report

MIDLINE REPORT

ACCELERATING ACTION TO END CHILD MARRIAGE IN BANGLADESH

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List of Abbreviations

BALIKA	Bangladeshi Association for Life Skills, Income, and Knowledge for Adolescents
DHS	Demographic and Health Survey
DWA	Department of Women Affairs
GOB	Government of Bangladesh
GP	Gender Promoters
GPECM	Global Programme to Accelerate Action to End Child Marriage
IRB	Institutional Review Board
KRC	Kishori Resource Centre
MoWCA	Ministry of Women and Children Affairs
ToT	Training of Trainers

Chapter 1. Introduction

This report describes results from the midline survey of Accelerating Action to End Child Marriage in Bangladesh. The objective of the program is to identify effective and scalable approaches to end child marriage by empowering girls and communities. To bring about social norms change, the program experiments with alternative means of community engagement that can be offered in conjunction with skills development opportunities for adolescent girls. The program is being assessed in a multi-arm cluster randomized trial. This report explores the impact on the prevalence of child marriage in two districts of Bangladesh as well as on a range of other indicators at the end of approximately 11 months of intervention.

Bangladesh has made significant progress on key development indicators such as life expectancy and total fertility rate, yet it has the highest rates of child marriage in Asia [1]. It ranks among the five countries with the highest rate of child marriage in the world with more than one in five girls marrying before the age of 15 and over half of all women aged 20–24 married by exact age 18 [2] [3]. A series of national surveys suggest that there is considerable variation within country in the age at which girls marry, but overall levels of early marriage prevalence have changed very little over the past two decades even though there has been considerable investment and progress in associated indicators such as girls' education and women and children's health [4].

Previous research has found that child marriage is associated with negative outcomes for girls [5-11]. Among underlying factors supporting the practice of marrying girls off soon after puberty are community cultural norms that need to be addressed, namely the economics of dowry and the sexual safety of girls. Dowry practices motivate child marriage because later marriage entails higher dowries [12]. Concerns about sexual safety are often cited as an additional reason to marry off daughters, because of perceived and real threats, as a preemptive strategy of safe-guarding their chastity [13]. These correlations suggest that in addition to empowering girls, there may be strategies of focused engagement in segments of the community that can be effective at addressing the normative drivers of child marriage.

In 2016, the Population Council completed a rigorous evaluation of three approaches to adolescent-girl-focused skill-building strategies under the BALIKA project. The study found that a program that provides opportunities for girls to advance education, develop skills, and enhance awareness of rights, combined with efforts to engage the community to change norms, can be effective in reducing child marriage. Girls in intervention communities were one-third less likely to be married before age 18 than girls living in control communities [14].

This project builds on the BALIKA study to test whether an additional social norms component added to the skills development programs, aimed at addressing community-level norms about females (and particularly adolescents), can offer additional benefits for ending child marriage in the communities. This project also aims to answer important questions about sustainable scaling-up of girl programs. Can the program be as effective when delivered through a government, relative to a nongovernment, initiative? One important variation from the tested model is that this intervention made mentors responsible for three Kishori Resource Centres in three different unions instead of one. The Centres were not usually located in the union where the mentors live (although in the same Upazila) and thus mentors had to travel farther distances. However, after a few months of implementation, the workload and travel to three different unions by one person was assessed to be excessive. Additional mentors were recruited to reduce each mentor's assignment to two unions instead of three.

Chapter 2. Program Description

This project is part of the UNFPA-UNICEF Global Program to Accelerate Action to End Child Marriage (GPECM). The project focuses on skill building and community engagement to create an enabling environment for girls to have a risk-free childhood and safe transition to adulthood. The project aims at empowering girls with life skills and livelihood and gender awareness training, and engaging communities to address normative drivers of child marriage.

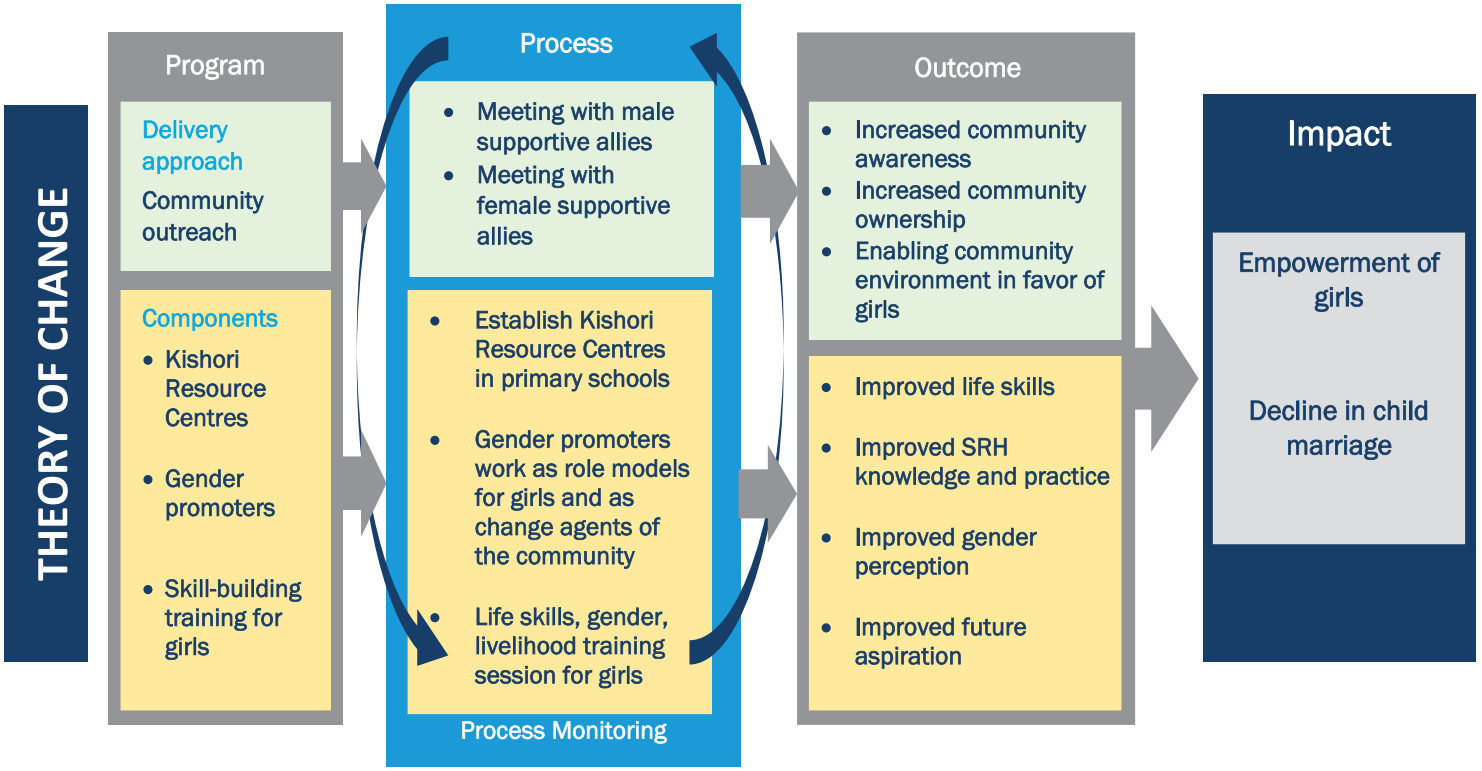
The partnership

The Population Council is partnering on this project with UNFPA and the Ministry of Women and Children Affairs (MoWCA) Government of Bangladesh (GOB) to delay child marriage. On behalf of MoWCA, the Department of Women Affairs (DWA) implements the field-level project activities while the field-level DWA Officers at the District and Upazila levels are involved in the overall management of the project. The Population Council provides technical assistance to the ministry to implement the project effectively. Specific roles of the Population Council include:

