

ROSAMIE, 15, PHILIPPINES, 2021



For caregivers, girls' physical development is regarded as a signal for them to communicate warnings about avoiding boys and men – and in Jane's mother's case, more explicitly avoiding sexual relationships:

“ I always tell her that at her age and now that her body has started to develop, she should not be involved with boys or men because she can get easily get pregnant. I also tell her that although breasts are becoming large and her body changing, she should focus on her studies because being involved in sexual affairs is for grown-up adults. ”

JANE'S MOTHER, UGANDA, 2021

The girls themselves show a shift over time regarding their attitudes towards romantic relationships: they criticise peers who they see in relationships in early adolescence, then as they get older, they comment increasingly less on their peers' relationships, with some indicating that they themselves are or have been in relationships.

Central to the discussion of menstruation as a point of significant change for the girls are caregivers' concerns about the risks they now consider the girls are exposed to. Pregnancy is the most prominent of these risks across the cohort data, with menstruation appearing to be associated in some cases with a “woman's body” that is able to – or expected to – bear children:

“ ... she definitely has to change her ways and be more careful because if now she plays with any man she gets pregnant because she is now a woman, and this worries me. ”

AMELIA'S MOTHER, UGANDA, 2018

“ I tell her, there's a lot of danger now ... It's because there is the risk of her getting pregnant, it's too much, she already has a woman's body, she's already menstruated, the risk is getting pregnant, going out there and someone doing something bad to her. ”

LARISSA'S MOTHER, BRAZIL, 2017

In many cases the fear of pregnancy is linked by caregivers to gender-based violence (GBV) rather than a result of consensual sexual relationships.

Some, like Amelia's mother in Uganda (2018), discuss the concern that due to physical changes brought by puberty, men will now regard the girls as adults, increasing their risk of experiencing harassment and other forms of GBV. Rosamie's mother in the Philippines expresses concern about her daughter's development as having a “good build” that will attract “bad guys” (2017). The girls themselves report the impact that harassment has on their wellbeing and how they feel about their bodies. For example, in 2021, Sheila (15) in Uganda explains that the changes in her body make her “feel bad” due to the reactions she receives from men who assume based on her appearance that she is ready for sexual relationships, which she refers to as “love affairs”.

As the girls' bodies mature, they are exposed to numerous forms of street harassment such as catcalling, wolf-whistling and insults by both boys and adult males. Examples increase as they enter late adolescence, which is a growing concern for caregivers. This behaviour from boys and men is normalised and depicted as an inevitable part of girls' experience of adolescence and adulthood:

“ Some boys when they're older they get a bit difficult, they want to, they tease, they want to touch them [i.e., girls]. ”

BESSY'S GRANDMOTHER, EL SALVADOR, 2018

Girls report frequent cases of unwanted attention, groping and touching from male peers with little ability to prevent what was happening. They report experiencing or witnessing harassment and assault from boys at school, particularly for girls whose bodies have developed: “*One girl has quite big boobs already. When she passed the boys, one of the boys grabbed her breasts*” (Reyna, 12, Philippines, 2018). This causes anxiety and leads some to avoid making friends with boys because they “*feel nervous and afraid of them*” (Nakry, 11, Cambodia, 2017).

Some girls report being told not to tell other people that they have started menstruating, in particular to boys and men, indicating again that norms associating puberty and menstruation with womanhood create assumptions about a girl's sexual maturity: “[*What should you do when you already have your period?*] *Don't show it to the boys*” (Edwina, 11, Philippines, 2017).

For Nakry (2018), menstruation also means isolation from her parents and friends, where she is sent to sleep in a separate room to avoid anyone seeing her periods. She says her relationship with her friends has changed since her periods began:

“It really changes. I am rarely with them ... My friends are also away from me when I have vaginal bleeding.”

NAKRY,12, CAMBODIA, 2018

In El Salvador, Gabriela's mother told her not to tell anyone about her period and says that her father himself does not know that she has started menstruating. Gabriela is concerned about how others will treat her if they find out. Not only does this indicate that there is shame attached to menstruation, but also that there are social sanctions for those who do not adhere to norms that define what are “acceptable” behaviours for girls who menstruate – who are now regarded as “grown up”. Here, the implication is that with menstruation, social norms have increased influence over girls' behaviour through fear of sanctions and ostracisation.

“My dad doesn't know, just my mum She told me that when it happens I should tell her and nobody else Because it's not something you tell everyone about because then they will know all that. [What could happen if they know?] They could make fun of me, they'll say – she's not a girl anymore, she's grown up, and we won't play with her – and all that.”

GABRIELA, 12, EL SALVADOR, 2018

While some caregivers, like Barbara's mother in Benin (2021), report telling girls explicitly that the risk of pregnancy is the reason they need to change certain behaviours, often the girls themselves discuss this advice in more ambiguous terms. This could either indicate that the girls prefer not to speak openly about sex and pregnancy, or that they aren't actually sure about the reasoning behind these new restrictions on the way they spend their time and who they spend it with.

Some caregivers also discuss expectations that with menstruation comes inherent changes in girls' behaviour that they need to prepare for. Dariana's mother in the Dominican Republic (2017), for example, says that when a girl starts menstruating, she'll start behaving like *“a little woman”* and is therefore likely to soon *“fall in love with a boy”*. Gabriela's mother in El Salvador (2017) associated menstruation as a turning point for more rebellious behaviours and worried about her turning into other girls who did what they like and no longer listened to their parents.

While menstruation is associated with a girl's body transitioning into that of a woman's, another aspect of caregivers' concern about this change is that girls remain inexperienced and “naïve”. In this way, some caregivers discuss how this gap in physical and psychological maturity increases girls' vulnerability to potential manipulation by others, in particular by boys and men who might “trick” them:

“When women start having menstruation, they expect to get pregnant so I worry that she might be playing around with some boys and she conceives or she might be tricked with gifts by boys leading to either getting pregnant or contracting certain diseases.”

NAMAZZI'S MOTHER, UGANDA, 2020



Girl returning home from school in the Dominican Republic.

©Plan International

4.1.3 Girls' sexual orientation

Across the cohort data, discussion of girls' romantic or sexual relationships is heteronormative and dominated by caregiver concern about the age at which girls will enter into relationships with boys, and what this will mean for their futures. In the Latin American, Caribbean, and West and East African cohort countries, romantic relationships are strongly associated with pregnancy and marriage or unions. In most cases – including the South-East Asian countries where pregnancy and marriage is referred to less than the consequences of “love” for adolescents – a key concern is that girls' education will be negatively impacted by a romantic relationship. This may be due to pregnancy, a loss of interest in, or distraction from school, or a partner that forces or manipulates a girl into leaving education:



“[Do you have any worries about Mirembe?] She can be tempted by young boys around, now that she has started her periods ... I am worried of her being tempted by boys and she fails to study, yet I want her to continue with her studies.”

MIREMBA'S FATHER, UGANDA, 2019

Discussion of sexuality is relatively limited in the cohort data and in some cases the term “sexuality” is used or interpreted by participants differently from its official definition.¹⁶⁶ A minority of caregivers – most notably in Togo – acknowledge girls' sexuality, most often when expressing concerns around friendships with the opposite sex. This is based on an expectation that girls will innately become attracted to boys or men and this would inevitably lead to sexual relations. Where there is acknowledgement of girls' sexuality by caregivers in other cohort countries, it is again discussed solely in terms of heterosexuality and in relation to concerns about entering into sexual relationships too young and how this could potentially impact on their future:

“I am quite worried because Doris is very ... how can I say this ... wherever she sees boys, she gets restless, so I don't know if it's the same thing that she is interested in boys, so I am scared that she will mess things up too soon.”

DORIS'S MOTHER, EL SALVADOR, 2018

The majority, however, depict girls as the objects of male desire, rather than having sexual desires themselves. The girls themselves do not speak openly about their sexual preference, and to date have not been asked directly about this during the study.¹⁶⁷ In Cambodia and the Philippines, some girls express anxiety about their future, having been told that at some point men will be interested in them – there is a sense that this is one-sided, and something imposed upon the girls whether they like it or not:

“I think I can finish grade 12. [Are you worried about any obstacles which may prevent you from making it?] Yes. I am worried that I will be engaged with someone. [What makes you think so?] I am afraid that men will love me when I grow up.”

LINA, 12, CAMBODIA, 2018

“I know that when you're already a young woman, someone will start to like you. [Who?] Males ...”

RUBYLYN, 15, PHILIPPINES, 2021

While caregiver concerns about pregnancy, girls' reputation, and distraction from studies as major risks of girls' sexuality dominate the data, caregivers also share concerns about what is implied if adolescents don't show any expression of sexuality. Notwithstanding a desire to prevent or delay as far as possible any sexual activity, for both boys and girls, in some cases caregivers' express that integration with boys is needed so that they don't “become lesbians”. This concern is sometimes echoed by girls themselves; Michelle in the Philippines outlines how a girl's friendship with boys can be interpreted by others in two contradictory ways regarding her sexuality:

166. In Togo and Uganda legislation is in place that criminalises LGBT people. In El Salvador same-sex marriages and unions are banned. In Benin, Cambodia, the Dominican Republic, the Philippines, and Vietnam national legislation does not recognise same-sex marriage. Same-sex marriage is legal in Brazil.

167. This is due to a number of factors including time constraints for multi-thematic interviews, cultural sensitivities when discussing certain topics, and the age of participants. This will be integrated into future rounds of data collection.

“ [Do you have friends who are boys?] **None.** [Why don't you have any friends who are boys?] **I don't like boys, I like girls.** [Why don't you like friends who are boys?] **Because other people might think ...** [What would other people think?] **They might think I'm a lesbian** [What is in your mind?] **My mother would think I have a boyfriend.** ”

MICHELLE, 13, PHILIPPINES, 2019

03 THE INFLUENCE OF RELIGION

Although sex is not necessarily spoken of as immoral in religious terms by most of the caregivers, it is still deemed as taboo and is concealed in language around protection rather than around the concept of sexual wellbeing.^{168,169} However, in some of the cohort countries, religious institutions have a key influence on caregivers' approach to girls' sexuality, in particular in Benin, Togo, the Philippines and the Dominican Republic.

Lelem's grandmother in Togo (2021) uses teachings from the church to shape her own communication with her grandchildren on sex. Alice's mother in Benin believes that due to their church teachings, Alice has all the information she needs on SRHR. Alice (12, Benin, 2018) herself explains what she has been taught about SRHR at church: “[*How do you think that girls should learn about sex and pregnancy?*] *Our church teaches us that girls should remain virgins until they marry.*” Ladi in Togo (2021) reports being spoken to about SRHR at Koranic school.

The links between the “immorality” of sex in terms of religion are not referred to except for a few cases in the Philippines, the Dominican Republic, Uganda and Benin, where sex is explicitly prohibited and the importance of virginity and chastity are highlighted:

“ God always rewards patience. When you get married, God wants you to be pure, a virgin. I always talk to her about that, I say: ‘Whenever we go to an event, we're invited to a church, or if there's a wedding’. I say: ‘Look, she got married, can you see why she got married in church? Because she's pure.’ ”

DARIANA'S MOTHER,
DOMINICAN REPUBLIC, 2020

4.2 RISK MITIGATION PRIORITISED OVER SEXUAL WELLBEING

Overall, the cohort girls discuss SRHR education as a necessary tool to mitigate the risks they associate with puberty and sex. There is no discussion of sexual wellbeing or positive attitudes towards sexual health or pleasure in the cohort data, which may be a reflection of how this subject is addressed by schools, family and community members, as well as religious institutions where they report receiving information on SRHR.

4.2.1 SRHR dialogue as a risk mitigation strategy

For caregivers who view some level of SRHR education as necessary for girls, their reasoning for this is most often to ensure that girls can protect themselves from pregnancy and from GBV.

“ Generally, I also explain to her about life when she is growing up. I tell her about what she needs to do and how to protect herself when she comes into puberty. I tell her to try to take care of herself. ”

OANH'S MOTHER, VIETNAM, 2018

168. Such as sexual self-esteem, sexual self-efficacy, sexual self-concept, sexual agency, sexual arousal, desire and pleasure, sexual satisfaction, sexual assertiveness, positive body image, relationship communication, and absence of pain, anxiety and negative effects.

169. Plan International, Rutgers and Karolinska Institute (2021) *Young people's perspective of sexual wellbeing and consent: A Literature Review*, https://plan-international.org/uploads/2021/12/young_peoples_perspectives_of_sexual_wellbeing_and_consent_-_a_literature_review.pdf, accessed 4 April 2022.



Pregnant adolescent girl in Togo.
©Plan International

Likewise, the most prominent reason that girls report wanting to know more about SRHR is to avoid negative consequences of sex such as unintended pregnancy and sexually transmitted infections and “other bad things happening”. They believe that they can better protect themselves if they are more informed:

“I’d like more information on sexuality, it would help me when I start to go out with boys. I would know how to avoid pregnancy and sexually transmitted diseases.”

THEA, 15, BENIN, 2021

In some cases, particularly in the West and East Africa cohort countries, caregivers share being motivated to talk about sexuality and puberty by fears that girls may be “tricked” or “led astray” by boys or other peers if they remain uninformed. Some girls reiterate this reasoning themselves: *“Yes, they should be given as much information as possible so that they can avoid being tricked by boys”* (Isabelle, 15, Benin, 2021). For Isabelle in Benin, being more informed about SRHR also includes being equipped to respond to sexual harassment from boys and men in her community.

In some cases, like that of Tene in Togo, the girls reiterate similar discourses as caregivers around the role that SRHR education plays in teaching girls how to behave appropriately: *“Yes, it would teach me how to behave properly. [Do you think that girls should be taught about sex and puberty?] Yes, so they learn what is good to do and what is bad”* (Tene, 15, Togo, 2021). For caregivers who do speak to girls about menstruation before they start their periods, preparing girls for menstruation and bodily changes are also often strongly tied to risk.

Protected sex is discussed by some of the caregivers and girls, but it is rare in responses as a risk mitigation strategy in relation to sex in comparison with abstinence. When Stephany in El Salvador asked her mother about contraception, her mother said she was surprised and didn’t know what to say. However, Stephany’s curiosity did end up leading to a conversation about contraception where her mother explained that she was “on the pill” and how it works but that Stephany was not allowed to use it yet, as she was still a girl (12 years old); but her mother confirmed that Stephany could use it when older and in a relationship. The dialogue between Stephany and her mother perhaps illustrates how despite some initial reticence among caregivers to talk openly about SRHR matters, they are willing to engage, even when the subject

is considered difficult to broach. Discussions like these also potentially pave the way for Stephany to feel more comfortable when she is sexually active in coming to her mother for advice and for fostering more positive future dialogues.

Only three girls raised contraception when discussing if girls should be taught about sex and puberty. All three (Natalia in Brazil, Chesa in the Philippines and Tan in Vietnam, 2021) shared that condoms were a way for girls to take better care of themselves by being able to avoid pregnancy and sexually transmitted infections.

4.2.2 Risk is individualised

As evidenced, using SRHR dialogue as a risk mitigation strategy against “negative” SRHR outcomes for girls is common across the cohort. This information and advice communicated to girls on risk avoidance is heavily individualised; girls report being told to reduce their movement, stay away from boys and men, change their appearance, dress, and behaviour, all to protect their physical, and reputational, safety:

“[My mother told me] that you have to take care of yourself very much, very much when you get your period ... because there are times when ... Sometimes they say that we have to be careful with our body because of the drunk men.”

VALERIA, 11, EL SALVADOR, 2017

Even as the cohort girls enter later adolescence it is still deemed taboo to talk about sex with them and social norms in relation to conversations about sex continue to be rigid. As the girls get older, norms that regulate adolescent girls’ sexuality combine with conservative attitudes that oppose girls becoming sexually active before marriage.¹⁷⁰ This is demonstrated by caregivers’ discussions being focused predominantly on abstinence and staying away from boys and men: *“Parents encourage them to abstain because telling them more will lead them into having sex”* (Amelia’s mother, Uganda, 2021).

(i) Unintended pregnancies

The high value placed on abstinence is generally spoken of in terms of being for girls’ protection and thus it limits their mobility. The key advice given by caregivers to girls to prevent pregnancy is to avoid boys and not allow anyone to “touch” them. The language used by caregivers and girls conveys

a sense of fear of the potential outcomes that puberty brings and underlines the responsibility of girls to mitigate the risk that boys and men ostensibly pose to them.

