



MONITORING AND EVALUATION

COMPARATIVE STATISTICAL ANALYSIS OF BASELINE, PULSE, AND MIDTERM SURVEYS

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On the cover: A Trained Peer Educator at SIKAP’s 2021 Youth Summit in Lianga, Cagwait, talking about SRHR to with a group of teenagers.

Sexual Health and Empowerment (SHE) Partners:



Jose Chacon, SHE Project Officer for Monitoring, Evaluation and Learning (MEL), Oxfam Canada, designed this study and coordinated the implementation of the three surveys analyzed. Rodrigo Morales, consultant, supported the statistical analysis and hypothesis designed. Manuel Rivera, MEL Officer, and Alex Wilson, Program Officer, Oxfam Canada, supported the review, analysis, and final report.

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Disclaimer

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Abbreviations and Acronyms

FP	Family Planning
GBV	Gender Based Violence
NDHS	National Demographic and Health Survey
PNTA	Prefer Not to Answer
SHE	Sexual Health and Empowerment Project
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
VAWG	Violence against Women and Girls

Definitions

The following definitions are intended to help the reader navigate terminology in this study¹:

- **ATTITUDE** is how a person feels about or judges a certain thing or behaviour. Attitudes can be shaped by social norms, morals, religious or family teachings, or past experiences, among other influences. Attitudes are held by individuals, whereas social norms are held at the group or collective level. Individual attitudes can either follow or deviate from what social norms dictate. For example, a woman might feel it is important for her to tolerate violence to keep her family together, even though the social norm in her community dictates that domestic violence is unacceptable.
- **BEHAVIOUR** is what a person does or how a person acts. “Typical behaviour” refers to what people commonly do, and “appropriate behaviour” to what people should do. Social norms provide the often-unspoken rules or expectations for behaviour. In this framework, specific behaviours discussed include sexual and reproductive health (SRH) seeking behaviour, acts of violence against women and girls (VAWG), and gender-based violence (GBV).
- **FAMILY PLANNING (FP)**, as defined by the World Health Organization (WHO),² allows individuals and couples to anticipate and attain their desired number of children and plan the spacing and timing of births. FP is achieved by contraceptive methods and the treatment of involuntary infertility. A woman’s ability to space and limit her pregnancies has a direct impact on her health, well-being, and the outcome of each pregnancy.³ In the Philippines, the 2017 National Demographic and Health Survey (NDHS) did not provide a definition for FP. From the statistical results, family planning is equivalent to contraceptive use. While we recognize this language is sometimes contested or problematic, we use it in this study to ensure consistency and clarity with the language used by official demographic information and resources in the Philippines (i.e., NDHS 2013 to 2017).
- **NORMS** are shared beliefs about what constitutes typical and appropriate behaviour in a group. Norms represent an individual’s “basic knowledge of what others do and think they should do.”⁴ Social norms often provide unspoken rules or expectations for behaviour.
- **SOCIAL NORMS** influence behaviour through social approval or disapproval.⁵ Social sanctions – such as stigma, criticism, shaming or teasing, social exclusion, and even violence – may result from not complying with expectations. Alternately, if a person acts in accordance with social norms, they feel as though they are acting correctly, and are more likely to be accepted, better regarded, or included by those around them.
- **POWER** is the ability to influence or control the behaviour of people, as well as one’s own behaviour and life. The use of power does not need to involve physical force or the threat of force (coercion), although it can. Power exists in relationships, within families, and in households. The amount of

1 Haylock, Laura. (2016) “A Conceptual Framework for evaluating Oxfam’s work towards Attitude, Norm and Behaviour Change to end Violence against Women and Girls/Gender-based Violence”, Oxfam Canada, p. 7-9.
 2 Shaw, D. (March 22, 2010). The ABCs of family planning [OpEd for Globe and Mail]. https://www.who.int/pmnch/media/news/2010/20100322_d_shaw_oped/en/.
 3 Shaw, D. (March 22, 2010). The ABCs of family planning [OpEd for Globe and Mail]. https://www.who.int/pmnch/media/news/2010/20100322_d_shaw_oped/en/.
 4 Alexander-Scott, M., Bell, E. and Holden, J. (2016) DFID Guidance Note: Shifting Social Norms to Tackle VAWG. London: VAWG Helpdesk, Department for International Development (DFID), p. 11-12.
 5 Mackie, G., Moneti, F., Shakya, H., & Denny, E. (2015). What are social norms? How are they measured. San Diego, CA. p. 21.

relative power a person has in comparison to one’s partner and others in the household is a critical issue when examining violence against women and girls (VAWG). Greater power inequality in family relationships can be a risk factor for the occurrence of VAWG. For this reason, one of Oxfam’s strategies to end VAWG is the social and economic empowerment of women and girls, so that power relationships are more equitable.

- **VIOLENCE** is “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation.”⁶ Generally, anything that is executed in an injurious or damaging way may be described as violent, even if it is not intended to be violent (by a person or against a person).

Interpersonal violence can be divided into two subcategories:

- **Family and Intimate Partner Violence:** This is violence largely between family members and intimate partners. It usually, though not exclusively, takes place in the home. This includes forms of violence like child abuse, intimate partner violence and elderly abuse.
- **Community Violence:** This is violence between individuals who are unrelated, and who may or may not know each other, generally taking place outside the home. This includes youth violence, random acts of violence, rape, or sexual assault by strangers, and violence in institutional settings such as schools, workplaces, prisons, and nursing homes.
- **VIOLENCE AGAINST WOMEN AND GIRLS (VAWG)** and **GENDER-BASED VIOLENCE (GBV)** represent physical or other types of violence used to enforce gender norms or due to gender identities.⁷ VAWG and GBV can include physical, sexual, and psychological violence within the family and community, and violence perpetrated or condoned by the State.⁸ We understand GBV as “any form of violence against an individual based on that person’s biological sex, gender identity or expression, or perceived adherence to socially defined expectations of what it means to be a man or woman, boy or girl.”⁹ VAWG, the largest subset of GBV, specifically refers to violence against women and girls.
- **WOMEN’S REPRODUCTIVE AUTONOMY** refers to women’s power to decide and control matters associated with contraceptive use, pregnancy, and childbearing.¹⁰
- **WOMEN’S SEXUAL AUTONOMY** refers to women’s ability to resist unwanted sex and their ability to make healthy decisions about sexuality.¹¹

6 World Health Organization. (2002). World report on violence and health: summary. Geneva: WHO; 2002. World Health Organization, p. 4. https://www.who.int/violence_injury_prevention/violence/world_report/en/summary_en.pdf

7 WHO, “Violence against women”, http://www.who.int/topics/gender_based_violence/en/.

8 Raab, Michaela (2012). Ending Violence Against Women: An Oxfam Guide. <https://policy-practice.oxfam.org/resources/ending-violence-against-women-an-oxfam-guide-254118/>

9 JHPIEGO, (2018), *Gender Service Delivery Standards: Facilitation Guide*, p. 15.

10 Upadhyay, U. D., et al. (2014). Women’s empowerment and fertility: a review of the literature. *Social science & medicine*, 115, 111-120.

11 Shaw, D. (March 22, 2010). The ABCs of family planning [OpEd for Globe and Mail]. https://www.who.int/pmnch/media/news/2010/20100322_d_shaw_oped/en/.

INTRODUCTION

The Sexual Health and Empowerment (SHE) project is a six-year (2018-2025) project co-funded by Global Affairs Canada (GAC), Oxfam Canada (OCA), Oxfam in the Philippines (OiPh), and Jhpiego. The project aims to empower women and girls in six disadvantaged and conflict-affected regions of the Philippines by (i) improving their knowledge and awareness of Sexual and Reproductive Health and Rights (SRHR); (ii) strengthening the capacities and skills of health service providers (HSPs) and health practitioners within the health system to deliver rights-based, comprehensive SRHR information and quality youth-friendly services; and, (iii) enhancing the capacities and effectiveness of women's rights organizations (WROs) and women's movements to advance SRHR agendas and prevent gender-based violence (GBV). The SHE project is implemented in association with OiPh and Jhpiego and through the efforts of 11 local partner organizations.

The SHE project has carried out three population-based surveys: a Baseline Survey (2019), Pulse Survey (2020), and Midterm Survey (2021), which have generated a wealth of data to inform the project's strategies. Both qualitative and quantitative data collections methods were used in all surveys in line with feminist research methods. Best practices and ethical guidelines were strictly followed as these surveys gathered data on VAWG. In all cases, informed consent from adults and parents or guardians of minors was obtained. The geographic areas for the surveys were selected based on literature review, consultations with project implementing partners, availability of funds, timelines, and accessibility.

For the Baseline Survey, a sample of nine municipalities was selected (see Table 1 below). The quantitative study included face-to-face surveys using structured mobile-based questionnaires with 1,923 community members (with an equal ratio of female and male adolescents and adults). For the Pulse Survey, a sample of seven municipalities was selected, and 1,004 face-to-face surveys were conducted using the same questionnaire used during the Baseline Survey, with a few additions. The COVID19 pandemic limited face-to-face interactions and forced the project to conduct only phone interviews during the Midterm Survey. A sample of 14 municipalities was selected and 674 phone surveys were conducted using a shorter questionnaire while maintaining the same wording as the Baseline and Pulse Surveys.

Table 1: Sample Comparison Between All Surveys

Baseline Survey (2019) 1,923 Face-to-Face Interviews Nine Municipalities	Pulse Survey (2020) 1,004 Face-to-Face Interviews Seven Municipalities	Midterm Survey (2021) 674 Phone Interviews 14 Municipalities
1. Bongao		1. Bongao
2. Dancagan		2. Dancagan
3. Jabonga		3. Jabonga
4. San Isidro	1. San Isidro	4. San Isidro
5. Santa Margarita	2. Santa Margarita	5. Santiago
6. Santiago		6. Sapa-Sapa
7. Sapa-Sapa		7. Santa Margarita
8. Sumilao		8. Sumilao
9. Victoria		9. Victoria
	3. Buug	10. Buug
	4. Cagwait	11. Cagwait
	5. Clarin	12. Clarin
	6. Ganassi	13. Ganassi
	7. Mobo	14. Mobo

During the Midterm Survey planning, it was clear that the survey questionnaire would need to be adapted to accommodate the respondents' attention spans during phone interviews. The calculations for the Community Attitudes Index were adjusted due to the reduced number of questions.

For the purpose of this analysis, only a small set of variables were selected among the surveys to test three predefined hypotheses. The Methodology section describes the variables, indexes and weights used. The Research Hypothesis Analysis section presents the findings for each hypothesis. Finally, a set of conclusions and recommendations are listed at the end of the study.

RESEARCH HYPOTHESES

1. An increase in positive attitudes is positively linked to changes in the following behaviours: (i) rejection of GBV, (ii) rejection of early marriage, and (iii) acceptance of women making decisions about their reproductive health.
2. A decrease in men’s positive attitudes towards SRHR indicates a setback in terms of Women’s Reproductive Autonomy.
3. An increase in knowledge about FP is linked to an increase in health-seeking behaviours.

METHODOLOGY

This section describes the variables, indexes, weights, and statistical procedures used to test the three hypotheses.

For the first hypothesis (increase in positive attitudes is positively linked to changes in behaviours including the rejection of GBV and early marriage), we contrasted changes in the global SRHR Community Attitudes Index with changes in two new indices: (1) GBV Occurrence Index and (2) GBV Acceptance Index. Then, we compared changes in positive attitudes toward Women’s Reproductive Autonomy against scores associated with rejection of early marriage for girls under 16 and 18 years of age.