- Design and implement baseline, midline, and endline evaluations
- Develop and implement an effective M&E system
- Develop guidelines to implement community engagement interventions
- Provide training and technical assistance in project implementation

Target beneficiaries

The project intends to reach more than 13,000 girls aged 10–19, who may be in or out of school and married or unmarried. The project targets 10–19-year-old girls with a preference given to younger adolescents (12–14). The benefits of this program also extend to those reached indirectly by planned activities, including community members who participate in community events and household members of adolescent girls (including parents, in-laws, and husbands) who are primarily engaged to permit girls' participation in program activities.



Community outreach

Community outreach activities can facilitate the social change necessary to raise the status of girls in the community by reducing inequalities, violence, and harmful social norms related to sexual harassment and dowry. Under this project, community engagement strategies involve frequent interactions with community members to foster an environment that values girls as assets rather than as liabilities to both households and the community.

Community engagement activities are carried out and facilitated by young women recruited by the program and designated as Gender Promoters (GPs). Community group meetings are held to exchange ideas and information. GPs carry out community engagement activities and facilitate separate bimonthly community group meetings with adult men and women identified by the girls as supportive allies. GPs use a series of short videos at group meetings to prompt discussions on a range of social issues related to child marriage. Topics such as school dropout, poverty, gender discrimination within the family, harassment, violence, and peer pressure stimulate discussions among the participants as issues relating to child marriage. The discussions are intended to stimulate collective reflection and critical thinking about the issues.

Kishori Resource Centres

The skill-building intervention for girls takes place in 72 Kishori Resource Centres (KRCs), which are located in primary schools. Each center is equipped with laptops, internet, modem, and

associated reading materials to run the sessions for two adolescent groups. Each adolescent group has 30 members comprising both married and unmarried and in-school and out-of-school girls. Each group receives equivalent hours of curriculum-based training, and culturally sensitive parts of the curriculum are customized to be appropriate for marital status and age. The intervention is designed to run for a period of 12 months in two phases for each cohort for a total of two years, enrolling two cohorts of adolescent girls. The midline survey was held after approximately 11 months, upon completion of the first phase which only covered the basic life-skills and gender rights awareness curriculum. The program has been on hiatus interrupted by COVID-19 and is yet to cover the livelihood curriculum of the skill-building package for the first cohort of adolescent girls.

Kishori Resource Centre (KRC) management committee

The project also formed the Kishori Resource Centre (KRC) management committee, which is involved in both Kishori Resource Centre management and advocacy for girls in the community to ensure local ownership of the project and to harmonize activities through community participation. The committee is composed of local representatives (Union Porishod Chairmen), male and female members, parents, schoolteachers, and locally influential individuals. Program personnel convene meetings with this committee bimonthly to discuss issues related to center management and development of the KRC.

Gender promoters (GPs)

GPs are the key personnel who implement project activities. MoWCA recruited 36 young females holding at least a secondary school completion certificate, aged between 22 and 30 years and living in the intervention Upazila(s) to serve as mentors for the adolescents. MoWCA short-listed application forms against local advertisements for the post of GPs. Short-listed candidates participated in a formal written examination and following the written result faced viva for final selection. The main activities of GPs are:

- Conduct life skills, gender awareness, and livelihoods training among adolescent girls
- Provide alternatives to child marriage and mitigate the impact on married girls by encouraging their access to education, health, and economic opportunities
- Engage the community in support groups and related activities to change social norms

Each GP is assigned to two KRCs usually located at a Government Primary School in the intervention community. GP assignments considered travel time from their residence and tried to assign locations that involved the shortest travel. It so happened that the selection process meant that none of the GPs live in the localities where intervention activities are implemented. GPs needed to travel between two and four hours to reach their assigned KRCs and received a travel allowance. In addition to extending work hours, these distances created obstacles for the GPs to maintain regular communication with the parents and guardians to follow up on girls' attendance at the KRCs.

Training

The GPs received two rigorous training sessions to receive guidance on how to facilitate sessions and successfully conduct community engagement activities in the field. The training sessions were conducted by the Population Council team with the support of MoWCA and UNFPA. The first training session was six days and provided detailed orientation on the structured curriculum on life-skills and gender awareness. In addition to training on the curriculum, GPs were trained on community engagement activities and monitoring activities using SurveyCTO software. A second training session was five days and focused on a skills training for livelihoods curriculum that includes computing skills, mobile phone repair and maintenance, and entrepreneurship. In between the first and second training sessions, GPs also received an additional three-day training—two days on basic computer training and one day on facilitation of adolescent skills training.

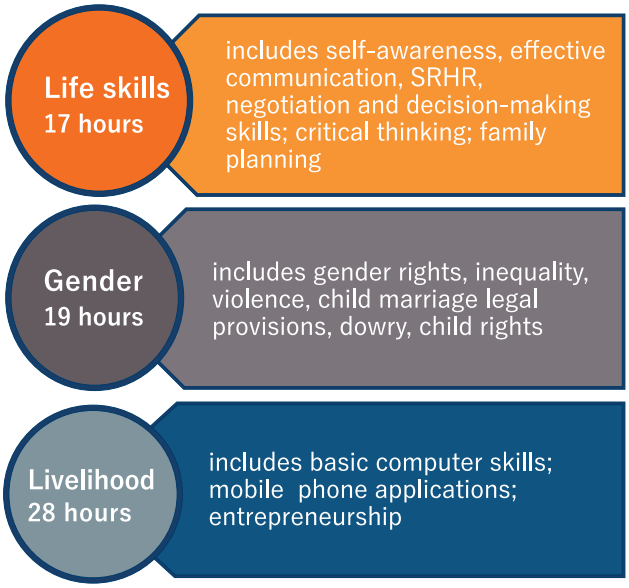
Virtual networking

The program used social media to promote interaction between GPs and program managers. GPs from each of the two districts were connected to each other and to their respective supervisors through two separate Messenger and WhatsApp groups for Bogura and Jamalpur districts. All GPs communicated with each other and regularly posted updates of their activities including the sessions, community outreach activities, and center management committee meetings. Through the groups, the program managers and supervisors can reach the GPs remotely to share instructions and ideas for ease of implementation of project activities in the field.