Some caregivers like Dariana’s mother in the Dominican Republic (2018) focus on reducing girls’ interaction with peers who are regarded as a bad influence – those who are already in relationships and viewed as inappropriate in their behaviours and who may pose a risk to the girls themselves if they follow suit. Jacqueline’s mother in Benin (2021) has taken a similar approach, as Jacqueline (15) herself explains: *“I have grown a bit since I last saw you and I have started my periods. My mother told me to stop seeing certain friends who she didn’t approve of, they were friendly with boys.”*

Caregivers want girls to demonstrate “appropriate behaviours” to avoid unintended pregnancies, essentially allocating full responsibility for becoming pregnant to girls, and none to boys and men. A common belief was the girls should focus on their studies and ignore boys’ advances in order to avoid early pregnancy and secure their future:

“My daughter’s graduating classmate didn’t graduate because she got pregnant. He [the boyfriend] also did not graduate. That’s why, I always tell them to finish their education because look at our lives who didn’t study.”

MARICEL’S MOTHER, PHILIPPINES, 2021

“Yes, I have spoken to her about that [sex and adolescence], I have. It’s a subject that raises lots of issues and what she says is, ‘not me, dad, I want to study’. We make a few jokes, I tell her she’s not going to have a boyfriend, especially now that she’s bigger, ‘I won’t, dad, I want to get ahead’, but it comes from her.”

KAREN’S FATHER, EL SALVADOR, 2018

However, Saily’s mother (2018) takes a slightly different approach, acknowledging that it is impossible to separate boys and girls completely and that friendships with boys are acceptable *“as long as there is respect”*. She notes that prohibiting Saily from interacting with boys isn’t realistic but advises her to not be *“too trusting”*, not to let them touch her, and to not *“let it cross any lines”*. (Saily’s mother, Dominican Republic, 2018).

170. Buller, A.M., Schulte, M.C. (2018) “Aligning human rights and social norms for adolescent sexual and reproductive health and rights”, *Reproductive Health Matters*, 26(52), 38–45, DOI: 10.1080/09688080.2018.1542914

04 ABORTION DISCUSSION IN BENIN AND UGANDA

Abortion is rarely discussed by the caregivers or the girls, potentially because it is illegal or legally restricted in all cohort countries except for Vietnam, Benin and Cambodia. There are also no direct questions on it due to the legal restrictions and sensitivities around it in most of the cohort countries. Therefore, it is unclear what norms or attitudes are in play in relation to abortion, but in Uganda and Benin respondents refer to some discussions around abortion:

“One of my classmates who was 14 made friends with a young boy over Facebook. When they met up, they had sexual relations and she became pregnant. She wanted to have an abortion, but her parents and the boy’s parents wouldn’t let her, so she kept the baby.”

THEA, 15, BENIN, 2021

“I thank God that at least she [Joy’s sister] was not tempted to abort the child. Had she done that, I really would not have known that she slept with a man.”

JOY’S GRANDMOTHER, UGANDA, 2021

Respondents shared stories where girls have died while trying to abort, indicating the abortion is not considered a safe option: *“My sister had a friend who died recently while aborting”* (Amelia, 15, Uganda, 2021). Abortion in Uganda is legal in limited circumstances but due to unclear and complex abortion law, adolescents are forced to seek unsafe abortion. Approximately 85,000 women each year receive treatment for complications from unsafe abortion and an additional 65,000 women experience complications but do not seek medical treatment.*

“If they take their own decisions, it could be fatal for them. Here in the neighbourhood, we had the case of a girl who decided herself to marry my brother-in-law. When the girl became pregnant, the husband convinced with his first wife to abort the child and the girl died.”

MARGARET’S AUNT, BENIN, 2021

In 2021, Benin’s parliament voted to legalise abortion in most circumstances. The move has been ground-breaking in the region, which goes beyond the policy goal of the Maputo Protocol.** The Ministry of Health estimated that 15 per cent of maternal deaths in the country resulted from unsafe abortion.*** It is widely acknowledged that the new law could potentially save the lives of thousands of women, but steps will need to be taken for the implementation of the law to be fully realised and accepted within communities. As Catherine (16 in 2022) indicates: *“I heard at school that the government passed laws to encourage abortion, this saddened me a lot because, by aborting, children are killed.”*

*The Center for Reproductive Rights, the International Women’s Human Rights Clinic (IWHRC) at Georgetown Law, and the O’Neill Institute for National and Global Health Law (O’Neill Institute) at Georgetown Law (2016) Facing Uganda Law on Abortion. Available at: <https://www.reproductiverights.org/sites/default/files/documents/Uganda-Abortion-Law-Experiences.pdf>, accessed 8 April 2022.

** Partners for Reproductive Justice (2019) ‘Benin strengthens reproductive health and rights for women and girls’. Available at: <https://www.ipas.org/news/benin-strengthens-reproductive-health-and-rights-for-women-and-girls/>, accessed 8 April 2022.

***Ibid



(ii) GBV

In 2009 focus group discussions were conducted with adolescent relatives and neighbours of the cohort girls in Brazil, Uganda and the Philippines, and in 2010 in Benin, Togo and Vietnam. During these discussions and in the ongoing interview transcripts the prevalence of sexual violence – predominantly rape – was raised frequently as a specific threat facing adolescent girls in their daily lives, demonstrating that it is a community-wide concern across many of the cohort countries. Many grandparents highlighted in 2007 and 2008 increased anxieties around the risk of sexual violence for young female family members. The worries and anxieties around violence worsen in the later years of the data. Similarly to harassment, the threat of sexual violence is highlighted as an increased risk as the girls in the community get older. It begins to be referred to more frequently between the ages of 10 and 15 compared with the interviews when the girls were below 10 years old:

“I told Nakry, ‘You are mature, so you have to look after your body’. I tell her to wear bra, but she can’t. I told her not to be childish anymore. Local villagers tell their daughters to wear bra, too. I am afraid that Nakry will be raped.”

NAKRY’S MOTHER, CAMBODIA, 2017

“Because they don’t feel safe when they’re out on their own because of all these reasons, there are a lot of gang members these days, some men try to rape, try to grab them by force and sometimes we can’t defend ourselves.”

HILLARY, 15, EL SALVADOR, 2021

The volume of cases and stories of sexual harassment and violence in their communities meant that caregivers and girls also took individual responsibility to avoid sexual violence from taking place. In response to the increased danger as they age, girls reported feeling as if they had to change their own behaviour when they reached a certain age in order to protect themselves.

Even in cases of rape, it was deemed to be a risk that a girl should seek to avoid, and caregivers outlined normative expectations regarding what a girl should and shouldn’t do in order to avoid sexual violence: *“She should avoid moving late in the night – she shouldn’t move beyond 6pm in the evening, because she can be raped along the way”* (Rebecca’s mother, Uganda, 2021).



Both girls and their caregivers had devised strategies to help cope with the levels of violence and harassment present in their communities. Caregivers and the girls themselves had devised protective measures that included restricting the girls’ movements (particularly at certain times of day), travelling in groups or with a companion and avoiding males altogether. In some countries there were named areas that girls were not allowed to go to: in Uganda, the trading centre, dance halls and the borehole (at night) were named as areas that girls should not go; in the Philippines, the local beach was mentioned; and in Cambodia, a nearby forest: *“girls cannot go out at night, or they are raped”* (Davy, 13, Cambodia, 2019).

However, with all strategies, the onus is on the girl to protect herself from rape and other forms of sexual violence and assault. This narrative is very similar to the discussions around early pregnancy where the responsibility is also on girls to “prevent” violence and “protect themselves”: *“If a girl doesn’t protect herself from violence and abuse, she will get into problems”* (Sylvia, 15, Uganda, 2021). In Uganda, there were also comments from some of the girls that they had to be physically strong to be able to fight back when sexual violence did occur. *“[Is it important for girls to be strong and fit?] Yes, because it can help her when she in a problem for example if maybe someone wants to rape her, she can fight against them”* (Amelia, 12, Uganda, 2018). Some caregivers even advised their daughters not to go to the bathrooms alone while at school to prevent the risk of sexual violence.

4.3 SOCIAL AND GENDER NORMS

4.3.1 Norms and roles influencing caregiver–adolescent SRHR dialogue

There were clear gender roles in place between male and female caregivers in relation to talking to girls about SRHR. In most of the cohort countries, mothers and other female caregivers provide knowledge about menstruation, and caution regarding boys and sex appears to be the norm. Fathers participating in the study generally defer to the girls' mothers when asked about SRHR and indicate that this is tied to traditional gender roles by stating that this topic is a "women's issue". Fathers indicated that they didn't know about such subjects and that it was easier for females to talk about these things together. There is also a suggestion that norms dictating what is "acceptable" for men and women to address also limit father–adolescent communication on SRHR. Some participants explained that it is regarded as inappropriate for male caregivers to talk to daughters – and in some cases sons – about SRHR.

Sisters, aunts and female cousins are also cited as common and acceptable sources of information for girls. Dembe's grandmother (2021) explains that in Uganda the extended family is traditionally the primary communicator of SRHR information:

“It is a long-standing practice that it is always the aunt of the girl who is to speak to the girl about sex and puberty. [Why is this like that?] I think it is just our culture and also because parents feel shy to speak to their children but these days a few sensible parents talk to their children on their own without engaging others.”

DEMBE'S GRANDMOTHER, UGANDA, 2021

It also appears that sensitivity to social sanctions influences some caregivers' approach to discussing SRHR:

“I do not know if other parents ever talk to their daughters because they rarely talk about it. On the other hand, as a mother I think that if I'm talking about sex with my daughter, I'm afraid that the others will laugh at me.”

NAKRY'S MOTHER, CAMBODIA, 2021

4.3.2 Norms around pregnancy

Adolescent girls who are or have been pregnant are seen to transgress acceptable cultural and social norms and therefore judged to be “inappropriate” or a “bad influence” by both caregivers and the girls themselves. Caregivers and girls describe girls who got pregnant as wayward and dabbling in inappropriate behaviours: *“She liked smoking, gambling, so maybe that's why she got pregnant”* (Darna's aunt, Philippines, 2021). This kind of attitude seemed to play into norms that girls who got pregnant deserve it in some way or another:

“My old friend – she is lazy. She doesn't do her homework but waits and copies it from someone else. She became pregnant last year, she has already slept with a boy.”

NANA-ADJA, 15, TOGO, 2021

In Uganda, girls and sometimes caregivers perceived those girls who got pregnant as engaging in sex because they were disobedient, or because they or their families were “greedy” for material goods. Caregivers there referred to girls as “seducing men” in order to receive goods and money and girls echoed these sentiments: *“Some of them have poor reasoning because while home, parents are providing everything yet at the offer of a single chapatti, some girls give in to sex”* (Amelia, 15, Uganda, 2021). Several girls responded that they would not wish to be like girls who got pregnant early. However, a study by Plan International found that for many girls in Uganda receiving gifts or money from their boyfriends or partners was a normal expectation of being in a relationship and improved their sexual wellbeing.¹⁷¹

“There are four categories of people in this community that I don't want to be like. [What do they do?] There are girls who sleep around with boys, some of them went for early marriage, some got pregnant, and some eloped.”

REBECCA, 15, UGANDA, 2021

Girls also associated those who got pregnant with other problematic people in the community like “drunkards”.

171. Plan International, Rutgers and Karolinska Institute (2021) *Young people's perspective of sexual wellbeing and consent: A Literature Review*, https://plan-international.org/uploads/2021/12/young_peoples_perspectives_of_sexual_wellbeing_and_consent_-_a_literature_review.pdf, accessed 4 April 2022.

Rebecca's mother (Uganda, 2019) shares that even in cases of rape that result in pregnancy or sexually transmitted infections (STIs) it is the girl who will be laughed at by the community. Folami (Togo, 2021) who had a baby last year also mentions the negative sanctions incurred by digressing from community expectations to wait until marriage before having a baby: these take the form of gossip and isolation from girls in her community. She cites that she only hangs around with boys now as they were less likely to gossip and cause trouble for her. No longer having relationships with girls in her community meant Folami's mother (2021) had additional worries about her getting pregnant for a second time.

Folami's mother (2021) also shared that she had tried to support Folami to stay in school and offered to help mind her baby while she attended: *"I asked her to return to school as I am going to look after the baby but to my great surprise, she refused categorically"*. Folami's experiences

of social stigma seemed to outweigh the support that her mother could offer and her chances of potentially staying in school. Community norms around stigma and shame seemed to represent more of a hardship for Folami than actually having the baby itself.

Examples like that of Folami are seen across the Africa cohort data. Pregnancy is seen as the individual moral failure of the pregnant girl, and this carries social sanctions of shame for the girl and her family. The ultimate value is upon maintaining honour. However, in the other cohort countries it was more common for people to consider this situation as "sad" because of the effect it had on a girl's educational outcomes and aspirations:

“They continue studying but it's not the same, because they soon get pregnant and don't stay on at school.”

SHARINA'S MOTHER, DOMINICAN REPUBLIC, 2018



*Girl in Philippines
peers through the
window of her house.*

©Plan International

05 EXPERIENCES OF PREGNANCY, ASPIRATIONS AND PARENTAL VIEWS



As of March 2022, four of the cohort girls were pregnant or had had their child. Folami (Togo) and Griselda (Dominican Republic) had their babies at 14, Hillary is pregnant at 14 (El Salvador) and Doris is pregnant at 15 (El Salvador).

Both Griselda and Folami describe a great change in their lives, after having had their children. They both see less of their friends and have increased household responsibilities. Folami says the baby has helped her to grow up both physically and mentally, however she also expresses that she regrets becoming pregnant or she would still be at school. Griselda says that she was frightened when she first found out but says she is happier in her new life and enjoys being a mother. She also says that she is financially better off since moving in with her partner.

Folami, Hillary and Doris have dropped out of school. However, Doris had dropped out prior to the pregnancy. Griselda missed out on school due to the pregnancy and is behind but has decided to re-enrol in school – a night school as the school would not let her come back during the day. Griselda expresses that the ability to study remotely during the COVID-19 pandemic has made it much easier for her and she would like to continue with online lessons. Her close friend or husband looks after the baby when she has her school lessons.

Doris says that she is happy since learning of her pregnancy, but it is difficult: she and her baby's father have split up and she is seven months pregnant. She says that when he found out she was pregnant, he left her for someone else. Doris says she was upset at first but now she is looking forward to being a single mother and believes it will be easier as she will not have to do things for her husband.

Hillary did not bring up her pregnancy during the interview.

Aspirations

Folami's aspirations have changed since her pregnancy and she would now prefer to learn a trade and become a seamstress like her mother. Her mother wishes that Folami would stay in school and become a school principal.

Hillary didn't have clear aspirations for the future and said maybe she would like to do hair braiding.

In 2021, before she was pregnant, Doris said she envisaged a union and motherhood five years in the future.

The birth of Griselda's son seems to have made Griselda more determined: *"I want to get ahead to make something of my life"*. She is ambitious and wants to become a doctor, potentially a surgeon. She said her friend who is a doctor has inspired her. In the meantime, she says she will study and work in a betting shop to make ends meet. She saw herself in five years' time having her own house, job and maybe going to university.

Family dynamics

Folami mother's regrets that she got pregnant but mentions some positive effects such as her listening more and having more patience. Her mother is supportive and helps to look after the baby.

Griselda seems also to have a supportive family, although her sister is sad about her having a child. Her father gives her money for the baby and her birth mother helps her and advises her but lives far away. She also still has a close relationship with her grandmother. However, her stepmother (who has moved to Spain for work but sends remittances) will no longer speak to her since the pregnancy.

Hillary's mother expresses regret at the pregnancy because now she is not finishing her education but does say that she is growing up and more focused since marrying. She also says that she is mainly sad because Hillary used to help her with the housework and help look after her little brother. Hillary also had a job and she used to give half her earnings to help the family. Hillary mother says she is well-off in her union and brings her family food to help.

Doris' mother was angry when she first found out but is coming to terms with the pregnancy.

4.3.3 Norms around GBV

In many discussions, harassment was something that was normalised in many communities and many of the girls attempt to shrug it off as something that happens: *“You know what men are like when they’ve had a couple of drinks, they say all sort of things to women. [Do you think it happens because of the drinks?] Yes, mostly [laughs]. Haven’t you been harassed?”* (Griselda, 12, Dominican Republic, 2018). Sometimes damaging gender norms were reinforced by the girls and their caregivers. In many instances, it appeared that people think that harassment and sometimes even violence was something that girls allowed to happen: *“Girls should control where they go and learn how to conduct themselves to avoid being victims of violence”* (Alice, 15, Benin, 2021). Even where caregivers had previously discussed the pervasiveness of sexual violence and harassment present in the communities they lived in, it was still seen that girls could merely avoid being groped and harassed. Girls also echoed that they could avoid GBV by demonstrating the right behaviours and being well informed: *“My teacher even taught me about how to avoid pregnancy, and rape. It is very important for us to be well-informed because it prevents us from being raped”* (Davy, 12, Cambodia, 2018).