The GBV Occurrence Index describes in Table 2 measures the incidence of GBV using the following question and associated variables:

Table 2: GBV Occurrence Index “Has your spouse ever done any of these things to you?”¹²

STATEMENT IN SURVEY	VARIABLE NAME	SCORE ATTRIBUTION	SCORE VALUE
Yelling, cursing, or insulting	e2b1yell		
Slapping or spanking	e2b2slap		
Throwing something at the other, pushing, shoving, or grabbing and twisting the arm	e2b3thro		
Knocking on the head, kicking, biting, pulling hair, or punching	e2b4knoc	1 Never	0
Tie up and hit, hitting or trying to hit with an object, or beating up while restrained	e2b5tie	2 One time	1
Threatening with knife, gun, or axe, or throwing acid	e2b6thre	3 From 2 to 4 times	1
Burning or choking	e2b7burn	4 From 5 to 10 times	1
Forced him/her to have sex when he/she did not want to	e2b8forc	5 Once a week	1
Threaten their life or that of a loved one	e2b9thre	99 Don’t know	0.5
Not allowing them to leave the house or locking them in the house	e2b10leav		
Not allowing them to work or earn a living	e2b11work		
Not allowing them to keep or spend the money they earned	e2b12spen		

¹² This question and variables were included in all three surveys.

We assigned value=0 to option 1 “Never” and =0.5 to option 99 “Don’t Know”. All other response options had a value=1. Therefore, higher index values represent a higher incidence of gender violence. We chose to assign a value of 1 to frequencies of GBV higher than 0 because, from the descriptive analysis, we identified a low level of responses for response options 2 to 5. Therefore, a maximum value of 1 for each type of violence helped reveal instances of violence in everyday life.

The second index, described in Table 3, measures the acceptance of GBV in the communities. Two questions available in the Pulse and Midterm Surveys were used to calculate the score.

Table 3: GBV Acceptance Index

In your opinion, is a husband justified in hitting or beating his wife/partner in the following situations:				
If she goes out without telling him?	If she neglects the children?	if she argues with him?	If she burns the food?	If she refuses to have sex with him?
GEN133a	GEN133b	GEN133c	GEN133d	GEN133e
In your opinion, DO OTHER WOMEN in your community feel that a husband is justified in hitting or beating his wife/partner in the following situations:				
If she goes out without telling him?	If she neglects the children?	if she argues with him?	If she burns the food?	If she refuses to have sex with him?
GEN134a	GEN134b	GEN134c	GEN134d	GEN134e

Different weights were used to calculate the index score for the Pulse and Midterm Surveys, as the response options available for each survey were different. Weights were adjusted to indicate that higher index scores correspond to higher acceptance of gender violence in the community. Weight distribution is presented in Table 4.

Table 4: Weights for the GBV Acceptance Index

PULSE SURVEY		MIDTERM SURVEY	
SCORE ATTRIBUTION	SCORE VALUE	SCORE ATTRIBUTION	SCORE VALUE
1 Yes	1	1 Strongly disagree	0
2 No	0	2 Disagree	0
3 PNTA (prefer not to answer)	0.5	3 Neither agree nor disagree	0.5
		4 Agree	1
		5 Strongly agree	1
		98 PNTA (prefer not to answer)	0.5

Regarding the questions about the rejection of early marriage for girls under 16 and 18 years of age, the weights were adjusted to indicate that the closer the score is to 1, the higher the level of rejection. Adjusted weights are presented in Table 5.

Table 5: Weights for Rejection of Early Marriage

	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	PNTA
Score Attribution	5	4	3	2	1	0
Score Value	1	0.75	0	0	0	-

Seven questions from the Baseline and 11 questions from the Midterm Survey were used to measure community acceptance of women’s decisions about reproductive health. The difference in the number of questions between surveys is a result of the methodological decision to ask separately about attitudes towards women and girls. The weights attributed to the response options in the case of the two surveys are the same. Values closer to one indicate greater reproductive autonomy, and values closer to zero indicate less reproductive autonomy.

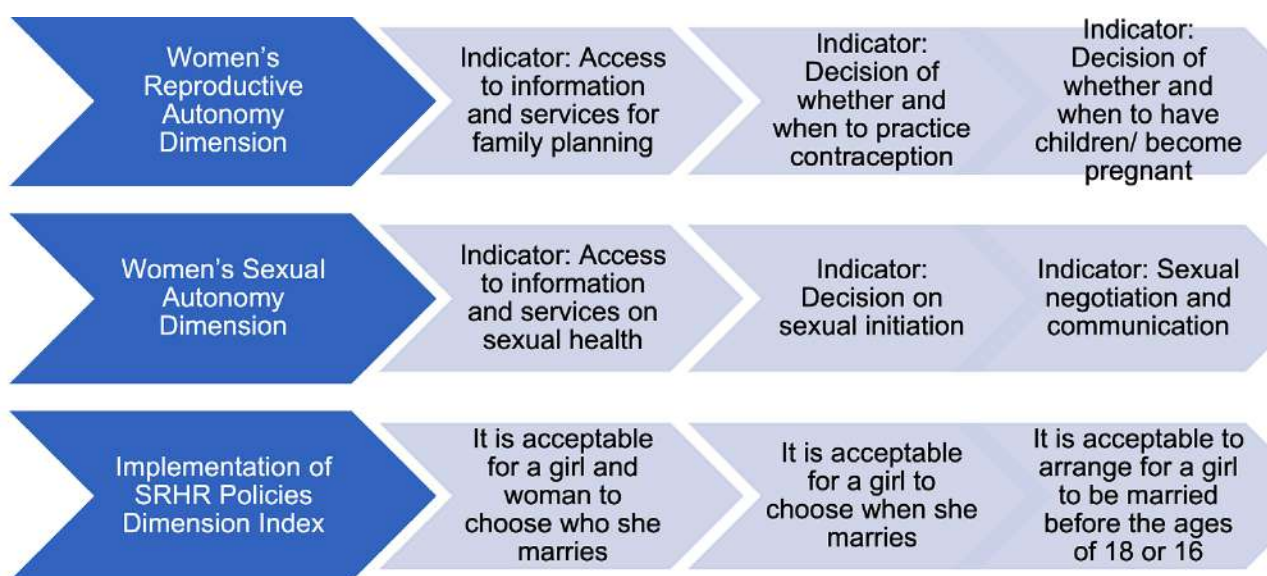
Table 6: Women’s Reproductive Autonomy: Community Acceptance of Women’s Decisions about Reproductive Health

STATEMENTS		
Baseline	Midterm	Score attribution and value
Is it acceptable that family planning services are accessible for women and girls?	Is it acceptable that family planning services are accessible for women?	1 Strongly disagree (0) 2 Disagree (0) 3 Neither agree nor disagree (0.5) 4 Agree (1) 5 Strongly agree (1) 98 PNTA (0.5)
	Is it acceptable that family planning services are accessible for girls?	
Is it acceptable that counselling on reproductive health is accessible for women and girls?	Is it acceptable that counselling on reproductive health is accessible for women?	
	Is it acceptable that counselling on reproductive health is accessible for girls?	
How do you feel about girls and women deciding on the use of a contraceptive method to prevent pregnancy?	How do you feel about girls deciding on the use of a contraceptive method to prevent pregnancy?	
	How do you feel about women deciding on the use of a contraceptive method to prevent pregnancy?	
How do you feel about girls and women deciding on the choice of the contraceptive method to prevent pregnancy?	How do you feel about girls deciding on the choice of the contraceptive method to prevent pregnancy?	
	How do you feel about women deciding on the choice of the contraceptive method to prevent pregnancy?	
How do you feel about girls and women deciding on when to have a baby?		
How do you feel about girls and women deciding on how many children they want have?		
How do you feel about girls and women deciding whether they can terminate an unplanned pregnancy?		

In addition, the question “Who makes the decision about how many children you should have?”, was also used as a proxy indicator of Women’s Reproductive Autonomy, although this question was only available from the Pulse survey. Results disaggregated by age groups are presented in the Research Hypotheses Analysis section of this document. To facilitate the analysis and understanding of the results, the 11 response options included in the questionnaire were summarized into three: (1) respondent and husband or partner jointly, (2) respondent alone, and (3) husband or partner or others.¹³

Regarding the second hypothesis (a decrease in men’s positive attitudes towards SRHR indicates a setback in terms of Women’s Reproductive Autonomy), the starting point of this analysis is the high variability observed in the results for men and boys during the redesign of the index. To better understand whether this variability corresponds to a setback in positive attitudes towards Women’s Reproductive Autonomy, the analysis relies on questions and variables available in all three surveys and dimensions. Figure 1 presents the indicators associated with each dimension.

Figure 1
SRHR Community Attitudes Index: Dimensions and Indicators



To test the third hypothesis (an increase in knowledge about FP is linked to an increase in health-seeking behaviours) and quantify the increase in demand for rural health services, the following questions and variables were used:

¹³ The others category includes: respondents and mother jointly, respondent’s mother, respondents and mother-in-law, father, respondent’s and father jointly, respondent’s and father-in-law, respondents and father-in-law jointly and others.

Table 7: Variables Used to Test the Third Hypothesis

STATEMENT IN SURVEY	VARIABLE NAME	RESPONSE OPTIONS
The following questions refer to family planning methods to plan, delay or avoid pregnancies		
Are you using anything now?	c20fpnow	1 Yes 2 No 98 PNTA
If yes, did you discuss and decide jointly with your partner?	c21partnerdiscuss	1 Yes 2 No 98 PNTA
Which method are you using now to delay or avoid getting pregnant?	c22fpusenow	1 Female Sterilization 2 Male Sterilization 3 Implant 4 Intrauterine Device (IUD) 5 Injectables 6 Pill 7 Emergency Contraception 8 Male Condom 9 Female Condom 10 Diaphragm 11 Foam/Jelly 12 Standard Days/Cycle Beads 13 Lactational Amenorrhea Method (LAM) 14 Rhythm Method 15 Withdrawal 16 Other Traditional Method
Where did you obtain your [most recent/current method] when you started using it?	c24fpobtain	1 Regional Hospital 2 District Hospital 3 Rural Health Unit 4 Barangay Health Centre 5 Midwife 6 Barangay Health Worker 7 Pharmacy 8 Private Clinic 9 Private Hospital 10 Friend 11 Family Member
Did you and your partner ever discuss family planning? ¹⁴	c21partnerdiscuss_1	1 Yes 2 No

¹⁴ This question is only available in the Pulse and Midterm Surveys.

RESEARCH HYPOTHESIS ANALYSIS

A two-step process was implemented:

1. Frequencies estimation and comparison between surveys for all variables of interest to identify trends in the data.
2. The Mann-Whitney U Test was applied to test if there was a significant difference between the values found in each survey. The U Test is a nonparametric null hypothesis test to compare outcomes between two independent groups when dealing with continuous variables such as the index.

In addition, to facilitate the reader’s understanding of the findings, some visualizations have been prepared and tables of test results are included.

HYPOTHESIS NO 1.

An increase in positive attitudes is positively linked to changes in the following behaviours: (i) rejection of GBV, (ii) rejection of early marriage, and (iii) acceptance of women making decisions about their reproductive health.

Figures 2 and 3 show the comparison between the scores of the SRHR Community Attitudes Index and the GBV Occurrence Index for women and girls, according to the data collected through the Baseline, Pulse and Midterm Surveys.