Skills training

Skills training for adolescent girls included sessions on life skills, gender rights awareness, and livelihood skills. Centers were equipped with audio-visual resources to facilitate instruction, such as the Meena cartoon and video campaigns against child marriage by MoWCA. The curriculum was developed by the Population Council in consultation with MoWCA and UNFPA, and was finalized at a national-level workshop involving different stakeholders

Adolescents receive two hours of after-school sessions once a week in groups of 30.



Intervention timeline

Over the course of the program, each group receives a total of 64 hours of training with a structured curriculum—17 hours of life skills, 19 hours of gender awareness, and 28 hours of livelihoods. As of midline, the program had completed the life skills and gender awareness components.

The skills training intervention was planned in two phases. Life skills and gender rights awareness sessions were designed to be delivered in the first phase before the midline, while livelihoods sessions were planned to be delivered in the second phase following the midline. The Training of Trainers (ToT) on life skills and gender rights awareness for the GPs was held in February 2019 and the intervention started immediately after the training in March 2019.[1] After the first phase of the intervention, which ended in November 2019, the GPs received livelihoods training in December 2019 anticipating that the second phase of activities for the first cohort of girls would start in January/February 2020. That was delayed initially due to[2] administrative issues and later due to COVID-19.

Program monitoring

The program is monitored through a remotely observable digital monitoring system, dashboards customized for the program, and standard conventional paper-based monitoring. The monitoring system is designed to help administer immediate corrective measures, if needed, and to provide timely feedback to the program management team and frontline implementers. The monitoring data also serves to document activities of the program in an efficient manner. Digital monitoring allows program implementers to show the exact location and time of activity, and to capture photo evidence of events arranged. Combined, digital and paper-based monitoring tracks ongoing progress and documents program activities to serve as a historical record. If monitored and acted upon in real time, the digital system can also be a useful administering and management tool that is remotely operable.

Three different monitoring forms were developed to record girls' attendance, track project activities, and assess the quality of the session. The attendance tracking form records individuals' session attendance longitudinally. When the GP conducts a session, she takes attendance and sends the information to the SurveyCTO server. Along with information on attendance, the chapter number of the session topic is entered in the digital form so that the progress of the sessions can be followed up. The associated dashboard allows remote and summary visualization of activities such as average number of girls in attendance that is presented per session, per KRC, as well as tracking the date, time, and GPS locations.

Another form tracks information about community activities that the GPs are performing in the field. As with the attendance form, the GPs can transmit information about community activities, such as the nature of the meeting, date, time, number of participants, and location. A third form was designed for program managers to document their assessment of a session's quality. It includes indicators of observations about the skills and capacity of GPs.

To date, the digital monitoring system has not been used to its full extent due to the unavailability of field-level staff time. Department of Women Affairs staff at the Upazila and District levels who

[1] In October 2019, a new set of GPs received training on the Life Skills and Gender Rights curriculum; they joined later after a decision was made to increase the number of GPs from 24 to 36 to share the existing workload.
[2] Program activities were halted for the duration of COVID-19-related school closures and is expected to resume once school resumes.

are designated to carry out the tasks of reviewing and providing feedback have many competing demands on their time that get priority over these routine activities. In addition, the GPs and other frontline personnel who are responsible for entering data faced challenges in the initial months because they were not familiar with the software. To analyze the reasons for incomplete entry, the Population Council compared attendance data from the hardcopy registers maintained at the KRCs. The Council found that GPs could record approximately 67 percent of sessions conducted. The total number of sessions recorded in the register is 2,624, while the number of digitally recorded sessions is 1,763. The average attendance is also slightly higher in the register, which is 18 attendees compared to the digital data, where it was recorded that 16.4 out of an expected 30 girls per session attended. This pattern of variance is similar in Bogura and Jamalpur. Both sources suggest that, on average, sessions have 60 percent attendance. Attendance is higher among schoolgirls compared to girls who are no longer in school.

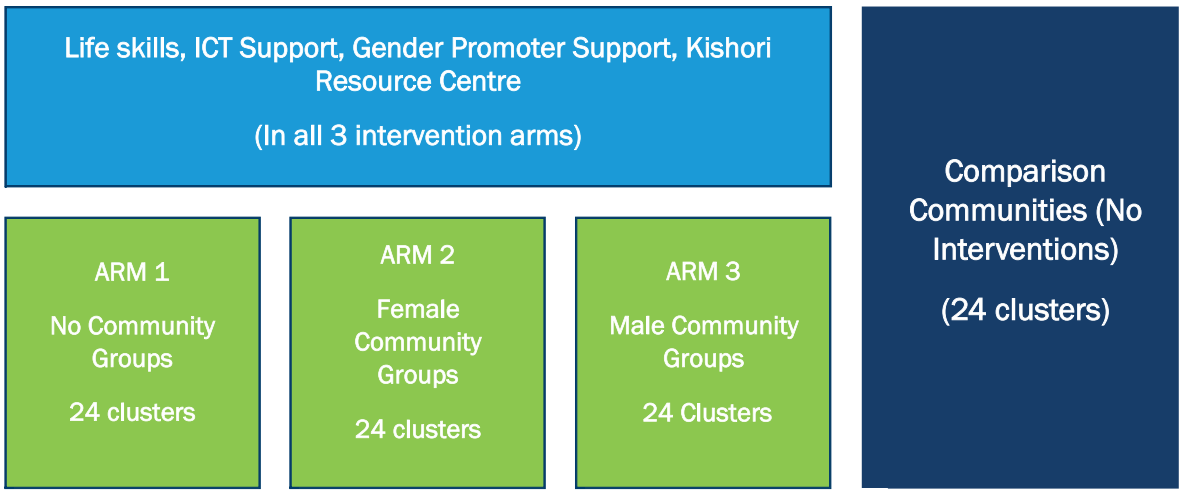
Chapter 3. Research Design and Methodology

The research design to assess the impact of Accelerating Action to End Child Marriage in Bangladesh program activities is a four-arm cluster randomized controlled trial using a repeated cross-section sampling strategy. The intervention components include the same skill-building activities, and the study intervention arms vary only in terms of the community engagement strategies employed. The repeated cross-section sampling is intended to ensure that the sample at each survey captures a representative sample of adolescent girls who lived in the program area at the time of the survey. It does not reflect the experience of adolescent girls who may have resided in the area and left. The sample is NOT limited to participants in the program for two reasons. This ensures that impact measures are not erroneously driven by the selective participation of girls who are more advantaged to begin with and because it has been observed in prior research that intervention effects are not limited to participants alone [14].