There was also evidence of a culture of damaging attitudes towards girls which often conflated sexual violence with early pregnancy (by choice) and blamed girls for a perpetrator’s actions. Annabelle’s father (Benin, 2018) mentioned that women provoke men by dressing in jeans or short dresses and wearing lipstick.

Sexual violence was seen as something that brought shame to the girl: *“Like if a female is raped, they may not report it because it’s shameful”* (Amelia’s mother, Uganda, 2017). It also was seen as shameful for her family rather than something that lay with the perpetrator: *“There was a 15-year-old girl who got into trouble of pregnancy and her grandfather felt embarrassed about her because she was violated by three boys. Therefore, I felt worried when she was growing up to that age”* (Tien’s grandfather, Vietnam, 2018).

Harmful norms around intimate partner violence (IPV) were also present in some of the cohort countries and these are brought up across the different years of data collection. In Benin and Uganda, rigid gender norms are demonstrated where women are expected to obey their husbands and seek permission to do certain activities. When they stray from these expectations, they are sanctioned. Isabelle’s

mother (Benin, 2015) mentions that she will be beaten if she asks her husband about household finances such as savings, as this is deemed a man’s domain. She confirms that the community would support his reaction as women should not ask such questions of their husband. Violence is used as a way to exert control and ensure that women do not deviate from society’s expected gender roles: *“Some families in our community experience such violence especially between husband and wife – for example, when a wife fails to seek permission while going somewhere”* (Beti’s mother, Uganda, 2021).

Community norms around gendered dynamics of males managing income in a household and harmful masculine behaviours of men having multiple partners seemed to increase experiences of violence among the cohort:

“The year wasn’t good for me as a person. My husband wanted to chase me. He beat me up. He wants me to go away from this home. He married another woman. However I do all the farmwork. When I grow my maize, he takes it away ... He put me out of the family shop and instead put that other woman he married. Yet the money that we started that shop with was given to us by my own mother.”

SHEILA’S MOTHER, UGANDA, 2012

Namazzi’s mother (Uganda, 2017) also describes a number of violent encounters with her partner who married another wife. She explains how her garden was given to the new wife to harvest food and when she complained about this, she was beaten, so she stopped complaining. A couple of years later in another interview, she continues to blame herself:

“Yes, he will come back because we never divorced, and I still consider him my husband. Men are difficult to understand ... I think he got fed up of my continuous health challenge of being sick.”

NAMAZZI’S MOTHER, UGANDA, 2021

Discriminatory beliefs which value women as wives and mothers rather than individuals are present across the cohort; Namazzi’s mother saw herself as not living up to the ideals of womanhood due to her long-term illness and saw this as an acceptable explanation for why her husband was violent and eventually left.

These harmful norms around violence are worsened by community sanctions when wives lose “honour” by being left by their husbands:

“I often hear men threatening their wives ... I feel sorry for these women because it’s not honourable to be thrown out and become single again” (Eleanor’s mother, Benin, 2017). Norms like this make it more difficult for women to go to the authorities to report violence and ultimately make it very difficult for them to leave violent partners.



06 THE LACK OF INSTITUTIONAL JUSTICE

The norms around GBV across the cohort countries were often bolstered by a lack of justice for girls: ***“Girls that have experienced violence do not receive justice. The rights of children in this community are not protected”*** (Dembe, 15, Uganda, 2021). Responses in Uganda pointed to frustrations with the authorities regarding sexual violence in their communities, saying that authorities are aware, but nothing is actioned and violations against girls have worsened during the COVID-19 period. Joy’s grandmother (2021) also pointed to parents not following up on these kind of cases: ***“Some parents and guardians do not care about following up such cases [in relation to the rape of a 15-year-old in the community] to the extent that they may say, ‘I have had enough of this girl’.”*** It is unclear whether parents and caregivers do not follow up because they know it will not be actioned or due to the shame and stigma around sexual violence in these communities.

Shifa (15, Uganda, 2021) shared a story where a girl was impregnated by her brother-in-law, but no action was taken against him; instead she was returned to her parents’ house. Although caregivers and girls did point to some systems in place to deal with such matters, these systems revealed a clear implementation gap, where a crime like rape which should be dealt with by the police was seen as a “women’s issue” and was therefore left with female councillors to deal with.

Similarly, one of the families in the Asia cohort noted a lack of action by authorities. They filed a complaint with the authorities against an older man in the village who had sexually abused the cohort girl and her sister. The father (2012) explained the response from the local authorities regarding the case: ***“They***

just suggested ... to just forget about it as the old man is not really from here and has returned back to his hometown.”

There were sometimes examples of justice for girls, but this was rare in the data. For example, in El Salvador, two caregivers spoke about sexual abuse cases against girls where perpetrators were brought to justice and imprisoned although one of the caregivers expressed surprise at this result.

Some caregivers in El Salvador described not wanting to go to authorities for fear of gang reprisals. Susana’s mother (2014) shared a story where she was nearly choked to death at the hands of her partner but confirmed that she did not call the police as it was too big a risk due to the presence of gangs in the area; instead the neighbours took him away and she hasn’t seen him since. In 2019, El Salvador had the second-highest femicide rate in Latin America and Susana’s story exposes the challenges of reporting GBV. Similarly, Karen’s mother (El Salvador, 2021) describes the presence of gangs who “know everything” as a reason for not reporting a frightening incident of someone sending her videos of Karen on Facebook and threatening Karen: ***“they told me that they knew where she studied and all that ... I told the teacher if her dad or I don’t come, don’t let the girl go out. We got quite scared. This went on for about six months. [Haven’t you reported him to the police] No, because I’m afraid that if he’s someone we know and we report him, something could happen to the girl.”***

In many of the cohort countries, laws aimed at protecting women and girls are ineffective. However, access to justice needs to be part of a wider socialisation around norms around violence against women and girls.

4.3.4 Heteronormativity and homophobia

Homophobic attitudes are prominent in the data, with both caregivers and girls using derogatory terminology to describe individuals who do not adhere to acceptable gender norms. In this way, it is not always clear if participants are referring to an individual's actual sexual identity or demonstrating a strong association between sexuality and gender roles wherein transgression of norms is understood as an indication of homosexuality. This is particularly visible in the cohort data from the Philippines and Vietnam where girls describe some of their male friends and male family members as "gay".

In 2012, Christine's mother (Philippines) describes how Christine's brother's behaviour is interpreted as an indication of his sexuality:

“For me, he's not gay; he just moves like a gay. He doesn't seem to be gay. I asked him if he's gay. [He's not?] No. He just seems to be gay because he's good at dancing ... People look at him; his body's gay.”

CHRISTINE'S MOTHER, PHILIPPINES, 2012

She discusses actions they have taken to prevent Christine's brother from becoming homosexual, for example, teaching him to fetch water so he doesn't become "gay".

In 2018, she repeats these attitudes with Christine: **“She takes a bath and combs her hair. But she's not too complicated. [So, she was complicated before?] Not really, she was like a lesbian before [How?] She acts like a boy.”**

Christine herself repeats some of these ideas in 2021: **“[What did you think of Jen in the story?] Lesbian. [Why did you say that Jen is a lesbian?] Yes, because she likes the game of basketball. [Aren't there any girls who play basketball in the barangay?] No, all I see are boys.”** (Christine, 15, Philippines, 2021).

For Amelia in Uganda, a girl dressing in traditionally boys' clothes and playing with boys means that she might be identified as transgender by others in the community: **“Perhaps to some extent it helps her because a boy may fear her thinking she is transgender. [In which way does this help her?] Boys cannot bother her so much”** (Amelia, 15, Uganda, 2021).

There is an overall sense that homosexuality is negative and something that can and should be prevented by caregivers in their upbringing of children. In some instances, there also appears to be a conflation between gender identity and sexuality made by caregivers who interpret girls' – as well as boys' – behaviour that challenges gender norms as an indication of their sexuality. The cohort girls themselves have not disclosed any questioning of their gender identity nor did they label their sexual orientation during interviews. Dariana's father (Dominican Republic, 2019) points to parents' responsibilities to monitor girls' behaviours that he believes can lead to a change in sexuality, insisting that boys must be boys and girls must be girls. For him, allowing girls to behave like boys or men is how they become “homosexual” and parents need to watch out for these behaviours.

Similarly, in 2021, Reyna's mother in the Philippines said that Reyna had told them that she identified as a boy – Reyna does not mention this in any of the interviews. There is an assumption then made that being a “boy” means being a “lesbian” and that this can be “changed”:

“She said something to us, even though we didn't agree. [She said what?] That she's a boy. (Laughs) [Reyna? How was it when she told you that?] Oh! I don't believe she's like that, but I can't do anything if she's really being like that, a lesbian, but as much as I can change her, I'll do it. Because people like that ... you can change whether you are a man or a woman, that disease is in your mind ... Well maybe she just followed her sister who is also a lesbian ... She only told her mother once ... that ... she said she's a lesbian and has a girlfriend oh!”

REYNA'S FATHER, PHILIPPINES, 2021

Despite saying that he will try to change Reyna, the main concern for Reyna's father appears to be rooted in his belief that homosexual relationships carry implications in terms of having children. Cultural norms indicate that children will take care of their parents when they are older, and he worries that his daughter will suffer with no children to take care of her when she is old.



Concerned about bullying, Fernanda's father advises her to change her appearance to be more in line with what is regarded as "acceptable" for girls:

“ [She prefers wearing boys' shirts?] Yes. Shirts, because she likes playing ball a lot, and people started saying things. [About her shirt?] Yes, because she only wanted to wear that, and then I said, my daughter, you're a big girl now, try to wear nice clothes. Because the other girls started talking, kept teasing her, like, hey, girl, are you going to be a dyke?¹⁷² And she got angry. ”

FERNANDA'S FATHER, BRAZIL, 2018

In Vietnam (2014 and 2015), some of the cohort girls outline similar interpretations of "unacceptable" behaviour for boys and girls. These types of attitudes start when the girls are young (eight and nine years old). Trinh and Oanh share comments around gendered stereotypes such as only boys can play football, girls who play football are lesbians and boys who play skipping or with teddies are "gay". Hang (2014) also demonstrates these sentiments: *"I think only females play with dolls so if boys play dolls, they might be gays and I will not make friends with them."* Hang's comments indicate that these types of opinions are something that she is overhearing rather than understands: when asked what the word "gay" means she is unable to explain it and says she only knows it through television.

In the Dominican Republic, participants discuss how boys who carry out domestic chores are labelled, or fear being labelled, as "gay". During a life history interview, Leyla's father describes his experiences:

“ Wash dishes ... they said I was gay, because I washed up, cooked and looked after my brother and sold things in the shop. [How old were you at the time?] From seven to nine years. ”

LEYLA'S FATHER, DOMINICAN REPUBLIC, 2011

Dariana's mother also talks about how these norms have impacted on her son and how she challenges these expectations:

“ I have the boy washing the dishes, also sweeping inside the house but he cries, and tells me 'I am not gay'. I tell him doing chores is not only for girls ... I tell him that the day you finish school and move into your own house, you will rot due to the dirt in your house, and then he gets quiet. He is 11 years old. ”

DARIANA'S MOTHER, DOMINICAN REPUBLIC, 2015

4.4 CAREGIVERS FEEL ILL-EQUIPPED



It is clear that while there are distinct policy and cultural contexts and prevalent norms across the nine cohort countries that are influencing caregiver attitudes and behaviours towards SRHR education, caregivers also experience common challenges when it comes to communicating about SRHR with their daughters: What should I tell her? When should I tell her? What will be the outcome of her receiving this information?

Often caregivers are faced with navigating social taboos surrounding the discussion of sex. When explaining why they have not talked to the girls about SRHR, caregivers explain that they fear that by talking to girls about sex it will encourage them to have sex. The older the girls get, the more aware caregivers appear to be that this may not be an effective approach. Here instead, it is possible to see the core challenge that many face: a lack of personal knowledge about SRHR themselves. Roumany's sister and Bopha's great-aunt in Cambodia comment on the limitations they believe "other" caregivers experience in relation to SRHR dialogue:

“ There is usually no ban on talking about it, but it has to do with one's knowledge and shyness. ”

ROUMANY'S SISTER, CAMBODIA, 2021

“ I think that 90 per cent have never spoken to their daughters about sex and puberty because they are not educated and do not know about this issue. Moreover, they never knew that information and they weren't interested as they only go to work at field. ”

BOPHA'S GREAT-AUNT, CAMBODIA, 2021

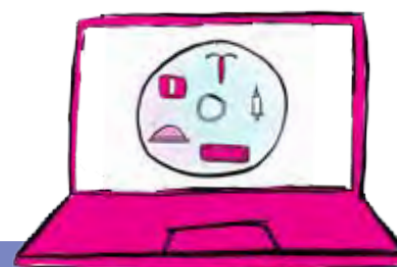
172. Translator's note: he uses the word "sapatão", which in Brazilian Portuguese is a sexual slur.

Nguyet's mother admits that she feels as though adolescents are more informed than parents on these issues, which is likely to lower her confidence and have a significant impact on how and what she communicates to Nguyet: *"To be honest, I am a mother, but I do not know about that as much as the kids nowadays – they know more"* (Nguyet's mother, Vietnam, 2018).

For some cohort caregivers, school SRHR education is viewed as a supplement to the information they communicate to their daughters themselves, while others suggest that because they believe that girls have learnt about it at school, it is not necessary for them to address SRHR issues with them:

"I never talked to her about sexual and reproductive health, but she did get knowledge from school ... The knowledge she has gained is enough. I want my child to know more so that she can take care and protect herself ... I never talked to her about sexual health because I thought it was unnecessary. Also, she was shy and did not dare to talk."

NAKRY'S MOTHER, CAMBODIA, 2021



07 INTERNET AS A KEY SOURCE IN VIETNAM

In 2021, girls and caregivers in Vietnam talk about the role that the internet and social media play in informing girls about SRHR. Hang (2021) explains that she has carried out research on menstruation online for a school presentation: *"... on the internet, I mainly learn about what to do in the case of a woman's period ..."*

Thom (2021) describes that even though she has been taught about SRHR at school and at home she prefers to learn about it on the internet due to the breadth of information she can access there: *"I will ... search on the internet and pick up the information that is suitable for me. [Why do you choose the internet but not your teacher or mother?] Because I find the information on internet quite wide, wider than my questions."*

Thom's mother is aware that she accesses information on SRHR online but thinks it is just basic information and not sufficient enough. In the past (2019), Thom's mother reports using online information to help teach her: *"[Where do you think she gets information from about her health and her body?] From me ... she often asks me 'why is that?' ... When I am busy, I download the information from the internet ... I let her read it ... then she understands ... she can protect herself."*

Hoa's father (2021) also reports using the internet to access educational information on SRHR: *"My wife often talks*

confidentially and confides in our daughter every day. My wife mentions stories about puberty and reproductive health when talking about other daily stories. [Where do you often get this information?] We often get this information from the internet."

Sen's mother (2021) isn't sure what Sen has been taught at school and while she speaks to her about SRHR, she thinks that Sen does not want to speak to her parents on this topic and isn't entirely sure where she gets this necessary information from. She believes that she accesses it from her mobile phone as girls may prefer to learn about this elsewhere.

For some fathers, the internet appears to be a good source, though not a sufficient alternative to addressing sensitive subjects with daughters: *"Children are very flexible now and there is enough information on the internet. There may be classes of sex and the reproductive health at school. [Are there any activities in the commune for her to get this information?] No, there aren't. She mainly gets information at school or on the internet. [Do you think she has enough information about her health and her body?] I don't think she has enough information. She is developing now ... It is good if parents can speak to their daughters about these topics. However, in fact, I think it's still hard for parents to speak to children. I find it quite difficult to speak to my daughter..."* (Hoa's father, Vietnam, 2021).

4.5 INTERGENERATIONAL DYNAMICS OF SRHR

4.5.1 Impact of caregivers' own experiences on SRHR dialogue

For many female caregivers, the priority is ensuring that girls do not repeat the negative experiences that they themselves encountered as adolescents and young adults. Others report that behaviours related to romantic relationships have changed for the worse since they were adolescents. What is clear is that most caregivers regard their approach to parenting, including the advice they give and the restrictions they impose, as an important influencing factor on outcomes for girls.