Figure 2: GBV Occurrence Index (girls, ages 15-19)

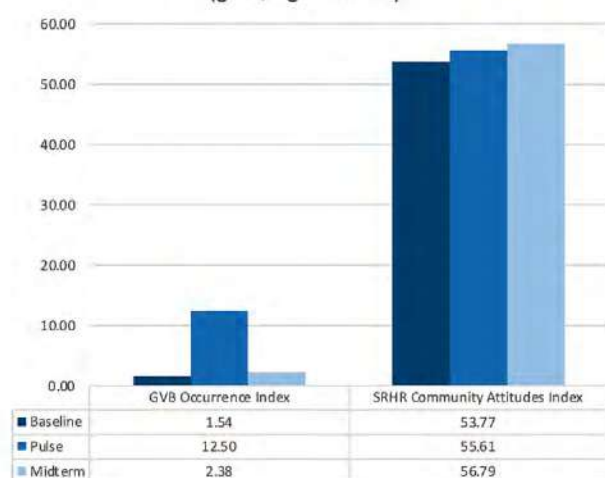
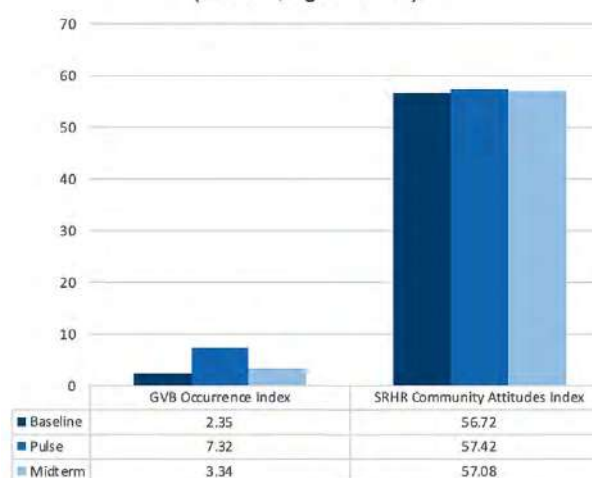


Figure 3: GBV Occurrence Index (women, ages 20-49)



The two graphs show a different distribution for the two indices. The SRHR Community Attitudes Index shows less variability than the GBV Occurrence Index. Based on the responses of women and girls, there is a small increase, of about 1 point, in GBV occurrence between the Baseline and the Midterm Survey for both women and girls. However, it is important to note that this does not mean that GBV occurrence

is low in the areas covered by the survey, or that these numbers show the true magnitude of the phenomenon. It only shows that a small number of respondents were willing to report the occurrence of such phenomena. An increase in the number of cases can also be read as an increase in the willingness of respondents to report this type of violence.

When comparing the GBV Occurrence Index with the SRHR Community Attitudes Index, two interpretations are possible. On one hand, if we take the GBV Index as a willingness to denounce violence, then there is a positive correlation between GBV Occurrence Index scores and those of the SRHR Index. As positive attitudes towards SRHR increase, there is also an increase in the willingness to denounce GBV. On the other hand, if we interpret the GBV Index as a proxy indicator of the incidence of the phenomenon by the number of cases, then, there is a negative correlation with the SRHR Index scores. In this case, as positive attitudes towards SRHR increase, there is also an increase in the occurrence of GBV, which may be a sign of a setback for the perceived empowerment of women. We will explore this last issue as part of the second hypothesis testing when analyzing men’s and boys’ attitudes towards Women’s Reproductive and Sexual Autonomy.

TESTING THE STATISTICAL SIGNIFICANCE OF THE DIFFERENCES OBSERVED IN THE GBV OCCURRENCE INDEX

Tables 8 and 9 show the results of the Mann-Whitney U Test for the independent scores of women and girls in the SRHR Community Index, when comparing (i) Baseline and Pulse Survey, (ii) Pulse and Midterm Survey, and (iii) Baseline and Midterm Survey. According to the obtained results, the null hypothesis (Ho) is rejected, which means that there seems to be evidence that the observed increases in the SRHR Community Index, positive attitudes towards SRHR, are statistically significant for both women and girls and not attributable to chance or error.

Table 8: SRHR Community Index (girls)

	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEYS
Mann-Whitney U Test	8367.000	35227.000	8502.000
Z	-5.881	-5.960	-5.169
P-Value	0.000	0.000	0.000

Table 9: SRHR Community Index (women)

	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEYS
Mann-Whitney U Test	433808.000	35591.000	274224.500
Z	-9.569	-6.210	-5.013
P-Value	0.000	0.000	0.000

Tables 10 and 11 show the results of the U Test for the independent scores of women and girls in the GBV Occurrence Index. In this case, the p values obtained are greater than 0.05, which means that we can not reject the null hypothesis and therefore, there is not enough evidence to affirm that the observed changes in the GBV Occurrence Index are real and not attributable to error or chance, except in the case of the changes observed between the Baseline and the Pulse Survey.

It is important to highlight two things about these results: first, that the lack of statistical significance when scores from the Baseline and Pulse Surveys are compared against the Midterm Survey scores may be due to methodological issues associated with the sample size and response rate of the Midterm Survey, and second, that the test does not account for the reality of the changes or its causes, but only if the differences observed are statistically reliable beyond error or chance.

Table 10: GBV Occurrence Index (girls)

	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEYS
Mann-Whitney U Test	1042.500	35.500	14130.500
Z	-7.423	-1.780	-1.855
P-Value	0.000	0.075	0.064

Table 11: GBV Occurrence Index (women)

	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEYS
Mann-Whitney U Test	26538.000	37726.500	48031.500
Z	-8.111	-0.929	-0.134
P-Value	0.000	0.353	0.893

As stated before, to further explore the relationship between attitudes towards SRHR and GBV, a GBV Acceptance Index was created using questions available in both the Pulse and Midterm Survey, but unfortunately, not available in the Baseline Survey (see Table 3: GBV Acceptance Index). Figures 4 and 5 show the comparison between the scores of the SRHR Community Attitudes Index and the GBV Acceptance Index for women and girls.

Figure 4: GBV Acceptance Index (girls, ages 15-19)

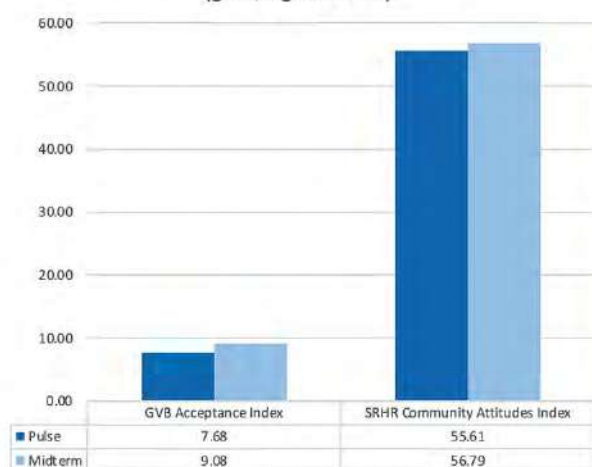
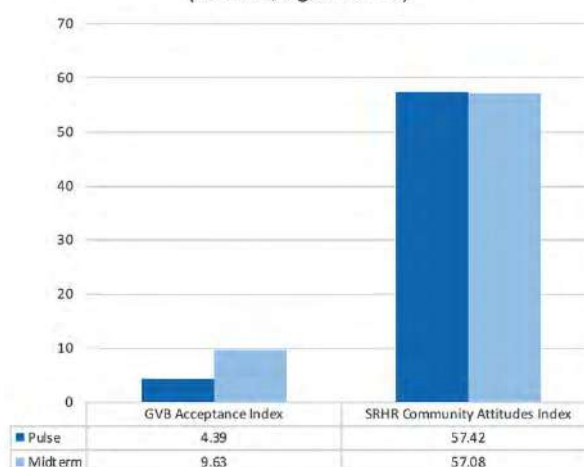


Figure 5: GBV Acceptance Index (women, ages 15-19)



Both figures show that GBV acceptance scores increased from Pulse to Midterm Survey for both women and women girls and the increase was steeper for women than for girls. Positive attitudes towards SRHR increased slightly for girls and decreased slightly for women. Based on these data, there does not appear to be a clear relationship between changes in attitudes towards SRHR and the acceptability of gender-based violence in the surveyed groups. However, to test whether the observed differences were significant, a U-test was applied.

TESTING THE STATISTICAL SIGNIFICANCE OF THE DIFFERENCES OBSERVED IN THE GBV ACCEPTANCE INDEX

Tables 12 and 13 show the results from the Mann-Whitney U Test for women and girls. In both cases, p values were greater than 0.05, which means that we can not reject the null hypothesis and therefore, there is not enough evidence to affirm that the observed differences are not due to chance or error. Nevertheless, the fact that women show a higher acceptance of GBV than girls in the Midterm Survey is a relevant finding for the SHE project that may deserve further exploration.

Table 12: GBV Acceptance Index (girls)

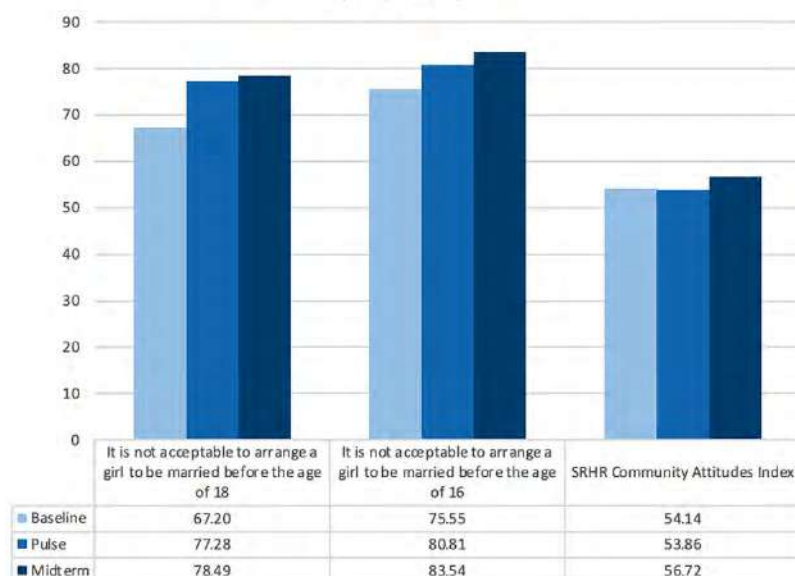
	PULSE-MIDTERM SURVEYS
Mann-Whitney U Test	16957.500
Z	-1.906
P-Value	0.057

Table 13: GBV Acceptance Index (women)

	PULSE-MIDTERM SURVEYS
Mann-Whitney U Test	24390.000
Z	-1.836
P value	0.066

Regarding the rejection of early marriage for girls under 16 and 18 years of age, Figure 6 shows the results for both questions along with the scores for the SRHR Community Index. The aggregated results for all groups show that there was an increase in the rejection of early marriage alongside an increase in the SRHR Community Index scores. It is noteworthy that rejection rates are higher for girls under the age of 16 (83.54 at Midterm) than for girls under the age of 18 (78.49 at Midterm), although both values are high and the increase in rejection between the Baseline and the Midterm survey is steeper (11 points) in the case of girls under the age of 18.

Figure 6: rejection of early marriage (all groups)



In addition, taken together, there appears to be a positive relationship between the index scores and the results obtained about the rejection of early marriage: the higher the index scores, the higher the levels of rejection.