Cluster randomized controlled trial design

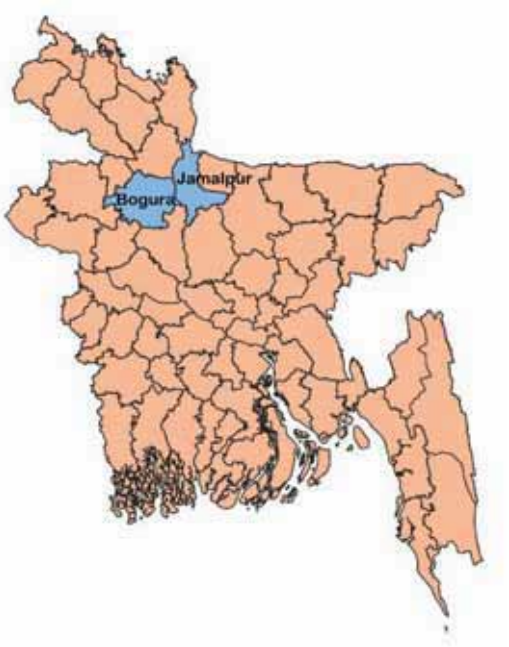
The interventions are randomized at the community level and each arm comprises 24 communities. The analysis measures impact at the community level. The community for our purposes is usually a village or a cluster of villages. Seventy-two communities were allocated to three intervention arms, while another 24 communities served as a control arm. The design intends to assess the impact of skills, as well as the added contribution of community engagement activities involving women and men. The three unique intervention arms are as follows:

- Skill-building intervention with no community engagement
- Skill-building intervention with female community members as supportive allies
- Skill-building intervention with male community members as supportive allies



Study site

This project is being implemented in Bogura and Jamalpur districts—two districts among the 21 districts identified by the United Nations partner agencies as vulnerable in terms of child marriage prevalence. Sample size calculations based on a minimal detectable effect between intervention and control arms determined that a total of 96 clusters are needed for adequate power. At the first stage of randomization, 96 unions from 17 Upazilas of Bogura and Jamalpur were randomly selected. After that, one government primary school from each union was randomly selected and later randomly assigned to receive one of the three interventions designed to delay marriage or to serve as a control arm.



Sample size calculation

The sample size for the two-level four-arm cluster randomized controlled trial was calculated by comparing statistical power using the proportion of females aged 15–19 married as the population parameter. Data from the 2011 Population and Housing Census, the latest available at baseline, were used to obtain estimates of the proportion of females currently married. On average, 48 percent of girls aged 15–19 are currently married in our proposed areas and we expect a decrease of 20 percent to 38 percent of girls 15–19 being currently married during the project period. We calculated the optimal sample size that would allow adequate statistical power to detect an impact within a reasonable timeframe and would be logistically feasible to implement. We assumed an intra-cluster correlation of k=0.05 and an average cluster size of 30 adolescents per union. Based on these assumptions, calculation of the number of unions per arm was performed by using the following formula:

$$c = 1 + \frac{\left(Z_{1-\alpha/2} + Z_{1-\beta}\right)^2 \left[\frac{P_1(1-P_1)}{n} + \frac{P_2(1-P_2)}{n} + k^2(P_1^2 + P_2^2)\right]}{(P_1 - P_2)^2}$$

Where, c is the required number of unions per arm, $Z_{1-\alpha/2}$=$Z_{0.975} = 1.96$ is the probability of falsely rejecting a true null hypothesis (α) = 0.05, $Z_{1-\beta}$=$Z_{0.18} = 0.92\ is$ the probability of failing to reject a false null hypothesis (β) = 0.82, $P_1 - P_2$ represents expected magnitude of the effect of a program or difference between the treatment and control group, n the cluster size, P1 is the probability of an event in the control group, and P2 the probability of an event in the treatment group.

It was found that a minimum of 24 unions per arm and a sample of 30 adolescents in each union with 720 respondents per arm is sufficient to measure the impact of the program with 83 percent statistical power. From the two program districts, 96 unions were selected from a possible 157 available unions (excluding 20 unions from Jamalpur where UNICEF is already working) using the random number generation sampsi command in STATA 13.0. The 96 clusters were then randomly assigned to one of four arms, and 30 individual adolescent respondents were randomly selected from households within 2 km (1.25 mi) of the selected schools in each union from the list of adolescents identified in a household enumeration survey. The targeted final sample size was 2,880 girls (30 per union) in order to detect a 20 percent reduction in child marriage prevalence by the end of the intervention period.

Household listing

For the midline survey, a household listing was conducted of approximately 300 households living closest to each randomly selected school within a 2 km walkable distance. Before the midline survey, a household listing conducted on December 2017 prior to the baseline survey was updated. The baseline listing in 2017 enumerated girls aged 10–21 years. Households enumerated at baseline were revisited in 2020 and updated to identify all girls between the ages of 10 and 21. The updates involved new enumeration of girls aged 10–12 who were previously too young to be enumerated as well as girls who may have joined the household.

In addition, any other girl living in the selected household who was not in the original 2017 listing was also included.

For the midline survey all 29,749 households counted at baseline were contacted for re-enumeration at midline. A total of 11,833 girls aged 12–19 are listed from 96 unions, where 9,907 girls are counted from the enumeration data of 2017 and 1,926 girls are from re-enumeration data of 2020; that is 123 adolescent girls aged 12–19 from each union. The definition of a household was the same as that used by Demographic and Health Surveys, including that members belong to the same household head and share the same pot or kitchen. The household listing (enumeration and re-enumeration) included a short survey completed by interviewing the head of the household or, if he/she was not available, the spouse of the head or another adult household member. The household instrument included basic demographic

information on all members and detailed information on the schooling, marital status, age at marriage, and childbearing status of adolescent girls. For household enumeration at baseline, a filter question was asked at the start of the interview to identify whether a particular household meets criteria for listing *"How many adolescent girls 10–21 years of age live in this household."* The question included two additional years on either end of the age bracket to minimize intentional age misreporting and age heaping. For midline household re-enumeration, two filter questions were asked at the beginning, *"How many adolescent girls 10–12 years of age live in this household?"* and *"How many adolescent girls 13–19 years old are now in the household who joined the household after 2017"?*

Re-enumeration team

Re-enumeration was conducted by a team comprised of both male and female interviewers who had the educational qualification of a bachelor's degree. Listing of households took place just prior to the survey date to minimize nonresponse rates. In the case of the presence of multiple eligible respondents in the same household, only one respondent was selected randomly for the midline survey. Data were collected electronically using mobile phones and were monitored remotely to ensure quality.