There are, however, a number of female caregivers who discuss their own negative experiences of being unprepared for menstruation, but do not provide their own daughters with any information either. It is clear that some caregivers themselves feel unprepared even as adults to discuss this topic and are unsure what to tell girls: *"It was a bit difficult for me because I didn't know that at that age ... I didn't expect her to get it when she was still so young"* (Sharina's mother, Dominican Republic, 2018). Valerie's mother (2017) in the Dominican Republic describes not having the experience of a mother raising her and not having anyone to go to for advice around SRHR which ultimately affected how she passed down advice to her own daughter: *"when my daughter developed, I didn't even notice. When she got her period, I did not realise."* Jocelyn's mother (2019) also shares that she did not notice the first time her daughter menstruated because Jocelyn hid it from her, which she guesses was from embarrassment.

Stories like this demonstrate the need for multiple avenues for girls to talk about SRHR. Patricia in Brazil (11 in 2017) demonstrates the importance of SRHR education in school, in situations where family members do not, or are not able to, prepare girls for menstruation themselves:

“ [And did you know what it was when it happened?] Yes, I did ... No, she [my mother] hadn't talked to me [about it]. [But did you know what menstruation was?] Yes, I did ... My teacher, at school, she had explained it to us. [And what did you say to your mother?] That I'd had my period ... She was surprised. **”**

PATRICIA, 11, BRAZIL, 2017

A key influencing factor in caregivers' approach to SRHR was that female caregivers did not want girls to repeat their own experiences specifically of early and forced marriages or unions and adolescent pregnancy. Green et al. (2019) state that norms in relation to CEFMU can affect women negatively both physically and mentally in ways that have broader lasting impacts. Some of the caregivers shared experiences of traumatic childbirth experiences which they could not forget. Many of the mothers and caregivers expressed regret over these experiences of child marriage and early pregnancy and wanted different outcomes for their daughters or female relatives:

“ I was naïve, I didn't go to school and that's why I got married very quickly. I want Essohana to go far in her studies before she becomes a wife. **”**

ESSOHANA'S MOTHER, TOGO, 2018

“ I had my first daughter when I was about 13 ... He must have been 50-something because when I got together with him, he had like eight children... I wouldn't want her [Valerie] to have the same experience, no, because the reality is that you suffer, you have a tough time. **”**

VALERIE'S MOTHER, DOMINICAN REPUBLIC, 2018

Many caregivers often associated unhappiness with having married young: *"I don't want her to be miserable like me. I got married early because I quit school early"* (Sen's mother, Vietnam, 2021). Caregivers also correlated marriage with ending certain freedoms in ways that are potentially linked to norms around motherhood and what is acceptable for mothers to do once married. Christine's mother (2021) in the Philippines regretted getting married early and said it was important that Christine enjoys herself first as once she is married, she will no longer be "allowed to do things anymore".

The negative consequences of early marriage and adolescent pregnancy were frequently spoken of in relation to stopping educational opportunities:

“ I tell her all the time, because young people these days get carried away by feelings, they get married, and all that happens is that they throw away their education. **”**

SHARINA'S MOTHER, DOMINICAN REPUBLIC, 2017



Mother and daughter in Uganda.
©Plan International

In Latin America and the Caribbean, the cohort girls also demonstrated this awareness and were generally in agreement with their mothers' depictions of the negative consequences in relation to their education:

“I think it was very wrong for her ... to have me at 15... she didn't even finish her studies, she didn't go to university. I think she should have finished her studies and gone to university before having a relationship.”

JULIANA, 12, BRAZIL, 2018

Caregivers emphasised how they wanted their daughters to be successful and have better life prospects, and they viewed marriage and pregnancy as a barrier to this. This outlook seemed to sometimes influence the protective approach they had with their daughters in terms of relationships with males. Caregivers perceived relationships with males as a risk and thus this perception perpetuates gendered norms in that they are monitoring their girls' behaviours and curtailing their movements:

“When my mum raised me, she was working so she would leave me on my own. That's how I got a boyfriend at a very early age and then I moved in with him. And then I regretted it, that's why I tell Hillary that she should take care and not get involved with guys, because she is so young ... That's why I say it's different because I don't go out to work so as not to leave her on her own. If I leave her on her own, I am sure she will do something worse.”

HILLARY'S MOTHER, EL SALVADOR, 2018

Many of the caregivers also shared past experiences of sexual violence and abuse and in some cases the cohort girls themselves had also witnessed sexual abuse or had themselves experienced abuse. Caregivers express fears around daughters having similar negative experiences and trust is limited even between their own family members. This was particularly evident in the Latin America and Caribbean and the Asia cohorts: *“As a mother I am always advising her. I tell her don't let anyone lay a hand on you, on your parts, not even your dad”* (Madelin's mother, Dominican Republic, 2016). In Vietnam, Uyen's grandfather also warned her about trusting relatives and would not let a male cousin bring her to school due to fear of her being raped. Some caregivers in the Latin America and Caribbean cohort also expressed concern when the girls' mothers were dating new men, as this seemed to bring an added danger. For example, when Saily was as young as five, her grandmother discussed these fears:

“I hear on the news that husbands rape their wife's daughter who is not their own, many even rape their own daughters, and I am afraid of her living with her mother for that reason. I have that fear, that's why I always want her to live with me because I look after her.”

SAIDY'S GRANDMOTHER, DOMINICAN REPUBLIC, 2012

Susana's grandmother also expressed concerns over the way that the new boyfriend of Susana's mother looked at her granddaughters. She noted that one day at her house he had grabbed Susana inappropriately and noted *“at my age you don't make mistakes”*. She noted Susana's reaction that something was not right and that her mother hadn't noticed as she was intoxicated. Three days later her grandmother agreed with Susana's paternal side of the family to keep the girls in her care.

Caregivers in all the cohort countries apart from Togo discussed experiences of intimate-partner violence. Alcohol is mentioned in Vietnam and some of the Latin America cohort as escalating male violence: *“There was domestic violence because I was drunk and could not control myself, but it rarely happened ... I felt sad and ashamed”* (Hoa’s father, Vietnam, 2013). However, it is clear that harmful social norms are present and also act as a catalyst for violence (see [section 4.3.3](#)).

Some of the caregiver sample also mentions being exposed to IPV at home. In 2011 and 2012, some of the caregivers report through their life history interviews experiencing a violent childhood with unequal power dynamics in the household. Then later caregivers describe entering into violent relationships themselves:

“They used to fight, he drank a lot and he used to hit my mum. They didn’t respect each other, and it scared my siblings and me when they fought because they used to say to each other that they were going to kill each other. [Did you go to school, how old were you when you finished school?] Yes, I studied until I was 13 ... I was starting 7th when I started going out with someone. From then on my life changed because he used to hit me and he was very jealous.”

RAQUEL’S MOTHER, EL SALVADOR, 2012

Experience of unequal gender norms and exposure to violence as a child seemed to perpetuate intergenerational transmission of violence later in their lives.

It is notable that while caregivers describe their own negative experiences and express fears for their daughters around adolescent pregnancy, CEFMU and GBV, this is rarely translated into open discussion with girls about fostering positive intimate relationships, sex or contraception.

4.5.2 Breaking the cycle

A small number of caregivers do, however, discuss more positive approaches to communicating with girls about SRHR in a way that is often tied to a desire to break the generational cycle of negative experiences.

Some female caregivers, in Vietnam in particular, explain that their mothers did not speak to them about menstruation when they were younger, but that they see the importance of discussing it with their own daughters, approaching the topic differently to the previous generation:

“Yes, when we have a bath together, I show her what changes could be and the menstruation and tell her how to care her body. At grade 6 some girls have their periods but not Huong. My mother didn’t tell me that as she was busy with her business.”

HUONG’S MOTHER, VIETNAM, 2017

Thom’s mother (Vietnam, 2021) also attempts to normalise periods with her daughter, telling her it is a “common phenomenon” and “nothing scary”. Some caregivers, from Brazil, Viet Nam, and El Salvador, also describe taking a positive approach to discussing and preparing the girls for menstruation. Often, these caregivers refer to the fear and anxiety that they know girls can experience when faced with their first period and want to prevent this so they know what to expect:

“She is afraid because it has already happened to her sister, then she is afraid. But I say no, it’s normal. It happens to all girls, and they learn to use tampons.”

FERNANDA’S MOTHER, BRAZIL, 2017

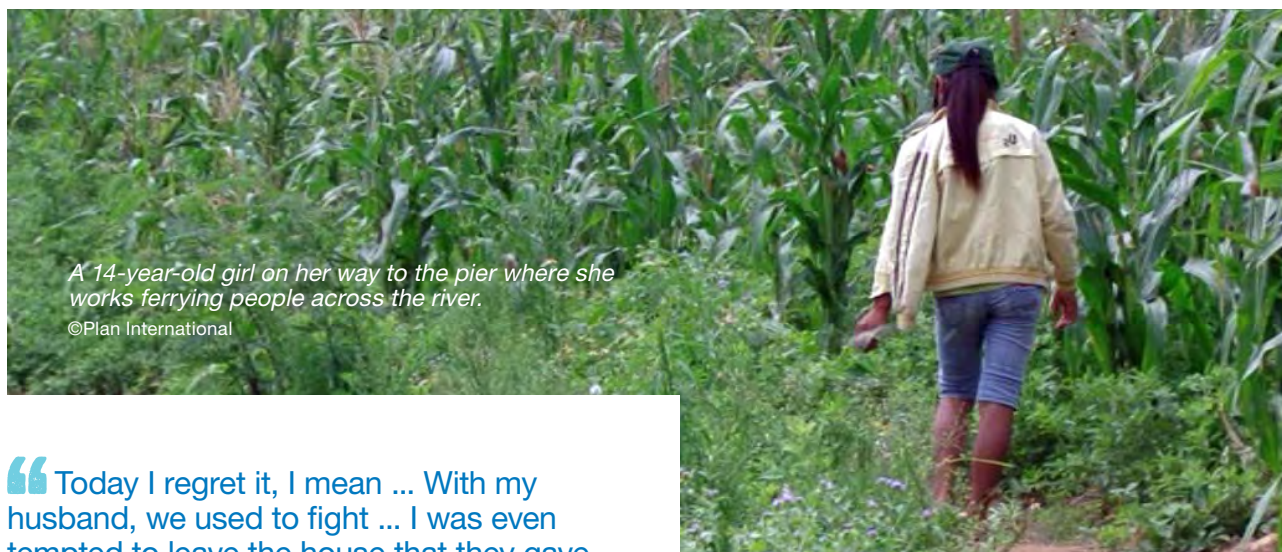
In some cases, however, the information they want to communicate to girls about menstruation may perpetuate myths associated with periods – as Natalia’s mother in Brazil illustrates:

“I think they [school] should teach them, explain things to them, because there are many of them who are scared, right? Because we don’t really know anything, then suddenly it happens, and everybody gets scared, dear Mary. But here, at home, I always tell them, right? What’s going to be like when their time comes, and when it happens they must tell me, because then you can’t eat this, you can’t eat that.”

NATALIA’S MOTHER, BRAZIL, 2017

For Hillary’s mother in El Salvador, her regret at entering a union at 13 years old where she was subject to abuse influences how she communicates with her daughter about SRHR issues. This leads Hillary’s mother to speak more openly with her daughter:





“Today I regret it, I mean ... With my husband, we used to fight ... I was even tempted to leave the house that they gave me because of how he treated me ... I tell her to take care of herself, that she should not move in with someone so young. That’s why I advise her, and I tell her a lot, frequently I tell her, so that she doesn’t pay attention to any man who is just going to trick her. Because I tell her that she can move in with someone or get married when she is 20 years old or older ... That she takes care of herself so that she gets to that age because I was really young when I moved in with someone and it creates suffering ... Because there are lousy men who tell you that you can’t do anything, and I tell her that it is better for her to keep thinking a lot, that she studies so that she can get to an older age, an adult.”

HILLARY’S MOTHER, EL SALVADOR, 2016

Stephany’s mother in El Salvador (2018) also notes that she got into a relationship too young (13 years old) because she never had anyone to talk to her and give her advice. She makes a point that now as a mother she advises her daughter as she wants her to enter relationships much later than she did. Similarly, Juliana’s grandmother (Brazil, 2017) highlights the importance of open communication about relationships and dating for girls to avoid making decisions that they may later regret, linking her own negative experiences to the lack of closeness and poor communication from her own mother. She noted that her mother never spoke to her about SRHR, in particular never addressing intimate relationships, and while her mother did provide “everything she needed”, she explains that the lack of this support in her own adolescence leads her to always try to sit down and talk about these issues with Juliana (11 years old).

4.6 GENERATIONAL CHANGES

4.6.1 Perceived changes in girls’ behaviours

Examples from Vietnam, Togo, Uganda and the Dominican Republic show that not all caregivers are concerned about girls repeating their own past experiences, but rather they are critical of negative changes that they have noticed in society which may lead girls to make the “wrong” decisions. Sen’s mother (Vietnam 2016) mentions differences in adolescent behaviour from when they were teenagers:

“Each generation’s behaviour is different, so we need to keep an eye on it ... If girls now are given too much freedom, they will hang out with their boyfriends immediately. We were the same at that age but the teenagers at that time didn’t dare to cross the limits, now they do.”

SEN’S MOTHER, VIETNAM, 2016

Lelem’s grandmother in Togo similarly comments on generational changes in adolescent approaches to relationships:

“Girls no longer introduce their boyfriends to their parents. This is a negative change; in the past a boy would come to the house so his future in-laws could get to know him, and he would be respectful to them if he met them in the street”

LELEM’S GRANDMOTHER, TOGO, 2021

Some caregivers see generational changes in parenting approaches as a key factor in influencing negative outcomes. Sheila's mother in Uganda (2021) states that softer parenting approaches with girls is enabling them to enter relationships at a young age as they are allowed too many freedoms. Saidy's grandmother (2017) in the Dominican Republic echoes similar views:

“... when I was growing up, girls would never go out without their mum. These days mothers let them go out on their own. Before they didn't give them so much permission to go around with boyfriends. I don't raise mine like that, I am sorry, but I can't raise them that way ... I didn't give my daughters permission to come and go as they liked ... After 6pm, Saidy is here with me ... I can't go to bed and leave Saidy out on the street; that is what is happening more and more with girls today, who get pregnant at the age of 12 and 13 because their mums go out whenever they like.”

SAIDY'S GRANDMOTHER, DOMINICAN REPUBLIC, 2017

Hoa's father (Vietnam 2018) suggests that there has been a change in society regarding girls' and women's sexuality, stating that nowadays too many young people have sex at an early age; so he prohibits Hoa from meeting with boys. Azia's mother (Togo 2021) also reflects that women and girls are too sexually free these days: *“A negative change has been that girls and women are familiar with sexual promiscuity and a love of money which devalue women.”* She seems to allude to girls exchanging sex for money without acknowledging girls' economic vulnerability and poverty as being at the core of this issue.



A young woman hangs up washing to dry outside her home in the Dominican Republic.

©Plan International

4.6.2 Changes in their communities

Caregivers also highlight generational changes in their community with increased violence being a worry. Both caregivers and girls refer to communities as dangerous and not places where girls feel safe; they reveal that they are not safe due to issues of sexual harassment and assault, the threat of sexual violence: *“Previously, I could say yes, they were safe. Now it is not safe for women to walk alone especially at night”* (Michelle's father, Philippines, 2021). While in most cases, this was in the context of public spaces, in some instances girls and caregivers also mentioned that school and homes were not safe from GBV: *“Domestic violence happens a lot. Rapes happen very often nowadays”* (Amanda's mother, Brazil, 2018). This was particularly evident in the cohorts from Latin America and the Caribbean, Cambodia and Uganda.

“Worse, and the older I get, it is getting even worse. In the times when I was growing up I never saw a man killing a woman. And now you see that every day. Or a son being violent towards his mother.”

LEYLA'S MOTHER, DOMINICAN REPUBLIC, 2012

The countries in Latin America and the Caribbean also noted the presence of gangs making communities unsafe.

The norms and behaviours in particular around forced and child marriages appear to have changed since the caregivers were young, and these changes are acknowledged in the early years of the girls' lives. The widespread existence of laws prohibiting marriage below the age of 18 in the cohort countries,¹⁷³ as well as the inclusion of this prohibition in varying specificities in international agreements, shows that norm change has occurred on some level already in relation to CEFMU:¹⁷⁴ *“Forced marriage is abolished and the excision of young girls is forbidden making childbirth easier”* (Mangazia's uncle, Togo, 2009).