TESTING THE STATISTICAL SIGNIFICANCE OF THE DIFFERENCES OBSERVED IN REJECTION OF EARLY MARRIAGE AT AN AGGREGATE LEVEL

Table 14 shows the results from the Mann-Whitney U Test. In both cases, p values were below the threshold of significance ($p < 0.05$) and therefore the null hypothesis can be dismissed. There seems to be evidence that the observed increases in rejection of early marriage are statistically significant and not due to chance or error.

Table 14: Rejection of Early Marriage (aggregated comparison)

	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEYS
MARRIAGE OF GIRLS UNDER 18 YEARS OLD (D15AG18_1)			
Mann-Whitney U Test	535575.500	259678.000	390182.500
Z	-7.039	-3.604	-9.527
P-Value	0.000	0.000	0.000
MARRIAGE OF GIRLS UNDER 16 YEARS OLD (D16AG16_1)			
Mann-Whitney U Test	686624.000	274224.500	433808.000
Z	-4.959	-5.013	-9.569
P-Value	0.000	0.000	0.000

Looking at the disaggregated results for girls and women, rejection increased more for girls than for women in the case of early marriage under 18 and more for women than for girls in the case of marriage under 16. For girls, the rejection of early marriage for those under 18 years of age rises from 65.5 in the Baseline to 80.25 in the Midterm Survey, almost a 15-point difference, while for women, rejection of early marriage increases from 68.08 in the Baseline to 78.05 in the Midterm Survey, an 11-point difference. In turn, the rejection of marriage for children under 16 years of age rose from 78.8 to 84.4 among girls, almost a 6-point difference, and from 79.6 to 82.5 among women, almost an 8-point difference. In both cases, girls and women, an increase in positive attitudes toward SRHR were reported and it was slightly higher for girls than for women, which is consistent with the aggregate finding that higher increases in the index scores are linked to higher rejection of early marriage. A graphical description is presented in Figures 7 and 8.

Figure 7: rejection of early marriage (girls, ages 15-19)

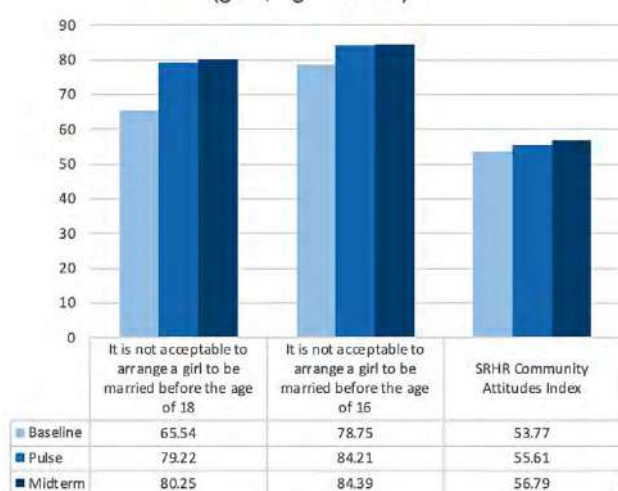
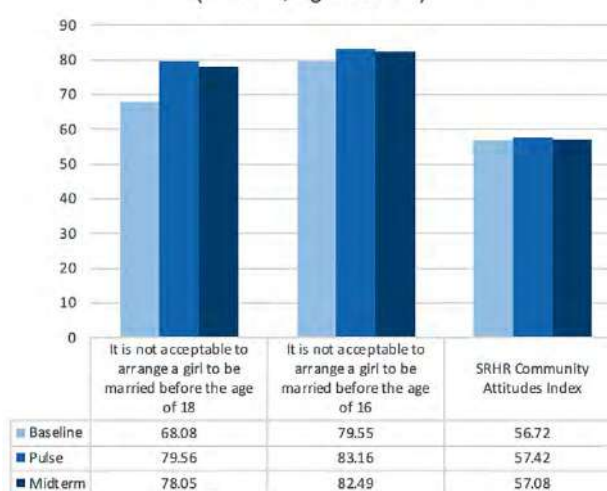


Figure 8: rejection of early marriage (women, ages 20-49)



TESTING THE STATISTICAL SIGNIFICANCE OF THE DIFFERENCES OBSERVED IN REJECTION OF EARLY MARRIAGE FOR WOMEN AND GIRLS.

Tables 15 and 16 show the results from the Mann-Whitney U Test for women and girls. In both cases, early marriage under 18 and under 16, all p values were below the threshold of significance ($p < 0.05$) and therefore the null hypothesis can be dismissed. There seems to be evidence that the observed increases in women and girls' rejection of early marriage are statistically significant and not due to chance or error.

Table 15: Rejection of Early Marriage under 18 years old
(Disaggregated by women and girls)

	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEY
EARLY MARRIAGE IN GIRLS UNDER 18 YEARS OLD (WOMEN)			
Mann-Whitney U Test	36797.500	259678.000	46620.500
Z	-3.576	-3.604	-3.926
P-Value	0.000	0.000	0.000
EARLY MARRIAGE IN GIRLS UNDER 18 YEARS OLD (GIRLS)			
Mann-Whitney U Test	35729.000	274224.500	24038.000
Z	-4.780	-5.013	-5.228
P-Value	0.000	0.000	0.000

Table 16: Rejection of Early Marriage under 16 years old
(Disaggregated by women and girls)

	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEYS
EARLY MARRIAGE IN GIRLS UNDER 16 YEARS OLD (WOMEN)			
Mann-Whitney U Test	45811.000	274224.500	53635.000
Z	-2.126	-5.013	-2.818
P-Value	0.034	0.000	0.005
EARLY MARRIAGE IN GIRLS UNDER 16 YEARS OLD (GIRLS)			
Mann-Whitney U Test	41604.000	433808.000	28759.000
Z	-3.626	-9.569	-3.135
P-Value	0.000	0.000	0.002

Men and boys also show an increase in rejection of early marriage. As in the case of women and girls, the greatest rejection was reported for early marriage of girls under 16 years of age and the increase is higher for boys than for men in both cases. Likewise, men and boys reported increases in the SRHR Community Attitudes index score and it is interesting to note that the variation between Baseline and Midterm Surveys is greater for men than for boys. A graphical description is presented in Figures 9 and 10.

Figure 9: rejection of early marriage (boys, ages 15-19)

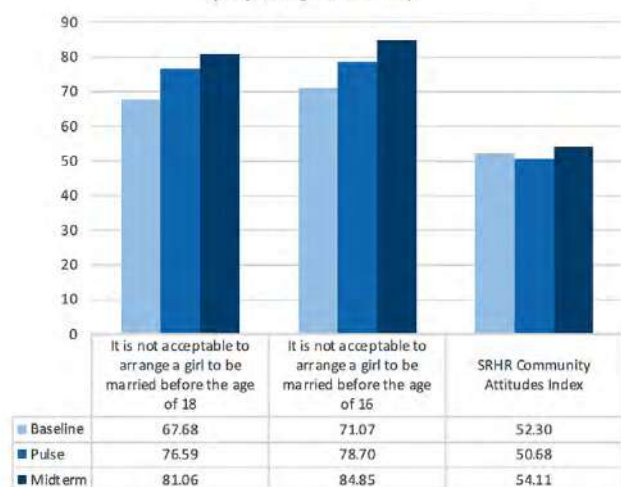
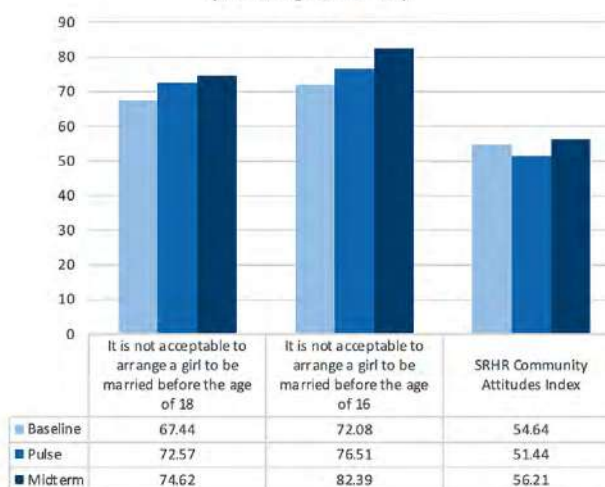


Figure 10: rejection of early marriage (men, ages 20-49)



TESTING THE STATISTICAL SIGNIFICANCE OF THE DIFFERENCES OBSERVED IN REJECTION OF EARLY MARRIAGE FOR MEN AND BOYS.

Tables 17 and 18 show the results from the Mann-Whitney U Test for men and boys. In both cases, early marriage under 18 and under 16, all p values were below the threshold of significance ($p < 0.05$) and therefore the null hypothesis can be dismissed. There seems to be evidence that the observed increases in men and boys’ rejection of early marriage of girls under 16 and 18 years of age are statistically significant and not due to chance or error.

Table 17: Rejection of Early Marriage under 18 years old

(Disaggregated by men and boys)

	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEYS
EARLY MARRIAGE IN GIRLS UNDER 18 YEARS OLD (MEN)			
Mann-Whitney U Test	29952.500	274224.500	16965.000
Z	-3.834	-5.013	-3.592
P-Value	0.000	0.000	0.000
EARLY MARRIAGE IN GIRLS UNDER 18 YEARS OLD (BOYS)			
Mann-Whitney U Test	29952.500	5501.000	7788.000
Z	-3.834	-3.224	-5.195
P-Value	0.000	0.001	0.000

Table 18: Rejection of Early Marriage under 16 years old
(Disaggregated by men and boys)

	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEYS
EARLY MARRIAGE IN GIRLS UNDER 16 YEARS OLD (MEN)			
Mann-Whitney U Test	35729.000	11181.500	18023.500
Z	-4.780	-4.201	-4.966
P-Value	0.000	0.000	0.000
EARLY MARRIAGE IN GIRLS UNDER 16 YEARS OLD (BOYS)			
Mann-Whitney U Test	38205.000	5467.500	8312.500
Z	-3.395	-4.247	-5.959
P-Value	0.001	0.000	0.000

Up to this point, there seems to be evidence that an increase in positive attitudes toward SRHR does not necessarily result in a reduction of GBV occurrence or acceptance over a 3-year period, but may be positively linked with a rejection of early marriage of girls under 16 and 18 years of age.

The last component of the first hypothesis is that an increase in positive attitudes is positively linked to an increase in the acceptance of women making decisions about their reproductive health. The following section presents the corresponding analysis, but it is first necessary to remind the reader about a consideration noted in the methodological section of this document and summarized in Table 19, that may affect the comparability of the results between the Baseline and the other two surveys.

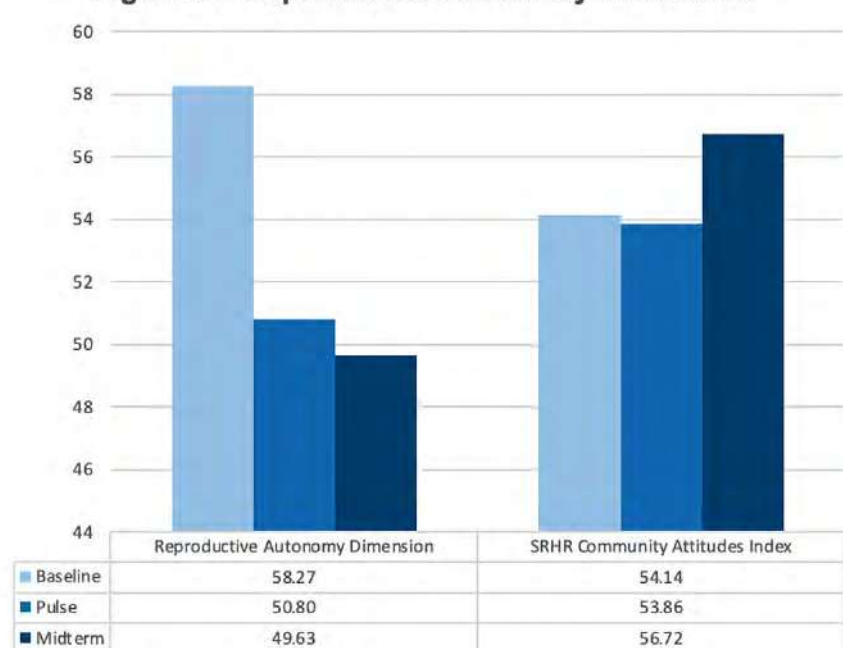
Unlike the Pulse and Midterm Surveys, the Baseline has fewer questions on acceptability and use of contraceptive methods to prevent pregnancy and a lower level of disaggregation of responses. The Baseline asks about feelings towards women and girls together rather than separately, therefore, the respondents were only able to express their attitudes towards each group separately in the Pulse and Midterm Surveys.