Survey team

The Population Council deployed 25 female interviewers and 5 female supervisors for the individual-level interviews, all holding at least a bachelor's degree. The team was closely supervised by staff members of the Population Council. Five supervisors with considerably higher data-collection experience were recruited to oversee interviewers divided into five groups. All the interviewers were trained for a period of six days in December 2019. Interviewer training sessions included specific instructions on mobile-based survey instruments, management of devices, collecting data on GPS location, and other applications as needed during the survey. The training also offered briefings about the study area, and about the objectives of the research and ethical issues in conducting research including the informed consent process prescribed by the Institutional Review Board (IRB) of the Population Council.

Data collection

Midline data were collected on Android-based mobile phones utilizing SurveyCTO, a cloud-based data collection tool that harnesses the flexibility of open data kit, and integrated monitoring dashboards were developed to visualize data, check irregularities, and monitor the overall progress of the survey. Data were collected with smart phones that had SurveyCTO preloaded. Spatial coordinates were collected to identify the location of study areas as well as service-delivery points. The survey was conducted between January and mid-February 2020.

Ethical issues

The research protocol was approved by the Population Council Institutional Review Board (PC-IRB). The research teams discussed and developed methods and procedural measures in relation

to matters such as data recording style, personal identifiers, transcription and processing procedures, the lifespan of unprocessed data, type and places of storage, and data safety and right of access. To maintain data confidentiality, all access to data is password protected and strictly limited to the research team. Data were collected only after receiving informed consent from each respondent. Guardians' assent and participants' informed consent was obtained for minor unmarried girls (aged 12–17); married minor girls were considered emancipated minors and were able to consent to their own participation. All interviews were conducted in private. Confidentiality was maintained throughout the training of interviewers, including learning the definition of confidentiality and ways to maintain confidentiality during data collection and afterward. Data were analyzed and presented with anonymity.

Chapter 4. Midline Survey Results

The midline survey was conducted among a representative sample of adolescent girls aged 12–19 in the 96 selected unions from January to February 2020. The survey was conducted right after the completion of life skills and gender activities conducted by GPs in 72 selected KRCs. For the midline survey, 2,870 adolescent girls in the 12–19 age group were randomly selected from 31,822 households listed, an average of 30 per union.

The midline survey was conducted after completion of life-skills and gender rights awareness training, and engaging communities to address normative drivers of child marriage. The survey offers an interim measure of program impact on a range of outcomes of interest. The midline assessment follows the overall design of the study and measures impact at the cluster or community level. The measures of impact of the three program approaches are tested against a set of control communities where research was conducted but programs were not implemented.

The midline survey captured information on adolescent experiences, knowledge, and attitudes in the domains of marriage, schooling attainment and transitions, literacy, numeracy skills and ability, reproductive health, gender-based violence, gender attitudes, labor-force participation and savings, mobility, migration, and social life.

Highlights

- Among ever-married girls, 59% were married before or at the age of 15 years
- 91% of girls were married before the age of 18 years (for ever-married girls)
- 66% of girls discontinued schooling because of marriage
- 65% of parents are concerned about the safety of their adolescent girls
- 23% of girls mentioned that they are allowed to go to the Kishori Resource Centre
- 92% of girls have proper menstrual knowledge
- 94% of adolescent girls think that people should be treated similarly irrespective of their gender
- 69% of adolescent girls are affirmative on women's rights to divorce

To complete the targeted 2,870 interviews, the teams contacted 3,984 adolescents who were randomly selected from the household listing of adolescent girls in 29,749 households. Among all successful interviews, 84.9 percent were interviewed on the first visit, 9.6 percent on the second visit, and 5.5 percent on the third visit. Out of 3,984 attempted interviews, 1,114 girls were not successfully interviewed. The breakdown of reasons for these unsuccessful interviews is as follows: 401 girls (36 percent) had left the household because of marriage and another 390 girls (35 percent) were not present in the household after three visits. In addition, 80 girls (7.2 percent) had left the households for higher study. Interviewers failed to locate 33 of these households (3.0 percent). Thirty-three girls (3%) were not between 12 and 19 even though they were listed as such in the household listing. A total of 175 girls were replaced for other reasons (15.7%) and 2 girls refused to be interviewed (0.2%).

Background and demographic characteristics

Table 1 shows socioeconomic and demographic characteristics of respondents by intervention strategy from the baseline survey. The baseline survey established that the randomization of interventions worked and the four groups were comparable, i.e. balanced. None of the differences across arms were significant other than the variable measuring average number of siblings. Since the baseline confirmed that the randomization is balanced, we follow standard and recommended protocol and assess impact by comparing the intervention arms to the control arm.

At baseline, the mean age of the respondents ranged between 14.8 and 15.1 years in the four arms. The proportion ever-married ranged between 19 percent in the control arm and 22.2 percent in the male support group arm. Approximately 80 percent of the respondents were in school. Mean age at first marriage varied less across the arms and ranged between 14.7 and 14.9 years. The highest percentage of girls who owned a birth registration card (68.8 percent) was found in the “female support group” arm, and the lowest (63.7 percent) in the “no support group” arm.

Table 1: Socioeconomic and demographic characteristics of survey respondents by intervention strategy, project baseline survey

Variable	ARM 1: No Support Group	ARM 2: Female Support Group	ARM 3: Male Support Group	Control
Respondent’s age (mean)	15.1	14.8	15.0	14.9
Ever-married girl (%)	21.7	20.4	22.2	19.0
Girls in school (%)	82.0	80.6	80.6	82.5
Birth registration (%)	63.7	68.8	64.0	66.4
By age group				
12–14 age group (%)	44.3	49.1	46.7	44.8
15–17 age group (%)	38.9	37.8	36.8	42.3
18–19 age group (%)	16.8	13.1	16.5	12.9
Number of siblings (mean)	2.2	2.0**	2.1	2.2
Father's education				
None (%)	43.9	39.3	39.4	42.6
Less than secondary (%)	41.2	42.5	44.3	41.1

Mother's education				
None (%)	44.4	41.3	40.8	41.0
Less than secondary (%)	49.5	50.5	49.9	52.4
Father's occupation				
Service/Skilled (%)	10.5	10.8	13.7	12.2
Business/Shopkeeper/Abroad (%)	18.9	20.0	22.6	21.2
Agriculture (%)	45.7	43.3	37.9	40.9
Wealth index				
Poorest (%)	28.4	25.0	22.6	25.4
Poorer (%)	23.7	17.5	22.0	19.6
Middle (%)	16.7	21.4	18.3	20.0
Richer (%)	14.9	19.8	18.2	19.9
Richest (%)	16.3	16.4	18.9	15.1
Respondent ownership of assets				
Mobile (%)	23.5	21.5	26.1	23.5
(N)	**750**	**749**	**747**	**744**
Age at first marriage (mean)	14.9	14.7	14.8	14.7
(N)	**163**	**153**	**166**	**141**

Significantly different from control group at **p<0.05.