Alternatively, the presence and awareness of legislation has acted as a catalyst to enable communities and individuals to challenge and question the practice of CEFMU. Education was the primary driver cited with the changes around marriages, which aligns with quantitative research

173. The legal age to marry across the cohort countries is 18 but there are exceptions to this rule in Brazil (age 16 with parental or legal representatives' consent), Togo, and Cambodia (can marry from 16 with parental consent in exceptional circumstances).

174. See: https://www.alignplatform.org/sites/default/files/2019-04/align_child_marriage_thinkpiece.pdf

that draws correlations between years of education and age at first marriage.¹⁷⁵ Margaret's mother in Benin noticed changes in 2009: *"The opportunities are that girls now go to school, and they are free to choose their husband"*. Respondents in Vietnam also noted the influence of different media channels providing more information and leading to a decrease in CEFMU. In Benin, one respondent refers to women's empowerment in relation to increased knowledge and participation in decision-making, which seems to have aided norm change around the practice of forced marriage:

“In the past, parents didn't discuss things with their children and there were lots of cases of forced marriage. Now, women are much better informed and can take decisions. Parents also talk a lot more to their daughters and ask their advice before making a decision. This is a very good thing for girls and women.”

THEA'S MOTHER, BENIN, 2021

The prevailing attitude from both the girls and their caregivers across all contexts was against forced and early marriage: *"It is not right because we should not force girls to marry at a young age"* (Lina, 15, Cambodia, 2021). All the caregivers and girls disagreed with the story where a girl was married off by her parents at 14 years old because of financial strain and they had not heard of cases like this in their community. Some of the caregivers had particularly emotive responses to the story, making it clear that it was not just the laws which forbade it but something they themselves were also deeply opposed to: *"I'm angry! You don't force your child into marriage, why? Just because you can no longer afford to feed her? Aiza [girl in the story] is too young"* (Reyna's father, Philippines, 2021).

Many girls in Vietnam and some of the girls in Cambodia and El Salvador were knowledgeable about the role of rights and used rights-based language when referring to the story of early marriage. They were familiar with the legalities around early marriage and their right to refuse to get married: *"Because it's against the law to force a girl to get married because there are other ways of overcoming these problems"* (Susana, El Salvador, 2021). This awareness potentially points to evidence of impacts from structural-level policies, or government/non-government programmes in relation to CEFMU in these countries.

4.6.3 Early marriages still persist

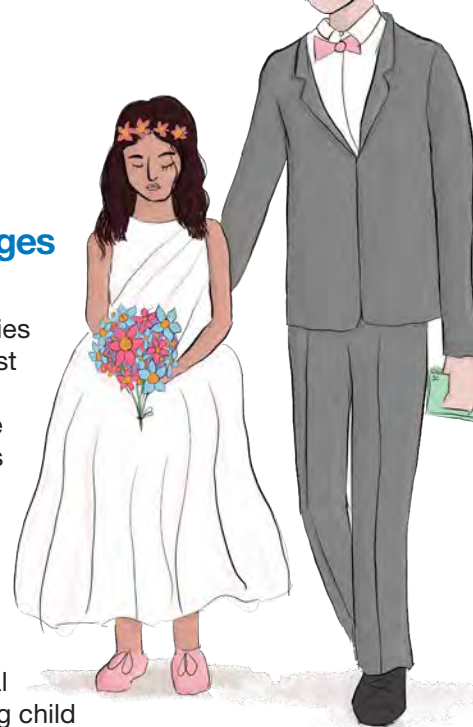
However, although families spoke of changes against this practice, it is clear that it still exists in some of the communities. This was usually referenced in the discourse as something that happened in "other" communities and "not here". Empirical work on the effectiveness of legal frameworks in preventing child marriage point to challenges including the use of legal exceptions to minimum age laws.¹⁷⁶ However, even in countries like Vietnam, El Salvador and the Philippines where there are no legal exceptions, there seemed to be a gap between the policy and the practice. For example, many respondents in Vietnam said that they thought forced marriages happened in the "mountainous areas".

In some cases, there were differences between how the caregivers and the girl responded in relation to the topic. For example, Darna's mother (Philippines, 2021) shared that there were no cases of forced marriages in their community like that of the girl in the story but only examples of early marriages: *"if the child wants to get married, they can't be stopped. Sometimes there are cases like that."* However, Darna contradicted this statement in her interview:

“I had this classmate, she wanted to study so she could learn more. We were only in 6th grade then, but her parents were poor and had nothing to eat, like Anabel's story. Then she was married off to a man who was 37, she was 17. The man had money, had land, so her parents made her marry him. She followed what her parents said even if she didn't want to. When we chat, she tells me that she wants to study. I was sad because we were quite close.”

DARNA, 15, PHILIPPINES, 2021

It is unclear whether Darna's mother was genuinely unaware of the situation of Darna's friend or whether she did not wish to mention such cases happening within the community.



175. Kamal, S.M., Hassan, C.H., Alam, G.M. and Ying, Y. (2015) "Child marriage in Bangladesh: trends and determinants", *Journal of Biosocial Science* 47(1): 120–139

176. See: https://www.alignplatform.org/sites/default/files/2019-04/align_child_marriage_thinkpiece.pdf

Sometimes there were acknowledgements of the existence of early marriage in their own communities, often through referencing some of the descriptive norms present in the community:

“Most girls from the age of 13 onwards here, they start getting married, having boyfriends.”

DARIANA'S MOTHER, DOMINICAN REPUBLIC, 2014

“I think it's always been the same way here, it hasn't changed for the better, it's still the same. Yes, because most children here enter into unions at a very young age.”

STEPHANY'S MOTHER, EL SALVADOR, 2021

Early marriage, discussed as a “choice” between adolescents was more frequently discussed as an issue in communities rather than forced marriages. This was predominantly mentioned in the Philippines, El Salvador, Cambodia and the Dominican Republic but there were also some examples in Vietnam. Caregivers shared stories of young people falling in love, getting married and quitting school. The girls themselves often confirmed these types of stories, sharing examples of when peers had married.

“It is the same, but children marry according to love, and they are 15 or 16, and parents do not force.”

LINA, 15, CAMBODIA, 2021

“There is [a case in the community], but then it wasn't her family who insisted that the child get married; it was she [the child] who decided to get married.”

DOLORES, 15, PHILIPPINES, 2021

In the Latin America and the Caribbean cohort, unions with older men were much more commonly referred to rather than two peers “falling in love”:

“She went off with a guy, she's [Hillary] 14 years old, right, and the guy is 25 ... This is the second time she's entered into a union but she's fine now, this one takes good care of her, he's younger than the first one.”

HILLARY'S GRANDMOTHER, EL SALVADOR, 2021

It was clear that some girls entered into informal marriages by choice because they perceived that older men could potentially support them and possibly used the opportunity as a strategy against poverty. Two girls (one in El Salvador and the other in the Dominican Republic) mentioned living more comfortably since entering a union with their partners.

In the Dominican Republic and El Salvador, the legal age to marry is 18 with no exceptions. Yet the continued presence of CEFMU points to issues with legal systems that do not enforce the legislation on CEFMU. Fundamentally, informal unions which are not recognised by the church or state often remain beyond the administrative purview of government agencies, creating loopholes for avoiding sanctions:¹⁷⁷

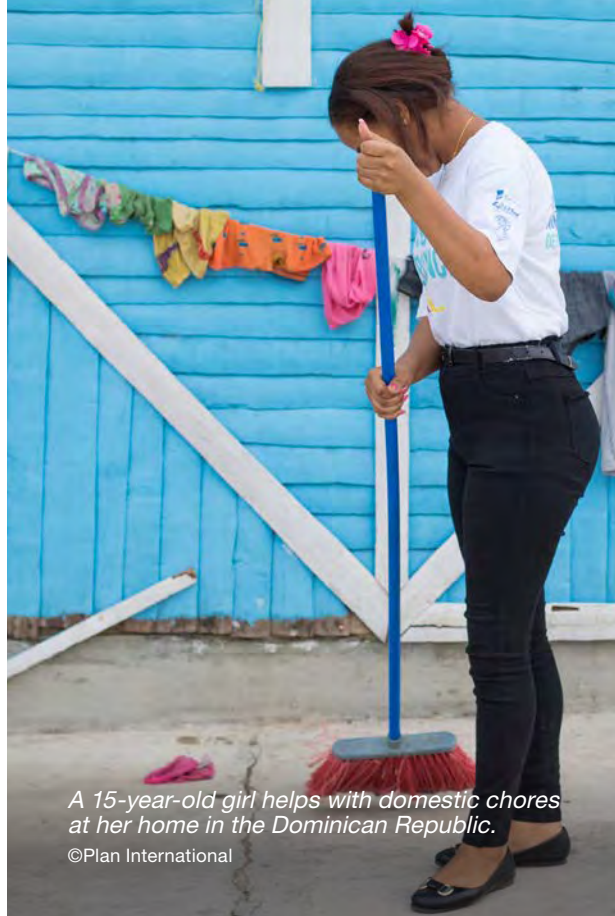
“Some of them [get married] with a kid their own age, but some also enter into unions with much older men. No, no one does anything, their mums try to get help ... the police say that if she went of her own free will, they can't do anything, even if she's under-age.”

GLADYS, 15, EL SALVADOR, 2021

COVID-19 was also cited as another influencing factor in the prevalence of CEFMU in their communities, with some caregivers and girls citing that a lot of girls had entered into unions during the pandemic, and some had subsequently got pregnant: *“In my community, there are a lot of girls have to drop out of school and parents forced to get married young because of COVID-19”* (Southany, 15, Cambodia, 2021).

It was rare to see in the data girls or caregivers discussing the reasoning behind the issue of early marriage. Only Uyen in Vietnam (15 in 2021) referenced socio-economic factors being a reason behind the occurrence: *“If there are many poor people in a community, girls will be forced to get married early like Mai [the girl in the story]. If there are many rich people in a community, the situation will be different.”* In general, there was a lack of understanding of the structural gender inequalities which fostered CEFMU in communities. Only a few caregivers acknowledged the girls' capacity and vulnerability in the early stages of adolescence as a key problematic factor in relation to their choices around early marriages.

177. Greene, M.E.A. (n.d.) *A Hidden Reality for Adolescent Girls: Child, Early and Forced Marriages and Unions in Latin American and the Caribbean*. Regional Report. Plan International in the Americas and the United Nations Population Fund (UNFPA), Regional Office for Latin America and the Caribbean.



A 15-year-old girl helps with domestic chores at her home in the Dominican Republic.

©Plan International

There has been generational progress on attitudes to CEFMU across the cohort communities. Overall, what seems to perpetuate the continued cases of CEFMU within communities is the lack of will among many families and institutions to intervene to prevent CEFMU, instead accepting it as something that happens.

4.7 RECOMMENDATIONS MADE BY CAREGIVERS AND GIRLS

4.7.1 What caregivers say

In 2021, caregivers were asked what they thought would help them to speak to girls about SRHR. A common theme in their answers was an acknowledgement that caregivers generally do need support to overcome the challenges they experience when communicating with adolescents about SRHR. Some caregivers cited that they wanted support from relevant organisations to increase their own knowledge of SRHR and to help develop positive communication approaches with adolescents – this was a key recommendation for some caregivers. Bopha's great-aunt (Cambodia, 2021) noted that parents need to be taught in order to gain knowledge around SRHR. She mentioned using different media channels to convey messages; she also said that teachers should more frequently communicate with parents about what to say around SRHR. Miremba's mother describes the support of third parties as empowering parents to communicate with their children:

“Parents should be sensitised on how to speak to their children about sex and puberty so as to empower them to speak to their daughters. Because when you are able to speak to a child and she is able to understand what you are telling her, she can change into a better person.”

MIREMBA'S MOTHER, UGANDA, 2021

In a number of cases, participants suggested that caregivers themselves need to change their approach to discussing SRHR with girls. At the same time, they acknowledged the challenges encountered by many adults in terms of their own knowledge, social taboos and doubt over what they should be telling their daughters:

“I think they need to open their minds, because once you have a girl who is going through puberty, you have to tell her how things are ... They need more trust and more affection.”

SHARINA'S MOTHER, DOMINICAN REPUBLIC, 2021

Some, like Djoumai's mother, identify a need for parents to challenge norms that limit communication on SRHR: *“I think parents should speak to their children about sex and puberty and break the taboo surrounding it”* (Djoumai's mother, Togo, 2021). Joy's grandmother (Uganda, 2021) suggests seeking support from other parents and providing collective support to each other; she also acknowledged challenging norms and encouraging parents to talk to their daughters.

Others, however, believe that girls should be informed directly by external organisations or groups of people with the knowledge and resources necessary to teach girls about these issues. There is a sense from some caregivers that they would be more comfortable with this than addressing sensitive topics themselves: *“It would help parents if there were meetings for girls about sex and puberty to raise awareness of how they should behave at this age”* (Essohana's mother, Togo, 2021). The involvement of other extended family members is also viewed as helpful in supporting parents to address sensitive issues as respondents thought that other family members might be more comfortable than parents in talking to girls about these issues.

4.7.2 What the girls say

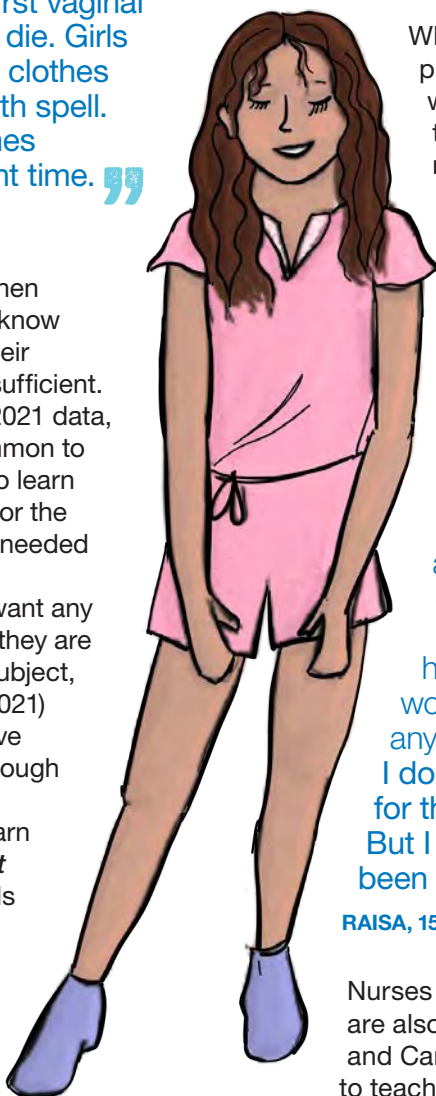
When asked what they know about puberty, the cohort girls are generally aware that they will experience some physical changes during adolescence. For some, the changes to their bodies are viewed negatively – in particular when they have developed ahead of their peers. A number of girls also express anxiety about menstruation that is rooted in misinformation and myths that perpetuate negative associations with periods and limit girls' understanding of their sexual and reproductive health:

“I am afraid that someone notices it. I am afraid of being chased away by boys. I often heard that the first vaginal bleeding can cause a tree to die. Girls were advised not to dry their clothes outdoors, or they are cast with spell. Then, I dare not dry my clothes outdoors, even at day or night time.”

NAKRY, 12, CAMBODIA, 2018

The majority of the cohort girls (when asked) say that they would like to know more about SRHR and feel that their current level of knowledge is not sufficient. This is particularly notable in the 2021 data, while in previous years it was common to see girls say that they would like to learn more but viewed it as something for the future rather than something they needed in the present.

A few girls state that they do not want any more information, either because they are “shy” or uncomfortable with the subject, or as in Folami’s case (15, Togo, 2021) because they feel they already have experience and have been told enough by their mothers. However, Folami did think that other girls should learn more: *“No, my mother has taught me enough. [Do you think that girls should be taught about sex and puberty?] Yes, so that girls won’t make a mistake that ends in pregnancy which would stop them attending school, like me actually.”*



When it comes to preferred sources of information on SRHR, the girls' most common preference is their mother or other female caregivers – which may be a result of perceived “acceptable” gender roles in the household:

“For me, my aunt whom I live with, should talk to me about these things. Parents should also talk to their children, so they don’t learn false information from other people” (Margaret, 15, Benin, 2021). This shifts in some cases over time, with a preference for school or “teachers” to be the ones to address these topics with girls increasing slightly with age. While a combination of both female family members and teachers is often cited as a good scenario, for some girls at 15, they share that speaking with a teacher would be awkward and uncomfortable.