Table 19: Differences in acceptance of women’s decisions about reproductive health questions between the Baseline, Pulse and Midterm Surveys

STATEMENTS	
BASELINE	PULSE AND MIDTERM
How do you feel about girls and women deciding on the use of a contraceptive method to prevent pregnancy?	How do you feel about girls deciding on the use of a contraceptive method to prevent pregnancy?
	How do you feel about women deciding on the use of a contraceptive method to prevent pregnancy?
How do you feel about girls and women deciding on the choice of the contraceptive method to prevent pregnancy?	How do you feel about girls deciding on the choice of the contraceptive method to prevent pregnancy?
	How do you feel about women deciding on the choice of the contraceptive method to prevent pregnancy?

Figure 11 shows that the scores of the reproductive autonomy dimension of the index went from 58.27 in the Baseline Survey to 50.80 in the Pulse Survey, and then, down to 49.63 in the Midterm Survey, a drop of almost 9 points between the Baseline and the Midterm Survey, but much sharper between the Baseline and the Pulse Survey (7 points) and flatter between the Pulse and the Midterm Survey (2 points). Due to the methodological differences highlighted earlier, the drop from the Baseline to the Midterm Survey may be explained, at least in part, by a difference in the wording of the questions, and not necessarily reflect a sharp change in attitudes. The similarity of values between the Pulse and Midterm Surveys leaves some room for doubt. Further research may be necessary.

Figure 11: Reproductive Autonomy Dimension



To try to clarify the effect of these methodological considerations on the comparability of results between surveys and the interpretation of the results obtained in terms of acceptance of Women’s Reproductive Autonomy, results by age and sex groups are presented below.

First, in Figure 12, we see a slight increase in girls’ scores in the Women’s Reproductive Autonomy Dimension Index between the Pulse and Midterm Surveys. Girls seem to be the only group that has increased both their acceptance of women using and choosing contraceptives and their SRHR index score. Meanwhile, in the case of women (see figure 13), there is a reduction in the Women’s Reproductive Autonomy Index score of more than 8 points between the Baseline and the Midterm Survey, but a nearly flat variation in the SRHR Community Attitudes Index score.

Figure 12: Reproductive Autonomy Dimension (girls, ages 15-19)

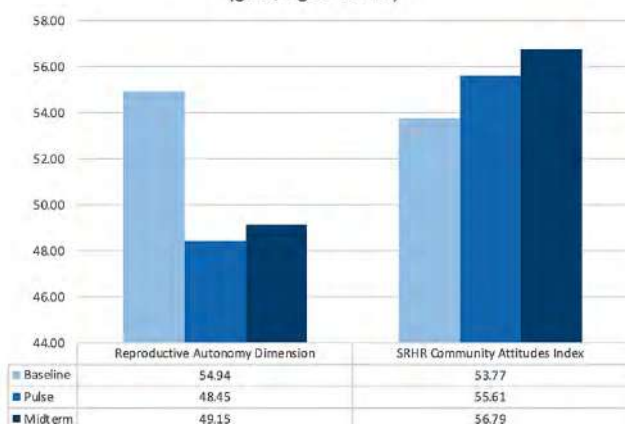
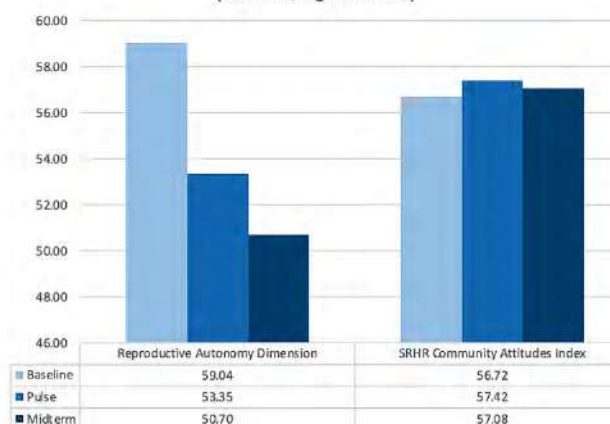


Figure 13: Reproductive Autonomy Dimension (women, ages 20-49)



Boys and men show greater variability in their attitudes toward Women’s Reproductive Autonomy. The acceptance of Women’s Reproductive Autonomy drops for both groups between the Pulse and Midterm Surveys, but boys show the sharpest drop, going from 49.5 to 41.1. By contrast, the drop in men’s scores is less than one point going from 51.05 to 50.3 (see figures 14 and 15). The results for men and boys are reviewed in more detail in the next section when testing the second hypothesis.

Figure 14: Reproductive Autonomy Dimension (boys, ages 15-19)

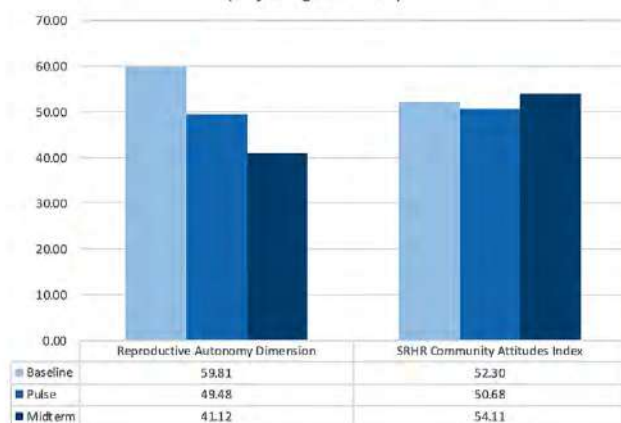
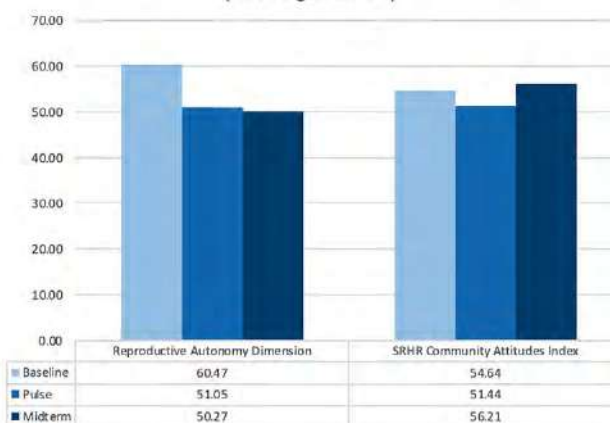


Figure 15: Reproductive Autonomy Dimension (men, ages 20-49)



Based on the data presented so far, the evidence seems to suggest that an increase in positive attitudes towards SRHR is only positively linked to an increase in acceptance of women’s decisions about reproductive health in the case of girls. For all other sex-age groups (women, men, boys), the evidence suggests a drop in the level of acceptance, even when there are increases in the SRHR Index scores. At the aggregate level (all groups together), the behaviour of the Women’s Reproductive Autonomy index mirrors that of the three aforementioned groups.

TESTING THE STATISTICAL SIGNIFICANCE OF THE DIFFERENCES OBSERVED IN ACCEPTANCE OF WOMEN'S DECISIONS ABOUT REPRODUCTIVE HEALTH (WOMEN AND GIRLS)

Tables 20 and 21 show the results from the Mann-Whitney U Test for girls and women. In both cases, p values were below the threshold of significance ($p < 0.05$) and therefore the null hypothesis can be dismissed. There seems to be evidence that the observed changes in women's and girls' acceptance of women's decisions about reproductive health (positive for girls and negative for women) between Pulse and Midterm Surveys are statistically significant and not due to chance or error. Changes observed in the SRHR Index were statistically significant and have already been reported in Tables 8 and 9 of this report.

Table 20: Reproductive Autonomy Dimension (Women and Girls)

(Aggregate level)

	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEYS
Mann-Whitney U Test	678504.500	325238.500	449880.500
Z	-10.910	-0.874	-10.312
P-Value	0.000	0.002	0.000

Table 21: Reproductive Autonomy Dimension disaggregated by age-sex groups

REPRODUCTIVE AUTONOMY DIMENSION (GIRLS)			
	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEYS
Mann-Whitney U Test	42315.500	9111.500	8312.500
Z	-4.296	-5.330	-5.959
P-Value	0.000	0.000	0.000
REPRODUCTIVE AUTONOMY DIMENSION (WOMEN)			
	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEYS
Mann-Whitney U Test	43540.500	8367.000	46823.000
Z	-4.550	-5.881	-6.270
P-Value	0.000	0.000	0.000

To complement the analysis of the relationship between women's and girls' attitudes towards SRHR and Women's Reproductive Autonomy, the following question, available only in the Pulse and Midterm Surveys, was included in the comparison: "Who makes the decision about how many children you should have?". This particular question serves as a proxy indicator to analyze the autonomy that women exercise over their own reproductive decisions, and how they share this power with others (particularly their partners).

Figure 16 shows that the percentage of girls who think they are the ones that should make the decision about how many children to have increased by almost 3 percentage points between the Pulse and Midterm Survey, and this increase is accompanied by an increase in positive attitudes towards SRHR (see Figure 17). It is noteworthy the drop in influence by “others”, almost 12 points between Pulse and Midterm Survey, which may suggest that a reduction in the influence of “others” is linked to an increase in women’s and girls’ positive attitudes towards SRHR. Further research may be necessary to understand better this relationship.

Figure 16: Who makes the decision about how many children you should have (girls, ages 15-19)

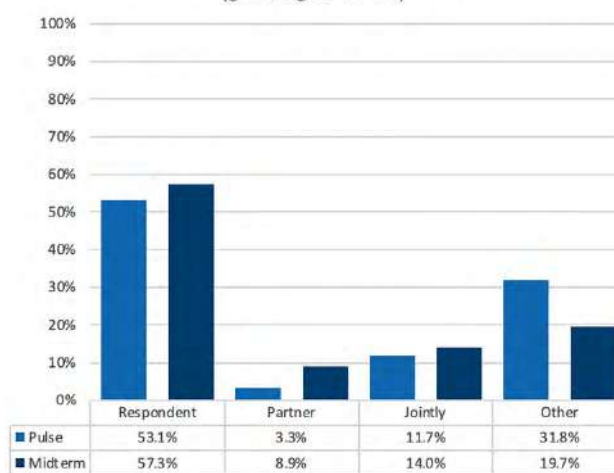
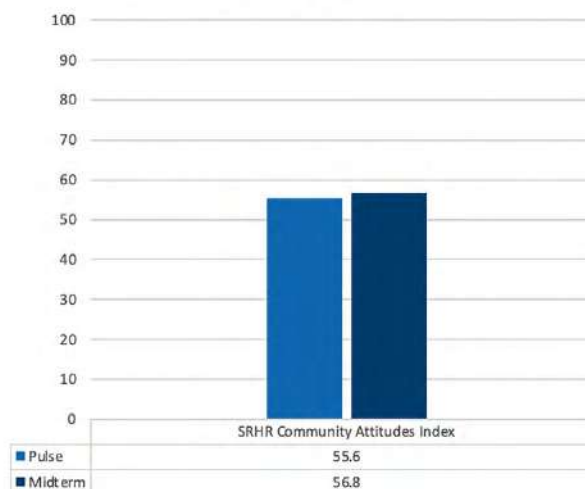


Figure 17: SRHR Community Attitudes Index (girls, ages 15-19)



Lastly, the analysis for women shows a different dynamic. The percentage of those who stated “it is a joint decision”¹⁵ decreased from 46.9% to 42.2% between the Pulse and Midterm Survey. Although there is an increase in the proportion of women who believe it is their decision, there is also an increase in the percentage of women who think it is their partner’s or other’s decision, but the value for “others” remains low – under 5% (see Figure 18).