Marriage and school discontinuation

Table 2 presents data from the midline survey on marital status, schooling status, and reasons for school discontinuation. We discuss data from the midline survey in terms of comparison between intervention and control arms. These comparisons are not statistically significant unless noted otherwise.

Compared to the control arm, we find that only girls living in the unions where male support group interventions are implemented had 10 percent lower odds of marriage (Arm 3). The probability of marriage in the other two intervention arms are no different from the control arm.

There are some detectable differences in the timing of marriage for those who are married but that is also variable by arm. The proportion of ever-married girls whose age at first marriage was "less than 15 years" decreased by 30 percent for Arm 1, whereas the other intervention groups were not different than the control group (Arm 4). However, the proportion of girls whose age at first marriage was "less than 18 years" was almost 70 percent lower in Arm 2 and Arm 3 compared to the control group.

Marriage registration is common among Muslims in Bangladesh and is important for formalizing the marriage contract. The interventions had a positive impact on marriages registered in two of three intervention arms—Arm 1 (1.5 times higher) and Arm 3 (1.2 times higher, or a 20 percent increase)—whereas there was a significantly negative impact at Arm 2 (50 percent decrease) compared to the control group.

The proportion of girls who are currently out of school is lower in all three intervention arms compared to the control group suggesting that schooling improved, although differences are not

statistically significant. Reported reasons for school discontinuation in the survey are marriage, financial constraint, student's lack of interest, competing time demands because of household chores, and parents' not wanting girls to study. Data show that the primary reason for school discontinuation is marriage—in Arm 1, girls who discontinued are 1.7 times more likely than girls in the control arm to attribute school discontinuation to marriage. Arm 2 has 1.3 times higher school discontinuation due to marriage of adolescent girls compared to the control arm. By contrast, Arm 3 reported that discontinuation attributed to marriage was 59.2 percent, which is 30 percent lower compared to the control group. However, school discontinuation due to household chores is significantly (2.8 times) higher in Arm 2, 2.3 times higher in Arm 1, and 1.3 times higher Arm 3 compared to the control group.

Table 2: Marital status, schooling status, and reasons for school discontinuation among respondents, by intervention strategy

	ARM 1: No Support Group		ARM 2: Female Support Group		ARM 3: Male Support Group		Control
Variable	Percent	Odds Ratio	Percent	Odds Ratio	Percent	Odds Ratio	Percent
Marital status of respondent							
Ever-married girl (%)	19.1	1.0	19.2	1.0	17.3	0.9	18.6
(N)	717		718		719		716
Age at first marriage for ever-married girls							
Marriage at age <=15 (%)	52.6	0.7	60.9	1.0	60.5	1.0	61.7
Marriage at age <18 (%)	89.8	1.0	93.5	1.7	93.6	1.7	89.5
Marriage registration (%)	83.2	1.5	63.8	0.5*	79.8	1.2	76.7
(N)	137		138		124		133
Schooling status							
Currently In school (%)	85.0		85.5		85.2		84.7
Currently out of school (%)	15.0	1.0	14.5	0.9	14.8	1.0	15.3
(N)	709		703		703		701
Reasons for discontinuation among out-of-school girls							
Got married (%)	72.8	1.7	70.1	1.3	59.2	0.7	64.2
Financial constraint (%)	26.3	0.9	22.2	0.7	25.0	0.8	28.5
Student's lack of interest (%)	16.7	1.3	12.0	0.8	23.3	2.0*	13.8
Household chores (%)	11.4	2.3	14.5	2.8**	7.5	1.3	5.7
Parents did not want (%)	23.7	1.2	25.6	1.4	11.7	0.5*	20.3
(N)	114		117		120		123

Significantly different from control group at **p<0.05, * p<0.1.
Reference = Control group.
Odds Ratio refers to the intervention rate relative to the control group

Daily time use and livelihood

The study tried to capture adolescent girls' daily use of time by asking a series of questions on how their time was spent the day before the interview. This time-use information captures income-generating activities, time at school, childcare, household chores, agricultural work, spending time

with friends/leisure time (*adda,* in Bangla), and transportation. Table 3 shows how respondents spent the previous day, by major activity categories.

Average time spent in school is the product of factors such as the number of days that schools are in session, average school day, whether the person is enrolled, and the degree of absenteeism. Differences across study arms measure the last two factors, proportions enrolled, and level of absenteeism. Findings revealed that a positive change happened in the average time spent in school for all intervention groups compared to the control group. Adolescent girls in Arm 1 spend 28 percent more time, in Arm 2 spend 22.4 percent more time, and in Arm 3 spend 20.1 percent more time in school compared to the control group. The comparison is statistically significant only for Arm 1.

In rural Bangladesh, adolescent girls are often relied on to provide childcare for their siblings, their own children, and children of other family members. Girls in all three intervention arms spent less time taking care of children compared to the control group, but the difference is statistically significant only for Arm 2. Time spent doing agricultural work was lower by 47 percent and 63 percent in both Arm 2 and Arm 3 but increased by 17.5 percent in Arm 1 compared to the control group. Time spent on school homework was slightly higher among the intervention arms, and time spent with friends/leisure was slightly lower in the intervention arms compared to the control group.

Since relatively few girls report working for money, the time-use data does not include much time spent working outside the home. As shown in Table 3, only about 1 in 10 girls have ever worked for money and the overall percent who report currently working ranges from 5 to 8 percent in the four arms. Slightly higher percentages report actively saving money as an economic activity. Overall participation in economic activities is lower in the intervention areas in comparison to the control group.

Table 3: Average daily time use data and livelihood indicators of respondents, by intervention strategy

	ARM 1: No Support Group		ARM 2: Female Support Group		ARM 3: Male Support Group		Control
Variable	Percent	Difference (%)	Percent	Difference (%)	Percent	Difference (%)	Percent
Time use							
Time spent at school	2.8	**28.3***	**2.7**	22.4	2.6	20.1	2.2
(N)	**717**		**718**		**719**		**716**
Time spent on personal cleanliness	1.3	-4.5	1.4	-0.4	1.5	5.1	1.4
(N)	**716**		**717**		**717**		**713**
Time spent on childcare	0.4	-23.6	0.4	**-30.1 ****	0.4	-19.7	0.5
(N)	**714**		**709**		**715**		**709**
Time spent on agriculture	0.1	17.5	0.0	-46.9	0.0	-62.9	0.1
(N)	**717**		**718**		**719**		**716**
Time spent on household chores	1.5	-7.5	1.7	4.5	1.5	-8.4	1.6
(N)	**717**		**715**		**719**		**716**
School homework	2.2	3.6	2.2	3.9	2.2	2.0	2.1
(N)	**711**		**713**		**712**		**708**

Time spent on *adda*	1.5	-12.1	1.5	-13.7	1.6	-6.4	1.7
(N)	707		711		714		710
Transportation	0.5	15.4	0.5	25.3	0.5	20.2	0.4
(N)	716		717		719		714
Other workforce participation indicators							
Ever worked to earn money (%)	11.9	25.0	10.6	11.6	11.4	20.3	9.5
Currently working engagement (%)	5.6	2.6	4.9	-10.5	7.9	45.8	5.4
Save money for the future	11.4	-11.9	14.1	8.3	10.4	-19.7	13.0
(N)	717		718		719		716

Significantly different from control group at **p<0.05, *p<0.1.
Difference expressed relative to control arm.