While family members may be preferred over teachers, for girls whose caregivers have not spoken to them about SRHR, school is their main source of knowledge and helps to fill important gaps:

“[Okay, who do you think should teach girls about sex and puberty?] Well, their parents. [Only their parents?] I think so. [What about at school?] Also. But mostly their parents. [For example, you were only told about it at school; your mum and dad didn’t tell you about it.] No. [So, in your case, if the school hadn’t told you about it, you wouldn’t know, you wouldn’t have any information about it?] No ... I don’t know if they are waiting for the right time or something. But I wouldn’t know, if I hadn’t been told about it at school.”

RAISA, 15, DOMINICAN REPUBLIC, 2021

Nurses and medical sources of information are also cited by some girls in Togo, Uganda and Cambodia as among those best placed to teach them about SRHR.

A young girl
with her
daughter on her
back.
©Plan International

05

CONCLUSION

*A teenage girl from Benin
walks along the road
with her baby on her back.*
©Plan International

Both the girls and their caregivers consider SRHR as important and a natural part of adolescence to be navigated. However, the insights from the RCRL study demonstrate that more often than not girls are uninformed and ill-equipped to deal with their sexual and reproductive health in a positive way.

The lack of access to SRHR information experienced by caregivers, alongside poor or non-existent comprehensive sexuality education curriculums, only limit girls' options in how they navigate their SRH during adolescence. Rigid cultural and gender norms prioritise SRH education at home and at school as solely a means to avoid pregnancy and violence, effectively excluding any discussion of girls' sexual wellbeing.



Girl practicing putting a condom on a cucumber in a sex education class in Vietnam.

©Plan International

While each country has its own distinct cultural and policy context, all our research took place in poor rural or semi-rural communities. It was apparent that many of the hardships the girls faced reflect the combined effects of poverty and inequitable gendered norms. There are important similarities among attitudes, norms, and practices in relation to gender, age and sexuality, which allow damaging gender norms that control girls' sexuality and uphold harmful ideals of both womanhood and manhood to prevail across the cohort communities. These norms give rise to stigma and gender-based violence which has had a significant impact on the lives of many of the girls and their female caregivers in the study.

It is clear that social and gender norms continue to be a key influence on caregiver– adolescent communication around SRHR and caregivers have conservative attitudes in relation to girls' SRH. Despite expressing negative associations with their own experiences of SRHR as adolescents, female caregivers face difficulties in changing the narrative communicated to girls about their bodies and sexuality. Male caregivers are excluded from girls' SRHR education and struggle to navigate gender norms that discourage their involvement in dialogue with adolescents about their SRH. Beliefs and attitudes of caregivers around SRHR are often echoed by the girls themselves. They begin to monitor their own behaviour as well as that of their peers, repeating dialogues about how a girl should behave and thus ensuring that cycles of stigma and shame continue to be reproduced for girls who transgress any of these societal expectations.

Throughout the girls' life course these social and gender norms evolve to become more rigid and as girls enter into later adolescence they are monitored more closely. Menarche continues to be a key turning point for caregivers to begin to communicate on SRHR, but it also marks a moment when caregivers believe they have to more strictly manage girls' sexuality and behaviours.

Girls' choices are determined and constrained by culturally determined expectations and beliefs about how their sexual lives should unfold. Promoting the SRH rights of girls requires intergenerational dialogue alongside the development and reinforcement of supportive social norms, as well as policies and programmes that ensure that girls can make informed decisions about their SRHR and have their own sexual agency.

A young mother with dark, curly hair is shown in profile, holding her young daughter. They are outdoors in a lush green environment with trees and foliage in the background. The lighting is bright, creating a silhouette effect on the mother and child. The mother is wearing a dark top, and the child is wearing a light-colored sleeveless top and a patterned skirt.

06

RECOMMENDATIONS

*Young mother with
daughter in Brazil.*
© Plan International

Firstly, it should be noted that the contexts across the RCRL study vary vastly, and every recommendation needs to be tailored and applied according to the various settings both across and within countries.

From the findings, it is clear that girls want more information from their caregivers on SRHR and caregivers want more support to be able to communicate effectively on SRHR with adolescent girls. A starting point for improving adolescent girls' SRHR is an enabling policy environment, but this needs to coincide with normalising open and honest discussions about sexual and reproductive health both in the formal and non-formal education settings and in community discourse.

NATIONAL GOVERNMENTS SHOULD:

- **Ensure** access to quality and affordable gender and adolescent responsive SRHR services including those which prevent and respond to GBV. These should be developed and implemented in consultation with adolescent girls, including those who are survivors of sexual violence and girls who are married and/or parenting and includes improved contraception access for adolescents in rural settings.
- **Develop, implement and monitor** policies that create a supportive environment for adolescent mothers: removing policies which implicitly or explicitly excludes girls from school and providing timely and adolescent-responsive support for girls who are pregnant or parenting where they can learn in a safe space that is flexible for their needs.
- **Strengthen** prevention and response to GBV and harmful practices, including CEFMU of adolescents with adults, embedding a rights-based and gender-transformative approach that recognises both adolescents' agency and the need to transform harmful norms and practices that drive different forms of violence.
- **Strengthen** comprehensive sexuality education (CSE) and include it in the early years of schooling to respond to the age and stage of learners using a sex-positive approach that promotes understanding of gender including diverse sexual orientations, gender identities, gender expressions and/or sex characteristics (SOGIESC).¹⁷⁸ It should include a phased approach which is adaptable and recognises the specific contextual and community norms present so that governments or education ministries can work to overcome the challenges that arise with CSE delivery in each setting.
- **Encourage** a "whole school approach" to CSE. CSE programmes should include activities to inform caregivers about the goals and content of CSE and build their support.

NGOS AND CSOS SHOULD:

- **Support** caregivers to actively engage with their children's SRHR by building knowledge and backing efforts to improve child-caregiver communication around GBV and sexuality including socialisation on diverse SOGIESC. Young people look first to their caregivers for support and information and need to feel that they can ask for help without embarrassment or confusion from either side. This entails providing opportunities for dialogue between and within generations to discuss experiences around SRHR.

178. Plan International (2021) Translating CSE commitments into action. Available here: <https://plan-international.org/publications/translating-cse-commitments-into-action/>, accessed 23 May 2022

Norms and values that reduce stigma around SRHR must be promoted to improve health outcomes. Social and gender norms are entrenched across the RCRL communities and continue to influence caregivers' approaches around SRHR in relation to expected behaviours around relationships and sexual activity. Norms around GBV demonstrate that while policies might exist to prevent and respond to GBV, these are not always adequately enforced or monitored in a gender and age responsive way. All actors must share the responsibility of challenging social and gender norms.

DONORS SHOULD:

- **Ensure** that long term cross-sectoral investment is focused on efforts to shift gender norms that centre adolescent sexuality, agency and bodily autonomy in relation to critical SRHR issues that are affecting adolescent girls, including GBV and CEFMU.

NGOS AND CSOS SHOULD:

- **Enable** intergenerational dialogues that focus on transforming negative social and gender norms while building new positive ones; challenging myths and taboos around menstruation, intimate relationships and gender identity and sexuality; normalising discussions around sex, contraception and sexual wellbeing; and challenging norms that stigmatise the use of contraception and solely promote abstinence. Awareness should be strengthened around the links between CEFMU, GBV, adolescent sexuality and early pregnancy, and how harmful social norms perpetuate these.
- **Implement** interventions at school and in communities that aim to reduce stigma and discrimination against pregnant and parenting girls and survivors of sexual violence, which will help them to access SRH services with empathy and support.
- **Engage** fathers and male peers in girls' SRHR by promoting gender equitable attitudes that aim to improve SRHR outcomes and foster positive relationships. Men and boys should be engaged to critically assess norms around traditional views of masculinity and femininity that place responsibility for caring for a girl's sexual and reproductive health solely with women.
- **Foster** norm change through a mix of interventions including the use of media, as well as providing a range of information sources on SRHR for young people to access.



Young girls walking in Uganda.
©Plan International



07

ANNEXES

ANNEX 1

TABLE 3 DETAILED LOCATION INFORMATION FOR COHORT GIRLS

LATIN AMERICA AND THE CARIBBEAN			
COUNTRY	LOCATION	GIRLS' NAMES	LOCATION INFORMATION
BRAZIL	Codó, Maranhão	<ul style="list-style-type: none"> Bianca Camila Gabriela Natália 	Four of the girls live in São Luís, the capital of Maranhão province, and four live in Codó where three live in a rural area and one in a semi-urban community. All have access to school and live close to it, but because of the pandemic and the strike in public education, they are at a great disadvantage regarding their education. Some families rely on agriculture for a living and the rest have informal jobs such as selling products at the market, painting, unregistered employees, and government assistance.
	São Luís, Maranhão	<ul style="list-style-type: none"> Fernanda Juliana Larissa Sofia 	There are a high number of child marriages and teenage pregnancies in these two areas. The girls who live in São Luís have access to the internet, although this is precarious, and the girls in Codó do not have access to a mobile phone because there is no signal in the region, as well as having a poor economy.
DOMINICAN REPUBLIC	Azua Province and San Juan Province	<ul style="list-style-type: none"> Dariana Nicol Chantal Griselda Katerin Leyla Madelin Raisa Rebeca Saidy Sharina Valerie 	<p>Azua</p> <p>The livelihoods of the communities depend on agriculture, especially tomato and banana cultivation. One of the communities is a coffee-growing area. They have rural clinics for primary healthcare, electricity but access to water is limited. Levels of violence within families are high. The girls mentioned are from low-income families. All have access to basic education, but not all have access to secondary education and have to travel several kilometres to get there. Internet access is not free and is paid for but is still limited due to low connectivity levels. During the pandemic, schooling levels decreased in these areas and school dropouts were common due to a lack of online connectivity and poor access.</p>
			<p>San Juan</p> <p>The communities are rural agricultural areas. Males in the communities are generally engaged in agriculture and farming and women mainly in domestic work. All the communities have access to basic and secondary education, access to rural clinics, drinking water, electricity, internet via mobile phones, and law and order centres (police stations). The girls involved in the study live in safe communities, where they have the freedom to move around without fear of being physically or mentally harmed.</p>
EL SALVADOR	Department of La Libertad	<ul style="list-style-type: none"> Hillary Bessy Valeria Karen Mariel Rebeca Susana Gabriela Stephany Doris Gladys Raquel 	The girls participating in the study live in the department of La Libertad in El Salvador. Some of the families live in remote rural communities, in mountainous areas that are difficult to access during the rainy season. Others live in semi-rural areas. Due to the geographical location of the communities, there are permanent risks of flooding and landslides due to heavy rains during the annual season. Both drought and floods affect crops and harvests. This forces families to look for alternative employment, generally doing manual work, or various trades, directly impacting on family finances, so they continue to have limited access to sanitation and drinking water. The families are located in coastal areas that are more prone to trafficking and commercial sexual exploitation, school dropouts; this is aggravated by the pandemic, mainly affecting children and adolescents. Gangs are present in the areas and the families participating in the study live in constant fear for their personal safety. Some of the girls' mothers are survivors of sexual violence. The girls in the study live with their extended family and are mostly supported by their grandparents. Access to connectivity and internet is complicated because the signal in the area is weak, and the quality of phones is poor.

WEST AND EAST AFRICA

COUNTRY	LOCATION	GIRLS' NAMES	LOCATION INFORMATION
BENIN	Couffo department in central south region, 120 km from the capital Cotonou	<ul style="list-style-type: none"> • Alice • Annabelle • Barbara • Catherine • Eleanor • Isabelle • Jacqueline • Layla • Margaret • Thea 	The girls live in a semi-urban area characterised by strong agricultural activity supplemented by the trade in foodstuffs, and raising ruminants and poultry. The education levels of children are quite high but children, especially girls also frequently drop out of school. The area is prone to child trafficking. Unfavourable social norms characterise the area where the girls live, in particular in relation to sexual violence and CEFMU.
TOGO	Located south and east of Sokodé, the capital of the Central region	<ul style="list-style-type: none"> • Azia • Djoumai • Essohana • Fezire • Reine • Anti –Yara • Ayomide • Ladi • Larba • Lelem • Mangazia • Nana-Adja • Nini-Rike • Tene 	The girls live in rural communities with a low standard of living and mainly reliant on agriculture. Drought has become more frequent in recent years, which has caused particular hardships for such communities. Education levels are low and there is limited access to the internet due to lack of resources. Islam is the dominant religion.
UGANDA	Located in East Central Region, 144 km from the capital Kampala	<ul style="list-style-type: none"> • Amelia • Beti • Dembe • Jane • Joy • Justine • Mirembe • Namazzi • Nimisha • Rebecca • Sheila • Shifa • Sylvia 	<p>All girls participating in the study are located in rural communities that depend on farming as a source of food and income. Sugarcane is predominantly grown in the region for sale by most families. Of late these communities have experienced prolonged drought which could lead to food insecurity. The level of education is low across all these communities and adolescent pregnancy and school dropout are commonplace. There is no access to internet due to lack of infrastructure.</p> <p>Christianity is the dominant religion.</p>

SOUTH-EAST ASIA

COUNTRY	LOCATION	GIRLS' NAMES	LOCATION INFORMATION
CAMBODIA	Tboung Khnum province	<ul style="list-style-type: none"> • Roumany • Davy • Puthea • Kannitha • Mony 	The girls and their families are from two villages in the same commune. Most of the people are farmers. Recently due to COVID-19, people's incomes have fallen because market prices are very low. Education is generally accessible and most children study at upper secondary school. However, this is dependent on a family's financial situation. Since the pandemic, the dropout rate is increasing, and more people are migrating to earn money at another province or town. Internet access is low, and COVID-19 meant that students had to study online but many couldn't access the internet.
CAMBODIA	Siem Reap Province	<ul style="list-style-type: none"> • Bopha • Lina • Leakhana • Nakry • Reaksmey • Sothany 	The girls live in rural communities where the majority of villagers work in agriculture. The province is home to many temples which are popular with tourists. Education is generally accessible and most children study at upper secondary school. However, this is dependent on a family's financial situation. Internet access is low.
PHILIPPINES	Northern Samar Province in the Eastern Visayas Region	<ul style="list-style-type: none"> • Jocelyn • Melanie • Dolores • Rubylyn 	The four girls live in a rural area in the province of Northern Samar, Philippines. Many areas in the province have been affected by decades of armed conflict between government forces and communist rebel groups, causing displacement within three communities in Northern Samar. The poverty incidence is high, among the poorest provinces in the country. The area is also extremely vulnerable to the following hazards: typhoon, landslide, tsunami, earthquake, flooding, drought, and climate change impacts, such as sea level rises. Agriculture is the main economic source of the area. Basic education is low, at least a fifth of children aged 6 to 16 years were not in school. Many households have no access to a safe water supply and some have no access to sanitary toilet facilities. Internet connectivity in the village is poor.
PHILIPPINES	Located north-east on the Masbate Island Province in south-eastern part of Luzon Region	<ul style="list-style-type: none"> • Maricel • Reyna • Rosamie • Jasmine • Chesa Darna • Mahalia • Christine • Michelle • Kayla 	The girls are located in a rural area on the island province of Masbate. The poverty rate is 42.27% (2015) and primary sources of income in the area are corn, rice, fish, coconut and livestock. The region is highly vulnerable to typhoons, floods, drought and susceptible to climate change hazards. These natural occurrences frequently lead to severe damage of properties, infrastructure, and loss of livelihoods in agriculture. Around 55% of children attended elementary school, and just over a fifth reached secondary school. The presence of a communist rebel group in the area hinders the economic growth and development of the area. About 91% of the population are members of the Roman Catholic Church.
VIETNAM	Located in the central part of Quang Ngai province – name of districts are Son Ting and Nghia Han	<ul style="list-style-type: none"> • Ly • Uyen • Tan • Sen (Son Ting District) • Kim • Quynh • Yen • Huong • Tien (Nghia Hanh) 	<p>Quang Ngai province is the least urbanised and second-poorest province on the South-Central Coast.</p> <p>Son Tinh District:</p> <p>The communities are mainly focused on agriculture, fishing and forestry industries.</p> <p>Nghia Hanh District:</p> <p>Predominantly an agricultural area which is far from any urban areas. Residents follow a traditional way of life with strong family ties. There is high unemployment with lots of young men and women moving to find work in the southern provinces.</p>