Figure 19 shows no change in positive attitudes for women; therefore, the reason for change in their attitudes about who can make decisions about their reproductive health lies outside the data captured by these surveys. The power dynamics between women and their partners could explain their change in opinion and could be explored in more depth with tools other than surveys.

¹⁵ Joint decision-making is conceptualized as a decision-making process, occurring in the context of the marital or intimate relationship, in which both couple partners participate or take part in a decision that affects either of them.

Figure 18: Who makes the decision about how many children you should have (women, ages 20-49)

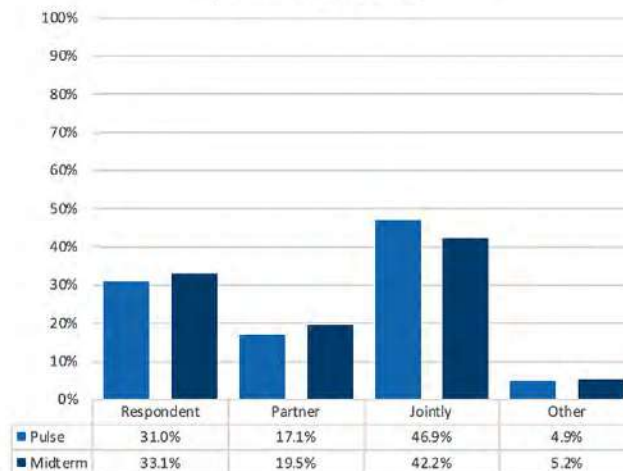
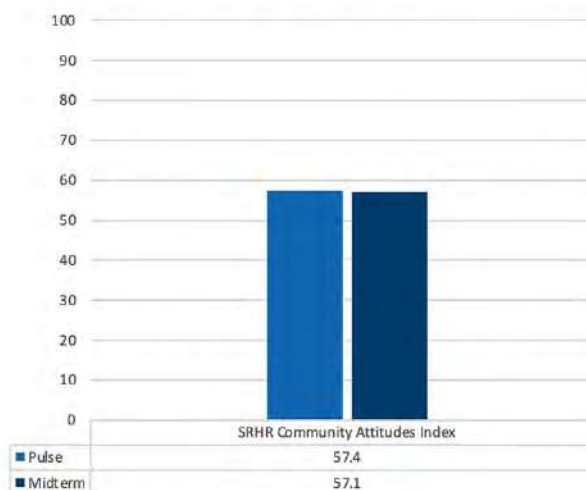


Figure 19: SRHR Community Attitudes Index (women, ages 20-49)

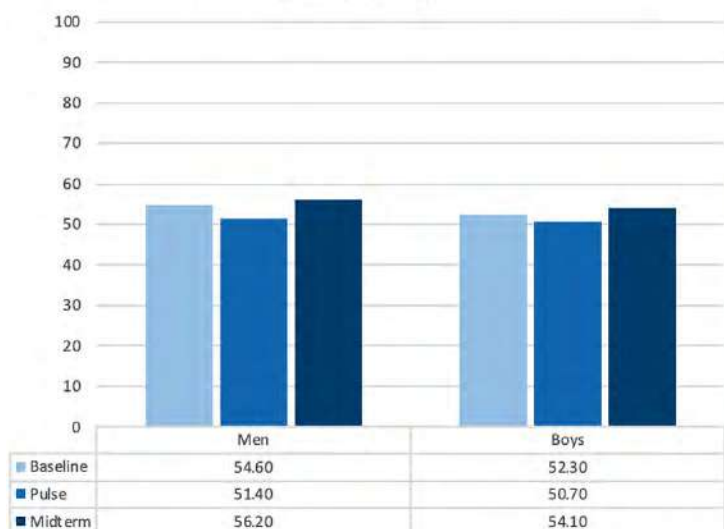


HYPOTHESIS NO 2.

A DECREASE IN MEN'S POSITIVE ATTITUDES TOWARDS SRHR INDICATES A SETBACK IN TERMS OF WOMEN'S REPRODUCTIVE AUTONOMY.

During the redesign of the SRHR Index, it was identified that men's and boys' attitudes towards SRHR show greater variability than those of women and girls (see Figure 20). Men's and boys' scores on the SRHR Community Attitudes Index dropped during the first year of project implementation according to the Pulse Survey results, although they show a slight recovery by the end of the third year according to data from the Midterm Survey. In this section, a deeper analysis of male attitudes towards Women's Reproductive and Sexual Autonomy, and SRHR policies, is presented, along with some explanations for the observed variability and whether that variability is linked to a setback in terms of Women's Reproductive Autonomy.

Figure 20: SRHR Community Attitudes Index (Men and boys)



Regarding the subindex, Figures 21 and 22 show a significant drop in both boys' and men's positive attitudes toward Women's Reproductive Autonomy indicators. This reduction is sharper for boys, with an average difference of more than 20 points between the Baseline and Midterm Surveys and 9 points between the Pulse and Midterm Surveys. For men, the decrease in positive attitudes lower, about 11 points on average between the Baseline and Midterm Surveys and less than one point between the Pulse and Midterm survey. Finally, it is noteworthy that in the case of men there is an increase of 2.3 points in positive attitudes towards women's autonomy to decide whether and when to use contraceptive methods between the Pulse and Midterm Surveys.

Figure 21: Women's Reproductive Autonomy Dimension (boys, ages 15-19)

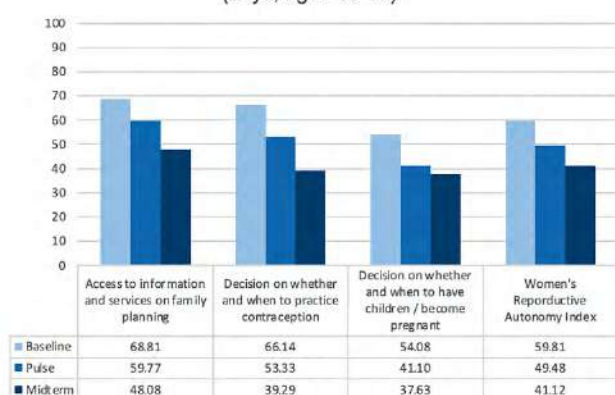
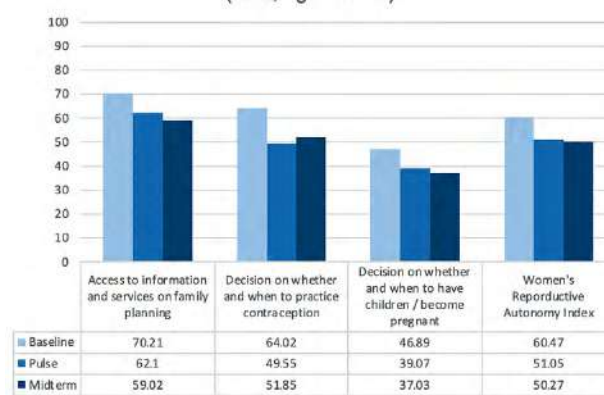


Figure 22: Women's Reproductive Autonomy Dimension (men, ages 20-49)



TESTING THE STATISTICAL SIGNIFICANCE OF THE DIFFERENCES OBSERVED IN MEN'S AND BOYS' ATTITUDES TOWARDS WOMEN'S REPRODUCTIVE AUTONOMY

Tables 22 to 24 show the results from the Mann-Whitney U Test for the three indicators of the Women's Reproductive Autonomy dimension in the case of boys. In all cases, p values were below the threshold of significance ($p < 0.05$) and therefore the null hypothesis can be dismissed. There seems to be evidence that the observed changes in boys's attitudes towards Women's Reproductive autonomy are statistically significant and not due to chance or error showing a setback in this particular dimension of the SRHR Community Attitudes Index.

Table 22: Indicator: Access to information and services on family planning (boys)

	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEYS
Mann-Whitney U Test	39249.500	6271.500	9111.500
Z	-6.360	-2.509	-5.330
P-Value	0.000	0.012	0.000

Table 23: Indicator: Decision on whether and when to practice contraception (boys)

	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEYS
Mann-Whitney U Test	35848.000	5692.500	8367.000
Z	-7.133	-5.940	-5.881
P-Value	0.000	0.000	0.000

Table 24: Indicator: Decision on whether and when to have children/become pregnant (boys)

	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEYS
Mann-Whitney U Test	35227.000	40227.000	9008.000
Z	-5.960	-3.654	-5.158
P-Value	0.000	0.000	0.000

The same test was performed for the three indicators of the Women’s Reproductive Autonomy dimension to test the differences in men’s attitudes. In all cases, p values were below the 0.05 threshold, which means that the observed differences were found statistically significant for this age-sex group. Tables 25 to 27 show the results for the U Test.

Table 25: Indicator: Access to information and services on family planning (men)

	BASELINE-PULSE	PULSE-MIDTERM	BASELINE-MIDTERM
Mann-Whitney U Test	35591.000	39249.500	20547.000
Z	-6.210	-6.360	-4.537
P-Value	0.000	0.000	0.000

Table 26: Indicator: Decision on whether and when to practice contraception (men)

	BASELINE-PULSE	PULSE-MIDTERM	BASELINE-MIDTERM
Mann-Whitney U Test	33806.000	5467.500	30113.000
Z	-7.172	-6.360	-4.046
P-Value	0.000	0.000	0.000

Table 27: Indicator: Decision on whether and when to have children/become pregnant (men)

	BASELINE-PULSE SURVEYS	PULSE-MIDTERM SURVEYS	BASELINE-MIDTERM SURVEYS
Mann-Whitney U Test	40227.000	300126.000	21780.000
Z	-3.654	-3.738	-3.713
P-Value	0.000	0.000	0.000

Regarding Women’s Sexual Autonomy, data from the three surveys shows a reduction in men’s and boys’ positive attitudes towards women’s and girls’ access to information and services regarding sexual health and initiating sexual relations, which may be signalling a setback. However, both groups show a sharp increase in the sexual negotiation and communication indicator between the Baseline and Midterm Surveys. It seems like men and boys are more open to discussing sexual relations with women and girls, although they still have difficulties letting women and girls make their own decisions. At the aggregate level, both groups reported higher scores in the Women’s Sexual Autonomy dimension (see Figures 23 and 24).