Safety, security, and mobility

Table 4 shows a range of indicators that reflect attitudes and behaviors related to safety, security, and mobility along with harassment-related information revealed in the survey. Responses suggest that girls perceive their parents to be less concerned about their safety in Arm 2 and Arm 3 relative to the control. Respondents in Arm 1 and Arm 2 are 1.3 times and 1.2 times more likely to say they observe *purdah* for security reasons, whereas the respondents in Arm 3 are 20 percent less likely to observe purdah for security relative to the control group. All the arms show almost similar results when the respondents were asked whether they are allowed to go to school/college/madrasah, and more than 78 percent of respondents gave positive answers.

Table 4: Safety, security, and mobility-related indicators among respondents, by intervention strategy

	ARM 1: No Support Group		ARM 2: Female Support Group		ARM 3: Male Support Group		Control
Variable	Percent	Odds Ratio	Percent	Odds Ratio	Percent	Odds Ratio	Midline
Parents are concerned about girls' safety	67.9	1.0	63.1	0.8	61.5	0.8	67.5
Use of purdah for security	97.2	1.3	96.0	1.2	95.4	0.8	96.7
Allowed outside after sunset (%)	9.1	0.9	7.2	0.7	10.4	1.0	10.1
Allowed to go to these places							
School/College/Madrasah (%)	78.9	1.0	79.4	1.0	80.8	1.1	78.8
KRC/Kishori Kendra (%)	32.2	54.5*	29.7	50.3*	30.0	54.1*	1.0
Library (%)	12.7	1.1	13.8	1.2	13.4	1.2	11.6
Market (%)	58.0	1.0	58.5	1.0	65.8	1.4	59.1
Friend's house (%)	67.4	1.2	63.4	1.0	63.4	1.0	63.1
Playground (%)	17.0	0.9	16.6	0.9	16.8	0.9	17.6
Ever experienced harassment at home (%)	5.6	0.6	5.2	0.5	6.7	0.8	8.8
Ever experienced harassment in the community (%)	30.1	1.0	23.3	0.7	27.3	0.9	29.7
(N)	717		718		719		717

Ever experienced harassment at school (%)	9.9	0.9	7.0	0.6**	11.5	1.1	11.1
Sexual harassment at school (%)	6.1	1.0	4.7	0.8	7.5	1.2	6.1
(N)	709		703		703		701
Sexual harassment in the community (%)	8.1	0.8	5.4	0.4**	9.0	0.8	10.5
(N)	717		718		719		717

Significantly different from control group at **p<0.05, *p<0.01.
Reference = Control group
Odds Ratio (OR) refers to the ratio of the relative incidence (odds) of an outcome in the intervention group relative to the relative incidence in the control group.

The respondents were asked about their experience of harassment and violence at home, in public places, and in school. In general, respondents in the intervention arms were less likely to report harassment at home relative to the control group. For example, the respondents in Arm 1, Arm 2, and Arm 3 have less experience of harassment at home (40 percent, 50 percent, and 20 percent less, respectively) in comparison to the control group. Respondents were significantly less likely to report experiencing harassment at school in Arm 1 and Arm 2 compared to the control group.

Sexual and reproductive health and knowledge

Table 5 presents a range of sexual and reproductive health knowledge indicators such as correct knowledge about menstruation, antenatal and postnatal care, knowledge of HIV, sexually transmitted infections, and family planning. In all these indicators, intervention arms report greater knowledge and awareness compared to the control group. By contrast, the use of sanitary menstrual pads and menstrual regulation are two indicators where intervention arms compared unfavorably relative to the control group.

Comparison of intervention and control arms suggests that knowledge regarding menstruation improved significantly as a result of the intervention and is 1.6 times higher in Arm 1, 1.3 times higher in Arm 2, and 1.2 times higher in Arm 3, compared to the control group.

Table 5: Percentage changes in adolescents' responses regarding sexual and reproductive health knowledge and practices, by intervention strategy.

	ARM 1: No Support Group		ARM 2: Female Support Group		ARM 3: Male Support Group		Control
Variable	Percent	Odds Ratio	Percent	Odds Ratio	Percent	Odds Ratio	Percent
Menstruation knowledge (%)	93.4	1.6**	92.1	1.3	91.7	1.2	90.1
(N)	717		718		719		716
Knew about menstruation before experiencing (%)	50.5	0.8	54.6	0.9	59.3	1.1	56.6
Correct fertility period (%)	9.7	0.9	7.4	0.6	10.9	1.0	11.0
(N)	670		661		659		645
Using sanitary pad (%)	52.6	0.9	52.4	0.9	58.3	1.1	55.6
Familiar with ANC (%)	64.9	1.2	59.8	1.0	59.4	1.0	60.0
(N)	717		718		719		717
Correct knowledge on ANC (%)	66.0	1.1	56.4	0.7*	66.7	1.1	63.5
(N)	465		429		427		430

Familiar with PNC (%)	41.3	1.0	32.2	0.6*	36.6	0.8	41.0
(N)	717		718		719		717
Correct Knowledge of PNC (%)	38.5	1.2	37.2	1.1	37.3	1.2	34.0
(N)	296		231		263		294
Knowledge about HIV (%)	63.9	1.1	62.3	1.0	62.3	1.0	62.5
Sexually transmitted disease (%)	5.6	1.2	6.0	1.3	6.3	1.3	4.9
Menstrual regulation (%)	18.7	0.9	17.3	0.8	12.1	0.5	20.0
Knowledge about family planning (%)	74.6	1.2	70.2	0.9	70.9	1.0	72.1
(N)	717		718		719		716

Significantly different from control group at **p<0.05, *p<0.1.
Reference = Control group
Odds Ratio (OR) refers to the ratio of the relative incidence (odds) of an outcome in the intervention group relative to the relative incidence in a control group.

Gender equality

This section explores attitudinal indicators regarding gender equality as measured in a series of questions regarding gender equitable norms. Table 6 shows perceptions regarding gender equality, violence, women's role and rights, by intervention strategy. In general, these attitudinal indicators suggest that girls' responses are more gender equitable in the intervention arms relative to the control arm. Respondents in intervention arms did not agree with a statement that women deserve to be beaten (under certain circumstances), or to the view that women should tolerate violence to keep their family together. Respondents also agreed to a statement that people should be treated equally irrespective of their gender. Respondents of Arm 2 and Arm 3 showed higher agreement on women's rights to divorce.