ANNEX 2

TABLE 4 OUTLINE OF DATA SOURCES FOR ANALYTICAL FRAMEWORK

SOCIO-ECOLOGICAL SPHERE	SOURCE
SOCIETY	
Policies and regulations	Secondary data: Review of relevant SRHR policies and regulations in each cohort country
Institutions and curriculum (including leaders of institutions)	Secondary data: Review of government's National Sexuality Education Framework in each cohort country and any key changes to curriculum, leaders' stance on sexual education and sexuality issues Primary data: any discussion of sexual education and non-formal curricula, local school implementation, the girl and her caregiver(s)
Services and infrastructure	Secondary data: Review of national/regional-level SRHR services in each cohort country Primary data: any discussion of SRHR services by the girl and her caregiver(s) (provision, access to, cost, experience of, adolescent health literacy, facility characteristics, equity and non-discrimination, etc)
Media and technology	Primary data: any discussion of media and technology related to SRHR by the girl and her caregiver(s)
COMMUNITY	
Information and communication	Primary data: any discussion of how SRHR is discussed in cohort girl's community by the girl and her caregiver(s)
Knowledge sources	Primary data: any discussion of who provides knowledge on SRHR and in which spaces this is discussed in the cohort girl's community by the girl and her caregiver(s)
Access to spaces	Primary data: any discussion of community members' access to these spaces (who does/does not have access, which norms dictate access) in the cohort girl's community by the girl and her caregiver(s)
Leaders in community	Primary data: any discussion of community leaders' influence in relation to SRHR
ADOLESCENT GIRL	
<ul style="list-style-type: none"> • Self-efficacy/confidence • Personal aspirations • Knowledge and skills • Beliefs, attitudes and values • Body development and age • Perceived norms and risks 	Primary data: any discussion by the cohort girl or her caregiver(s) of the girls' beliefs, attitudes, development, perceptions, knowledge, skills, and aspirations related to SRHR
FAMILY/PEERS	
<ul style="list-style-type: none"> • Family configuration • Social support • Communication • Peer influence/support • Family influence/support 	Primary data: any discussion by the cohort girl or her caregiver(s) of the girls' family support and social networks, relationships and communication related to SRHR

ANNEX 3

TABLE 5 HOUSEHOLD CONTEXT OF EACH GIRL

KEY: ● PARTICIPATED ● TEMPORARY ABSENCE ● DIED ● MIGRATED ● LEFT STUDY ● NOT PART OF STUDY		2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)																
BRAZIL																	
AMANDA	Mother (housewife, 39), mother's partner (temporary salesperson, 28) and her two sisters (17, 5). Amanda is enrolled in school. Family receives family allowance. [Bolsa Família – a federal government social welfare programme that provides financial aid to poor Brazilian families.]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
BIANCA	Mother (field worker, 37), brothers (17, 12) and sister (8). Sister (19) left the household after getting married and father has left after a recent separation. Family receives family allowance (Bolsa Família). Bianca is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
BEATRIZ	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
CAMILA	Mother (hair stylist, 33) and brothers (15, 11). Uncle (43) and grandmother (85) moved out to another home. Family receives family allowance (Bolsa Família). Camila is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
CATARINA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ELENA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
FELICIANA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
FERNANDA	Father (field worker, 41), mother (field worker, 36) and sisters (16, 10 and 2). Family receives family allowance (Bolsa Família). They also received Emergency Allowance [Auxílio Emergencial – a federal government income distribution programme for families directly affected by the difficulties caused by the COVID-19 pandemic.] Fernanda is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
FLORENCIA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
JULIANA	Grandfather (self-employed selling fish at local market, 50), grandmother (self-employed selling cake and snacks, 49) and sister (13). Family received Emergency COVID-19 allowance. Juliana is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● PARTICIPATED ● TEMPORARY ABSENCE ● DIED ● MIGRATED ● LEFT STUDY ● NOT PART OF STUDY

NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
LARISSA	Mother (janitor, 33), grandfather (unemployed; has requested his pension, 66). The grandfather had a stroke in the past year but received medical attention within the public health system. Grandmother (retired, 59), aunt (student, 22), uncle (driver, 36) and brother (6). Family received Emergency COVID-19 allowance. Larissa is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
LUIZA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MARGARIDA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
NATÁLIA	Father (field worker, 56), mother (seamstress, 51), brother (student, 18), nephew (8) and sister (babysitter, 20). Brother (23) left the household due to marriage. Family receives family allowance (Bolsa Família). Natália is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PATRÍCIA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PIETRA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SANCIA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SOFIA	Father (painter, 35 years), mother (homemaker, 35 years) and brothers (13 and 8 years). Family receives family allowance (Bolsa Família) and also received emergency COVID-19 allowance. Sofia is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
TATIANA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
VALENTINA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

DOMINICAN REPUBLIC

ANA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
CARA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
CHANTAL	Grandmother (homemaker, 50), mother (homemaker, 31), aunt (14), sister (10) and brothers (2 years and 14 months). Father left almost three years ago illegally to Puerto Rico and sends home remittances. Family receives food and electricity support through the government's Solidarity programme. Chantal is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● PARTICIPATED ● TEMPORARY ABSENCE ● DIED ● MIGRATED ● LEFT STUDY ● NOT PART OF STUDY

NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
DARIANA	Father (farmer, 37), mother (homemaker, 35) and sister. Family receives the government's Solidarity programme. Dariana is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
GRISELDA	Griselda's husband (baker) and Griselda's son (8 months). Stepmother is working abroad. Father and mother are divorced – mother is in contact with Griselda. Griselda is enrolled in school but is behind in classes due to her pregnancy.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
KATERIN	Father (scrap metal collector, 35), mother (house-cleaner, 35) and sisters (9, 12). Katerin is not involved in school because she does not want to attend.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
LEYLA	Mother (unemployed, 36), stepfather (farmer, 38) brothers (water truck driver, 21), brother (water truck assistant, 18), brothers (5 and 3 years, 5 months) and sister (20) and sister-in-law. Leyla's grandmother lives in Spain and sends home remittances. Leyla is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MADIELIN	Father (carpenter, 45), mother (homemaker, 35) and brother (8). Family received government pandemic support for one year. Madelin is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
NICOL	Father (public transportation official, 45), mother (homemaker, 37), brother (gas pump assistant, 20) and sister (10). Family receives the government's Solidarity programme.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
RAISA	Father (surveyor, 36), mother (homemaker, 35), sister (5) and twin siblings (2). Raissa was recently diagnosed with Juvenile Rheumatoid Arthritis. Raissa is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
REBECA	Father (trader, 49), mother (trader, 39) and sisters (20, 17). Family receives food, gas and electricity support through the government's Solidarity programme. They also received pandemic support funds. Rebecca is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SAIDY	Grandmother (farmer, 61). Her brother moved this year to live with her father in Santo Domingo. Mother (35) does not live in the household and can no longer contribute to support Saidy. Saidy's father gives an allowance to the grandmother for supporting the girl. Her uncle works in fast food in New York and sends money home to support the family. Family receives food and gas support through the government's Solidarity programme.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● PARTICIPATED ● TEMPORARY ABSENCE ● DIED ● MIGRATED ● LEFT STUDY ● NOT PART OF STUDY

NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
SHARINA	Father (farmer, 35), mother (homemaker, 29), sisters (13, 5) and brother (9). Family receives food and gas support through the government's Solidarity programme. Sharina is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
VALERIE	Father (farmer), mother (homemaker, 37), brothers (17, 13, 11) and sister (9). Brother (19) recently left the household. Family receives food and gas support through the government's Solidarity programme. Valerie is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

EL SALVADOR

ANDREA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
BESSY	Grandfather (farmer, 52), grandmother (homemaker, 59), great-grandmother (not working, 73) and sister (17). The family received government pandemic support three times during the year. Bessy is enrolled in school. Bessy has been diagnosed with high blood pressure.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
DORIS	Mother (garden centre worker, 31) and brother (9). Family receives remittances once a year from an aunt in the USA. Doris' 19-year-old cousin recently left the household to live with his partner. Doris is not currently attending school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
GABRIELA	Father (driver but had to take a recent break due to foot fracture, 37), mother (merchant and domestic worker, 30) and sister (13). Family received government financial support and food aid during the pandemic. Gabriela is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
GLADYS	Mother (merchant, 31), stepfather (mill owner, 31), stepbrother (12) and sister (7). The family receives remittances from two aunts and two cousins in the USA on an ad-hoc basis. The family received government financial support and food aid during the pandemic. Gladys is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
HILLARY	Mother (homemaker, 29), father (farmer, 34), brothers (16 years and 18 months) and sisters (12, 7). Hillary has recently left the household to move in with her partner. The family received food aid during the pandemic. Hillary's sister has recently been ill with typhoid. Hillary has dropped out of school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
KAREN	Mother (32, maid), father (35, waiter) and sister (4). Karen is enrolled in school	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● PARTICIPATED ● TEMPORARY ABSENCE ● DIED ● MIGRATED ● LEFT STUDY ● NOT PART OF STUDY

NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
MARIEL	Grandfather (oyster-gatherer, 69), grandmother (homemaker, 63) and cousin (17). The father works in the USA as a painter and sends remittances home every month. Mariel is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
RAQUEL	Father (policeman, 45), grandmother (homemaker, 76), aunt (seamstress, 50), aunt (homemaker, 42), sister (11) and cousins (21, 11, 11). Family received government food aid during the pandemic. Raquel is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
REBECCA	Aunt (homemaker, 24), uncle (waiter, 25), cousins (6,3). Uncle sends home remittances from USA on rare occasions. Received government financial support and food aid during the pandemic. Rebecca was not allowed to enrol in school due to repeatedly failing a grade.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
STEPHANY	Father (mason's assistant, 34), mother (homemaker, 30) and brother (9). The family receives regular food aid from the government. Stephany is currently enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SUSANA	Grandmother (merchant, 60), father (baker, 33), stepmother (homemaker, 20), uncle (38, driver), sister (10), brother (1) and cousin (18). Cousin who is a domestic worker in the USA sends remittances on special occasions. Family receives regular food aid from the government and also received one-time pandemic support. Susana is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
VALERIA	Grandmother (seamstress, 61), aunts (merchants, 33, 19), uncle (temporary worker, 24), uncle-in-law (fisherman, 30), uncle-in-law (merchant, 23), sister (2), brother (5) and cousins (13, 5). Family receives regular food aid from the government and also received one-time pandemic support. Valeria had to temporarily leave school to live with her aunt during the pandemic.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

CAMBODIA

BOPHA	Father (farmer/construction worker, 39), mother (farmer, 32), sister (13), brother (10). Aunt is a primary school teacher in the same village, gives remittances to the family during the year. Bopha is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
DAVY	Father (farmer, 53), mother (farmer, 41), brother (farmer, 18), sister-in-law (farmer, 19), brothers (13 and 10). Brother and uncle in the village gave the family remittances to support the ailing grandfather before he died. Davy is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: PARTICIPATED TEMPORARY ABSENCE DIED MIGRATED LEFT STUDY NOT PART OF STUDY																	
NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
KANNITHA	Mother (labourer, 52). Mother is now divorced from Kannitha's father. Sister (trader, 22). Brother-in-law (farmer, 26), brother-in-law (trader, 23), sister (homemaker, 20). Kannitha is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
KANYA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
LEAKHENA	Father (policeman, 50), mother (farmer, 41), sister (18). Her brother, sister, brother-in-law have recently moved out. Uncle is a civil servant in the village, gives the family remittances every month. Leakhana is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
LINA	Father (farmer, 37), mother (cleaner, 34), brother (16), sisters (14 and 9), female cousin (17), grandmother (farmer, 62). Lina is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEALEA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MONY	Father (farmer, 35), mother (farmer, 34), younger brother (6).	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
NAKRY	Father (not working and living with a disability, 51), mother (sells groceries, 45), brothers (13 and 5), sisters (16 and 10). Nakry has received a government scholarship for school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PUTHEA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
REAKSMEY	Father (farmer, 60), mother (farmer, 60), brother (11). Family receives government financial support on a monthly basis. Reaksmeys is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ROUMANY	Grandmother (63), sister (factory worker, 21), brother-in-law (farmer, 26) and nephew (6 months). Brother in Phnom Penh is a car repairer and sends remittances every month. Family received government financial support on a monthly basis during the pandemic. Roumany has recently been ill with pneumonia. Roumany is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SOKANHA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SOTHANY	Father (farmer, 36), mother (farmer, 34), sister (8). Sothany is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
THEARIKA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● PARTICIPATED ● TEMPORARY ABSENCE ● DIED ● MIGRATED ● LEFT STUDY ● NOT PART OF STUDY

NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
PHILIPPINES																	
ANGELA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
CHESA	Father (farmer, 43), mother (homemaker, 40), sisters (21 and 5), brothers (16 and 12). The family receives monthly remittances from an uncle who is a livestock manager in Taiwan. They also receive a conditional cash transfer every two months from the Department of Social Welfare and Development and received a one-off fertiliser donation from the Department of Agriculture. Chesa is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
CHRISTINE	Father (farmer, 48), mother (homemaker, 41), brother (worm collector, sells for bait, 19), brother (5), grandmother (82), cousin (18). Family receives conditional cash transfer every two months from the Department of Social Welfare and Development. Christine is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
DARNA	Uncle (district village councillor, 62), aunt (homemaker, 62), cousin (10). Family receives remittances from a cousin who is sailor every month and intermittently from a cousin who is a cashier in Abu Dhabi. Darna is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
DOLORES	Father (farmer, 38), mother (housewife, manages small store, 33), sisters (12 and 10). Dolores is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
JASMINE	Father (fisherman, 44), mother (farmer and Nipa maker – thatched palm leaves, 43), niece (5). Jasmine and her sister (17) have recently moved into their grandmother's house because of safety concerns that their own house may collapse in a typhoon. They also receive a conditional cash transfer every two months from the Department of Social Welfare and Development and received a one-off fertiliser donation from the Department of Agriculture. They also received one-time relief goods during the pandemic. Jasmine is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
JOCELYN	Father (driver, 48), mother (homemaker, 46), brothers (17, 12, and 8). Sister (20) recently left to work as a cashier in Manila and sends home remittances twice monthly. Jocelyn is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
KYLA	Father (pastor, 51), mother (pastor, 56), sister (unemployed, 22), sister (student, 20) and niece (1). Sister (saleswoman, 25) recently left the household to work in Manila and sends home money when requested. Kyla is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● PARTICIPATED ● TEMPORARY ABSENCE ● DIED ● MIGRATED ● LEFT STUDY ● NOT PART OF STUDY																			
NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021		
MAHALIA	Father (farmer/fisherman, 56), mother (homemaker, 56), brothers (24, 20 and 18), sister (16). Family received government support during lockdown twice. Mahalia is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
MARICEL	Father (resort caretaker, 60), mother (resort caretaker, 40), sister (18). Family used to receive remittances from brothers and sister in the cities but during the pandemic they have lost their work. Family receives a conditional cash transfer every two months from the Department of Social Welfare and Development. Maricel is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
MELANIE	Father (government employee, 47), sister (17), brother (14). Mother recently left the household to work as a housekeeper in Manila. Sister (18) left to work as a nanny in a nearby municipality and sister (20) left due to marriage. Family receives a conditional cash transfer every two months from the Department of Social Welfare and Development. Melanie is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
MICHELLE	Father (farmer, 48), mother (homemaker, 47), brother (salesman, 21), sister (cashier, 23) sisters (19, 13 and 10). Family receives a conditional cash transfer every two months from the Department of Social Welfare and Development. Michelle is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
NICOLE	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
REYNA	Father (farmer, 58), mother (housewife, 47), sister (housewife, 24), brother (student, 21), sister (student, 18). Another three male cousins live in the household (7, 4 and 4). Sister (29) is self-employed in Manila and sends money home every month for his children. Reyna is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
ROSAMIE	Father (farmer, 52), mother (homemaker, 46), sister-in-law (local government employee, 29), sisters (19, 11) and nephew (2). Family receives a conditional cash transfer every two months from the Department of Social Welfare and Development. Rosamie is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
RUBYLYN	Father (construction worker, 47), mother (homemaker, 38), sister (10). Family receives a conditional cash transfer every two months from the Department of Social Welfare and Development. Rubylyn is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		