Figure 23: Women’s Sexual Autonomy Dimension (boys, ages 15-19)

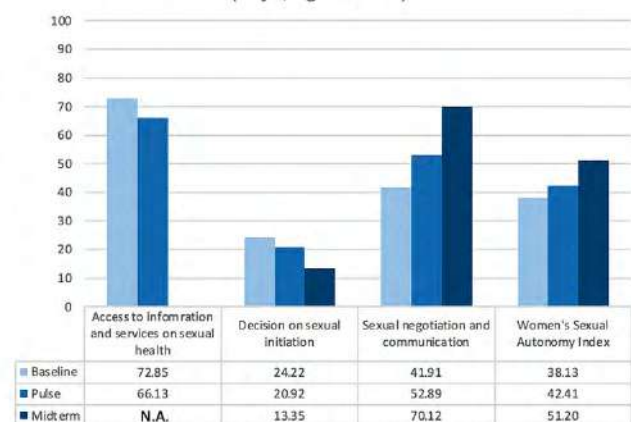
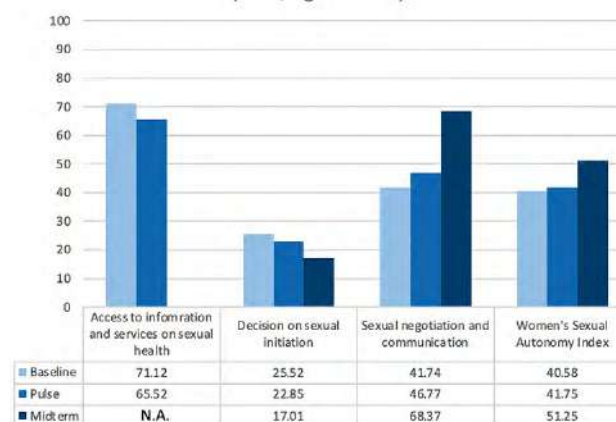


Figure 24: Women’s Sexual Autonomy Dimension (men, ages 20-49)



Regarding the Implementation of SRHR Policies Dimension, all sex-age groups showed an overall increase in positive attitudes. However, between the Baseline and Midterm Survey, both men and boys experienced a drop in the indicator related to whether it is acceptable for a girl to choose whom she marries. For all the other indicators that make up this dimension, including rejection of early marriage for girls under 18 and 16 years of age (see Figures 9 and 10), positive attitudes increased (see Figures 25 and 26). Positive results under this dimension are mainly due to higher rejection rates of early marriage and those changes are statistically significant for both groups.

Figure 25: Implementation of SRHR Policies Dimension
(boys, ages 15-19)

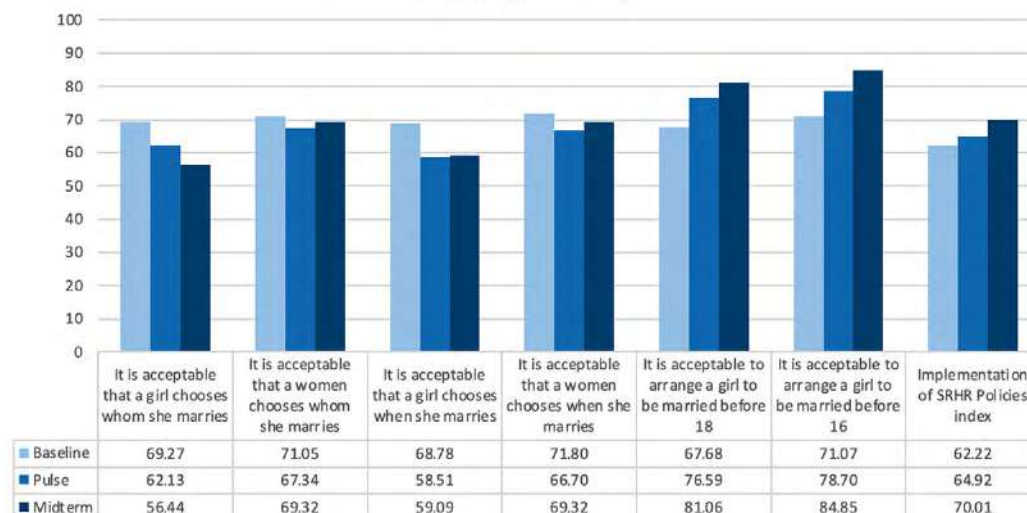
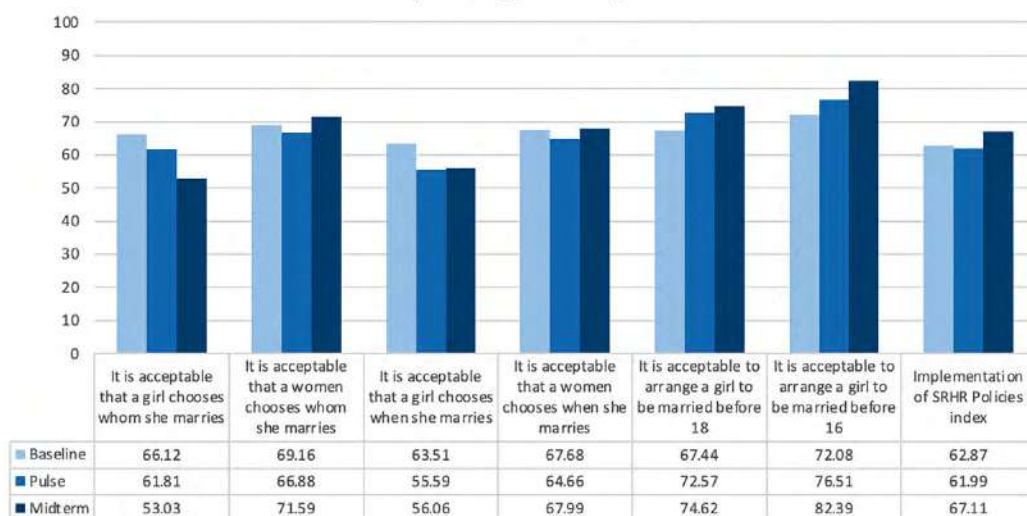


Figure 26: Implementation of SRHR Policies Dimension
(men, ages 20-49)



Although evidence is not conclusive due to the high variability of results for men and boys, there are some elements that indicate a possible setback in men’s and boys’ attitudes towards women’s reproductive and sexual autonomy that need to be taken into consideration both for programming as well as for further research: First, a sharp decrease in positive attitudes of boys and men in all indicators of the Women’s Reproductive Autonomy Dimension. Second, a drop regarding the sexual autonomy indicator of women and girls’ sexual initiation and access to information and services on sexual health, and third, regarding the Implementation of SRHR Policies Dimension, a drop in the indicator related to whether it is acceptable for a girl to choose whom she marries.

HYPOTHESIS NO 3.

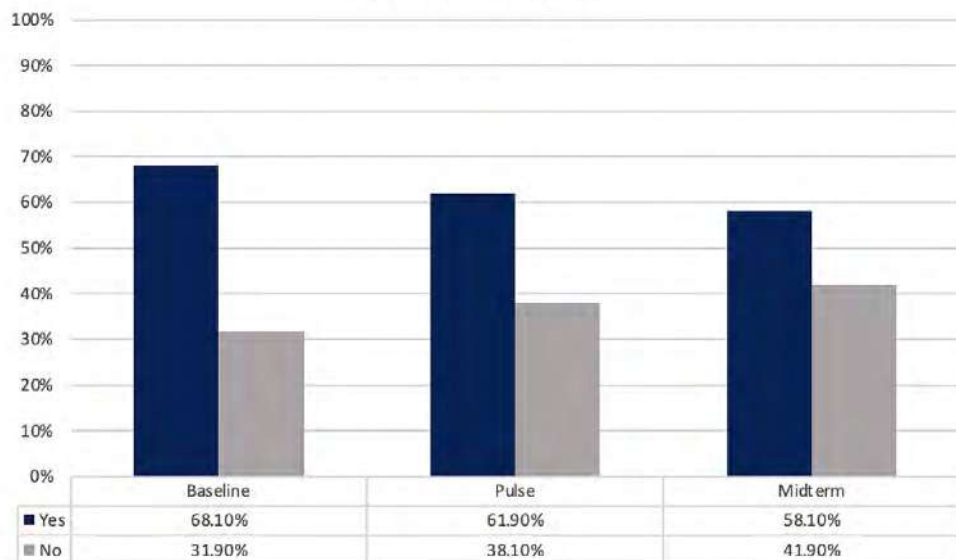
AN INCREASE IN KNOWLEDGE ABOUT FP IS LINKED TO AN INCREASE IN HEALTH-SEEKING BEHAVIOURS.

The questions about knowledge of contraceptive methods are not comparable between surveys, due to differences in the phrasing of the questions and the response options. However, descriptive data from the Midterm Survey shows that on average 71.6% of respondents have at least some basic knowledge of contraceptive methods, 22.9% have a good amount, and 5.5% felt confident about their level of knowledge on this topic.

In addition, to the question “Do you know where to obtain a family planning method?”, 72% of the respondents claimed to know where to go, compared to only 40% during the baseline. This data seems consistent with findings from the Midterm Evaluation Qualitative Component showing that awareness-raising activities like workshops were perceived by key informants from the community, partners, and health facilities as effective in changing knowledge and attitudes among community members around SRHR.

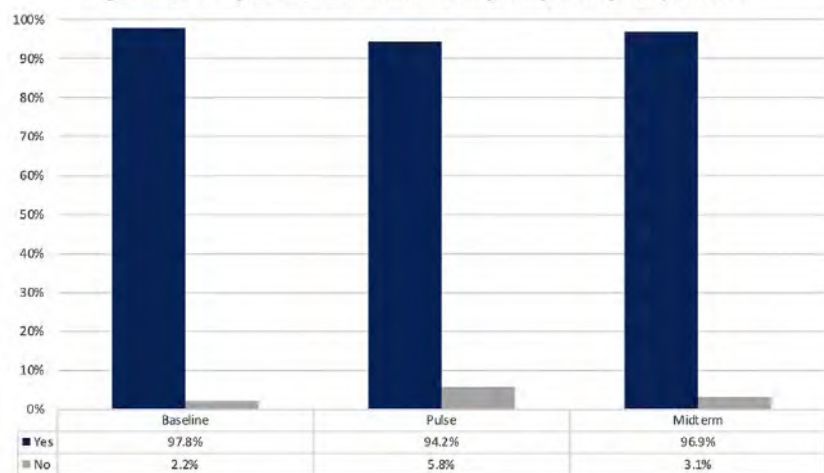
Regarding the use of contraceptive methods, data from the three surveys show that the percentage of women and girls who reported using contraceptive methods to delay or avoid pregnancy is still low, which is consistent with a historical well-documented trend in the Philippines, explained by reasons and barriers such as health concerns about the effects of contraception, the belief that they are unlikely to become pregnant, cost restrictions or lack of support from partners. Figure 27 presents the results to the question “Are you currently using a method to delay or avoid getting pregnant?” by survey. However, methodological limitations regarding sample size and statistical power limit the comparability of results between surveys.