In a specific question where the respondents were asked whether a woman should always obey her husband, 15 percent showed disagreement across the intervention areas.

Table 6: Beliefs and attitudes about gender equality (agreement-disagreement) among respondents, by intervention strategy

		ARM 1: No Support Group		ARM 2: Female Support Group		ARM 3: Male Support Group		Control
Variable	Category	Percent	Odds Ratio	Percent	Odds Ratio	Percent	Odds Ratio	Percent
Believe in gender equality								
Women deserve to be beaten	Disagree (%)	50.4	1.2	47.2	1.1	48.7	1.1	45.8
Women should tolerate violence in order to keep the family together	Disagree (%)	64.9	1.2	62.1	1.0	61.5	1.0	61.4
People should be treated similarly irrespective of gender	Agree (%)	94.1	1.2	92.8	0.9	94.9	1.3	93.3
Women should always obey their husband	Disagree (%)	14.5	0.8	12.8	0.7	17.4	1.0	17.0
Men should have final say in all family matters	Disagree (%)	56.5	1.1	56.1	1.1	57.4	1.2	53.7
Women should have the right to divorce	Agree (%)	64.7	0.9	73.4	1.4*	72.0	1.3	67.2
(N)		717		718		719		717

Women cannot refuse to have sex with their husband	Disagree (%)	57.0	0.8	67.5	1.2	65.1	1.1	63.5
If a woman is raped, she is usually to blame for putting herself in that situation	Disagree (%)	71.0	1.0	74.0	1.2	70.5	1.0	71.4
(N)		435		443		410		433

Significantly different from control group at *p<0.1.
Odds Ratio (OR) refers to the ratio of the relative incidence (odds) of an outcome in the intervention group relative to the relative incidence in a control group.

Chapter 5. Discussion and Recommendations

Accelerating Action to End Child Marriage in Bangladesh was designed to identify ways to scale up skill-building activities along with alternative community participation strategies to ensure the long-term sustainability of the program. Although changes in indicators of program impact, as measured by comparing intervention to control groups, are generally in the right direction, in most instances the midline results are not statistically significant. Thus, we are unable to say that the results conclusively show a positive impact of the interventions at midline, which evaluated the impact of the first phase of interventions and was conducted after a little under a year of program activities.

There may be several explanations for the observed response patterns in terms of program impact. First, we find that although the program was offered to adolescents of all ages, the age distribution of program participants (not shown) suggests that the highest participation was among 12–14-year-olds, with about 50 percent of all participants belonging to this age group. On the other hand, mean age at first marriage across the intervention arms is around 15 years. It is likely that as these young participants reach older adolescence, when they are at higher risk of marriage or dropping out, the impact of interventions will become more evident. After the midline survey the cohort will receive additional livelihood interventions. An assessment at endline after the completion of more training will be crucial to document a realistic impact of the intervention.

Second, as described earlier, a major objective of the research design was to assess the impact of strategies to engage men and women in community conversations during the course of the program, alongside skills training for girls. Community outreach activities are not expected to show immediate impact but rather are expected to unfold over time as they rely on a process of diffusion of new norms and values through an interactive and iterative process. There were several administrative delays in the implementation of community outreach activities and there were interruptions in the implementation plan due to severe floods that affected the community. As a result, most of the community engagement activities took place in the months immediately preceding the survey. We anticipate stronger results at endline as the community engagement strategies take time to show results.

Despite disappointing results on child marriage and school dropout it is important to note that while the program did not document significant change in behavioral indicators related to child

marriage and schooling, there are several important positive attitudinal impact indicators that may reap benefits later. There are promising changes in indicators related to the respondents' beliefs in gender equality, and strong agreement observed among the respondents when they were asked about equal treatment irrespective of gender. Three-fourths of the respondents agree that women have the right to divorce, indicating their affirmation of seeking legal rights. The result revealed from the gender-related indicators guides the program on how to craft the future intervention to boost up the girls toward their rights, including combating child marriage.

There is also a positive impact on behaviors with some intervention girls spending more time in school, less time on childcare, and reporting less harassment at home and in school. These are also positive changes that may have a cumulative impact on marriage and school dropout in later adolescence.

Some part of the explanation for weak impact may lie in the effectiveness of program implementation. The success of BALIKA interventions was in part attributable to the effective use of a digital monitoring system to identify weak implementation and take timely corrective action. From the accountability point of view, digital monitoring implies better implementation with quality outcome. Due to the unavailability of dedicated field-level staff, the guidance and supervision of all the digital tools could not be implemented properly. However, the key implementer of the project, MoWCA, has adopted the digital monitoring techniques and identified them as a unique feature of the project. We expect to show better results in future implementation.

Finally, based on our observations in the field as well as remote interactions we are reassured that the GPs are important assets for the program and show promise. They are well known to girls and their families and serve as trusted role models and mentors. However, in the program design, one GP is assigned to two centers. GPs had to travel quite a long distance and the workload was intensive in terms of maintaining two batches in each center for a total of 120 girls in each center. Feedback on workloads from the GPs to help improve project outcome may be important to consider in the future. It is likely that recruiting mentors who reside in the community where the program is being implemented will yield better impact.

Some Program Modifications to Consider

- Gender promoters, recruited from and living in the localities where they work, can be the most important resource in implementing project activities with the adolescent girls, their families, and the communities. Girls can freely interact with the mentors and admire them. The mentors can be important role models of women's empowerment in the communities. Families and other community members rely on and trust the mentors more if they are from the same locality. Investing in mentors (gender promoters), strengthening their skills, and providing them with opportunities is critical for adolescent programs.

- Kishori Resource Centres or safe spaces for girls are well accepted by the families and communities. Adolescent girls are allowed to visit KRC without facing any obstacles from the family or community members. A KRC/safe space also encourages girls' mobility by ensuring a safe and risk-free platform where they can interact with others and learn new skills from their mentors. Programs should plan to create centers as safe spaces and ensure sustainability.

- A digital monitoring platform is an effective tool for observing and checking the progress of project activities in real time. The main purpose of digital monitoring is to capture and present data immediately through a dashboard that enables program managers and field implementers to have proper reflections of the status and progress of work as per plan and to make timely decisions accordingly. It is important to have a strong monitoring mechanism with required human resources to oversee all the activities at the field level for smooth implementation activities and to ensure achieving the best program outcome.

- To evaluate program impact, it is imperative that the full intervention cycle can be completed in due time. The duration of the project may offer better output when full-term intervention activities are underway. Not having a full-term intervention cycle may not yield the impact expected. Interventions should ensure full-term implementation of project activities.

- Half of the girls under the program coverage belong to the younger age group (12–14), hence there is less immediate impact pertaining to child marriage. Since the younger age cohort are less likely to be exposed to marriage immediately and also are not socially entitled to make decisions regarding their marriages, the impact of the intervention may be observed at a later time period.

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