KEY: ● PARTICIPATED ● TEMPORARY ABSENCE ● DIED ● MIGRATED ● LEFT STUDY ● NOT PART OF STUDY

NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
VIETNAM																	
CHAU	Father (farmer, 37), mother (farmer, 43), sisters (12 and 10), brother (5). Chau is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
HANG	Father (farmer, 46), mother (commune official, 39), brother (11). Hang is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
HOA	Father (farmer, 46), mother (farmer, 51), brother (freelancer, 22). Hoa is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
HUONG	Father (village leader of the cooperative, 48), mother (farmer, 43), brother (15), paternal grandfather (retired, 83). Huong is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
KIEU	Father (mechanic, 37), mother (labourer, 36) and brother (12). Kieu has left school as they wanted her to repeat a grade, she fell behind due to COVID-19 and she did not want to repeat.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
KIM	Father (chairman of the commune, 47), mother (tailor, 46), brother (student, 21). Kim is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
LY	Mother (labourer; single parent, 52). Ly is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MAI	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
NGUYET	Nguyet's mother passed away. She lives with her uncle (farmer, 44), grandfather (72), aunt (44), cousin (freelancer, 24), cousin (11), sister (sales staff, 18), twin sister (15) and niece (2). Nguyet is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
NHI	Father (farmer, 44), mother (farmer, 42), brother (student, 19). Family received government compensation for losing their pigs to swine flu. Nhi is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
OANH	Father (freelance farmer, 46), mother (labourer, 40), sister (12). Older sister (22) works in Japan and sends remittances every month. Oanh is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
QUYNH	Father (farmer, 51), mother (kindergarten teacher, 46), grandmother (84), grandfather (85) and brother (student, 18). Family receives government health insurance. Quynh is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SEN	Father (driver, 45), mother (homemaker, 42), brother (11), sister (10). Brother (enrolled in the military, 22). Family receives government health insurance. Sen is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● PARTICIPATED ● TEMPORARY ABSENCE ● DIED ● MIGRATED ● LEFT STUDY ● NOT PART OF STUDY

NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
TAN	Father (farmer, 43), mother (farmer, 39), sister (41), brother (6). The family receives social insurance from the government. Tan is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
THI	Father (labourer, 38), mother (insurance sales, 36), sister (16), brothers (5 and 1). Family receives government financial support for electricity. Thi is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
THOM	Father (electrician/plumber, 45), mother (accountant, 37), sister (5). Thom is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
TIEN	Grandmother (80), maternal grandfather (85). Tien's mother (49) works in Ho Chi Minh city and sends money home for Tien. The grandfather receives a government pension. Tien is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
TRINH	Father (farmer, 41), mother (farmer, 36) sisters (10 and 7), brother (5). Family receives government financial support for electricity and received government health insurance. Trinh is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
UYEN	Mother (not working, 47), grandfather (83). Grandmother passed away this year. Aunt is a government employee in the city and sends home remittances every few months. Grandfather receives elderly allowance from the government. Uyen is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
YEN	Father (bricklayer, 45), mother (bricklayer, 38), brother (14). Yen is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

BENIN

ALICE	Father (pastor and farmer, 45), mother (sells beans, 43), two brothers (21, student), sister (18) and cousin (11). Her sister (24) recently married and left the household. A female child (7) they were hosting recently left to return to her parents. Alice recently had malaria and fever and had to go to hospital. Alice is enrolled in school but is two years behind for her age.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ANNABELLE	Father (taxi driver/trader, 47), mother (trader, 42), brother, (student, 23), brothers (12, 8), sister (19). Mother has recently been in hospital with high blood pressure and diabetes. Annabelle is enrolled in school and is ahead in her grades.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
BARBARA	Father (tailor, 59), mother (dressmaker, 44), brothers (students, 19 and 12). Father has recently been in hospital with artery hypertension. Barbara is enrolled in school but is one year behind for her age.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● PARTICIPATED ● TEMPORARY ABSENCE ● DIED ● MIGRATED ● LEFT STUDY ● NOT PART OF STUDY

NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
OMALARA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
CATHERINE	Father (painter decorator, 46), mother (trader, 43), brothers (students, 17, 11 and 8). Catherine is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
IANNA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ELEANOR	Mother (farmer and trader, 54), grandmother (96) and sister (17), one sister-in-law (20). Brother (20) recently dropped out of school to live with older brother and learn paving stone making. Father is deceased. Eleanor dropped out of school this year.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ISABELLE	Aunt (trader, 39), male cousin (dressmaker, 25), male cousin (apprentice-tailor, 23) and male cousins (students, 21 and 18), female cousin (13). Her uncle (47) who works for the Benin Electric Power Company was posted to northern Benin. Isabelle was recently in hospital due to malaria. Isabelle is enrolled in school but is three years behind.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
LILLIAN	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ELAINE	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
JACQUELINE	Father (shop manager, 40), mother (trader, 34), two sisters (10, 8), brothers (7, 4 and 3). Her eldest brother has dropped out of school. Her father and eldest brother (7 years) have gone to stay part-time with the paternal grandfather near the shop he manages. Jacqueline is enrolled in school but is one year behind.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
LAYLA	Layla's boss (saleswoman, 49), husband of her boss (51, door-to-door canvasser), male children of her boss (students, 30 and 21) and (hairdresser, 19). Daughters of her boss (computer specialist, 28) and (students, 16, 10 and 4). Daughter-in-law of boss (student, 19). Niece of her boss (13) and granddaughter of her boss (1 month). Layla has dropped out of school and is a live-in domestic employee.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MARGARET	Uncle (primary school teacher, 43), lives in another town Monday to Friday. Aunt (trader and farmer, 42), female cousin (16). Margaret's aunt has been very ill with artery hypertension and the grandmother has been in hospital with diabetes and infections. Margaret is enrolled in school but is five years behind.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● PARTICIPATED ● TEMPORARY ABSENCE ● DIED ● MIGRATED ● LEFT STUDY ● NOT PART OF STUDY

NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
THEA	Mother (trader, 46), grandmother (trader 67), aunt (16) three brothers (apprentice, 21 and student 17) and male cousin (8). Father deceased. Her brother (20) has completed his studies at the agricultural high school and has left the household to do an internship. Five-year-old cousin has also recently left to return to her parents. Thea is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ELIZABETH	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

TOGO

ADJOA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ALA-WONI	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
AYOMIDE	Grandfather (farmer, 76), other grandfather (farmer, 73), grandmother (homemaker, 60), half-brother (7). Father and mother absent. Cousin (14) recently moved out. Ayomide dropped out of school as they couldn't afford the fees.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ANTI-YARA	Father (farmer, 35), mother (homemaker, 40) and sister (9). Anti-Yara is enrolled in school but is two years behind in her grade. Her brother left the household to continue to study elsewhere. The father was very ill for three months, due to this he lost his job as a builder.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MANGAZIA	Polygamous family. Father (farmer, 33), mother (27), two stepmothers (both 29), brothers and half-brothers (carpenter (19), Koranic teacher (18) and students (12, 10)), sisters (and half-sisters) (8,7). Mangazia is enrolled in school but is not in the correct grade for her age.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MELYAH	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ADJOA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
REINE	Grandfather (farmer, 80), grandmother (homemaker, 60), aunt (homemaker, 39), brother (7), one sister (14), one uncle (26), male cousins (19 and 7), female cousin (11), niece (19) and nephew (16). Her aunt, who lives in Nigeria, sends remittances to the family. Mother and father are absent. Reine has had recently had malaria and is enrolled in school but one year behind.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ARIA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ISOKA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● PARTICIPATED ● TEMPORARY ABSENCE ● DIED ● MIGRATED ● LEFT STUDY ● NOT PART OF STUDY

NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
LARBA	Father (painter, 38), mother (trader, 30), brothers (3 and 1) and sister (18 and 9). Her sister (7) recently left to live with her aunt in Benin. Larba and her brother recently had malaria. Larba is enrolled in school but is one grade behind for her age.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
AISSA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ESI	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ESSOHANA	Mother (trader, 45) two brothers (tailor, 30 and 27), sisters-in-law (traders, 20, 19) and sister (dressmaker, 18). Essohana is enrolled in school but is one grade behind for her age.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
AZIA	Mother (58), father (80), brothers (25,18), three half-brothers (16,14,13), sister-in-law (28), sister (22). Her brother (35) recently left to move into another house. The family receives remittances from Azia's half-brother twice a year. He lives in Gabon. Azia has been sick for three months with an abscess. Azia is enrolled in school but is two years behind in her grade.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
IARA	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
DOFI	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
FOLAMI	Grandmother (homemaker, 61), uncle (farmer, 52), aunt (trader, 40), mother (dressmaker, 32), three younger sisters (9,7,4) and Folami's son. Folami and her mother newly moved into this household. Folami recently had malaria. She has dropped out of school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
NINI-RIKE	Nini-Rike lives in a polyamorous household with 18 people, including: father (40), mother (35), brother (carpenter,18), brothers (12, 7, 6) and sisters (8, 7, 4). Nini-Rike recently had measles. The father recently got married and one stepmother had a baby. Nini-Rike has dropped out of school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
LELEM	Uncle (community health worker, 43), father (farmer, 46), grandmother (trader, 60), aunt (dressmaker 35), aunt (homemaker, 32), female cousins (15 and 13). Her parents are divorced; her mother remarried but she visits her regularly. Lelem's twin sister, other grandmother, uncle all died in the past year. Lelem is enrolled in school but is two years behind in her grade.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● PARTICIPATED ● TEMPORARY ABSENCE ● DIED ● MIGRATED ● LEFT STUDY ● NOT PART OF STUDY																			
NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021		
DJOURMAI	Father (farmer, 56), mother (trader, 42), uncle (farmer, 38), brother (mason, 23), brother (worker, 27), sisters (traders, 38 and 26) and sister (animal breeder, 21). Uncle (69) in Germany works on the port and sends remittances home. Djoumai recently had malaria and is enrolled in school but is not in the correct grade for her age.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
TENE	Mother (homemaker, 43), aunt (student, 20), brothers (apprentice tiler, 25; painter, 22; electrician, 18) and male cousin (2). Sister (30) is a domestic worker in Saudi Arabia and sends remittances home every three months. Tene had malaria recently and is enrolled in school but is not in the correct grade for her age.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
OMOROSE	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
NANA-ADJA	Nana-Adja lives in a polyamorous household with 14 people. Father (tiler, 50), mother (homemaker, 44), other wife (homemaker, 45), uncle (tiler, 20), uncle (apprentice, tiler), half-brother (electrician, 21), half-brothers (students, 15, 12, 11, 10 and 9), half-sister (dressmaker, 17), sister (6). Two of her brothers emigrated in the past year: one went to Niger to work as a plumber and the second went to the Ivory Coast to work as a tiler. Nana-Adja is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
FEZIRE	Father (trader, 40), mother (trader, 30) uncle (motorcycle cab driver, 35), brothers (students, 20, 15 and 12), sister-in-law (homemaker, 21), sisters (8 and 2) and male cousins (8 and 6 months). Fezire recently had malaria. Fezire is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
LADI	Ladi lives in a polyamorous household with 17 people among those are a father (trader, 50), mother (homemaker, 35), grandmother (homemaker, 80), uncles (traders, 50, 29; motorcycle cab driver, 30), stepmother (30, homemaker) and sisters (students, 18 and 14). Ladi recently had malaria. Ladi is enrolled in school but is two years behind in her grade.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
IZEGBE	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		

KEY: ● PARTICIPATED ● TEMPORARY ABSENCE ● DIED ● MIGRATED ● LEFT STUDY ● NOT PART OF STUDY

NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
ANTI	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
UGANDA																	
AMELIA	Father (shopkeeper, 62), mother (shopkeeper, 55), brothers (students 20, 17 and 5) and sisters (students, 24 and 18). Other family members recently moved out – uncle (30) moved to new home, stepsisters (28, 26 and 24) and stepbrother (19) also moved to a new home. Amelia has had malaria recently. Amelia is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
BETI	Father (teacher, 53), mother (farmer, 43), grandmother (farmer, 65), brothers (students, 20 and 9), sisters (students, 18, 8, 6 and 4). Brother (24) recently left to train in the army. Beti recently had malaria. Beti is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
DEMBE	Dembe moved this year from her aunt's house into her grandmother's house. There are 22 people in this household: grandmother (59), aunts (20, 20), brother (7), stepbrothers (14, 5, 5 and 5), male cousins (10, 8, 7, 2 and 3 months), nephew (3), sister (15), stepsisters (9, 8, 5, 5) and nieces (9 and 2 months). Five uncles and one aunt live and work in other parts of Uganda and send remittances home. Dembe's father recently passed away. Dembe is enrolled in school but has repeated a grade.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
JANE	Jane normally lives with her sister in another town but is currently living with her father (farmer, 52), mother (farmer, 44), brothers (farmer, 18 and students 11, 9, 7 and 5), sister-in-law (17) and nieces (2 and 3 months). Jane is enrolled in school but has repeated a grade.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
JOY	Grandfather (shopkeeper, 62), step-grandmother (farmer, 47), aunts (18, 13 and 3), uncles (24, 7 and 6) and cousin (8 months). Uncle (28) recently left the household for work and aunt recently left as she married. Previously Joy has been sick with cerebral malaria. Joy recently dropped out of school to get married.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
JUSTINE	Father (vet, 52), mother (farmer, 49), brothers (33 and 17), sister (18) and male cousins (15 and 6). Cousins (4 and 7 months) recently left to return to his parents to start school. Justine has been unwell with malaria. Justine is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MIREMBA	Father (farmer, 38), mother (farmer, 39), brother (student, 14) and sisters (19; farmer, 17 and student, 17). Miremba recently had malaria. She is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● PARTICIPATED ● TEMPORARY ABSENCE ● DIED ● MIGRATED ● LEFT STUDY ● NOT PART OF STUDY																	
NAME	SUMMARY OF HOUSEHOLD CONTEXT (2021)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
NAMAZZI	Mother (farmer, 45). The father has left the family for another woman. Her sister recently left the household to move in with her husband. Brother (23) in Kampala sometimes sends remittances. Namazzi recently had malaria. Namazzi is enrolled in school but is not in the correct grade for her age.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
NASICHE	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
NIMISHA	Father (farmer, 56), mother (farmer, 52), brothers (students, 18 and 16), nephews (6 and 3) and sister (12). Her brother recently left the household to work elsewhere. Nimisha has been ill for three months with malaria and a skin condition. Nimisha is enrolled in school.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
REBECCA	Father (farmer, 39), mother (farmer, 34), brothers (6, 4, 4 and 2) and sisters (12, 10, 8, 6 and 2). Rebecca is currently enrolled in school but is two years behind as the parents couldn't pay the fees.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SHEILA	Mother is divorced. (35) Sheila's father passed away and she remarried but he has since left her and his children. Half- sisters (4 and 18 months). Brother (15) left the household for work. Sheila is currently enrolled in school but is two years behind as the parents couldn't pay the fees. Two of her uncles have recently died.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SHIFA	Polyamorous household includes mother (40). She also lives with brothers (8 and 6), sisters (15, 4 and 18 months). Shifa's stepfather and grandfather passed away. Three other sisters and a brother have left the household for work near Kampala and send remittances home. Shifa is enrolled in school but has to repeat her grade.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SYLVIA	Father (farmer, 53), mother (farmer, 43), uncle (farmer, 32), sisters (12, 9, 4 and 15 months) and cousin (11). Two brothers have left the household for work. Sylvia has recently had malaria and is enrolled in school but is not in the correct grade for her age.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ACHEN	Data not held for 2021.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●



A young girl and her sister carry water back to their home in Benin.

©Plan International



About Plan International

We strive to advance children's rights and equality for girls all over the world. We recognise the power and potential of every single child. But this is often suppressed by poverty, violence, exclusion and discrimination. And it's girls who are most affected. As an independent development and humanitarian organisation, we work alongside children, young people, our supporters and partners to tackle the root causes of the challenges facing girls and all vulnerable children. We support children's rights from birth until they reach adulthood, and enable children to prepare for and respond to crises and adversity. We drive changes in practice and policy at local, national and global levels using our reach, experience and knowledge. For over 80 years we have been building powerful partnerships for children, and we are active in over 75 countries.

Plan International

International Headquarters
Dukes Court, Duke Street, Woking,
Surrey GU21 5BH, United Kingdom

Tel: +44 (0) 1483 755155

Fax: +44 (0) 1483 756505

E-mail: info@plan-international.org

plan-international.org

Published in 2022. Text © Plan International

-  facebook.com/planinternational
-  twitter.com/planglobal
-  instagram.com/planinternational
-  linkedin.com/company/plan-international
-  youtube.com/user/planinternationaltv