**Figure 27: Are you currently using a method to delay or avoid getting pregnant?
(women and girls)**



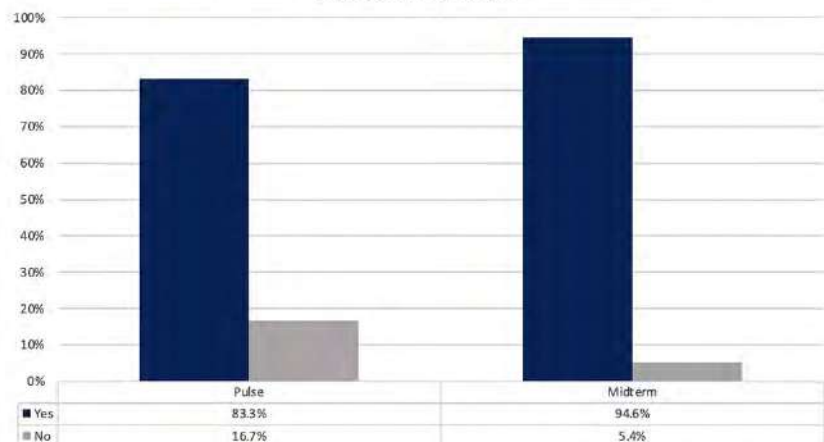
Women who reported using contraceptive methods were also asked whether this decision was taken in consultation or discussed with their partners. Between the Baseline and the Midterm Survey, the percentage of women who said they had consulted or discussed this decision with their partner decreased by less than one percentage point. Overall, no significant changes are observed in this variable (see Figure 28).

Figure 28: Did you discuss and decide jointly with your partner?



For the Pulse and Midterm Surveys, an additional question was introduced regarding whether women and their partners have ever discussed family planning together (see Figure 29). 83% of women responded “yes” during the Pulse Survey and 95% responded affirmatively during the Midterm Survey. This data seems to indicate that partners still play a critical role in women’s decision to use contraceptive methods or access family planning services. Regarding the increase in the percentage of women who answered “yes”, there are two possible explanations, both congruent with the data presented in this document: first, that Women’s Reproductive Autonomy has decreased, and second, that now men are more open to sexual communication and negotiation. Further research may be necessary.

Figure 29: Have you and your partner ever discussed family planning together?



Regarding the most-used planning methods, Figure 30 and 31 present the results reported by women respondents across the three surveys. The collected data shows that the contraceptive pill is the preferred method women use to avoid pregnancy (45%), findings from the Midterm Survey shows an increase in women’s preference for long-acting reversible contraceptives. While only 5.2% of women preferred subdermal progestin implants at the Baseline, this number increased to 18.7% at the Midterm. Similarly, the preference for IUDs increased from 3.5% to 9.3%. These methods are shown to be very effective at preventing pregnancies without requiring ongoing efforts on the part of the user, with a rapid return of fertility after the devices are removed. The Midterm Survey also found a reduction in preferences for ineffective methods, namely withdrawal, from 13.9% at the Baseline to 11.4% at the Pulse Survey. These findings, along with evidence that women are increasingly able to find their preferred contraceptive commodities locally (with women obtaining their first contraceptive methods at the Barangay Health Centre increasing from 44% at the Baseline to 77% at the Midterm) suggest improved SRHR in project areas from the Baseline to the Midterm Survey.

Figure 30: Which method are you currently using to delay or avoid getting pregnant?

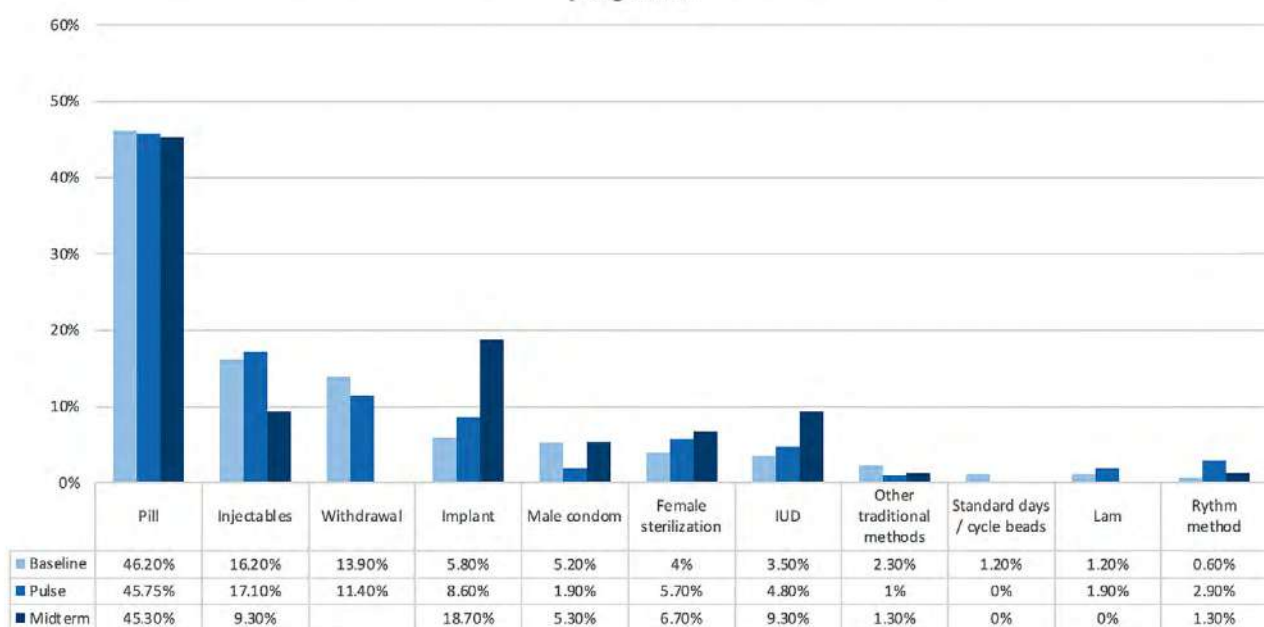
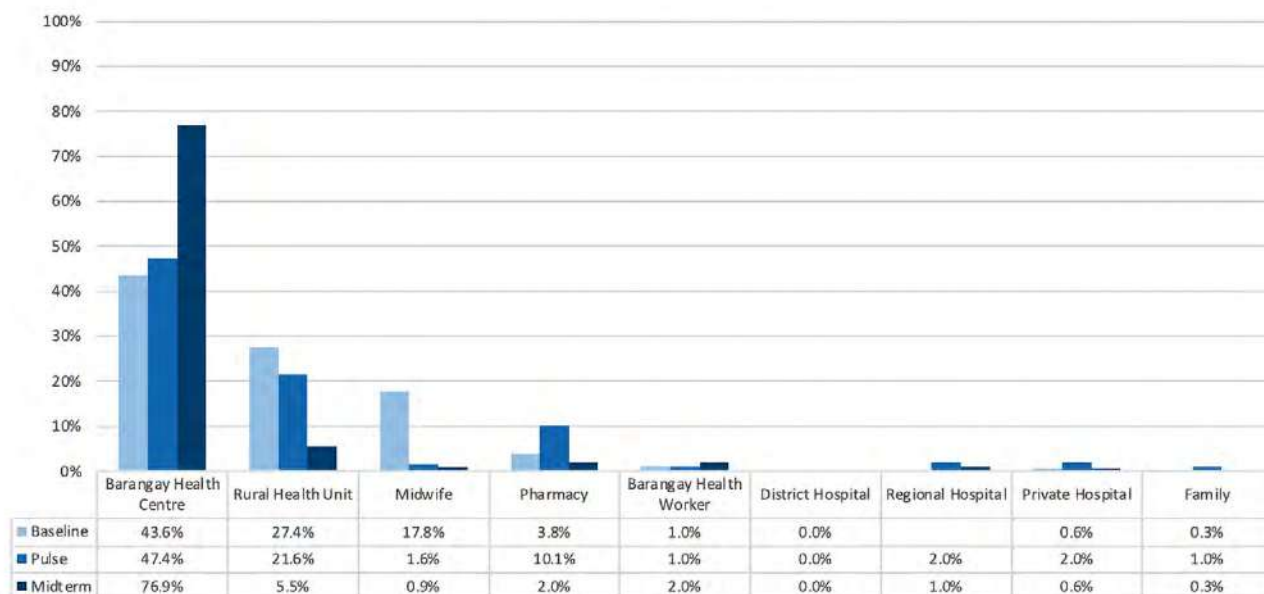


Figure 31: Where did you obtain your (most recent / current method) when you began using it?



CONCLUSIONS

The general overview is positive, particularly with regard to the increase in the overall SRHR index score for all sex-age groups; the increase in rejection of early marriage among all groups, especially among men and boys; an increase in girls’ acceptance of women’s right to use and choose contraceptives; and a more open disposition of men and boys to sexual negotiation and communication. However, there are also some issues, such as the low level of use of contraceptive methods by women and girls or a possible setback in men’s and boys’ attitudes towards Women’s Reproductive and Sexual Autonomy, that may require further research to better understand their causes and/or concrete programmatic actions to effectively address them.

Based on the available data, there does not appear to be a clear relationship between changes in attitudes towards SRHR and the occurrence or acceptability of gender-based violence in the surveyed groups. Two interpretations were identified: first, as positive attitudes towards SRHR increase, there is also an increase in the willingness to denounce GBV, which means that the relationship is positive and a higher occurrence rate does not necessarily mean an increase in actual cases, but rather the partial disclosure of what was previously a hidden figure. Second, if we interpret the GBV Index as a proxy indicator of the actual incidence of the phenomenon, then, there is a negative link with the SRHR Index scores, and in this case, as positive attitudes towards SRHR increase, there is also an increase in the occurrence of GBV, which may be a sign of a setback in men’s and boy’s attitudes and behaviour towards women’s empowerment.

In relation to the topic of who decides how many children a woman should have (a proxy indicator of Women's Reproductive Autonomy), the percentage of girls who consider this to be their own decision increased from the Pulse Survey to the Midterm Survey. Therefore, in the case of girls, evidence shows that an increase in positive attitudes towards SRHR is positively linked to an increase in the acceptance of Women's Reproductive Autonomy.

Although evidence is not conclusive due to the high variability of results for men and boys, there are some elements that indicate a possible setback in men's and boys' attitudes towards Women's Reproductive and Sexual Autonomy: 1) a sharp decrease in positive attitudes of boys and men in all indicators of the Women's Reproductive Autonomy Dimension; 2) a drop regarding the sexual autonomy indicator of women and girls' sexual initiation and access to information and services on sexual health; and, 3) regarding the Implementation of SRHR Policies Dimension, a drop in the indicator related to whether it is acceptable for a girl to choose whom she marries. This decline is tempered only by an increase in the rejection of early marriage and a greater willingness to engage in sexual negotiation and communication.

Lastly, it is important to highlight that data from this comparison shows that around 60% of the women surveyed reported using a family planning method and an increase in women's preference for long-acting reversible contraceptives and a sustained drop in preference for ineffective methods. This data also shows that the Barangay Health Centre has become the main supplier of contraceptive methods for the surveyed population.

RECOMMENDATIONS

Explore and implement alternative methods and tools, such as focus groups or anonymous interviews in safe spaces, to address the under-reporting of GBV/VAWC information in surveys and future research initiatives. It is recommended to hire experienced interviewers on this topic and provide respondents with opportunities for relaxation, debriefing, and counselling.

New questions have been introduced in the Midterm Survey to assess levels of knowledge about different contraceptive methods. It would be useful to include these questions in future Pulse and Endline Surveys to facilitate a comparative analysis of levels of knowledge. Similarly, we suggest incorporating more questions that assess knowledge about SRHR services other than family planning.

Given the evidence of reduced positive attitudes among men and boys, as shown in the SRHR Index indicators, the incorporation of questions that seek to measure the existence of negative actions or behaviours in daily life is recommended. Possible alternative questions may arise from holding workshops or focus groups directly in the communities or from a review of the forms or questionnaires used to investigate, more widely and indirectly, attitudes towards gender violence.

Enhanced project activities with health service providers and women and girls in the community to address fears, misconceptions, and barriers to the use of effective contraceptive methods.